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: 15-0157	Period: From 07/01/2019 To 06/30/2020	Worksheet S Parts I-III Date/Time Prepared: 11/18/2020 5:26 pm

PART I - COST REPORT STATUS

Provider use only

1. [X] Electronically prepared cost report — Date: 11/18/2020 Time: 5:26 pm
2. [ ] Manually prepared cost report
3. [0] If this is an amended report enter the number of times the provider resubmitted this cost report
4. [F] Medicare Utilization. Enter "F" for full or "L" for low.

Contractor use only

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

PART II - CERTIFICATION

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

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

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by ASCENSION ST. VINCENT CARMEL (15-0157) for the cost reporting period beginning 07/01/2019 and ending 06/30/2020 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

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

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

_____
Title

_____
Date

	Cost Center Description	Title V	Title XVIII Part A	Title XVIII Part B	HIT	Title XIX	
		1.00	2.00	3.00	4.00	5.00	
	PART III - SETTLEMENT SUMMARY						
1.00	Hospital	0	194,006	95,945	0	0	1.00
2.00	Subprovider - IPF	0	0	0		0	2.00
3.00	Subprovider - IRF	0	0	0		0	3.00
5.00	Swing Bed - SNF	0	0	0		0	5.00
6.00	Swing Bed - NF	0				0	6.00
200.00	Total	0	194,006	95,945	0	0	200.00

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 15-0157	Period: From 07/01/2019 To 06/30/2020	Worksheet S-2 Part I Date/Time Prepared: 11/18/2020 5:26 pm

	1.00	2.00	3.00	4.00	
	Hospital and Hospital Health Care Complex Address:				
1.00	Street: 13500 NORTH MERIDIAN STREET	PO Box:			1.00
2.00	City: CARMEL	State: IN	Zip Code: 46033	County: HAMILTON	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	ASCENSION ST. VINCENT CARMEL	150157	26900	1	01/14/2004	N	P	O	3.00
4.00	Subprovider - IPF									4.00
5.00	Subprovider - IRF									5.00
6.00	Subprovider - (Other)									6.00
7.00	Swing Beds - SNF									7.00
8.00	Swing Beds - NF									8.00
9.00	Hospital-Based SNF									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)	07/01/2019	06/30/2020	20.00
21.00	Type of Control (see instructions)	1		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.	562	287	9	0	2,404	0	24.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-0157 | Period: From 07/01/2019 To 06/30/2020 | Worksheet S-2 Part I Date/Time Prepared: 11/18/2020 5:26 pm

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

		Urban/Rural S	Date of Geogr	
		1.00	2.00	
26.00	Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter "1" for urban or "2" for rural.	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)	N	N	39.00
40.00	Is this hospital subject to the HAC program reduction adjustment? Enter "Y" for yes or "N" for no in column 1, for discharges prior to October 1. Enter "Y" for yes or "N" for no in column 2, for discharges on or after October 1. (see instructions)	N	N	40.00

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-0157 | Period: From 07/01/2019 To 06/30/2020 | Worksheet S-2 Part I | Date/Time Prepared: 11/18/2020 5:26 pm

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

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-0157 | Period: From 07/01/2019 To 06/30/2020 | Worksheet S-2 Part I | Date/Time Prepared: 11/18/2020 5:26 pm

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

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-0157 | Period: From 07/01/2019 To 06/30/2020 | Worksheet S-2 Part I Date/Time Prepared: 11/18/2020 5:26 pm

				1.00	
	Long Term Care Hospital PPS				
80.00	Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for no.			N	80.00
81.00	Is this a LTCH co-located within another hospital for part or all of the cost reporting period? Enter "Y" for yes and "N" for no.			N	81.00
	TEFRA Providers				
85.00	Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no.			N	85.00
86.00	Did this facility establish a new Other subprovider (excluded unit) under 42 CFR Section §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.				86.00
87.00	Is this hospital an extended neoplastic disease care hospital classified under section 1886(d)(1)(B)(vi)? Enter "Y" for yes or "N" for no.			N	87.00
			V	XIX	
			1.00	2.00	
	Title V and XIX Services				
90.00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.		N	Y	90.00
91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.		N	Y	91.00
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.			N	92.00
93.00	Does this facility operate an ICF/IID facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.		N	N	93.00
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.		N	N	94.00
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.		0.00	0.00	95.00
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.		N	N	96.00
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.		0.00	0.00	97.00
98.00	Does title V or XIX follow Medicare (title XVIII) for the interns and residents post stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.		N	Y	98.00
98.01	Does title V or XIX follow Medicare (title XVIII) for the reporting of charges on Wkst. C, Pt. I? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.		N	Y	98.01
98.02	Does title V or XIX follow Medicare (title XVIII) for the calculation of observation bed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.		N	Y	98.02
98.03	Does title V or XIX follow Medicare (title XVIII) for a critical access hospital (CAH) reimbursed 101% of inpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.		N	N	98.03
98.04	Does title V or XIX follow Medicare (title XVIII) for a CAH reimbursed 101% of outpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.		N	N	98.04
98.05	Does title V or XIX follow Medicare (title XVIII) and add back the RCE disallowance on Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.		N	Y	98.05
98.06	Does title V or XIX follow Medicare (title XVIII) when cost reimbursed for Wkst. D, Pts. I through IV? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.		N	Y	98.06
	Rural Providers				
105.00	Does this hospital qualify as a CAH?		N		105.00
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)		N		106.00
107.00	Column 1: If line 105 is Y, is this facility eligible for cost reimbursement for I&R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) Column 2: If column 1 is Y and line 70 or line 75 is Y, do you train I&Rs in an approved medical education program in the CAH's excluded IPF and/or IRF unit(s)? Enter "Y" for yes or "N" for no in column 2. (see instructions)		N		107.00
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.		N		108.00
		Physical	Occupational	Speech	Respiratory	
		1.00	2.00	3.00	4.00	
109.00	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.	N	N	N	N	109.00
					1.00	
110.00	Did this hospital participate in the Rural Community Hospital Demonstration project (§410A Demonstration)for the current cost reporting period? Enter "Y" for yes or "N" for no. If yes, complete Worksheet E, Part A, lines 200 through 218, and Worksheet E-2, lines 200 through 215, as applicable.				N	110.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 15-0157	Period: From 07/01/2019 To 06/30/2020	Worksheet S-2 Part I Date/Time Prepared: 11/18/2020 5:26 pm

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

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

		Premiums	Losses	Insurance	
		1.00	2.00	3.00	
118.01	List amounts of malpractice premiums and paid losses:	0	0	672,176	118.01

		1.00	2.00	
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein.	N		118.02
119.00	DO NOT USE THIS LINE			119.00
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 1, "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2, "Y" for yes or "N" for no.	N	N	120.00
121.00	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter "Y" for yes or "N" for no.	Y		121.00
122.00	Does the cost report contain healthcare related taxes as defined in §1903(w)(3) of the Act?Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2 the Worksheet A line number where these taxes are included.	Y	5.00	122.00
	Transplant Center Information			
125.00	Does this facility operate a transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.	N		125.00
126.00	If this is a Medicare certified kidney transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			126.00
127.00	If this is a Medicare certified heart transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			127.00
128.00	If this is a Medicare certified liver transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			128.00
129.00	If this is a Medicare certified lung transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			129.00
130.00	If this is a Medicare certified pancreas transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			130.00
131.00	If this is a Medicare certified intestinal transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			131.00
132.00	If this is a Medicare certified islet transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			132.00
133.00	Removed and reserved			133.00
134.00	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.			134.00
	All Providers			
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)	Y	15H046	140.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-0157 | Period: From 07/01/2019 To 06/30/2020 | Worksheet S-2 Part I | Date/Time Prepared: 11/18/2020 5:26 pm

	1.00	2.00	3.00	
	If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number.			
141.00	Name: ST. VINCENT HEALTH	Contractor's Name: WPS	Contractor's Number: 08101	141.00
142.00	Street: 250 WEST 96TH STREET	PO Box:		142.00
143.00	City: INDIANAPOLIS	State: IN	Zip Code: 46260	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: 15-0157 | Period: From 07/01/2019 To 06/30/2020 | Worksheet S-2 Part II Date/Time Prepared: 11/18/2020 5:26 pm

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

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

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

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

		Y/N	
		1.00	
	Bad Debts		
12.00	Is the provider seeking reimbursement for bad debts? If yes, see instructions.	Y	12.00
13.00	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.	N	13.00
14.00	If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.	N	14.00
	Bed Complement		
15.00	Did total beds available change from the prior cost reporting period? If yes, see instructions.	Y	15.00

		Part A		Part B		
		Y/N	Date	Y/N	Date	
		1.00	2.00	3.00	4.00	
	PS&R Data					
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see instructions)	Y	10/26/2020	Y	10/26/2020	16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	N		N		17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N		N		18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		N		19.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 15-0157 | Period: From 07/01/2019 To 06/30/2020 | Worksheet S-2 Part II Date/Time Prepared: 11/18/2020 5:26 pm

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

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

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

		1.00	2.00	
	Cost Report Preparer Contact Information			
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	JOHN	KUHN	41.00
42.00	Enter the employer/company name of the cost report preparer.	ST. VINCENT HEALTH		42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	317-583-3236	JOHN.KUHN@STVINCENT.ORG	43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider CCN: 15-0157	Period: From 07/01/2019 To 06/30/2020	Worksheet S-2 Part II Date/Time Prepared: 11/18/2020 5:26 pm

		3.00		
	Cost Report Preparer Contact Information			
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	REIMBURSEMENT 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: 15-0157 | Period: From 07/01/2019 To 06/30/2020 | Worksheet S-3 Part I | Date/Time Prepared: 11/18/2020 5:26 pm

	Component	Worksheet A Line Number	No. of Beds	Bed Days Available	CAH Hours	I/P Days / O/P Visits / Trips Title V	
		1.00	2.00	3.00	4.00	5.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30.00	128	46,848	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)		128	46,848	0.00	0	7.00
8.00	INTENSIVE CARE UNIT	31.00	10	3,660	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	NEONATAL INTENSIVE CARE UNIT	35.00	15	5,490	0.00	0	12.00
13.00	NURSERY	43.00				0	13.00
14.00	Total (see instructions)		153	55,998	0.00	0	14.00
15.00	CAH visits					0	15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)	30.00					24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	26.25
27.00	Total (sum of lines 14-26)		153				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: 15-0157 | Period: From 07/01/2019 To 06/30/2020 | Worksheet S-3 Part I | Date/Time Prepared: 11/18/2020 5:26 pm

	Component	I/P Days / O/P Visits / Trips			Full Time Equivalents		
		Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
		6.00	7.00	8.00	9.00	10.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	3,200	191	12,737			1.00
2.00	HMO and other (see instructions)	2,087	2,413				2.00
3.00	HMO IPF Subprovider	0	0				3.00
4.00	HMO IRF Subprovider	0	0				4.00
5.00	Hospital Adults & Peds. Swing Bed SNF	0	0	0			5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	0			6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	3,200	191	12,737			7.00
8.00	INTENSIVE CARE UNIT	1,246	174	1,582			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	NEONATAL INTENSIVE CARE UNIT	0	428	2,499			12.00
13.00	NURSERY		56	2,914			13.00
14.00	Total (see instructions)	4,446	849	19,732	0.00	468.79	14.00
15.00	CAH visits	0	0	0			15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)			0			24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						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	468.79	27.00
28.00	Observation Bed Days		0	1,917			28.00
29.00	Ambulance Trips	0					29.00
30.00	Employee discount days (see instruction)			796			30.00
31.00	Employee discount days - IRF			0			31.00
32.00	Labor & delivery days (see instructions)	0	0	865			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: 15-0157 | Period: From 07/01/2019 To 06/30/2020 | Worksheet S-3 Part I | Date/Time Prepared: 11/18/2020 5:26 pm

	Component	Full Time Equivalents	Discharges				
		Nonpaid Workers	Title V	Title XVIII	Title XIX	Total All Patients	
		11.00	12.00	13.00	14.00	15.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)		0	1,126	62	4,970	1.00
2.00	HMO and other (see instructions)			436	656		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	NEONATAL INTENSIVE CARE UNIT						12.00
13.00	NURSERY						13.00
14.00	Total (see instructions)	0.00	0	1,126	62	4,970	14.00
15.00	CAH visits						15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)						24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0.00					26.25
27.00	Total (sum of lines 14-26)	0.00					27.00
28.00	Observation Bed Days						28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)						32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00	LTCH non-covered days			0			33.00
33.01	LTCH site neutral days and discharges			0			33.01

HOSPITAL WAGE INDEX INFORMATION | Provider CCN: 15-0157 | Period: From 07/01/2019 To 06/30/2020 | Worksheet S-3 Part II | Date/Time Prepared: 11/18/2020 5:26 pm

		Wkst. A Line Number	Amount Reported	Reclassification of Salaries (from Wkst. A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
	PART II - WAGE DATA							
	SALARIES							
1.00	Total salaries (see instructions)	200.00	36,464,139	-137,468	36,326,671	967,340.01	37.55	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		36,031	0	36,031	221.12	162.95	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		1,902,778	0	1,902,778	12,623.51	150.73	5.00
6.00	Non-physician-Part B for hospital-based RHC and FQHC services		110,661	0	110,661	2,080.00	53.20	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		802,076	0	802,076	16,238.28	49.39	8.00
9.00	SNF	44.00	0	0	0	0.00	0.00	9.00
10.00	Excluded area salaries (see instructions)		1,275,378	75,347	1,350,725	43,238.21	31.24	10.00
	OTHER WAGES & RELATED COSTS							
11.00	Contract labor: Direct Patient Care		676,624	0	676,624	7,683.41	88.06	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		2,288,401	0	2,288,401	36,999.38	61.85	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		7,794,222	0	7,794,222	176,206.67	44.23	14.01
14.02	Related organization salaries		0	0	0	0.00	0.00	14.02
15.00	Home office: Physician Part A - Administrative		0	0	0	0.00	0.00	15.00
16.00	Home office and Contract Physicians Part A - Teaching		0	0	0	0.00	0.00	16.00
16.01	Home office Physicians Part A - Teaching		0	0	0	0.00	0.00	16.01
16.02	Home office contract Physicians Part A - Teaching		0	0	0	0.00	0.00	16.02
	WAGE-RELATED COSTS							
17.00	Wage-related costs (core) (see instructions)		8,700,310	-137,468	8,562,842			17.00
18.00	Wage-related costs (other) (see instructions)							18.00
19.00	Excluded areas		326,399	0	326,399			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		9,420	0	9,420			22.00
22.01	Physician Part A - Teaching		0	0	0			22.01
23.00	Physician Part B		497,495	0	497,495			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)		2,370,501	0	2,370,501			25.50
25.51	Related organization wage-related (core)		0	0	0			25.51
25.52	Home office: Physician Part A - Administrative - wage-related (core)		0	0	0			25.52

HOSPITAL WAGE INDEX INFORMATION | Provider CCN: 15-0157 | Period: From 07/01/2019 To 06/30/2020 | Worksheet S-3 Part II Date/Time Prepared: 11/18/2020 5:26 pm

		Wkst. A Line Number	Amount Reported	Reclassification of Salaries (from Wkst. A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
25.53	Home office: Physicians Part A - Teaching - wage-related (core)		0	0	0			25.53
	OVERHEAD COSTS - DIRECT SALARIES							
26.00	Employee Benefits Department	4.00	760,105	-137,468	622,637	134.40	4,632.72	26.00
27.00	Administrative & General	5.00	1,901,154	-829,106	1,072,048	59,708.39	17.95	27.00
28.00	Administrative & General under contract (see inst.)		0	0	0	0.00	0.00	28.00
29.00	Maintenance & Repairs	6.00	0	0	0	0.00	0.00	29.00
30.00	Operation of Plant	7.00	-371	371	0	0.00	0.00	30.00
31.00	Laundry & Linen Service	8.00	0	0	0	0.00	0.00	31.00
32.00	Housekeeping	9.00	0	0	0	0.00	0.00	32.00
33.00	Housekeeping under contract (see instructions)		1,399,380	0	1,399,380	56,850.00	24.62	33.00
34.00	Dietary	10.00	1,456	0	1,456	0.00	0.00	34.00
35.00	Dietary under contract (see instructions)		677,625	0	677,625	23,030.40	29.42	35.00
36.00	Cafeteria	11.00	0	0	0	0.00	0.00	36.00
37.00	Maintenance of Personnel	12.00	0	0	0	0.00	0.00	37.00
38.00	Nursing Administration	13.00	1,526,387	36,510	1,562,897	37,376.22	41.82	38.00
39.00	Central Services and Supply	14.00	420,818	19,950	440,768	21,557.05	20.45	39.00
40.00	Pharmacy	15.00	1,883,584	5,063	1,888,647	40,471.76	46.67	40.00
41.00	Medical Records & Medical Records Library	16.00	0	0	0	0.00	0.00	41.00
42.00	Social Service	17.00	33,662	0	33,662	1,214.11	27.73	42.00
43.00	Other General Service	18.00	0	0	0	0.00	0.00	43.00

HOSPITAL WAGE INDEX INFORMATION | Provider CCN: 15-0157 | Period: From 07/01/2019 To 06/30/2020 | Worksheet S-3 Part III Date/Time Prepared: 11/18/2020 5:26 pm

