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: 15-0104	Period: From 01/01/2019 To 12/31/2019	Worksheet S Parts I-III Date/Time Prepared: 3/31/2020 8:18 am

PART I - COST REPORT STATUS

Provider use only

1. [X] Electronically filed cost report — Date: 3/31/2020 Time: 8:18 am
2. [ ] Manually submitted cost report
3. [0] If this is an amended report enter the number of times the provider resubmitted this cost report
4. [F] Medicare Utilization. Enter "F" for full or "L" for low.

Contractor use only

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

PART II - CERTIFICATION

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

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

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by WITHAM MEMORIAL HOSPITAL (15-0104) 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) GEORGE POGAS
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	146,753	197,455	0	-227,374	1.00
2.00	Subprovider - IPF	0	6,961	-370		0	2.00
3.00	Subprovider - IRF	0	0	0		0	3.00
4.00	SUBPROVIDER I						4.00
5.00	Swing bed - SNF	0	0	0		0	5.00
6.00	Swing bed - NF	0				0	6.00
7.00	SKILLED NURSING FACILITY	0	16,903	-409		0	7.00
200.00	Total	0	170,617	196,676	0	-227,374	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: 15-0104 | Period: From 01/01/2019 To 12/31/2019 | Worksheet S-2 Part I | Date/Time Prepared: 3/31/2020 8:18 am

		1.00	2.00	3.00	4.00	
	Hospital and Hospital Health Care Complex Address:					
1.00	Street:	2605 N. LEBANON STREET	PO Box:			1.00
2.00	City:	LEBANON	State: IN	Zip Code: 46052-	County: BOONE	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	WITHAM MEMORIAL HOSPITAL	150104	26900	1	07/01/1966	N	P	O	3.00
4.00	Subprovider - IPF	WITHAM HOSPITAL GEROPSYCH	15S104	26900	4	01/01/2000	N	P	N	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	WITHAM HOSPITAL ECU	155832	26900		05/07/2015	N	P	N	9.00
10.00	Hospital-Based NF									10.00
11.00	Hospital-Based OLTC									11.00
12.00	Hospital-Based HHA									12.00
13.00	Separately Certified ASC									13.00
14.00	Hospital-Based Hospice									14.00
15.00	Hospital-Based Health Clinic - RHC									15.00
16.00	Hospital-Based Health Clinic - FQHC									16.00
17.00	Hospital-Based (CMHC) I									17.00
18.00	Renal Dialysis									18.00
19.00	Other									19.00

		From:	To:	
		1.00	2.00	
20.00	Cost Reporting Period (mm/dd/yyyy)	01/01/2019	12/31/2019	20.00
21.00	Type of Control (see instructions)	9		21.00

		1.00	2.00	3.00	
	Inpatient PPS Information				
22.00	Does this facility qualify and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.106(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no.	Y	N		22.00
22.01	Did this hospital receive interim uncompensated care payments for this cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)	Y	Y		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.	325	1,506	0	0	308	0	24.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-0104 | Period: From 01/01/2019 To 12/31/2019 | Worksheet S-2 Part I | Date/Time Prepared: 3/31/2020 8:18 am

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

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-0104 | Period: From 01/01/2019 To 12/31/2019 | Worksheet S-2 Part I | Date/Time Prepared: 3/31/2020 8:18 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)				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

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

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

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

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

		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	Y	91.00
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.		N	92.00
93.00	Does this facility operate an ICF/IID facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.	N	N	93.00
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.	N	N	94.00
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	95.00
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.	N	N	96.00
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	97.00
98.00	Does title V or XIX follow Medicare (title XVIII) for the interns and residents post stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.00
98.01	Does title V or XIX follow Medicare (title XVIII) for the reporting of charges on Wkst. C, Pt. I? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.01
98.02	Does title V or XIX follow Medicare (title XVIII) for the calculation of observation bed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.02
98.03	Does title V or XIX follow Medicare (title XVIII) for a critical access hospital (CAH) reimbursed 101% of inpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.03
98.04	Does title V or XIX follow Medicare (title XVIII) for a CAH reimbursed 101% of outpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.04
98.05	Does title V or XIX follow Medicare (title XVIII) and add back the RCE disallowance on Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.05
98.06	Does title V or XIX follow Medicare (title XVIII) when cost reimbursed for Wkst. D, Pts. I through IV? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.06
	Rural Providers			
105.00	Does this hospital qualify as a CAH?	N		105.00
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)	N		106.00
107.00	If this facility qualifies as a CAH, is it eligible for cost reimbursement for I&R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) If yes, the GME elimination is not made on Wkst. B, Pt. I, col. 25 and the program is cost reimbursed. If yes complete Wkst. D-2, Pt. II.	N		107.00
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	N		108.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-0104 | Period: From 01/01/2019 To 12/31/2019 | Worksheet S-2 Part I | Date/Time Prepared: 3/31/2020 8:18 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	N	N	N	109.00

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

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

		1.00	2.00	3.00	
	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.	2			118.00

		Premiums	Losses	Insurance	
		1.00	2.00	3.00	
118.01	List amounts of malpractice premiums and paid losses:	998,524	0	0	118.01

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-0104 | Period: From 01/01/2019 To 12/31/2019 | Worksheet S-2 Part I | Date/Time Prepared: 3/31/2020 8:18 am

		1.00	2.00	
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)	N		140.00

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

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

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

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

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

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

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

		1.00	
	Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act		
167.00	Is this provider a meaningful user under §1886(n)? Enter "Y" for yes or "N" for no.	Y	167.00
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)		168.00
168.01	If this provider is a CAH and is not a meaningful user, does this provider qualify for a hardship exception under §413.70(a)(6)(ii)? Enter "Y" for yes or "N" for no. (see instructions)		168.01
169.00	If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)	9.99	169.00

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

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

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider CCN: 15-0104	Period: From 01/01/2019 To 12/31/2019	Worksheet S-2 Part II Date/Time Prepared: 3/31/2020 8:18 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)	Y			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	05/30/2020	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	03/23/2020	Y	03/23/2020	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.	N		N		18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		N		19.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider CCN: 15-0104	Period: From 01/01/2019 To 12/31/2019	Worksheet S-2 Part II Date/Time Prepared: 3/31/2020 8:18 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?			36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.			37.00
38.00	If line 36 is yes , was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.			38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.			39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.			40.00

		1.00	2.00	
	Cost Report Preparer Contact Information			
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	TINA	SEVERS	41.00
42.00	Enter the employer/company name of the cost report preparer.	BLUE & CO., LLC		42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	317-713-7946	TSEVERS@BLUEANDCO.COM	43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider CCN: 15-0104	Period: From 01/01/2019 To 12/31/2019	Worksheet S-2 Part II Date/Time Prepared: 3/31/2020 8:18 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.	MANAGER		41.00
42.00	Enter the employer/company name of the cost report preparer.			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.			43.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 15-0104 | Period: From 01/01/2019 To 12/31/2019 | Worksheet S-3 Part I Date/Time Prepared: 3/31/2020 8:18 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	60	21,900	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)		60	21,900	0.00	0	7.00
8.00	INTENSIVE CARE UNIT	31.00	8	2,920	0.00	0	8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY	43.00				0	13.00
14.00	Total (see instructions)		68	24,820	0.00	0	14.00
15.00	CAH visits					0	15.00
16.00	SUBPROVIDER - IPF	40.00	10	3,650		0	16.00
17.00	SUBPROVIDER - IRF	41.00	0	0		0	17.00
18.00	SUBPROVIDER	42.00	0	0		0	18.00
19.00	SKILLED NURSING FACILITY	44.00	18	6,570		0	19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)	30.00					24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	26.25
27.00	Total (sum of lines 14-26)		96				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: 15-0104 | Period: From 01/01/2019 To 12/31/2019 | Worksheet S-3 Part I Date/Time Prepared: 3/31/2020 8:18 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)	2,125	317	5,428			1.00
2.00	HMO and other (see instructions)	1,350	1,725				2.00
3.00	HMO IPF Subprovider	9	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)	2,125	317	5,428			7.00
8.00	INTENSIVE CARE UNIT	781	0	1,705			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		0	1,080			13.00
14.00	Total (see instructions)	2,906	317	8,213	0.00	953.48	14.00
15.00	CAH visits	0	0	0			15.00
16.00	SUBPROVIDER - IPF	2,535	0	3,211	0.00	30.26	16.00
17.00	SUBPROVIDER - IRF	0	0	0	0.00	0.00	17.00
18.00	SUBPROVIDER		0	0	0.00	0.00	18.00
19.00	SKILLED NURSING FACILITY	3,051	0	5,125	0.00	33.26	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)			3			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	1,017.00	27.00
28.00	Observation Bed Days		0	2,058			28.00
29.00	Ambulance Trips	1,963					29.00
30.00	Employee discount days (see instruction)			163			30.00
31.00	Employee discount days - IRF			0			31.00
32.00	Labor & delivery days (see instructions)	0	97	150			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: 15-0104 | Period: From 01/01/2019 To 12/31/2019 | Worksheet S-3 Part I Date/Time Prepared: 3/31/2020 8:18 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	812	63	2,252	1.00
2.00	HMO and other (see instructions)			351	423		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	812	63	2,252	14.00
15.00	CAH visits						15.00
16.00	SUBPROVIDER - IPF	0.00	0	157	0	234	16.00
17.00	SUBPROVIDER - IRF	0.00	0	0	0	0	17.00
18.00	SUBPROVIDER	0.00	0		0	0	18.00
19.00	SKILLED NURSING FACILITY	0.00					19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)						24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0.00					26.25
27.00	Total (sum of lines 14-26)	0.00					27.00
28.00	Observation Bed Days						28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)						32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00	LTCH non-covered days			0			33.00
33.01	LTCH site neutral days and discharges			0			33.01

HOSPITAL WAGE INDEX INFORMATION	Provider CCN: 15-0104	Period: From 01/01/2019 To 12/31/2019	Worksheet S-3 Part II Date/Time Prepared: 3/31/2020 8:18 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	65,734,449	1,154,710	66,889,159	1,706,971.00	39.19	1.00
2.00	Non-physician anesthetist Part A		0	0	0	0.00	0.00	2.00
3.00	Non-physician anesthetist Part B		0	0	0	0.00	0.00	3.00
4.00	Physician-Part A - Administrative		0	0	0	0.00	0.00	4.00
4.01	Physicians - Part A - Teaching		0	0	0	0.00	0.00	4.01
5.00	Physician and Non Physician-Part B		0	0	0	0.00	0.00	5.00
6.00	Non-physician-Part B for hospital-based RHC and FQHC services		0	0	0	0.00	0.00	6.00
7.00	Interns & residents (in an approved program)	21.00	0	0	0	0.00	0.00	7.00
7.01	Contracted interns and residents (in an approved programs)		0	0	0	0.00	0.00	7.01
8.00	Home office and/or related organization personnel		0	0	0	0.00	0.00	8.00
9.00	SNF	44.00	1,042,284	22,344	1,064,628	44,099.00	24.14	9.00
10.00	Excluded area salaries (see instructions)		32,762,792	93,444	32,856,236	646,162.00	50.85	10.00
	OTHER WAGES & RELATED COSTS							
11.00	Contract labor: Direct Patient Care		1,608,250	0	1,608,250	19,577.00	82.15	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		0	0	0	0.00	0.00	14.01
14.02	Related organization salaries		0	0	0	0.00	0.00	14.02
15.00	Home office: Physician Part A - Administrative		0	0	0	0.00	0.00	15.00
16.00	Home office and Contract Physicians Part A - Teaching		0	0	0	0.00	0.00	16.00
	WAGE-RELATED COSTS							
17.00	Wage-related costs (core) (see instructions)		11,676,599	0	11,676,599			17.00
18.00	Wage-related costs (other) (see instructions)							18.00
19.00	Excluded areas		8,890,231	0	8,890,231			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)		0	0	0			25.50
25.51	Related organization wage-related (core)		0	0	0			25.51
25.52	Home office: Physician Part A - Administrative - wage-related (core)		0	0	0			25.52
25.53	Home office & Contract Physicians Part A - Teaching - wage-related (core)		0	0	0			25.53

HOSPITAL WAGE INDEX INFORMATION | Provider CCN: 15-0104 | Period: From 01/01/2019 To 12/31/2019 | Worksheet S-3 Part II Date/Time Prepared: 3/31/2020 8:18 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	
	OVERHEAD COSTS - DIRECT SALARIES							
26.00	Employee Benefits Department	4.00	34,331	0	34,331	14,289.00	2.40	26.00
27.00	Administrative & General	5.00	6,921,034	354,402	7,275,436	215,023.00	33.84	27.00
28.00	Administrative & General under contract (see inst.)		1,680,443	0	1,680,443	21,270.00	79.01	28.00
29.00	Maintenance & Repairs	6.00	0	0	0	0.00	0.00	29.00
30.00	Operation of Plant	7.00	666,851	24,463	691,314	21,920.00	31.54	30.00
31.00	Laundry & Linen Service	8.00	31,210	842	32,052	2,121.00	15.11	31.00
32.00	Housekeeping	9.00	472,740	7,621	480,361	29,609.00	16.22	32.00
33.00	Housekeeping under contract (see instructions)		0	0	0	0.00	0.00	33.00
34.00	Dietary	10.00	982,099	-129,795	852,304	40,680.00	20.95	34.00
35.00	Dietary under contract (see instructions)		0	0	0	0.00	0.00	35.00
36.00	Cafeteria	11.00	0	155,690	155,690	12,341.00	12.62	36.00
37.00	Maintenance of Personnel	12.00	0	0	0	0.00	0.00	37.00
38.00	Nursing Administration	13.00	612,959	17,659	630,618	13,398.00	47.07	38.00
39.00	Central Services and Supply	14.00	0	0	0	0.00	0.00	39.00
40.00	Pharmacy	15.00	695,146	13,583	708,729	19,808.00	35.78	40.00
41.00	Medical Records & Medical Records Library	16.00	1,329,044	36,431	1,365,475	48,860.00	27.95	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: 15-0104 | Period: From 01/01/2019 To 12/31/2019 | Worksheet S-3 Part III Date/Time Prepared: 3/31/2020 8:18 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)		67,414,892	1,154,710	68,569,602	1,728,241.00	39.68	1.00
2.00	Excluded area salaries (see instructions)		33,805,076	115,788	33,920,864	690,261.00	49.14	2.00
3.00	Subtotal salaries (line 1 minus line 2)		33,609,816	1,038,922	34,648,738	1,037,980.00	33.38	3.00
4.00	Subtotal other wages & related costs (see inst.)		1,608,250	0	1,608,250	19,577.00	82.15	4.00
5.00	Subtotal wage-related costs (see inst.)		11,676,599	0	11,676,599	0.00	33.70	5.00
6.00	Total (sum of lines 3 thru 5)		46,894,665	1,038,922	47,933,587	1,057,557.00	45.32	6.00
7.00	Total overhead cost (see instructions)		13,425,857	480,896	13,906,753	439,319.00	31.66	7.00

HOSPITAL WAGE RELATED COSTS	Provider CCN: 15-0104	Period: From 01/01/2019 To 12/31/2019	Worksheet S-3 Part IV Date/Time Prepared: 3/31/2020 8:18 am

		Amount Reported	
		1.00	
	PART IV - WAGE RELATED COSTS		
	Part A - Core List		
	RETIREMENT COST		
1.00	401K Employer Contributions	2,830,438	1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution	0	2.00
3.00	Nonqualified Defined Benefit Plan Cost (see instructions)	0	3.00
4.00	Qualified Defined Benefit Plan Cost (see instructions)	0	4.00
	PLAN ADMINISTRATIVE COSTS (Paid to External Organization)		
5.00	401K/TSA Plan Administration fees	0	5.00
6.00	Legal/Accounting/Management Fees-Pension Plan	0	6.00
7.00	Employee Managed Care Program Administration Fees	0	7.00
	HEALTH AND INSURANCE COST		
8.00	Health Insurance (Purchased or Self Funded)	0	8.00
8.01	Health Insurance (Self Funded without a Third Party Administrator)	12,003,428	8.01
8.02	Health Insurance (Self Funded with a Third Party Administrator)	0	8.02
8.03	Health Insurance (Purchased)	0	8.03
9.00	Prescription Drug Plan	1,965,942	9.00
10.00	Dental, Hearing and Vision Plan	485,058	10.00
11.00	Life Insurance (If employee is owner or beneficiary)	94,946	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)	266,451	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)	0	14.00
15.00	'Workers' Compensation Insurance	432,585	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	2,389,760	17.00
18.00	Medicare Taxes - Employers Portion Only	0	18.00
19.00	Unemployment Insurance	98,222	19.00
20.00	State or Federal Unemployment Taxes	0	20.00
	OTHER		
21.00	Executive Deferred Compensation (Other Than Retirement Cost Reported on lines 1 through 4 above. (see instructions))	0	21.00
22.00	Day Care Cost and Allowances	0	22.00
23.00	Tuition Reimbursement	0	23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)	20,566,830	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: 15-0104 | Period: From 01/01/2019 To 12/31/2019 | Worksheet S-3 Part V Date/Time Prepared: 3/31/2020 8:18 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	1,608,250	20,566,830	1.00
2.00	Hospital	1,608,250	20,566,830	2.00
3.00	Subprovider - IPF	0	0	3.00
4.00	Subprovider - IRF	0	0	4.00
5.00	Subprovider - (Other)	0	0	5.00
6.00	Swing Beds - SNF	0	0	6.00
7.00	Swing Beds - NF	0	0	7.00
8.00	Hospital-Based SNF	0	0	8.00
9.00	Hospital-Based NF			9.00
10.00	Hospital-Based OLTC			10.00
11.00	Hospital-Based HHA			11.00
12.00	Separately Certified ASC			12.00
13.00	Hospital-Based Hospice			13.00
14.00	Hospital-Based Health Clinic RHC			14.00
15.00	Hospital-Based Health Clinic FQHC			15.00
16.00	Hospital-Based-CMHC			16.00
17.00	Renal Dialysis			17.00
18.00	Other	0	0	18.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA | Provider CCN: 15-0104 | Period: From 01/01/2019 To 12/31/2019 | Worksheet S-10 | Date/Time Prepared: 3/31/2020 8:18 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)	0.196421	1.00
	Medicaid (see instructions for each line)		
2.00	Net revenue from Medicaid	-645,987	2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?		3.00
4.00	If line 3 is yes, does line 2 include all DSH and/or supplemental payments from Medicaid?		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	41,685,002	6.00
7.00	Medicaid cost (line 1 times line 6)	8,187,810	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)	8,833,797	8.00
	Children's Health Insurance Program (CHIP) (see instructions for each line)		
9.00	Net revenue from stand-alone CHIP	0	9.00
10.00	Stand-alone CHIP charges	0	10.00
11.00	Stand-alone CHIP cost (line 1 times line 10)	0	11.00
12.00	Difference between net revenue and costs for stand-alone CHIP (line 11 minus line 9; if < zero then enter zero)	0	12.00
	Other state or local government indigent care program (see instructions for each line)		
13.00	Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9)	0	13.00
14.00	Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)	0	14.00
15.00	State or local indigent care program cost (line 1 times line 14)	0	15.00
16.00	Difference between net revenue and costs for state or local indigent care program (line 15 minus line 13; if < zero then enter zero)	0	16.00
	Grants, donations and total unreimbursed cost for Medicaid, CHIP and state/local indigent care programs (see instructions for each line)		
17.00	Private grants, donations, or endowment income restricted to funding charity care	0	17.00
18.00	Government grants, appropriations or transfers for support of hospital operations	0	18.00
19.00	Total unreimbursed cost for Medicaid , CHIP and state and local indigent care programs (sum of lines 8, 12 and 16)	8,833,797	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)	4,199,369	1,719,628	5,918,997	20.00
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	824,844	1,719,628	2,544,472	21.00
22.00	Payments received from patients for amounts previously written off as charity care	0	0	0	22.00
23.00	Cost of charity care (line 21 minus line 22)	824,844	1,719,628	2,544,472	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)	9,607,393	26.00
27.00	Medicare reimbursable bad debts for the entire hospital complex (see instructions)	262,134	27.00
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)	403,284	27.01
28.00	Non-Medicare bad debt expense (see instructions)	9,204,109	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)	1,949,030	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)	4,493,502	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	13,327,299	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 15-0104 | Period: From 01/01/2019 To 12/31/2019 | Worksheet A | Date/Time Prepared: 3/31/2020 8:18 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	NEW CAP REL COSTS-BLDG & FIXT		3,091,245	3,091,245	-14,253	3,076,992	1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP		0	0	4,611,701	4,611,701	2.00
3.00	00300	OTHER CAPITAL RELATED COSTS		0	0	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	34,331	18,377,469	18,411,800	-731,434	17,680,366	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	6,921,034	17,027,320	23,948,354	-1,013,986	22,934,368	5.00
7.00	00700	OPERATION OF PLANT	666,851	3,128,007	3,794,858	-135,347	3,659,511	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	31,210	532,881	564,091	682	564,773	8.00
9.00	00900	HOUSEKEEPING	472,740	393,465	866,205	4,002	870,207	9.00
10.00	01000	DIETARY	982,099	1,085,032	2,067,131	-353,991	1,713,140	10.00
11.00	01100	CAFETERIA	0	0	0	349,470	349,470	11.00
13.00	01300	NURSING ADMINISTRATION	612,959	100,165	713,124	-26,299	686,825	13.00
15.00	01500	PHARMACY	695,146	10,425,154	11,120,300	-4,289,811	6,830,489	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,329,044	363,856	1,692,900	26,711	1,719,611	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	3,775,903	1,178,111	4,954,014	-355,007	4,599,007	30.00
31.00	03100	INTENSIVE CARE UNIT	1,318,565	566,860	1,885,425	-193,723	1,691,702	31.00
40.00	04000	SUBPROVIDER - IPF	1,120,243	148,294	1,268,537	-15,675	1,252,862	40.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	0	42.00
43.00	04300	NURSERY	0	55,910	55,910	0	55,910	43.00
44.00	04400	SKILLED NURSING FACILITY	1,042,284	598,498	1,640,782	-89,229	1,551,553	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,335,507	7,760,463	10,095,970	-6,657,141	3,438,829	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,658,570	4,374,206	6,032,776	-485,245	5,547,531	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	0	55.00
55.01	05501	ULTRA SOUND	353,589	542,971	896,560	-134,838	761,722	55.01
57.00	05700	CT SCAN	200,381	1,118,808	1,319,189	-423,458	895,731	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	340,254	733,171	1,073,425	-218,958	854,467	58.00
59.00	05900	CARDIAC CATHETERIZATION	318,990	1,990,483	2,309,473	-871,133	1,438,340	59.00
60.00	06000	LABORATORY	3,094,530	4,602,983	7,697,513	-264,058	7,433,455	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	200,237	200,237	-1,537	198,700	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
66.00	06600	PHYSICAL THERAPY	1,684,271	338,678	2,022,949	33,803	2,056,752	66.00
67.00	06700	OCCUPATIONAL THERAPY	413,334	49,795	463,129	12,089	475,218	67.00
67.01	06701	AUDIOLOGY	222,951	199,186	422,137	-5,461	416,676	67.01
68.00	06800	SPEECH PATHOLOGY	215,088	22,698	237,786	5,736	243,522	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
69.01	06901	CARDIOLOGY	1,186,464	420,448	1,606,912	-123,116	1,483,796	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	-10,328	-10,328	3,281,930	3,271,602	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	4,970,665	4,970,665	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	4,216,352	4,216,352	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	OTHER OUTPATIENT SERVICE COST CENTER	198,697	87,429	286,126	1,448	287,574	90.01
90.02	09002	CLINIC	0	0	0	0	0	90.02
90.03	09003	DERMATOLOGY CLINIC	0	2,701	2,701	0	2,701	90.03
90.04	09004	ENT CLINIC	0	0	0	0	0	90.04
90.05	09005	SURGERY CLINIC	0	1,090	1,090	-653	437	90.05
90.07	09007	UROLOGY CLINIC	0	7,940	7,940	-1,748	6,192	90.07
90.09	09009	GASTROENTEROLOGY CLINIC	227	8,723	8,950	3,013	11,963	90.09
90.11	09011	NEUROLOGY CLINIC	0	4,373	4,373	0	4,373	90.11
90.12	09012	OPTHAMOLOGY CLINIC	0	28,103	28,103	-20,627	7,476	90.12
90.13	09013	ALLERGY CLINIC	101,810	53,589	155,399	-1,232	154,167	90.13
90.14	09014	WOUND CARE	247,381	481,278	728,659	-61,360	667,299	90.14
91.00	09100	EMERGENCY	2,517,447	3,519,304	6,036,751	-568,145	5,468,606	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	2,478,576	572,216	3,050,792	-115,919	2,934,873	95.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	36,570,476	84,182,812	120,753,288	344,218	121,097,506	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	28,825,560	10,236,527	39,062,087	-341,515	38,720,572	192.00
194.00	07950	THORNTOWN OFFICE BUILDING	0	0	0	0	0	194.00
194.01	07951	CAFE/BOUTIQUE	0	0	0	0	0	194.01
194.02	07952	OTHER NONREIMB	70,919	76,004	146,923	-297	146,626	194.02
194.03	07953	RETAIL PHARMACY	267,494	1,794,786	2,062,280	-2,406	2,059,874	194.03
200.00		TOTAL (SUM OF LINES 118 through 199)	65,734,449	96,290,129	162,024,578	0	162,024,578	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 15-0104 | Period: From 01/01/2019 To 12/31/2019 | Worksheet A | Date/Time Prepared: 3/31/2020 8:18 am

		Cost Center Description	Adjustments (See A-8)	Net Expenses For Allocation	
			6.00	7.00	
		GENERAL SERVICE COST CENTERS			
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT	-891,284	2,185,708	1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP	0	4,611,701	2.00
3.00	00300	OTHER CAPITAL RELATED COSTS	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-5,538,509	12,141,857	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-7,471,821	15,462,547	5.00
7.00	00700	OPERATION OF PLANT	-104	3,659,407	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	564,773	8.00
9.00	00900	HOUSEKEEPING	0	870,207	9.00
10.00	01000	DIETARY	-351,393	1,361,747	10.00
11.00	01100	CAFETERIA	0	349,470	11.00
13.00	01300	NURSING ADMINISTRATION	0	686,825	13.00
15.00	01500	PHARMACY	0	6,830,489	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-1,368	1,718,243	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS	0	4,599,007	30.00
31.00	03100	INTENSIVE CARE UNIT	0	1,691,702	31.00
40.00	04000	SUBPROVIDER - IPF	0	1,252,862	40.00
41.00	04100	SUBPROVIDER - IRF	0	0	41.00
42.00	04200	SUBPROVIDER	0	0	42.00
43.00	04300	NURSERY	0	55,910	43.00
44.00	04400	SKILLED NURSING FACILITY	0	1,551,553	44.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	-6,088	3,432,741	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-410,462	5,137,069	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	55.00
55.01	05501	ULTRA SOUND	0	761,722	55.01
57.00	05700	CT SCAN	0	895,731	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	854,467	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	1,438,340	59.00
60.00	06000	LABORATORY	-120,000	7,313,455	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	198,700	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	64.00
66.00	06600	PHYSICAL THERAPY	0	2,056,752	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	475,218	67.00
67.01	06701	AUDIOLOGY	-261,388	155,288	67.01
68.00	06800	SPEECH PATHOLOGY	0	243,522	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	69.00
69.01	06901	CARDIOLOGY	0	1,483,796	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	-16,029	3,255,573	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	4,970,665	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	4,216,352	73.00
		OUTPATIENT SERVICE COST CENTERS			
90.00	09000	CLINIC	0	0	90.00
90.01	09001	OTHER OUTPATIENT SERVICE COST CENTER	0	287,574	90.01
90.02	09002	CLINIC	0	0	90.02
90.03	09003	DERMATOLOGY CLINIC	-2,701	0	90.03
90.04	09004	ENT CLINIC	0	0	90.04
90.05	09005	SURGERY CLINIC	-1,090	-653	90.05
90.07	09007	UROLOGY CLINIC	-7,940	-1,748	90.07
90.09	09009	GASTROENTEROLOGY CLINIC	-8,950	3,013	90.09
90.11	09011	NEUROLOGY CLINIC	-4,373	0	90.11
90.12	09012	OPTHAMOLOGY CLINIC	-28,103	-20,627	90.12
90.13	09013	ALLERGY CLINIC	0	154,167	90.13
90.14	09014	WOUND CARE	0	667,299	90.14
91.00	09100	EMERGENCY	-2,602,200	2,866,406	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)			92.00
		OTHER REIMBURSABLE COST CENTERS			
95.00	09500	AMBULANCE SERVICES	-8,838	2,926,035	95.00
		SPECIAL PURPOSE COST CENTERS			
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-17,732,641	103,364,865	118.00
		NONREIMBURSABLE COST CENTERS			
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	38,720,572	192.00
194.00	07950	THORNTOWN OFFICE BUILDING	0	0	194.00
194.01	07951	CAFE/BOUTIQUE	0	0	194.01
194.02	07952	OTHER NONREIMB	0	146,626	194.02
194.03	07953	RETAIL PHARMACY	0	2,059,874	194.03
200.00		TOTAL (SUM OF LINES 118 through 199)	-17,732,641	144,291,937	200.00

