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: 15-0010	Period: From 07/01/2019 To 06/30/2020	Worksheet S Parts I-III Date/Time Prepared: 11/20/2020 9:38 am

PART I - COST REPORT STATUS

Provider use only

1. [X] Electronically prepared cost report — Date: 11/20/2020 Time: 9:38 am
2. [ ] Manually prepared cost report
3. [0] If this is an amended report enter the number of times the provider resubmitted this cost report
4. [F] Medicare Utilization. Enter "F" for full or "L" for low.

Contractor use only

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

PART II - CERTIFICATION

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

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

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by ASCENSION ST VINCENT KOKOMO (15-0010) 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	380,362	97,377	0	0	1.00
2.00	Subprovider - IPF	0	0	0		0	2.00
3.00	Subprovider - IRF	0	14,663	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	395,025	97,377	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: 15-0010	Period: From 07/01/2019 To 06/30/2020	Worksheet S-2 Part I Date/Time Prepared: 11/20/2020 9:38 am

	1.00	2.00	3.00	4.00	
	Hospital and Hospital Health Care Complex Address:				
1.00	Street: 1907 WEST SYCAMORE	PO Box:			1.00
2.00	City: KOKOMO	State: IN	Zip Code: 46901	County:	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 KOKOMO	150010	29020	1	07/01/1966	N	P	O	3.00
4.00	Subprovider - IPF									4.00
5.00	Subprovider - IRF	ASCENSION ST VINCENT KOKOMO REHAB	15T010	29020	5	07/01/2002	N	P	O	5.00
6.00	Subprovider - (Other)									6.00
7.00	Swing Beds - SNF									7.00
8.00	Swing Beds - NF									8.00
9.00	Hospital-Based SNF									9.00
10.00	Hospital-Based NF									10.00
11.00	Hospital-Based OLTC									11.00
12.00	Hospital-Based HHA									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	Y	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.	574	275	0	2	3,420	0	24.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-0010 | Period: From 07/01/2019 To 06/30/2020 | Worksheet S-2 Part I Date/Time Prepared: 11/20/2020 9:38 am

		In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of State Medicaid paid days	Out-of State Medicaid eligible unpaid	Medicaid HMO days	Other Medicaid days	
		1.00	2.00	3.00	4.00	5.00	6.00	
25.00	If this provider is an IRF, enter the in-state Medicaid paid days in column 1, the in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5.	0	30	0	0	308		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.				58.00
59.00	Are costs claimed on line 100 of Worksheet A? If yes, complete Wkst. D-2, Pt. I.	N			59.00

		NAHE 413.85 Y/N	Worksheet A Line #	Pass-Through Qualification Criterion Code	
		1.00	2.00	3.00	
60.00	Are you claiming nursing and allied health education (NAHE) costs for any programs that meet the criteria under 42 CFR 413.85? (see instructions) Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", are you impacted by CR 11642 (or subsequent CR) NAHE MA payment adjustement? Enter "Y" for yes or "N" for no in column 2.	Y	Y		60.00
60.01	If line 60 is yes, complete columns 2 and 3 for each program. (see instructions)		23.00	1	60.01

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-0010 | Period: From 07/01/2019 To 06/30/2020 | Worksheet S-2 Part I | Date/Time Prepared: 11/20/2020 9:38 am

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

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-0010 | Period: From 07/01/2019 To 06/30/2020 | Worksheet S-2 Part I Date/Time Prepared: 11/20/2020 9:38 am

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

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 15-0010	Period: From 07/01/2019 To 06/30/2020	Worksheet S-2 Part I Date/Time Prepared: 11/20/2020 9:38 am

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

		V	XIX	
		1.00	2.00	
	Title V and XIX Services			
90.00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.	N	Y	90.00
91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.	N	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)			106.00
107.00	Column 1: If line 105 is Y, is this facility eligible for cost reimbursement for I&R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) Column 2: If column 1 is Y and line 70 or line 75 is Y, do you train I&Rs in an approved medical education program in the CAH's excluded IPF and/or IRF unit(s)? Enter "Y" for yes or "N" for no in column 2. (see instructions)			107.00
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	N		108.00

		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.					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: 15-0010 | Period: From 07/01/2019 To 06/30/2020 | Worksheet S-2 Part I Date/Time Prepared: 11/20/2020 9:38 am

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

		1.00	2.00	3.00	
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.	2			118.00

		Premiums	Losses	Insurance	
		1.00	2.00	3.00	
118.01	List amounts of malpractice premiums and paid losses:	0	0	656,020	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	15HO46	140.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-0010 | Period: From 07/01/2019 To 06/30/2020 | Worksheet S-2 Part I | Date/Time Prepared: 11/20/2020 9:38 am

	1.00	2.00	3.00	
	If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number.			
141.00	Name: ST VINCENT HEALTH	Contractor's Name: WPS	Contractor's Number: 08101	141.00
142.00	Street: 250 W 96TH STREET, SUITE 215	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.	Y		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: 15-0010 | Period: From 07/01/2019 To 06/30/2020 | Worksheet S-2 Part II | Date/Time Prepared: 11/20/2020 9:38 am

			Y/N	Date	
			1.00	2.00	
	General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format.				
	COMPLETED BY ALL HOSPITALS				
	Provider Organization and Operation				
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)		N		1.00
		Y/N	Date	V/I	
		1.00	2.00	3.00	
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.	N			2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)	Y			3.00
		Y/N	Type	Date	
		1.00	2.00	3.00	
	Financial Data and Reports				
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	Y	A		4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.	N			5.00
			Y/N	Legal Oper.	
			1.00	2.00	
	Approved Educational Activities				
6.00	Column 1: Are costs claimed for nursing school? Column 2: If yes, is the provider is the legal operator of the program?		N		6.00
7.00	Are costs claimed for Allied Health Programs? If "Y" see instructions.		Y		7.00
8.00	Were nursing school and/or allied health programs approved and/or renewed during the cost reporting period? If yes, see instructions.		N		8.00
9.00	Are costs claimed for Interns and Residents in an approved graduate medical education program in the current cost report? If yes, see instructions.		N		9.00
10.00	Was an approved Intern and Resident GME program initiated or renewed in the current cost reporting period? If yes, see instructions.		N		10.00
11.00	Are GME cost directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions.		N		11.00
				Y/N	
				1.00	
	Bad Debts				
12.00	Is the provider seeking reimbursement for bad debts? If yes, see instructions.			Y	12.00
13.00	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.			N	13.00
14.00	If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.			N	14.00
	Bed Complement				
15.00	Did total beds available change from the prior cost reporting period? If yes, see instructions.			N	15.00
		Part A		Part B	
		Y/N	Date	Y/N	Date
		1.00	2.00	3.00	4.00
	PS&R Data				
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see instructions)	Y	10/26/2020	Y	10/26/2020
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	N		N	
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N		N	
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		N	

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 15-0010 | Period: From 07/01/2019 To 06/30/2020 | Worksheet S-2 Part II Date/Time Prepared: 11/20/2020 9:38 am

		Description		Y/N	Y/N	
		0		1.00	3.00	
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:			N	N	20.00
		Y/N	Date	Y/N	Date	
		1.00	2.00	3.00	4.00	
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		N		21.00
					1.00	
	COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)					
	Capital Related Cost					
22.00	Have assets been relifed for Medicare purposes? If yes, see instructions					22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.					23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions					24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.					25.00
26.00	Were assets subject to Sec.2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.					26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.					27.00
	Interest Expense					
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.					28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions					29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.					30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.					31.00
	Purchased Services					
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.					32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.					33.00
	Provider-Based Physicians					
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.					34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.					35.00
				Y/N	Date	
				1.00	2.00	
	Home Office Costs					
36.00	Were home office costs claimed on the cost report?			Y		36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.			Y		37.00
38.00	If line 36 is yes , was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.			N		38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.			N		39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.			N		40.00
		1.00		2.00		
	Cost Report Preparer Contact Information					
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	JILL		HILL		41.00
42.00	Enter the employer/company name of the cost report preparer.	ASCENSION HEALTH				42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	317-583-3519		JILL.HILL1@ASCENSION.ORG		43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider CCN: 15-0010	Period: From 07/01/2019 To 06/30/2020	Worksheet S-2 Part II Date/Time Prepared: 11/20/2020 9:38 am

		3.00		
	Cost Report Preparer Contact Information			
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	MANAGER NET REVENUE MANAGEMENT		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: 15-0010 | Period: From 07/01/2019 To 06/30/2020 | Worksheet S-3 Part I Date/Time Prepared: 11/20/2020 9:38 am

	Component	Worksheet A Line Number	No. of Beds	Bed Days Available	CAH Hours	I/P Days / O/P Visits / Trips Title V	
		1.00	2.00	3.00	4.00	5.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30.00	98	35,868	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)		98	35,868	0.00	0	7.00
8.00	INTENSIVE CARE UNIT	31.00	13	4,758	0.00	0	8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY	43.00				0	13.00
14.00	Total (see instructions)		111	40,626	0.00	0	14.00
15.00	CAH visits					0	15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF	41.00	18	6,588		0	17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						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)		129				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)		8	2,928			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: 15-0010 | Period: From 07/01/2019 To 06/30/2020 | Worksheet S-3 Part I | Date/Time Prepared: 11/20/2020 9:38 am

	Component	I/P Days / O/P Visits / Trips			Full Time Equivalents		
		Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
		6.00	7.00	8.00	9.00	10.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	5,442	401	13,854			1.00
2.00	HMO and other (see instructions)	3,871	3,420				2.00
3.00	HMO IPF Subprovider	0	0				3.00
4.00	HMO IRF Subprovider	0	308				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)	5,442	401	13,854			7.00
8.00	INTENSIVE CARE UNIT	852	281	1,935			8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY		169	1,630			13.00
14.00	Total (see instructions)	6,294	851	17,419	0.00	463.76	14.00
15.00	CAH visits	0	0	0			15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF	2,556	30	4,306	0.00	0.00	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	463.76	27.00
28.00	Observation Bed Days		0	971			28.00
29.00	Ambulance Trips	1,940					29.00
30.00	Employee discount days (see instruction)			116			30.00
31.00	Employee discount days - IRF			27			31.00
32.00	Labor & delivery days (see instructions)	0	0	255			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: 15-0010 | Period: From 07/01/2019 To 06/30/2020 | Worksheet S-3 Part I | Date/Time Prepared: 11/20/2020 9:38 am

	Component	Full Time Equivalents	Discharges				
		Nonpaid Workers	Title V	Title XVIII	Title XIX	Total All Patients	
		11.00	12.00	13.00	14.00	15.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)		0	1,485	291	4,482	1.00
2.00	HMO and other (see instructions)			598	1,160		2.00
3.00	HMO IPF Subprovider				0		3.00
4.00	HMO IRF Subprovider				19		4.00
5.00	Hospital Adults & Peds. Swing Bed SNF						5.00
6.00	Hospital Adults & Peds. Swing Bed NF						6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)						7.00
8.00	INTENSIVE CARE UNIT						8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY						13.00
14.00	Total (see instructions)	0.00	0	1,485	291	4,482	14.00
15.00	CAH visits						15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF	0.00	0	211	3	323	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: 15-0010 | Period: From 07/01/2019 To 06/30/2020 | Worksheet S-3 Part II | Date/Time Prepared: 11/20/2020 9:38 am

		Wkst. A Line Number	Amount Reported	Reclassification of Salaries (from Wkst. A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
	PART II - WAGE DATA							
	SALARIES							
1.00	Total salaries (see instructions)	200.00	31,666,357	629	31,666,986	965,095.35	32.81	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		97,422	0	97,422	487.11	200.00	4.00
4.01	Physicians - Part A - Teaching		0	0	0	0.00	0.00	4.01
5.00	Physician and Non Physician-Part B		1,043,154	0	1,043,154	17,396.47	59.96	5.00
6.00	Non-physician-Part B for hospital-based RHC and FQHC services		0	0	0	0.00	0.00	6.00
7.00	Interns & residents (in an approved program)	21.00	0	0	0	0.00	0.00	7.00
7.01	Contracted interns and residents (in an approved programs)		0	0	0	0.00	0.00	7.01
8.00	Home office and/or related organization personnel		0	0	0	0.00	0.00	8.00
9.00	SNF	44.00	0	0	0	0.00	0.00	9.00
10.00	Excluded area salaries (see instructions)		3,248,429	97,128	3,345,557	106,897.00	31.30	10.00
	OTHER WAGES & RELATED COSTS							
11.00	Contract labor: Direct Patient Care		455,057	0	455,057	5,241.75	86.81	11.00
12.00	Contract labor: Top level management and other management and administrative services		0	0	0	0.00	0.00	12.00
13.00	Contract labor: Physician-Part A - Administrative		0	0	0	0.00	0.00	13.00
14.00	Home office and/or related organization salaries and wage-related costs		0	0	0	0.00	0.00	14.00
14.01	Home office salaries		7,702,957	0	7,702,957	174,385.00	44.17	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)		8,198,349	0	8,198,349			17.00
18.00	Wage-related costs (other) (see instructions)							18.00
19.00	Excluded areas		766,750	0	766,750			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		22,328	0	22,328			22.00
22.01	Physician Part A - Teaching		0	0	0			22.01
23.00	Physician Part B		239,077	0	239,077			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)		2,387,955	0	2,387,955			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: 15-0010 | Period: From 07/01/2019 To 06/30/2020 | Worksheet S-3 Part II Date/Time Prepared: 11/20/2020 9:38 am

		Wkst. A Line Number	Amount Reported	Reclassification of Salaries (from Wkst. A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
25.53	Home office: Physicians Part A - Teaching - wage-related (core)		0	0	0			25.53
	OVERHEAD COSTS - DIRECT SALARIES							
26.00	Employee Benefits Department	4.00	800,974	0	800,974	307.36	2,605.98	26.00
27.00	Administrative & General	5.00	2,754,168	-871,259	1,882,909	116,313.54	16.19	27.00
28.00	Administrative & General under contract (see inst.)		782,759	0	782,759	5,108.00	153.24	28.00
29.00	Maintenance & Repairs	6.00	0	0	0	0.00	0.00	29.00
30.00	Operation of Plant	7.00	-629	629	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	119	0	119	7.37	16.15	32.00
33.00	Housekeeping under contract (see instructions)		1,230,194	0	1,230,194	56,133.00	21.92	33.00
34.00	Dietary	10.00	0	0	0	0.00	0.00	34.00
35.00	Dietary under contract (see instructions)		482,944	0	482,944	21,044.00	22.95	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	1,443,951	43,538	1,487,489	39,035.74	38.11	38.00
39.00	Central Services and Supply	14.00	0	0	0	0.00	0.00	39.00
40.00	Pharmacy	15.00	1,535,120	10,156	1,545,276	33,962.08	45.50	40.00
41.00	Medical Records & Medical Records Library	16.00	0	0	0	0.00	0.00	41.00
42.00	Social Service	17.00	0	0	0	0.00	0.00	42.00
43.00	Other General Service	18.00	0	0	0	0.00	0.00	43.00

HOSPITAL WAGE INDEX INFORMATION | Provider CCN: 15-0010 | Period: From 07/01/2019 To 06/30/2020 | Worksheet S-3 Part III Date/Time Prepared: 11/20/2020 9:38 am

		Worksheet A Line Number	Amount Reported	Reclassification of Salaries (from Worksheet A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
	PART III - HOSPITAL WAGE INDEX SUMMARY							
1.00	Net salaries (see instructions)		33,119,100	629	33,119,729	1,029,983.88	32.16	1.00
2.00	Excluded area salaries (see instructions)		3,248,429	97,128	3,345,557	106,897.00	31.30	2.00
3.00	Subtotal salaries (line 1 minus line 2)		29,870,671	-96,499	29,774,172	923,086.88	32.26	3.00
4.00	Subtotal other wages & related costs (see inst.)		8,158,014	0	8,158,014	179,626.75	45.42	4.00
5.00	Subtotal wage-related costs (see inst.)		10,608,632	0	10,608,632	0.00	35.63	5.00
6.00	Total (sum of lines 3 thru 5)		48,637,317	-96,499	48,540,818	1,102,713.63	44.02	6.00
7.00	Total overhead cost (see instructions)		9,029,600	-816,936	8,212,664	271,911.09	30.20	7.00

HOSPITAL WAGE RELATED COSTS | Provider CCN: 15-0010 | Period: From 07/01/2019 To 06/30/2020 | Worksheet S-3 Part IV | Date/Time Prepared: 11/20/2020 9:38 am

		Amount Reported	
		1.00	
	PART IV - WAGE RELATED COSTS		
	Part A - Core List		
	RETIREMENT COST		
1.00	401K Employer Contributions	1,586,624	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	281,380	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)	3,588,678	8.02
8.03	Health Insurance (Purchased)	0	8.03
9.00	Prescription Drug Plan	985,557	9.00
10.00	Dental, Hearing and Vision Plan	147,928	10.00
11.00	Life Insurance (If employee is owner or beneficiary)	33,377	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)	263,649	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)	0	14.00
15.00	'Workers' Compensation Insurance	16,236	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	2,288,081	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	16,688	20.00
	OTHER		
21.00	Executive Deferred Compensation (Other Than Retirement Cost Reported on lines 1 through 4 above. (see instructions))	0	21.00
22.00	Day Care Cost and Allowances	0	22.00
23.00	Tuition Reimbursement	18,306	23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)	9,226,504	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: 15-0010 | Period: From 07/01/2019 To 06/30/2020 | Worksheet S-3 Part V Date/Time Prepared: 11/20/2020 9:38 am

	Cost Center Description	Contract Labor	Benefit Cost	
		1.00	2.00	
	PART V - Contract Labor and Benefit Cost			
	Hospital and Hospital-Based Component Identification:			
1.00	Total facility's contract labor and benefit cost	455,057	9,226,504	1.00
2.00	Hospital	455,057	9,226,504	2.00
3.00	Subprovider - IPF			3.00
4.00	Subprovider - IRF	0	0	4.00
5.00	Subprovider - (Other)	0	0	5.00
6.00	Swing Beds - SNF	0	0	6.00
7.00	Swing Beds - NF	0	0	7.00
8.00	Hospital-Based SNF			8.00
9.00	Hospital-Based NF			9.00
10.00	Hospital-Based OLTC			10.00
11.00	Hospital-Based HHA			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	0	0	17.00
18.00	Other	0	0	18.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA | Provider CCN: 15-0010 | Period: From 07/01/2019 To 06/30/2020 | Worksheet S-10 | Date/Time Prepared: 11/20/2020 9:38 am

		1.00	
	Uncompensated and indigent care cost computation		
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided by line 202 column 8)	0.224410	1.00
	Medicaid (see instructions for each line)		
2.00	Net revenue from Medicaid	11,224,303	2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?		3.00
4.00	If line 3 is yes, does line 2 include all DSH and/or supplemental payments from Medicaid?		4.00
5.00	If line 4 is no, then enter DSH and/or supplemental payments from Medicaid	0	5.00
6.00	Medicaid charges	90,182,017	6.00
7.00	Medicaid cost (line 1 times line 6)	20,237,746	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)	9,013,443	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)	9,013,443	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)	13,710,893	2,080,655	15,791,548	20.00
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	3,076,861	2,080,655	5,157,516	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)	3,076,861	2,080,655	5,157,516	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)	4,660,738	26.00
27.00	Medicare reimbursable bad debts for the entire hospital complex (see instructions)	413,892	27.00
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)	636,757	27.01
28.00	Non-Medicare bad debt expense (see instructions)	4,023,981	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)	1,125,887	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)	6,283,403	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	15,296,846	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 15-0010 | Period: From 07/01/2019 To 06/30/2020 | Worksheet A | Date/Time Prepared: 11/20/2020 9:38 am