		Worksheet A Line Number	Amount Reported	Reclassification of Salaries (from Worksheet A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
	PART III - HOSPITAL WAGE INDEX SUMMARY							
1.00	Net salaries (see instructions)		35,725,629	-137,468	35,588,161	1,016,278.62	35.02	1.00
2.00	Excluded area salaries (see instructions)		1,275,378	75,347	1,350,725	43,238.21	31.24	2.00
3.00	Subtotal salaries (line 1 minus line 2)		34,450,251	-212,815	34,237,436	973,040.41	35.19	3.00
4.00	Subtotal other wages & related costs (see inst.)		10,759,247	0	10,759,247	220,889.46	48.71	4.00
5.00	Subtotal wage-related costs (see inst.)		11,080,231	-137,468	10,942,763	0.00	31.96	5.00
6.00	Total (sum of lines 3 thru 5)		56,289,729	-350,283	55,939,446	1,193,929.87	46.85	6.00
7.00	Total overhead cost (see instructions)		8,603,800	-904,680	7,699,120	240,342.33	32.03	7.00

HOSPITAL WAGE RELATED COSTS | Provider CCN: 15-0157 | Period: From 07/01/2019 To 06/30/2020 | Worksheet S-3 Part IV Date/Time Prepared: 11/18/2020 5:26 pm

		Amount Reported	
		1.00	
	PART IV - WAGE RELATED COSTS		
	Part A - Core List		
	RETIREMENT COST		
1.00	401K Employer Contributions	1,316,711	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	238,305	7.00
	HEALTH AND INSURANCE COST		
8.00	Health Insurance (Purchased or Self Funded)	0	8.00
8.01	Health Insurance (Self Funded without a Third Party Administrator)	0	8.01
8.02	Health Insurance (Self Funded with a Third Party Administrator)	3,854,448	8.02
8.03	Health Insurance (Purchased)	0	8.03
9.00	Prescription Drug Plan	1,049,801	9.00
10.00	Dental, Hearing and Vision Plan	128,362	10.00
11.00	Life Insurance (If employee is owner or beneficiary)	26,477	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)	260,296	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)	0	14.00
15.00	'Workers' Compensation Insurance	13,226	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	2,567,926	17.00
18.00	Medicare Taxes - Employers Portion Only	0	18.00
19.00	Unemployment Insurance	0	19.00
20.00	State or Federal Unemployment Taxes	3,005	20.00
	OTHER		
21.00	Executive Deferred Compensation (Other Than Retirement Cost Reported on lines 1 through 4 above. (see instructions))	58,702	21.00
22.00	Day Care Cost and Allowances	0	22.00
23.00	Tuition Reimbursement	16,366	23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)	9,533,625	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: 15-0157 | Period: From 07/01/2019 To 06/30/2020 | Worksheet S-3 Part V Date/Time Prepared: 11/18/2020 5:26 pm

	Cost Center Description	Contract Labor	Benefit Cost	
		1.00	2.00	
	PART V - Contract Labor and Benefit Cost			
	Hospital and Hospital-Based Component Identification:			
1.00	Total facility's contract labor and benefit cost	676,624	9,533,625	1.00
2.00	Hospital	676,624	9,533,625	2.00
3.00	Subprovider - IPF			3.00
4.00	Subprovider - IRF			4.00
5.00	Subprovider - (Other)	0	0	5.00
6.00	Swing Beds - SNF	0	0	6.00
7.00	Swing Beds - NF	0	0	7.00
8.00	Hospital-Based SNF			8.00
9.00	Hospital-Based NF			9.00
10.00	Hospital-Based OLTC			10.00
11.00	Hospital-Based HHA			11.00
12.00	Separately Certified ASC			12.00
13.00	Hospital-Based Hospice			13.00
14.00	Hospital-Based Health Clinic RHC			14.00
15.00	Hospital-Based Health Clinic FQHC			15.00
16.00	Hospital-Based-CMHC			16.00
17.00	Renal Dialysis			17.00
18.00	Other	0	0	18.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA | Provider CCN: 15-0157 | Period: From 07/01/2019 To 06/30/2020 | Worksheet S-10 | Date/Time Prepared: 11/18/2020 5:26 pm

		1.00	
	Uncompensated and indigent care cost computation		
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided by line 202 column 8)	0.184964	1.00
	Medicaid (see instructions for each line)		
2.00	Net revenue from Medicaid	2,412,821	2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?	N	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	71,415,587	6.00
7.00	Medicaid cost (line 1 times line 6)	13,209,313	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)	10,796,492	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)	10,796,492	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)	11,642,951	2,393,056	14,036,007	20.00
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	2,153,527	2,393,056	4,546,583	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)	2,153,527	2,393,056	4,546,583	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)	5,743,013	26.00
27.00	Medicare reimbursable bad debts for the entire hospital complex (see instructions)	155,506	27.00
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)	239,240	27.01
28.00	Non-Medicare bad debt expense (see instructions)	5,503,773	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)	1,101,734	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)	5,648,317	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	16,444,809	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 15-0157 | Period: From 07/01/2019 To 06/30/2020 | Worksheet A | Date/Time Prepared: 11/18/2020 5:26 pm

		Cost Center Description	Salaries	Other	Total (col. 1 + col. 2)	Reclassifications (See A-6)	Reclassified Trial Balance (col. 3 +- col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT		7,936,302	7,936,302	-9,448	7,926,854	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		4,705,731	4,705,731	0	4,705,731	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	760,105	7,503,778	8,263,883	0	8,263,883	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	1,901,154	35,485,266	37,386,420	-819,658	36,566,762	5.00
7.00	00700	OPERATION OF PLANT	-371	4,277,195	4,276,824	371	4,277,195	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	506,470	506,470	0	506,470	8.00
9.00	00900	HOUSEKEEPING	0	1,962,654	1,962,654	0	1,962,654	9.00
10.00	01000	DIETARY	1,456	1,893,404	1,894,860	-905,463	989,397	10.00
11.00	01100	CAFETERIA	0	11,246	11,246	905,463	916,709	11.00
13.00	01300	NURSING ADMINISTRATION	1,526,387	377,467	1,903,854	36,510	1,940,364	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	420,818	40,109	460,927	19,950	480,877	14.00
15.00	01500	PHARMACY	1,883,584	332,688	2,216,272	5,063	2,221,335	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	33,662	48,640	82,302	0	82,302	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	9,281,766	2,897,257	12,179,023	-846,452	11,332,571	30.00
31.00	03100	INTENSIVE CARE UNIT	1,819,631	442,627	2,262,258	4,934	2,267,192	31.00
35.00	02060	NEONATAL INTENSIVE CARE UNIT	1,891,606	243,515	2,135,121	0	2,135,121	35.00
43.00	04300	NURSERY	0	0	0	1,063,425	1,063,425	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	3,657,905	5,403,996	9,061,901	226,515	9,288,416	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,982,805	1,845,830	3,828,635	0	3,828,635	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,857,757	776,947	2,634,704	74,292	2,708,996	54.00
54.01	03480	ONCOLOGY	0	0	0	0	0	54.01
54.02	05402	ULTRASOUND	197,592	21,604	219,196	3,674	222,870	54.02
57.00	05700	CT SCAN	588,148	216,315	804,463	3,877	808,340	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	267,428	177,684	445,112	4,954	450,066	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	36	3,153,591	3,153,627	0	3,153,627	60.00
65.00	06500	RESPIRATORY THERAPY	809,368	246,376	1,055,744	1,471	1,057,215	65.00
66.00	06600	PHYSICAL THERAPY	536,028	65,308	601,336	5,423	606,759	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	8,514	2,100	10,614	0	10,614	68.00
69.00	06900	ELECTROCARDIOLOGY	116,766	24,275	141,041	5,196	146,237	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	8,920	2,677	11,597	0	11,597	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	4,819,365	4,819,365	0	4,819,365	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	6,248,743	6,248,743	0	6,248,743	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	3,772,719	3,772,719	0	3,772,719	73.00
75.00	07500	ASC (NON-DISTINCT PART)	2,532,879	5,648,755	8,181,634	0	8,181,634	75.00
76.00	03330	ENDOSCOPY	1,606,766	1,498,170	3,104,936	58,608	3,163,544	76.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	1,498,051	822,588	2,320,639	85,948	2,406,587	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	35,188,761	103,411,392	138,600,153	-75,347	138,524,806	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	119,045	355,801	474,846	3,663	478,509	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	424,672	81,675	506,347	2,056	508,403	192.00
194.00	07950	MISSION EFFECTIVENESS	0	0	0	0	0	194.00
194.01	07951	MARKETING	0	0	0	0	0	194.01
194.02	07952	JOINT VENTURES	0	0	0	0	0	194.02
194.04	07954	SCHOOL NURSE	573,110	41,598	614,708	69,628	684,336	194.04
194.06	07956	SPORTS MEDICINE & OB PHYS	158,551	113,299	271,850	0	271,850	194.06
200.00		TOTAL (SUM OF LINES 118 through 199)	36,464,139	104,003,765	140,467,904	0	140,467,904	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 15-0157 | Period: From 07/01/2019 To 06/30/2020 | Worksheet A | Date/Time Prepared: 11/18/2020 5:26 pm

		Cost Center Description	Adjustments (See A-8)	Net Expenses For Allocation		
			6.00	7.00		
		GENERAL SERVICE COST CENTERS				
1.00	00100	CAP REL COSTS-BLDG & FIXT	-1,479,652	6,447,202		1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	-80,204	4,625,527		2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-199,935	8,063,948		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-9,513,927	27,052,835		5.00
7.00	00700	OPERATION OF PLANT	-5,983	4,271,212		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	506,470		8.00
9.00	00900	HOUSEKEEPING	0	1,962,654		9.00
10.00	01000	DIETARY	-11,334	978,063		10.00
11.00	01100	CAFETERIA	-359,071	557,638		11.00
13.00	01300	NURSING ADMINISTRATION	-22,235	1,918,129		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	-3,750	477,127		14.00
15.00	01500	PHARMACY	-1,072	2,220,263		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0		16.00
17.00	01700	SOCIAL SERVICE	0	82,302		17.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	-2,508,049	8,824,522		30.00
31.00	03100	INTENSIVE CARE UNIT	0	2,267,192		31.00
35.00	02060	NEONATAL INTENSIVE CARE UNIT	-4,500	2,130,621		35.00
43.00	04300	NURSERY	0	1,063,425		43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	-260	9,288,156		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	-715,052	3,113,583		52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-164,939	2,544,057		54.00
54.01	03480	ONCOLOGY	0	0		54.01
54.02	05402	ULTRASOUND	0	222,870		54.02
57.00	05700	CT SCAN	-23,667	784,673		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	-4,465	445,601		58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0		59.00
60.00	06000	LABORATORY	0	3,153,627		60.00
65.00	06500	RESPIRATORY THERAPY	0	1,057,215		65.00
66.00	06600	PHYSICAL THERAPY	-46	606,713		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	10,614		68.00
69.00	06900	ELECTROCARDIOLOGY	0	146,237		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	11,597		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	4,819,365		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	6,248,743		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	3,772,719		73.00
75.00	07500	ASC (NON-DISTINCT PART)	-702,704	7,478,930		75.00
76.00	03330	ENDOSCOPY	849	3,164,393		76.00
		OUTPATIENT SERVICE COST CENTERS				
91.00	09100	EMERGENCY	-136,930	2,269,657		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				92.00
		SPECIAL PURPOSE COST CENTERS				
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-15,936,926	122,587,880		118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	478,509		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	508,403		192.00
194.00	07950	MISSION EFFECTIVENESS	0	0		194.00
194.01	07951	MARKETING	0	0		194.01
194.02	07952	JOINT VENTURES	0	0		194.02
194.04	07954	SCHOOL NURSE	0	684,336		194.04
194.06	07956	SPORTS MEDICINE & OB PHYS	0	271,850		194.06
200.00		TOTAL (SUM OF LINES 118 through 199)	-15,936,926	124,530,978		200.00

RECLASSIFICATIONS | Provider CCN: 15-0157 | Period: From 07/01/2019 To 06/30/2020 | Worksheet A-6 | Date/Time Prepared: 11/18/2020 5:26 pm

	Increases					
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
	A - NURSERY RECLASS					
1.00	NURSERY	43.00	877,774	185,651		1.00
	TOTALS		877,774	185,651		
	B - PTO ACCRUAL					
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	137,468		1.00
	TOTALS		0	137,468		
	C - CAFETERIA RECLASS					
1.00	CAFETERIA	11.00	0	905,463		1.00
	TOTALS		0	905,463		
	D - SECURITY SALARY RECLASS					
1.00	OPERATION OF PLANT	7.00	371	0		1.00
	TOTALS		371	0		
	E - PANDEMIC SALARY RECLASS					
1.00	NURSING ADMINISTRATION	13.00	36,510	0		1.00
2.00	CENTRAL SERVICES & SUPPLY	14.00	19,950	0		2.00
3.00	PHARMACY	15.00	5,063	0		3.00
4.00	ADULTS & PEDIATRICS	30.00	216,973	0		4.00
5.00	INTENSIVE CARE UNIT	31.00	4,934	0		5.00
6.00	OPERATING ROOM	50.00	226,515	0		6.00
7.00	RADIOLOGY-DIAGNOSTIC	54.00	74,292	0		7.00
8.00	ULTRASOUND	54.02	3,674	0		8.00
9.00	CT SCAN	57.00	3,877	0		9.00
10.00	MAGNETIC RESONANCE IMAGING (MRI)	58.00	4,954	0		10.00
11.00	RESPIRATORY THERAPY	65.00	1,471	0		11.00
12.00	PHYSICAL THERAPY	66.00	5,423	0		12.00
13.00	ELECTROCARDIOLOGY	69.00	5,196	0		13.00
14.00	ENDOSCOPY	76.00	58,608	0		14.00
15.00	EMERGENCY	91.00	85,948	0		15.00
16.00	GIFT, FLOWER, COFFEE SHOP & CANTEEN	190.00	3,663	0		16.00
17.00	PHYSICIANS' PRIVATE OFFICES	192.00	2,056	0		17.00
18.00	SCHOOL NURSE	194.04	69,628	0		18.00
	TOTALS		828,735	0		
	F - INTEREST RECLASS					
1.00	ADMINISTRATIVE & GENERAL	5.00	0	9,448		1.00
	TOTALS		0	9,448		
500.00	Grand Total: Increases		1,706,880	1,238,030		500.00

RECLASSIFICATIONS | Provider CCN: 15-0157 | Period: From 07/01/2019 To 06/30/2020 | Worksheet A-6 | Date/Time Prepared: 11/18/2020 5:26 pm

	Decreases						
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	A - NURSERY RECLASS						
1.00	ADULTS & PEDIATRICS	30.00	877,774	185,651	0		1.00
	TOTALS		877,774	185,651			
	B - PTO ACCRUAL						
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	137,468	0	0		1.00
	TOTALS		137,468	0			
	C - CAFETERIA RECLASS						
1.00	DIETARY	10.00	0	905,463	0		1.00
	TOTALS		0	905,463			
	D - SECURITY SALARY RECLASS						
1.00	ADMINISTRATIVE & GENERAL	5.00	371	0	0		1.00
	TOTALS		371	0			
	E - PANDEMIC SALARY RECLASS						
1.00	ADMINISTRATIVE & GENERAL	5.00	828,735	0	0		1.00
2.00		0.00	0	0	0		2.00
3.00		0.00	0	0	0		3.00
4.00		0.00	0	0	0		4.00
5.00		0.00	0	0	0		5.00
6.00		0.00	0	0	0		6.00
7.00		0.00	0	0	0		7.00
8.00		0.00	0	0	0		8.00
9.00		0.00	0	0	0		9.00
10.00		0.00	0	0	0		10.00
11.00		0.00	0	0	0		11.00
12.00		0.00	0	0	0		12.00
13.00		0.00	0	0	0		13.00
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
	TOTALS		828,735	0			
	F - INTEREST RECLASS						
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	9,448	11		1.00
	TOTALS		0	9,448			
500.00	Grand Total: Decreases		1,844,348	1,100,562			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-0157 | Period: From 07/01/2019 To 06/30/2020 | Worksheet A-7 Part I | Date/Time Prepared: 11/18/2020 5:26 pm

		Beginning Balances	Acquisitions: Purchases	Acquisitions: Donation	Acquisitions: Total	Disposals and Retirements	
		1.00	2.00	3.00	4.00	5.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	15,676,014	0	0	0	0	1.00
2.00	Land Improvements	2,564,800	54,033	0	54,033	0	2.00
3.00	Buildings and Fixtures	83,678,549	954,694	0	954,694	595,415	3.00
4.00	Building Improvements	3,288,035	0	0	0	0	4.00
5.00	Fixed Equipment	16,127,482	1,407,013	0	1,407,013	-302,957	5.00
6.00	Movable Equipment	46,709,097	2,858,204	0	2,858,204	-283,431	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	168,043,977	5,273,944	0	5,273,944	9,027	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	168,043,977	5,273,944	0	5,273,944	9,027	10.00

		Ending Balance	Fully Depreciated Assets	
		6.00	7.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES			
1.00	Land	15,676,014	0	1.00
2.00	Land Improvements	2,618,833	0	2.00
3.00	Buildings and Fixtures	84,037,828	0	3.00
4.00	Building Improvements	3,288,035	0	4.00
5.00	Fixed Equipment	17,837,452	0	5.00
6.00	Movable Equipment	49,850,732	0	6.00
7.00	HIT designated Assets	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	173,308,894	0	8.00
9.00	Reconciling Items	0	0	9.00
10.00	Total (line 8 minus line 9)	173,308,894	0	10.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-0157 | Period: From 07/01/2019 To 06/30/2020 | Worksheet A-7 Part II | Date/Time Prepared: 11/18/2020 5:26 pm

	Cost Center Description	SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	CAP REL COSTS-BLDG & FIXT	3,341,312	3,687,742	714,915	0	192,333	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	3,728,687	911,242	0	153	1,234	2.00
3.00	Total (sum of lines 1-2)	7,069,999	4,598,984	714,915	153	193,567	3.00

