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: 15-0128	Period: From 01/01/2020 To 12/31/2020	Worksheet S Parts I-III Date/Time Prepared: 8/2/2021 3:42 pm

PART I - COST REPORT STATUS

Provider use only

1. [X] Electronically prepared cost report — Date: 8/2/2021 Time: 3:42 pm
2. [ ] Manually prepared cost report
3. [0] If this is an amended report enter the number of times the provider resubmitted this cost report
4. [F] Medicare Utilization. Enter "F" for full or "L" for low.

Contractor use only

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

PART II - CERTIFICATION

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

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

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by COMMUNITY HOSPITAL SOUTH (15-0128) 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.

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

(Signed) 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 Part A	Title XVIII Part B	HIT	Title XIX	
		1.00	2.00	3.00	4.00	5.00	
	PART III - SETTLEMENT SUMMARY						
1.00	Hospital	0	689,596	-110,514	0	0	1.00
2.00	Subprovider - IPF	0	0	0		0	2.00
3.00	Subprovider - IRF	0	0	0		0	3.00
5.00	Swing Bed - SNF	0	0	0		0	5.00
6.00	Swing Bed - NF	0				0	6.00
200.00	Total	0	689,596	-110,514	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: 15-0128 | Period: From 01/01/2020 To 12/31/2020 | Worksheet S-2 Part I Date/Time Prepared: 8/2/2021 3:42 pm

	1.00	2.00	3.00	4.00	
	Hospital and Hospital Health Care Complex Address:				
1.00	Street: 1402 EAST COUNTY LINE ROAD SOUTH	PO Box:			1.00
2.00	City: INDIANAPOLIS	State: IN	Zip Code: 46227	County: MARION	2.00

		Component Name	CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N) V	XVIII	XIX	
		1.00	2.00	3.00	4.00	5.00	6.00	7.00	8.00	
	Hospital and Hospital-Based Component Identification:									
3.00	Hospital	COMMUNITY HOSPITAL SOUTH	150128	26900	1	07/01/1966	N	P	P	3.00
4.00	Subprovider - IPF									4.00
5.00	Subprovider - IRF									5.00
6.00	Subprovider - (Other)									6.00
7.00	Swing Beds - SNF									7.00
8.00	Swing Beds - NF									8.00
9.00	Hospital-Based SNF									9.00
10.00	Hospital-Based NF									10.00
11.00	Hospital-Based OLTC									11.00
12.00	Hospital-Based HHA									12.00
13.00	Separately Certified ASC									13.00
14.00	Hospital-Based Hospice									14.00
15.00	Hospital-Based Health Clinic - RHC									15.00
16.00	Hospital-Based Health Clinic - FQHC									16.00
17.00	Hospital-Based (CMHC) I									17.00
18.00	Renal Dialysis									18.00
19.00	Other									19.00

		From:	To:	
		1.00	2.00	
20.00	Cost Reporting Period (mm/dd/yyyy)	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	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.	1,805	332	0	7	7,256	38	24.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-0128 | Period: From 01/01/2020 To 12/31/2020 | Worksheet S-2 Part I | Date/Time Prepared: 8/2/2021 3:42 pm

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

		Urban/Rural S	Date of Geogr	
		1.00	2.00	
26.00	Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter "1" for urban or "2" for rural.	2		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	10/01/2020	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	XVIII	XIX	
		1.00	2.00	3.00	
	Prospective Payment System (PPS)-Capital				
45.00	Does this facility qualify and receive Capital payment for disproportionate share in accordance with 42 CFR Section §412.320? (see instructions)	N	N	N	45.00
46.00	Is this facility eligible for additional payment exception for extraordinary circumstances pursuant to 42 CFR §412.348(f)? If yes, complete Wkst. L, Pt. III and Wkst. L-1, Pt. I through Pt. III.	N	N	N	46.00
47.00	Is this a new hospital under 42 CFR §412.300(b) PPS capital? Enter "Y for yes or "N" for no.	N	N	N	47.00
48.00	Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.	N	N	N	48.00
	Teaching Hospitals				
56.00	Is this a hospital involved in training residents in approved GME programs? Enter "Y" for yes or "N" for no 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 adjustement? Enter "Y" for yes or "N" for no in column 2.	N			60.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-0128 | Period: From 01/01/2020 To 12/31/2020 | Worksheet S-2 Part I | Date/Time Prepared: 8/2/2021 3:42 pm

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

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-0128 | Period: From 01/01/2020 To 12/31/2020 | Worksheet S-2 Part I | Date/Time Prepared: 8/2/2021 3:42 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	2.10	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 MEDICINE	1350	0.00	7.58	0.000000	67.00

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 15-0128	Period: From 01/01/2020 To 12/31/2020	Worksheet S-2 Part I Date/Time Prepared: 8/2/2021 3:42 pm

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

		V	XIX	
		1.00	2.00	
	Title V and XIX Services			
90.00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.	N	Y	90.00
91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.	N	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. I? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.01
98.02	Does title V or XIX follow Medicare (title XVIII) for the calculation of observation bed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.02
98.03	Does title V or XIX follow Medicare (title XVIII) for a critical access hospital (CAH) reimbursed 101% of inpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.03
98.04	Does title V or XIX follow Medicare (title XVIII) for a CAH reimbursed 101% of outpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.04
98.05	Does title V or XIX follow Medicare (title XVIII) and add back the RCE disallowance on Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.05
98.06	Does title V or XIX follow Medicare (title XVIII) when cost reimbursed for Wkst. D, Pts. I through IV? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.06
	Rural Providers			
105.00	Does this hospital qualify as a CAH?	N		105.00
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)			106.00
107.00	Column 1: If line 105 is Y, is this facility eligible for cost reimbursement for I&R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) Column 2: If column 1 is Y and line 70 or line 75 is Y, do you train I&Rs in an approved medical education program in the CAH's excluded IPF and/or IRF unit(s)? Enter "Y" for yes or "N" for no in column 2. (see instructions)			107.00
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	N		108.00

		Physical	Occupational	Speech	Respiratory	
		1.00	2.00	3.00	4.00	
109.00	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.					109.00

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-0128 | Period: From 01/01/2020 To 12/31/2020 | Worksheet S-2 Part I Date/Time Prepared: 8/2/2021 3:42 pm

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

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

		Premiums	Losses	Insurance	
		1.00	2.00	3.00	
118.01	List amounts of malpractice premiums and paid losses:	814,774	0	0	118.01

		1.00	2.00	
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein.	N		118.02
119.00	DO NOT USE THIS LINE			119.00
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 1, "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2, "Y" for yes or "N" for no.	N	N	120.00
121.00	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter "Y" for yes or "N" for no.	Y		121.00
122.00	Does the cost report contain healthcare related taxes as defined in §1903(w)(3) of the Act?Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2 the Worksheet A line number where these taxes are included.	N		122.00
	Transplant Center Information			
125.00	Does this facility operate a transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.	N		125.00
126.00	If this is a Medicare certified kidney transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			126.00
127.00	If this is a Medicare certified heart transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			127.00
128.00	If this is a Medicare certified liver transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			128.00
129.00	If this is a Medicare certified lung transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			129.00
130.00	If this is a Medicare certified pancreas transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			130.00
131.00	If this is a Medicare certified intestinal transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			131.00
132.00	If this is a Medicare certified islet transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			132.00
133.00	Removed and reserved			133.00
134.00	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.			134.00
	All Providers			
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)	Y	HB0720	140.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-0128 | Period: From 01/01/2020 To 12/31/2020 | Worksheet S-2 Part I Date/Time Prepared: 8/2/2021 3:42 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

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

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

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

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

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

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

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 15-0128 | Period: From 01/01/2020 To 12/31/2020 | Worksheet S-2 Part II | Date/Time Prepared: 8/2/2021 3:42 pm

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

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

		Y/N	Type	Date	
		1.00	2.00	3.00	
	Financial Data and Reports				
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	Y	A	03/26/2020	4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.	N			5.00