		Cost Center Description	Salaries	Other	Total (col. 1 + col. 2)	Reclassifications (See A-6)	Reclassified Trial Balance (col. 3 +- col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT		3,217,701	3,217,701	562,604	3,780,305	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		3,761,732	3,761,732	0	3,761,732	2.00
3.00	00300	OTHER CAP REL COSTS		0	0	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	800,974	7,393,499	8,194,473	0	8,194,473	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	2,754,168	41,085,455	43,839,623	-871,259	42,968,364	5.00
7.00	00700	OPERATION OF PLANT	-629	3,579,337	3,578,708	0	3,578,708	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0	430,197	430,197	8.00
9.00	00900	HOUSEKEEPING	119	1,863,511	1,863,630	-380,080	1,483,550	9.00
10.00	01000	DIETARY	0	2,156,098	2,156,098	-1,484,764	671,334	10.00
11.00	01100	CAFETERIA	0	0	0	1,483,829	1,483,829	11.00
13.00	01300	NURSING ADMINISTRATION	1,443,951	306,572	1,750,523	43,538	1,794,061	13.00
15.00	01500	PHARMACY	1,535,120	4,273,088	5,808,208	12,692,481	18,500,689	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	0	16.00
23.00	02300	ALLIED HEALTH RAD. TECH PROGRAM	77,476	34,260	111,736	78,412	190,148	23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	4,638,892	544,294	5,183,186	500,604	5,683,790	30.00
31.00	03100	INTENSIVE CARE UNIT	1,317,909	122,713	1,440,622	36,875	1,477,497	31.00
41.00	04100	SUBPROVIDER - IRF	1,075,086	102,841	1,177,927	12,487	1,190,414	41.00
43.00	04300	NURSERY	0	0	0	393,244	393,244	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,861,622	1,742,133	4,603,755	113,852	4,717,607	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,810,673	218,364	2,029,037	-674,270	1,354,767	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,616,704	758,737	2,375,441	-44,102	2,331,339	54.00
54.01	03630	ULTRA SOUND	262,332	21,140	283,472	16,271	299,743	54.01
56.00	05600	RADIOISOTOPE	646,337	285,362	931,699	3,365	935,064	56.00
57.00	05700	CT SCAN	383,038	36,340	419,378	7,352	426,730	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	281,306	63,738	345,044	4,830	349,874	58.00
59.00	05900	CARDIAC CATHETERIZATION	9,194	6,359	15,553	498	16,051	59.00
60.00	06000	LABORATORY	0	5,779,804	5,779,804	0	5,779,804	60.00
65.00	06500	RESPIRATORY THERAPY	846,191	68,509	914,700	17,327	932,027	65.00
66.00	06600	PHYSICAL THERAPY	2,954,536	428,418	3,382,954	-858,033	2,524,921	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	896,212	896,212	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	179,153	179,153	68.00
69.00	06900	ELECTROCARDIOLOGY	546,319	153,648	699,967	6,531	706,498	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	366,198	89,992	456,190	22,917	479,107	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	199,944	3,260,869	3,460,813	10,982	3,471,795	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	2,311,289	2,311,289	0	2,311,289	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	197,863	197,863	0	197,863	74.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	656,621	58,869	715,490	15,116	730,606	76.00
76.01	03190	CHEMOTHERAPY	483,744	17,770,123	18,253,867	-12,682,234	5,571,633	76.01
76.02	03330	ENDOSCOPY	18,374	17,051	35,425	10,569	45,994	76.02
76.03	03950	WOUND CARE CENTER	185,296	789,773	975,069	7,688	982,757	76.03
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	1,798,995	363,846	2,162,841	4,183	2,167,024	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	945,043	124,460	1,069,503	4,413	1,073,916	95.00
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0	0	0	0	0	98.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE		562,604	562,604	-562,604	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	30,515,533	103,550,392	134,065,925	-1,816	134,064,109	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	1,021,876	3,138,853	4,160,729	659	4,161,388	192.00
192.01	19201	ASC MOB	32	17,302	17,334	0	17,334	192.01
192.02	19202	EDUCATION CENTER	0	10,446	10,446	0	10,446	192.02
192.03	19203	MARKETING	0	101	101	0	101	192.03
194.00	07950	CLINIC OF HOPE	128,916	21,193	150,109	1,157	151,266	194.00
194.01	07951	GIFT SHOP	0	0	0	0	0	194.01
194.02	07952	FOUNDATION	0	0	0	0	0	194.02
200.00		TOTAL (SUM OF LINES 118 through 199)	31,666,357	106,738,287	138,404,644	0	138,404,644	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 15-0010 | Period: From 07/01/2019 To 06/30/2020 | Worksheet A | Date/Time Prepared: 11/20/2020 9:38 am

		Cost Center Description	Adjustments (See A-8)	Net Expenses For Allocation		
			6.00	7.00		
		GENERAL SERVICE COST CENTERS				
1.00	00100	CAP REL COSTS-BLDG & FIXT	-562,604	3,217,701		1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	-26,746	3,734,986		2.00
3.00	00300	OTHER CAP REL COSTS	0	0		3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-352,317	7,842,156		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-8,332,583	34,635,781		5.00
7.00	00700	OPERATION OF PLANT	-42,785	3,535,923		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	430,197		8.00
9.00	00900	HOUSEKEEPING	0	1,483,550		9.00
10.00	01000	DIETARY	-61,653	609,681		10.00
11.00	01100	CAFETERIA	-420,216	1,063,613		11.00
13.00	01300	NURSING ADMINISTRATION	-14,145	1,779,916		13.00
15.00	01500	PHARMACY	0	18,500,689		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-5,110	-5,110		16.00
23.00	02300	ALLIED HEALTH RAD. TECH PROGRAM	-25,316	164,832		23.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	-3,322	5,680,468		30.00
31.00	03100	INTENSIVE CARE UNIT	0	1,477,497		31.00
41.00	04100	SUBPROVIDER - IRF	0	1,190,414		41.00
43.00	04300	NURSERY	0	393,244		43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	-35,967	4,681,640		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	-6,271	1,348,496		52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-59,620	2,271,719		54.00
54.01	03630	ULTRA SOUND	0	299,743		54.01
56.00	05600	RADIOISOTOPE	0	935,064		56.00
57.00	05700	CT SCAN	0	426,730		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	349,874		58.00
59.00	05900	CARDIAC CATHETERIZATION	0	16,051		59.00
60.00	06000	LABORATORY	-45,054	5,734,750		60.00
65.00	06500	RESPIRATORY THERAPY	0	932,027		65.00
66.00	06600	PHYSICAL THERAPY	-17,440	2,507,481		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	896,212		67.00
68.00	06800	SPEECH PATHOLOGY	0	179,153		68.00
69.00	06900	ELECTROCARDIOLOGY	0	706,498		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	479,107		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	-167	3,471,628		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	2,311,289		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0		73.00
74.00	07400	RENAL DIALYSIS	0	197,863		74.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	-2,899	727,707		76.00
76.01	03190	CHEMOTHERAPY	-21,900	5,549,733		76.01
76.02	03330	ENDOSCOPY	0	45,994		76.02
76.03	03950	WOUND CARE CENTER	-2,005	980,752		76.03
		OUTPATIENT SERVICE COST CENTERS				
91.00	09100	EMERGENCY	0	2,167,024		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES	0	1,073,916		95.00
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0	0		98.00
		SPECIAL PURPOSE COST CENTERS				
113.00	11300	INTEREST EXPENSE	0	0		113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-10,038,120	124,025,989		118.00
		NONREIMBURSABLE COST CENTERS				
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	4,161,388		192.00
192.01	19201	ASC MOB	0	17,334		192.01
192.02	19202	EDUCATION CENTER	0	10,446		192.02
192.03	19203	MARKETING	0	101		192.03
194.00	07950	CLINIC OF HOPE	0	151,266		194.00
194.01	07951	GIFT SHOP	0	0		194.01
194.02	07952	FOUNDATION	0	0		194.02
200.00		TOTAL (SUM OF LINES 118 through 199)	-10,038,120	128,366,524		200.00

RECLASSIFICATIONS | Provider CCN: 15-0010 | Period: From 07/01/2019 To 06/30/2020 | Worksheet A-6 | Date/Time Prepared: 11/20/2020 9:38 am

		Increases			
	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
	A - LAUNDRY RECLASS				
1.00	LAUNDRY & LINEN SERVICE	8.00	0	430,197	1.00
2.00		0.00	0	0	2.00
3.00		0.00	0	0	3.00
4.00		0.00	0	0	4.00
5.00		0.00	0	0	5.00
6.00		0.00	0	0	6.00
7.00		0.00	0	0	7.00
8.00		0.00	0	0	8.00
	TOTALS		0	430,197	
	B - LABOR AND DELIVERY RECLASS				
1.00	ADULTS & PEDIATRICS	30.00	305,101	48,084	1.00
2.00	NURSERY	43.00	339,706	53,538	2.00
	TOTALS		644,807	101,622	
	C - CAFETERIA RECLASS				
1.00	CAFETERIA	11.00	0	1,483,829	1.00
	TOTALS		0	1,483,829	
	D - INTEREST EXPENSE				
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	562,604	1.00
	TOTALS		0	562,604	
	E - CHEMOTHERAPY DRUG RECLASS				
1.00	PHARMACY	15.00	0	12,682,325	1.00
	TOTALS		0	12,682,325	
	F - PT-OT-ST RECLASS				
1.00	OCCUPATIONAL THERAPY	67.00	782,716	113,496	1.00
2.00	SPEECH PATHOLOGY	68.00	156,465	22,688	2.00
	TOTALS		939,181	136,184	
	G - ALLIED HEALTH RADIOLOGY TECH PROGRAM				
1.00	ALLIED HEALTH RAD. TECH PROGRAM	23.00	78,412	0	1.00
	TOTALS		78,412	0	
	H - PANDEMIC RECLASS				
1.00	NURSING ADMINISTRATION	13.00	43,538	0	1.00
2.00	PHARMACY	15.00	10,156	0	2.00
3.00	ADULTS & PEDIATRICS	30.00	147,419	0	3.00
4.00	INTENSIVE CARE UNIT	31.00	36,875	0	4.00
5.00	SUBPROVIDER - IRF	41.00	12,487	0	5.00
6.00	OPERATING ROOM	50.00	113,852	0	6.00
7.00	DELIVERY ROOM & LABOR ROOM	52.00	72,159	0	7.00
8.00	RADIOLOGY-DIAGNOSTIC	54.00	45,139	0	8.00
9.00	ULTRA SOUND	54.01	16,271	0	9.00
10.00	RADIOISOTOPE	56.00	3,365	0	10.00
11.00	CT SCAN	57.00	7,352	0	11.00
12.00	MAGNETIC RESONANCE IMAGING (MRI)	58.00	4,830	0	12.00
13.00	CARDIAC CATHETERIZATION	59.00	498	0	13.00
14.00	RESPIRATORY THERAPY	65.00	17,327	0	14.00
15.00	PHYSICAL THERAPY	66.00	247,051	0	15.00
16.00	ELECTROCARDIOLOGY	69.00	6,531	0	16.00
17.00	ELECTROENCEPHALOGRAPHY	70.00	31,551	0	17.00
18.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	10,982	0	18.00
19.00	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	76.00	15,116	0	19.00
20.00	CHEMOTHERAPY	76.01	91	0	20.00
21.00	ENDOSCOPY	76.02	10,569	0	21.00
22.00	WOUND CARE CENTER	76.03	7,688	0	22.00
23.00	EMERGENCY	91.00	4,183	0	23.00
24.00	AMBULANCE SERVICES	95.00	4,413	0	24.00
25.00	PHYSICIANS' PRIVATE OFFICES	192.00	659	0	25.00
26.00	CLINIC OF HOPE	194.00	1,157	0	26.00
	TOTALS		871,259	0	
	I - OPERATION OF PLANT SALARY				
1.00	OPERATION OF PLANT	7.00	629	0	1.00
	TOTALS		629	0	
500.00	Grand Total: Increases		2,534,288	15,396,761	500.00

RECLASSIFICATIONS | Provider CCN: 15-0010 | Period: From 07/01/2019 To 06/30/2020 | Worksheet A-6 | Date/Time Prepared: 11/20/2020 9:38 am

		Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	A - LAUNDRY RECLASS						
1.00	ELECTROENCEPHALOGRAPHY	70.00	0	8,634	0		1.00
2.00	PHYSICAL THERAPY	66.00	0	8,078	0		2.00
3.00	PHYSICAL THERAPY	66.00	0	12,107	0		3.00
4.00	PHYSICAL THERAPY	66.00	0	9,534	0		4.00
5.00	RADIOLOGY-DIAGNOSTIC	54.00	0	1,058	0		5.00
6.00	RADIOLOGY-DIAGNOSTIC	54.00	0	9,771	0		6.00
7.00	HOUSEKEEPING	9.00	0	380,080	0		7.00
8.00	DIETARY	10.00	0	935	0		8.00
	TOTALS		0	430,197			
	B - LABOR AND DELIVERY RECLASS						
1.00	DELIVERY ROOM & LABOR ROOM	52.00	644,807	101,622	0		1.00
2.00		0.00	0	0	0		2.00
	TOTALS		644,807	101,622			
	C - CAFETERIA RECLASS						
1.00	DIETARY	10.00	0	1,483,829	0		1.00
	TOTALS		0	1,483,829			
	D - INTEREST EXPENSE						
1.00	INTEREST EXPENSE	113.00	0	562,604	11		1.00
	TOTALS		0	562,604			
	E - CHEMOTHERAPY DRUG RECLASS						
1.00	CHEMOTHERAPY	76.01	0	12,682,325	0		1.00
	TOTALS		0	12,682,325			
	F - PT-OT-ST RECLASS						
1.00	PHYSICAL THERAPY	66.00	939,181	136,184	0		1.00
2.00		0.00	0	0	0		2.00
	TOTALS		939,181	136,184			
	G - ALLIED HEALTH RADIOLOGY TECH PROGRAM						
1.00	RADIOLOGY-DIAGNOSTIC	54.00	78,412	0	0		1.00
	TOTALS		78,412	0			
	H - PANDEMIC RECLASS						
1.00	ADMINISTRATIVE & GENERAL	5.00	871,259	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
19.00		0.00	0	0	0		19.00
20.00		0.00	0	0	0		20.00
21.00		0.00	0	0	0		21.00
22.00		0.00	0	0	0		22.00
23.00		0.00	0	0	0		23.00
24.00		0.00	0	0	0		24.00
25.00		0.00	0	0	0		25.00
26.00		0.00	0	0	0		26.00
	TOTALS		871,259	0			
	I - OPERATION OF PLANT SALARY						
1.00	OPERATION OF PLANT	7.00	0	629	0		1.00
	TOTALS		0	629			
500.00	Grand Total: Decreases		2,533,659	15,397,390			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-0010 | Period: From 07/01/2019 To 06/30/2020 | Worksheet A-7 Part I | Date/Time Prepared: 11/20/2020 9:38 am

		Beginning Balances	Acquisitions: Purchases	Acquisitions: Donation	Acquisitions: Total	Disposals and Retirements	
		1.00	2.00	3.00	4.00	5.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	722,779	0	0	0	197,500	1.00
2.00	Land Improvements	1,764,978	0	0	0	0	2.00
3.00	Buildings and Fixtures	57,470,695	1,722,268	0	1,722,268	1,162,478	3.00
4.00	Building Improvements	13,420,703	5,581,002	0	5,581,002	0	4.00
5.00	Fixed Equipment	21,765,515	187,860	0	187,860	28,956	5.00
6.00	Movable Equipment	46,189,168	4,281,424	0	4,281,424	80,703	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	141,333,838	11,772,554	0	11,772,554	1,469,637	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	141,333,838	11,772,554	0	11,772,554	1,469,637	10.00

		Ending Balance	Fully Depreciated Assets	
		6.00	7.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES			
1.00	Land	525,279	0	1.00
2.00	Land Improvements	1,764,978	0	2.00
3.00	Buildings and Fixtures	58,030,485	0	3.00
4.00	Building Improvements	19,001,705	0	4.00
5.00	Fixed Equipment	21,924,419	0	5.00
6.00	Movable Equipment	50,389,889	0	6.00
7.00	HIT designated Assets	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	151,636,755	0	8.00
9.00	Reconciling Items	0	0	9.00
10.00	Total (line 8 minus line 9)	151,636,755	0	10.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-0010 | Period: From 07/01/2019 To 06/30/2020 | Worksheet A-7 Part II | Date/Time Prepared: 11/20/2020 9:38 am

	Cost Center Description	SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	CAP REL COSTS-BLDG & FIXT	2,789,335	428,366	0	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2,836,236	925,496	0	0	0	2.00
3.00	Total (sum of lines 1-2)	5,625,571	1,353,862	0	0	0	3.00

	Cost Center Description	SUMMARY OF CAPITAL		
		Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)	
		14.00	15.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2			
1.00	CAP REL COSTS-BLDG & FIXT	0	3,217,701	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	3,761,732	2.00
3.00	Total (sum of lines 1-2)	0	6,979,433	3.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-0010 | Period: From 07/01/2019 To 06/30/2020 | Worksheet A-7 Part III | Date/Time Prepared: 11/20/2020 9:38 am

	Cost Center Description	COMPUTATION OF RATIOS			ALLOCATION OF OTHER CAPITAL		
		Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	
		1.00	2.00	3.00	4.00	5.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	1.000000	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	0.000000	0	2.00
3.00	Total (sum of lines 1-2)	0	0	0	1.000000	0	3.00

	Cost Center Description	ALLOCATION OF OTHER CAPITAL			SUMMARY OF CAPITAL		
		Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	Depreciation	Lease	
		6.00	7.00	8.00	9.00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	2,789,335	428,366	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	2,809,490	925,496	2.00
3.00	Total (sum of lines 1-2)	0	0	0	5,598,825	1,353,862	3.00

	Cost Center Description	SUMMARY OF CAPITAL					
		Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	0	3,217,701	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	0	3,734,986	2.00
3.00	Total (sum of lines 1-2)	0	0	0	0	6,952,687	3.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 15-0010 | Period: From 07/01/2019 To 06/30/2020 | Worksheet A-8 | Date/Time Prepared: 11/20/2020 9:38 am

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
1.00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)	B	-555,169	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	-45,097	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)	B	-14,250	ADMINISTRATIVE & GENERAL	5.00	0	7.00
8.00	Television and radio service (chapter 21)	A	-9,119	ADMINISTRATIVE & GENERAL	5.00	0	8.00
9.00	Parking lot (chapter 21)		0		0.00	0	9.00
10.00	Provider-based physician adjustment	A-8-2	-550,962			0	10.00
11.00	Sale of scrap, waste, etc. (chapter 23)	B	-259	OPERATION OF PLANT	7.00	0	11.00
12.00	Related organization transactions (chapter 10)	A-8-1	2,634,331			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests	B	-420,216	CAFETERIA	11.00	0	14.00
15.00	Rental of quarters to employee and others		0		0.00	0	15.00
16.00	Sale of medical and surgical supplies to other than patients		0		0.00	0	16.00
17.00	Sale of drugs to other than patients		0		0.00	0	17.00
18.00	Sale of medical records and abstracts	B	-5,110	MEDICAL RECORDS & LIBRARY	16.00	0	18.00
19.00	Nursing and allied health education (tuition, fees, books, etc.)		0		0.00	0	19.00
20.00	Vending machines		0		0.00	0	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	0	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	RESPIRATORY THERAPY	65.00		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	PHYSICAL THERAPY	66.00		24.00
25.00	Utilization review - physicians' compensation (chapter 21)		0	*** Cost Center Deleted ***	114.00		25.00
26.00	Depreciation - CAP REL COSTS-BLDG & FIXT		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	LATE PENALTY FEES	B	-25	WOUND CARE CENTER	76.03	0	33.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 15-0010 | Period: From 07/01/2019 To 06/30/2020 | Worksheet A-8 | Date/Time Prepared: 11/20/2020 9:38 am

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
33.01	BUILDING RENTAL INCOME	B	-21,900	CHEMOTHERAPY	76.01	0	33.01
33.02	BUILDING RENTAL INCOME	B	-2,087	WOUND CARE CENTER	76.03	0	33.02
33.03	BUILDING RENTAL INCOME	B	-13,778	OPERATION OF PLANT	7.00	0	33.03
33.04	BUILDING RENTAL INCOME	B	-24,518	OPERATION OF PLANT	7.00	0	33.04
33.05	PATIENT INTEREST INCOME	B	17,342	ADMINISTRATIVE & GENERAL	5.00	0	33.05
33.06	LATE PENALTY FEES	B	-68	OPERATION OF PLANT	7.00	0	33.06
33.07	MEDICAL STAFF DUES	B	-24,253	ADMINISTRATIVE & GENERAL	5.00	0	33.07
33.08	MISCELLANEOUS INCOME	B	-20	ADULTS & PEDIATRICS	30.00	0	33.08
33.09	MISCELLANEOUS INCOME	B	-17,440	PHYSICAL THERAPY	66.00	0	33.09
33.10	MISCELLANEOUS INCOME	B	-694	RADIOLOGY-DIAGNOSTIC	54.00	0	33.10
33.11	MISCELLANEOUS INCOME	B	-194	LABORATORY	60.00	0	33.11
33.12	MISCELLANEOUS INCOME	B	-25	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.12
33.13	MISCELLANEOUS INCOME	B	-301	OPERATION OF PLANT	7.00	0	33.13
33.14	MISCELLANEOUS INCOME	B	-523	DIETARY	10.00	0	33.14
33.15	MISCELLANEOUS INCOME	B	-10,545	ALLIED HEALTH RAD. TECH PROGRAM	23.00	0	33.15
33.16	ACCOMODATION FEES	B	-20	ADMINISTRATIVE & GENERAL	5.00	0	33.16
33.17	UNCLAIMED PROPERTY EXEMPTIONS	B	-21,923	ADMINISTRATIVE & GENERAL	5.00	0	33.17
33.18	MEALS ON WHEELS	B	-61,130	DIETARY	10.00	0	33.18
33.19	SEMINARS AND TUITION REVENUE	B	-80	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.19
33.20	SEMINARS AND TUITION REVENUE	B	-14,771	ALLIED HEALTH RAD. TECH PROGRAM	23.00	0	33.20
33.21	OTHER REAL ESTATE REVENUE	B	107	WOUND CARE CENTER	76.03	0	33.21
33.22	BILLING ARRANGEMENT REVENUE	B	-1,250	ADMINISTRATIVE & GENERAL	5.00	0	33.22
33.23	GAIN ON DISPOSAL OF ASSETS	B	-26,746	CAP REL COSTS-MVBLE EQUIP	2.00	9	33.23
33.24	LOBBYING EXPENSES	A	-1,672	ADMINISTRATIVE & GENERAL	5.00	0	33.24
33.25	PROVIDER TAX ASSESSMENT	A	-10,785,989	ADMINISTRATIVE & GENERAL	5.00	0	33.25
33.26	TELEVISION EXPENSE	A	-3,861	OPERATION OF PLANT	7.00	0	33.26
33.27	CHARITABLE DONATIONS	A	-14,145	NURSING ADMINISTRATION	13.00	0	33.27
33.28	ADVERTISING AND PROMOTIONAL ITEMS	A	-24,003	ADMINISTRATIVE & GENERAL	5.00	0	33.28
33.29	MARKETING	A	-6,271	DELIVERY ROOM & LABOR ROOM	52.00	0	33.29
33.30	CORPORATE SPONSORSHIPS	A	-9,250	ADMINISTRATIVE & GENERAL	5.00	0	33.30
33.31	LATE FEES AND PENALTIES ASSESSED	A	-167	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	33.31
33.32	MID LEVEL PROVIDERS	A	-669	ADMINISTRATIVE & GENERAL	5.00	0	33.32
33.33	MID LEVEL PROVIDERS	A	-1,400	ADULTS & PEDIATRICS	30.00	0	33.33
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-10,038,120				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: 15-0010 | Period: From 07/01/2019 To 06/30/2020 | Worksheet A-8-1 | Date/Time Prepared: 11/20/2020 9:38 am

	Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in Wks. A, column 5	
	1.00	2.00	3.00	4.00	5.00	
	A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:					
1.00	5.00	ADMINISTRATIVE & GENERAL	HOME OFFICE CAPITAL	2,156,473	0	1.00
2.00	5.00	ADMINISTRATIVE & GENERAL	HOME OFFICE INTEREST	37,662	0	2.00
3.00	5.00	ADMINISTRATIVE & GENERAL	HOME OFFICE OTHER	26,589,107	25,796,699	3.00
3.01	4.00	EMPLOYEE BENEFITS DEPARTMENT	SVH CHARGEBACK	540	540	3.01
3.02	5.00	ADMINISTRATIVE & GENERAL	SVH CHARGEBACK	-9,520	-9,520	3.02
3.03	15.00	PHARMACY	SVH CHARGEBACK	-53,723	-53,723	3.03
3.04	23.00	ALLIED HEALTH RAD. TECH PROG	SVH CHARGEBACK	27,225	27,225	3.04
3.05	54.00	RADIOLOGY-DIAGNOSTIC	SVH CHARGEBACK	91,148	91,148	3.05
3.06	56.00	RADIOISOTOPE	SVH CHARGEBACK	8,106	8,106	3.06
3.07	59.00	CARDIAC CATHETERIZATION	SVH CHARGEBACK	5,000	5,000	3.07
3.08	69.00	ELECTROCARDIOLOGY	SVH CHARGEBACK	5,000	5,000	3.08
3.09	192.00	PHYSICIANS' PRIVATE OFFICES	SVH CHARGEBACK	2,884,319	2,884,319	3.09
3.10	1.00	CAP REL COSTS-BLDG & FIXT	INTEREST EXPENSE	555,169	562,604	3.10
3.11	5.00	ADMINISTRATIVE & GENERAL	INTEREST EXPENSE	7,435	0	3.11
3.12	4.00	EMPLOYEE BENEFITS DEPARTMENT	HEALTH INSURANCE	5,995,823	6,348,035	3.12
4.00	0.00			0	0	4.00
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.			38,299,764	35,665,433	5.00

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

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

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

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

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

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

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS	Provider CCN: 15-0010	Period: From 07/01/2019 To 06/30/2020	Worksheet A-8-1 Date/Time Prepared: 11/20/2020 9:38 am

	Net Adjustments (col. 4 minus col. 5)*	Wkst. A-7 Ref.		
	6.00	7.00		
	A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:			
1.00	2,156,473	0		1.00
2.00	37,662	0		2.00
3.00	792,408	0		3.00
3.01	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
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	-7,435	11		3.10
3.11	7,435	11		3.11
3.12	-352,212	0		3.12
4.00	0	0		4.00
5.00	2,634,331			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			6.00
7.00			7.00
8.00			8.00
9.00			9.00
10.00			10.00
100.00			100.00

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

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

PROVIDER BASED PHYSICIAN ADJUSTMENT | Provider CCN: 15-0010 | Period: From 07/01/2019 To 06/30/2020 | Worksheet A-8-2 | Date/Time Prepared: 11/20/2020 9:38 am

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	5.00	ADMINISTRATIVE & GENERAL	744,190	405,608	337,782	211,500	15,255	1.00
2.00	30.00	ADULTS & PEDIATRICS	2,410	1,400	1,010	211,500	5	2.00
3.00	50.00	OPERATING ROOM	56,710	16,070	40,640	211,500	204	3.00
4.00	54.00	RADIOLOGY-DIAGNOSTIC	58,926	58,926	0	0	0	4.00
5.00	60.00	LABORATORY	106,988	0	106,988	211,500	611	5.00
6.00	76.00	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	2,899	2,899	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			972,123	484,903	486,420		16,075	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	1,551,170	77,559	0	0	0	1.00
2.00	30.00	ADULTS & PEDIATRICS	508	25	0	0	0	2.00
3.00	50.00	OPERATING ROOM	20,743	1,037	0	0	0	3.00
4.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	4.00
5.00	60.00	LABORATORY	62,128	3,106	0	0	0	5.00
6.00	76.00	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			1,634,549	81,727	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	1,551,170	0	406,408		1.00
2.00	30.00	ADULTS & PEDIATRICS	0	508	502	1,902		2.00
3.00	50.00	OPERATING ROOM	0	20,743	19,897	35,967		3.00
4.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	58,926		4.00
5.00	60.00	LABORATORY	0	62,128	44,860	44,860		5.00
6.00	76.00	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0	0	2,899		6.00
7.00	0.00		0	0	0	0		7.00
8.00	0.00		0	0	0	0		8.00
9.00	0.00		0	0	0	0		9.00
10.00	0.00		0	0	0	0		10.00
200.00			0	1,634,549	65,259	550,962		200.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-0010 | Period: From 07/01/2019 To 06/30/2020 | Worksheet B Part I Date/Time Prepared: 11/20/2020 9:38 am

		Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS BLDG & FIXT	CAPITAL RELATED COSTS MVBLE EQUIP	EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
			0	1.00	2.00	4.00	4A	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	3,217,701	3,217,701				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	3,734,986		3,734,986			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	7,842,156	124,463	46	7,966,665		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	34,635,781	486,520	26,829	485,988	35,635,118	5.00
7.00	00700	OPERATION OF PLANT	3,535,923	446,493	162,483	0	4,144,899	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	430,197	5,029	1,252	0	436,478	8.00
9.00	00900	HOUSEKEEPING	1,483,550	19,563	0	31	1,503,144	9.00
10.00	01000	DIETARY	609,681	50,533	7,458	0	667,672	10.00
11.00	01100	CAFETERIA	1,063,613	61,261	16,461	0	1,141,335	11.00
13.00	01300	NURSING ADMINISTRATION	1,779,916	53,018	191,926	383,928	2,408,788	13.00
15.00	01500	PHARMACY	18,500,689	31,057	0	398,843	18,930,589	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-5,110	23,757	4,810	0	23,457	16.00
23.00	02300	ALLIED HEALTH RAD. TECH PROGRAM	164,832	8,699	0	40,235	213,766	23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	5,680,468	285,856	76,413	1,314,116	7,356,853	30.00
31.00	03100	INTENSIVE CARE UNIT	1,477,497	54,717	57,633	349,677	1,939,524	31.00
41.00	04100	SUBPROVIDER - IRF	1,190,414	131,725	639	280,708	1,603,486	41.00
43.00	04300	NURSERY	393,244	15,621	14,528	87,680	511,073	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	4,681,640	316,972	423,851	767,985	6,190,448	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,348,496	31,688	49,862	319,540	1,749,586	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,271,719	231,266	895,103	408,691	3,806,779	54.00
54.01	03630	ULTRA SOUND	299,743	0	59,611	71,909	431,263	54.01
56.00	05600	RADIOISOTOPE	935,064	19,417	705,991	167,691	1,828,163	56.00
57.00	05700	CT SCAN	426,730	0	14,836	100,762	542,328	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	349,874	0	298,273	73,853	722,000	58.00
59.00	05900	CARDIAC CATHETERIZATION	16,051	3,883	18,167	2,502	40,603	59.00
60.00	06000	LABORATORY	5,734,750	76,697	3,503	0	5,814,950	60.00
65.00	06500	RESPIRATORY THERAPY	932,027	12,009	44,677	222,878	1,211,591	65.00
66.00	06600	PHYSICAL THERAPY	2,507,481	70,047	24,050	583,938	3,185,516	66.00
67.00	06700	OCCUPATIONAL THERAPY	896,212	30,057	9,340	202,023	1,137,632	67.00
68.00	06800	SPEECH PATHOLOGY	179,153	10,097	1,868	40,384	231,502	68.00
69.00	06900	ELECTROCARDIOLOGY	706,498	38,863	171,081	142,693	1,059,135	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	479,107	26,485	28,904	102,661	637,157	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	3,471,628	41,834	119,431	54,441	3,687,334	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	2,311,289	0	0	0	2,311,289	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	197,863	0	0	0	197,863	74.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	727,707	44,572	0	173,379	945,658	76.00
76.01	03190	CHEMOTHERAPY	5,549,733	29,125	0	124,880	5,703,738	76.01
76.02	03330	ENDOSCOPY	45,994	0	54,615	7,470	108,079	76.02
76.03	03950	WOUND CARE CENTER	980,752	0	7,894	49,810	1,038,456	76.03
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	2,167,024	187,762	78,907	465,409	2,899,102	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	1,073,916	38,523	164,544	245,059	1,522,042	95.00
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0	0	0	0	0	98.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	124,025,989	3,007,609	3,734,986	7,669,164	123,518,396	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	4,161,388	198,354	0	263,921	4,623,663	192.00
192.01	19201	ASC MOB	17,334	0	0	8	17,342	192.01
192.02	19202	EDUCATION CENTER	10,446	0	0	0	10,446	192.02
192.03	19203	MARKETING	101	0	0	0	101	192.03
194.00	07950	CLINIC OF HOPE	151,266	0	0	33,572	184,838	194.00
194.01	07951	GIFT SHOP	0	9,990	0	0	9,990	194.01
194.02	07952	FOUNDATION	0	1,748	0	0	1,748	194.02
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)	128,366,524	3,217,701	3,734,986	7,966,665	128,366,524	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-0010 | Period: From 07/01/2019 To 06/30/2020 | Worksheet B Part I Date/Time Prepared: 11/20/2020 9:38 am

		Cost Center Description	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
			5.00	7.00	8.00	9.00	10.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	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	35,635,118					5.00
7.00	00700	OPERATION OF PLANT	1,592,814	5,737,713				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	167,731	13,357	617,566			8.00
9.00	00900	HOUSEKEEPING	577,633	51,960	189,627	2,322,364		9.00
10.00	01000	DIETARY	256,575	134,218	0	0	1,058,465	10.00
11.00	01100	CAFETERIA	438,596	162,712	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	925,656	140,820	0	1,778	0	13.00
15.00	01500	PHARMACY	7,274,718	82,491	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	9,014	63,099	0	593	0	16.00
23.00	02300	ALLIED HEALTH RAD. TECH PROGRAM	82,147	23,105	0	0	0	23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,827,114	759,256	197,228	726,726	674,982	30.00
31.00	03100	INTENSIVE CARE UNIT	745,326	145,332	52,582	177,823	94,275	31.00
41.00	04100	SUBPROVIDER - IRF	616,192	349,870	5,166	177,823	209,793	41.00
43.00	04300	NURSERY	196,397	41,490	8,066	92,278	79,415	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,378,884	841,899	6,179	355,645	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	672,336	84,167	21,865	194,585	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,462,880	614,259	14,474	36,157	0	54.00
54.01	03630	ULTRA SOUND	165,727	0	3,806	7,706	0	54.01
56.00	05600	RADIOISOTOPE	702,532	51,573	0	26,673	0	56.00
57.00	05700	CT SCAN	208,407	0	6,928	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	277,452	0	1,817	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	15,603	10,315	0	11,855	0	59.00
60.00	06000	LABORATORY	2,234,586	203,713	455	73,500	0	60.00
65.00	06500	RESPIRATORY THERAPY	465,594	31,898	418	3,556	0	65.00
66.00	06600	PHYSICAL THERAPY	1,224,140	186,049	0	8,085	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	437,173	79,835	0	4,327	0	67.00
68.00	06800	SPEECH PATHOLOGY	88,962	26,818	387	8,334	0	68.00
69.00	06900	ELECTROCARDIOLOGY	407,008	103,223	0	4,742	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	244,849	70,345	0	30,230	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,416,980	111,114	9,740	66,387	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	888,189	0	43	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	68	26,673	0	73.00
74.00	07400	RENAL DIALYSIS	76,035	0	0	11,855	0	74.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	363,400	118,386	3,480	23,710	0	76.00
76.01	03190	CHEMOTHERAPY	2,191,850	77,359	0	0	0	76.01
76.02	03330	ENDOSCOPY	41,533	0	0	0	0	76.02
76.03	03950	WOUND CARE CENTER	399,061	0	0	37,936	0	76.03
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	1,114,076	498,710	94,442	213,387	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	584,895	102,321	795	0	0	95.00
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0	0	0	0	0	98.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	33,772,065	5,179,694	617,566	2,322,364	1,058,465	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	1,776,795	526,843	0	0	0	192.00
192.01	19201	ASC MOB	6,664	0	0	0	0	192.01
192.02	19202	EDUCATION CENTER	4,014	0	0	0	0	192.02
192.03	19203	MARKETING	39	0	0	0	0	192.03
194.00	07950	CLINIC OF HOPE	71,030	0	0	0	0	194.00
194.01	07951	GIFT SHOP	3,839	26,534	0	0	0	194.01
194.02	07952	FOUNDATION	672	4,642	0	0	0	194.02
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)	35,635,118	5,737,713	617,566	2,322,364	1,058,465	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-0010 | Period: From 07/01/2019 To 06/30/2020 | Worksheet B Part I Date/Time Prepared: 11/20/2020 9:38 am

		Cost Center Description	CAFETERIA	NURSING ADMINISTRATION	PHARMACY	MEDICAL RECORDS & LIBRARY	ALLIED HEALTH RAD. TECH PROGRAM	
			11.00	13.00	15.00	16.00	23.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
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	1,742,643					11.00
13.00	01300	NURSING ADMINISTRATION	81,718	3,558,760				13.00
15.00	01500	PHARMACY	71,096	18,196	26,377,090			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	96,163		16.00
23.00	02300	ALLIED HEALTH RAD. TECH PROGRAM	12,269	0	0	0	331,287	23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	349,289	1,223,683	0	5,453	0	30.00
31.00	03100	INTENSIVE CARE UNIT	77,001	317,519	0	1,523	0	31.00
41.00	04100	SUBPROVIDER - IRF	74,835	290,095	0	1,444	0	41.00
43.00	04300	NURSERY	20,946	0	0	652	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	173,113	522,516	0	15,831	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	71,885	491,739	0	2,178	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	98,105	49,116	0	4,300	118,712	54.00
54.01	03630	ULTRA SOUND	12,341	0	0	1,131	31,228	54.01
56.00	05600	RADIOISOTOPE	37,997	16,140	0	3,970	109,613	56.00
57.00	05700	CT SCAN	20,151	461	0	2,058	56,833	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	14,574	169	0	540	14,901	58.00
59.00	05900	CARDIAC CATHETERIZATION	542	933	0	122	0	59.00
60.00	06000	LABORATORY	0	0	0	13,049	0	60.00
65.00	06500	RESPIRATORY THERAPY	55,345	4,512	0	2,042	0	65.00
66.00	06600	PHYSICAL THERAPY	120,630	67	0	2,306	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	46,850	0	0	894	0	67.00
68.00	06800	SPEECH PATHOLOGY	9,366	0	0	179	0	68.00
69.00	06900	ELECTROCARDIOLOGY	34,499	36,704	0	2,385	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	25,539	0	0	1,070	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	22,075	333	0	2,630	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	1,785	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	26,244,459	10,704	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	184	0	74.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	50,555	10,679	0	723	0	76.00
76.01	03190	CHEMOTHERAPY	28,543	40,155	0	2,390	0	76.01
76.02	03330	ENDOSCOPY	833	7,188	0	109	0	76.02
76.03	03950	WOUND CARE CENTER	15,330	36,058	0	3,225	0	76.03
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	115,662	487,073	0	11,536	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	94,826	856	0	1,750	0	95.00
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0	0	0	0	0	98.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	1,735,915	3,554,192	26,244,459	96,163	331,287	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	72	122,370	0	0	192.00
192.01	19201	ASC MOB	0	0	0	0	0	192.01
192.02	19202	EDUCATION CENTER	0	0	0	0	0	192.02
192.03	19203	MARKETING	0	0	0	0	0	192.03
194.00	07950	CLINIC OF HOPE	6,561	4,496	10,261	0	0	194.00
194.01	07951	GIFT SHOP	0	0	0	0	0	194.01
194.02	07952	FOUNDATION	167	0	0	0	0	194.02
200.00		Cross Foot Adjustments					0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	1,742,643	3,558,760	26,377,090	96,163	331,287	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-0010 | Period: From 07/01/2019 To 06/30/2020 | Worksheet B Part I | Date/Time Prepared: 11/20/2020 9:38 am

		Cost Center Description	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			24.00	25.00	26.00		
		GENERAL SERVICE COST CENTERS					
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
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
15.00	01500	PHARMACY					15.00
16.00	01600	MEDICAL RECORDS & LIBRARY					16.00
23.00	02300	ALLIED HEALTH RAD. TECH PROGRAM					23.00
		INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	14,120,584	0	14,120,584		30.00
31.00	03100	INTENSIVE CARE UNIT	3,550,905	0	3,550,905		31.00
41.00	04100	SUBPROVIDER - IRF	3,328,704	0	3,328,704		41.00
43.00	04300	NURSERY	950,317	0	950,317		43.00
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	10,484,515	0	10,484,515		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	3,288,341	0	3,288,341		52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	6,204,782	0	6,204,782		54.00
54.01	03630	ULTRA SOUND	653,202	0	653,202		54.01
56.00	05600	RADIOISOTOPE	2,776,661	0	2,776,661		56.00
57.00	05700	CT SCAN	837,166	0	837,166		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	1,031,453	0	1,031,453		58.00
59.00	05900	CARDIAC CATHETERIZATION	79,973	0	79,973		59.00
60.00	06000	LABORATORY	8,340,253	0	8,340,253		60.00
65.00	06500	RESPIRATORY THERAPY	1,774,956	0	1,774,956		65.00
66.00	06600	PHYSICAL THERAPY	4,726,793	0	4,726,793		66.00
67.00	06700	OCCUPATIONAL THERAPY	1,706,711	0	1,706,711		67.00
68.00	06800	SPEECH PATHOLOGY	365,548	0	365,548		68.00
69.00	06900	ELECTROCARDIOLOGY	1,647,696	0	1,647,696		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	1,009,190	0	1,009,190		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	5,316,593	0	5,316,593		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	3,201,306	0	3,201,306		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	26,281,904	0	26,281,904		73.00
74.00	07400	RENAL DIALYSIS	285,937	0	285,937		74.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	1,516,591	0	1,516,591		76.00
76.01	03190	CHEMOTHERAPY	8,044,035	0	8,044,035		76.01
76.02	03330	ENDOSCOPY	157,742	0	157,742		76.02
76.03	03950	WOUND CARE CENTER	1,530,066	0	1,530,066		76.03
		OUTPATIENT SERVICE COST CENTERS					
91.00	09100	EMERGENCY	5,433,988	0	5,433,988		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)		0			92.00
		OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES	2,307,485	0	2,307,485		95.00
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0	0	0		98.00
		SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	120,953,397	0	120,953,397		118.00
		NONREIMBURSABLE COST CENTERS					
192.00	19200	PHYSICIANS' PRIVATE OFFICES	7,049,743	0	7,049,743		192.00
192.01	19201	ASC MOB	24,006	0	24,006		192.01
192.02	19202	EDUCATION CENTER	14,460	0	14,460		192.02
192.03	19203	MARKETING	140	0	140		192.03
194.00	07950	CLINIC OF HOPE	277,186	0	277,186		194.00
194.01	07951	GIFT SHOP	40,363	0	40,363		194.01
194.02	07952	FOUNDATION	7,229	0	7,229		194.02
200.00		Cross Foot Adjustments	0	0	0		200.00
201.00		Negative Cost Centers	0	0	0		201.00
202.00		TOTAL (sum lines 118 through 201)	128,366,524	0	128,366,524		202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-0010 | Period: From 07/01/2019 To 06/30/2020 | Worksheet B Part II Date/Time Prepared: 11/20/2020 9:38 am

		Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS BLDG & FIXT	CAPITAL RELATED COSTS MVBLE EQUIP	Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
			0	1.00	2.00	2A	4.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	124,463	46	124,509	124,509	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	2,156,473	486,520	26,829	2,669,822	7,596	5.00
7.00	00700	OPERATION OF PLANT	0	446,493	162,483	608,976	0	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	5,029	1,252	6,281	0	8.00
9.00	00900	HOUSEKEEPING	0	19,563	0	19,563	0	9.00
10.00	01000	DIETARY	0	50,533	7,458	57,991	0	10.00
11.00	01100	CAFETERIA	0	61,261	16,461	77,722	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	53,018	191,926	244,944	6,001	13.00
15.00	01500	PHARMACY	0	31,057	0	31,057	6,234	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	23,757	4,810	28,567	0	16.00
23.00	02300	ALLIED HEALTH RAD. TECH PROGRAM	0	8,699	0	8,699	629	23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	285,856	76,413	362,269	20,534	30.00
31.00	03100	INTENSIVE CARE UNIT	0	54,717	57,633	112,350	5,465	31.00
41.00	04100	SUBPROVIDER - IRF	0	131,725	639	132,364	4,387	41.00
43.00	04300	NURSERY	0	15,621	14,528	30,149	1,370	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	316,972	423,851	740,823	12,003	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	31,688	49,862	81,550	4,994	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	231,266	895,103	1,126,369	6,388	54.00
54.01	03630	ULTRA SOUND	0	0	59,611	59,611	1,124	54.01
56.00	05600	RADIOISOTOPE	0	19,417	705,991	725,408	2,621	56.00
57.00	05700	CT SCAN	0	0	14,836	14,836	1,575	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	298,273	298,273	1,154	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	3,883	18,167	22,050	39	59.00
60.00	06000	LABORATORY	0	76,697	3,503	80,200	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	12,009	44,677	56,686	3,483	65.00
66.00	06600	PHYSICAL THERAPY	0	70,047	24,050	94,097	9,127	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	30,057	9,340	39,397	3,157	67.00
68.00	06800	SPEECH PATHOLOGY	0	10,097	1,868	11,965	631	68.00
69.00	06900	ELECTROCARDIOLOGY	0	38,863	171,081	209,944	2,230	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	26,485	28,904	55,389	1,605	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	41,834	119,431	161,265	851	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
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	44,572	0	44,572	2,710	76.00
76.01	03190	CHEMOTHERAPY	0	29,125	0	29,125	1,952	76.01
76.02	03330	ENDOSCOPY	0	0	54,615	54,615	117	76.02
76.03	03950	WOUND CARE CENTER	0	0	7,894	7,894	778	76.03
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0	187,762	78,907	266,669	7,274	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				0		92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	38,523	164,544	203,067	3,830	95.00
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0	0	0	0	0	98.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	2,156,473	3,007,609	3,734,986	8,899,068	119,859	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	198,354	0	198,354	4,125	192.00
192.01	19201	ASC MOB	0	0	0	0	0	192.01
192.02	19202	EDUCATION CENTER	0	0	0	0	0	192.02
192.03	19203	MARKETING	0	0	0	0	0	192.03
194.00	07950	CLINIC OF HOPE	0	0	0	0	525	194.00
194.01	07951	GIFT SHOP	0	9,990	0	9,990	0	194.01
194.02	07952	FOUNDATION	0	1,748	0	1,748	0	194.02
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)	2,156,473	3,217,701	3,734,986	9,109,160	124,509	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-0010 | Period: From 07/01/2019 To 06/30/2020 | Worksheet B Part II Date/Time Prepared: 11/20/2020 9:38 am

		Cost Center Description	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
			5.00	7.00	8.00	9.00	10.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	2,677,418					5.00
7.00	00700	OPERATION OF PLANT	119,676	728,652				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	12,602	1,696	20,579			8.00
9.00	00900	HOUSEKEEPING	43,400	6,599	6,319	75,881		9.00
10.00	01000	DIETARY	19,278	17,045	0	0	94,314	10.00
11.00	01100	CAFETERIA	32,954	20,663	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	69,549	17,883	0	58	0	13.00
15.00	01500	PHARMACY	546,568	10,476	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	677	8,013	0	19	0	16.00
23.00	02300	ALLIED HEALTH RAD. TECH PROGRAM	6,172	2,934	0	0	0	23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	212,414	96,421	6,571	23,746	60,145	30.00
31.00	03100	INTENSIVE CARE UNIT	56,000	18,456	1,752	5,810	8,400	31.00
41.00	04100	SUBPROVIDER - IRF	46,297	44,431	172	5,810	18,693	41.00
43.00	04300	NURSERY	14,756	5,269	269	3,015	7,076	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	178,737	106,916	206	11,620	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	50,516	10,689	729	6,358	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	109,913	78,007	482	1,181	0	54.00
54.01	03630	ULTRA SOUND	12,452	0	127	252	0	54.01
56.00	05600	RADIOISOTOPE	52,785	6,549	0	872	0	56.00
57.00	05700	CT SCAN	15,659	0	231	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	20,846	0	61	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	1,172	1,310	0	387	0	59.00
60.00	06000	LABORATORY	167,895	25,870	15	2,402	0	60.00
65.00	06500	RESPIRATORY THERAPY	34,982	4,051	14	116	0	65.00
66.00	06600	PHYSICAL THERAPY	91,975	23,627	0	264	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	32,847	10,138	0	141	0	67.00
68.00	06800	SPEECH PATHOLOGY	6,684	3,406	13	272	0	68.00
69.00	06900	ELECTROCARDIOLOGY	30,580	13,109	0	155	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	18,397	8,933	0	988	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	106,464	14,111	325	2,169	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	66,734	0	1	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	2	872	0	73.00
74.00	07400	RENAL DIALYSIS	5,713	0	0	387	0	74.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	27,304	15,034	116	775	0	76.00
76.01	03190	CHEMOTHERAPY	164,684	9,824	0	0	0	76.01
76.02	03330	ENDOSCOPY	3,121	0	0	0	0	76.02
76.03	03950	WOUND CARE CENTER	29,983	0	0	1,240	0	76.03
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	83,706	63,333	3,147	6,972	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	43,946	12,994	27	0	0	95.00
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0	0	0	0	0	98.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	2,537,438	657,787	20,579	75,881	94,314	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	133,499	66,906	0	0	0	192.00
192.01	19201	ASC MOB	501	0	0	0	0	192.01
192.02	19202	EDUCATION CENTER	302	0	0	0	0	192.02
192.03	19203	MARKETING	3	0	0	0	0	192.03
194.00	07950	CLINIC OF HOPE	5,337	0	0	0	0	194.00
194.01	07951	GIFT SHOP	288	3,370	0	0	0	194.01
194.02	07952	FOUNDATION	50	589	0	0	0	194.02
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	2,677,418	728,652	20,579	75,881	94,314	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-0010 | Period: From 07/01/2019 To 06/30/2020 | Worksheet B Part II Date/Time Prepared: 11/20/2020 9:38 am

		Cost Center Description	CAFETERIA	NURSING ADMINISTRATION	PHARMACY	MEDICAL RECORDS & LIBRARY	ALLIED HEALTH RAD. TECH PROGRAM	
			11.00	13.00	15.00	16.00	23.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
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	131,339					11.00
13.00	01300	NURSING ADMINISTRATION	6,159	344,594				13.00
15.00	01500	PHARMACY	5,358	1,762	601,455			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	35,395		16.00
23.00	02300	ALLIED HEALTH RAD. TECH PROGRAM	925	0	0	0	19,359	23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	26,325	118,491	0	2,022		30.00
31.00	03100	INTENSIVE CARE UNIT	5,803	30,745	0	565		31.00
41.00	04100	SUBPROVIDER - IRF	5,640	28,090	0	536		41.00
43.00	04300	NURSERY	1,579	0	0	242		43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	13,047	50,595	0	5,611		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	5,418	47,615	0	807		52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	7,394	4,756	0	1,594		54.00
54.01	03630	ULTRA SOUND	930	0	0	419		54.01
56.00	05600	RADIOISOTOPE	2,864	1,563	0	1,472		56.00
57.00	05700	CT SCAN	1,519	45	0	763		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	1,098	16	0	200		58.00
59.00	05900	CARDIAC CATHETERIZATION	41	90	0	45		59.00
60.00	06000	LABORATORY	0	0	0	4,838		60.00
65.00	06500	RESPIRATORY THERAPY	4,171	437	0	757		65.00
66.00	06600	PHYSICAL THERAPY	9,092	6	0	855		66.00
67.00	06700	OCCUPATIONAL THERAPY	3,531	0	0	332		67.00
68.00	06800	SPEECH PATHOLOGY	706	0	0	66		68.00
69.00	06900	ELECTROCARDIOLOGY	2,600	3,554	0	884		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	1,925	0	0	397		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,664	32	0	975		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	662		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	598,431	3,969		73.00
74.00	07400	RENAL DIALYSIS	0	0	0	68		74.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	3,810	1,034	0	268		76.00
76.01	03190	CHEMOTHERAPY	2,151	3,888	0	886		76.01
76.02	03330	ENDOSCOPY	63	696	0	40		76.02
76.03	03950	WOUND CARE CENTER	1,155	3,491	0	1,196		76.03
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	8,717	47,163	0	4,277		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	7,147	83	0	649		95.00
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0	0	0	0		98.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	130,832	344,152	598,431	35,395	0	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	7	2,790	0		192.00
192.01	19201	ASC MOB	0	0	0	0		192.01
192.02	19202	EDUCATION CENTER	0	0	0	0		192.02
192.03	19203	MARKETING	0	0	0	0		192.03
194.00	07950	CLINIC OF HOPE	494	435	234	0		194.00
194.01	07951	GIFT SHOP	0	0	0	0		194.01
194.02	07952	FOUNDATION	13	0	0	0		194.02
200.00		Cross Foot Adjustments					19,359	200.00
201.00		Negative Cost Centers	0	0	0	1,881	0	201.00
202.00		TOTAL (sum lines 118 through 201)	131,339	344,594	601,455	37,276	19,359	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-0010 | Period: From 07/01/2019 To 06/30/2020 | Worksheet B Part II | Date/Time Prepared: 11/20/2020 9:38 am

		Cost Center Description	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			24.00	25.00	26.00		
		GENERAL SERVICE COST CENTERS					
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
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
15.00	01500	PHARMACY					15.00
16.00	01600	MEDICAL RECORDS & LIBRARY					16.00
23.00	02300	ALLIED HEALTH RAD. TECH PROGRAM					23.00
		INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	928,938	0	928,938		30.00
31.00	03100	INTENSIVE CARE UNIT	245,346	0	245,346		31.00
41.00	04100	SUBPROVIDER - IRF	286,420	0	286,420		41.00
43.00	04300	NURSERY	63,725	0	63,725		43.00
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	1,119,558	0	1,119,558		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	208,676	0	208,676		52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,336,084	0	1,336,084		54.00
54.01	03630	ULTRA SOUND	74,915	0	74,915		54.01
56.00	05600	RADIOISOTOPE	794,134	0	794,134		56.00
57.00	05700	CT SCAN	34,628	0	34,628		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	321,648	0	321,648		58.00
59.00	05900	CARDIAC CATHETERIZATION	25,134	0	25,134		59.00
60.00	06000	LABORATORY	281,220	0	281,220		60.00
65.00	06500	RESPIRATORY THERAPY	104,697	0	104,697		65.00
66.00	06600	PHYSICAL THERAPY	229,043	0	229,043		66.00
67.00	06700	OCCUPATIONAL THERAPY	89,543	0	89,543		67.00
68.00	06800	SPEECH PATHOLOGY	23,743	0	23,743		68.00
69.00	06900	ELECTROCARDIOLOGY	263,056	0	263,056		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	87,634	0	87,634		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	287,856	0	287,856		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	67,397	0	67,397		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	603,274	0	603,274		73.00
74.00	07400	RENAL DIALYSIS	6,168	0	6,168		74.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	95,623	0	95,623		76.00
76.01	03190	CHEMOTHERAPY	212,510	0	212,510		76.01
76.02	03330	ENDOSCOPY	58,652	0	58,652		76.02
76.03	03950	WOUND CARE CENTER	45,737	0	45,737		76.03
		OUTPATIENT SERVICE COST CENTERS					
91.00	09100	EMERGENCY	491,258	0	491,258		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)		0			92.00
		OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES	271,743	0	271,743		95.00
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0	0	0		98.00
		SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	8,658,360	0	8,658,360		118.00
		NONREIMBURSABLE COST CENTERS					
192.00	19200	PHYSICIANS' PRIVATE OFFICES	405,681	0	405,681		192.00
192.01	19201	ASC MOB	501	0	501		192.01
192.02	19202	EDUCATION CENTER	302	0	302		192.02
192.03	19203	MARKETING	3	0	3		192.03
194.00	07950	CLINIC OF HOPE	7,025	0	7,025		194.00
194.01	07951	GIFT SHOP	13,648	0	13,648		194.01
194.02	07952	FOUNDATION	2,400	0	2,400		194.02
200.00		Cross Foot Adjustments	19,359	0	19,359		200.00
201.00		Negative Cost Centers	1,881	0	1,881		201.00
202.00		TOTAL (sum lines 118 through 201)	9,109,160	0	9,109,160		202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-0010 | Period: From 07/01/2019 To 06/30/2020 | Worksheet B-1 | Date/Time Prepared: 11/20/2020 9:38 am

		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	331,432					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		2,701,720				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	12,820	33	30,866,012			4.00
5.00	00500	ADMINISTRATIVE & GENERAL	50,113	19,407	1,882,909	-35,635,118	92,731,406	5.00
7.00	00700	OPERATION OF PLANT	45,990	117,533	0	0	4,144,899	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	518	906	0	0	436,478	8.00
9.00	00900	HOUSEKEEPING	2,015	0	119	0	1,503,144	9.00
10.00	01000	DIETARY	5,205	5,395	0	0	667,672	10.00
11.00	01100	CAFETERIA	6,310	11,907	0	0	1,141,335	11.00
13.00	01300	NURSING ADMINISTRATION	5,461	138,831	1,487,489	0	2,408,788	13.00
15.00	01500	PHARMACY	3,199	0	1,545,276	0	18,930,589	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	2,447	3,479	0	0	23,457	16.00
23.00	02300	ALLIED HEALTH RAD. TECH PROGRAM	896	0	155,888	0	213,766	23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	29,444	55,274	5,091,412	0	7,356,853	30.00
31.00	03100	INTENSIVE CARE UNIT	5,636	41,689	1,354,784	0	1,939,524	31.00
41.00	04100	SUBPROVIDER - IRF	13,568	462	1,087,573	0	1,603,486	41.00
43.00	04300	NURSERY	1,609	10,509	339,706	0	511,073	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	32,649	306,595	2,975,474	0	6,190,448	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	3,264	36,068	1,238,025	0	1,749,586	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	23,821	647,476	1,583,431	0	3,806,779	54.00
54.01	03630	ULTRA SOUND	0	43,120	278,603	0	431,263	54.01
56.00	05600	RADIOISOTOPE	2,000	510,682	649,702	0	1,828,163	56.00
57.00	05700	CT SCAN	0	10,732	390,390	0	542,328	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	215,757	286,136	0	722,000	58.00
59.00	05900	CARDIAC CATHETERIZATION	400	13,141	9,692	0	40,603	59.00
60.00	06000	LABORATORY	7,900	2,534	0	0	5,814,950	60.00
65.00	06500	RESPIRATORY THERAPY	1,237	32,317	863,518	0	1,211,591	65.00
66.00	06600	PHYSICAL THERAPY	7,215	17,397	2,262,406	0	3,185,516	66.00
67.00	06700	OCCUPATIONAL THERAPY	3,096	6,756	782,716	0	1,137,632	67.00
68.00	06800	SPEECH PATHOLOGY	1,040	1,351	156,465	0	231,502	68.00
69.00	06900	ELECTROCARDIOLOGY	4,003	123,752	552,850	0	1,059,135	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	2,728	20,908	397,749	0	637,157	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	4,309	86,391	210,926	0	3,687,334	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	2,311,289	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	197,863	74.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	4,591	0	671,737	0	945,658	76.00
76.01	03190	CHEMOTHERAPY	3,000	0	483,835	0	5,703,738	76.01
76.02	03330	ENDOSCOPY	0	39,506	28,943	0	108,079	76.02
76.03	03950	WOUND CARE CENTER	0	5,710	192,984	0	1,038,456	76.03
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	19,340	57,078	1,803,178	0	2,899,102	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	3,968	119,024	949,456	0	1,522,042	95.00
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0	0	0	0	0	98.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	309,792	2,701,720	29,713,372	-35,635,118	87,883,278	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	20,431	0	1,022,535	0	4,623,663	192.00
192.01	19201	ASC MOB	0	0	32	0	17,342	192.01
192.02	19202	EDUCATION CENTER	0	0	0	0	10,446	192.02
192.03	19203	MARKETING	0	0	0	0	101	192.03
194.00	07950	CLINIC OF HOPE	0	0	130,073	0	184,838	194.00
194.01	07951	GIFT SHOP	1,029	0	0	0	9,990	194.01
194.02	07952	FOUNDATION	180	0	0	0	1,748	194.02
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)	3,217,701	3,734,986	7,966,665		35,635,118	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	9.708480	1.382447	0.258105		0.384283	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)			124,509		2,677,418	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)			0.004034		0.028873	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-0010 | Period: From 07/01/2019 To 06/30/2020 | Worksheet B-1 | Date/Time Prepared: 11/20/2020 9:38 am

		Cost Center Description	CAPITAL RELATED COSTS					
			BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (DOLLAR VALUE)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
			1.00	2.00	4.00	5A	5.00	
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: 15-0010 | Period: From 07/01/2019 To 06/30/2020 | Worksheet B-1 | Date/Time Prepared: 11/20/2020 9:38 am

		Cost Center Description	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (HOURS OF SERVICE)	DIETARY (TOTAL PATIENT DAYS)	CAFETERIA (MANHOURS)	
			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	222,509					7.00
8.00	00800	LAUNDRY & LINEN SERVICE	518	317,519				8.00
9.00	00900	HOUSEKEEPING	2,015	97,496	195,900			9.00
10.00	01000	DIETARY	5,205	0	0	21,725		10.00
11.00	01100	CAFETERIA	6,310	0	0	0	832,450	11.00
13.00	01300	NURSING ADMINISTRATION	5,461	0	150	0	39,036	13.00
15.00	01500	PHARMACY	3,199	0	0	0	33,962	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	2,447	0	50	0	0	16.00
23.00	02300	ALLIED HEALTH RAD. TECH PROGRAM	896	0	0	0	5,861	23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	29,444	101,403	61,302	13,854	166,853	30.00
31.00	03100	INTENSIVE CARE UNIT	5,636	27,035	15,000	1,935	36,783	31.00
41.00	04100	SUBPROVIDER - IRF	13,568	2,656	15,000	4,306	35,748	41.00
43.00	04300	NURSERY	1,609	4,147	7,784	1,630	10,006	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	32,649	3,177	30,000	0	82,695	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	3,264	11,242	16,414	0	34,339	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	23,821	7,442	3,050	0	46,864	54.00
54.01	03630	ULTRA SOUND	0	1,957	650	0	5,895	54.01
56.00	05600	RADIOISOTOPE	2,000	0	2,250	0	18,151	56.00
57.00	05700	CT SCAN	0	3,562	0	0	9,626	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	934	0	0	6,962	58.00
59.00	05900	CARDIAC CATHETERIZATION	400	0	1,000	0	259	59.00
60.00	06000	LABORATORY	7,900	234	6,200	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	1,237	215	300	0	26,438	65.00
66.00	06600	PHYSICAL THERAPY	7,215	0	682	0	57,624	66.00
67.00	06700	OCCUPATIONAL THERAPY	3,096	0	365	0	22,380	67.00
68.00	06800	SPEECH PATHOLOGY	1,040	199	703	0	4,474	68.00
69.00	06900	ELECTROCARDIOLOGY	4,003	0	400	0	16,480	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	2,728	0	2,550	0	12,200	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	4,309	5,008	5,600	0	10,545	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	22	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	35	2,250	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	1,000	0	0	74.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	4,591	1,789	2,000	0	24,150	76.00
76.01	03190	CHEMOTHERAPY	3,000	0	0	0	13,635	76.01
76.02	03330	ENDOSCOPY	0	0	0	0	398	76.02
76.03	03950	WOUND CARE CENTER	0	0	3,200	0	7,323	76.03
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	19,340	48,557	18,000	0	55,251	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	3,968	409	0	0	45,298	95.00
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0	0	0	0	0	98.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	200,869	317,519	195,900	21,725	829,236	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	20,431	0	0	0	0	192.00
192.01	19201	ASC MOB	0	0	0	0	0	192.01
192.02	19202	EDUCATION CENTER	0	0	0	0	0	192.02
192.03	19203	MARKETING	0	0	0	0	0	192.03
194.00	07950	CLINIC OF HOPE	0	0	0	0	3,134	194.00
194.01	07951	GIFT SHOP	1,029	0	0	0	0	194.01
194.02	07952	FOUNDATION	180	0	0	0	80	194.02
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	5,737,713	617,566	2,322,364	1,058,465	1,742,643	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	25.786431	1.944973	11.854844	48.721059	2.093391	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	728,652	20,579	75,881	94,314	131,339	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	3.274708	0.064812	0.387346	4.341266	0.157774	205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)						206.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-0010 | Period: From 07/01/2019 To 06/30/2020 | Worksheet B-1 | Date/Time Prepared: 11/20/2020 9:38 am