	Increases				
	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
	A - EMPLOYEE BENEFITS				
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	432,585	1.00
	TOTALS		0	432,585	
	B - INSURANCE RECLASS				
1.00	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	100,662	1.00
	TOTALS		0	100,662	
	C - CAFETERIA RECLASS				
1.00	CAFETERIA	11.00	155,690	193,780	1.00
	TOTALS		155,690	193,780	
	D - MME DEPRECIATION RECLASS				
1.00	NEW CAP REL COSTS-MVBLE EQUIP	2.00	0	4,611,701	1.00
2.00		0.00	0	0	2.00
3.00		0.00	0	0	3.00
4.00		0.00	0	0	4.00
5.00		0.00	0	0	5.00
6.00		0.00	0	0	6.00
7.00		0.00	0	0	7.00
8.00		0.00	0	0	8.00
9.00		0.00	0	0	9.00
10.00		0.00	0	0	10.00
11.00		0.00	0	0	11.00
12.00		0.00	0	0	12.00
13.00		0.00	0	0	13.00
14.00		0.00	0	0	14.00
15.00		0.00	0	0	15.00
16.00		0.00	0	0	16.00
17.00		0.00	0	0	17.00
18.00		0.00	0	0	18.00
19.00		0.00	0	0	19.00
20.00		0.00	0	0	20.00
21.00		0.00	0	0	21.00
22.00		0.00	0	0	22.00
23.00		0.00	0	0	23.00
24.00		0.00	0	0	24.00
25.00		0.00	0	0	25.00
27.00		0.00	0	0	27.00
28.00		0.00	0	0	28.00
29.00		0.00	0	0	29.00
30.00		0.00	0	0	30.00
31.00		0.00	0	0	31.00
32.00		0.00	0	0	32.00
33.00		0.00	0	0	33.00
34.00		0.00	0	0	34.00
35.00		0.00	0	0	35.00
36.00		0.00	0	0	36.00
37.00		0.00	0	0	37.00
38.00		0.00	0	0	38.00
	TOTALS		0	4,611,701	
	E - DRUGS RECLASS				
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	4,282,089	1.00
	TOTALS		0	4,282,089	
	F - MED SUPPLY IMPLANTS RECLASS				
1.00	IMPL. DEV. CHARGED TO PATIENT	72.00	0	4,970,665	1.00
2.00		0.00	0	0	2.00
3.00		0.00	0	0	3.00
4.00		0.00	0	0	4.00
5.00		0.00	0	0	5.00
6.00		0.00	0	0	6.00
7.00		0.00	0	0	7.00
	TOTALS		0	4,970,665	
	G - CHARGEABLE MED SUPPLIES RECLASS				
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	3,294,950	1.00
2.00		0.00	0	0	2.00
3.00		0.00	0	0	3.00
4.00		0.00	0	0	4.00
5.00		0.00	0	0	5.00
6.00		0.00	0	0	6.00
7.00		0.00	0	0	7.00
8.00		0.00	0	0	8.00
9.00		0.00	0	0	9.00

	Increases				
	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
10.00		0.00	0	0	10.00
11.00		0.00	0	0	11.00
12.00		0.00	0	0	12.00
13.00		0.00	0	0	13.00
14.00		0.00	0	0	14.00
15.00		0.00	0	0	15.00
16.00		0.00	0	0	16.00
17.00		0.00	0	0	17.00
18.00		0.00	0	0	18.00
19.00		0.00	0	0	19.00
20.00		0.00	0	0	20.00
21.00		0.00	0	0	21.00
22.00		0.00	0	0	22.00
23.00		0.00	0	0	23.00
24.00		0.00	0	0	24.00
25.00		0.00	0	0	25.00
26.00		0.00	0	0	26.00
27.00		0.00	0	0	27.00
28.00		0.00	0	0	28.00
29.00		0.00	0	0	29.00
30.00		0.00	0	0	30.00
	TOTALS		0	3,294,950	
	H - BONUS RECLASS				
1.00	ADMINISTRATIVE & GENERAL	5.00	354,402	0	1.00
2.00	OPERATION OF PLANT	7.00	24,463	0	2.00
3.00	LAUNDRY & LINEN SERVICE	8.00	842	0	3.00
4.00	HOUSEKEEPING	9.00	7,621	0	4.00
5.00	DIETARY	10.00	25,895	0	5.00
6.00	NURSING ADMINISTRATION	13.00	17,659	0	6.00
7.00	PHARMACY	15.00	13,583	0	7.00
8.00	MEDICAL RECORDS & LIBRARY	16.00	36,431	0	8.00
9.00	ADULTS & PEDIATRICS	30.00	97,388	0	9.00
10.00	INTENSIVE CARE UNIT	31.00	28,964	0	10.00
11.00	SUBPROVIDER - IPF	40.00	27,874	0	11.00
12.00	SKILLED NURSING FACILITY	44.00	22,344	0	12.00
13.00	OPERATING ROOM	50.00	70,883	0	13.00
14.00	RADIOLOGY-DIAGNOSTIC	54.00	59,941	0	14.00
15.00	ULTRA SOUND	55.01	5,531	0	15.00
16.00	CT SCAN	57.00	7,143	0	16.00
17.00	MAGNETIC RESONANCE IMAGING (MRI)	58.00	10,185	0	17.00
18.00	CARDIAC CATHETERIZATION	59.00	9,338	0	18.00
19.00	LABORATORY	60.00	69,567	0	19.00
20.00	PHYSICAL THERAPY	66.00	53,222	0	20.00
21.00	OCCUPATIONAL THERAPY	67.00	12,590	0	21.00
22.00	AUDIOLOGY	67.01	5,218	0	22.00
23.00	SPEECH PATHOLOGY	68.00	5,736	0	23.00
24.00	CARDIOLOGY	69.01	32,566	0	24.00
25.00	OTHER OUTPATIENT SERVICE COST CENTER	90.01	8,085	0	25.00
26.00	GASTROENTEROLOGY CLINIC	90.09	3,013	0	26.00
27.00	ALLERGY CLINIC	90.13	2,122	0	27.00
28.00	WOUND CARE	90.14	9,593	0	28.00
29.00	EMERGENCY	91.00	66,941	0	29.00
30.00	AMBULANCE SERVICES	95.00	65,570	0	30.00
	TOTALS		1,154,710	0	
500.00	Grand Total: Increases		1,310,400	17,886,432	500.00

RECLASSIFICATIONS | Provider CCN: 15-0104 | Period: From 01/01/2019 To 12/31/2019 | Worksheet A-6 | Date/Time Prepared: 3/31/2020 8:18 am

	Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.	
	6.00	7.00	8.00	9.00	10.00	
	A - EMPLOYEE BENEFITS					
1.00	ADMINISTRATIVE & GENERAL	5.00	0	432,585	0	1.00
	TOTALS		0	432,585		
	B - INSURANCE RECLASS					
1.00	ADMINISTRATIVE & GENERAL	5.00	0	100,662	12	1.00
	TOTALS		0	100,662		
	C - CAFETERIA RECLASS					
1.00	DIETARY	10.00	155,690	193,780	0	1.00
	TOTALS		155,690	193,780		
	D - MME DEPRECIATION RECLASS					
1.00	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	114,915	9	1.00
2.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	7,427	0	2.00
3.00	ADMINISTRATIVE & GENERAL	5.00	0	822,887	0	3.00
4.00	OPERATION OF PLANT	7.00	0	159,430	0	4.00
5.00	LAUNDRY & LINEN SERVICE	8.00	0	160	0	5.00
6.00	HOUSEKEEPING	9.00	0	2,958	0	6.00
7.00	DIETARY	10.00	0	30,200	0	7.00
8.00	NURSING ADMINISTRATION	13.00	0	43,958	0	8.00
9.00	PHARMACY	15.00	0	3,999	0	9.00
10.00	MEDICAL RECORDS & LIBRARY	16.00	0	9,637	0	10.00
11.00	ADULTS & PEDIATRICS	30.00	0	160,955	0	11.00
12.00	INTENSIVE CARE UNIT	31.00	0	72,135	0	12.00
13.00	SUBPROVIDER - IPF	40.00	0	12,901	0	13.00
14.00	SKILLED NURSING FACILITY	44.00	0	61,915	0	14.00
15.00	OPERATING ROOM	50.00	0	609,228	0	15.00
16.00	RADIOLOGY-DIAGNOSTIC	54.00	0	454,876	0	16.00
17.00	ULTRA SOUND	55.01	0	134,056	0	17.00
18.00	CT SCAN	57.00	0	414,608	0	18.00
19.00	MAGNETIC RESONANCE IMAGING (MRI)	58.00	0	222,574	0	19.00
20.00	CARDIAC CATHETERIZATION	59.00	0	187,439	0	20.00
21.00	LABORATORY	60.00	0	308,056	0	21.00
22.00	BLOOD STORING, PROCESSING & TRANS.	63.00	0	1,537	0	22.00
23.00	PHYSICAL THERAPY	66.00	0	18,241	0	23.00
24.00	OCCUPATIONAL THERAPY	67.00	0	483	0	24.00
25.00	AUDIOLOGY	67.01	0	10,574	0	25.00
27.00	CARDIOLOGY	69.01	0	141,192	0	27.00
28.00	OTHER OUTPATIENT SERVICE COST CENTER	90.01	0	4,667	0	28.00
29.00	SURGERY CLINIC	90.05	0	653	0	29.00
30.00	UROLOGY CLINIC	90.07	0	24	0	30.00
31.00	OPTHAMOLOGY CLINIC	90.12	0	20,627	0	31.00
32.00	ALLERGY CLINIC	90.13	0	3,221	0	32.00
33.00	WOUND CARE	90.14	0	26,085	0	33.00
34.00	EMERGENCY	91.00	0	132,730	0	34.00
35.00	AMBULANCE SERVICES	95.00	0	162,757	0	35.00
36.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	251,916	0	36.00
37.00	OTHER NONREIMB	194.02	0	297	0	37.00
38.00	RETAIL PHARMACY	194.03	0	2,383	0	38.00
	TOTALS		0	4,611,701		
	E - DRUGS RECLASS					
1.00	PHARMACY	15.00	0	4,282,089	0	1.00
	TOTALS		0	4,282,089		
	F - MED SUPPLY IMPLANTS RECLASS					
1.00	INTENSIVE CARE UNIT	31.00	0	908	0	1.00
2.00	OPERATING ROOM	50.00	0	4,158,884	0	2.00
3.00	RADIOLOGY-DIAGNOSTIC	54.00	0	41,735	0	3.00
4.00	CARDIAC CATHETERIZATION	59.00	0	675,453	0	4.00
5.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	13,020	0	5.00
6.00	DRUGS CHARGED TO PATIENTS	73.00	0	65,737	0	6.00
7.00	WOUND CARE	90.14	0	14,928	0	7.00
	TOTALS		0	4,970,665		
	G - CHARGEABLE MED SUPPLIES RECLASS					
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	1,882	0	1.00
2.00	ADMINISTRATIVE & GENERAL	5.00	0	12,254	0	2.00
3.00	OPERATION OF PLANT	7.00	0	380	0	3.00
4.00	HOUSEKEEPING	9.00	0	661	0	4.00
5.00	DIETARY	10.00	0	216	0	5.00
6.00	PHARMACY	15.00	0	17,306	0	6.00
7.00	MEDICAL RECORDS & LIBRARY	16.00	0	83	0	7.00
8.00	ADULTS & PEDIATRICS	30.00	0	291,440	0	8.00

RECLASSIFICATIONS | Provider CCN: 15-0104 | Period: From 01/01/2019 To 12/31/2019 | Worksheet A-6 | Date/Time Prepared: 3/31/2020 8:18 am

	Decreases						
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
9.00	INTENSIVE CARE UNIT	31.00	0	149,644	0		9.00
10.00	SUBPROVIDER - IPF	40.00	0	30,648	0		10.00
11.00	SKILLED NURSING FACILITY	44.00	0	49,658	0		11.00
12.00	OPERATING ROOM	50.00	0	1,959,912	0		12.00
13.00	RADIOLOGY-DIAGNOSTIC	54.00	0	48,575	0		13.00
14.00	ULTRA SOUND	55.01	0	6,313	0		14.00
15.00	CT SCAN	57.00	0	15,993	0		15.00
16.00	MAGNETIC RESONANCE IMAGING (MRI)	58.00	0	6,569	0		16.00
17.00	CARDIAC CATHETERIZATION	59.00	0	17,579	0		17.00
18.00	LABORATORY	60.00	0	25,569	0		18.00
19.00	PHYSICAL THERAPY	66.00	0	1,178	0		19.00
20.00	OCCUPATIONAL THERAPY	67.00	0	18	0		20.00
21.00	AUDIOLOGY	67.01	0	105	0		21.00
22.00	CARDIOLOGY	69.01	0	14,490	0		22.00
23.00	OTHER OUTPATIENT SERVICE COST CENTER	90.01	0	1,970	0		23.00
24.00	UROLOGY CLINIC	90.07	0	1,724	0		24.00
25.00	ALLERGY CLINIC	90.13	0	133	0		25.00
26.00	WOUND CARE	90.14	0	29,940	0		26.00
27.00	EMERGENCY	91.00	0	502,356	0		27.00
28.00	AMBULANCE SERVICES	95.00	0	18,732	0		28.00
29.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	89,599	0		29.00
30.00	RETAIL PHARMACY	194.03	0	23	0		30.00
	TOTALS		0	3,294,950			
	H - BONUS RECLASS						
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	1,154,710	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
14.00		0.00	0	0	0		14.00
15.00		0.00	0	0	0		15.00
16.00		0.00	0	0	0		16.00
17.00		0.00	0	0	0		17.00
18.00		0.00	0	0	0		18.00
19.00		0.00	0	0	0		19.00
20.00		0.00	0	0	0		20.00
21.00		0.00	0	0	0		21.00
22.00		0.00	0	0	0		22.00
23.00		0.00	0	0	0		23.00
24.00		0.00	0	0	0		24.00
25.00		0.00	0	0	0		25.00
26.00		0.00	0	0	0		26.00
27.00		0.00	0	0	0		27.00
28.00		0.00	0	0	0		28.00
29.00		0.00	0	0	0		29.00
30.00		0.00	0	0	0		30.00
	TOTALS		0	1,154,710			
500.00	Grand Total: Decreases		155,690	19,041,142			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-0104 | Period: From 01/01/2019 To 12/31/2019 | Worksheet A-7 Part I Date/Time Prepared: 3/31/2020 8:18 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	15,743,378	76,582	0	76,582	0	1.00
2.00	Land Improvements	0	0	0	0	0	2.00
3.00	Buildings and Fixtures	84,993,937	839,531	0	839,531	0	3.00
4.00	Building Improvements	0	0	0	0	0	4.00
5.00	Fixed Equipment	2,228,155	43,486	0	43,486	0	5.00
6.00	Movable Equipment	56,679,756	4,046,529	0	4,046,529	12,996	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	159,645,226	5,006,128	0	5,006,128	12,996	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	159,645,226	5,006,128	0	5,006,128	12,996	10.00

		Ending Balance	Fully Depreciated Assets	
		6.00	7.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES			
1.00	Land	15,819,960	0	1.00
2.00	Land Improvements	0	0	2.00
3.00	Buildings and Fixtures	85,833,468	0	3.00
4.00	Building Improvements	0	0	4.00
5.00	Fixed Equipment	2,271,641	0	5.00
6.00	Movable Equipment	60,713,289	0	6.00
7.00	HIT designated Assets	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	164,638,358	0	8.00
9.00	Reconciling Items	0	0	9.00
10.00	Total (line 8 minus line 9)	164,638,358	0	10.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-0104 | Period: From 01/01/2019 To 12/31/2019 | Worksheet A-7 Part II | Date/Time Prepared: 3/31/2020 8:18 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	NEW CAP REL COSTS-BLDG & FIXT	3,091,245	0	0	0	0	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	3,091,245	0	0	0	0	3.00

	Cost Center Description	SUMMARY OF CAPITAL		
		Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)	
		14.00	15.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2			
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	3,091,245	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0	2.00
3.00	Total (sum of lines 1-2)	0	3,091,245	3.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-0104 | Period: From 01/01/2019 To 12/31/2019 | Worksheet A-7 Part III Date/Time Prepared: 3/31/2020 8:18 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	NEW CAP REL COSTS-BLDG & FIXT	85,833,468	0	85,833,468	0.585707	0	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	60,713,289	0	60,713,289	0.414293	0	2.00
3.00	Total (sum of lines 1-2)	146,546,757	0	146,546,757	1.000000	0	3.00

	Cost Center Description	ALLOCATION OF OTHER CAPITAL			SUMMARY OF CAPITAL		
		Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	Depreciation	Lease	
		6.00	7.00	8.00	9.00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	0	0	2,976,330	-57,650	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0	0	4,611,701	0	2.00
3.00	Total (sum of lines 1-2)	0	0	0	7,588,031	-57,650	3.00

	Cost Center Description	SUMMARY OF CAPITAL					
		Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	NEW CAP REL COSTS-BLDG & FIXT	-833,634	100,662	0	0	2,185,708	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0	0	0	4,611,701	2.00
3.00	Total (sum of lines 1-2)	-833,634	100,662	0	0	6,797,409	3.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 15-0104 | Period: From 01/01/2019 To 12/31/2019 | Worksheet A-8 | Date/Time Prepared: 3/31/2020 8:18 am

				Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted			
	Cost Center Description	Basis/Code (2)	Amount	Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
1.00	Investment income - NEW CAP REL COSTS-BLDG & FIXT (chapter 2)		0	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	1.00
2.00	Investment income - NEW CAP REL COSTS-MVBLE EQUIP (chapter 2)		0	NEW CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
3.00	Investment income - other (chapter 2)		0		0.00	0	3.00
4.00	Trade, quantity, and time discounts (chapter 8)		0		0.00	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)		0		0.00	0	5.00
6.00	Rental of provider space by suppliers (chapter 8)		0		0.00	0	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)	B	-4,066	ADMINISTRATIVE & GENERAL	5.00	0	7.00
8.00	Television and radio service (chapter 21)		0		0.00	0	8.00
9.00	Parking lot (chapter 21)		0		0.00	0	9.00
10.00	Provider-based physician adjustment	A-8-2	-3,132,662			0	10.00
11.00	Sale of scrap, waste, etc. (chapter 23)		0		0.00	0	11.00
12.00	Related organization transactions (chapter 10)	A-8-1	0			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests	B	-288,242	DIETARY	10.00	0	14.00
15.00	Rental of quarters to employee and others		0		0.00	0	15.00
16.00	Sale of medical and surgical supplies to other than patients	B	-700	MEDICAL RECORDS & LIBRARY	16.00	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
19.01	Nursing and allied health education (tuition, fees, books, etc.)		0		0.00	0	19.01
20.00	Vending machines	B	-2,049	DIETARY	10.00	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	*** Cost Center Deleted ***	65.00		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	PHYSICAL THERAPY	66.00		24.00
25.00	Utilization review - physicians' compensation (chapter 21)		0	*** Cost Center Deleted ***	114.00		25.00
26.00	Depreciation - NEW CAP REL COSTS-BLDG & FIXT		0	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
27.00	Depreciation - NEW CAP REL COSTS-MVBLE EQUIP		0	NEW CAP REL COSTS-MVBLE EQUIP	2.00	0	27.00
28.00	Non-physician Anesthetist		0	*** Cost Center Deleted ***	19.00		28.00
29.00	Physicians' assistant		0		0.00	0	29.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 15-0104 | Period: From 01/01/2019 To 12/31/2019 | Worksheet A-8 | Date/Time Prepared: 3/31/2020 8:18 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	
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	OCCUPATIONAL THERAPY	67.00		30.00
30.99	Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS	30.00		30.99
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	SPEECH PATHOLOGY	68.00		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest		0		0.00	0	32.00
33.00	HOSPITAL ADMINISTRAT SPONSORSHIPS/DO	A	-31,775	ADMINISTRATIVE & GENERAL	5.00	0	33.00
33.01	LEASE INCOME	B	-43,200	NEW CAP REL COSTS-BLDG & FIXT	1.00	10	33.01
33.02	WELLNESS REVENUE	B	-55,220	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.02
33.03	EDUCATION REVENUE	B	-2,570	ADMINISTRATIVE & GENERAL	5.00	0	33.03
33.04	MEDICAL STAFF FEES	B	-4,640	ADMINISTRATIVE & GENERAL	5.00	0	33.04
33.05	VOLUNTEER MISC REVENUE	B	-13,529	ADMINISTRATIVE & GENERAL	5.00	0	33.05
33.06	CASH (SHORT) OVER	B	437	ADMINISTRATIVE & GENERAL	5.00	0	33.06
33.07	MISC INCOME RECEIVED	B	-17,323	ADMINISTRATIVE & GENERAL	5.00	0	33.07
33.08	PLANT OPERATIONS	B	-104	OPERATION OF PLANT	7.00	0	33.08
33.09	MEALS ON WHEELS	B	-47,139	DIETARY	10.00	0	33.09
33.10	HEAD START	B	-10,113	DIETARY	10.00	0	33.10
33.11	AMBULANCE REV	B	-8,838	AMBULANCE SERVICES	95.00	0	33.11
33.12	CENTRAL SUPPLY	B	-3,063	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	33.12
33.13	CICOA MEAL VOUCHERS	B	-3,850	DIETARY	10.00	0	33.13
33.14	MEDICAL RECORDS	B	-668	MEDICAL RECORDS & LIBRARY	16.00	0	33.14
33.15	CENTRAL SUPPLY PURCHASING DISCOUNTS	B	-12,966	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	33.15
33.16	BANK FEES	A	-6,088	OPERATING ROOM	50.00	0	33.16
33.17	DERMATOLOGY CLINIC RENT	A	-2,701	DERMATOLOGY CLINIC	90.03	0	33.17
33.18	SURGERY CLINIC RENT	A	-1,090	SURGERY CLINIC	90.05	0	33.18
33.19	UROLOGY CLINIC RENT	A	-7,940	UROLOGY CLINIC	90.07	0	33.19
33.20	GASTROENTEROLOGY CLINIC RENT	A	-8,950	GASTROENTEROLOGY CLINIC	90.09	0	33.20
33.21	NEUROLOGY CLINIC RENT	A	-4,373	NEUROLOGY CLINIC	90.11	0	33.21
33.22	EYE INSTITUTE RENT	A	-28,103	OPTHAMOLOGY CLINIC	90.12	0	33.22
33.23	2015 BOND INTEREST ON INVEST	B	-61,585	NEW CAP REL COSTS-BLDG & FIXT	1.00	11	33.23
33.24	INTEREST INCOME - UNNECESSARY BORROW	B	-96,404	NEW CAP REL COSTS-BLDG & FIXT	1.00	11	33.24
33.25	GAIN ON INVESTMENT	B	-652,601	NEW CAP REL COSTS-BLDG & FIXT	1.00	11	33.25
33.26	VOLUNTEER REVENUE INTEREST	B	-160	ADMINISTRATIVE & GENERAL	5.00	0	33.26
33.27	GAIN/(LOSS) CIHA	A	-213,200	ADMINISTRATIVE & GENERAL	5.00	0	33.27
33.28	GAIN/(LOSS) SHO SPC	B	90,748	ADMINISTRATIVE & GENERAL	5.00	0	33.28
33.29	GAIN/(LOSS) SHO RRG	B	-42,178	ADMINISTRATIVE & GENERAL	5.00	0	33.29
33.30	HEARING AID COSTS	A	-261,388	AUDIOLOGY	67.01	0	33.30
33.31	BANK FEES	A	-434,143	ADMINISTRATIVE & GENERAL	5.00	0	33.31
33.32	LOBBYING EXPENSE-IHA DUES	A	-2,704	ADMINISTRATIVE & GENERAL	5.00	0	33.32
33.33	LOBBYING EXPENSE-AHA DUES	A	-4,516	ADMINISTRATIVE & GENERAL	5.00	0	33.33
33.34	NON-REIMBURSABLE ADVERTISING COSTS	A	-228,187	ADMINISTRATIVE & GENERAL	5.00	0	33.34
33.35	SELF INSURANCE CLAIMS PAID	B	-5,483,289	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.35
33.36	HAF FEE	A	-6,439,643	ADMINISTRATIVE & GENERAL	5.00	0	33.36
33.37	EMPLOYEE HEALTH REV CLIENT	B	-124,372	ADMINISTRATIVE & GENERAL	5.00	0	33.37
33.38	2017 BOND INTEREST ON INVESTMENT	B	-23,044	NEW CAP REL COSTS-BLDG & FIXT	1.00	11	33.38
33.39	1208 N LEBANON RENTAL INCOME	B	-14,450	NEW CAP REL COSTS-BLDG & FIXT	1.00	10	33.39
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-17,732,641				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.

ADJUSTMENTS TO EXPENSES	Provider CCN: 15-0104	Period: From 01/01/2019 To 12/31/2019	Worksheet A-8 Date/Time Prepared: 3/31/2020 8:18 am

			Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted			
Cost Center Description	Basis/Code (2)	Amount	Cost Center	Line #	Wkst. A-7 Ref.	
	1.00	2.00	3.00	4.00	5.00	

B. Amount Received - if cost cannot be determined.
(3) Additional adjustments may be made on lines 33 thru 49 and subscripts thereof.
Note: See instructions for column 5 referencing to Worksheet A-7.