		Y/N	Legal Oper.	
		1.00	2.00	
	Approved Educational Activities			
6.00	Column 1: Are costs claimed for nursing school? Column 2: If yes, is the provider is the legal operator of the program?	N		6.00
7.00	Are costs claimed for Allied Health Programs? If "Y" see instructions.	N		7.00
8.00	Were nursing school and/or allied health programs approved and/or renewed during the cost reporting period? If yes, see instructions.	N		8.00
9.00	Are costs claimed for Interns and Residents in an approved graduate medical education program in the current cost report? If yes, see instructions.	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	
	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	06/26/2020	Y	06/26/2020	17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N		N		18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		N		19.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 15-0128 | Period: From 01/01/2020 To 12/31/2020 | Worksheet S-2 Part II Date/Time Prepared: 8/2/2021 3:42 pm

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

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

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

		1.00	2.00	
	Cost Report Preparer Contact Information			
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	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	SBISHOP@ECOMMUNITY.COM	43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider CCN: 15-0128	Period: From 01/01/2020 To 12/31/2020	Worksheet S-2 Part II Date/Time Prepared: 8/2/2021 3:42 pm

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 15-0128 | Period: From 01/01/2020 To 12/31/2020 | Worksheet S-3 Part I Date/Time Prepared: 8/2/2021 3:42 pm

	Component	Worksheet A Line Number	No. of Beds	Bed Days Available	CAH Hours	I/P Days / O/P Visits / Trips Title V	
		1.00	2.00	3.00	4.00	5.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30.00	157	57,462	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)		157	57,462	0.00	0	7.00
8.00	INTENSIVE CARE UNIT	31.00	12	4,392	0.00	0	8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY	43.00				0	13.00
14.00	Total (see instructions)		169	61,854	0.00	0	14.00
15.00	CAH visits					0	15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)	30.00					24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	26.25
27.00	Total (sum of lines 14-26)		169				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: 15-0128 | Period: From 01/01/2020 To 12/31/2020 | Worksheet S-3 Part I | Date/Time Prepared: 8/2/2021 3:42 pm

	Component	I/P Days / O/P Visits / Trips			Full Time Equivalents		
		Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
		6.00	7.00	8.00	9.00	10.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	10,425	1,586	33,562			1.00
2.00	HMO and other (see instructions)	8,173	6,506				2.00
3.00	HMO IPF Subprovider	0	0				3.00
4.00	HMO IRF Subprovider	0	0				4.00
5.00	Hospital Adults & Peds. Swing Bed SNF	0	0	0			5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	0			6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	10,425	1,586	33,562			7.00
8.00	INTENSIVE CARE UNIT	1,040	0	2,987			8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY		1,308	2,529			13.00
14.00	Total (see instructions)	11,465	2,894	39,078	9.69	915.95	14.00
15.00	CAH visits	0	0	0			15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)			218			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)				9.69	915.95	27.00
28.00	Observation Bed Days		521	4,062			28.00
29.00	Ambulance Trips	0					29.00
30.00	Employee discount days (see instruction)			493			30.00
31.00	Employee discount days - IRF			0			31.00
32.00	Labor & delivery days (see instructions)	0	38	610			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: 15-0128 | Period: From 01/01/2020 To 12/31/2020 | Worksheet S-3 Part I | Date/Time Prepared: 8/2/2021 3:42 pm

	Component	Full Time Equivalents	Discharges				
		Nonpaid Workers	Title V	Title XVIII	Title XIX	Total All Patients	
		11.00	12.00	13.00	14.00	15.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)		0	2,530	250	8,984	1.00
2.00	HMO and other (see instructions)			1,617	1,566		2.00
3.00	HMO IPF Subprovider				0		3.00
4.00	HMO IRF Subprovider				0		4.00
5.00	Hospital Adults & Peds. Swing Bed SNF						5.00
6.00	Hospital Adults & Peds. Swing Bed NF						6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)						7.00
8.00	INTENSIVE CARE UNIT						8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY						13.00
14.00	Total (see instructions)	0.00	0	2,530	250	8,984	14.00
15.00	CAH visits						15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)						24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0.00					26.25
27.00	Total (sum of lines 14-26)	0.00					27.00
28.00	Observation Bed Days						28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)						32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00	LTCH non-covered days			0			33.00
33.01	LTCH site neutral days and discharges			0			33.01

HOSPITAL WAGE INDEX INFORMATION | Provider CCN: 15-0128 | Period: From 01/01/2020 To 12/31/2020 | Worksheet S-3 Part II Date/Time Prepared: 8/2/2021 3:42 pm

		Wkst. A Line Number	Amount Reported	Reclassification of Salaries (from Wkst. A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
	PART II - WAGE DATA							
	SALARIES							
1.00	Total salaries (see instructions)	200.00	68,215,998	-375,051	67,840,947	1,905,183.00	35.61	1.00
2.00	Non-physician anesthetist Part A		548,284	0	548,284	4,499.00	121.87	2.00
3.00	Non-physician anesthetist Part B		0	0	0	0.00	0.00	3.00
4.00	Physician-Part A - Administrative		190,616	0	190,616	1,120.00	170.19	4.00
4.01	Physicians - Part A - Teaching		0	0	0	0.00	0.00	4.01
5.00	Physician and Non Physician-Part B		302,116	0	302,116	4,160.00	72.62	5.00
6.00	Non-physician-Part B for hospital-based RHC and FQHC services		0	0	0	0.00	0.00	6.00
7.00	Interns & residents (in an approved program)	21.00	0	0	0	0.00	0.00	7.00
7.01	Contracted interns and residents (in an approved programs)		0	0	0	0.00	0.00	7.01
8.00	Home office and/or related organization personnel		0	0	0	0.00	0.00	8.00
9.00	SNF	44.00	0	0	0	0.00	0.00	9.00
10.00	Excluded area salaries (see instructions)		384,547	-8,484	376,063	14,556.00	25.84	10.00
	OTHER WAGES & RELATED COSTS							
11.00	Contract labor: Direct Patient Care		1,544,924	0	1,544,924	14,994.00	103.04	11.00
12.00	Contract labor: Top level management and other management and administrative services		0	0	0	0.00	0.00	12.00
13.00	Contract labor: Physician-Part A - Administrative		2,043,898	0	2,043,898	21,905.00	93.31	13.00
14.00	Home office and/or related organization salaries and wage-related costs		0	0	0	0.00	0.00	14.00
14.01	Home office salaries		17,835,207	0	17,835,207	406,017.00	43.93	14.01
14.02	Related organization salaries		0	0	0	0.00	0.00	14.02
15.00	Home office: Physician Part A - Administrative		335,132	0	335,132	3,078.00	108.88	15.00
16.00	Home office and Contract Physicians Part A - Teaching		0	0	0	0.00	0.00	16.00
16.01	Home office Physicians Part A - Teaching		0	0	0	0.00	0.00	16.01
16.02	Home office contract Physicians Part A - Teaching		0	0	0	0.00	0.00	16.02
	WAGE-RELATED COSTS							
17.00	Wage-related costs (core) (see instructions)		16,226,521	0	16,226,521			17.00
18.00	Wage-related costs (other) (see instructions)							18.00
19.00	Excluded areas		115,525	0	115,525			19.00
20.00	Non-physician anesthetist Part A		43,904	0	43,904			20.00
21.00	Non-physician anesthetist Part B		0	0	0			21.00
22.00	Physician Part A - Administrative		12,183	0	12,183			22.00
22.01	Physician Part A - Teaching		0	0	0			22.01
23.00	Physician Part B		45,250	0	45,250			23.00
24.00	Wage-related costs (RHC/FQHC)		0	0	0			24.00
25.00	Interns & residents (in an approved program)		0	0	0			25.00
25.50	Home office wage-related (core)		3,522,889	0	3,522,889			25.50
25.51	Related organization wage-related (core)		0	0	0			25.51
25.52	Home office: Physician Part A - Administrative - wage-related (core)		0	0	0			25.52

HOSPITAL WAGE INDEX INFORMATION | Provider CCN: 15-0128 | Period: From 01/01/2020 To 12/31/2020 | Worksheet S-3 Part II | Date/Time Prepared: 8/2/2021 3:42 pm