		Cost Center Description	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (HOURS OF SERVICE)	DIETARY (TOTAL PATIENT DAYS)	CAFETERIA (MANHOURS)	
			7.00	8.00	9.00	10.00	11.00	
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-0010 | Period: From 07/01/2019 To 06/30/2020 | Worksheet B-1 | Date/Time Prepared: 11/20/2020 9:38 am

		Cost Center Description	NURSING ADMINISTRATION (DIRECT NURS. HRS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)	ALLIED HEALTH RAD. TECH PROGRAM (ASSIGNED TIME)		
			13.00	15.00	16.00	23.00		
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
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	694,124					13.00
15.00	01500	PHARMACY	3,549	4,323,757				15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	538,983,902			16.00
23.00	02300	ALLIED HEALTH RAD. TECH PROGRAM	0	0	0	67,409,212		23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	238,675	0	30,637,517	0		30.00
31.00	03100	INTENSIVE CARE UNIT	61,931	0	8,557,536	0		31.00
41.00	04100	SUBPROVIDER - IRF	56,582	0	8,114,502	0		41.00
43.00	04300	NURSERY	0	0	3,664,241	0		43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	101,915	0	87,667,723	0		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	95,912	0	12,233,480	0		52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	9,580	0	24,158,867	24,158,866		54.00
54.01	03630	ULTRA SOUND	0	0	6,353,608	6,353,608		54.01
56.00	05600	RADIOISOTOPE	3,148	0	22,301,683	22,301,683		56.00
57.00	05700	CT SCAN	90	0	11,563,267	11,563,267		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	33	0	3,031,789	3,031,788		58.00
59.00	05900	CARDIAC CATHETERIZATION	182	0	687,206	0		59.00
60.00	06000	LABORATORY	0	0	73,310,410	0		60.00
65.00	06500	RESPIRATORY THERAPY	880	0	11,472,701	0		65.00
66.00	06600	PHYSICAL THERAPY	13	0	12,955,671	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	5,023,974	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0	1,004,291	0		68.00
69.00	06900	ELECTROCARDIOLOGY	7,159	0	13,396,902	0		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	6,010,122	0		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	65	0	14,772,904	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	10,030,644	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	4,302,016	60,136,091	0		73.00
74.00	07400	RENAL DIALYSIS	0	0	1,036,423	0		74.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	2,083	0	4,061,759	0		76.00
76.01	03190	CHEMOTHERAPY	7,832	0	13,429,160	0		76.01
76.02	03330	ENDOSCOPY	1,402	0	609,949	0		76.02
76.03	03950	WOUND CARE CENTER	7,033	0	18,119,370	0		76.03
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	95,002	0	64,809,444	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	167	0	9,832,668	0		95.00
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0	0	0	0		98.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	693,233	4,302,016	538,983,902	67,409,212		118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	14	20,059	0	0		192.00
192.01	19201	ASC MOB	0	0	0	0		192.01
192.02	19202	EDUCATION CENTER	0	0	0	0		192.02
192.03	19203	MARKETING	0	0	0	0		192.03
194.00	07950	CLINIC OF HOPE	877	1,682	0	0		194.00
194.01	07951	GIFT SHOP	0	0	0	0		194.01
194.02	07952	FOUNDATION	0	0	0	0		194.02
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)	3,558,760	26,377,090	96,163	331,287		202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	5.126980	6.100502	0.000178	0.004915		203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	344,594	601,455	37,276	19,359		204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.496444	0.139105	0.000066	0.000287		205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)				0		206.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-0010 | Period: From 07/01/2019 To 06/30/2020 | Worksheet B-1 | Date/Time Prepared: 11/20/2020 9:38 am

		Cost Center Description	NURSING ADMINISTRATION (DIRECT NURS. HRS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)	ALLIED HEALTH RAD. TECH PROGRAM (ASSIGNED TIME)		
			13.00	15.00	16.00	23.00		
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)				0.000000		207.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-0010 | Period: From 07/01/2019 To 06/30/2020 | Worksheet C Part I Date/Time Prepared: 11/20/2020 9:38 am

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		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	RCE Disallowance	Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	14,120,584		14,120,584	502	14,121,086	30.00
31.00	03100	INTENSIVE CARE UNIT	3,550,905		3,550,905	0	3,550,905	31.00
41.00	04100	SUBPROVIDER - IRF	3,328,704		3,328,704	0	3,328,704	41.00
43.00	04300	NURSERY	950,317		950,317	0	950,317	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	10,484,515		10,484,515	19,897	10,504,412	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	3,288,341		3,288,341	0	3,288,341	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	6,204,782		6,204,782	0	6,204,782	54.00
54.01	03630	ULTRA SOUND	653,202		653,202	0	653,202	54.01
56.00	05600	RADIOISOTOPE	2,776,661		2,776,661	0	2,776,661	56.00
57.00	05700	CT SCAN	837,166		837,166	0	837,166	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	1,031,453		1,031,453	0	1,031,453	58.00
59.00	05900	CARDIAC CATHETERIZATION	79,973		79,973	0	79,973	59.00
60.00	06000	LABORATORY	8,340,253		8,340,253	44,860	8,385,113	60.00
65.00	06500	RESPIRATORY THERAPY	1,774,956	0	1,774,956	0	1,774,956	65.00
66.00	06600	PHYSICAL THERAPY	4,726,793	0	4,726,793	0	4,726,793	66.00
67.00	06700	OCCUPATIONAL THERAPY	1,706,711	0	1,706,711	0	1,706,711	67.00
68.00	06800	SPEECH PATHOLOGY	365,548	0	365,548	0	365,548	68.00
69.00	06900	ELECTROCARDIOLOGY	1,647,696		1,647,696	0	1,647,696	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	1,009,190		1,009,190	0	1,009,190	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	5,316,593		5,316,593	0	5,316,593	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	3,201,306		3,201,306	0	3,201,306	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	26,281,904		26,281,904	0	26,281,904	73.00
74.00	07400	RENAL DIALYSIS	285,937		285,937	0	285,937	74.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	1,516,591		1,516,591	0	1,516,591	76.00
76.01	03190	CHEMOTHERAPY	8,044,035		8,044,035	0	8,044,035	76.01
76.02	03330	ENDOSCOPY	157,742		157,742	0	157,742	76.02
76.03	03950	WOUND CARE CENTER	1,530,066		1,530,066	0	1,530,066	76.03
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	5,433,988		5,433,988	0	5,433,988	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	924,897		924,897		924,897	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	2,307,485		2,307,485	0	2,307,485	95.00
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0		0	0	0	98.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	121,878,294	0	121,878,294	65,259	121,943,553	200.00
201.00		Less Observation Beds	924,897		924,897		924,897	201.00
202.00		Total (see instructions)	120,953,397	0	120,953,397	65,259	121,018,656	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-0010 | Period: From 07/01/2019 To 06/30/2020 | Worksheet C Part I Date/Time Prepared: 11/20/2020 9:38 am

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		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	28,482,086		28,482,086			30.00
31.00	03100	INTENSIVE CARE UNIT	8,557,536		8,557,536			31.00
41.00	04100	SUBPROVIDER - IRF	8,114,502		8,114,502			41.00
43.00	04300	NURSERY	3,664,241		3,664,241			43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	26,931,419	60,736,304	87,667,723	0.119594	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	10,850,320	1,383,160	12,233,480	0.268798	0.000000	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,714,198	21,444,669	24,158,867	0.256832	0.000000	54.00
54.01	03630	ULTRA SOUND	1,252,092	5,101,516	6,353,608	0.102808	0.000000	54.01
56.00	05600	RADIOISOTOPE	267,160	22,034,523	22,301,683	0.124505	0.000000	56.00
57.00	05700	CT SCAN	2,791,490	8,771,777	11,563,267	0.072399	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	601,236	2,430,553	3,031,789	0.340213	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	191,667	495,539	687,206	0.116374	0.000000	59.00
60.00	06000	LABORATORY	28,321,320	44,989,090	73,310,410	0.113766	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	7,929,207	3,543,494	11,472,701	0.154711	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	4,211,480	8,744,191	12,955,671	0.364844	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	3,439,942	1,584,032	5,023,974	0.339713	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	655,326	348,965	1,004,291	0.363986	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	2,576,193	10,820,709	13,396,902	0.122991	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	234,940	5,775,182	6,010,122	0.167915	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	7,446,407	7,326,497	14,772,904	0.359888	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	6,741,056	3,289,588	10,030,644	0.319153	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	14,764,986	45,371,105	60,136,091	0.437040	0.000000	73.00
74.00	07400	RENAL DIALYSIS	1,017,699	18,724	1,036,423	0.275888	0.000000	74.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	3,561	4,058,198	4,061,759	0.373383	0.000000	76.00
76.01	03190	CHEMOTHERAPY	224,882	13,204,278	13,429,160	0.598998	0.000000	76.01
76.02	03330	ENDOSCOPY	62,022	547,927	609,949	0.258615	0.000000	76.02
76.03	03950	WOUND CARE CENTER	130,707	17,988,663	18,119,370	0.084444	0.000000	76.03
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	13,325,945	51,483,499	64,809,444	0.083846	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	404,643	1,750,788	2,155,431	0.429101	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	2,274	9,830,394	9,832,668	0.234675	0.000000	95.00
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0	0	0	0.000000	0.000000	98.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	185,910,537	353,073,365	538,983,902			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	185,910,537	353,073,365	538,983,902			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-0010 | Period: From 07/01/2019 To 06/30/2020 | Worksheet C Part I Date/Time Prepared: 11/20/2020 9:38 am

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		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
41.00	04100	SUBPROVIDER - IRF		41.00
43.00	04300	NURSERY		43.00
		ANCILLARY SERVICE COST CENTERS		
50.00	05000	OPERATING ROOM	0.119821	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.268798	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.256832	54.00
54.01	03630	ULTRA SOUND	0.102808	54.01
56.00	05600	RADIOISOTOPE	0.124505	56.00
57.00	05700	CT SCAN	0.072399	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.340213	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.116374	59.00
60.00	06000	LABORATORY	0.114378	60.00
65.00	06500	RESPIRATORY THERAPY	0.154711	65.00
66.00	06600	PHYSICAL THERAPY	0.364844	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.339713	67.00
68.00	06800	SPEECH PATHOLOGY	0.363986	68.00
69.00	06900	ELECTROCARDIOLOGY	0.122991	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.167915	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.359888	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.319153	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.437040	73.00
74.00	07400	RENAL DIALYSIS	0.275888	74.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0.373383	76.00
76.01	03190	CHEMOTHERAPY	0.598998	76.01
76.02	03330	ENDOSCOPY	0.258615	76.02
76.03	03950	WOUND CARE CENTER	0.084444	76.03
		OUTPATIENT SERVICE COST CENTERS		
91.00	09100	EMERGENCY	0.083846	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.429101	92.00
		OTHER REIMBURSABLE COST CENTERS		
95.00	09500	AMBULANCE SERVICES	0.234675	95.00
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0.000000	98.00
		SPECIAL PURPOSE COST CENTERS		
113.00	11300	INTEREST EXPENSE		113.00
200.00		Subtotal (see instructions)		200.00
201.00		Less Observation Beds		201.00
202.00		Total (see instructions)		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-0010 | Period: From 07/01/2019 To 06/30/2020 | Worksheet C Part I Date/Time Prepared: 11/20/2020 9:38 am

Title XIX | Hospital | Cost

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	RCE Disallowance	Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	14,120,584		14,120,584	502	14,121,086	30.00
31.00	03100	INTENSIVE CARE UNIT	3,550,905		3,550,905	0	3,550,905	31.00
41.00	04100	SUBPROVIDER - IRF	3,328,704		3,328,704	0	3,328,704	41.00
43.00	04300	NURSERY	950,317		950,317	0	950,317	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	10,484,515		10,484,515	19,897	10,504,412	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	3,288,341		3,288,341	0	3,288,341	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	6,204,782		6,204,782	0	6,204,782	54.00
54.01	03630	ULTRA SOUND	653,202		653,202	0	653,202	54.01
56.00	05600	RADIOISOTOPE	2,776,661		2,776,661	0	2,776,661	56.00
57.00	05700	CT SCAN	837,166		837,166	0	837,166	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	1,031,453		1,031,453	0	1,031,453	58.00
59.00	05900	CARDIAC CATHETERIZATION	79,973		79,973	0	79,973	59.00
60.00	06000	LABORATORY	8,340,253		8,340,253	44,860	8,385,113	60.00
65.00	06500	RESPIRATORY THERAPY	1,774,956	0	1,774,956	0	1,774,956	65.00
66.00	06600	PHYSICAL THERAPY	4,726,793	0	4,726,793	0	4,726,793	66.00
67.00	06700	OCCUPATIONAL THERAPY	1,706,711	0	1,706,711	0	1,706,711	67.00
68.00	06800	SPEECH PATHOLOGY	365,548	0	365,548	0	365,548	68.00
69.00	06900	ELECTROCARDIOLOGY	1,647,696		1,647,696	0	1,647,696	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	1,009,190		1,009,190	0	1,009,190	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	5,316,593		5,316,593	0	5,316,593	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	3,201,306		3,201,306	0	3,201,306	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	26,281,904		26,281,904	0	26,281,904	73.00
74.00	07400	RENAL DIALYSIS	285,937		285,937	0	285,937	74.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	1,516,591		1,516,591	0	1,516,591	76.00
76.01	03190	CHEMOTHERAPY	8,044,035		8,044,035	0	8,044,035	76.01
76.02	03330	ENDOSCOPY	157,742		157,742	0	157,742	76.02
76.03	03950	WOUND CARE CENTER	1,530,066		1,530,066	0	1,530,066	76.03
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	5,433,988		5,433,988	0	5,433,988	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	924,897		924,897		924,897	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	2,307,485		2,307,485	0	2,307,485	95.00
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0		0	0	0	98.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	121,878,294	0	121,878,294	65,259	121,943,553	200.00
201.00		Less Observation Beds	924,897		924,897		924,897	201.00
202.00		Total (see instructions)	120,953,397	0	120,953,397	65,259	121,018,656	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-0010 | Period: From 07/01/2019 To 06/30/2020 | Worksheet C Part I Date/Time Prepared: 11/20/2020 9:38 am

Title XIX | Hospital | Cost

		Cost Center Description	Charges Inpatient	Charges Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	28,482,086		28,482,086			30.00
31.00	03100	INTENSIVE CARE UNIT	8,557,536		8,557,536			31.00
41.00	04100	SUBPROVIDER - IRF	8,114,502		8,114,502			41.00
43.00	04300	NURSERY	3,664,241		3,664,241			43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	26,931,419	60,736,304	87,667,723	0.119594	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	10,850,320	1,383,160	12,233,480	0.268798	0.000000	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,714,198	21,444,669	24,158,867	0.256832	0.000000	54.00
54.01	03630	ULTRA SOUND	1,252,092	5,101,516	6,353,608	0.102808	0.000000	54.01
56.00	05600	RADIOISOTOPE	267,160	22,034,523	22,301,683	0.124505	0.000000	56.00
57.00	05700	CT SCAN	2,791,490	8,771,777	11,563,267	0.072399	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	601,236	2,430,553	3,031,789	0.340213	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	191,667	495,539	687,206	0.116374	0.000000	59.00
60.00	06000	LABORATORY	28,321,320	44,989,090	73,310,410	0.113766	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	7,929,207	3,543,494	11,472,701	0.154711	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	4,211,480	8,744,191	12,955,671	0.364844	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	3,439,942	1,584,032	5,023,974	0.339713	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	655,326	348,965	1,004,291	0.363986	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	2,576,193	10,820,709	13,396,902	0.122991	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	234,940	5,775,182	6,010,122	0.167915	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	7,446,407	7,326,497	14,772,904	0.359888	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	6,741,056	3,289,588	10,030,644	0.319153	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	14,764,986	45,371,105	60,136,091	0.437040	0.000000	73.00
74.00	07400	RENAL DIALYSIS	1,017,699	18,724	1,036,423	0.275888	0.000000	74.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	3,561	4,058,198	4,061,759	0.373383	0.000000	76.00
76.01	03190	CHEMOTHERAPY	224,882	13,204,278	13,429,160	0.598998	0.000000	76.01
76.02	03330	ENDOSCOPY	62,022	547,927	609,949	0.258615	0.000000	76.02
76.03	03950	WOUND CARE CENTER	130,707	17,988,663	18,119,370	0.084444	0.000000	76.03
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	13,325,945	51,483,499	64,809,444	0.083846	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	404,643	1,750,788	2,155,431	0.429101	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	2,274	9,830,394	9,832,668	0.234675	0.000000	95.00
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0	0	0	0.000000	0.000000	98.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	185,910,537	353,073,365	538,983,902			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	185,910,537	353,073,365	538,983,902			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-0010 | Period: From 07/01/2019 To 06/30/2020 | Worksheet C Part I Date/Time Prepared: 11/20/2020 9:38 am

Title XIX | Hospital | Cost

		Cost Center Description	PPS Inpatient Ratio		
			11.00		
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS			30.00
31.00	03100	INTENSIVE CARE UNIT			31.00
41.00	04100	SUBPROVIDER - IRF			41.00
43.00	04300	NURSERY			43.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0.000000		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000		52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000		54.00
54.01	03630	ULTRA SOUND	0.000000		54.01
56.00	05600	RADIOISOTOPE	0.000000		56.00
57.00	05700	CT SCAN	0.000000		57.00
58.00	05800	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
74.00	07400	RENAL DIALYSIS	0.000000		74.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0.000000		76.00
76.01	03190	CHEMOTHERAPY	0.000000		76.01
76.02	03330	ENDOSCOPY	0.000000		76.02
76.03	03950	WOUND CARE CENTER	0.000000		76.03
		OUTPATIENT SERVICE COST CENTERS			
91.00	09100	EMERGENCY	0.000000		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000		92.00
		OTHER REIMBURSABLE COST CENTERS			
95.00	09500	AMBULANCE SERVICES	0.000000		95.00
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0.000000		98.00
		SPECIAL PURPOSE COST CENTERS			
113.00	11300	INTEREST EXPENSE			113.00
200.00		Subtotal (see instructions)			200.00
201.00		Less Observation Beds			201.00
202.00		Total (see instructions)			202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS | Provider CCN: 15-0010 | Period: From 07/01/2019 To 06/30/2020 | Worksheet D Part I Date/Time Prepared: 11/20/2020 9:38 am

Title XVIII | Hospital | PPS

	Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	928,938	0	928,938	14,825	62.66	30.00
31.00	INTENSIVE CARE UNIT	245,346		245,346	1,935	126.79	31.00
41.00	SUBPROVIDER - IRF	286,420	0	286,420	4,306	66.52	41.00
43.00	NURSERY	63,725		63,725	1,630	39.10	43.00
200.00	Total (lines 30 through 199)	1,524,429		1,524,429	22,696		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	5,442	340,996				30.00
31.00	INTENSIVE CARE UNIT	852	108,025				31.00
41.00	SUBPROVIDER - IRF	2,556	170,025				41.00
43.00	NURSERY	0	0				43.00
200.00	Total (lines 30 through 199)	8,850	619,046				200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS | Provider CCN: 15-0010 | Period: From 07/01/2019 To 06/30/2020 | Worksheet D Part II Date/Time Prepared: 11/20/2020 9:38 am