PROVIDER BASED PHYSICIAN ADJUSTMENT | Provider CCN: 15-0104 | Period: From 01/01/2019 To 12/31/2019 | Worksheet A-8-2 | Date/Time Prepared: 3/31/2020 8:18 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	0.00		0	0	0	0	0	1.00
2.00	54.00	RADIOLOGY-DIAGNOSTIC	410,462	410,462	0	0	0	2.00
3.00	60.00	LABORATORY	120,000	120,000	0	0	0	3.00
4.00	91.00	EMERGENCY	2,602,200	2,602,200	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			3,132,662	3,132,662	0		0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	0.00		0	0	0	0	0	1.00
2.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	2.00
3.00	60.00	LABORATORY	0	0	0	0	0	3.00
4.00	91.00	EMERGENCY	0	0	0	0	0	4.00
5.00	0.00		0	0	0	0	0	5.00
6.00	0.00		0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			0	0	0	0	0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment		
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00	0.00		0	0	0	0		1.00
2.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	410,462		2.00
3.00	60.00	LABORATORY	0	0	0	120,000		3.00
4.00	91.00	EMERGENCY	0	0	0	2,602,200		4.00
5.00	0.00		0	0	0	0		5.00
6.00	0.00		0	0	0	0		6.00
7.00	0.00		0	0	0	0		7.00
8.00	0.00		0	0	0	0		8.00
9.00	0.00		0	0	0	0		9.00
10.00	0.00		0	0	0	0		10.00
200.00			0	0	0	3,132,662		200.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-0104 | Period: From 01/01/2019 To 12/31/2019 | Worksheet B Part I | Date/Time Prepared: 3/31/2020 8:18 am

		Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
				NEW BLDG & FIXT	NEW MVBLE EQUIP			
			0	1.00	2.00	4.00	4A	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT	2,185,708	2,185,708				1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP	4,611,701		4,611,701			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	12,141,857	4,971	10,488	12,157,316		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	15,462,547	158,863	335,191	1,323,009	17,279,610	5.00
7.00	00700	OPERATION OF PLANT	3,659,407	208,128	439,136	125,713	4,432,384	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	564,773	0	0	5,829	570,602	8.00
9.00	00900	HOUSEKEEPING	870,207	23,966	50,567	87,352	1,032,092	9.00
10.00	01000	DIETARY	1,361,747	53,646	113,190	154,988	1,683,571	10.00
11.00	01100	CAFETERIA	349,470	0	0	28,312	377,782	11.00
13.00	01300	NURSING ADMINISTRATION	686,825	0	0	114,675	801,500	13.00
15.00	01500	PHARMACY	6,830,489	16,561	34,943	128,880	7,010,873	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,718,243	26,161	55,198	248,306	2,047,908	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	4,599,007	174,006	367,142	704,342	5,844,497	30.00
31.00	03100	INTENSIVE CARE UNIT	1,691,702	47,787	100,828	245,043	2,085,360	31.00
40.00	04000	SUBPROVIDER - IPF	1,252,862	54,714	115,443	208,780	1,631,799	40.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	0	42.00
43.00	04300	NURSERY	55,910	0	0	0	55,910	43.00
44.00	04400	SKILLED NURSING FACILITY	1,551,553	41,433	87,420	193,598	1,874,004	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	3,432,741	138,877	293,022	437,592	4,302,232	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	5,137,069	169,847	358,366	312,504	5,977,786	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	0	55.00
55.01	05501	ULTRA SOUND	761,722	0	0	65,305	827,027	55.01
57.00	05700	CT SCAN	895,731	0	0	37,737	933,468	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	854,467	14,571	30,744	63,726	963,508	58.00
59.00	05900	CARDIAC CATHETERIZATION	1,438,340	12,282	25,914	59,705	1,536,241	59.00
60.00	06000	LABORATORY	7,313,455	79,209	167,127	575,378	8,135,169	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	198,700	0	0	0	198,700	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
66.00	06600	PHYSICAL THERAPY	2,056,752	76,664	161,757	315,956	2,611,129	66.00
67.00	06700	OCCUPATIONAL THERAPY	475,218	0	0	77,453	552,671	67.00
67.01	06701	AUDIOLOGY	155,288	0	0	41,492	196,780	67.01
68.00	06800	SPEECH PATHOLOGY	243,522	0	0	40,156	283,678	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
69.01	06901	CARDIOLOGY	1,483,796	7,900	16,669	221,676	1,730,041	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	3,255,573	0	0	0	3,255,573	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	4,970,665	0	0	0	4,970,665	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	4,216,352	0	0	0	4,216,352	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	OTHER OUTPATIENT SERVICE COST CENTER	287,574	32,644	68,876	37,602	426,696	90.01
90.02	09002	CLINIC	0	0	0	0	0	90.02
90.03	09003	DERMATOLOGY CLINIC	0	0	0	0	0	90.03
90.04	09004	ENT CLINIC	0	0	0	0	0	90.04
90.05	09005	SURGERY CLINIC	-653	0	0	0	-653	90.05
90.07	09007	UROLOGY CLINIC	-1,748	0	0	0	-1,748	90.07
90.09	09009	GASTROENTEROLOGY CLINIC	3,013	0	0	589	3,602	90.09
90.11	09011	NEUROLOGY CLINIC	0	0	0	0	0	90.11
90.12	09012	OPTHAMOLOGY CLINIC	-20,627	0	0	0	-20,627	90.12
90.13	09013	ALLERGY CLINIC	154,167	0	0	18,900	173,067	90.13
90.14	09014	WOUND CARE	667,299	29,928	63,146	46,730	807,103	90.14
91.00	09100	EMERGENCY	2,866,406	209,819	442,704	469,961	3,988,890	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	2,926,035	40,655	85,780	462,643	3,515,113	95.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	103,364,865	1,622,632	3,423,651	6,853,932	96,310,355	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	5,330	11,245	0	16,575	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	38,720,572	366,769	773,855	5,241,845	45,103,041	192.00
194.00	07950	THORNTOWN OFFICE BUILDING	0	0	0	0	0	194.00
194.01	07951	CAFE/BOUTIQUE	0	12,094	25,518	0	37,612	194.01
194.02	07952	OTHER NONREIMB	146,626	175,467	370,224	12,896	705,213	194.02
194.03	07953	RETAIL PHARMACY	2,059,874	3,416	7,208	48,643	2,119,141	194.03
200.00		Cross Foot Adjustments					0	200.00
201.00		Negative Cost Centers		0	0	0	0	201.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 15-0104

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

Worksheet B Part I

Date/Time Prepared: 3/31/2020 8:18 am

	Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
			NEW BLDG & FIXT	NEW MVBLE EQUIP			
		0	1.00	2.00	4.00	4A	
202.00	TOTAL (sum lines 118 through 201)	144,291,937	2,185,708	4,611,701	12,157,316	144,291,937	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-0104 | Period: From 01/01/2019 To 12/31/2019 | Worksheet B Part I | Date/Time Prepared: 3/31/2020 8:18 am

		Cost Center Description	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
			5.00	7.00	8.00	9.00	10.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	17,279,610					5.00
7.00	00700	OPERATION OF PLANT	602,902	5,035,286				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	77,614	0	648,216			8.00
9.00	00900	HOUSEKEEPING	140,387	76,866	0	1,249,345		9.00
10.00	01000	DIETARY	229,003	172,059	0	83,368	2,168,001	10.00
11.00	01100	CAFETERIA	51,387	0	0	27,796	0	11.00
13.00	01300	NURSING ADMINISTRATION	109,022	0	0	12,569	0	13.00
15.00	01500	PHARMACY	953,633	53,116	0	25,379	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	278,561	83,906	0	55,592	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	794,980	558,088	33,783	422,313	884,446	30.00
31.00	03100	INTENSIVE CARE UNIT	283,655	153,267	7,673	112,150	0	31.00
40.00	04000	SUBPROVIDER - IPF	221,961	175,483	6,368	133,362	494,421	40.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	0	42.00
43.00	04300	NURSERY	7,605	0	3,181	0	0	43.00
44.00	04400	SKILLED NURSING FACILITY	254,906	132,886	4,680	0	789,134	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	585,198	445,419	83,054	24,895	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	813,110	544,748	54,311	112,634	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	0	55.00
55.01	05501	ULTRA SOUND	112,494	0	14,421	7,251	0	55.01
57.00	05700	CT SCAN	126,972	0	71,685	11,118	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	131,058	46,733	26,888	10,635	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	208,963	39,392	27,904	0	0	59.00
60.00	06000	LABORATORY	1,106,562	254,048	92,314	47,616	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	27,028	0	1,757	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	5,352	0	0	64.00
66.00	06600	PHYSICAL THERAPY	355,171	245,884	13,061	17,161	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	75,175	0	5,853	8,218	0	67.00
67.01	06701	AUDIOLOGY	26,766	0	1,497	6,043	0	67.01
68.00	06800	SPEECH PATHOLOGY	38,586	0	1,823	3,626	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
69.01	06901	CARDIOLOGY	235,324	25,339	25,290	36,497	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	442,830	0	14,080	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	676,120	0	24,363	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	573,517	0	62,413	26,346	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	OTHER OUTPATIENT SERVICE COST CENTER	58,040	104,698	0	64,776	0	90.01
90.02	09002	CLINIC	0	0	0	0	0	90.02
90.03	09003	DERMATOLOGY CLINIC	0	0	0	0	0	90.03
90.04	09004	ENT CLINIC	0	0	0	0	0	90.04
90.05	09005	SURGERY CLINIC	0	0	0	0	0	90.05
90.07	09007	UROLOGY CLINIC	0	0	248	0	0	90.07
90.09	09009	GASTROENTEROLOGY CLINIC	490	0	0	0	0	90.09
90.11	09011	NEUROLOGY CLINIC	0	0	0	0	0	90.11
90.12	09012	OPTHAMOLOGY CLINIC	0	0	0	0	0	90.12
90.13	09013	ALLERGY CLINIC	23,541	0	1,139	0	0	90.13
90.14	09014	WOUND CARE	109,784	95,987	8,095	0	0	90.14
91.00	09100	EMERGENCY	542,577	672,949	50,018	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	478,133	48,213	6,965	0	0	95.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	10,753,055	3,929,081	648,216	1,249,345	2,168,001	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	2,255	17,094	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	6,135,010	1,039,365	0	0	0	192.00
194.00	07950	THORNTOWN OFFICE BUILDING	0	0	0	0	0	194.00
194.01	07951	CAFE/BOUTIQUE	5,116	38,789	0	0	0	194.01
194.02	07952	OTHER NONREIMB	95,924	0	0	0	0	194.02
194.03	07953	RETAIL PHARMACY	288,250	10,957	0	0	0	194.03
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)	17,279,610	5,035,286	648,216	1,249,345	2,168,001	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-0104 | Period: From 01/01/2019 To 12/31/2019 | Worksheet B Part I Date/Time Prepared: 3/31/2020 8:18 am

		Cost Center Description	CAFETERIA	NURSING ADMINISTRATION	PHARMACY	MEDICAL RECORDS & LIBRARY	Subtotal	
			11.00	13.00	15.00	16.00	24.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA	456,965					11.00
13.00	01300	NURSING ADMINISTRATION	8,841	931,932				13.00
15.00	01500	PHARMACY	17,683	0	8,060,684			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	35,831	0	0	2,501,798		16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	120,525	212,251	1,082	614,799	9,486,764	30.00
31.00	03100	INTENSIVE CARE UNIT	9,772	71,469	86	127,829	2,851,261	31.00
40.00	04000	SUBPROVIDER - IPF	15,356	72,246	101	152,177	2,903,274	40.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	0	42.00
43.00	04300	NURSERY	0	0	0	0	66,696	43.00
44.00	04400	SKILLED NURSING FACILITY	0	80,214	6,227	0	3,142,051	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	10,703	140,354	41,606	220,657	5,854,118	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	13,030	0	4,684	590,449	8,110,752	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	2,317	0	2,317	55.00
55.01	05501	ULTRA SOUND	1,396	0	0	63,915	1,026,504	55.01
57.00	05700	CT SCAN	1,861	0	1,757	73,045	1,219,906	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	4,653	0	4,521	39,566	1,227,562	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	16,636	16	0	1,829,152	59.00
60.00	06000	LABORATORY	38,158	0	249	60,871	9,734,987	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	227,485	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	5,352	64.00
66.00	06600	PHYSICAL THERAPY	19,079	62,830	4,431	118,698	3,447,444	66.00
67.00	06700	OCCUPATIONAL THERAPY	7,911	20,668	0	51,740	722,236	67.00
67.01	06701	AUDIOLOGY	8,376	14,554	0	0	254,016	67.01
68.00	06800	SPEECH PATHOLOGY	8,841	11,008	0	0	347,562	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
69.01	06901	CARDIOLOGY	19,079	66,060	298	114,133	2,252,061	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	9,772	0	0	0	3,722,255	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	5,671,148	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	4,878,628	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	97	0	97	90.00
90.01	09001	OTHER OUTPATIENT SERVICE COST CENTER	15,822	11,653	0	255,658	937,343	90.01
90.02	09002	CLINIC	0	0	0	0	0	90.02
90.03	09003	DERMATOLOGY CLINIC	0	0	0	0	0	90.03
90.04	09004	ENT CLINIC	0	0	0	0	0	90.04
90.05	09005	SURGERY CLINIC	0	0	266	0	-387	90.05
90.07	09007	UROLOGY CLINIC	0	0	961	0	-539	90.07
90.09	09009	GASTROENTEROLOGY CLINIC	0	9,630	0	0	13,722	90.09
90.11	09011	NEUROLOGY CLINIC	0	0	8,462	0	8,462	90.11
90.12	09012	OPTHAMOLOGY CLINIC	0	0	0	0	-20,627	90.12
90.13	09013	ALLERGY CLINIC	0	5,984	20,162	0	223,893	90.13
90.14	09014	WOUND CARE	0	16,037	20,219	0	1,057,225	90.14
91.00	09100	EMERGENCY	29,782	113,341	74,654	0	5,472,211	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	60,494	0	17,690	0	4,126,608	95.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	456,965	924,935	209,886	2,483,537	80,801,539	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	0	0	0	35,924	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	3,026	4,675,474	18,261	56,974,177	192.00
194.00	07950	THORNTOWN OFFICE BUILDING	0	0	0	0	0	194.00
194.01	07951	CAFE/BOUTIQUE	0	0	0	0	81,517	194.01
194.02	07952	OTHER NONREIMB	0	3,971	0	0	805,108	194.02
194.03	07953	RETAIL PHARMACY	0	0	3,175,324	0	5,593,672	194.03
200.00		Cross Foot Adjustments					0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	456,965	931,932	8,060,684	2,501,798	144,291,937	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-0104 | Period: From 01/01/2019 To 12/31/2019 | Worksheet B Part I | Date/Time Prepared: 3/31/2020 8:18 am

		Cost Center Description	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			25.00	26.00	
		GENERAL SERVICE COST CENTERS			
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT			1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT			4.00
5.00	00500	ADMINISTRATIVE & GENERAL			5.00
7.00	00700	OPERATION OF PLANT			7.00
8.00	00800	LAUNDRY & LINEN SERVICE			8.00
9.00	00900	HOUSEKEEPING			9.00
10.00	01000	DIETARY			10.00
11.00	01100	CAFETERIA			11.00
13.00	01300	NURSING ADMINISTRATION			13.00
15.00	01500	PHARMACY			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY			16.00
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS	0	9,486,764	30.00
31.00	03100	INTENSIVE CARE UNIT	0	2,851,261	31.00
40.00	04000	SUBPROVIDER - IPF	0	2,903,274	40.00
41.00	04100	SUBPROVIDER - IRF	0	0	41.00
42.00	04200	SUBPROVIDER	0	0	42.00
43.00	04300	NURSERY	0	66,696	43.00
44.00	04400	SKILLED NURSING FACILITY	0	3,142,051	44.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0	5,854,118	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	8,110,752	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	2,317	55.00
55.01	05501	ULTRA SOUND	0	1,026,504	55.01
57.00	05700	CT SCAN	0	1,219,906	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	1,227,562	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	1,829,152	59.00
60.00	06000	LABORATORY	0	9,734,987	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	227,485	63.00
64.00	06400	INTRAVENOUS THERAPY	0	5,352	64.00
66.00	06600	PHYSICAL THERAPY	0	3,447,444	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	722,236	67.00
67.01	06701	AUDIOLOGY	0	254,016	67.01
68.00	06800	SPEECH PATHOLOGY	0	347,562	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	69.00
69.01	06901	CARDIOLOGY	0	2,252,061	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	3,722,255	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	5,671,148	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	4,878,628	73.00
		OUTPATIENT SERVICE COST CENTERS			
90.00	09000	CLINIC	0	97	90.00
90.01	09001	OTHER OUTPATIENT SERVICE COST CENTER	0	937,343	90.01
90.02	09002	CLINIC	0	0	90.02
90.03	09003	DERMATOLOGY CLINIC	0	0	90.03
90.04	09004	ENT CLINIC	0	0	90.04
90.05	09005	SURGERY CLINIC	0	-387	90.05
90.07	09007	UROLOGY CLINIC	0	-539	90.07
90.09	09009	GASTROENTEROLOGY CLINIC	0	13,722	90.09
90.11	09011	NEUROLOGY CLINIC	0	8,462	90.11
90.12	09012	OPTHAMOLOGY CLINIC	0	-20,627	90.12
90.13	09013	ALLERGY CLINIC	0	223,893	90.13
90.14	09014	WOUND CARE	0	1,057,225	90.14
91.00	09100	EMERGENCY	0	5,472,211	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0		92.00
		OTHER REIMBURSABLE COST CENTERS			
95.00	09500	AMBULANCE SERVICES	0	4,126,608	95.00
		SPECIAL PURPOSE COST CENTERS			
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	80,801,539	118.00
		NONREIMBURSABLE COST CENTERS			
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	35,924	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	56,974,177	192.00
194.00	07950	THORNTOWN OFFICE BUILDING	0	0	194.00
194.01	07951	CAFE/BOUTIQUE	0	81,517	194.01
194.02	07952	OTHER NONREIMB	0	805,108	194.02
194.03	07953	RETAIL PHARMACY	0	5,593,672	194.03
200.00		Cross Foot Adjustments	0	0	200.00
201.00		Negative Cost Centers	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	0	144,291,937	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-0104 | Period: From 01/01/2019 To 12/31/2019 | Worksheet B Part II | Date/Time Prepared: 3/31/2020 8:18 am

		Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
				NEW BLDG & FIXT	NEW MVBLE EQUIP			
			0	1.00	2.00	2A	4.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	4,971	10,488	15,459	15,459	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	0	158,863	335,191	494,054	1,681	5.00
7.00	00700	OPERATION OF PLANT	0	208,128	439,136	647,264	160	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0	0	7	8.00
9.00	00900	HOUSEKEEPING	0	23,966	50,567	74,533	111	9.00
10.00	01000	DIETARY	0	53,646	113,190	166,836	197	10.00
11.00	01100	CAFETERIA	0	0	0	0	36	11.00
13.00	01300	NURSING ADMINISTRATION	0	0	0	0	146	13.00
15.00	01500	PHARMACY	0	16,561	34,943	51,504	164	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	26,161	55,198	81,359	315	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	174,006	367,142	541,148	895	30.00
31.00	03100	INTENSIVE CARE UNIT	0	47,787	100,828	148,615	311	31.00
40.00	04000	SUBPROVIDER - IPF	0	54,714	115,443	170,157	265	40.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	0	42.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
44.00	04400	SKILLED NURSING FACILITY	0	41,433	87,420	128,853	246	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	138,877	293,022	431,899	556	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	169,847	358,366	528,213	397	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	0	55.00
55.01	05501	ULTRA SOUND	0	0	0	0	83	55.01
57.00	05700	CT SCAN	0	0	0	0	48	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	14,571	30,744	45,315	81	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	12,282	25,914	38,196	76	59.00
60.00	06000	LABORATORY	0	79,209	167,127	246,336	731	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
66.00	06600	PHYSICAL THERAPY	0	76,664	161,757	238,421	401	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	98	67.00
67.01	06701	AUDIOLOGY	0	0	0	0	53	67.01
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	51	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
69.01	06901	CARDIOLOGY	0	7,900	16,669	24,569	282	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	OTHER OUTPATIENT SERVICE COST CENTER	0	32,644	68,876	101,520	48	90.01
90.02	09002	CLINIC	0	0	0	0	0	90.02
90.03	09003	DERMATOLOGY CLINIC	0	0	0	0	0	90.03
90.04	09004	ENT CLINIC	0	0	0	0	0	90.04
90.05	09005	SURGERY CLINIC	0	0	0	0	0	90.05
90.07	09007	UROLOGY CLINIC	0	0	0	0	0	90.07
90.09	09009	GASTROENTEROLOGY CLINIC	0	0	0	0	1	90.09
90.11	09011	NEUROLOGY CLINIC	0	0	0	0	0	90.11
90.12	09012	OPTHAMOLOGY CLINIC	0	0	0	0	0	90.12
90.13	09013	ALLERGY CLINIC	0	0	0	0	24	90.13
90.14	09014	WOUND CARE	0	29,928	63,146	93,074	59	90.14
91.00	09100	EMERGENCY	0	209,819	442,704	652,523	597	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				0		92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	40,655	85,780	126,435	588	95.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	1,622,632	3,423,651	5,046,283	8,708	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	5,330	11,245	16,575	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	366,769	773,855	1,140,624	6,673	192.00
194.00	07950	THORNTOWN OFFICE BUILDING	0	0	0	0	0	194.00
194.01	07951	CAFE/BOUTIQUE	0	12,094	25,518	37,612	0	194.01
194.02	07952	OTHER NONREIMB	0	175,467	370,224	545,691	16	194.02
194.03	07953	RETAIL PHARMACY	0	3,416	7,208	10,624	62	194.03
200.00		Cross Foot Adjustments				0		200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	0	2,185,708	4,611,701	6,797,409	15,459	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-0104 | Period: From 01/01/2019 To 12/31/2019 | Worksheet B Part II Date/Time Prepared: 3/31/2020 8:18 am

		Cost Center Description	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
			5.00	7.00	8.00	9.00	10.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	495,735					5.00
7.00	00700	OPERATION OF PLANT	17,295	664,719				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	2,226	0	2,233			8.00
9.00	00900	HOUSEKEEPING	4,027	10,147	0	88,818		9.00
10.00	01000	DIETARY	6,569	22,714	0	5,927	202,243	10.00
11.00	01100	CAFETERIA	1,474	0	0	1,976	0	11.00
13.00	01300	NURSING ADMINISTRATION	3,127	0	0	894	0	13.00
15.00	01500	PHARMACY	27,356	7,012	0	1,804	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	7,991	11,077	0	3,952	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	22,805	73,674	107	30,023	82,506	30.00
31.00	03100	INTENSIVE CARE UNIT	8,137	20,233	24	7,973	0	31.00
40.00	04000	SUBPROVIDER - IPF	6,367	23,166	20	9,481	46,122	40.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	0	42.00
43.00	04300	NURSERY	218	0	10	0	0	43.00
44.00	04400	SKILLED NURSING FACILITY	7,312	17,543	15	0	73,615	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	16,787	58,801	264	1,770	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	23,325	71,913	172	8,007	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	0	55.00
55.01	05501	ULTRA SOUND	3,227	0	46	515	0	55.01
57.00	05700	CT SCAN	3,642	0	228	790	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	3,760	6,169	85	756	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	5,994	5,200	89	0	0	59.00
60.00	06000	LABORATORY	31,743	33,537	467	3,385	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	775	0	6	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	17	0	0	64.00
66.00	06600	PHYSICAL THERAPY	10,189	32,460	41	1,220	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	2,157	0	19	584	0	67.00
67.01	06701	AUDIOLOGY	768	0	5	430	0	67.01
68.00	06800	SPEECH PATHOLOGY	1,107	0	6	258	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
69.01	06901	CARDIOLOGY	6,751	3,345	80	2,595	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	12,703	0	45	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	19,396	0	77	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	16,452	0	198	1,873	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	OTHER OUTPATIENT SERVICE COST CENTER	1,665	13,821	0	4,605	0	90.01
90.02	09002	CLINIC	0	0	0	0	0	90.02
90.03	09003	DERMATOLOGY CLINIC	0	0	0	0	0	90.03
90.04	09004	ENT CLINIC	0	0	0	0	0	90.04
90.05	09005	SURGERY CLINIC	0	0	0	0	0	90.05
90.07	09007	UROLOGY CLINIC	0	0	1	0	0	90.07
90.09	09009	GASTROENTEROLOGY CLINIC	14	0	0	0	0	90.09
90.11	09011	NEUROLOGY CLINIC	0	0	0	0	0	90.11
90.12	09012	OPTHAMOLOGY CLINIC	0	0	0	0	0	90.12
90.13	09013	ALLERGY CLINIC	675	0	4	0	0	90.13
90.14	09014	WOUND CARE	3,149	12,671	26	0	0	90.14
91.00	09100	EMERGENCY	15,565	88,838	159	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	13,716	6,365	22	0	0	95.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	308,464	518,686	2,233	88,818	202,243	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	65	2,257	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	176,038	137,208	0	0	0	192.00
194.00	07950	THORNTOWN OFFICE BUILDING	0	0	0	0	0	194.00
194.01	07951	CAFE/BOUTIQUE	147	5,121	0	0	0	194.01
194.02	07952	OTHER NONREIMB	2,752	0	0	0	0	194.02
194.03	07953	RETAIL PHARMACY	8,269	1,447	0	0	0	194.03
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)	495,735	664,719	2,233	88,818	202,243	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-0104 | Period: From 01/01/2019 To 12/31/2019 | Worksheet B Part II Date/Time Prepared: 3/31/2020 8:18 am

		Cost Center Description	CAFETERIA	NURSING ADMINISTRATION	PHARMACY	MEDICAL RECORDS & LIBRARY	Subtotal	
			11.00	13.00	15.00	16.00	24.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA	3,486					11.00
13.00	01300	NURSING ADMINISTRATION	67	4,234				13.00
15.00	01500	PHARMACY	135	0	87,975			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	273	0	0	104,967		16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	920	964	12	25,794	778,848	30.00
31.00	03100	INTENSIVE CARE UNIT	75	325	1	5,363	191,057	31.00
40.00	04000	SUBPROVIDER - IPF	117	328	1	6,385	262,409	40.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	0	42.00
43.00	04300	NURSERY	0	0	0	0	228	43.00
44.00	04400	SKILLED NURSING FACILITY	0	364	68	0	228,016	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	82	638	454	9,258	520,509	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	99	0	51	24,773	656,950	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	25	0	25	55.00
55.01	05501	ULTRA SOUND	11	0	0	2,682	6,564	55.01
57.00	05700	CT SCAN	14	0	19	3,065	7,806	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	35	0	49	1,660	57,910	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	76	0	0	49,631	59.00
60.00	06000	LABORATORY	291	0	3	2,554	319,047	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	781	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	17	64.00
66.00	06600	PHYSICAL THERAPY	146	285	48	4,980	288,191	66.00
67.00	06700	OCCUPATIONAL THERAPY	60	94	0	2,171	5,183	67.00
67.01	06701	AUDIOLOGY	64	66	0	0	1,386	67.01
68.00	06800	SPEECH PATHOLOGY	67	50	0	0	1,539	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
69.01	06901	CARDIOLOGY	146	300	3	4,789	42,860	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	75	0	0	0	12,823	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	19,473	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	18,523	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	1	0	1	90.00
90.01	09001	OTHER OUTPATIENT SERVICE COST CENTER	121	53	0	10,727	132,560	90.01
90.02	09002	CLINIC	0	0	0	0	0	90.02
90.03	09003	DERMATOLOGY CLINIC	0	0	0	0	0	90.03
90.04	09004	ENT CLINIC	0	0	0	0	0	90.04
90.05	09005	SURGERY CLINIC	0	0	3	0	3	90.05
90.07	09007	UROLOGY CLINIC	0	0	10	0	11	90.07
90.09	09009	GASTROENTEROLOGY CLINIC	0	44	0	0	59	90.09
90.11	09011	NEUROLOGY CLINIC	0	0	92	0	92	90.11
90.12	09012	OPTHAMOLOGY CLINIC	0	0	0	0	0	90.12
90.13	09013	ALLERGY CLINIC	0	27	220	0	950	90.13
90.14	09014	WOUND CARE	0	73	221	0	109,273	90.14
91.00	09100	EMERGENCY	227	515	815	0	759,239	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	461	0	193	0	147,780	95.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	3,486	4,202	2,289	104,201	4,619,744	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	0	0	0	18,897	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	14	51,031	766	1,512,354	192.00
194.00	07950	THORNTOWN OFFICE BUILDING	0	0	0	0	0	194.00
194.01	07951	CAFE/BOUTIQUE	0	0	0	0	42,880	194.01
194.02	07952	OTHER NONREIMB	0	18	0	0	548,477	194.02
194.03	07953	RETAIL PHARMACY	0	0	34,655	0	55,057	194.03
200.00		Cross Foot Adjustments					0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	3,486	4,234	87,975	104,967	6,797,409	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 15-0104 | Period: From 01/01/2019 To 12/31/2019 | Worksheet B Part II | Date/Time Prepared: 3/31/2020 8:18 am