		Wkst. A Line Number	Amount Reported	Reclassification of Salaries (from Wkst. A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
25.53	Home office: Physicians Part A - Teaching - wage-related (core)		0	0	0			25.53
	OVERHEAD COSTS - DIRECT SALARIES							
26.00	Employee Benefits Department	4.00	0	0	0	0.00	0.00	26.00
27.00	Administrative & General	5.00	7,220,134	-3,835	7,216,299	143,127.00	50.42	27.00
28.00	Administrative & General under contract (see inst.)		4,962,583	0	4,962,583	46,926.00	105.75	28.00
29.00	Maintenance & Repairs	6.00	0	0	0	0.00	0.00	29.00
30.00	Operation of Plant	7.00	1,530,232	-5,564	1,524,668	58,302.00	26.15	30.00
31.00	Laundry & Linen Service	8.00	0	0	0	0.00	0.00	31.00
32.00	Housekeeping	9.00	1,449,420	-7,000	1,442,420	90,419.00	15.95	32.00
33.00	Housekeeping under contract (see instructions)		0	0	0	0.00	0.00	33.00
34.00	Dietary	10.00	1,252,986	-827,466	425,520	24,302.00	17.51	34.00
35.00	Dietary under contract (see instructions)		288,868	0	288,868	4,160.00	69.44	35.00
36.00	Cafeteria	11.00	0	815,781	815,781	45,345.00	17.99	36.00
37.00	Maintenance of Personnel	12.00	0	0	0	0.00	0.00	37.00
38.00	Nursing Administration	13.00	267,483	-416	267,067	16,355.00	16.33	38.00
39.00	Central Services and Supply	14.00	0	0	0	0.00	0.00	39.00
40.00	Pharmacy	15.00	0	0	0	0.00	0.00	40.00
41.00	Medical Records & Medical Records Library	16.00	286,009	-587	285,422	6,205.00	46.00	41.00
42.00	Social Service	17.00	1,403,968	-3,181	1,400,787	34,311.00	40.83	42.00
43.00	Other General Service	18.00	0	0	0	0.00	0.00	43.00

HOSPITAL WAGE INDEX INFORMATION | Provider CCN: 15-0128 | Period: From 01/01/2020 To 12/31/2020 | Worksheet S-3 Part III Date/Time Prepared: 8/2/2021 3:42 pm

		Worksheet A Line Number	Amount Reported	Reclassification of Salaries (from Worksheet A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
	PART III - HOSPITAL WAGE INDEX SUMMARY							
1.00	Net salaries (see instructions)		72,617,049	-375,051	72,241,998	1,947,610.00	37.09	1.00
2.00	Excluded area salaries (see instructions)		384,547	-8,484	376,063	14,556.00	25.84	2.00
3.00	Subtotal salaries (line 1 minus line 2)		72,232,502	-366,567	71,865,935	1,933,054.00	37.18	3.00
4.00	Subtotal other wages & related costs (see inst.)		21,759,161	0	21,759,161	445,994.00	48.79	4.00
5.00	Subtotal wage-related costs (see inst.)		19,761,593	0	19,761,593	0.00	27.50	5.00
6.00	Total (sum of lines 3 thru 5)		113,753,256	-366,567	113,386,689	2,379,048.00	47.66	6.00
7.00	Total overhead cost (see instructions)		18,661,683	-32,268	18,629,415	469,452.00	39.68	7.00

HOSPITAL WAGE RELATED COSTS | Provider CCN: 15-0128 | Period: From 01/01/2020 To 12/31/2020 | Worksheet S-3 Part IV Date/Time Prepared: 8/2/2021 3:42 pm

		Amount Reported	
		1.00	
	PART IV - WAGE RELATED COSTS		
	Part A - Core List		
	RETIREMENT COST		
1.00	401K Employer Contributions	1,406,100	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)	23,970	4.00
	PLAN ADMINISTRATIVE COSTS (Paid to External Organization)		
5.00	401K/TSA Plan Administration fees	0	5.00
6.00	Legal/Accounting/Management Fees-Pension Plan	618,803	6.00
7.00	Employee Managed Care Program Administration Fees	0	7.00
	HEALTH AND INSURANCE COST		
8.00	Health Insurance (Purchased or Self Funded)	0	8.00
8.01	Health Insurance (Self Funded without a Third Party Administrator)	0	8.01
8.02	Health Insurance (Self Funded with a Third Party Administrator)	5,855,051	8.02
8.03	Health Insurance (Purchased)	0	8.03
9.00	Prescription Drug Plan	874,111	9.00
10.00	Dental, Hearing and Vision Plan	49,817	10.00
11.00	Life Insurance (If employee is owner or beneficiary)	1,931,976	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)	685,992	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)	0	14.00
15.00	'Workers' Compensation Insurance	6,232	15.00
16.00	Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. Non cumulative portion)	0	16.00
	TAXES		
17.00	FICA-Employers Portion Only	4,913,779	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
	OTHER		
21.00	Executive Deferred Compensation (Other Than Retirement Cost Reported on lines 1 through 4 above. (see instructions))	0	21.00
22.00	Day Care Cost and Allowances	0	22.00
23.00	Tuition Reimbursement	77,550	23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)	16,443,381	24.00
	Part B - Other than Core Related Cost		
25.00	OTHER WAGE RELATED COSTS (SPECIFY)		25.00

HOSPITAL CONTRACT LABOR AND BENEFIT COST | Provider CCN: 15-0128 | Period: From 01/01/2020 To 12/31/2020 | Worksheet S-3 Part V | Date/Time Prepared: 8/2/2021 3:42 pm

	Cost Center Description	Contract Labor	Benefit Cost	
		1.00	2.00	
	PART V - Contract Labor and Benefit Cost			
	Hospital and Hospital-Based Component Identification:			
1.00	Total facility's contract labor and benefit cost	1,544,924	16,443,381	1.00
2.00	Hospital	1,544,924	16,327,856	2.00
3.00	Subprovider - IPF			3.00
4.00	Subprovider - IRF			4.00
5.00	Subprovider - (Other)	0	0	5.00
6.00	Swing Beds - SNF	0	0	6.00
7.00	Swing Beds - NF	0	0	7.00
8.00	Hospital-Based SNF			8.00
9.00	Hospital-Based NF			9.00
10.00	Hospital-Based OLTC			10.00
11.00	Hospital-Based HHA			11.00
12.00	Separately Certified ASC			12.00
13.00	Hospital-Based Hospice			13.00
14.00	Hospital-Based Health Clinic RHC			14.00
15.00	Hospital-Based Health Clinic FQHC			15.00
16.00	Hospital-Based-CMHC			16.00
17.00	Renal Dialysis	0	0	17.00
18.00	Other	0	115,525	18.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA | Provider CCN: 15-0128 | Period: From 01/01/2020 To 12/31/2020 | Worksheet S-10 | Date/Time Prepared: 8/2/2021 3:42 pm

		1.00	
	Uncompensated and indigent care cost computation		
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided by line 202 column 8)	0.206174	1.00
	Medicaid (see instructions for each line)		
2.00	Net revenue from Medicaid	38,112,404	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	-14,289,637	5.00
6.00	Medicaid charges	169,585,560	6.00
7.00	Medicaid cost (line 1 times line 6)	34,964,133	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)	11,141,366	8.00
	Children's Health Insurance Program (CHIP) (see instructions for each line)		
9.00	Net revenue from stand-alone CHIP	0	9.00
10.00	Stand-alone CHIP charges	0	10.00
11.00	Stand-alone CHIP cost (line 1 times line 10)	0	11.00
12.00	Difference between net revenue and costs for stand-alone CHIP (line 11 minus line 9; if < zero then enter zero)	0	12.00
	Other state or local government indigent care program (see instructions for each line)		
13.00	Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9)	0	13.00
14.00	Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)	0	14.00
15.00	State or local indigent care program cost (line 1 times line 14)	0	15.00
16.00	Difference between net revenue and costs for state or local indigent care program (line 15 minus line 13; if < zero then enter zero)	0	16.00
	Grants, donations and total unreimbursed cost for Medicaid, CHIP and state/local indigent care programs (see instructions for each line)		
17.00	Private grants, donations, or endowment income restricted to funding charity care	0	17.00
18.00	Government grants, appropriations or transfers for support of hospital operations	0	18.00
19.00	Total unreimbursed cost for Medicaid , CHIP and state and local indigent care programs (sum of lines 8, 12 and 16)	11,141,366	19.00

