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: 15-0125	Period: From 07/01/2019 To 06/30/2020	Worksheet S Parts I-III Date/Time Prepared: 11/25/2020 3:02 pm

PART I - COST REPORT STATUS

Provider use only

1. [X] Electronically prepared cost report — Date: 11/25/2020 Time: 3:02 pm
2. [ ] Manually prepared cost report
3. [0] If this is an amended report enter the number of times the provider resubmitted this cost report
4. [F] Medicare Utilization. Enter "F" for full or "L" for low.

Contractor use only

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

PART II - CERTIFICATION

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

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

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by COMMUNITY HOSPITAL (15-0125) 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.

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

(Signed) DANIEL O'BRIEN
Officer or Administrator of Provider(s)

CFO
Title

11/25/2020 03:02:39 PM
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	589,440	145,787	0	0	1.00
2.00	Subprovider - IPF	0	0	0		0	2.00
3.00	Subprovider - IRF	0	24,077	8		0	3.00
5.00	Swing Bed - SNF	0	0	0		0	5.00
6.00	Swing Bed - NF	0				0	6.00
9.00	HOME HEALTH AGENCY I	0	0	0		0	9.00
200.00	Total	0	613,517	145,795	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: 15-0125 | Period: From 07/01/2019 To 06/30/2020 | Worksheet S-2 Part I Date/Time Prepared: 11/25/2020 3:02 pm

	1.00	2.00	3.00	4.00	
	Hospital and Hospital Health Care Complex Address:				
1.00	Street: 901 MACARTHUR BOULEVARD	PO Box:			1.00
2.00	City: MUNSTER	State: IN	Zip Code: 46321	County: LAKE	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	COMMUNITY HOSPITAL	150125	23844	1	10/03/1973	N	P	P	3.00
4.00	Subprovider - IPF									4.00
5.00	Subprovider - IRF	THE REHAB CENTER AT COMMUNITY	15T125	23844	5	06/30/1996	N	P	P	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	COMMUNITY HOME HEALTH SERVICES	157487	23844		01/07/1997	N	P	N	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)	2		21.00

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

		In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of State Medicaid paid days	Out-of State Medicaid eligible unpaid	Medicaid HMO days	Other Medicaid days	
		1.00	2.00	3.00	4.00	5.00	6.00	
24.00	If this provider is an IPPS hospital, enter the in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.	2,226	393	637	664	9,358	0	24.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-0125 | Period: From 07/01/2019 To 06/30/2020 | Worksheet S-2 Part I | Date/Time Prepared: 11/25/2020 3:02 pm

		In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of State Medicaid paid days	Out-of State Medicaid eligible unpaid	Medicaid HMO days	Other Medicaid days	
		1.00	2.00	3.00	4.00	5.00	6.00	
25.00	If this provider is an IRF, enter the in-state Medicaid paid days in column 1, the in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5.	39	22	0	0	113		25.00

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

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

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

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

		NAHE 413.85 Y/N	Worksheet A Line #	Pass-Through Qualification Criterion Code	
		1.00	2.00	3.00	
60.00	Are you claiming nursing and allied health education (NAHE) costs for any programs that meet the criteria under 42 CFR 413.85? (see instructions) Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", are you impacted by CR 11642 (or subsequent CR) NAHE MA payment adjustement? Enter "Y" for yes or "N" for no in column 2.	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: 15-0125 | Period: From 07/01/2019 To 06/30/2020 | Worksheet S-2 Part I | Date/Time Prepared: 11/25/2020 3:02 pm

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

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-0125 | Period: From 07/01/2019 To 06/30/2020 | Worksheet S-2 Part I | Date/Time Prepared: 11/25/2020 3:02 pm

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

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

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

		1.00	2.00	3.00	
	Inpatient Psychiatric Facility PPS				
70.00	Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? Enter "Y" for yes or "N" for no.	N			70.00
71.00	If line 70 is yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost report filed on or before November 15, 2004? Enter "Y" for yes or "N" for no. (see 42 CFR 412.424(d)(1)(iii)(c)) Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)			0	71.00
	Inpatient Rehabilitation Facility PPS				
75.00	Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF subprovider? Enter "Y" for yes and "N" for no.	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: 15-0125	Period: From 07/01/2019 To 06/30/2020	Worksheet S-2 Part I Date/Time Prepared: 11/25/2020 3:02 pm

			1.00	
	Long Term Care Hospital PPS			
80.00	Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for no.		N	80.00
81.00	Is this a LTCH co-located within another hospital for part or all of the cost reporting period? Enter "Y" for yes and "N" for no.		N	81.00
	TEFRA Providers			
85.00	Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no.		N	85.00
86.00	Did this facility establish a new Other subprovider (excluded unit) under 42 CFR Section §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.			86.00
87.00	Is this hospital an extended neoplastic disease care hospital classified under section 1886(d)(1)(B)(vi)? Enter "Y" for yes or "N" for no.		N	87.00
		V	XIX	
		1.00	2.00	
	Title V and XIX Services			
90.00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.	N	Y	90.00
91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.	N	Y	91.00
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.		N	92.00
93.00	Does this facility operate an ICF/IID facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.	N	N	93.00
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.	N	N	94.00
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	95.00
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.	N	N	96.00
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	97.00
98.00	Does title V or XIX follow Medicare (title XVIII) for the interns and residents post stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N	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	N	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.		N	N	N	109.00

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 15-0125	Period: From 07/01/2019 To 06/30/2020	Worksheet S-2 Part I Date/Time Prepared: 11/25/2020 3:02 pm

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

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

		Premiums	Losses	Insurance	
		1.00	2.00	3.00	
118.01	List amounts of malpractice premiums and paid losses:	1	0	0	118.01

		1.00	2.00	
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein.	N		118.02
119.00	DO NOT USE THIS LINE			119.00
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 1, "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2, "Y" for yes or "N" for no.	N	N	120.00
121.00	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter "Y" for yes or "N" for no.	Y		121.00
122.00	Does the cost report contain healthcare related taxes as defined in §1903(w)(3) of the Act?Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2 the Worksheet A line number where these taxes are included.	N		122.00
	Transplant Center Information			
125.00	Does this facility operate a transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.	N		125.00
126.00	If this is a Medicare certified kidney transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			126.00
127.00	If this is a Medicare certified heart transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			127.00
128.00	If this is a Medicare certified liver transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			128.00
129.00	If this is a Medicare certified lung transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			129.00
130.00	If this is a Medicare certified pancreas transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			130.00
131.00	If this is a Medicare certified intestinal transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			131.00
132.00	If this is a Medicare certified islet transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			132.00
133.00	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	15H054	140.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-0125 | Period: From 07/01/2019 To 06/30/2020 | Worksheet S-2 Part I | Date/Time Prepared: 11/25/2020 3:02 pm

	1.00	2.00	3.00	
	If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number.			
141.00	Name: COMMUNITY FOUNDATION OF NW IN, INC.	Contractor's Name: WPS	Contractor's Number: 08001	141.00
142.00	Street: 10100 DON POWERS DRIVE	PO Box:		142.00
143.00	City: MUNSTER	State: IN	Zip Code: 46321	143.00

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

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

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

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

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

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

		1.00	
	Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act		
167.00	Is this provider a meaningful user under §1886(n)? Enter "Y" for yes or "N" for no.	Y	167.00
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)		168.00
168.01	If this provider is a CAH and is not a meaningful user, does this provider qualify for a hardship exception under §413.70(a)(6)(ii)? Enter "Y" for yes or "N" for no. (see instructions)		168.01
169.00	If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)	0.00	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: 15-0125 | Period: From 07/01/2019 To 06/30/2020 | Worksheet S-2 Part II | Date/Time Prepared: 11/25/2020 3:02 pm

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

		Y/N	Date	V/I	
		1.00	2.00	3.00	
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.	N			2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)	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.	Y	15.00

		Part A		Part B		
		Y/N	Date	Y/N	Date	
		1.00	2.00	3.00	4.00	
	PS&R Data					
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see instructions)	N		N		16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	Y	10/16/2019	Y	10/16/2019	17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N		N		18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	Y		Y		19.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 15-0125 | Period: From 07/01/2019 To 06/30/2020 | Worksheet S-2 Part II Date/Time Prepared: 11/25/2020 3:02 pm

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

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

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

		1.00	2.00	
	Cost Report Preparer Contact Information			
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	CATHERINE	WOERNER	41.00
42.00	Enter the employer/company name of the cost report preparer.	COMMUNITY HOSPITAL		42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	12197031267	CATHERINE.R.WOERNER@COMHS.ORG	43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider CCN: 15-0125	Period: From 07/01/2019 To 06/30/2020	Worksheet S-2 Part II Date/Time Prepared: 11/25/2020 3:02 pm

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 15-0125 | Period: From 07/01/2019 To 06/30/2020 | Worksheet S-3 Part I | Date/Time Prepared: 11/25/2020 3:02 pm

	Component	Worksheet A Line Number	No. of Beds	Bed Days Available	CAH Hours	I/P Days / O/P Visits / Trips Title V	
		1.00	2.00	3.00	4.00	5.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30.00	349	127,734	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)		349	127,734	0.00	0	7.00
8.00	INTENSIVE CARE UNIT	31.00	39	14,274	0.00	0	8.00
9.00	CORONARY CARE UNIT						9.00
9.01	NEONATAL INTENSIVE CARE	32.01	32	11,712	0.00	0	9.01
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)		420	153,720	0.00	0	14.00
15.00	CAH visits					0	15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF	41.00	25	9,150		0	17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY	101.00				0	22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						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)		445				27.00
28.00	Observation Bed Days					0	28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)		0	0			32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00	LTCH non-covered days						33.00
33.01	LTCH site neutral days and discharges						33.01

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 15-0125 | Period: From 07/01/2019 To 06/30/2020 | Worksheet S-3 Part I | Date/Time Prepared: 11/25/2020 3:02 pm

	Component	I/P Days / O/P Visits / Trips			Full Time Equivalents		
		Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
		6.00	7.00	8.00	9.00	10.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30,506	1,651	66,967			1.00
2.00	HMO and other (see instructions)	15,720	10,799				2.00
3.00	HMO IPF Subprovider	0	0				3.00
4.00	HMO IRF Subprovider	603	135				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)	30,506	1,651	66,967			7.00
8.00	INTENSIVE CARE UNIT	4,653	5	10,863			8.00
9.00	CORONARY CARE UNIT						9.00
9.01	NEONATAL INTENSIVE CARE	0	328	4,299			9.01
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		223	3,110			13.00
14.00	Total (see instructions)	35,159	2,207	85,239	0.00	2,449.88	14.00
15.00	CAH visits	0	0	0			15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF	6,181	39	7,717	0.00	41.52	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	30,217	0	48,341	0.00	46.71	22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)			25			24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0.00	0.00	26.25
27.00	Total (sum of lines 14-26)				0.00	2,538.11	27.00
28.00	Observation Bed Days		0	14,475			28.00
29.00	Ambulance Trips	0					29.00
30.00	Employee discount days (see instruction)			0			30.00
31.00	Employee discount days - IRF			0			31.00
32.00	Labor & delivery days (see instructions)	0	272	666			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: 15-0125 | Period: From 07/01/2019 To 06/30/2020 | Worksheet S-3 Part I | Date/Time Prepared: 11/25/2020 3:02 pm

	Component	Full Time Equivalents	Discharges				
		Nonpaid Workers	Title V	Title XVIII	Title XIX	Total All Patients	
		11.00	12.00	13.00	14.00	15.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)		0	6,543	323	15,966	1.00
2.00	HMO and other (see instructions)			2,375	1,825		2.00
3.00	HMO IPF Subprovider				0		3.00
4.00	HMO IRF Subprovider				13		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
9.01	NEONATAL INTENSIVE CARE						9.01
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	6,543	323	15,966	14.00
15.00	CAH visits						15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF	0.00	0	562	3	707	17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY	0.00					22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						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: 15-0125 | Period: From 07/01/2019 To 06/30/2020 | Worksheet S-3 Part II | Date/Time Prepared: 11/25/2020 3:02 pm

		Wkst. A Line Number	Amount Reported	Reclassification of Salaries (from Wkst. A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
	PART II - WAGE DATA							
	SALARIES							
1.00	Total salaries (see instructions)	200.00	178,608,684	0	178,608,684	5,279,276.00	33.83	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		3,896,783	0	3,896,783	47,777.00	81.56	3.00
4.00	Physician-Part A - Administrative		0	0	0	0.00	0.00	4.00
4.01	Physicians - Part A - Teaching		0	0	0	0.00	0.00	4.01
5.00	Physician and Non Physician-Part B		9,729,508	0	9,729,508	64,884.00	149.95	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)		10,192,838	585,584	10,778,422	332,702.00	32.40	10.00
	OTHER WAGES & RELATED COSTS							
11.00	Contract labor: Direct Patient Care		3,196,093	0	3,196,093	32,734.64	97.64	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		761,523	0	761,523	5,062.00	150.44	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		21,110,038	0	21,110,038	622,910.00	33.89	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)		52,860,204	0	52,860,204			17.00
18.00	Wage-related costs (other) (see instructions)							18.00
19.00	Excluded areas		3,647,383	0	3,647,383			19.00
20.00	Non-physician anesthetist Part A		0	0	0			20.00
21.00	Non-physician anesthetist Part B		957,596	0	957,596			21.00
22.00	Physician Part A - Administrative		0	0	0			22.00
22.01	Physician Part A - Teaching		0	0	0			22.01
23.00	Physician Part B		1,977,908	0	1,977,908			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)		5,448,650	0	5,448,650			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: 15-0125 | Period: From 07/01/2019 To 06/30/2020 | Worksheet S-3 Part II | Date/Time Prepared: 11/25/2020 3:02 pm

		Wkst. A Line Number	Amount Reported	Reclassification of Salaries (from Wkst. A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
25.53	Home office: Physicians Part A - Teaching - wage-related (core)		0	0	0			25.53
	OVERHEAD COSTS - DIRECT SALARIES							
26.00	Employee Benefits Department	4.00	686,885	0	686,885	23,469.00	29.27	26.00
27.00	Administrative & General	5.00	16,523,649	0	16,523,649	513,595.00	32.17	27.00
28.00	Administrative & General under contract (see inst.)		2,958,038	0	2,958,038	22,700.72	130.31	28.00
29.00	Maintenance & Repairs	6.00	0	0	0	0.00	0.00	29.00
30.00	Operation of Plant	7.00	5,470,197	0	5,470,197	193,002.00	28.34	30.00
31.00	Laundry & Linen Service	8.00	133,756	0	133,756	9,891.00	13.52	31.00
32.00	Housekeeping	9.00	3,485,612	0	3,485,612	215,849.00	16.15	32.00
33.00	Housekeeping under contract (see instructions)		0	0	0	0.00	0.00	33.00
34.00	Dietary	10.00	3,786,783	-1,167,583	2,619,200	135,314.00	19.36	34.00
35.00	Dietary under contract (see instructions)		0	0	0	0.00	0.00	35.00
36.00	Cafeteria	11.00	0	1,167,583	1,167,583	65,528.00	17.82	36.00
37.00	Maintenance of Personnel	12.00	0	0	0	0.00	0.00	37.00
38.00	Nursing Administration	13.00	3,833,468	-178,817	3,654,651	80,942.00	45.15	38.00
39.00	Central Services and Supply	14.00	0	0	0	0.00	0.00	39.00
40.00	Pharmacy	15.00	4,129,674	-127,973	4,001,701	99,657.00	40.15	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	825,591	0	825,591	28,364.00	29.11	42.00
43.00	Other General Service	18.00	0	0	0	0.00	0.00	43.00

HOSPITAL WAGE INDEX INFORMATION | Provider CCN: 15-0125 | Period: From 07/01/2019 To 06/30/2020 | Worksheet S-3 Part III Date/Time Prepared: 11/25/2020 3:02 pm

		Worksheet A Line Number	Amount Reported	Reclassification of Salaries (from Worksheet A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
	PART III - HOSPITAL WAGE INDEX SUMMARY							
1.00	Net salaries (see instructions)		167,940,431	0	167,940,431	5,189,315.72	32.36	1.00
2.00	Excluded area salaries (see instructions)		10,192,838	585,584	10,778,422	332,702.00	32.40	2.00
3.00	Subtotal salaries (line 1 minus line 2)		157,747,593	-585,584	157,162,009	4,856,613.72	32.36	3.00
4.00	Subtotal other wages & related costs (see inst.)		25,067,654	0	25,067,654	660,706.64	37.94	4.00
5.00	Subtotal wage-related costs (see inst.)		58,308,854	0	58,308,854	0.00	37.10	5.00
6.00	Total (sum of lines 3 thru 5)		241,124,101	-585,584	240,538,517	5,517,320.36	43.60	6.00
7.00	Total overhead cost (see instructions)		41,833,653	-306,790	41,526,863	1,388,311.72	29.91	7.00

HOSPITAL WAGE RELATED COSTS | Provider CCN: 15-0125 | Period: From 07/01/2019 To 06/30/2020 | Worksheet S-3 Part IV Date/Time Prepared: 11/25/2020 3:02 pm

		Amount Reported	
		1.00	
	PART IV - WAGE RELATED COSTS		
	Part A - Core List		
	RETIREMENT COST		
1.00	401K Employer Contributions	0	1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution	5,783,631	2.00
3.00	Nonqualified Defined Benefit Plan Cost (see instructions)	0	3.00
4.00	Qualified Defined Benefit Plan Cost (see instructions)	16,666,667	4.00
	PLAN ADMINISTRATIVE COSTS (Paid to External Organization)		
5.00	401K/TSA Plan Administration fees	0	5.00
6.00	Legal/Accounting/Management Fees-Pension Plan	0	6.00
7.00	Employee Managed Care Program Administration Fees	0	7.00
	HEALTH AND INSURANCE COST		
8.00	Health Insurance (Purchased or Self Funded)	0	8.00
8.01	Health Insurance (Self Funded without a Third Party Administrator)	0	8.01
8.02	Health Insurance (Self Funded with a Third Party Administrator)	20,765,725	8.02
8.03	Health Insurance (Purchased)	0	8.03
9.00	Prescription Drug Plan	0	9.00
10.00	Dental, Hearing and Vision Plan	1,546,652	10.00
11.00	Life Insurance (If employee is owner or beneficiary)	142,898	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)	114,901	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)	0	14.00
15.00	'Workers' Compensation Insurance	1,308,049	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	10,169,155	17.00
18.00	Medicare Taxes - Employers Portion Only	2,491,883	18.00
19.00	Unemployment Insurance	453,530	19.00
20.00	State or Federal Unemployment Taxes	0	20.00
	OTHER		
21.00	Executive Deferred Compensation (Other Than Retirement Cost Reported on lines 1 through 4 above. (see instructions))	0	21.00
22.00	Day Care Cost and Allowances	0	22.00
23.00	Tuition Reimbursement	0	23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)	59,443,091	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: 15-0125 | Period: From 07/01/2019 To 06/30/2020 | Worksheet S-3 Part V | Date/Time Prepared: 11/25/2020 3:02 pm

	Cost Center Description	Contract Labor	Benefit Cost	
		1.00	2.00	
	PART V - Contract Labor and Benefit Cost			
	Hospital and Hospital-Based Component Identification:			
1.00	Total facility's contract labor and benefit cost	3,196,093	59,443,091	1.00
2.00	Hospital	3,196,093	59,443,091	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	0	0	11.00
12.00	Separately Certified ASC			12.00
13.00	Hospital-Based Hospice			13.00
14.00	Hospital-Based Health Clinic RHC			14.00
15.00	Hospital-Based Health Clinic FQHC			15.00
16.00	Hospital-Based-CMHC			16.00
17.00	Renal Dialysis			17.00
18.00	Other	0	0	18.00

HOME HEALTH AGENCY STATISTICAL DATA | Provider CCN: 15-0125 | Component CCN: 15-7487 | Period: From 07/01/2019 To 06/30/2020 | Worksheet S-4 | Date/Time Prepared: 11/25/2020 3:02 pm

Home Health Agency I | PPS

					1.00		
0.00	County				LAKE		0.00
		Title V	Title XVIII	Title XIX	Other	Total	
		1.00	2.00	3.00	4.00	5.00	
	HOME HEALTH AGENCY STATISTICAL DATA						
1.00	Home Health Aide Hours	0	2,268	0	881	3,149	1.00
2.00	Unduplicated Census Count (see instructions)	0.00	1,143.00	0.00	1,630.00	2,773.00	2.00
				Number of Employees (Full Time Equivalent)			
		Enter the number of hours in your normal work week		Staff	Contract	Total	
		0		1.00	2.00	3.00	
	HOME HEALTH AGENCY - NUMBER OF EMPLOYEES						
3.00	Administrator and Assistant Administrator(s)		40.00	0.00	0.00	0.00	3.00
4.00	Director(s) and Assistant Director(s)			1.85	0.00	1.85	4.00
5.00	Other Administrative Personnel			18.68	0.00	18.68	5.00
6.00	Direct Nursing Service			12.64	0.00	12.64	6.00
7.00	Nursing Supervisor			0.00	0.00	0.00	7.00
8.00	Physical Therapy Service			7.96	0.04	8.00	8.00
9.00	Physical Therapy Supervisor			0.00	0.00	0.00	9.00
10.00	Occupational Therapy Service			4.22	0.23	4.45	10.00
11.00	Occupational Therapy Supervisor			0.00	0.00	0.00	11.00
12.00	Speech Pathology Service			0.03	0.00	0.03	12.00
13.00	Speech Pathology Supervisor			0.00	0.00	0.00	13.00
14.00	Medical Social Service			0.01	0.00	0.01	14.00
15.00	Medical Social Service Supervisor			0.00	0.00	0.00	15.00
16.00	Home Health Aide			1.61	0.00	1.61	16.00
17.00	Home Health Aide Supervisor			0.00	0.00	0.00	17.00
18.00	Other (specify)			0.00	0.00	0.00	18.00
	HOME HEALTH AGENCY CBSA CODES						
19.00	Enter in column 1 the number of CBSAs where you provided services during the cost reporting period.			1			19.00
20.00	List those CBSA code(s) in column 1 serviced during this cost reporting period (line 20 contains the first code).			23844			20.00
		Full Episodes					
		Without Outliers	With Outliers	LUPA Episodes	PEP Only Episodes	Total (cols. 1-4)	
		1.00	2.00	3.00	4.00	5.00	
	PPS ACTIVITY DATA						
21.00	Skilled Nursing Visits	11,543	3,061	287	256	15,147	21.00
22.00	Skilled Nursing Visit Charges	2,204,244	586,347	55,166	48,489	2,894,246	22.00
23.00	Physical Therapy Visits	7,062	1,396	99	166	8,723	23.00
24.00	Physical Therapy Visit Charges	1,569,759	315,096	22,242	36,827	1,943,924	24.00
25.00	Occupational Therapy Visits	2,703	792	17	89	3,601	25.00
26.00	Occupational Therapy Visit Charges	596,781	179,047	3,822	19,689	799,339	26.00
27.00	Speech Pathology Visits	304	151	2	9	466	27.00
28.00	Speech Pathology Visit Charges	67,763	34,037	460	2,059	104,319	28.00
29.00	Medical Social Service Visits	11	1	0	0	12	29.00
30.00	Medical Social Service Visit Charges	2,752	262	0	0	3,014	30.00
31.00	Home Health Aide Visits	1,596	623	3	46	2,268	31.00
32.00	Home Health Aide Visit Charges	226,478	88,627	420	6,552	322,077	32.00
33.00	Total visits (sum of lines 21, 23, 25, 27, 29, and 31)	23,219	6,024	408	566	30,217	33.00
34.00	Other Charges	0	0	0	0	0	34.00
35.00	Total Charges (sum of lines 22, 24, 26, 28, 30, 32, and 34)	4,667,777	1,203,416	82,110	113,616	6,066,919	35.00
36.00	Total Number of Episodes (standard/non outlier)	1,499		2,268	32	3,799	36.00
37.00	Total Number of Outlier Episodes		196		7	203	37.00
38.00	Total Non-Routine Medical Supply Charges	341,226	181,628	9,352	4,552	536,758	38.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA | Provider CCN: 15-0125 | Period: From 07/01/2019 To 06/30/2020 | Worksheet S-10 | Date/Time Prepared: 11/25/2020 3:02 pm

		1.00	
	Uncompensated and indigent care cost computation		
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided by line 202 column 8)	0.229370	1.00
	Medicaid (see instructions for each line)		
2.00	Net revenue from Medicaid	12,955,792	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	208,908,063	6.00
7.00	Medicaid cost (line 1 times line 6)	47,917,242	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)	34,961,450	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)	3,894	13.00
14.00	Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)	7,896	14.00
15.00	State or local indigent care program cost (line 1 times line 14)	1,811	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)	34,961,450	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)	16,924,319	2,459,053	19,383,372	20.00
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	3,881,931	2,459,053	6,340,984	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)	3,881,931	2,459,053	6,340,984	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)	15,516,319	26.00
27.00	Medicare reimbursable bad debts for the entire hospital complex (see instructions)	1,192,519	27.00
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)	1,834,643	27.01
28.00	Non-Medicare bad debt expense (see instructions)	13,681,676	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)	3,780,290	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)	10,121,274	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	45,082,724	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 15-0125 | Period: From 07/01/2019 To 06/30/2020 | Worksheet A | Date/Time Prepared: 11/25/2020 3:02 pm

		Cost Center Description	Salaries	Other	Total (col. 1 + col. 2)	Reclassifications (See A-6)	Reclassified Trial Balance (col. 3 +- col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT		14,708,420	14,708,420	299,807	15,008,227	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		13,231,694	13,231,694	26,303	13,257,997	2.00
3.00	00300	OTHER CAP REL COSTS		0	0	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	686,885	21,771,817	22,458,702	-7,514	22,451,188	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	16,523,649	96,858,002	113,381,651	-2,145,070	111,236,581	5.00
6.00	00600	MAINTENANCE & REPAIRS	0	0	0	0	0	6.00
7.00	00700	OPERATION OF PLANT	5,470,197	10,680,746	16,150,943	14,307	16,165,250	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	133,756	1,466,290	1,600,046	110,882	1,710,928	8.00
9.00	00900	HOUSEKEEPING	3,485,612	1,503,872	4,989,484	-166,689	4,822,795	9.00
10.00	01000	DIETARY	3,786,783	2,672,016	6,458,799	-2,249,189	4,209,610	10.00
11.00	01100	CAFETERIA	0	0	0	2,242,423	2,242,423	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	3,833,468	1,040,389	4,873,857	-189,057	4,684,800	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	0	14.00
15.00	01500	PHARMACY	4,129,674	15,198,089	19,327,763	472,259	19,800,022	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	566	566	4,387	4,953	16.00
17.00	01700	SOCIAL SERVICE	825,591	106,505	932,096	0	932,096	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0	22.00
23.00	02300	PARAMED ED PRGM-(PHARMACY)	200,019	17,128	217,147	127,973	345,120	23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	37,054,924	9,615,231	46,670,155	-1,902,758	44,767,397	30.00
31.00	03100	INTENSIVE CARE UNIT	11,493,957	2,384,255	13,878,212	67,794	13,946,006	31.00
32.01	02060	NEONATAL INTENSIVE CARE	3,091,905	765,682	3,857,587	22,538	3,880,125	32.01
41.00	04100	SUBPROVIDER - IRF	2,392,759	1,204,783	3,597,542	26,418	3,623,960	41.00
43.00	04300	NURSERY	0	0	0	1,651,479	1,651,479	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	29,476,215	16,465,066	45,941,281	-1,917	45,939,364	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	2,354,991	534,490	2,889,481	20,889	2,910,370	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	8,610,421	7,338,474	15,948,895	49,900	15,998,795	54.00
60.00	06000	LABORATORY	6,408,816	9,075,153	15,483,969	552,526	16,036,495	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	371,041	2,181,677	2,552,718	0	2,552,718	62.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	3,768,249	1,183,628	4,951,877	0	4,951,877	65.00
66.00	06600	PHYSICAL THERAPY	7,441,806	3,672,674	11,114,480	22,675	11,137,155	66.00
70.00	07000	ELECTROENCEPHALOGRAPHY	740,081	307,182	1,047,263	-522	1,046,741	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	23,789,662	23,789,662	0	23,789,662	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	32,025,703	32,025,703	0	32,025,703	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03140	CARDIOLOGY	8,380,840	5,207,169	13,588,009	-352,084	13,235,925	76.00
76.97	07697	CARDIAC REHABILITATION	884,864	130,514	1,015,378	0	1,015,378	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	2,320,567	754,788	3,075,355	-1,439	3,073,916	90.00
91.00	09100	EMERGENCY	7,141,554	2,587,198	9,728,752	72,785	9,801,537	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	4,414,136	979,629	5,393,765	-9,050	5,384,715	101.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	175,422,760	299,458,492	474,881,252	-1,239,944	473,641,308	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
191.00	19100	RESEARCH	421,714	126,640	548,354	538,052	1,086,406	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	1,047,975	1,047,975	15,218	1,063,193	192.00
194.00	07950	ADVERTISING	0	0	0	686,674	686,674	194.00
194.01	07951	FITNESS POINTE	1,220,640	834,203	2,054,843	0	2,054,843	194.01
194.02	07952	FITNESS POINTE SPA/PRO SHOP/DIETARY	242,838	112,793	355,631	0	355,631	194.02
194.03	07953	RETAIL PHARMACY	875,020	13,100,824	13,975,844	0	13,975,844	194.03
194.04	07954	HOSPICE	0	0	0	0	0	194.04
194.05	07955	RUSH RESIDENTS	0	0	0	0	0	194.05
194.06	07956	EINSTEIN BAGELS	99,039	117,616	216,655	0	216,655	194.06
194.07	07957	NORTHWESTERN IMAGING	326,673	262,825	589,498	0	589,498	194.07
200.00		TOTAL (SUM OF LINES 118 through 199)	178,608,684	315,061,368	493,670,052	0	493,670,052	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 15-0125 | Period: From 07/01/2019 To 06/30/2020 | Worksheet A | Date/Time Prepared: 11/25/2020 3:02 pm

