

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: 15-0169	Period: From 01/01/2020 To 12/31/2020	Worksheet S Parts I-III Date/Time Prepared: 8/2/2021 3:48 pm
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**PART I - COST REPORT STATUS**

Provider use only 1.  Electronically prepared cost report Date: 8/2/2021 Time: 3:48 pm  
 2.  Manually prepared cost report  
 3.  If this is an amended report enter the number of times the provider resubmitted this cost report  
 4.  Medicare Utilization. Enter "F" for full or "L" for low.

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

**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 OF INDIANA, INC. ( 15-0169 ) for the cost reporting period beginning 01/01/2020 and ending 12/31/2020 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

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

(Signed) HOLLY MILLARD  
 Officer or Administrator of Provider(s)

NETWORK SVP OF FINANCE  
 Title

(Dated when report is electronically signed.)  
 Date

Cost Center Description	Title V	Title XVIII		HIT	Title XIX	
		Part A	Part B			
	1.00	2.00	3.00	4.00	5.00	
<b>PART III - SETTLEMENT SUMMARY</b>						
1.00 Hospital	0	358,708	-138,809	0	0	1.00
2.00 Subprovider - IPF	0	5,210	22		0	2.00
3.00 Subprovider - IRF	0	0	0		0	3.00
5.00 Swing Bed - SNF	0	0	0		0	5.00
6.00 Swing Bed - NF	0				0	6.00
200.00 Total	0	363,918	-138,787	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: 15-0169		Period: From 01/01/2020 To 12/31/2020		Worksheet S-2 Part I Date/Time Prepared: 8/2/2021 3:48 pm			
1.00		2.00		3.00		4.00					
Hospital and Hospital Health Care Complex Address:											
1.00 Street: 7150 CLEARVISTA DRIVE		PO Box:									
2.00 City: INDIANAPOLIS		State: IN		Zip Code: 46256		County: MARION					
		Component Name		CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N)			
				1.00	2.00	3.00	4.00	5.00	6.00	7.00	8.00
				V	XVIII	XIX					
Hospital and Hospital-Based Component Identification:											
3.00 Hospital		COMMUNITY HOSPITAL OF INDIANA, INC.		150169	26900	1	02/25/2008	N	P	P	3.00
4.00 Subprovider - IPF		COMMUNITY MENTAL HEALTH		15S169	26900	4	01/01/2010	N	P	O	4.00
5.00 Subprovider - IRF											5.00
6.00 Subprovider - (Other)											6.00
7.00 Swing Beds - SNF											7.00
8.00 Swing Beds - NF											8.00
9.00 Hospital-Based SNF											9.00
10.00 Hospital-Based NF											10.00
11.00 Hospital-Based OLTC											11.00
12.00 Hospital-Based HHA											12.00
13.00 Separately Certified ASC											13.00
14.00 Hospital-Based Hospice											14.00
15.00 Hospital-Based Health Clinic - RHC											15.00
16.00 Hospital-Based Health Clinic - FQHC											16.00
17.00 Hospital-Based (CMHC) I											17.00
18.00 Renal Dialysis											18.00
19.00 Other											19.00
							From:	To:			
							1.00	2.00			
20.00 Cost Reporting Period (mm/dd/yyyy)							01/01/2020	12/31/2020		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 days	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.				4,098	2,628	11	0	21,298	70		24.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA				Provider CCN: 15-0169		Period: From 01/01/2020 To 12/31/2020		Worksheet S-2 Part I Date/Time Prepared: 8/2/2021 3:48 pm	
		In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of- State Medicaid paid days	Out-of- State Medicaid eligible unpaid	Medicaid HMO days	Other Medicaid days		
		1.00	2.00	3.00	4.00	5.00	6.00		
25.00	If this provider is an IRF, enter the in-state Medicaid paid days in column 1, the in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5.	0	0	0	0	0	0		25.00
						Urban/Rural	S	Date of Geogr	
						1.00		2.00	
26.00	Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter "1" for urban or "2" for rural.					1			26.00
27.00	Enter your standard geographic classification (not wage) status at the end of the cost reporting period. Enter in column 1, "1" for urban or "2" for rural. If applicable, enter the effective date of the geographic reclassification in column 2.					1			27.00
35.00	If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period.					0			35.00
						Beginning:	Ending:		
						1.00	2.00		
36.00	Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.								36.00
37.00	If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status is in effect in the cost reporting period.					0			37.00
37.01	Is this hospital a former MDH that is eligible for the MDH transitional payment in accordance with FY 2016 OPPS final rule? Enter "Y" for yes or "N" for no. (see instructions)								37.01
38.00	If line 37 is 1, enter the beginning and ending dates of MDH status. If line 37 is greater than 1, subscript this line for the number of periods in excess of one and enter subsequent dates.								38.00
						Y/N	Y/N		
						1.00	2.00		
39.00	Does this facility qualify for the inpatient hospital payment adjustment for low volume hospitals in accordance with 42 CFR §412.101(b)(2)(i), (ii), or (iii)? Enter in column 1 "Y" for yes or "N" for no. Does the facility meet the mileage requirements in accordance with 42 CFR 412.101(b)(2)(i), (ii), or (iii)? Enter in column 2 "Y" for yes or "N" for no. (see instructions)					N	N		39.00
40.00	Is this hospital subject to the HAC program reduction adjustment? Enter "Y" for yes or "N" for no in column 1, for discharges prior to October 1. Enter "Y" for yes or "N" for no in column 2, for discharges on or after October 1. (see instructions)					Y	Y		40.00
						V	XVII	XIX	
						1.00	2.00	3.00	
<b>Prospective Payment System (PPS)-Capital</b>									
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
<b>Teaching Hospitals</b>									
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.					Y	Y		56.00
57.00	If line 56 is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y" did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If column 2 is "N", complete Wkst. D, Parts III & IV and D-2, Pt. II, if applicable.					N			57.00
58.00	If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, chapter 21, §2148? If yes, complete Wkst. D-5.					N			58.00
59.00	Are costs claimed on line 100 of Worksheet A? If yes, complete Wkst. D-2, Pt. I.					N			59.00
				NAHE 413.85 Y/N	Worksheet A Line #	Pass-Through Qualification Criterion Code			
				1.00	2.00	3.00			
60.00	Are you claiming nursing and allied health education (NAHE) costs for any programs that meet the criteria under 42 CFR 413.85? (see instructions) Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", are you impacted by CR 11642 (or subsequent CR) NAHE MA payment adjustment? Enter "Y" for yes or "N" for no in column 2.					N			60.00

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	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	
<b>ACA Provisions Affecting the Health Resources and Services Administration (HRSA)</b>							
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
<b>Teaching Hospitals that Claim Residents in Nonprovider Settings</b>							
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		
64.00	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. 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: 15-0169

Period:  
From 01/01/2020  
To 12/31/2020

Worksheet S-2  
Part I  
Date/Time Prepared:  
8/2/2021 3:48 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	66.26	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)	FAMILY PRACTICE	1350	0.00	0.93	0.000000	67.00	
							1.00 2.00 3.00	
70.00	Inpatient Psychiatric Facility PPS Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? Enter "Y" for yes or "N" for no.					Y		70.00
71.00	If line 70 is yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost report filed on or before November 15, 2004? Enter "Y" for yes or "N" for no. (see 42 CFR 412.424(d)(1)(iii)(c)) Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)					N	N 0	71.00
Inpatient Rehabilitation Facility PPS								
75.00	Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF subprovider? Enter "Y" for yes and "N" for no.					N		75.00
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

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						1.00			
<b>Long Term Care Hospital PPS</b>									
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	
<b>TEFRA Providers</b>									
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		
<b>Title V and XIX Services</b>									
90.00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.					N	Y	90.00	
91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.					N	N	91.00	
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.						N	92.00	
93.00	Does this facility operate an ICF/IID facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.					N	N	93.00	
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.					N	N	94.00	
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.					0.00	0.00	95.00	
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.					N	N	96.00	
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.					0.00	0.00	97.00	
98.00	Does title V or XIX follow Medicare (title XVIII) for the interns and residents post stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.					Y	N	98.00	
98.01	Does title V or XIX follow Medicare (title XVIII) for the reporting of charges on Wkst. C, Pt. 1? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.					Y	Y	98.01	
98.02	Does title V or XIX follow Medicare (title XVIII) for the calculation of observation bed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.					Y	Y	98.02	
98.03	Does title V or XIX follow Medicare (title XVIII) for a critical access hospital (CAH) reimbursed 101% of inpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.					N	N	98.03	
98.04	Does title V or XIX follow Medicare (title XVIII) for a CAH reimbursed 101% of outpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.					N	N	98.04	
98.05	Does title V or XIX follow Medicare (title XVIII) and add back the RCE disallowance on Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.					Y	Y	98.05	
98.06	Does title V or XIX follow Medicare (title XVIII) when cost reimbursed for Wkst. D, Pts. I through IV? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.					Y	Y	98.06	
<b>Rural Providers</b>									
105.00	Does this hospital qualify as a CAH?					N		105.00	
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)					N		106.00	
107.00	Column 1: If line 105 is Y, is this facility eligible for cost reimbursement for I&R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) Column 2: If column 1 is Y and line 70 or line 75 is Y, do you train I&Rs in an approved medical education program in the CAH's excluded IPF and/or IRF unit(s)? Enter "Y" for yes or "N" for no in column 2. (see instructions)					N		107.00	
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.					N		108.00	
						Physical	Occupational	Speech	Respiratory
						1.00	2.00	3.00	4.00
109.00	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.					N	N	N	N
						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: 15-0169	Period: From 01/01/2020 To 12/31/2020	Worksheet S-2 Part I Date/Time Prepared: 8/2/2021 3:48 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		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:	1,370,521	0	0
		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	HB0720	140.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 15-0169		Period: From 01/01/2020 To 12/31/2020		Worksheet S-2 Part I Date/Time Prepared: 8/2/2021 3:48 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 HEALTH NETWORK	Contractor's Name: WISCONSIN PHYSICIANS SERVICES		Contractor's Number: 08101				141.00		
142.00	Street: 1500 NORTH RITTER AVENUE	PO Box:						142.00		
143.00	City: INDIANAPOLIS	State: IN		Zip Code: 46219-3095				143.00		
144.00 Are provider based physicians' costs included in Worksheet A?										
Y								144.00		
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		
Y										
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.								146.00		
N										
								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	
								1.00		
								1.00		
								2.00		
								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	N	N	155.00		
156.00	Subprovider - IPF	N	N	N	N	N	N	156.00		
157.00	Subprovider - IRF	N	N	N	N	N	N	157.00		
158.00	SUBPROVIDER							158.00		
159.00	SNF	N	N	N	N	N	N	159.00		
160.00	HOME HEALTH AGENCY	N	N	N	N	N	N	160.00		
161.00	CMHC	N	N	N	N	N	N	161.00		
								1.00		
Multi campus										
165.00 Is this hospital part of a Multi campus hospital that has one or more campuses in different CBSAs? Enter "Y" for yes or "N" for no.								N	165.00	
								1.00		
								5.00		
166.00 If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions)								0.00	166.00	
								1.00		
Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act										
167.00 Is this provider a meaningful user under §1886(n)? Enter "Y" for yes or "N" for no.								Y	167.00	
168.00 If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)									168.00	
168.01 If this provider is a CAH and is not a meaningful user, does this provider qualify for a hardship exception under §413.70(a)(6)(ii)? Enter "Y" for yes or "N" for no. (see instructions)									168.01	
169.00 If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)								9.99	169.00	
								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. 1, 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: 15-0169		Period: From 01/01/2020 To 12/31/2020		Worksheet S-2 Part II Date/Time Prepared: 8/2/2021 3:48 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				
		1.00	2.00				
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				
		1.00	2.00				
Financial Data and Reports							
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	Y	A	03/25/2021			4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.	N					5.00
		Y/N	Legal Oper.				
		1.00	2.00				
Approved Educational Activities							
6.00	Column 1: Are costs claimed for nursing school? Column 2: If yes, is the provider is the legal operator of the program?	N					6.00
7.00	Are costs claimed for Allied Health Programs? If "Y" see instructions.	N					7.00
8.00	Were nursing school and/or allied health programs approved and/or renewed during the cost reporting period? If yes, see instructions.	N					8.00
9.00	Are costs claimed for Interns and Residents in an approved graduate medical education program in the current cost report? If yes, see instructions.	Y					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					1.00
Bad Debts							
12.00	Is the provider seeking reimbursement for bad debts? If yes, see instructions.			Y			12.00
13.00	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.			N			13.00
14.00	If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.			N			14.00
Bed Complement							
15.00	Did total beds available change from the prior cost reporting period? If yes, see instructions.			N			15.00
		Part A		Part B			
		Y/N	Date	Y/N	Date		
		1.00	2.00	3.00	4.00		
PS&R Data							
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)	N		N			16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	Y	07/01/2021	Y	07/01/2021		17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N		N			18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		N			19.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 15-0169	Period: From 01/01/2020 To 12/31/2020	Worksheet S-2 Part II Date/Time Prepared: 8/2/2021 3:48 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	
<b>COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)</b>					
<b>Capital Related Cost</b>					
22.00	Have assets been relieved 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
<b>Interest Expense</b>					
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
<b>Purchased Services</b>					
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
<b>Provider-Based Physicians</b>					
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	
<b>Home Office Costs</b>					
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	
<b>Cost Report Preparer Contact Information</b>					
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.	SHIRLEY		BISHOP	41.00
42.00	Enter the employer/company name of the cost report preparer.	COMMUNITY HEALTH NETWORK			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	317-355-4135		SBI SHOP@ECOMMUNITY.COM	43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE

Provider CCN: 15-0169

Period:  
From 01/01/2020  
To 12/31/2020

Worksheet S-2  
Part II  
Date/Time Prepared:  
8/2/2021 3:48 pm

		3.00	
<b>Cost Report Preparer Contact Information</b>			
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.	DI RECTOR 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: 15-0169

Period:  
From 01/01/2020  
To 12/31/2020

Worksheet S-3  
Part I  
Date/Time Prepared:  
8/2/2021 3:48 pm

Component	Worksheet A	No. of Beds	Bed Days Available	CAH Hours	I/P Days / O/P	
	Line Number				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	238	87,108	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)		238	87,108	0.00	0	7.00
8.00 INTENSIVE CARE UNIT	31.00	24	8,784	0.00	0	8.00
9.00 CORONARY CARE UNIT						9.00
10.00 BURN INTENSIVE CARE UNIT						10.00
11.00 SURGICAL INTENSIVE CARE UNIT						11.00
12.00 NEONATAL INTENSIVE CARE UNIT	35.00	48	17,568	0.00	0	12.00
13.00 NURSERY	43.00				0	13.00
14.00 Total (see instructions)		310	113,460	0.00	0	14.00
15.00 CAH visits					0	15.00
16.00 SUBPROVIDER - IPF	40.00	18	6,588		0	16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY						22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
24.10 HOSPICE (non-distinct part)	30.00					24.10
25.00 CMHC - CMHC						25.00
26.00 RURAL HEALTH CLINIC						26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	26.25
27.00 Total (sum of lines 14-26)		328				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: 15-0169

Period:  
From 01/01/2020  
To 12/31/2020

Worksheet S-3  
Part I  
Date/Time Prepared:  
8/2/2021 3:48 pm

Component	I/P Days / O/P Visits / Trips			Full Time Equivalents		
	Title XVII I	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)	15,397	2,240	54,065			1.00
2.00 HMO and other (see instructions)	11,710	21,543				2.00
3.00 HMO IPF Subprovider	0	0				3.00
4.00 HMO IRF Subprovider	0	0				4.00
5.00 Hospital Adults & Peds. Swing Bed SNF	0	0	0			5.00
6.00 Hospital Adults & Peds. Swing Bed NF	0	0	0			6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)	15,397	2,240	54,065			7.00
8.00 INTENSIVE CARE UNIT	1,723	0	6,562			8.00
9.00 CORONARY CARE UNIT						9.00
10.00 BURN INTENSIVE CARE UNIT						10.00
11.00 SURGICAL INTENSIVE CARE UNIT						11.00
12.00 NEONATAL INTENSIVE CARE UNIT	0	1,444	13,390			12.00
13.00 NURSERY		2,808	7,288			13.00
14.00 Total (see instructions)	17,120	6,492	81,305	4.07	1,505.60	14.00
15.00 CAH visits	0	0	0			15.00
16.00 SUBPROVIDER - IPF	2,038	0	4,029	3.12	24.95	16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY						22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
24.10 HOSPICE (non-distinct part)			216			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)				7.19	1,530.55	27.00
28.00 Observation Bed Days		1,244	5,507			28.00
29.00 Ambulance Trips	0					29.00
30.00 Employee discount days (see instruction)			2,085			30.00
31.00 Employee discount days - IRF			0			31.00
32.00 Labor & delivery days (see instructions)	0	70	1,575			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: 15-0169

Period:  
From 01/01/2020  
To 12/31/2020

Worksheet S-3  
Part I  
Date/Time Prepared:  
8/2/2021 3:48 pm

Component	Full Time Equivalents	Discharges			Total All Patients	
		Title V	Title XVIII	Title XIX		
		11.00	12.00	13.00		
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	3,504	194	15,959	1.00
2.00 HMO and other (see instructions)			2,129	999		2.00
3.00 HMO IPF Subprovider				0		3.00
4.00 HMO IRF Subprovider				0		4.00
5.00 Hospital Adults & Peds. Swing Bed SNF						5.00
6.00 Hospital Adults & Peds. Swing Bed NF						6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)						7.00
8.00 INTENSIVE CARE UNIT						8.00
9.00 CORONARY CARE UNIT						9.00
10.00 BURN INTENSIVE CARE UNIT						10.00
11.00 SURGICAL INTENSIVE CARE UNIT						11.00
12.00 NEONATAL INTENSIVE CARE UNIT						12.00
13.00 NURSERY						13.00
14.00 Total (see instructions)	0.00	0	3,504	194	15,959	14.00
15.00 CAH visits						15.00
16.00 SUBPROVIDER - IPF	0.00	0	188	0	390	16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY						22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
24.10 HOSPICE (non-distinct part)						24.10
25.00 CMHC - CMHC						25.00
26.00 RURAL HEALTH CLINIC						26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER	0.00					26.25
27.00 Total (sum of lines 14-26)	0.00					27.00
28.00 Observation Bed Days						28.00
29.00 Ambulance Trips						29.00
30.00 Employee discount days (see instruction)						30.00
31.00 Employee discount days - IRF						31.00
32.00 Labor & delivery days (see instructions)						32.00
32.01 Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00 LTCH non-covered days			0			33.00
33.01 LTCH site neutral days and discharges			0			33.01

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 15-0169

Period:  
From 01/01/2020  
To 12/31/2020

Worksheet S-3  
Part II  
Date/Time Prepared:  
8/2/2021 3:48 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	
<b>PART II - WAGE DATA</b>							
<b>SALARIES</b>							
1.00	Total salaries (see instructions)	200.00	113,946,024	-617,780	113,328,244	3,183,546.00	35.60
2.00	Non-physician anesthetist Part A		0	0	0	0.00	0.00
3.00	Non-physician anesthetist Part B		0	0	0	0.00	0.00
4.00	Physician-Part A - Administrative		492,652	0	492,652	1,080.00	456.16
4.01	Physicians - Part A - Teaching		0	0	0	0.00	0.00
5.00	Physician and Non-Physician-Part B		226,414	0	226,414	3,158.00	71.70
6.00	Non-physician-Part B for hospital-based RHC and FQHC services		0	0	0	0.00	0.00
7.00	Interns & residents (in an approved program)	21.00	0	0	0	0.00	0.00
7.01	Contracted interns and residents (in an approved programs)		0	0	0	0.00	0.00
8.00	Home office and/or related organization personnel		0	0	0	0.00	0.00
9.00	SNF	44.00	0	0	0	0.00	0.00
10.00	Excluded area salaries (see instructions)		3,143,123	-1,751	3,141,372	95,006.00	33.06
<b>OTHER WAGES &amp; RELATED COSTS</b>							
11.00	Contract Labor: Direct Patient Care		947,185	0	947,185	15,151.00	62.52
12.00	Contract labor: Top level management and other management and administrative services		0	0	0	0.00	0.00
13.00	Contract Labor: Physician-Part A - Administrative		2,212,631	0	2,212,631	18,365.00	120.48
14.00	Home office and/or related organization salaries and wage-related costs		0	0	0	0.00	0.00
14.01	Home office salaries		30,515,585	0	30,515,585	693,844.00	43.98
14.02	Related organization salaries		0	0	0	0.00	0.00
15.00	Home office: Physician Part A - Administrative		1,537,764	0	1,537,764	12,656.00	121.50
16.00	Home office and Contract Physicians Part A - Teaching		0	0	0	0.00	0.00
16.01	Home office Physicians Part A - Teaching		0	0	0	0.00	0.00
16.02	Home office contract Physicians Part A - Teaching		0	0	0	0.00	0.00
<b>WAGE-RELATED COSTS</b>							
17.00	Wage-related costs (core) (see instructions)		26,729,404	0	26,729,404		
18.00	Wage-related costs (other) (see instructions)						
19.00	Excluded areas		806,837	0	806,837		
20.00	Non-physician anesthetist Part A		0	0	0		
21.00	Non-physician anesthetist Part B		0	0	0		
22.00	Physician Part A - Administrative		11,735	0	11,735		
22.01	Physician Part A - Teaching		0	0	0		
23.00	Physician Part B		34,313	0	34,313		
24.00	Wage-related costs (RHC/FQHC)		0	0	0		
25.00	Interns & residents (in an approved program)		0	0	0		
25.50	Home office wage-related (core)		6,037,437	0	6,037,437		
25.51	Related organization wage-related (core)		0	0	0		
25.52	Home office: Physician Part A - Administrative - wage-related (core)		0	0	0		

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 15-0169

Period:  
From 01/01/2020  
To 12/31/2020

Worksheet S-3  
Part II  
Date/Time Prepared:  
8/2/2021 3:48 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
<b>OVERHEAD COSTS - DIRECT SALARIES</b>							
26.00	Employee Benefits Department	158,926	0	158,926	3,016.00	52.69	26.00
27.00	Administrative & General	11,673,901	-9,521	11,664,380	218,598.00	53.36	27.00
28.00	Administrative & General under contract (see inst.)	7,968,049	0	7,968,049	75,658.00	105.32	28.00
29.00	Maintenance & Repairs	0	0	0	0.00	0.00	29.00
30.00	Operation of Plant	2,970,230	-9,410	2,960,820	115,191.00	25.70	30.00
31.00	Laundry & Linen Service	0	0	0	0.00	0.00	31.00
32.00	Housekeeping	2,929,719	-26,537	2,903,182	174,448.00	16.64	32.00
33.00	Housekeeping under contract (see instructions)	391,329	0	391,329	9,911.00	39.48	33.00
34.00	Dietary	2,518,982	-1,759,350	759,632	40,490.00	18.76	34.00
35.00	Dietary under contract (see instructions)	491,179	0	491,179	6,240.00	78.71	35.00
36.00	Cafeteria	0	1,748,848	1,748,848	91,946.00	19.02	36.00
37.00	Maintenance of Personnel	0	0	0	0.00	0.00	37.00
38.00	Nursing Administration	2,104,041	-13,668	2,090,373	57,883.00	36.11	38.00
39.00	Central Services and Supply	818,111	-4,825	813,286	34,595.00	23.51	39.00
40.00	Pharmacy	6,768,246	-1,645,172	5,123,074	120,085.00	42.66	40.00
41.00	Medical Records & Medical Records Library	402,251	-1,303	400,948	9,986.00	40.15	41.00
42.00	Social Service	1,749,110	-6,911	1,742,199	43,143.00	40.38	42.00
43.00	Other General Service	0	0	0	0.00	0.00	43.00



HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 15-0169

Period:  
From 01/01/2020  
To 12/31/2020

Worksheet S-3  
Part III  
Date/Time Prepared:  
8/2/2021 3:48 pm

	Worksheet A Line Number	Amount Reported	Recl assi fi cati on 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	
<b>PART III - HOSPITAL WAGE INDEX SUMMARY</b>							
1.00	Net salaries (see instructions)	122,570,167	-617,780	121,952,387	3,272,197.00	37.27	1.00
2.00	Excluded area salaries (see instructions)	3,143,123	-1,751	3,141,372	95,006.00	33.06	2.00
3.00	Subtotal salaries (line 1 minus line 2)	119,427,044	-616,029	118,811,015	3,177,191.00	37.39	3.00
4.00	Subtotal other wages & related costs (see inst.)	35,213,165	0	35,213,165	740,016.00	47.58	4.00
5.00	Subtotal wage-related costs (see inst.)	32,778,576	0	32,778,576	0.00	27.59	5.00
6.00	Total (sum of lines 3 thru 5)	187,418,785	-616,029	186,802,756	3,917,207.00	47.69	6.00
7.00	Total overhead cost (see instructions)	40,944,074	-1,727,849	39,216,225	1,001,190.00	39.17	7.00

HOSPITAL WAGE RELATED COSTS	Provider CCN: 15-0169	Period: From 01/01/2020 To 12/31/2020	Worksheet S-3 Part IV Date/Time Prepared: 8/2/2021 3:48 pm
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		Amount Reported	
		1.00	
<b>PART IV - WAGE RELATED COSTS</b>			
<b>Part A - Core List</b>			
<b>RETIREMENT COST</b>			
1.00	401K Employer Contributions	2,353,993	1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution	0	2.00
3.00	Nonqualified Defined Benefit Plan Cost (see instructions)	0	3.00
4.00	Qualified Defined Benefit Plan Cost (see instructions)	9,810	4.00
<b>PLAN ADMINISTRATIVE COSTS (Paid to External Organization)</b>			
5.00	401K/TSA Plan Administration fees	0	5.00
6.00	Legal/Accounting/Management Fees-Pension Plan	253,239	6.00
7.00	Employee Managed Care Program Administration Fees	0	7.00
<b>HEALTH AND INSURANCE COST</b>			
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)	10,461,259	8.02
8.03	Health Insurance (Purchased)	0	8.03
9.00	Prescription Drug Plan	1,561,863	9.00
10.00	Dental, Hearing and Vision Plan	89,013	10.00
11.00	Life Insurance (If employee is owner or beneficiary)	3,452,059	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)	1,173,365	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)	0	14.00
15.00	'Workers' Compensation Insurance	11,135	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
<b>TAXES</b>			
17.00	FICA-Employers Portion Only	8,084,032	17.00
18.00	Medicare Taxes - Employers Portion Only	0	18.00
19.00	Unemployment Insurance	0	19.00
20.00	State or Federal Unemployment Taxes	0	20.00
<b>OTHER</b>			
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	132,519	23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)	27,582,287	24.00
<b>Part B - Other than Core Related Cost</b>			
25.00	OTHER WAGE RELATED COSTS (SPECIFY)		25.00

HOSPITAL CONTRACT LABOR AND BENEFIT COST		Provider CCN: 15-0169	Period: From 01/01/2020 To 12/31/2020	Worksheet S-3 Part V Date/Time Prepared: 8/2/2021 3:48 pm
Cost Center Description		Contract Labor	Benefit Cost	
PART V - Contract Labor and Benefit Cost		1.00	2.00	
Hospital and Hospital-Based Component Identification:				
1.00	Total facility's contract labor and benefit cost	947,185	27,582,287	1.00
2.00	Hospital	947,185	26,775,450	2.00
3.00	Subprovider - IPF	0	568,244	3.00
4.00	Subprovider - IRF			4.00
5.00	Subprovider - (Other)	0	0	5.00
6.00	Swing Beds - SNF	0	0	6.00
7.00	Swing Beds - NF	0	0	7.00
8.00	Hospital-Based SNF			8.00
9.00	Hospital-Based NF			9.00
10.00	Hospital-Based OLTC			10.00
11.00	Hospital-Based HHA			11.00
12.00	Separately Certified ASC			12.00
13.00	Hospital-Based Hospice			13.00
14.00	Hospital-Based Health Clinic RHC			14.00
15.00	Hospital-Based Health Clinic FQHC			15.00
16.00	Hospital-Based-CMHC			16.00
17.00	Renal Dialysis	0	0	17.00
18.00	Other	0	238,593	18.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA	Provider CCN: 15-0169	Period: From 01/01/2020 To 12/31/2020	Worksheet S-10 Date/Time Prepared: 8/2/2021 3:48 pm
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			1.00		
<b>Uncompensated and indigent care cost computation</b>					
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided by line 202 column 8)		0.243185	1.00	
Medicaid (see instructions for each line)					
2.00	Net revenue from Medicaid		76,747,519	2.00	
3.00	Did you receive DSH or supplemental payments from Medicaid?		Y	3.00	
4.00	If line 3 is yes, does line 2 include all DSH and/or supplemental payments from Medicaid?		Y	4.00	
5.00	If line 4 is no, then enter DSH and/or supplemental payments from Medicaid		-28,847,144	5.00	
6.00	Medicaid charges		324,171,087	6.00	
7.00	Medicaid cost (line 1 times line 6)		78,833,546	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)		30,933,171	8.00	
<b>Children's Health Insurance Program (CHIP) (see instructions for each line)</b>					
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	
<b>Other state or local government indigent care program (see instructions for each line)</b>					
13.00	Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9)		0	13.00	
14.00	Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)		0	14.00	
15.00	State or local indigent care program cost (line 1 times line 14)		0	15.00	
16.00	Difference between net revenue and costs for state or local indigent care program (line 15 minus line 13; if < zero then enter zero)		0	16.00	
<b>Grants, donations and total unreimbursed cost for Medicaid, CHIP and state/local indigent care programs (see instructions for each line)</b>					
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)		30,933,171	19.00	
			Uninsured patients	Insured patients	Total (col. 1 + col. 2)
			1.00	2.00	3.00
<b>Uncompensated Care (see instructions for each line)</b>					
20.00	Charity care charges and uninsured discounts for the entire facility (see instructions)	20,585,198	3,145,214	23,730,412	20.00
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	5,006,011	3,145,214	8,151,225	21.00
22.00	Payments received from patients for amounts previously written off as charity care	19,532	175	19,707	22.00
23.00	Cost of charity care (line 21 minus line 22)	4,986,479	3,145,039	8,131,518	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)			24,447,236	26.00
27.00	Medicare reimbursable bad debts for the entire hospital complex (see instructions)			298,688	27.00
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)			459,519	27.01
28.00	Non-Medicare bad debt expense (see instructions)			23,987,717	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)			5,994,284	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)			14,125,802	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)			45,058,973	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 15-0169

Period:  
From 01/01/2020  
To 12/31/2020

Worksheet A

Date/Time Prepared:  
8/2/2021 3:48 pm

Cost Center Description		Salaries	Other	Total (col. 1 + col. 2)	Reclassified (See A-6)	Reclassified Trial Balance (col. 3 +/- col. 4)		
		1.00	2.00	3.00	4.00	5.00		
<b>GENERAL SERVICE COST CENTERS</b>								
1.00	00100	CAP REL COSTS-BLDG & FIXT	0	0	19,089,210	19,089,210	1.00	
2.00	00200	CAP REL COSTS-MVBLE EQUIP	0	0	16,008,457	16,008,457	2.00	
3.00	00300	OTHER CAP REL COSTS	0	0	0	0	3.00	
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	158,926	210,351	369,277	-88,545	280,732	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	11,673,901	145,328,000	157,001,901	-21,202,738	135,799,163	5.00
7.00	00700	OPERATION OF PLANT	2,970,230	7,257,481	10,227,711	-401,389	9,826,322	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	983,957	983,957	-80	983,877	8.00
9.00	00900	HOUSEKEEPING	2,929,719	1,850,775	4,780,494	-24,051	4,756,443	9.00
10.00	01000	DIETARY	2,518,982	2,747,095	5,266,077	-3,684,198	1,581,879	10.00
11.00	01100	CAFETERIA	0	0	0	3,592,188	3,592,188	11.00
13.00	01300	NURSING ADMINISTRATION	2,104,041	521,887	2,625,928	-25,002	2,600,926	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	818,111	3,003,995	3,822,106	-2,776,466	1,045,640	14.00
15.00	01500	PHARMACY	6,768,246	37,230,458	43,998,704	-38,024,502	5,974,202	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	402,251	95,833	498,084	-80	498,004	16.00
17.00	01700	SOCIAL SERVICE	1,749,110	465,275	2,214,385	-36	2,214,349	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
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>								
30.00	03000	ADULTS & PEDIATRICS	34,192,180	24,738,424	58,930,604	-11,819,977	47,110,627	30.00
31.00	03100	INTENSIVE CARE UNIT	4,807,884	2,368,326	7,176,210	-786,703	6,389,507	31.00
35.00	02060	NEONATAL INTENSIVE CARE UNIT	7,612,232	3,615,967	11,228,199	-700,683	10,527,516	35.00
40.00	04000	SUBPROVIDER - I PF	1,811,833	482,628	2,294,461	-20,454	2,274,007	40.00
43.00	04300	NURSERY	0	0	0	2,358,032	2,358,032	43.00
<b>ANCILLARY SERVICE COST CENTERS</b>								
50.00	05000	OPERATING ROOM	4,420,285	30,026,206	34,446,491	-20,241,826	14,204,665	50.00
51.00	05100	RECOVERY ROOM	2,357,006	1,209,978	3,566,984	-215,919	3,351,065	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	78,431	2,204	80,635	5,830,378	5,911,013	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,320,966	1,747,759	5,068,725	-1,172,288	3,896,437	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	536,495	3,189,050	3,725,545	-2,692,746	1,032,799	55.00
57.00	05700	CT SCAN	943,566	882,780	1,826,346	-194,408	1,631,938	57.00
58.00	05800	MRI	480,637	1,551,911	2,032,548	-385,048	1,647,500	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	-29,973	-29,973	33,060	3,087	59.00
60.00	06000	LABORATORY	0	11,322,370	11,322,370	0	11,322,370	60.00
64.00	06400	INTRAVENOUS THERAPY	664,570	314,376	978,946	-74,930	904,016	64.00
65.00	06500	RESPIRATORY THERAPY	2,995,219	1,984,168	4,979,387	-708,376	4,271,011	65.00
66.00	06600	PHYSICAL THERAPY	5,948,703	2,999,903	8,948,606	-3,658,321	5,290,285	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	2,041,545	2,041,545	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	441,686	441,686	68.00
69.00	06900	ELECTROCARDIOLOGY	32,585	446,833	479,418	4,406	483,824	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	811,719	763,185	1,574,904	-262,456	1,312,448	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	14,384,461	14,384,461	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	11,681,234	11,681,234	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	14,549,559	14,549,559	73.00
73.01	07301	SPECIALTY PHARMACY	0	15,387,821	15,387,821	25,285,669	40,673,490	73.01
74.00	07400	RENAL DIALYSIS	0	1,159,345	1,159,345	0	1,159,345	74.00
76.00	03330	ENDOSCOPY	1,174,801	2,401,846	3,576,647	-1,550,170	2,026,477	76.00
76.01	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0	76.01
76.02	03951	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0	76.02
76.03	03952	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0	76.03
76.04	03953	WOUND CARE	275,133	475,260	750,393	-131,554	618,839	76.04
76.06	03954	IMAGING CENTER	1,579,875	2,417,748	3,997,623	-1,161,067	2,836,556	76.06
76.07	03955	BREAST DIAGNOSTIC CENTER	0	9,079,082	9,079,082	-434,888	8,644,194	76.07
<b>OUTPATIENT SERVICE COST CENTERS</b>								
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	04950	INFUSION CENTER	107,616	2,211,906	2,319,522	-2,165,324	154,198	90.01
90.26	04975	SPINE CENTER	165,633	52,420	218,053	-92	217,961	90.26
91.00	09100	EMERGENCY	6,203,848	3,038,345	9,242,193	-454,363	8,787,830	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	0	92.00
<b>SPECIAL PURPOSE COST CENTERS</b>								
113.00	11300	INTEREST EXPENSE	0	0	0	0	0	113.00
114.00	11400	UTILIZATION REVIEW-SNF	0	0	0	0	0	114.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	112,614,734	323,534,975	436,149,709	241,205	436,390,914	118.00
<b>NONREIMBURSABLE COST CENTERS</b>								
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	102,989	102,989	0	102,989	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950	HOME OFFICE	0	0	0	0	0	194.00
194.06	07956	PAVILLIONS	0	161,343	161,343	-122,007	39,336	194.06
194.08	07958	OTHER NRCC	1,331,290	553,846	1,885,136	-119,198	1,765,938	194.08