		Uninsured patients	Insured patients	Total (col. 1 + col. 2)	
		1.00	2.00	3.00	
	Uncompensated Care (see instructions for each line)				
20.00	Charity care charges and uninsured discounts for the entire facility (see instructions)	15,030,431	2,220,085	17,250,516	20.00
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	3,098,884	2,220,085	5,318,969	21.00
22.00	Payments received from patients for amounts previously written off as charity care	15,589	0	15,589	22.00
23.00	Cost of charity care (line 21 minus line 22)	3,083,295	2,220,085	5,303,380	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)	18,350,237	26.00
27.00	Medicare reimbursable bad debts for the entire hospital complex (see instructions)	284,534	27.00
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)	437,745	27.01
28.00	Non-Medicare bad debt expense (see instructions)	17,912,492	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)	3,846,301	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)	9,149,681	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	20,291,047	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 15-0128 | Period: From 01/01/2020 To 12/31/2020 | Worksheet A | Date/Time Prepared: 8/2/2021 3:42 pm

		Cost Center Description	Salaries	Other	Total (col. 1 + col. 2)	Reclassifications (See A-6)	Reclassified Trial Balance (col. 3 +- col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT		0	0	9,779,187	9,779,187	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		0	0	7,094,095	7,094,095	2.00
3.00	00300	OTHER CAP REL COSTS		0	0	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	86	86	0	86	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	7,220,134	82,418,171	89,638,305	-8,920,056	80,718,249	5.00
7.00	00700	OPERATION OF PLANT	1,530,232	4,044,799	5,575,031	-138,493	5,436,538	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	658,570	658,570	0	658,570	8.00
9.00	00900	HOUSEKEEPING	1,449,420	1,038,180	2,487,600	-13,905	2,473,695	9.00
10.00	01000	DIETARY	1,252,986	1,607,603	2,860,589	-1,887,152	973,437	10.00
11.00	01100	CAFETERIA	0	0	0	1,816,751	1,816,751	11.00
13.00	01300	NURSING ADMINISTRATION	267,483	63,268	330,751	0	330,751	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	286,009	75,414	361,423	0	361,423	16.00
17.00	01700	SOCIAL SERVICE	1,403,968	372,207	1,776,175	-1,841	1,774,334	17.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM. COSTS APPRVD	0	0	0	0	0	22.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	22,767,239	14,025,349	36,792,588	-5,339,525	31,453,063	30.00
31.00	03100	INTENSIVE CARE UNIT	3,094,176	1,382,729	4,476,905	-429,939	4,046,966	31.00
43.00	04300	NURSERY	0	0	0	673,785	673,785	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	3,222,453	17,553,118	20,775,571	-14,036,959	6,738,612	50.00
51.00	05100	RECOVERY ROOM	2,704,057	1,198,726	3,902,783	-182,116	3,720,667	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	587,529	26,608	614,137	3,115,732	3,729,869	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,813,023	1,822,704	3,635,727	-1,079,259	2,556,468	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	632,176	1,498,207	2,130,383	-1,049,500	1,080,883	55.00
57.00	05700	CT SCAN	738,697	682,325	1,421,022	139,438	1,560,460	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	366,774	237,596	604,370	-19,393	584,977	58.00
59.00	05900	CARDIAC CATHETERIZATION	1,374,294	7,402,730	8,777,024	-5,895,468	2,881,556	59.00
60.00	06000	LABORATORY	0	7,393,694	7,393,694	-2,253	7,391,441	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	1,947,510	1,069,415	3,016,925	-386,743	2,630,182	65.00
66.00	06600	PHYSICAL THERAPY	2,881,760	1,349,131	4,230,891	-1,625,129	2,605,762	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	892,180	892,180	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	236,219	236,219	68.00
69.00	06900	ELECTROCARDIOLOGY	940,854	522,191	1,463,045	-95,212	1,367,833	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	364,731	343,433	708,164	-122,201	585,963	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	418,538	1,407,665	1,826,203	9,865,190	11,691,393	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	9,177,048	9,177,048	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,971,720	8,445,418	11,417,138	-4,437	11,412,701	73.00
74.00	07400	RENAL DIALYSIS	0	543,396	543,396	-2,063	541,333	74.00
76.00	03950	ENDOSCOPY	546,556	998,088	1,544,644	-651,730	892,914	76.00
76.06	03330	IMAGING CENTER	879,282	857,383	1,736,665	-534,615	1,202,050	76.06
76.97	07697	CARDIAC REHABILITATION	226,802	94,049	320,851	-19,028	301,823	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	04950	DIABETIC CARE CENTER	0	0	0	0	0	90.01
90.02	04951	ANTI-COAGULATION CLINIC	517,020	162,971	679,991	-15,309	664,682	90.02
90.03	04952	PALLIATIVE CARE	0	0	0	0	0	90.03
90.04	04953	SPINE CENTER	160,973	138,809	299,782	-69,136	230,646	90.04
91.00	09100	EMERGENCY	5,265,055	2,203,703	7,468,758	-255,731	7,213,027	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	67,831,451	161,637,736	229,469,187	12,432	229,481,619	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	121,719	121,719	0	121,719	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	LEASED OFFICE SPACE	0	0	0	0	0	194.06
194.08	07958	MISC NONREIMBURSABLE COST CENTERS	384,547	593,206	977,753	-12,432	965,321	194.08
200.00		TOTAL (SUM OF LINES 118 through 199)	68,215,998	162,352,661	230,568,659	0	230,568,659	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 15-0128 | Period: From 01/01/2020 To 12/31/2020 | Worksheet A | Date/Time Prepared: 8/2/2021 3:42 pm

		Cost Center Description	Adjustments (See A-8)	Net Expenses For Allocation		
			6.00	7.00		
		GENERAL SERVICE COST CENTERS				
1.00	00100	CAP REL COSTS-BLDG & FIXT	-2,067,573	7,711,614		1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	3,250,867	10,344,962		2.00
3.00	00300	OTHER CAP REL COSTS	0	0		3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	1,872,620	1,872,706		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-48,579,321	32,138,928		5.00
7.00	00700	OPERATION OF PLANT	-161,917	5,274,621		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	658,570		8.00
9.00	00900	HOUSEKEEPING	0	2,473,695		9.00
10.00	01000	DIETARY	-14,211	959,226		10.00
11.00	01100	CAFETERIA	-1,092,139	724,612		11.00
13.00	01300	NURSING ADMINISTRATION	2,096,822	2,427,573		13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,450,671	1,812,094		16.00
17.00	01700	SOCIAL SERVICE	0	1,774,334		17.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	794,286	794,286		21.00
22.00	02200	I&R SERVICES-OTHER PRGM. COSTS APPRVD	1,177,937	1,177,937		22.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	-307,760	31,145,303		30.00
31.00	03100	INTENSIVE CARE UNIT	0	4,046,966		31.00
43.00	04300	NURSERY	0	673,785		43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	-353,786	6,384,826		50.00
51.00	05100	RECOVERY ROOM	0	3,720,667		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	3,729,869		52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-179,395	2,377,073		54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	1,080,883		55.00
57.00	05700	CT SCAN	0	1,560,460		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	584,977		58.00
59.00	05900	CARDIAC CATHETERIZATION	0	2,881,556		59.00
60.00	06000	LABORATORY	0	7,391,441		60.00
64.00	06400	INTRAVENOUS THERAPY	0	0		64.00
65.00	06500	RESPIRATORY THERAPY	0	2,630,182		65.00
66.00	06600	PHYSICAL THERAPY	-18,601	2,587,161		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	892,180		67.00
68.00	06800	SPEECH PATHOLOGY	0	236,219		68.00
69.00	06900	ELECTROCARDIOLOGY	0	1,367,833		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	585,963		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	2,020,567	13,711,960		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	9,177,048		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	118,769	11,531,470		73.00
74.00	07400	RENAL DIALYSIS	0	541,333		74.00
76.00	03950	ENDOSCOPY	0	892,914		76.00
76.06	03330	IMAGING CENTER	-422	1,201,628		76.06
76.97	07697	CARDIAC REHABILITATION	-1,697	300,126		76.97
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0	0		90.00
90.01	04950	DIABETIC CARE CENTER	0	0		90.01
90.02	04951	ANTI-COAGULATION CLINIC	-302,116	362,566		90.02
90.03	04952	PALLIATIVE CARE	0	0		90.03
90.04	04953	SPINE CENTER	0	230,646		90.04
91.00	09100	EMERGENCY	828,418	8,041,445		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				92.00
		SPECIAL PURPOSE COST CENTERS				
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-39,467,981	190,013,638		118.00
		NONREIMBURSABLE COST CENTERS				
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	121,719		192.00
193.00	19300	NONPAID WORKERS	0	0		193.00
194.00	07950	HOME OFFICE	0	0		194.00
194.06	07956	LEASED OFFICE SPACE	0	0		194.06
194.08	07958	MISC NONREIMBURSABLE COST CENTERS	0	965,321		194.08
200.00		TOTAL (SUM OF LINES 118 through 199)	-39,467,981	191,100,678		200.00