		Cost Center Description	Adjustments (See A-8)	Net Expenses For Allocation		
			6.00	7.00		
		GENERAL SERVICE COST CENTERS				
1.00	00100	CAP REL COSTS-BLDG & FIXT	36,927	15,045,154		1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	1,945,127	15,203,124		2.00
3.00	00300	OTHER CAP REL COSTS	0	0		3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	2,877,859	25,329,047		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-45,996,912	65,239,669		5.00
6.00	00600	MAINTENANCE & REPAIRS	0	0		6.00
7.00	00700	OPERATION OF PLANT	7	16,165,257		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	1,710,928		8.00
9.00	00900	HOUSEKEEPING	-79,272	4,743,523		9.00
10.00	01000	DIETARY	-182	4,209,428		10.00
11.00	01100	CAFETERIA	-418,344	1,824,079		11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0		12.00
13.00	01300	NURSING ADMINISTRATION	289,254	4,974,054		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0		14.00
15.00	01500	PHARMACY	-1,485	19,798,537		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	5,245,619	5,250,572		16.00
17.00	01700	SOCIAL SERVICE	0	932,096		17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0		19.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0		21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0		22.00
23.00	02300	PARAMED ED PRGM-(PHARMACY)	0	345,120		23.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	-120,956	44,646,441		30.00
31.00	03100	INTENSIVE CARE UNIT	-1,008,586	12,937,420		31.00
32.01	02060	NEONATAL INTENSIVE CARE	-320,618	3,559,507		32.01
41.00	04100	SUBPROVIDER - IRF	0	3,623,960		41.00
43.00	04300	NURSERY	0	1,651,479		43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	-13,916,525	32,022,839		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	-5,388	2,904,982		52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-64,652	15,934,143		54.00
60.00	06000	LABORATORY	-54,409	15,982,086		60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	2,552,718		62.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0		62.30
65.00	06500	RESPIRATORY THERAPY	-7,214	4,944,663		65.00
66.00	06600	PHYSICAL THERAPY	0	11,137,155		66.00
70.00	07000	ELECTROENCEPHALOGRAPHY	-2,643	1,044,098		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	23,789,662		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	32,025,703		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0		73.00
76.00	03140	CARDIOLOGY	-91,006	13,144,919		76.00
76.97	07697	CARDIAC REHABILITATION	-39,971	975,407		76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0		76.98
76.99	07699	LITHOTRIPSY	0	0		76.99
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	-147,556	2,926,360		90.00
91.00	09100	EMERGENCY	-11,016	9,790,521		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				92.00
		OTHER REIMBURSABLE COST CENTERS				
101.00	10100	HOME HEALTH AGENCY	112,773	5,497,488		101.00
		SPECIAL PURPOSE COST CENTERS				
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-51,779,169	421,862,139		118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		190.00
191.00	19100	RESEARCH	-13,170	1,073,236		191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	8	1,063,201		192.00
194.00	07950	ADVERTISING	0	686,674		194.00
194.01	07951	FITNESS POINTE	0	2,054,843		194.01
194.02	07952	FITNESS POINTE SPA/PRO SHOP/DIETARY	0	355,631		194.02
194.03	07953	RETAIL PHARMACY	0	13,975,844		194.03
194.04	07954	HOSPICE	0	0		194.04
194.05	07955	RUSH RESIDENTS	0	0		194.05
194.06	07956	EINSTEIN BAGELS	0	216,655		194.06
194.07	07957	NORTHWESTERN IMAGING	0	589,498		194.07
200.00		TOTAL (SUM OF LINES 118 through 199)	-51,792,331	441,877,721		200.00

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		Increases			
	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
	A - BUILDING INSURANCE				
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	299,807	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	26,303	2.00
	TOTALS		0	326,110	
	B - NURSING FLOAT SALARIES				
1.00	INTENSIVE CARE UNIT	31.00	89,376	0	1.00
2.00	NEONATAL INTENSIVE CARE	32.01	24,282	0	2.00
3.00	DELIVERY ROOM & LABOR ROOM	52.00	20,889	0	3.00
4.00	EMERGENCY	91.00	72,814	0	4.00
5.00	SUBPROVIDER - IRF	41.00	26,418	0	5.00
6.00	NURSERY	43.00	11,677	0	6.00
	TOTALS		245,456	0	
	C - CAFETERIA EXPENSE				
1.00	CAFETERIA	11.00	1,167,583	1,074,840	1.00
	TOTALS		1,167,583	1,074,840	
	D - RESEARCH				
1.00	RESEARCH	191.00	431,193	106,859	1.00
2.00		0.00	0	0	2.00
	TOTALS		431,193	106,859	
	E - ADVERTISING NON-REIMBURSABLE				
1.00	ADVERTISING	194.00	0	686,674	1.00
2.00		0.00	0	0	2.00
3.00		0.00	0	0	3.00
4.00		0.00	0	0	4.00
5.00		0.00	0	0	5.00
6.00		0.00	0	0	6.00
7.00		0.00	0	0	7.00
8.00		0.00	0	0	8.00
9.00		0.00	0	0	9.00
10.00		0.00	0	0	10.00
11.00		0.00	0	0	11.00
12.00		0.00	0	0	12.00
13.00		0.00	0	0	13.00
14.00		0.00	0	0	14.00
	TOTALS		0	686,674	
	F - RECLASS NURSERY				
1.00	NURSERY	43.00	1,305,584	334,218	1.00
	TOTALS		1,305,584	334,218	
	G - RECLASS PRECEPTOR TIME				
1.00	PARAMED ED PRGM-(PHARMACY)	23.00	127,973	0	1.00
	TOTALS		127,973	0	
	H - LINEN RECLASS FOR OFFSITES SJ				
1.00	RADIOLOGY-DIAGNOSTIC	54.00	0	7,263	1.00
2.00	PHYSICAL THERAPY	66.00	0	2,905	2.00
3.00	CARDIOLOGY	76.00	0	1,453	3.00
4.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	13,073	4.00
5.00	RADIOLOGY-DIAGNOSTIC	54.00	0	18,364	5.00
6.00	CARDIOLOGY	76.00	0	7,870	6.00
7.00	CLINIC	90.00	0	2,623	7.00
8.00	RADIOLOGY-DIAGNOSTIC	54.00	0	6,434	8.00
9.00	CARDIOLOGY	76.00	0	2,145	9.00
10.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	2,145	10.00
11.00	LAUNDRY & LINEN SERVICE	8.00	0	110,882	11.00
12.00		0.00	0	0	12.00
13.00		0.00	0	0	13.00
14.00		0.00	0	0	14.00
15.00		0.00	0	0	15.00
16.00		0.00	0	0	16.00
17.00		0.00	0	0	17.00
18.00		0.00	0	0	18.00
19.00		0.00	0	0	19.00
20.00		0.00	0	0	20.00
	TOTALS		0	175,157	
	I - RECLASS OFFSITE HOUSEK COSTS SJ				
1.00	ADMINISTRATIVE & GENERAL	5.00	0	44,675	1.00
2.00	OPERATION OF PLANT	7.00	0	14,267	2.00
3.00	HOUSEKEEPING	9.00	0	492	3.00
4.00	MEDICAL RECORDS & LIBRARY	16.00	0	4,387	4.00
5.00	RADIOLOGY-DIAGNOSTIC	54.00	0	19,185	5.00
6.00	LABORATORY	60.00	0	4,177	6.00
7.00	PHYSICAL THERAPY	66.00	0	20,114	7.00
8.00	CARDIOLOGY	76.00	0	2,103	8.00
9.00	ADMINISTRATIVE & GENERAL	5.00	0	8,407	9.00
10.00	OPERATION OF PLANT	7.00	0	470	10.00

RECLASSIFICATIONS | Provider CCN: 15-0125 | Period: From 07/01/2019 To 06/30/2020 | Worksheet A-6 | Date/Time Prepared: 11/25/2020 3:02 pm

	Increases					
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
11.00	RADIOLOGY-DIAGNOSTIC	54.00	0	4,365		11.00
12.00	LABORATORY	60.00	0	1,531		12.00
	TOTALS		0	124,173		
	J - COVID COSTS					
1.00	PHARMACY	15.00	0	600,232		1.00
2.00	LABORATORY	60.00	0	547,486		2.00
	TOTALS		0	1,147,718		
500.00	Grand Total: Increases		3,277,789	3,975,749		500.00

RECLASSIFICATIONS | Provider CCN: 15-0125 | Period: From 07/01/2019 To 06/30/2020 | Worksheet A-6 | Date/Time Prepared: 11/25/2020 3:02 pm

		Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	A - BUILDING INSURANCE						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	299,807	12		1.00
2.00	ADMINISTRATIVE & GENERAL	5.00	0	26,303	12		2.00
	TOTALS		0	326,110			
	B - NURSING FLOAT SALARIES						
1.00	ADULTS & PEDIATRICS	30.00	245,456	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
	TOTALS		245,456	0			
	C - CAFETERIA EXPENSE						
1.00	DIETARY	10.00	1,167,583	1,074,840	0		1.00
	TOTALS		1,167,583	1,074,840			
	D - RESEARCH						
1.00	CARDIOLOGY	76.00	252,376	106,859	0		1.00
2.00	NURSING ADMINISTRATION	13.00	178,817	0	0		2.00
	TOTALS		431,193	106,859			
	E - ADVERTISING NON-REIMBURSABLE						
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	7,514	0		1.00
2.00	ADMINISTRATIVE & GENERAL	5.00	0	617,471	0		2.00
3.00	OPERATION OF PLANT	7.00	0	272	0		3.00
4.00	DIETARY	10.00	0	6,148	0		4.00
5.00	NURSING ADMINISTRATION	13.00	0	10,240	0		5.00
6.00	ADULTS & PEDIATRICS	30.00	0	17,134	0		6.00
7.00	NEONATAL INTENSIVE CARE	32.01	0	1,744	0		7.00
8.00	RADIOLOGY-DIAGNOSTIC	54.00	0	5,711	0		8.00
9.00	LABORATORY	60.00	0	668	0		9.00
10.00	PHYSICAL THERAPY	66.00	0	280	0		10.00
11.00	ELECTROENCEPHALOGRAPHY	70.00	0	522	0		11.00
12.00	CARDIOLOGY	76.00	0	6,420	0		12.00
13.00	CLINIC	90.00	0	3,500	0		13.00
14.00	HOME HEALTH AGENCY	101.00	0	9,050	0		14.00
	TOTALS		0	686,674			
	F - RECLASS NURSERY						
1.00	ADULTS & PEDIATRICS	30.00	1,305,584	334,218	0		1.00
	TOTALS		1,305,584	334,218			
	G - RECLASS PRECEPTOR TIME						
1.00	PHARMACY	15.00	127,973	0	0		1.00
	TOTALS		127,973	0			
	H - LINEN RECLASS FOR OFFSITES SJ						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	24,694	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	HOUSEKEEPING	9.00	0	28,857	0		5.00
6.00		0.00	0	0	0		6.00
7.00		0.00	0	0	0		7.00
8.00	ADMINISTRATIVE & GENERAL	5.00	0	10,724	0		8.00
9.00		0.00	0	0	0		9.00
10.00		0.00	0	0	0		10.00
11.00	ADMINISTRATIVE & GENERAL	5.00	0	56,662	0		11.00
12.00	OPERATION OF PLANT	7.00	0	158	0		12.00
13.00	HOUSEKEEPING	9.00	0	28,924	0		13.00
14.00	DIETARY	10.00	0	618	0		14.00
15.00	ADULTS & PEDIATRICS	30.00	0	366	0		15.00
16.00	INTENSIVE CARE UNIT	31.00	0	21,582	0		16.00
17.00	OPERATING ROOM	50.00	0	1,917	0		17.00
18.00	PHYSICAL THERAPY	66.00	0	64	0		18.00
19.00	CLINIC	90.00	0	562	0		19.00
20.00	EMERGENCY	91.00	0	29	0		20.00
	TOTALS		0	175,157			
	I - RECLASS OFFSITE HOUSEK COSTS SJ						
1.00	HOUSEKEEPING	9.00	0	109,400	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	ADMINISTRATIVE & GENERAL	5.00	0	14,773	0		9.00
10.00		0.00	0	0	0		10.00

RECLASSIFICATIONS | Provider CCN: 15-0125 | Period: From 07/01/2019 To 06/30/2020 | Worksheet A-6 | Date/Time Prepared: 11/25/2020 3:02 pm

		Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
11.00		0.00	0	0	0		11.00
12.00		0.00	0	0	0		12.00
	TOTALS		0	124,173			
	J - COVID COSTS						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	1,147,718	0		1.00
2.00		0.00	0	0	0		2.00
	TOTALS		0	1,147,718			
500.00	Grand Total: Decreases		3,277,789	3,975,749			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-0125 | Period: From 07/01/2019 To 06/30/2020 | Worksheet A-7 Part I | Date/Time Prepared: 11/25/2020 3:02 pm

		Beginning Balances	Acquisitions: Purchases	Acquisitions: Donation	Acquisitions: Total	Disposals and Retirements	
		1.00	2.00	3.00	4.00	5.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	13,736,798	0	0	0	539,936	1.00
2.00	Land Improvements	1,257,038	395,782	0	395,782	14,850	2.00
3.00	Buildings and Fixtures	387,492,049	9,753,231	0	9,753,231	2,123,500	3.00
4.00	Building Improvements	0	0	0	0	0	4.00
5.00	Fixed Equipment	0	0	0	0	0	5.00
6.00	Movable Equipment	147,574,739	9,906,751	0	9,906,751	4,679,684	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	550,060,624	20,055,764	0	20,055,764	7,357,970	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	550,060,624	20,055,764	0	20,055,764	7,357,970	10.00

		Ending Balance	Fully Depreciated Assets	
		6.00	7.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES			
1.00	Land	13,196,862	0	1.00
2.00	Land Improvements	1,637,970	0	2.00
3.00	Buildings and Fixtures	395,121,780	0	3.00
4.00	Building Improvements	0	0	4.00
5.00	Fixed Equipment	0	0	5.00
6.00	Movable Equipment	152,801,806	0	6.00
7.00	HIT designated Assets	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	562,758,418	0	8.00
9.00	Reconciling Items	0	0	9.00
10.00	Total (line 8 minus line 9)	562,758,418	0	10.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-0125 | Period: From 07/01/2019 To 06/30/2020 | Worksheet A-7 Part II | Date/Time Prepared: 11/25/2020 3:02 pm

	Cost Center Description	SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	CAP REL COSTS-BLDG & FIXT	13,287,060	1,421,360	0	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	10,820,611	2,411,083	0	0	0	2.00
3.00	Total (sum of lines 1-2)	24,107,671	3,832,443	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	14,708,420	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	13,231,694	2.00
3.00	Total (sum of lines 1-2)	0	27,940,114	3.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-0125 | Period: From 07/01/2019 To 06/30/2020 | Worksheet A-7 Part III Date/Time Prepared: 11/25/2020 3:02 pm

	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	409,956,612	0	409,956,612	0.728477	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	152,801,806	0	152,801,806	0.271523	0	2.00
3.00	Total (sum of lines 1-2)	562,758,418	0	562,758,418	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	13,485,611	1,259,736	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	12,765,738	2,411,083	2.00
3.00	Total (sum of lines 1-2)	0	0	0	26,251,349	3,670,819	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	299,807	0	0	15,045,154	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	26,303	0	0	15,203,124	2.00
3.00	Total (sum of lines 1-2)	0	326,110	0	0	30,248,278	3.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 15-0125 | Period: From 07/01/2019 To 06/30/2020 | Worksheet A-8 | Date/Time Prepared: 11/25/2020 3:02 pm

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
1.00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)		0	CAP REL COSTS-BLDG & FIXT	1.00	0	1.00
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
3.00	Investment income - other (chapter 2)		0		0.00	0	3.00
4.00	Trade, quantity, and time discounts (chapter 8)		0		0.00	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)		0		0.00	0	5.00
6.00	Rental of provider space by suppliers (chapter 8)		0		0.00	0	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)		0		0.00	0	7.00
8.00	Television and radio service (chapter 21)		0		0.00	0	8.00
9.00	Parking lot (chapter 21)		0		0.00	0	9.00
10.00	Provider-based physician adjustment	A-8-2	-14,280,833			0	10.00
11.00	Sale of scrap, waste, etc. (chapter 23)		0		0.00	0	11.00
12.00	Related organization transactions (chapter 10)	A-8-1	-34,292,794			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests		0		0.00	0	14.00
15.00	Rental of quarters to employee and others		0		0.00	0	15.00
16.00	Sale of medical and surgical supplies to other than patients		0		0.00	0	16.00
17.00	Sale of drugs to other than patients		0		0.00	0	17.00
18.00	Sale of medical records and abstracts		0		0.00	0	18.00
19.00	Nursing and allied health education (tuition, fees, books, etc.)		0		0.00	0	19.00
20.00	Vending machines		0		0.00	0	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	0	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	RESPIRATORY THERAPY	65.00		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	PHYSICAL THERAPY	66.00		24.00
25.00	Utilization review - physicians' compensation (chapter 21)		0	*** Cost Center Deleted ***	114.00		25.00
26.00	Depreciation - CAP REL COSTS-BLDG & FIXT		0	CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	27.00
28.00	Non-physician Anesthetist		0	NONPHYSICIAN ANESTHETISTS	19.00		28.00
29.00	Physicians' assistant		0		0.00	0	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	*** Cost Center Deleted ***	67.00		30.00
30.99	Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS	30.00		30.99
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	*** Cost Center Deleted ***	68.00		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest		0		0.00	0	32.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 15-0125 | Period: From 07/01/2019 To 06/30/2020 | Worksheet A-8 | Date/Time Prepared: 11/25/2020 3:02 pm

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
33.00	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	33.00
35.00	A&G OTHER INCOME	B	-115,502	ADMINISTRATIVE & GENERAL	5.00	0	35.00
36.00	OFFSET ICU FEES	A	-112,000	INTENSIVE CARE UNIT	31.00	0	36.00
36.01	OFFSET PHYSICIAN FEES	A	-18,000	ADMINISTRATIVE & GENERAL	5.00	0	36.01
36.02	OFFSET PHYSICIAN FEES OCC HEALTH	A	0	CLINIC	90.00	0	36.02
36.03	OFFSET LASER CLINIC FEES	A	-4,550	CARDIOLOGY	76.00	0	36.03
36.04	OFFSET ON CALL FEES	A	-544,000	ADMINISTRATIVE & GENERAL	5.00	0	36.04
36.05	OFFSET NP SALARIES WOUND	A	-131,177	CLINIC	90.00	0	36.05
36.06	OFFSET NP SALARIES NEURO IMCU	A	-55,729	ADULTS & PEDIATRICS	30.00	0	36.06
36.07	OFFSET NP SALARIES WOUND ICU	A	-878,562	INTENSIVE CARE UNIT	31.00	0	36.07
36.08	OFFSET NP SALARIES WOUND NEONATOLOGY	A	-278,932	NEONATAL INTENSIVE CARE	32.01	0	36.08
36.09	OFFSET NP SALARIES WOUND A&G	A	-93,127	ADMINISTRATIVE & GENERAL	5.00	0	36.09
37.00	OFFSET MAMMO FEES	A	-17,030	RADIOLOGY-DIAGNOSTIC	54.00	0	37.00
38.00	OFFSET OTHER OP REV	B	-25,627	RADIOLOGY-DIAGNOSTIC	54.00	0	38.00
40.00	PHYSICIAN RENTAL-LAB	B	-25,045	LABORATORY	60.00	0	40.00
42.00	VARIOUS EH&W OFFSETS	B	-1,098	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	42.00
42.01	EMPLOYEE CAFE REV	B	-417,400	CAFETERIA	11.00	0	42.01
42.04	OFFSET NURS ADMIN OTHER REVENUE	B	0	NURSING ADMINISTRATION	13.00	0	42.04
42.05	OTHER INCOME ACUTE	B	-873	ADULTS & PEDIATRICS	30.00	0	42.05
43.00	OFFSET OTHER INCOME ICU	B	-40	INTENSIVE CARE UNIT	31.00	0	43.00
43.02	OFFSET RESEARCH COSTS HEART CTR	A	0	CARDIOLOGY	76.00	0	43.02
43.07	OTHER INCOME ER	B	-16	EMERGENCY	91.00	0	43.07
43.08	OTHER INCOME CARDIOLOGY	B	-2,262	CARDIOLOGY	76.00	0	43.08
43.09	OFFSET OTHER INCOME HHA	B	0	HOME HEALTH AGENCY	101.00	0	43.09
43.10	OFFSET RESEARCH RELATED COSTS N	A	0	NURSING ADMINISTRATION	13.00	0	43.10
44.00	OTHER INCOME	B	0	DIETARY	10.00	0	44.00
45.00	OFFSET NEONATOLOGY FEES	A	-1,620	NEONATAL INTENSIVE CARE	32.01	0	45.00
45.01	EMPLOYEE CAFETERIA REVENUE	B	0	CAFETERIA	11.00	0	45.01
45.02	OFFSET RELEASED TEMP REST OP IN	B	-630	NEONATAL INTENSIVE CARE	32.01	0	45.02
45.03	OTHER INCOME DIETARY	B	-944	CAFETERIA	11.00	0	45.03
45.04	TELEPHONE SERVICE	A	-186,353	ADMINISTRATIVE & GENERAL	5.00	0	45.04
45.05	TELEPHONE SERVICE	A	-24,222	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	45.05
45.06	TELEPHONE SERVICE	A	-2,216	CAP REL COSTS-MVBLE EQUIP	2.00	9	45.06
45.07	OTHER INCOME	B	-182	DIETARY	10.00	0	45.07
45.08	TELEVISION SERVICE	A	0	OPERATION OF PLANT	7.00	0	45.08
45.09	TELEVISION SERVICE	A	-7,018	CAP REL COSTS-MVBLE EQUIP	2.00	9	45.09
45.21	PARETN ASSET DEP AJE	A	-2,672	CAP REL COSTS-BLDG & FIXT	1.00	9	45.21
45.29	OFFSET RELEASED TEMP REST OP IN	B	-46,106	ADMINISTRATIVE & GENERAL	5.00	0	45.29
45.30	OFFSET RELEASED TEMP REST OP IN	B	-71,423	CARDIOLOGY	76.00	0	45.30
45.31	OFFSET RELEASED TEMP REST OP IN	B	-5,395	RESPIRATORY THERAPY	65.00	0	45.31
45.32	OFFSET RELEASED TEMP REST OP IN	B	-11,000	EMERGENCY	91.00	0	45.32
45.33	NON-PT CARE RELATED EXPENSES	A	-3,162	ADMINISTRATIVE & GENERAL	5.00	0	45.33
45.35	OFFSET RELEASED TEMP REST OP IN	B	-5,129	RADIOLOGY-DIAGNOSTIC	54.00	0	45.35
45.36	OFFSET RELEASED TEMP REST OP IN	B	0	PHARMACY	15.00	0	45.36
46.00	OFFSET SURGERY INCOME	B	0	OPERATING ROOM	50.00	0	46.00
47.00	OFFSET CARDIAC REHAB CLASS INCO	B	-39,971	CARDIAC REHABILITATION	76.97	0	47.00
47.01	CLEANING SERVICES-SJ SV	A	-10,418	ADMINISTRATIVE & GENERAL	5.00	0	47.01
47.03	CLEANING SERVICES-SJ SV	A	-79,273	HOUSEKEEPING	9.00	0	47.03
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-51,792,331				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.