Title XVIII | Hospital | PPS

		Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,119,558	87,667,723	0.012770	11,336,854	144,772	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	208,676	12,233,480	0.017058	34,526	589	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,336,084	24,158,867	0.055304	1,226,921	67,854	54.00
54.01	03630	ULTRA SOUND	74,915	6,353,608	0.011791	498,652	5,880	54.01
56.00	05600	RADIOISOTOPE	794,134	22,301,683	0.035609	80,560	2,869	56.00
57.00	05700	CT SCAN	34,628	11,563,267	0.002995	1,217,200	3,646	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	321,648	3,031,789	0.106092	232,750	24,693	58.00
59.00	05900	CARDIAC CATHETERIZATION	25,134	687,206	0.036574	80,340	2,938	59.00
60.00	06000	LABORATORY	281,220	73,310,410	0.003836	11,340,355	43,502	60.00
65.00	06500	RESPIRATORY THERAPY	104,697	11,472,701	0.009126	3,231,624	29,492	65.00
66.00	06600	PHYSICAL THERAPY	229,043	12,955,671	0.017679	1,019,607	18,026	66.00
67.00	06700	OCCUPATIONAL THERAPY	89,543	5,023,974	0.017823	818,125	14,581	67.00
68.00	06800	SPEECH PATHOLOGY	23,743	1,004,291	0.023642	178,348	4,217	68.00
69.00	06900	ELECTROCARDIOLOGY	263,056	13,396,902	0.019636	1,703,011	33,440	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	87,634	6,010,122	0.014581	160,812	2,345	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	287,856	14,772,904	0.019485	3,036,712	59,170	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	67,397	10,030,644	0.006719	3,538,073	23,772	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	603,274	60,136,091	0.010032	5,614,278	56,322	73.00
74.00	07400	RENAL DIALYSIS	6,168	1,036,423	0.005951	437,530	2,604	74.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	95,623	4,061,759	0.023542	0	0	76.00
76.01	03190	CHEMOTHERAPY	212,510	13,429,160	0.015825	6,375	101	76.01
76.02	03330	ENDOSCOPY	58,652	609,949	0.096159	28,262	2,718	76.02
76.03	03950	WOUND CARE CENTER	45,737	18,119,370	0.002524	123,477	312	76.03
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	491,258	64,809,444	0.007580	5,607,168	42,502	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	60,843	2,155,431	0.028228	193,735	5,469	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0	0	0.000000	0	0	98.00
200.00		Total (lines 50 through 199)	6,923,031	480,332,869		51,745,295	591,814	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 15-0010 | Period: From 07/01/2019 To 06/30/2020 | Worksheet D Part III Date/Time Prepared: 11/20/2020 9:38 am

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		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
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
200.00		Total (lines 30 through 199)	0	0	0	0	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	14,825	0.00	5,442	30.00
31.00	03100	INTENSIVE CARE UNIT		0	1,935	0.00	852	31.00
41.00	04100	SUBPROVIDER - IRF	0	0	4,306	0.00	2,556	41.00
43.00	04300	NURSERY		0	1,630	0.00	0	43.00
200.00		Total (lines 30 through 199)		0	22,696		8,850	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
41.00	04100	SUBPROVIDER - IRF	0		41.00
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: 15-0010 | Period: From 07/01/2019 To 06/30/2020 | Worksheet D Part IV Date/Time Prepared: 11/20/2020 9:38 am

Title XVIII | Hospital | PPS

		Cost Center Description	Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health	
			1.00	2A	2.00	3A	3.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	118,712	54.00
54.01	03630	ULTRA SOUND	0	0	0	0	31,228	54.01
56.00	05600	RADIOISOTOPE	0	0	0	0	109,613	56.00
57.00	05700	CT SCAN	0	0	0	0	56,833	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	14,901	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
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0	0	0	0	76.00
76.01	03190	CHEMOTHERAPY	0	0	0	0	0	76.01
76.02	03330	ENDOSCOPY	0	0	0	0	0	76.02
76.03	03950	WOUND CARE CENTER	0	0	0	0	0	76.03
		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
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0	0	0	0	0	98.00
200.00		Total (lines 50 through 199)	0	0	0	0	331,287	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 15-0010 | Period: From 07/01/2019 To 06/30/2020 | Worksheet D Part IV Date/Time Prepared: 11/20/2020 9:38 am

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		Cost Center Description	All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7) (see instructions)	
			4.00	5.00	6.00	7.00	8.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	87,667,723	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	12,233,480	0.000000	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	118,712	118,712	24,158,867	0.004914	54.00
54.01	03630	ULTRA SOUND	0	31,228	31,228	6,353,608	0.004915	54.01
56.00	05600	RADIOISOTOPE	0	109,613	109,613	22,301,683	0.004915	56.00
57.00	05700	CT SCAN	0	56,833	56,833	11,563,267	0.004915	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	14,901	14,901	3,031,789	0.004915	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	687,206	0.000000	59.00
60.00	06000	LABORATORY	0	0	0	73,310,410	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	11,472,701	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	12,955,671	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	5,023,974	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	1,004,291	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	13,396,902	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	6,010,122	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	14,772,904	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	10,030,644	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	60,136,091	0.000000	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	1,036,423	0.000000	74.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0	0	4,061,759	0.000000	76.00
76.01	03190	CHEMOTHERAPY	0	0	0	13,429,160	0.000000	76.01
76.02	03330	ENDOSCOPY	0	0	0	609,949	0.000000	76.02
76.03	03950	WOUND CARE CENTER	0	0	0	18,119,370	0.000000	76.03
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0	0	0	64,809,444	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	2,155,431	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0	0	0	0	0.000000	98.00
200.00		Total (lines 50 through 199)	0	331,287	331,287	480,332,869		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 15-0010 | Period: From 07/01/2019 To 06/30/2020 | Worksheet D Part IV Date/Time Prepared: 11/20/2020 9:38 am

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		Cost Center Description	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
			9.00	10.00	11.00	12.00	13.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.000000	11,336,854	0	16,717,585	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	34,526	0	3,526	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.004914	1,226,921	6,029	5,051,123	24,821	54.00
54.01	03630	ULTRA SOUND	0.004915	498,652	2,451	1,405,405	6,908	54.01
56.00	05600	RADIOISOTOPE	0.004915	80,560	396	5,690,524	27,969	56.00
57.00	05700	CT SCAN	0.004915	1,217,200	5,983	2,762,444	13,577	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.004915	232,750	1,144	710,831	3,494	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	80,340	0	160,605	0	59.00
60.00	06000	LABORATORY	0.000000	11,340,355	0	6,761,762	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.000000	3,231,624	0	295,727	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	1,019,607	0	40,890	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	818,125	0	10,700	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	178,348	0	14,442	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	1,703,011	0	5,028,563	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	160,812	0	1,046,649	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	3,036,712	0	1,758,419	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	3,538,073	0	1,468,963	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	5,614,278	0	22,188,502	0	73.00
74.00	07400	RENAL DIALYSIS	0.000000	437,530	0	0	0	74.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0.000000	0	0	0	0	76.00
76.01	03190	CHEMOTHERAPY	0.000000	6,375	0	4,107,709	0	76.01
76.02	03330	ENDOSCOPY	0.000000	28,262	0	109,430	0	76.02
76.03	03950	WOUND CARE CENTER	0.000000	123,477	0	6,240,111	0	76.03
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0.000000	5,607,168	0	11,357,989	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	193,735	0	646,261	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0.000000	0	0	0	0	98.00
200.00		Total (lines 50 through 199)		51,745,295	16,003	93,578,160	76,769	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-0010 | Period: From 07/01/2019 To 06/30/2020 | Worksheet D Part V Date/Time Prepared: 11/20/2020 9:38 am

Title XVIII | Hospital | PPS

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.119594	16,717,585	0	0	1,999,323	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.268798	3,526	0	0	948	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.256832	5,051,123	0	0	1,297,290	54.00
54.01	03630	ULTRA SOUND	0.102808	1,405,405	0	0	144,487	54.01
56.00	05600	RADIOISOTOPE	0.124505	5,690,524	0	0	708,499	56.00
57.00	05700	CT SCAN	0.072399	2,762,444	0	0	199,998	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.340213	710,831	0	0	241,834	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.116374	160,605	0	0	18,690	59.00
60.00	06000	LABORATORY	0.113766	6,761,762	0	0	769,259	60.00
65.00	06500	RESPIRATORY THERAPY	0.154711	295,727	0	0	45,752	65.00
66.00	06600	PHYSICAL THERAPY	0.364844	40,890	0	0	14,918	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.339713	10,700	0	0	3,635	67.00
68.00	06800	SPEECH PATHOLOGY	0.363986	14,442	0	0	5,257	68.00
69.00	06900	ELECTROCARDIOLOGY	0.122991	5,028,563	0	0	618,468	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.167915	1,046,649	0	0	175,748	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.359888	1,758,419	0	0	632,834	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.319153	1,468,963	0	0	468,824	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.437040	22,188,502	0	11,552	9,697,263	73.00
74.00	07400	RENAL DIALYSIS	0.275888	0	0	0	0	74.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0.373383	0	0	0	0	76.00
76.01	03190	CHEMOTHERAPY	0.598998	4,107,709	0	0	2,460,509	76.01
76.02	03330	ENDOSCOPY	0.258615	109,430	0	0	28,300	76.02
76.03	03950	WOUND CARE CENTER	0.084444	6,240,111	0	0	526,940	76.03
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0.083846	11,357,989	0	0	952,322	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.429101	646,261	0	0	277,311	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0.234675		0			95.00
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0.000000	0	0	0	0	98.00
200.00		Subtotal (see instructions)		93,578,160	0	11,552	21,288,409	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 - line 201)		93,578,160	0	11,552	21,288,409	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-0010 | Period: From 07/01/2019 To 06/30/2020 | Worksheet D Part V Date/Time Prepared: 11/20/2020 9:38 am

Title XVIII | Hospital | PPS

		Cost Center Description	Costs: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	0		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0		52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0		54.00
54.01	03630	ULTRA SOUND	0	0		54.01
56.00	05600	RADIOISOTOPE	0	0		56.00
57.00	05700	CT SCAN	0	0		57.00
58.00	05800	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	5,049		73.00
74.00	07400	RENAL DIALYSIS	0	0		74.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0		76.00
76.01	03190	CHEMOTHERAPY	0	0		76.01
76.02	03330	ENDOSCOPY	0	0		76.02
76.03	03950	WOUND CARE CENTER	0	0		76.03
		OUTPATIENT SERVICE COST CENTERS				
91.00	09100	EMERGENCY	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0		92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES	0			95.00
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0	0		98.00
200.00		Subtotal (see instructions)	0	5,049		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	0	5,049		202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 15-0010 | Component CCN: 15-T010 | Period: From 07/01/2019 To 06/30/2020 | Worksheet D Part II Date/Time Prepared: 11/20/2020 9:38 am

Title XVIII | Subprovider - IRF | PPS

		Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,119,558	87,667,723	0.012770	108,397	1,384	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	208,676	12,233,480	0.017058	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,336,084	24,158,867	0.055304	46,139	2,552	54.00
54.01	03630	ULTRA SOUND	74,915	6,353,608	0.011791	19,385	229	54.01
56.00	05600	RADIOISOTOPE	794,134	22,301,683	0.035609	0	0	56.00
57.00	05700	CT SCAN	34,628	11,563,267	0.002995	32,300	97	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	321,648	3,031,789	0.106092	2,850	302	58.00
59.00	05900	CARDIAC CATHETERIZATION	25,134	687,206	0.036574	0	0	59.00
60.00	06000	LABORATORY	281,220	73,310,410	0.003836	1,171,647	4,494	60.00
65.00	06500	RESPIRATORY THERAPY	104,697	11,472,701	0.009126	208,410	1,902	65.00
66.00	06600	PHYSICAL THERAPY	229,043	12,955,671	0.017679	1,285,994	22,735	66.00
67.00	06700	OCCUPATIONAL THERAPY	89,543	5,023,974	0.017823	1,104,700	19,689	67.00
68.00	06800	SPEECH PATHOLOGY	23,743	1,004,291	0.023642	174,028	4,114	68.00
69.00	06900	ELECTROCARDIOLOGY	263,056	13,396,902	0.019636	96,663	1,898	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	87,634	6,010,122	0.014581	2,308	34	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	287,856	14,772,904	0.019485	238,269	4,643	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	67,397	10,030,644	0.006719	17,513	118	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	603,274	60,136,091	0.010032	546,886	5,486	73.00
74.00	07400	RENAL DIALYSIS	6,168	1,036,423	0.005951	110,459	657	74.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	95,623	4,061,759	0.023542	0	0	76.00
76.01	03190	CHEMOTHERAPY	212,510	13,429,160	0.015825	0	0	76.01
76.02	03330	ENDOSCOPY	58,652	609,949	0.096159	0	0	76.02
76.03	03950	WOUND CARE CENTER	45,737	18,119,370	0.002524	4,245	11	76.03
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	491,258	64,809,444	0.007580	45,916	348	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	2,155,431	0.000000	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0	0	0.000000	0	0	98.00
200.00		Total (lines 50 through 199)	6,862,188	480,332,869		5,216,109	70,693	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-0010
Component CCN: 15-T010

Period: From 07/01/2019 To 06/30/2020

Worksheet D Part IV Date/Time Prepared: 11/20/2020 9:38 am

Title XVIII | Subprovider - IRF | PPS

		Cost Center Description	Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health	
			1.00	2A	2.00	3A	3.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	118,712	54.00
54.01	03630	ULTRA SOUND	0	0	0	0	31,228	54.01
56.00	05600	RADIOISOTOPE	0	0	0	0	109,613	56.00
57.00	05700	CT SCAN	0	0	0	0	56,833	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	14,901	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
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0	0	0	0	76.00
76.01	03190	CHEMOTHERAPY	0	0	0	0	0	76.01
76.02	03330	ENDOSCOPY	0	0	0	0	0	76.02
76.03	03950	WOUND CARE CENTER	0	0	0	0	0	76.03
		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
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0	0	0	0	0	98.00
200.00		Total (lines 50 through 199)	0	0	0	0	331,287	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-0010 | Component CCN: 15-T010 | Period: From 07/01/2019 To 06/30/2020 | Worksheet D Part IV Date/Time Prepared: 11/20/2020 9:38 am

Title XVIII | Subprovider - IRF | PPS

		Cost Center Description	All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7) (see instructions)	
			4.00	5.00	6.00	7.00	8.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	87,667,723	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	12,233,480	0.000000	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	118,712	118,712	24,158,867	0.004914	54.00
54.01	03630	ULTRA SOUND	0	31,228	31,228	6,353,608	0.004915	54.01
56.00	05600	RADIOISOTOPE	0	109,613	109,613	22,301,683	0.004915	56.00
57.00	05700	CT SCAN	0	56,833	56,833	11,563,267	0.004915	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	14,901	14,901	3,031,789	0.004915	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	687,206	0.000000	59.00
60.00	06000	LABORATORY	0	0	0	73,310,410	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	11,472,701	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	12,955,671	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	5,023,974	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	1,004,291	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	13,396,902	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	6,010,122	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	14,772,904	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	10,030,644	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	60,136,091	0.000000	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	1,036,423	0.000000	74.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0	0	4,061,759	0.000000	76.00
76.01	03190	CHEMOTHERAPY	0	0	0	13,429,160	0.000000	76.01
76.02	03330	ENDOSCOPY	0	0	0	609,949	0.000000	76.02
76.03	03950	WOUND CARE CENTER	0	0	0	18,119,370	0.000000	76.03
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0	0	0	64,809,444	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	2,155,431	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0	0	0	0	0.000000	98.00
200.00		Total (lines 50 through 199)	0	331,287	331,287	480,332,869		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-0010 | Component CCN: 15-T010 | Period: From 07/01/2019 To 06/30/2020 | Worksheet D Part IV Date/Time Prepared: 11/20/2020 9:38 am

Title XVIII | Subprovider - IRF | PPS

		Cost Center Description	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
			9.00	10.00	11.00	12.00	13.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.000000	108,397	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.004914	46,139	227	0	0	54.00
54.01	03630	ULTRA SOUND	0.004915	19,385	95	0	0	54.01
56.00	05600	RADIOISOTOPE	0.004915	0	0	0	0	56.00
57.00	05700	CT SCAN	0.004915	32,300	159	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.004915	2,850	14	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	0	0	0	0	59.00
60.00	06000	LABORATORY	0.000000	1,171,647	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.000000	208,410	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	1,285,994	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	1,104,700	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	174,028	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	96,663	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	2,308	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	238,269	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	17,513	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	546,886	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0.000000	110,459	0	0	0	74.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0.000000	0	0	0	0	76.00
76.01	03190	CHEMOTHERAPY	0.000000	0	0	0	0	76.01
76.02	03330	ENDOSCOPY	0.000000	0	0	0	0	76.02
76.03	03950	WOUND CARE CENTER	0.000000	4,245	0	0	0	76.03
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0.000000	45,916	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	0	0	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0.000000	0	0	0	0	98.00
200.00		Total (lines 50 through 199)		5,216,109	495	0	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-0010 | Period: From 07/01/2019 To 06/30/2020 | Worksheet D Part V Date/Time Prepared: 11/20/2020 9:38 am

Title XIX | Hospital | Cost

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.119594	0	6,502,486	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.268798	0	721,848	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.256832	0	2,680,001	0	0	54.00
54.01	03630	ULTRA SOUND	0.102808	0	690,916	0	0	54.01
56.00	05600	RADIOISOTOPE	0.124505	0	1,361,293	0	0	56.00
57.00	05700	CT SCAN	0.072399	0	1,392,127	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.340213	0	338,418	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.116374	0	16,076	0	0	59.00
60.00	06000	LABORATORY	0.113766	0	9,014,545	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.154711	0	613,944	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.364844	0	969,855	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.339713	0	376,668	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.363986	0	75,296	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.122991	0	727,090	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.167915	0	963,792	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.359888	0	843,469	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.319153	0	89,054	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.437040	0	2,173,938	0	0	73.00
74.00	07400	RENAL DIALYSIS	0.275888	0	0	0	0	74.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0.373383	0	1,006,295	0	0	76.00
76.01	03190	CHEMOTHERAPY	0.598998	0	4,572,695	0	0	76.01
76.02	03330	ENDOSCOPY	0.258615	0	86,972	0	0	76.02
76.03	03950	WOUND CARE CENTER	0.084444	0	2,659,510	0	0	76.03
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0.083846	0	15,946,157	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.429101	0	286,578	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0.234675	0	0			95.00
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0.000000	0	0	0	0	98.00
200.00		Subtotal (see instructions)		0	54,109,023	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	54,109,023	0	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-0010 | Period: From 07/01/2019 To 06/30/2020 | Worksheet D Part V Date/Time Prepared: 11/20/2020 9:38 am

Title XIX | Hospital | Cost

		Cost Center Description	Costs: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	
			6.00	7.00	
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	777,658	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	194,031	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	688,310	0	54.00
54.01	03630	ULTRA SOUND	71,032	0	54.01
56.00	05600	RADIOISOTOPE	169,488	0	56.00
57.00	05700	CT SCAN	100,789	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	115,134	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	1,871	0	59.00
60.00	06000	LABORATORY	1,025,549	0	60.00
65.00	06500	RESPIRATORY THERAPY	94,984	0	65.00
66.00	06600	PHYSICAL THERAPY	353,846	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	127,959	0	67.00
68.00	06800	SPEECH PATHOLOGY	27,407	0	68.00
69.00	06900	ELECTROCARDIOLOGY	89,426	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	161,835	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	303,554	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	28,422	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	950,098	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	74.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	375,733	0	76.00
76.01	03190	CHEMOTHERAPY	2,739,035	0	76.01
76.02	03330	ENDOSCOPY	22,492	0	76.02
76.03	03950	WOUND CARE CENTER	224,580	0	76.03
		OUTPATIENT SERVICE COST CENTERS			
91.00	09100	EMERGENCY	1,337,021	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	122,971	0	92.00
		OTHER REIMBURSABLE COST CENTERS			
95.00	09500	AMBULANCE SERVICES	0		95.00
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0	0	98.00
200.00		Subtotal (see instructions)	10,103,225	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0		201.00
202.00		Net Charges (line 200 - line 201)	10,103,225	0	202.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-0010 | Period: From 07/01/2019 To 06/30/2020 | Worksheet D-1 | Date/Time Prepared: 11/20/2020 9:38 am

Title XVIII | Hospital | PPS

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	14,825	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	14,825	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)	13,854	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions)	5,442	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)	0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period	0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15.00	Total nursery days (title V or XIX only)	0	15.00
16.00	Nursery days (title V or XIX only)	0	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period	0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period	0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)	14,121,086	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)	0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)	0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)	0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)	0	25.00
26.00	Total swing-bed cost (see instructions)	0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	14,121,086	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	28.00
29.00	Private room charges (excluding swing-bed charges)	0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)	0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)	0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)	0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	14,121,086	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)	952.52	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	5,183,614	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)	5,183,614	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-0010 | Period: From 07/01/2019 To 06/30/2020 | Worksheet D-1 | Date/Time Prepared: 11/20/2020 9:38 am

Title XVIII | Hospital | PPS

	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)	0	0	0.00	0	0	42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	3,550,905	1,935	1,835.09	852	1,563,497	43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	10,040,356	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	16,787,467	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)	449,021	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	607,817	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	1,056,838	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	15,730,629	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)	971	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	952.52	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	924,897	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-0010 | Period: From 07/01/2019 To 06/30/2020 | Worksheet D-1 | Date/Time Prepared: 11/20/2020 9:38 am