		Cost Center Description	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			25.00	26.00	
		GENERAL SERVICE COST CENTERS			
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT			1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT			4.00
5.00	00500	ADMINISTRATIVE & GENERAL			5.00
7.00	00700	OPERATION OF PLANT			7.00
8.00	00800	LAUNDRY & LINEN SERVICE			8.00
9.00	00900	HOUSEKEEPING			9.00
10.00	01000	DIETARY			10.00
11.00	01100	CAFETERIA			11.00
13.00	01300	NURSING ADMINISTRATION			13.00
15.00	01500	PHARMACY			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY			16.00
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS	0	778,848	30.00
31.00	03100	INTENSIVE CARE UNIT	0	191,057	31.00
40.00	04000	SUBPROVIDER - IPF	0	262,409	40.00
41.00	04100	SUBPROVIDER - IRF	0	0	41.00
42.00	04200	SUBPROVIDER	0	0	42.00
43.00	04300	NURSERY	0	228	43.00
44.00	04400	SKILLED NURSING FACILITY	0	228,016	44.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0	520,509	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	656,950	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	25	55.00
55.01	05501	ULTRA SOUND	0	6,564	55.01
57.00	05700	CT SCAN	0	7,806	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	57,910	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	49,631	59.00
60.00	06000	LABORATORY	0	319,047	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	781	63.00
64.00	06400	INTRAVENOUS THERAPY	0	17	64.00
66.00	06600	PHYSICAL THERAPY	0	288,191	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	5,183	67.00
67.01	06701	AUDIOLOGY	0	1,386	67.01
68.00	06800	SPEECH PATHOLOGY	0	1,539	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	69.00
69.01	06901	CARDIOLOGY	0	42,860	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	12,823	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	19,473	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	18,523	73.00
		OUTPATIENT SERVICE COST CENTERS			
90.00	09000	CLINIC	0	1	90.00
90.01	09001	OTHER OUTPATIENT SERVICE COST CENTER	0	132,560	90.01
90.02	09002	CLINIC	0	0	90.02
90.03	09003	DERMATOLOGY CLINIC	0	0	90.03
90.04	09004	ENT CLINIC	0	0	90.04
90.05	09005	SURGERY CLINIC	0	3	90.05
90.07	09007	UROLOGY CLINIC	0	11	90.07
90.09	09009	GASTROENTEROLOGY CLINIC	0	59	90.09
90.11	09011	NEUROLOGY CLINIC	0	92	90.11
90.12	09012	OPTHAMOLOGY CLINIC	0	0	90.12
90.13	09013	ALLERGY CLINIC	0	950	90.13
90.14	09014	WOUND CARE	0	109,273	90.14
91.00	09100	EMERGENCY	0	759,239	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0		92.00
		OTHER REIMBURSABLE COST CENTERS			
95.00	09500	AMBULANCE SERVICES	0	147,780	95.00
		SPECIAL PURPOSE COST CENTERS			
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	4,619,744	118.00
		NONREIMBURSABLE COST CENTERS			
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	18,897	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	1,512,354	192.00
194.00	07950	THORNTOWN OFFICE BUILDING	0	0	194.00
194.01	07951	CAFE/BOUTIQUE	0	42,880	194.01
194.02	07952	OTHER NONREIMB	0	548,477	194.02
194.03	07953	RETAIL PHARMACY	0	55,057	194.03
200.00		Cross Foot Adjustments	0	0	200.00
201.00		Negative Cost Centers	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	0	6,797,409	202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-0104 | Period: From 01/01/2019 To 12/31/2019 | Worksheet B-1 | Date/Time Prepared: 3/31/2020 8:18 am

		Cost Center Description	CAPITAL RELATED COSTS NEW BLDG & FIXT (SQUARE FEET)	NEW MVBLE EQUIP (SQUARE FEET)	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	NEW CAP REL COSTS-BLDG & FIXT	255,907					1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP		255,907				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	582	582	66,854,828			4.00
5.00	00500	ADMINISTRATIVE & GENERAL	18,600	18,600	7,275,436	-17,279,610	127,035,355	5.00
7.00	00700	OPERATION OF PLANT	24,368	24,368	691,314	0	4,432,384	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	32,052	0	570,602	8.00
9.00	00900	HOUSEKEEPING	2,806	2,806	480,361	0	1,032,092	9.00
10.00	01000	DIETARY	6,281	6,281	852,304	0	1,683,571	10.00
11.00	01100	CAFETERIA	0	0	155,690	0	377,782	11.00
13.00	01300	NURSING ADMINISTRATION	0	0	630,618	0	801,500	13.00
15.00	01500	PHARMACY	1,939	1,939	708,729	0	7,010,873	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	3,063	3,063	1,365,475	0	2,047,908	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	20,373	20,373	3,873,291	0	5,844,497	30.00
31.00	03100	INTENSIVE CARE UNIT	5,595	5,595	1,347,529	0	2,085,360	31.00
40.00	04000	SUBPROVIDER - IPF	6,406	6,406	1,148,117	0	1,631,799	40.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	0	42.00
43.00	04300	NURSERY	0	0	0	0	55,910	43.00
44.00	04400	SKILLED NURSING FACILITY	4,851	4,851	1,064,628	0	1,874,004	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	16,260	16,260	2,406,390	0	4,302,232	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	19,886	19,886	1,718,511	0	5,977,786	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	0	55.00
55.01	05501	ULTRA SOUND	0	0	359,120	0	827,027	55.01
57.00	05700	CT SCAN	0	0	207,524	0	933,468	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	1,706	1,706	350,439	0	963,508	58.00
59.00	05900	CARDIAC CATHETERIZATION	1,438	1,438	328,328	0	1,536,241	59.00
60.00	06000	LABORATORY	9,274	9,274	3,164,097	0	8,135,169	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	198,700	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
66.00	06600	PHYSICAL THERAPY	8,976	8,976	1,737,493	0	2,611,129	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	425,924	0	552,671	67.00
67.01	06701	AUDIOLOGY	0	0	228,169	0	196,780	67.01
68.00	06800	SPEECH PATHOLOGY	0	0	220,824	0	283,678	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
69.01	06901	CARDIOLOGY	925	925	1,219,030	0	1,730,041	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	3,255,573	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	4,970,665	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	4,216,352	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	OTHER OUTPATIENT SERVICE COST CENTER	3,822	3,822	206,782	0	426,696	90.01
90.02	09002	CLINIC	0	0	0	0	0	90.02
90.03	09003	DERMATOLOGY CLINIC	0	0	0	0	0	90.03
90.04	09004	ENT CLINIC	0	0	0	0	0	90.04
90.05	09005	SURGERY CLINIC	0	0	0	653	0	90.05
90.07	09007	UROLOGY CLINIC	0	0	0	1,748	0	90.07
90.09	09009	GASTROENTEROLOGY CLINIC	0	0	3,240	0	3,602	90.09
90.11	09011	NEUROLOGY CLINIC	0	0	0	0	0	90.11
90.12	09012	OPTHAMOLOGY CLINIC	0	0	0	20,627	0	90.12
90.13	09013	ALLERGY CLINIC	0	0	103,932	0	173,067	90.13
90.14	09014	WOUND CARE	3,504	3,504	256,974	0	807,103	90.14
91.00	09100	EMERGENCY	24,566	24,566	2,584,388	0	3,988,890	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	4,760	4,760	2,544,146	0	3,515,113	95.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	189,981	189,981	37,690,855	-17,256,582	79,053,773	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	624	624	0	0	16,575	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	42,942	42,942	28,825,560	0	45,103,041	192.00
194.00	07950	THORNTOWN OFFICE BUILDING	0	0	0	0	0	194.00
194.01	07951	CAFE/BOUTIQUE	1,416	1,416	0	0	37,612	194.01
194.02	07952	OTHER NONREIMB	20,544	20,544	70,919	0	705,213	194.02
194.03	07953	RETAIL PHARMACY	400	400	267,494	0	2,119,141	194.03
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-0104 | Period: From 01/01/2019 To 12/31/2019 | Worksheet B-1 | Date/Time Prepared: 3/31/2020 8:18 am

		Cost Center Description	CAPITAL RELATED COSTS					
			NEW BLDG & FIXT (SQUARE FEET)	NEW MVBLE EQUIP (SQUARE FEET)	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)	2,185,708	4,611,701	12,157,316		17,279,610	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	8.541025	18.021004	0.181846		0.136022	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)			15,459		495,735	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)			0.000231		0.003902	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: 15-0104 | Period: From 01/01/2019 To 12/31/2019 | Worksheet B-1 | Date/Time Prepared: 3/31/2020 8:18 am

		Cost Center Description	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (GROSS CHARGES)	HOUSEKEEPING (HOURS OF SERVICE)	DIETARY (MEALS SERVED)	CAFETERIA (MEALS SERVED)	
			7.00	8.00	9.00	10.00	11.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT	183,813					7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	411,478,661				8.00
9.00	00900	HOUSEKEEPING	2,806	0	129,223			9.00
10.00	01000	DIETARY	6,281	0	8,623	42,240		10.00
11.00	01100	CAFETERIA	0	0	2,875	0	982	11.00
13.00	01300	NURSING ADMINISTRATION	0	0	1,300	0	19	13.00
15.00	01500	PHARMACY	1,939	0	2,625	0	38	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	3,063	0	5,750	0	77	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	20,373	21,449,437	43,681	17,232	259	30.00
31.00	03100	INTENSIVE CARE UNIT	5,595	4,871,688	11,600	0	21	31.00
40.00	04000	SUBPROVIDER - IPF	6,406	4,043,285	13,794	9,633	33	40.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	0	42.00
43.00	04300	NURSERY	0	2,019,366	0	0	0	43.00
44.00	04400	SKILLED NURSING FACILITY	4,851	2,971,566	0	15,375	0	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	16,260	52,732,763	2,575	0	23	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	19,886	34,483,364	11,650	0	28	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	0	55.00
55.01	05501	ULTRA SOUND	0	9,156,109	750	0	3	55.01
57.00	05700	CT SCAN	0	45,514,164	1,150	0	4	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	1,706	17,071,948	1,100	0	10	58.00
59.00	05900	CARDIAC CATHETERIZATION	1,438	17,716,676	0	0	0	59.00
60.00	06000	LABORATORY	9,274	58,524,884	4,925	0	82	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	1,115,505	0	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0	3,398,014	0	0	0	64.00
66.00	06600	PHYSICAL THERAPY	8,976	8,292,784	1,775	0	41	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	3,716,264	850	0	17	67.00
67.01	06701	AUDIOLOGY	0	950,473	625	0	18	67.01
68.00	06800	SPEECH PATHOLOGY	0	1,157,664	375	0	19	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
69.01	06901	CARDIOLOGY	925	16,057,275	3,775	0	41	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	8,939,408	0	0	21	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	15,468,574	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	39,627,105	2,725	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	OTHER OUTPATIENT SERVICE COST CENTER	3,822	0	6,700	0	34	90.01
90.02	09002	CLINIC	0	0	0	0	0	90.02
90.03	09003	DERMATOLOGY CLINIC	0	0	0	0	0	90.03
90.04	09004	ENT CLINIC	0	0	0	0	0	90.04
90.05	09005	SURGERY CLINIC	0	0	0	0	0	90.05
90.07	09007	UROLOGY CLINIC	0	157,556	0	0	0	90.07
90.09	09009	GASTROENTEROLOGY CLINIC	0	0	0	0	0	90.09
90.11	09011	NEUROLOGY CLINIC	0	0	0	0	0	90.11
90.12	09012	OPTHAMOLOGY CLINIC	0	0	0	0	0	90.12
90.13	09013	ALLERGY CLINIC	0	723,323	0	0	0	90.13
90.14	09014	WOUND CARE	3,504	5,139,410	0	0	0	90.14
91.00	09100	EMERGENCY	24,566	31,757,712	0	0	64	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	1,760	4,422,344	0	0	130	95.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	143,431	411,478,661	129,223	42,240	982	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	624	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	37,942	0	0	0	0	192.00
194.00	07950	THORNTOWN OFFICE BUILDING	0	0	0	0	0	194.00
194.01	07951	CAFE/BOUTIQUE	1,416	0	0	0	0	194.01
194.02	07952	OTHER NONREIMB	0	0	0	0	0	194.02
194.03	07953	RETAIL PHARMACY	400	0	0	0	0	194.03
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)	5,035,286	648,216	1,249,345	2,168,001	456,965	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	27.393525	0.001575	9.668132	51.325781	465.341141	203.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 15-0104 | Period: From 01/01/2019 To 12/31/2019 | Worksheet B-1 | Date/Time Prepared: 3/31/2020 8:18 am

		Cost Center Description	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (GROSS CHARGES)	HOUSEKEEPING (HOURS OF SERVICE)	DIETARY (MEALS SERVED)	CAFETERIA (MEALS SERVED)	
			7.00	8.00	9.00	10.00	11.00	
204.00		Cost to be allocated (per Wkst. B, Part II)	664,719	2,233	88,818	202,243	3,486	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	3.616279	0.000005	0.687323	4.787950	3.549898	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: 15-0104 | Period: From 01/01/2019 To 12/31/2019 | Worksheet B-1 | Date/Time Prepared: 3/31/2020 8:18 am

		Cost Center Description	NURSING ADMINISTRATION (DIRECT NRSING HRS)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (TIME SPENT)	
			13.00	15.00	16.00	
		GENERAL SERVICE COST CENTERS				
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT				1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT				4.00
5.00	00500	ADMINISTRATIVE & GENERAL				5.00
7.00	00700	OPERATION OF PLANT				7.00
8.00	00800	LAUNDRY & LINEN SERVICE				8.00
9.00	00900	HOUSEKEEPING				9.00
10.00	01000	DIETARY				10.00
11.00	01100	CAFETERIA				11.00
13.00	01300	NURSING ADMINISTRATION	444,963			13.00
15.00	01500	PHARMACY	0	4,143,826		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	41,100	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	101,342	556	10,100	30.00
31.00	03100	INTENSIVE CARE UNIT	34,124	44	2,100	31.00
40.00	04000	SUBPROVIDER - IPF	34,495	52	2,500	40.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	41.00
42.00	04200	SUBPROVIDER	0	0	0	42.00
43.00	04300	NURSERY	0	0	0	43.00
44.00	04400	SKILLED NURSING FACILITY	38,299	3,201	0	44.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	67,014	21,389	3,625	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	2,408	9,700	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	1,191	0	55.00
55.01	05501	ULTRA SOUND	0	0	1,050	55.01
57.00	05700	CT SCAN	0	903	1,200	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	2,324	650	58.00
59.00	05900	CARDIAC CATHETERIZATION	7,943	8	0	59.00
60.00	06000	LABORATORY	0	128	1,000	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	64.00
66.00	06600	PHYSICAL THERAPY	29,999	2,278	1,950	66.00
67.00	06700	OCCUPATIONAL THERAPY	9,868	0	850	67.00
67.01	06701	AUDIOLOGY	6,949	0	0	67.01
68.00	06800	SPEECH PATHOLOGY	5,256	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	69.00
69.01	06901	CARDIOLOGY	31,541	153	1,875	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0	50	0	90.00
90.01	09001	OTHER OUTPATIENT SERVICE COST CENTER	5,564	0	4,200	90.01
90.02	09002	CLINIC	0	0	0	90.02
90.03	09003	DERMATOLOGY CLINIC	0	0	0	90.03
90.04	09004	ENT CLINIC	0	0	0	90.04
90.05	09005	SURGERY CLINIC	0	137	0	90.05
90.07	09007	UROLOGY CLINIC	0	494	0	90.07
90.09	09009	GASTROENTEROLOGY CLINIC	4,598	0	0	90.09
90.11	09011	NEUROLOGY CLINIC	0	4,350	0	90.11
90.12	09012	OPTHAMOLOGY CLINIC	0	0	0	90.12
90.13	09013	ALLERGY CLINIC	2,857	10,365	0	90.13
90.14	09014	WOUND CARE	7,657	10,394	0	90.14
91.00	09100	EMERGENCY	54,116	38,378	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES	0	9,094	0	95.00
		SPECIAL PURPOSE COST CENTERS				
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	441,622	107,897	40,800	118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	1,445	2,403,562	300	192.00
194.00	07950	THORNTOWN OFFICE BUILDING	0	0	0	194.00
194.01	07951	CAFE/BOUTIQUE	0	0	0	194.01
194.02	07952	OTHER NONREIMB	1,896	0	0	194.02
194.03	07953	RETAIL PHARMACY	0	1,632,367	0	194.03
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)	931,932	8,060,684	2,501,798	202.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 15-0104

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

Worksheet B-1

Date/Time Prepared: 3/31/2020 8:18 am

		Cost Center Description	NURSING ADMINISTRATION (DIRECT NRSING HRS)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (TIME SPENT)		
			13.00	15.00	16.00		
203.00		Unit cost multiplier (Wkst. B, Part I)	2.094403	1.945227	60.870998		203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	4,234	87,975	104,967		204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.009515	0.021230	2.553942		205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)					206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)					207.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-0104 | Period: From 01/01/2019 To 12/31/2019 | Worksheet C Part I Date/Time Prepared: 3/31/2020 8:18 am

Title XVIII | Hospital | PPS

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	Costs RCE Disallowance	Costs Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	9,486,764		9,486,764	0	9,486,764	30.00
31.00	03100	INTENSIVE CARE UNIT	2,851,261		2,851,261	0	2,851,261	31.00
40.00	04000	SUBPROVIDER - IPF	2,903,274		2,903,274	0	2,903,274	40.00
41.00	04100	SUBPROVIDER - IRF	0		0	0	0	41.00
42.00	04200	SUBPROVIDER	0		0	0	0	42.00
43.00	04300	NURSERY	66,696		66,696	0	66,696	43.00
44.00	04400	SKILLED NURSING FACILITY	3,142,051		3,142,051	0	3,142,051	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	5,854,118		5,854,118	0	5,854,118	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	8,110,752		8,110,752	0	8,110,752	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	2,317		2,317	0	2,317	55.00
55.01	05501	ULTRA SOUND	1,026,504		1,026,504	0	1,026,504	55.01
57.00	05700	CT SCAN	1,219,906		1,219,906	0	1,219,906	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	1,227,562		1,227,562	0	1,227,562	58.00
59.00	05900	CARDIAC CATHETERIZATION	1,829,152		1,829,152	0	1,829,152	59.00
60.00	06000	LABORATORY	9,734,987		9,734,987	0	9,734,987	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	227,485		227,485	0	227,485	63.00
64.00	06400	INTRAVENOUS THERAPY	5,352		5,352	0	5,352	64.00
66.00	06600	PHYSICAL THERAPY	3,447,444	0	3,447,444	0	3,447,444	66.00
67.00	06700	OCCUPATIONAL THERAPY	722,236	0	722,236	0	722,236	67.00
67.01	06701	AUDIOLOGY	254,016	0	254,016	0	254,016	67.01
68.00	06800	SPEECH PATHOLOGY	347,562	0	347,562	0	347,562	68.00
69.00	06900	ELECTROCARDIOLOGY	0		0	0	0	69.00
69.01	06901	CARDIOLOGY	2,252,061		2,252,061	0	2,252,061	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	3,722,255		3,722,255	0	3,722,255	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	5,671,148		5,671,148	0	5,671,148	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	4,878,628		4,878,628	0	4,878,628	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	97		97	0	97	90.00
90.01	09001	OTHER OUTPATIENT SERVICE COST CENTER	937,343		937,343	0	937,343	90.01
90.02	09002	CLINIC	0		0	0	0	90.02
90.03	09003	DERMATOLOGY CLINIC	0		0	0	0	90.03
90.04	09004	ENT CLINIC	0		0	0	0	90.04
90.05	09005	SURGERY CLINIC	0		0	0	0	90.05
90.07	09007	UROLOGY CLINIC	0		0	0	0	90.07
90.09	09009	GASTROENTEROLOGY CLINIC	13,722		13,722	0	13,722	90.09
90.11	09011	NEUROLOGY CLINIC	8,462		8,462	0	8,462	90.11
90.12	09012	OPTHAMOLOGY CLINIC	0		0	0	0	90.12
90.13	09013	ALLERGY CLINIC	223,893		223,893	0	223,893	90.13
90.14	09014	WOUND CARE	1,057,225		1,057,225	0	1,057,225	90.14
91.00	09100	EMERGENCY	5,472,211		5,472,211	0	5,472,211	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	2,608,042		2,608,042		2,608,042	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	4,126,608		4,126,608	0	4,126,608	95.00
200.00		Subtotal (see instructions)	83,431,134	0	83,431,134	0	83,431,134	200.00
201.00		Less Observation Beds	2,608,042		2,608,042		2,608,042	201.00
202.00		Total (see instructions)	80,823,092	0	80,823,092	0	80,823,092	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-0104 | Period: From 01/01/2019 To 12/31/2019 | Worksheet C Part I | Date/Time Prepared: 3/31/2020 8:18 am

Title XVIII | Hospital | PPS

		Cost Center Description	Charges Inpatient	Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	16,148,736		16,148,736			30.00
31.00	03100	INTENSIVE CARE UNIT	4,871,688		4,871,688			31.00
40.00	04000	SUBPROVIDER - IPF	4,043,285		4,043,285			40.00
41.00	04100	SUBPROVIDER - IRF	0		0			41.00
42.00	04200	SUBPROVIDER	0		0			42.00
43.00	04300	NURSERY	2,019,366		2,019,366			43.00
44.00	04400	SKILLED NURSING FACILITY	2,971,566		2,971,566			44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	8,591,524	44,141,239	52,732,763	0.111015	0.000000	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,549,019	32,934,345	34,483,364	0.235208	0.000000	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0.000000	0.000000	55.00
55.01	05501	ULTRA SOUND	445,936	8,710,173	9,156,109	0.112111	0.000000	55.01
57.00	05700	CT SCAN	4,899,408	40,614,756	45,514,164	0.026803	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	625,029	16,446,919	17,071,948	0.071905	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	4,048,944	13,667,732	17,716,676	0.103245	0.000000	59.00
60.00	06000	LABORATORY	9,191,085	49,333,799	58,524,884	0.166339	0.000000	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	480,854	634,651	1,115,505	0.203930	0.000000	63.00
64.00	06400	INTRAVENOUS THERAPY	1,350,409	2,047,605	3,398,014	0.001575	0.000000	64.00
66.00	06600	PHYSICAL THERAPY	2,688,509	5,604,275	8,292,784	0.415716	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	2,586,658	1,129,606	3,716,264	0.194345	0.000000	67.00
67.01	06701	AUDIOLOGY	398	950,075	950,473	0.267252	0.000000	67.01
68.00	06800	SPEECH PATHOLOGY	219,397	938,267	1,157,664	0.300227	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0.000000	0.000000	69.00
69.01	06901	CARDIOLOGY	5,333,221	10,724,054	16,057,275	0.140252	0.000000	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	3,658,014	5,281,394	8,939,408	0.416387	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	3,983,420	11,485,154	15,468,574	0.366624	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	9,080,925	30,546,180	39,627,105	0.123113	0.000000	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0.000000	0.000000	90.00
90.01	09001	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0.000000	0.000000	90.01
90.02	09002	CLINIC	0	0	0	0.000000	0.000000	90.02
90.03	09003	DERMATOLOGY CLINIC	0	0	0	0.000000	0.000000	90.03
90.04	09004	ENT CLINIC	0	0	0	0.000000	0.000000	90.04
90.05	09005	SURGERY CLINIC	0	0	0	0.000000	0.000000	90.05
90.07	09007	UROLOGY CLINIC	0	157,556	157,556	0.000000	0.000000	90.07
90.09	09009	GASTROENTEROLOGY CLINIC	0	0	0	0.000000	0.000000	90.09
90.11	09011	NEUROLOGY CLINIC	0	0	0	0.000000	0.000000	90.11
90.12	09012	OPTHAMOLOGY CLINIC	0	0	0	0.000000	0.000000	90.12
90.13	09013	ALLERGY CLINIC	0	723,323	723,323	0.309534	0.000000	90.13
90.14	09014	WOUND CARE	102,004	5,037,406	5,139,410	0.205709	0.000000	90.14
91.00	09100	EMERGENCY	3,816,803	27,940,909	31,757,712	0.172311	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	5,300,701	5,300,701	0.492018	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	2,032	4,420,312	4,422,344	0.933127	0.000000	95.00
200.00		Subtotal (see instructions)	92,708,230	318,770,431	411,478,661			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	92,708,230	318,770,431	411,478,661			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-0104 | Period: From 01/01/2019 To 12/31/2019 | Worksheet C Part I Date/Time Prepared: 3/31/2020 8:18 am

Title XVIII | Hospital | PPS

		Cost Center Description	PPS Inpatient Ratio	
			11.00	
		INPATIENT ROUTINE SERVICE COST CENTERS		
30.00	03000	ADULTS & PEDIATRICS		30.00
31.00	03100	INTENSIVE CARE UNIT		31.00
40.00	04000	SUBPROVIDER - IPF		40.00
41.00	04100	SUBPROVIDER - IRF		41.00
42.00	04200	SUBPROVIDER		42.00
43.00	04300	NURSERY		43.00
44.00	04400	SKILLED NURSING FACILITY		44.00
		ANCILLARY SERVICE COST CENTERS		
50.00	05000	OPERATING ROOM	0.111015	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.235208	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.000000	55.00
55.01	05501	ULTRA SOUND	0.112111	55.01
57.00	05700	CT SCAN	0.026803	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.071905	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.103245	59.00
60.00	06000	LABORATORY	0.166339	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.203930	63.00
64.00	06400	INTRAVENOUS THERAPY	0.001575	64.00
66.00	06600	PHYSICAL THERAPY	0.415716	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.194345	67.00
67.01	06701	AUDIOLOGY	0.267252	67.01
68.00	06800	SPEECH PATHOLOGY	0.300227	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	69.00
69.01	06901	CARDIOLOGY	0.140252	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.416387	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.366624	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.123113	73.00
		OUTPATIENT SERVICE COST CENTERS		
90.00	09000	CLINIC	0.000000	90.00
90.01	09001	OTHER OUTPATIENT SERVICE COST CENTER	0.000000	90.01
90.02	09002	CLINIC	0.000000	90.02
90.03	09003	DERMATOLOGY CLINIC	0.000000	90.03
90.04	09004	ENT CLINIC	0.000000	90.04
90.05	09005	SURGERY CLINIC	0.000000	90.05
90.07	09007	UROLOGY CLINIC	0.000000	90.07
90.09	09009	GASTROENTEROLOGY CLINIC	0.000000	90.09
90.11	09011	NEUROLOGY CLINIC	0.000000	90.11
90.12	09012	OPTHAMOLOGY CLINIC	0.000000	90.12
90.13	09013	ALLERGY CLINIC	0.309534	90.13
90.14	09014	WOUND CARE	0.205709	90.14
91.00	09100	EMERGENCY	0.172311	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.492018	92.00
		OTHER REIMBURSABLE COST CENTERS		
95.00	09500	AMBULANCE SERVICES	0.933127	95.00
200.00		Subtotal (see instructions)		200.00
201.00		Less Observation Beds		201.00
202.00		Total (see instructions)		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 15-0104 | Period: From 01/01/2019 To 12/31/2019 | Worksheet C Part I | Date/Time Prepared: 3/31/2020 8:18 am