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES		Provider CCN: 15-0169		Period: From 01/01/2020 To 12/31/2020		Worksheet A Date/Time Prepared: 8/2/2021 3:48 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	
194.10	07960 COMMUNITY REHAB HOSPITAL	0	0	0	0	0	194.10
200.00	TOTAL (SUM OF LINES 118 through 199)	113,946,024	324,353,153	438,299,177	0	438,299,177	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 15-0169

Period:  
From 01/01/2020  
To 12/31/2020

Worksheet A  
Date/Time Prepared:  
8/2/2021 3:48 pm

Cost Center Description			Adjustments (See A-8)	Net Expenses For Allocation	
			6.00	7.00	
<b>GENERAL SERVICE COST CENTERS</b>					
1.00	00100	CAP REL COSTS-BLDG & FIXT	-5,421,334	13,667,876	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	5,468,245	21,476,702	2.00
3.00	00300	OTHER CAP REL COSTS	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	3,208,143	3,488,875	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-81,511,482	54,287,681	5.00
7.00	00700	OPERATION OF PLANT	878,061	10,704,383	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	983,877	8.00
9.00	00900	HOUSEKEEPING	0	4,756,443	9.00
10.00	01000	DIETARY	-8,565	1,573,314	10.00
11.00	01100	CAFETERIA	-1,910,953	1,681,235	11.00
13.00	01300	NURSING ADMINISTRATION	3,829,188	6,430,114	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	3,520,764	4,566,404	14.00
15.00	01500	PHARMACY	-99,115	5,875,087	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	2,440,156	2,938,160	16.00
17.00	01700	SOCIAL SERVICE	0	2,214,349	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	19.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	589,754	589,754	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	874,613	874,613	22.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>					
30.00	03000	ADULTS & PEDIATRICS	160,879	47,271,506	30.00
31.00	03100	INTENSIVE CARE UNIT	0	6,389,507	31.00
35.00	02060	NEONATAL INTENSIVE CARE UNIT	-348,539	10,178,977	35.00
40.00	04000	SUBPROVIDER - I PF	-40,344	2,233,663	40.00
43.00	04300	NURSERY	0	2,358,032	43.00
<b>ANCILLARY SERVICE COST CENTERS</b>					
50.00	05000	OPERATING ROOM	-142,500	14,062,165	50.00
51.00	05100	RECOVERY ROOM	0	3,351,065	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	5,911,013	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	42,396	3,938,833	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	-37,520	995,279	55.00
57.00	05700	CT SCAN	0	1,631,938	57.00
58.00	05800	MRI	0	1,647,500	58.00
59.00	05900	CARDIAC CATHETERIZATION	225,145	228,232	59.00
60.00	06000	LABORATORY	-31	11,322,339	60.00
64.00	06400	INTRAVENOUS THERAPY	0	904,016	64.00
65.00	06500	RESPIRATORY THERAPY	0	4,271,011	65.00
66.00	06600	PHYSICAL THERAPY	-2,560	5,287,725	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	2,041,545	67.00
68.00	06800	SPEECH PATHOLOGY	0	441,686	68.00
69.00	06900	ELECTROCARDIOLOGY	54,296	538,120	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	51,556	1,364,004	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	14,384,461	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	11,681,234	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	370,810	14,920,369	73.00
73.01	07301	SPECIALTY PHARMACY	21,217	40,694,707	73.01
74.00	07400	RENAL DIALYSIS	0	1,159,345	74.00
76.00	03330	ENDOSCOPY	0	2,026,477	76.00
76.01	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	76.01
76.02	03951	OTHER ANCILLARY SERVICE COST CENTERS	0	0	76.02
76.03	03952	OTHER ANCILLARY SERVICE COST CENTERS	0	0	76.03
76.04	03953	WOUND CARE	0	618,839	76.04
76.06	03954	IMAGING CENTER	0	2,836,556	76.06
76.07	03955	BREAST DIAGNOSTIC CENTER	0	8,644,194	76.07
<b>OUTPATIENT SERVICE COST CENTERS</b>					
90.00	09000	CLINIC	0	0	90.00
90.01	04950	INFUSION CENTER	0	154,198	90.01
90.26	04975	SPINE CENTER	0	217,961	90.26
91.00	09100	EMERGENCY	1,073,851	9,861,681	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART			92.00
<b>SPECIAL PURPOSE COST CENTERS</b>					
113.00	11300	INTEREST EXPENSE	0	0	113.00
114.00	11400	UTILIZATION REVIEW-SNF	0	0	114.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-66,713,869	369,677,045	118.00
<b>NONREIMBURSABLE COST CENTERS</b>					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	190.00
191.00	19100	RESEARCH	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	102,989	192.00
193.00	19300	NONPAID WORKERS	0	0	193.00
194.00	07950	HOME OFFICE	0	0	194.00
194.06	07956	PAVILLIONS	0	39,336	194.06
194.08	07958	OTHER NRCC	0	1,765,938	194.08
194.10	07960	COMMUNITY REHAB HOSPITAL	0	0	194.10
200.00		TOTAL (SUM OF LINES 118 through 199)	-66,713,869	371,585,308	200.00

		Increases				
Cost Center		Line #	Salary	Other		
2.00	3.00	4.00	5.00			
<b>A - Chargeable Medical Supplies</b>						
1.00	CARDIAC CATHETERIZATION	59.00	0	1,378	1.00	
2.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	14,384,461	2.00	
3.00		0.00	0	0	3.00	
4.00		0.00	0	0	4.00	
5.00		0.00	0	0	5.00	
6.00		0.00	0	0	6.00	
7.00		0.00	0	0	7.00	
8.00		0.00	0	0	8.00	
9.00		0.00	0	0	9.00	
10.00		0.00	0	0	10.00	
11.00		0.00	0	0	11.00	
12.00		0.00	0	0	12.00	
13.00		0.00	0	0	13.00	
14.00		0.00	0	0	14.00	
15.00		0.00	0	0	15.00	
16.00		0.00	0	0	16.00	
17.00		0.00	0	0	17.00	
18.00		0.00	0	0	18.00	
19.00		0.00	0	0	19.00	
20.00		0.00	0	0	20.00	
21.00		0.00	0	0	21.00	
22.00		0.00	0	0	22.00	
23.00		0.00	0	0	23.00	
24.00		0.00	0	0	24.00	
25.00		0.00	0	0	25.00	
26.00		0.00	0	0	26.00	
TOTALS			0	14,385,839		
<b>B - Implantable Device Reclass</b>						
1.00	CARDIAC CATHETERIZATION	59.00		33,182	1.00	
2.00	IMPL. DEV. CHARGED TO PATIENTS	72.00		11,681,234	2.00	
3.00					3.00	
4.00					4.00	
TOTALS			0	11,714,416		
<b>C - Drugs Charges to Pat</b>						
1.00	CARDIAC CATHETERIZATION	59.00	0	27	1.00	
2.00	ELECTROCARDIOLOGY	69.00	0	4,546	2.00	
3.00	DRUGS CHARGED TO PATIENTS	73.00	0	14,549,559	3.00	
4.00		0.00	0	0	4.00	
5.00		0.00	0	0	5.00	
6.00		0.00	0	0	6.00	
7.00		0.00	0	0	7.00	
8.00		0.00	0	0	8.00	
9.00		0.00	0	0	9.00	
10.00		0.00	0	0	10.00	
11.00		0.00	0	0	11.00	
12.00		0.00	0	0	12.00	
13.00		0.00	0	0	13.00	
14.00		0.00	0	0	14.00	
15.00		0.00	0	0	15.00	
16.00		0.00	0	0	16.00	
17.00		0.00	0	0	17.00	
18.00		0.00	0	0	18.00	
19.00		0.00	0	0	19.00	
20.00		0.00	0	0	20.00	
21.00		0.00	0	0	21.00	
22.00		0.00	0	0	22.00	
23.00		0.00	0	0	23.00	
24.00		0.00	0	0	24.00	
25.00		0.00	0	0	25.00	
TOTALS			0	14,554,132		
<b>D - Depreciation Expense</b>						
1.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	16,844,995	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	



RECLASSIFICATIONS

Provider CCN: 15-0169

Period:  
From 01/01/2020  
To 12/31/2020

Worksheet A-6

Date/Time Prepared:  
8/2/2021 3:48 pm

	Increases					
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
11.00		0.00	0	0		11.00
12.00		0.00	0	0		12.00
13.00		0.00	0	0		13.00
14.00		0.00	0	0		14.00
15.00		0.00	0	0		15.00
16.00		0.00	0	0		16.00
17.00		0.00	0	0		17.00
18.00		0.00	0	0		18.00
19.00		0.00	0	0		19.00
20.00		0.00	0	0		20.00
21.00		0.00	0	0		21.00
22.00		0.00	0	0		22.00
23.00		0.00	0	0		23.00
24.00		0.00	0	0		24.00
25.00		0.00	0	0		25.00
26.00		0.00	0	0		26.00
27.00		0.00	0	0		27.00
28.00		0.00	0	0		28.00
29.00		0.00	0	0		29.00
30.00		0.00	0	0		30.00
31.00		0.00	0	0		31.00
32.00		0.00	0	0		32.00
	TOTALS		0	16,844,995		
E - Interest Expense						
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	10,607,739		1.00
	TOTALS		0	10,607,739		
F - Other Capital Rental						
1.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	7,433,684		1.00
2.00		0.00	0	0		2.00
3.00		0.00	0	0		3.00
4.00		0.00	0	0		4.00
5.00		0.00	0	0		5.00
6.00		0.00	0	0		6.00
7.00		0.00	0	0		7.00
8.00		0.00	0	0		8.00
9.00		0.00	0	0		9.00
10.00		0.00	0	0		10.00
11.00		0.00	0	0		11.00
12.00		0.00	0	0		12.00
13.00		0.00	0	0		13.00
14.00		0.00	0	0		14.00
15.00		0.00	0	0		15.00
16.00		0.00	0	0		16.00
17.00		0.00	0	0		17.00
18.00		0.00	0	0		18.00
19.00		0.00	0	0		19.00
20.00		0.00	0	0		20.00
21.00		0.00	0	0		21.00
22.00		0.00	0	0		22.00
23.00		0.00	0	0		23.00
24.00		0.00	0	0		24.00
25.00		0.00	0	0		25.00
26.00		0.00	0	0		26.00
27.00		0.00	0	0		27.00
28.00		0.00	0	0		28.00
29.00		0.00	0	0		29.00
30.00		0.00	0	0		30.00
	TOTALS		0	7,433,684		
G - STD BENEFIT						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	9,521		1.00
2.00	OPERATION OF PLANT	7.00	0	9,410		2.00
3.00	HOUSEKEEPING	9.00	0	26,537		3.00
4.00	DIETARY	10.00	0	10,502		4.00
5.00	NURSING ADMINISTRATION	13.00	0	13,668		5.00
6.00	CENTRAL SERVICES & SUPPLY	14.00	0	4,825		6.00
7.00	PHARMACY	15.00	0	23,263		7.00
8.00	MEDICAL RECORDS & LIBRARY	16.00	0	1,303		8.00
9.00	SOCIAL SERVICE	17.00	0	6,911		9.00
10.00	ADULTS & PEDIATRICS	30.00	0	215,150		10.00
11.00	INTENSIVE CARE UNIT	31.00	0	29,159		11.00
12.00	NEONATAL INTENSIVE CARE UNIT	35.00	0	79,929		12.00
13.00	SUBPROVIDER - IPF	40.00	0	1,751		13.00
14.00	OPERATING ROOM	50.00	0	29,930		14.00
15.00	RECOVERY ROOM	51.00	0	7,625		15.00

		Increases			
	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
16.00	RADIOLOGY-DIAGNOSTIC	54.00	0	13,104	16.00
17.00	RADIOLOGY-THERAPEUTIC	55.00	0	1,618	17.00
18.00	CT SCAN	57.00	0	5,960	18.00
19.00	INTRAVENOUS THERAPY	64.00	0	691	19.00
20.00	RESPIRATORY THERAPY	65.00	0	31,886	20.00
21.00	PHYSICAL THERAPY	66.00	0	38,464	21.00
22.00	ELECTROENCEPHALOGRAPHY	70.00	0	2,407	22.00
23.00	ENDOSCOPY	76.00	0	3,860	23.00
24.00	IMAGING CENTER	76.06	0	6,055	24.00
25.00	EMERGENCY	91.00	0	44,251	25.00
	TOTALS		0	617,780	
<b>H - Labor and Delivery</b>					
1.00	NURSERY	43.00	1,623,272	734,760	1.00
2.00	DELIVERY ROOM & LABOR ROOM	52.00	4,013,639	1,816,739	2.00
	TOTALS		5,636,911	2,551,499	
<b>I - Cafeteria</b>					
1.00	CAFETERIA	11.00	1,748,848	1,843,340	1.00
	TOTALS		1,748,848	1,843,340	
<b>J - Therapy</b>					
1.00	OCCUPATIONAL THERAPY	67.00	1,403,930	637,615	1.00
2.00	SPEECH PATHOLOGY	68.00	303,739	137,947	2.00
	TOTALS		1,707,669	775,562	
<b>K - Building Depreciation</b>					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	8,270,222	1.00
	TOTALS		0	8,270,222	
<b>L - Capital Insurance Costs</b>					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	211,249	1.00
	TOTALS		0	211,249	
<b>M - Radiology Support</b>					
1.00	RADIOLOGY-THERAPEUTIC	55.00	99,615	36,795	1.00
2.00	CT SCAN	57.00	162,466	60,010	2.00
3.00	MRI	58.00	69,563	25,694	3.00
	TOTALS		331,644	122,499	
<b>N - Specialty Pharmacy</b>					
1.00	SPECIALTY PHARMACY	73.01	1,621,909	23,663,760	1.00
	TOTALS		1,621,909	23,663,760	
500.00	Grand Total: Increases		11,046,981	113,596,716	500.00

RECLASSIFICATIONS

Provider CCN: 15-0169

Period:  
From 01/01/2020  
To 12/31/2020

Worksheet A-6  
Date/Time Prepared:  
8/2/2021 3:48 pm

Decreases							
Cost Center	Line #	Salary	Other	Wkst.	A-7 Ref.		
6.00	7.00	8.00	9.00	10.00			
<b>A - Chargeable Medical Supplies</b>							
1.00	ADMINISTRATIVE & GENERAL	5.00	0	6,510	0		1.00
2.00	OPERATION OF PLANT	7.00	0	91,203	0		2.00
3.00	DIETARY	10.00	0	1,602	0		3.00
4.00	CENTRAL SERVICES & SUPPLY	14.00	0	362,732	0		4.00
5.00	PHARMACY	15.00	0	251,244	0		5.00
6.00	ADULTS & PEDIATRICS	30.00	0	1,964,435	0		6.00
7.00	INTENSIVE CARE UNIT	31.00	0	430,024	0		7.00
8.00	NEONATAL INTENSIVE CARE UNIT	35.00	0	512,469	0		8.00
9.00	SUBPROVIDER - IPF	40.00	0	2,781	0		9.00
10.00	OPERATING ROOM	50.00	0	7,264,972	0		10.00
11.00	RECOVERY ROOM	51.00	0	205,118	0		11.00
12.00	RADIOLOGY-DIAGNOSTIC	54.00	0	235,990	0		12.00
13.00	RADIOLOGY-THERAPEUTIC	55.00	0	1,050,387	0		13.00
14.00	CT SCAN	57.00	0	52,988	0		14.00
15.00	MRI	58.00	0	13,848	0		15.00
16.00	INTRAVENOUS THERAPY	64.00	0	69,785	0		16.00
17.00	RESPIRATORY THERAPY	65.00	0	485,691	0		17.00
18.00	PHYSICAL THERAPY	66.00	0	11,661	0		18.00
19.00	ELECTROENCEPHALOGRAPHY	70.00	0	16,539	0		19.00
20.00	ENDOSCOPY	76.00	0	1,005,176	0		20.00
21.00	WOUND CARE	76.04	0	23,297	0		21.00
22.00	IMAGING CENTER	76.06	0	79,616	0		22.00
23.00	BREAST DIAGNOSTIC CENTER	76.07	0	14,847	0		23.00
24.00	INFUSION CENTER	90.01	0	5,359	0		24.00
25.00	EMERGENCY	91.00	0	227,470	0		25.00
26.00	OTHER NRCC	194.08	0	95	0		26.00
	<b>TOTALS</b>		0	<b>14,385,839</b>			
<b>B - Implantable Device Reclass</b>							
1.00	OPERATING ROOM	50.00		10,353,916			1.00
2.00	RADIOLOGY-THERAPEUTIC	55.00		1,183,285			2.00
3.00	ENDOSCOPY	76.00		177,015			3.00
4.00	WOUND CARE	76.04		200			4.00
	<b>TOTALS</b>		0	<b>11,714,416</b>			
<b>C - Drugs Charges to Pat</b>							
1.00	ADMINISTRATIVE & GENERAL	5.00	0	389	0		1.00
2.00	NURSING ADMINISTRATION	13.00	0	5	0		2.00
3.00	CENTRAL SERVICES & SUPPLY	14.00	0	1,207	0		3.00
4.00	PHARMACY	15.00	0	11,772,903	0		4.00
5.00	ADULTS & PEDIATRICS	30.00	0	68,132	0		5.00
6.00	INTENSIVE CARE UNIT	31.00	0	14,279	0		6.00
7.00	NEONATAL INTENSIVE CARE UNIT	35.00	0	2,615	0		7.00
8.00	SUBPROVIDER - IPF	40.00	0	314	0		8.00
9.00	OPERATING ROOM	50.00	0	124,137	0		9.00
10.00	RECOVERY ROOM	51.00	0	1,764	0		10.00
11.00	RADIOLOGY-DIAGNOSTIC	54.00	0	96,444	0		11.00
12.00	RADIOLOGY-THERAPEUTIC	55.00	0	17,287	0		12.00
13.00	CT SCAN	57.00	0	139,917	0		13.00
14.00	MRI	58.00	0	74,187	0		14.00
15.00	INTRAVENOUS THERAPY	64.00	0	2,289	0		15.00
16.00	RESPIRATORY THERAPY	65.00	0	1,458	0		16.00
17.00	PHYSICAL THERAPY	66.00	0	4,839	0		17.00
18.00	ELECTROENCEPHALOGRAPHY	70.00	0	1,783	0		18.00
19.00	ENDOSCOPY	76.00	0	3,038	0		19.00
20.00	WOUND CARE	76.04	0	1,856	0		20.00
21.00	IMAGING CENTER	76.06	0	120,111	0		21.00
22.00	INFUSION CENTER	90.01	0	2,077,078	0		22.00
23.00	EMERGENCY	91.00	0	24,968	0		23.00
24.00	PAVILLIONS	194.06	0	4	0		24.00
25.00	OTHER NRCC	194.08	0	3,128	0		25.00
	<b>TOTALS</b>		0	<b>14,554,132</b>			
<b>D - Depreciation Expense</b>							
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	710	9		1.00
2.00	ADMINISTRATIVE & GENERAL	5.00	0	9,597,249	0		2.00
3.00	OPERATION OF PLANT	7.00	0	184,631	0		3.00
4.00	HOUSEKEEPING	9.00	0	5,790	0		4.00
5.00	DIETARY	10.00	0	90,089	0		5.00
6.00	NURSING ADMINISTRATION	13.00	0	23,447	0		6.00
7.00	CENTRAL SERVICES & SUPPLY	14.00	0	76,591	0		7.00
8.00	PHARMACY	15.00	0	66,296	0		8.00
9.00	ADULTS & PEDIATRICS	30.00	0	1,579,969	0		9.00
10.00	INTENSIVE CARE UNIT	31.00	0	342,004	0		10.00
11.00	NEONATAL INTENSIVE CARE UNIT	35.00	0	180,007	0		11.00
12.00	SUBPROVIDER - IPF	40.00	0	16,960	0		12.00

RECLASSIFICATIONS

Provider CCN: 15-0169

Period:  
From 01/01/2020  
To 12/31/2020

Worksheet A-6  
Date/Time Prepared:  
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Decreases							
Cost Center	Line #	Salary	Other	Wkst.	A-7 Ref.		
6.00	7.00	8.00	9.00	10.00			
13.00	OPERATING ROOM	50.00	0	1,627,067	0	13.00	
14.00	RECOVERY ROOM	51.00	0	9,037	0	14.00	
15.00	RADIOLOGY-DIAGNOSTIC	54.00	0	385,232	0	15.00	
16.00	RADIOLOGY-THERAPEUTIC	55.00	0	578,197	0	16.00	
17.00	CT SCAN	57.00	0	223,979	0	17.00	
18.00	MRI	58.00	0	392,190	0	18.00	
19.00	CARDIAC CATHETERIZATION	59.00	0	1,527	0	19.00	
20.00	INTRAVENOUS THERAPY	64.00	0	2,856	0	20.00	
21.00	RESPIRATORY THERAPY	65.00	0	55,583	0	21.00	
22.00	PHYSICAL THERAPY	66.00	0	288,168	0	22.00	
23.00	ELECTROCARDIOLOGY	69.00	0	140	0	23.00	
24.00	ELECTROENCEPHALOGRAPHY	70.00	0	58,063	0	24.00	
25.00	ENDOSCOPY	76.00	0	352,543	0	25.00	
26.00	WOUND CARE	76.04	0	27,701	0	26.00	
27.00	IMAGING CENTER	76.06	0	422,030	0	27.00	
28.00	BREAST DIAGNOSTIC CENTER	76.07	0	3,521	0	28.00	
29.00	INFUSION CENTER	90.01	0	23,996	0	29.00	
30.00	EMERGENCY	91.00	0	201,898	0	30.00	
31.00	PAVILLIONS	194.06	0	18,258	0	31.00	
32.00	OTHER NRCC	194.08	0	9,266	0	32.00	
	TOTALS		0	16,844,995			
E - Interest Expense							
1.00	ADMINISTRATIVE & GENERAL	5.00	0	10,607,739	11	1.00	
	TOTALS		0	10,607,739			
F - Other Capital Rental							
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	87,835	10	1.00	
2.00	ADMINISTRATIVE & GENERAL	5.00	0	779,602	0	2.00	
3.00	OPERATION OF PLANT	7.00	0	125,555	0	3.00	
4.00	LAUNDRY & LINEN SERVICE	8.00	0	80	0	4.00	
5.00	HOUSEKEEPING	9.00	0	18,261	0	5.00	
6.00	DIETARY	10.00	0	319	0	6.00	
7.00	NURSING ADMINISTRATION	13.00	0	1,550	0	7.00	
8.00	CENTRAL SERVICES & SUPPLY	14.00	0	2,335,936	0	8.00	
9.00	PHARMACY	15.00	0	648,390	0	9.00	
10.00	MEDICAL RECORDS & LIBRARY	16.00	0	80	0	10.00	
11.00	SOCIAL SERVICE	17.00	0	36	0	11.00	
12.00	ADULTS & PEDIATRICS	30.00	0	19,031	0	12.00	
13.00	INTENSIVE CARE UNIT	31.00	0	396	0	13.00	
14.00	NEONATAL INTENSIVE CARE UNIT	35.00	0	5,592	0	14.00	
15.00	SUBPROVIDER - IPF	40.00	0	399	0	15.00	
16.00	OPERATING ROOM	50.00	0	871,734	0	16.00	
17.00	RADIOLOGY-DIAGNOSTIC	54.00	0	479	0	17.00	
18.00	MRI	58.00	0	80	0	18.00	
19.00	RESPIRATORY THERAPY	65.00	0	165,644	0	19.00	
20.00	PHYSICAL THERAPY	66.00	0	870,422	0	20.00	
21.00	ELECTROENCEPHALOGRAPHY	70.00	0	186,071	0	21.00	
22.00	ENDOSCOPY	76.00	0	12,398	0	22.00	
23.00	WOUND CARE	76.04	0	78,500	0	23.00	
24.00	IMAGING CENTER	76.06	0	539,310	0	24.00	
25.00	BREAST DIAGNOSTIC CENTER	76.07	0	416,520	0	25.00	
26.00	INFUSION CENTER	90.01	0	58,891	0	26.00	
27.00	SPINE CENTER	90.26	0	92	0	27.00	
28.00	EMERGENCY	91.00	0	27	0	28.00	
29.00	PAVILLIONS	194.06	0	103,745	0	29.00	
30.00	OTHER NRCC	194.08	0	106,709	0	30.00	
	TOTALS		0	7,433,684			
G - STD BENEFIT							
1.00	ADMINISTRATIVE & GENERAL	5.00	9,521	0	0	1.00	
2.00	OPERATION OF PLANT	7.00	9,410	0	0	2.00	
3.00	HOUSEKEEPING	9.00	26,537	0	0	3.00	
4.00	DIETARY	10.00	10,502	0	0	4.00	
5.00	NURSING ADMINISTRATION	13.00	13,668	0	0	5.00	
6.00	CENTRAL SERVICES & SUPPLY	14.00	4,825	0	0	6.00	
7.00	PHARMACY	15.00	23,263	0	0	7.00	
8.00	MEDICAL RECORDS & LIBRARY	16.00	1,303	0	0	8.00	
9.00	SOCIAL SERVICE	17.00	6,911	0	0	9.00	
10.00	ADULTS & PEDIATRICS	30.00	215,150	0	0	10.00	
11.00	INTENSIVE CARE UNIT	31.00	29,159	0	0	11.00	
12.00	NEONATAL INTENSIVE CARE UNIT	35.00	79,929	0	0	12.00	
13.00	SUBPROVIDER - IPF	40.00	1,751	0	0	13.00	
14.00	OPERATING ROOM	50.00	29,930	0	0	14.00	
15.00	RECOVERY ROOM	51.00	7,625	0	0	15.00	
16.00	RADIOLOGY-DIAGNOSTIC	54.00	13,104	0	0	16.00	
17.00	RADIOLOGY-THERAPEUTIC	55.00	1,618	0	0	17.00	

Provider CCN: 15-0169

Period:  
From 01/01/2020  
To 12/31/2020

Worksheet A-6  
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		Decreases						
	Cost Center	Line #	Salary	Other	Wkst. A-7	Ref.		
	6.00	7.00	8.00	9.00	10.00			
18.00	CT SCAN	57.00	5,960	0	0	0		18.00
19.00	INTRAVENOUS THERAPY	64.00	691	0	0	0		19.00
20.00	RESPIRATORY THERAPY	65.00	31,886	0	0	0		20.00
21.00	PHYSICAL THERAPY	66.00	38,464	0	0	0		21.00
22.00	ELECTROENCEPHALOGRAPHY	70.00	2,407	0	0	0		22.00
23.00	ENDOSCOPY	76.00	3,860	0	0	0		23.00
24.00	IMAGING CENTER	76.06	6,055	0	0	0		24.00
25.00	EMERGENCY	91.00	44,251	0	0	0		25.00
	TOTALS		617,780	0				
<b>H - Labor and Delivery</b>								
1.00	ADULTS & PEDIATRICS	30.00	5,636,911	2,551,499	0	0		1.00
2.00		0.00	0	0	0	0		2.00
	TOTALS		5,636,911	2,551,499				
<b>I - Cafeteria</b>								
1.00	DIETARY	10.00	1,748,848	1,843,340	0	0		1.00
	TOTALS		1,748,848	1,843,340				
<b>J - Therapy</b>								
1.00	PHYSICAL THERAPY	66.00	1,707,669	775,562	0	0		1.00
2.00		0.00	0	0	0	0		2.00
	TOTALS		1,707,669	775,562				
<b>K - Building Depreciation</b>								
1.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	8,270,222	9	9		1.00
	TOTALS		0	8,270,222				
<b>L - Capital Insurance Costs</b>								
1.00	ADMINISTRATIVE & GENERAL	5.00	0	211,249	12	12		1.00
	TOTALS		0	211,249				
<b>M - Radiology Support</b>								
1.00	RADIOLOGY-DIAGNOSTIC	54.00	331,644	122,499	0	0		1.00
2.00		0.00	0	0	0	0		2.00
3.00		0.00	0	0	0	0		3.00
	TOTALS		331,644	122,499				
<b>N - Specialty Pharmacy</b>								
1.00	PHARMACY	15.00	1,621,909	23,663,760	0	0		1.00
	TOTALS		1,621,909	23,663,760				
500.00	Grand Total: Decreases		11,664,761	112,978,936				500.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 15-0169

Period:  
From 01/01/2020  
To 12/31/2020

Worksheet A-7  
Part I  
Date/Time Prepared:  
8/2/2021 3:48 pm

		Beginning Balances	Acquisitions			Disposals and Retirements	
			Purchases	Donation	Total		
			1.00	2.00	3.00		
<b>PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES</b>							
1.00	Land	2,705,851	0	0	0	0	1.00
2.00	Land Improvements	4,358,832	0	0	0	0	2.00
3.00	Buildings and Fixtures	323,581,869	2,974,522	0	2,974,522	-216,170	3.00
4.00	Building Improvements	3,219,527	336,490	0	336,490	-1,055,408	4.00
5.00	Fixed Equipment	0	0	0	0	0	5.00
6.00	Movable Equipment	120,360,146	2,957,485	0	2,957,485	-91,017	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	454,226,225	6,268,497	0	6,268,497	-1,362,595	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	454,226,225	6,268,497	0	6,268,497	-1,362,595	10.00
		Ending Balance	Fully Depreciated Assets				
		6.00	7.00				
<b>PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES</b>							
1.00	Land	2,705,851	0				1.00
2.00	Land Improvements	4,358,832	0				2.00
3.00	Buildings and Fixtures	326,772,561	0				3.00
4.00	Building Improvements	4,611,425	0				4.00
5.00	Fixed Equipment	0	0				5.00
6.00	Movable Equipment	123,408,648	0				6.00
7.00	HIT designated Assets	0	0				7.00
8.00	Subtotal (sum of lines 1-7)	461,857,317	0				8.00
9.00	Reconciling Items	0	0				9.00
10.00	Total (line 8 minus line 9)	461,857,317	0				10.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 15-0169

Period:  
From 01/01/2020  
To 12/31/2020

Worksheet A-7  
Part II  
Date/Time Prepared:  
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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	0	0	0	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	0	0	0	0	0	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)				
		14.00	15.00				
PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2							
1.00	CAP REL COSTS-BLDG & FIXT	0	0				1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0				2.00
3.00	Total (sum of lines 1-2)	0	0				3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 15-0169

Period:  
From 01/01/2020  
To 12/31/2020

Worksheet A-7  
Part III  
Date/Time Prepared:  
8/2/2021 3:48 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	338,448,668	0	338,448,668	0.732799	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	123,408,648	0	123,408,648	0.267201	0	2.00
3.00	Total (sum of lines 1-2)	461,857,316	0	461,857,316	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	8,270,222	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	14,043,018	7,433,684	2.00
3.00	Total (sum of lines 1-2)	0	0	0	22,313,240	7,433,684	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	5,186,405	211,249	0	0	13,667,876	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	0	21,476,702	2.00
3.00	Total (sum of lines 1-2)	5,186,405	211,249	0	0	35,144,578	3.00



Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted		Wkst. A-7 Ref.		
			Cost Center	Line #			
			3.00	4.00			
		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)	B	-4,009		ADMINISTRATIVE & GENERAL	5.00	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	-756,687				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	5,452,977				0	12.00
13.00 Laundry and linen service			0		0.00	0	13.00
14.00 Cafeteria-employees and guests	B	-1,851,209		CAFETERIA	11.00	0	14.00
15.00 Rental of quarters to employee and others			0		0.00	0	15.00
16.00 Sale of medical and surgical supplies to other than patients			0		0.00	0	16.00
17.00 Sale of drugs to other than patients			0		0.00	0	17.00
18.00 Sale of medical records and abstracts			0		0.00	0	18.00
19.00 Nursing and allied health education (tuition, fees, books, etc.)			0		0.00	0	19.00
20.00 Vending machines			0		0.00	0	20.00
21.00 Income from imposition of interest, finance or penalty charges (chapter 21)			0		0.00	0	21.00
22.00 Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments			0		0.00	0	22.00
23.00 Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3		0	RESPIRATORY THERAPY	65.00		23.00
24.00 Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3		0	PHYSICAL THERAPY	66.00		24.00
25.00 Utilization review - physicians' compensation (chapter 21)				UTILIZATION REVIEW-SNF	114.00		25.00
26.00 Depreciation - CAP REL COSTS-BLDG & FIXT			0	CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
27.00 Depreciation - CAP REL COSTS-MVBLE EQUIP			0	CAP REL COSTS-MVBLE EQUIP	2.00	0	27.00
28.00 Non-physician Anesthetist			0	NONPHYSICIAN ANESTHETISTS	19.00		28.00
29.00 Physicians' assistant			0		0.00	0	29.00
30.00 Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3		0	OCCUPATIONAL THERAPY	67.00		30.00
30.99 Hospice (non-distinct) (see instructions)				ADULTS & PEDIATRICS	30.00		30.99
31.00 Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3		0	SPEECH PATHOLOGY	68.00		31.00
32.00 CAH HIT Adjustment for Depreciation and Interest			0		0.00	0	32.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 15-0169

Period:  
From 01/01/2020  
To 12/31/2020

Worksheet A-8

Date/Time Prepared:  
8/2/2021 3:48 pm

Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted		Wkst. A-7 Ref.
			Cost Center	Line #	
	1.00	2.00	3.00	4.00	5.00
33.00 OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0 33.00
33.01 Misc Revenue	B	-95,512	EMPLOYEE BENEFITS DEPARTMENT	4.00	0 33.01
33.02 Misc Revenue	B	-10,277	ADMINISTRATIVE & GENERAL	5.00	0 33.02
33.03 Misc Revenue	B	-28,250	OPERATION OF PLANT	7.00	0 33.03
33.04 Misc Revenue	B	-8,565	DIETARY	10.00	0 33.04
33.05 Misc Revenue	B	-99,115	PHARMACY	15.00	0 33.05
33.06 Misc Revenue	B	-2,125	NEONATAL INTENSIVE CARE UNIT	35.00	0 33.06
33.07 Misc Revenue	B	-142,500	OPERATING ROOM	50.00	0 33.07
33.08 Misc Revenue	B	-79,524	RADIOLOGY-DIAGNOSTIC	54.00	0 33.08
33.09 Misc Revenue	B	-31	LABORATORY	60.00	0 33.09
33.10 Misc Revenue	B	-2,260	PHYSICAL THERAPY	66.00	0 33.10
33.11 Space Rental Income	B	-19,800	OPERATION OF PLANT	7.00	0 33.11
33.12 Investment Income	B	-13,110,559	ADMINISTRATIVE & GENERAL	5.00	0 33.12
34.00 HAF Tax Offset	A	-29,005,196	ADMINISTRATIVE & GENERAL	5.00	0 34.00
34.01 00 NON-ALLOW INTEREST EXPENSE	A	-3,337,106	CAP REL COSTS-BLDG & FIXT	1.00	11 34.01
34.02 LOC Non-Allow Interest Expense	A	-89,088	CAP REL COSTS-BLDG & FIXT	1.00	11 34.02
34.03 12A NON-ALLOW INTEREST EXPENSE	A	-689,010	CAP REL COSTS-BLDG & FIXT	1.00	11 34.03
34.04 12B Non-Allow Interest Expense	A	-99,004	CAP REL COSTS-BLDG & FIXT	1.00	11 34.04
34.05 50M BMO NON-ALLOW INTEREST EXPENSE	A	-19,182	CAP REL COSTS-BLDG & FIXT	1.00	11 34.05
34.06 16AB NON-ALLOW INTEREST EXPENSE	A	-365,050	CAP REL COSTS-BLDG & FIXT	1.00	11 34.06
34.07 20A NON-ALLOW INTEREST EXPENSE	A	-822,894	CAP REL COSTS-BLDG & FIXT	1.00	11 34.07
34.08 DEBT ISSUANCE EXPENSE	A	27,791	ADMINISTRATIVE & GENERAL	5.00	0 34.08
34.09 LOSS ON ASSETS	A	-8,861	ADMINISTRATIVE & GENERAL	5.00	0 34.09
34.10 LOSS ON ASSETS	A	-37,520	RADIOLOGY-THERAPEUTIC	55.00	0 34.10
34.11 LOSS ON ASSETS	A	-46,497	ADULTS & PEDIATRICS	30.00	0 34.11
35.00 Bad Debt	A	-21,456,789	ADMINISTRATIVE & GENERAL	5.00	0 35.00
35.01 APP	A	-226,414	NEONATAL INTENSIVE CARE UNIT	35.00	0 35.01
35.02 SPONSORSHIP	A	-1,000	ADMINISTRATIVE & GENERAL	5.00	0 35.02
35.03 SPONSORSHIP	A	-300	PHYSICAL THERAPY	66.00	0 35.03
36.00 Meals of Wheels Cost	A	-59,744	CAFETERIA	11.00	0 36.00
36.01 CARDIAC CATH SHARED SERVICES	A	225,145	CARDIAC CATHETERIZATION	59.00	0 36.01
36.02 CARDIAC MONITORING SHARED SERVICES	A	54,296	ELECTROCARDIOLOGY	69.00	0 36.02
50.00 TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-66,713,869			50.00

(1) Description - all chapter references in this column pertain to CMS Pub. 15-1.