	Cost Center Description	SUMMARY OF CAPITAL		
		Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)	
		14.00	15.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2			
1.00	CAP REL COSTS-BLDG & FIXT	0	7,936,302	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	64,415	4,705,731	2.00
3.00	Total (sum of lines 1-2)	64,415	12,642,033	3.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-0157 | Period: From 07/01/2019 To 06/30/2020 | Worksheet A-7 Part III Date/Time Prepared: 11/18/2020 5:26 pm

	Cost Center Description	COMPUTATION OF RATIOS: Gross Assets	COMPUTATION OF RATIOS: Capitalized Leases	COMPUTATION OF RATIOS: Gross Assets for Ratio (col. 1 - col. 2)	ALLOCATION OF OTHER CAPITAL: Ratio (see instructions)	ALLOCATION OF OTHER CAPITAL: Insurance	
		1.00	2.00	3.00	4.00	5.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	123,458,161	0	123,458,161	0.712359	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	49,850,732	0	49,850,732	0.287641	0	2.00
3.00	Total (sum of lines 1-2)	173,308,893	0	173,308,893	1.000000	0	3.00

	Cost Center Description	ALLOCATION OF OTHER CAPITAL: Taxes	ALLOCATION OF OTHER CAPITAL: Other Capital-Related Costs	ALLOCATION OF OTHER CAPITAL: Total (sum of cols. 5 through 7)	SUMMARY OF CAPITAL: Depreciation	SUMMARY OF CAPITAL: Lease	
		6.00	7.00	8.00	9.00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	3,341,312	3,687,742	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	3,728,687	911,242	2.00
3.00	Total (sum of lines 1-2)	0	0	0	7,069,999	4,598,984	3.00

	Cost Center Description	SUMMARY OF CAPITAL: Interest	SUMMARY OF CAPITAL: Insurance (see instructions)	SUMMARY OF CAPITAL: Taxes (see instructions)	SUMMARY OF CAPITAL: Other Capital-Related Costs (see instructions)	SUMMARY OF CAPITAL: Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0	0	192,333	-774,185	6,447,202	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	153	1,234	-15,789	4,625,527	2.00
3.00	Total (sum of lines 1-2)	0	153	193,567	-789,974	11,072,729	3.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 15-0157 | Period: From 07/01/2019 To 06/30/2020 | Worksheet A-8 | Date/Time Prepared: 11/18/2020 5:26 pm

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
1.00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)	B	-705,467	CAP REL COSTS-BLDG & FIXT	1.00	11	1.00
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
3.00	Investment income - other (chapter 2)	B	-48,037	ADMINISTRATIVE & GENERAL	5.00	0	3.00
4.00	Trade, quantity, and time discounts (chapter 8)		0		0.00	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)		0		0.00	0	5.00
6.00	Rental of provider space by suppliers (chapter 8)		0		0.00	0	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)		0		0.00	0	7.00
8.00	Television and radio service (chapter 21)	A	-4,971	OPERATION OF PLANT	7.00	0	8.00
9.00	Parking lot (chapter 21)		0		0.00	0	9.00
10.00	Provider-based physician adjustment	A-8-2	-3,479,520			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	760,267			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests	B	-356,254	CAFETERIA	11.00	0	14.00
15.00	Rental of quarters to employee and others		0		0.00	0	15.00
16.00	Sale of medical and surgical supplies to other than patients		0		0.00	0	16.00
17.00	Sale of drugs to other than patients		0		0.00	0	17.00
18.00	Sale of medical records and abstracts		0		0.00	0	18.00
19.00	Nursing and allied health education (tuition, fees, books, etc.)		0		0.00	0	19.00
20.00	Vending machines	B	-2,817	CAFETERIA	11.00	0	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	0	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	RESPIRATORY THERAPY	65.00		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	PHYSICAL THERAPY	66.00		24.00
25.00	Utilization review - physicians' compensation (chapter 21)		0	*** Cost Center Deleted ***	114.00		25.00
26.00	Depreciation - CAP REL COSTS-BLDG & FIXT		0	CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	27.00
28.00	Non-physician Anesthetist		0	*** Cost Center Deleted ***	19.00		28.00
29.00	Physicians' assistant		0		0.00	0	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	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	DONATIONS MADE	A	-1,330	ADMINISTRATIVE & GENERAL	5.00	0	33.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 15-0157 | Period: From 07/01/2019 To 06/30/2020 | Worksheet A-8 | Date/Time Prepared: 11/18/2020 5:26 pm

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
33.01	BILLING ARRANGEMENTS	B	-852,340	ADMINISTRATIVE & GENERAL	5.00	0	33.01
33.02	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	33.02
33.03	MEALS ON WHEELS	B	-10,080	DIETARY	10.00	0	33.03
34.00	ADMINISTRATIVE FEES	B	-2,900	ADMINISTRATIVE & GENERAL	5.00	0	34.00
35.00	CONSOLIDATING ENTRY	B	-2,895,956	ADMINISTRATIVE & GENERAL	5.00	0	35.00
36.00	SEMINARS TUITION REVENUE	B	-400	ADMINISTRATIVE & GENERAL	5.00	0	36.00
37.00	ACCOMODATION FEES - BARIATRIC	B	-2,698	ADULTS & PEDIATRICS	30.00	0	37.00
38.00	OTHER MISC REVENUE - A&G	B	-41,200	RADIOLOGY-DIAGNOSTIC	54.00	0	38.00
38.01	OTHER MISC REVENUE - ROUTINE	B	3,310	ADULTS & PEDIATRICS	30.00	0	38.01
39.00	OTHER MISC REVENUE - RADIOLOGY	B	-600	RADIOLOGY-DIAGNOSTIC	54.00	0	39.00
40.00	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	40.00
41.00	OTHER MISC REVENUE - ASC	B	-685,812	ASC (NON-DISTINCT PART)	75.00	0	41.00
42.00	OTHER MISC REVENUE - ENDO	B	849	ENDOSCOPY	76.00	0	42.00
42.01	LATE PENALTY FEES - MAINT	B	-1,012	OPERATION OF PLANT	7.00	0	42.01
43.00	REVENUES FROM EXTERNAL PARTIES	B	-1,500	ADULTS & PEDIATRICS	30.00	0	43.00
44.00	VENDING MACHINES - DIETARY	B	-1,254	DIETARY	10.00	0	44.00
44.01	UNCLAIMED PROPERTY EXEMPTIONS	B	-13,887	ADMINISTRATIVE & GENERAL	5.00	0	44.01
45.00	RENTAL OF HOSPITAL SPACE	B	-705,733	CAP REL COSTS-BLDG & FIXT	1.00	14	45.00
46.00	ONSITE CLINICS OTHER REVENUE	B	-96,248	ADULTS & PEDIATRICS	30.00	0	46.00
47.00	IFUE OPERATING COMFORT IMAGING	B	-68,452	CAP REL COSTS-BLDG & FIXT	1.00	14	47.00
49.00	LOSS ON SALE DISPOSAL PPE	B	-80,204	CAP REL COSTS-MVBLE EQUIP	2.00	14	49.00
49.01	ENTERTAINMENT - A&G	A	-8,187	ADMINISTRATIVE & GENERAL	5.00	0	49.01
49.02	ENTERTAINMENT - NURS ADMIN	A	-71	NURSING ADMINISTRATION	13.00	0	49.02
49.03	ENTERTAINMENT - ROUTINE	A	-257	ADULTS & PEDIATRICS	30.00	0	49.03
49.04	ENTERTAINMENT - OR	A	-260	OPERATING ROOM	50.00	0	49.04
49.05	ENTERTAINMENT - L&D	A	-129	DELIVERY ROOM & LABOR ROOM	52.00	0	49.05
49.06	ENTERTAINMENT - RADIOLOGY	A	-881	RADIOLOGY-DIAGNOSTIC	54.00	0	49.06
49.07	ENTERTAINMENT - PT	A	-46	PHYSICAL THERAPY	66.00	0	49.07
49.08	ENTERTAIMENT - ED	A	-378	EMERGENCY	91.00	0	49.08
49.09	ADVERTISING - ADMIN	A	-1,555	ADMINISTRATIVE & GENERAL	5.00	0	49.09
49.10	ADVERTISING - ASC	A	-16,892	ASC (NON-DISTINCT PART)	75.00	0	49.10
49.11	CORPORATE SPONSORSHIP	A	-8,000	ADMINISTRATIVE & GENERAL	5.00	0	49.11
49.12	MARKETING - ADMIN	A	-3,510	ADMINISTRATIVE & GENERAL	5.00	0	49.12
49.13	MARKETING - CS&S	A	-3,750	CENTRAL SERVICES & SUPPLY	14.00	0	49.13
49.14	MARKETING - ROUTINE	A	-29,301	ADULTS & PEDIATRICS	30.00	0	49.14
49.15	CHARITABLE EXPENSE - NURS ADMIN	A	-22,164	NURSING ADMINISTRATION	13.00	0	49.15
49.16	CHARITABLE EXPENSE - PHARMACY	A	-1,072	PHARMACY	15.00	0	49.16
49.17	LATE PENALTY FEES	A	-192	ADMINISTRATIVE & GENERAL	5.00	0	49.17
49.18	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	49.18
49.19	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	49.19
49.20	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	49.20
49.21	TELEPHONE OFFSET - DEPRECIATION	A	0		0.00	0	49.21
49.22	LOBBYING	A	-1,925	ADMINISTRATIVE & GENERAL	5.00	0	49.22
49.23	PROVIDER ASSESSMENT OFFSET	B	-6,544,110	ADMINISTRATIVE & GENERAL	5.00	0	49.23
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-15,936,926				50.00

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

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS | Provider CCN: 15-0157 | Period: From 07/01/2019 To 06/30/2020 | Worksheet A-8-1 | Date/Time Prepared: 11/18/2020 5:26 pm

	Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in Wks. A, column 5	
	1.00	2.00	3.00	4.00	5.00	
	A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:					
1.00	4.00	EMPLOYEE BENEFITS DEPARTMENT	HEALTH INSURANCE	5,271,918	5,471,853	1.00
2.00	5.00	ADMINISTRATIVE & GENERAL	HOME OFFICE - CAPITAL	2,209,573	0	2.00
3.00	5.00	ADMINISTRATIVE & GENERAL	HOME OFFICE - INTEREST	38,589	0	3.00
3.01	5.00	ADMINISTRATIVE & GENERAL	HOME OFFICE - OTHER	22,732,737	24,020,697	3.01
3.02	0.00			0	0	3.02
3.03	4.00	EMPLOYEE BENEFITS DEPARTMENT	SVH CHARGEBACKS	200,548	200,548	3.03
3.04	5.00	ADMINISTRATIVE & GENERAL	SVH CHARGEBACKS	450,257	450,257	3.04
3.05	13.00	NURSING ADMINISTRATION	SVH CHARGEBACKS	-4,805	-4,805	3.05
3.06	15.00	PHARMACY	SVH CHARGEBACKS	48,000	48,000	3.06
3.07	30.00	ADULTS & PEDIATRICS	SVH CHARGEBACKS	1,318	1,318	3.07
3.08	31.00	INTENSIVE CARE UNIT	SVH CHARGEBACKS	230,000	230,000	3.08
3.09	35.00	NEONATAL INTENSIVE CARE UNIT	SVH CHARGEBACKS	402,835	402,835	3.09
3.10	52.00	DELIVERY ROOM & LABOR ROOM	SVH CHARGEBACKS	246,485	246,485	3.10
3.11	54.00	RADIOLOGY-DIAGNOSTIC	SVH CHARGEBACKS	79,178	79,178	3.11
3.12	66.00	PHYSICAL THERAPY	SVH CHARGEBACKS	39,768	39,768	3.12
4.00	0.00			0	0	4.00
4.01	1.00	CAP REL COSTS-BLDG & FIXT	INTEREST	714,915	714,915	4.01
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.			32,661,316	31,901,049	5.00

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

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

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

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

6.00	G	ST. VINCENT HEA	100.00	ST. VINCENT HEA	100.00	6.00
7.00	G	ASCENSION HEALT	100.00	ASCENSION HEALT	100.00	7.00
8.00			0.00		0.00	8.00
9.00			0.00		0.00	9.00
10.00			0.00		0.00	10.00
100.00	G. Other (financial or non-financial) specify:	HOME OFFICE				100.00

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

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

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS	Provider CCN: 15-0157	Period: From 07/01/2019 To 06/30/2020	Worksheet A-8-1 Date/Time Prepared: 11/18/2020 5:26 pm

	Net Adjustments (col. 4 minus col. 5)*	Wkst. A-7 Ref.		
	6.00	7.00		
	A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:			
1.00	-199,935	0		1.00
2.00	2,209,573	0		2.00
3.00	38,589	0		3.00
3.01	-1,287,960	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
3.06	0	0		3.06
3.07	0	0		3.07
3.08	0	0		3.08
3.09	0	0		3.09
3.10	0	0		3.10
3.11	0	0		3.11
3.12	0	0		3.12
4.00	0	0		4.00
4.01	0	11		4.01
5.00	760,267			5.00

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

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

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

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

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

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

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

PROVIDER BASED PHYSICIAN ADJUSTMENT | Provider CCN: 15-0157 | Period: From 07/01/2019 To 06/30/2020 | Worksheet A-8-2 | Date/Time Prepared: 11/18/2020 5:26 pm

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	5.00	ADMINISTRATIVE & GENERAL	91,800	91,800	0	0	0	1.00
2.00	30.00	ADULTS & PEDIATRICS	2,709,005	2,381,355	327,650	211,500	8,784	2.00
3.00	35.00	NEONATAL INTENSIVE CARE UNIT	4,500	4,500	0	0	0	3.00
4.00	50.00	OPERATING ROOM	1,315,397	0	1,315,397	246,400	25,061	4.00
5.00	52.00	DELIVERY ROOM & LABOR ROOM	997,277	216,713	780,564	237,100	2,477	5.00
6.00	54.00	RADIOLOGY-DIAGNOSTIC	157,814	0	157,814	271,900	272	6.00
7.00	57.00	CT SCAN	23,667	23,667	0	0	0	7.00
8.00	58.00	MAGNETIC RESONANCE IMAGING (MRI)	4,465	4,465	0	0	0	8.00
9.00	91.00	EMERGENCY	156,482	0	156,482	211,500	196	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			5,460,407	2,722,500	2,737,907		36,790	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	5.00	ADMINISTRATIVE & GENERAL	0	0	0	0	0	1.00
2.00	30.00	ADULTS & PEDIATRICS	893,181	44,659	0	0	0	2.00
3.00	35.00	NEONATAL INTENSIVE CARE UNIT	0	0	0	0	0	3.00
4.00	50.00	OPERATING ROOM	2,968,765	148,438	0	0	0	4.00
5.00	52.00	DELIVERY ROOM & LABOR ROOM	282,354	14,118	0	0	0	5.00
6.00	54.00	RADIOLOGY-DIAGNOSTIC	35,556	1,778	0	0	0	6.00
7.00	57.00	CT SCAN	0	0	0	0	0	7.00
8.00	58.00	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	8.00
9.00	91.00	EMERGENCY	19,930	997	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			4,199,786	209,990	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	5.00	ADMINISTRATIVE & GENERAL	0	0	0	91,800		1.00
2.00	30.00	ADULTS & PEDIATRICS	0	893,181	0	2,381,355		2.00
3.00	35.00	NEONATAL INTENSIVE CARE UNIT	0	0	0	4,500		3.00
4.00	50.00	OPERATING ROOM	0	2,968,765	0	0		4.00
5.00	52.00	DELIVERY ROOM & LABOR ROOM	0	282,354	498,210	714,923		5.00
6.00	54.00	RADIOLOGY-DIAGNOSTIC	0	35,556	122,258	122,258		6.00
7.00	57.00	CT SCAN	0	0	0	23,667		7.00
8.00	58.00	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	4,465		8.00
9.00	91.00	EMERGENCY	0	19,930	136,552	136,552		9.00
10.00	0.00		0	0	0	0		10.00
200.00			0	4,199,786	757,020	3,479,520		200.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-0157 | Period: From 07/01/2019 To 06/30/2020 | Worksheet B Part I | Date/Time Prepared: 11/18/2020 5:26 pm

		Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
				BLDG & FIXT	MVBLE EQUIP			
			0	1.00	2.00	4.00	4A	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	6,447,202	6,447,202				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	4,625,527		4,625,527			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	8,063,948	84,844	0	8,148,792		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	27,052,835	409,626	451,620	244,676	28,158,757	5.00
7.00	00700	OPERATION OF PLANT	4,271,212	753,033	13,329	0	5,037,574	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	506,470	33,218	0	0	539,688	8.00
9.00	00900	HOUSEKEEPING	1,962,654	115,741	31,635	0	2,110,030	9.00
10.00	01000	DIETARY	978,063	141,608	1,968	332	1,121,971	10.00
11.00	01100	CAFETERIA	557,638	165,221	1,753	0	724,612	11.00
13.00	01300	NURSING ADMINISTRATION	1,918,129	2,971	86,772	356,703	2,364,575	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	477,127	143,625	45,729	100,597	767,078	14.00
15.00	01500	PHARMACY	2,220,263	113,031	166,094	431,050	2,930,438	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	6,570	0	0	6,570	16.00
17.00	01700	SOCIAL SERVICE	82,302	15,590	0	7,683	105,575	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	8,824,522	1,463,196	276,392	1,967,571	12,531,681	30.00
31.00	03100	INTENSIVE CARE UNIT	2,267,192	149,804	124,124	416,424	2,957,544	31.00
35.00	02060	NEONATAL INTENSIVE CARE UNIT	2,130,621	149,110	37,101	431,725	2,748,557	35.00
43.00	04300	NURSERY	1,063,425	263,833	14,949	200,336	1,542,543	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	9,288,156	574,846	1,196,892	886,549	11,946,443	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	3,113,583	305,355	71,569	452,540	3,943,047	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,544,057	297,766	245,497	440,955	3,528,275	54.00
54.01	03480	ONCOLOGY	0	0	0	0	0	54.01
54.02	05402	ULTRASOUND	222,870	18,712	87,705	45,935	375,222	54.02
57.00	05700	CT SCAN	784,673	83,478	190,737	135,119	1,194,007	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	445,601	172,766	579,845	62,166	1,260,378	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	3,153,627	104,661	0	8	3,258,296	60.00
65.00	06500	RESPIRATORY THERAPY	1,057,215	52,645	87,358	185,059	1,382,277	65.00
66.00	06600	PHYSICAL THERAPY	606,713	43,820	0	123,576	774,109	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	10,614	499	0	1,943	13,056	68.00
69.00	06900	ELECTROCARDIOLOGY	146,237	4,315	14,886	27,836	193,274	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	11,597	477	9,188	2,036	23,298	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	4,819,365	0	0	0	4,819,365	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	6,248,743	0	0	0	6,248,743	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	3,772,719	0	0	0	3,772,719	73.00
75.00	07500	ASC (NON-DISTINCT PART)	7,478,930	274,869	208,709	578,084	8,540,592	75.00
76.00	03330	ENDOSCOPY	3,164,393	114,072	595,796	380,092	4,254,353	76.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	2,269,657	295,207	55,157	361,519	2,981,540	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					0	92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	122,587,880	6,354,509	4,594,805	7,840,514	122,156,187	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	478,509	35,863	0	28,006	542,378	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	508,403	0	150	97,393	605,946	192.00
194.00	07950	MISSION EFFECTIVENESS	0	0	0	0	0	194.00
194.01	07951	MARKETING	0	0	0	0	0	194.01
194.02	07952	JOINT VENTURES	0	0	0	0	0	194.02
194.04	07954	SCHOOL NURSE	684,336	19,189	0	146,693	850,218	194.04
194.06	07956	SPORTS MEDICINE & OB PHYS	271,850	37,641	30,572	36,186	376,249	194.06
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)	124,530,978	6,447,202	4,625,527	8,148,792	124,530,978	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-0157 | Period: From 07/01/2019 To 06/30/2020 | Worksheet B Part I | Date/Time Prepared: 11/18/2020 5:26 pm

		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	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	28,158,757					5.00
7.00	00700	OPERATION OF PLANT	1,471,914	6,509,488				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	157,690	41,585	738,963			8.00
9.00	00900	HOUSEKEEPING	616,523	144,896	0	2,871,449		9.00
10.00	01000	DIETARY	327,825	177,279	0	80,507	1,707,582	10.00
11.00	01100	CAFETERIA	211,722	206,839	0	93,931	0	11.00
13.00	01300	NURSING ADMINISTRATION	690,898	3,719	0	1,689	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	224,130	179,803	18,883	81,654	0	14.00
15.00	01500	PHARMACY	856,236	141,503	0	64,260	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,920	8,225	0	3,735	0	16.00
17.00	01700	SOCIAL SERVICE	30,848	19,517	0	8,863	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	3,661,641	1,831,775	228,668	831,858	1,486,668	30.00
31.00	03100	INTENSIVE CARE UNIT	864,156	187,540	24,014	85,167	123,304	31.00
35.00	02060	NEONATAL INTENSIVE CARE UNIT	803,093	186,671	0	84,772	0	35.00
43.00	04300	NURSERY	450,711	330,291	63,250	149,994	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	3,490,595	719,648	150,309	326,812	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,152,107	382,272	19,012	173,600	97,610	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,030,916	372,772	47,937	169,286	0	54.00
54.01	03480	ONCOLOGY	0	0	0	0	0	54.01
54.02	05402	ULTRASOUND	109,635	23,425	2,991	10,638	0	54.02
57.00	05700	CT SCAN	348,873	104,505	10,979	47,459	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	368,266	216,285	15,977	98,221	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	952,032	131,025	0	59,502	0	60.00
65.00	06500	RESPIRATORY THERAPY	403,883	65,906	376	29,930	0	65.00
66.00	06600	PHYSICAL THERAPY	226,185	54,859	963	24,913	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	3,815	624	17	284	0	68.00
69.00	06900	ELECTROCARDIOLOGY	56,472	5,402	51	2,453	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	6,807	597	4	271	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,408,156	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1,825,801	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,102,339	0	0	0	0	73.00
75.00	07500	ASC (NON-DISTINCT PART)	2,495,450	344,108	30,029	156,269	0	75.00
76.00	03330	ENDOSCOPY	1,243,067	142,806	43,532	64,852	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	871,167	369,569	78,597	167,831	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	27,464,873	6,393,446	735,589	2,818,751	1,707,582	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	158,476	44,897	0	20,389	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	177,050	0	0	0	0	192.00
194.00	07950	MISSION EFFECTIVENESS	0	0	0	0	0	194.00
194.01	07951	MARKETING	0	0	0	0	0	194.01
194.02	07952	JOINT VENTURES	0	0	0	0	0	194.02
194.04	07954	SCHOOL NURSE	248,423	24,023	0	10,909	0	194.04
194.06	07956	SPORTS MEDICINE & OB PHYS	109,935	47,122	3,374	21,400	0	194.06
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)	28,158,757	6,509,488	738,963	2,871,449	1,707,582	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-0157 | Period: From 07/01/2019 To 06/30/2020 | Worksheet B Part I | Date/Time Prepared: 11/18/2020 5:26 pm

		Cost Center Description	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
			11.00	13.00	14.00	15.00	16.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
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	1,237,104					11.00
13.00	01300	NURSING ADMINISTRATION	52,070	3,112,951				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	30,617	17,341	1,319,506			14.00
15.00	01500	PHARMACY	56,205	14,011	4,687	4,067,340		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	20,450	16.00
17.00	01700	SOCIAL SERVICE	1,681	0	0	0	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	292,136	1,038,209	24,097	0	1,847	30.00
31.00	03100	INTENSIVE CARE UNIT	50,816	262,278	9,297	0	435	31.00
35.00	02060	NEONATAL INTENSIVE CARE UNIT	65,208	239,796	6,070	0	710	35.00
43.00	04300	NURSERY	34,238	153,878	3,255	0	277	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	153,891	487,788	262,868	0	6,410	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	73,796	300,820	16,011	0	1,354	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	67,847	86,888	25,774	0	918	54.00
54.01	03480	ONCOLOGY	0	0	0	0	0	54.01
54.02	05402	ULTRASOUND	19,742	0	125	0	112	54.02
57.00	05700	CT SCAN	20,714	1,839	9,106	0	345	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	9,686	1,340	5,349	0	112	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0	0	19	0	1,440	60.00
65.00	06500	RESPIRATORY THERAPY	31,989	818	12,048	0	194	65.00
66.00	06600	PHYSICAL THERAPY	19,055	3,048	779	0	114	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	316	0	16	0	5	68.00
69.00	06900	ELECTROCARDIOLOGY	3,188	0	1,075	0	204	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	152	0	2	0	38	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	325,126	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	433,912	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	4,067,340	0	73.00
75.00	07500	ASC (NON-DISTINCT PART)	104,874	0	125,718	0	2,591	75.00
76.00	03330	ENDOSCOPY	68,843	123,337	38,600	0	1,684	76.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	53,813	221,491	15,041	0	1,660	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	1,210,877	2,952,882	1,318,975	4,067,340	20,450	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	7,882	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	12,381	0	11	0	0	192.00
194.00	07950	MISSION EFFECTIVENESS	0	0	0	0	0	194.00
194.01	07951	MARKETING	0	0	0	0	0	194.01
194.02	07952	JOINT VENTURES	0	0	0	0	0	194.02
194.04	07954	SCHOOL NURSE	0	160,069	0	0	0	194.04
194.06	07956	SPORTS MEDICINE & OB PHYS	5,964	0	520	0	0	194.06
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	1,237,104	3,112,951	1,319,506	4,067,340	20,450	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-0157 | Period: From 07/01/2019 To 06/30/2020 | Worksheet B Part I | Date/Time Prepared: 11/18/2020 5:26 pm

		Cost Center Description	SOCIAL SERVICE	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			17.00	24.00	25.00	26.00		
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY						15.00
16.00	01600	MEDICAL RECORDS & LIBRARY						16.00
17.00	01700	SOCIAL SERVICE	166,484					17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	37,368	21,965,948	0	21,965,948		30.00
31.00	03100	INTENSIVE CARE UNIT	17,084	4,581,635	0	4,581,635		31.00
35.00	02060	NEONATAL INTENSIVE CARE UNIT	27,735	4,162,612	0	4,162,612		35.00
43.00	04300	NURSERY	0	2,728,437	0	2,728,437		43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	3,271	17,548,035	0	17,548,035		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	21,062	6,180,691	0	6,180,691		52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	5,330,613	0	5,330,613		54.00
54.01	03480	ONCOLOGY	0	0	0	0		54.01
54.02	05402	ULTRASOUND	0	541,890	0	541,890		54.02
57.00	05700	CT SCAN	0	1,737,827	0	1,737,827		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	1,975,614	0	1,975,614		58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0		59.00
60.00	06000	LABORATORY	0	4,402,314	0	4,402,314		60.00
65.00	06500	RESPIRATORY THERAPY	0	1,927,421	0	1,927,421		65.00
66.00	06600	PHYSICAL THERAPY	0	1,104,025	0	1,104,025		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	18,133	0	18,133		68.00
69.00	06900	ELECTROCARDIOLOGY	0	262,119	0	262,119		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	31,169	0	31,169		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	6,552,647	0	6,552,647		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	8,508,456	0	8,508,456		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	8,942,398	0	8,942,398		73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	11,799,631	0	11,799,631		75.00
76.00	03330	ENDOSCOPY	8,722	5,989,796	0	5,989,796		76.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	42,508	4,803,217	0	4,803,217		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)			0			92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	157,750	121,094,628	0	121,094,628		118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	774,022	0	774,022		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	8,734	804,122	0	804,122		192.00
194.00	07950	MISSION EFFECTIVENESS	0	0	0	0		194.00
194.01	07951	MARKETING	0	0	0	0		194.01
194.02	07952	JOINT VENTURES	0	0	0	0		194.02
194.04	07954	SCHOOL NURSE	0	1,293,642	0	1,293,642		194.04
194.06	07956	SPORTS MEDICINE & OB PHYS	0	564,564	0	564,564		194.06
200.00		Cross Foot Adjustments		0	0	0		200.00
201.00		Negative Cost Centers	0	0	0	0		201.00
202.00		TOTAL (sum lines 118 through 201)	166,484	124,530,978	0	124,530,978		202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-0157 | Period: From 07/01/2019 To 06/30/2020 | Worksheet B Part II Date/Time Prepared: 11/18/2020 5:26 pm

		Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS BLDG & FIXT	CAPITAL RELATED COSTS MVBLE EQUIP	Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
			0	1.00	2.00	2A	4.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	84,844	0	84,844	84,844	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	2,209,573	409,626	451,620	3,070,819	2,547	5.00
7.00	00700	OPERATION OF PLANT	0	753,033	13,329	766,362	0	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	33,218	0	33,218	0	8.00
9.00	00900	HOUSEKEEPING	0	115,741	31,635	147,376	0	9.00
10.00	01000	DIETARY	0	141,608	1,968	143,576	3	10.00
11.00	01100	CAFETERIA	0	165,221	1,753	166,974	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	2,971	86,772	89,743	3,713	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	143,625	45,729	189,354	1,047	14.00
15.00	01500	PHARMACY	0	113,031	166,094	279,125	4,487	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	6,570	0	6,570	0	16.00
17.00	01700	SOCIAL SERVICE	0	15,590	0	15,590	80	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	1,463,196	276,392	1,739,588	20,496	30.00
31.00	03100	INTENSIVE CARE UNIT	0	149,804	124,124	273,928	4,335	31.00
35.00	02060	NEONATAL INTENSIVE CARE UNIT	0	149,110	37,101	186,211	4,494	35.00
43.00	04300	NURSERY	0	263,833	14,949	278,782	2,086	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	574,846	1,196,892	1,771,738	9,229	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	305,355	71,569	376,924	4,711	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	297,766	245,497	543,263	4,591	54.00
54.01	03480	ONCOLOGY	0	0	0	0	0	54.01
54.02	05402	ULTRASOUND	0	18,712	87,705	106,417	478	54.02
57.00	05700	CT SCAN	0	83,478	190,737	274,215	1,407	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	172,766	579,845	752,611	647	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0	104,661	0	104,661	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	52,645	87,358	140,003	1,927	65.00
66.00	06600	PHYSICAL THERAPY	0	43,820	0	43,820	1,286	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	499	0	499	20	68.00
69.00	06900	ELECTROCARDIOLOGY	0	4,315	14,886	19,201	290	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	477	9,188	9,665	21	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	274,869	208,709	483,578	6,018	75.00
76.00	03330	ENDOSCOPY	0	114,072	595,796	709,868	3,957	76.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0	295,207	55,157	350,364	3,764	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				0		92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	2,209,573	6,354,509	4,594,805	13,158,887	81,634	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	35,863	0	35,863	292	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	150	150	1,014	192.00
194.00	07950	MISSION EFFECTIVENESS	0	0	0	0	0	194.00
194.01	07951	MARKETING	0	0	0	0	0	194.01
194.02	07952	JOINT VENTURES	0	0	0	0	0	194.02
194.04	07954	SCHOOL NURSE	0	19,189	0	19,189	1,527	194.04
194.06	07956	SPORTS MEDICINE & OB PHYS	0	37,641	30,572	68,213	377	194.06
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)	2,209,573	6,447,202	4,625,527	13,282,302	84,844	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-0157 | Period: From 07/01/2019 To 06/30/2020 | Worksheet B Part II | Date/Time Prepared: 11/18/2020 5:26 pm

		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	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	3,073,366					5.00
7.00	00700	OPERATION OF PLANT	160,653	927,015				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	17,211	5,922	56,351			8.00
9.00	00900	HOUSEKEEPING	67,291	20,635	0	235,302		9.00
10.00	01000	DIETARY	35,781	25,246	0	6,597	211,203	10.00
11.00	01100	CAFETERIA	23,109	29,456	0	7,697	0	11.00
13.00	01300	NURSING ADMINISTRATION	75,409	530	0	138	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	24,463	25,606	1,440	6,691	0	14.00
15.00	01500	PHARMACY	93,455	20,151	0	5,266	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	210	1,171	0	306	0	16.00
17.00	01700	SOCIAL SERVICE	3,367	2,779	0	726	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	399,607	260,864	17,438	68,168	183,879	30.00
31.00	03100	INTENSIVE CARE UNIT	94,319	26,707	1,831	6,979	15,251	31.00
35.00	02060	NEONATAL INTENSIVE CARE UNIT	87,654	26,584	0	6,947	0	35.00
43.00	04300	NURSERY	49,193	47,037	4,823	12,291	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	380,984	102,485	11,462	26,781	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	125,748	54,439	1,450	14,226	12,073	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	112,520	53,086	3,656	13,872	0	54.00
54.01	03480	ONCOLOGY	0	0	0	0	0	54.01
54.02	05402	ULTRASOUND	11,966	3,336	228	872	0	54.02
57.00	05700	CT SCAN	38,078	14,883	837	3,889	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	40,195	30,801	1,218	8,049	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	103,910	18,659	0	4,876	0	60.00
65.00	06500	RESPIRATORY THERAPY	44,082	9,386	29	2,453	0	65.00
66.00	06600	PHYSICAL THERAPY	24,687	7,812	73	2,041	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	416	89	1	23	0	68.00
69.00	06900	ELECTROCARDIOLOGY	6,164	769	4	201	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	743	85	0	22	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	153,694	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	199,279	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	120,316	0	0	0	0	73.00
75.00	07500	ASC (NON-DISTINCT PART)	272,368	49,004	2,290	12,805	0	75.00
76.00	03330	ENDOSCOPY	135,676	20,337	3,320	5,314	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	95,084	52,630	5,994	13,753	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	2,997,632	910,489	56,094	230,983	211,203	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	17,297	6,394	0	1,671	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	19,324	0	0	0	0	192.00
194.00	07950	MISSION EFFECTIVENESS	0	0	0	0	0	194.00
194.01	07951	MARKETING	0	0	0	0	0	194.01
194.02	07952	JOINT VENTURES	0	0	0	0	0	194.02
194.04	07954	SCHOOL NURSE	27,114	3,421	0	894	0	194.04
194.06	07956	SPORTS MEDICINE & OB PHYS	11,999	6,711	257	1,754	0	194.06
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	3,073,366	927,015	56,351	235,302	211,203	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-0157 | Period: From 07/01/2019 To 06/30/2020 | Worksheet B Part II | Date/Time Prepared: 11/18/2020 5:26 pm