Title XIX | Hospital | Cost

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	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	9,486,764		9,486,764	0	9,486,764	30.00
31.00	03100	INTENSIVE CARE UNIT	2,851,261		2,851,261	0	2,851,261	31.00
40.00	04000	SUBPROVIDER - IPF	2,903,274		2,903,274	0	2,903,274	40.00
41.00	04100	SUBPROVIDER - IRF	0		0	0	0	41.00
42.00	04200	SUBPROVIDER	0		0	0	0	42.00
43.00	04300	NURSERY	66,696		66,696	0	66,696	43.00
44.00	04400	SKILLED NURSING FACILITY	3,142,051		3,142,051	0	3,142,051	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	5,854,118		5,854,118	0	5,854,118	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	8,110,752		8,110,752	0	8,110,752	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	2,317		2,317	0	2,317	55.00
55.01	05501	ULTRA SOUND	1,026,504		1,026,504	0	1,026,504	55.01
57.00	05700	CT SCAN	1,219,906		1,219,906	0	1,219,906	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	1,227,562		1,227,562	0	1,227,562	58.00
59.00	05900	CARDIAC CATHETERIZATION	1,829,152		1,829,152	0	1,829,152	59.00
60.00	06000	LABORATORY	9,734,987		9,734,987	0	9,734,987	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	227,485		227,485	0	227,485	63.00
64.00	06400	INTRAVENOUS THERAPY	5,352		5,352	0	5,352	64.00
66.00	06600	PHYSICAL THERAPY	3,447,444	0	3,447,444	0	3,447,444	66.00
67.00	06700	OCCUPATIONAL THERAPY	722,236	0	722,236	0	722,236	67.00
67.01	06701	AUDIOLOGY	254,016	0	254,016	0	254,016	67.01
68.00	06800	SPEECH PATHOLOGY	347,562	0	347,562	0	347,562	68.00
69.00	06900	ELECTROCARDIOLOGY	0		0	0	0	69.00
69.01	06901	CARDIOLOGY	2,252,061		2,252,061	0	2,252,061	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	3,722,255		3,722,255	0	3,722,255	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	5,671,148		5,671,148	0	5,671,148	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	4,878,628		4,878,628	0	4,878,628	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	97		97	0	97	90.00
90.01	09001	OTHER OUTPATIENT SERVICE COST CENTER	937,343		937,343	0	937,343	90.01
90.02	09002	CLINIC	0		0	0	0	90.02
90.03	09003	DERMATOLOGY CLINIC	0		0	0	0	90.03
90.04	09004	ENT CLINIC	0		0	0	0	90.04
90.05	09005	SURGERY CLINIC	0		0	0	0	90.05
90.07	09007	UROLOGY CLINIC	0		0	0	0	90.07
90.09	09009	GASTROENTEROLOGY CLINIC	13,722		13,722	0	13,722	90.09
90.11	09011	NEUROLOGY CLINIC	8,462		8,462	0	8,462	90.11
90.12	09012	OPTHAMOLOGY CLINIC	0		0	0	0	90.12
90.13	09013	ALLERGY CLINIC	223,893		223,893	0	223,893	90.13
90.14	09014	WOUND CARE	1,057,225		1,057,225	0	1,057,225	90.14
91.00	09100	EMERGENCY	5,472,211		5,472,211	0	5,472,211	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	2,608,042		2,608,042		2,608,042	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	4,126,608		4,126,608	0	4,126,608	95.00
200.00		Subtotal (see instructions)	83,431,134	0	83,431,134	0	83,431,134	200.00
201.00		Less Observation Beds	2,608,042		2,608,042		2,608,042	201.00
202.00		Total (see instructions)	80,823,092	0	80,823,092	0	80,823,092	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-0104 | Period: From 01/01/2019 To 12/31/2019 | Worksheet C Part I | Date/Time Prepared: 3/31/2020 8:18 am

Title XIX | Hospital | Cost

		Cost Center Description	Charges					
			Inpatient	Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	16,148,736		16,148,736			30.00
31.00	03100	INTENSIVE CARE UNIT	4,871,688		4,871,688			31.00
40.00	04000	SUBPROVIDER - IPF	4,043,285		4,043,285			40.00
41.00	04100	SUBPROVIDER - IRF	0		0			41.00
42.00	04200	SUBPROVIDER	0		0			42.00
43.00	04300	NURSERY	2,019,366		2,019,366			43.00
44.00	04400	SKILLED NURSING FACILITY	2,971,566		2,971,566			44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	8,591,524	44,141,239	52,732,763	0.111015	0.000000	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,549,019	32,934,345	34,483,364	0.235208	0.000000	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0.000000	0.000000	55.00
55.01	05501	ULTRA SOUND	445,936	8,710,173	9,156,109	0.112111	0.000000	55.01
57.00	05700	CT SCAN	4,899,408	40,614,756	45,514,164	0.026803	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	625,029	16,446,919	17,071,948	0.071905	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	4,048,944	13,667,732	17,716,676	0.103245	0.000000	59.00
60.00	06000	LABORATORY	9,191,085	49,333,799	58,524,884	0.166339	0.000000	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	480,854	634,651	1,115,505	0.203930	0.000000	63.00
64.00	06400	INTRAVENOUS THERAPY	1,350,409	2,047,605	3,398,014	0.001575	0.000000	64.00
66.00	06600	PHYSICAL THERAPY	2,688,509	5,604,275	8,292,784	0.415716	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	2,586,658	1,129,606	3,716,264	0.194345	0.000000	67.00
67.01	06701	AUDIOLOGY	398	950,075	950,473	0.267252	0.000000	67.01
68.00	06800	SPEECH PATHOLOGY	219,397	938,267	1,157,664	0.300227	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0.000000	0.000000	69.00
69.01	06901	CARDIOLOGY	5,333,221	10,724,054	16,057,275	0.140252	0.000000	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	3,658,014	5,281,394	8,939,408	0.416387	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	3,983,420	11,485,154	15,468,574	0.366624	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	9,080,925	30,546,180	39,627,105	0.123113	0.000000	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0.000000	0.000000	90.00
90.01	09001	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0.000000	0.000000	90.01
90.02	09002	CLINIC	0	0	0	0.000000	0.000000	90.02
90.03	09003	DERMATOLOGY CLINIC	0	0	0	0.000000	0.000000	90.03
90.04	09004	ENT CLINIC	0	0	0	0.000000	0.000000	90.04
90.05	09005	SURGERY CLINIC	0	0	0	0.000000	0.000000	90.05
90.07	09007	UROLOGY CLINIC	0	157,556	157,556	0.000000	0.000000	90.07
90.09	09009	GASTROENTEROLOGY CLINIC	0	0	0	0.000000	0.000000	90.09
90.11	09011	NEUROLOGY CLINIC	0	0	0	0.000000	0.000000	90.11
90.12	09012	OPTHAMOLOGY CLINIC	0	0	0	0.000000	0.000000	90.12
90.13	09013	ALLERGY CLINIC	0	723,323	723,323	0.309534	0.000000	90.13
90.14	09014	WOUND CARE	102,004	5,037,406	5,139,410	0.205709	0.000000	90.14
91.00	09100	EMERGENCY	3,816,803	27,940,909	31,757,712	0.172311	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	5,300,701	5,300,701	0.492018	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	2,032	4,420,312	4,422,344	0.933127	0.000000	95.00
200.00		Subtotal (see instructions)	92,708,230	318,770,431	411,478,661			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	92,708,230	318,770,431	411,478,661			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-0104 | Period: From 01/01/2019 To 12/31/2019 | Worksheet C Part I Date/Time Prepared: 3/31/2020 8:18 am

Title XIX | Hospital | Cost

		Cost Center Description	PPS Inpatient Ratio	
			11.00	
		INPATIENT ROUTINE SERVICE COST CENTERS		
30.00	03000	ADULTS & PEDIATRICS		30.00
31.00	03100	INTENSIVE CARE UNIT		31.00
40.00	04000	SUBPROVIDER - IPF		40.00
41.00	04100	SUBPROVIDER - IRF		41.00
42.00	04200	SUBPROVIDER		42.00
43.00	04300	NURSERY		43.00
44.00	04400	SKILLED NURSING FACILITY		44.00
		ANCILLARY SERVICE COST CENTERS		
50.00	05000	OPERATING ROOM	0.000000	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.000000	55.00
55.01	05501	ULTRA SOUND	0.000000	55.01
57.00	05700	CT SCAN	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	59.00
60.00	06000	LABORATORY	0.000000	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.000000	63.00
64.00	06400	INTRAVENOUS THERAPY	0.000000	64.00
66.00	06600	PHYSICAL THERAPY	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	67.00
67.01	06701	AUDIOLOGY	0.000000	67.01
68.00	06800	SPEECH PATHOLOGY	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	69.00
69.01	06901	CARDIOLOGY	0.000000	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	73.00
		OUTPATIENT SERVICE COST CENTERS		
90.00	09000	CLINIC	0.000000	90.00
90.01	09001	OTHER OUTPATIENT SERVICE COST CENTER	0.000000	90.01
90.02	09002	CLINIC	0.000000	90.02
90.03	09003	DERMATOLOGY CLINIC	0.000000	90.03
90.04	09004	ENT CLINIC	0.000000	90.04
90.05	09005	SURGERY CLINIC	0.000000	90.05
90.07	09007	UROLOGY CLINIC	0.000000	90.07
90.09	09009	GASTROENTEROLOGY CLINIC	0.000000	90.09
90.11	09011	NEUROLOGY CLINIC	0.000000	90.11
90.12	09012	OPTHAMOLOGY CLINIC	0.000000	90.12
90.13	09013	ALLERGY CLINIC	0.000000	90.13
90.14	09014	WOUND CARE	0.000000	90.14
91.00	09100	EMERGENCY	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS		
95.00	09500	AMBULANCE SERVICES	0.000000	95.00
200.00		Subtotal (see instructions)		200.00
201.00		Less Observation Beds		201.00
202.00		Total (see instructions)		202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS | Provider CCN: 15-0104 | Period: From 01/01/2019 To 12/31/2019 | Worksheet D Part I Date/Time Prepared: 3/31/2020 8:18 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	778,848	0	778,848	7,486	104.04	30.00
31.00	INTENSIVE CARE UNIT	191,057		191,057	1,705	112.06	31.00
40.00	SUBPROVIDER - IPF	262,409	0	262,409	3,211	81.72	40.00
41.00	SUBPROVIDER - IRF	0	0	0	0	0.00	41.00
42.00	SUBPROVIDER	0	0	0	0	0.00	42.00
43.00	NURSERY	228		228	1,080	0.21	43.00
44.00	SKILLED NURSING FACILITY	228,016		228,016	5,125	44.49	44.00
200.00	Total (lines 30 through 199)	1,460,558		1,460,558	18,607		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	2,125	221,085	30.00
31.00	INTENSIVE CARE UNIT	781	87,519	31.00
40.00	SUBPROVIDER - IPF	2,535	207,160	40.00
41.00	SUBPROVIDER - IRF	0	0	41.00
42.00	SUBPROVIDER	0	0	42.00
43.00	NURSERY	0	0	43.00
44.00	SKILLED NURSING FACILITY	3,051	135,739	44.00
200.00	Total (lines 30 through 199)	8,492	651,503	200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS | Provider CCN: 15-0104 | Period: From 01/01/2019 To 12/31/2019 | Worksheet D Part II Date/Time Prepared: 3/31/2020 8:18 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	520,509	52,732,763	0.009871	4,844,427	47,819	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	656,950	34,483,364	0.019051	969,860	18,477	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	25	0	0.000000	0	0	55.00
55.01	05501	ULTRA SOUND	6,564	9,156,109	0.000717	70,105	50	55.01
57.00	05700	CT SCAN	7,806	45,514,164	0.000172	2,011,146	346	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	57,910	17,071,948	0.003392	271,886	922	58.00
59.00	05900	CARDIAC CATHETERIZATION	49,631	17,716,676	0.002801	447,522	1,254	59.00
60.00	06000	LABORATORY	319,047	58,524,884	0.005451	4,077,019	22,224	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	781	1,115,505	0.000700	191,312	134	63.00
64.00	06400	INTRAVENOUS THERAPY	17	3,398,014	0.000005	523,046	3	64.00
66.00	06600	PHYSICAL THERAPY	288,191	8,292,784	0.034752	442,059	15,362	66.00
67.00	06700	OCCUPATIONAL THERAPY	5,183	3,716,264	0.001395	336,611	470	67.00
67.01	06701	AUDIOLOGY	1,386	950,473	0.001458	0	0	67.01
68.00	06800	SPEECH PATHOLOGY	1,539	1,157,664	0.001329	77,670	103	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0.000000	0	0	69.00
69.01	06901	CARDIOLOGY	42,860	16,057,275	0.002669	3,585,261	9,569	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	12,823	8,939,408	0.001434	1,239,351	1,777	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	19,473	15,468,574	0.001259	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	18,523	39,627,105	0.000467	3,090,864	1,443	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	1	0	0.000000	0	0	90.00
90.01	09001	OTHER OUTPATIENT SERVICE COST CENTER	132,560	0	0.000000	0	0	90.01
90.02	09002	CLINIC	0	0	0.000000	0	0	90.02
90.03	09003	DERMATOLOGY CLINIC	0	0	0.000000	0	0	90.03
90.04	09004	ENT CLINIC	0	0	0.000000	0	0	90.04
90.05	09005	SURGERY CLINIC	0	0	0.000000	0	0	90.05
90.07	09007	UROLOGY CLINIC	0	0	0.000000	0	0	90.07
90.09	09009	GASTROENTEROLOGY CLINIC	59	0	0.000000	0	0	90.09
90.11	09011	NEUROLOGY CLINIC	92	0	0.000000	0	0	90.11
90.12	09012	OPTHAMOLOGY CLINIC	0	0	0.000000	0	0	90.12
90.13	09013	ALLERGY CLINIC	950	723,323	0.001313	0	0	90.13
90.14	09014	WOUND CARE	109,273	5,139,410	0.021262	3,865	82	90.14
91.00	09100	EMERGENCY	759,239	31,757,712	0.023907	1,643,724	39,297	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	214,115	5,300,701	0.040394	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)	3,225,507	376,844,120		23,825,728	159,332	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 15-0104 | Period: From 01/01/2019 To 12/31/2019 | Worksheet D Part III Date/Time Prepared: 3/31/2020 8:18 am

Title XVIII | Hospital | PPS

		Cost Center Description	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health Cost	All Other Medical Education Cost	
			1A	1.00	2A	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	0	40.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	0	42.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0		44.00
200.00		Total (lines 30 through 199)	0	0	0	0	0	200.00

		Cost Center Description	Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days	
			4.00	5.00	6.00	7.00	8.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	0	7,486	0.00	2,125	30.00
31.00	03100	INTENSIVE CARE UNIT		0	1,705	0.00	781	31.00
40.00	04000	SUBPROVIDER - IPF	0	0	3,211	0.00	2,535	40.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0.00	0	41.00
42.00	04200	SUBPROVIDER	0	0	0	0.00	0	42.00
43.00	04300	NURSERY		0	1,080	0.00	0	43.00
44.00	04400	SKILLED NURSING FACILITY		0	5,125	0.00	3,051	44.00
200.00		Total (lines 30 through 199)		0	18,607		8,492	200.00

		Cost Center Description	Inpatient Program Pass-Through Cost (col. 7 x col. 8)	
			9.00	
		INPATIENT ROUTINE SERVICE COST CENTERS		
30.00	03000	ADULTS & PEDIATRICS	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	31.00
40.00	04000	SUBPROVIDER - IPF	0	40.00
41.00	04100	SUBPROVIDER - IRF	0	41.00
42.00	04200	SUBPROVIDER	0	42.00
43.00	04300	NURSERY	0	43.00
44.00	04400	SKILLED NURSING FACILITY	0	44.00
200.00		Total (lines 30 through 199)	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-0104 | Period: From 01/01/2019 To 12/31/2019 | Worksheet D Part IV | Date/Time Prepared: 3/31/2020 8:18 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
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	0	55.00
55.01	05501	ULTRA SOUND	0	0	0	0	0	55.01
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
67.01	06701	AUDIOLOGY	0	0	0	0	0	67.01
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
69.01	06901	CARDIOLOGY	0	0	0	0	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	0	90.01
90.02	09002	CLINIC	0	0	0	0	0	90.02
90.03	09003	DERMATOLOGY CLINIC	0	0	0	0	0	90.03
90.04	09004	ENT CLINIC	0	0	0	0	0	90.04
90.05	09005	SURGERY CLINIC	0	0	0	0	0	90.05
90.07	09007	UROLOGY CLINIC	0	0	0	0	0	90.07
90.09	09009	GASTROENTEROLOGY CLINIC	0	0	0	0	0	90.09
90.11	09011	NEUROLOGY CLINIC	0	0	0	0	0	90.11
90.12	09012	OPTHAMOLOGY CLINIC	0	0	0	0	0	90.12
90.13	09013	ALLERGY CLINIC	0	0	0	0	0	90.13
90.14	09014	WOUND CARE	0	0	0	0	0	90.14
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: 15-0104 | Period: From 01/01/2019 To 12/31/2019 | Worksheet D Part IV | Date/Time Prepared: 3/31/2020 8:18 am

Title XVIII | Hospital | PPS

		Cost Center Description	All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	
			4.00	5.00	6.00	7.00	8.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	52,732,763	0.000000	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	34,483,364	0.000000	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	0.000000	55.00
55.01	05501	ULTRA SOUND	0	0	0	9,156,109	0.000000	55.01
57.00	05700	CT SCAN	0	0	0	45,514,164	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	17,071,948	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	17,716,676	0.000000	59.00
60.00	06000	LABORATORY	0	0	0	58,524,884	0.000000	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	1,115,505	0.000000	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	3,398,014	0.000000	64.00
66.00	06600	PHYSICAL THERAPY	0	0	0	8,292,784	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	3,716,264	0.000000	67.00
67.01	06701	AUDIOLOGY	0	0	0	950,473	0.000000	67.01
68.00	06800	SPEECH PATHOLOGY	0	0	0	1,157,664	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0.000000	69.00
69.01	06901	CARDIOLOGY	0	0	0	16,057,275	0.000000	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	8,939,408	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	15,468,574	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	39,627,105	0.000000	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0.000000	90.00
90.01	09001	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	0.000000	90.01
90.02	09002	CLINIC	0	0	0	0	0.000000	90.02
90.03	09003	DERMATOLOGY CLINIC	0	0	0	0	0.000000	90.03
90.04	09004	ENT CLINIC	0	0	0	0	0.000000	90.04
90.05	09005	SURGERY CLINIC	0	0	0	0	0.000000	90.05
90.07	09007	UROLOGY CLINIC	0	0	0	157,556	0.000000	90.07
90.09	09009	GASTROENTEROLOGY CLINIC	0	0	0	0	0.000000	90.09
90.11	09011	NEUROLOGY CLINIC	0	0	0	0	0.000000	90.11
90.12	09012	OPTHAMOLOGY CLINIC	0	0	0	0	0.000000	90.12
90.13	09013	ALLERGY CLINIC	0	0	0	723,323	0.000000	90.13
90.14	09014	WOUND CARE	0	0	0	5,139,410	0.000000	90.14
91.00	09100	EMERGENCY	0	0	0	31,757,712	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	5,300,701	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	377,001,676		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-0104 | Period: From 01/01/2019 To 12/31/2019 | Worksheet D Part IV | Date/Time Prepared: 3/31/2020 8:18 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	4,844,427	0	15,410,988	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	969,860	0	11,202,131	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.000000	0	0	0	0	55.00
55.01	05501	ULTRA SOUND	0.000000	70,105	0	998,867	0	55.01
57.00	05700	CT SCAN	0.000000	2,011,146	0	9,082,757	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000	271,886	0	5,566,627	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	447,522	0	1,754,763	0	59.00
60.00	06000	LABORATORY	0.000000	4,077,019	0	5,704,955	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.000000	191,312	0	272,707	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0.000000	523,046	0	473,661	0	64.00
66.00	06600	PHYSICAL THERAPY	0.000000	442,059	0	18,426	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	336,611	0	9,755	0	67.00
67.01	06701	AUDIOLOGY	0.000000	0	0	0	0	67.01
68.00	06800	SPEECH PATHOLOGY	0.000000	77,670	0	124,006	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	0	0	0	0	69.00
69.01	06901	CARDIOLOGY	0.000000	3,585,261	0	7,472,328	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	1,239,351	0	1,041,171	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.000000	0	0	21,760	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	3,090,864	0	11,111,888	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.000000	0	0	0	0	90.00
90.01	09001	OTHER OUTPATIENT SERVICE COST CENTER	0.000000	0	0	0	0	90.01
90.02	09002	CLINIC	0.000000	0	0	0	0	90.02
90.03	09003	DERMATOLOGY CLINIC	0.000000	0	0	0	0	90.03
90.04	09004	ENT CLINIC	0.000000	0	0	0	0	90.04
90.05	09005	SURGERY CLINIC	0.000000	0	0	0	0	90.05
90.07	09007	UROLOGY CLINIC	0.000000	0	0	0	0	90.07
90.09	09009	GASTROENTEROLOGY CLINIC	0.000000	0	0	0	0	90.09
90.11	09011	NEUROLOGY CLINIC	0.000000	0	0	0	0	90.11
90.12	09012	OPTHAMOLOGY CLINIC	0.000000	0	0	0	0	90.12
90.13	09013	ALLERGY CLINIC	0.000000	0	0	0	0	90.13
90.14	09014	WOUND CARE	0.000000	3,865	0	1,062,269	0	90.14
91.00	09100	EMERGENCY	0.000000	1,643,724	0	5,143,853	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	0	0	2,505,637	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)		23,825,728	0	78,978,549	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-0104 | Period: From 01/01/2019 To 12/31/2019 | Worksheet D Part V Date/Time Prepared: 3/31/2020 8:18 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	0.111015	15,410,988	0	131	1,710,851	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.235208	11,202,131	0	4	2,634,831	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.000000	0	0	0	0	55.00
55.01	05501	ULTRA SOUND	0.112111	998,867	0	0	111,984	55.01
57.00	05700	CT SCAN	0.026803	9,082,757	0	577	243,445	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.071905	5,566,627	0	3	400,268	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.103245	1,754,763	0	0	181,171	59.00
60.00	06000	LABORATORY	0.166339	5,704,955	4,431	0	948,957	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.203930	272,707	0	0	55,613	63.00
64.00	06400	INTRAVENOUS THERAPY	0.001575	473,661	0	0	746	64.00
66.00	06600	PHYSICAL THERAPY	0.415716	18,426	0	0	7,660	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.194345	9,755	0	0	1,896	67.00
67.01	06701	AUDIOLOGY	0.267252	0	0	0	0	67.01
68.00	06800	SPEECH PATHOLOGY	0.300227	124,006	0	0	37,230	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	0	0	0	0	69.00
69.01	06901	CARDIOLOGY	0.140252	7,472,328	0	53	1,048,009	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.416387	1,041,171	0	0	433,530	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.366624	21,760	0	0	7,978	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.123113	11,111,888	0	63,277	1,368,018	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.000000	0	0	0	0	90.00
90.01	09001	OTHER OUTPATIENT SERVICE COST CENTER	0.000000	0	0	0	0	90.01
90.02	09002	CLINIC	0.000000	0	0	0	0	90.02
90.03	09003	DERMATOLOGY CLINIC	0.000000	0	0	0	0	90.03
90.04	09004	ENT CLINIC	0.000000	0	0	0	0	90.04
90.05	09005	SURGERY CLINIC	0.000000	0	0	0	0	90.05
90.07	09007	UROLOGY CLINIC	0.000000	0	0	0	0	90.07
90.09	09009	GASTROENTEROLOGY CLINIC	0.000000	0	0	0	0	90.09
90.11	09011	NEUROLOGY CLINIC	0.000000	0	0	0	0	90.11
90.12	09012	OPTHAMOLOGY CLINIC	0.000000	0	0	0	0	90.12
90.13	09013	ALLERGY CLINIC	0.309534	0	0	0	0	90.13
90.14	09014	WOUND CARE	0.205709	1,062,269	0	5,316	218,518	90.14
91.00	09100	EMERGENCY	0.172311	5,143,853	0	109	886,342	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.492018	2,505,637	0	27	1,232,819	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0.933127		0			95.00
200.00		Subtotal (see instructions)		78,978,549	4,431	69,497	11,529,866	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 - line 201)		78,978,549	4,431	69,497	11,529,866	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-0104 | Period: From 01/01/2019 To 12/31/2019 | Worksheet D Part V Date/Time Prepared: 3/31/2020 8:18 am

Title XVIII | Hospital | PPS

		Cost Center Description	Costs		
			Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	
			6.00	7.00	
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0	15	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	1	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	55.00
55.01	05501	ULTRA SOUND	0	0	55.01
57.00	05700	CT SCAN	0	15	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	59.00
60.00	06000	LABORATORY	737	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	64.00
66.00	06600	PHYSICAL THERAPY	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	67.00
67.01	06701	AUDIOLOGY	0	0	67.01
68.00	06800	SPEECH PATHOLOGY	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	69.00
69.01	06901	CARDIOLOGY	0	7	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	7,790	73.00
		OUTPATIENT SERVICE COST CENTERS			
90.00	09000	CLINIC	0	0	90.00
90.01	09001	OTHER OUTPATIENT SERVICE COST CENTER	0	0	90.01
90.02	09002	CLINIC	0	0	90.02
90.03	09003	DERMATOLOGY CLINIC	0	0	90.03
90.04	09004	ENT CLINIC	0	0	90.04
90.05	09005	SURGERY CLINIC	0	0	90.05
90.07	09007	UROLOGY CLINIC	0	0	90.07
90.09	09009	GASTROENTEROLOGY CLINIC	0	0	90.09
90.11	09011	NEUROLOGY CLINIC	0	0	90.11
90.12	09012	OPTHAMOLOGY CLINIC	0	0	90.12
90.13	09013	ALLERGY CLINIC	0	0	90.13
90.14	09014	WOUND CARE	0	1,094	90.14
91.00	09100	EMERGENCY	0	19	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	13	92.00
		OTHER REIMBURSABLE COST CENTERS			
95.00	09500	AMBULANCE SERVICES	0		95.00
200.00		Subtotal (see instructions)	737	8,954	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0		201.00
202.00		Net Charges (line 200 - line 201)	737	8,954	202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 15-0104 | Component CCN: 15-S104 | Period: From 01/01/2019 To 12/31/2019 | Worksheet D Part II | Date/Time Prepared: 3/31/2020 8:18 am