ADJUSTMENTS TO EXPENSES | Provider CCN: 15-0125 | Period: From 07/01/2019 To 06/30/2020 | Worksheet A-8 | Date/Time Prepared: 11/25/2020 3:02 pm

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

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: 15-0125 | Period: From 07/01/2019 To 06/30/2020 | Worksheet A-8-1 | Date/Time Prepared: 11/25/2020 3:02 pm

	Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in Wks. A, column 5	
	1.00	2.00	3.00	4.00	5.00	
	A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:					
1.00	5.00	ADMINISTRATIVE & GENERAL	ADMINISTRATIVE NONCAPITAL CO	16,232,796	55,405,674	1.00
2.00	1.00	CAP REL COSTS-BLDG & FIXT	BLDG DEPR	201,223	0	2.00
3.00	2.00	CAP REL COSTS-MVBLE EQUIP	EQ DEPR	1,954,361	0	3.00
3.01	5.00	ADMINISTRATIVE & GENERAL	TELECOMMUNICATIONS	1,315,272	0	3.01
3.02	16.00	MEDICAL RECORDS & LIBRARY	MEDICAL RECORDS	5,245,619	0	3.02
3.03	5.00	ADMINISTRATIVE & GENERAL	PATIENT ACCTING	6,722,179	0	3.03
3.04	4.00	EMPLOYEE BENEFITS DEPARTMENT	ALLOCATED BENEFIT COSTS	2,903,179	0	3.04
3.05	5.00	ADMINISTRATIVE & GENERAL	ALLOCATED SALARY COSTS	14,362,057	0	3.05
3.06	13.00	NURSING ADMINISTRATION	CANCER REGISTRY	289,254	0	3.06
3.07	1.00	CAP REL COSTS-BLDG & FIXT	CDC LEASE DEPRECIATION	61,188	261,720	3.07
3.08	5.00	ADMINISTRATIVE & GENERAL	CDC LEASE EXPENSES	29	0	3.08
3.09	7.00	OPERATION OF PLANT	CDC LEASE EXPENSES	7	0	3.09
3.10	9.00	HOUSEKEEPING	CDC LEASE EXPENSES	1	0	3.10
3.11	54.00	RADIOLOGY-DIAGNOSTIC	CDC LEASE EXPENSES	39	0	3.11
3.12	60.00	LABORATORY	CDC LEASE EXPENSES	4	0	3.12
3.13	76.00	CARDIOLOGY	CDC LEASE EXPENSES	1	0	3.13
3.14	192.00	PHYSICIANS' PRIVATE OFFICES	CDC LEASE EXPENSES	8	0	3.14
3.15	5.00	ADMINISTRATIVE & GENERAL	PHYSICIAN ALLOCATION	0	28,121,257	3.15
3.16	1.00	CAP REL COSTS-BLDG & FIXT	901 RIDGE RD LEASE	178,713	96,711	3.16
3.18	101.00	HOME HEALTH AGENCY	901 RIDGE RD EXPENSES	112,773	0	3.18
3.21	1.00	CAP REL COSTS-BLDG & FIXT	800 MACARTHUR LEASE	31,046	74,140	3.21
3.22	5.00	ADMINISTRATIVE & GENERAL	800 MACARTHUR LEASE EXP	56,959	0	3.22
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.			49,666,708	83,959,502	5.00

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

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

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

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

6.00	B		0.00	CFNI	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

(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: 15-0125 | Period: From 07/01/2019 To 06/30/2020 | Worksheet A-8-1 | Date/Time Prepared: 11/25/2020 3:02 pm

	Net Adjustments (col. 4 minus col. 5)*	Wkst. A-7 Ref.		
	6.00	7.00		
	A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:			
1.00	-39,172,878	0		1.00
2.00	201,223	9		2.00
3.00	1,954,361	9		3.00
3.01	1,315,272	0		3.01
3.02	5,245,619	0		3.02
3.03	6,722,179	0		3.03
3.04	2,903,179	0		3.04
3.05	14,362,057	0		3.05
3.06	289,254	0		3.06
3.07	-200,532	10		3.07
3.08	29	0		3.08
3.09	7	0		3.09
3.10	1	0		3.10
3.11	39	0		3.11
3.12	4	0		3.12
3.13	1	0		3.13
3.14	8	0		3.14
3.15	-28,121,257	0		3.15
3.16	82,002	10		3.16
3.18	112,773	0		3.18
3.21	-43,094	10		3.21
3.22	56,959	0		3.22
4.00	0	0		4.00
5.00	-34,292,794			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	HEALTHCARE		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: 15-0125 | Period: From 07/01/2019 To 06/30/2020 | Worksheet A-8-2 | Date/Time Prepared: 11/25/2020 3:02 pm

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	5.00	AGGREGATE-ADMINISTRATIVE & GENERAL	297,773	133,866	163,907	211,500	1,526	1.00
2.00	15.00	AGGREGATE-PHARMACY	8,094	0	8,094	211,500	65	2.00
3.00	30.00	AGGREGATE-ADULTS & PEDIATRICS	121,195	0	121,195	211,500	559	3.00
4.00	31.00	AGGREGATE-INTENSIVE CARE UNIT	55,708	0	55,708	211,500	371	4.00
5.00	32.01	AGGREGATE-NEONATAL INTENSIVE CARE	59,773	30,000	29,773	211,500	200	5.00
6.00	50.00	AGGREGATE-OPERATING ROOM	75,638	0	75,638	246,400	433	6.00
7.00	50.00	AGGREGATE-OPERATING ROOM	13,892,181	13,892,181	0	0	0	7.00
8.00	52.00	AGGREGATE-DELIVERY ROOM & LABOR ROOM	16,675	0	16,675	211,500	111	8.00
9.00	54.00	AGGREGATE-RADIOLOGY-DIAGNOSTIC	41,350	0	41,350	271,900	187	9.00
10.00	60.00	AGGREGATE-LABORATORY	78,550	0	78,550	260,300	393	10.00
11.00	65.00	AGGREGATE-RESPIRATORY THERAPY	31,104	0	31,104	211,500	288	11.00
12.00	70.00	AGGREGATE-ELECTROENCEPHALOGRAPHY	33,758	0	33,758	211,500	306	12.00
13.00	76.00	AGGREGATE-CARDIOLOGY	27,618	0	27,618	211,500	146	13.00
14.00	90.00	AGGREGATE-CLINIC	43,427	0	43,427	211,500	266	14.00
15.00	191.00	AGGREGATE-RESEARCH	34,727	0	34,727	211,500	212	15.00
200.00			14,817,571	14,056,047	761,524		5,063	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	AGGREGATE-ADMINISTRATIVE & GENERAL	155,168	7,758	0	0	0	1.00
2.00	15.00	AGGREGATE-PHARMACY	6,609	330	0	0	0	2.00
3.00	30.00	AGGREGATE-ADULTS & PEDIATRICS	56,841	2,842	0	0	0	3.00
4.00	31.00	AGGREGATE-INTENSIVE CARE UNIT	37,724	1,886	0	0	0	4.00
5.00	32.01	AGGREGATE-NEONATAL INTENSIVE CARE	20,337	1,017	0	0	0	5.00
6.00	50.00	AGGREGATE-OPERATING ROOM	51,294	2,565	0	0	0	6.00
7.00	50.00	AGGREGATE-OPERATING ROOM	0	0	0	0	0	7.00
8.00	52.00	AGGREGATE-DELIVERY ROOM & LABOR ROOM	11,287	564	0	0	0	8.00
9.00	54.00	AGGREGATE-RADIOLOGY-DIAGNOSTIC	24,445	1,222	0	0	0	9.00
10.00	60.00	AGGREGATE-LABORATORY	49,182	2,459	0	0	0	10.00
11.00	65.00	AGGREGATE-RESPIRATORY THERAPY	29,285	1,464	0	0	0	11.00
12.00	70.00	AGGREGATE-ELECTROENCEPHALOGRAPHY	31,115	1,556	0	0	0	12.00
13.00	76.00	AGGREGATE-CARDIOLOGY	14,846	742	0	0	0	13.00
14.00	90.00	AGGREGATE-CLINIC	27,048	1,352	0	0	0	14.00
15.00	191.00	AGGREGATE-RESEARCH	21,557	1,078	0	0	0	15.00
200.00			536,738	26,835	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	AGGREGATE-ADMINISTRATIVE & GENERAL	0	155,168	8,739	142,605		1.00
2.00	15.00	AGGREGATE-PHARMACY	0	6,609	1,485	1,485		2.00
3.00	30.00	AGGREGATE-ADULTS & PEDIATRICS	0	56,841	64,354	64,354		3.00
4.00	31.00	AGGREGATE-INTENSIVE CARE UNIT	0	37,724	17,984	17,984		4.00
5.00	32.01	AGGREGATE-NEONATAL INTENSIVE CARE	0	20,337	9,436	39,436		5.00
6.00	50.00	AGGREGATE-OPERATING ROOM	0	51,294	24,344	24,344		6.00
7.00	50.00	AGGREGATE-OPERATING ROOM	0	0	0	13,892,181		7.00
8.00	52.00	AGGREGATE-DELIVERY ROOM & LABOR ROOM	0	11,287	5,388	5,388		8.00
9.00	54.00	AGGREGATE-RADIOLOGY-DIAGNOSTIC	0	24,445	16,905	16,905		9.00
10.00	60.00	AGGREGATE-LABORATORY	0	49,182	29,368	29,368		10.00

PROVIDER BASED PHYSICIAN ADJUSTMENT | Provider CCN: 15-0125 | Period: From 07/01/2019 To 06/30/2020 | Worksheet A-8-2 | Date/Time Prepared: 11/25/2020 3:02 pm

	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		
11.00	65.00	AGGREGATE-RESPIRATORY THERAPY	0	29,285	1,819	1,819		11.00
12.00	70.00	AGGREGATE-ELECTROENCEPHALOGRAPHY	0	31,115	2,643	2,643		12.00
13.00	76.00	AGGREGATE-CARDIOLOGY	0	14,846	12,772	12,772		13.00
14.00	90.00	AGGREGATE-CLINIC	0	27,048	16,379	16,379		14.00
15.00	191.00	AGGREGATE-RESEARCH	0	21,557	13,170	13,170		15.00
200.00			0	536,738	224,786	14,280,833		200.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-0125 | Period: From 07/01/2019 To 06/30/2020 | Worksheet B Part I Date/Time Prepared: 11/25/2020 3:02 pm

		Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS BLDG & FIXT	CAPITAL RELATED COSTS MVBLE EQUIP	EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
			0	1.00	2.00	4.00	4A	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	15,045,154	15,045,154				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	15,203,124		15,203,124			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	25,329,047	65,260	6,626	25,400,933		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	65,239,669	1,237,013	534,560	2,532,481	69,543,723	5.00
6.00	00600	MAINTENANCE & REPAIRS	0	0	0	0	0	6.00
7.00	00700	OPERATION OF PLANT	16,165,257	2,319,344	520,208	838,384	19,843,193	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	1,710,928	25,549	0	20,500	1,756,977	8.00
9.00	00900	HOUSEKEEPING	4,743,523	62,192	31,292	534,219	5,371,226	9.00
10.00	01000	DIETARY	4,209,428	188,095	100,419	401,429	4,899,371	10.00
11.00	01100	CAFETERIA	1,824,079	192,614	0	178,948	2,195,641	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	4,974,054	47,884	164,572	560,126	5,746,636	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	0	14.00
15.00	01500	PHARMACY	19,798,537	83,532	462,473	613,317	20,957,859	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	5,250,572	89,275	437	0	5,340,284	16.00
17.00	01700	SOCIAL SERVICE	932,096	17,392	0	126,533	1,076,021	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0	22.00
23.00	02300	PARAMED ED PRGM-(PHARMACY)	345,120	3,720	0	50,269	399,109	23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	44,646,441	2,905,554	633,717	5,441,493	53,627,205	30.00
31.00	03100	INTENSIVE CARE UNIT	12,937,420	617,993	503,526	1,775,308	15,834,247	31.00
32.01	02060	NEONATAL INTENSIVE CARE	3,559,507	181,275	163,964	477,599	4,382,345	32.01
41.00	04100	SUBPROVIDER - IRF	3,623,960	202,762	27,297	370,773	4,224,792	41.00
43.00	04300	NURSERY	1,651,479	28,926	0	201,889	1,882,294	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	32,022,839	1,610,836	3,673,417	2,649,544	39,956,636	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	2,904,982	252,539	123,662	364,137	3,645,320	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	15,934,143	673,773	4,089,818	1,319,668	22,017,402	54.00
60.00	06000	LABORATORY	15,982,086	292,282	708,222	982,241	17,964,831	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	2,552,718	24,423	29,362	56,867	2,663,370	62.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	4,944,663	59,044	97,606	577,537	5,678,850	65.00
66.00	06600	PHYSICAL THERAPY	11,137,155	643,085	139,361	1,140,561	13,060,162	66.00
70.00	07000	ELECTROENCEPHALOGRAPHY	1,044,098	43,871	80,450	113,428	1,281,847	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	23,789,662	0	0	0	23,789,662	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	32,025,703	0	0	0	32,025,703	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03140	CARDIOLOGY	13,144,919	666,497	2,249,620	1,245,801	17,306,837	76.00
76.97	07697	CARDIAC REHABILITATION	975,407	73,678	29,855	135,618	1,214,558	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	2,926,360	122,884	21,174	355,659	3,426,077	90.00
91.00	09100	EMERGENCY	9,790,521	407,416	184,478	1,105,703	11,488,118	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					0	92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	5,497,488	0	216	676,528	6,174,232	101.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	421,862,139	13,138,708	14,576,332	24,846,560	418,774,528	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	19,708	0	0	19,708	190.00
191.00	19100	RESEARCH	1,073,236	6,477	2,127	130,720	1,212,560	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	1,063,201	904,172	2,089	0	1,969,462	192.00
194.00	07950	ADVERTISING	686,674	0	0	0	686,674	194.00
194.01	07951	FITNESS POINTE	2,054,843	754,646	61,344	187,080	3,057,913	194.01
194.02	07952	FITNESS POINTE SPA/PRO SHOP/DIETARY	355,631	24,179	5,489	37,218	422,517	194.02
194.03	07953	RETAIL PHARMACY	13,975,844	28,959	39,421	134,109	14,178,333	194.03
194.04	07954	HOSPICE	0	115,232	0	0	115,232	194.04
194.05	07955	RUSH RESIDENTS	0	0	0	0	0	194.05
194.06	07956	EINSTEIN BAGELS	216,655	9,871	6,613	15,179	248,318	194.06
194.07	07957	NORTHWESTERN IMAGING	589,498	43,202	509,709	50,067	1,192,476	194.07
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)	441,877,721	15,045,154	15,203,124	25,400,933	441,877,721	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-0125 | Period: From 07/01/2019 To 06/30/2020 | Worksheet B Part I | Date/Time Prepared: 11/25/2020 3:02 pm

		Cost Center Description	ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
			5.00	6.00	7.00	8.00	9.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	69,543,723					5.00
6.00	00600	MAINTENANCE & REPAIRS	0	0				6.00
7.00	00700	OPERATION OF PLANT	3,706,272	0	23,549,465			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	328,165	0	52,669	2,137,811		8.00
9.00	00900	HOUSEKEEPING	1,003,227	0	128,209	0	6,502,662	9.00
10.00	01000	DIETARY	915,095	0	387,754	3,864	3,319	10.00
11.00	01100	CAFETERIA	410,097	0	397,071	0	8,012	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	1,073,345	0	98,713	0	1,908	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	0	14.00
15.00	01500	PHARMACY	3,914,467	0	172,201	0	6,028	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	997,448	0	184,040	0	3,815	16.00
17.00	01700	SOCIAL SERVICE	200,977	0	35,853	0	2,861	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0	22.00
23.00	02300	PARAMED ED PRGM-(PHARMACY)	74,545	0	7,668	0	267	23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	10,016,303	0	5,989,760	804,450	2,468,349	30.00
31.00	03100	INTENSIVE CARE UNIT	2,957,489	0	1,273,983	140,916	326,704	31.00
32.01	02060	NEONATAL INTENSIVE CARE	818,526	0	373,696	2,641	77,775	32.01
41.00	04100	SUBPROVIDER - IRF	789,098	0	417,990	149,804	250,322	41.00
43.00	04300	NURSERY	351,571	0	59,631	62,665	15,528	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	7,463,021	0	3,320,717	276,509	1,418,566	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	680,866	0	520,605	92,399	259,459	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,112,366	0	1,388,974	183,165	214,248	54.00
60.00	06000	LABORATORY	3,355,435	0	602,535	0	125,523	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	497,459	0	50,349	0	0	62.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	1,060,684	0	121,718	0	13,735	65.00
66.00	06600	PHYSICAL THERAPY	2,439,351	0	1,325,711	37,183	107,477	66.00
70.00	07000	ELECTROENCEPHALOGRAPHY	239,421	0	90,439	19,107	19,458	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	4,443,385	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	5,981,697	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03140	CARDIOLOGY	3,232,536	0	1,373,974	194,372	218,254	76.00
76.97	07697	CARDIAC REHABILITATION	226,853	0	151,886	3,220	23,273	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	639,916	0	253,323	26,213	46,375	90.00
91.00	09100	EMERGENCY	2,145,728	0	839,882	141,303	786,104	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	1,153,211	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	65,228,554	0	19,619,351	2,137,811	6,397,360	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	3,681	0	40,629	0	0	190.00
191.00	19100	RESEARCH	226,480	0	13,352	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	367,852	0	1,863,939	0	103,013	192.00
194.00	07950	ADVERTISING	128,256	0	0	0	0	194.00
194.01	07951	FITNESS POINTE	571,151	0	1,555,693	0	0	194.01
194.02	07952	FITNESS POINTE SPA/PRO SHOP/DIETARY	78,917	0	49,844	0	0	194.02
194.03	07953	RETAIL PHARMACY	2,648,201	0	59,699	0	2,289	194.03
194.04	07954	HOSPICE	21,523	0	237,550	0	0	194.04
194.05	07955	RUSH RESIDENTS	0	0	0	0	0	194.05
194.06	07956	EINSTEIN BAGELS	46,380	0	20,348	0	0	194.06
194.07	07957	NORTHWESTERN IMAGING	222,728	0	89,060	0	0	194.07
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)	69,543,723	0	23,549,465	2,137,811	6,502,662	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-0125 | Period: From 07/01/2019 To 06/30/2020 | Worksheet B Part I | Date/Time Prepared: 11/25/2020 3:02 pm

		Cost Center Description	DIETARY	CAFETERIA	MAINTENANCE OF PERSONNEL	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	
			10.00	11.00	12.00	13.00	14.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY	6,209,403					10.00
11.00	01100	CAFETERIA	0	3,010,821				11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0			12.00
13.00	01300	NURSING ADMINISTRATION	0	61,784	0	6,982,386		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	0	14.00
15.00	01500	PHARMACY	0	76,075	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	0	21,659	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0	22.00
23.00	02300	PARAMED ED PRGM-(PHARMACY)	0	8,098	0	0	0	23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	5,189,824	858,432	0	3,034,393	0	30.00
31.00	03100	INTENSIVE CARE UNIT	438,485	223,048	0	788,431	0	31.00
32.01	02060	NEONATAL INTENSIVE CARE	0	60,593	0	214,185	0	32.01
41.00	04100	SUBPROVIDER - IRF	477,256	65,928	0	233,045	0	41.00
43.00	04300	NURSERY	0	29,137	0	102,995	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	453,273	0	1,602,241	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	103,838	52,130	0	184,267	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	187,940	0	0	0	54.00
60.00	06000	LABORATORY	0	177,921	0	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	7,892	0	0	0	62.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0	80,727	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	154,801	0	0	0	66.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	19,610	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03140	CARDIOLOGY	0	177,000	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0	18,451	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	47,779	0	168,881	0	90.00
91.00	09100	EMERGENCY	0	185,003	0	653,948	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	6,209,403	2,967,281	0	6,982,386	0	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
191.00	19100	RESEARCH	0	18,896	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07950	ADVERTISING	0	0	0	0	0	194.00
194.01	07951	FITNESS POINTE	0	0	0	0	0	194.01
194.02	07952	FITNESS POINTE SPA/PRO SHOP/DIETARY	0	0	0	0	0	194.02
194.03	07953	RETAIL PHARMACY	0	19,150	0	0	0	194.03
194.04	07954	HOSPICE	0	0	0	0	0	194.04
194.05	07955	RUSH RESIDENTS	0	0	0	0	0	194.05
194.06	07956	EINSTEIN BAGELS	0	5,494	0	0	0	194.06
194.07	07957	NORTHWESTERN IMAGING	0	0	0	0	0	194.07
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)	6,209,403	3,010,821	0	6,982,386	0	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-0125 | Period: From 07/01/2019 To 06/30/2020 | Worksheet B Part I Date/Time Prepared: 11/25/2020 3:02 pm

		Cost Center Description	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	NONPHYSICIAN ANESTHETISTS	INTERNS & RESIDENTS SERVICES-SALARY & FRINGES APPRV	
			15.00	16.00	17.00	19.00	21.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
12.00	01200	MAINTENANCE OF PERSONNEL						12.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY	25,126,630					15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	6,525,587				16.00
17.00	01700	SOCIAL SERVICE	0	0	1,337,371			17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0		19.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0		0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0			22.00
23.00	02300	PARAMED ED PRGM-(PHARMACY)	0	0	0			23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	545,313	953,086	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	104,976	152,716	0	0	31.00
32.01	02060	NEONATAL INTENSIVE CARE	0	102,856	60,437	0	0	32.01
41.00	04100	SUBPROVIDER - IRF	0	35,386	108,488	0	0	41.00
43.00	04300	NURSERY	0	20,421	43,721	0	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	1,115,418	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	37,217	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	1,137,394	0	0	0	54.00
60.00	06000	LABORATORY	0	728,277	0	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	41,774	0	0	0	62.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0	117,233	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	172,763	0	0	0	66.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	53,387	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	186,911	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	282,042	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	25,126,630	505,134	0	0	0	73.00
76.00	03140	CARDIOLOGY	0	701,253	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0	9,713	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	48,298	0	0	0	90.00
91.00	09100	EMERGENCY	0	547,801	18,923	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	32,020	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	25,126,630	6,525,587	1,337,371	0	0	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07950	ADVERTISING	0	0	0	0	0	194.00
194.01	07951	FITNESS POINTE	0	0	0	0	0	194.01
194.02	07952	FITNESS POINTE SPA/PRO SHOP/DIETARY	0	0	0	0	0	194.02
194.03	07953	RETAIL PHARMACY	0	0	0	0	0	194.03
194.04	07954	HOSPICE	0	0	0	0	0	194.04
194.05	07955	RUSH RESIDENTS	0	0	0	0	0	194.05
194.06	07956	EINSTEIN BAGELS	0	0	0	0	0	194.06
194.07	07957	NORTHWESTERN IMAGING	0	0	0	0	0	194.07
200.00		Cross Foot Adjustments				0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	25,126,630	6,525,587	1,337,371	0	0	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-0125 | Period: From 07/01/2019 To 06/30/2020 | Worksheet B Part I | Date/Time Prepared: 11/25/2020 3:02 pm

		Cost Center Description	INTERNS & RESIDENTS SERVICES-OTHER PRGM COSTS APPRV	PARAMED ED PRGM-(PHARMACY)	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			22.00	23.00	24.00	25.00	26.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
12.00	01200	MAINTENANCE OF PERSONNEL						12.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY						15.00
16.00	01600	MEDICAL RECORDS & LIBRARY						16.00
17.00	01700	SOCIAL SERVICE						17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS						19.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV						21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0					22.00
23.00	02300	PARAMED ED PRGM-(PHARMACY)		489,687				23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	0	83,487,115	0	83,487,115	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	22,240,995	0	22,240,995	31.00
32.01	02060	NEONATAL INTENSIVE CARE	0	0	6,093,054	0	6,093,054	32.01
41.00	04100	SUBPROVIDER - IRF	0	0	6,752,109	0	6,752,109	41.00
43.00	04300	NURSERY	0	0	2,567,963	0	2,567,963	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	55,606,381	0	55,606,381	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	5,576,101	0	5,576,101	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	29,241,489	0	29,241,489	54.00
60.00	06000	LABORATORY	0	0	22,954,522	0	22,954,522	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	3,260,844	0	3,260,844	62.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0	0	7,072,947	0	7,072,947	65.00
66.00	06600	PHYSICAL THERAPY	0	0	17,297,448	0	17,297,448	66.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	1,723,269	0	1,723,269	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	28,419,958	0	28,419,958	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	38,289,442	0	38,289,442	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	489,687	26,121,451	0	26,121,451	73.00
76.00	03140	CARDIOLOGY	0	0	23,204,226	0	23,204,226	76.00
76.97	07697	CARDIAC REHABILITATION	0	0	1,647,954	0	1,647,954	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	4,656,862	0	4,656,862	90.00
91.00	09100	EMERGENCY	0	0	16,806,810	0	16,806,810	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				0		92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	7,359,463	0	7,359,463	101.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	489,687	410,380,403	0	410,380,403	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	64,018	0	64,018	190.00
191.00	19100	RESEARCH	0	0	1,471,288	0	1,471,288	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	4,304,266	0	4,304,266	192.00
194.00	07950	ADVERTISING	0	0	814,930	0	814,930	194.00
194.01	07951	FITNESS POINTE	0	0	5,184,757	0	5,184,757	194.01
194.02	07952	FITNESS POINTE SPA/PRO SHOP/DIETARY	0	0	551,278	0	551,278	194.02
194.03	07953	RETAIL PHARMACY	0	0	16,907,672	0	16,907,672	194.03
194.04	07954	HOSPICE	0	0	374,305	0	374,305	194.04
194.05	07955	RUSH RESIDENTS	0	0	0	0	0	194.05
194.06	07956	EINSTEIN BAGELS	0	0	320,540	0	320,540	194.06
194.07	07957	NORTHWESTERN IMAGING	0	0	1,504,264	0	1,504,264	194.07
200.00		Cross Foot Adjustments	0	0	0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	0	489,687	441,877,721	0	441,877,721	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-0125 | Period: From 07/01/2019 To 06/30/2020 | Worksheet B Part II | Date/Time Prepared: 11/25/2020 3:02 pm

		Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS BLDG & FIXT	CAPITAL RELATED COSTS MVBLE EQUIP	Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
			0	1.00	2.00	2A	4.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	65,260	6,626	71,886	71,886	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	0	1,237,013	534,560	1,771,573	7,171	5.00
6.00	00600	MAINTENANCE & REPAIRS	0	0	0	0	0	6.00
7.00	00700	OPERATION OF PLANT	0	2,319,344	520,208	2,839,552	2,374	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	25,549	0	25,549	58	8.00
9.00	00900	HOUSEKEEPING	0	62,192	31,292	93,484	1,513	9.00
10.00	01000	DIETARY	0	188,095	100,419	288,514	1,137	10.00
11.00	01100	CAFETERIA	0	192,614	0	192,614	507	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	0	47,884	164,572	212,456	1,586	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	0	14.00
15.00	01500	PHARMACY	0	83,532	462,473	546,005	1,737	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	89,275	437	89,712	0	16.00
17.00	01700	SOCIAL SERVICE	0	17,392	0	17,392	358	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0	22.00
23.00	02300	PARAMED ED PRGM-(PHARMACY)	0	3,720	0	3,720	142	23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	2,905,554	633,717	3,539,271	15,367	30.00
31.00	03100	INTENSIVE CARE UNIT	0	617,993	503,526	1,121,519	5,027	31.00
32.01	02060	NEONATAL INTENSIVE CARE	0	181,275	163,964	345,239	1,352	32.01
41.00	04100	SUBPROVIDER - IRF	0	202,762	27,297	230,059	1,050	41.00
43.00	04300	NURSERY	0	28,926	0	28,926	572	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	1,610,836	3,673,417	5,284,253	7,503	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	252,539	123,662	376,201	1,031	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	673,773	4,089,818	4,763,591	3,737	54.00
60.00	06000	LABORATORY	0	292,282	708,222	1,000,504	2,781	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	24,423	29,362	53,785	161	62.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0	59,044	97,606	156,650	1,635	65.00
66.00	06600	PHYSICAL THERAPY	0	643,085	139,361	782,446	3,230	66.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	43,871	80,450	124,321	321	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03140	CARDIOLOGY	0	666,497	2,249,620	2,916,117	3,528	76.00
76.97	07697	CARDIAC REHABILITATION	0	73,678	29,855	103,533	384	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	122,884	21,174	144,058	1,007	90.00
91.00	09100	EMERGENCY	0	407,416	184,478	591,894	3,131	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				0		92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	216	216	1,916	101.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	13,138,708	14,576,332	27,715,040	70,316	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	19,708	0	19,708	0	190.00
191.00	19100	RESEARCH	0	6,477	2,127	8,604	370	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	904,172	2,089	906,261	0	192.00
194.00	07950	ADVERTISING	0	0	0	0	0	194.00
194.01	07951	FITNESS POINTE	0	754,646	61,344	815,990	530	194.01
194.02	07952	FITNESS POINTE SPA/PRO SHOP/DIETARY	0	24,179	5,489	29,668	105	194.02
194.03	07953	RETAIL PHARMACY	0	28,959	39,421	68,380	380	194.03
194.04	07954	HOSPICE	0	115,232	0	115,232	0	194.04
194.05	07955	RUSH RESIDENTS	0	0	0	0	0	194.05
194.06	07956	EINSTEIN BAGELS	0	9,871	6,613	16,484	43	194.06
194.07	07957	NORTHWESTERN IMAGING	0	43,202	509,709	552,911	142	194.07
200.00		Cross Foot Adjustments				0		200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	0	15,045,154	15,203,124	30,248,278	71,886	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-0125 | Period: From 07/01/2019 To 06/30/2020 | Worksheet B Part II | Date/Time Prepared: 11/25/2020 3:02 pm