(2) Basis for adjustment (see instructions).

A. Costs - if cost, including applicable overhead, can be determined.

B. Amount Received - if cost cannot be determined.

(3) Additional adjustments may be made on lines 33 thru 49 and subscripts thereof.

Note: See instructions for column 5 referencing to Worksheet A-7.

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS

Provider CCN: 15-0169

Period: From 01/01/2020 To 12/31/2020

Worksheet A-8-1

Date/Time Prepared: 8/2/2021 3:48 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	
<b>A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:</b>					
1.00	21.00	I&R SERVICES-SALARY & FRINGE	INTERNS & RESIDENTS	589,754	0
2.00	22.00	I&R SERVICES-OTHER PRGM COST	INTERNS & RESIDENTS	874,613	0
3.00	5.00	ADMINISTRATIVE & GENERAL	7250 CLEARVISTA	283,410	225,961
3.01	70.00	ELECTROENCEPHALOGRAPHY	7250 CLEARVISTA	155,812	104,256
3.02	73.01	SPECIALTY PHARMACY	7250 CLEARVISTA	63,737	42,520
4.00	2.00	CAP REL COSTS-MVBLE EQUIP	HOME OFFICE	5,468,245	0
4.01	4.00	EMPLOYEE BENEFITS DEPARTMENT	HOME OFFICE	3,303,655	0
4.02	5.00	ADMINISTRATIVE & GENERAL	HOME OFFICE	48,854,685	66,722,287
4.03	7.00	OPERATION OF PLANT	HOME OFFICE	926,111	0
4.04	13.00	NURSING ADMINISTRATION	HOME OFFICE	3,829,188	0
4.05	14.00	CENTRAL SERVICES & SUPPLY	HOME OFFICE	3,520,764	0
4.06	16.00	MEDICAL RECORDS & LIBRARY	HOME OFFICE	2,440,156	0
4.07	30.00	ADULTS & PEDIATRICS	HOME OFFICE	207,376	0
4.08	54.00	RADIOLOGY-DIAGNOSTIC	HOME OFFICE	121,920	0
4.09	73.00	DRUGS CHARGED TO PATIENTS	HOME OFFICE	370,810	0
4.10	5.00	ADMINISTRATIVE & GENERAL	CPN MEDICAL DIRECTOR	463,914	0
4.11	91.00	EMERGENCY	CPN CALL	1,073,851	0
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.			72,548,001	67,095,024

\* 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.

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

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	CHNW	100.00	0.00	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:			0.00	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.

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS	Provider CCN: 15-0169	Period: From 01/01/2020 To 12/31/2020	Worksheet A-8-1 Date/Time Prepared: 8/2/2021 3:48 pm
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	Net Adjustments (col. 4 minus col. 5)*	Wkst. A-7 Ref.	
	6.00	7.00	
<b>A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:</b>			
1.00	589,754	0	1.00
2.00	874,613	0	2.00
3.00	57,449	0	3.00
3.01	51,556	0	3.01
3.02	21,217	0	3.02
4.00	5,468,245	9	4.00
4.01	3,303,655	0	4.01
4.02	-17,867,602	0	4.02
4.03	926,111	0	4.03
4.04	3,829,188	0	4.04
4.05	3,520,764	0	4.05
4.06	2,440,156	0	4.06
4.07	207,376	0	4.07
4.08	121,920	0	4.08
4.09	370,810	0	4.09
4.10	463,914	0	4.10
4.11	1,073,851	0	4.11
5.00	5,452,977		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>B. INTERRELATIONSHIP TO RELATED ORGANIZATION(S) AND/OR HOME OFFICE:</b>		

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 requested information, the cost report is considered incomplete and not acceptable for purposes of claiming reimbursement under title XVIII.

6.00		6.00
7.00		7.00
8.00		8.00
9.00		9.00
10.00		10.00
100.00		100.00

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

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

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 15-0169

Period:  
From 01/01/2020  
To 12/31/2020

Worksheet A-8-2

Date/Time Prepared:  
8/2/2021 3:48 pm

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	5.00	ADMINISTRATIVE & GENERAL	706,160	213,507	492,653	211,500	1,080	1.00
2.00	35.00	NEONATAL INTENSIVE CARE UNIT	120,000	120,000	0	0	0	2.00
3.00	40.00	SUBPROVIDER - IPF	40,344	40,344	0	0	0	3.00
4.00	0.00		0	0	0	0	0	4.00
5.00	0.00		0	0	0	0	0	5.00
6.00	0.00		0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			866,504	373,851	492,653		1,080	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	5.00	ADMINISTRATIVE & GENERAL	109,817	5,491	0	0	0	1.00
2.00	35.00	NEONATAL INTENSIVE CARE UNIT	0	0	0	0	0	2.00
3.00	40.00	SUBPROVIDER - IPF	0	0	0	0	0	3.00
4.00	0.00		0	0	0	0	0	4.00
5.00	0.00		0	0	0	0	0	5.00
6.00	0.00		0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			109,817	5,491	0	0	0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment	
	1.00	2.00	15.00	16.00	17.00	18.00	
1.00	5.00	ADMINISTRATIVE & GENERAL	0	109,817	382,836	596,343	1.00
2.00	35.00	NEONATAL INTENSIVE CARE UNIT	0	0	0	120,000	2.00
3.00	40.00	SUBPROVIDER - IPF	0	0	0	40,344	3.00
4.00	0.00		0	0	0	0	4.00
5.00	0.00		0	0	0	0	5.00
6.00	0.00		0	0	0	0	6.00
7.00	0.00		0	0	0	0	7.00
8.00	0.00		0	0	0	0	8.00
9.00	0.00		0	0	0	0	9.00
10.00	0.00		0	0	0	0	10.00
200.00			0	109,817	382,836	756,687	200.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 15-0169

Period:  
From 01/01/2020  
To 12/31/2020

Worksheet B  
Part I  
Date/Time Prepared:  
8/2/2021 3:48 pm

Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
		BLDG & FIXT	MVBLE EQUIP			
	0	1.00	2.00	4.00	4A	
<b>GENERAL SERVICE COST CENTERS</b>						
1.00 00100	CAP REL COSTS-BLDG & FIXT	13,667,876	13,667,876			1.00
2.00 00200	CAP REL COSTS-MVBLE EQUIP	21,476,702		21,476,702		2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	3,488,875	6,001	87,345	3,582,221	4.00
5.00 00500	ADMINISTRATIVE & GENERAL	54,287,681	396,429	8,937,536	369,224	5.00
7.00 00700	OPERATION OF PLANT	10,704,383	1,739,016	260,479	93,722	7.00
8.00 00800	LAUNDRY & LINEN SERVICE	983,877	50,608	79	0	8.00
9.00 00900	HOUSEKEEPING	4,756,443	126,040	23,725	91,897	9.00
10.00 01000	DIETARY	1,573,314	135,862	20,381	24,045	10.00
11.00 01100	CAFETERIA	1,681,235	308,549	61,698	55,358	11.00
13.00 01300	NURSING ADMINISTRATION	6,430,114	9,142	24,658	66,169	13.00
14.00 01400	CENTRAL SERVICES & SUPPLY	4,566,404	319,356	2,378,986	25,744	14.00
15.00 01500	PHARMACY	5,875,087	158,178	703,537	162,166	15.00
16.00 01600	MEDICAL RECORDS & LIBRARY	2,938,160	5,649	79	12,692	16.00
17.00 01700	SOCIAL SERVICE	2,214,349	37,411	36	55,148	17.00
19.00 01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	19.00
21.00 02100	I&R SERVICES-SALARY & FRINGES APPRV	589,754	0	0	0	21.00
22.00 02200	I&R SERVICES-OTHER PRGM COSTS APPRV	874,613	0	0	0	22.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>						
30.00 03000	ADULTS & PEDIATRICS	47,271,506	4,377,591	876,207	897,038	30.00
31.00 03100	INTENSIVE CARE UNIT	6,389,507	858,116	176,983	151,266	31.00
35.00 02060	NEONATAL INTENSIVE CARE UNIT	10,178,977	817,259	169,191	238,428	35.00
40.00 04000	SUBPROVIDER - IPF	2,233,663	150,302	12,812	57,296	40.00
43.00 04300	NURSERY	2,358,032	334,873	46,812	51,383	43.00
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00 05000	OPERATING ROOM	14,062,165	640,165	2,447,214	138,972	50.00
51.00 05100	RECOVERY ROOM	3,351,065	343,640	7,212	74,367	51.00
52.00 05200	DELIVERY ROOM & LABOR ROOM	5,911,013	827,971	115,745	129,530	52.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	3,938,833	218,584	356,453	94,209	54.00
55.00 05500	RADIOLOGY-THERAPEUTIC	995,279	244,439	436,094	20,084	55.00
57.00 05700	CT SCAN	1,631,938	31,832	224,535	34,822	57.00
58.00 05800	MRI	1,647,500	117,930	279,501	17,416	58.00
59.00 05900	CARDIAC CATHETERIZATION	228,232	0	1,506	0	59.00
60.00 06000	LABORATORY	11,322,339	125,220	0	0	60.00
64.00 06400	INTRAVENOUS THERAPY	904,016	176,297	2,817	21,014	64.00
65.00 06500	RESPIRATORY THERAPY	4,271,011	135,440	218,228	93,801	65.00
66.00 06600	PHYSICAL THERAPY	5,287,725	21,800	1,059,193	133,028	66.00
67.00 06700	OCCUPATIONAL THERAPY	2,041,545	0	68,807	44,440	67.00
68.00 06800	SPEECH PATHOLOGY	441,686	0	14,886	9,615	68.00
69.00 06900	ELECTROCARDIOLOGY	538,120	0	0	1,031	69.00
70.00 07000	ELECTROENCEPHALOGRAPHY	1,364,004	74,448	240,825	25,618	70.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENT	14,384,461	0	0	0	71.00
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	11,681,234	0	0	0	72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	14,920,369	0	0	0	73.00
73.01 07301	SPECIALTY PHARMACY	40,694,707	0	0	51,340	73.01
74.00 07400	RENAL DIALYSIS	1,159,345	2,438	0	0	74.00
76.00 03330	ENDOSCOPY	2,026,477	174,703	338,936	37,065	76.00
76.01 03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	76.01
76.02 03951	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	76.02
76.03 03952	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	76.03
76.04 03953	WOUND CARE	618,839	0	104,761	8,709	76.04
76.06 03954	IMAGING CENTER	2,836,556	0	880,815	49,818	76.06
76.07 03955	BREAST DIAGNOSTIC CENTER	8,644,194	0	414,347	0	76.07
<b>OUTPATIENT SERVICE COST CENTERS</b>						
90.00 09000	CLINIC	0	0	0	0	90.00
90.01 04950	INFUSION CENTER	154,198	0	81,763	3,406	90.01
90.26 04975	SPINE CENTER	217,961	0	91	5,243	90.26
91.00 09100	EMERGENCY	9,861,681	595,604	167,677	194,976	91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	92.00
<b>SPECIAL PURPOSE COST CENTERS</b>						
113.00 11300	INTEREST EXPENSE	0	0	0	0	113.00
114.00 11400	UTILIZATION REVIEW-SNF	0	0	0	0	114.00
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	369,677,045	13,560,893	21,241,950	3,540,080	118.00
<b>NONREIMBURSABLE COST CENTERS</b>						
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	82,370	0	0	190.00
191.00 19100	RESEARCH	0	0	0	0	191.00
192.00 19200	PHYSICIANS' PRIVATE OFFICES	102,989	0	0	0	192.00
193.00 19300	NONPAID WORKERS	0	0	0	0	193.00
194.00 07950	HOME OFFICE	0	0	0	0	194.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 15-0169

Period:  
From 01/01/2020  
To 12/31/2020

Worksheet B  
Part I  
Date/Time Prepared:  
8/2/2021 3:48 pm

Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
		BLDG & FIXT	MVBLE EQUIP			
	0	1.00	2.00	4.00	4A	
194.06 07956 PAVILLIONS	39,336	0	120,349	0	159,685	194.06
194.08 07958 OTHER NRCC	1,765,938	24,613	114,403	42,141	1,947,095	194.08
194.10 07960 COMMUNITY REHAB HOSPITAL	0	0	0	0	0	194.10
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)	371,585,308	13,667,876	21,476,702	3,582,221	371,585,308	202.00

COST ALLOCATION - GENERAL SERVICE COSTS			Provider CCN: 15-0169		Period: From 01/01/2020 To 12/31/2020		Worksheet B Part I Date/Time Prepared: 8/2/2021 3:48 pm	
Cost Center Description			ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
			5.00	7.00	8.00	9.00	10.00	
<b>GENERAL SERVICE COST CENTERS</b>								
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	63,990,870					5.00
7.00	00700	OPERATION OF PLANT	2,662,362	15,459,962				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	215,227	67,879	1,317,670			8.00
9.00	00900	HOUSEKEEPING	1,039,786	169,053	0	6,206,944		9.00
10.00	01000	DIETARY	364,812	182,227	0	74,300	2,374,941	10.00
11.00	01100	CAFETERIA	438,299	413,846	0	168,739	0	11.00
13.00	01300	NURSING ADMINISTRATION	1,358,492	12,262	0	4,999	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	1,516,684	428,339	0	174,648	0	14.00
15.00	01500	PHARMACY	1,435,234	212,158	0	86,504	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	615,075	7,577	0	3,089	0	16.00
17.00	01700	SOCIAL SERVICE	479,927	50,178	0	20,459	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	122,690	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	181,951	0	0	0	0	22.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>								
30.00	03000	ADULTS & PEDIATRICS	11,113,923	5,871,494	657,828	2,394,008	1,985,913	30.00
31.00	03100	INTENSIVE CARE UNIT	1,576,054	1,150,958	68,603	469,285	241,035	31.00
35.00	02060	NEONATAL INTENSIVE CARE UNIT	2,372,412	1,096,158	47,515	446,941	0	35.00
40.00	04000	SUBPROVIDER - I PF	510,536	201,594	9,652	82,197	147,993	40.00
43.00	04300	NURSERY	580,649	449,153	33,818	183,135	0	43.00
<b>ANCILLARY SERVICE COST CENTERS</b>								
50.00	05000	OPERATING ROOM	3,596,634	858,628	62,851	350,092	0	50.00
51.00	05100	RECOVERY ROOM	785,603	460,911	0	187,929	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,452,977	1,110,526	83,608	452,799	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	958,646	293,179	81,074	119,539	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	352,807	327,857	12,859	133,678	0	55.00
57.00	05700	CT SCAN	400,080	42,696	0	17,408	0	57.00
58.00	05800	MRI	429,042	158,175	0	64,493	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	47,794	0	0	0	0	59.00
60.00	06000	LABORATORY	2,381,504	167,953	0	68,480	0	60.00
64.00	06400	INTRAVENOUS THERAPY	229,702	236,461	0	96,413	0	64.00
65.00	06500	RESPIRATORY THERAPY	981,614	181,661	0	74,069	0	65.00
66.00	06600	PHYSICAL THERAPY	1,352,597	29,239	0	11,922	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	448,274	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	96,984	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	112,163	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	354,680	99,854	0	40,714	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	2,992,486	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	2,430,117	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	3,103,974	0	0	0	0	73.00
73.01	07301	SPECIALTY PHARMACY	8,476,645	0	0	0	0	73.01
74.00	07400	RENAL DIALYSIS	241,693	3,270	0	1,333	0	74.00
76.00	03330	ENDOSCOPY	536,146	234,323	25,863	95,541	0	76.00
76.01	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0	76.01
76.02	03951	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0	76.02
76.03	03952	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0	76.03
76.04	03953	WOUND CARE	152,347	0	0	0	0	76.04
76.06	03954	IMAGING CENTER	783,711	0	0	0	0	76.06
76.07	03955	BREAST DIAGNOSTIC CENTER	1,884,503	0	0	0	0	76.07
<b>OUTPATIENT SERVICE COST CENTERS</b>								
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	04950	INFUSION CENTER	49,797	0	0	0	0	90.01
90.26	04975	SPINE CENTER	46,453	0	0	0	0	90.26
91.00	09100	EMERGENCY	2,250,937	798,861	233,999	325,723	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
<b>SPECIAL PURPOSE COST CENTERS</b>								
113.00	11300	INTEREST EXPENSE						113.00
114.00	11400	UTILIZATION REVIEW-SNF						114.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	63,514,023	15,316,470	1,317,670	6,148,437	2,374,941	118.00
<b>NONREIMBURSABLE COST CENTERS</b>								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	17,136	110,480	0	45,047	0	190.00
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	21,425	0	0	0	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950	HOME OFFICE	0	0	0	0	0	194.00
194.06	07956	PAVILLIONS	33,220	0	0	0	0	194.06
194.08	07958	OTHER NRCC	405,066	33,012	0	13,460	0	194.08
194.10	07960	COMMUNITY REHAB HOSPITAL	0	0	0	0	0	194.10
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00



COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 15-0169

Period:  
From 01/01/2020  
To 12/31/2020

Worksheet B  
Part I  
Date/Time Prepared:  
8/2/2021 3:48 pm

Cost Center Description	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
	5.00	7.00	8.00	9.00	10.00	
202.00   TOTAL (sum lines 118 through 201)	63,990,870	15,459,962	1,317,670	6,206,944	2,374,941	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 15-0169

Period:  
From 01/01/2020  
To 12/31/2020

Worksheet B  
Part I  
Date/Time Prepared:  
8/2/2021 3:48 pm

Cost Center Description		CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
		11.00	13.00	14.00	15.00	16.00	
<b>GENERAL SERVICE COST CENTERS</b>							
1.00	00100						1.00
2.00	00200						2.00
4.00	00400						4.00
5.00	00500						5.00
7.00	00700						7.00
8.00	00800						8.00
9.00	00900						9.00
10.00	01000						10.00
11.00	01100	3,127,724					11.00
13.00	01300	76,419	7,982,255				13.00
14.00	01400	46,397	0	9,456,558			14.00
15.00	01500	158,297	0	279,021	9,070,182		15.00
16.00	01600	13,646	0	0	0	3,595,967	16.00
17.00	01700	57,314	0	55	0	0	17.00
19.00	01900	0	0	0	0	0	19.00
21.00	02100	0	0	0	0	0	21.00
22.00	02200	0	0	0	0	0	22.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000	1,058,948	3,900,648	544,906	0	452,341	30.00
31.00	03100	182,860	673,566	105,919	0	69,900	31.00
35.00	02060	251,091	924,896	149,924	0	266,551	35.00
40.00	04000	68,231	251,330	15,149	0	22,418	40.00
43.00	04300	60,044	221,171	29,500	0	23,618	43.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000	161,026	593,140	1,291,614	0	456,292	50.00
51.00	05100	81,878	0	65,767	0	79,064	51.00
52.00	05200	147,380	542,874	72,940	0	58,397	52.00
54.00	05400	98,253	0	27,061	0	88,756	54.00
55.00	05500	19,105	0	35,989	0	89,285	55.00
57.00	05700	38,210	0	33,605	0	171,952	57.00
58.00	05800	16,376	0	1,812	0	74,698	58.00
59.00	05900	0	0	631	0	10,329	59.00
60.00	06000	0	0	306,950	0	288,348	60.00
64.00	06400	21,834	0	12,024	0	7,467	64.00
65.00	06500	103,712	0	98,848	0	73,161	65.00
66.00	06600	35,480	0	20,713	0	45,274	66.00
67.00	06700	43,668	0	5,082	0	16,184	67.00
68.00	06800	8,188	0	1,099	0	4,883	68.00
69.00	06900	2,729	0	97	0	23,354	69.00
70.00	07000	30,022	0	26,972	0	22,163	70.00
71.00	07100	0	0	2,939,074	0	132,667	71.00
72.00	07200	0	0	2,386,745	0	96,010	72.00
73.00	07300	0	0	0	9,070,182	260,050	73.00
73.01	07301	49,127	0	698,519	0	139,299	73.01
74.00	07400	0	0	181	0	10,964	74.00
76.00	03330	43,668	0	62,166	0	58,869	76.00
76.01	03950	0	0	0	0	0	76.01
76.02	03951	0	0	0	0	0	76.02
76.03	03952	0	0	0	0	0	76.03
76.04	03953	10,917	0	14,994	0	5,728	76.04
76.06	03954	0	0	32,553	0	116,696	76.06
76.07	03955	0	0	1,174	0	59,442	76.07
<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.00	09000	0	0	0	0	0	90.00
90.01	04950	5,459	0	1,693	0	1,064	90.01
90.26	04975	0	0	750	0	939	90.26
91.00	09100	237,445	874,630	185,576	0	369,804	91.00
92.00	09200	0	0	0	0	0	92.00
<b>SPECIAL PURPOSE COST CENTERS</b>							
113.00	11300	0	0	0	0	0	113.00
114.00	11400	0	0	0	0	0	114.00
118.00	11800	3,127,724	7,982,255	9,449,103	9,070,182	3,595,967	118.00
<b>NONREIMBURSABLE COST CENTERS</b>							
190.00	19000	0	0	0	0	0	190.00
191.00	19100	0	0	0	0	0	191.00
192.00	19200	0	0	5,564	0	0	192.00
193.00	19300	0	0	0	0	0	193.00
194.00	07950	0	0	0	0	0	194.00
194.06	07956	0	0	578	0	0	194.06
194.08	07958	0	0	1,313	0	0	194.08
194.10	07960	0	0	0	0	0	194.10
200.00							200.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 15-0169

Period:  
From 01/01/2020  
To 12/31/2020

Worksheet B  
Part I  
Date/Time Prepared:  
8/2/2021 3:48 pm

Cost Center Description		CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
		11.00	13.00	14.00	15.00	16.00	
201.00	Negative Cost Centers	0	0	0	0	0	201.00
202.00	TOTAL (sum lines 118 through 201)	3,127,724	7,982,255	9,456,558	9,070,182	3,595,967	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 15-0169

Period:  
From 01/01/2020  
To 12/31/2020

Worksheet B  
Part I  
Date/Time Prepared:  
8/2/2021 3:48 pm

Cost Center Description	SOCIAL SERVICE	NONPHYSICIAN ANESTHETISTS	INTERNS & RESIDENTS		Subtotal	
			SERVICES-SALARY & FRINGES APPRV	SERVICES-OTHER PRGM COSTS APPRV		
			17.00	19.00		
<b>GENERAL SERVICE COST CENTERS</b>						
1.00 00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00 00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00 00500	ADMINISTRATIVE & GENERAL					5.00
7.00 00700	OPERATION OF PLANT					7.00
8.00 00800	LAUNDRY & LINEN SERVICE					8.00
9.00 00900	HOUSEKEEPING					9.00
10.00 01000	DIETARY					10.00
11.00 01100	CAFETERIA					11.00
13.00 01300	NURSING ADMINISTRATION					13.00
14.00 01400	CENTRAL SERVICES & SUPPLY					14.00
15.00 01500	PHARMACY					15.00
16.00 01600	MEDICAL RECORDS & LIBRARY					16.00
17.00 01700	SOCIAL SERVICE	2,914,877				17.00
19.00 01900	NONPHYSICIAN ANESTHETISTS	0	0			19.00
21.00 02100	I&R SERVICES-SALARY & FRINGES APPRV	0		712,444		21.00
22.00 02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0			1,056,564	22.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>						
30.00 03000	ADULTS & PEDIATRICS	1,846,776	0	318,545	472,407	30.00
31.00 03100	INTENSIVE CARE UNIT	224,148	0	0	0	31.00
35.00 02060	NEONATAL INTENSIVE CARE UNIT	457,382	0	0	0	35.00
40.00 04000	SUBPROVIDER - I/PF	137,624	0	309,123	458,434	40.00
43.00 04300	NURSERY	248,947	0	0	0	43.00
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00 05000	OPERATING ROOM	0	0	21,380	31,706	50.00
51.00 05100	RECOVERY ROOM	0	0	0	0	51.00
52.00 05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	52.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	54.00
55.00 05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	55.00
57.00 05700	CT SCAN	0	0	0	0	57.00
58.00 05800	MRI	0	0	0	0	58.00
59.00 05900	CARDIAC CATHETERIZATION	0	0	0	0	59.00
60.00 06000	LABORATORY	0	0	0	0	60.00
64.00 06400	INTRAVENOUS THERAPY	0	0	0	0	64.00
65.00 06500	RESPIRATORY THERAPY	0	0	0	0	65.00
66.00 06600	PHYSICAL THERAPY	0	0	12,453	18,468	66.00
67.00 06700	OCCUPATIONAL THERAPY	0	0	0	0	67.00
68.00 06800	SPEECH PATHOLOGY	0	0	0	0	68.00
69.00 06900	ELECTROCARDIOLOGY	0	0	0	0	69.00
70.00 07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	70.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	71.00
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
73.01 07301	SPECIALTY PHARMACY	0	0	0	0	73.01
74.00 07400	RENAL DIALYSIS	0	0	0	0	74.00
76.00 03330	ENDOSCOPY	0	0	0	0	76.00
76.01 03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	76.01
76.02 03951	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	76.02
76.03 03952	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	76.03
76.04 03953	WOUND CARE	0	0	0	0	76.04
76.06 03954	IMAGING CENTER	0	0	0	0	76.06
76.07 03955	BREAST DIAGNOSTIC CENTER	0	0	0	0	76.07
<b>OUTPATIENT SERVICE COST CENTERS</b>						
90.00 09000	CLINIC	0	0	0	0	90.00
90.01 04950	INFUSION CENTER	0	0	0	0	90.01
90.26 04975	SPINE CENTER	0	0	0	0	90.26
91.00 09100	EMERGENCY	0	0	50,943	75,549	91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	92.00
<b>SPECIAL PURPOSE COST CENTERS</b>						
113.00 11300	INTEREST EXPENSE					113.00
114.00 11400	UTILIZATION REVIEW-SNF					114.00
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	2,914,877	0	712,444	1,056,564	118.00
<b>NONREIMBURSABLE COST CENTERS</b>						
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	190.00
191.00 19100	RESEARCH	0	0	0	0	191.00
192.00 19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	192.00
193.00 19300	NONPAID WORKERS	0	0	0	0	193.00
194.00 07950	HOME OFFICE	0	0	0	0	194.00
194.06 07956	PAVILLIONS	0	0	0	0	194.06
194.08 07958	OTHER NRCC	0	0	0	0	194.08

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 15-0169

Period:  
From 01/01/2020  
To 12/31/2020

Worksheet B  
Part I  
Date/Time Prepared:  
8/2/2021 3:48 pm

Cost Center Description			SOCIAL SERVICE	NONPHYSICIAN ANESTHETISTS	INTERNS & RESIDENTS		Subtotal	
					SERVICES-SALARY & FRINGES APPRV	SERVICES-OTHER PRGM COSTS APPRV		
					17.00	19.00		
194.10	07960	COMMUNITY REHAB HOSPITAL	0	0	0	0	0	194.10
200.00		Cross Foot Adjustments		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)	2,914,877	0	712,444	1,056,564	371,585,308	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 15-0169

Period:  
From 01/01/2020  
To 12/31/2020

Worksheet B  
Part I  
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Cost Center Description		Intern & Residents Cost & Post Stepdown Adjustments	Total	
		25.00	26.00	
<b>GENERAL SERVICE COST CENTERS</b>				
1.00	00100	CAP REL COSTS-BLDG & FIXT		1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT		4.00
5.00	00500	ADMINISTRATIVE & GENERAL		5.00
7.00	00700	OPERATION OF PLANT		7.00
8.00	00800	LAUNDRY & LINEN SERVICE		8.00
9.00	00900	HOUSEKEEPING		9.00
10.00	01000	DIETARY		10.00
11.00	01100	CAFETERIA		11.00
13.00	01300	NURSING ADMINISTRATION		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY		14.00
15.00	01500	PHARMACY		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY		16.00
17.00	01700	SOCIAL SERVICE		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
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>				
30.00	03000	ADULTS & PEDIATRICS	-790,952	30.00
31.00	03100	INTENSIVE CARE UNIT	0	31.00
35.00	02060	NEONATAL INTENSIVE CARE UNIT	0	35.00
40.00	04000	SUBPROVIDER - I PF	-767,557	40.00
43.00	04300	NURSERY	0	43.00
<b>ANCILLARY SERVICE COST CENTERS</b>				
50.00	05000	OPERATING ROOM	-53,086	50.00
51.00	05100	RECOVERY ROOM	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	55.00
57.00	05700	CT SCAN	0	57.00
58.00	05800	MRI	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	59.00
60.00	06000	LABORATORY	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	65.00
66.00	06600	PHYSICAL THERAPY	-30,921	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	69.00
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	0	73.00
73.01	07301	SPECIALTY PHARMACY	0	73.01
74.00	07400	RENAL DIALYSIS	0	74.00
76.00	03330	ENDOSCOPY	0	76.00
76.01	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	76.01
76.02	03951	OTHER ANCILLARY SERVICE COST CENTERS	0	76.02
76.03	03952	OTHER ANCILLARY SERVICE COST CENTERS	0	76.03
76.04	03953	WOUND CARE	0	76.04
76.06	03954	IMAGING CENTER	0	76.06
76.07	03955	BREAST DIAGNOSTIC CENTER	0	76.07
<b>OUTPATIENT SERVICE COST CENTERS</b>				
90.00	09000	CLINIC	0	90.00
90.01	04950	INFUSION CENTER	0	90.01
90.26	04975	SPINE CENTER	0	90.26
91.00	09100	EMERGENCY	-126,492	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	92.00
<b>SPECIAL PURPOSE COST CENTERS</b>				
113.00	11300	INTEREST EXPENSE		113.00
114.00	11400	UTILIZATION REVIEW-SNF		114.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-1,769,008	118.00
<b>NONREIMBURSABLE COST CENTERS</b>				
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
193.00	19300	NONPAID WORKERS	0	193.00
194.00	07950	HOME OFFICE	0	194.00
194.06	07956	PAVILLIONS	0	194.06
194.08	07958	OTHER NRCC	0	194.08

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 15-0169

Period:  
From 01/01/2020  
To 12/31/2020

Worksheet B  
Part I  
Date/Time Prepared:  
8/2/2021 3:48 pm

Cost Center Description			Intern & Residents Cost & Post Stepdown Adjustments	Total	
			25.00	26.00	
194.10	07960	COMMUNITY REHAB HOSPITAL	0	0	194.10
200.00		Cross Foot Adjustments	0	0	200.00
201.00		Negative Cost Centers	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	-1,769,008	369,816,300	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 15-0169

Period:  
From 01/01/2020  
To 12/31/2020

Worksheet B  
Part II  
Date/Time Prepared:  
8/2/2021 3:48 pm

Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
		BLDG & FIXT	MVBLE EQUIP			
		0	1.00			
<b>GENERAL SERVICE COST CENTERS</b>						
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	6,001	87,345	93,346	4.00
5.00 00500	ADMINISTRATIVE & GENERAL	83,466	396,429	8,937,536	9,417,431	5.00
7.00 00700	OPERATION OF PLANT	0	1,739,016	260,479	1,999,495	7.00
8.00 00800	LAUNDRY & LINEN SERVICE	0	50,608	79	50,687	8.00
9.00 00900	HOUSEKEEPING	0	126,040	23,725	149,765	9.00
10.00 01000	DIETARY	0	135,862	20,381	156,243	10.00
11.00 01100	CAFETERIA	0	308,549	61,698	370,247	11.00
13.00 01300	NURSING ADMINISTRATION	0	9,142	24,658	33,800	13.00
14.00 01400	CENTRAL SERVICES & SUPPLY	0	319,356	2,378,986	2,698,342	14.00
15.00 01500	PHARMACY	0	158,178	703,537	861,715	15.00
16.00 01600	MEDICAL RECORDS & LIBRARY	0	5,649	79	5,728	16.00
17.00 01700	SOCIAL SERVICE	0	37,411	36	37,447	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	0	22.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>						
30.00 03000	ADULTS & PEDIATRICS	0	4,377,591	876,207	5,253,798	30.00
31.00 03100	INTENSIVE CARE UNIT	0	858,116	176,983	1,035,099	31.00
35.00 02060	NEONATAL INTENSIVE CARE UNIT	0	817,259	169,191	986,450	35.00
40.00 04000	SUBPROVIDER - I PF	0	150,302	12,812	163,114	40.00
43.00 04300	NURSERY	0	334,873	46,812	381,685	43.00
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00 05000	OPERATING ROOM	0	640,165	2,447,214	3,087,379	50.00
51.00 05100	RECOVERY ROOM	0	343,640	7,212	350,852	51.00
52.00 05200	DELIVERY ROOM & LABOR ROOM	0	827,971	115,745	943,716	52.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	0	218,584	356,453	575,037	54.00
55.00 05500	RADIOLOGY-THERAPEUTIC	0	244,439	436,094	680,533	55.00
57.00 05700	CT SCAN	0	31,832	224,535	256,367	57.00
58.00 05800	MRI	0	117,930	279,501	397,431	58.00
59.00 05900	CARDIAC CATHETERIZATION	0	0	1,506	1,506	59.00
60.00 06000	LABORATORY	0	125,220	0	125,220	60.00
64.00 06400	INTRAVENOUS THERAPY	0	176,297	2,817	179,114	64.00
65.00 06500	RESPIRATORY THERAPY	0	135,440	218,228	353,668	65.00
66.00 06600	PHYSICAL THERAPY	0	21,800	1,059,193	1,080,993	66.00
67.00 06700	OCCUPATIONAL THERAPY	0	0	68,807	68,807	67.00
68.00 06800	SPEECH PATHOLOGY	0	0	14,886	14,886	68.00
69.00 06900	ELECTROCARDIOLOGY	0	0	0	0	69.00
70.00 07000	ELECTROENCEPHALOGRAPHY	45,888	74,448	240,825	361,161	70.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	71.00
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
73.01 07301	SPECIALTY PHARMACY	18,771	0	0	18,771	73.01
74.00 07400	RENAL DIALYSIS	0	2,438	0	2,438	74.00
76.00 03330	ENDOSCOPY	0	174,703	338,936	513,639	76.00
76.01 03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	76.01
76.02 03951	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	76.02
76.03 03952	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	76.03
76.04 03953	WOUND CARE	0	0	104,761	104,761	76.04
76.06 03954	IMAGING CENTER	0	0	880,815	880,815	76.06
76.07 03955	BREAST DIAGNOSTIC CENTER	0	0	414,347	414,347	76.07
<b>OUTPATIENT SERVICE COST CENTERS</b>						
90.00 09000	CLINIC	0	0	0	0	90.00
90.01 04950	INFUSION CENTER	0	0	81,763	81,763	90.01
90.26 04975	SPINE CENTER	0	0	91	91	90.26
91.00 09100	EMERGENCY	0	595,604	167,677	763,281	91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	92.00
<b>SPECIAL PURPOSE COST CENTERS</b>						
113.00 11300	INTEREST EXPENSE					113.00
114.00 11400	UTILIZATION REVIEW-SNF					114.00
118.00 11800	SUBTOTALS (SUM OF LINES 1 through 117)	148,125	13,560,893	21,241,950	34,950,968	118.00
<b>NONREIMBURSABLE COST CENTERS</b>						
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	82,370	0	82,370	190.00
191.00 19100	RESEARCH	0	0	0	0	191.00
192.00 19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	192.00
193.00 19300	NONPAID WORKERS	0	0	0	0	193.00
194.00 07950	HOME OFFICE	0	0	0	0	194.00
194.06 07956	PAVILLIONS	0	0	120,349	120,349	194.06



ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 15-0169		Period: From 01/01/2020 To 12/31/2020		Worksheet B Part II Date/Time Prepared: 8/2/2021 3:48 pm	
Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS DEPARTMENT		
		BLDG & FIXT	MVBLE EQUIP				
	0	1.00	2.00	2A	4.00		
194.08 07958 OTHER NRCC	0	24,613	114,403	139,016	1,098	194.08	
194.10 07960 COMMUNITY REHAB HOSPITAL	0	0	0	0	0	194.10	
200.00 Cross Foot Adjustments				0		200.00	
201.00 Negative Cost Centers				0		201.00	
202.00 TOTAL (sum lines 118 through 201)	148,125	13,667,876	21,476,702	35,292,703	93,346	202.00	

ALLOCATION OF CAPITAL RELATED COSTS			Provider CCN: 15-0169	Period: From 01/01/2020 To 12/31/2020	Worksheet B Part II Date/Time Prepared: 8/2/2021 3:48 pm		
Cost Center Description			ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY
			5.00	7.00	8.00	9.00	10.00
<b>GENERAL SERVICE COST CENTERS</b>							
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	9,427,054				5.00
7.00	00700	OPERATION OF PLANT	392,221	2,394,159			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	31,707	10,512	92,906		8.00
9.00	00900	HOUSEKEEPING	153,182	26,180	0	331,522	9.00
10.00	01000	DIETARY	53,744	28,220	0	3,968	242,802
11.00	01100	CAFETERIA	64,570	64,089	0	9,013	0
13.00	01300	NURSING ADMINISTRATION	200,134	1,899	0	267	0
14.00	01400	CENTRAL SERVICES & SUPPLY	223,439	66,333	0	9,328	0
15.00	01500	PHARMACY	211,440	32,855	0	4,620	0
16.00	01600	MEDICAL RECORDS & LIBRARY	90,613	1,173	0	165	0
17.00	01700	SOCIAL SERVICE	70,703	7,771	0	1,093	0
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	18,075	0	0	0	0
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	26,805	0	0	0	0
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000	ADULTS & PEDIATRICS	1,637,189	909,271	46,382	127,866	203,030
31.00	03100	INTENSIVE CARE UNIT	232,185	178,240	4,837	25,065	24,642
35.00	02060	NEONATAL INTENSIVE CARE UNIT	349,505	169,753	3,350	23,872	0
40.00	04000	SUBPROVIDER - I/PF	75,212	31,219	681	4,390	15,130
43.00	04300	NURSERY	85,542	69,557	2,384	9,781	0
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000	OPERATING ROOM	529,858	132,969	4,431	18,699	0
51.00	05100	RECOVERY ROOM	115,736	71,378	0	10,038	0
52.00	05200	DELIVERY ROOM & LABOR ROOM	214,054	171,978	5,895	24,185	0
54.00	05400	RADIOLOGY-DIAGNOSTIC	141,228	45,402	5,716	6,385	0
55.00	05500	RADIOLOGY-THERAPEUTIC	51,976	50,773	907	7,140	0
57.00	05700	CT SCAN	58,940	6,612	0	930	0
58.00	05800	MRI	63,207	24,495	0	3,445	0
59.00	05900	CARDIAC CATHETERIZATION	7,041	0	0	0	0
60.00	06000	LABORATORY	350,845	26,009	0	3,658	0
64.00	06400	INTRAVENOUS THERAPY	33,840	36,619	0	5,150	0
65.00	06500	RESPIRATORY THERAPY	144,612	28,132	0	3,956	0
66.00	06600	PHYSICAL THERAPY	199,266	4,528	0	637	0
67.00	06700	OCCUPATIONAL THERAPY	66,040	0	0	0	0
68.00	06800	SPEECH PATHOLOGY	14,288	0	0	0	0
69.00	06900	ELECTROCARDIOLOGY	16,524	0	0	0	0
70.00	07000	ELECTROENCEPHALOGRAPHY	52,252	15,464	0	2,175	0
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	440,855	0	0	0	0
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	358,006	0	0	0	0
73.00	07300	DRUGS CHARGED TO PATIENTS	457,279	0	0	0	0
73.01	07301	SPECIALTY PHARMACY	1,248,785	0	0	0	0
74.00	07400	RENAL DIALYSIS	35,606	506	0	71	0
76.00	03330	ENDOSCOPY	78,985	36,288	1,824	5,103	0
76.01	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0
76.02	03951	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0
76.03	03952	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0
76.04	03953	WOUND CARE	22,444	0	0	0	0
76.06	03954	IMAGING CENTER	115,457	0	0	0	0
76.07	03955	BREAST DIAGNOSTIC CENTER	277,626	0	0	0	0
<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.00	09000	CLINIC	0	0	0	0	0
90.01	04950	INFUSION CENTER	7,336	0	0	0	0
90.26	04975	SPINE CENTER	6,844	0	0	0	0
91.00	09100	EMERGENCY	331,609	123,713	16,499	17,397	0
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					
<b>SPECIAL PURPOSE COST CENTERS</b>							
113.00	11300	INTEREST EXPENSE					113.00
114.00	11400	UTILIZATION REVIEW-SNF					114.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	9,356,805	2,371,938	92,906	328,397	242,802
<b>NONREIMBURSABLE COST CENTERS</b>							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	2,524	17,109	0	2,406	0
191.00	19100	RESEARCH	0	0	0	0	0
192.00	19200	PHYSICIANS' PRIVATE OFFICES	3,156	0	0	0	0
193.00	19300	NONPAID WORKERS	0	0	0	0	0
194.00	07950	HOME OFFICE	0	0	0	0	0
194.06	07956	PAVILLIONS	4,894	0	0	0	0
194.08	07958	OTHER NRCC	59,675	5,112	0	719	0
194.10	07960	COMMUNITY REHAB HOSPITAL	0	0	0	0	0
200.00		Cross Foot Adjustments					200.00
201.00		Negative Cost Centers	0	0	0	0	0

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 15-0169			Period: From 01/01/2020 To 12/31/2020		Worksheet B Part II Date/Time Prepared: 8/2/2021 3:48 pm	
Cost Center Description		ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY		
202.00	TOTAL (sum lines 118 through 201)	9,427,054	2,394,159	92,906	331,522	242,802	202.00	

ALLOCATION OF CAPITAL RELATED COSTS			Provider CCN: 15-0169		Period: From 01/01/2020 To 12/31/2020		Worksheet B Part II Date/Time Prepared: 8/2/2021 3:48 pm	
Cost Center Description			CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
			11.00	13.00	14.00	15.00	16.00	
<b>GENERAL SERVICE COST CENTERS</b>								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA	509,362					11.00
13.00	01300	NURSING ADMINISTRATION	12,445	250,270				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	7,556	0	3,005,669			14.00
15.00	01500	PHARMACY	25,779	0	88,684	1,229,320		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	2,222	0	0	0	100,232	16.00
17.00	01700	SOCIAL SERVICE	9,334	0	17	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
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>								
30.00	03000	ADULTS & PEDIATRICS	172,455	122,297	173,193	0	12,523	30.00
31.00	03100	INTENSIVE CARE UNIT	29,779	21,119	33,665	0	1,935	31.00
35.00	02060	NEONATAL INTENSIVE CARE UNIT	40,891	28,999	47,652	0	7,379	35.00
40.00	04000	SUBPROVIDER - I PF	11,112	7,880	4,815	0	621	40.00
43.00	04300	NURSERY	9,778	6,934	9,376	0	654	43.00
<b>ANCILLARY SERVICE COST CENTERS</b>								
50.00	05000	OPERATING ROOM	26,224	18,597	410,526	0	13,310	50.00
51.00	05100	RECOVERY ROOM	13,334	0	20,904	0	2,189	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	24,001	17,021	23,183	0	1,617	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	16,001	0	8,601	0	2,457	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	3,111	0	11,439	0	2,472	55.00
57.00	05700	CT SCAN	6,223	0	10,681	0	4,760	57.00
58.00	05800	MRI	2,667	0	576	0	2,068	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	200	0	286	59.00
60.00	06000	LABORATORY	0	0	97,561	0	7,983	60.00
64.00	06400	INTRAVENOUS THERAPY	3,556	0	3,822	0	207	64.00
65.00	06500	RESPIRATORY THERAPY	16,890	0	31,418	0	2,025	65.00
66.00	06600	PHYSICAL THERAPY	5,778	0	6,583	0	1,253	66.00
67.00	06700	OCCUPATIONAL THERAPY	7,112	0	1,615	0	448	67.00
68.00	06800	SPEECH PATHOLOGY	1,333	0	349	0	135	68.00
69.00	06900	ELECTROCARDIOLOGY	444	0	31	0	647	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	4,889	0	8,573	0	614	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	934,153	0	3,673	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	758,603	0	2,658	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	1,229,320	7,199	73.00
73.01	07301	SPECIALTY PHARMACY	8,000	0	222,017	0	3,856	73.01
74.00	07400	RENAL DIALYSIS	0	0	58	0	304	74.00
76.00	03330	ENDOSCOPY	7,112	0	19,759	0	1,630	76.00
76.01	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0	76.01
76.02	03951	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0	76.02
76.03	03952	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0	76.03
76.04	03953	WOUND CARE	1,778	0	4,766	0	159	76.04
76.06	03954	IMAGING CENTER	0	0	10,347	0	3,231	76.06
76.07	03955	BREAST DIAGNOSTIC CENTER	0	0	373	0	1,646	76.07
<b>OUTPATIENT SERVICE COST CENTERS</b>								
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	04950	INFUSION CENTER	889	0	538	0	29	90.01
90.26	04975	SPINE CENTER	0	0	238	0	26	90.26
91.00	09100	EMERGENCY	38,669	27,423	58,983	0	10,238	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
<b>SPECIAL PURPOSE COST CENTERS</b>								
113.00	11300	INTEREST EXPENSE						113.00
114.00	11400	UTILIZATION REVIEW-SNF						114.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	509,362	250,270	3,003,299	1,229,320	100,232	118.00
<b>NONREIMBURSABLE COST CENTERS</b>								
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	1,769	0	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950	HOME OFFICE	0	0	0	0	0	194.00
194.06	07956	PAVILLIONS	0	0	184	0	0	194.06
194.08	07958	OTHER NRCC	0	0	417	0	0	194.08
194.10	07960	COMMUNITY REHAB HOSPITAL	0	0	0	0	0	194.10
200.00		Cross Foot Adjustments						200.00

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 15-0169			Period: From 01/01/2020 To 12/31/2020		Worksheet B Part II Date/Time Prepared: 8/2/2021 3:48 pm	
Cost Center Description		CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY		
		11.00	13.00	14.00	15.00	16.00		
201.00	Negative Cost Centers	0	0	0	0	0	0	201.00
202.00	TOTAL (sum lines 118 through 201)	509,362	250,270	3,005,669	1,229,320	100,232		202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 15-0169

Period:  
From 01/01/2020  
To 12/31/2020

Worksheet B  
Part II  
Date/Time Prepared:  
8/2/2021 3:48 pm

Cost Center Description	SOCIAL SERVICE	NONPHYSICIAN ANESTHETISTS	INTERNS & RESIDENTS		Subtotal	
			SERVICES-SALARY & FRINGES APPRV	SERVICES-OTHER PRGM COSTS APPRV		
			17.00	19.00		
<b>GENERAL SERVICE COST CENTERS</b>						
1.00 00100						1.00
2.00 00200						2.00
4.00 00400						4.00
5.00 00500						5.00
7.00 00700						7.00
8.00 00800						8.00
9.00 00900						9.00
10.00 01000						10.00
11.00 01100						11.00
13.00 01300						13.00
14.00 01400						14.00
15.00 01500						15.00
16.00 01600						16.00
17.00 01700	127,802					17.00
19.00 01900		0				19.00
21.00 02100			18,075			21.00
22.00 02200				26,805		22.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>						
30.00 03000	80,971				8,762,336	30.00
31.00 03100	9,828				1,600,336	31.00
35.00 02060	20,054				1,684,119	35.00
40.00 04000	6,034				321,701	40.00
43.00 04300	10,915				587,945	43.00
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00 05000	0				4,245,615	50.00
51.00 05100	0				586,369	51.00
52.00 05200	0				1,429,026	52.00
54.00 05400	0				803,282	54.00
55.00 05500	0				808,874	55.00
57.00 05700	0				345,421	57.00
58.00 05800	0				494,343	58.00
59.00 05900	0				9,033	59.00
60.00 06000	0				611,276	60.00
64.00 06400	0				262,856	64.00
65.00 06500	0				583,146	65.00
66.00 06600	0				1,302,505	66.00
67.00 06700	0				145,180	67.00
68.00 06800	0				31,242	68.00
69.00 06900	0				17,673	69.00
70.00 07000	0				445,796	70.00
71.00 07100	0				1,378,681	71.00
72.00 07200	0				1,119,267	72.00
73.00 07300	0				1,693,798	73.00
73.01 07301	0				1,502,767	73.01
74.00 07400	0				38,983	74.00
76.00 03330	0				665,306	76.00
76.01 03950	0				0	76.01
76.02 03951	0				0	76.02
76.03 03952	0				0	76.03
76.04 03953	0				134,135	76.04
76.06 03954	0				1,011,148	76.06
76.07 03955	0				693,992	76.07
<b>OUTPATIENT SERVICE COST CENTERS</b>						
90.00 09000	0				0	90.00
90.01 04950	0				90,644	90.01
90.26 04975	0				7,336	90.26
91.00 09100	0				1,392,894	91.00
92.00 09200	0				0	92.00
<b>SPECIAL PURPOSE COST CENTERS</b>						
113.00 11300						113.00
114.00 11400						114.00
118.00	127,802	0	0	0	34,807,025	118.00
<b>NONREIMBURSABLE COST CENTERS</b>						
190.00 19000	0				104,409	190.00
191.00 19100	0				0	191.00
192.00 19200	0				4,925	192.00
193.00 19300	0				0	193.00
194.00 07950	0				0	194.00
194.06 07956	0				125,427	194.06
194.08 07958	0				206,037	194.08

ALLOCATION OF CAPITAL RELATED COSTS			Provider CCN: 15-0169		Period: From 01/01/2020 To 12/31/2020		Worksheet B Part II Date/Time Prepared: 8/2/2021 3:48 pm	
Cost Center Description			SOCIAL SERVICE	NONPHYSICIAN ANESTHETISTS	INTERNS & RESIDENTS		Subtotal	
					SERVICES-SALAR Y & FRINGES APPRV	SERVICES-OTHER PRGM COSTS APPRV		
194.10	07960	COMMUNITY REHAB HOSPITAL	17.00	19.00	21.00	22.00	24.00	
			0				0	194.10
200.00		Cross Foot Adjustments		0	18,075	26,805	44,880	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	127,802	0	18,075	26,805	35,292,703	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 15-0169

Period:  
From 01/01/2020  
To 12/31/2020

Worksheet B  
Part II  
Date/Time Prepared:  
8/2/2021 3:48 pm

Cost Center Description		Intern & Residents Cost & Post Stepdown Adjustments	Total	
		25.00	26.00	
<b>GENERAL SERVICE COST CENTERS</b>				
1.00	00100	CAP REL COSTS-BLDG & FIXT		1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT		4.00
5.00	00500	ADMINISTRATIVE & GENERAL		5.00
7.00	00700	OPERATION OF PLANT		7.00
8.00	00800	LAUNDRY & LINEN SERVICE		8.00
9.00	00900	HOUSEKEEPING		9.00
10.00	01000	DIETARY		10.00
11.00	01100	CAFETERIA		11.00
13.00	01300	NURSING ADMINISTRATION		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY		14.00
15.00	01500	PHARMACY		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY		16.00
17.00	01700	SOCIAL SERVICE		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
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>				
30.00	03000	ADULTS & PEDIATRICS	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	31.00
35.00	02060	NEONATAL INTENSIVE CARE UNIT	0	35.00
40.00	04000	SUBPROVIDER - I PF	0	40.00
43.00	04300	NURSERY	0	43.00
<b>ANCILLARY SERVICE COST CENTERS</b>				
50.00	05000	OPERATING ROOM	0	50.00
51.00	05100	RECOVERY ROOM	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	55.00
57.00	05700	CT SCAN	0	57.00
58.00	05800	MRI	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	59.00
60.00	06000	LABORATORY	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	65.00
66.00	06600	PHYSICAL THERAPY	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	69.00
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	0	73.00
73.01	07301	SPECIALTY PHARMACY	0	73.01
74.00	07400	RENAL DIALYSIS	0	74.00
76.00	03330	ENDOSCOPY	0	76.00
76.01	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	76.01
76.02	03951	OTHER ANCILLARY SERVICE COST CENTERS	0	76.02
76.03	03952	OTHER ANCILLARY SERVICE COST CENTERS	0	76.03
76.04	03953	WOUND CARE	0	76.04
76.06	03954	IMAGING CENTER	0	76.06
76.07	03955	BREAST DIAGNOSTIC CENTER	0	76.07
<b>OUTPATIENT SERVICE COST CENTERS</b>				
90.00	09000	CLINIC	0	90.00
90.01	04950	INFUSION CENTER	0	90.01
90.26	04975	SPINE CENTER	0	90.26
91.00	09100	EMERGENCY	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	92.00
<b>SPECIAL PURPOSE COST CENTERS</b>				
113.00	11300	INTEREST EXPENSE		113.00
114.00	11400	UTILIZATION REVIEW-SNF		114.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	118.00
<b>NONREIMBURSABLE COST CENTERS</b>				
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
193.00	19300	NONPAID WORKERS	0	193.00
194.00	07950	HOME OFFICE	0	194.00
194.06	07956	PAVILLIONS	0	194.06
194.08	07958	OTHER NRCC	0	194.08



ALLOCATION OF CAPITAL RELATED COSTS			Provider CCN: 15-0169		Period: From 01/01/2020 To 12/31/2020		Worksheet B Part II Date/Time Prepared: 8/2/2021 3:48 pm	
Cost Center Description			Intern & Residents Cost & Post Stepdown Adjustments	Total				
			25.00		26.00			
194.10	07960	COMMUNITY REHAB HOSPITAL	0		0			194.10
200.00		Cross Foot Adjustments	0		44,880			200.00
201.00		Negative Cost Centers	0		0			201.00
202.00		TOTAL (sum lines 118 through 201)	0		35,292,703			202.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 15-0169

Period:  
From 01/01/2020  
To 12/31/2020

Worksheet B-1

Date/Time Prepared:  
8/2/2021 3:48 pm

Cost Center Description	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
	BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (DOLLAR VALUE)				
	1.00	2.00				
<b>GENERAL SERVICE COST CENTERS</b>						
1.00 00100	CAP REL COSTS-BLDG & FIXT	583,084				1.00
2.00 00200	CAP REL COSTS-MVBLE EQUIP		21,771,818			2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	256	88,545	113,169,318		4.00
5.00 00500	ADMINISTRATIVE & GENERAL	16,912	9,060,349	11,664,380	-63,990,870	5.00
7.00 00700	OPERATION OF PLANT	74,188	264,058	2,960,820	0	7.00
8.00 00800	LAUNDRY & LINEN SERVICE	2,159	80	0	0	8.00
9.00 00900	HOUSEKEEPING	5,377	24,051	2,903,182	0	9.00
10.00 01000	DIETARY	5,796	20,661	759,632	0	10.00
11.00 01100	CAFETERIA	13,163	62,546	1,748,848	0	11.00
13.00 01300	NURSING ADMINISTRATION	390	24,997	2,090,373	0	13.00
14.00 01400	CENTRAL SERVICES & SUPPLY	13,624	2,411,676	813,286	0	14.00
15.00 01500	PHARMACY	6,748	713,204	5,123,074	0	15.00
16.00 01600	MEDICAL RECORDS & LIBRARY	241	80	400,948	0	16.00
17.00 01700	SOCIAL SERVICE	1,596	36	1,742,199	0	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	0	22.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>						
30.00 03000	ADULTS & PEDIATRICS	186,752	888,247	28,340,119	0	30.00
31.00 03100	INTENSIVE CARE UNIT	36,608	179,415	4,778,725	0	31.00
35.00 02060	NEONATAL INTENSIVE CARE UNIT	34,865	171,516	7,532,303	0	35.00
40.00 04000	SUBPROVIDER - IPF	6,412	12,988	1,810,082	0	40.00
43.00 04300	NURSERY	14,286	47,455	1,623,272	0	43.00
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00 05000	OPERATING ROOM	27,310	2,480,842	4,390,355	0	50.00
51.00 05100	RECOVERY ROOM	14,660	7,311	2,349,381	0	51.00
52.00 05200	DELIVERY ROOM & LABOR ROOM	35,322	117,335	4,092,070	0	52.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	9,325	361,351	2,976,218	0	54.00
55.00 05500	RADIOLOGY-THERAPEUTIC	10,428	442,086	634,492	0	55.00
57.00 05700	CT SCAN	1,358	227,620	1,100,072	0	57.00
58.00 05800	MRI	5,031	283,342	550,200	0	58.00
59.00 05900	CARDIAC CATHETERIZATION	0	1,527	0	0	59.00
60.00 06000	LABORATORY	5,342	0	0	0	60.00
64.00 06400	INTRAVENOUS THERAPY	7,521	2,856	663,879	0	64.00
65.00 06500	RESPIRATORY THERAPY	5,778	221,227	2,963,333	0	65.00
66.00 06600	PHYSICAL THERAPY	930	1,073,748	4,202,570	0	66.00
67.00 06700	OCCUPATIONAL THERAPY	0	69,752	1,403,930	0	67.00
68.00 06800	SPEECH PATHOLOGY	0	15,091	303,739	0	68.00
69.00 06900	ELECTROCARDIOLOGY	0	0	32,585	0	69.00
70.00 07000	ELECTROENCEPHALOGRAPHY	3,176	244,134	809,312	0	70.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	71.00
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
73.01 07301	SPECIALTY PHARMACY	0	0	1,621,909	0	73.01
74.00 07400	RENAL DIALYSIS	104	0	0	0	74.00
76.00 03330	ENDOSCOPY	7,453	343,593	1,170,941	0	76.00
76.01 03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	76.01
76.02 03951	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	76.02
76.03 03952	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	76.03
76.04 03953	WOUND CARE	0	106,201	275,133	0	76.04
76.06 03954	IMAGING CENTER	0	892,919	1,573,820	0	76.06
76.07 03955	BREAST DIAGNOSTIC CENTER	0	420,041	0	0	76.07
<b>OUTPATIENT SERVICE COST CENTERS</b>						
90.00 09000	CLINIC	0	0	0	0	90.00
90.01 04950	INFUSION CENTER	0	82,887	107,616	0	90.01
90.26 04975	SPINE CENTER	0	92	165,633	0	90.26
91.00 09100	EMERGENCY	25,409	169,981	6,159,597	0	91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART					92.00
<b>SPECIAL PURPOSE COST CENTERS</b>						
113.00 11300	INTEREST EXPENSE					113.00
114.00 11400	UTILIZATION REVIEW-SNF					114.00
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	578,520	21,533,840	111,838,028	-63,990,870	305,302,299
<b>NONREIMBURSABLE COST CENTERS</b>						
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	3,514	0	0	0	190.00
191.00 19100	RESEARCH	0	0	0	0	191.00
192.00 19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	192.00
193.00 19300	NONPAID WORKERS	0	0	0	0	193.00
194.00 07950	HOME OFFICE	0	0	0	0	194.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 15-0169

Period:  
From 01/01/2020  
To 12/31/2020

Worksheet B-1

Date/Time Prepared:  
8/2/2021 3:48 pm

Cost Center Description	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
	BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (DOLLAR VALUE)				
	1.00	2.00				
194.06 07956 PAVILLIONS	0	122,003	0	0	159,685	194.06
194.08 07958 OTHER NRCC	1,050	115,975	1,331,290	0	1,947,095	194.08
194.10 07960 COMMUNITY REHAB HOSPITAL	0	0	0	0	0	194.10
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)	13,667,876	21,476,702	3,582,221		63,990,870	202.00
203.00 Unit cost multiplier (Wkst. B, Part I)	23.440664	0.986445	0.031654		0.208036	203.00
204.00 Cost to be allocated (per Wkst. B, Part II)			93,346		9,427,054	204.00
205.00 Unit cost multiplier (Wkst. B, Part II)			0.000825		0.030648	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: 15-0169

Period:  
From 01/01/2020  
To 12/31/2020

Worksheet B-1

Date/Time Prepared:  
8/2/2021 3:48 pm

Cost Center Description		OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	CAFETERIA (MEALS SERVED)	
		7.00	8.00	9.00	10.00	11.00	
<b>GENERAL SERVICE COST CENTERS</b>							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500	ADMINISTRATIVE & GENERAL					5.00
7.00	00700	OPERATION OF PLANT	491,728				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	2,159	254,745			8.00
9.00	00900	HOUSEKEEPING	5,377	0	484,192		9.00
10.00	01000	DIETARY	5,796	0	5,796	64,656	10.00
11.00	01100	CAFETERIA	13,163	0	13,163	0	11.00
13.00	01300	NURSING ADMINISTRATION	390	0	390	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	13,624	0	13,624	0	14.00
15.00	01500	PHARMACY	6,748	0	6,748	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	241	0	241	0	16.00
17.00	01700	SOCIAL SERVICE	1,596	0	1,596	0	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	0	22.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000	ADULTS & PEDIATRICS	186,752	127,178	186,752	54,065	30.00
31.00	03100	INTENSIVE CARE UNIT	36,608	13,263	36,608	6,562	31.00
35.00	02060	NEONATAL INTENSIVE CARE UNIT	34,865	9,186	34,865	0	35.00
40.00	04000	SUBPROVIDER - IPF	6,412	1,866	6,412	4,029	40.00
43.00	04300	NURSERY	14,286	6,538	14,286	0	43.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000	OPERATING ROOM	27,310	12,151	27,310	0	50.00
51.00	05100	RECOVERY ROOM	14,660	0	14,660	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	35,322	16,164	35,322	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	9,325	15,674	9,325	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	10,428	2,486	10,428	0	55.00
57.00	05700	CT SCAN	1,358	0	1,358	0	57.00
58.00	05800	MRI	5,031	0	5,031	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	59.00
60.00	06000	LABORATORY	5,342	0	5,342	0	60.00
64.00	06400	INTRAVENOUS THERAPY	7,521	0	7,521	0	64.00
65.00	06500	RESPIRATORY THERAPY	5,778	0	5,778	0	65.00
66.00	06600	PHYSICAL THERAPY	930	0	930	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	3,176	0	3,176	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
73.01	07301	SPECIALTY PHARMACY	0	0	0	0	73.01
74.00	07400	RENAL DIALYSIS	104	0	104	0	74.00
76.00	03330	ENDOSCOPY	7,453	5,000	7,453	0	76.00
76.01	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	76.01
76.02	03951	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	76.02
76.03	03952	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	76.03
76.04	03953	WOUND CARE	0	0	0	0	76.04
76.06	03954	IMAGING CENTER	0	0	0	0	76.06
76.07	03955	BREAST DIAGNOSTIC CENTER	0	0	0	0	76.07
<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.00	09000	CLINIC	0	0	0	0	90.00
90.01	04950	INFUSION CENTER	0	0	0	0	90.01
90.26	04975	SPINE CENTER	0	0	0	0	90.26
91.00	09100	EMERGENCY	25,409	45,239	25,409	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					92.00
<b>SPECIAL PURPOSE COST CENTERS</b>							
113.00	11300	INTEREST EXPENSE					113.00
114.00	11400	UTILIZATION REVIEW-SNF					114.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	487,164	254,745	479,628	64,656	1,146
<b>NONREIMBURSABLE COST CENTERS</b>							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	3,514	0	3,514	0	190.00
191.00	19100	RESEARCH	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	193.00
194.00	07950	HOME OFFICE	0	0	0	0	194.00
194.06	07956	PAVILLIONS	0	0	0	0	194.06
194.08	07958	OTHER NRCC	1,050	0	1,050	0	194.08
194.10	07960	COMMUNITY REHAB HOSPITAL	0	0	0	0	194.10

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 15-0169

Period:  
From 01/01/2020  
To 12/31/2020

Worksheet B-1

Date/Time Prepared:  
8/2/2021 3:48 pm

Cost Center Description		OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	CAFETERIA (MEALS SERVED)	
		7.00	8.00	9.00	10.00	11.00	
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)	15,459,962	1,317,670	6,206,944	2,374,941	3,127,724	202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	31.440068	5.172506	12.819179	36.731951	2,729.253054	203.00
204.00	Cost to be allocated (per Wkst. B, Part II)	2,394,159	92,906	331,522	242,802	509,362	204.00
205.00	Unit cost multiplier (Wkst. B, Part II)	4.868869	0.364702	0.684691	3.755290	444.469459	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: 15-0169

Period:  
From 01/01/2020  
To 12/31/2020

Worksheet B-1

Date/Time Prepared:  
8/2/2021 3:48 pm

Cost Center Description			NURSING ADMINISTRATION  (DIRECT NRSNG HRS)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS CHAR GES)	SOCIAL SERVICE  (TIME SPENT)	
			13.00	14.00	15.00	16.00	17.00	
<b>GENERAL SERVICE COST CENTERS</b>								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION	794					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	46,282,407				14.00
15.00	01500	PHARMACY	0	1,365,587	14,653,392			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	1,508,469,729		16.00
17.00	01700	SOCIAL SERVICE	0	269	0	0	85,334	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
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>								
30.00	03000	ADULTS & PEDIATRICS	388	2,666,883	0	189,740,179	54,065	30.00
31.00	03100	INTENSIVE CARE UNIT	67	518,391	0	29,320,631	6,562	31.00
35.00	02060	NEONATAL INTENSIVE CARE UNIT	92	733,760	0	111,808,358	13,390	35.00
40.00	04000	SUBPROVIDER - I/PF	25	74,141	0	9,403,664	4,029	40.00
43.00	04300	NURSERY	22	144,378	0	9,906,848	7,288	43.00
<b>ANCILLARY SERVICE COST CENTERS</b>								
50.00	05000	OPERATING ROOM	59	6,321,431	0	191,491,447	0	50.00
51.00	05100	RECOVERY ROOM	0	321,880	0	33,164,576	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	54	356,985	0	24,495,294	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	132,443	0	37,229,733	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	176,136	0	37,451,555	0	55.00
57.00	05700	CT SCAN	0	164,470	0	72,127,637	0	57.00
58.00	05800	MRI	0	8,866	0	31,333,210	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	3,087	0	4,332,485	0	59.00
60.00	06000	LABORATORY	0	1,502,279	0	120,951,460	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0	58,848	0	3,132,146	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	483,783	0	30,688,543	0	65.00
66.00	06600	PHYSICAL THERAPY	0	101,374	0	18,990,859	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	24,874	0	6,788,773	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	5,381	0	2,048,154	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	474	0	9,796,094	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	132,009	0	9,296,517	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	14,384,460	0	55,648,722	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	11,681,234	0	40,272,549	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	14,653,392	109,081,472	0	73.00
73.01	07301	SPECIALTY PHARMACY	0	3,418,698	0	58,430,692	0	73.01
74.00	07400	RENAL DIALYSIS	0	887	0	4,598,982	0	74.00
76.00	03330	ENDOSCOPY	0	304,255	0	24,693,541	0	76.00
76.01	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0	76.01
76.02	03951	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0	76.02
76.03	03952	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0	76.03
76.04	03953	WOUND CARE	0	73,385	0	2,402,705	0	76.04
76.06	03954	IMAGING CENTER	0	159,323	0	48,949,872	0	76.06
76.07	03955	BREAST DIAGNOSTIC CENTER	0	5,745	0	24,933,705	0	76.07
<b>OUTPATIENT SERVICE COST CENTERS</b>								
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	04950	INFUSION CENTER	0	8,284	0	446,475	0	90.01
90.26	04975	SPINE CENTER	0	3,672	0	393,777	0	90.26
91.00	09100	EMERGENCY	87	908,247	0	155,119,074	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
<b>SPECIAL PURPOSE COST CENTERS</b>								
113.00	11300	INTEREST EXPENSE						113.00
114.00	11400	UTILIZATION REVIEW-SNF						114.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	794	46,245,919	14,653,392	1,508,469,729	85,334	118.00
<b>NONREIMBURSABLE COST CENTERS</b>								
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	27,233	0	0	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950	HOME OFFICE	0	0	0	0	0	194.00
194.06	07956	PAVILLIONS	0	2,831	0	0	0	194.06
194.08	07958	OTHER NRCC	0	6,424	0	0	0	194.08

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 15-0169

Period:  
From 01/01/2020  
To 12/31/2020

Worksheet B-1

Date/Time Prepared:  
8/2/2021 3:48 pm

Cost Center Description			NURSING ADMINISTRATION  (DIRECT NRSING HRS)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS CHAR GES)	SOCIAL SERVICE  (TIME SPENT)	
			13.00	14.00	15.00	16.00	17.00	
194.10	07960	COMMUNITY REHAB HOSPITAL	0	0	0	0	0	194.10
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)	7,982,255	9,456,558	9,070,182	3,595,967	2,914,877	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	10,053.217884	0.204323	0.618982	0.002384	34.158448	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	250,270	3,005,669	1,229,320	100,232	127,802	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	315.201511	0.064942	0.083893	0.000066	1.497668	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: 15-0169