		Cost Center Description	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
			11.00	13.00	14.00	15.00	16.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
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	227,236					11.00
13.00	01300	NURSING ADMINISTRATION	9,564	179,097				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	5,624	998	255,223			14.00
15.00	01500	PHARMACY	10,324	806	907	414,521		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	8,257	16.00
17.00	01700	SOCIAL SERVICE	309	0	0	0	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	53,661	59,731	4,661	0	770	30.00
31.00	03100	INTENSIVE CARE UNIT	9,334	15,090	1,798	0	181	31.00
35.00	02060	NEONATAL INTENSIVE CARE UNIT	11,978	13,796	1,174	0	296	35.00
43.00	04300	NURSERY	6,289	8,853	630	0	116	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	28,267	28,064	50,844	0	2,406	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	13,555	17,307	3,097	0	564	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	12,462	4,999	4,985	0	382	54.00
54.01	03480	ONCOLOGY	0	0	0	0	0	54.01
54.02	05402	ULTRASOUND	3,626	0	24	0	47	54.02
57.00	05700	CT SCAN	3,805	106	1,761	0	144	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	1,779	77	1,035	0	47	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0	0	4	0	600	60.00
65.00	06500	RESPIRATORY THERAPY	5,876	47	2,330	0	81	65.00
66.00	06600	PHYSICAL THERAPY	3,500	175	151	0	47	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	58	0	3	0	2	68.00
69.00	06900	ELECTROCARDIOLOGY	586	0	208	0	85	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	28	0	0	0	16	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	62,885	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	83,932	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	414,521	0	73.00
75.00	07500	ASC (NON-DISTINCT PART)	19,264	0	24,316	0	1,079	75.00
76.00	03330	ENDOSCOPY	12,645	7,096	7,466	0	702	76.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	9,885	12,743	2,909	0	692	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	222,419	169,888	255,120	414,521	8,257	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	1,448	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	2,274	0	2	0	0	192.00
194.00	07950	MISSION EFFECTIVENESS	0	0	0	0	0	194.00
194.01	07951	MARKETING	0	0	0	0	0	194.01
194.02	07952	JOINT VENTURES	0	0	0	0	0	194.02
194.04	07954	SCHOOL NURSE	0	9,209	0	0	0	194.04
194.06	07956	SPORTS MEDICINE & OB PHYS	1,095	0	101	0	0	194.06
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)	227,236	179,097	255,223	414,521	8,257	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-0157 | Period: From 07/01/2019 To 06/30/2020 | Worksheet B Part II | Date/Time Prepared: 11/18/2020 5:26 pm

		Cost Center Description	SOCIAL SERVICE	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			17.00	24.00	25.00	26.00		
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY						15.00
16.00	01600	MEDICAL RECORDS & LIBRARY						16.00
17.00	01700	SOCIAL SERVICE	22,851					17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	5,129	2,813,992	0	2,813,992		30.00
31.00	03100	INTENSIVE CARE UNIT	2,345	452,098	0	452,098		31.00
35.00	02060	NEONATAL INTENSIVE CARE UNIT	3,807	342,941	0	342,941		35.00
43.00	04300	NURSERY	0	410,100	0	410,100		43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	449	2,412,709	0	2,412,709		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	2,891	626,985	0	626,985		52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	753,816	0	753,816		54.00
54.01	03480	ONCOLOGY	0	0	0	0		54.01
54.02	05402	ULTRASOUND	0	126,994	0	126,994		54.02
57.00	05700	CT SCAN	0	339,125	0	339,125		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	836,459	0	836,459		58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0		59.00
60.00	06000	LABORATORY	0	232,710	0	232,710		60.00
65.00	06500	RESPIRATORY THERAPY	0	206,214	0	206,214		65.00
66.00	06600	PHYSICAL THERAPY	0	83,592	0	83,592		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	1,111	0	1,111		68.00
69.00	06900	ELECTROCARDIOLOGY	0	27,508	0	27,508		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	10,580	0	10,580		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	216,579	0	216,579		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	283,211	0	283,211		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	534,837	0	534,837		73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	870,722	0	870,722		75.00
76.00	03330	ENDOSCOPY	1,197	907,578	0	907,578		76.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	5,834	553,652	0	553,652		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)			0			92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	21,652	13,043,513	0	13,043,513		118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	62,965	0	62,965		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	1,199	23,963	0	23,963		192.00
194.00	07950	MISSION EFFECTIVENESS	0	0	0	0		194.00
194.01	07951	MARKETING	0	0	0	0		194.01
194.02	07952	JOINT VENTURES	0	0	0	0		194.02
194.04	07954	SCHOOL NURSE	0	61,354	0	61,354		194.04
194.06	07956	SPORTS MEDICINE & OB PHYS	0	90,507	0	90,507		194.06
200.00		Cross Foot Adjustments		0	0	0		200.00
201.00		Negative Cost Centers	0	0	0	0		201.00
202.00		TOTAL (sum lines 118 through 201)	22,851	13,282,302	0	13,282,302		202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-0157 | Period: From 07/01/2019 To 06/30/2020 | Worksheet B-1 | Date/Time Prepared: 11/18/2020 5:26 pm

		Cost Center Description	CAPITAL RELATED COSTS BLDG & FIXT (SQUARE FEET)	CAPITAL RELATED COSTS MVBLE EQUIP (DOLLAR VALUE)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
			1.00	2.00	4.00	5A	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	297,346					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		4,705,731				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	3,913	0	35,704,034			4.00
5.00	00500	ADMINISTRATIVE & GENERAL	18,892	459,451	1,072,048	-28,158,757	96,372,221	5.00
7.00	00700	OPERATION OF PLANT	34,730	13,560	0	0	5,037,574	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	1,532	0	0	0	539,688	8.00
9.00	00900	HOUSEKEEPING	5,338	32,184	0	0	2,110,030	9.00
10.00	01000	DIETARY	6,531	2,002	1,456	0	1,121,971	10.00
11.00	01100	CAFETERIA	7,620	1,783	0	0	724,612	11.00
13.00	01300	NURSING ADMINISTRATION	137	88,277	1,562,897	0	2,364,575	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	6,624	46,522	440,768	0	767,078	14.00
15.00	01500	PHARMACY	5,213	168,974	1,888,647	0	2,930,438	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	303	0	0	0	6,570	16.00
17.00	01700	SOCIAL SERVICE	719	0	33,662	0	105,575	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	67,483	281,185	8,620,965	0	12,531,681	30.00
31.00	03100	INTENSIVE CARE UNIT	6,909	126,276	1,824,565	0	2,957,544	31.00
35.00	02060	NEONATAL INTENSIVE CARE UNIT	6,877	37,744	1,891,606	0	2,748,557	35.00
43.00	04300	NURSERY	12,168	15,208	877,774	0	1,542,543	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	26,512	1,217,645	3,884,420	0	11,946,443	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	14,083	72,810	1,982,805	0	3,943,047	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	13,733	249,754	1,932,049	0	3,528,275	54.00
54.01	03480	ONCOLOGY	0	0	0	0	0	54.01
54.02	05402	ULTRASOUND	863	89,226	201,266	0	375,222	54.02
57.00	05700	CT SCAN	3,850	194,044	592,025	0	1,194,007	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	7,968	589,899	272,382	0	1,260,378	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	4,827	0	36	0	3,258,296	60.00
65.00	06500	RESPIRATORY THERAPY	2,428	88,873	810,839	0	1,382,277	65.00
66.00	06600	PHYSICAL THERAPY	2,021	0	541,451	0	774,109	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	23	0	8,514	0	13,056	68.00
69.00	06900	ELECTROCARDIOLOGY	199	15,144	121,962	0	193,274	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	22	9,347	8,920	0	23,298	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	4,819,365	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	6,248,743	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	3,772,719	73.00
75.00	07500	ASC (NON-DISTINCT PART)	12,677	212,328	2,532,879	0	8,540,592	75.00
76.00	03330	ENDOSCOPY	5,261	606,127	1,665,374	0	4,254,353	76.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	13,615	56,113	1,583,999	0	2,981,540	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	293,071	4,674,476	34,353,309	-28,158,757	93,997,430	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	1,654	0	122,708	0	542,378	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	153	426,728	0	605,946	192.00
194.00	07950	MISSION EFFECTIVENESS	0	0	0	0	0	194.00
194.01	07951	MARKETING	0	0	0	0	0	194.01
194.02	07952	JOINT VENTURES	0	0	0	0	0	194.02
194.04	07954	SCHOOL NURSE	885	0	642,738	0	850,218	194.04
194.06	07956	SPORTS MEDICINE & OB PHYS	1,736	31,102	158,551	0	376,249	194.06
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)	6,447,202	4,625,527	8,148,792		28,158,757	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	21.682491	0.982956	0.228232		0.292187	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)			84,844		3,073,366	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)			0.002376		0.031891	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: 15-0157 | Period: From 07/01/2019 To 06/30/2020 | Worksheet B-1 | Date/Time Prepared: 11/18/2020 5:26 pm

		Cost Center Description	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	CAFETERIA (HOURS OF SERVICE)	
			7.00	8.00	9.00	10.00	11.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT	239,811					7.00
8.00	00800	LAUNDRY & LINEN SERVICE	1,532	567,935				8.00
9.00	00900	HOUSEKEEPING	5,338	0	232,941			9.00
10.00	01000	DIETARY	6,531	0	6,531	45,257		10.00
11.00	01100	CAFETERIA	7,620	0	7,620	0	893,413	11.00
13.00	01300	NURSING ADMINISTRATION	137	0	137	0	37,604	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	6,624	14,513	6,624	0	22,111	14.00
15.00	01500	PHARMACY	5,213	0	5,213	0	40,590	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	303	0	303	0	0	16.00
17.00	01700	SOCIAL SERVICE	719	0	719	0	1,214	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	67,483	175,745	67,483	39,402	210,977	30.00
31.00	03100	INTENSIVE CARE UNIT	6,909	18,456	6,909	3,268	36,698	31.00
35.00	02060	NEONATAL INTENSIVE CARE UNIT	6,877	0	6,877	0	47,092	35.00
43.00	04300	NURSERY	12,168	48,611	12,168	0	24,726	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	26,512	115,521	26,512	0	111,137	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	14,083	14,612	14,083	2,587	53,294	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	13,733	36,842	13,733	0	48,998	54.00
54.01	03480	ONCOLOGY	0	0	0	0	0	54.01
54.02	05402	ULTRASOUND	863	2,299	863	0	14,257	54.02
57.00	05700	CT SCAN	3,850	8,438	3,850	0	14,959	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	7,968	12,279	7,968	0	6,995	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	4,827	0	4,827	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	2,428	289	2,428	0	23,102	65.00
66.00	06600	PHYSICAL THERAPY	2,021	740	2,021	0	13,761	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	23	13	23	0	228	68.00
69.00	06900	ELECTROCARDIOLOGY	199	39	199	0	2,302	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	22	3	22	0	110	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
75.00	07500	ASC (NON-DISTINCT PART)	12,677	23,079	12,677	0	75,738	75.00
76.00	03330	ENDOSCOPY	5,261	33,457	5,261	0	49,717	76.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	13,615	60,406	13,615	0	38,863	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	235,536	565,342	228,666	45,257	874,473	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	1,654	0	1,654	0	5,692	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	8,941	192.00
194.00	07950	MISSION EFFECTIVENESS	0	0	0	0	0	194.00
194.01	07951	MARKETING	0	0	0	0	0	194.01
194.02	07952	JOINT VENTURES	0	0	0	0	0	194.02
194.04	07954	SCHOOL NURSE	885	0	885	0	0	194.04
194.06	07956	SPORTS MEDICINE & OB PHYS	1,736	2,593	1,736	0	4,307	194.06
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)	6,509,488	738,963	2,871,449	1,707,582	1,237,104	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	27.144243	1.301140	12.326937	37.730782	1.384694	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	927,015	56,351	235,302	211,203	227,236	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	3.865607	0.099221	1.010136	4.666748	0.254346	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: 15-0157 | Period: From 07/01/2019 To 06/30/2020 | Worksheet B-1 | Date/Time Prepared: 11/18/2020 5:26 pm

		Cost Center Description	NURSING ADMINISTRATION (DIRECT NURS. HRS.)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (PATIENT REVENUE)	SOCIAL SERVICE (TIME SPENT)	
			13.00	14.00	15.00	16.00	17.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
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	429,927					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	2,395	19,002,129				14.00
15.00	01500	PHARMACY	1,935	67,504	3,772,719			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	563,288,156		16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	13,896	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	143,386	347,020	0	51,311,229	3,119	30.00
31.00	03100	INTENSIVE CARE UNIT	36,223	133,879	0	12,074,264	1,426	31.00
35.00	02060	NEONATAL INTENSIVE CARE UNIT	33,118	87,418	0	19,732,356	2,315	35.00
43.00	04300	NURSERY	21,252	46,873	0	7,702,534	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	67,368	3,785,539	0	173,287,983	273	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	41,546	230,574	0	37,614,113	1,758	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	12,000	371,168	0	25,489,487	0	54.00
54.01	03480	ONCOLOGY	0	0	0	0	0	54.01
54.02	05402	ULTRASOUND	0	1,803	0	3,121,903	0	54.02
57.00	05700	CT SCAN	254	131,128	0	9,577,269	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	185	77,028	0	3,111,874	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0	278	0	39,988,288	0	60.00
65.00	06500	RESPIRATORY THERAPY	113	173,505	0	5,387,672	0	65.00
66.00	06600	PHYSICAL THERAPY	421	11,222	0	3,155,352	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	230	0	150,609	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	15,488	0	5,679,724	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	34	0	1,049,458	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	4,682,116	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	6,248,743	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	3,772,719	0	0	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	1,810,450	0	71,964,463	0	75.00
76.00	03330	ENDOSCOPY	17,034	555,878	0	46,775,502	728	76.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	30,590	216,606	0	46,114,076	3,548	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	407,820	18,994,484	3,772,719	563,288,156	13,167	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	160	0	0	729	192.00
194.00	07950	MISSION EFFECTIVENESS	0	0	0	0	0	194.00
194.01	07951	MARKETING	0	0	0	0	0	194.01
194.02	07952	JOINT VENTURES	0	0	0	0	0	194.02
194.04	07954	SCHOOL NURSE	22,107	0	0	0	0	194.04
194.06	07956	SPORTS MEDICINE & OB PHYS	0	7,485	0	0	0	194.06
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)	3,112,951	1,319,506	4,067,340	20,450	166,484	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	7.240650	0.069440	1.078092	0.000036	11.980714	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	179,097	255,223	414,521	8,257	22,851	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.416575	0.013431	0.109873	0.000015	1.644430	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: 15-0157 | Period: From 07/01/2019 To 06/30/2020 | Worksheet C Part I Date/Time Prepared: 11/18/2020 5:26 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	RCE Disallowance	Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	21,965,948		21,965,948	0	21,965,948	30.00
31.00	03100	INTENSIVE CARE UNIT	4,581,635		4,581,635	0	4,581,635	31.00
35.00	02060	NEONATAL INTENSIVE CARE UNIT	4,162,612		4,162,612	0	4,162,612	35.00
43.00	04300	NURSERY	2,728,437		2,728,437	0	2,728,437	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	17,548,035		17,548,035	0	17,548,035	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	6,180,691		6,180,691	498,210	6,678,901	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	5,330,613		5,330,613	122,258	5,452,871	54.00
54.01	03480	ONCOLOGY	0		0	0	0	54.01
54.02	05402	ULTRASOUND	541,890		541,890	0	541,890	54.02
57.00	05700	CT SCAN	1,737,827		1,737,827	0	1,737,827	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	1,975,614		1,975,614	0	1,975,614	58.00
59.00	05900	CARDIAC CATHETERIZATION	0		0	0	0	59.00
60.00	06000	LABORATORY	4,402,314		4,402,314	0	4,402,314	60.00
65.00	06500	RESPIRATORY THERAPY	1,927,421	0	1,927,421	0	1,927,421	65.00
66.00	06600	PHYSICAL THERAPY	1,104,025	0	1,104,025	0	1,104,025	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	18,133	0	18,133	0	18,133	68.00
69.00	06900	ELECTROCARDIOLOGY	262,119		262,119	0	262,119	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	31,169		31,169	0	31,169	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	6,552,647		6,552,647	0	6,552,647	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	8,508,456		8,508,456	0	8,508,456	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	8,942,398		8,942,398	0	8,942,398	73.00
75.00	07500	ASC (NON-DISTINCT PART)	11,799,631		11,799,631	0	11,799,631	75.00
76.00	03330	ENDOSCOPY	5,989,796		5,989,796	0	5,989,796	76.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	4,803,217		4,803,217	136,552	4,939,769	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	2,873,525		2,873,525		2,873,525	92.00
200.00		Subtotal (see instructions)	123,968,153	0	123,968,153	757,020	124,725,173	200.00
201.00		Less Observation Beds	2,873,525		2,873,525		2,873,525	201.00
202.00		Total (see instructions)	121,094,628	0	121,094,628	757,020	121,851,648	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-0157 | Period: From 07/01/2019 To 06/30/2020 | Worksheet C Part I Date/Time Prepared: 11/18/2020 5:26 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Charges Inpatient	Charges Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	43,287,519		43,287,519			30.00
31.00	03100	INTENSIVE CARE UNIT	12,074,264		12,074,264			31.00
35.00	02060	NEONATAL INTENSIVE CARE UNIT	19,732,356		19,732,356			35.00
43.00	04300	NURSERY	7,702,534		7,702,534			43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	61,434,861	111,853,122	173,287,983	0.101265	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	36,770,952	843,161	37,614,113	0.164318	0.000000	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,408,874	23,080,614	25,489,488	0.209130	0.000000	54.00
54.01	03480	ONCOLOGY	0	0	0	0.000000	0.000000	54.01
54.02	05402	ULTRASOUND	512,553	2,609,350	3,121,903	0.173577	0.000000	54.02
57.00	05700	CT SCAN	1,944,335	7,632,934	9,577,269	0.181453	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	216,550	2,895,324	3,111,874	0.634863	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0.000000	0.000000	59.00
60.00	06000	LABORATORY	19,533,461	20,454,827	39,988,288	0.110090	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	4,766,497	2,576,224	7,342,721	0.262494	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	1,440,023	1,715,330	3,155,353	0.349890	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0.000000	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	122,251	28,358	150,609	0.120398	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	986,366	2,738,309	3,724,675	0.070374	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	452,756	596,702	1,049,458	0.029700	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	13,339,292	22,970,957	36,310,249	0.180463	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	14,421,669	5,508,561	19,930,230	0.426912	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	22,433,175	12,731,927	35,165,102	0.254298	0.000000	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	71,964,463	71,964,463	0.163965	0.000000	75.00
76.00	03330	ENDOSCOPY	1,974,867	44,800,635	46,775,502	0.128054	0.000000	76.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	7,848,820	38,265,256	46,114,076	0.104159	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1,401,364	6,622,345	8,023,709	0.358129	0.000000	92.00
200.00		Subtotal (see instructions)	274,805,339	379,888,399	654,693,738			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	274,805,339	379,888,399	654,693,738			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-0157 | Period: From 07/01/2019 To 06/30/2020 | Worksheet C Part I Date/Time Prepared: 11/18/2020 5:26 pm