Title XVIII | Hospital | PPS

	Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	928,938	14,121,086	0.065784	924,897	60,843	90.00
91.00	Nursing School cost	0	14,121,086	0.000000	924,897	0	91.00
92.00	Allied health cost	0	14,121,086	0.000000	924,897	0	92.00
93.00	All other Medical Education	0	14,121,086	0.000000	924,897	0	93.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 15-0010 Component CCN: 15-T010	Period: From 07/01/2019 To 06/30/2020	Worksheet D-1 Date/Time Prepared: 11/20/2020 9:38 am
	Title XVIII	Subprovider - IRF	PPS

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	4,306	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	4,306	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.	0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)	4,306	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)	2,556	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)	0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period	0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15.00	Total nursery days (title V or XIX only)	0	15.00
16.00	Nursery days (title V or XIX only)	0	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period	0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period	0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)	3,328,704	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)	0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)	0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)	0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)	0	25.00
26.00	Total swing-bed cost (see instructions)	0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	3,328,704	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	28.00
29.00	Private room charges (excluding swing-bed charges)	0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)	0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)	0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)	0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	3,328,704	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)	773.04	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	1,975,890	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)	0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)	1,975,890	41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 15-0010 | Period: From 07/01/2019 To 06/30/2020 | Worksheet D-1

Component CCN: 15-T010 | Date/Time Prepared: 11/20/2020 9:38 am

Title XVIII | Subprovider - IRF | PPS

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

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	1,481,514	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	3,457,404	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)	170,025	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	71,188	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	241,213	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	3,216,191	53.00
	TARGET AMOUNT AND LIMIT COMPUTATION		
54.00	Program discharges	0	54.00
55.00	Target amount per discharge	0.00	55.00
56.00	Target amount (line 54 x line 55)	0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)	0	57.00
58.00	Bonus payment (see instructions)	0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket	0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket	0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)	0	61.00
62.00	Relief payment (see instructions)	0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)	0	63.00
	PROGRAM INPATIENT ROUTINE SWING BED COST		
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)	0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)	0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)	0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)	0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)	0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)	0	69.00
	PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY		
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)		70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)		71.00
72.00	Program routine service cost (line 9 x line 71)		72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)		73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)		74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)		75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)		76.00
77.00	Program capital-related costs (line 9 x line 76)		77.00
78.00	Inpatient routine service cost (line 74 minus line 77)		78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)		79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)		80.00
81.00	Inpatient routine service cost per diem limitation		81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)		82.00
83.00	Reasonable inpatient routine service costs (see instructions)		83.00
84.00	Program inpatient ancillary services (see instructions)		84.00
85.00	Utilization review - physician compensation (see instructions)		85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)		86.00
	PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST		
87.00	Total observation bed days (see instructions)	0	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	0.00	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	0	89.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 15-0010 Component CCN: 15-T010	Period: From 07/01/2019 To 06/30/2020	Worksheet D-1 Date/Time Prepared: 11/20/2020 9:38 am
	Title XVIII	Subprovider - IRF	PPS

	Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	286,420	3,328,704	0.086045	0	0	90.00
91.00	Nursing School cost	0	3,328,704	0.000000	0	0	91.00
92.00	Allied health cost	0	3,328,704	0.000000	0	0	92.00
93.00	All other Medical Education	0	3,328,704	0.000000	0	0	93.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-0010 | Period: From 07/01/2019 To 06/30/2020 | Worksheet D-1 | Date/Time Prepared: 11/20/2020 9:38 am

Title XIX | Hospital | Cost

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	14,825	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	14,825	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)	13,854	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)	401	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)	0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period	0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15.00	Total nursery days (title V or XIX only)	1,630	15.00
16.00	Nursery days (title V or XIX only)	169	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period	0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period	0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)	14,120,584	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)	0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)	0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)	0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)	0	25.00
26.00	Total swing-bed cost (see instructions)	0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	14,120,584	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	28.00
29.00	Private room charges (excluding swing-bed charges)	0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)	0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)	0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)	0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	14,120,584	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)	952.48	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	381,944	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)	381,944	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-0010 | Period: From 07/01/2019 To 06/30/2020 | Worksheet D-1 | Date/Time Prepared: 11/20/2020 9:38 am

Title XIX | Hospital | Cost

	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)	950,317	1,630	583.02	169	98,530	42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	3,550,905	1,935	1,835.09	281	515,660	43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	4,893,674	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	5,889,808	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)	971	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	952.48	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	924,858	89.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 15-0010	Period: From 07/01/2019 To 06/30/2020	Worksheet D-1 Date/Time Prepared: 11/20/2020 9:38 am
	Title XIX	Hospital	Cost

	Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	928,938	14,120,584	0.065786	924,858	60,843	90.00
91.00	Nursing School cost	0	14,120,584	0.000000	924,858	0	91.00
92.00	Allied health cost	0	14,120,584	0.000000	924,858	0	92.00
93.00	All other Medical Education	0	14,120,584	0.000000	924,858	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 15-0010 | Period: From 07/01/2019 To 06/30/2020 | Worksheet D-3 | Date/Time Prepared: 11/20/2020 9:38 am

Title XVIII | Hospital | PPS

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		10,310,995		30.00
31.00	03100	INTENSIVE CARE UNIT		3,653,889		31.00
41.00	04100	SUBPROVIDER - IRF		0		41.00
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.119821	11,336,854	1,358,393	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.268798	34,526	9,281	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.256832	1,226,921	315,113	54.00
54.01	03630	ULTRA SOUND	0.102808	498,652	51,265	54.01
56.00	05600	RADIOISOTOPE	0.124505	80,560	10,030	56.00
57.00	05700	CT SCAN	0.072399	1,217,200	88,124	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.340213	232,750	79,185	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.116374	80,340	9,349	59.00
60.00	06000	LABORATORY	0.114378	11,340,355	1,297,087	60.00
65.00	06500	RESPIRATORY THERAPY	0.154711	3,231,624	499,968	65.00
66.00	06600	PHYSICAL THERAPY	0.364844	1,019,607	371,997	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.339713	818,125	277,928	67.00
68.00	06800	SPEECH PATHOLOGY	0.363986	178,348	64,916	68.00
69.00	06900	ELECTROCARDIOLOGY	0.122991	1,703,011	209,455	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.167915	160,812	27,003	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.359888	3,036,712	1,092,876	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.319153	3,538,073	1,129,187	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.437040	5,614,278	2,453,664	73.00
74.00	07400	RENAL DIALYSIS	0.275888	437,530	120,709	74.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0.373383	0	0	76.00
76.01	03190	CHEMOTHERAPY	0.598998	6,375	3,819	76.01
76.02	03330	ENDOSCOPY	0.258615	28,262	7,309	76.02
76.03	03950	WOUND CARE CENTER	0.084444	123,477	10,427	76.03
		OUTPATIENT SERVICE COST CENTERS				
91.00	09100	EMERGENCY	0.083846	5,607,168	470,139	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.429101	193,735	83,132	92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES				95.00
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0.000000	0	0	98.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		51,745,295	10,040,356	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)		51,745,295		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

Provider CCN: 15-0010 | Component CCN: 15-T010 | Period: From 07/01/2019 To 06/30/2020 | Worksheet D-3 | Date/Time Prepared: 11/20/2020 9:38 am

Title XVIII | Subprovider - IRF | PPS

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		0		30.00
31.00	03100	INTENSIVE CARE UNIT		0		31.00
41.00	04100	SUBPROVIDER - IRF		4,780,363		41.00
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.119821	108,397	12,988	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.268798	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.256832	46,139	11,850	54.00
54.01	03630	ULTRA SOUND	0.102808	19,385	1,993	54.01
56.00	05600	RADIOISOTOPE	0.124505	0	0	56.00
57.00	05700	CT SCAN	0.072399	32,300	2,338	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.340213	2,850	970	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.116374	0	0	59.00
60.00	06000	LABORATORY	0.114378	1,171,647	134,011	60.00
65.00	06500	RESPIRATORY THERAPY	0.154711	208,410	32,243	65.00
66.00	06600	PHYSICAL THERAPY	0.364844	1,285,994	469,187	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.339713	1,104,700	375,281	67.00
68.00	06800	SPEECH PATHOLOGY	0.363986	174,028	63,344	68.00
69.00	06900	ELECTROCARDIOLOGY	0.122991	96,663	11,889	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.167915	2,308	388	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.359888	238,269	85,750	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.319153	17,513	5,589	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.437040	546,886	239,011	73.00
74.00	07400	RENAL DIALYSIS	0.275888	110,459	30,474	74.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0.373383	0	0	76.00
76.01	03190	CHEMOTHERAPY	0.598998	0	0	76.01
76.02	03330	ENDOSCOPY	0.258615	0	0	76.02
76.03	03950	WOUND CARE CENTER	0.084444	4,245	358	76.03
		OUTPATIENT SERVICE COST CENTERS				
91.00	09100	EMERGENCY	0.083846	45,916	3,850	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.429101	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES				95.00
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0.000000	0	0	98.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		5,216,109	1,481,514	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)		5,216,109		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 15-0010 | Period: From 07/01/2019 To 06/30/2020 | Worksheet D-3 | Date/Time Prepared: 11/20/2020 9:38 am

Title XIX | Hospital | Cost

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		4,984,706		30.00
31.00	03100	INTENSIVE CARE UNIT		1,534,934		31.00
41.00	04100	SUBPROVIDER - IRF		0		41.00
43.00	04300	NURSERY		1,598,130		43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.119594	4,246,634	507,872	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.268798	5,484,755	1,474,291	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.256832	349,910	89,868	54.00
54.01	03630	ULTRA SOUND	0.102808	119,500	12,286	54.01
56.00	05600	RADIOISOTOPE	0.124505	11,522	1,435	56.00
57.00	05700	CT SCAN	0.072399	328,020	23,748	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.340213	77,353	26,316	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.116374	25,947	3,020	59.00
60.00	06000	LABORATORY	0.113766	4,659,713	530,117	60.00
65.00	06500	RESPIRATORY THERAPY	0.154711	1,060,649	164,094	65.00
66.00	06600	PHYSICAL THERAPY	0.364844	198,614	72,463	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.339713	77,137	26,204	67.00
68.00	06800	SPEECH PATHOLOGY	0.363986	15,420	5,613	68.00
69.00	06900	ELECTROCARDIOLOGY	0.122991	300,106	36,910	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.167915	39,342	6,606	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.359888	1,139,782	410,194	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.319153	563,092	179,713	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.437040	2,525,386	1,103,695	73.00
74.00	07400	RENAL DIALYSIS	0.275888	61,353	16,927	74.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0.373383	340	127	76.00
76.01	03190	CHEMOTHERAPY	0.598998	35,364	21,183	76.01
76.02	03330	ENDOSCOPY	0.258615	5,496	1,421	76.02
76.03	03950	WOUND CARE CENTER	0.084444	1,695	143	76.03
		OUTPATIENT SERVICE COST CENTERS				
91.00	09100	EMERGENCY	0.083846	2,139,966	179,428	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.429101	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES				95.00
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0.000000	0	0	98.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		23,467,096	4,893,674	200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0		201.00
202.00		Net charges (line 200 minus line 201)		23,467,096		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

Provider CCN: 15-0010 | Component CCN: 15-T010 | Period: From 07/01/2019 To 06/30/2020 | Worksheet D-3 | Date/Time Prepared: 11/20/2020 9:38 am

Title XIX | Subprovider - IRF | Cost

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		0		30.00
31.00	03100	INTENSIVE CARE UNIT		0		31.00
41.00	04100	SUBPROVIDER - IRF		738,781		41.00
43.00	04300	NURSERY		0		43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.119594	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.268798	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.256832	8,327	2,139	54.00
54.01	03630	ULTRA SOUND	0.102808	0	0	54.01
56.00	05600	RADIOISOTOPE	0.124505	0	0	56.00
57.00	05700	CT SCAN	0.072399	3,444	249	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.340213	3,958	1,347	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.116374	0	0	59.00
60.00	06000	LABORATORY	0.113766	150,715	17,146	60.00
65.00	06500	RESPIRATORY THERAPY	0.154711	31,971	4,946	65.00
66.00	06600	PHYSICAL THERAPY	0.364844	284,125	103,661	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.339713	110,347	37,486	67.00
68.00	06800	SPEECH PATHOLOGY	0.363986	22,058	8,029	68.00
69.00	06900	ELECTROCARDIOLOGY	0.122991	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.167915	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.359888	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.319153	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.437040	128,673	56,235	73.00
74.00	07400	RENAL DIALYSIS	0.275888	0	0	74.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0.373383	0	0	76.00
76.01	03190	CHEMOTHERAPY	0.598998	0	0	76.01
76.02	03330	ENDOSCOPY	0.258615	0	0	76.02
76.03	03950	WOUND CARE CENTER	0.084444	0	0	76.03
		OUTPATIENT SERVICE COST CENTERS				
91.00	09100	EMERGENCY	0.083846	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.429101	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES				95.00
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0.000000	0	0	98.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		743,618	231,238	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)		743,618		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0010	Period: From 07/01/2019 To 06/30/2020	Worksheet E Part A Date/Time Prepared: 11/20/2020 9:38 am
	Title XVIII	Hospital	PPS

		1.00	
	PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS		
1.00	DRG Amounts Other than Outlier Payments	0	1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1 (see instructions)	3,228,033	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1 (see instructions)	9,891,288	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)	38,287	2.03
2.04	Outlier payments for discharges occurring on or after October 1 (see instructions)	150,893	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)	116.35	4.00
	Indirect Medical Education Adjustment		
5.00	FTE count for allopathic and osteopathic programs for the most recent cost reporting period ending on or before 12/31/1996.(see instructions)	0.00	5.00
6.00	FTE count for allopathic and osteopathic programs that meet the criteria for an add-on to the cap for new programs in accordance with 42 CFR 413.79(e)	0.00	6.00
7.00	MMA Section 422 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(1)	0.00	7.00
7.01	ACA § 5503 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(2) If the cost report straddles July 1, 2011 then see instructions.	0.00	7.01
8.00	Adjustment (increase or decrease) to the FTE count for allopathic and osteopathic programs for affiliated programs in accordance with 42 CFR 413.75(b), 413.79(c)(2)(iv), 64 FR 26340 (May 12, 1998), and 67 FR 50069 (August 1, 2002).	0.00	8.00
8.01	The amount of increase if the hospital was awarded FTE cap slots under § 5503 of the ACA. If the cost report straddles July 1, 2011, see instructions.	0.00	8.01
8.02	The amount of increase if the hospital was awarded FTE cap slots from a closed teaching hospital under § 5506 of ACA. (see instructions)	0.00	8.02
9.00	Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus lines (8, 8,01 and 8,02) (see instructions)	0.00	9.00
10.00	FTE count for allopathic and osteopathic programs in the current year from your records	0.00	10.00
11.00	FTE count for residents in dental and podiatric programs.	0.00	11.00
12.00	Current year allowable FTE (see instructions)	0.00	12.00
13.00	Total allowable FTE count for the prior year.	0.00	13.00
14.00	Total allowable FTE count for the penultimate year if that year ended on or after September 30, 1997, otherwise enter zero.	0.00	14.00
15.00	Sum of lines 12 through 14 divided by 3.	0.00	15.00
16.00	Adjustment for residents in initial years of the program	0.00	16.00
17.00	Adjustment for residents displaced by program or hospital closure	0.00	17.00
18.00	Adjusted rolling average FTE count	0.00	18.00
19.00	Current year resident to bed ratio (line 18 divided by line 4).	0.000000	19.00
20.00	Prior year resident to bed ratio (see instructions)	0.000000	20.00
21.00	Enter the lesser of lines 19 or 20 (see instructions)	0.000000	21.00
22.00	IME payment adjustment (see instructions)	0	22.00
22.01	IME payment adjustment - Managed Care (see instructions)	0	22.01
	Indirect Medical Education Adjustment for the Add-on for § 422 of the MMA		
23.00	Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 CFR 412.105 (f)(1)(iv)(C).	0.00	23.00
24.00	IME FTE Resident Count Over Cap (see instructions)	0.00	24.00
25.00	If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see instructions)	0.00	25.00
26.00	Resident to bed ratio (divide line 25 by line 4)	0.000000	26.00
27.00	IME payments adjustment factor. (see instructions)	0.000000	27.00
28.00	IME add-on adjustment amount (see instructions)	0	28.00
28.01	IME add-on adjustment amount - Managed Care (see instructions)	0	28.01
29.00	Total IME payment (sum of lines 22 and 28)	0	29.00
29.01	Total IME payment - Managed Care (sum of lines 22.01 and 28.01)	0	29.01
	Disproportionate Share Adjustment		
30.00	Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)	4.71	30.00
31.00	Percentage of Medicaid patient days (see instructions)	24.01	31.00
32.00	Sum of lines 30 and 31	28.72	32.00
33.00	Allowable disproportionate share percentage (see instructions)	12.91	33.00
34.00	Disproportionate share adjustment (see instructions)	423,426	34.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0010	Period: From 07/01/2019 To 06/30/2020	Worksheet E Part A Date/Time Prepared: 11/20/2020 9:38 am
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		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)	0.000155566	0.000168128	35.01
35.02	Hospital uncompensated care payment (If line 34 is zero, enter zero on this line) (see instructions)	1,286,977	1,403,970	35.02
35.03	Pro rata share of the hospital uncompensated care payment amount (see instructions)	324,389	1,051,060	35.03
36.00	Total uncompensated care (sum of columns 1 and 2 on line 35.03)	1,375,449		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)	15,107,376		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)		15,107,376	49.00
50.00	Payment for inpatient program capital (from Wkst. L, Pt. I and Pt. II, as applicable)		1,113,361	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		31,194	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)		16,003	58.00
59.00	Total (sum of amounts on lines 49 through 58)		16,267,934	59.00
60.00	Primary payer payments		0	60.00
61.00	Total amount payable for program beneficiaries (line 59 minus line 60)		16,267,934	61.00
62.00	Deductibles billed to program beneficiaries		1,585,716	62.00
63.00	Coinsurance billed to program beneficiaries		18,777	63.00
64.00	Allowable bad debts (see instructions)		180,701	64.00
65.00	Adjusted reimbursable bad debts (see instructions)		117,456	65.00
66.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		36,299	66.00
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)		14,780,897	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)		14,324	70.93
70.94	HRR adjustment amount (see instructions)		-38,712	70.94
70.95	Recovery of accelerated depreciation		0	70.95

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0010	Period: From 07/01/2019 To 06/30/2020	Worksheet E Part A Date/Time Prepared: 11/20/2020 9:38 am
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		FFY (yyyy)	Amount	
		0	1.00	
70.96	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period prior to 10/1)	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)		14,756,509	71.00
71.01	Sequestration adjustment (see instructions)		246,434	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		14,129,713	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)		380,362	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		382,318	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: 15-0010 | Period: From 07/01/2019 To 06/30/2020 | Worksheet E Part A Exhibit 4 Date/Time Prepared: 11/20/2020 9:38 am

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		W/S E, Part A line	Amounts (from E, Part A)	Pre/Post Entitlement	Period Prior to 10/01	Period On/After 10/01	Total (Col 2 through 4)	
		0	1.00	2.00	3.00	4.00	5.00	
1.00	DRG amounts other than outlier payments	1.00	0	0	0	0	0	1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1	1.01	3,228,033	0	3,228,033		3,228,033	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	9,891,288	0		9,891,288	9,891,288	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	38,287	0	38,287		38,287	2.02
2.03	Outlier payments for discharges occurring on or after October 1 (see instructions)	2.04	150,893	0		150,893	150,893	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	0.1291	0.1291	0.1291	0.1291		10.00
11.00	Disproportionate share adjustment (see instructions)	34.00	423,426	0	104,185	319,241	423,426	11.00
11.01	Uncompensated care payments	36.00	1,375,449	0	324,389	1,051,060	1,375,449	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	15,107,376	0	3,694,894	11,412,482	15,107,376	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	15,107,376	0	3,694,894	11,412,482	15,107,376	15.00
16.00	Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable)	50.00	1,113,361	0	277,584	835,777	1,113,361	16.00

LOW VOLUME CALCULATION EXHIBIT 4 | Provider CCN: 15-0010 | Period: From 07/01/2019 To 06/30/2020 | Worksheet E Part A Exhibit 4 Date/Time Prepared: 11/20/2020 9:38 am

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		W/S E, Part A line	Amounts (from E, Part A)	Pre/Post Entitlement	Period Prior to 10/01	Period On/After 10/01	Total (Col 2 through 4)	
		0	1.00	2.00	3.00	4.00	5.00	
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	3,972,478	12,248,259	16,220,737	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	1,044,184	0	261,300	782,884	1,044,184	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	6,630	0	632	5,998	6,630	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	0.0599	0.0599	0.0599	0.0599		24.00
25.00	Disproportionate share adjustment (see instructions)	11.00	62,547	0	15,652	46,895	62,547	25.00
26.00	Total prospective capital payments (see instructions)	12.00	1,113,361	0	277,584	835,777	1,113,361	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: 15-0010 | Period: From 07/01/2019 To 06/30/2020 | Worksheet E Part A Exhibit 5 Date/Time Prepared: 11/20/2020 9:38 am