Title XVIII | Subprovider - IPF | PPS

		Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	520,509	52,732,763	0.009871	7,876	78	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	656,950	34,483,364	0.019051	44,324	844	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	25	0	0.000000	0	0	55.00
55.01	05501	ULTRA SOUND	6,564	9,156,109	0.000717	2,597	2	55.01
57.00	05700	CT SCAN	7,806	45,514,164	0.000172	28,277	5	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	57,910	17,071,948	0.003392	16,567	56	58.00
59.00	05900	CARDIAC CATHETERIZATION	49,631	17,716,676	0.002801	3,182	9	59.00
60.00	06000	LABORATORY	319,047	58,524,884	0.005451	535,363	2,918	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	781	1,115,505	0.000700	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	17	3,398,014	0.000005	3,693	0	64.00
66.00	06600	PHYSICAL THERAPY	288,191	8,292,784	0.034752	38,859	1,350	66.00
67.00	06700	OCCUPATIONAL THERAPY	5,183	3,716,264	0.001395	16,125	22	67.00
67.01	06701	AUDIOLOGY	1,386	950,473	0.001458	0	0	67.01
68.00	06800	SPEECH PATHOLOGY	1,539	1,157,664	0.001329	7,221	10	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0.000000	0	0	69.00
69.01	06901	CARDIOLOGY	42,860	16,057,275	0.002669	53,970	144	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	12,823	8,939,408	0.001434	34,880	50	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	19,473	15,468,574	0.001259	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	18,523	39,627,105	0.000467	732,157	342	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	1	0	0.000000	0	0	90.00
90.01	09001	OTHER OUTPATIENT SERVICE COST CENTER	132,560	0	0.000000	0	0	90.01
90.02	09002	CLINIC	0	0	0.000000	0	0	90.02
90.03	09003	DERMATOLOGY CLINIC	0	0	0.000000	0	0	90.03
90.04	09004	ENT CLINIC	0	0	0.000000	0	0	90.04
90.05	09005	SURGERY CLINIC	0	0	0.000000	0	0	90.05
90.07	09007	UROLOGY CLINIC	0	0	0.000000	0	0	90.07
90.09	09009	GASTROENTEROLOGY CLINIC	59	0	0.000000	0	0	90.09
90.11	09011	NEUROLOGY CLINIC	92	0	0.000000	0	0	90.11
90.12	09012	OPTHAMOLOGY CLINIC	0	0	0.000000	0	0	90.12
90.13	09013	ALLERGY CLINIC	950	723,323	0.001313	0	0	90.13
90.14	09014	WOUND CARE	109,273	5,139,410	0.021262	15	0	90.14
91.00	09100	EMERGENCY	759,239	31,757,712	0.023907	19,781	473	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	5,300,701	0.000000	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)	3,011,392	376,844,120		1,544,887	6,303	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-0104
Component CCN: 15-S104

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

Worksheet D Part IV
Date/Time Prepared: 3/31/2020 8:18 am

Title XVIII | Subprovider - IPF | PPS

		Cost Center Description	Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health	
			1.00	2A	2.00	3A	3.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	0	55.00
55.01	05501	ULTRA SOUND	0	0	0	0	0	55.01
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
67.01	06701	AUDIOLOGY	0	0	0	0	0	67.01
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
69.01	06901	CARDIOLOGY	0	0	0	0	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	0	90.01
90.02	09002	CLINIC	0	0	0	0	0	90.02
90.03	09003	DERMATOLOGY CLINIC	0	0	0	0	0	90.03
90.04	09004	ENT CLINIC	0	0	0	0	0	90.04
90.05	09005	SURGERY CLINIC	0	0	0	0	0	90.05
90.07	09007	UROLOGY CLINIC	0	0	0	0	0	90.07
90.09	09009	GASTROENTEROLOGY CLINIC	0	0	0	0	0	90.09
90.11	09011	NEUROLOGY CLINIC	0	0	0	0	0	90.11
90.12	09012	OPTHAMOLOGY CLINIC	0	0	0	0	0	90.12
90.13	09013	ALLERGY CLINIC	0	0	0	0	0	90.13
90.14	09014	WOUND CARE	0	0	0	0	0	90.14
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: 15-0104 | Component CCN: 15-S104 | Period: From 01/01/2019 To 12/31/2019 | Worksheet D Part IV | Date/Time Prepared: 3/31/2020 8:18 am

Title XVIII | Subprovider - IPF | PPS

		Cost Center Description	All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	
			4.00	5.00	6.00	7.00	8.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	52,732,763	0.000000	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	34,483,364	0.000000	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	0.000000	55.00
55.01	05501	ULTRA SOUND	0	0	0	9,156,109	0.000000	55.01
57.00	05700	CT SCAN	0	0	0	45,514,164	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	17,071,948	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	17,716,676	0.000000	59.00
60.00	06000	LABORATORY	0	0	0	58,524,884	0.000000	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	1,115,505	0.000000	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	3,398,014	0.000000	64.00
66.00	06600	PHYSICAL THERAPY	0	0	0	8,292,784	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	3,716,264	0.000000	67.00
67.01	06701	AUDIOLOGY	0	0	0	950,473	0.000000	67.01
68.00	06800	SPEECH PATHOLOGY	0	0	0	1,157,664	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0.000000	69.00
69.01	06901	CARDIOLOGY	0	0	0	16,057,275	0.000000	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	8,939,408	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	15,468,574	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	39,627,105	0.000000	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0.000000	90.00
90.01	09001	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	0.000000	90.01
90.02	09002	CLINIC	0	0	0	0	0.000000	90.02
90.03	09003	DERMATOLOGY CLINIC	0	0	0	0	0.000000	90.03
90.04	09004	ENT CLINIC	0	0	0	0	0.000000	90.04
90.05	09005	SURGERY CLINIC	0	0	0	0	0.000000	90.05
90.07	09007	UROLOGY CLINIC	0	0	0	157,556	0.000000	90.07
90.09	09009	GASTROENTEROLOGY CLINIC	0	0	0	0	0.000000	90.09
90.11	09011	NEUROLOGY CLINIC	0	0	0	0	0.000000	90.11
90.12	09012	OPTHAMOLOGY CLINIC	0	0	0	0	0.000000	90.12
90.13	09013	ALLERGY CLINIC	0	0	0	723,323	0.000000	90.13
90.14	09014	WOUND CARE	0	0	0	5,139,410	0.000000	90.14
91.00	09100	EMERGENCY	0	0	0	31,757,712	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	5,300,701	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	377,001,676		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-0104 | Component CCN: 15-S104 | Period: From 01/01/2019 To 12/31/2019 | Worksheet D Part IV | Date/Time Prepared: 3/31/2020 8:18 am

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		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	7,876	0	0	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	44,324	0	37	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.000000	0	0	0	0	55.00
55.01	05501	ULTRA SOUND	0.000000	2,597	0	0	0	55.01
57.00	05700	CT SCAN	0.000000	28,277	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000	16,567	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	3,182	0	0	0	59.00
60.00	06000	LABORATORY	0.000000	535,363	0	0	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.000000	0	0	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0.000000	3,693	0	0	0	64.00
66.00	06600	PHYSICAL THERAPY	0.000000	38,859	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	16,125	0	0	0	67.00
67.01	06701	AUDIOLOGY	0.000000	0	0	0	0	67.01
68.00	06800	SPEECH PATHOLOGY	0.000000	7,221	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	0	0	0	0	69.00
69.01	06901	CARDIOLOGY	0.000000	53,970	0	0	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	34,880	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.000000	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	732,157	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.000000	0	0	0	0	90.00
90.01	09001	OTHER OUTPATIENT SERVICE COST CENTER	0.000000	0	0	0	0	90.01
90.02	09002	CLINIC	0.000000	0	0	0	0	90.02
90.03	09003	DERMATOLOGY CLINIC	0.000000	0	0	0	0	90.03
90.04	09004	ENT CLINIC	0.000000	0	0	0	0	90.04
90.05	09005	SURGERY CLINIC	0.000000	0	0	0	0	90.05
90.07	09007	UROLOGY CLINIC	0.000000	0	0	0	0	90.07
90.09	09009	GASTROENTEROLOGY CLINIC	0.000000	0	0	0	0	90.09
90.11	09011	NEUROLOGY CLINIC	0.000000	0	0	0	0	90.11
90.12	09012	OPTHAMOLOGY CLINIC	0.000000	0	0	0	0	90.12
90.13	09013	ALLERGY CLINIC	0.000000	0	0	0	0	90.13
90.14	09014	WOUND CARE	0.000000	15	0	0	0	90.14
91.00	09100	EMERGENCY	0.000000	19,781	0	1,223	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)		1,544,887	0	1,260	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 15-0104 | Component CCN: 15-S104 | Period: From 01/01/2019 To 12/31/2019 | Worksheet D Part V | Date/Time Prepared: 3/31/2020 8:18 am

Title XVIII | Subprovider - IPF | PPS

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.111015	0	0	10	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.235208	37	0	0	9	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.000000	0	0	0	0	55.00
55.01	05501	ULTRA SOUND	0.112111	0	0	0	0	55.01
57.00	05700	CT SCAN	0.026803	0	0	44	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.071905	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.103245	0	0	0	0	59.00
60.00	06000	LABORATORY	0.166339	0	0	0	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.203930	0	0	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0.001575	0	0	0	0	64.00
66.00	06600	PHYSICAL THERAPY	0.415716	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.194345	0	0	0	0	67.00
67.01	06701	AUDIOLOGY	0.267252	0	0	0	0	67.01
68.00	06800	SPEECH PATHOLOGY	0.300227	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	0	0	0	0	69.00
69.01	06901	CARDIOLOGY	0.140252	0	0	4	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.416387	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.366624	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.123113	0	0	4,827	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.000000	0	0	0	0	90.00
90.01	09001	OTHER OUTPATIENT SERVICE COST CENTER	0.000000	0	0	0	0	90.01
90.02	09002	CLINIC	0.000000	0	0	0	0	90.02
90.03	09003	DERMATOLOGY CLINIC	0.000000	0	0	0	0	90.03
90.04	09004	ENT CLINIC	0.000000	0	0	0	0	90.04
90.05	09005	SURGERY CLINIC	0.000000	0	0	0	0	90.05
90.07	09007	UROLOGY CLINIC	0.000000	0	0	0	0	90.07
90.09	09009	GASTROENTEROLOGY CLINIC	0.000000	0	0	0	0	90.09
90.11	09011	NEUROLOGY CLINIC	0.000000	0	0	0	0	90.11
90.12	09012	OPTHAMOLOGY CLINIC	0.000000	0	0	0	0	90.12
90.13	09013	ALLERGY CLINIC	0.309534	0	0	0	0	90.13
90.14	09014	WOUND CARE	0.205709	0	0	406	0	90.14
91.00	09100	EMERGENCY	0.172311	1,223	0	0	211	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.492018	0	0	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0.933127		0			95.00
200.00		Subtotal (see instructions)		1,260	0	5,291	220	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 - line 201)		1,260	0	5,291	220	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-0104 | Component CCN: 15-S104 | Period: From 01/01/2019 To 12/31/2019 | Worksheet D Part V | Date/Time Prepared: 3/31/2020 8:18 am

Title XVIII | Subprovider - IPF | PPS

		Cost Center Description	Costs		
			Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	
			6.00	7.00	
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0	1	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	55.00
55.01	05501	ULTRA SOUND	0	0	55.01
57.00	05700	CT SCAN	0	1	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	59.00
60.00	06000	LABORATORY	0	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	64.00
66.00	06600	PHYSICAL THERAPY	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	67.00
67.01	06701	AUDIOLOGY	0	0	67.01
68.00	06800	SPEECH PATHOLOGY	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	69.00
69.01	06901	CARDIOLOGY	0	1	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	594	73.00
		OUTPATIENT SERVICE COST CENTERS			
90.00	09000	CLINIC	0	0	90.00
90.01	09001	OTHER OUTPATIENT SERVICE COST CENTER	0	0	90.01
90.02	09002	CLINIC	0	0	90.02
90.03	09003	DERMATOLOGY CLINIC	0	0	90.03
90.04	09004	ENT CLINIC	0	0	90.04
90.05	09005	SURGERY CLINIC	0	0	90.05
90.07	09007	UROLOGY CLINIC	0	0	90.07
90.09	09009	GASTROENTEROLOGY CLINIC	0	0	90.09
90.11	09011	NEUROLOGY CLINIC	0	0	90.11
90.12	09012	OPTHAMOLOGY CLINIC	0	0	90.12
90.13	09013	ALLERGY CLINIC	0	0	90.13
90.14	09014	WOUND CARE	0	84	90.14
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	681	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0		201.00
202.00		Net Charges (line 200 - line 201)	0	681	202.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 15-0104 Component CCN: 15-5832	Period: From 01/01/2019 To 12/31/2019	Worksheet D Part IV Date/Time Prepared: 3/31/2020 8:18 am
	Title XVIII	Skilled Nursing Facility	PPS

		Cost Center Description	Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health	
			1.00	2A	2.00	3A	3.00	
	ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	0	55.00
55.01	05501	ULTRA SOUND	0	0	0	0	0	55.01
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
67.01	06701	AUDIOLOGY	0	0	0	0	0	67.01
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
69.01	06901	CARDIOLOGY	0	0	0	0	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
	OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	0	90.01
90.02	09002	CLINIC	0	0	0	0	0	90.02
90.03	09003	DERMATOLOGY CLINIC	0	0	0	0	0	90.03
90.04	09004	ENT CLINIC	0	0	0	0	0	90.04
90.05	09005	SURGERY CLINIC	0	0	0	0	0	90.05
90.07	09007	UROLOGY CLINIC	0	0	0	0	0	90.07
90.09	09009	GASTROENTEROLOGY CLINIC	0	0	0	0	0	90.09
90.11	09011	NEUROLOGY CLINIC	0	0	0	0	0	90.11
90.12	09012	OPTHAMOLOGY CLINIC	0	0	0	0	0	90.12
90.13	09013	ALLERGY CLINIC	0	0	0	0	0	90.13
90.14	09014	WOUND CARE	0	0	0	0	0	90.14
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: 15-0104 | Component CCN: 15-5832 | Period: From 01/01/2019 To 12/31/2019 | Worksheet D Part IV | Date/Time Prepared: 3/31/2020 8:18 am

Title XVIII | Skilled Nursing Facility | PPS

		Cost Center Description	All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	
			4.00	5.00	6.00	7.00	8.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	52,732,763	0.000000	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	34,483,364	0.000000	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	0.000000	55.00
55.01	05501	ULTRA SOUND	0	0	0	9,156,109	0.000000	55.01
57.00	05700	CT SCAN	0	0	0	45,514,164	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	17,071,948	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	17,716,676	0.000000	59.00
60.00	06000	LABORATORY	0	0	0	58,524,884	0.000000	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	1,115,505	0.000000	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	3,398,014	0.000000	64.00
66.00	06600	PHYSICAL THERAPY	0	0	0	8,292,784	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	3,716,264	0.000000	67.00
67.01	06701	AUDIOLOGY	0	0	0	950,473	0.000000	67.01
68.00	06800	SPEECH PATHOLOGY	0	0	0	1,157,664	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0.000000	69.00
69.01	06901	CARDIOLOGY	0	0	0	16,057,275	0.000000	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	8,939,408	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	15,468,574	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	39,627,105	0.000000	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0.000000	90.00
90.01	09001	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	0.000000	90.01
90.02	09002	CLINIC	0	0	0	0	0.000000	90.02
90.03	09003	DERMATOLOGY CLINIC	0	0	0	0	0.000000	90.03
90.04	09004	ENT CLINIC	0	0	0	0	0.000000	90.04
90.05	09005	SURGERY CLINIC	0	0	0	0	0.000000	90.05
90.07	09007	UROLOGY CLINIC	0	0	0	157,556	0.000000	90.07
90.09	09009	GASTROENTEROLOGY CLINIC	0	0	0	0	0.000000	90.09
90.11	09011	NEUROLOGY CLINIC	0	0	0	0	0.000000	90.11
90.12	09012	OPTHAMOLOGY CLINIC	0	0	0	0	0.000000	90.12
90.13	09013	ALLERGY CLINIC	0	0	0	723,323	0.000000	90.13
90.14	09014	WOUND CARE	0	0	0	5,139,410	0.000000	90.14
91.00	09100	EMERGENCY	0	0	0	31,757,712	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	5,300,701	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	377,001,676		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-0104 | Component CCN: 15-5832 | Period: From 01/01/2019 To 12/31/2019 | Worksheet D Part IV | Date/Time Prepared: 3/31/2020 8:18 am

Title XVIII | Skilled Nursing Facility | PPS

		Cost Center Description	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
			9.00	10.00	11.00	12.00	13.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.000000	63,565	0	0	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	39,577	0	0	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.000000	0	0	0	0	55.00
55.01	05501	ULTRA SOUND	0.000000	2,453	0	0	0	55.01
57.00	05700	CT SCAN	0.000000	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	26,534	0	0	0	59.00
60.00	06000	LABORATORY	0.000000	244,122	0	0	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.000000	0	0	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0.000000	15,511	0	0	0	64.00
66.00	06600	PHYSICAL THERAPY	0.000000	1,111,384	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	1,199,192	0	0	0	67.00
67.01	06701	AUDIOLOGY	0.000000	0	0	0	0	67.01
68.00	06800	SPEECH PATHOLOGY	0.000000	66,995	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	0	0	0	0	69.00
69.01	06901	CARDIOLOGY	0.000000	513,147	0	0	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	148,488	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.000000	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	1,208,563	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.000000	0	0	0	0	90.00
90.01	09001	OTHER OUTPATIENT SERVICE COST CENTER	0.000000	0	0	0	0	90.01
90.02	09002	CLINIC	0.000000	0	0	0	0	90.02
90.03	09003	DERMATOLOGY CLINIC	0.000000	0	0	0	0	90.03
90.04	09004	ENT CLINIC	0.000000	0	0	0	0	90.04
90.05	09005	SURGERY CLINIC	0.000000	0	0	0	0	90.05
90.07	09007	UROLOGY CLINIC	0.000000	0	0	0	0	90.07
90.09	09009	GASTROENTEROLOGY CLINIC	0.000000	0	0	0	0	90.09
90.11	09011	NEUROLOGY CLINIC	0.000000	0	0	0	0	90.11
90.12	09012	OPTHAMOLOGY CLINIC	0.000000	0	0	0	0	90.12
90.13	09013	ALLERGY CLINIC	0.000000	0	0	0	0	90.13
90.14	09014	WOUND CARE	0.000000	122	0	0	0	90.14
91.00	09100	EMERGENCY	0.000000	672	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)		4,640,325	0	0	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 15-0104 | Component CCN: 15-5832 | Period: From 01/01/2019 To 12/31/2019 | Worksheet D Part V | Date/Time Prepared: 3/31/2020 8:18 am

Title XVIII | Skilled Nursing Facility | PPS

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.111015	0	0	0	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.235208	0	0	0	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.000000	0	0	0	0	55.00
55.01	05501	ULTRA SOUND	0.112111	0	0	0	0	55.01
57.00	05700	CT SCAN	0.026803	0	0	139	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.071905	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.103245	0	0	0	0	59.00
60.00	06000	LABORATORY	0.166339	0	0	0	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.203930	0	0	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0.001575	0	0	0	0	64.00
66.00	06600	PHYSICAL THERAPY	0.415716	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.194345	0	0	0	0	67.00
67.01	06701	AUDIOLOGY	0.267252	0	0	0	0	67.01
68.00	06800	SPEECH PATHOLOGY	0.300227	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	0	0	0	0	69.00
69.01	06901	CARDIOLOGY	0.140252	0	0	16	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.416387	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.366624	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.123113	0	0	5,101	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.000000	0	0	0	0	90.00
90.01	09001	OTHER OUTPATIENT SERVICE COST CENTER	0.000000	0	0	0	0	90.01
90.02	09002	CLINIC	0.000000	0	0	0	0	90.02
90.03	09003	DERMATOLOGY CLINIC	0.000000	0	0	0	0	90.03
90.04	09004	ENT CLINIC	0.000000	0	0	0	0	90.04
90.05	09005	SURGERY CLINIC	0.000000	0	0	0	0	90.05
90.07	09007	UROLOGY CLINIC	0.000000	0	0	0	0	90.07
90.09	09009	GASTROENTEROLOGY CLINIC	0.000000	0	0	0	0	90.09
90.11	09011	NEUROLOGY CLINIC	0.000000	0	0	0	0	90.11
90.12	09012	OPTHAMOLOGY CLINIC	0.000000	0	0	0	0	90.12
90.13	09013	ALLERGY CLINIC	0.309534	0	0	0	0	90.13
90.14	09014	WOUND CARE	0.205709	0	0	8	0	90.14
91.00	09100	EMERGENCY	0.172311	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.492018	0	0	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0.933127		0			95.00
200.00		Subtotal (see instructions)		0	0	5,264	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 - line 201)		0	0	5,264	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 15-0104 | Component CCN: 15-5832 | Period: From 01/01/2019 To 12/31/2019 | Worksheet D Part V | Date/Time Prepared: 3/31/2020 8:18 am

Title XVIII | Skilled Nursing Facility | PPS

		Cost Center Description	Costs: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	
			6.00	7.00	
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	55.00
55.01	05501	ULTRA SOUND	0	0	55.01
57.00	05700	CT SCAN	0	4	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	59.00
60.00	06000	LABORATORY	0	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	64.00
66.00	06600	PHYSICAL THERAPY	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	67.00
67.01	06701	AUDIOLOGY	0	0	67.01
68.00	06800	SPEECH PATHOLOGY	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	69.00
69.01	06901	CARDIOLOGY	0	2	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	628	73.00
		OUTPATIENT SERVICE COST CENTERS			
90.00	09000	CLINIC	0	0	90.00
90.01	09001	OTHER OUTPATIENT SERVICE COST CENTER	0	0	90.01
90.02	09002	CLINIC	0	0	90.02
90.03	09003	DERMATOLOGY CLINIC	0	0	90.03
90.04	09004	ENT CLINIC	0	0	90.04
90.05	09005	SURGERY CLINIC	0	0	90.05
90.07	09007	UROLOGY CLINIC	0	0	90.07
90.09	09009	GASTROENTEROLOGY CLINIC	0	0	90.09
90.11	09011	NEUROLOGY CLINIC	0	0	90.11
90.12	09012	OPTHAMOLOGY CLINIC	0	0	90.12
90.13	09013	ALLERGY CLINIC	0	0	90.13
90.14	09014	WOUND CARE	0	2	90.14
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	636	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0		201.00
202.00		Net Charges (line 200 - line 201)	0	636	202.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-0104 | Period: From 01/01/2019 To 12/31/2019 | Worksheet D-1 | Date/Time Prepared: 3/31/2020 8:18 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)	7,486	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	7,486	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)	5,428	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)	2,125	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)	9,486,764	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)	9,486,764	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)	9,486,764	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)	1,267.27	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	2,692,949	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)	2,692,949	41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 15-0104 | Period: From 01/01/2019 To 12/31/2019 | Worksheet D-1 | Date/Time Prepared: 3/31/2020 8:18 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	2,851,261	1,705	1,672.29	781	1,306,058	43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	3,567,399	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	7,566,406	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)	308,604	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	159,332	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	467,936	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	7,098,470	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)	2,058	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	1,267.27	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	2,608,042	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-0104 | Period: From 01/01/2019 To 12/31/2019 | Worksheet D-1 | Date/Time Prepared: 3/31/2020 8:18 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	778,848	9,486,764	0.082098	2,608,042	214,115	90.00
91.00	Nursing School cost	0	9,486,764	0.000000	2,608,042	0	91.00
92.00	Allied health cost	0	9,486,764	0.000000	2,608,042	0	92.00
93.00	All other Medical Education	0	9,486,764	0.000000	2,608,042	0	93.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 15-0104 | Component CCN: 15-S104 | Period: From 01/01/2019 To 12/31/2019 | Worksheet D-1 | Date/Time Prepared: 3/31/2020 8:18 am

Title XVIII | Subprovider - IPF | PPS

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	3,211	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	3,211	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)	3,211	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)	2,535	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)	0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period	0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15.00	Total nursery days (title V or XIX only)	0	15.00
16.00	Nursery days (title V or XIX only)	0	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period	0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period	0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)	2,903,274	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)	0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)	0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)	0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)	0	25.00
26.00	Total swing-bed cost (see instructions)	0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	2,903,274	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)	2,903,274	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)	904.17	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	2,292,071	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)	2,292,071	41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 15-0104 | Component CCN: 15-S104 | Period: From 01/01/2019 To 12/31/2019 | Worksheet D-1 | Date/Time Prepared: 3/31/2020 8:18 am

Title XVIII | Subprovider - IPF | PPS

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

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	240,024	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	2,532,095	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)	207,160	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	6,303	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	213,463	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	2,318,632	53.00
	TARGET AMOUNT AND LIMIT COMPUTATION		
54.00	Program discharges	0	54.00
55.00	Target amount per discharge	0.00	55.00
56.00	Target amount (line 54 x line 55)	0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)	0	57.00
58.00	Bonus payment (see instructions)	0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket	0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket	0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)	0	61.00
62.00	Relief payment (see instructions)	0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)	0	63.00
	PROGRAM INPATIENT ROUTINE SWING BED COST		
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)	0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)	0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)	0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)	0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)	0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)	0	69.00
	PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY		
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)		70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)		71.00
72.00	Program routine service cost (line 9 x line 71)		72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)		73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)		74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)		75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)		76.00
77.00	Program capital-related costs (line 9 x line 76)		77.00
78.00	Inpatient routine service cost (line 74 minus line 77)		78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)		79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)		80.00
81.00	Inpatient routine service cost per diem limitation		81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)		82.00
83.00	Reasonable inpatient routine service costs (see instructions)		83.00
84.00	Program inpatient ancillary services (see instructions)		84.00
85.00	Utilization review - physician compensation (see instructions)		85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)		86.00
	PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST		
87.00	Total observation bed days (see instructions)	0	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	0.00	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	0	89.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 15-0104 | Component CCN: 15-S104 | Period: From 01/01/2019 To 12/31/2019 | Worksheet D-1 | Date/Time Prepared: 3/31/2020 8:18 am

Title XVIII | Subprovider - IPF | PPS

	Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	262,409	2,903,274	0.090384	0	0	90.00
91.00	Nursing School cost	0	2,903,274	0.000000	0	0	91.00
92.00	Allied health cost	0	2,903,274	0.000000	0	0	92.00
93.00	All other Medical Education	0	2,903,274	0.000000	0	0	93.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 15-0104 | Component CCN: 15-5832 | Period: From 01/01/2019 To 12/31/2019 | Worksheet D-1 | Date/Time Prepared: 3/31/2020 8:18 am

Title XVIII | Skilled Nursing Facility | PPS

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	5,125	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	5,125	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)	5,125	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)	3,051	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)	3,142,051	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)	3,142,051	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	28.00
29.00	Private room charges (excluding swing-bed charges)	0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)	0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)	0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)	0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	3,142,051	37.00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY		
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS		
38.00	Adjusted general inpatient routine service cost per diem (see instructions)		38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)		40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)		41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 15-0104 | Component CCN: 15-5832 | Period: From 01/01/2019 To 12/31/2019 | Worksheet D-1 | Date/Time Prepared: 3/31/2020 8:18 am