Title XVIII | Hospital | PPS

		Cost Center Description	PPS Inpatient Ratio		
			11.00		
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS			30.00
31.00	03100	INTENSIVE CARE UNIT			31.00
35.00	02060	NEONATAL INTENSIVE CARE UNIT			35.00
43.00	04300	NURSERY			43.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0.101265		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.177564		52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.213926		54.00
54.01	03480	ONCOLOGY	0.000000		54.01
54.02	05402	ULTRASOUND	0.173577		54.02
57.00	05700	CT SCAN	0.181453		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.634863		58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000		59.00
60.00	06000	LABORATORY	0.110090		60.00
65.00	06500	RESPIRATORY THERAPY	0.262494		65.00
66.00	06600	PHYSICAL THERAPY	0.349890		66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000		67.00
68.00	06800	SPEECH PATHOLOGY	0.120398		68.00
69.00	06900	ELECTROCARDIOLOGY	0.070374		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.029700		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.180463		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.426912		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.254298		73.00
75.00	07500	ASC (NON-DISTINCT PART)	0.163965		75.00
76.00	03330	ENDOSCOPY	0.128054		76.00
		OUTPATIENT SERVICE COST CENTERS			
91.00	09100	EMERGENCY	0.107121		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.358129		92.00
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: 15-0157 | Period: From 07/01/2019 To 06/30/2020 | Worksheet C Part I Date/Time Prepared: 11/18/2020 5:26 pm

Title XIX | Hospital | Cost

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	RCE Disallowance	Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	21,965,948		21,965,948	0	21,965,948	30.00
31.00	03100	INTENSIVE CARE UNIT	4,581,635		4,581,635	0	4,581,635	31.00
35.00	02060	NEONATAL INTENSIVE CARE UNIT	4,162,612		4,162,612	0	4,162,612	35.00
43.00	04300	NURSERY	2,728,437		2,728,437	0	2,728,437	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	17,548,035		17,548,035	0	17,548,035	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	6,180,691		6,180,691	498,210	6,678,901	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	5,330,613		5,330,613	122,258	5,452,871	54.00
54.01	03480	ONCOLOGY	0		0	0	0	54.01
54.02	05402	ULTRASOUND	541,890		541,890	0	541,890	54.02
57.00	05700	CT SCAN	1,737,827		1,737,827	0	1,737,827	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	1,975,614		1,975,614	0	1,975,614	58.00
59.00	05900	CARDIAC CATHETERIZATION	0		0	0	0	59.00
60.00	06000	LABORATORY	4,402,314		4,402,314	0	4,402,314	60.00
65.00	06500	RESPIRATORY THERAPY	1,927,421	0	1,927,421	0	1,927,421	65.00
66.00	06600	PHYSICAL THERAPY	1,104,025	0	1,104,025	0	1,104,025	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	18,133	0	18,133	0	18,133	68.00
69.00	06900	ELECTROCARDIOLOGY	262,119		262,119	0	262,119	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	31,169		31,169	0	31,169	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	6,552,647		6,552,647	0	6,552,647	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	8,508,456		8,508,456	0	8,508,456	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	8,942,398		8,942,398	0	8,942,398	73.00
75.00	07500	ASC (NON-DISTINCT PART)	11,799,631		11,799,631	0	11,799,631	75.00
76.00	03330	ENDOSCOPY	5,989,796		5,989,796	0	5,989,796	76.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	4,803,217		4,803,217	136,552	4,939,769	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	2,873,525		2,873,525		2,873,525	92.00
200.00		Subtotal (see instructions)	123,968,153	0	123,968,153	757,020	124,725,173	200.00
201.00		Less Observation Beds	2,873,525		2,873,525		2,873,525	201.00
202.00		Total (see instructions)	121,094,628	0	121,094,628	757,020	121,851,648	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-0157 | Period: From 07/01/2019 To 06/30/2020 | Worksheet C Part I Date/Time Prepared: 11/18/2020 5:26 pm

Title XIX | Hospital | Cost

		Cost Center Description	Charges Inpatient	Charges Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	43,287,519		43,287,519			30.00
31.00	03100	INTENSIVE CARE UNIT	12,074,264		12,074,264			31.00
35.00	02060	NEONATAL INTENSIVE CARE UNIT	19,732,356		19,732,356			35.00
43.00	04300	NURSERY	7,702,534		7,702,534			43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	61,434,861	111,853,122	173,287,983	0.101265	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	36,770,952	843,161	37,614,113	0.164318	0.000000	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,408,874	23,080,614	25,489,488	0.209130	0.000000	54.00
54.01	03480	ONCOLOGY	0	0	0	0.000000	0.000000	54.01
54.02	05402	ULTRASOUND	512,553	2,609,350	3,121,903	0.173577	0.000000	54.02
57.00	05700	CT SCAN	1,944,335	7,632,934	9,577,269	0.181453	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	216,550	2,895,324	3,111,874	0.634863	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0.000000	0.000000	59.00
60.00	06000	LABORATORY	19,533,461	20,454,827	39,988,288	0.110090	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	4,766,497	2,576,224	7,342,721	0.262494	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	1,440,023	1,715,330	3,155,353	0.349890	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0.000000	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	122,251	28,358	150,609	0.120398	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	986,366	2,738,309	3,724,675	0.070374	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	452,756	596,702	1,049,458	0.029700	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	13,339,292	22,970,957	36,310,249	0.180463	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	14,421,669	5,508,561	19,930,230	0.426912	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	22,433,175	12,731,927	35,165,102	0.254298	0.000000	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	71,964,463	71,964,463	0.163965	0.000000	75.00
76.00	03330	ENDOSCOPY	1,974,867	44,800,635	46,775,502	0.128054	0.000000	76.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	7,848,820	38,265,256	46,114,076	0.104159	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1,401,364	6,622,345	8,023,709	0.358129	0.000000	92.00
200.00		Subtotal (see instructions)	274,805,339	379,888,399	654,693,738			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	274,805,339	379,888,399	654,693,738			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-0157 | Period: From 07/01/2019 To 06/30/2020 | Worksheet C Part I Date/Time Prepared: 11/18/2020 5:26 pm

Title XIX | Hospital | Cost

		Cost Center Description	PPS Inpatient Ratio		
			11.00		
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS			30.00
31.00	03100	INTENSIVE CARE UNIT			31.00
35.00	02060	NEONATAL INTENSIVE CARE UNIT			35.00
43.00	04300	NURSERY			43.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0.000000		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000		52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000		54.00
54.01	03480	ONCOLOGY	0.000000		54.01
54.02	05402	ULTRASOUND	0.000000		54.02
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
65.00	06500	RESPIRATORY THERAPY	0.000000		65.00
66.00	06600	PHYSICAL THERAPY	0.000000		66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000		67.00
68.00	06800	SPEECH PATHOLOGY	0.000000		68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000		73.00
75.00	07500	ASC (NON-DISTINCT PART)	0.000000		75.00
76.00	03330	ENDOSCOPY	0.000000		76.00
		OUTPATIENT SERVICE COST CENTERS			
91.00	09100	EMERGENCY	0.000000		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000		92.00
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: 15-0157 | Period: From 07/01/2019 To 06/30/2020 | Worksheet D Part I Date/Time Prepared: 11/18/2020 5:26 pm

Title XVIII | Hospital | PPS

	Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	2,813,992	0	2,813,992	14,654	192.03	30.00
31.00	INTENSIVE CARE UNIT	452,098		452,098	1,582	285.78	31.00
35.00	NEONATAL INTENSIVE CARE UNIT	342,941		342,941	2,499	137.23	35.00
43.00	NURSERY	410,100		410,100	2,914	140.73	43.00
200.00	Total (lines 30 through 199)	4,019,131		4,019,131	21,649		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	3,200	614,496	30.00
31.00	INTENSIVE CARE UNIT	1,246	356,082	31.00
35.00	NEONATAL INTENSIVE CARE UNIT	0	0	35.00
43.00	NURSERY	0	0	43.00
200.00	Total (lines 30 through 199)	4,446	970,578	200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS | Provider CCN: 15-0157 | Period: From 07/01/2019 To 06/30/2020 | Worksheet D Part II Date/Time Prepared: 11/18/2020 5:26 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,412,709	173,287,983	0.013923	18,380,661	255,914	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	626,985	37,614,113	0.016669	50,520	842	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	753,816	25,489,488	0.029574	1,372,570	40,592	54.00
54.01	03480	ONCOLOGY	0	0	0.000000	0	0	54.01
54.02	05402	ULTRASOUND	126,994	3,121,903	0.040678	149,476	6,080	54.02
57.00	05700	CT SCAN	339,125	9,577,269	0.035409	756,858	26,800	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	836,459	3,111,874	0.268796	82,428	22,156	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0.000000	0	0	59.00
60.00	06000	LABORATORY	232,710	39,988,288	0.005819	6,021,153	35,037	60.00
65.00	06500	RESPIRATORY THERAPY	206,214	7,342,721	0.028084	1,807,643	50,766	65.00
66.00	06600	PHYSICAL THERAPY	83,592	3,155,353	0.026492	588,573	15,592	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0.000000	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	1,111	150,609	0.007377	56,398	416	68.00
69.00	06900	ELECTROCARDIOLOGY	27,508	3,724,675	0.007385	388,094	2,866	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	10,580	1,049,458	0.010081	243,460	2,454	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	216,579	36,310,249	0.005965	2,632,848	15,705	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	283,211	19,930,230	0.014210	6,427,793	91,339	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	534,837	35,165,102	0.015209	5,078,799	77,243	73.00
75.00	07500	ASC (NON-DISTINCT PART)	870,722	71,964,463	0.012099	0	0	75.00
76.00	03330	ENDOSCOPY	907,578	46,775,502	0.019403	629,604	12,216	76.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	553,652	46,114,076	0.012006	3,370,297	40,464	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	368,119	8,023,709	0.045879	527,600	24,206	92.00
200.00		Total (lines 50 through 199)	9,392,501	571,897,065		48,564,775	720,688	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 15-0157 | Period: From 07/01/2019 To 06/30/2020 | Worksheet D Part III Date/Time Prepared: 11/18/2020 5:26 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health Cost	All Other Medical Education Cost	
			1A	1.00	2A	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
35.00	02060	NEONATAL INTENSIVE CARE UNIT	0	0	0	0	0	35.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
200.00		Total (lines 30 through 199)	0	0	0	0	0	200.00

		Cost Center Description	Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days	
			4.00	5.00	6.00	7.00	8.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	0	14,654	0.00	3,200	30.00
31.00	03100	INTENSIVE CARE UNIT		0	1,582	0.00	1,246	31.00
35.00	02060	NEONATAL INTENSIVE CARE UNIT		0	2,499	0.00	0	35.00
43.00	04300	NURSERY		0	2,914	0.00	0	43.00
200.00		Total (lines 30 through 199)		0	21,649		4,446	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
35.00	02060	NEONATAL INTENSIVE CARE UNIT	0	35.00
43.00	04300	NURSERY	0	43.00
200.00		Total (lines 30 through 199)	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 15-0157 | Period: From 07/01/2019 To 06/30/2020 | Worksheet D Part IV Date/Time Prepared: 11/18/2020 5:26 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health	
			1.00	2A	2.00	3A	3.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
54.01	03480	ONCOLOGY	0	0	0	0	0	54.01
54.02	05402	ULTRASOUND	0	0	0	0	0	54.02
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
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	0	75.00
76.00	03330	ENDOSCOPY	0	0	0	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0		0		0	92.00
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: 15-0157 | Period: From 07/01/2019 To 06/30/2020 | Worksheet D Part IV Date/Time Prepared: 11/18/2020 5:26 pm

Title XVIII | Hospital | PPS

		Cost Center Description	All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7) (see instructions)	
			4.00	5.00	6.00	7.00	8.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	173,287,983	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	37,614,113	0.000000	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	25,489,488	0.000000	54.00
54.01	03480	ONCOLOGY	0	0	0	0	0.000000	54.01
54.02	05402	ULTRASOUND	0	0	0	3,121,903	0.000000	54.02
57.00	05700	CT SCAN	0	0	0	9,577,269	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	3,111,874	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0.000000	59.00
60.00	06000	LABORATORY	0	0	0	39,988,288	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	7,342,721	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	3,155,353	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	150,609	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	3,724,675	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	1,049,458	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	36,310,249	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	19,930,230	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	35,165,102	0.000000	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	71,964,463	0.000000	75.00
76.00	03330	ENDOSCOPY	0	0	0	46,775,502	0.000000	76.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0	0	0	46,114,076	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	8,023,709	0.000000	92.00
200.00		Total (lines 50 through 199)	0	0	0	571,897,065		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 15-0157 | Period: From 07/01/2019 To 06/30/2020 | Worksheet D Part IV Date/Time Prepared: 11/18/2020 5:26 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
			9.00	10.00	11.00	12.00	13.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.000000	18,380,661	0	15,330,563	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	50,520	0	33,643	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	1,372,570	0	1,535,956	0	54.00
54.01	03480	ONCOLOGY	0.000000	0	0	0	0	54.01
54.02	05402	ULTRASOUND	0.000000	149,476	0	672,732	0	54.02
57.00	05700	CT SCAN	0.000000	756,858	0	2,182,875	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000	82,428	0	669,940	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	0	0	0	0	59.00
60.00	06000	LABORATORY	0.000000	6,021,153	0	4,493,143	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.000000	1,807,643	0	841,068	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	588,573	0	25,285	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	56,398	0	1,627	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	388,094	0	785,694	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	243,460	0	125,000	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	2,632,848	0	1,714,596	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	6,427,793	0	890,427	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	5,078,799	0	3,096,501	0	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0.000000	0	0	0	0	75.00
76.00	03330	ENDOSCOPY	0.000000	629,604	0	4,072,229	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0.000000	3,370,297	0	8,022,341	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	527,600	0	1,770,709	0	92.00
200.00		Total (lines 50 through 199)		48,564,775	0	46,264,329	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-0157 | Period: From 07/01/2019 To 06/30/2020 | Worksheet D Part V Date/Time Prepared: 11/18/2020 5:26 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.101265	15,330,563	0	0	1,552,449	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.164318	33,643	0	0	5,528	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.209130	1,535,956	0	0	321,214	54.00
54.01	03480	ONCOLOGY	0.000000	0	0	0	0	54.01
54.02	05402	ULTRASOUND	0.173577	672,732	0	0	116,771	54.02
57.00	05700	CT SCAN	0.181453	2,182,875	0	0	396,089	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.634863	669,940	0	0	425,320	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	0	0	0	0	59.00
60.00	06000	LABORATORY	0.110090	4,493,143	0	0	494,650	60.00
65.00	06500	RESPIRATORY THERAPY	0.262494	841,068	0	0	220,775	65.00
66.00	06600	PHYSICAL THERAPY	0.349890	25,285	0	0	8,847	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.120398	1,627	0	0	196	68.00
69.00	06900	ELECTROCARDIOLOGY	0.070374	785,694	0	0	55,292	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.029700	125,000	0	0	3,713	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.180463	1,714,596	0	0	309,421	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.426912	890,427	0	0	380,134	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.254298	3,096,501	0	4,896	787,434	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0.163965	0	0	0	0	75.00
76.00	03330	ENDOSCOPY	0.128054	4,072,229	0	0	521,465	76.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0.104159	8,022,341	0	0	835,599	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.358129	1,770,709	0	0	634,142	92.00
200.00		Subtotal (see instructions)		46,264,329	0	4,896	7,069,039	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 - line 201)		46,264,329	0	4,896	7,069,039	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-0157 | Period: From 07/01/2019 To 06/30/2020 | Worksheet D Part V Date/Time Prepared: 11/18/2020 5:26 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Costs: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	0		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0		52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0		54.00
54.01	03480	ONCOLOGY	0	0		54.01
54.02	05402	ULTRASOUND	0	0		54.02
57.00	05700	CT SCAN	0	0		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
65.00	06500	RESPIRATORY THERAPY	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	1,245		73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0		75.00
76.00	03330	ENDOSCOPY	0	0		76.00
		OUTPATIENT SERVICE COST CENTERS				
91.00	09100	EMERGENCY	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0		92.00
200.00		Subtotal (see instructions)	0	1,245		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	0	1,245		202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-0157 | Period: From 07/01/2019 To 06/30/2020 | Worksheet D Part V Date/Time Prepared: 11/18/2020 5:26 pm

Title XIX | Hospital | Cost

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.101265	0	10,050,523	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.164318	0	160,685	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.209130	0	1,207,897	0	0	54.00
54.01	03480	ONCOLOGY	0.000000	0	0	0	0	54.01
54.02	05402	ULTRASOUND	0.173577	0	252,776	0	0	54.02
57.00	05700	CT SCAN	0.181453	0	602,029	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.634863	0	184,628	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	0	0	0	0	59.00
60.00	06000	LABORATORY	0.110090	0	2,338,020	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.262494	0	259,336	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.349890	0	136,769	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.120398	0	1,409	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.070374	0	268,754	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.029700	0	84,342	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.180463	0	1,796,004	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.426912	0	399,451	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.254298	0	1,039,269	0	0	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0.163965	0	10,853,688	0	0	75.00
76.00	03330	ENDOSCOPY	0.128054	0	3,401,592	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0.104159	0	5,147,447	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.358129	0	540,938	0	0	92.00
200.00		Subtotal (see instructions)		0	38,725,557	0	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 - line 201)		0	38,725,557	0	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-0157 | Period: From 07/01/2019 To 06/30/2020 | Worksheet D Part V Date/Time Prepared: 11/18/2020 5:26 pm