Period:  
From 01/01/2020  
To 12/31/2020

Worksheet B-1  
Date/Time Prepared:  
8/2/2021 3:48 pm

Cost Center Description	NONPHYSICIAN ANESTHETISTS (ASSIGNED TIME)	INTERNS & RESIDENTS			
		SERVICES-SALARY & FRINGES APPRV (ASSIGNED TIME)	SERVICES-OTHER PRGM COSTS APPRV (ASSIGNED TIME)		
		19.00	21.00		
<b>GENERAL SERVICE COST CENTERS</b>					
1.00 00100	CAP REL COSTS-BLDG & FIXT				1.00
2.00 00200	CAP REL COSTS-MVBLE EQUIP				2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT				4.00
5.00 00500	ADMINISTRATIVE & GENERAL				5.00
7.00 00700	OPERATION OF PLANT				7.00
8.00 00800	LAUNDRY & LINEN SERVICE				8.00
9.00 00900	HOUSEKEEPING				9.00
10.00 01000	DIETARY				10.00
11.00 01100	CAFETERIA				11.00
13.00 01300	NURSING ADMINISTRATION				13.00
14.00 01400	CENTRAL SERVICES & SUPPLY				14.00
15.00 01500	PHARMACY				15.00
16.00 01600	MEDICAL RECORDS & LIBRARY				16.00
17.00 01700	SOCIAL SERVICE				17.00
19.00 01900	NONPHYSICIAN ANESTHETISTS	0			19.00
21.00 02100	I&R SERVICES-SALARY & FRINGES APPRV		71,912		21.00
22.00 02200	I&R SERVICES-OTHER PRGM COSTS APPRV			71,912	22.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>					
30.00 03000	ADULTS & PEDIATRICS	0	32,153	32,153	30.00
31.00 03100	INTENSIVE CARE UNIT	0	0	0	31.00
35.00 02060	NEONATAL INTENSIVE CARE UNIT	0	0	0	35.00
40.00 04000	SUBPROVIDER - IPF	0	31,202	31,202	40.00
43.00 04300	NURSERY	0	0	0	43.00
<b>ANCILLARY SERVICE COST CENTERS</b>					
50.00 05000	OPERATING ROOM	0	2,158	2,158	50.00
51.00 05100	RECOVERY ROOM	0	0	0	51.00
52.00 05200	DELIVERY ROOM & LABOR ROOM	0	0	0	52.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	0	0	0	54.00
55.00 05500	RADIOLOGY-THERAPEUTIC	0	0	0	55.00
57.00 05700	CT SCAN	0	0	0	57.00
58.00 05800	MRI	0	0	0	58.00
59.00 05900	CARDIAC CATHETERIZATION	0	0	0	59.00
60.00 06000	LABORATORY	0	0	0	60.00
64.00 06400	INTRAVENOUS THERAPY	0	0	0	64.00
65.00 06500	RESPIRATORY THERAPY	0	0	0	65.00
66.00 06600	PHYSICAL THERAPY	0	1,257	1,257	66.00
67.00 06700	OCCUPATIONAL THERAPY	0	0	0	67.00
68.00 06800	SPEECH PATHOLOGY	0	0	0	68.00
69.00 06900	ELECTROCARDIOLOGY	0	0	0	69.00
70.00 07000	ELECTROENCEPHALOGRAPHY	0	0	0	70.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	71.00
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	0	0	0	73.00
73.01 07301	SPECIALTY PHARMACY	0	0	0	73.01
74.00 07400	RENAL DIALYSIS	0	0	0	74.00
76.00 03330	ENDOSCOPY	0	0	0	76.00
76.01 03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	76.01
76.02 03951	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	76.02
76.03 03952	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	76.03
76.04 03953	WOUND CARE	0	0	0	76.04
76.06 03954	IMAGING CENTER	0	0	0	76.06
76.07 03955	BREAST DIAGNOSTIC CENTER	0	0	0	76.07
<b>OUTPATIENT SERVICE COST CENTERS</b>					
90.00 09000	CLINIC	0	0	0	90.00
90.01 04950	INFUSION CENTER	0	0	0	90.01
90.26 04975	SPINE CENTER	0	0	0	90.26
91.00 09100	EMERGENCY	0	5,142	5,142	91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART				92.00
<b>SPECIAL PURPOSE COST CENTERS</b>					
113.00 11300	INTEREST EXPENSE				113.00
114.00 11400	UTILIZATION REVIEW-SNF				114.00
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	0	71,912	71,912	118.00
<b>NONREIMBURSABLE COST CENTERS</b>					
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
193.00 19300	NONPAID WORKERS	0	0	0	193.00
194.00 07950	HOME OFFICE	0	0	0	194.00



COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 15-0169

Period:  
From 01/01/2020  
To 12/31/2020

Worksheet B-1

Date/Time Prepared:  
8/2/2021 3:48 pm

Cost Center Description	INTERNS & RESIDENTS			
	NONPHYSICIAN ANESTHETISTS (ASSIGNED TIME)	SERVICES-SALAR	SERVICES-OTHER	
		Y & FRINGES APPRV (ASSIGNED TIME)	PRGM COSTS APPRV (ASSIGNED TIME)	
	19.00	21.00	22.00	
194.06 07956 PAVILLIONS	0	0	0	194.06
194.08 07958 OTHER NRCC	0	0	0	194.08
194.10 07960 COMMUNITY REHAB HOSPITAL	0	0	0	194.10
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	712,444	1,056,564	202.00
203.00 Unit cost multiplier (Wkst. B, Part I)	0.000000	9.907164	14.692457	203.00
204.00 Cost to be allocated (per Wkst. B, Part II)	0	18,075	26,805	204.00
205.00 Unit cost multiplier (Wkst. B, Part II)	0.000000	0.251349	0.372747	205.00
206.00 NAHE adjustment amount to be allocated (per Wkst. B-2)				206.00
207.00 NAHE unit cost multiplier (Wkst. D, Parts III and IV)				207.00

COMPUTATION OF RATIO OF COSTS TO CHARGES			Provider CCN: 15-0169	Period: From 01/01/2020 To 12/31/2020	Worksheet C Part I Date/Time Prepared: 8/2/2021 3:48 pm	
			Title XVIII	Hospital	PPS	
Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs			
			Total Costs	RCE Disallowance	Total Costs	
	1.00	2.00	3.00	4.00	5.00	
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>						
30.00	03000 ADULTS & PEDIATRICS		83,249,127	0	83,249,127	30.00
31.00	03100 INTENSIVE CARE UNIT		12,338,200	0	12,338,200	31.00
35.00	02060 NEONATAL INTENSIVE CARE UNIT		17,416,725	0	17,416,725	35.00
40.00	04000 SUBPROVIDER - IPF		3,900,797	0	3,900,797	40.00
43.00	04300 NURSERY		4,621,135	0	4,621,135	43.00
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00	05000 OPERATING ROOM		24,658,793	0	24,658,793	50.00
51.00	05100 RECOVERY ROOM		5,437,436	0	5,437,436	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM		10,905,760	0	10,905,760	52.00
54.00	05400 RADIOLOGY-DIAGNOSTIC		6,274,587	0	6,274,587	54.00
55.00	05500 RADIOLOGY-THERAPEUTIC		2,667,476	0	2,667,476	55.00
57.00	05700 CT SCAN		2,627,078	0	2,627,078	57.00
58.00	05800 MRI		2,806,943	0	2,806,943	58.00
59.00	05900 CARDIAC CATHETERIZATION		288,492	0	288,492	59.00
60.00	06000 LABORATORY		14,660,794	0	14,660,794	60.00
64.00	06400 INTRAVENOUS THERAPY		1,708,045	0	1,708,045	64.00
65.00	06500 RESPIRATORY THERAPY	0	6,231,545	0	6,231,545	65.00
66.00	06600 PHYSICAL THERAPY	0	7,996,971	0	7,996,971	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	2,668,000	0	2,668,000	67.00
68.00	06800 SPEECH PATHOLOGY	0	577,341	0	577,341	68.00
69.00	06900 ELECTROCARDIOLOGY		677,494	0	677,494	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY		2,279,300	0	2,279,300	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT		20,448,688	0	20,448,688	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS		16,594,106	0	16,594,106	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS		27,354,575	0	27,354,575	73.00
73.01	07301 SPECIALTY PHARMACY		50,109,637	0	50,109,637	73.01
74.00	07400 RENAL DIALYSIS		1,419,224	0	1,419,224	74.00
76.00	03330 ENDOSCOPY		3,633,757	0	3,633,757	76.00
76.01	03950 OTHER ANCILLARY SERVICE COST CENTERS		0	0	0	76.01
76.02	03951 OTHER ANCILLARY SERVICE COST CENTERS		0	0	0	76.02
76.03	03952 OTHER ANCILLARY SERVICE COST CENTERS		0	0	0	76.03
76.04	03953 WOUND CARE		916,295	0	916,295	76.04
76.06	03954 IMAGING CENTER		4,700,149	0	4,700,149	76.06
76.07	03955 BREAST DIAGNOSTIC CENTER		11,003,660	0	11,003,660	76.07
<b>OUTPATIENT SERVICE COST CENTERS</b>						
90.00	09000 CLINIC		0	0	0	90.00
90.01	04950 INFUSION CENTER		297,380	0	297,380	90.01
90.26	04975 SPINE CENTER		271,437	0	271,437	90.26
91.00	09100 EMERGENCY		16,096,913	0	16,096,913	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART		7,695,757	0	7,695,757	92.00
<b>SPECIAL PURPOSE COST CENTERS</b>						
113.00	11300 INTEREST EXPENSE					113.00
114.00	11400 UTILIZATION REVIEW-SNF					114.00
200.00	Subtotal (see instructions)		374,533,617	0	374,533,617	200.00
201.00	Less Observation Beds		7,695,757	0	7,695,757	201.00
202.00	Total (see instructions)		366,837,860	0	366,837,860	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 15-0169

Period:  
From 01/01/2020  
To 12/31/2020

Worksheet C  
Part I  
Date/Time Prepared:  
8/2/2021 3:48 pm

		Title XVIII			Hospital	PPS	
Cost Center Description		Charges			Cost or Other Ratio	TEFRA Inpatient Ratio	
		Inpatient	Outpatient	Total (col. 6 + col. 7)			
		6.00	7.00	8.00	9.00	10.00	
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000	ADULTS & PEDIATRICS	180,394,113		180,394,113		30.00
31.00	03100	INTENSIVE CARE UNIT	29,320,631		29,320,631		31.00
35.00	02060	NEONATAL INTENSIVE CARE UNIT	111,808,358		111,808,358		35.00
40.00	04000	SUBPROVIDER - I/PF	9,403,664		9,403,664		40.00
43.00	04300	NURSERY	9,906,848		9,906,848		43.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000	OPERATING ROOM	119,336,921	72,154,526	191,491,447	0.128772	50.00
51.00	05100	RECOVERY ROOM	17,607,567	15,557,009	33,164,576	0.163953	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	24,495,294	0	24,495,294	0.445219	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	11,228,950	26,000,783	37,229,733	0.168537	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	13,892,447	23,559,108	37,451,555	0.071225	55.00
57.00	05700	CT SCAN	25,382,373	46,745,264	72,127,637	0.036423	57.00
58.00	05800	MRI	5,539,201	25,794,009	31,333,210	0.089584	58.00
59.00	05900	CARDIAC CATHETERIZATION	4,319,038	13,447	4,332,485	0.066588	59.00
60.00	06000	LABORATORY	80,078,929	40,872,531	120,951,460	0.121212	60.00
64.00	06400	INTRAVENOUS THERAPY	1,466,616	1,665,530	3,132,146	0.545327	64.00
65.00	06500	RESPIRATORY THERAPY	29,038,164	1,650,379	30,688,543	0.203058	65.00
66.00	06600	PHYSICAL THERAPY	4,521,623	14,469,236	18,990,859	0.421096	66.00
67.00	06700	OCCUPATIONAL THERAPY	4,374,524	2,414,249	6,788,773	0.393002	67.00
68.00	06800	SPEECH PATHOLOGY	1,492,873	555,281	2,048,154	0.281884	68.00
69.00	06900	ELECTROCARDIOLOGY	8,356,933	1,439,161	9,796,094	0.069160	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	783,674	8,512,843	9,296,517	0.245178	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	36,107,835	19,540,887	55,648,722	0.367460	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	27,301,845	12,970,704	40,272,549	0.412045	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	77,352,280	31,729,192	109,081,472	0.250772	73.00
73.01	07301	SPECIALTY PHARMACY	0	58,430,692	58,430,692	0.857591	73.01
74.00	07400	RENAL DIALYSIS	4,598,982	0	4,598,982	0.308595	74.00
76.00	03330	ENDOSCOPY	6,410,816	18,282,725	24,693,541	0.147154	76.00
76.01	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0.000000	76.01
76.02	03951	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0.000000	76.02
76.03	03952	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0.000000	76.03
76.04	03953	WOUND CARE	917,440	1,485,265	2,402,705	0.381360	76.04
76.06	03954	IMAGING CENTER	491,304	48,458,568	48,949,872	0.096020	76.06
76.07	03955	BREAST DIAGNOSTIC CENTER	26,783	24,906,922	24,933,705	0.441317	76.07
<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.00	09000	CLINIC	0	0	0	0.000000	90.00
90.01	04950	INFUSION CENTER	0	446,475	446,475	0.666062	90.01
90.26	04975	SPINE CENTER	0	393,777	393,777	0.689317	90.26
91.00	09100	EMERGENCY	37,683,934	117,435,140	155,119,074	0.103771	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	2,137,685	7,208,381	9,346,066	0.823422	92.00
<b>SPECIAL PURPOSE COST CENTERS</b>							
113.00	11300	INTEREST EXPENSE					113.00
114.00	11400	UTILIZATION REVIEW-SNF					114.00
200.00		Subtotal (see instructions)	885,777,645	622,692,084	1,508,469,729		200.00
201.00		Less Observation Beds					201.00
202.00		Total (see instructions)	885,777,645	622,692,084	1,508,469,729		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 15-0169	Period: From 01/01/2020 To 12/31/2020	Worksheet C Part I Date/Time Prepared: 8/2/2021 3:48 pm
		Title XVIII	Hospital	PPS

Cost Center Description		PPS Inpatient Ratio		
		11.00		
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>				
30.00	03000 ADULTS & PEDIATRICS			30.00
31.00	03100 INTENSIVE CARE UNIT			31.00
35.00	02060 NEONATAL INTENSIVE CARE UNIT			35.00
40.00	04000 SUBPROVIDER - IPF			40.00
43.00	04300 NURSERY			43.00
<b>ANCILLARY SERVICE COST CENTERS</b>				
50.00	05000 OPERATING ROOM	0.128772		50.00
51.00	05100 RECOVERY ROOM	0.163953		51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.445219		52.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.168537		54.00
55.00	05500 RADIOLOGY-THERAPEUTIC	0.071225		55.00
57.00	05700 CT SCAN	0.036423		57.00
58.00	05800 MRI	0.089584		58.00
59.00	05900 CARDIAC CATHETERIZATION	0.066588		59.00
60.00	06000 LABORATORY	0.121212		60.00
64.00	06400 INTRAVENOUS THERAPY	0.545327		64.00
65.00	06500 RESPIRATORY THERAPY	0.203058		65.00
66.00	06600 PHYSICAL THERAPY	0.421096		66.00
67.00	06700 OCCUPATIONAL THERAPY	0.393002		67.00
68.00	06800 SPEECH PATHOLOGY	0.281884		68.00
69.00	06900 ELECTROCARDIOLOGY	0.069160		69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0.245178		70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.367460		71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.412045		72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.250772		73.00
73.01	07301 SPECIALTY PHARMACY	0.857591		73.01
74.00	07400 RENAL DIALYSIS	0.308595		74.00
76.00	03330 ENDOSCOPY	0.147154		76.00
76.01	03950 OTHER ANCILLARY SERVICE COST CENTERS	0.000000		76.01
76.02	03951 OTHER ANCILLARY SERVICE COST CENTERS	0.000000		76.02
76.03	03952 OTHER ANCILLARY SERVICE COST CENTERS	0.000000		76.03
76.04	03953 WOUND CARE	0.381360		76.04
76.06	03954 IMAGING CENTER	0.096020		76.06
76.07	03955 BREAST DIAGNOSTIC CENTER	0.441317		76.07
<b>OUTPATIENT SERVICE COST CENTERS</b>				
90.00	09000 CLINIC	0.000000		90.00
90.01	04950 INFUSION CENTER	0.666062		90.01
90.26	04975 SPINE CENTER	0.689317		90.26
91.00	09100 EMERGENCY	0.103771		91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0.823422		92.00
<b>SPECIAL PURPOSE COST CENTERS</b>				
113.00	11300 INTEREST EXPENSE			113.00
114.00	11400 UTILIZATION REVIEW-SNF			114.00
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: 15-0169

Period:  
From 01/01/2020  
To 12/31/2020

Worksheet C  
Part I  
Date/Time Prepared:  
8/2/2021 3:48 pm

		Title XIX		Hospital		PPS	
Cost Center Description		Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs			
				Total Costs	RCE Disallowance		
		1.00	2.00	3.00	4.00	5.00	
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000 ADULTS & PEDIATRICS	84,040,079		84,040,079	0	84,040,079	30.00
31.00	03100 INTENSIVE CARE UNIT	12,338,200		12,338,200	0	12,338,200	31.00
35.00	02060 NEONATAL INTENSIVE CARE UNIT	17,416,725		17,416,725	0	17,416,725	35.00
40.00	04000 SUBPROVIDER - IPF	4,668,354		4,668,354	0	4,668,354	40.00
43.00	04300 NURSERY	4,621,135		4,621,135	0	4,621,135	43.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000 OPERATING ROOM	24,711,879		24,711,879	0	24,711,879	50.00
51.00	05100 RECOVERY ROOM	5,437,436		5,437,436	0	5,437,436	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	10,905,760		10,905,760	0	10,905,760	52.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	6,274,587		6,274,587	0	6,274,587	54.00
55.00	05500 RADIOLOGY-THERAPEUTIC	2,667,476		2,667,476	0	2,667,476	55.00
57.00	05700 CT SCAN	2,627,078		2,627,078	0	2,627,078	57.00
58.00	05800 MRI	2,806,943		2,806,943	0	2,806,943	58.00
59.00	05900 CARDIAC CATHETERIZATION	288,492		288,492	0	288,492	59.00
60.00	06000 LABORATORY	14,660,794		14,660,794	0	14,660,794	60.00
64.00	06400 INTRAVENOUS THERAPY	1,708,045		1,708,045	0	1,708,045	64.00
65.00	06500 RESPIRATORY THERAPY	6,231,545	0	6,231,545	0	6,231,545	65.00
66.00	06600 PHYSICAL THERAPY	8,027,892	0	8,027,892	0	8,027,892	66.00
67.00	06700 OCCUPATIONAL THERAPY	2,668,000	0	2,668,000	0	2,668,000	67.00
68.00	06800 SPEECH PATHOLOGY	577,341	0	577,341	0	577,341	68.00
69.00	06900 ELECTROCARDIOLOGY	677,494		677,494	0	677,494	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	2,279,300		2,279,300	0	2,279,300	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	20,448,688		20,448,688	0	20,448,688	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	16,594,106		16,594,106	0	16,594,106	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	27,354,575		27,354,575	0	27,354,575	73.00
73.01	07301 SPECIALTY PHARMACY	50,109,637		50,109,637	0	50,109,637	73.01
74.00	07400 RENAL DIALYSIS	1,419,224		1,419,224	0	1,419,224	74.00
76.00	03330 ENDOSCOPY	3,633,757		3,633,757	0	3,633,757	76.00
76.01	03950 OTHER ANCILLARY SERVICE COST CENTERS	0		0	0	0	76.01
76.02	03951 OTHER ANCILLARY SERVICE COST CENTERS	0		0	0	0	76.02
76.03	03952 OTHER ANCILLARY SERVICE COST CENTERS	0		0	0	0	76.03
76.04	03953 WOUND CARE	916,295		916,295	0	916,295	76.04
76.06	03954 IMAGING CENTER	4,700,149		4,700,149	0	4,700,149	76.06
76.07	03955 BREAST DIAGNOSTIC CENTER	11,003,660		11,003,660	0	11,003,660	76.07
<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.00	09000 CLINIC	0		0	0	0	90.00
90.01	04950 INFUSION CENTER	297,380		297,380	0	297,380	90.01
90.26	04975 SPINE CENTER	271,437		271,437	0	271,437	90.26
91.00	09100 EMERGENCY	16,223,405		16,223,405	0	16,223,405	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	7,695,757		7,695,757	0	7,695,757	92.00
<b>SPECIAL PURPOSE COST CENTERS</b>							
113.00	11300 INTEREST EXPENSE						113.00
114.00	11400 UTILIZATION REVIEW-SNF						114.00
200.00	Subtotal (see instructions)	376,302,625	0	376,302,625	0	376,302,625	200.00
201.00	Less Observation Beds	7,695,757		7,695,757		7,695,757	201.00
202.00	Total (see instructions)	368,606,868	0	368,606,868	0	368,606,868	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 15-0169

Period:  
From 01/01/2020  
To 12/31/2020

Worksheet C  
Part I  
Date/Time Prepared:  
8/2/2021 3:48 pm

		Title XIX			Hospital	PPS	
Cost Center Description		Charges			Cost or Other Ratio	TEFRA Inpatient Ratio	
		Inpatient	Outpatient	Total (col. 6 + col. 7)			
		6.00	7.00	8.00	9.00	10.00	
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000	ADULTS & PEDIATRICS	180,394,113		180,394,113		30.00
31.00	03100	INTENSIVE CARE UNIT	29,320,631		29,320,631		31.00
35.00	02060	NEONATAL INTENSIVE CARE UNIT	111,808,358		111,808,358		35.00
40.00	04000	SUBPROVIDER - I PF	9,403,664		9,403,664		40.00
43.00	04300	NURSERY	9,906,848		9,906,848		43.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000	OPERATING ROOM	119,336,921	72,154,526	191,491,447	0.129050	50.00
51.00	05100	RECOVERY ROOM	17,607,567	15,557,009	33,164,576	0.163953	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	24,495,294	0	24,495,294	0.445219	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	11,228,950	26,000,783	37,229,733	0.168537	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	13,892,447	23,559,108	37,451,555	0.071225	55.00
57.00	05700	CT SCAN	25,382,373	46,745,264	72,127,637	0.036423	57.00
58.00	05800	MRI	5,539,201	25,794,009	31,333,210	0.089584	58.00
59.00	05900	CARDIAC CATHETERIZATION	4,319,038	13,447	4,332,485	0.066588	59.00
60.00	06000	LABORATORY	80,078,929	40,872,531	120,951,460	0.121212	60.00
64.00	06400	INTRAVENOUS THERAPY	1,466,616	1,665,530	3,132,146	0.545327	64.00
65.00	06500	RESPIRATORY THERAPY	29,038,164	1,650,379	30,688,543	0.203058	65.00
66.00	06600	PHYSICAL THERAPY	4,521,623	14,469,236	18,990,859	0.422724	66.00
67.00	06700	OCCUPATIONAL THERAPY	4,374,524	2,414,249	6,788,773	0.393002	67.00
68.00	06800	SPEECH PATHOLOGY	1,492,873	555,281	2,048,154	0.281884	68.00
69.00	06900	ELECTROCARDIOLOGY	8,356,933	1,439,161	9,796,094	0.069160	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	783,674	8,512,843	9,296,517	0.245178	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	36,107,835	19,540,887	55,648,722	0.367460	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	27,301,845	12,970,704	40,272,549	0.412045	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	77,352,280	31,729,192	109,081,472	0.250772	73.00
73.01	07301	SPECIALTY PHARMACY	0	58,430,692	58,430,692	0.857591	73.01
74.00	07400	RENAL DIALYSIS	4,598,982	0	4,598,982	0.308595	74.00
76.00	03330	ENDOSCOPY	6,410,816	18,282,725	24,693,541	0.147154	76.00
76.01	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0.000000	76.01
76.02	03951	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0.000000	76.02
76.03	03952	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0.000000	76.03
76.04	03953	WOUND CARE	917,440	1,485,265	2,402,705	0.381360	76.04
76.06	03954	IMAGING CENTER	491,304	48,458,568	48,949,872	0.096020	76.06
76.07	03955	BREAST DIAGNOSTIC CENTER	26,783	24,906,922	24,933,705	0.441317	76.07
<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.00	09000	CLINIC	0	0	0	0.000000	90.00
90.01	04950	INFUSION CENTER	0	446,475	446,475	0.666062	90.01
90.26	04975	SPINE CENTER	0	393,777	393,777	0.689317	90.26
91.00	09100	EMERGENCY	37,683,934	117,435,140	155,119,074	0.104587	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	2,137,685	7,208,381	9,346,066	0.823422	92.00
<b>SPECIAL PURPOSE COST CENTERS</b>							
113.00	11300	INTEREST EXPENSE					113.00
114.00	11400	UTILIZATION REVIEW-SNF					114.00
200.00		Subtotal (see instructions)	885,777,645	622,692,084	1,508,469,729		200.00
201.00		Less Observation Beds					201.00
202.00		Total (see instructions)	885,777,645	622,692,084	1,508,469,729		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES			Provider CCN: 15-0169	Period: From 01/01/2020 To 12/31/2020	Worksheet C Part I Date/Time Prepared: 8/2/2021 3:48 pm
Cost Center Description			PPS Inpatient Ratio 11.00	Title XIX	Hospital
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>					
30.00	03000	ADULTS & PEDIATRICS			30.00
31.00	03100	INTENSIVE CARE UNIT			31.00
35.00	02060	NEONATAL INTENSIVE CARE UNIT			35.00
40.00	04000	SUBPROVIDER - IPF			40.00
43.00	04300	NURSERY			43.00
<b>ANCILLARY SERVICE COST CENTERS</b>					
50.00	05000	OPERATING ROOM	0.129050		50.00
51.00	05100	RECOVERY ROOM	0.163953		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.445219		52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.168537		54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.071225		55.00
57.00	05700	CT SCAN	0.036423		57.00
58.00	05800	MRI	0.089584		58.00
59.00	05900	CARDIAC CATHETERIZATION	0.066588		59.00
60.00	06000	LABORATORY	0.121212		60.00
64.00	06400	INTRAVENOUS THERAPY	0.545327		64.00
65.00	06500	RESPIRATORY THERAPY	0.203058		65.00
66.00	06600	PHYSICAL THERAPY	0.422724		66.00
67.00	06700	OCCUPATIONAL THERAPY	0.393002		67.00
68.00	06800	SPEECH PATHOLOGY	0.281884		68.00
69.00	06900	ELECTROCARDIOLOGY	0.069160		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.245178		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.367460		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.412045		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.250772		73.00
73.01	07301	SPECIALTY PHARMACY	0.857591		73.01
74.00	07400	RENAL DIALYSIS	0.308595		74.00
76.00	03330	ENDOSCOPY	0.147154		76.00
76.01	03950	OTHER ANCILLARY SERVICE COST CENTERS	0.000000		76.01
76.02	03951	OTHER ANCILLARY SERVICE COST CENTERS	0.000000		76.02
76.03	03952	OTHER ANCILLARY SERVICE COST CENTERS	0.000000		76.03
76.04	03953	WOUND CARE	0.381360		76.04
76.06	03954	IMAGING CENTER	0.096020		76.06
76.07	03955	BREAST DIAGNOSTIC CENTER	0.441317		76.07
<b>OUTPATIENT SERVICE COST CENTERS</b>					
90.00	09000	CLINIC	0.000000		90.00
90.01	04950	INFUSION CENTER	0.666062		90.01
90.26	04975	SPINE CENTER	0.689317		90.26
91.00	09100	EMERGENCY	0.104587		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.823422		92.00
<b>SPECIAL PURPOSE COST CENTERS</b>					
113.00	11300	INTEREST EXPENSE			113.00
114.00	11400	UTILIZATION REVIEW-SNF			114.00
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: 15-0169

Period: From 01/01/2020 To 12/31/2020

Worksheet C Part II Date/Time Prepared: 8/2/2021 3:48 pm

Cost Center Description		Title XIX			Hospital	PPS	
		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	
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000 OPERATING ROOM	24,711,879	4,245,615	20,466,264	0	0	50.00
51.00	05100 RECOVERY ROOM	5,437,436	586,369	4,851,067	0	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	10,905,760	1,429,026	9,476,734	0	0	52.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	6,274,587	803,282	5,471,305	0	0	54.00
55.00	05500 RADIOLOGY-THERAPEUTIC	2,667,476	808,874	1,858,602	0	0	55.00
57.00	05700 CT SCAN	2,627,078	345,421	2,281,657	0	0	57.00
58.00	05800 MRI	2,806,943	494,343	2,312,600	0	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	288,492	9,033	279,459	0	0	59.00
60.00	06000 LABORATORY	14,660,794	611,276	14,049,518	0	0	60.00
64.00	06400 INTRAVENOUS THERAPY	1,708,045	262,856	1,445,189	0	0	64.00
65.00	06500 RESPIRATORY THERAPY	6,231,545	583,146	5,648,399	0	0	65.00
66.00	06600 PHYSICAL THERAPY	8,027,892	1,302,505	6,725,387	0	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	2,668,000	145,180	2,522,820	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	577,341	31,242	546,099	0	0	68.00
69.00	06900 ELECTROCARDIOLOGY	677,494	17,673	659,821	0	0	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	2,279,300	445,796	1,833,504	0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	20,448,688	1,378,681	19,070,007	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	16,594,106	1,119,267	15,474,839	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	27,354,575	1,693,798	25,660,777	0	0	73.00
73.01	07301 SPECIALTY PHARMACY	50,109,637	1,502,767	48,606,870	0	0	73.01
74.00	07400 RENAL DIALYSIS	1,419,224	38,983	1,380,241	0	0	74.00
76.00	03330 ENDOSCOPY	3,633,757	665,306	2,968,451	0	0	76.00
76.01	03950 OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0	76.01
76.02	03951 OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0	76.02
76.03	03952 OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0	76.03
76.04	03953 WOUND CARE	916,295	134,135	782,160	0	0	76.04
76.06	03954 IMAGING CENTER	4,700,149	1,011,148	3,689,001	0	0	76.06
76.07	03955 BREAST DIAGNOSTIC CENTER	11,003,660	693,992	10,309,668	0	0	76.07
<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.00	09000 CLINIC	0	0	0	0	0	90.00
90.01	04950 INFUSION CENTER	297,380	90,644	206,736	0	0	90.01
90.26	04975 SPINE CENTER	271,437	7,336	264,101	0	0	90.26
91.00	09100 EMERGENCY	16,223,405	1,392,894	14,830,511	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	7,695,757	810,009	6,885,748	0	0	92.00
<b>SPECIAL PURPOSE COST CENTERS</b>							
113.00	11300 INTEREST EXPENSE						113.00
114.00	11400 UTILIZATION REVIEW-SNF						114.00
200.00	Subtotal (sum of lines 50 thru 199)	253,218,132	22,660,597	230,557,535	0	0	200.00
201.00	Less Observation Beds	7,695,757	810,009	6,885,748	0	0	201.00
202.00	Total (line 200 minus line 201)	245,522,375	21,850,588	223,671,787	0	0	202.00