Title XVIII | Skilled Nursing Facility | PPS

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

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)		48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)		49.00
	PASS THROUGH COST ADJUSTMENTS		
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)		50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)		51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)		52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)		53.00
	TARGET AMOUNT AND LIMIT COMPUTATION		
54.00	Program discharges		54.00
55.00	Target amount per discharge		55.00
56.00	Target amount (line 54 x line 55)		56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)		57.00
58.00	Bonus payment (see instructions)		58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket		59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket		60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)		61.00
62.00	Relief payment (see instructions)		62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)		63.00
	PROGRAM INPATIENT ROUTINE SWING BED COST		
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)		64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)		65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)		66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)		67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)		68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)		69.00
	PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY		
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)	3,142,051	70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)	613.08	71.00
72.00	Program routine service cost (line 9 x line 71)	1,870,507	72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)	0	73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)	1,870,507	74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)	0	75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)	0.00	76.00
77.00	Program capital-related costs (line 9 x line 76)	0	77.00
78.00	Inpatient routine service cost (line 74 minus line 77)	0	78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)	0	79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)	0	80.00
81.00	Inpatient routine service cost per diem limitation	0.00	81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)	0	82.00
83.00	Reasonable inpatient routine service costs (see instructions)	1,870,507	83.00
84.00	Program inpatient ancillary services (see instructions)	1,057,932	84.00
85.00	Utilization review - physician compensation (see instructions)	0	85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)	2,928,439	86.00
	PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST		
87.00	Total observation bed days (see instructions)	0	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	0.00	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	0	89.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 15-0104 | Period: From 01/01/2019 To 12/31/2019 | Worksheet D-1

Component CCN: 15-5832 | Date/Time Prepared: 3/31/2020 8:18 am

Title XVIII | Skilled Nursing Facility | PPS

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

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 15-0104 | Period: From 01/01/2019 To 12/31/2019 | Worksheet D-1 | Date/Time Prepared: 3/31/2020 8:18 am

Title XIX | Hospital | Cost

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	7,486	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	7,486	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)	5,428	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)	317	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)	1,080	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)	9,486,764	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)	9,486,764	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)	9,486,764	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)	1,267.27	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	401,725	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)	401,725	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-0104 | Period: From 01/01/2019 To 12/31/2019 | Worksheet D-1 | Date/Time Prepared: 3/31/2020 8:18 am

Title XIX | Hospital | Cost

	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)	66,696	1,080	61.76	0	0	42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	2,851,261	1,705	1,672.29	0	0	43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	171,394	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	573,119	49.00
	PASS THROUGH COST ADJUSTMENTS		
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)	0	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	0	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	0	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	0	53.00
	TARGET AMOUNT AND LIMIT COMPUTATION		
54.00	Program discharges	0	54.00
55.00	Target amount per discharge	0.00	55.00
56.00	Target amount (line 54 x line 55)	0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)	0	57.00
58.00	Bonus payment (see instructions)	0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket	0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket	0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)	0	61.00
62.00	Relief payment (see instructions)	0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)	0	63.00
	PROGRAM INPATIENT ROUTINE SWING BED COST		
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)	0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)	0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)	0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)	0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)	0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)	0	69.00
	PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY		
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)		70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)		71.00
72.00	Program routine service cost (line 9 x line 71)		72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)		73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)		74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)		75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)		76.00
77.00	Program capital-related costs (line 9 x line 76)		77.00
78.00	Inpatient routine service cost (line 74 minus line 77)		78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)		79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)		80.00
81.00	Inpatient routine service cost per diem limitation		81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)		82.00
83.00	Reasonable inpatient routine service costs (see instructions)		83.00
84.00	Program inpatient ancillary services (see instructions)		84.00
85.00	Utilization review - physician compensation (see instructions)		85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)		86.00
	PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST		
87.00	Total observation bed days (see instructions)	2,058	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	1,267.27	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	2,608,042	89.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 15-0104	Period: From 01/01/2019 To 12/31/2019	Worksheet D-1 Date/Time Prepared: 3/31/2020 8:18 am
	Title XIX	Hospital	Cost

	Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	778,848	9,486,764	0.082098	2,608,042	214,115	90.00
91.00	Nursing School cost	0	9,486,764	0.000000	2,608,042	0	91.00
92.00	Allied health cost	0	9,486,764	0.000000	2,608,042	0	92.00
93.00	All other Medical Education	0	9,486,764	0.000000	2,608,042	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 15-0104 | Period: From 01/01/2019 To 12/31/2019 | Worksheet D-3 | Date/Time Prepared: 3/31/2020 8:18 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		2,292,350		30.00
31.00	03100	INTENSIVE CARE UNIT		1,937,539		31.00
40.00	04000	SUBPROVIDER - IPF		0		40.00
41.00	04100	SUBPROVIDER - IRF		0		41.00
42.00	04200	SUBPROVIDER		0		42.00
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.111015	4,844,427	537,804	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.235208	969,860	228,119	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.000000	0	0	55.00
55.01	05501	ULTRA SOUND	0.112111	70,105	7,860	55.01
57.00	05700	CT SCAN	0.026803	2,011,146	53,905	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.071905	271,886	19,550	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.103245	447,522	46,204	59.00
60.00	06000	LABORATORY	0.166339	4,077,019	678,167	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.203930	191,312	39,014	63.00
64.00	06400	INTRAVENOUS THERAPY	0.001575	523,046	824	64.00
66.00	06600	PHYSICAL THERAPY	0.415716	442,059	183,771	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.194345	336,611	65,419	67.00
67.01	06701	AUDIOLOGY	0.267252	0	0	67.01
68.00	06800	SPEECH PATHOLOGY	0.300227	77,670	23,319	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	0	0	69.00
69.01	06901	CARDIOLOGY	0.140252	3,585,261	502,840	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.416387	1,239,351	516,050	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.366624	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.123113	3,090,864	380,526	73.00
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0.000000	0	0	90.00
90.01	09001	OTHER OUTPATIENT SERVICE COST CENTER	0.000000	0	0	90.01
90.02	09002	CLINIC	0.000000	0	0	90.02
90.03	09003	DERMATOLOGY CLINIC	0.000000	0	0	90.03
90.04	09004	ENT CLINIC	0.000000	0	0	90.04
90.05	09005	SURGERY CLINIC	0.000000	0	0	90.05
90.07	09007	UROLOGY CLINIC	0.000000	0	0	90.07
90.09	09009	GASTROENTEROLOGY CLINIC	0.000000	0	0	90.09
90.11	09011	NEUROLOGY CLINIC	0.000000	0	0	90.11
90.12	09012	OPTHAMOLOGY CLINIC	0.000000	0	0	90.12
90.13	09013	ALLERGY CLINIC	0.309534	0	0	90.13
90.14	09014	WOUND CARE	0.205709	3,865	795	90.14
91.00	09100	EMERGENCY	0.172311	1,643,724	283,232	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.492018	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)		23,825,728	3,567,399	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)		23,825,728		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provider CCN: 15-0104 Component CCN: 15-S104	Period: From 01/01/2019 To 12/31/2019	Worksheet D-3 Date/Time Prepared: 3/31/2020 8:18 am
	Title XVIII	Subprovider - IPF	PPS

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		0		30.00
31.00	03100	INTENSIVE CARE UNIT		0		31.00
40.00	04000	SUBPROVIDER - IPF		3,181,130		40.00
41.00	04100	SUBPROVIDER - IRF		0		41.00
42.00	04200	SUBPROVIDER		0		42.00
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.111015	7,876	874	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.235208	44,324	10,425	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.000000	0	0	55.00
55.01	05501	ULTRA SOUND	0.112111	2,597	291	55.01
57.00	05700	CT SCAN	0.026803	28,277	758	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.071905	16,567	1,191	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.103245	3,182	329	59.00
60.00	06000	LABORATORY	0.166339	535,363	89,052	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.203930	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0.001575	3,693	6	64.00
66.00	06600	PHYSICAL THERAPY	0.415716	38,859	16,154	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.194345	16,125	3,134	67.00
67.01	06701	AUDIOLOGY	0.267252	0	0	67.01
68.00	06800	SPEECH PATHOLOGY	0.300227	7,221	2,168	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	0	0	69.00
69.01	06901	CARDIOLOGY	0.140252	53,970	7,569	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.416387	34,880	14,524	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.366624	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.123113	732,157	90,138	73.00
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0.000000	0	0	90.00
90.01	09001	OTHER OUTPATIENT SERVICE COST CENTER	0.000000	0	0	90.01
90.02	09002	CLINIC	0.000000	0	0	90.02
90.03	09003	DERMATOLOGY CLINIC	0.000000	0	0	90.03
90.04	09004	ENT CLINIC	0.000000	0	0	90.04
90.05	09005	SURGERY CLINIC	0.000000	0	0	90.05
90.07	09007	UROLOGY CLINIC	0.000000	0	0	90.07
90.09	09009	GASTROENTEROLOGY CLINIC	0.000000	0	0	90.09
90.11	09011	NEUROLOGY CLINIC	0.000000	0	0	90.11
90.12	09012	OPTHAMOLOGY CLINIC	0.000000	0	0	90.12
90.13	09013	ALLERGY CLINIC	0.309534	0	0	90.13
90.14	09014	WOUND CARE	0.205709	15	3	90.14
91.00	09100	EMERGENCY	0.172311	19,781	3,408	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.492018	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)		1,544,887	240,024	200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0		201.00
202.00		Net charges (line 200 minus line 201)		1,544,887		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provider CCN: 15-0104 Component CCN: 15-5832	Period: From 01/01/2019 To 12/31/2019	Worksheet D-3 Date/Time Prepared: 3/31/2020 8:18 am
	Title XVIII	Skilled Nursing Facility	PPS

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		0		30.00
31.00	03100	INTENSIVE CARE UNIT		0		31.00
40.00	04000	SUBPROVIDER - IPF		0		40.00
41.00	04100	SUBPROVIDER - IRF		0		41.00
42.00	04200	SUBPROVIDER		0		42.00
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.111015	63,565	7,057	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.235208	39,577	9,309	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.000000	0	0	55.00
55.01	05501	ULTRA SOUND	0.112111	2,453	275	55.01
57.00	05700	CT SCAN	0.026803	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.071905	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.103245	26,534	2,740	59.00
60.00	06000	LABORATORY	0.166339	244,122	40,607	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.203930	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0.001575	15,511	24	64.00
66.00	06600	PHYSICAL THERAPY	0.415716	1,111,384	462,020	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.194345	1,199,192	233,057	67.00
67.01	06701	AUDIOLOGY	0.267252	0	0	67.01
68.00	06800	SPEECH PATHOLOGY	0.300227	66,995	20,114	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	0	0	69.00
69.01	06901	CARDIOLOGY	0.140252	513,147	71,970	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.416387	148,488	61,828	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.366624	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.123113	1,208,563	148,790	73.00
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0.000000	0	0	90.00
90.01	09001	OTHER OUTPATIENT SERVICE COST CENTER	0.000000	0	0	90.01
90.02	09002	CLINIC	0.000000	0	0	90.02
90.03	09003	DERMATOLOGY CLINIC	0.000000	0	0	90.03
90.04	09004	ENT CLINIC	0.000000	0	0	90.04
90.05	09005	SURGERY CLINIC	0.000000	0	0	90.05
90.07	09007	UROLOGY CLINIC	0.000000	0	0	90.07
90.09	09009	GASTROENTEROLOGY CLINIC	0.000000	0	0	90.09
90.11	09011	NEUROLOGY CLINIC	0.000000	0	0	90.11
90.12	09012	OPTHAMOLOGY CLINIC	0.000000	0	0	90.12
90.13	09013	ALLERGY CLINIC	0.309534	0	0	90.13
90.14	09014	WOUND CARE	0.205709	122	25	90.14
91.00	09100	EMERGENCY	0.172311	672	116	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.492018	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)		4,640,325	1,057,932	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)		4,640,325		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provider CCN: 15-0104	Period: From 01/01/2019 To 12/31/2019	Worksheet D-3 Date/Time Prepared: 3/31/2020 8:18 am
	Title XIX	Hospital	Cost

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		794,137		30.00
31.00	03100	INTENSIVE CARE UNIT		95,129		31.00
40.00	04000	SUBPROVIDER - IPF		0		40.00
41.00	04100	SUBPROVIDER - IRF		0		41.00
42.00	04200	SUBPROVIDER		0		42.00
43.00	04300	NURSERY		213,420		43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.111015	190,891	21,192	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.235208	25,117	5,908	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.000000	0	0	55.00
55.01	05501	ULTRA SOUND	0.112111	12,191	1,367	55.01
57.00	05700	CT SCAN	0.026803	96,143	2,577	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.071905	10,108	727	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.103245	74,259	7,667	59.00
60.00	06000	LABORATORY	0.166339	200,519	33,354	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.203930	12,963	2,644	63.00
64.00	06400	INTRAVENOUS THERAPY	0.001575	38,758	61	64.00
66.00	06600	PHYSICAL THERAPY	0.415716	11,365	4,725	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.194345	5,907	1,148	67.00
67.01	06701	AUDIOLOGY	0.267252	0	0	67.01
68.00	06800	SPEECH PATHOLOGY	0.300227	1,220	366	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	0	0	69.00
69.01	06901	CARDIOLOGY	0.140252	68,364	9,588	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.416387	117,653	48,989	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.366624	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.123113	155,894	19,193	73.00
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0.000000	0	0	90.00
90.01	09001	OTHER OUTPATIENT SERVICE COST CENTER	0.000000	0	0	90.01
90.02	09002	CLINIC	0.000000	0	0	90.02
90.03	09003	DERMATOLOGY CLINIC	0.000000	0	0	90.03
90.04	09004	ENT CLINIC	0.000000	0	0	90.04
90.05	09005	SURGERY CLINIC	0.000000	0	0	90.05
90.07	09007	UROLOGY CLINIC	0.000000	0	0	90.07
90.09	09009	GASTROENTEROLOGY CLINIC	0.000000	0	0	90.09
90.11	09011	NEUROLOGY CLINIC	0.000000	0	0	90.11
90.12	09012	OPTHAMOLOGY CLINIC	0.000000	0	0	90.12
90.13	09013	ALLERGY CLINIC	0.309534	0	0	90.13
90.14	09014	WOUND CARE	0.205709	0	0	90.14
91.00	09100	EMERGENCY	0.172311	68,989	11,888	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.492018	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)		1,090,341	171,394	200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0		201.00
202.00		Net charges (line 200 minus line 201)		1,090,341		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0104	Period: From 01/01/2019 To 12/31/2019	Worksheet E Part A Date/Time Prepared: 3/31/2020 8:18 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)	4,595,337	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1 (see instructions)	1,553,725	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)	2,113	2.03
2.04	Outlier payments for discharges occurring on or after October 1 (see instructions)	3,628	2.04
3.00	Managed Care Simulated Payments	0	3.00
4.00	Bed days available divided by number of days in the cost reporting period (see instructions)	62.35	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)	3.37	30.00
31.00	Percentage of Medicaid patient days (see instructions)	25.09	31.00
32.00	Sum of lines 30 and 31	28.46	32.00
33.00	Allowable disproportionate share percentage (see instructions)	12.00	33.00
34.00	Disproportionate share adjustment (see instructions)	184,472	34.00

CALCULATION OF REIMBURSEMENT SETTLEMENT | Provider CCN: 15-0104 | Period: From 01/01/2019 To 12/31/2019 | Worksheet E Part A | Date/Time Prepared: 3/31/2020 8:18 am

		Title XVIII	Hospital	PPS
		Prior to 10/1	On/After 10/1	
		1.00	2.00	
	Uncompensated Care Adjustment			
35.00	Total uncompensated care amount (see instructions)	0	0	35.00
35.01	Factor 3 (see instructions)	0.000000000	0.000000000	35.01
35.02	Hospital uncompensated care payment (If line 34 is zero, enter zero on this line) (see instructions)	834,440	950,269	35.02
35.03	Pro rata share of the hospital uncompensated care payment amount (see instructions)	624,115	238,865	35.03
36.00	Total uncompensated care (sum of columns 1 and 2 on line 35.03)	862,980		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)	7,202,255		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)	7,202,255	49.00
50.00	Payment for inpatient program capital (from Wkst. L, Pt. I and Pt. II, as applicable)	499,039	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)	7,701,294	59.00
60.00	Primary payer payments	0	60.00
61.00	Total amount payable for program beneficiaries (line 59 minus line 60)	7,701,294	61.00
62.00	Deductibles billed to program beneficiaries	833,164	62.00
63.00	Coinsurance billed to program beneficiaries	5,115	63.00
64.00	Allowable bad debts (see instructions)	55,302	64.00
65.00	Adjusted reimbursable bad debts (see instructions)	35,946	65.00
66.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	15,980	66.00
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)	6,898,961	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)	47,973	70.93
70.94	HRR adjustment amount (see instructions)	-62,363	70.94
70.95	Recovery of accelerated depreciation	0	70.95

CALCULATION OF REIMBURSEMENT SETTLEMENT | Provider CCN: 15-0104 | Period: From 01/01/2019 To 12/31/2019 | Worksheet E Part A Date/Time Prepared: 3/31/2020 8:18 am

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		FFY (yyyy)	Amount	
		0	1.00	
70.96	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period prior to 10/1)	2019	591,570	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	278,676	70.97
70.98	Low Volume Payment-3		0	70.98
70.99	HAC adjustment amount (see instructions)		0	70.99
71.00	Amount due provider (line 67 minus lines 68 plus/minus lines 69 & 70)		7,754,817	71.00
71.01	Sequestration adjustment (see instructions)		155,096	71.01
71.02	Demonstration payment adjustment amount after sequestration		0	71.02
72.00	Interim payments		7,452,968	72.00
73.00	Tentative settlement (for contractor use only)		0	73.00
74.00	Balance due provider/program (line 71 minus lines 71.01, 71.02, 72, and 73)		146,753	74.00
75.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		132,386	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

LOW VOLUME CALCULATION EXHIBIT 4 | Provider CCN: 15-0104 | Period: From 01/01/2019 To 12/31/2019 | Worksheet E Part A Exhibit 4 Date/Time Prepared: 3/31/2020 8:18 am

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		W/S E, Part A line	Amounts (from E, Part A)	Pre/Post Entitlement	Period Prior to 10/01	Period On/After 10/01	Total (Col 2 through 4)	
		0	1.00	2.00	3.00	4.00	5.00	
1.00	DRG amounts other than outlier payments	1.00	0	0	0	0	0	1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1	1.01	4,595,337	0	4,595,337		4,595,337	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	1,553,725	0		1,553,725	1,553,725	1.02
1.03	DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October 1	1.03	0	0	0		0	1.03
1.04	DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1	1.04	0	0		0	0	1.04
2.00	Outlier payments for discharges (see instructions)	2.00						2.00
2.01	Outlier payments for discharges for Model 4 BPCI	2.02	0	0	0	0	0	2.01
2.02	Outlier payments for discharges occurring prior to October 1 (see instructions)	2.03	2,113	0	2,113		2,113	2.02
2.03	Outlier payments for discharges occurring on or after October 1 (see instructions)	2.04	3,628	0		3,628	3,628	2.03
3.00	Operating outlier reconciliation	2.01	0	0	0	0	0	3.00
4.00	Managed care simulated payments	3.00	0	0	0	0	0	4.00
	Indirect Medical Education Adjustment							
5.00	Amount from Worksheet E, Part A, line 21 (see instructions)	21.00	0.000000	0.000000	0.000000	0.000000		5.00
6.00	IME payment adjustment (see instructions)	22.00	0	0	0	0	0	6.00
6.01	IME payment adjustment for managed care (see instructions)	22.01	0	0	0	0	0	6.01
	Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA							
7.00	IME payment adjustment factor (see instructions)	27.00	0.000000	0.000000	0.000000	0.000000		7.00
8.00	IME adjustment (see instructions)	28.00	0	0	0	0	0	8.00
8.01	IME payment adjustment add on for managed care (see instructions)	28.01	0	0	0	0	0	8.01
9.00	Total IME payment (sum of lines 6 and 8)	29.00	0	0	0	0	0	9.00
9.01	Total IME payment for managed care (sum of lines 6.01 and 8.01)	29.01	0	0	0	0	0	9.01
	Disproportionate Share Adjustment							
10.00	Allowable disproportionate share percentage (see instructions)	33.00	0.1200	0.1200	0.1200	0.1200		10.00
11.00	Disproportionate share adjustment (see instructions)	34.00	184,472	0	137,860	46,612	184,472	11.00
11.01	Uncompensated care payments	36.00	862,980	0	624,115	238,865	862,980	11.01
	Additional payment for high percentage of ESRD beneficiary discharges							
12.00	Total ESRD additional payment (see instructions)	46.00	0	0	0	0	0	12.00
13.00	Subtotal (see instructions)	47.00	7,202,255	0	5,359,425	1,842,830	7,202,255	13.00
14.00	Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see instructions)	48.00	0	0	0	0	0	14.00
15.00	Total payment for inpatient operating costs (see instructions)	49.00	7,202,255	0	5,359,425	1,842,830	7,202,255	15.00

LOW VOLUME CALCULATION EXHIBIT 4 | Provider CCN: 15-0104 | Period: From 01/01/2019 To 12/31/2019 | Worksheet E Part A Exhibit 4 Date/Time Prepared: 3/31/2020 8:18 am

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		W/S E, Part A line	Amounts (from E, Part A)	Pre/Post Entitlement	Period Prior to 10/01	Period On/After 10/01	Total (Col 2 through 4)	
		0	1.00	2.00	3.00	4.00	5.00	
16.00	Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable)	50.00	499,039	0	-124,290	623,329	499,039	16.00
17.00	Special add-on payments for new technologies	54.00	0	0	0	0	0	17.00
17.01	Net organ aquisition cost							17.01
17.02	Credits received from manufacturers for replaced devices for applicable MS-DRGs	68.00	0	0	0	0	0	17.02
18.00	Capital outlier reconciliation adjustment amount (see instructions)	93.00	0	0	0	0	0	18.00
19.00	SUBTOTAL			0	5,235,135	2,466,159	7,701,294	19.00
		W/S L, line	(Amounts from L)					
		0	1.00	2.00	3.00	4.00	5.00	
20.00	Capital DRG other than outlier	1.00	497,810	0	-123,918	621,728	497,810	20.00
20.01	Model 4 BPCI Capital DRG other than outlier	1.01	0	0	0	0	0	20.01
21.00	Capital DRG outlier payments	2.00	1,229	0	-372	1,601	1,229	21.00
21.01	Model 4 BPCI Capital DRG outlier payments	2.01	0	0	0	0	0	21.01
22.00	Indirect medical education percentage (see instructions)	5.00	0.0000	0.0000	0.0000	0.0000		22.00
23.00	Indirect medical education adjustment (see instructions)	6.00	0	0	0	0	0	23.00
24.00	Allowable disproportionate share percentage (see instructions)	10.00	0.0000	0.0000	0.0000	0.0000		24.00
25.00	Disproportionate share adjustment (see instructions)	11.00	0	0	0	0	0	25.00
26.00	Total prospective capital payments (see instructions)	12.00	499,039	0	-124,290	623,329	499,039	26.00
		W/S E, Part A line	(Amounts to E, Part A)					
		0	1.00	2.00	3.00	4.00	5.00	
27.00	Low volume adjustment factor				0.113000	0.113000		27.00
28.00	Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)	70.96			591,570		591,570	28.00
29.00	Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)	70.97				278,676	278,676	29.00
100.00	Transfer low volume adjustments to Wkst. E, Pt. A.		Y					100.00

HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULATION EXHIBIT 5 | Provider CCN: 15-0104 | Period: From 01/01/2019 To 12/31/2019 | Worksheet E Part A Exhibit 5 Date/Time Prepared: 3/31/2020 8:18 am

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		Wkst. E, Pt. A, line	Amt. from Wkst. E, Pt. A)	Period to 10/01	Period on after 10/01	Total (cols. 2 and 3)	
		0	1.00	2.00	3.00	4.00	
1.00	DRG amounts other than outlier payments	1.00					1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1	1.01	4,595,337	4,595,337		4,595,337	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	1,553,725		1,553,725	1,553,725	1.02
1.03	DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October 1	1.03	0	0		0	1.03
1.04	DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1	1.04	0		0	0	1.04
2.00	Outlier payments for discharges (see instructions)	2.00					2.00
2.01	Outlier payments for discharges for Model 4 BPCI	2.02	0	0	0	0	2.01
2.02	Outlier payments for discharges occurring prior to October 1 (see instructions)	2.03	2,113	2,113		2,113	2.02
2.03	Outlier payments for discharges occurring on or after October 1 (see instructions)	2.04	3,628		3,628	3,628	2.03
3.00	Operating outlier reconciliation	2.01	0	0	0	0	3.00
4.00	Managed care simulated payments	3.00	0	0	0	0	4.00
	Indirect Medical Education Adjustment						
5.00	Amount from Worksheet E, Part A, line 21 (see instructions)	21.00	0.000000	0.000000	0.000000		5.00
6.00	IME payment adjustment (see instructions)	22.00	0	0	0	0	6.00
6.01	IME payment adjustment for managed care (see instructions)	22.01	0	0	0	0	6.01
	Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA						
7.00	IME payment adjustment factor (see instructions)	27.00	0.000000	0.000000	0.000000		7.00
8.00	IME adjustment (see instructions)	28.00	0	0	0	0	8.00
8.01	IME payment adjustment add on for managed care (see instructions)	28.01	0	0	0	0	8.01
9.00	Total IME payment (sum of lines 6 and 8)	29.00	0	0	0	0	9.00
9.01	Total IME payment for managed care (sum of lines 6.01 and 8.01)	29.01	0	0	0	0	9.01
	Disproportionate Share Adjustment						
10.00	Allowable disproportionate share percentage (see instructions)	33.00	0.1200	0.1200	0.1200		10.00
11.00	Disproportionate share adjustment (see instructions)	34.00	184,472	137,860	46,612	184,472	11.00
11.01	Uncompensated care payments	36.00	862,980	624,115	238,865	862,980	11.01
	Additional payment for high percentage of ESRD beneficiary discharges						
12.00	Total ESRD additional payment (see instructions)	46.00	0	0	0	0	12.00
13.00	Subtotal (see instructions)	47.00	7,202,255	5,359,425	1,842,830	7,202,255	13.00
14.00	Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see instructions)	48.00	0	0	0	0	14.00
15.00	Total payment for inpatient operating costs (see instructions)	49.00	7,202,255	5,359,425	1,842,830	7,202,255	15.00
16.00	Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable)	50.00	499,039	-124,290	623,329	499,039	16.00
17.00	Special add-on payments for new technologies	54.00	0	0	0	0	17.00
17.01	Net organ acquisition cost						17.01
17.02	Credits received from manufacturers for replaced devices for applicable MS-DRGs	68.00	0	0	0	0	17.02
18.00	Capital outlier reconciliation adjustment amount (see instructions)	93.00	0	0	0	0	18.00
19.00	SUBTOTAL			5,235,135	2,466,159	7,701,294	19.00

HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULATION EXHIBIT 5 | Provider CCN: 15-0104 | Period: From 01/01/2019 To 12/31/2019 | Worksheet E Part A Exhibit 5 Date/Time Prepared: 3/31/2020 8:18 am