Title XIX | Hospital | Cost

		Cost Center Description	Costs: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	1,017,766	0		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	26,403	0		52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	252,607	0		54.00
54.01	03480	ONCOLOGY	0	0		54.01
54.02	05402	ULTRASOUND	43,876	0		54.02
57.00	05700	CT SCAN	109,240	0		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	117,213	0		58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0		59.00
60.00	06000	LABORATORY	257,393	0		60.00
65.00	06500	RESPIRATORY THERAPY	68,074	0		65.00
66.00	06600	PHYSICAL THERAPY	47,854	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	170	0		68.00
69.00	06900	ELECTROCARDIOLOGY	18,913	0		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	2,505	0		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	324,112	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	170,530	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	264,284	0		73.00
75.00	07500	ASC (NON-DISTINCT PART)	1,779,625	0		75.00
76.00	03330	ENDOSCOPY	435,587	0		76.00
		OUTPATIENT SERVICE COST CENTERS				
91.00	09100	EMERGENCY	536,153	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	193,726	0		92.00
200.00		Subtotal (see instructions)	5,666,031	0		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	5,666,031	0		202.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 15-0157	Period: From 07/01/2019 To 06/30/2020	Worksheet D-1 Date/Time Prepared: 11/18/2020 5:26 pm
	Title XVIII	Hospital	PPS

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	14,654	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	14,654	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)	12,737	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions)	3,200	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)	21,965,948	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)	21,965,948	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)	21,965,948	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)	1,498.97	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	4,796,704	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)	4,796,704	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-0157 | Period: From 07/01/2019 To 06/30/2020 | Worksheet D-1 | Date/Time Prepared: 11/18/2020 5:26 pm

Title XVIII | Hospital | PPS

	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)	0	0	0.00	0	0	42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	4,581,635	1,582	2,896.10	1,246	3,608,541	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	NEONATAL INTENSIVE CARE UNIT	4,162,612	2,499	1,665.71	0	0	47.00

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	8,905,524	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	17,310,769	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)	970,578	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	720,688	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	1,691,266	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	15,619,503	53.00
	TARGET AMOUNT AND LIMIT COMPUTATION		
54.00	Program discharges	0	54.00
55.00	Target amount per discharge	0.00	55.00
56.00	Target amount (line 54 x line 55)	0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)	0	57.00
58.00	Bonus payment (see instructions)	0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket	0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket	0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)	0	61.00
62.00	Relief payment (see instructions)	0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)	0	63.00
	PROGRAM INPATIENT ROUTINE SWING BED COST		
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)	0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)	0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)	0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)	0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)	0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)	0	69.00
	PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY		
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)		70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)		71.00
72.00	Program routine service cost (line 9 x line 71)		72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)		73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)		74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)		75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)		76.00
77.00	Program capital-related costs (line 9 x line 76)		77.00
78.00	Inpatient routine service cost (line 74 minus line 77)		78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)		79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)		80.00
81.00	Inpatient routine service cost per diem limitation		81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)		82.00
83.00	Reasonable inpatient routine service costs (see instructions)		83.00
84.00	Program inpatient ancillary services (see instructions)		84.00
85.00	Utilization review - physician compensation (see instructions)		85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)		86.00
	PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST		
87.00	Total observation bed days (see instructions)	1,917	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	1,498.97	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	2,873,525	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-0157 | Period: From 07/01/2019 To 06/30/2020 | Worksheet D-1 | Date/Time Prepared: 11/18/2020 5:26 pm

Title XVIII | Hospital | PPS

	Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	2,813,992	21,965,948	0.128107	2,873,525	368,119	90.00
91.00	Nursing School cost	0	21,965,948	0.000000	2,873,525	0	91.00
92.00	Allied health cost	0	21,965,948	0.000000	2,873,525	0	92.00
93.00	All other Medical Education	0	21,965,948	0.000000	2,873,525	0	93.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 15-0157	Period: From 07/01/2019 To 06/30/2020	Worksheet D-1 Date/Time Prepared: 11/18/2020 5:26 pm
	Title XIX	Hospital	Cost

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	14,654	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	14,654	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)	12,737	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions)	191	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)	2,914	15.00
16.00	Nursery days (title V or XIX only)	56	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)	21,965,948	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)	21,965,948	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)	21,965,948	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)	1,498.97	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	286,303	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)	286,303	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-0157 | Period: From 07/01/2019 To 06/30/2020 | Worksheet D-1 | Date/Time Prepared: 11/18/2020 5:26 pm

Title XIX | Hospital | Cost

	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)	2,728,437	2,914	936.32	56	52,434	42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	4,581,635	1,582	2,896.10	174	503,921	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	NEONATAL INTENSIVE CARE UNIT	4,162,612	2,499	1,665.71	428	712,924	47.00

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	3,451,906	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	5,007,488	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)	1,917	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	1,498.97	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	2,873,525	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-0157 | Period: From 07/01/2019 To 06/30/2020 | Worksheet D-1 | Date/Time Prepared: 11/18/2020 5:26 pm

Title XIX | Hospital | Cost

	Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	2,813,992	21,965,948	0.128107	2,873,525	368,119	90.00
91.00	Nursing School cost	0	21,965,948	0.000000	2,873,525	0	91.00
92.00	Allied health cost	0	21,965,948	0.000000	2,873,525	0	92.00
93.00	All other Medical Education	0	21,965,948	0.000000	2,873,525	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 15-0157 | Period: From 07/01/2019 To 06/30/2020 | Worksheet D-3 | Date/Time Prepared: 11/18/2020 5:26 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		11,564,715		30.00
31.00	03100	INTENSIVE CARE UNIT		3,816,884		31.00
35.00	02060	NEONATAL INTENSIVE CARE UNIT		0		35.00
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.101265	18,380,661	1,861,318	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.177564	50,520	8,971	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.213926	1,372,570	293,628	54.00
54.01	03480	ONCOLOGY	0.000000	0	0	54.01
54.02	05402	ULTRASOUND	0.173577	149,476	25,946	54.02
57.00	05700	CT SCAN	0.181453	756,858	137,334	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.634863	82,428	52,330	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	0	0	59.00
60.00	06000	LABORATORY	0.110090	6,021,153	662,869	60.00
65.00	06500	RESPIRATORY THERAPY	0.262494	1,807,643	474,495	65.00
66.00	06600	PHYSICAL THERAPY	0.349890	588,573	205,936	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.120398	56,398	6,790	68.00
69.00	06900	ELECTROCARDIOLOGY	0.070374	388,094	27,312	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.029700	243,460	7,231	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.180463	2,632,848	475,132	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.426912	6,427,793	2,744,102	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.254298	5,078,799	1,291,528	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0.163965	0	0	75.00
76.00	03330	ENDOSCOPY	0.128054	629,604	80,623	76.00
		OUTPATIENT SERVICE COST CENTERS				
91.00	09100	EMERGENCY	0.107121	3,370,297	361,030	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.358129	527,600	188,949	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		48,564,775	8,905,524	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)		48,564,775		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 15-0157 | Period: From 07/01/2019 To 06/30/2020 | Worksheet D-3 | Date/Time Prepared: 11/18/2020 5:26 pm

Title XIX | Hospital | Cost

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		4,702,781		30.00
31.00	03100	INTENSIVE CARE UNIT		1,853,157		31.00
35.00	02060	NEONATAL INTENSIVE CARE UNIT		5,336,734		35.00
43.00	04300	NURSERY		717,895		43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.101265	6,503,116	658,538	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.164318	3,455,342	567,775	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.209130	257,706	53,894	54.00
54.01	03480	ONCOLOGY	0.000000	0	0	54.01
54.02	05402	ULTRASOUND	0.173577	69,367	12,041	54.02
57.00	05700	CT SCAN	0.181453	161,496	29,304	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.634863	17,570	11,155	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	0	0	59.00
60.00	06000	LABORATORY	0.110090	2,249,109	247,604	60.00
65.00	06500	RESPIRATORY THERAPY	0.262494	668,311	175,428	65.00
66.00	06600	PHYSICAL THERAPY	0.349890	147,965	51,771	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.120398	12,297	1,481	68.00
69.00	06900	ELECTROCARDIOLOGY	0.070374	73,914	5,202	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.029700	6,872	204	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.180463	1,416,334	255,596	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.426912	1,245,565	531,747	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.254298	3,002,031	763,410	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0.163965	0	0	75.00
76.00	03330	ENDOSCOPY	0.128054	182,148	23,325	76.00
		OUTPATIENT SERVICE COST CENTERS				
91.00	09100	EMERGENCY	0.104159	608,981	63,431	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.358129	0	0	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		20,078,124	3,451,906	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)		20,078,124		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0157	Period: From 07/01/2019 To 06/30/2020	Worksheet E Part A Date/Time Prepared: 11/18/2020 5:26 pm
	Title XVIII	Hospital	PPS

		1.00	
	PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS		
1.00	DRG Amounts Other than Outlier Payments	0	1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1 (see instructions)	2,873,207	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1 (see instructions)	9,343,873	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)	24,318	2.03
2.04	Outlier payments for discharges occurring on or after October 1 (see instructions)	212,722	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)	147.76	4.00
	Indirect Medical Education Adjustment		
5.00	FTE count for allopathic and osteopathic programs for the most recent cost reporting period ending on or before 12/31/1996.(see instructions)	0.00	5.00
6.00	FTE count for allopathic and osteopathic programs that meet the criteria for an add-on to the cap for new programs in accordance with 42 CFR 413.79(e)	0.00	6.00
7.00	MMA Section 422 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(1)	0.00	7.00
7.01	ACA § 5503 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(2) If the cost report straddles July 1, 2011 then see instructions.	0.00	7.01
8.00	Adjustment (increase or decrease) to the FTE count for allopathic and osteopathic programs for affiliated programs in accordance with 42 CFR 413.75(b), 413.79(c)(2)(iv), 64 FR 26340 (May 12, 1998), and 67 FR 50069 (August 1, 2002).	0.00	8.00
8.01	The amount of increase if the hospital was awarded FTE cap slots under § 5503 of the ACA. If the cost report straddles July 1, 2011, see instructions.	0.00	8.01
8.02	The amount of increase if the hospital was awarded FTE cap slots from a closed teaching hospital under § 5506 of ACA. (see instructions)	0.00	8.02
9.00	Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus lines (8, 8,01 and 8,02) (see instructions)	0.00	9.00
10.00	FTE count for allopathic and osteopathic programs in the current year from your records	0.00	10.00
11.00	FTE count for residents in dental and podiatric programs.	0.00	11.00
12.00	Current year allowable FTE (see instructions)	0.00	12.00
13.00	Total allowable FTE count for the prior year.	0.00	13.00
14.00	Total allowable FTE count for the penultimate year if that year ended on or after September 30, 1997, otherwise enter zero.	0.00	14.00
15.00	Sum of lines 12 through 14 divided by 3.	0.00	15.00
16.00	Adjustment for residents in initial years of the program	0.00	16.00
17.00	Adjustment for residents displaced by program or hospital closure	0.00	17.00
18.00	Adjusted rolling average FTE count	0.00	18.00
19.00	Current year resident to bed ratio (line 18 divided by line 4).	0.000000	19.00
20.00	Prior year resident to bed ratio (see instructions)	0.000000	20.00
21.00	Enter the lesser of lines 19 or 20 (see instructions)	0.000000	21.00
22.00	IME payment adjustment (see instructions)	0	22.00
22.01	IME payment adjustment - Managed Care (see instructions)	0	22.01
	Indirect Medical Education Adjustment for the Add-on for § 422 of the MMA		
23.00	Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 CFR 412.105 (f)(1)(iv)(C).	0.00	23.00
24.00	IME FTE Resident Count Over Cap (see instructions)	0.00	24.00
25.00	If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see instructions)	0.00	25.00
26.00	Resident to bed ratio (divide line 25 by line 4)	0.000000	26.00
27.00	IME payments adjustment factor. (see instructions)	0.000000	27.00
28.00	IME add-on adjustment amount (see instructions)	0	28.00
28.01	IME add-on adjustment amount - Managed Care (see instructions)	0	28.01
29.00	Total IME payment (sum of lines 22 and 28)	0	29.00
29.01	Total IME payment - Managed Care (sum of lines 22.01 and 28.01)	0	29.01
	Disproportionate Share Adjustment		
30.00	Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)	2.42	30.00
31.00	Percentage of Medicaid patient days (see instructions)	15.25	31.00
32.00	Sum of lines 30 and 31	17.67	32.00
33.00	Allowable disproportionate share percentage (see instructions)	4.24	33.00
34.00	Disproportionate share adjustment (see instructions)	129,501	34.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0157	Period: From 07/01/2019 To 06/30/2020	Worksheet E Part A Date/Time Prepared: 11/18/2020 5:26 pm
	Title XVIII	Hospital	PPS

		Prior to 10/1	On/After 10/1	
		1.00	2.00	
	Uncompensated Care Adjustment			
35.00	Total uncompensated care amount (see instructions)	8,272,872,447	8,350,599,096	35.00
35.01	Factor 3 (see instructions)	0.000131448	0.000197126	35.01
35.02	Hospital uncompensated care payment (If line 34 is zero, enter zero on this line) (see instructions)	1,087,453	1,646,116	35.02
35.03	Pro rata share of the hospital uncompensated care payment amount (see instructions)	274,098	1,232,338	35.03
36.00	Total uncompensated care (sum of columns 1 and 2 on line 35.03)	1,506,436		36.00
	Additional payment for high percentage of ESRD beneficiary discharges (lines 40 through 46)			
40.00	Total Medicare discharges on Worksheet S-3, Part I excluding discharges for MS-DRGs 652, 682, 683, 684 and 685 (see instructions)	0		40.00
		Before 1/1	On/After 1/1	
		1.00	1.01	
41.00	Total ESRD Medicare discharges excluding MS-DRGs 652, 682, 683, 684 an 685. (see instructions)	0	0	41.00
41.01	Total ESRD Medicare covered and paid discharges excluding MS-DRGs 652, 682, 683, 684 an 685. (see instructions)	0	0	41.01
42.00	Divide line 41 by line 40 (if less than 10%, you do not qualify for adjustment)	0.00		42.00
43.00	Total Medicare ESRD inpatient days excluding MS-DRGs 652, 682, 683, 684 an 685. (see instructions)	0		43.00
44.00	Ratio of average length of stay to one week (line 43 divided by line 41 divided by 7 days)	0.000000		44.00
45.00	Average weekly cost for dialysis treatments (see instructions)	0.00	0.00	45.00
46.00	Total additional payment (line 45 times line 44 times line 41.01)	0		46.00
47.00	Subtotal (see instructions)	14,090,057		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)	14,090,057	49.00
50.00	Payment for inpatient program capital (from Wkst. L, Pt. I and Pt. II, as applicable)	1,051,785	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)	15,141,842	59.00
60.00	Primary payer payments	7,820	60.00
61.00	Total amount payable for program beneficiaries (line 59 minus line 60)	15,134,022	61.00
62.00	Deductibles billed to program beneficiaries	1,209,384	62.00
63.00	Coinsurance billed to program beneficiaries	16,148	63.00
64.00	Allowable bad debts (see instructions)	93,989	64.00
65.00	Adjusted reimbursable bad debts (see instructions)	61,093	65.00
66.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	29,985	66.00
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)	13,969,583	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)	79,264	70.93
70.94	HRR adjustment amount (see instructions)	-26,018	70.94
70.95	Recovery of accelerated depreciation	0	70.95

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0157	Period: From 07/01/2019 To 06/30/2020	Worksheet E Part A Date/Time Prepared: 11/18/2020 5:26 pm
	Title XVIII	Hospital	PPS

		FFY (yyyy)	Amount	
		0	1.00	
70.96	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period prior to 10/1)	0	0	70.96
70.97	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period ending on or after 10/1)	0	0	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)		14,022,829	71.00
71.01	Sequestration adjustment (see instructions)		234,181	71.01
71.02	Demonstration payment adjustment amount after sequestration		0	71.02
71.03	Sequestration adjustment-PARHM pass-throughs			71.03
72.00	Interim payments		13,594,642	72.00
72.01	Interim payments-PARHM			72.01
73.00	Tentative settlement (for contractor use only)		0	73.00
73.01	Tentative settlement-PARHM (for contractor use only)			73.01
74.00	Balance due provider/program (line 71 minus lines 71.01, 71.02, 72, and 73)		194,006	74.00
74.01	Balance due provider/program-PARHM (see instructions)			74.01
75.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		277,237	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: 15-0157 | Period: From 07/01/2019 To 06/30/2020 | Worksheet E Part A Exhibit 4 Date/Time Prepared: 11/18/2020 5:26 pm