RECLASSIFICATIONS | Provider CCN: 15-0128 | Period: From 01/01/2020 To 12/31/2020 | Worksheet A-6 | Date/Time Prepared: 8/2/2021 3:42 pm

		Increases				
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
	A - Chargeable Medical Supplies					
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	11,101,035		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
	TOTALS		0	11,101,035		
	B - Implantable Device Reclass					
1.00	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	9,177,048		1.00
2.00		0.00	0	0		2.00
3.00		0.00	0	0		3.00
	TOTALS		0	9,177,048		
	C - Drugs Charges to Pat					
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	472,496		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
	TOTALS		0	472,496		
	D - Depreciation Expense					
1.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	9,346,220		1.00
2.00	CT SCAN	57.00	0	126,697		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

RECLASSIFICATIONS | Provider CCN: 15-0128 | Period: From 01/01/2020 To 12/31/2020 | Worksheet A-6 | Date/Time Prepared: 8/2/2021 3:42 pm

		Increases			
	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
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
	TOTALS		0	9,472,917	
	E - Interest Expense				
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	4,568,230	1.00
	TOTALS		0	4,568,230	
	F - Other Capital Rental				
1.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	2,824,903	1.00
2.00	RESPIRATORY THERAPY	65.00	0	775	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
	TOTALS		0	2,825,678	
	G - STD BENEFIT				
1.00	ADMINISTRATIVE & GENERAL	5.00	0	3,835	1.00
2.00	OPERATION OF PLANT	7.00	0	5,564	2.00
3.00	HOUSEKEEPING	9.00	0	7,000	3.00
4.00	DIETARY	10.00	0	11,685	4.00
5.00	NURSING ADMINISTRATION	13.00	0	416	5.00
6.00	MEDICAL RECORDS & LIBRARY	16.00	0	587	6.00
7.00	SOCIAL SERVICE	17.00	0	3,181	7.00
8.00	ADULTS & PEDIATRICS	30.00	0	172,326	8.00
9.00	INTENSIVE CARE UNIT	31.00	0	11,454	9.00
10.00	OPERATING ROOM	50.00	0	26,690	10.00
11.00	RECOVERY ROOM	51.00	0	14,970	11.00
12.00	RADIOLOGY-DIAGNOSTIC	54.00	0	2,549	12.00
13.00	RADIOLOGY-THERAPEUTIC	55.00	0	253	13.00
14.00	CT SCAN	57.00	0	5,429	14.00
15.00	CARDIAC CATHETERIZATION	59.00	0	2,785	15.00
16.00	RESPIRATORY THERAPY	65.00	0	18,677	16.00
17.00	PHYSICAL THERAPY	66.00	0	21,764	17.00
18.00	ELECTROCARDIOLOGY	69.00	0	5,470	18.00
19.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	73	19.00
20.00	DRUGS CHARGED TO PATIENTS	73.00	0	16,151	20.00
21.00	ENDOSCOPY	76.00	0	5,334	21.00
22.00	IMAGING CENTER	76.06	0	3,590	22.00
23.00	CARDIAC REHABILITATION	76.97	0	1,087	23.00
24.00	EMERGENCY	91.00	0	25,697	24.00
25.00	MISC NONREIMBURSABLE COST CENTERS	194.08	0	8,484	25.00
	TOTALS		0	375,051	
	H - Labor and Delivery				
1.00	NURSERY	43.00	475,047	198,738	1.00
2.00	DELIVERY ROOM & LABOR ROOM	52.00	2,196,722	919,010	2.00
	TOTALS		2,671,769	1,117,748	
	I - Cafeteria				
1.00	CAFETERIA	11.00	815,781	1,000,970	1.00
	TOTALS		815,781	1,000,970	
	J - Therapy				
1.00	OCCUPATIONAL THERAPY	67.00	687,307	204,873	1.00
2.00	SPEECH PATHOLOGY	68.00	181,976	54,243	2.00
	TOTALS		869,283	259,116	

RECLASSIFICATIONS | Provider CCN: 15-0128 | Period: From 01/01/2020 To 12/31/2020 | Worksheet A-6 | Date/Time Prepared: 8/2/2021 3:42 pm

		Increases				
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
	K - Building Depreciation					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	5,077,028		1.00
	TOTALS		0	5,077,028		
	L - Capital Insurance Costs					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	133,929		1.00
	TOTALS		0	133,929		
	M - Radiology Support Staff					
1.00	RADIOLOGY-THERAPEUTIC	55.00	55,142	27,222		1.00
2.00	CT SCAN	57.00	142,659	70,425		2.00
3.00	MAGNETIC RESONANCE IMAGING (MRI)	58.00	29,123	14,377		3.00
	TOTALS		226,924	112,024		
500.00	Grand Total: Increases		4,583,757	45,693,270		500.00

RECLASSIFICATIONS | Provider CCN: 15-0128 | Period: From 01/01/2020 To 12/31/2020 | Worksheet A-6 | Date/Time Prepared: 8/2/2021 3:42 pm

		Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	A - Chargeable Medical Supplies						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	31,245	0		1.00
2.00	DIETARY	10.00	0	221	0		2.00
3.00	ADULTS & PEDIATRICS	30.00	0	1,033,945	0		3.00
4.00	INTENSIVE CARE UNIT	31.00	0	254,748	0		4.00
5.00	OPERATING ROOM	50.00	0	5,021,406	0		5.00
6.00	RECOVERY ROOM	51.00	0	129,447	0		6.00
7.00	RADIOLOGY-DIAGNOSTIC	54.00	0	324,438	0		7.00
8.00	RADIOLOGY-THERAPEUTIC	55.00	0	619,101	0		8.00
9.00	CT SCAN	57.00	0	27,034	0		9.00
10.00	MAGNETIC RESONANCE IMAGING (MRI)	58.00	0	13,550	0		10.00
11.00	CARDIAC CATHETERIZATION	59.00	0	2,533,191	0		11.00
12.00	RESPIRATORY THERAPY	65.00	0	358,671	0		12.00
13.00	PHYSICAL THERAPY	66.00	0	3,516	0		13.00
14.00	ELECTROCARDIOLOGY	69.00	0	8,996	0		14.00
15.00	ELECTROENCEPHALOGRAPHY	70.00	0	6,591	0		15.00
16.00	DRUGS CHARGED TO PATIENTS	73.00	0	75,046	0		16.00
17.00	RENAL DIALYSIS	74.00	0	1,595	0		17.00
18.00	ENDOSCOPY	76.00	0	367,612	0		18.00
19.00	IMAGING CENTER	76.06	0	129,655	0		19.00
20.00	CARDIAC REHABILITATION	76.97	0	1,651	0		20.00
21.00	EMERGENCY	91.00	0	159,343	0		21.00
22.00	MISC NONREIMBURSABLE COST CENTERS	194.08	0	33	0		22.00
	TOTALS		0	11,101,035			
	B - Implantable Device Reclass						
1.00	OPERATING ROOM	50.00	0	6,378,880	0		1.00
2.00	RADIOLOGY-THERAPEUTIC	55.00	0	257,743	0		2.00
3.00	CARDIAC CATHETERIZATION	59.00	0	2,540,425	0		3.00
	TOTALS		0	9,177,048			
	C - Drugs Charges to Pat						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	11,108	0		1.00
2.00	ADULTS & PEDIATRICS	30.00	0	43,890	0		2.00
3.00	INTENSIVE CARE UNIT	31.00	0	10,766	0		3.00
4.00	OPERATING ROOM	50.00	0	801	0		4.00
5.00	RECOVERY ROOM	51.00	0	9,283	0		5.00
6.00	RADIOLOGY-DIAGNOSTIC	54.00	0	124,904	0		6.00
7.00	RADIOLOGY-THERAPEUTIC	55.00	0	3,404	0		7.00
8.00	CT SCAN	57.00	0	173,309	0		8.00
9.00	CARDIAC CATHETERIZATION	59.00	0	51,751	0		9.00
10.00	RESPIRATORY THERAPY	65.00	0	1,133	0		10.00
11.00	PHYSICAL THERAPY	66.00	0	1,041	0		11.00
12.00	ELECTROCARDIOLOGY	69.00	0	2,009	0		12.00
13.00	ELECTROENCEPHALOGRAPHY	70.00	0	364	0		13.00
14.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	808	0		14.00
15.00	RENAL DIALYSIS	74.00	0	468	0		15.00
16.00	ENDOSCOPY	76.00	0	549	0		16.00
17.00	IMAGING CENTER	76.06	0	20,696	0		17.00
18.00	EMERGENCY	91.00	0	14,682	0		18.00
19.00	MISC NONREIMBURSABLE COST CENTERS	194.08	0	1,530	0		19.00
	TOTALS		0	472,496			
	D - Depreciation Expense						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	3,974,959	9		1.00
2.00	OPERATION OF PLANT	7.00	0	133,668	0		2.00
3.00	HOUSEKEEPING	9.00	0	4,724	0		3.00
4.00	DIETARY	10.00	0	70,020	0		4.00
5.00	SOCIAL SERVICE	17.00	0	1,805	0		5.00
6.00	ADULTS & PEDIATRICS	30.00	0	422,942	0		6.00
7.00	INTENSIVE CARE UNIT	31.00	0	164,425	0		7.00
8.00	OPERATING ROOM	50.00	0	2,394,609	0		8.00
9.00	RECOVERY ROOM	51.00	0	38,888	0		9.00
10.00	RADIOLOGY-DIAGNOSTIC	54.00	0	290,969	0		10.00
11.00	RADIOLOGY-THERAPEUTIC	55.00	0	251,545	0		11.00
12.00	MAGNETIC RESONANCE IMAGING (MRI)	58.00	0	49,343	0		12.00
13.00	CARDIAC CATHETERIZATION	59.00	0	768,409	0		13.00
14.00	LABORATORY	60.00	0	2,173	0		14.00
15.00	RESPIRATORY THERAPY	65.00	0	27,714	0		15.00
16.00	PHYSICAL THERAPY	66.00	0	131,570	0		16.00
17.00	ELECTROCARDIOLOGY	69.00	0	83,888	0		17.00
18.00	ELECTROENCEPHALOGRAPHY	70.00	0	13,673	0		18.00

RECLASSIFICATIONS | Provider CCN: 15-0128 | Period: From 01/01/2020 To 12/31/2020 | Worksheet A-6 | Date/Time Prepared: 8/2/2021 3:42 pm

		Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
19.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	30,764	0		19.00
20.00	DRUGS CHARGED TO PATIENTS	73.00	0	61,717	0		20.00
21.00	ENDOSCOPY	76.00	0	283,080	0		21.00
22.00	IMAGING CENTER	76.06	0	139,340	0		22.00
23.00	CARDIAC REHABILITATION	76.97	0	17,377	0		23.00
24.00	ANTI-COAGULATION CLINIC	90.02	0	15,309	0		24.00
25.00	SPINE CENTER	90.04	0	14,082	0		25.00
26.00	EMERGENCY	91.00	0	81,626	0		26.00
27.00	MISC NONREIMBURSABLE COST CENTERS	194.08	0	4,298	0		27.00
	TOTALS		0	9,472,917			
	E - Interest Expense						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	4,568,230	11		1.00
	TOTALS		0	4,568,230			
	F - Other Capital Rental						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	200,585	10		1.00
2.00	OPERATION OF PLANT	7.00	0	4,825	0		2.00
3.00	HOUSEKEEPING	9.00	0	9,181	0		3.00
4.00	DIETARY	10.00	0	160	0		4.00
5.00	SOCIAL SERVICE	17.00	0	36	0		5.00
6.00	ADULTS & PEDIATRICS	30.00	0	49,231	0		6.00
7.00	OPERATING ROOM	50.00	0	241,263	0		7.00
8.00	RECOVERY ROOM	51.00	0	4,498	0		8.00
9.00	RADIOLOGY-THERAPEUTIC	55.00	0	71	0		9.00
10.00	CARDIAC CATHETERIZATION	59.00	0	1,692	0		10.00
11.00	LABORATORY	60.00	0	80	0		11.00
12.00	PHYSICAL THERAPY	66.00	0	360,603	0		12.00
13.00	ELECTROCARDIOLOGY	69.00	0	319	0		13.00
14.00	ELECTROENCEPHALOGRAPHY	70.00	0	101,573	0		14.00
15.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	1,204,273	0		15.00
16.00	DRUGS CHARGED TO PATIENTS	73.00	0	340,170	0		16.00
17.00	ENDOSCOPY	76.00	0	489	0		17.00
18.00	IMAGING CENTER	76.06	0	244,924	0		18.00
19.00	SPINE CENTER	90.04	0	55,054	0		19.00
20.00	EMERGENCY	91.00	0	80	0		20.00
21.00	MISC NONREIMBURSABLE COST CENTERS	194.08	0	6,571	0		21.00
	TOTALS		0	2,825,678			
	G - STD BENEFIT						
1.00	ADMINISTRATIVE & GENERAL	5.00	3,835	0	0		1.00
2.00	OPERATION OF PLANT	7.00	5,564	0	0		2.00
3.00	HOUSEKEEPING	9.00	7,000	0	0		3.00
4.00	DIETARY	10.00	11,685	0	0		4.00
5.00	NURSING ADMINISTRATION	13.00	416	0	0		5.00
6.00	MEDICAL RECORDS & LIBRARY	16.00	587	0	0		6.00
7.00	SOCIAL SERVICE	17.00	3,181	0	0		7.00
8.00	ADULTS & PEDIATRICS	30.00	172,326	0	0		8.00
9.00	INTENSIVE CARE UNIT	31.00	11,454	0	0		9.00
10.00	OPERATING ROOM	50.00	26,690	0	0		10.00
11.00	RECOVERY ROOM	51.00	14,970	0	0		11.00
12.00	RADIOLOGY-DIAGNOSTIC	54.00	2,549	0	0		12.00
13.00	RADIOLOGY-THERAPEUTIC	55.00	253	0	0		13.00
14.00	CT SCAN	57.00	5,429	0	0		14.00
15.00	CARDIAC CATHETERIZATION	59.00	2,785	0	0		15.00
16.00	RESPIRATORY THERAPY	65.00	18,677	0	0		16.00
17.00	PHYSICAL THERAPY	66.00	21,764	0	0		17.00
18.00	ELECTROCARDIOLOGY	69.00	5,470	0	0		18.00
19.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	73	0	0		19.00
20.00	DRUGS CHARGED TO PATIENTS	73.00	16,151	0	0		20.00
21.00	ENDOSCOPY	76.00	5,334	0	0		21.00
22.00	IMAGING CENTER	76.06	3,590	0	0		22.00
23.00	CARDIAC REHABILITATION	76.97	1,087	0	0		23.00
24.00	EMERGENCY	91.00	25,697	0	0		24.00
25.00	MISC NONREIMBURSABLE COST CENTERS	194.08	8,484	0	0		25.00
	TOTALS		375,051	0			
	H - Labor and Delivery						
1.00	ADULTS & PEDIATRICS	30.00	2,671,769	1,117,748	0		1.00
2.00		0.00	0	0	0		2.00
	TOTALS		2,671,769	1,117,748			

RECLASSIFICATIONS | Provider CCN: 15-0128 | Period: From 01/01/2020 To 12/31/2020 | Worksheet A-6 | Date/Time Prepared: 8/2/2021 3:42 pm