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

Provider CCN: 15-0169

Period:  
From 01/01/2020  
To 12/31/2020

Worksheet C  
Part II  
Date/Time Prepared:  
8/2/2021 3:48 pm

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)	Title XIX	
					Hospital	PPS
		6.00	7.00	8.00		
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00	05000 OPERATING ROOM	24,711,879	191,491,447	0.129050		50.00
51.00	05100 RECOVERY ROOM	5,437,436	33,164,576	0.163953		51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	10,905,760	24,495,294	0.445219		52.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	6,274,587	37,229,733	0.168537		54.00
55.00	05500 RADIOLOGY-THERAPEUTIC	2,667,476	37,451,555	0.071225		55.00
57.00	05700 CT SCAN	2,627,078	72,127,637	0.036423		57.00
58.00	05800 MRI	2,806,943	31,333,210	0.089584		58.00
59.00	05900 CARDIAC CATHETERIZATION	288,492	4,332,485	0.066588		59.00
60.00	06000 LABORATORY	14,660,794	120,951,460	0.121212		60.00
64.00	06400 INTRAVENOUS THERAPY	1,708,045	3,132,146	0.545327		64.00
65.00	06500 RESPIRATORY THERAPY	6,231,545	30,688,543	0.203058		65.00
66.00	06600 PHYSICAL THERAPY	8,027,892	18,990,859	0.422724		66.00
67.00	06700 OCCUPATIONAL THERAPY	2,668,000	6,788,773	0.393002		67.00
68.00	06800 SPEECH PATHOLOGY	577,341	2,048,154	0.281884		68.00
69.00	06900 ELECTROCARDIOLOGY	677,494	9,796,094	0.069160		69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	2,279,300	9,296,517	0.245178		70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	20,448,688	55,648,722	0.367460		71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	16,594,106	40,272,549	0.412045		72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	27,354,575	109,081,472	0.250772		73.00
73.01	07301 SPECIALTY PHARMACY	50,109,637	58,430,692	0.857591		73.01
74.00	07400 RENAL DIALYSIS	1,419,224	4,598,982	0.308595		74.00
76.00	03330 ENDOSCOPY	3,633,757	24,693,541	0.147154		76.00
76.01	03950 OTHER ANCILLARY SERVICE COST CENTERS	0	0	0.000000		76.01
76.02	03951 OTHER ANCILLARY SERVICE COST CENTERS	0	0	0.000000		76.02
76.03	03952 OTHER ANCILLARY SERVICE COST CENTERS	0	0	0.000000		76.03
76.04	03953 WOUND CARE	916,295	2,402,705	0.381360		76.04
76.06	03954 IMAGING CENTER	4,700,149	48,949,872	0.096020		76.06
76.07	03955 BREAST DIAGNOSTIC CENTER	11,003,660	24,933,705	0.441317		76.07
<b>OUTPATIENT SERVICE COST CENTERS</b>						
90.00	09000 CLINIC	0	0	0.000000		90.00
90.01	04950 INFUSION CENTER	297,380	446,475	0.666062		90.01
90.26	04975 SPINE CENTER	271,437	393,777	0.689317		90.26
91.00	09100 EMERGENCY	16,223,405	155,119,074	0.104587		91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	7,695,757	9,346,066	0.823422		92.00
<b>SPECIAL PURPOSE COST CENTERS</b>						
113.00	11300 INTEREST EXPENSE					113.00
114.00	11400 UTILIZATION REVIEW-SNF					114.00
200.00	Subtotal (sum of lines 50 thru 199)	253,218,132	1,167,636,115			200.00
201.00	Less Observation Beds	7,695,757	0			201.00
202.00	Total (line 200 minus line 201)	245,522,375	1,167,636,115			202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS		Provider CCN: 15-0169	Period: From 01/01/2020 To 12/31/2020	Worksheet D Part I Date/Time Prepared: 8/2/2021 3:48 pm
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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	8,762,336	0	8,762,336	59,572	147.09	30.00
31.00	INTENSIVE CARE UNIT	1,600,336		1,600,336	6,562	243.88	31.00
35.00	NEONATAL INTENSIVE CARE UNIT	1,684,119		1,684,119	13,390	125.77	35.00
40.00	SUBPROVIDER - IPF	321,701	0	321,701	4,029	79.85	40.00
43.00	NURSERY	587,945		587,945	7,288	80.67	43.00
200.00	Total (lines 30 through 199)	12,956,437		12,956,437	90,841		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	15,397	2,264,745				30.00
31.00	INTENSIVE CARE UNIT	1,723	420,205				31.00
35.00	NEONATAL INTENSIVE CARE UNIT	0	0				35.00
40.00	SUBPROVIDER - IPF	2,038	162,734				40.00
43.00	NURSERY	0	0				43.00
200.00	Total (lines 30 through 199)	19,158	2,847,684				200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS		Provider CCN: 15-0169	Period: From 01/01/2020 To 12/31/2020	Worksheet D Part II Date/Time Prepared: 8/2/2021 3:48 pm
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Cost Center Description		Title XVIII			Hospital	PPS		
		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		
<b>ANCILLARY SERVICE COST CENTERS</b>								
50.00	05000	OPERATING ROOM	4,245,615	191,491,447	0.022171	35,061,252	777,343	50.00
51.00	05100	RECOVERY ROOM	586,369	33,164,576	0.017681	3,841,944	67,929	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,429,026	24,495,294	0.058339	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	803,282	37,229,733	0.021576	2,841,842	61,316	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	808,874	37,451,555	0.021598	5,911,449	127,675	55.00
57.00	05700	CT SCAN	345,421	72,127,637	0.004789	8,754,808	41,927	57.00
58.00	05800	MRI	494,343	31,333,210	0.015777	1,688,673	26,642	58.00
59.00	05900	CARDIAC CATHETERIZATION	9,033	4,332,485	0.002085	1,862,009	3,882	59.00
60.00	06000	LABORATORY	611,276	120,951,460	0.005054	23,187,288	117,189	60.00
64.00	06400	INTRAVENOUS THERAPY	262,856	3,132,146	0.083922	374,455	31,425	64.00
65.00	06500	RESPIRATORY THERAPY	583,146	30,688,543	0.019002	5,445,653	103,478	65.00
66.00	06600	PHYSICAL THERAPY	1,302,505	18,990,859	0.068586	1,724,519	118,278	66.00
67.00	06700	OCCUPATIONAL THERAPY	145,180	6,788,773	0.021385	1,415,133	30,263	67.00
68.00	06800	SPEECH PATHOLOGY	31,242	2,048,154	0.015254	420,667	6,417	68.00
69.00	06900	ELECTROCARDIOLOGY	17,673	9,796,094	0.001804	2,906,905	5,244	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	445,796	9,296,517	0.047953	206,987	9,926	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1,378,681	55,648,722	0.024775	7,161,730	177,432	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1,119,267	40,272,549	0.027792	11,317,948	314,548	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,693,798	109,081,472	0.015528	19,005,618	295,119	73.00
73.01	07301	SPECIALTY PHARMACY	1,502,767	58,430,692	0.025719	0	0	73.01
74.00	07400	RENAL DIALYSIS	38,983	4,598,982	0.008476	1,855,217	15,725	74.00
76.00	03330	ENDOSCOPY	665,306	24,693,541	0.026943	2,520,790	67,918	76.00
76.01	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0.000000	0	0	76.01
76.02	03951	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0.000000	0	0	76.02
76.03	03952	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0.000000	0	0	76.03
76.04	03953	WOUND CARE	134,135	2,402,705	0.055827	349,744	19,525	76.04
76.06	03954	IMAGING CENTER	1,011,148	48,949,872	0.020657	41,960	867	76.06
76.07	03955	BREAST DIAGNOSTIC CENTER	693,992	24,933,705	0.027833	1,384	39	76.07
<b>OUTPATIENT SERVICE COST CENTERS</b>								
90.00	09000	CLINIC	0	0	0.000000	0	0	90.00
90.01	04950	INFUSION CENTER	90,644	446,475	0.203021	0	0	90.01
90.26	04975	SPINE CENTER	7,336	393,777	0.018630	0	0	90.26
91.00	09100	EMERGENCY	1,392,894	155,119,074	0.008980	12,376,254	111,139	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	810,009	9,346,066	0.086668	1,232,709	106,836	92.00
200.00		Total (lines 50 through 199)	22,660,597	1,167,636,115		151,506,938	2,638,082	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS		Provider CCN: 15-0169	Period: From 01/01/2020 To 12/31/2020	Worksheet D Part III Date/Time Prepared: 8/2/2021 3:48 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	PPS
INPATIENT ROUTINE SERVICE COST CENTERS			1A	1.00	2A	2.00	3.00	
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
35.00	02060	NEONATAL INTENSIVE CARE UNIT	0	0	0	0	0	35.00
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	0	40.00
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 col. 1 through 3, minus col. 4)	Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days	
INPATIENT ROUTINE SERVICE COST CENTERS			4.00	5.00	6.00	7.00	8.00	
30.00	03000	ADULTS & PEDIATRICS	0	0	59,572	0.00	15,397	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	6,562	0.00	1,723	31.00
35.00	02060	NEONATAL INTENSIVE CARE UNIT	0	0	13,390	0.00	0	35.00
40.00	04000	SUBPROVIDER - IPF	0	0	4,029	0.00	2,038	40.00
43.00	04300	NURSERY	0	0	7,288	0.00	0	43.00
200.00		Total (lines 30 through 199)	0	0	90,841	0.00	19,158	200.00
Cost Center Description			Inpatient Program Pass-Through Cost (col. 7 x col. 8)					
INPATIENT ROUTINE SERVICE COST CENTERS			9.00					
30.00	03000	ADULTS & PEDIATRICS	0					30.00
31.00	03100	INTENSIVE CARE UNIT	0					31.00
35.00	02060	NEONATAL INTENSIVE CARE UNIT	0					35.00
40.00	04000	SUBPROVIDER - IPF	0					40.00
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: 15-0169	Period: From 01/01/2020 To 12/31/2020	Worksheet D Part IV Date/Time Prepared: 8/2/2021 3:48 pm
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Cost Center Description	Title XVIII					
	Non Physician Anesthetist Cost		Nursing School Post-Stepdown Adjustments		Hospital Allied Health Post-Stepdown Adjustments	
	1.00	2A	2.00	3A	3.00	
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00 05000 OPERATING ROOM	0	0	0	0	0	50.00
51.00 05100 RECOVERY ROOM	0	0	0	0	0	51.00
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
55.00 05500 RADIOLOGY-THERAPEUTIC	0	0	0	0	0	55.00
57.00 05700 CT SCAN	0	0	0	0	0	57.00
58.00 05800 MRI	0	0	0	0	0	58.00
59.00 05900 CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00 06000 LABORATORY	0	0	0	0	0	60.00
64.00 06400 INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00 06500 RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00 06600 PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00 06700 OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00 06800 SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00 06900 ELECTROCARDIOLOGY	0	0	0	0	0	69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO 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
73.01 07301 SPECIALTY PHARMACY	0	0	0	0	0	73.01
74.00 07400 RENAL DIALYSIS	0	0	0	0	0	74.00
76.00 03330 ENDOSCOPY	0	0	0	0	0	76.00
76.01 03950 OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0	76.01
76.02 03951 OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0	76.02
76.03 03952 OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0	76.03
76.04 03953 WOUND CARE	0	0	0	0	0	76.04
76.06 03954 IMAGING CENTER	0	0	0	0	0	76.06
76.07 03955 BREAST DIAGNOSTIC CENTER	0	0	0	0	0	76.07
<b>OUTPATIENT SERVICE COST CENTERS</b>						
90.00 09000 CLINIC	0	0	0	0	0	90.00
90.01 04950 INFUSION CENTER	0	0	0	0	0	90.01
90.26 04975 SPINE CENTER	0	0	0	0	0	90.26
91.00 09100 EMERGENCY	0	0	0	0	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	0	92.00
200.00 Total (lines 50 through 199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 15-0169	Period: From 01/01/2020 To 12/31/2020	Worksheet D Part IV Date/Time Prepared: 8/2/2021 3:48 pm
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Cost Center Description	All Other Medical Education Cost	Total Cost (sum of col. 1, 2, 3, and 4)	Total Outpatient Cost (sum of col. 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	
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00 05000 OPERATING ROOM	0	0	0	191,491,447	0.000000	50.00
51.00 05100 RECOVERY ROOM	0	0	0	33,164,576	0.000000	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0	0	24,495,294	0.000000	52.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	0	0	0	37,229,733	0.000000	54.00
55.00 05500 RADIOLOGY-THERAPEUTIC	0	0	0	37,451,555	0.000000	55.00
57.00 05700 CT SCAN	0	0	0	72,127,637	0.000000	57.00
58.00 05800 MRI	0	0	0	31,333,210	0.000000	58.00
59.00 05900 CARDIAC CATHETERIZATION	0	0	0	4,332,485	0.000000	59.00
60.00 06000 LABORATORY	0	0	0	120,951,460	0.000000	60.00
64.00 06400 INTRAVENOUS THERAPY	0	0	0	3,132,146	0.000000	64.00
65.00 06500 RESPIRATORY THERAPY	0	0	0	30,688,543	0.000000	65.00
66.00 06600 PHYSICAL THERAPY	0	0	0	18,990,859	0.000000	66.00
67.00 06700 OCCUPATIONAL THERAPY	0	0	0	6,788,773	0.000000	67.00
68.00 06800 SPEECH PATHOLOGY	0	0	0	2,048,154	0.000000	68.00
69.00 06900 ELECTROCARDIOLOGY	0	0	0	9,796,094	0.000000	69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	0	0	0	9,296,517	0.000000	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	55,648,722	0.000000	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	40,272,549	0.000000	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0	0	109,081,472	0.000000	73.00
73.01 07301 SPECIALTY PHARMACY	0	0	0	58,430,692	0.000000	73.01
74.00 07400 RENAL DIALYSIS	0	0	0	4,598,982	0.000000	74.00
76.00 03330 ENDOSCOPY	0	0	0	24,693,541	0.000000	76.00
76.01 03950 OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0.000000	76.01
76.02 03951 OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0.000000	76.02
76.03 03952 OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0.000000	76.03
76.04 03953 WOUND CARE	0	0	0	2,402,705	0.000000	76.04
76.06 03954 IMAGING CENTER	0	0	0	48,949,872	0.000000	76.06
76.07 03955 BREAST DIAGNOSTIC CENTER	0	0	0	24,933,705	0.000000	76.07
<b>OUTPATIENT SERVICE COST CENTERS</b>						
90.00 09000 CLINIC	0	0	0	0	0.000000	90.00
90.01 04950 INFUSION CENTER	0	0	0	446,475	0.000000	90.01
90.26 04975 SPINE CENTER	0	0	0	393,777	0.000000	90.26
91.00 09100 EMERGENCY	0	0	0	155,119,074	0.000000	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	9,346,066	0.000000	92.00
200.00 Total (lines 50 through 199)	0	0	0	1,167,636,115		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 15-0169	Period: From 01/01/2020 To 12/31/2020	Worksheet D Part IV Date/Time Prepared: 8/2/2021 3:48 pm
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Cost Center Description		Title XVIII					Hospital	PPS
		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		
<b>ANCILLARY SERVICE COST CENTERS</b>								
50.00	05000 OPERATING ROOM	0.000000	35,061,252	0	15,088,157	0	50.00	
51.00	05100 RECOVERY ROOM	0.000000	3,841,944	0	2,248,522	0	51.00	
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.000000	0	0	0	0	52.00	
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.000000	2,841,842	0	3,691,953	0	54.00	
55.00	05500 RADIOLOGY-THERAPEUTIC	0.000000	5,911,449	0	11,179,284	0	55.00	
57.00	05700 CT SCAN	0.000000	8,754,808	0	7,875,249	0	57.00	
58.00	05800 MRI	0.000000	1,688,673	0	12,198,633	0	58.00	
59.00	05900 CARDIAC CATHETERIZATION	0.000000	1,862,009	0	0	0	59.00	
60.00	06000 LABORATORY	0.000000	23,187,288	0	6,726,515	0	60.00	
64.00	06400 INTRAVENOUS THERAPY	0.000000	374,455	0	497,309	0	64.00	
65.00	06500 RESPIRATORY THERAPY	0.000000	5,445,653	0	238,713	0	65.00	
66.00	06600 PHYSICAL THERAPY	0.000000	1,724,519	0	76,829	0	66.00	
67.00	06700 OCCUPATIONAL THERAPY	0.000000	1,415,133	0	16,793	0	67.00	
68.00	06800 SPEECH PATHOLOGY	0.000000	420,667	0	5,091	0	68.00	
69.00	06900 ELECTROCARDIOLOGY	0.000000	2,906,905	0	262,426	0	69.00	
70.00	07000 ELECTROENCEPHALOGRAPHY	0.000000	206,987	0	1,564,284	0	70.00	
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	7,161,730	0	4,261,914	0	71.00	
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.000000	11,317,948	0	3,492,195	0	72.00	
73.00	07300 DRUGS CHARGED TO PATIENTS	0.000000	19,005,618	0	12,364,652	0	73.00	
73.01	07301 SPECIALTY PHARMACY	0.000000	0	0	0	0	73.01	
74.00	07400 RENAL DIALYSIS	0.000000	1,855,217	0	0	0	74.00	
76.00	03330 ENDOSCOPY	0.000000	2,520,790	0	4,976,263	0	76.00	
76.01	03950 OTHER ANCILLARY SERVICE COST CENTERS	0.000000	0	0	0	0	76.01	
76.02	03951 OTHER ANCILLARY SERVICE COST CENTERS	0.000000	0	0	0	0	76.02	
76.03	03952 OTHER ANCILLARY SERVICE COST CENTERS	0.000000	0	0	0	0	76.03	
76.04	03953 WOUND CARE	0.000000	349,744	0	413,753	0	76.04	
76.06	03954 IMAGING CENTER	0.000000	41,960	0	12,701,121	0	76.06	
76.07	03955 BREAST DIAGNOSTIC CENTER	0.000000	1,384	0	2,724,246	0	76.07	
<b>OUTPATIENT SERVICE COST CENTERS</b>								
90.00	09000 CLINIC	0.000000	0	0	0	0	90.00	
90.01	04950 INFUSION CENTER	0.000000	0	0	278,166	0	90.01	
90.26	04975 SPINE CENTER	0.000000	0	0	0	0	90.26	
91.00	09100 EMERGENCY	0.000000	12,376,254	0	13,482,398	0	91.00	
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0.000000	1,232,709	0	3,972,704	0	92.00	
200.00	Total (lines 50 through 199)		151,506,938	0	120,337,170	0	200.00	

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST		Provider CCN: 15-0169	Period: From 01/01/2020 To 12/31/2020	Worksheet D Part V Date/Time Prepared: 8/2/2021 3:48 pm
		Title XVIII	Hospital	PPS

Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges			Costs	
		PPS Reimbursed Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	PPS Services (see inst.)	
	1.00	2.00	3.00	4.00	5.00	
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00 05000 OPERATING ROOM	0.128772	15,088,157	17,781	0	1,942,932	
51.00 05100 RECOVERY ROOM	0.163953	2,248,522	0	0	368,652	
52.00 05200 DELIVERY ROOM & LABOR ROOM	0.445219	0	0	0	0	
54.00 05400 RADIOLOGY-DIAGNOSTIC	0.168537	3,691,953	0	0	622,231	
55.00 05500 RADIOLOGY-THERAPEUTIC	0.071225	11,179,284	0	0	796,245	
57.00 05700 CT SCAN	0.036423	7,875,249	0	0	286,840	
58.00 05800 MRI	0.089584	12,198,633	0	0	1,092,802	
59.00 05900 CARDIAC CATHETERIZATION	0.066588	0	0	0	0	
60.00 06000 LABORATORY	0.121212	6,726,515	0	0	815,334	
64.00 06400 INTRAVENOUS THERAPY	0.545327	497,309	0	0	271,196	
65.00 06500 RESPIRATORY THERAPY	0.203058	238,713	0	0	48,473	
66.00 06600 PHYSICAL THERAPY	0.421096	76,829	0	0	32,352	
67.00 06700 OCCUPATIONAL THERAPY	0.393002	16,793	0	0	6,600	
68.00 06800 SPEECH PATHOLOGY	0.281884	5,091	0	0	1,435	
69.00 06900 ELECTROCARDIOLOGY	0.069160	262,426	0	0	18,149	
70.00 07000 ELECTROENCEPHALOGRAPHY	0.245178	1,564,284	0	0	383,528	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.367460	4,261,914	0	0	1,566,083	
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0.412045	3,492,195	0	0	1,438,941	
73.00 07300 DRUGS CHARGED TO PATIENTS	0.250772	12,364,652	0	52,560	3,100,709	
73.01 07301 SPECIALTY PHARMACY	0.857591	0	0	0	0	
74.00 07400 RENAL DIALYSIS	0.308595	0	0	0	0	
76.00 03330 ENDOSCOPY	0.147154	4,976,263	5,927	0	732,277	
76.01 03950 OTHER ANCILLARY SERVICE COST CENTERS	0.000000	0	0	0	0	
76.02 03951 OTHER ANCILLARY SERVICE COST CENTERS	0.000000	0	0	0	0	
76.03 03952 OTHER ANCILLARY SERVICE COST CENTERS	0.000000	0	0	0	0	
76.04 03953 WOUND CARE	0.381360	413,753	0	0	157,789	
76.06 03954 IMAGING CENTER	0.096020	12,701,121	0	0	1,219,562	
76.07 03955 BREAST DIAGNOSTIC CENTER	0.441317	2,724,246	0	0	1,202,256	
<b>OUTPATIENT SERVICE COST CENTERS</b>						
90.00 09000 CLINIC	0.000000	0	0	0	0	
90.01 04950 INFUSION CENTER	0.666062	278,166	0	0	185,276	
90.26 04975 SPINE CENTER	0.689317	0	0	0	0	
91.00 09100 EMERGENCY	0.103771	13,482,398	0	0	1,399,082	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0.823422	3,972,704	0	0	3,271,212	
200.00		Subtotal (see instructions)	120,337,170	23,708	52,560	20,959,956
201.00		Less PBP Clinic Lab. Services-Program Only Charges		0	0	
202.00		Net Charges (line 200 - line 201)	120,337,170	23,708	52,560	20,959,956



APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 15-0169	Period: From 01/01/2020 To 12/31/2020	Worksheet D Part V Date/Time Prepared: 8/2/2021 3:48 pm
	Title XVIII	Hospital	PPS

Cost Center Description	Costs		Hospital	PPS
	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
	6.00	7.00		
<b>ANCILLARY SERVICE COST CENTERS</b>				
50.00 05000 OPERATING ROOM	2,290	0		50.00
51.00 05100 RECOVERY ROOM	0	0		51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0		52.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	0	0		54.00
55.00 05500 RADIOLOGY-THERAPEUTIC	0	0		55.00
57.00 05700 CT SCAN	0	0		57.00
58.00 05800 MRI	0	0		58.00
59.00 05900 CARDIAC CATHETERIZATION	0	0		59.00
60.00 06000 LABORATORY	0	0		60.00
64.00 06400 INTRAVENOUS THERAPY	0	0		64.00
65.00 06500 RESPIRATORY THERAPY	0	0		65.00
66.00 06600 PHYSICAL THERAPY	0	0		66.00
67.00 06700 OCCUPATIONAL THERAPY	0	0		67.00
68.00 06800 SPEECH PATHOLOGY	0	0		68.00
69.00 06900 ELECTROCARDIOLOGY	0	0		69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	0	0		70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO 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	13,181		73.00
73.01 07301 SPECIALTY PHARMACY	0	0		73.01
74.00 07400 RENAL DIALYSIS	0	0		74.00
76.00 03330 ENDOSCOPY	872	0		76.00
76.01 03950 OTHER ANCILLARY SERVICE COST CENTERS	0	0		76.01
76.02 03951 OTHER ANCILLARY SERVICE COST CENTERS	0	0		76.02
76.03 03952 OTHER ANCILLARY SERVICE COST CENTERS	0	0		76.03
76.04 03953 WOUND CARE	0	0		76.04
76.06 03954 IMAGING CENTER	0	0		76.06
76.07 03955 BREAST DIAGNOSTIC CENTER	0	0		76.07
<b>OUTPATIENT SERVICE COST CENTERS</b>				
90.00 09000 CLINIC	0	0		90.00
90.01 04950 INFUSION CENTER	0	0		90.01
90.26 04975 SPINE CENTER	0	0		90.26
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)	3,162	13,181		200.00
201.00 Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00 Net Charges (line 200 - line 201)	3,162	13,181		202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS			Provider CCN: 15-0169 Component CCN: 15-S169		Period: From 01/01/2020 To 12/31/2020		Worksheet D Part II Date/Time Prepared: 8/2/2021 3:48 pm	
			Title XVIII		Subprovider - IPF		PPS	
Cost Center Description			Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
<b>ANCILLARY SERVICE COST CENTERS</b>								
50.00	05000	OPERATING ROOM	4,245,615	191,491,447	0.022171	1,645	36	50.00
51.00	05100	RECOVERY ROOM	586,369	33,164,576	0.017681	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,429,026	24,495,294	0.058339	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	803,282	37,229,733	0.021576	31,787	686	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	808,874	37,451,555	0.021598	0	0	55.00
57.00	05700	CT SCAN	345,421	72,127,637	0.004789	117,428	562	57.00
58.00	05800	MRI	494,343	31,333,210	0.015777	7,959	126	58.00
59.00	05900	CARDIAC CATHETERIZATION	9,033	4,332,485	0.002085	66,264	138	59.00
60.00	06000	LABORATORY	611,276	120,951,460	0.005054	806,718	4,077	60.00
64.00	06400	INTRAVENOUS THERAPY	262,856	3,132,146	0.083922	15,605	1,310	64.00
65.00	06500	RESPIRATORY THERAPY	583,146	30,688,543	0.019002	19,132	364	65.00
66.00	06600	PHYSICAL THERAPY	1,302,505	18,990,859	0.068586	53,539	3,672	66.00
67.00	06700	OCCUPATIONAL THERAPY	145,180	6,788,773	0.021385	41,375	885	67.00
68.00	06800	SPEECH PATHOLOGY	31,242	2,048,154	0.015254	4,417	67	68.00
69.00	06900	ELECTROCARDIOLOGY	17,673	9,796,094	0.001804	39,032	70	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	445,796	9,296,517	0.047953	5,532	265	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1,378,681	55,648,722	0.024775	23,989	594	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1,119,267	40,272,549	0.027792	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,693,798	109,081,472	0.015528	399,380	6,202	73.00
73.01	07301	SPECIALTY PHARMACY	1,502,767	58,430,692	0.025719	0	0	73.01
74.00	07400	RENAL DIALYSIS	38,983	4,598,982	0.008476	0	0	74.00
76.00	03330	ENDOSCOPY	665,306	24,693,541	0.026943	0	0	76.00
76.01	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0.000000	0	0	76.01
76.02	03951	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0.000000	0	0	76.02
76.03	03952	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0.000000	0	0	76.03
76.04	03953	WOUND CARE	134,135	2,402,705	0.055827	0	0	76.04
76.06	03954	IMAGING CENTER	1,011,148	48,949,872	0.020657	0	0	76.06
76.07	03955	BREAST DIAGNOSTIC CENTER	693,992	24,933,705	0.027833	0	0	76.07
<b>OUTPATIENT SERVICE COST CENTERS</b>								
90.00	09000	CLINIC	0	0	0.000000	0	0	90.00
90.01	04950	INFUSION CENTER	90,644	446,475	0.203021	0	0	90.01
90.26	04975	SPINE CENTER	7,336	393,777	0.018630	0	0	90.26
91.00	09100	EMERGENCY	1,392,894	155,119,074	0.008980	342,660	3,077	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	9,346,066	0.000000	0	0	92.00
200.00		Total (lines 50 through 199)	21,850,588	1,167,636,115		1,976,462	22,131	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 15-0169 Component CCN: 15-S169	Period: From 01/01/2020 To 12/31/2020	Worksheet D Part IV Date/Time Prepared: 8/2/2021 3:48 pm
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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	
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000 OPERATING ROOM	0	0	0	0	0	50.00
51.00	05100 RECOVERY ROOM	0	0	0	0	0	51.00
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
55.00	05500 RADIOLOGY-THERAPEUTIC	0	0	0	0	0	55.00
57.00	05700 CT SCAN	0	0	0	0	0	57.00
58.00	05800 MRI	0	0	0	0	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000 LABORATORY	0	0	0	0	0	60.00
64.00	06400 INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500 RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600 PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900 ELECTROCARDIOLOGY	0	0	0	0	0	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO 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
73.01	07301 SPECIALTY PHARMACY	0	0	0	0	0	73.01
74.00	07400 RENAL DIALYSIS	0	0	0	0	0	74.00
76.00	03330 ENDOSCOPY	0	0	0	0	0	76.00
76.01	03950 OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0	76.01
76.02	03951 OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0	76.02
76.03	03952 OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0	76.03
76.04	03953 WOUND CARE	0	0	0	0	0	76.04
76.06	03954 IMAGING CENTER	0	0	0	0	0	76.06
76.07	03955 BREAST DIAGNOSTIC CENTER	0	0	0	0	0	76.07
<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.00	09000 CLINIC	0	0	0	0	0	90.00
90.01	04950 INFUSION CENTER	0	0	0	0	0	90.01
90.26	04975 SPINE CENTER	0	0	0	0	0	90.26
91.00	09100 EMERGENCY	0	0	0	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	0	92.00
200.00	Total (lines 50 through 199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 15-0169 Component CCN: 15-S169	Period: From 01/01/2020 To 12/31/2020	Worksheet D Part IV Date/Time Prepared: 8/2/2021 3:48 pm
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Cost Center Description		All Other Medical Education Cost	Total Cost (sum of col s. 1, 2, 3, and 4)	Total Outpatient Cost (sum of col s. 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	
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000 OPERATING ROOM	0	0	0	191,491,447	0.000000	50.00
51.00	05100 RECOVERY ROOM	0	0	0	33,164,576	0.000000	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	0	24,495,294	0.000000	52.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	0	0	37,229,733	0.000000	54.00
55.00	05500 RADIOLOGY-THERAPEUTIC	0	0	0	37,451,555	0.000000	55.00
57.00	05700 CT SCAN	0	0	0	72,127,637	0.000000	57.00
58.00	05800 MRI	0	0	0	31,333,210	0.000000	58.00
59.00	05900 CARDIAC CATHETERIZATION	0	0	0	4,332,485	0.000000	59.00
60.00	06000 LABORATORY	0	0	0	120,951,460	0.000000	60.00
64.00	06400 INTRAVENOUS THERAPY	0	0	0	3,132,146	0.000000	64.00
65.00	06500 RESPIRATORY THERAPY	0	0	0	30,688,543	0.000000	65.00
66.00	06600 PHYSICAL THERAPY	0	0	0	18,990,859	0.000000	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	0	0	6,788,773	0.000000	67.00
68.00	06800 SPEECH PATHOLOGY	0	0	0	2,048,154	0.000000	68.00
69.00	06900 ELECTROCARDIOLOGY	0	0	0	9,796,094	0.000000	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0	0	9,296,517	0.000000	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	55,648,722	0.000000	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	40,272,549	0.000000	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	0	109,081,472	0.000000	73.00
73.01	07301 SPECIALTY PHARMACY	0	0	0	58,430,692	0.000000	73.01
74.00	07400 RENAL DIALYSIS	0	0	0	4,598,982	0.000000	74.00
76.00	03330 ENDOSCOPY	0	0	0	24,693,541	0.000000	76.00
76.01	03950 OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0.000000	76.01
76.02	03951 OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0.000000	76.02
76.03	03952 OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0.000000	76.03
76.04	03953 WOUND CARE	0	0	0	2,402,705	0.000000	76.04
76.06	03954 IMAGING CENTER	0	0	0	48,949,872	0.000000	76.06
76.07	03955 BREAST DIAGNOSTIC CENTER	0	0	0	24,933,705	0.000000	76.07
<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.00	09000 CLINIC	0	0	0	0	0.000000	90.00
90.01	04950 INFUSION CENTER	0	0	0	446,475	0.000000	90.01
90.26	04975 SPINE CENTER	0	0	0	393,777	0.000000	90.26
91.00	09100 EMERGENCY	0	0	0	155,119,074	0.000000	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	9,346,066	0.000000	92.00
200.00	Total (lines 50 through 199)	0	0	0	1,167,636,115		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 15-0169 Component CCN: 15-S169	Period: From 01/01/2020 To 12/31/2020	Worksheet D Part IV Date/Time Prepared: 8/2/2021 3:48 pm
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Cost Center Description		Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
		9.00	10.00	11.00	12.00	13.00	
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000 OPERATING ROOM	0.000000	1,645	0	0	0	50.00
51.00	05100 RECOVERY ROOM	0.000000	0	0	0	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.000000	0	0	0	0	52.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.000000	31,787	0	0	0	54.00
55.00	05500 RADIOLOGY-THERAPEUTIC	0.000000	0	0	0	0	55.00
57.00	05700 CT SCAN	0.000000	117,428	0	0	0	57.00
58.00	05800 MRI	0.000000	7,959	0	0	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	0.000000	66,264	0	0	0	59.00
60.00	06000 LABORATORY	0.000000	806,718	0	47	0	60.00
64.00	06400 INTRAVENOUS THERAPY	0.000000	15,605	0	0	0	64.00
65.00	06500 RESPIRATORY THERAPY	0.000000	19,132	0	0	0	65.00
66.00	06600 PHYSICAL THERAPY	0.000000	53,539	0	0	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.000000	41,375	0	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0.000000	4,417	0	0	0	68.00
69.00	06900 ELECTROCARDIOLOGY	0.000000	39,032	0	276	0	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0.000000	5,532	0	0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	23,989	0	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	0	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.000000	399,380	0	43	0	73.00
73.01	07301 SPECIALTY PHARMACY	0.000000	0	0	0	0	73.01
74.00	07400 RENAL DIALYSIS	0.000000	0	0	0	0	74.00
76.00	03330 ENDOSCOPY	0.000000	0	0	0	0	76.00
76.01	03950 OTHER ANCILLARY SERVICE COST CENTERS	0.000000	0	0	0	0	76.01
76.02	03951 OTHER ANCILLARY SERVICE COST CENTERS	0.000000	0	0	0	0	76.02
76.03	03952 OTHER ANCILLARY SERVICE COST CENTERS	0.000000	0	0	0	0	76.03
76.04	03953 WOUND CARE	0.000000	0	0	0	0	76.04
76.06	03954 IMAGING CENTER	0.000000	0	0	0	0	76.06
76.07	03955 BREAST DIAGNOSTIC CENTER	0.000000	0	0	0	0	76.07
<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.00	09000 CLINIC	0.000000	0	0	0	0	90.00
90.01	04950 INFUSION CENTER	0.000000	0	0	0	0	90.01
90.26	04975 SPINE CENTER	0.000000	0	0	0	0	90.26
91.00	09100 EMERGENCY	0.000000	342,660	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)		1,976,462	0	366	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 15-0169 Component CCN: 15-S169	Period: From 01/01/2020 To 12/31/2020	Worksheet D Part V Date/Time Prepared: 8/2/2021 3:48 pm
Title XVIII		Subprovider - IPF	PPS

Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges			PPS Services (see inst.)	Costs (see inst.)
		PPS Reimbursed Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
	1.00	2.00	3.00	4.00	5.00	
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00 05000 OPERATING ROOM	0.128772	0	0	0	0	50.00
51.00 05100 RECOVERY ROOM	0.163953	0	0	0	0	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0.445219	0	0	0	0	52.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	0.168537	0	0	0	0	54.00
55.00 05500 RADIOLOGY-THERAPEUTIC	0.071225	0	0	0	0	55.00
57.00 05700 CT SCAN	0.036423	0	0	0	0	57.00
58.00 05800 MRI	0.089584	0	0	0	0	58.00
59.00 05900 CARDIAC CATHETERIZATION	0.066588	0	0	0	0	59.00
60.00 06000 LABORATORY	0.121212	47	0	0	6	60.00
64.00 06400 INTRAVENOUS THERAPY	0.545327	0	0	0	0	64.00
65.00 06500 RESPIRATORY THERAPY	0.203058	0	0	0	0	65.00
66.00 06600 PHYSICAL THERAPY	0.421096	0	0	0	0	66.00
67.00 06700 OCCUPATIONAL THERAPY	0.393002	0	0	0	0	67.00
68.00 06800 SPEECH PATHOLOGY	0.281884	0	0	0	0	68.00
69.00 06900 ELECTROCARDIOLOGY	0.069160	276	0	0	19	69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	0.245178	0	0	0	0	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.367460	0	0	0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0.412045	0	0	0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0.250772	43	0	2,224	11	73.00
73.01 07301 SPECIALTY PHARMACY	0.857591	0	0	0	0	73.01
74.00 07400 RENAL DIALYSIS	0.308595	0	0	0	0	74.00
76.00 03330 ENDOSCOPY	0.147154	0	0	0	0	76.00
76.01 03950 OTHER ANCILLARY SERVICE COST CENTERS	0.000000	0	0	0	0	76.01
76.02 03951 OTHER ANCILLARY SERVICE COST CENTERS	0.000000	0	0	0	0	76.02
76.03 03952 OTHER ANCILLARY SERVICE COST CENTERS	0.000000	0	0	0	0	76.03
76.04 03953 WOUND CARE	0.381360	0	0	0	0	76.04
76.06 03954 IMAGING CENTER	0.096020	0	0	0	0	76.06
76.07 03955 BREAST DIAGNOSTIC CENTER	0.441317	0	0	0	0	76.07
<b>OUTPATIENT SERVICE COST CENTERS</b>						
90.00 09000 CLINIC	0.000000	0	0	0	0	90.00
90.01 04950 INFUSION CENTER	0.666062	0	0	0	0	90.01
90.26 04975 SPINE CENTER	0.689317	0	0	0	0	90.26
91.00 09100 EMERGENCY	0.103771	0	0	0	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0.823422	0	0	0	0	92.00
200.00 Subtotal (see instructions)		366	0	2,224	36	200.00
201.00 Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00 Net Charges (line 200 - line 201)		366	0	2,224	36	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 15-0169 Component CCN: 15-S169	Period: From 01/01/2020 To 12/31/2020	Worksheet D Part V Date/Time Prepared: 8/2/2021 3:48 pm
	Title XVIII	Subprovider - IPF	PPS

Cost Center Description	Costs		
	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	
	6.00	7.00	
<b>ANCILLARY SERVICE COST CENTERS</b>			
50.00 05000 OPERATING ROOM	0	0	50.00
51.00 05100 RECOVERY ROOM	0	0	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0	52.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	0	0	54.00
55.00 05500 RADIOLOGY-THERAPEUTIC	0	0	55.00
57.00 05700 CT SCAN	0	0	57.00
58.00 05800 MRI	0	0	58.00
59.00 05900 CARDIAC CATHETERIZATION	0	0	59.00
60.00 06000 LABORATORY	0	0	60.00
64.00 06400 INTRAVENOUS THERAPY	0	0	64.00
65.00 06500 RESPIRATORY THERAPY	0	0	65.00
66.00 06600 PHYSICAL THERAPY	0	0	66.00
67.00 06700 OCCUPATIONAL THERAPY	0	0	67.00
68.00 06800 SPEECH PATHOLOGY	0	0	68.00
69.00 06900 ELECTROCARDIOLOGY	0	0	69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	0	0	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO 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	558	73.00
73.01 07301 SPECIALTY PHARMACY	0	0	73.01
74.00 07400 RENAL DIALYSIS	0	0	74.00
76.00 03330 ENDOSCOPY	0	0	76.00
76.01 03950 OTHER ANCILLARY SERVICE COST CENTERS	0	0	76.01
76.02 03951 OTHER ANCILLARY SERVICE COST CENTERS	0	0	76.02
76.03 03952 OTHER ANCILLARY SERVICE COST CENTERS	0	0	76.03
76.04 03953 WOUND CARE	0	0	76.04
76.06 03954 IMAGING CENTER	0	0	76.06
76.07 03955 BREAST DIAGNOSTIC CENTER	0	0	76.07
<b>OUTPATIENT SERVICE COST CENTERS</b>			
90.00 09000 CLINIC	0	0	90.00
90.01 04950 INFUSION CENTER	0	0	90.01
90.26 04975 SPINE CENTER	0	0	90.26
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	558	200.00
201.00 Less PBP Clinic Lab. Services-Program Only Charges	0		201.00
202.00 Net Charges (line 200 - line 201)	0	558	202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS		Provider CCN: 15-0169	Period: From 01/01/2020 To 12/31/2020	Worksheet D Part I Date/Time Prepared: 8/2/2021 3:48 pm
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Cost Center Description		Title XIX			Hospital	PPS	
		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	8,762,336	0	8,762,336	59,572	147.09	30.00
31.00	INTENSIVE CARE UNIT	1,600,336		1,600,336	6,562	243.88	31.00
35.00	NEONATAL INTENSIVE CARE UNIT	1,684,119		1,684,119	13,390	125.77	35.00
40.00	SUBPROVIDER - IPF	321,701	0	321,701	4,029	79.85	40.00
43.00	NURSERY	587,945		587,945	7,288	80.67	43.00
200.00	Total (lines 30 through 199)	12,956,437		12,956,437	90,841		200.00
Cost Center Description		Inpatient Program days	Inpatient Program Capital Cost (col. 5 x col. 6)				
		6.00	7.00				
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	ADULTS & PEDIATRICS	2,240	329,482				
31.00	INTENSIVE CARE UNIT	0	0				
35.00	NEONATAL INTENSIVE CARE UNIT	1,444	181,612				
40.00	SUBPROVIDER - IPF	0	0				
43.00	NURSERY	2,808	226,521				
200.00	Total (lines 30 through 199)	6,492	737,615				



APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS		Provider CCN: 15-0169	Period: From 01/01/2020 To 12/31/2020	Worksheet D Part II Date/Time Prepared: 8/2/2021 3:48 pm
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Cost Center Description		Title XIX			Hospital	PPS		
		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		
<b>ANCILLARY SERVICE COST CENTERS</b>								
50.00	05000	OPERATING ROOM	4,245,615	191,491,447	0.022171	2,714,513	60,183	50.00
51.00	05100	RECOVERY ROOM	586,369	33,164,576	0.017681	405,494	7,170	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,429,026	24,495,294	0.058339	552,016	32,204	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	803,282	37,229,733	0.021576	530,674	11,450	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	808,874	37,451,555	0.021598	779,244	16,830	55.00
57.00	05700	CT SCAN	345,421	72,127,637	0.004789	1,000,665	4,792	57.00
58.00	05800	MRI	494,343	31,333,210	0.015777	225,323	3,555	58.00
59.00	05900	CARDIAC CATHETERIZATION	9,033	4,332,485	0.002085	41,898	87	59.00
60.00	06000	LABORATORY	611,276	120,951,460	0.005054	3,506,320	17,721	60.00
64.00	06400	INTRAVENOUS THERAPY	262,856	3,132,146	0.083922	68,554	5,753	64.00
65.00	06500	RESPIRATORY THERAPY	583,146	30,688,543	0.019002	1,843,876	35,037	65.00
66.00	06600	PHYSICAL THERAPY	1,302,505	18,990,859	0.068586	121,257	8,317	66.00
67.00	06700	OCCUPATIONAL THERAPY	145,180	6,788,773	0.021385	170,175	3,639	67.00
68.00	06800	SPEECH PATHOLOGY	31,242	2,048,154	0.015254	89,041	1,358	68.00
69.00	06900	ELECTROCARDIOLOGY	17,673	9,796,094	0.001804	296,953	536	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	445,796	9,296,517	0.047953	64,562	3,096	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1,378,681	55,648,722	0.024775	1,614,721	40,005	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1,119,267	40,272,549	0.027792	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,693,798	109,081,472	0.015528	2,992,487	46,467	73.00
73.01	07301	SPECIALTY PHARMACY	1,502,767	58,430,692	0.025719	0	0	73.01
74.00	07400	RENAL DIALYSIS	38,983	4,598,982	0.008476	227,358	1,927	74.00
76.00	03330	ENDOSCOPY	665,306	24,693,541	0.026943	201,930	5,441	76.00
76.01	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0.000000	0	0	76.01
76.02	03951	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0.000000	0	0	76.02
76.03	03952	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0.000000	0	0	76.03
76.04	03953	WOUND CARE	134,135	2,402,705	0.055827	33,594	1,875	76.04
76.06	03954	IMAGING CENTER	1,011,148	48,949,872	0.020657	0	0	76.06
76.07	03955	BREAST DIAGNOSTIC CENTER	693,992	24,933,705	0.027833	0	0	76.07
<b>OUTPATIENT SERVICE COST CENTERS</b>								
90.00	09000	CLINIC	0	0	0.000000	0	0	90.00
90.01	04950	INFUSION CENTER	90,644	446,475	0.203021	0	0	90.01
90.26	04975	SPINE CENTER	7,336	393,777	0.018630	0	0	90.26
91.00	09100	EMERGENCY	1,392,894	155,119,074	0.008980	1,512,007	13,578	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	810,009	9,346,066	0.086668	236,965	20,537	92.00
200.00		Total (lines 50 through 199)	22,660,597	1,167,636,115		19,229,627	341,558	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS		Provider CCN: 15-0169	Period: From 01/01/2020 To 12/31/2020	Worksheet D Part III Date/Time Prepared: 8/2/2021 3:48 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	
35.00	02060	NEONATAL INTENSIVE CARE UNIT	0	0	0	0	0	35.00	
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	0	40.00	
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 col. 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	59,572	0.00	2,240	30.00	
31.00	03100	INTENSIVE CARE UNIT	0	0	6,562	0.00	0	31.00	
35.00	02060	NEONATAL INTENSIVE CARE UNIT	0	0	13,390	0.00	1,444	35.00	
40.00	04000	SUBPROVIDER - IPF	0	0	4,029	0.00	0	40.00	
43.00	04300	NURSERY	0	0	7,288	0.00	2,808	43.00	
200.00		Total (lines 30 through 199)	0	0	90,841	0.00	6,492	200.00	
Cost Center Description			Inpatient Program Pass-Through Cost (col. 7 x col. 8)						
			9.00						
INPATIENT ROUTINE SERVICE COST CENTERS									
30.00	03000	ADULTS & PEDIATRICS	0						30.00
31.00	03100	INTENSIVE CARE UNIT	0						31.00
35.00	02060	NEONATAL INTENSIVE CARE UNIT	0						35.00
40.00	04000	SUBPROVIDER - IPF	0						40.00
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: 15-0169	Period: From 01/01/2020 To 12/31/2020	Worksheet D Part IV Date/Time Prepared: 8/2/2021 3:48 pm
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Cost Center Description	Title XIX			Hospital		PPS	
	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		
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00 05000 OPERATING ROOM	0	0	0	0	0	0	50.00
51.00 05100 RECOVERY ROOM	0	0	0	0	0	0	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	0	52.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	0	54.00
55.00 05500 RADIOLOGY-THERAPEUTIC	0	0	0	0	0	0	55.00
57.00 05700 CT SCAN	0	0	0	0	0	0	57.00
58.00 05800 MRI	0	0	0	0	0	0	58.00
59.00 05900 CARDIAC CATHETERIZATION	0	0	0	0	0	0	59.00
60.00 06000 LABORATORY	0	0	0	0	0	0	60.00
64.00 06400 INTRAVENOUS THERAPY	0	0	0	0	0	0	64.00
65.00 06500 RESPIRATORY THERAPY	0	0	0	0	0	0	65.00
66.00 06600 PHYSICAL THERAPY	0	0	0	0	0	0	66.00
67.00 06700 OCCUPATIONAL THERAPY	0	0	0	0	0	0	67.00
68.00 06800 SPEECH PATHOLOGY	0	0	0	0	0	0	68.00
69.00 06900 ELECTROCARDIOLOGY	0	0	0	0	0	0	69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	0	0	0	0	0	0	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	0	73.00
73.01 07301 SPECIALTY PHARMACY	0	0	0	0	0	0	73.01
74.00 07400 RENAL DIALYSIS	0	0	0	0	0	0	74.00
76.00 03330 ENDOSCOPY	0	0	0	0	0	0	76.00
76.01 03950 OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0	0	76.01
76.02 03951 OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0	0	76.02
76.03 03952 OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0	0	76.03
76.04 03953 WOUND CARE	0	0	0	0	0	0	76.04
76.06 03954 IMAGING CENTER	0	0	0	0	0	0	76.06
76.07 03955 BREAST DIAGNOSTIC CENTER	0	0	0	0	0	0	76.07
<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.00 09000 CLINIC	0	0	0	0	0	0	90.00
90.01 04950 INFUSION CENTER	0	0	0	0	0	0	90.01
90.26 04975 SPINE CENTER	0	0	0	0	0	0	90.26
91.00 09100 EMERGENCY	0	0	0	0	0	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	0	0	92.00
200.00 Total (lines 50 through 199)	0	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 15-0169	Period: From 01/01/2020 To 12/31/2020	Worksheet D Part IV Date/Time Prepared: 8/2/2021 3:48 pm
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Cost Center Description	Title XIX			Hospital	PPS	
	All Other Medical Education Cost	Total Cost (sum of col. 1, 2, 3, and 4)	Total Outpatient Cost (sum of col. 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	
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00 05000 OPERATING ROOM	0	0	0	191,491,447	0.000000	50.00
51.00 05100 RECOVERY ROOM	0	0	0	33,164,576	0.000000	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0	0	24,495,294	0.000000	52.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	0	0	0	37,229,733	0.000000	54.00
55.00 05500 RADIOLOGY-THERAPEUTIC	0	0	0	37,451,555	0.000000	55.00
57.00 05700 CT SCAN	0	0	0	72,127,637	0.000000	57.00
58.00 05800 MRI	0	0	0	31,333,210	0.000000	58.00
59.00 05900 CARDIAC CATHETERIZATION	0	0	0	4,332,485	0.000000	59.00
60.00 06000 LABORATORY	0	0	0	120,951,460	0.000000	60.00
64.00 06400 INTRAVENOUS THERAPY	0	0	0	3,132,146	0.000000	64.00
65.00 06500 RESPIRATORY THERAPY	0	0	0	30,688,543	0.000000	65.00
66.00 06600 PHYSICAL THERAPY	0	0	0	18,990,859	0.000000	66.00
67.00 06700 OCCUPATIONAL THERAPY	0	0	0	6,788,773	0.000000	67.00
68.00 06800 SPEECH PATHOLOGY	0	0	0	2,048,154	0.000000	68.00
69.00 06900 ELECTROCARDIOLOGY	0	0	0	9,796,094	0.000000	69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	0	0	0	9,296,517	0.000000	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	55,648,722	0.000000	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	40,272,549	0.000000	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0	0	109,081,472	0.000000	73.00
73.01 07301 SPECIALTY PHARMACY	0	0	0	58,430,692	0.000000	73.01
74.00 07400 RENAL DIALYSIS	0	0	0	4,598,982	0.000000	74.00
76.00 03330 ENDOSCOPY	0	0	0	24,693,541	0.000000	76.00
76.01 03950 OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0.000000	76.01
76.02 03951 OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0.000000	76.02
76.03 03952 OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0.000000	76.03
76.04 03953 WOUND CARE	0	0	0	2,402,705	0.000000	76.04
76.06 03954 IMAGING CENTER	0	0	0	48,949,872	0.000000	76.06
76.07 03955 BREAST DIAGNOSTIC CENTER	0	0	0	24,933,705	0.000000	76.07
<b>OUTPATIENT SERVICE COST CENTERS</b>						
90.00 09000 CLINIC	0	0	0	0	0.000000	90.00
90.01 04950 INFUSION CENTER	0	0	0	446,475	0.000000	90.01
90.26 04975 SPINE CENTER	0	0	0	393,777	0.000000	90.26
91.00 09100 EMERGENCY	0	0	0	155,119,074	0.000000	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	9,346,066	0.000000	92.00
200.00 Total (lines 50 through 199)	0	0	0	1,167,636,115		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 15-0169	Period: From 01/01/2020 To 12/31/2020	Worksheet D Part IV Date/Time Prepared: 8/2/2021 3:48 pm
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Cost Center Description		Title XIX			Hospital		PPS
		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	
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000 OPERATING ROOM	0.000000	2,714,513	0	0	0	50.00
51.00	05100 RECOVERY ROOM	0.000000	405,494	0	0	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.000000	552,016	0	0	0	52.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.000000	530,674	0	0	0	54.00
55.00	05500 RADIOLOGY-THERAPEUTIC	0.000000	779,244	0	0	0	55.00
57.00	05700 CT SCAN	0.000000	1,000,665	0	0	0	57.00
58.00	05800 MRI	0.000000	225,323	0	0	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	0.000000	41,898	0	0	0	59.00
60.00	06000 LABORATORY	0.000000	3,506,320	0	0	0	60.00
64.00	06400 INTRAVENOUS THERAPY	0.000000	68,554	0	0	0	64.00
65.00	06500 RESPIRATORY THERAPY	0.000000	1,843,876	0	0	0	65.00
66.00	06600 PHYSICAL THERAPY	0.000000	121,257	0	0	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.000000	170,175	0	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0.000000	89,041	0	0	0	68.00
69.00	06900 ELECTROCARDIOLOGY	0.000000	296,953	0	0	0	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0.000000	64,562	0	0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	1,614,721	0	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	0	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.000000	2,992,487	0	0	0	73.00
73.01	07301 SPECIALTY PHARMACY	0.000000	0	0	0	0	73.01
74.00	07400 RENAL DIALYSIS	0.000000	227,358	0	0	0	74.00
76.00	03330 ENDOSCOPY	0.000000	201,930	0	0	0	76.00
76.01	03950 OTHER ANCILLARY SERVICE COST CENTERS	0.000000	0	0	0	0	76.01
76.02	03951 OTHER ANCILLARY SERVICE COST CENTERS	0.000000	0	0	0	0	76.02
76.03	03952 OTHER ANCILLARY SERVICE COST CENTERS	0.000000	0	0	0	0	76.03
76.04	03953 WOUND CARE	0.000000	33,594	0	0	0	76.04
76.06	03954 IMAGING CENTER	0.000000	0	0	0	0	76.06
76.07	03955 BREAST DIAGNOSTIC CENTER	0.000000	0	0	0	0	76.07
<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.00	09000 CLINIC	0.000000	0	0	0	0	90.00
90.01	04950 INFUSION CENTER	0.000000	0	0	0	0	90.01
90.26	04975 SPINE CENTER	0.000000	0	0	0	0	90.26
91.00	09100 EMERGENCY	0.000000	1,512,007	0	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0.000000	236,965	0	0	0	92.00
200.00	Total (lines 50 through 199)		19,229,627	0	0	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 15-0169

Period:  
From 01/01/2020  
To 12/31/2020

Worksheet D  
Part V  
Date/Time Prepared:  
8/2/2021 3:48 pm

		Title XIX		Hospital		PPS	
Cost Center Description		Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges		Costs		PPS Services (see inst.)
			PPS Reimbursed Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
		1.00	2.00	3.00	4.00	5.00	
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000 OPERATING ROOM	0.129050	0	1,402,919	0	0	50.00
51.00	05100 RECOVERY ROOM	0.163953	0	302,531	0	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.445219	0	0	0	0	52.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.168537	0	923,311	0	0	54.00
55.00	05500 RADIOLOGY-THERAPEUTIC	0.071225	0	424,927	0	0	55.00
57.00	05700 CT SCAN	0.036423	0	2,027,516	0	0	57.00
58.00	05800 MRI	0.089584	0	169,706	0	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	0.066588	0	0	0	0	59.00
60.00	06000 LABORATORY	0.121212	0	1,852,557	0	0	60.00
64.00	06400 INTRAVENOUS THERAPY	0.545327	0	25,437	0	0	64.00
65.00	06500 RESPIRATORY THERAPY	0.203058	0	65,747	0	0	65.00
66.00	06600 PHYSICAL THERAPY	0.422724	0	116,208	0	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.393002	0	47,298	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0.281884	0	34,519	0	0	68.00
69.00	06900 ELECTROCARDIOLOGY	0.069160	0	41,599	0	0	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0.245178	0	153,845	0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.367460	0	335,458	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.412045	0	0	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.250772	0	569,554	0	0	73.00
73.01	07301 SPECIALTY PHARMACY	0.857591	0	0	0	0	73.01
74.00	07400 RENAL DIALYSIS	0.308595	0	0	0	0	74.00
76.00	03330 ENDOSCOPY	0.147154	0	240,573	0	0	76.00
76.01	03950 OTHER ANCILLARY SERVICE COST CENTERS	0.000000	0	0	0	0	76.01
76.02	03951 OTHER ANCILLARY SERVICE COST CENTERS	0.000000	0	0	0	0	76.02
76.03	03952 OTHER ANCILLARY SERVICE COST CENTERS	0.000000	0	0	0	0	76.03
76.04	03953 WOUND CARE	0.381360	0	29,451	0	0	76.04
76.06	03954 IMAGING CENTER	0.096020	0	440,717	0	0	76.06
76.07	03955 BREAST DIAGNOSTIC CENTER	0.441317	0	159,380	0	0	76.07
<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.00	09000 CLINIC	0.000000	0	0	0	0	90.00
90.01	04950 INFUSION CENTER	0.666062	0	192	0	0	90.01
90.26	04975 SPINE CENTER	0.689317	0	0	0	0	90.26
91.00	09100 EMERGENCY	0.104587	0	7,859,686	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0.823422	0	0	0	0	92.00
200.00	Subtotal (see instructions)		0	17,223,131	0	0	200.00
201.00	Less PBP Clinic Lab. Services-Program Only Charges			0	0	0	201.00
202.00	Net Charges (line 200 - line 201)		0	17,223,131	0	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 15-0169	Period: From 01/01/2020 To 12/31/2020	Worksheet D Part V Date/Time Prepared: 8/2/2021 3:48 pm
	Title XIX	Hospital	PPS

Cost Center Description	Costs		Hospital	PPS
	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
	6.00	7.00		
<b>ANCILLARY SERVICE COST CENTERS</b>				
50.00 05000 OPERATING ROOM	181,047	0		50.00
51.00 05100 RECOVERY ROOM	49,601	0		51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0		52.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	155,612	0		54.00
55.00 05500 RADIOLOGY-THERAPEUTIC	30,265	0		55.00
57.00 05700 CT SCAN	73,848	0		57.00
58.00 05800 MRI	15,203	0		58.00
59.00 05900 CARDIAC CATHETERIZATION	0	0		59.00
60.00 06000 LABORATORY	224,552	0		60.00
64.00 06400 INTRAVENOUS THERAPY	13,871	0		64.00
65.00 06500 RESPIRATORY THERAPY	13,350	0		65.00
66.00 06600 PHYSICAL THERAPY	49,124	0		66.00
67.00 06700 OCCUPATIONAL THERAPY	18,588	0		67.00
68.00 06800 SPEECH PATHOLOGY	9,730	0		68.00
69.00 06900 ELECTROCARDIOLOGY	2,877	0		69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	37,719	0		70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	123,267	0		71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0		72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	142,828	0		73.00
73.01 07301 SPECIALTY PHARMACY	0	0		73.01
74.00 07400 RENAL DIALYSIS	0	0		74.00
76.00 03330 ENDOSCOPY	35,401	0		76.00
76.01 03950 OTHER ANCILLARY SERVICE COST CENTERS	0	0		76.01
76.02 03951 OTHER ANCILLARY SERVICE COST CENTERS	0	0		76.02
76.03 03952 OTHER ANCILLARY SERVICE COST CENTERS	0	0		76.03
76.04 03953 WOUND CARE	11,231	0		76.04
76.06 03954 IMAGING CENTER	42,318	0		76.06
76.07 03955 BREAST DIAGNOSTIC CENTER	70,337	0		76.07
<b>OUTPATIENT SERVICE COST CENTERS</b>				
90.00 09000 CLINIC	0	0		90.00
90.01 04950 INFUSION CENTER	128	0		90.01
90.26 04975 SPINE CENTER	0	0		90.26
91.00 09100 EMERGENCY	822,021	0		91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0		92.00
200.00 Subtotal (see instructions)	2,122,918	0		200.00
201.00 Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00 Net Charges (line 200 - line 201)	2,122,918	0		202.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 15-0169	Period: From 01/01/2020 To 12/31/2020	Worksheet D-1 Date/Time Prepared: 8/2/2021 3:48 pm
Cost Center Description		Title XVIII	Hospital	PPS
		1.00		
<b>PART I - ALL PROVIDER COMPONENTS</b>				
<b>INPATIENT DAYS</b>				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		59,572	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		59,572	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)		54,065	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)		15,397	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
<b>SWING BED ADJUSTMENT</b>				
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)		83,249,127	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)		83,249,127	27.00
<b>PRIVATE ROOM DIFFERENTIAL ADJUSTMENT</b>				
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)		83,249,127	37.00
<b>PART II - HOSPITAL AND SUBPROVIDERS ONLY</b>				
<b>PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS</b>				
38.00	Adjusted general inpatient routine service cost per diem (see instructions)		1,397.45	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		21,516,538	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)		21,516,538	41.00



COMPUTATION OF INPATIENT OPERATING COST				Provider CCN: 15-0169	Period: From 01/01/2020 To 12/31/2020	Worksheet D-1 Date/Time Prepared: 8/2/2021 3:48 pm
Title XVIII				Hospital	PPS	
Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
	1.00	2.00	3.00	4.00	5.00	
42.00 NURSERY (title V & XIX only)	0	0	0.00	0	0	42.00
Intensive Care Type Inpatient Hospital Units						
43.00 INTENSIVE CARE UNIT	12,338,200	6,562	1,880.25	1,723	3,239,671	43.00
44.00 CORONARY CARE UNIT						44.00
45.00 BURN INTENSIVE CARE UNIT						45.00
46.00 SURGICAL INTENSIVE CARE UNIT						46.00
47.00 NEONATAL INTENSIVE CARE UNIT	17,416,725	13,390	1,300.73	0	0	47.00
Cost Center Description						
					1.00	
48.00 Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					27,854,254	48.00
49.00 Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					52,610,463	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)					2,684,950	50.00
51.00 Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					2,638,082	51.00
52.00 Total Program excludable cost (sum of lines 50 and 51)					5,323,032	52.00
53.00 Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					47,287,431	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)					5,507	87.00
88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					1,397.45	88.00
89.00 Observation bed cost (line 87 x line 88) (see instructions)					7,695,757	89.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 15-0169		Period: From 01/01/2020 To 12/31/2020		Worksheet D-1 Date/Time Prepared: 8/2/2021 3:48 pm	
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)	PPS
		1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00	Capital-related cost	8,762,336	83,249,127	0.105254	7,695,757	810,009	90.00
91.00	Nursing School cost	0	83,249,127	0.000000	7,695,757	0	91.00
92.00	Allied health cost	0	83,249,127	0.000000	7,695,757	0	92.00
93.00	All other Medical Education	0	83,249,127	0.000000	7,695,757	0	93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 15-0169 Component CCN: 15-S169	Period: From 01/01/2020 To 12/31/2020	Worksheet D-1 Date/Time Prepared: 8/2/2021 3:48 pm
		Title XVIII	Subprovider - IPF	PPS
Cost Center Description				1.00
<b>PART I - ALL PROVIDER COMPONENTS</b>				
<b>INPATIENT DAYS</b>				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)			4,029 1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)			4,029 2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.			0 3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)			4,029 4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period			0 5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)			0 6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period			0 7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)			0 8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions)			2,038 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
<b>SWING BED ADJUSTMENT</b>				
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period			0.00 17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period			0.00 18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period			0.00 19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period			0.00 20.00
21.00	Total general inpatient routine service cost (see instructions)			3,900,797 21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)			0 22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)			0 23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)			0 24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)			0 25.00
26.00	Total swing-bed cost (see instructions)			0 26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)			3,900,797 27.00
<b>PRIVATE ROOM DIFFERENTIAL ADJUSTMENT</b>				
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)			0 28.00
29.00	Private room charges (excluding swing-bed charges)			0 29.00
30.00	Semi-private room charges (excluding swing-bed charges)			0 30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)			0.000000 31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)			0.00 32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)			0.00 33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)			0.00 34.00
35.00	Average per diem private room cost differential (line 34 x line 31)			0.00 35.00
36.00	Private room cost differential adjustment (line 3 x line 35)			0 36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)			3,900,797 37.00
<b>PART II - HOSPITAL AND SUBPROVIDERS ONLY</b>				
<b>PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS</b>				
38.00	Adjusted general inpatient routine service cost per diem (see instructions)			968.18 38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)			1,973,151 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)			1,973,151 41.00

COMPUTATION OF INPATIENT OPERATING COST				Provider CCN: 15-0169 Component CCN: 15-S169	Period: From 01/01/2020 To 12/31/2020	Worksheet D-1 Date/Time Prepared: 8/2/2021 3:48 pm
				Title XVIII	Subprovider - IPF	PPS
Cost Center Description	Total	Total	Average Per	Program Days	Program Cost (col. 3 x col. 4)	
	Inpatient Cost	Inpatient Days	Diem (col. 1 ÷ col. 2)			
	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
<b>Intensive Care Type Inpatient Hospital Units</b>						
43.00 INTENSIVE CARE UNIT	0	0	0.00	0	0	43.00
44.00 CORONARY CARE UNIT						44.00
45.00 BURN INTENSIVE CARE UNIT						45.00
46.00 SURGICAL INTENSIVE CARE UNIT						46.00
47.00 NEONATAL INTENSIVE CARE UNIT	0	0	0.00	0	0	47.00
<b>Cost Center Description</b>						
					1.00	
48.00 Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					313,781	48.00
49.00 Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					2,286,932	49.00
<b>PASS THROUGH COST ADJUSTMENTS</b>						
50.00 Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)					162,734	50.00
51.00 Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					22,131	51.00
52.00 Total Program excludable cost (sum of lines 50 and 51)					184,865	52.00
53.00 Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					2,102,067	53.00
<b>TARGET AMOUNT AND LIMIT COMPUTATION</b>						
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
<b>PROGRAM INPATIENT ROUTINE SWING BED COST</b>						
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
<b>PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY</b>						
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
<b>PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST</b>						
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: 15-0169 Component CCN: 15-S169		Period: From 01/01/2020 To 12/31/2020		Worksheet D-1 Date/Time Prepared: 8/2/2021 3:48 pm	
		Title XVIII		Subprovider - IPF		PPS	
Cost Center Description		Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00	Capital-related cost	321,701	3,900,797	0.082471	0	0	90.00
91.00	Nursing School cost	0	3,900,797	0.000000	0	0	91.00
92.00	Allied health cost	0	3,900,797	0.000000	0	0	92.00
93.00	All other Medical Education	0	3,900,797	0.000000	0	0	93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 15-0169	Period: From 01/01/2020 To 12/31/2020	Worksheet D-1 Date/Time Prepared: 8/2/2021 3:48 pm
Cost Center Description		Title XIX	Hospital	PPS
		1.00		
<b>PART I - ALL PROVIDER COMPONENTS</b>				
<b>INPATIENT DAYS</b>				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		59,572	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		59,572	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)		54,065	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions)		2,240	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)		7,288	15.00
16.00	Nursery days (title V or XIX only)		2,808	16.00
<b>SWING BED ADJUSTMENT</b>				
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)		84,040,079	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)		84,040,079	27.00
<b>PRIVATE ROOM DIFFERENTIAL ADJUSTMENT</b>				
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)		84,040,079	37.00
<b>PART II - HOSPITAL AND SUBPROVIDERS ONLY</b>				
<b>PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS</b>				
38.00	Adjusted general inpatient routine service cost per diem (see instructions)		1,410.73	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		3,160,035	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)		3,160,035	41.00

COMPUTATION OF INPATIENT OPERATING COST			Provider CCN: 15-0169	Period: From 01/01/2020 To 12/31/2020	Worksheet D-1 Date/Time Prepared: 8/2/2021 3:48 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)	
42.00 NURSERY (title V & XIX only)	4,621,135	7,288	634.07	2,808	1,780,469	42.00
Intensive Care Type Inpatient Hospital Units						
43.00 INTENSIVE CARE UNIT	12,338,200	6,562	1,880.25	0	0	43.00
44.00 CORONARY CARE UNIT						44.00
45.00 BURN INTENSIVE CARE UNIT						45.00
46.00 SURGICAL INTENSIVE CARE UNIT						46.00
47.00 NEONATAL INTENSIVE CARE UNIT	17,416,725	13,390	1,300.73	1,444	1,878,254	47.00
Cost Center Description						
					1.00	
48.00 Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					3,693,051	48.00
49.00 Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					10,511,809	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)					737,615	50.00
51.00 Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					341,558	51.00
52.00 Total Program excludable cost (sum of lines 50 and 51)					1,079,173	52.00
53.00 Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					9,432,636	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)					5,507	87.00
88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					1,410.73	88.00
89.00 Observation bed cost (line 87 x line 88) (see instructions)					7,768,890	89.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 15-0169		Period: From 01/01/2020 To 12/31/2020		Worksheet D-1 Date/Time Prepared: 8/2/2021 3:48 pm	
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)	PPS
		1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00	Capital-related cost	8,762,336	84,040,079	0.104264	7,768,890	810,016	90.00
91.00	Nursing School cost	0	84,040,079	0.000000	7,768,890	0	91.00
92.00	Allied health cost	0	84,040,079	0.000000	7,768,890	0	92.00
93.00	All other Medical Education	0	84,040,079	0.000000	7,768,890	0	93.00



INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 15-0169	Period: From 01/01/2020 To 12/31/2020	Worksheet D-3 Date/Time Prepared: 8/2/2021 3:48 pm	
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	
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>					
30.00	03000	ADULTS & PEDIATRICS		33,862,107	30.00
31.00	03100	INTENSIVE CARE UNIT		7,477,707	31.00
35.00	02060	NEONATAL INTENSIVE CARE UNIT		0	35.00
40.00	04000	SUBPROVIDER - IPF		0	40.00
43.00	04300	NURSERY			43.00
<b>ANCILLARY SERVICE COST CENTERS</b>					
50.00	05000	OPERATING ROOM	0.128772	35,061,252	50.00
51.00	05100	RECOVERY ROOM	0.163953	3,841,944	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.445219	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.168537	2,841,842	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.071225	5,911,449	55.00
57.00	05700	CT SCAN	0.036423	8,754,808	57.00
58.00	05800	MRI	0.089584	1,688,673	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.066588	1,862,009	59.00
60.00	06000	LABORATORY	0.121212	23,187,288	60.00
64.00	06400	INTRAVENOUS THERAPY	0.545327	374,455	64.00
65.00	06500	RESPIRATORY THERAPY	0.203058	5,445,653	65.00
66.00	06600	PHYSICAL THERAPY	0.421096	1,724,519	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.393002	1,415,133	67.00
68.00	06800	SPEECH PATHOLOGY	0.281884	420,667	68.00
69.00	06900	ELECTROCARDIOLOGY	0.069160	2,906,905	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.245178	206,987	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.367460	7,161,730	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.412045	11,317,948	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.250772	19,005,618	73.00
73.01	07301	SPECIALTY PHARMACY	0.857591	0	73.01
74.00	07400	RENAL DIALYSIS	0.308595	1,855,217	74.00
76.00	03330	ENDOSCOPY	0.147154	2,520,790	76.00
76.01	03950	OTHER ANCILLARY SERVICE COST CENTERS	0.000000	0	76.01
76.02	03951	OTHER ANCILLARY SERVICE COST CENTERS	0.000000	0	76.02
76.03	03952	OTHER ANCILLARY SERVICE COST CENTERS	0.000000	0	76.03
76.04	03953	WOUND CARE	0.381360	349,744	76.04
76.06	03954	IMAGING CENTER	0.096020	41,960	76.06
76.07	03955	BREAST DIAGNOSTIC CENTER	0.441317	1,384	76.07
<b>OUTPATIENT SERVICE COST CENTERS</b>					
90.00	09000	CLINIC	0.000000	0	90.00
90.01	04950	INFUSION CENTER	0.666062	0	90.01
90.26	04975	SPINE CENTER	0.689317	0	90.26
91.00	09100	EMERGENCY	0.103771	12,376,254	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.823422	1,232,709	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		151,506,938	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)		151,506,938	202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 15-0169 Component CCN: 15-S169	Period: From 01/01/2020 To 12/31/2020	Worksheet D-3 Date/Time Prepared: 8/2/2021 3:48 pm	
		Title XVIII	Subprovider - IPF	PPS	
Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>					
30.00	03000	ADULTS & PEDIATRICS		0	30.00
31.00	03100	INTENSIVE CARE UNIT		0	31.00
35.00	02060	NEONATAL INTENSIVE CARE UNIT		0	35.00
40.00	04000	SUBPROVIDER - IPF		4,769,276	40.00
43.00	04300	NURSERY			43.00
<b>ANCILLARY SERVICE COST CENTERS</b>					
50.00	05000	OPERATING ROOM	0.128772	1,645	50.00
51.00	05100	RECOVERY ROOM	0.163953	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.445219	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.168537	31,787	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.071225	0	55.00
57.00	05700	CT SCAN	0.036423	117,428	57.00
58.00	05800	MRI	0.089584	7,959	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.066588	66,264	59.00
60.00	06000	LABORATORY	0.121212	806,718	60.00
64.00	06400	INTRAVENOUS THERAPY	0.545327	15,605	64.00
65.00	06500	RESPIRATORY THERAPY	0.203058	19,132	65.00
66.00	06600	PHYSICAL THERAPY	0.421096	53,539	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.393002	41,375	67.00
68.00	06800	SPEECH PATHOLOGY	0.281884	4,417	68.00
69.00	06900	ELECTROCARDIOLOGY	0.069160	39,032	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.245178	5,532	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.367460	23,989	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.412045	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.250772	399,380	73.00
73.01	07301	SPECIALTY PHARMACY	0.857591	0	73.01
74.00	07400	RENAL DIALYSIS	0.308595	0	74.00
76.00	03330	ENDOSCOPY	0.147154	0	76.00
76.01	03950	OTHER ANCILLARY SERVICE COST CENTERS	0.000000	0	76.01
76.02	03951	OTHER ANCILLARY SERVICE COST CENTERS	0.000000	0	76.02
76.03	03952	OTHER ANCILLARY SERVICE COST CENTERS	0.000000	0	76.03
76.04	03953	WOUND CARE	0.381360	0	76.04
76.06	03954	IMAGING CENTER	0.096020	0	76.06
76.07	03955	BREAST DIAGNOSTIC CENTER	0.441317	0	76.07
<b>OUTPATIENT SERVICE COST CENTERS</b>					
90.00	09000	CLINIC	0.000000	0	90.00
90.01	04950	INFUSION CENTER	0.666062	0	90.01
90.26	04975	SPINE CENTER	0.689317	0	90.26
91.00	09100	EMERGENCY	0.103771	342,660	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.823422	0	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		1,976,462	200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0	201.00
202.00		Net charges (line 200 minus line 201)		1,976,462	202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 15-0169	Period: From 01/01/2020 To 12/31/2020	Worksheet D-3 Date/Time Prepared: 8/2/2021 3:48 pm	
Cost Center Description		Title XIX	Hospital	PPS	
		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>					
30.00	03000	ADULTS & PEDIATRICS		6,797,079	30.00
31.00	03100	INTENSIVE CARE UNIT		1,526,845	31.00
35.00	02060	NEONATAL INTENSIVE CARE UNIT		13,096,192	35.00
40.00	04000	SUBPROVIDER - IPF		482,915	40.00
43.00	04300	NURSERY		556,253	43.00
<b>ANCILLARY SERVICE COST CENTERS</b>					
50.00	05000	OPERATING ROOM	0.129050	2,714,513	350,308 50.00
51.00	05100	RECOVERY ROOM	0.163953	405,494	66,482 51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.445219	552,016	245,768 52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.168537	530,674	89,438 54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.071225	779,244	55,502 55.00
57.00	05700	CT SCAN	0.036423	1,000,665	36,447 57.00
58.00	05800	MRI	0.089584	225,323	20,185 58.00
59.00	05900	CARDIAC CATHETERIZATION	0.066588	41,898	2,790 59.00
60.00	06000	LABORATORY	0.121212	3,506,320	425,008 60.00
64.00	06400	INTRAVENOUS THERAPY	0.545327	68,554	37,384 64.00
65.00	06500	RESPIRATORY THERAPY	0.203058	1,843,876	374,414 65.00
66.00	06600	PHYSICAL THERAPY	0.422724	121,257	51,258 66.00
67.00	06700	OCCUPATIONAL THERAPY	0.393002	170,175	66,879 67.00
68.00	06800	SPEECH PATHOLOGY	0.281884	89,041	25,099 68.00
69.00	06900	ELECTROCARDIOLOGY	0.069160	296,953	20,537 69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.245178	64,562	15,829 70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.367460	1,614,721	593,345 71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.412045	0	0 72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.250772	2,992,487	750,432 73.00
73.01	07301	SPECIALTY PHARMACY	0.857591	0	0 73.01
74.00	07400	RENAL DIALYSIS	0.308595	227,358	70,162 74.00
76.00	03330	ENDOSCOPY	0.147154	201,930	29,715 76.00
76.01	03950	OTHER ANCILLARY SERVICE COST CENTERS	0.000000	0	0 76.01
76.02	03951	OTHER ANCILLARY SERVICE COST CENTERS	0.000000	0	0 76.02
76.03	03952	OTHER ANCILLARY SERVICE COST CENTERS	0.000000	0	0 76.03
76.04	03953	WOUND CARE	0.381360	33,594	12,811 76.04
76.06	03954	IMAGING CENTER	0.096020	0	0 76.06
76.07	03955	BREAST DIAGNOSTIC CENTER	0.441317	0	0 76.07
<b>OUTPATIENT SERVICE COST CENTERS</b>					
90.00	09000	CLINIC	0.000000	0	0 90.00
90.01	04950	INFUSION CENTER	0.666062	0	0 90.01
90.26	04975	SPINE CENTER	0.689317	0	0 90.26
91.00	09100	EMERGENCY	0.104587	1,512,007	158,136 91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.823422	236,965	195,122 92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		19,229,627	3,693,051 200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0	0 201.00
202.00		Net charges (line 200 minus line 201)		19,229,627	202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 15-0169	Period: From 01/01/2020 To 12/31/2020	Worksheet E Part A Date/Time Prepared: 8/2/2021 3:48 pm
		Title XVIII	Hospital	PPS
		1.00		
<b>PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS</b>				
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)		26,664,815	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1 (see instructions)		9,294,856	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)		815,141	2.03
2.04	Outlier payments for discharges occurring on or after October 1 (see instructions)		175,733	2.04
3.00	Managed Care Simulated Payments		23,926,561	3.00
4.00	Bed days available divided by number of days in the cost reporting period (see instructions)		294.36	4.00
<b>Indirect Medical Education Adjustment</b>				
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).		4.09	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)		4.09	9.00
10.00	FTE count for allopathic and osteopathic programs in the current year from your records		4.36	10.00
11.00	FTE count for residents in dental and podiatric programs.		2.83	11.00
12.00	Current year allowable FTE (see instructions)		6.92	12.00
13.00	Total allowable FTE count for the prior year.		6.14	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.		5.39	14.00
15.00	Sum of lines 12 through 14 divided by 3.		6.15	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		6.15	18.00
19.00	Current year resident to bed ratio (line 18 divided by line 4).		0.020893	19.00
20.00	Prior year resident to bed ratio (see instructions)		0.021325	20.00
21.00	Enter the lesser of lines 19 or 20 (see instructions)		0.020893	21.00
22.00	IME payment adjustment (see instructions)		408,286	22.00
22.01	IME payment adjustment - Managed Care (see instructions)		271,662	22.01
<b>Indirect Medical Education Adjustment for the Add-on for § 422 of the MMA</b>				
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)		0.27	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)		408,286	29.00
29.01	Total IME payment - Managed Care (sum of lines 22.01 and 28.01)		271,662	29.01
<b>Disproportionate Share Adjustment</b>				
30.00	Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)		3.66	30.00
31.00	Percentage of Medicaid patient days (see instructions)		33.08	31.00
32.00	Sum of lines 30 and 31		36.74	32.00
33.00	Allowable disproportionate share percentage (see instructions)		19.53	33.00
34.00	Disproportionate share adjustment (see instructions)		1,755,731	34.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 15-0169	Period: From 01/01/2020 To 12/31/2020	Worksheet E Part A Date/Time Prepared: 8/2/2021 3:48 pm
		Title XVIII	Hospital	PPS
		Prior to 10/1	On/After 10/1	
		1.00	2.00	
<b>Uncompensated Care Adjustment</b>				
35.00	Total uncompensated care amount (see instructions)	8,350,599,096	8,290,014,521	35.00
35.01	Factor 3 (see instructions)	0.000049391	0.000145077	35.01
35.02	Hospital uncompensated care payment (If line 34 is zero, enter zero on this line) (see instructions)	412,446	1,202,694	35.02
35.03	Pro rata share of the hospital uncompensated care payment amount (see instructions)	308,771	303,145	35.03
36.00	Total uncompensated care (sum of columns 1 and 2 on line 35.03)	611,916		36.00
<b>Additional payment for high percentage of ESRD beneficiary discharges (lines 40 through 46)</b>				
40.00	Total Medicare discharges, excluding MS-DRGs 652, 682, 683, 684 and 685. (see instructions)		0	40.00
41.00	Total ESRD Medicare discharges excluding MS-DRGs 652, 682, 683, 684 and 685. (see instructions)		0	41.00
41.01	Total ESRD Medicare covered and paid discharges excluding MS-DRGs 652, 682, 683, 684 and 685. (see instructions)		0	41.01
42.00	Divide line 41 by line 40 (if less than 10%, you do not qualify for adjustment)	0.00		42.00
43.00	Total Medicare ESRD inpatient days excluding MS-DRGs 652, 682, 683, 684 and 685. (see instructions)		0	43.00
44.00	Ratio of average length of stay to one week (line 43 divided by line 41 divided by 7 days)	0.000000		44.00
45.00	Average weekly cost for dialysis treatments (see instructions)	0.00		45.00
46.00	Total additional payment (line 45 times line 44 times line 41.01)		0	46.00
47.00	Subtotal (see instructions)	39,726,478		47.00
48.00	Hospital specific payments (to be completed by SCH and MDH, small rural hospitals only. (see instructions)		0	48.00
				<b>Amount</b>
				<b>1.00</b>
49.00	Total payment for inpatient operating costs (see instructions)		39,998,140	49.00
50.00	Payment for inpatient program capital (from Wkst. L, Pt. I and Pt. II, as applicable)		3,176,420	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).		161,862	52.00
53.00	Nursing and Allied Health Managed Care payment		0	53.00
54.00	Special add-on payments for new technologies		108,511	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 instructions)		0	56.00
57.00	Routine service other pass through costs (from Wkst. D, Pt. III, column 9, lines 30 through 35).		0	57.00
58.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 11 line 200)		0	58.00
59.00	Total (sum of amounts on lines 49 through 58)		43,444,933	59.00
60.00	Primary payer payments		19,221	60.00
61.00	Total amount payable for program beneficiaries (line 59 minus line 60)		43,425,712	61.00
62.00	Deductibles billed to program beneficiaries		3,404,984	62.00
63.00	Coinurance billed to program beneficiaries		137,357	63.00
64.00	Allowable bad debts (see instructions)		146,827	64.00
65.00	Adjusted reimbursable bad debts (see instructions)		95,438	65.00
66.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		75,660	66.00
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)		39,978,809	67.00
68.00	Credits received from manufacturers for replaced devices for applicable to MS-DRGs (see instructions)		0	68.00
69.00	Outlier payments reconciliation (sum of lines 93, 95 and 96). (For SCH see instructions)		0	69.00
70.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	70.00
70.50	Rural Community Hospital Demonstration Project (\$410A Demonstration) adjustment (see instructions)		0	70.50
70.87	Demonstration payment adjustment amount before sequestration		0	70.87
70.88	SCH or MDH volume decrease adjustment (contractor use only)		0	70.88
70.89	Pioneer ACO demonstration payment adjustment amount (see instructions)		0	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)		-203,435	70.93
70.94	HRR adjustment amount (see instructions)		-331,208	70.94
70.95	Recovery of accelerated depreciation		0	70.95