Title XVIII | Hospital | PPS

		W/S E, Part A line	Amounts (from E, Part A)	Pre/Post Entitlement	Period Prior to 10/01	Period On/After 10/01	Total (Col 2 through 4)	
		0	1.00	2.00	3.00	4.00	5.00	
1.00	DRG amounts other than outlier payments	1.00	0	0	0	0	0	1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1	1.01	2,873,207	0	2,873,207		2,873,207	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	9,343,873	0		9,343,873	9,343,873	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	24,318	0	24,318		24,318	2.02
2.03	Outlier payments for discharges occurring on or after October 1 (see instructions)	2.04	212,722	0		212,722	212,722	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	0.0424	0.0424	0.0424	0.0424		10.00
11.00	Disproportionate share adjustment (see instructions)	34.00	129,501	0	30,456	99,045	129,501	11.00
11.01	Uncompensated care payments	36.00	1,506,436	0	274,098	1,232,338	1,506,436	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	14,090,057	0	3,202,079	10,887,978	14,090,057	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	14,090,057	0	3,202,079	10,887,978	14,090,057	15.00
16.00	Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable)	50.00	1,051,785	0	248,501	803,284	1,051,785	16.00

LOW VOLUME CALCULATION EXHIBIT 4 | Provider CCN: 15-0157 | Period: From 07/01/2019 To 06/30/2020 | Worksheet E Part A Exhibit 4 Date/Time Prepared: 11/18/2020 5:26 pm

Title XVIII | Hospital | PPS

		W/S E, Part A line	Amounts (from E, Part A)	Pre/Post Entitlement	Period Prior to 10/01	Period On/After 10/01	Total (Col 2 through 4)	
		0	1.00	2.00	3.00	4.00	5.00	
17.00	Special add-on payments for new technologies	54.00	0	0	0	0	0	17.00
17.01	Net organ aquisition cost							17.01
17.02	Credits received from manufacturers for replaced devices for applicable MS-DRGs	68.00	0	0	0	0	0	17.02
18.00	Capital outlier reconciliation adjustment amount (see instructions)	93.00	0	0	0	0	0	18.00
19.00	SUBTOTAL			0	3,450,580	11,691,262	15,141,842	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	973,246	0	233,774	739,472	973,246	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	43,113	0	6,218	36,895	43,113	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	0.0364	0.0364	0.0364	0.0364		24.00
25.00	Disproportionate share adjustment (see instructions)	11.00	35,426	0	8,509	26,917	35,426	25.00
26.00	Total prospective capital payments (see instructions)	12.00	1,051,785	0	248,501	803,284	1,051,785	26.00
		W/S E, Part A line	(Amounts to E, Part A)					
		0	1.00	2.00	3.00	4.00	5.00	
27.00	Low volume adjustment factor				0.000000	0.000000		27.00
28.00	Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)	70.96			0		0	28.00
29.00	Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)	70.97				0	0	29.00
100.00	Transfer low volume adjustments to Wkst. E, Pt. A.		Y					100.00

HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULATION EXHIBIT 5 | Provider CCN: 15-0157 | Period: From 07/01/2019 To 06/30/2020 | Worksheet E Part A Exhibit 5 Date/Time Prepared: 11/18/2020 5:26 pm

Title XVIII | Hospital | PPS

		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	2,873,207	2,873,207		2,873,207	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	9,343,873		9,343,873	9,343,873	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	24,318	24,318		24,318	2.02
2.03	Outlier payments for discharges occurring on or after October 1 (see instructions)	2.04	212,722		212,722	212,722	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	0.0424	0.0424	0.0424		10.00
11.00	Disproportionate share adjustment (see instructions)	34.00	129,501	30,456	99,045	129,501	11.00
11.01	Uncompensated care payments	36.00	1,506,436	274,098	1,232,338	1,506,436	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	14,090,057	3,202,079	10,887,978	14,090,057	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	14,090,057	3,202,079	10,887,978	14,090,057	15.00
16.00	Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable)	50.00	1,051,785	248,501	803,284	1,051,785	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			3,450,580	11,691,262	15,141,842	19.00

HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULATION EXHIBIT 5 | Provider CCN: 15-0157 | Period: From 07/01/2019 To 06/30/2020 | Worksheet E Part A Exhibit 5 Date/Time Prepared: 11/18/2020 5:26 pm

Title XVIII | Hospital | PPS

		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	973,246	233,774	739,472	973,246	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	43,113	6,218	36,895	43,113	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	0.0364	0.0364	0.0364		24.00
25.00	Disproportionate share adjustment (see instructions)	11.00	35,426	8,509	26,917	35,426	25.00
26.00	Total prospective capital payments (see instructions)	12.00	1,051,785	248,501	803,284	1,051,785	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	0	0		0	28.00
29.00	Low volume adjustment on or after October 1	70.97	0		0	0	29.00
30.00	HVBP payment adjustment (see instructions)	70.93	79,264	28,208	51,056	79,264	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	-26,018	-1,724	-24,294	-26,018	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: 15-0157	Period: From 07/01/2019 To 06/30/2020	Worksheet E Part B Date/Time Prepared: 11/18/2020 5:26 pm
	Title XVIII	Hospital	PPS

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	1,245	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)	7,069,039	2.00
3.00	OPPS payments	6,161,469	3.00
4.00	Outlier payment (see instructions)	66,880	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)	1,245	11.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
12.00	Ancillary service charges	4,896	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)	4,896	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)	4,896	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)	3,651	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)	1,245	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)	6,228,349	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)	1,215,985	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)	5,013,609	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)	5,013,609	30.00
31.00	Primary payer payments	190	31.00
32.00	Subtotal (line 30 minus line 31)	5,013,419	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)	145,251	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	94,413	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	90,243	36.00
37.00	Subtotal (see instructions)	5,107,832	37.00
38.00	MSP-LCC reconciliation amount from PS&R	0	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	39.00
39.50	Pioneer ACO demonstration payment adjustment (see instructions)		39.50
39.97	Demonstration payment adjustment amount before sequestration	0	39.97
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)	0	39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION	0	39.99
40.00	Subtotal (see instructions)	5,107,832	40.00
40.01	Sequestration adjustment (see instructions)	85,301	40.01
40.02	Demonstration payment adjustment amount after sequestration	0	40.02
40.03	Sequestration adjustment-PARHM pass-throughs		40.03
41.00	Interim payments	4,926,586	41.00
41.01	Interim payments-PARHM		41.01
42.00	Tentative settlement (for contractors use only)	0	42.00
42.01	Tentative settlement-PARHM (for contractor use only)		42.01
43.00	Balance due provider/program (see instructions)	95,945	43.00
43.01	Balance due provider/program-PARHM (see instructions)		43.01
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	44.00
	TO BE COMPLETED BY CONTRACTOR		
90.00	Original outlier amount (see instructions)	0	90.00
91.00	Outlier reconciliation adjustment amount (see instructions)	0	91.00
92.00	The rate used to calculate the Time Value of Money	0.00	92.00
93.00	Time Value of Money (see instructions)	0	93.00
94.00	Total (sum of lines 91 and 93)	0	94.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 15-0157 | Period: From 07/01/2019 To 06/30/2020 | Worksheet E-1 Part I | Date/Time Prepared: 11/18/2020 5:26 pm

Title XVIII | Hospital | PPS

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		13,594,642		4,926,586	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)		13,594,642		4,926,586	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		194,006		95,945	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		13,788,648		5,022,531	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: 15-0157	Period: From 07/01/2019 To 06/30/2020	Worksheet E-1 Part II Date/Time Prepared: 11/18/2020 5:26 pm
	Title XVIII	Hospital	PPS

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

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0157	Period: From 07/01/2019 To 06/30/2020	Worksheet E-3 Part VII Date/Time Prepared: 11/18/2020 5:26 pm
	Title XIX	Hospital	Cost

		Inpatient	Outpatient	
		1.00	2.00	
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR XIX SERVICES			
	COMPUTATION OF NET COST OF COVERED SERVICES			
1.00	Inpatient hospital/SNF/NF services	5,007,488		1.00
2.00	Medical and other services		5,666,031	2.00
3.00	Organ acquisition (certified transplant centers only)	0		3.00
4.00	Subtotal (sum of lines 1, 2 and 3)	5,007,488	5,666,031	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)	5,007,488	5,666,031	7.00
	COMPUTATION OF LESSER OF COST OR CHARGES			
	Reasonable Charges			
8.00	Routine service charges	4,702,781		8.00
9.00	Ancillary service charges	20,078,124	38,725,557	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)	24,780,905	38,725,557	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)	24,780,905	38,725,557	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)	19,773,417	33,059,526	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)	5,007,488	5,666,031	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)	5,007,488	5,666,031	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)	5,007,488	5,666,031	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)	5,007,488	5,666,031	36.00
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	37.00
38.00	Subtotal (line 36 ± line 37)	5,007,488	5,666,031	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)	5,007,488	5,666,031	40.00
41.00	Interim payments	5,007,488	5,666,031	41.00
42.00	Balance due provider/program (line 40 minus line 41)	0	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: 15-0157 | Period: From 07/01/2019 To 06/30/2020 | Worksheet G | Date/Time Prepared: 11/18/2020 5:26 pm

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
	CURRENT ASSETS					
1.00	Cash on hand in banks	5,196,952	0	0	0	1.00
2.00	Temporary investments	0	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	57,573,685	0	0	0	4.00
5.00	Other receivable	3,747,219	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-26,587,763	0	0	0	6.00
7.00	Inventory	2,711,013	0	0	0	7.00
8.00	Prepaid expenses	185,322	0	0	0	8.00
9.00	Other current assets	62,988	0	0	0	9.00
10.00	Due from other funds	20,293,881	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	63,183,297	0	0	0	11.00
	FIXED ASSETS					
12.00	Land	15,676,014	0	0	0	12.00
13.00	Land improvements	2,618,832	0	0	0	13.00
14.00	Accumulated depreciation	-2,302,652	0	0	0	14.00
15.00	Buildings	84,037,828	0	0	0	15.00
16.00	Accumulated depreciation	-52,130,712	0	0	0	16.00
17.00	Leasehold improvements	3,288,035	0	0	0	17.00
18.00	Accumulated depreciation	-2,613,879	0	0	0	18.00
19.00	Fixed equipment	17,837,452	0	0	0	19.00
20.00	Accumulated depreciation	-6,038,233	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	49,850,732	0	0	0	23.00
24.00	Accumulated depreciation	-39,471,541	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)	70,751,876	0	0	0	30.00
	OTHER ASSETS					
31.00	Investments	0	232,862	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	33,334,517	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	33,334,517	232,862	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	167,269,690	232,862	0	0	36.00
	CURRENT LIABILITIES					
37.00	Accounts payable	2,800,720	0	0	0	37.00
38.00	Salaries, wages, and fees payable	2,189,455	0	0	0	38.00
39.00	Payroll taxes payable	433,071	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	18,729,045	0	0	0	43.00
44.00	Other current liabilities	20,394,966	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	44,547,257	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	29,487,208	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	29,487,208	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	74,034,465	0	0	0	51.00
	CAPITAL ACCOUNTS					
52.00	General fund balance	93,235,225				52.00
53.00	Specific purpose fund		232,862			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)	93,235,225	232,862	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	167,269,690	232,862	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES | Provider CCN: 15-0157 | Period: From 07/01/2019 To 06/30/2020 | Worksheet G-1 | Date/Time Prepared: 11/18/2020 5:26 pm

		General Fund		Special Purpose Fund		Endowment Fund	
		1.00	2.00	3.00	4.00	5.00	
1.00	Fund balances at beginning of period		107,374,875		238,848		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		93,333,165				2.00
3.00	Total (sum of line 1 and line 2)		200,708,040		238,848		3.00
4.00	Additions (credit adjustments) (specify)	0		0		0	4.00
5.00	OTHER ACTIVITY	0		-3,262		0	5.00
6.00	OTHER ADJUSTMENT	0		-2,725		0	6.00
7.00	TRANSFERS TO AFFILIATES	14,400		0		0	7.00
8.00	ROUNDING	0		1		0	8.00
9.00		0		0		0	9.00
10.00	Total additions (sum of line 4-9)		14,400		-5,986		10.00
11.00	Subtotal (line 3 plus line 10)		200,722,440		232,862		11.00
12.00	Deductions (debit adjustments) (specify)	0		0		0	12.00
13.00		0		0		0	13.00
14.00	DISTRIBUTIONS	10,570,865		0		0	14.00
15.00	NET ASSET TRANS TO FROM ALPHA	96,916,346		0		0	15.00
16.00	CONSOLIDATION AMOUNT	0		0		0	16.00
17.00	ROUNDING	4		0		0	17.00
18.00	Total deductions (sum of lines 12-17)		107,487,215		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		93,235,225		232,862		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	OTHER ACTIVITY		0			5.00
6.00	OTHER ADJUSTMENT		0			6.00
7.00	TRANSFERS TO AFFILIATES		0			7.00
8.00	ROUNDING		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	DISTRIBUTIONS		0			14.00
15.00	NET ASSET TRANS TO FROM ALPHA		0			15.00
16.00	CONSOLIDATION AMOUNT		0			16.00
17.00	ROUNDING		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: 15-0157 | Period: From 07/01/2019 To 06/30/2020 | Worksheet G-2 Parts I & II Date/Time Prepared: 11/18/2020 5:26 pm

	Cost Center Description	Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospital	50,775,291		50,775,291	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	0		0	5.00
6.00	Swing bed - NF	0		0	6.00
7.00	SKILLED NURSING FACILITY				7.00
8.00	NURSING FACILITY				8.00
9.00	OTHER LONG TERM CARE				9.00
10.00	Total general inpatient care services (sum of lines 1-9)	50,775,291		50,775,291	10.00
	Intensive Care Type Inpatient Hospital Services				
11.00	INTENSIVE CARE UNIT	12,074,264		12,074,264	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	NEONATAL INTENSIVE CARE UNIT	19,732,356		19,732,356	15.00
16.00	Total intensive care type inpatient hospital services (sum of lines 11-15)	31,806,620		31,806,620	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	82,581,911		82,581,911	17.00
18.00	Ancillary services	182,975,951	340,668,364	523,644,315	18.00
19.00	Outpatient services	9,247,476	39,220,035	48,467,511	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				23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	PHYSICIAN PRIVATE OFFICES	0	3,074,246	3,074,246	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	274,805,338	382,962,645	657,767,983	28.00
	PART II - OPERATING EXPENSES				
29.00	Operating expenses (per Wkst. A, column 3, line 200)		140,467,904		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	ROUNDING	4			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)		4		42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer to Wkst. G-3, line 4)		140,467,900		43.00

STATEMENT OF REVENUES AND EXPENSES | Provider CCN: 15-0157 | Period: From 07/01/2019 To 06/30/2020 | Worksheet G-3 | Date/Time Prepared: 11/18/2020 5:26 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	657,767,983	1.00
2.00	Less contractual allowances and discounts on patients' accounts	435,678,918	2.00
3.00	Net patient revenues (line 1 minus line 2)	222,089,065	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	140,467,900	4.00
5.00	Net income from service to patients (line 3 minus line 4)	81,621,165	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	356,254	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	247,566	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	4,071	21.00
22.00	Rental of hospital space	705,733	22.00
23.00	Governmental appropriations	0	23.00
24.00	MEALS ON WHEELS	10,080	24.00
24.01	CONTRACT SERVICES REVENUE	878,412	24.01
24.02	OTHER MISCELLANEOUS REVENUE	723,306	24.02
24.04	LATE PENALTY FEES	1,231	24.04
24.05	OTHER NONOPERATING	0	24.05
24.06	CONSOLIDATING AMOUNT (NEEDS TO BE OF	2,895,956	24.06
24.07	SEMINARS TUITION REVENUE	400	24.07
24.08	MEDICAL AFFAIRS ADMIN - ADMINISTRATI	2,900	24.08
24.09	UNCLAIMED PROPERTY EXCEPTION	80,204	24.09
24.10	INTRA/INTERCOMPANY OPERATING REVENUE	73,633	24.10
24.11	AUXILIARY/GIFT SHOP INCOME	68,452	24.11
24.12	BILLING ARRANGEMENTS	852,340	24.12
24.13	UNRESTRICTED DONATIONS REVENUE	25	24.13
24.14	ON SITE CLINICS OTHER REVENUE	96,441	24.14
24.15	ACCOMODATION FEES	2,698	24.15
24.16	HHS STIMULUS OP REV 30B	13,887	24.16
24.17	PATIENT INTEREST INCOME	4,023	24.17
24.18	REVENUES FROM EXTERNAL PARTIES	4,223	24.18
24.19	GAIN ON SALE DISPOSAL PPE	1,500	24.19
24.20	HHS STIMULUS OP REV 30B	0	24.20
24.50	COVID-19 PHE Funding	4,689,997	24.50
25.00	Total other income (sum of lines 6-24)	11,713,332	25.00
26.00	Total (line 5 plus line 25)	93,334,497	26.00
27.00	LOSS FROM UNCONSOLIDATED ENTITIES	0	27.00
27.01	ROUNDING	2	27.01
27.02	NET ASSETS REL FROM RESTRICTED FUNDS	0	27.02
27.03	DONATIONS	1,330	27.03
28.00	Total other expenses (sum of line 27 and subscripts)	1,332	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	93,333,165	29.00

CALCULATION OF CAPITAL PAYMENT	Provider CCN: 15-0157	Period: From 07/01/2019 To 06/30/2020	Worksheet L Parts I-III Date/Time Prepared: 11/18/2020 5:26 pm
	Title XVIII	Hospital	PPS

		1.00	
	PART I - FULLY PROSPECTIVE METHOD		
	CAPITAL FEDERAL AMOUNT		
1.00	Capital DRG other than outlier	973,246	1.00
1.01	Model 4 BPCI Capital DRG other than outlier	0	1.01
2.00	Capital DRG outlier payments	43,113	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)	50.49	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)	2.42	7.00
8.00	Percentage of Medicaid patient days to total days (see instructions)	15.25	8.00
9.00	Sum of lines 7 and 8	17.67	9.00
10.00	Allowable disproportionate share percentage (see instructions)	3.64	10.00
11.00	Disproportionate share adjustment (see instructions)	35,426	11.00
12.00	Total prospective capital payments (see instructions)	1,051,785	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