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		Wkst. L, line	(Amt. from Wkst. L)				
		0	1.00	2.00	3.00	4.00	
20.00	Capital DRG other than outlier	1.00	497,810	-123,918	621,728	497,810	20.00
20.01	Model 4 BPCI Capital DRG other than outlier	1.01	0	0	0	0	20.01
21.00	Capital DRG outlier payments	2.00	1,229	-372	1,601	1,229	21.00
21.01	Model 4 BPCI Capital DRG outlier payments	2.01	0	0	0	0	21.01
22.00	Indirect medical education percentage (see instructions)	5.00	0.0000	0.0000	0.0000		22.00
23.00	Indirect medical education adjustment (see instructions)	6.00	0	0	0	0	23.00
24.00	Allowable disproportionate share percentage (see instructions)	10.00	0.0000	0.0000	0.0000		24.00
25.00	Disproportionate share adjustment (see instructions)	11.00	0	0	0	0	25.00
26.00	Total prospective capital payments (see instructions)	12.00	499,039	-124,290	623,329	499,039	26.00
		Wkst. E, Pt. A, line	(Amt. from Wkst. E, Pt. A)				
		0	1.00	2.00	3.00	4.00	
27.00							27.00
28.00	Low volume adjustment prior to October 1	70.96	591,570	591,570		591,570	28.00
29.00	Low volume adjustment on or after October 1	70.97	278,676		278,676	278,676	29.00
30.00	HVBP payment adjustment (see instructions)	70.93	47,973	42,065	5,908	47,973	30.00
30.01	HVBP payment adjustment for HSP bonus payment (see instructions)	70.90	0	0	0	0	30.01
31.00	HRR adjustment (see instructions)	70.94	-62,363	-50,089	-12,274	-62,363	31.00
31.01	HRR adjustment for HSP bonus payment (see instructions)	70.91	0	0	0	0	31.01
						(Amt. to Wkst. E, Pt. A)	
		0	1.00	2.00	3.00	4.00	
32.00	HAC Reduction Program adjustment (see instructions)	70.99		0	0	0	32.00
100.00	Transfer HAC Reduction Program adjustment to Wkst. E, Pt. A.		N				100.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0104	Period: From 01/01/2019 To 12/31/2019	Worksheet E Part B Date/Time Prepared: 3/31/2020 8:18 am
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		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	9,691	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)	11,529,866	2.00
3.00	OPPS payments	13,622,383	3.00
4.00	Outlier payment (see instructions)	9,478	4.00
4.01	Outlier reconciliation amount (see instructions)	0	4.01
5.00	Enter the hospital specific payment to cost ratio (see instructions)	0.000	5.00
6.00	Line 2 times line 5	0	6.00
7.00	Sum of lines 3, 4, and 4.01, divided by line 6	0.00	7.00
8.00	Transitional corridor payment (see instructions)	0	8.00
9.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200	0	9.00
10.00	Organ acquisitions	0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)	9,691	11.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
12.00	Ancillary service charges	73,928	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)	73,928	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)	73,928	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)	64,237	19.00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)	0	20.00
21.00	Lesser of cost or charges (see instructions)	9,691	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)	13,631,861	24.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
25.00	Deductibles and coinsurance amounts (for CAH, see instructions)	886	25.00
26.00	Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)	2,469,169	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)	11,171,497	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)	11,171,497	30.00
31.00	Primary payer payments	903	31.00
32.00	Subtotal (line 30 minus line 31)	11,170,594	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)	310,517	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	201,836	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	225,114	36.00
37.00	Subtotal (see instructions)	11,372,430	37.00
38.00	MSP-LCC reconciliation amount from PS&R	141	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)	11,372,289	40.00
40.01	Sequestration adjustment (see instructions)	227,446	40.01
40.02	Demonstration payment adjustment amount after sequestration	0	40.02
41.00	Interim payments	10,947,388	41.00
42.00	Tentative settlement (for contractors use only)	0	42.00
43.00	Balance due provider/program (see instructions)	197,455	43.00
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	44.00
	TO BE COMPLETED BY CONTRACTOR		
90.00	Original outlier amount (see instructions)	0	90.00
91.00	Outlier reconciliation adjustment amount (see instructions)	0	91.00
92.00	The rate used to calculate the Time Value of Money	0.00	92.00
93.00	Time Value of Money (see instructions)	0	93.00
94.00	Total (sum of lines 91 and 93)	0	94.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0104 Component CCN: 15-S104	Period: From 01/01/2019 To 12/31/2019	Worksheet E Part B Date/Time Prepared: 3/31/2020 8:18 am
	Title XVIII	Subprovider - IPF	PPS

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	681	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)	220	2.00
3.00	OPPS payments	346	3.00
4.00	Outlier payment (see instructions)	0	4.00
4.01	Outlier reconciliation amount (see instructions)	0	4.01
5.00	Enter the hospital specific payment to cost ratio (see instructions)	0.000	5.00
6.00	Line 2 times line 5	0	6.00
7.00	Sum of lines 3, 4, and 4.01, divided by line 6	0.00	7.00
8.00	Transitional corridor payment (see instructions)	0	8.00
9.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200	0	9.00
10.00	Organ acquisitions	0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)	681	11.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
12.00	Ancillary service charges	5,291	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)	5,291	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)	5,291	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)	4,610	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)	681	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)	346	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)	0	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)	1,027	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)	1,027	30.00
31.00	Primary payer payments	0	31.00
32.00	Subtotal (line 30 minus line 31)	1,027	32.00
	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)		
33.00	Composite rate ESRD (from Wkst. I-5, line 11)	0	33.00
34.00	Allowable bad debts (see instructions)	0	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	0	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	0	36.00
37.00	Subtotal (see instructions)	1,027	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)	1,027	40.00
40.01	Sequestration adjustment (see instructions)	21	40.01
40.02	Demonstration payment adjustment amount after sequestration	0	40.02
41.00	Interim payments	1,376	41.00
42.00	Tentative settlement (for contractors use only)	0	42.00
43.00	Balance due provider/program (see instructions)	-370	43.00
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	44.00
	TO BE COMPLETED BY CONTRACTOR		
90.00	Original outlier amount (see instructions)	0	90.00
91.00	Outlier reconciliation adjustment amount (see instructions)	0	91.00
92.00	The rate used to calculate the Time Value of Money	0.00	92.00
93.00	Time Value of Money (see instructions)	0	93.00
94.00	Total (sum of lines 91 and 93)	0	94.00

CALCULATION OF REIMBURSEMENT SETTLEMENT | Provider CCN: 15-0104 | Period: From 01/01/2019 To 12/31/2019 | Worksheet E Part B

Component CCN: 15-5832 | Date/Time Prepared: 3/31/2020 8:18 am

Title XVIII | Skilled Nursing Facility | PPS

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	636	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)	0	2.00
3.00	OPPS payments		3.00
4.00	Outlier payment (see instructions)		4.00
4.01	Outlier reconciliation amount (see instructions)		4.01
5.00	Enter the hospital specific payment to cost ratio (see instructions)		5.00
6.00	Line 2 times line 5	0	6.00
7.00	Sum of lines 3, 4, and 4.01, divided by line 6	0.00	7.00
8.00	Transitional corridor payment (see instructions)	0	8.00
9.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200	0	9.00
10.00	Organ acquisitions	0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)	636	11.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
12.00	Ancillary service charges	5,264	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)	5,264	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)	5,264	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)	4,628	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)	636	21.00
22.00	Interns and residents (see instructions)	0	22.00
23.00	Cost of physicians' services in a teaching hospital (see instructions)	0	23.00
24.00	Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)	0	24.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
25.00	Deductibles and coinsurance amounts (for CAH, see instructions)	0	25.00
26.00	Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)		26.00
27.00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions)	636	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)	636	30.00
31.00	Primary payer payments	0	31.00
32.00	Subtotal (line 30 minus line 31)	636	32.00
	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)		
33.00	Composite rate ESRD (from Wkst. I-5, line 11)	0	33.00
34.00	Allowable bad debts (see instructions)	0	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	0	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	0	36.00
37.00	Subtotal (see instructions)	636	37.00
38.00	MSP-LCC reconciliation amount from PS&R		38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	39.00
39.50	Pioneer ACO demonstration payment adjustment (see instructions)		39.50
39.97	Demonstration payment adjustment amount before sequestration	0	39.97
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)	0	39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION	0	39.99
40.00	Subtotal (see instructions)	636	40.00
40.01	Sequestration adjustment (see instructions)	13	40.01
40.02	Demonstration payment adjustment amount after sequestration	0	40.02
41.00	Interim payments	1,032	41.00
42.00	Tentative settlement (for contractors use only)	0	42.00
43.00	Balance due provider/program (see instructions)	-409	43.00
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	44.00
	TO BE COMPLETED BY CONTRACTOR		
90.00	Original outlier amount (see instructions)		90.00
91.00	Outlier reconciliation adjustment amount (see instructions)		91.00
92.00	The rate used to calculate the Time Value of Money		92.00
93.00	Time Value of Money (see instructions)		93.00
94.00	Total (sum of lines 91 and 93)		94.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED | Provider CCN: 15-0104 | Period: From 01/01/2019 To 12/31/2019 | Worksheet E-1 Part I Date/Time Prepared: 3/31/2020 8:18 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		7,452,968		10,947,388	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)		7,452,968		10,947,388	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		146,753		197,455	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		7,599,721		11,144,843	7.00

			Contractor Number	NPR Date (Mo/Day/Yr)	
		0	1.00	2.00	
8.00	Name of Contractor				8.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 15-0104 | Component CCN: 15-S104 | Period: From 01/01/2019 To 12/31/2019 | Worksheet E-1 Part I | Date/Time Prepared: 3/31/2020 8:18 am

Title XVIII | Subprovider - IPF | PPS

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		2,321,709		1,376	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
	Program to Provider					
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
	Provider to Program					
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		2,321,709		1,376	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		6,961		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		370	6.02
7.00	Total Medicare program liability (see instructions)		2,328,670		1,006	7.00
				Contractor Number	NPR Date (Mo/Day/Yr)	
		0		1.00	2.00	
8.00	Name of Contractor					8.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 15-0104 | Component CCN: 15-5832 | Period: From 01/01/2019 To 12/31/2019 | Worksheet E-1 Part I | Date/Time Prepared: 3/31/2020 8:18 am

Title XVIII | Skilled Nursing Facility | PPS

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		1,275,849		1,032	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)		1,275,849		1,032	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		16,903		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		409	6.02
7.00	Total Medicare program liability (see instructions)		1,292,752		623	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: 15-0104 | Period: From 01/01/2019 To 12/31/2019 | Worksheet E-1 Part II Date/Time Prepared: 3/31/2020 8:18 am

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

CALCULATION OF REIMBURSEMENT SETTLEMENT

Provider CCN: 15-0104 | Component CCN: 15-S104 | Period: From 01/01/2019 To 12/31/2019 | Worksheet E-3 Part II | Date/Time Prepared: 3/31/2020 8:18 am

Title XVIII | Subprovider - IPF | PPS

		1.00	
	PART II - MEDICARE PART A SERVICES - IPF PPS		
1.00	Net Federal IPF PPS Payments (excluding outlier, ECT, and medical education payments)	2,518,099	1.00
2.00	Net IPF PPS Outlier Payments	8,683	2.00
3.00	Net IPF PPS ECT Payments	0	3.00
4.00	Unweighted intern and resident FTE count in the most recent cost report filed on or before November 15, 2004. (see instructions)	0.00	4.00
4.01	Cap increases for the unweighted intern and resident FTE count for residents that were displaced by program or hospital closure, that would not be counted without a temporary cap adjustment under 42 CFR §412.424(d)(1)(iii)(F)(1) or (2) (see instructions)	0.00	4.01
5.00	New Teaching program adjustment. (see instructions)	0.00	5.00
6.00	Current year's unweighted FTE count of I&R excluding FTEs in the new program growth period of a "new teaching program" (see instuctions)	0.00	6.00
7.00	Current year's unweighted I&R FTE count for residents within the new program growth period of a "new teaching program" (see instuctions)	0.00	7.00
8.00	Intern and resident count for IPF PPS medical education adjustment (see instructions)	0.00	8.00
9.00	Average Daily Census (see instructions)	8.797260	9.00
10.00	Teaching Adjustment Factor {((1 + (line 8/line 9)) raised to the power of .5150 -1}.	0.000000	10.00
11.00	Teaching Adjustment (line 1 multiplied by line 10).	0	11.00
12.00	Adjusted Net IPF PPS Payments (sum of lines 1, 2, 3 and 11)	2,526,782	12.00
13.00	Nursing and Allied Health Managed Care payment (see instruction)	0	13.00
14.00	Organ acquisition (DO NOT USE THIS LINE)		14.00
15.00	Cost of physicians' services in a teaching hospital (see instructions)	0	15.00
16.00	Subtotal (see instructions)	2,526,782	16.00
17.00	Primary payer payments	0	17.00
18.00	Subtotal (line 16 less line 17).	2,526,782	18.00
19.00	Deductibles	134,844	19.00
20.00	Subtotal (line 18 minus line 19)	2,391,938	20.00
21.00	Coinsurance	22,847	21.00
22.00	Subtotal (line 20 minus line 21)	2,369,091	22.00
23.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)	10,928	23.00
24.00	Adjusted reimbursable bad debts (see instructions)	7,103	24.00
25.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	0	25.00
26.00	Subtotal (sum of lines 22 and 24)	2,376,194	26.00
27.00	Direct graduate medical education payments (from Wkst. E-4, line 49)	0	27.00
28.00	Other pass through costs (see instructions)	0	28.00
29.00	Outlier payments reconciliation	0	29.00
30.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	30.00
30.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	30.50
30.99	Demonstration payment adjustment amount before sequestration	0	30.99
31.00	Total amount payable to the provider (see instructions)	2,376,194	31.00
31.01	Sequestration adjustment (see instructions)	47,524	31.01
31.02	Demonstration payment adjustment amount after sequestration	0	31.02
32.00	Interim payments	2,321,709	32.00
33.00	Tentative settlement (for contractor use only)	0	33.00
34.00	Balance due provider/program (line 31 minus lines 31.01, 31.02, 32 and 33)	6,961	34.00
35.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	35.00
	TO BE COMPLETED BY CONTRACTOR		
50.00	Original outlier amount from Worksheet E-3, Part II, line 2	8,683	50.00
51.00	Outlier reconciliation adjustment amount (see instructions)	0	51.00
52.00	The rate used to calculate the Time Value of Money	0.00	52.00
53.00	Time Value of Money (see instructions)	0	53.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0104 Component CCN: 15-5832	Period: From 01/01/2019 To 12/31/2019	Worksheet E-3 Part VI Date/Time Prepared: 3/31/2020 8:18 am
	Title XVIII	Skilled Nursing Facility	PPS

		1.00	
	PART VI - CALCULATION OF REIMBURSEMENT SETTLEMEMENT - ALL OTHER HEALTH SERVICES FOR TITLE XVIII PART A PPS SNF SERVICES		
	PROSPECTIVE PAYMENT AMOUNT (SEE INSTRUCTIONS)		
1.00	Resource Utilization Group Payment (RUGS)	1,462,838	1.00
2.00	Routine service other pass through costs	0	2.00
3.00	Ancillary service other pass through costs	0	3.00
4.00	Subtotal (sum of lines 1 through 3)	1,462,838	4.00
	COMPUTATION OF NET COST OF COVERED SERVICES		
5.00	Medical and other services (Do not use this line as vaccine costs are included in line 1 of W/S E, Part B. This line is now shaded.)		5.00
6.00	Deductible	0	6.00
7.00	Coinsurance	160,952	7.00
8.00	Allowable bad debts (see instructions)	26,537	8.00
9.00	Reimbursable bad debts for dual eligible beneficiaries (see instructions)	0	9.00
10.00	Adjusted reimbursable bad debts (see instructions)	17,249	10.00
11.00	Utilization review	0	11.00
12.00	Subtotal (sum of lines 4, 5 minus lines 6 and 7, plus lines 10 and 11)(see instructions)	1,319,135	12.00
13.00	Inpatient primary payer payments	0	13.00
14.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	14.00
14.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	14.50
14.99	Demonstration payment adjustment amount before sequestration	0	14.99
15.00	Subtotal (see instructions	1,319,135	15.00
15.01	Sequestration adjustment (see instructions)	26,383	15.01
15.02	Demonstration payment adjustment amount after sequestration	0	15.02
16.00	Interim payments	1,275,849	16.00
17.00	Tentative settlement (for contractor use only)	0	17.00
18.00	Balance due provider/program (line 15 minus lines 15.01, 15.02, 16, and 17)	16,903	18.00
19.00	Protested amounts (nonallowable cost report items) in accordance with CMS 19 Pub. 15-2, chapter 1, §115.2	0	19.00

CALCULATION OF REIMBURSEMENT SETTLEMENT | Provider CCN: 15-0104 | Period: From 01/01/2019 To 12/31/2019 | Worksheet E-3 Part VII Date/Time Prepared: 3/31/2020 8:18 am

		Title XIX	Hospital	Cost
		Inpatient	Outpatient	
		1.00	2.00	
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR XIX SERVICES			
	COMPUTATION OF NET COST OF COVERED SERVICES			
1.00	Inpatient hospital/SNF/NF services	573,119		1.00
2.00	Medical and other services		0	2.00
3.00	Organ acquisition (certified transplant centers only)	0		3.00
4.00	Subtotal (sum of lines 1, 2 and 3)	573,119	0	4.00
5.00	Inpatient primary payer payments	0		5.00
6.00	Outpatient primary payer payments		0	6.00
7.00	Subtotal (line 4 less sum of lines 5 and 6)	573,119	0	7.00
	COMPUTATION OF LESSER OF COST OR CHARGES			
	Reasonable Charges			
8.00	Routine service charges	1,102,686		8.00
9.00	Ancillary service charges	1,090,341	0	9.00
10.00	Organ acquisition charges, net of revenue	0		10.00
11.00	Incentive from target amount computation	0		11.00
12.00	Total reasonable charges (sum of lines 8 through 11)	2,193,027	0	12.00
	CUSTOMARY CHARGES			
13.00	Amount actually collected from patients liable for payment for services on a charge basis	0	0	13.00
14.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)	0	0	14.00
15.00	Ratio of line 13 to line 14 (not to exceed 1.000000)	0.000000	0.000000	15.00
16.00	Total customary charges (see instructions)	2,193,027	0	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)	1,619,908	0	17.00
18.00	Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 16) (see instructions)	0	0	18.00
19.00	Interns and Residents (see instructions)	0	0	19.00
20.00	Cost of physicians' services in a teaching hospital (see instructions)	0	0	20.00
21.00	Cost of covered services (enter the lesser of line 4 or line 16)	573,119	0	21.00
	PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be completed for PPS providers.			
22.00	Other than outlier payments	0	0	22.00
23.00	Outlier payments	0	0	23.00
24.00	Program capital payments	0		24.00
25.00	Capital exception payments (see instructions)	0		25.00
26.00	Routine and Ancillary service other pass through costs	0	0	26.00
27.00	Subtotal (sum of lines 22 through 26)	0	0	27.00
28.00	Customary charges (title V or XIX PPS covered services only)	0	0	28.00
29.00	Titles V or XIX (sum of lines 21 and 27)	573,119	0	29.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT			
30.00	Excess of reasonable cost (from line 18)	0	0	30.00
31.00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)	573,119	0	31.00
32.00	Deductibles	0	0	32.00
33.00	Coinsurance	0	0	33.00
34.00	Allowable bad debts (see instructions)	0	0	34.00
35.00	Utilization review	0		35.00
36.00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)	573,119	0	36.00
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	37.00
38.00	Subtotal (line 36 ± line 37)	573,119	0	38.00
39.00	Direct graduate medical education payments (from Wkst. E-4)	0		39.00
40.00	Total amount payable to the provider (sum of lines 38 and 39)	573,119	0	40.00
41.00	Interim payments	800,493	0	41.00
42.00	Balance due provider/program (line 40 minus line 41)	-227,374	0	42.00
43.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, chapter 1, §115.2	0	0	43.00

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

Provider CCN: 15-0104 | Period: From 01/01/2019 To 12/31/2019 | Worksheet G | Date/Time Prepared: 3/31/2020 8:18 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	29,757,329	0	0	0	1.00
2.00	Temporary investments	5,933,032	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	22,218,310	0	0	0	4.00
5.00	Other receivable	1,998,485	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	0	0	0	0	6.00
7.00	Inventory	3,329,377	0	0	0	7.00
8.00	Prepaid expenses	0	0	0	0	8.00
9.00	Other current assets	1,590,034	0	0	0	9.00
10.00	Due from other funds	0	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	64,826,567	0	0	0	11.00
	FIXED ASSETS					
12.00	Land	0	0	0	0	12.00
13.00	Land improvements	5,899,319	0	0	0	13.00
14.00	Accumulated depreciation	0	0	0	0	14.00
15.00	Buildings	38,310,413	0	0	0	15.00
16.00	Accumulated depreciation	0	0	0	0	16.00
17.00	Leasehold improvements	0	0	0	0	17.00
18.00	Accumulated depreciation	0	0	0	0	18.00
19.00	Fixed equipment	0	0	0	0	19.00
20.00	Accumulated depreciation	0	0	0	0	20.00
21.00	Automobiles and trucks	0	0	0	0	21.00
22.00	Accumulated depreciation	0	0	0	0	22.00
23.00	Major movable equipment	160,192,540	0	0	0	23.00
24.00	Accumulated depreciation	-86,014,309	0	0	0	24.00
25.00	Minor equipment depreciable	0	0	0	0	25.00
26.00	Accumulated depreciation	0	0	0	0	26.00
27.00	HIT designated Assets	0	0	0	0	27.00
28.00	Accumulated depreciation	0	0	0	0	28.00
29.00	Minor equipment-nondepreciable	0	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	118,387,963	0	0	0	30.00
	OTHER ASSETS					
31.00	Investments	0	0	0	0	31.00
32.00	Deposits on leases	0	0	0	0	32.00
33.00	Due from owners/officers	0	0	0	0	33.00
34.00	Other assets	27,373,446	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	27,373,446	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	210,587,976	0	0	0	36.00
	CURRENT LIABILITIES					
37.00	Accounts payable	4,648,996	0	0	0	37.00
38.00	Salaries, wages, and fees payable	10,178,495	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	0	0	0	0	40.00
41.00	Deferred income	0	0	0	0	41.00
42.00	Accelerated payments	0				42.00
43.00	Due to other funds	0	0	0	0	43.00
44.00	Other current liabilities	4,427,152	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	19,254,643	0	0	0	45.00
	LONG TERM LIABILITIES					
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	0	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	41,711,539	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	41,711,539	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	60,966,182	0	0	0	51.00
	CAPITAL ACCOUNTS					
52.00	General fund balance	149,621,794				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)	149,621,794	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	210,587,976	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES | Provider CCN: 15-0104 | Period: From 01/01/2019 To 12/31/2019 | Worksheet G-1 | Date/Time Prepared: 3/31/2020 8:18 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		141,614,729		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		8,007,065				2.00
3.00	Total (sum of line 1 and line 2)		149,621,794		0		3.00
4.00	Additions (credit adjustments) (specify)	0		0		0	4.00
5.00		0		0		0	5.00
6.00		0		0		0	6.00
7.00		0		0		0	7.00
8.00		0		0		0	8.00
9.00		0		0		0	9.00
10.00	Total additions (sum of line 4-9)		0		0		10.00
11.00	Subtotal (line 3 plus line 10)		149,621,794		0		11.00
12.00	Deductions (debit adjustments) (specify)	0		0		0	12.00
13.00		0		0		0	13.00
14.00		0		0		0	14.00
15.00		0		0		0	15.00
16.00		0		0		0	16.00
17.00		0		0		0	17.00
18.00	Total deductions (sum of lines 12-17)		0		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		149,621,794		0		19.00

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

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES | Provider CCN: 15-0104 | Period: From 01/01/2019 To 12/31/2019 | Worksheet G-2 Parts I & II Date/Time Prepared: 3/31/2020 8:18 am

	Cost Center Description	Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospital	18,168,102		18,168,102	1.00
2.00	SUBPROVIDER - IPF	4,043,285		4,043,285	2.00
3.00	SUBPROVIDER - IRF	0		0	3.00
4.00	SUBPROVIDER	0		0	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	2,971,566		2,971,566	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)	25,182,953		25,182,953	10.00
	Intensive Care Type Inpatient Hospital Services				
11.00	INTENSIVE CARE UNIT	4,871,688		4,871,688	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)	4,871,688		4,871,688	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	30,054,641		30,054,641	17.00
18.00	Ancillary services	58,732,750	276,412,655	335,145,405	18.00
19.00	Outpatient services	3,918,807	39,159,895	43,078,702	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	2,032	4,420,312	4,422,344	23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	EH&S, DIETARY, PHYSICIAN PRIVATE OFF	-456,042	60,095,293	59,639,251	27.00
27.01	PROFESSIONAL FEE	-457,082	57,144	-399,938	27.01
27.02	SELF-INSURED	1,446,415	9,709,862	11,156,277	27.02
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	93,241,521	389,855,161	483,096,682	28.00
	PART II - OPERATING EXPENSES				
29.00	Operating expenses (per Wkst. A, column 3, line 200)		162,024,578		29.00
30.00	ADD (SPECIFY)	0			30.00
31.00		0			31.00
32.00		0			32.00
33.00		0			33.00
34.00		0			34.00
35.00		0			35.00
36.00	Total additions (sum of lines 30-35)		0		36.00
37.00	DEDUCT (SPECIFY)	0			37.00
38.00		0			38.00
39.00		0			39.00
40.00		0			40.00
41.00		0			41.00
42.00	Total deductions (sum of lines 37-41)		0		42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer to Wkst. G-3, line 4)		162,024,578		43.00

STATEMENT OF REVENUES AND EXPENSES | Provider CCN: 15-0104 | Period: From 01/01/2019 To 12/31/2019 | Worksheet G-3 | Date/Time Prepared: 3/31/2020 8:18 am

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	483,096,682	1.00
2.00	Less contractual allowances and discounts on patients' accounts	324,279,723	2.00
3.00	Net patient revenues (line 1 minus line 2)	158,816,959	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	162,024,578	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-3,207,619	5.00
	OTHER INCOME		
6.00	Contributions, donations, bequests, etc	0	6.00
7.00	Income from investments	0	7.00
8.00	Revenues from telephone and other miscellaneous communication services	0	8.00
9.00	Revenue from television and radio service	0	9.00
10.00	Purchase discounts	0	10.00
11.00	Rebates and refunds of expenses	0	11.00
12.00	Parking lot receipts	0	12.00
13.00	Revenue from laundry and linen service	0	13.00
14.00	Revenue from meals sold to employees and guests	0	14.00
15.00	Revenue from rental of living quarters	0	15.00
16.00	Revenue from sale of medical and surgical supplies to other than patients	0	16.00
17.00	Revenue from sale of drugs to other than patients	0	17.00
18.00	Revenue from sale of medical records and abstracts	0	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	0	20.00
21.00	Rental of vending machines	0	21.00
22.00	Rental of hospital space	0	22.00
23.00	Governmental appropriations	0	23.00
24.00	OTHER OPERATING INCOME	3,446,256	24.00
24.01	NON-OPERATING INCOME	7,768,428	24.01
25.00	Total other income (sum of lines 6-24)	11,214,684	25.00
26.00	Total (line 5 plus line 25)	8,007,065	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)	8,007,065	29.00

CALCULATION OF CAPITAL PAYMENT	Provider CCN: 15-0104	Period: From 01/01/2019 To 12/31/2019	Worksheet L Parts I-III Date/Time Prepared: 3/31/2020 8:18 am
	Title XVIII	Hospital	PPS

		1.00	
	PART I - FULLY PROSPECTIVE METHOD		
	CAPITAL FEDERAL AMOUNT		
1.00	Capital DRG other than outlier	497,810	1.00
1.01	Model 4 BPCI Capital DRG other than outlier	0	1.01
2.00	Capital DRG outlier payments	1,229	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)	20.40	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)	499,039	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