		Cost Center Description	ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
			5.00	6.00	7.00	8.00	9.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	1,778,744					5.00
6.00	00600	MAINTENANCE & REPAIRS	0	0				6.00
7.00	00700	OPERATION OF PLANT	94,791	0	2,936,717			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	8,393	0	6,568	40,568		8.00
9.00	00900	HOUSEKEEPING	25,658	0	15,988	0	136,643	9.00
10.00	01000	DIETARY	23,404	0	48,355	73	70	10.00
11.00	01100	CAFETERIA	10,489	0	49,516	0	168	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	27,452	0	12,310	0	40	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	0	14.00
15.00	01500	PHARMACY	100,116	0	21,474	0	127	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	25,511	0	22,951	0	80	16.00
17.00	01700	SOCIAL SERVICE	5,140	0	4,471	0	60	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0	22.00
23.00	02300	PARAMED ED PRGM-(PHARMACY)	1,907	0	956	0	6	23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	256,283	0	746,948	15,267	51,869	30.00
31.00	03100	INTENSIVE CARE UNIT	75,640	0	158,871	2,674	6,865	31.00
32.01	02060	NEONATAL INTENSIVE CARE	20,934	0	46,601	50	1,634	32.01
41.00	04100	SUBPROVIDER - IRF	20,182	0	52,125	2,843	5,260	41.00
43.00	04300	NURSERY	8,992	0	7,436	1,189	326	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	190,873	0	414,107	5,247	29,809	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	17,414	0	64,922	1,753	5,452	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	105,177	0	173,211	3,476	4,502	54.00
60.00	06000	LABORATORY	85,818	0	75,139	0	2,638	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	12,723	0	6,279	0	0	62.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	27,128	0	15,179	0	289	65.00
66.00	06600	PHYSICAL THERAPY	62,388	0	165,322	706	2,258	66.00
70.00	07000	ELECTROENCEPHALOGRAPHY	6,123	0	11,278	363	409	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	113,643	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	152,987	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03140	CARDIOLOGY	82,675	0	171,340	3,688	4,586	76.00
76.97	07697	CARDIAC REHABILITATION	5,802	0	18,941	61	489	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	16,366	0	31,591	497	974	90.00
91.00	09100	EMERGENCY	54,879	0	104,737	2,681	16,519	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	29,494	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	1,668,382	0	2,446,616	40,568	134,430	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	94	0	5,067	0	0	190.00
191.00	19100	RESEARCH	5,792	0	1,665	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	9,408	0	232,441	0	2,165	192.00
194.00	07950	ADVERTISING	3,280	0	0	0	0	194.00
194.01	07951	FITNESS POINTE	14,608	0	194,001	0	0	194.01
194.02	07952	FITNESS POINTE SPA/PRO SHOP/DIETARY	2,018	0	6,216	0	0	194.02
194.03	07953	RETAIL PHARMACY	67,730	0	7,445	0	48	194.03
194.04	07954	HOSPICE	550	0	29,623	0	0	194.04
194.05	07955	RUSH RESIDENTS	0	0	0	0	0	194.05
194.06	07956	EINSTEIN BAGELS	1,186	0	2,537	0	0	194.06
194.07	07957	NORTHWESTERN IMAGING	5,696	0	11,106	0	0	194.07
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	1,778,744	0	2,936,717	40,568	136,643	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-0125 | Period: From 07/01/2019 To 06/30/2020 | Worksheet B Part II | Date/Time Prepared: 11/25/2020 3:02 pm

		Cost Center Description	DIETARY	CAFETERIA	MAINTENANCE OF PERSONNEL	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	
			10.00	11.00	12.00	13.00	14.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY	361,553					10.00
11.00	01100	CAFETERIA	0	253,294				11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0			12.00
13.00	01300	NURSING ADMINISTRATION	0	5,198	0	259,042		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	0	14.00
15.00	01500	PHARMACY	0	6,400	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	0	1,822	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0	22.00
23.00	02300	PARAMED ED PRGM-(PHARMACY)	0	681	0	0	0	23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	302,186	72,217	0	112,575	0	30.00
31.00	03100	INTENSIVE CARE UNIT	25,532	18,765	0	29,250	0	31.00
32.01	02060	NEONATAL INTENSIVE CARE	0	5,098	0	7,946	0	32.01
41.00	04100	SUBPROVIDER - IRF	27,789	5,546	0	8,646	0	41.00
43.00	04300	NURSERY	0	2,451	0	3,821	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	38,133	0	59,442	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	6,046	4,386	0	6,836	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	15,811	0	0	0	54.00
60.00	06000	LABORATORY	0	14,968	0	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	664	0	0	0	62.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0	6,791	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	13,023	0	0	0	66.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	1,650	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03140	CARDIOLOGY	0	14,891	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0	1,552	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	4,020	0	6,265	0	90.00
91.00	09100	EMERGENCY	0	15,564	0	24,261	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	361,553	249,631	0	259,042	0	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
191.00	19100	RESEARCH	0	1,590	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07950	ADVERTISING	0	0	0	0	0	194.00
194.01	07951	FITNESS POINTE	0	0	0	0	0	194.01
194.02	07952	FITNESS POINTE SPA/PRO SHOP/DIETARY	0	0	0	0	0	194.02
194.03	07953	RETAIL PHARMACY	0	1,611	0	0	0	194.03
194.04	07954	HOSPICE	0	0	0	0	0	194.04
194.05	07955	RUSH RESIDENTS	0	0	0	0	0	194.05
194.06	07956	EINSTEIN BAGELS	0	462	0	0	0	194.06
194.07	07957	NORTHWESTERN IMAGING	0	0	0	0	0	194.07
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)	361,553	253,294	0	259,042	0	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-0125 | Period: From 07/01/2019 To 06/30/2020 | Worksheet B Part II | Date/Time Prepared: 11/25/2020 3:02 pm

		Cost Center Description	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	NONPHYSICIAN ANESTHETISTS	INTERNS & RESIDENTS SERVICES-SALARY & FRINGES APPRV	
			15.00	16.00	17.00	19.00	21.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
12.00	01200	MAINTENANCE OF PERSONNEL						12.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY	675,859					15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	138,254				16.00
17.00	01700	SOCIAL SERVICE	0	0	29,243			17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0		19.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0		0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0			22.00
23.00	02300	PARAMED ED PRGM-(PHARMACY)	0	0	0			23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	11,513	20,840			30.00
31.00	03100	INTENSIVE CARE UNIT	0	2,216	3,339			31.00
32.01	02060	NEONATAL INTENSIVE CARE	0	2,172	1,322			32.01
41.00	04100	SUBPROVIDER - IRF	0	747	2,372			41.00
43.00	04300	NURSERY	0	431	956			43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	23,550	0			50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	786	0			52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	24,492	0			54.00
60.00	06000	LABORATORY	0	15,376	0			60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	882	0			62.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0			62.30
65.00	06500	RESPIRATORY THERAPY	0	2,475	0			65.00
66.00	06600	PHYSICAL THERAPY	0	3,648	0			66.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	1,127	0			70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	3,946	0			71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	5,955	0			72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	675,859	10,665	0			73.00
76.00	03140	CARDIOLOGY	0	14,806	0			76.00
76.97	07697	CARDIAC REHABILITATION	0	205	0			76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0			76.98
76.99	07699	LITHOTRIPSY	0	0	0			76.99
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	1,020	0			90.00
91.00	09100	EMERGENCY	0	11,566	414			91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	676	0			101.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	675,859	138,254	29,243	0	0	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0			190.00
191.00	19100	RESEARCH	0	0	0			191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0			192.00
194.00	07950	ADVERTISING	0	0	0			194.00
194.01	07951	FITNESS POINTE	0	0	0			194.01
194.02	07952	FITNESS POINTE SPA/PRO SHOP/DIETARY	0	0	0			194.02
194.03	07953	RETAIL PHARMACY	0	0	0			194.03
194.04	07954	HOSPICE	0	0	0			194.04
194.05	07955	RUSH RESIDENTS	0	0	0			194.05
194.06	07956	EINSTEIN BAGELS	0	0	0			194.06
194.07	07957	NORTHWESTERN IMAGING	0	0	0			194.07
200.00		Cross Foot Adjustments				0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	675,859	138,254	29,243	0	0	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-0125 | Period: From 07/01/2019 To 06/30/2020 | Worksheet B Part II | Date/Time Prepared: 11/25/2020 3:02 pm

		Cost Center Description	INTERNS & RESIDENTS SERVICES-OTHER PRGM COSTS APPRV	PARAMED ED PRGM-(PHARMACY)	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			22.00	23.00	24.00	25.00	26.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
12.00	01200	MAINTENANCE OF PERSONNEL						12.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY						15.00
16.00	01600	MEDICAL RECORDS & LIBRARY						16.00
17.00	01700	SOCIAL SERVICE						17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS						19.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV						21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0					22.00
23.00	02300	PARAMED ED PRGM-(PHARMACY)		7,412				23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS			5,144,336	0	5,144,336	30.00
31.00	03100	INTENSIVE CARE UNIT			1,449,698	0	1,449,698	31.00
32.01	02060	NEONATAL INTENSIVE CARE			432,348	0	432,348	32.01
41.00	04100	SUBPROVIDER - IRF			356,619	0	356,619	41.00
43.00	04300	NURSERY			55,100	0	55,100	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM			6,052,917	0	6,052,917	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM			484,827	0	484,827	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC			5,093,997	0	5,093,997	54.00
60.00	06000	LABORATORY			1,197,224	0	1,197,224	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL			74,494	0	74,494	62.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS			0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY			210,147	0	210,147	65.00
66.00	06600	PHYSICAL THERAPY			1,033,021	0	1,033,021	66.00
70.00	07000	ELECTROENCEPHALOGRAPHY			145,592	0	145,592	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT			117,589	0	117,589	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS			158,942	0	158,942	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS			686,524	0	686,524	73.00
76.00	03140	CARDIOLOGY			3,211,631	0	3,211,631	76.00
76.97	07697	CARDIAC REHABILITATION			130,967	0	130,967	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY			0	0	0	76.98
76.99	07699	LITHOTRIPSY			0	0	0	76.99
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC			205,798	0	205,798	90.00
91.00	09100	EMERGENCY			825,646	0	825,646	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				0		92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY			32,302	0	32,302	101.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	0	27,099,719	0	27,099,719	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN			24,869	0	24,869	190.00
191.00	19100	RESEARCH			18,021	0	18,021	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES			1,150,275	0	1,150,275	192.00
194.00	07950	ADVERTISING			3,280	0	3,280	194.00
194.01	07951	FITNESS POINTE			1,025,129	0	1,025,129	194.01
194.02	07952	FITNESS POINTE SPA/PRO SHOP/DIETARY			38,007	0	38,007	194.02
194.03	07953	RETAIL PHARMACY			145,594	0	145,594	194.03
194.04	07954	HOSPICE			145,405	0	145,405	194.04
194.05	07955	RUSH RESIDENTS			0	0	0	194.05
194.06	07956	EINSTEIN BAGELS			20,712	0	20,712	194.06
194.07	07957	NORTHWESTERN IMAGING			569,855	0	569,855	194.07
200.00		Cross Foot Adjustments	0	7,412	7,412	0	7,412	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	0	7,412	30,248,278	0	30,248,278	202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-0125 | Period: From 07/01/2019 To 06/30/2020 | Worksheet B-1 | Date/Time Prepared: 11/25/2020 3:02 pm

		Cost Center Description	CAPITAL RELATED COSTS BLDG & FIXT (SQUARE FEET)	CAPITAL RELATED COSTS MVBLE EQUIP (NEW- $ 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	922,172					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		10,820,612				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	4,000	4,716	165,733,036			4.00
5.00	00500	ADMINISTRATIVE & GENERAL	75,821	380,466	16,523,649	-69,543,723	372,333,998	5.00
6.00	00600	MAINTENANCE & REPAIRS	0	0	0	0	0	6.00
7.00	00700	OPERATION OF PLANT	142,161	370,251	5,470,197	0	19,843,193	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	1,566	0	133,756	0	1,756,977	8.00
9.00	00900	HOUSEKEEPING	3,812	22,272	3,485,612	0	5,371,226	9.00
10.00	01000	DIETARY	11,529	71,472	2,619,200	0	4,899,371	10.00
11.00	01100	CAFETERIA	11,806	0	1,167,583	0	2,195,641	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	2,935	117,132	3,654,651	0	5,746,636	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	0	14.00
15.00	01500	PHARMACY	5,120	329,159	4,001,701	0	20,957,859	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	5,472	311	0	0	5,340,284	16.00
17.00	01700	SOCIAL SERVICE	1,066	0	825,591	0	1,076,021	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0	22.00
23.00	02300	PARAMED ED PRGM-(PHARMACY)	228	0	327,992	0	399,109	23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	178,092	451,039	35,503,884	0	53,627,205	30.00
31.00	03100	INTENSIVE CARE UNIT	37,879	358,378	11,583,333	0	15,834,247	31.00
32.01	02060	NEONATAL INTENSIVE CARE	11,111	116,699	3,116,187	0	4,382,345	32.01
41.00	04100	SUBPROVIDER - IRF	12,428	19,428	2,419,177	0	4,224,792	41.00
43.00	04300	NURSERY	1,773	0	1,317,261	0	1,882,294	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	98,734	2,614,504	17,287,452	0	39,956,636	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	15,479	88,015	2,375,880	0	3,645,320	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	41,298	2,910,868	8,610,421	0	22,017,402	54.00
60.00	06000	LABORATORY	17,915	504,067	6,408,816	0	17,964,831	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	1,497	20,898	371,041	0	2,663,370	62.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	3,619	69,470	3,768,249	0	5,678,850	65.00
66.00	06600	PHYSICAL THERAPY	39,417	99,188	7,441,806	0	13,060,162	66.00
70.00	07000	ELECTROENCEPHALOGRAPHY	2,689	57,259	740,081	0	1,281,847	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	23,789,662	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	32,025,703	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03140	CARDIOLOGY	40,852	1,601,136	8,128,464	0	17,306,837	76.00
76.97	07697	CARDIAC REHABILITATION	4,516	21,249	884,864	0	1,214,558	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	7,532	15,070	2,320,567	0	3,426,077	90.00
91.00	09100	EMERGENCY	24,972	131,300	7,214,368	0	11,488,118	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	154	4,414,136	0	6,174,232	101.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	805,319	10,374,501	162,115,919	-69,543,723	349,230,805	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	1,208	0	0	0	19,708	190.00
191.00	19100	RESEARCH	397	1,514	852,907	0	1,212,560	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	55,420	1,487	0	0	1,969,462	192.00
194.00	07950	ADVERTISING	0	0	0	0	686,674	194.00
194.01	07951	FITNESS POINTE	46,255	43,661	1,220,640	0	3,057,913	194.01
194.02	07952	FITNESS POINTE SPA/PRO SHOP/DIETARY	1,482	3,907	242,838	0	422,517	194.02
194.03	07953	RETAIL PHARMACY	1,775	28,057	875,020	0	14,178,333	194.03
194.04	07954	HOSPICE	7,063	0	0	0	115,232	194.04
194.05	07955	RUSH RESIDENTS	0	0	0	0	0	194.05
194.06	07956	EINSTEIN BAGELS	605	4,707	99,039	0	248,318	194.06
194.07	07957	NORTHWESTERN IMAGING	2,648	362,778	326,673	0	1,192,476	194.07
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)	15,045,154	15,203,124	25,400,933		69,543,723	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	16.314911	1.405015	0.153264		0.186778	203.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-0125 | Period: From 07/01/2019 To 06/30/2020 | Worksheet B-1 | Date/Time Prepared: 11/25/2020 3:02 pm

		Cost Center Description	CAPITAL RELATED COSTS					
			BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (NEW- $ VALUE)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
			1.00	2.00	4.00	5A	5.00	
204.00		Cost to be allocated (per Wkst. B, Part II)			71,886		1,778,744	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)			0.000434		0.004777	205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)						206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-0125 | Period: From 07/01/2019 To 06/30/2020 | Worksheet B-1 | Date/Time Prepared: 11/25/2020 3:02 pm

		Cost Center Description	MAINTENANCE & REPAIRS (SQUARE FEET)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS)	HOUSEKEEPING (TIME SPENT)	DIETARY (PATIENT MEALS)	
			6.00	7.00	8.00	9.00	10.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS	842,351					6.00
7.00	00700	OPERATION OF PLANT	142,161	700,190				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	1,566	1,566	99,581			8.00
9.00	00900	HOUSEKEEPING	3,812	3,812	0	340,873		9.00
10.00	01000	DIETARY	11,529	11,529	180	174	298,217	10.00
11.00	01100	CAFETERIA	11,806	11,806	0	420	0	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	2,935	2,935	0	100	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	0	14.00
15.00	01500	PHARMACY	5,120	5,120	0	316	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	5,472	5,472	0	200	0	16.00
17.00	01700	SOCIAL SERVICE	1,066	1,066	0	150	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0	22.00
23.00	02300	PARAMED ED PRGM-(PHARMACY)	228	228	0	14	0	23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	178,092	178,092	37,472	129,392	249,250	30.00
31.00	03100	INTENSIVE CARE UNIT	37,879	37,879	6,564	17,126	21,059	31.00
32.01	02060	NEONATAL INTENSIVE CARE	11,111	11,111	123	4,077	0	32.01
41.00	04100	SUBPROVIDER - IRF	12,428	12,428	6,978	13,122	22,921	41.00
43.00	04300	NURSERY	1,773	1,773	2,919	814	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	98,734	98,734	12,880	74,362	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	15,479	15,479	4,304	13,601	4,987	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	41,298	41,298	8,532	11,231	0	54.00
60.00	06000	LABORATORY	17,915	17,915	0	6,580	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	1,497	1,497	0	0	0	62.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	3,619	3,619	0	720	0	65.00
66.00	06600	PHYSICAL THERAPY	39,417	39,417	1,732	5,634	0	66.00
70.00	07000	ELECTROENCEPHALOGRAPHY	2,689	2,689	890	1,020	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03140	CARDIOLOGY	40,852	40,852	9,054	11,441	0	76.00
76.97	07697	CARDIAC REHABILITATION	4,516	4,516	150	1,220	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	7,532	7,532	1,221	2,431	0	90.00
91.00	09100	EMERGENCY	24,972	24,972	6,582	41,208	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	725,498	583,337	99,581	335,353	298,217	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	1,208	1,208	0	0	0	190.00
191.00	19100	RESEARCH	397	397	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	55,420	55,420	0	5,400	0	192.00
194.00	07950	ADVERTISING	0	0	0	0	0	194.00
194.01	07951	FITNESS POINTE	46,255	46,255	0	0	0	194.01
194.02	07952	FITNESS POINTE SPA/PRO SHOP/DIETARY	1,482	1,482	0	0	0	194.02
194.03	07953	RETAIL PHARMACY	1,775	1,775	0	120	0	194.03
194.04	07954	HOSPICE	7,063	7,063	0	0	0	194.04
194.05	07955	RUSH RESIDENTS	0	0	0	0	0	194.05
194.06	07956	EINSTEIN BAGELS	605	605	0	0	0	194.06
194.07	07957	NORTHWESTERN IMAGING	2,648	2,648	0	0	0	194.07
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	0	23,549,465	2,137,811	6,502,662	6,209,403	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.000000	33.632964	21.468061	19.076495	20.821761	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	0	2,936,717	40,568	136,643	361,553	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.000000	4.194172	0.407387	0.400862	1.212382	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-0125 | Period: From 07/01/2019 To 06/30/2020 | Worksheet B-1 | Date/Time Prepared: 11/25/2020 3:02 pm

		Cost Center Description	MAINTENANCE & REPAIRS (SQUARE FEET)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS)	HOUSEKEEPING (TIME SPENT)	DIETARY (PATIENT MEALS)	
			6.00	7.00	8.00	9.00	10.00	
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: 15-0125 | Period: From 07/01/2019 To 06/30/2020 | Worksheet B-1 | Date/Time Prepared: 11/25/2020 3:02 pm

		Cost Center Description	CAFETERIA (FTES)	MAINTENANCE OF PERSONNEL (NUMBER HOUSED)	NURSING ADMINISTRATION (NURSING HOURS)	CENTRAL SERVICES & SUPPLY (COSTED REQ .)	PHARMACY (COSTED REQ .)	
			11.00	12.00	13.00	14.00	15.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA	189,614					11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0				12.00
13.00	01300	NURSING ADMINISTRATION	3,891	0	2,587,543			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0		14.00
15.00	01500	PHARMACY	4,791	0	0	0	100	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	1,364	0	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0	22.00
23.00	02300	PARAMED ED PRGM-(PHARMACY)	510	0	0	0	0	23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	54,062	0	1,124,490	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	14,047	0	292,178	0	0	31.00
32.01	02060	NEONATAL INTENSIVE CARE	3,816	0	79,373	0	0	32.01
41.00	04100	SUBPROVIDER - IRF	4,152	0	86,362	0	0	41.00
43.00	04300	NURSERY	1,835	0	38,168	0	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	28,546	0	593,761	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	3,283	0	68,286	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	11,836	0	0	0	0	54.00
60.00	06000	LABORATORY	11,205	0	0	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	497	0	0	0	0	62.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	5,084	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	9,749	0	0	0	0	66.00
70.00	07000	ELECTROENCEPHALOGRAPHY	1,235	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	100	73.00
76.00	03140	CARDIOLOGY	11,147	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	1,162	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	3,009	0	62,584	0	0	90.00
91.00	09100	EMERGENCY	11,651	0	242,341	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	186,872	0	2,587,543	0	100	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
191.00	19100	RESEARCH	1,190	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07950	ADVERTISING	0	0	0	0	0	194.00
194.01	07951	FITNESS POINTE	0	0	0	0	0	194.01
194.02	07952	FITNESS POINTE SPA/PRO SHOP/DIETARY	0	0	0	0	0	194.02
194.03	07953	RETAIL PHARMACY	1,206	0	0	0	0	194.03
194.04	07954	HOSPICE	0	0	0	0	0	194.04
194.05	07955	RUSH RESIDENTS	0	0	0	0	0	194.05
194.06	07956	EINSTEIN BAGELS	346	0	0	0	0	194.06
194.07	07957	NORTHWESTERN IMAGING	0	0	0	0	0	194.07
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)	3,010,821	0	6,982,386	0	25,126,630	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	15.878685	0.000000	2.698462	0.000000	251,266.300000	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	253,294	0	259,042	0	675,859	204.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-0125 | Period: From 07/01/2019 To 06/30/2020 | Worksheet B-1 | Date/Time Prepared: 11/25/2020 3:02 pm

		Cost Center Description	CAFETERIA (FTES)	MAINTENANCE OF PERSONNEL (NUMBER HOUSED)	NURSING ADMINISTRATION (NURSING HOURS)	CENTRAL SERVICES & SUPPLY (COSTED REQ .)	PHARMACY (COSTED REQ .)	
			11.00	12.00	13.00	14.00	15.00	
205.00		Unit cost multiplier (Wkst. B, Part II)	1.335840	0.000000	0.100111	0.000000	6,758.590000	205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)						206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-0125 | Period: From 07/01/2019 To 06/30/2020 | Worksheet B-1 | Date/Time Prepared: 11/25/2020 3:02 pm

		Cost Center Description	MEDICAL RECORDS & LIBRARY (GROSS REVENUE)	SOCIAL SERVICE (TIME SPENT)	NONPHYSICIAN ANESTHETISTS (ASSIGNED TIME)	INTERNS & RESIDENTS SERVICES-SALARY & FRINGES APPRV (ASSIGNED TIME)	INTERNS & RESIDENTS SERVICES-OTHER PRGM COSTS APPRV (ASSIGNED TIME)	
			16.00	17.00	19.00	21.00	22.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
12.00	01200	MAINTENANCE OF PERSONNEL						12.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY						15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,789,164,017					16.00
17.00	01700	SOCIAL SERVICE	0	95,130				17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0			19.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0		0		21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0			0	22.00
23.00	02300	PARAMED ED PRGM-(PHARMACY)	0	0				23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	149,523,612	67,795	0	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	28,784,285	10,863	0	0	0	31.00
32.01	02060	NEONATAL INTENSIVE CARE	28,202,953	4,299	0	0	0	32.01
41.00	04100	SUBPROVIDER - IRF	9,702,695	7,717	0	0	0	41.00
43.00	04300	NURSERY	5,599,391	3,110	0	0	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	305,845,365	0	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	10,204,874	0	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	311,732,541	0	0	0	0	54.00
60.00	06000	LABORATORY	199,692,123	0	0	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	11,454,287	0	0	0	0	62.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	32,145,120	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	47,371,197	0	0	0	0	66.00
70.00	07000	ELECTROENCEPHALOGRAPHY	14,638,571	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	51,250,695	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	77,335,456	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	138,506,628	0	0	0	0	73.00
76.00	03140	CARDIOLOGY	192,282,034	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	2,663,212	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	13,243,230	0	0	0	0	90.00
91.00	09100	EMERGENCY	150,205,944	1,346	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	8,779,804	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	1,789,164,017	95,130	0	0	0	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07950	ADVERTISING	0	0	0	0	0	194.00
194.01	07951	FITNESS POINTE	0	0	0	0	0	194.01
194.02	07952	FITNESS POINTE SPA/PRO SHOP/DIETARY	0	0	0	0	0	194.02
194.03	07953	RETAIL PHARMACY	0	0	0	0	0	194.03
194.04	07954	HOSPICE	0	0	0	0	0	194.04
194.05	07955	RUSH RESIDENTS	0	0	0	0	0	194.05
194.06	07956	EINSTEIN BAGELS	0	0	0	0	0	194.06
194.07	07957	NORTHWESTERN IMAGING	0	0	0	0	0	194.07
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	6,525,587	1,337,371	0	0	0	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.003647	14.058352	0.000000	0.000000	0.000000	203.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-0125 | Period: From 07/01/2019 To 06/30/2020 | Worksheet B-1 | Date/Time Prepared: 11/25/2020 3:02 pm

		Cost Center Description	MEDICAL RECORDS & LIBRARY (GROSS REVENUE)	SOCIAL SERVICE (TIME SPENT)	NONPHYSICIAN ANESTHETISTS (ASSIGNED TIME)	INTERNS & RESIDENTS SERVICES-SALARY & FRINGES APPRV (ASSIGNED TIME)	INTERNS & RESIDENTS SERVICES-OTHER PRGM COSTS APPRV (ASSIGNED TIME)	
			16.00	17.00	19.00	21.00	22.00	
204.00		Cost to be allocated (per Wkst. B, Part II)	138,254	29,243	0	0	0	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.000077	0.307400	0.000000	0.000000	0.000000	205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)						206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-0125 | Period: From 07/01/2019 To 06/30/2020 | Worksheet B-1 | Date/Time Prepared: 11/25/2020 3:02 pm