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 15-0169	Period: From 01/01/2020 To 12/31/2020	Worksheet E Part A Date/Time Prepared: 8/2/2021 3:48 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)			420,297 70.99
71.00	Amount due provider (line 67 minus lines 68 plus/minus lines 69 & 70)			39,023,869 71.00
71.01	Sequestration adjustment (see instructions)			257,558 71.01
71.02	Demonstration payment adjustment amount after sequestration			0 71.02
71.03	Sequestration adjustment-PARHM pass-throughs			0 71.03
72.00	Interim payments			38,407,603 72.00
72.01	Interim payments-PARHM			0 72.01
73.00	Tentative settlement (for contractor use only)			0 73.00
73.01	Tentative settlement-PARHM (for contractor use only)			0 73.01
74.00	Balance due provider/program (line 71 minus lines 71.01, 71.02, 72, and 73)			358,708 74.00
74.01	Balance due provider/program-PARHM (see instructions)			0 74.01
75.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2			1,024,988 75.00
<b>TO BE COMPLETED BY CONTRACTOR (lines 90 through 96)</b>				
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. 1, 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
<b>HSP Bonus Payment Amount</b>				
100.00	HSP bonus amount (see instructions)		0	0 100.00
<b>HVBP Adjustment for HSP Bonus Payment</b>				
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
<b>HRR Adjustment for HSP Bonus Payment</b>				
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
<b>Rural Community Hospital Demonstration Project (\$410A Demonstration) Adjustment</b>				
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
<b>Cost Reimbursement</b>				
201.00	Medicare inpatient service costs (from Wkst. D-1, Pt. 11, line 49)			201.00
202.00	Medicare discharges (see instructions)			202.00
203.00	Case-mix adjustment factor (see instructions)			203.00
<b>Computation of Demonstration Target Amount Limitation (N/A in first year of the current 5-year demonstration period)</b>				
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
<b>Adjustment to Medicare Part A Inpatient Reimbursement</b>				
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
<b>Comparison of PPS versus Cost Reimbursement</b>				
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: 15-0169	Period: From 01/01/2020 To 12/31/2020	Worksheet E Part B Date/Time Prepared: 8/2/2021 3:48 pm
		Title XVIII	Hospital	PPS
		1.00		
<b>PART B - MEDICAL AND OTHER HEALTH SERVICES</b>				
1.00	Medical and other services (see instructions)		16,343	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)		20,959,956	2.00
3.00	OPPS payments		15,936,290	3.00
4.00	Outlier payment (see instructions)		273,730	4.00
4.01	Outlier reconciliation amount (see instructions)		0	4.01
5.00	Enter the hospital specific payment to cost ratio (see instructions)		0.000	5.00
6.00	Line 2 times line 5		0	6.00
7.00	Sum of lines 3, 4, and 4.01, divided by line 6		0.00	7.00
8.00	Transitional corridor payment (see instructions)		0	8.00
9.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200		0	9.00
10.00	Organ acquisitions		0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)		16,343	11.00
<b>COMPUTATION OF LESSER OF COST OR CHARGES</b>				
<b>Reasonable charges</b>				
12.00	Ancillary service charges		76,268	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)		76,268	14.00
<b>Customary charges</b>				
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 charge basis 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)		76,268	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)		59,925	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)		16,343	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)		16,210,020	24.00
<b>COMPUTATION OF REIMBURSEMENT SETTLEMENT</b>				
25.00	Deductibles and coinsurance amounts (for CAH, see instructions)		4,742	25.00
26.00	Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)		2,892,567	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)		13,329,054	27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 50)		61,866	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)		13,390,920	30.00
31.00	Primary payer payments		1,656	31.00
32.00	Subtotal (line 30 minus line 31)		13,389,264	32.00
<b>ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)</b>				
33.00	Composite rate ESRD (from Wkst. I-5, line 11)		0	33.00
34.00	Allowable bad debts (see instructions)		307,320	34.00
35.00	Adjusted reimbursable bad debts (see instructions)		199,758	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		282,136	36.00
37.00	Subtotal (see instructions)		13,589,022	37.00
38.00	MSP-LCC reconciliation amount from PS&R		204	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	39.00
39.50	Pioneer ACO demonstration payment adjustment (see instructions)		0	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)		13,588,818	40.00
40.01	Sequestration adjustment (see instructions)		89,686	40.01
40.02	Demonstration payment adjustment amount after sequestration		0	40.02
40.03	Sequestration adjustment-PARHM pass-throughs		0	40.03
41.00	Interim payments		13,637,941	41.00
41.01	Interim payments-PARHM		0	41.01
42.00	Tentative settlement (for contractors use only)		0	42.00
42.01	Tentative settlement-PARHM (for contractor use only)		0	42.01
43.00	Balance due provider/program (see instructions)		-138,809	43.00
43.01	Balance due provider/program-PARHM (see instructions)		0	43.01
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		0	44.00
<b>TO BE COMPLETED BY CONTRACTOR</b>				
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: 15-0169 Component CCN: 15-S169	Period: From 01/01/2020 To 12/31/2020	Worksheet E Part B Date/Time Prepared: 8/2/2021 3:48 pm
		Title XVIII	Subprovider - IPF	PPS
				1.00
<b>PART B - MEDICAL AND OTHER HEALTH SERVICES</b>				
1.00	Medical and other services (see instructions)		558	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)		36	2.00
3.00	OPPS payments		270	3.00
4.00	Outlier payment (see instructions)		0	4.00
4.01	Outlier reconciliation amount (see instructions)		0	4.01
5.00	Enter the hospital specific payment to cost ratio (see instructions)		0.000	5.00
6.00	Line 2 times line 5		0	6.00
7.00	Sum of lines 3, 4, and 4.01, divided by line 6		0.00	7.00
8.00	Transitional corridor payment (see instructions)		0	8.00
9.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200		0	9.00
10.00	Organ acquisitions		0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)		558	11.00
<b>COMPUTATION OF LESSER OF COST OR CHARGES</b>				
<b>Reasonable charges</b>				
12.00	Ancillary service charges		2,224	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)		2,224	14.00
<b>Customary charges</b>				
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 charge basis 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)		2,224	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)		1,666	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)		558	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)		270	24.00
<b>COMPUTATION OF REIMBURSEMENT SETTLEMENT</b>				
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)		16	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)		812	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)		812	30.00
31.00	Primary payer payments		0	31.00
32.00	Subtotal (line 30 minus line 31)		812	32.00
<b>ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)</b>				
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)		812	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 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)		812	40.00
40.01	Sequestration adjustment (see instructions)		5	40.01
40.02	Demonstration payment adjustment amount after sequestration		0	40.02
40.03	Sequestration adjustment-PARHM pass-throughs		0	40.03
41.00	Interim payments		785	41.00
41.01	Interim payments-PARHM		0	41.01
42.00	Tentative settlement (for contractors use only)		0	42.00
42.01	Tentative settlement-PARHM (for contractor use only)		0	42.01
43.00	Balance due provider/program (see instructions)		22	43.00
43.01	Balance due provider/program-PARHM (see instructions)		0	43.01
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		0	44.00
<b>TO BE COMPLETED BY CONTRACTOR</b>				
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: 15-0169

Period:  
From 01/01/2020  
To 12/31/2020

Worksheet E-1  
Part I  
Date/Time Prepared:  
8/2/2021 3:48 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		38,312,103		13,533,641	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	08/05/2020	95,500	08/05/2020	104,300	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)		95,500		104,300	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)		38,407,603		13,637,941	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		358,708		0	6.01	
6.02	SETTLEMENT TO PROGRAM		0		138,809	6.02	
7.00	Total Medicare program liability (see instructions)		38,766,311		13,499,132	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: 15-0169  
Component CCN: 15-S169

Period:  
From 01/01/2020  
To 12/31/2020

Worksheet E-1  
Part I  
Date/Time Prepared:  
8/2/2021 3:48 pm

Title XVIII

Subprovider -  
IPF

PPS

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider					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		1,896,037		785	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
Program to Provider						
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
Provider to Program						
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		1,896,037		785	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		5,210		22	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		1,901,247		807	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: 15-0169	Period: From 01/01/2020 To 12/31/2020	Worksheet E-1 Part II Date/Time Prepared: 8/2/2021 3:48 pm
		Title XVIII	Hospital	PPS
				1.00
<b>TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS</b>				
<b>HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION</b>				
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
<b>INPATIENT HOSPITAL SERVICES UNDER THE IPPS &amp; CAH</b>				
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: 15-0169 Component CCN: 15-S169	Period: From 01/01/2020 To 12/31/2020	Worksheet E-3 Part II Date/Time Prepared: 8/2/2021 3:48 pm
		Title XVIII	Subprovider - IPF	PPS
				1.00
<b>PART II - MEDICARE PART A SERVICES - IPF PPS</b>				
1.00	Net Federal IPF PPS Payments (excluding outlier, ECT, and medical education payments)			2,064,569 1.00
2.00	Net IPF PPS Outlier Payments			20,674 2.00
3.00	Net IPF PPS ECT Payments			0 3.00
4.00	Unweighted intern and resident FTE count in the most recent cost report filed on or before November 15, 2004. (see instructions)			0.00 4.00
4.01	Cap increases for the unweighted intern and resident FTE count for residents that were displaced by program or hospital closure, that would not be counted without a temporary cap adjustment under 42 CFR §412.424(d)(1)(iii)(F)(1) or (2) (see instructions)			0.00 4.01
5.00	New Teaching program adjustment. (see instructions)			0.00 5.00
6.00	Current year's unweighted FTE count of I&R excluding FTEs in the new program growth period of a "new teaching program" (see instructions)			0.00 6.00
7.00	Current year's unweighted I&R FTE count for residents within the new program growth period of a "new teaching program" (see instructions)			0.00 7.00
8.00	Intern and resident count for IPF PPS medical education adjustment (see instructions)			0.00 8.00
9.00	Average Daily Census (see instructions)			11.008197 9.00
10.00	Teaching Adjustment Factor $\{(1 + (\text{line 8}/\text{line 9})) \text{ raised to the power of } .5150 - 1\}$ .			0.000000 10.00
11.00	Teaching Adjustment (line 1 multiplied by line 10).			0 11.00
12.00	Adjusted Net IPF PPS Payments (sum of lines 1, 2, 3 and 11)			2,085,243 12.00
13.00	Nursing and Allied Health Managed Care payment (see instruction)			0 13.00
14.00	Organ acquisition (DO NOT USE THIS LINE)			0 14.00
15.00	Cost of physicians' services in a teaching hospital (see instructions)			0 15.00
16.00	Subtotal (see instructions)			2,085,243 16.00
17.00	Primary payer payments			0 17.00
18.00	Subtotal (line 16 less line 17).			2,085,243 18.00
19.00	Deductibles			149,160 19.00
20.00	Subtotal (line 18 minus line 19)			1,936,083 20.00
21.00	Coinsurance			25,696 21.00
22.00	Subtotal (line 20 minus line 21)			1,910,387 22.00
23.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)			5,372 23.00
24.00	Adjusted reimbursable bad debts (see instructions)			3,492 24.00
25.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			0 25.00
26.00	Subtotal (sum of lines 22 and 24)			1,913,879 26.00
27.00	Direct graduate medical education payments (see instructions)			0 27.00
28.00	Other pass through costs (see instructions)			0 28.00
29.00	Outlier payments reconciliation			0 29.00
30.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0 30.00
30.50	Pioneer ACO demonstration payment adjustment (see instructions)			0 30.50
30.99	Demonstration payment adjustment amount before sequestration			0 30.99
31.00	Total amount payable to the provider (see instructions)			1,913,879 31.00
31.01	Sequestration adjustment (see instructions)			12,632 31.01
31.02	Demonstration payment adjustment amount after sequestration			0 31.02
32.00	Interim payments			1,896,037 32.00
33.00	Tentative settlement (for contractor use only)			0 33.00
34.00	Balance due provider/program (line 31 minus lines 31.01, 31.02, 32 and 33)			5,210 34.00
35.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2			0 35.00
<b>TO BE COMPLETED BY CONTRACTOR</b>				
50.00	Original outlier amount from Worksheet E-3, Part II, line 2			20,674 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

DIRECT GRADUATE MEDICAL EDUCATION (GME) & ESRD OUTPATIENT DIRECT MEDICAL EDUCATION COSTS		Provider CCN: 15-0169	Period: From 01/01/2020 To 12/31/2020	Worksheet E-4 Date/Time Prepared: 8/2/2021 3:48 pm	
		Title XVIII	Hospital	PPS	
				1.00	
<b>COMPUTATION OF TOTAL DIRECT GME AMOUNT</b>					
1.00	Unweighted resident FTE count for allopathic and osteopathic programs for cost reporting periods ending on or before December 31, 1996.			0.00	1.00
2.00	Unweighted FTE resident cap add-on for new programs per 42 CFR 413.79(e)(1) (see instructions)			0.00	2.00
3.00	Amount of reduction to Direct GME cap under section 422 of MMA			0.00	3.00
3.01	Direct GME cap reduction amount under ACA §5503 in accordance with 42 CFR §413.79 (m). (see instructions for cost reporting periods straddling 7/1/2011)			0.00	3.01
4.00	Adjustment (plus or minus) to the FTE cap for allopathic and osteopathic programs due to a Medicare GME affiliation agreement (42 CFR §413.75(b) and § 413.79 (f))			4.10	4.00
4.01	ACA Section 5503 increase to the Direct GME FTE Cap (see instructions for cost reporting periods straddling 7/1/2011)			0.00	4.01
4.02	ACA Section 5506 number of additional direct GME FTE cap slots (see instructions for cost reporting periods straddling 7/1/2011)			0.00	4.02
5.00	FTE adjusted cap (line 1 plus line 2 minus line 3 and 3.01 plus or minus line 4 plus lines 4.01 and 4.02 plus applicable subscripts)			4.10	5.00
6.00	Unweighted resident FTE count for allopathic and osteopathic programs for the current year from your records (see instructions)			4.36	6.00
7.00	Enter the lesser of line 5 or line 6			4.10	7.00
		Primary Care	Other	Total	
		1.00	2.00	3.00	
8.00	Weighted FTE count for physicians in an allopathic and osteopathic program for the current year.	0.93	3.43	4.36	8.00
9.00	If line 6 is less than 5 enter the amount from line 8, otherwise multiply line 8 times the result of line 5 divided by the amount on line 6.	0.87	3.23	4.10	9.00
10.00	Weighted dental and podiatric resident FTE count for the current year		2.83		10.00
10.01	Unweighted dental and podiatric resident FTE count for the current year		2.83		10.01
11.00	Total weighted FTE count	0.87	6.06		11.00
12.00	Total weighted resident FTE count for the prior cost reporting year (see instructions)	1.49	4.65		12.00
13.00	Total weighted resident FTE count for the penultimate cost reporting year (see instructions)	1.27	4.12		13.00
14.00	Rolling average FTE count (sum of lines 11 through 13 divided by 3).	1.21	4.94		14.00
15.00	Adjustment for residents in initial years of new programs	0.00	0.00		15.00
15.01	Unweighted adjustment for residents in initial years of new programs	0.00	0.00		15.01
16.00	Adjustment for residents displaced by program or hospital closure	0.00	0.00		16.00
16.01	Unweighted adjustment for residents displaced by program or hospital closure	0.00	0.00		16.01
17.00	Adjusted rolling average FTE count	1.21	4.94		17.00
18.00	Per resident amount	96,394.28	96,394.28		18.00
19.00	Approved amount for resident costs	116,637	476,188	592,825	19.00
				1.00	
20.00	Additional unweighted allopathic and osteopathic direct GME FTE resident cap slots received under 42 Sec. 413.79(c)(4)			0.00	20.00
21.00	Direct GME FTE unweighted resident count over cap (see instructions)			0.26	21.00
22.00	Allowable additional direct GME FTE Resident Count (see instructions)			0.00	22.00
23.00	Enter the locality adjustment national average per resident amount (see instructions)			0.00	23.00
24.00	Multiply line 22 time line 23			0	24.00
25.00	Total direct GME amount (sum of lines 19 and 24)			592,825	25.00
		Inpatient Part A	Managed Care	Total	
		1.00	2.00	3.00	
<b>COMPUTATION OF PROGRAM PATIENT LOAD</b>					
26.00	Inpatient Days (see instructions) (Title XIX - see S-2 Part IX, line 3.02, column 2)	19,158	11,710		26.00
27.00	Total Inpatient Days (see instructions)	79,621	79,621		27.00
28.00	Ratio of inpatient days to total inpatient days	0.240615	0.147072		28.00
29.00	Program direct GME amount	142,643	87,188	229,831	29.00
29.01	Percent reduction for MA DGME		7.00		29.01
30.00	Reduction for direct GME payments for Medicare Advantage		6,103	6,103	30.00
31.00	Net Program direct GME amount			223,728	31.00

DIRECT GRADUATE MEDICAL EDUCATION (GME) & ESRD OUTPATIENT DIRECT MEDICAL EDUCATION COSTS		Provider CCN: 15-0169	Period: From 01/01/2020 To 12/31/2020	Worksheet E-4 Date/Time Prepared: 8/2/2021 3:48 pm
		Title XVIII	Hospital	PPS
		1.00		
<b>DIRECT MEDICAL EDUCATION COSTS FOR ESRD COMPOSITE RATE - TITLE XVIII ONLY (NURSING SCHOOL AND PARAMEDICAL EDUCATION COSTS)</b>				
32.00	Renal dialysis direct medical education costs (from Wkst. B, Pt. I, sum of col. 20 and 23, lines 74 and 94)		0	32.00
33.00	Renal dialysis and home dialysis total charges (Wkst. C, Pt. I, col. 8, sum of lines 74 and 94)		4,598,982	33.00
34.00	Ratio of direct medical education costs to total charges (line 32 ÷ line 33)		0.000000	34.00
35.00	Medicare outpatient ESRD charges (see instructions)		0	35.00
36.00	Medicare outpatient ESRD direct medical education costs (line 34 x line 35)		0	36.00
<b>APPORTIONMENT BASED ON MEDICARE REASONABLE COST - TITLE XVIII ONLY</b>				
<b>Part A Reasonable Cost</b>				
37.00	Reasonable cost (see instructions)		54,897,395	37.00
38.00	Organ acquisition costs (Wkst. D-4, Pt. III, col. 1, line 69)		0	38.00
39.00	Cost of physicians' services in a teaching hospital (see instructions)		0	39.00
40.00	Primary payer payments (see instructions)		19,221	40.00
41.00	Total Part A reasonable cost (sum of lines 37 through 39 minus line 40)		54,878,174	41.00
<b>Part B Reasonable Cost</b>				
42.00	Reasonable cost (see instructions)		20,976,893	42.00
43.00	Primary payer payments (see instructions)		1,656	43.00
44.00	Total Part B reasonable cost (line 42 minus line 43)		20,975,237	44.00
45.00	Total reasonable cost (sum of lines 41 and 44)		75,853,411	45.00
46.00	Ratio of Part A reasonable cost to total reasonable cost (line 41 ÷ line 45)		0.723477	46.00
47.00	Ratio of Part B reasonable cost to total reasonable cost (line 44 ÷ line 45)		0.276523	47.00
<b>ALLOCATION OF MEDICARE DIRECT GME COSTS BETWEEN PART A AND PART B</b>				
48.00	Total program GME payment (line 31)		223,728	48.00
49.00	Part A Medicare GME payment (line 46 x 48) (title XVIII only) (see instructions)		161,862	49.00
50.00	Part B Medicare GME payment (line 47 x 48) (title XVIII only) (see instructions)		61,866	50.00

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

Provider CCN: 15-0169

Period:  
From 01/01/2020  
To 12/31/2020

Worksheet G  
Date/Time Prepared:  
8/2/2021 3:48 pm

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
<b>CURRENT ASSETS</b>						
1.00	Cash on hand in banks	8,700	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	307,262,169	0	0	0	4.00
5.00	Other receivable	-225,936,710	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	593,366	0	0	0	6.00
7.00	Inventory	7,543,956	0	0	0	7.00
8.00	Prepaid expenses	0	0	0	0	8.00
9.00	Other current assets	4,767,654	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)	94,239,135	0	0	0	11.00
<b>FIXED ASSETS</b>						
12.00	Land	2,705,851	0	0	0	12.00
13.00	Land improvements	4,358,832	0	0	0	13.00
14.00	Accumulated depreciation	0	0	0	0	14.00
15.00	Buildings	326,772,560	0	0	0	15.00
16.00	Accumulated depreciation	0	0	0	0	16.00
17.00	Leasehold improvements	4,611,425	0	0	0	17.00
18.00	Accumulated depreciation	0	0	0	0	18.00
19.00	Fixed equipment	122,988,387	0	0	0	19.00
20.00	Accumulated depreciation	0	0	0	0	20.00
21.00	Automobiles and trucks	103,991	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	-255,913,251	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	316,270	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	205,944,065	0	0	0	30.00
<b>OTHER ASSETS</b>						
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	1,133,415,406	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	1,133,415,406	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	1,433,598,606	0	0	0	36.00
<b>CURRENT LIABILITIES</b>						
37.00	Accounts payable	2,000,665	0	0	0	37.00
38.00	Salaries, wages, and fees payable	0	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	0	0	0	42.00
43.00	Due to other funds	0	0	0	0	43.00
44.00	Other current liabilities	16,678,432	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	18,679,097	0	0	0	45.00
<b>LONG TERM LIABILITIES</b>						
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	20,558,318	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	20,558,318	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	39,237,415	0	0	0	51.00
<b>CAPITAL ACCOUNTS</b>						
52.00	General fund balance	1,394,361,191	0	0	0	52.00
53.00	Specific purpose fund	0	0	0	0	53.00
54.00	Donor created - endowment fund balance - restricted	0	0	0	0	54.00
55.00	Donor created - endowment fund balance - unrestricted	0	0	0	0	55.00
56.00	Governing body created - endowment fund balance	0	0	0	0	56.00
57.00	Plant fund balance - invested in plant	0	0	0	0	57.00
58.00	Plant fund balance - reserve for plant improvement, replacement, and expansion	0	0	0	0	58.00
59.00	Total fund balances (sum of lines 52 thru 58)	1,394,361,191	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	1,433,598,606	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 15-0169

Period:  
From 01/01/2020  
To 12/31/2020

Worksheet G-1

Date/Time Prepared:  
8/2/2021 3:48 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		1,265,676,286		0	1.00
2.00	Net income (loss) (From Wkst. G-3, line 29)		128,684,905			2.00
3.00	Total (sum of line 1 and line 2)		1,394,361,191		0	3.00
4.00	Additions (credit adjustments) (specify)	0		0		4.00
5.00		0		0		5.00
6.00		0		0		6.00
7.00		0		0		7.00
8.00		0		0		8.00
9.00		0		0		9.00
10.00	Total additions (sum of line 4-9)		0		0	10.00
11.00	Subtotal (line 3 plus line 10)		1,394,361,191		0	11.00
12.00	Deductions (debit adjustments) (specify)	0		0		12.00
13.00		0		0		13.00
14.00		0		0		14.00
15.00		0		0		15.00
16.00		0		0		16.00
17.00		0		0		17.00
18.00	Total deductions (sum of lines 12-17)		0		0	18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		1,394,361,191		0	19.00
		Endowment Fund		Plant Fund		
		6.00	7.00	8.00		
1.00	Fund balances at beginning of period	0		0		1.00
2.00	Net income (loss) (From Wkst. G-3, line 29)					2.00
3.00	Total (sum of line 1 and line 2)	0		0		3.00
4.00	Additions (credit adjustments) (specify)		0			4.00
5.00			0			5.00
6.00			0			6.00
7.00			0			7.00
8.00			0			8.00
9.00			0			9.00
10.00	Total additions (sum of line 4-9)	0		0		10.00
11.00	Subtotal (line 3 plus line 10)	0		0		11.00
12.00	Deductions (debit adjustments) (specify)		0			12.00
13.00			0			13.00
14.00			0			14.00
15.00			0			15.00
16.00			0			16.00
17.00			0			17.00
18.00	Total deductions (sum of lines 12-17)	0		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)	0		0		19.00



STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES

Provider CCN: 15-0169

Period:  
From 01/01/2020  
To 12/31/2020

Worksheet G-2  
Parts I & II  
Date/Time Prepared:  
8/2/2021 3:48 pm

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
<b>PART I - PATIENT REVENUES</b>					
General Inpatient Routine Services					
1.00	Hospital	168,706,375		168,706,375	1.00
2.00	SUBPROVIDER - IPF	9,403,664		9,403,664	2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF		0	0	5.00
6.00	Swing bed - NF		0	0	6.00
7.00	SKILLED NURSING FACILITY				7.00
8.00	NURSING FACILITY				8.00
9.00	OTHER LONG TERM CARE				9.00
10.00	Total general inpatient care services (sum of lines 1-9)	178,110,039		178,110,039	10.00
Intensive Care Type Inpatient Hospital Services					
11.00	INTENSIVE CARE UNIT	29,445,481		29,445,481	11.00
12.00	CORONARY CARE UNIT				12.00
13.00	BURN INTENSIVE CARE UNIT				13.00
14.00	SURGICAL INTENSIVE CARE UNIT				14.00
15.00	NEONATAL INTENSIVE CARE UNIT	117,924,265		117,924,265	15.00
16.00	Total intensive care type inpatient hospital services (sum of lines 11-15)	147,369,746		147,369,746	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	325,479,785		325,479,785	17.00
18.00	Ancillary services	556,450,424	610,427,949	1,166,878,373	18.00
19.00	Outpatient services		0	0	19.00
20.00	RURAL HEALTH CLINIC		0	0	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER		0	0	21.00
22.00	HOME HEALTH AGENCY				22.00
23.00	AMBULANCE SERVICES				23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	PRO FEES		486,312	486,312	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	881,930,209	610,914,261	1,492,844,470	28.00
<b>PART II - OPERATING EXPENSES</b>					
29.00	Operating expenses (per Wkst. A, column 3, line 200)		438,299,177		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)		438,299,177		43.00

STATEMENT OF REVENUES AND EXPENSES

Provider CCN: 15-0169

Period:  
From 01/01/2020  
To 12/31/2020

Worksheet G-3

Date/Time Prepared:  
8/2/2021 3:48 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	1,492,844,470	1.00
2.00	Less contractual allowances and discounts on patients' accounts	1,026,434,371	2.00
3.00	Net patient revenues (line 1 minus line 2)	466,410,099	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	438,299,177	4.00
5.00	Net income from service to patients (line 3 minus line 4)	28,110,922	5.00
<b>OTHER INCOME</b>			
6.00	Contributions, donations, bequests, etc	265,399	6.00
7.00	Income from investments	13,110,559	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	4,009	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	1,851,209	14.00
15.00	Revenue from rental of living quarters	0	15.00
16.00	Revenue from sale of medical and surgical supplies to other than patients	0	16.00
17.00	Revenue from sale of drugs to other than patients	0	17.00
18.00	Revenue from sale of medical records and abstracts	0	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	0	20.00
21.00	Rental of vending machines	0	21.00
22.00	Rental of hospital space	59,105,051	22.00
23.00	Governmental appropriations	0	23.00
24.00	OTHER (SPECIFY)	0	24.00
24.50	COVID-19 PHE Funding	26,237,756	24.50
25.00	Total other income (sum of lines 6-24)	100,573,983	25.00
26.00	Total (line 5 plus line 25)	128,684,905	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)	128,684,905	29.00

CALCULATION OF CAPITAL PAYMENT		Provider CCN: 15-0169	Period: From 01/01/2020 To 12/31/2020	Worksheet L Parts I-III Date/Time Prepared: 8/2/2021 3:48 pm
		Title XVIII	Hospital	PPS
				1.00
<b>PART I - FULLY PROSPECTIVE METHOD</b>				
<b>CAPITAL FEDERAL AMOUNT</b>				
1.00	Capital DRG other than outlier		2,808,200	1.00
1.01	Model 4 BPCI Capital DRG other than outlier		0	1.01
2.00	Capital DRG outlier payments		128,400	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)		212.23	3.00
4.00	Number of interns & residents (see instructions)		6.15	4.00
5.00	Indirect medical education percentage (see instructions)		0.82	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)		23,027	6.00
7.00	Percentage of SSI recipient patient days to Medicare Part A patient days (Worksheet E, part A line 30) (see instructions)		3.66	7.00
8.00	Percentage of Medicaid patient days to total days (see instructions)		33.08	8.00
9.00	Sum of lines 7 and 8		36.74	9.00
10.00	Allowable disproportionate share percentage (see instructions)		7.72	10.00
11.00	Disproportionate share adjustment (see instructions)		216,793	11.00
12.00	Total prospective capital payments (see instructions)		3,176,420	12.00
				1.00
<b>PART II - PAYMENT UNDER REASONABLE COST</b>				
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
<b>PART III - COMPUTATION OF EXCEPTION PAYMENTS</b>				
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