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		Wkst. E, Pt. A, line	Amt. from Wkst. E, Pt. A)	Period to 10/01	Period on after 10/01	Total (cols. 2 and 3)	
		0	1.00	2.00	3.00	4.00	
1.00	DRG amounts other than outlier payments	1.00					1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1	1.01	3,228,033	3,228,033		3,228,033	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	9,891,288		9,891,288	9,891,288	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	38,287	38,287		38,287	2.02
2.03	Outlier payments for discharges occurring on or after October 1 (see instructions)	2.04	150,893		150,893	150,893	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	0.1291	0.1291	0.1291		10.00
11.00	Disproportionate share adjustment (see instructions)	34.00	423,426	104,185	319,241	423,426	11.00
11.01	Uncompensated care payments	36.00	1,375,449	324,389	1,051,060	1,375,449	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	15,107,376	3,694,894	11,412,482	15,107,376	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	15,107,376	3,694,894	11,412,482	15,107,376	15.00
16.00	Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable)	50.00	1,113,361	277,584	835,777	1,113,361	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			3,972,478	12,248,259	16,220,737	19.00

HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULATION EXHIBIT 5 | Provider CCN: 15-0010 | Period: From 07/01/2019 To 06/30/2020 | Worksheet E Part A Exhibit 5 Date/Time Prepared: 11/20/2020 9:38 am

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		Wkst. L, line	(Amt. from Wkst. L)				
		0	1.00	2.00	3.00	4.00	
20.00	Capital DRG other than outlier	1.00	1,044,184	261,300	782,884	1,044,184	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	6,630	632	5,998	6,630	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	0.0599	0.0599	0.0599		24.00
25.00	Disproportionate share adjustment (see instructions)	11.00	62,547	15,652	46,895	62,547	25.00
26.00	Total prospective capital payments (see instructions)	12.00	1,113,361	277,584	835,777	1,113,361	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	14,324	8,661	5,663	14,324	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	-38,712	-9,038	-29,674	-38,712	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: 15-0010	Period: From 07/01/2019 To 06/30/2020	Worksheet E Part B Date/Time Prepared: 11/20/2020 9:38 am
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		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	5,049	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)	21,211,640	2.00
3.00	OPPS payments	17,267,084	3.00
4.00	Outlier payment (see instructions)	95,479	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	76,769	9.00
10.00	Organ acquisitions	0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)	5,049	11.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
12.00	Ancillary service charges	11,552	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)	11,552	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)	11,552	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)	6,503	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)	5,049	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)	17,439,332	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)	3,141,756	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)	14,302,625	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)	14,302,625	30.00
31.00	Primary payer payments	10,931	31.00
32.00	Subtotal (line 30 minus line 31)	14,291,694	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)	453,376	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	294,694	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	116,174	36.00
37.00	Subtotal (see instructions)	14,586,388	37.00
38.00	MSP-LCC reconciliation amount from PS&R	-138	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)	14,586,526	40.00
40.01	Sequestration adjustment (see instructions)	243,595	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	14,245,554	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)	97,377	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: 15-0010 | Period: From 07/01/2019 To 06/30/2020 | Worksheet E-1 Part I Date/Time Prepared: 11/20/2020 9:38 am

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		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		14,129,713		14,245,554	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)		14,129,713		14,245,554	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		380,362		97,377	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		14,510,075		14,342,931	7.00

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

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 15-0010 | Component CCN: 15-T010 | Period: From 07/01/2019 To 06/30/2020 | Worksheet E-1 Part I | Date/Time Prepared: 11/20/2020 9:38 am

Title XVIII | Subprovider - IRF | PPS

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		4,179,936		0	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)		4,179,936		0	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		14,663		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		4,194,599		0	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: 15-0010	Period: From 07/01/2019 To 06/30/2020	Worksheet E-1 Part II Date/Time Prepared: 11/20/2020 9:38 am
	Title XVIII	Hospital	PPS

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

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0010 Component CCN: 15-T010	Period: From 07/01/2019 To 06/30/2020	Worksheet E-3 Part III Date/Time Prepared: 11/20/2020 9:38 am
	Title XVIII	Subprovider - IRF	PPS

		1.00	
	PART III - MEDICARE PART A SERVICES - IRF PPS		
1.00	Net Federal PPS Payment (see instructions)	4,196,272	1.00
2.00	Medicare SSI ratio (IRF PPS only) (see instructions)	0.0000	2.00
3.00	Inpatient Rehabilitation LIP Payments (see instructions)	101,550	3.00
4.00	Outlier Payments	12,364	4.00
5.00	Unweighted intern and resident FTE count in the most recent cost reporting period ending on or prior to November 15, 2004 (see instructions)	0.00	5.00
5.01	Cap increases for the unweighted intern and resident FTE count for residents that were displaced by program or hospital closure, that would not be counted without a temporary cap adjustment under 42 CFR §412.424(d)(1)(iii)(F)(1) or (2) (see instructions)	0.00	5.01
6.00	New Teaching program adjustment. (see instructions)	0.00	6.00
7.00	Current year's unweighted FTE count of I&R excluding FTEs in the new program growth period of a "new teaching program" (see instructions)	0.00	7.00
8.00	Current year's unweighted I&R FTE count for residents within the new program growth period of a "new teaching program" (see instructions)	0.00	8.00
9.00	Intern and resident count for IRF PPS medical education adjustment (see instructions)	0.00	9.00
10.00	Average Daily Census (see instructions)	11.765027	10.00
11.00	Teaching Adjustment Factor (see instructions)	0.000000	11.00
12.00	Teaching Adjustment (see instructions)	0	12.00
13.00	Total PPS Payment (see instructions)	4,310,186	13.00
14.00	Nursing and Allied Health Managed Care payments (see instruction)	0	14.00
15.00	Organ acquisition (DO NOT USE THIS LINE)		15.00
16.00	Cost of physicians' services in a teaching hospital (see instructions)	0	16.00
17.00	Subtotal (see instructions)	4,310,186	17.00
18.00	Primary payer payments	0	18.00
19.00	Subtotal (line 17 less line 18).	4,310,186	19.00
20.00	Deductibles	33,132	20.00
21.00	Subtotal (line 19 minus line 20)	4,277,054	21.00
22.00	Coinsurance	13,453	22.00
23.00	Subtotal (line 21 minus line 22)	4,263,601	23.00
24.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)	2,680	24.00
25.00	Adjusted reimbursable bad debts (see instructions)	1,742	25.00
26.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	0	26.00
27.00	Subtotal (sum of lines 23 and 25)	4,265,343	27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 49)	0	28.00
29.00	Other pass through costs (see instructions)	495	29.00
30.00	Outlier payments reconciliation	0	30.00
31.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	31.00
31.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	31.50
31.99	Demonstration payment adjustment amount before sequestration	0	31.99
32.00	Total amount payable to the provider (see instructions)	4,265,838	32.00
32.01	Sequestration adjustment (see instructions)	71,239	32.01
32.02	Demonstration payment adjustment amount after sequestration	0	32.02
33.00	Interim payments	4,179,936	33.00
34.00	Tentative settlement (for contractor use only)	0	34.00
35.00	Balance due provider/program (line 32 minus lines 32.01, 32.02, 33, and 34)	14,663	35.00
36.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	36.00
	TO BE COMPLETED BY CONTRACTOR		
50.00	Original outlier amount from Wkst. E-3, Pt. III, line 4	12,364	50.00
51.00	Outlier reconciliation adjustment amount (see instructions)	0	51.00
52.00	The rate used to calculate the Time Value of Money	0.00	52.00
53.00	Time Value of Money (see instructions)	0	53.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0010	Period: From 07/01/2019 To 06/30/2020	Worksheet E-3 Part VII Date/Time Prepared: 11/20/2020 9:38 am
	Title XIX	Hospital	Cost

		Inpatient	Outpatient	
		1.00	2.00	
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR XIX SERVICES			
	COMPUTATION OF NET COST OF COVERED SERVICES			
1.00	Inpatient hospital/SNF/NF services	5,889,808		1.00
2.00	Medical and other services		10,103,225	2.00
3.00	Organ acquisition (certified transplant centers only)	0		3.00
4.00	Subtotal (sum of lines 1, 2 and 3)	5,889,808	10,103,225	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)	5,889,808	10,103,225	7.00
	COMPUTATION OF LESSER OF COST OR CHARGES			
	Reasonable Charges			
8.00	Routine service charges	0		8.00
9.00	Ancillary service charges	23,467,096	54,109,023	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)	23,467,096	54,109,023	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)	23,467,096	54,109,023	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)	17,577,288	44,005,798	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)	5,889,808	10,103,225	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)	5,889,808	10,103,225	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)	5,889,808	10,103,225	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)	5,889,808	10,103,225	36.00
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	37.00
38.00	Subtotal (line 36 ± line 37)	5,889,808	10,103,225	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)	5,889,808	10,103,225	40.00
41.00	Interim payments	5,889,808	10,103,225	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

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0010 Component CCN: 15-T010	Period: From 07/01/2019 To 06/30/2020	Worksheet E-3 Part VII Date/Time Prepared: 11/20/2020 9:38 am
	Title XIX	Subprovider - IRF	Cost

		Inpatient	Outpatient	
		1.00	2.00	
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR XIX SERVICES			
	COMPUTATION OF NET COST OF COVERED SERVICES			
1.00	Inpatient hospital/SNF/NF services	0		1.00
2.00	Medical and other services		0	2.00
3.00	Organ acquisition (certified transplant centers only)	0		3.00
4.00	Subtotal (sum of lines 1, 2 and 3)	0	0	4.00
5.00	Inpatient primary payer payments	0		5.00
6.00	Outpatient primary payer payments		0	6.00
7.00	Subtotal (line 4 less sum of lines 5 and 6)	0	0	7.00
	COMPUTATION OF LESSER OF COST OR CHARGES			
	Reasonable Charges			
8.00	Routine service charges	0		8.00
9.00	Ancillary service charges	743,618	0	9.00
10.00	Organ acquisition charges, net of revenue	0		10.00
11.00	Incentive from target amount computation	0		11.00
12.00	Total reasonable charges (sum of lines 8 through 11)	743,618	0	12.00
	CUSTOMARY CHARGES			
13.00	Amount actually collected from patients liable for payment for services on a charge basis	0	0	13.00
14.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)	0	0	14.00
15.00	Ratio of line 13 to line 14 (not to exceed 1.000000)	0.000000	0.000000	15.00
16.00	Total customary charges (see instructions)	743,618	0	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)	743,618	0	17.00
18.00	Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 16) (see instructions)	0	0	18.00
19.00	Interns and Residents (see instructions)	0	0	19.00
20.00	Cost of physicians' services in a teaching hospital (see instructions)	0	0	20.00
21.00	Cost of covered services (enter the lesser of line 4 or line 16)	0	0	21.00
	PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be completed for PPS providers.			
22.00	Other than outlier payments	0	0	22.00
23.00	Outlier payments	0	0	23.00
24.00	Program capital payments	0		24.00
25.00	Capital exception payments (see instructions)	0		25.00
26.00	Routine and Ancillary service other pass through costs	0	0	26.00
27.00	Subtotal (sum of lines 22 through 26)	0	0	27.00
28.00	Customary charges (title V or XIX PPS covered services only)	0	0	28.00
29.00	Titles V or XIX (sum of lines 21 and 27)	0	0	29.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT			
30.00	Excess of reasonable cost (from line 18)	0	0	30.00
31.00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)	0	0	31.00
32.00	Deductibles	0	0	32.00
33.00	Coinsurance	0	0	33.00
34.00	Allowable bad debts (see instructions)	0	0	34.00
35.00	Utilization review	0		35.00
36.00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)	0	0	36.00
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	37.00
38.00	Subtotal (line 36 ± line 37)	0	0	38.00
39.00	Direct graduate medical education payments (from Wkst. E-4)	0		39.00
40.00	Total amount payable to the provider (sum of lines 38 and 39)	0	0	40.00
41.00	Interim payments	0	0	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: 15-0010 | Period: From 07/01/2019 To 06/30/2020 | Worksheet G | Date/Time Prepared: 11/20/2020 9:38 am

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
	CURRENT ASSETS					
1.00	Cash on hand in banks	1,275	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	17,869,117	0	0	0	4.00
5.00	Other receivable	886,477	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	0	0	0	0	6.00
7.00	Inventory	1,991,375	0	0	0	7.00
8.00	Prepaid expenses	0	0	0	0	8.00
9.00	Other current assets	437,099	0	0	0	9.00
10.00	Due from other funds	2,531,088	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	23,716,431	0	0	0	11.00
	FIXED ASSETS					
12.00	Land	525,279	0	0	0	12.00
13.00	Land improvements	1,764,978	0	0	0	13.00
14.00	Accumulated depreciation	0	0	0	0	14.00
15.00	Buildings	76,378,767	0	0	0	15.00
16.00	Accumulated depreciation	0	0	0	0	16.00
17.00	Leasehold improvements	653,423	0	0	0	17.00
18.00	Accumulated depreciation	0	0	0	0	18.00
19.00	Fixed equipment	21,924,420	0	0	0	19.00
20.00	Accumulated depreciation	0	0	0	0	20.00
21.00	Automobiles and trucks	1,005,874	0	0	0	21.00
22.00	Accumulated depreciation	0	0	0	0	22.00
23.00	Major movable equipment	48,525,072	0	0	0	23.00
24.00	Accumulated depreciation	0	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	-119,651,372	0	0	0	28.00
29.00	Minor equipment-nondepreciable	9,979,406	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	41,105,847	0	0	0	30.00
	OTHER ASSETS					
31.00	Investments	0	0	0	0	31.00
32.00	Deposits on leases	1,889,359	0	0	0	32.00
33.00	Due from owners/officers	0	0	0	0	33.00
34.00	Other assets	341,050	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	2,230,409	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	67,052,687	0	0	0	36.00
	CURRENT LIABILITIES					
37.00	Accounts payable	6,229,577	0	0	0	37.00
38.00	Salaries, wages, and fees payable	2,790,306	0	0	0	38.00
39.00	Payroll taxes payable	658,624	0	0	0	39.00
40.00	Notes and loans payable (short term)	247,027	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	12,732,490	0	0	0	43.00
44.00	Other current liabilities	6,721,912	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	29,379,936	0	0	0	45.00
	LONG TERM LIABILITIES					
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	16,635,612	0	0	0	47.00
48.00	Unsecured loans	14,908,318	0	0	0	48.00
49.00	Other long term liabilities	4,218,214	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	35,762,144	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	65,142,080	0	0	0	51.00
	CAPITAL ACCOUNTS					
52.00	General fund balance	1,910,607				52.00
53.00	Specific purpose fund		0			53.00
54.00	Donor created - endowment fund balance - restricted			0		54.00
55.00	Donor created - endowment fund balance - unrestricted			0		55.00
56.00	Governing body created - endowment fund balance			0		56.00
57.00	Plant fund balance - invested in plant				0	57.00
58.00	Plant fund balance - reserve for plant improvement, replacement, and expansion				0	58.00
59.00	Total fund balances (sum of lines 52 thru 58)	1,910,607	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	67,052,687	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES | Provider CCN: 15-0010 | Period: From 07/01/2019 To 06/30/2020 | Worksheet G-1 | Date/Time Prepared: 11/20/2020 9:38 am

		General Fund		Special Purpose Fund		Endowment Fund	
		1.00	2.00	3.00	4.00	5.00	
1.00	Fund balances at beginning of period		15,631,016		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		19,066,990				2.00
3.00	Total (sum of line 1 and line 2)		34,698,006		0		3.00
4.00	Additions (credit adjustments) (specify)	0		0		0	4.00
5.00		0		0		0	5.00
6.00		0		0		0	6.00
7.00		0		0		0	7.00
8.00		0		0		0	8.00
9.00		0		0		0	9.00
10.00	Total additions (sum of line 4-9)		0		0		10.00
11.00	Subtotal (line 3 plus line 10)		34,698,006		0		11.00
12.00	INTERCOMPANY TRANSFERS	32,787,399		0		0	12.00
13.00		0		0		0	13.00
14.00		0		0		0	14.00
15.00		0		0		0	15.00
16.00		0		0		0	16.00
17.00		0		0		0	17.00
18.00	Total deductions (sum of lines 12-17)		32,787,399		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		1,910,607		0		19.00

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

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES | Provider CCN: 15-0010 | Period: From 07/01/2019 To 06/30/2020 | Worksheet G-2 Parts I & II | Date/Time Prepared: 11/20/2020 9:38 am

	Cost Center Description	Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospital	33,538,011		33,538,011	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF	8,075,414		8,075,414	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)	41,613,425		41,613,425	10.00
	Intensive Care Type Inpatient Hospital Services				
11.00	INTENSIVE CARE UNIT	8,432,806		8,432,806	11.00
12.00	CORONARY CARE UNIT				12.00
13.00	BURN INTENSIVE CARE UNIT				13.00
14.00	SURGICAL INTENSIVE CARE UNIT				14.00
15.00	OTHER SPECIAL CARE (SPECIFY)				15.00
16.00	Total intensive care type inpatient hospital services (sum of lines 11-15)	8,432,806		8,432,806	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	50,046,231		50,046,231	17.00
18.00	Ancillary services	135,864,307	0	135,864,307	18.00
19.00	Outpatient services	0	353,073,365	353,073,365	19.00
20.00	RURAL HEALTH CLINIC	0	0	0	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY				22.00
23.00	AMBULANCE SERVICES	0	0	0	23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	PHYSICIAN REVENUE	0	1,628,793	1,628,793	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	185,910,538	354,702,158	540,612,696	28.00
	PART II - OPERATING EXPENSES				
29.00	Operating expenses (per Wkst. A, column 3, line 200)		138,404,644		29.00
30.00	ADD (SPECIFY)	0			30.00
31.00		0			31.00
32.00		0			32.00
33.00		0			33.00
34.00		0			34.00
35.00		0			35.00
36.00	Total additions (sum of lines 30-35)		0		36.00
37.00	DEDUCT (SPECIFY)	0			37.00
38.00		0			38.00
39.00		0			39.00
40.00		0			40.00
41.00		0			41.00
42.00	Total deductions (sum of lines 37-41)		0		42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer to Wkst. G-3, line 4)		138,404,644		43.00

STATEMENT OF REVENUES AND EXPENSES	Provider CCN: 15-0010	Period: From 07/01/2019 To 06/30/2020	Worksheet G-3 Date/Time Prepared: 11/20/2020 9:38 am

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	540,612,696	1.00
2.00	Less contractual allowances and discounts on patients' accounts	382,021,758	2.00
3.00	Net patient revenues (line 1 minus line 2)	158,590,938	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	138,404,644	4.00
5.00	Net income from service to patients (line 3 minus line 4)	20,186,294	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	15,500	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	420,216	14.00
15.00	Revenue from rental of living quarters	0	15.00
16.00	Revenue from sale of medical and surgical supplies to other than patients	0	16.00
17.00	Revenue from sale of drugs to other than patients	0	17.00
18.00	Revenue from sale of medical records and abstracts	5,110	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	14,851	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	0	20.00
21.00	Rental of vending machines	0	21.00
22.00	Rental of hospital space	133,677	22.00
23.00	Governmental appropriations	0	23.00
24.00	MISCELLANEOUS INCOME	54,304	24.00
24.01	ASPR BIOTERROSIM GRANT	1,200	24.01
24.02	MEALS ON WHEELS	61,130	24.02
24.03	INTERCOMPANY RENTAL INCOME	140,952	24.03
24.04	FOUNDATION INTERCOMPANY TRANSFER	1,945	24.04
24.05	GAIN ON SALE OF ASSETS	26,746	24.05
24.06	PATIENT INTEREST INCOME	-17,342	24.06
24.07	LATE PENALTY FEES	974	24.07
24.08	UNCLAIMED PROPERTY	21,923	24.08
24.09	ASSETS RESTRICTED FOR USE	15,948	24.09
24.50	COVID-19 PHE Funding	3,202,422	24.50
25.00	Total other income (sum of lines 6-24)	4,099,556	25.00
26.00	Total (line 5 plus line 25)	24,285,850	26.00
27.00	BAD DEBTS	5,218,860	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	5,218,860	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	19,066,990	29.00

CALCULATION OF CAPITAL PAYMENT	Provider CCN: 15-0010	Period: From 07/01/2019 To 06/30/2020	Worksheet L Parts I-III Date/Time Prepared: 11/20/2020 9:38 am
	Title XVIII	Hospital	PPS

		1.00	
	PART I - FULLY PROSPECTIVE METHOD		
	CAPITAL FEDERAL AMOUNT		
1.00	Capital DRG other than outlier	1,044,184	1.00
1.01	Model 4 BPCI Capital DRG other than outlier	0	1.01
2.00	Capital DRG outlier payments	6,630	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)	44.15	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)	4.71	7.00
8.00	Percentage of Medicaid patient days to total days (see instructions)	24.01	8.00
9.00	Sum of lines 7 and 8	28.72	9.00
10.00	Allowable disproportionate share percentage (see instructions)	5.99	10.00
11.00	Disproportionate share adjustment (see instructions)	62,547	11.00
12.00	Total prospective capital payments (see instructions)	1,113,361	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