		Cost Center Description	PARAMED ED PRGM-(PHARMACY) (ASSIGNED TIME)		
			23.00		
		GENERAL SERVICE COST CENTERS			
1.00	00100	CAP REL COSTS-BLDG & FIXT			1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT			4.00
5.00	00500	ADMINISTRATIVE & GENERAL			5.00
6.00	00600	MAINTENANCE & REPAIRS			6.00
7.00	00700	OPERATION OF PLANT			7.00
8.00	00800	LAUNDRY & LINEN SERVICE			8.00
9.00	00900	HOUSEKEEPING			9.00
10.00	01000	DIETARY			10.00
11.00	01100	CAFETERIA			11.00
12.00	01200	MAINTENANCE OF PERSONNEL			12.00
13.00	01300	NURSING ADMINISTRATION			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY			14.00
15.00	01500	PHARMACY			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY			16.00
17.00	01700	SOCIAL SERVICE			17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS			19.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV			21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV			22.00
23.00	02300	PARAMED ED PRGM-(PHARMACY)	100		23.00
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS	0		30.00
31.00	03100	INTENSIVE CARE UNIT	0		31.00
32.01	02060	NEONATAL INTENSIVE CARE	0		32.01
41.00	04100	SUBPROVIDER - IRF	0		41.00
43.00	04300	NURSERY	0		43.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0		52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0		54.00
60.00	06000	LABORATORY	0		60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0		62.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0		62.30
65.00	06500	RESPIRATORY THERAPY	0		65.00
66.00	06600	PHYSICAL THERAPY	0		66.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	100		73.00
76.00	03140	CARDIOLOGY	0		76.00
76.97	07697	CARDIAC REHABILITATION	0		76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0		76.98
76.99	07699	LITHOTRIPSY	0		76.99
		OUTPATIENT SERVICE COST CENTERS			
90.00	09000	CLINIC	0		90.00
91.00	09100	EMERGENCY	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART			92.00
		OTHER REIMBURSABLE COST CENTERS			
101.00	10100	HOME HEALTH AGENCY	0		101.00
		SPECIAL PURPOSE COST CENTERS			
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	100		118.00
		NONREIMBURSABLE COST CENTERS			
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0		190.00
191.00	19100	RESEARCH	0		191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0		192.00
194.00	07950	ADVERTISING	0		194.00
194.01	07951	FITNESS POINTE	0		194.01
194.02	07952	FITNESS POINTE SPA/PRO SHOP/DIETARY	0		194.02
194.03	07953	RETAIL PHARMACY	0		194.03
194.04	07954	HOSPICE	0		194.04
194.05	07955	RUSH RESIDENTS	0		194.05
194.06	07956	EINSTEIN BAGELS	0		194.06
194.07	07957	NORTHWESTERN IMAGING	0		194.07
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)	489,687		202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	4,896.870000		203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	7,412		204.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-0125 | Period: From 07/01/2019 To 06/30/2020 | Worksheet B-1 | Date/Time Prepared: 11/25/2020 3:02 pm

		Cost Center Description	PARAMED ED PRGM-(PHARMACY) (ASSIGNED TIME)		
			23.00		
205.00		Unit cost multiplier (Wkst. B, Part II)	74.120000		205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)	0		206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)	0.000000		207.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-0125 | Period: From 07/01/2019 To 06/30/2020 | Worksheet C Part I Date/Time Prepared: 11/25/2020 3:02 pm

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		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	Costs RCE Disallowance	Costs Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	83,487,115		83,487,115	64,354	83,551,469	30.00
31.00	03100	INTENSIVE CARE UNIT	22,240,995		22,240,995	17,984	22,258,979	31.00
32.01	02060	NEONATAL INTENSIVE CARE	6,093,054		6,093,054	9,436	6,102,490	32.01
41.00	04100	SUBPROVIDER - IRF	6,752,109		6,752,109	0	6,752,109	41.00
43.00	04300	NURSERY	2,567,963		2,567,963	0	2,567,963	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	55,606,381		55,606,381	24,344	55,630,725	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	5,576,101		5,576,101	5,388	5,581,489	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	29,241,489		29,241,489	16,905	29,258,394	54.00
60.00	06000	LABORATORY	22,954,522		22,954,522	29,368	22,983,890	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	3,260,844		3,260,844	0	3,260,844	62.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0		0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	7,072,947	0	7,072,947	1,819	7,074,766	65.00
66.00	06600	PHYSICAL THERAPY	17,297,448	0	17,297,448	0	17,297,448	66.00
70.00	07000	ELECTROENCEPHALOGRAPHY	1,723,269		1,723,269	2,643	1,725,912	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	28,419,958		28,419,958	0	28,419,958	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	38,289,442		38,289,442	0	38,289,442	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	26,121,451		26,121,451	0	26,121,451	73.00
76.00	03140	CARDIOLOGY	23,204,226		23,204,226	12,772	23,216,998	76.00
76.97	07697	CARDIAC REHABILITATION	1,647,954		1,647,954	0	1,647,954	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0		0	0	0	76.98
76.99	07699	LITHOTRIPSY	0		0	0	0	76.99
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	4,656,862		4,656,862	16,379	4,673,241	90.00
91.00	09100	EMERGENCY	16,806,810		16,806,810	0	16,806,810	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	14,849,903		14,849,903		14,849,903	92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	7,359,463		7,359,463		7,359,463	101.00
200.00		Subtotal (see instructions)	425,230,306	0	425,230,306	201,392	425,431,698	200.00
201.00		Less Observation Beds	14,849,903		14,849,903		14,849,903	201.00
202.00		Total (see instructions)	410,380,403	0	410,380,403	201,392	410,581,795	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-0125 | Period: From 07/01/2019 To 06/30/2020 | Worksheet C Part I | Date/Time Prepared: 11/25/2020 3:02 pm

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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	110,448,396		110,448,396			30.00
31.00	03100	INTENSIVE CARE UNIT	28,784,285		28,784,285			31.00
32.01	02060	NEONATAL INTENSIVE CARE	28,202,953		28,202,953			32.01
41.00	04100	SUBPROVIDER - IRF	9,702,695		9,702,695			41.00
43.00	04300	NURSERY	5,599,391		5,599,391			43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	111,123,089	194,722,276	305,845,365	0.181812	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	7,569,436	2,635,438	10,204,874	0.546415	0.000000	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	64,822,982	246,909,559	311,732,541	0.093803	0.000000	54.00
60.00	06000	LABORATORY	65,904,667	133,787,456	199,692,123	0.114950	0.000000	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	7,266,439	4,187,848	11,454,287	0.284683	0.000000	62.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0.000000	0.000000	62.30
65.00	06500	RESPIRATORY THERAPY	29,160,703	2,984,417	32,145,120	0.220032	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	22,109,469	25,261,728	47,371,197	0.365147	0.000000	66.00
70.00	07000	ELECTROENCEPHALOGRAPHY	1,589,897	13,048,674	14,638,571	0.117721	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	24,299,619	26,951,076	51,250,695	0.554528	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	47,766,325	29,569,131	77,335,456	0.495109	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	85,897,095	52,609,533	138,506,628	0.188594	0.000000	73.00
76.00	03140	CARDIOLOGY	74,878,247	117,403,787	192,282,034	0.120678	0.000000	76.00
76.97	07697	CARDIAC REHABILITATION	416,955	2,246,257	2,663,212	0.618784	0.000000	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0.000000	0.000000	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0.000000	0.000000	76.99
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	482,413	12,760,817	13,243,230	0.351641	0.000000	90.00
91.00	09100	EMERGENCY	47,887,739	102,318,205	150,205,944	0.111892	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	5,384,775	33,690,441	39,075,216	0.380034	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	8,779,804	8,779,804			101.00
200.00		Subtotal (see instructions)	779,297,570	1,009,866,447	1,789,164,017			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	779,297,570	1,009,866,447	1,789,164,017			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-0125 | Period: From 07/01/2019 To 06/30/2020 | Worksheet C Part I Date/Time Prepared: 11/25/2020 3:02 pm

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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
32.01	02060	NEONATAL INTENSIVE CARE		32.01
41.00	04100	SUBPROVIDER - IRF		41.00
43.00	04300	NURSERY		43.00
		ANCILLARY SERVICE COST CENTERS		
50.00	05000	OPERATING ROOM	0.181892	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.546943	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.093857	54.00
60.00	06000	LABORATORY	0.115097	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0.284683	62.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0.000000	62.30
65.00	06500	RESPIRATORY THERAPY	0.220088	65.00
66.00	06600	PHYSICAL THERAPY	0.365147	66.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.117902	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.554528	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.495109	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.188594	73.00
76.00	03140	CARDIOLOGY	0.120744	76.00
76.97	07697	CARDIAC REHABILITATION	0.618784	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0.000000	76.98
76.99	07699	LITHOTRIPSY	0.000000	76.99
		OUTPATIENT SERVICE COST CENTERS		
90.00	09000	CLINIC	0.352878	90.00
91.00	09100	EMERGENCY	0.111892	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.380034	92.00
		OTHER REIMBURSABLE COST CENTERS		
101.00	10100	HOME HEALTH AGENCY		101.00
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: 15-0125 | Period: From 07/01/2019 To 06/30/2020 | Worksheet C Part I Date/Time Prepared: 11/25/2020 3:02 pm

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		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	Costs RCE Disallowance	Costs Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	83,487,115		83,487,115	64,354	83,551,469	30.00
31.00	03100	INTENSIVE CARE UNIT	22,240,995		22,240,995	17,984	22,258,979	31.00
32.01	02060	NEONATAL INTENSIVE CARE	6,093,054		6,093,054	9,436	6,102,490	32.01
41.00	04100	SUBPROVIDER - IRF	6,752,109		6,752,109	0	6,752,109	41.00
43.00	04300	NURSERY	2,567,963		2,567,963	0	2,567,963	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	55,606,381		55,606,381	24,344	55,630,725	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	5,576,101		5,576,101	5,388	5,581,489	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	29,241,489		29,241,489	16,905	29,258,394	54.00
60.00	06000	LABORATORY	22,954,522		22,954,522	29,368	22,983,890	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	3,260,844		3,260,844	0	3,260,844	62.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0		0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	7,072,947	0	7,072,947	1,819	7,074,766	65.00
66.00	06600	PHYSICAL THERAPY	17,297,448	0	17,297,448	0	17,297,448	66.00
70.00	07000	ELECTROENCEPHALOGRAPHY	1,723,269		1,723,269	2,643	1,725,912	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	28,419,958		28,419,958	0	28,419,958	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	38,289,442		38,289,442	0	38,289,442	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	26,121,451		26,121,451	0	26,121,451	73.00
76.00	03140	CARDIOLOGY	23,204,226		23,204,226	12,772	23,216,998	76.00
76.97	07697	CARDIAC REHABILITATION	1,647,954		1,647,954	0	1,647,954	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0		0	0	0	76.98
76.99	07699	LITHOTRIPSY	0		0	0	0	76.99
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	4,656,862		4,656,862	16,379	4,673,241	90.00
91.00	09100	EMERGENCY	16,806,810		16,806,810	0	16,806,810	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	14,849,903		14,849,903		14,849,903	92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	7,359,463		7,359,463		7,359,463	101.00
200.00		Subtotal (see instructions)	425,230,306	0	425,230,306	201,392	425,431,698	200.00
201.00		Less Observation Beds	14,849,903		14,849,903		14,849,903	201.00
202.00		Total (see instructions)	410,380,403	0	410,380,403	201,392	410,581,795	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-0125 | Period: From 07/01/2019 To 06/30/2020 | Worksheet C Part I Date/Time Prepared: 11/25/2020 3:02 pm

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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	110,448,396		110,448,396			30.00
31.00	03100	INTENSIVE CARE UNIT	28,784,285		28,784,285			31.00
32.01	02060	NEONATAL INTENSIVE CARE	28,202,953		28,202,953			32.01
41.00	04100	SUBPROVIDER - IRF	9,702,695		9,702,695			41.00
43.00	04300	NURSERY	5,599,391		5,599,391			43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	111,123,089	194,722,276	305,845,365	0.181812	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	7,569,436	2,635,438	10,204,874	0.546415	0.000000	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	64,822,982	246,909,559	311,732,541	0.093803	0.000000	54.00
60.00	06000	LABORATORY	65,904,667	133,787,456	199,692,123	0.114950	0.000000	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	7,266,439	4,187,848	11,454,287	0.284683	0.000000	62.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0.000000	0.000000	62.30
65.00	06500	RESPIRATORY THERAPY	29,160,703	2,984,417	32,145,120	0.220032	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	22,109,469	25,261,728	47,371,197	0.365147	0.000000	66.00
70.00	07000	ELECTROENCEPHALOGRAPHY	1,589,897	13,048,674	14,638,571	0.117721	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	24,299,619	26,951,076	51,250,695	0.554528	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	47,766,325	29,569,131	77,335,456	0.495109	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	85,897,095	52,609,533	138,506,628	0.188594	0.000000	73.00
76.00	03140	CARDIOLOGY	74,878,247	117,403,787	192,282,034	0.120678	0.000000	76.00
76.97	07697	CARDIAC REHABILITATION	416,955	2,246,257	2,663,212	0.618784	0.000000	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0.000000	0.000000	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0.000000	0.000000	76.99
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	482,413	12,760,817	13,243,230	0.351641	0.000000	90.00
91.00	09100	EMERGENCY	47,887,739	102,318,205	150,205,944	0.111892	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	5,384,775	33,690,441	39,075,216	0.380034	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	8,779,804	8,779,804			101.00
200.00		Subtotal (see instructions)	779,297,570	1,009,866,447	1,789,164,017			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	779,297,570	1,009,866,447	1,789,164,017			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-0125 | Period: From 07/01/2019 To 06/30/2020 | Worksheet C Part I Date/Time Prepared: 11/25/2020 3:02 pm

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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
32.01	02060	NEONATAL INTENSIVE CARE		32.01
41.00	04100	SUBPROVIDER - IRF		41.00
43.00	04300	NURSERY		43.00
		ANCILLARY SERVICE COST CENTERS		
50.00	05000	OPERATING ROOM	0.181892	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.546943	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.093857	54.00
60.00	06000	LABORATORY	0.115097	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0.284683	62.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0.000000	62.30
65.00	06500	RESPIRATORY THERAPY	0.220088	65.00
66.00	06600	PHYSICAL THERAPY	0.365147	66.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.117902	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.554528	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.495109	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.188594	73.00
76.00	03140	CARDIOLOGY	0.120744	76.00
76.97	07697	CARDIAC REHABILITATION	0.618784	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0.000000	76.98
76.99	07699	LITHOTRIPSY	0.000000	76.99
		OUTPATIENT SERVICE COST CENTERS		
90.00	09000	CLINIC	0.352878	90.00
91.00	09100	EMERGENCY	0.111892	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.380034	92.00
		OTHER REIMBURSABLE COST CENTERS		
101.00	10100	HOME HEALTH AGENCY		101.00
200.00		Subtotal (see instructions)		200.00
201.00		Less Observation Beds		201.00
202.00		Total (see instructions)		202.00

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

Provider CCN: 15-0125 | Period: From 07/01/2019 To 06/30/2020 | Worksheet C Part II Date/Time Prepared: 11/25/2020 3:02 pm

Title XIX | Hospital | PPS

		Cost Center Description	Total Cost (Wkst. B, Part I, col. 26)	Capital Cost (Wkst. B, Part II col. 26)	Operating Cost Net of Capital Cost (col. 1 - col. 2)	Capital Reduction	Operating Cost Reduction Amount	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	55,606,381	6,052,917	49,553,464	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	5,576,101	484,827	5,091,274	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	29,241,489	5,093,997	24,147,492	0	0	54.00
60.00	06000	LABORATORY	22,954,522	1,197,224	21,757,298	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	3,260,844	74,494	3,186,350	0	0	62.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	7,072,947	210,147	6,862,800	0	0	65.00
66.00	06600	PHYSICAL THERAPY	17,297,448	1,033,021	16,264,427	0	0	66.00
70.00	07000	ELECTROENCEPHALOGRAPHY	1,723,269	145,592	1,577,677	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	28,419,958	117,589	28,302,369	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	38,289,442	158,942	38,130,500	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	26,121,451	686,524	25,434,927	0	0	73.00
76.00	03140	CARDIOLOGY	23,204,226	3,211,631	19,992,595	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	1,647,954	130,967	1,516,987	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	4,656,862	205,798	4,451,064	0	0	90.00
91.00	09100	EMERGENCY	16,806,810	825,646	15,981,164	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	14,849,903	914,323	13,935,580	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	7,359,463	32,302	7,327,161	0	0	101.00
200.00		Subtotal (sum of lines 50 thru 199)	304,089,070	20,575,941	283,513,129	0	0	200.00
201.00		Less Observation Beds	14,849,903	914,323	13,935,580	0	0	201.00
202.00		Total (line 200 minus line 201)	289,239,167	19,661,618	269,577,549	0	0	202.00

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

Provider CCN: 15-0125 | Period: From 07/01/2019 To 06/30/2020 | Worksheet C Part II Date/Time Prepared: 11/25/2020 3:02 pm

Title XIX | Hospital | PPS

		Cost Center Description	Cost Net of Capital and Operating Cost Reduction	Total Charges (Worksheet C, Part I, column 8)	Outpatient Cost to Charge Ratio (col. 6 / col. 7)		
			6.00	7.00	8.00		
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	55,606,381	305,845,365	0.181812		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	5,576,101	10,204,874	0.546415		52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	29,241,489	311,732,541	0.093803		54.00
60.00	06000	LABORATORY	22,954,522	199,692,123	0.114950		60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	3,260,844	11,454,287	0.284683		62.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0.000000		62.30
65.00	06500	RESPIRATORY THERAPY	7,072,947	32,145,120	0.220032		65.00
66.00	06600	PHYSICAL THERAPY	17,297,448	47,371,197	0.365147		66.00
70.00	07000	ELECTROENCEPHALOGRAPHY	1,723,269	14,638,571	0.117721		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	28,419,958	51,250,695	0.554528		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	38,289,442	77,335,456	0.495109		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	26,121,451	138,506,628	0.188594		73.00
76.00	03140	CARDIOLOGY	23,204,226	192,282,034	0.120678		76.00
76.97	07697	CARDIAC REHABILITATION	1,647,954	2,663,212	0.618784		76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0.000000		76.98
76.99	07699	LITHOTRIPSY	0	0	0.000000		76.99
		OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	4,656,862	13,243,230	0.351641		90.00
91.00	09100	EMERGENCY	16,806,810	150,205,944	0.111892		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	14,849,903	39,075,216	0.380034		92.00
		OTHER REIMBURSABLE COST CENTERS					
101.00	10100	HOME HEALTH AGENCY	7,359,463	8,779,804	0.838226		101.00
200.00		Subtotal (sum of lines 50 thru 199)	304,089,070	1,606,426,297			200.00
201.00		Less Observation Beds	14,849,903	0			201.00
202.00		Total (line 200 minus line 201)	289,239,167	1,606,426,297			202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS | Provider CCN: 15-0125 | Period: From 07/01/2019 To 06/30/2020 | Worksheet D Part I Date/Time Prepared: 11/25/2020 3:02 pm

Title XVIII | Hospital | PPS

	Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	5,144,336	0	5,144,336	81,442	63.17	30.00
31.00	INTENSIVE CARE UNIT	1,449,698		1,449,698	10,863	133.45	31.00
32.01	NEONATAL INTENSIVE CARE	432,348		432,348	4,299	100.57	32.01
41.00	SUBPROVIDER - IRF	356,619	0	356,619	7,717	46.21	41.00
43.00	NURSERY	55,100		55,100	3,110	17.72	43.00
200.00	Total (lines 30 through 199)	7,438,101		7,438,101	107,431		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	30,506	1,927,064				30.00
31.00	INTENSIVE CARE UNIT	4,653	620,943				31.00
32.01	NEONATAL INTENSIVE CARE	0	0				32.01
41.00	SUBPROVIDER - IRF	6,181	285,624				41.00
43.00	NURSERY	0	0				43.00
200.00	Total (lines 30 through 199)	41,340	2,833,631				200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS | Provider CCN: 15-0125 | Period: From 07/01/2019 To 06/30/2020 | Worksheet D Part II Date/Time Prepared: 11/25/2020 3:02 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	6,052,917	305,845,365	0.019791	44,367,987	878,087	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	484,827	10,204,874	0.047509	28,608	1,359	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	5,093,997	311,732,541	0.016341	28,204,520	460,890	54.00
60.00	06000	LABORATORY	1,197,224	199,692,123	0.005995	28,365,250	170,050	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	74,494	11,454,287	0.006504	2,928,106	19,044	62.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0.000000	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	210,147	32,145,120	0.006537	13,531,300	88,454	65.00
66.00	06600	PHYSICAL THERAPY	1,033,021	47,371,197	0.021807	6,836,091	149,075	66.00
70.00	07000	ELECTROENCEPHALOGRAPHY	145,592	14,638,571	0.009946	827,062	8,226	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	117,589	51,250,695	0.002294	10,973,655	25,174	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	158,942	77,335,456	0.002055	22,112,795	45,442	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	686,524	138,506,628	0.004957	34,055,997	168,816	73.00
76.00	03140	CARDIOLOGY	3,211,631	192,282,034	0.016703	35,982,935	601,023	76.00
76.97	07697	CARDIAC REHABILITATION	130,967	2,663,212	0.049176	168,726	8,297	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0.000000	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0.000000	0	0	76.99
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	205,798	13,243,230	0.015540	145,195	2,256	90.00
91.00	09100	EMERGENCY	825,646	150,205,944	0.005497	21,453,421	117,929	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	914,323	39,075,216	0.023399	0	0	92.00
200.00		Total (lines 50 through 199)	20,543,639	1,597,646,493		249,981,648	2,744,122	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 15-0125 | Period: From 07/01/2019 To 06/30/2020 | Worksheet D Part III Date/Time Prepared: 11/25/2020 3:02 pm

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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
32.01	02060	NEONATAL INTENSIVE CARE	0	0	0	0	0	32.01
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	81,442	0.00	30,506	30.00
31.00	03100	INTENSIVE CARE UNIT		0	10,863	0.00	4,653	31.00
32.01	02060	NEONATAL INTENSIVE CARE		0	4,299	0.00	0	32.01
41.00	04100	SUBPROVIDER - IRF	0	0	7,717	0.00	6,181	41.00
43.00	04300	NURSERY		0	3,110	0.00	0	43.00
200.00		Total (lines 30 through 199)		0	107,431		41,340	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
32.01	02060	NEONATAL INTENSIVE CARE	0	32.01
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: 15-0125 | Period: From 07/01/2019 To 06/30/2020 | Worksheet D Part IV | Date/Time Prepared: 11/25/2020 3:02 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health	
			1.00	2A	2.00	3A	3.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0	0	0	62.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	489,687	73.00
76.00	03140	CARDIOLOGY	0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0		0		0	92.00
200.00		Total (lines 50 through 199)	0	0	0	0	489,687	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-0125 | Period: From 07/01/2019 To 06/30/2020 | Worksheet D Part IV Date/Time Prepared: 11/25/2020 3:02 pm

Title XVIII | Hospital | PPS

		Cost Center Description	All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7) (see instructions)	
			4.00	5.00	6.00	7.00	8.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	305,845,365	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	10,204,874	0.000000	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	311,732,541	0.000000	54.00
60.00	06000	LABORATORY	0	0	0	199,692,123	0.000000	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0	11,454,287	0.000000	62.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0.000000	62.30
65.00	06500	RESPIRATORY THERAPY	0	0	0	32,145,120	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	47,371,197	0.000000	66.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	14,638,571	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	51,250,695	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	77,335,456	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	489,687	489,687	138,506,628	0.003535	73.00
76.00	03140	CARDIOLOGY	0	0	0	192,282,034	0.000000	76.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	2,663,212	0.000000	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0.000000	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0.000000	76.99
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	13,243,230	0.000000	90.00
91.00	09100	EMERGENCY	0	0	0	150,205,944	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	39,075,216	0.000000	92.00
200.00		Total (lines 50 through 199)	0	489,687	489,687	1,597,646,493		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-0125 | Period: From 07/01/2019 To 06/30/2020 | Worksheet D Part IV Date/Time Prepared: 11/25/2020 3:02 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
			9.00	10.00	11.00	12.00	13.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.000000	44,367,987	0	52,541,323	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	28,608	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	28,204,520	0	77,868,349	0	54.00
60.00	06000	LABORATORY	0.000000	28,365,250	0	14,527,013	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0.000000	2,928,106	0	1,153,282	0	62.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0.000000	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0.000000	13,531,300	0	1,115,294	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	6,836,091	0	583,325	0	66.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	827,062	0	3,432,533	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	10,973,655	0	9,934,831	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	22,112,795	0	10,342,677	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.003535	34,055,997	120,388	20,410,469	72,151	73.00
76.00	03140	CARDIOLOGY	0.000000	35,982,935	0	51,245,530	0	76.00
76.97	07697	CARDIAC REHABILITATION	0.000000	168,726	0	997,485	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0.000000	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0.000000	0	0	0	0	76.99
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.000000	145,195	0	7,400,915	0	90.00
91.00	09100	EMERGENCY	0.000000	21,453,421	0	16,428,567	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	0	0	9,091,404	0	92.00
200.00		Total (lines 50 through 199)		249,981,648	120,388	277,072,997	72,151	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-0125 | Period: From 07/01/2019 To 06/30/2020 | Worksheet D Part V Date/Time Prepared: 11/25/2020 3:02 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.181812	52,541,323	0	26,738	9,552,643	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.546415	0	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.093803	77,868,349	0	0	7,304,285	54.00
60.00	06000	LABORATORY	0.114950	14,527,013	0	0	1,669,880	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0.284683	1,153,282	0	0	328,320	62.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0.000000	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0.220032	1,115,294	0	0	245,400	65.00
66.00	06600	PHYSICAL THERAPY	0.365147	583,325	0	0	212,999	66.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.117721	3,432,533	0	0	404,081	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.554528	9,934,831	0	0	5,509,142	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.495109	10,342,677	0	0	5,120,752	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.188594	20,410,469	0	113,940	3,849,292	73.00
76.00	03140	CARDIOLOGY	0.120678	51,245,530	0	0	6,184,208	76.00
76.97	07697	CARDIAC REHABILITATION	0.618784	997,485	0	0	617,228	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0.000000	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0.000000	0	0	0	0	76.99
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.351641	7,400,915	0	0	2,602,465	90.00
91.00	09100	EMERGENCY	0.111892	16,428,567	0	0	1,838,225	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.380034	9,091,404	0	0	3,455,043	92.00
200.00		Subtotal (see instructions)		277,072,997	0	140,678	48,893,963	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 - line 201)		277,072,997	0	140,678	48,893,963	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-0125 | Period: From 07/01/2019 To 06/30/2020 | Worksheet D Part V Date/Time Prepared: 11/25/2020 3:02 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Costs: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	4,861		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0		52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0		54.00
60.00	06000	LABORATORY	0	0		60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0		62.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0		62.30
65.00	06500	RESPIRATORY THERAPY	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0		66.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	21,488		73.00
76.00	03140	CARDIOLOGY	0	0		76.00
76.97	07697	CARDIAC REHABILITATION	0	0		76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0		76.98
76.99	07699	LITHOTRIPSY	0	0		76.99
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0	0		90.00
91.00	09100	EMERGENCY	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0		92.00
200.00		Subtotal (see instructions)	0	26,349		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	0	26,349		202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 15-0125 | Component CCN: 15-T125 | Period: From 07/01/2019 To 06/30/2020 | Worksheet D Part II Date/Time Prepared: 11/25/2020 3:02 pm

Title XVIII | Subprovider - IRF | PPS

		Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	6,052,917	305,845,365	0.019791	128,213	2,537	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	484,827	10,204,874	0.047509	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	5,093,997	311,732,541	0.016341	582,704	9,522	54.00
60.00	06000	LABORATORY	1,197,224	199,692,123	0.005995	1,208,741	7,246	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	74,494	11,454,287	0.006504	49,887	324	62.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0.000000	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	210,147	32,145,120	0.006537	693,498	4,533	65.00
66.00	06600	PHYSICAL THERAPY	1,033,021	47,371,197	0.021807	6,285,817	137,075	66.00
70.00	07000	ELECTROENCEPHALOGRAPHY	145,592	14,638,571	0.009946	13,307	132	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	117,589	51,250,695	0.002294	462,371	1,061	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	158,942	77,335,456	0.002055	19,592	40	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	686,524	138,506,628	0.004957	2,686,310	13,316	73.00
76.00	03140	CARDIOLOGY	3,211,631	192,282,034	0.016703	269,983	4,510	76.00
76.97	07697	CARDIAC REHABILITATION	130,967	2,663,212	0.049176	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0.000000	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0.000000	0	0	76.99
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	205,798	13,243,230	0.015540	17,228	268	90.00
91.00	09100	EMERGENCY	825,646	150,205,944	0.005497	471	3	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	39,075,216	0.000000	0	0	92.00
200.00		Total (lines 50 through 199)	19,629,316	1,597,646,493		12,418,122	180,567	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-0125
Component CCN: 15-T125

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

Worksheet D
Part IV
Date/Time Prepared:
11/25/2020 3:02 pm

Title XVIII

Subprovider - IRF

PPS

		Cost Center Description	Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health	
			1.00	2A	2.00	3A	3.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0	0	0	62.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	489,687	73.00
76.00	03140	CARDIOLOGY	0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0		0		0	92.00
200.00		Total (lines 50 through 199)	0	0	0	0	489,687	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-0125 | Component CCN: 15-T125 | Period: From 07/01/2019 To 06/30/2020 | Worksheet D Part IV | Date/Time Prepared: 11/25/2020 3:02 pm

Title XVIII | Subprovider - IRF | PPS

		Cost Center Description	All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7) (see instructions)	
			4.00	5.00	6.00	7.00	8.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	305,845,365	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	10,204,874	0.000000	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	311,732,541	0.000000	54.00
60.00	06000	LABORATORY	0	0	0	199,692,123	0.000000	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0	11,454,287	0.000000	62.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0.000000	62.30
65.00	06500	RESPIRATORY THERAPY	0	0	0	32,145,120	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	47,371,197	0.000000	66.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	14,638,571	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	51,250,695	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	77,335,456	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	489,687	489,687	138,506,628	0.003535	73.00
76.00	03140	CARDIOLOGY	0	0	0	192,282,034	0.000000	76.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	2,663,212	0.000000	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0.000000	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0.000000	76.99
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	13,243,230	0.000000	90.00
91.00	09100	EMERGENCY	0	0	0	150,205,944	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	39,075,216	0.000000	92.00
200.00		Total (lines 50 through 199)	0	489,687	489,687	1,597,646,493		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-0125 | Component CCN: 15-T125 | Period: From 07/01/2019 To 06/30/2020 | Worksheet D Part IV Date/Time Prepared: 11/25/2020 3:02 pm

Title XVIII | Subprovider - IRF | PPS

		Cost Center Description	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
			9.00	10.00	11.00	12.00	13.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.000000	128,213	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	0.000000	582,704	0	1,424	0	54.00
60.00	06000	LABORATORY	0.000000	1,208,741	0	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0.000000	49,887	0	0	0	62.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0.000000	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0.000000	693,498	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	6,285,817	0	0	0	66.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	13,307	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	462,371	0	122	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	19,592	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.003535	2,686,310	9,496	2,249	8	73.00
76.00	03140	CARDIOLOGY	0.000000	269,983	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0.000000	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0.000000	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0.000000	0	0	0	0	76.99
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.000000	17,228	0	0	0	90.00
91.00	09100	EMERGENCY	0.000000	471	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	0	0	0	0	92.00
200.00		Total (lines 50 through 199)		12,418,122	9,496	3,795	8	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 15-0125 | Component CCN: 15-T125 | Period: From 07/01/2019 To 06/30/2020 | Worksheet D Part V | Date/Time Prepared: 11/25/2020 3:02 pm

Title XVIII | Subprovider - IRF | PPS

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.181812	0	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.546415	0	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.093803	1,424	0	0	134	54.00
60.00	06000	LABORATORY	0.114950	0	0	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0.284683	0	0	0	0	62.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0.000000	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0.220032	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.365147	0	0	0	0	66.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.117721	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.554528	122	0	0	68	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.495109	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.188594	2,249	0	0	424	73.00
76.00	03140	CARDIOLOGY	0.120678	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0.618784	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0.000000	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0.000000	0	0	0	0	76.99
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.351641	0	0	0	0	90.00
91.00	09100	EMERGENCY	0.111892	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.380034	0	0	0	0	92.00
200.00		Subtotal (see instructions)		3,795	0	0	626	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 - line 201)		3,795	0	0	626	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 15-0125 | Component CCN: 15-T125 | Period: From 07/01/2019 To 06/30/2020 | Worksheet D Part V | Date/Time Prepared: 11/25/2020 3:02 pm

Title XVIII | Subprovider - IRF | PPS

		Cost Center Description	Costs: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	0		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0		52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0		54.00
60.00	06000	LABORATORY	0	0		60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0		62.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0		62.30
65.00	06500	RESPIRATORY THERAPY	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0		66.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0		73.00
76.00	03140	CARDIOLOGY	0	0		76.00
76.97	07697	CARDIAC REHABILITATION	0	0		76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0		76.98
76.99	07699	LITHOTRIPSY	0	0		76.99
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0	0		90.00
91.00	09100	EMERGENCY	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0		92.00
200.00		Subtotal (see instructions)	0	0		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	0	0		202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS | Provider CCN: 15-0125 | Period: From 07/01/2019 To 06/30/2020 | Worksheet D Part I Date/Time Prepared: 11/25/2020 3:02 pm

Title XIX | Hospital | PPS

	Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	5,144,336	0	5,144,336	81,442	63.17	30.00
31.00	INTENSIVE CARE UNIT	1,449,698		1,449,698	10,863	133.45	31.00
32.01	NEONATAL INTENSIVE CARE	432,348		432,348	4,299	100.57	32.01
41.00	SUBPROVIDER - IRF	356,619	0	356,619	7,717	46.21	41.00
43.00	NURSERY	55,100		55,100	3,110	17.72	43.00
200.00	Total (lines 30 through 199)	7,438,101		7,438,101	107,431		200.00

	Cost Center Description	Inpatient Program days	Inpatient Program Capital Cost (col. 5 x col. 6)				
		6.00	7.00				
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	1,651	104,294				30.00
31.00	INTENSIVE CARE UNIT	5	667				31.00
32.01	NEONATAL INTENSIVE CARE	328	32,987				32.01
41.00	SUBPROVIDER - IRF	39	1,802				41.00
43.00	NURSERY	223	3,952				43.00
200.00	Total (lines 30 through 199)	2,246	143,702				200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS | Provider CCN: 15-0125 | Period: From 07/01/2019 To 06/30/2020 | Worksheet D Part II Date/Time Prepared: 11/25/2020 3:02 pm

Title XIX | Hospital | PPS

		Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	6,052,917	305,845,365	0.019791	862,144	17,063	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	484,827	10,204,874	0.047509	128,268	6,094	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	5,093,997	311,732,541	0.016341	493,829	8,070	54.00
60.00	06000	LABORATORY	1,197,224	199,692,123	0.005995	734,466	4,403	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	74,494	11,454,287	0.006504	145,183	944	62.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0.000000	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	210,147	32,145,120	0.006537	195,610	1,279	65.00
66.00	06600	PHYSICAL THERAPY	1,033,021	47,371,197	0.021807	163,773	3,571	66.00
70.00	07000	ELECTROENCEPHALOGRAPHY	145,592	14,638,571	0.009946	30,631	305	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	117,589	51,250,695	0.002294	205,380	471	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	158,942	77,335,456	0.002055	301,270	619	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	686,524	138,506,628	0.004957	933,840	4,629	73.00
76.00	03140	CARDIOLOGY	3,211,631	192,282,034	0.016703	308,082	5,146	76.00
76.97	07697	CARDIAC REHABILITATION	130,967	2,663,212	0.049176	3,491	172	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0.000000	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0.000000	0	0	76.99
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	205,798	13,243,230	0.015540	20,883	325	90.00
91.00	09100	EMERGENCY	825,646	150,205,944	0.005497	289,850	1,593	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	914,323	39,075,216	0.023399	0	0	92.00
200.00		Total (lines 50 through 199)	20,543,639	1,597,646,493		4,816,700	54,684	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 15-0125 | Period: From 07/01/2019 To 06/30/2020 | Worksheet D Part III Date/Time Prepared: 11/25/2020 3:02 pm

Title XIX | Hospital | PPS

		Cost Center Description	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health Cost	All Other Medical Education Cost	
			1A	1.00	2A	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
32.01	02060	NEONATAL INTENSIVE CARE	0	0	0	0	0	32.01
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	81,442	0.00	1,651	30.00
31.00	03100	INTENSIVE CARE UNIT		0	10,863	0.00	5	31.00
32.01	02060	NEONATAL INTENSIVE CARE		0	4,299	0.00	328	32.01
41.00	04100	SUBPROVIDER - IRF	0	0	7,717	0.00	39	41.00
43.00	04300	NURSERY		0	3,110	0.00	223	43.00
200.00		Total (lines 30 through 199)		0	107,431		2,246	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
32.01	02060	NEONATAL INTENSIVE CARE	0	32.01
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: 15-0125 | Period: From 07/01/2019 To 06/30/2020 | Worksheet D Part IV | Date/Time Prepared: 11/25/2020 3:02 pm

Title XIX | Hospital | PPS

		Cost Center Description	Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health	
			1.00	2A	2.00	3A	3.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0	0	0	62.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	489,687	73.00
76.00	03140	CARDIOLOGY	0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0		0		0	92.00
200.00		Total (lines 50 through 199)	0	0	0	0	489,687	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-0125 | Period: From 07/01/2019 To 06/30/2020 | Worksheet D Part IV Date/Time Prepared: 11/25/2020 3:02 pm

Title XIX | Hospital | PPS

		Cost Center Description	All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7) (see instructions)	
			4.00	5.00	6.00	7.00	8.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	305,845,365	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	10,204,874	0.000000	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	311,732,541	0.000000	54.00
60.00	06000	LABORATORY	0	0	0	199,692,123	0.000000	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0	11,454,287	0.000000	62.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0.000000	62.30
65.00	06500	RESPIRATORY THERAPY	0	0	0	32,145,120	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	47,371,197	0.000000	66.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	14,638,571	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	51,250,695	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	77,335,456	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	489,687	489,687	138,506,628	0.003535	73.00
76.00	03140	CARDIOLOGY	0	0	0	192,282,034	0.000000	76.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	2,663,212	0.000000	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0.000000	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0.000000	76.99
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	13,243,230	0.000000	90.00
91.00	09100	EMERGENCY	0	0	0	150,205,944	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	39,075,216	0.000000	92.00
200.00		Total (lines 50 through 199)	0	489,687	489,687	1,597,646,493		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-0125 | Period: From 07/01/2019 To 06/30/2020 | Worksheet D Part IV | Date/Time Prepared: 11/25/2020 3:02 pm

Title XIX | Hospital | PPS

		Cost Center Description	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
			9.00	10.00	11.00	12.00	13.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.000000	862,144	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	128,268	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	493,829	0	0	0	54.00
60.00	06000	LABORATORY	0.000000	734,466	0	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0.000000	145,183	0	0	0	62.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0.000000	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0.000000	195,610	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	163,773	0	0	0	66.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	30,631	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	205,380	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	301,270	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.003535	933,840	3,301	0	0	73.00
76.00	03140	CARDIOLOGY	0.000000	308,082	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0.000000	3,491	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0.000000	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0.000000	0	0	0	0	76.99
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.000000	20,883	0	0	0	90.00
91.00	09100	EMERGENCY	0.000000	289,850	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	0	0	0	0	92.00
200.00		Total (lines 50 through 199)		4,816,700	3,301	0	0	200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 15-0125 | Component CCN: 15-T125 | Period: From 07/01/2019 To 06/30/2020 | Worksheet D Part II Date/Time Prepared: 11/25/2020 3:02 pm

Title XIX | 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	6,052,917	305,845,365	0.019791	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	484,827	10,204,874	0.047509	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	5,093,997	311,732,541	0.016341	0	0	54.00
60.00	06000	LABORATORY	1,197,224	199,692,123	0.005995	1,913	11	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	74,494	11,454,287	0.006504	0	0	62.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0.000000	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	210,147	32,145,120	0.006537	0	0	65.00
66.00	06600	PHYSICAL THERAPY	1,033,021	47,371,197	0.021807	10,832	236	66.00
70.00	07000	ELECTROENCEPHALOGRAPHY	145,592	14,638,571	0.009946	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	117,589	51,250,695	0.002294	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	158,942	77,335,456	0.002055	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	686,524	138,506,628	0.004957	1,938	10	73.00
76.00	03140	CARDIOLOGY	3,211,631	192,282,034	0.016703	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	130,967	2,663,212	0.049176	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0.000000	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0.000000	0	0	76.99
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	205,798	13,243,230	0.015540	0	0	90.00
91.00	09100	EMERGENCY	825,646	150,205,944	0.005497	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	39,075,216	0.000000	0	0	92.00
200.00		Total (lines 50 through 199)	19,629,316	1,597,646,493		14,683	257	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-0125 | Component CCN: 15-T125 | Period: From 07/01/2019 To 06/30/2020 | Worksheet D Part IV | Date/Time Prepared: 11/25/2020 3:02 pm

Title XIX | 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	0	54.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0	0	0	62.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	489,687	73.00
76.00	03140	CARDIOLOGY	0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0		0		0	92.00
200.00		Total (lines 50 through 199)	0	0	0	0	489,687	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-0125
Component CCN: 15-T125

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

Worksheet D
Part IV
Date/Time Prepared:
11/25/2020 3:02 pm

Title XIX | 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	305,845,365	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	10,204,874	0.000000	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	311,732,541	0.000000	54.00
60.00	06000	LABORATORY	0	0	0	199,692,123	0.000000	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0	11,454,287	0.000000	62.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0.000000	62.30
65.00	06500	RESPIRATORY THERAPY	0	0	0	32,145,120	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	47,371,197	0.000000	66.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	14,638,571	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	51,250,695	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	77,335,456	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	489,687	489,687	138,506,628	0.003535	73.00
76.00	03140	CARDIOLOGY	0	0	0	192,282,034	0.000000	76.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	2,663,212	0.000000	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0.000000	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0.000000	76.99
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	13,243,230	0.000000	90.00
91.00	09100	EMERGENCY	0	0	0	150,205,944	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	39,075,216	0.000000	92.00
200.00		Total (lines 50 through 199)	0	489,687	489,687	1,597,646,493		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-0125
Component CCN: 15-T125

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

Worksheet D
Part IV
Date/Time Prepared:
11/25/2020 3:02 pm

Title XIX | 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	0	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	0.000000	0	0	0	0	54.00
60.00	06000	LABORATORY	0.000000	1,913	0	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0.000000	0	0	0	0	62.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0.000000	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0.000000	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	10,832	0	0	0	66.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.003535	1,938	7	0	0	73.00
76.00	03140	CARDIOLOGY	0.000000	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0.000000	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0.000000	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0.000000	0	0	0	0	76.99
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.000000	0	0	0	0	90.00
91.00	09100	EMERGENCY	0.000000	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	0	0	0	0	92.00
200.00		Total (lines 50 through 199)		14,683	7	0	0	200.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-0125 | Period: From 07/01/2019 To 06/30/2020 | Worksheet D-1 | Date/Time Prepared: 11/25/2020 3:02 pm

Title XVIII | Hospital | PPS

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	81,442	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	81,442	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)	66,967	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)	30,506	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)	83,551,469	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)	83,551,469	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)	83,551,469	37.00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY		
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS		
38.00	Adjusted general inpatient routine service cost per diem (see instructions)	1,025.90	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	31,296,105	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)	31,296,105	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-0125 | Period: From 07/01/2019 To 06/30/2020 | Worksheet D-1 | Date/Time Prepared: 11/25/2020 3:02 pm

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	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	22,258,979	10,863	2,049.06	4,653	9,534,276	43.00
44.00	CORONARY CARE UNIT						44.00
44.01	NEONATAL INTENSIVE CARE	6,102,490	4,299	1,419.51	0	0	44.01
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)	50,760,156	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	91,590,537	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)	2,548,007	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	2,864,510	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	5,412,517	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	86,178,020	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)	14,475	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	1,025.90	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	14,849,903	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-0125 | Period: From 07/01/2019 To 06/30/2020 | Worksheet D-1 | Date/Time Prepared: 11/25/2020 3:02 pm

Title XVIII | Hospital | PPS

	Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	5,144,336	83,551,469	0.061571	14,849,903	914,323	90.00
91.00	Nursing School cost	0	83,551,469	0.000000	14,849,903	0	91.00
92.00	Allied health cost	0	83,551,469	0.000000	14,849,903	0	92.00
93.00	All other Medical Education	0	83,551,469	0.000000	14,849,903	0	93.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 15-0125 Component CCN: 15-T125	Period: From 07/01/2019 To 06/30/2020	Worksheet D-1 Date/Time Prepared: 11/25/2020 3:02 pm
	Title XVIII	Subprovider - IRF	PPS

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	7,717	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	7,717	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.	0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)	7,717	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions)	6,181	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)	6,752,109	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)	6,752,109	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)	6,752,109	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)	874.97	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	5,408,190	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)	5,408,190	41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 15-0125 | Component CCN: 15-T125 | Period: From 07/01/2019 To 06/30/2020 | Worksheet D-1 | Date/Time Prepared: 11/25/2020 3:02 pm

Title XVIII | Subprovider - IRF | PPS

	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)	0	0	0.00	0	0	42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	0	0	0.00	0	0	43.00
44.00	CORONARY CARE UNIT						44.00
44.01	NEONATAL INTENSIVE CARE	0	0	0.00	0	0	44.01
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	3,492,234	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	8,900,424	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)	285,624	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	190,063	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	475,687	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	8,424,737	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: 15-0125 | Component CCN: 15-T125 | Period: From 07/01/2019 To 06/30/2020 | Worksheet D-1 | Date/Time Prepared: 11/25/2020 3:02 pm

Title XVIII | Subprovider - IRF | PPS

	Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	356,619	6,752,109	0.052816	0	0	90.00
91.00	Nursing School cost	0	6,752,109	0.000000	0	0	91.00
92.00	Allied health cost	0	6,752,109	0.000000	0	0	92.00
93.00	All other Medical Education	0	6,752,109	0.000000	0	0	93.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-0125 | Period: From 07/01/2019 To 06/30/2020 | Worksheet D-1 | Date/Time Prepared: 11/25/2020 3:02 pm

Title XIX | Hospital | PPS

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	81,442	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	81,442	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)	66,967	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions)	1,651	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)	3,110	15.00
16.00	Nursery days (title V or XIX only)	223	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)	83,551,469	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)	83,551,469	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)	83,551,469	37.00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY		
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS		
38.00	Adjusted general inpatient routine service cost per diem (see instructions)	1,025.90	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	1,693,761	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)	1,693,761	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-0125 | Period: From 07/01/2019 To 06/30/2020 | Worksheet D-1 | Date/Time Prepared: 11/25/2020 3:02 pm

Title XIX | Hospital | PPS

	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)	2,567,963	3,110	825.71	223	184,133	42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	22,258,979	10,863	2,049.06	5	10,245	43.00
44.00	CORONARY CARE UNIT						44.00
44.01	NEONATAL INTENSIVE CARE	6,102,490	4,299	1,419.51	328	465,599	44.01
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)	1,023,977	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	3,377,715	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)	141,900	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	57,985	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	199,885	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	3,177,830	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)	14,475	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	1,025.90	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	14,849,903	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-0125 | Period: From 07/01/2019 To 06/30/2020 | Worksheet D-1 | Date/Time Prepared: 11/25/2020 3:02 pm

Title XIX | Hospital | PPS

	Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	5,144,336	83,551,469	0.061571	14,849,903	914,323	90.00
91.00	Nursing School cost	0	83,551,469	0.000000	14,849,903	0	91.00
92.00	Allied health cost	0	83,551,469	0.000000	14,849,903	0	92.00
93.00	All other Medical Education	0	83,551,469	0.000000	14,849,903	0	93.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 15-0125 Component CCN: 15-T125	Period: From 07/01/2019 To 06/30/2020	Worksheet D-1 Date/Time Prepared: 11/25/2020 3:02 pm
	Title XIX	Subprovider - IRF	PPS

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	7,717	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	7,717	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.	0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)	7,717	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)	39	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)	3,110	15.00
16.00	Nursery days (title V or XIX only)	223	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)	6,752,109	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)	6,752,109	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)	6,752,109	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)	874.97	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	34,124	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)	34,124	41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 15-0125 | Component CCN: 15-T125 | Period: From 07/01/2019 To 06/30/2020 | Worksheet D-1 | Date/Time Prepared: 11/25/2020 3:02 pm

Title XIX | 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
44.01	NEONATAL INTENSIVE CARE	0	0	0.00	0	0	44.01
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)	4,540	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	38,664	49.00
	PASS THROUGH COST ADJUSTMENTS		
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)	1,802	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	264	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	2,066	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	36,598	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: 15-0125 | Component CCN: 15-T125 | Period: From 07/01/2019 To 06/30/2020 | Worksheet D-1 | Date/Time Prepared: 11/25/2020 3:02 pm

Title XIX | 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	356,619	6,752,109	0.052816	0	0	90.00
91.00	Nursing School cost	0	6,752,109	0.000000	0	0	91.00
92.00	Allied health cost	0	6,752,109	0.000000	0	0	92.00
93.00	All other Medical Education	0	6,752,109	0.000000	0	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 15-0125 | Period: From 07/01/2019 To 06/30/2020 | Worksheet D-3 | Date/Time Prepared: 11/25/2020 3:02 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		53,190,164		30.00
31.00	03100	INTENSIVE CARE UNIT		13,313,791		31.00
32.01	02060	NEONATAL INTENSIVE CARE		0		32.01
41.00	04100	SUBPROVIDER - IRF		0		41.00
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.181892	44,367,987	8,070,182	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.546943	28,608	15,647	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.093857	28,204,520	2,647,192	54.00
60.00	06000	LABORATORY	0.115097	28,365,250	3,264,755	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0.284683	2,928,106	833,582	62.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0.000000	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0.220088	13,531,300	2,978,077	65.00
66.00	06600	PHYSICAL THERAPY	0.365147	6,836,091	2,496,178	66.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.117902	827,062	97,512	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.554528	10,973,655	6,085,199	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.495109	22,112,795	10,948,244	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.188594	34,055,997	6,422,757	73.00
76.00	03140	CARDIOLOGY	0.120744	35,982,935	4,344,724	76.00
76.97	07697	CARDIAC REHABILITATION	0.618784	168,726	104,405	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0.000000	0	0	76.98
76.99	07699	LITHOTRIPSY	0.000000	0	0	76.99
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0.352878	145,195	51,236	90.00
91.00	09100	EMERGENCY	0.111892	21,453,421	2,400,466	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.380034	0	0	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		249,981,648	50,760,156	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)		249,981,648		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

Provider CCN: 15-0125 | Component CCN: 15-T125 | Period: From 07/01/2019 To 06/30/2020 | Worksheet D-3 | Date/Time Prepared: 11/25/2020 3:02 pm

Title XVIII | Subprovider - IRF | PPS

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		0		30.00
31.00	03100	INTENSIVE CARE UNIT		0		31.00
32.01	02060	NEONATAL INTENSIVE CARE		0		32.01
41.00	04100	SUBPROVIDER - IRF		8,277,734		41.00
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.181892	128,213	23,321	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.546943	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.093857	582,704	54,691	54.00
60.00	06000	LABORATORY	0.115097	1,208,741	139,122	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0.284683	49,887	14,202	62.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0.000000	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0.220088	693,498	152,631	65.00
66.00	06600	PHYSICAL THERAPY	0.365147	6,285,817	2,295,247	66.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.117902	13,307	1,569	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.554528	462,371	256,398	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.495109	19,592	9,700	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.188594	2,686,310	506,622	73.00
76.00	03140	CARDIOLOGY	0.120744	269,983	32,599	76.00
76.97	07697	CARDIAC REHABILITATION	0.618784	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0.000000	0	0	76.98
76.99	07699	LITHOTRIPSY	0.000000	0	0	76.99
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0.352878	17,228	6,079	90.00
91.00	09100	EMERGENCY	0.111892	471	53	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.380034	0	0	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		12,418,122	3,492,234	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)		12,418,122		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 15-0125 | Period: From 07/01/2019 To 06/30/2020 | Worksheet D-3 | Date/Time Prepared: 11/25/2020 3:02 pm

Title XIX | Hospital | PPS

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		1,096,867		30.00
31.00	03100	INTENSIVE CARE UNIT		246,190		31.00
32.01	02060	NEONATAL INTENSIVE CARE		1,823,350		32.01
41.00	04100	SUBPROVIDER - IRF		0		41.00
43.00	04300	NURSERY		353,545		43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.181892	862,144	156,817	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.546943	128,268	70,155	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.093857	493,829	46,349	54.00
60.00	06000	LABORATORY	0.115097	734,466	84,535	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0.284683	145,183	41,331	62.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0.000000	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0.220088	195,610	43,051	65.00
66.00	06600	PHYSICAL THERAPY	0.365147	163,773	59,801	66.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.117902	30,631	3,611	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.554528	205,380	113,889	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.495109	301,270	149,161	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.188594	933,840	176,117	73.00
76.00	03140	CARDIOLOGY	0.120744	308,082	37,199	76.00
76.97	07697	CARDIAC REHABILITATION	0.618784	3,491	2,160	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0.000000	0	0	76.98
76.99	07699	LITHOTRIPSY	0.000000	0	0	76.99
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0.352878	20,883	7,369	90.00
91.00	09100	EMERGENCY	0.111892	289,850	32,432	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.380034	0	0	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		4,816,700	1,023,977	200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0		201.00
202.00		Net charges (line 200 minus line 201)		4,816,700		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

Provider CCN: 15-0125 | Component CCN: 15-T125 | Period: From 07/01/2019 To 06/30/2020 | Worksheet D-3 | Date/Time Prepared: 11/25/2020 3:02 pm

Title XIX | 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
32.01	02060	NEONATAL INTENSIVE CARE		0		32.01
41.00	04100	SUBPROVIDER - IRF		11,880		41.00
43.00	04300	NURSERY		0		43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.181892	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.546943	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.093857	0	0	54.00
60.00	06000	LABORATORY	0.115097	1,913	220	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0.284683	0	0	62.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0.000000	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0.220088	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.365147	10,832	3,955	66.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.117902	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.554528	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.495109	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.188594	1,938	365	73.00
76.00	03140	CARDIOLOGY	0.120744	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0.618784	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0.000000	0	0	76.98
76.99	07699	LITHOTRIPSY	0.000000	0	0	76.99
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0.352878	0	0	90.00
91.00	09100	EMERGENCY	0.111892	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.380034	0	0	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		14,683	4,540	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)		14,683		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0125	Period: From 07/01/2019 To 06/30/2020	Worksheet E Part A Date/Time Prepared: 11/25/2020 3:02 pm
	Title XVIII	Hospital	PPS

		1.00	
	PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS		
1.00	DRG Amounts Other than Outlier Payments	0	1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1 (see instructions)	18,884,373	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1 (see instructions)	52,868,941	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)	518,493	2.03
2.04	Outlier payments for discharges occurring on or after October 1 (see instructions)	1,178,904	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)	380.38	4.00
	Indirect Medical Education Adjustment		
5.00	FTE count for allopathic and osteopathic programs for the most recent cost reporting period ending on or before 12/31/1996.(see instructions)	0.00	5.00
6.00	FTE count for allopathic and osteopathic programs that meet the criteria for an add-on to the cap for new programs in accordance with 42 CFR 413.79(e)	0.00	6.00
7.00	MMA Section 422 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(1)	0.00	7.00
7.01	ACA § 5503 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(2) If the cost report straddles July 1, 2011 then see instructions.	0.00	7.01
8.00	Adjustment (increase or decrease) to the FTE count for allopathic and osteopathic programs for affiliated programs in accordance with 42 CFR 413.75(b), 413.79(c)(2)(iv), 64 FR 26340 (May 12, 1998), and 67 FR 50069 (August 1, 2002).	0.00	8.00
8.01	The amount of increase if the hospital was awarded FTE cap slots under § 5503 of the ACA. If the cost report straddles July 1, 2011, see instructions.	0.00	8.01
8.02	The amount of increase if the hospital was awarded FTE cap slots from a closed teaching hospital under § 5506 of ACA. (see instructions)	0.00	8.02
9.00	Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus lines (8, 8,01 and 8,02) (see instructions)	0.00	9.00
10.00	FTE count for allopathic and osteopathic programs in the current year from your records	0.00	10.00
11.00	FTE count for residents in dental and podiatric programs.	0.00	11.00
12.00	Current year allowable FTE (see instructions)	0.00	12.00
13.00	Total allowable FTE count for the prior year.	0.00	13.00
14.00	Total allowable FTE count for the penultimate year if that year ended on or after September 30, 1997, otherwise enter zero.	0.00	14.00
15.00	Sum of lines 12 through 14 divided by 3.	0.00	15.00
16.00	Adjustment for residents in initial years of the program	0.00	16.00
17.00	Adjustment for residents displaced by program or hospital closure	0.00	17.00
18.00	Adjusted rolling average FTE count	0.00	18.00
19.00	Current year resident to bed ratio (line 18 divided by line 4).	0.000000	19.00
20.00	Prior year resident to bed ratio (see instructions)	0.000000	20.00
21.00	Enter the lesser of lines 19 or 20 (see instructions)	0.000000	21.00
22.00	IME payment adjustment (see instructions)	0	22.00
22.01	IME payment adjustment - Managed Care (see instructions)	0	22.01
	Indirect Medical Education Adjustment for the Add-on for § 422 of the MMA		
23.00	Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 CFR 412.105 (f)(1)(iv)(C).	0.00	23.00
24.00	IME FTE Resident Count Over Cap (see instructions)	0.00	24.00
25.00	If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see instructions)	0.00	25.00
26.00	Resident to bed ratio (divide line 25 by line 4)	0.000000	26.00
27.00	IME payments adjustment factor. (see instructions)	0.000000	27.00
28.00	IME add-on adjustment amount (see instructions)	0	28.00
28.01	IME add-on adjustment amount - Managed Care (see instructions)	0	28.01
29.00	Total IME payment (sum of lines 22 and 28)	0	29.00
29.01	Total IME payment - Managed Care (sum of lines 22.01 and 28.01)	0	29.01
	Disproportionate Share Adjustment		
30.00	Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)	3.04	30.00
31.00	Percentage of Medicaid patient days (see instructions)	15.46	31.00
32.00	Sum of lines 30 and 31	18.50	32.00
33.00	Allowable disproportionate share percentage (see instructions)	4.78	33.00
34.00	Disproportionate share adjustment (see instructions)	857,452	34.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0125	Period: From 07/01/2019 To 06/30/2020	Worksheet E Part A Date/Time Prepared: 11/25/2020 3:02 pm
	Title XVIII	Hospital	PPS

		Prior to 10/1	On/After 10/1	
		1.00	2.00	
	Uncompensated Care Adjustment			
35.00	Total uncompensated care amount (see instructions)	8,272,872,447	8,350,599,096	35.00
35.01	Factor 3 (see instructions)	0.000396589	0.000300351	35.01
35.02	Hospital uncompensated care payment (If line 34 is zero, enter zero on this line) (see instructions)	3,280,933	2,508,108	35.02
35.03	Pro rata share of the hospital uncompensated care payment amount (see instructions)	826,976	1,877,655	35.03
36.00	Total uncompensated care (sum of columns 1 and 2 on line 35.03)	2,704,631		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)	77,012,794		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)		77,012,794	49.00
50.00	Payment for inpatient program capital (from Wkst. L, Pt. I and Pt. II, as applicable)		5,992,739	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		31,412	53.00
54.00	Special add-on payments for new technologies		41,578	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)		120,388	58.00
59.00	Total (sum of amounts on lines 49 through 58)		83,198,911	59.00
60.00	Primary payer payments		16,221	60.00
61.00	Total amount payable for program beneficiaries (line 59 minus line 60)		83,182,690	61.00
62.00	Deductibles billed to program beneficiaries		6,101,172	62.00
63.00	Coinsurance billed to program beneficiaries		543,356	63.00
64.00	Allowable bad debts (see instructions)		798,187	64.00
65.00	Adjusted reimbursable bad debts (see instructions)		518,822	65.00
66.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		168,231	66.00
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)		77,056,984	67.00
68.00	Credits received from manufacturers for replaced devices for applicable to MS-DRGs (see instructions)		516	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)		73,449	70.93
70.94	HRR adjustment amount (see instructions)		-1,019,486	70.94
70.95	Recovery of accelerated depreciation		0	70.95

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0125	Period: From 07/01/2019 To 06/30/2020	Worksheet E Part A Date/Time Prepared: 11/25/2020 3:02 pm
	Title XVIII	Hospital	PPS

		FFY (yyyy)	Amount	
		0	1.00	
70.96	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period prior to 10/1)	0	0	70.96
70.97	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period ending on or after 10/1)	0	0	70.97
70.98	Low Volume Payment-3		0	70.98
70.99	HAC adjustment amount (see instructions)		0	70.99
71.00	Amount due provider (line 67 minus lines 68 plus/minus lines 69 & 70)		76,110,431	71.00
71.01	Sequestration adjustment (see instructions)		1,271,044	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		74,249,947	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)		589,440	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		934,517	75.00
	TO BE COMPLETED BY CONTRACTOR (lines 90 through 96)			
90.00	Operating outlier amount from Wkst. E, Pt. A, line 2, or sum of 2.03 plus 2.04 (see instructions)		0	90.00
91.00	Capital outlier from Wkst. L, Pt. I, line 2		0	91.00
92.00	Operating outlier reconciliation adjustment amount (see instructions)		0	92.00
93.00	Capital outlier reconciliation adjustment amount (see instructions)		0	93.00
94.00	The rate used to calculate the time value of money (see instructions)		0.00	94.00
95.00	Time value of money for operating expenses (see instructions)		0	95.00
96.00	Time value of money for capital related expenses (see instructions)		0	96.00

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

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0125	Period: From 07/01/2019 To 06/30/2020	Worksheet E Part B Date/Time Prepared: 11/25/2020 3:02 pm
	Title XVIII	Hospital	PPS

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	26,349	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)	48,821,812	2.00
3.00	OPPS payments	46,840,560	3.00
4.00	Outlier payment (see instructions)	71,645	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	72,151	9.00
10.00	Organ acquisitions	0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)	26,349	11.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
12.00	Ancillary service charges	140,678	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)	140,678	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)	140,678	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)	114,329	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)	26,349	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)	46,984,356	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)	8,515,797	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)	38,494,908	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)	38,494,908	30.00
31.00	Primary payer payments	7,698	31.00
32.00	Subtotal (line 30 minus line 31)	38,487,210	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)	1,019,624	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	662,756	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	507,752	36.00
37.00	Subtotal (see instructions)	39,149,966	37.00
38.00	MSP-LCC reconciliation amount from PS&R	62	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)	39,149,904	40.00
40.01	Sequestration adjustment (see instructions)	653,803	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	38,350,314	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)	145,787	43.00
43.01	Balance due provider/program-PARHM (see instructions)		43.01
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	44.00
	TO BE COMPLETED BY CONTRACTOR		
90.00	Original outlier amount (see instructions)	0	90.00
91.00	Outlier reconciliation adjustment amount (see instructions)	0	91.00
92.00	The rate used to calculate the Time Value of Money	0.00	92.00
93.00	Time Value of Money (see instructions)	0	93.00
94.00	Total (sum of lines 91 and 93)	0	94.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0125 Component CCN: 15-T125	Period: From 07/01/2019 To 06/30/2020	Worksheet E Part B Date/Time Prepared: 11/25/2020 3:02 pm
	Title XVIII	Subprovider - IRF	PPS

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	0	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)	618	2.00
3.00	OPPS payments	214	3.00
4.00	Outlier payment (see instructions)	0	4.00
4.01	Outlier reconciliation amount (see instructions)	0	4.01
5.00	Enter the hospital specific payment to cost ratio (see instructions)	0.000	5.00
6.00	Line 2 times line 5	0	6.00
7.00	Sum of lines 3, 4, and 4.01, divided by line 6	0.00	7.00
8.00	Transitional corridor payment (see instructions)	0	8.00
9.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200	8	9.00
10.00	Organ acquisitions	0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)	0	11.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
12.00	Ancillary service charges	0	12.00
13.00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, line 69)	0	13.00
14.00	Total reasonable charges (sum of lines 12 and 13)	0	14.00
	Customary charges		
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis	0	15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a chargebasis had such payment been made in accordance with 42 CFR §413.13(e)	0	16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)	0.000000	17.00
18.00	Total customary charges (see instructions)	0	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)	0	19.00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)	0	20.00
21.00	Lesser of cost or charges (see instructions)	0	21.00
22.00	Interns and residents (see instructions)	0	22.00
23.00	Cost of physicians' services in a teaching hospital (see instructions)	0	23.00
24.00	Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)	222	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)	43	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)	179	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)	179	30.00
31.00	Primary payer payments	0	31.00
32.00	Subtotal (line 30 minus line 31)	179	32.00
	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)		
33.00	Composite rate ESRD (from Wkst. I-5, line 11)	0	33.00
34.00	Allowable bad debts (see instructions)	0	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	0	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	0	36.00
37.00	Subtotal (see instructions)	179	37.00
38.00	MSP-LCC reconciliation amount from PS&R	0	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	39.00
39.50	Pioneer ACO demonstration payment adjustment (see instructions)		39.50
39.97	Demonstration payment adjustment amount before sequestration	0	39.97
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)	0	39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION	0	39.99
40.00	Subtotal (see instructions)	179	40.00
40.01	Sequestration adjustment (see instructions)	3	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	168	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)	8	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: 15-0125 | Period: From 07/01/2019 To 06/30/2020 | Worksheet E-1 Part I | Date/Time Prepared: 11/25/2020 3:02 pm

Title XVIII | Hospital | PPS

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		73,797,993		37,765,287	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		392,954		585,027	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	02/05/2020	59,000		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)		59,000		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)		74,249,947		38,350,314	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		589,440		145,787	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		74,839,387		38,496,101	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: 15-0125 | Component CCN: 15-T125 | Period: From 07/01/2019 To 06/30/2020 | Worksheet E-1 Part I | Date/Time Prepared: 11/25/2020 3:02 pm

Title XVIII | Subprovider - IRF | PPS

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		11,175,807		168	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)		11,175,807		168	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		24,077		8	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		11,199,884		176	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: 15-0125	Period: From 07/01/2019 To 06/30/2020	Worksheet E-1 Part II Date/Time Prepared: 11/25/2020 3:02 pm
	Title XVIII	Hospital	PPS

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

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0125 Component CCN: 15-T125	Period: From 07/01/2019 To 06/30/2020	Worksheet E-3 Part III Date/Time Prepared: 11/25/2020 3:02 pm
	Title XVIII	Subprovider - IRF	PPS

		1.00	
	PART III - MEDICARE PART A SERVICES - IRF PPS		
1.00	Net Federal PPS Payment (see instructions)	11,228,112	1.00
2.00	Medicare SSI ratio (IRF PPS only) (see instructions)	0.0236	2.00
3.00	Inpatient Rehabilitation LIP Payments (see instructions)	161,685	3.00
4.00	Outlier Payments	70,725	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)	21.084699	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)	11,460,522	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)	11,460,522	17.00
18.00	Primary payer payments	0	18.00
19.00	Subtotal (line 17 less line 18).	11,460,522	19.00
20.00	Deductibles	53,724	20.00
21.00	Subtotal (line 19 minus line 20)	11,406,798	21.00
22.00	Coinsurance	37,136	22.00
23.00	Subtotal (line 21 minus line 22)	11,369,662	23.00
24.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)	16,832	24.00
25.00	Adjusted reimbursable bad debts (see instructions)	10,941	25.00
26.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	5,797	26.00
27.00	Subtotal (sum of lines 23 and 25)	11,380,603	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)	9,496	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)	11,390,099	32.00
32.01	Sequestration adjustment (see instructions)	190,215	32.01
32.02	Demonstration payment adjustment amount after sequestration	0	32.02
33.00	Interim payments	11,175,807	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)	24,077	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	70,725	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: 15-0125 | Period: From 07/01/2019 To 06/30/2020 | Worksheet E-3 Part VII | Date/Time Prepared: 11/25/2020 3:02 pm

Title XIX | Hospital | PPS

		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	3,519,952		8.00
9.00	Ancillary service charges	4,816,700	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)	8,336,652	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)	8,336,652	0	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)	8,336,652	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	3,301	0	26.00
27.00	Subtotal (sum of lines 22 through 26)	3,301	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)	3,301	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)	3,301	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)	3,301	0	36.00
37.00	ZERO OUT SETTLEMENT	-3,301	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

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0125 Component CCN: 15-T125	Period: From 07/01/2019 To 06/30/2020	Worksheet E-3 Part VII Date/Time Prepared: 11/25/2020 3:02 pm
	Title XIX	Subprovider - IRF	PPS

		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	11,880		8.00
9.00	Ancillary service charges	14,683	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)	26,563	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)	26,563	0	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)	26,563	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	7	0	26.00
27.00	Subtotal (sum of lines 22 through 26)	7	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)	7	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)	7	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)	7	0	36.00
37.00	ZERO OUT SETTLEMENT	-7	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: 15-0125 | Period: From 07/01/2019 To 06/30/2020 | Worksheet G | Date/Time Prepared: 11/25/2020 3:02 pm

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
	CURRENT ASSETS					
1.00	Cash on hand in banks	10,601	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	65,629,559	0	0	0	4.00
5.00	Other receivable	0	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	0	0	0	0	6.00
7.00	Inventory	13,680,700	0	0	0	7.00
8.00	Prepaid expenses	0	0	0	0	8.00
9.00	Other current assets	8,885,456	0	0	0	9.00
10.00	Due from other funds	0	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	88,206,316	0	0	0	11.00
	FIXED ASSETS					
12.00	Land	0	0	0	0	12.00
13.00	Land improvements	0	0	0	0	13.00
14.00	Accumulated depreciation	0	0	0	0	14.00
15.00	Buildings	196,470,455	0	0	0	15.00
16.00	Accumulated depreciation	0	0	0	0	16.00
17.00	Leasehold improvements	0	0	0	0	17.00
18.00	Accumulated depreciation	0	0	0	0	18.00
19.00	Fixed equipment	0	0	0	0	19.00
20.00	Accumulated depreciation	0	0	0	0	20.00
21.00	Automobiles and trucks	0	0	0	0	21.00
22.00	Accumulated depreciation	0	0	0	0	22.00
23.00	Major movable equipment	0	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	0	0	0	0	28.00
29.00	Minor equipment-nondepreciable	0	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	196,470,455	0	0	0	30.00
	OTHER ASSETS					
31.00	Investments	0	0	0	0	31.00
32.00	Deposits on leases	0	0	0	0	32.00
33.00	Due from owners/officers	0	0	0	0	33.00
34.00	Other assets	17,619,094	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	17,619,094	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	302,295,865	0	0	0	36.00
	CURRENT LIABILITIES					
37.00	Accounts payable	3,161,907	0	0	0	37.00
38.00	Salaries, wages, and fees payable	25,215,451	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	0	0	0	0	40.00
41.00	Deferred income	0	0	0	0	41.00
42.00	Accelerated payments	0				42.00
43.00	Due to other funds	0	0	0	0	43.00
44.00	Other current liabilities	79,103,864	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	107,481,222	0	0	0	45.00
	LONG TERM LIABILITIES					
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	0	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	18,260,375	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	18,260,375	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	125,741,597	0	0	0	51.00
	CAPITAL ACCOUNTS					
52.00	General fund balance	176,554,268				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)	176,554,268	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	302,295,865	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES | Provider CCN: 15-0125 | Period: From 07/01/2019 To 06/30/2020 | Worksheet G-1 | Date/Time Prepared: 11/25/2020 3:02 pm

		General Fund		Special Purpose Fund		Endowment Fund	
		1.00	2.00	3.00	4.00	5.00	
1.00	Fund balances at beginning of period		281,174,195		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		48,737,287				2.00
3.00	Total (sum of line 1 and line 2)		329,911,482		0		3.00
4.00	Additions (credit adjustments) (specify)	0		0		0	4.00
5.00	RESTRICTED CONTRIBUTIONS	176,000		0		0	5.00
6.00	INVESTMENT INCOME	6,000		0		0	6.00
7.00	NET ASSETS RELEASED	14,786		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)		196,786		0		10.00
11.00	Subtotal (line 3 plus line 10)		330,108,268		0		11.00
12.00	Deductions (debit adjustments) (specify)	0		0		0	12.00
13.00	NET ASSETS TRANSFERRED	153,338,000		0		0	13.00
14.00	PENSION RELATED ADJUSTMENT	54,000		0		0	14.00
15.00	NET ASSETS RELEASED	162,000		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)		153,554,000		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		176,554,268		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	RESTRICTED CONTRIBUTIONS		0		5.00
6.00	INVESTMENT INCOME		0		6.00
7.00	NET ASSETS RELEASED		0		7.00
8.00			0		8.00
9.00			0		9.00
10.00	Total additions (sum of line 4-9)	0		0	10.00
11.00	Subtotal (line 3 plus line 10)	0		0	11.00
12.00	Deductions (debit adjustments) (specify)		0		12.00
13.00	NET ASSETS TRANSFERRED		0		13.00
14.00	PENSION RELATED ADJUSTMENT		0		14.00
15.00	NET ASSETS RELEASED		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: 15-0125 | Period: From 07/01/2019 To 06/30/2020 | Worksheet G-2 Parts I & II Date/Time Prepared: 11/25/2020 3:02 pm

	Cost Center Description	Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospital	106,514,887		106,514,887	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF	9,576,846		9,576,846	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)	116,091,733		116,091,733	10.00
	Intensive Care Type Inpatient Hospital Services				
11.00	INTENSIVE CARE UNIT	29,532,807		29,532,807	11.00
12.00	CORONARY CARE UNIT				12.00
12.01	NEONATAL INTENSIVE CARE	28,307,151		28,307,151	12.01
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)	57,839,958		57,839,958	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	173,931,691		173,931,691	17.00
18.00	Ancillary services	605,220,821	0	605,220,821	18.00
19.00	Outpatient services	0	1,002,370,718	1,002,370,718	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		8,779,804	8,779,804	22.00
23.00	AMBULANCE SERVICES				23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	OTHER (PHYSICIAN OFFICES)	22,548,200	35,954,258	58,502,458	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	801,700,712	1,047,104,780	1,848,805,492	28.00
	PART II - OPERATING EXPENSES				
29.00	Operating expenses (per Wkst. A, column 3, line 200)		493,670,052		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)		493,670,052		43.00

STATEMENT OF REVENUES AND EXPENSES	Provider CCN: 15-0125	Period: From 07/01/2019 To 06/30/2020	Worksheet G-3 Date/Time Prepared: 11/25/2020 3:02 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	1,848,805,492	1.00
2.00	Less contractual allowances and discounts on patients' accounts	1,349,483,077	2.00
3.00	Net patient revenues (line 1 minus line 2)	499,322,415	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	493,670,052	4.00
5.00	Net income from service to patients (line 3 minus line 4)	5,652,363	5.00
	OTHER INCOME		
6.00	Contributions, donations, bequests, etc	31,603	6.00
7.00	Income from investments	284,046	7.00
8.00	Revenues from telephone and other miscellaneous communication services	0	8.00
9.00	Revenue from television and radio service	0	9.00
10.00	Purchase discounts	0	10.00
11.00	Rebates and refunds of expenses	0	11.00
12.00	Parking lot receipts	0	12.00
13.00	Revenue from laundry and linen service	0	13.00
14.00	Revenue from meals sold to employees and guests	2,133,641	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	14,603,866	17.00
18.00	Revenue from sale of medical records and abstracts	0	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	0	20.00
21.00	Rental of vending machines	23,674	21.00
22.00	Rental of hospital space	1,076,302	22.00
23.00	Governmental appropriations	2,818	23.00
24.00	REVENUE - CLASSES	36,414	24.00
24.01	ASSETS RELEASED FROM RESTRICTION	152,595	24.01
24.02	FITNESS POINTE/BEAUTY SHOP INCOME	2,498,979	24.02
24.03	GAINS ON SALE OF ASSETS	533,502	24.03
24.04	PENSION INCOME	159,662	24.04
24.05	OTHER REVENUE	267,700	24.05
24.50	COVID-19 PHE Funding	21,280,122	24.50
25.00	Total other income (sum of lines 6-24)	43,084,924	25.00
26.00	Total (line 5 plus line 25)	48,737,287	26.00
27.00	OTHER EXPENSES (SPECIFY)	0	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	0	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	48,737,287	29.00

ANALYSIS OF HOSPITAL-BASED HOME HEALTH AGENCY COSTS

Provider CCN: 15-0125 HHA CCN: 15-7487 | Period: From 07/01/2019 To 06/30/2020 | Worksheet H Date/Time Prepared: 11/25/2020 3:02 pm

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		Salaries	Employee Benefits	Transportation (see instructions)	Contracted/Purchased Services	Other Costs	Total (sum of cols. 1 thru 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
	GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. & Fixtures			0		0	0	1.00
2.00	Capital Related - Movable Equipment			0		0	0	2.00
3.00	Plant Operation & Maintenance	0	0	0	0	0	0	3.00
4.00	Transportation	0	0	0	0	0	0	4.00
5.00	Administrative and General	1,420,502	454,749	112,320	0	71,674	2,059,245	5.00
	HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	1,453,703	0	0	0	0	1,453,703	6.00
7.00	Physical Therapy	1,016,799	0	0	10,880	0	1,027,679	7.00
8.00	Occupational Therapy	399,136	0	0	36,705	0	435,841	8.00
9.00	Speech Pathology	56,108	0	0	0	0	56,108	9.00
10.00	Medical Social Services	1,078	0	0	0	0	1,078	10.00
11.00	Home Health Aide	66,810	0	0	0	0	66,810	11.00
12.00	Supplies (see instructions)	0	0	0	0	293,301	293,301	12.00
13.00	Drugs	0	0	0	0	0	0	13.00
14.00	DME	0	0	0	0	0	0	14.00
	HHA NONREIMBURSABLE SERVICES							
15.00	Home Dialysis Aide Services	0	0	0	0	0	0	15.00
16.00	Respiratory Therapy	0	0	0	0	0	0	16.00
17.00	Private Duty Nursing	0	0	0	0	0	0	17.00
18.00	Clinic	0	0	0	0	0	0	18.00
19.00	Health Promotion Activities	0	0	0	0	0	0	19.00
20.00	Day Care Program	0	0	0	0	0	0	20.00
21.00	Home Delivered Meals Program	0	0	0	0	0	0	21.00
22.00	Homemaker Service	0	0	0	0	0	0	22.00
23.00	All Others (specify)	0	0	0	0	0	0	23.00
23.50	Telemedicine	0	0	0	0	0	0	23.50
24.00	Total (sum of lines 1-23)	4,414,136	454,749	112,320	47,585	364,975	5,393,765	24.00

		Reclassification	Reclassified Trial Balance (col. 6 + col.7)	Adjustments	Net Expenses for Allocation (col. 8 + col. 9)			
		7.00	8.00	9.00	10.00			
	GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. & Fixtures	0	0	0	0			1.00
2.00	Capital Related - Movable Equipment	0	0	0	0			2.00
3.00	Plant Operation & Maintenance	0	0	0	0			3.00
4.00	Transportation	0	0	0	0			4.00
5.00	Administrative and General	-212,544	1,846,701	112,773	1,959,474			5.00
	HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	0	1,453,703	0	1,453,703			6.00
7.00	Physical Therapy	139,269	1,166,948	0	1,166,948			7.00
8.00	Occupational Therapy	56,555	492,396	0	492,396			8.00
9.00	Speech Pathology	7,670	63,778	0	63,778			9.00
10.00	Medical Social Services	0	1,078	0	1,078			10.00
11.00	Home Health Aide	0	66,810	0	66,810			11.00
12.00	Supplies (see instructions)	0	293,301	0	293,301			12.00
13.00	Drugs	0	0	0	0			13.00
14.00	DME	0	0	0	0			14.00
	HHA NONREIMBURSABLE SERVICES							
15.00	Home Dialysis Aide Services	0	0	0	0			15.00
16.00	Respiratory Therapy	0	0	0	0			16.00
17.00	Private Duty Nursing	0	0	0	0			17.00
18.00	Clinic	0	0	0	0			18.00
19.00	Health Promotion Activities	0	0	0	0			19.00
20.00	Day Care Program	0	0	0	0			20.00
21.00	Home Delivered Meals Program	0	0	0	0			21.00
22.00	Homemaker Service	0	0	0	0			22.00
23.00	All Others (specify)	0	0	0	0			23.00
23.50	Telemedicine	0	0	0	0			23.50
24.00	Total (sum of lines 1-23)	-9,050	5,384,715	112,773	5,497,488			24.00

Column, 6 line 24 should agree with the Worksheet A, column 3, line 101, or subscript as applicable.

COST ALLOCATION - HHA GENERAL SERVICE COST | Provider CCN: 15-0125 | HHA CCN: 15-7487 | Period: From 07/01/2019 To 06/30/2020 | Worksheet H-1 Part I | Date/Time Prepared: 11/25/2020 3:02 pm

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			Capital Related Costs					
		Net Expenses for Cost Allocation (from Wkst. H, col. 10)	Bldgs & Fixtures	Movable Equipment	Plant Operation & Maintenance	Transportation	Subtotal (cols. 0-4)	
		0	1.00	2.00	3.00	4.00	4A.00	
	GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. & Fixtures	0	0				0	1.00
2.00	Capital Related - Movable Equipment	0		0			0	2.00
3.00	Plant Operation & Maintenance	0	0	0	0		0	3.00
4.00	Transportation	0	0	0	0	0		4.00
5.00	Administrative and General	1,959,474	0	0	0	0	1,959,474	5.00
	HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	1,453,703	0	0	0	0	1,453,703	6.00
7.00	Physical Therapy	1,166,948	0	0	0	0	1,166,948	7.00
8.00	Occupational Therapy	492,396	0	0	0	0	492,396	8.00
9.00	Speech Pathology	63,778	0	0	0	0	63,778	9.00
10.00	Medical Social Services	1,078	0	0	0	0	1,078	10.00
11.00	Home Health Aide	66,810	0	0	0	0	66,810	11.00
12.00	Supplies (see instructions)	293,301	0	0	0	0	293,301	12.00
13.00	Drugs	0	0	0	0		0	13.00
14.00	DME	0	0	0	0	0	0	14.00
	HHA NONREIMBURSABLE SERVICES							
15.00	Home Dialysis Aide Services	0	0	0	0	0	0	15.00
16.00	Respiratory Therapy	0	0	0	0	0	0	16.00
17.00	Private Duty Nursing	0	0	0	0	0	0	17.00
18.00	Clinic	0	0	0	0	0	0	18.00
19.00	Health Promotion Activities	0	0	0	0	0	0	19.00
20.00	Day Care Program	0	0	0	0	0	0	20.00
21.00	Home Delivered Meals Program	0	0	0	0	0	0	21.00
22.00	Homemaker Service	0	0	0	0	0	0	22.00
23.00	All Others (specify)	0	0	0	0	0	0	23.00
23.50	Telemedicine	0	0	0	0	0	0	23.50
24.00	Total (sum of lines 1-23)	5,497,488	0	0	0	0	5,497,488	24.00

		Administrative & General	Total (cols. 4A + 5)		
		5.00	6.00		
	GENERAL SERVICE COST CENTERS				
1.00	Capital Related - Bldg. & Fixtures				1.00
2.00	Capital Related - Movable Equipment				2.00
3.00	Plant Operation & Maintenance				3.00
4.00	Transportation				4.00
5.00	Administrative and General	1,959,474			5.00
	HHA REIMBURSABLE SERVICES				
6.00	Skilled Nursing Care	805,112	2,258,815		6.00
7.00	Physical Therapy	646,295	1,813,243		7.00
8.00	Occupational Therapy	272,706	765,102		8.00
9.00	Speech Pathology	35,322	99,100		9.00
10.00	Medical Social Services	597	1,675		10.00
11.00	Home Health Aide	37,002	103,812		11.00
12.00	Supplies (see instructions)	162,440	455,741		12.00
13.00	Drugs	0	0		13.00
14.00	DME	0	0		14.00
	HHA NONREIMBURSABLE SERVICES				
15.00	Home Dialysis Aide Services	0	0		15.00
16.00	Respiratory Therapy	0	0		16.00
17.00	Private Duty Nursing	0	0		17.00
18.00	Clinic	0	0		18.00
19.00	Health Promotion Activities	0	0		19.00
20.00	Day Care Program	0	0		20.00
21.00	Home Delivered Meals Program	0	0		21.00
22.00	Homemaker Service	0	0		22.00
23.00	All Others (specify)	0	0		23.00
23.50	Telemedicine	0	0		23.50
24.00	Total (sum of lines 1-23)		5,497,488		24.00

COST ALLOCATION - HHA STATISTICAL BASIS | Provider CCN: 15-0125 | HHA CCN: 15-7487 | Period: From 07/01/2019 To 06/30/2020 | Worksheet H-1 Part II | Date/Time Prepared: 11/25/2020 3:02 pm

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		Capital Related Costs						
		Bldgs & Fixtures (SQUARE FEET)	Movable Equipment (DOLLAR VALUE)	Plant Operation & Maintenance (SQUARE FEET)	Transportation (MILEAGE)	Reconciliation	Administrative & General (ACCUM. COST)	
		1.00	2.00	3.00	4.00	5A.00	5.00	
	GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. & Fixtures	0				0		1.00
2.00	Capital Related - Movable Equipment		0			0		2.00
3.00	Plant Operation & Maintenance	0	0	0		0		3.00
4.00	Transportation (see instructions)	0	0	0	0			4.00
5.00	Administrative and General	0	0	0	0	-1,959,474	3,538,014	5.00
	HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	0	0	0	0	0	1,453,703	6.00
7.00	Physical Therapy	0	0	0	0	0	1,166,948	7.00
8.00	Occupational Therapy	0	0	0	0	0	492,396	8.00
9.00	Speech Pathology	0	0	0	0	0	63,778	9.00
10.00	Medical Social Services	0	0	0	0	0	1,078	10.00
11.00	Home Health Aide	0	0	0	0	0	66,810	11.00
12.00	Supplies (see instructions)	0	0	0	0	0	293,301	12.00
13.00	Drugs	0	0	0		0	0	13.00
14.00	DME	0	0	0	0	0	0	14.00
	HHA NONREIMBURSABLE SERVICES							
15.00	Home Dialysis Aide Services	0	0	0	0	0	0	15.00
16.00	Respiratory Therapy	0	0	0	0	0	0	16.00
17.00	Private Duty Nursing	0	0	0	0	0	0	17.00
18.00	Clinic	0	0	0	0	0	0	18.00
19.00	Health Promotion Activities	0	0	0	0	0	0	19.00
20.00	Day Care Program	0	0	0	0	0	0	20.00
21.00	Home Delivered Meals Program	0	0	0	0	0	0	21.00
22.00	Homemaker Service	0	0	0	0	0	0	22.00
23.00	All Others (specify)	0	0	0	0	0	0	23.00
23.50	Telemedicine	0	0	0	0	0	0	23.50
24.00	Total (sum of lines 1-23)	0	0	0	0	-1,959,474	3,538,014	24.00
25.00	Cost To Be Allocated (per Worksheet H-1, Part I)	0	0	0	0		1,959,474	25.00
26.00	Unit Cost Multiplier	0.000000	0.000000	0.000000	0.000000		0.553834	26.00

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

Provider CCN: 15-0125 | HHA CCN: 15-7487 | Period: From 07/01/2019 To 06/30/2020 | Worksheet H-2 Part I | Date/Time Prepared: 11/25/2020 3:02 pm

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	Cost Center Description	HHA Trial Balance (1)	CAPITAL RELATED COSTS BLDG & FIXT	CAPITAL RELATED COSTS MVBLE EQUIP	EMPLOYEE BENEFITS DEPARTMENT	Subtotal	ADMINISTRATIVE & GENERAL	
		0	1.00	2.00	4.00	4A	5.00	
1.00	Administrative and General	0	0	216	676,528	676,744	126,401	1.00
2.00	Skilled Nursing Care	2,258,815	0	0	0	2,258,815	421,897	2.00
3.00	Physical Therapy	1,813,243	0	0	0	1,813,243	338,674	3.00
4.00	Occupational Therapy	765,102	0	0	0	765,102	142,904	4.00
5.00	Speech Pathology	99,100	0	0	0	99,100	18,510	5.00
6.00	Medical Social Services	1,675	0	0	0	1,675	313	6.00
7.00	Home Health Aide	103,812	0	0	0	103,812	19,390	7.00
8.00	Supplies (see instructions)	455,741	0	0	0	455,741	85,122	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
19.50	Telemedicine	0	0	0	0	0	0	19.50
20.00	Total (sum of lines 1-19) (2)	5,497,488	0	216	676,528	6,174,232	1,153,211	20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.					0.000000		21.00

	Cost Center Description	MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	
		6.00	7.00	8.00	9.00	10.00	11.00	
1.00	Administrative and General	0	0	0	0	0	0	1.00
2.00	Skilled Nursing Care	0	0	0	0	0	0	2.00
3.00	Physical Therapy	0	0	0	0	0	0	3.00
4.00	Occupational Therapy	0	0	0	0	0	0	4.00
5.00	Speech Pathology	0	0	0	0	0	0	5.00
6.00	Medical Social Services	0	0	0	0	0	0	6.00
7.00	Home Health Aide	0	0	0	0	0	0	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
19.50	Telemedicine	0	0	0	0	0	0	19.50
20.00	Total (sum of lines 1-19) (2)	0	0	0	0	0	0	20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.							21.00

(1) Column 0, line 20 must agree with Wkst. A, column 7, line 101.
(2) Columns 0 through 26, line 20 must agree with the corresponding columns of Wkst. B, Part I, line 101.

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

Provider CCN: 15-0125 HHA CCN: 15-7487

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

Worksheet H-2 Part I Date/Time Prepared: 11/25/2020 3:02 pm

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	Cost Center Description	MAINTENANCE OF PERSONNEL	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	
		12.00	13.00	14.00	15.00	16.00	17.00	
1.00	Administrative and General	0	0	0	0	32,020	0	1.00
2.00	Skilled Nursing Care	0	0	0	0	0	0	2.00
3.00	Physical Therapy	0	0	0	0	0	0	3.00
4.00	Occupational Therapy	0	0	0	0	0	0	4.00
5.00	Speech Pathology	0	0	0	0	0	0	5.00
6.00	Medical Social Services	0	0	0	0	0	0	6.00
7.00	Home Health Aide	0	0	0	0	0	0	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
19.50	Telemedicine	0	0	0	0	0	0	19.50
20.00	Total (sum of lines 1-19) (2)	0	0	0	0	32,020	0	20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.							21.00

	Cost Center Description	NONPHYSICIAN ANESTHETISTS	INTERNS & RESIDENTS SERVICES-SALARY & FRINGES APPRV	INTERNS & RESIDENTS SERVICES-OTHER PRGM COSTS APPRV	PARAMED ED PRGM-(PHARMACY)	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	
		19.00	21.00	22.00	23.00	24.00	25.00	
1.00	Administrative and General	0	0	0	0	835,165	0	1.00
2.00	Skilled Nursing Care	0	0	0	0	2,680,712	0	2.00
3.00	Physical Therapy	0	0	0	0	2,151,917	0	3.00
4.00	Occupational Therapy	0	0	0	0	908,006	0	4.00
5.00	Speech Pathology	0	0	0	0	117,610	0	5.00
6.00	Medical Social Services	0	0	0	0	1,988	0	6.00
7.00	Home Health Aide	0	0	0	0	123,202	0	7.00
8.00	Supplies (see instructions)	0	0	0	0	540,863	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
19.50	Telemedicine	0	0	0	0	0	0	19.50
20.00	Total (sum of lines 1-19) (2)	0	0	0	0	7,359,463	0	20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.							21.00

(1) Column 0, line 20 must agree with Wkst. A, column 7, line 101.
(2) Columns 0 through 26, line 20 must agree with the corresponding columns of Wkst. B, Part I, line 101.

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

Provider CCN: 15-0125 HHA CCN: 15-7487

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

Worksheet H-2 Part I Date/Time Prepared: 11/25/2020 3:02 pm

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	Cost Center Description	Subtotal	Allocated HHA A&G (see Part II)	Total HHA Costs			
		26.00	27.00	28.00			
1.00	Administrative and General	835,165					1.00
2.00	Skilled Nursing Care	2,680,712	343,155	3,023,867			2.00
3.00	Physical Therapy	2,151,917	275,463	2,427,380			3.00
4.00	Occupational Therapy	908,006	116,232	1,024,238			4.00
5.00	Speech Pathology	117,610	15,055	132,665			5.00
6.00	Medical Social Services	1,988	254	2,242			6.00
7.00	Home Health Aide	123,202	15,771	138,973			7.00
8.00	Supplies (see instructions)	540,863	69,235	610,098			8.00
9.00	Drugs	0	0	0			9.00
10.00	DME	0	0	0			10.00
11.00	Home Dialysis Aide Services	0	0	0			11.00
12.00	Respiratory Therapy	0	0	0			12.00
13.00	Private Duty Nursing	0	0	0			13.00
14.00	Clinic	0	0	0			14.00
15.00	Health Promotion Activities	0	0	0			15.00
16.00	Day Care Program	0	0	0			16.00
17.00	Home Delivered Meals Program	0	0	0			17.00
18.00	Homemaker Service	0	0	0			18.00
19.00	All Others (specify)	0	0	0			19.00
19.50	Telemedicine	0	0	0			19.50
20.00	Total (sum of lines 1-19) (2)	7,359,463	835,165	7,359,463			20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.		0.128008				21.00

(1) Column 0, line 20 must agree with Wkst. A, column 7, line 101.
(2) Columns 0 through 26, line 20 must agree with the corresponding columns of Wkst. B, Part I, line 101.

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS

Provider CCN: 15-0125 | HHA CCN: 15-7487 | Period: From 07/01/2019 To 06/30/2020 | Worksheet H-2 Part II | Date/Time Prepared: 11/25/2020 3:02 pm

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	Cost Center Description	CAPITAL RELATED COSTS BLDG & FIXT (SQUARE FEET)	CAPITAL RELATED COSTS MVBLE EQUIP (NEW- $ VALUE)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	MAINTENANCE & REPAIRS (SQUARE FEET)	
		1.00	2.00	4.00	5A	5.00	6.00	
1.00	Administrative and General	0	154	4,414,136	0	676,744	0	1.00
2.00	Skilled Nursing Care	0	0	0	0	2,258,815	0	2.00
3.00	Physical Therapy	0	0	0	0	1,813,243	0	3.00
4.00	Occupational Therapy	0	0	0	0	765,102	0	4.00
5.00	Speech Pathology	0	0	0	0	99,100	0	5.00
6.00	Medical Social Services	0	0	0	0	1,675	0	6.00
7.00	Home Health Aide	0	0	0	0	103,812	0	7.00
8.00	Supplies (see instructions)	0	0	0	0	455,741	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
19.50	Telemedicine	0	0	0	0	0	0	19.50
20.00	Total (sum of lines 1-19)	0	154	4,414,136		6,174,232	0	20.00
21.00	Total cost to be allocated	0	216	676,528		1,153,211	0	21.00
22.00	Unit cost multiplier	0.000000	1.402597	0.153264		0.186778	0.000000	22.00

	Cost Center Description	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS)	HOUSEKEEPING (TIME SPENT)	DIETARY (PATIENT MEALS)	CAFETERIA (FTES)	MAINTENANCE OF PERSONNEL (NUMBER HOUSED)	
		7.00	8.00	9.00	10.00	11.00	12.00	
1.00	Administrative and General	0	0	0	0	0	0	1.00
2.00	Skilled Nursing Care	0	0	0	0	0	0	2.00
3.00	Physical Therapy	0	0	0	0	0	0	3.00
4.00	Occupational Therapy	0	0	0	0	0	0	4.00
5.00	Speech Pathology	0	0	0	0	0	0	5.00
6.00	Medical Social Services	0	0	0	0	0	0	6.00
7.00	Home Health Aide	0	0	0	0	0	0	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
19.50	Telemedicine	0	0	0	0	0	0	19.50
20.00	Total (sum of lines 1-19)	0	0	0	0	0	0	20.00
21.00	Total cost to be allocated	0	0	0	0	0	0	21.00
22.00	Unit cost multiplier	0.000000	0.000000	0.000000	0.000000	0.000000	0.000000	22.00

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS

Provider CCN: 15-0125 | HHA CCN: 15-7487 | Period: From 07/01/2019 To 06/30/2020 | Worksheet H-2 Part II | Date/Time Prepared: 11/25/2020 3:02 pm

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	Cost Center Description	NURSING ADMINISTRATION (NURSING HOURS)	CENTRAL SERVICES & SUPPLY (COSTED REQ .)	PHARMACY (COSTED REQ .)	MEDICAL RECORDS & LIBRARY (GROSS REVENUE)	SOCIAL SERVICE (TIME SPENT)	NONPHYSICIAN ANESTHETISTS (ASSIGNED TIME)	
		13.00	14.00	15.00	16.00	17.00	19.00	
1.00	Administrative and General	0	0	0	8,779,804	0	0	1.00
2.00	Skilled Nursing Care	0	0	0	0	0	0	2.00
3.00	Physical Therapy	0	0	0	0	0	0	3.00
4.00	Occupational Therapy	0	0	0	0	0	0	4.00
5.00	Speech Pathology	0	0	0	0	0	0	5.00
6.00	Medical Social Services	0	0	0	0	0	0	6.00
7.00	Home Health Aide	0	0	0	0	0	0	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
19.50	Telemedicine	0	0	0	0	0	0	19.50
20.00	Total (sum of lines 1-19)	0	0	0	8,779,804	0	0	20.00
21.00	Total cost to be allocated	0	0	0	32,020	0	0	21.00
22.00	Unit cost multiplier	0.000000	0.000000	0.000000	0.003647	0.000000	0.000000	22.00

	Cost Center Description	INTERNS & RESIDENTS SERVICES-SALARY & FRINGES APPRV (ASSIGNED TIME)	INTERNS & RESIDENTS SERVICES-OTHER PRGM COSTS APPRV (ASSIGNED TIME)	PARAMED ED PRGM-(PHARMACY) (ASSIGNED TIME)				
		21.00	22.00	23.00				
1.00	Administrative and General	0	0	0				1.00
2.00	Skilled Nursing Care	0	0	0				2.00
3.00	Physical Therapy	0	0	0				3.00
4.00	Occupational Therapy	0	0	0				4.00
5.00	Speech Pathology	0	0	0				5.00
6.00	Medical Social Services	0	0	0				6.00
7.00	Home Health Aide	0	0	0				7.00
8.00	Supplies (see instructions)	0	0	0				8.00
9.00	Drugs	0	0	0				9.00
10.00	DME	0	0	0				10.00
11.00	Home Dialysis Aide Services	0	0	0				11.00
12.00	Respiratory Therapy	0	0	0				12.00
13.00	Private Duty Nursing	0	0	0				13.00
14.00	Clinic	0	0	0				14.00
15.00	Health Promotion Activities	0	0	0				15.00
16.00	Day Care Program	0	0	0				16.00
17.00	Home Delivered Meals Program	0	0	0				17.00
18.00	Homemaker Service	0	0	0				18.00
19.00	All Others (specify)	0	0	0				19.00
19.50	Telemedicine	0	0	0				19.50
20.00	Total (sum of lines 1-19)	0	0	0				20.00
21.00	Total cost to be allocated	0	0	0				21.00
22.00	Unit cost multiplier	0.000000	0.000000	0.000000				22.00

APPORTIONMENT OF PATIENT SERVICE COSTS

Provider CCN: 15-0125 | HHA CCN: 15-7487 | Period: From 07/01/2019 To 06/30/2020 | Worksheet H-3 Part I | Date/Time Prepared: 11/25/2020 3:02 pm

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	Cost Center Description	From, Wkst. H-2, Part I, col. 28, line	Facility Costs (from Wkst. H-2, Part I)	Shared Ancillary Costs (from Part II)	Total HHA Costs (cols. 1 + 2)	Total Visits	Average Cost Per Visit (col. 3 ÷ col. 4)	
		0	1.00	2.00	3.00	4.00	5.00	
	PART I - COMPUTATION OF LESSER OF AGGREGATE PROGRAM COST, AGGREGATE OF THE PROGRAM LIMITATION COST, OR BENEFICIARY COST LIMITATION							
	Cost Per Visit Computation							
1.00	Skilled Nursing Care	2.00	3,023,867		3,023,867	23,788	127.12	1.00
2.00	Physical Therapy	3.00	2,427,380	0	2,427,380	14,635	165.86	2.00
3.00	Occupational Therapy	4.00	1,024,238	0	1,024,238	5,943	172.34	3.00
4.00	Speech Pathology	5.00	132,665	0	132,665	806	164.60	4.00
5.00	Medical Social Services	6.00	2,242		2,242	20	112.10	5.00
6.00	Home Health Aide	7.00	138,973		138,973	3,149	44.13	6.00
7.00	Total (sum of lines 1-6)		6,749,365	0	6,749,365	48,341		7.00

	Cost Center Description	Cost Limits	CBSA No. (1)	Part A	Program Visits Part B Not Subject to Deductibles & Coinsurance	Part B Subject to Deductibles		
		0	1.00	2.00	3.00	4.00	5.00	
	Limitation Cost Computation							
8.00	Skilled Nursing Care		23844	0	15,147			8.00
9.00	Physical Therapy		23844	0	8,723			9.00
10.00	Occupational Therapy		23844	0	3,601			10.00
11.00	Speech Pathology		23844	0	466			11.00
12.00	Medical Social Services		23844	0	12			12.00
13.00	Home Health Aide		23844	0	2,268			13.00
14.00	Total (sum of lines 8-13)			0	30,217			14.00

	Cost Center Description	From Wkst. H-2 Part I, col. 28, line	Facility Costs (from Wkst. H-2, Part I)	Shared Ancillary Costs (from Part II)	Total HHA Costs (cols. 1 + 2)	Total Charges (from HHA Records)	Ratio (col. 3 ÷ col. 4)	
		0	1.00	2.00	3.00	4.00	5.00	
	Supplies and Drugs Cost Computations							
15.00	Cost of Medical Supplies	8.00	610,098	0	610,098	557,276	1.094786	15.00
16.00	Cost of Drugs	9.00	0	0	0	0	0.000000	16.00

	Cost Center Description	Program Visits Part A	Program Visits Part B Not Subject to Deductibles & Coinsurance	Program Visits Part B Subject to Deductibles & Coinsurance	Cost of Services Part A	Part B Not Subject to Deductibles & Coinsurance	Part B Subject to Deductibles & Coinsurance	
		6.00	7.00	8.00	9.00	10.00	11.00	
	PART I - COMPUTATION OF LESSER OF AGGREGATE PROGRAM COST, AGGREGATE OF THE PROGRAM LIMITATION COST, OR BENEFICIARY COST LIMITATION							
	Cost Per Visit Computation							
1.00	Skilled Nursing Care	0	15,147		0	1,925,487		1.00
2.00	Physical Therapy	0	8,723		0	1,446,797		2.00
3.00	Occupational Therapy	0	3,601		0	620,596		3.00
4.00	Speech Pathology	0	466		0	76,704		4.00
5.00	Medical Social Services	0	12		0	1,345		5.00
6.00	Home Health Aide	0	2,268		0	100,087		6.00
7.00	Total (sum of lines 1-6)	0	30,217		0	4,171,016		7.00

	Cost Center Description							
		6.00	7.00	8.00	9.00	10.00	11.00	
	Limitation Cost Computation							
8.00	Skilled Nursing Care							8.00
9.00	Physical Therapy							9.00
10.00	Occupational Therapy							10.00
11.00	Speech Pathology							11.00
12.00	Medical Social Services							12.00
13.00	Home Health Aide							13.00
14.00	Total (sum of lines 8-13)							14.00

APPORTIONMENT OF PATIENT SERVICE COSTS | Provider CCN: 15-0125 | HHA CCN: 15-7487 | Period: From 07/01/2019 To 06/30/2020 | Worksheet H-3 Part I | Date/Time Prepared: 11/25/2020 3:02 pm

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	Cost Center Description	Program Covered Charges			Cost of Services			
			Part B			Part B		
		Part A	Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance	Part A	Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance	
		6.00	7.00	8.00	9.00	10.00	11.00	
	Supplies and Drugs Cost Computations							
15.00	Cost of Medical Supplies	0	536,758	0	0	587,635	0	15.00
16.00	Cost of Drugs		0	0		0	0	16.00

	Cost Center Description	Total Program Cost (sum of cols. 9-10)	
		12.00	
	PART I - COMPUTATION OF LESSER OF AGGREGATE PROGRAM COST, AGGREGATE OF THE PROGRAM LIMITATION COST, OR BENEFICIARY COST LIMITATION		
	Cost Per Visit Computation		
1.00	Skilled Nursing Care	1,925,487	1.00
2.00	Physical Therapy	1,446,797	2.00
3.00	Occupational Therapy	620,596	3.00
4.00	Speech Pathology	76,704	4.00
5.00	Medical Social Services	1,345	5.00
6.00	Home Health Aide	100,087	6.00
7.00	Total (sum of lines 1-6)	4,171,016	7.00

	Cost Center Description		
		12.00	
	Limitation Cost Computation		
8.00	Skilled Nursing Care		8.00
9.00	Physical Therapy		9.00
10.00	Occupational Therapy		10.00
11.00	Speech Pathology		11.00
12.00	Medical Social Services		12.00
13.00	Home Health Aide		13.00
14.00	Total (sum of lines 8-13)		14.00

APPORTIONMENT OF PATIENT SERVICE COSTS

Provider CCN: 15-0125
HHA CCN: 15-7487

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

Worksheet H-3
Part II
Date/Time Prepared:
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	Cost Center Description	From Wkst. C, Part I, col. 9, line	Cost to Charge Ratio	Total HHA Charge (from provider records)	HHA Shared Ancillary Costs (col. 1 x col. 2)	Transfer to Part I as Indicated		
		0	1.00	2.00	3.00	4.00		
	PART II - APPORTIONMENT OF COST OF HHA SERVICES FURNISHED BY SHARED HOSPITAL DEPARTMENTS							
1.00	Physical Therapy	66.00	0.365147	0	0	col. 2, line 2.00		1.00
2.00	Occupational Therapy							2.00
3.00	Speech Pathology							3.00
4.00	Cost of Medical Supplies	71.00	0.554528	0	0	col. 2, line 15.00		4.00
5.00	Cost of Drugs	73.00	0.188594	0	0	col. 2, line 16.00		5.00

CALCULATION OF HHA REIMBURSEMENT SETTLEMENT

Provider CCN: 15-0125 | HHA CCN: 15-7487 | Period: From 07/01/2019 To 06/30/2020 | Worksheet H-4 Part I-II | Date/Time Prepared: 11/25/2020 3:02 pm

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		Part A	Part B Not Subject to Deductibles & Coinsurance	Part B Subject to Deductibles & Coinsurance	
		1.00	2.00	3.00	
	PART I - COMPUTATION OF THE LESSER OF REASONABLE COST OR CUSTOMARY CHARGES				
	Reasonable Cost of Part A & Part B Services				
1.00	Reasonable cost of services (see instructions)	0	0	0	1.00
2.00	Total charges	0	0	0	2.00
	Customary Charges				
3.00	Amount actually collected from patients liable for payment for services on a charge basis (from your records)	0	0	0	3.00
4.00	Amount 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(b)	0	0	0	4.00
5.00	Ratio of line 3 to line 4 (not to exceed 1.000000)	0.000000	0.000000	0.000000	5.00
6.00	Total customary charges (see instructions)	0	0	0	6.00
7.00	Excess of total customary charges over total reasonable cost (complete only if line 6 exceeds line 1)	0	0	0	7.00
8.00	Excess of reasonable cost over customary charges (complete only if line 1 exceeds line 6)	0	0	0	8.00
9.00	Primary payer amounts	0	0	0	9.00

		Part A Services	Part B Services	
		1.00	2.00	
	PART II - COMPUTATION OF HHA REIMBURSEMENT SETTLEMENT			
10.00	Total reasonable cost (see instructions)	0	0	10.00
11.00	Total PPS Reimbursement - Full Episodes without Outliers	0	4,155,938	11.00
12.00	Total PPS Reimbursement - Full Episodes with Outliers	0	546,085	12.00
13.00	Total PPS Reimbursement - LUPA Episodes	0	71,093	13.00
14.00	Total PPS Reimbursement - PEP Episodes	0	51,806	14.00
15.00	Total PPS Outlier Reimbursement - Full Episodes with Outliers	0	132,763	15.00
16.00	Total PPS Outlier Reimbursement - PEP Episodes	0	3,080	16.00
17.00	Total Other Payments	0	0	17.00
18.00	DME Payments	0	0	18.00
19.00	Oxygen Payments	0	0	19.00
20.00	Prosthetic and Orthotic Payments	0	0	20.00
21.00	Part B deductibles billed to Medicare patients (exclude coinsurance)		0	21.00
22.00	Subtotal (sum of lines 10 thru 20 minus line 21)	0	4,960,765	22.00
23.00	Excess reasonable cost (from line 8)	0	0	23.00
24.00	Subtotal (line 22 minus line 23)	0	4,960,765	24.00
25.00	Coinsurance billed to program patients (from your records)		0	25.00
26.00	Net cost (line 24 minus line 25)	0	4,960,765	26.00
27.00	Reimbursable bad debts (from your records)			27.00
28.00	Reimbursable bad debts for dual eligible beneficiaries (see instructions)			28.00
29.00	Total costs - current cost reporting period (line 26 plus line 27)	0	4,960,765	29.00
30.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	30.00
30.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	0	30.50
30.99	Demonstration payment adjustment amount before sequestration	0	0	30.99
31.00	Subtotal (see instructions)	0	4,960,765	31.00
31.01	Sequestration adjustment (see instructions)	0	88,160	31.01
31.02	Demonstration payment adjustment amount after sequestration	0	0	31.02
32.00	Interim payments (see instructions)	0	4,872,605	32.00
33.00	Tentative settlement (for contractor use only)	0	0	33.00
34.00	Balance due provider/program (line 31 minus lines 31.01, 32, and 33)	0	0	34.00
35.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	0	35.00

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED HHAs FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES

Provider CCN: 15-0125 | HHA CCN: 15-7487 | Period: From 07/01/2019 To 06/30/2020 | Worksheet H-5 | Date/Time Prepared: 11/25/2020 3:02 pm

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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		0		4,872,605	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			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			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. H-4, Part II, column as appropriate, line 32)		0		4,872,605	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			0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
	Provider to Program					
5.50			0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		0		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		0		4,872,605	7.00

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

CALCULATION OF CAPITAL PAYMENT	Provider CCN: 15-0125	Period: From 07/01/2019 To 06/30/2020	Worksheet L Parts I-III Date/Time Prepared: 11/25/2020 3:02 pm
	Title XVIII	Hospital	PPS

		1.00	
	PART I - FULLY PROSPECTIVE METHOD		
	CAPITAL FEDERAL AMOUNT		
1.00	Capital DRG other than outlier	5,729,514	1.00
1.01	Model 4 BPCI Capital DRG other than outlier	0	1.01
2.00	Capital DRG outlier payments	44,358	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)	226.22	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)	3.04	7.00
8.00	Percentage of Medicaid patient days to total days (see instructions)	15.46	8.00
9.00	Sum of lines 7 and 8	18.50	9.00
10.00	Allowable disproportionate share percentage (see instructions)	3.82	10.00
11.00	Disproportionate share adjustment (see instructions)	218,867	11.00
12.00	Total prospective capital payments (see instructions)	5,992,739	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