	Decreases						
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	I - Cafeteria						
1.00	DIETARY	10.00	815,781	1,000,970	0		1.00
	TOTALS		815,781	1,000,970			
	J - Therapy						
1.00	PHYSICAL THERAPY	66.00	869,283	259,116	0		1.00
2.00		0.00	0	0	0		2.00
	TOTALS		869,283	259,116			
	K - Building Depreciation						
1.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	5,077,028	9		1.00
	TOTALS		0	5,077,028			
	L - Capital Insurance Costs						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	133,929	12		1.00
	TOTALS		0	133,929			
	M - Radiology Support Staff						
1.00	RADIOLOGY-DIAGNOSTIC	54.00	226,924	112,024	0		1.00
2.00		0.00	0	0	0		2.00
3.00		0.00	0	0	0		3.00
	TOTALS		226,924	112,024			
500.00	Grand Total: Decreases		4,958,808	45,318,219			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-0128 | Period: From 01/01/2020 To 12/31/2020 | Worksheet A-7 Part I | Date/Time Prepared: 8/2/2021 3:42 pm

		Beginning Balances	Acquisitions: Purchases	Acquisitions: Donation	Acquisitions: Total	Disposals and Retirements	
		1.00	2.00	3.00	4.00	5.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	1,254,312	567,320	0	567,320	0	1.00
2.00	Land Improvements	2,722,362	0	0	0	0	2.00
3.00	Buildings and Fixtures	183,134,843	5,351,380	0	5,351,380	2,869,684	3.00
4.00	Building Improvements	1,737,035	0	0	0	0	4.00
5.00	Fixed Equipment	0	0	0	0	0	5.00
6.00	Movable Equipment	82,595,663	1,025,395	0	1,025,395	-434,211	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	271,444,215	6,944,095	0	6,944,095	2,435,473	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	271,444,215	6,944,095	0	6,944,095	2,435,473	10.00

		Ending Balance	Fully Depreciated Assets	
		6.00	7.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES			
1.00	Land	1,821,632	0	1.00
2.00	Land Improvements	2,722,362	0	2.00
3.00	Buildings and Fixtures	185,616,539	0	3.00
4.00	Building Improvements	1,737,035	0	4.00
5.00	Fixed Equipment	0	0	5.00
6.00	Movable Equipment	84,055,269	0	6.00
7.00	HIT designated Assets	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	275,952,837	0	8.00
9.00	Reconciling Items	0	0	9.00
10.00	Total (line 8 minus line 9)	275,952,837	0	10.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-0128 | Period: From 01/01/2020 To 12/31/2020 | Worksheet A-7 Part II Date/Time Prepared: 8/2/2021 3:42 pm

	Cost Center Description	SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	CAP REL COSTS-BLDG & FIXT	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: 15-0128 | Period: From 01/01/2020 To 12/31/2020 | Worksheet A-7 Part III Date/Time Prepared: 8/2/2021 3:42 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	191,897,568	0	191,897,568	0.695400	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	84,055,268	0	84,055,268	0.304600	0	2.00
3.00	Total (sum of lines 1-2)	275,952,836	0	275,952,836	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	5,077,028	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	7,520,059	2,824,903	2.00
3.00	Total (sum of lines 1-2)	0	0	0	12,597,087	2,824,903	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	2,500,657	133,929	0	0	7,711,614	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	0	10,344,962	2.00
3.00	Total (sum of lines 1-2)	2,500,657	133,929	0	0	18,056,576	3.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 15-0128 | Period: From 01/01/2020 To 12/31/2020 | Worksheet A-8 | Date/Time Prepared: 8/2/2021 3:42 pm

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
1.00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)		0	CAP REL COSTS-BLDG & FIXT	1.00	0	1.00
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
3.00	Investment income - other (chapter 2)		0		0.00	0	3.00
4.00	Trade, quantity, and time discounts (chapter 8)		0		0.00	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)		0		0.00	0	5.00
6.00	Rental of provider space by suppliers (chapter 8)		0		0.00	0	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)		0		0.00	0	7.00
8.00	Television and radio service (chapter 21)		0		0.00	0	8.00
9.00	Parking lot (chapter 21)		0		0.00	0	9.00
10.00	Provider-based physician adjustment	A-8-2	-582,148			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	4,015,024			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests	B	-998,116	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)		0	*** Cost Center Deleted ***	114.00		25.00
26.00	Depreciation - CAP REL COSTS-BLDG & FIXT		0	CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	27.00
28.00	Non-physician Anesthetist		0	*** Cost Center Deleted ***	19.00		28.00
29.00	Physicians' assistant		0		0.00	0	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	OCCUPATIONAL THERAPY	67.00		30.00
30.99	Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS	30.00		30.99
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	SPEECH PATHOLOGY	68.00		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest		0		0.00	0	32.00
33.00	Loss on Assets	A	-69,786	OPERATING ROOM	50.00	0	33.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 15-0128 | Period: From 01/01/2020 To 12/31/2020 | Worksheet A-8 | Date/Time Prepared: 8/2/2021 3:42 pm

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
33.01	Misc Revenue	B	-20,561	ADMINISTRATIVE & GENERAL	5.00	0	33.01
33.02	Misc Revenue	B	-14,262	OPERATION OF PLANT	7.00	0	33.02
33.03	Misc Revenue	B	-14,211	DIETARY	10.00	0	33.03
33.04	Misc Revenue	B	-284,000	OPERATING ROOM	50.00	0	33.04
33.05	Misc Revenue	B	-274,384	RADIOLOGY-DIAGNOSTIC	54.00	0	33.05
33.06	Misc Revenue	B	-18,601	PHYSICAL THERAPY	66.00	0	33.06
33.07	Misc Revenue	B	-8,224	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	33.07
33.08	Misc Revenue	B	-46,800	DRUGS CHARGED TO PATIENTS	73.00	0	33.08
33.09	Misc Revenue	B	-422	IMAGING CENTER	76.06	0	33.09
33.10	Misc Revenue	B	-1,697	CARDIAC REHABILITATION	76.97	0	33.10
33.11	Purchased Discounts	B	-1,753	ADMINISTRATIVE & GENERAL	5.00	0	33.11
33.12	Space Rental Income	B	-698,227	OPERATION OF PLANT	7.00	0	33.12
33.13	Investment Income	B	-8,521,863	ADMINISTRATIVE & GENERAL	5.00	0	33.13
34.00	HAF Tax Offset	A	-14,577,377	ADMINISTRATIVE & GENERAL	5.00	0	34.00
34.01	LOC Non-Allow Interest Expense	A	-38,366	CAP REL COSTS-BLDG & FIXT	1.00	11	34.01
34.02	Non-Allowable Interest Expense 00	A	-29,723	CAP REL COSTS-BLDG & FIXT	1.00	11	34.02
34.03	2012B Non- Allow Interest Expense	A	-42,636	CAP REL COSTS-BLDG & FIXT	1.00	11	34.03
34.04	50M BMO Non- Allow Interest Expense	A	-8,261	CAP REL COSTS-BLDG & FIXT	1.00	11	34.04
34.05	12B Non-Allow Interest Expense	A	-157,209	CAP REL COSTS-BLDG & FIXT	1.00	11	34.05
34.06	50 BMO Loan Non- Allow Interest Expense	A	12,399	ADMINISTRATIVE & GENERAL	5.00	0	34.06
34.07	Non-Allowable Interest Expense 00	A	-1,437,127	CAP REL COSTS-BLDG & FIXT	1.00	11	34.07
34.08	00 Non-Allow Interest Expense	A	-354,251	CAP REL COSTS-BLDG & FIXT	1.00	11	34.08
35.00	Bad Debt	A	-14,828,510	ADMINISTRATIVE & GENERAL	5.00	0	35.00
35.01	Sponsorship	A	-70,750	ADMINISTRATIVE & GENERAL	5.00	0	35.01
36.00	Meals on Wheels Cost	A	-94,023	CAFETERIA	11.00	0	36.00
36.01	APP	A	-302,116	ANTI-COAGULATION CLINIC	90.02	0	36.01
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-39,467,981				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: 15-0128 | Period: From 01/01/2020 To 12/31/2020 | Worksheet A-8-1 | Date/Time Prepared: 8/2/2021 3:42 pm

	Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in Wks. A, column 5	
	1.00	2.00	3.00	4.00	5.00	
	A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:					
1.00	5.00	ADMINISTRATIVE & GENERAL	1550 COUNTY LN RD	91,409	67,057	1.00
2.00	30.00	ADULTS & PEDIATRICS	1550 COUNTY LN RD	53,735	39,420	2.00
3.00	2.00	CAP REL COSTS-MVBLE EQUIP	HOME OFFICE	3,250,867	0	3.00
3.01	4.00	EMPLOYEE BENEFITS DEPARTMENT	HOME OFFICE	1,872,620	0	3.01
3.02	5.00	ADMINISTRATIVE & GENERAL	HOME OFFICE	28,801,779	39,280,548	3.02
3.03	7.00	OPERATION OF PLANT	HOME OFFICE	550,572	0	3.03
3.04	13.00	NURSING ADMINISTRATION	HOME OFFICE	2,096,822	0	3.04
3.05	71.00	MEDICAL SUPPLIES CHARGED TO	HOME OFFICE	2,028,791	0	3.05
3.06	16.00	MEDICAL RECORDS & LIBRARY	HOME OFFICE	1,450,671	0	3.06
3.07	30.00	ADULTS & PEDIATRICS	HOME OFFICE	88,587	0	3.07
3.08	54.00	RADIOLOGY-DIAGNOSTIC	HOME OFFICE	94,989	0	3.08
3.09	73.00	DRUGS CHARGED TO PATIENTS	HOME OFFICE	165,569	0	3.09
3.10	21.00	I&R SERVICES-SALARY & FRINGE	INTERNS & RESIDENTS	794,286	0	3.10
3.11	22.00	I&R SERVICES-OTHER PRGM. COS	INTERNS & RESIDENTS	1,177,937	0	3.11
4.00	5.00	ADMINISTRATIVE & GENERAL	CPN MEDICAL DIRECTOR	54,997	0	4.00
4.01	91.00	EMERGENCY	CPN CALL	828,418	0	4.01
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.			43,402,049	39,387,025	5.00

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

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

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

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

6.00	C	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:	OTHER				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: 15-0128 | Period: From 01/01/2020 To 12/31/2020 | Worksheet A-8-1 | Date/Time Prepared: 8/2/2021 3:42 pm

	Net Adjustments (col. 4 minus col. 5)*	Wkst. A-7 Ref.		
	6.00	7.00		
	A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:			
1.00	24,352	0		1.00
2.00	14,315	0		2.00
3.00	3,250,867	9		3.00
3.01	1,872,620	0		3.01
3.02	-10,478,769	0		3.02
3.03	550,572	0		3.03
3.04	2,096,822	0		3.04
3.05	2,028,791	0		3.05
3.06	1,450,671	0		3.06
3.07	88,587	0		3.07
3.08	94,989	0		3.08
3.09	165,569	0		3.09
3.10	794,286	0		3.10
3.11	1,177,937	0		3.11
4.00	54,997	0		4.00
4.01	828,418	0		4.01
5.00	4,015,024			5.00

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

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

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

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

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

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

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

PROVIDER BASED PHYSICIAN ADJUSTMENT | Provider CCN: 15-0128 | Period: From 01/01/2020 To 12/31/2020 | Worksheet A-8-2 | Date/Time Prepared: 8/2/2021 3:42 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	285,371	94,755	190,616	211,500	1,120	1.00
2.00	30.00	ADULTS & PEDIATRICS	410,662	410,662	0	0	0	2.00
3.00	0.00		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			696,033	505,417	190,616		1,120	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	113,885	5,694	0	0	0	1.00
2.00	30.00	ADULTS & PEDIATRICS	0	0	0	0	0	2.00
3.00	0.00		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			113,885	5,694	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	113,885	76,731	171,486		1.00
2.00	30.00	ADULTS & PEDIATRICS	0	0	0	410,662		2.00
3.00	0.00		0	0	0	0		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	113,885	76,731	582,148		200.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-0128 | Period: From 01/01/2020 To 12/31/2020 | Worksheet B Part I Date/Time Prepared: 8/2/2021 3:42 pm

		Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS BLDG & FIXT	CAPITAL RELATED COSTS MVBLE EQUIP	EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
			0	1.00	2.00	4.00	4A	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	7,711,614	7,711,614				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	10,344,962		10,344,962			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	1,872,706	0	0	1,872,706		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	32,138,928	434,437	3,895,474	199,199	36,668,038	5.00
7.00	00700	OPERATION OF PLANT	5,274,621	1,449,452	60,294	42,087	6,826,454	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	658,570	21,028	0	0	679,598	8.00
9.00	00900	HOUSEKEEPING	2,473,695	45,154	13,457	39,817	2,572,123	9.00
10.00	01000	DIETARY	959,226	87,557	21,381	11,746	1,079,910	10.00
11.00	01100	CAFETERIA	724,612	163,378	44,017	22,519	954,526	11.00
13.00	01300	NURSING ADMINISTRATION	2,427,573	0	0	7,372	2,434,945	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,812,094	0	0	7,879	1,819,973	16.00
17.00	01700	SOCIAL SERVICE	1,774,334	21,124	1,782	38,667	1,835,907	17.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	794,286	0	0	0	794,286	21.00
22.00	02200	I&R SERVICES-OTHER PRGM. COSTS APPRVD	1,177,937	12,409	0	0	1,190,346	22.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	31,145,303	1,942,993	253,483	549,983	33,891,762	30.00
31.00	03100	INTENSIVE CARE UNIT	4,046,966	583,194	159,123	85,095	4,874,378	31.00
43.00	04300	NURSERY	673,785	50,079	8,530	13,113	745,507	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	6,384,826	699,417	1,636,129	88,216	8,808,588	50.00
51.00	05100	RECOVERY ROOM	3,720,667	163,609	41,460	74,230	3,999,966	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	3,729,869	231,542	39,442	76,856	4,077,709	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,377,073	235,775	249,120	43,712	2,905,680	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	1,080,883	0	241,813	18,966	1,341,662	55.00
57.00	05700	CT SCAN	1,560,460	28,955	0	24,179	1,613,594	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	584,977	32,399	16,915	10,928	645,219	58.00
59.00	05900	CARDIAC CATHETERIZATION	2,881,556	213,361	543,459	37,859	3,676,235	59.00
60.00	06000	LABORATORY	7,391,441	99,043	77	0	7,490,561	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	2,630,182	49,483	24,152	53,244	2,757,061	65.00
66.00	06600	PHYSICAL THERAPY	2,587,161	15,911	565,219	54,952	3,223,243	66.00
67.00	06700	OCCUPATIONAL THERAPY	892,180	5,425	30,368	18,972	946,945	67.00
68.00	06800	SPEECH PATHOLOGY	236,219	1,443	8,040	5,023	250,725	68.00
69.00	06900	ELECTROCARDIOLOGY	1,367,833	120,052	54,389	25,820	1,568,094	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	585,963	48,136	111,530	10,068	755,697	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	13,711,960	224,077	1,195,186	11,551	15,142,774	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	9,177,048	0	0	0	9,177,048	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	11,531,470	121,841	371,739	81,586	12,106,636	73.00
74.00	07400	RENAL DIALYSIS	541,333	23,318	0	0	564,651	74.00
76.00	03950	ENDOSCOPY	892,914	0	233,419	14,940	1,141,273	76.00
76.06	03330	IMAGING CENTER	1,201,628	0	371,872	24,173	1,597,673	76.06
76.97	07697	CARDIAC REHABILITATION	300,126	0	11,797	6,231	318,154	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	04950	DIABETIC CARE CENTER	0	0	0	0	0	90.01
90.02	04951	ANTI-COAGULATION CLINIC	362,566	0	2,039	14,272	378,877	90.02
90.03	04952	PALLIATIVE CARE	0	0	0	0	0	90.03
90.04	04953	SPINE CENTER	230,646	0	66,824	4,443	301,913	90.04
91.00	09100	EMERGENCY	8,041,445	575,729	61,914	144,627	8,823,715	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					0	92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	190,013,638	7,700,321	10,334,444	1,862,325	189,981,446	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	121,719	0	0	0	121,719	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	LEASED OFFICE SPACE	0	0	0	0	0	194.06
194.08	07958	MISC NONREIMBURSABLE COST CENTERS	965,321	11,293	10,518	10,381	997,513	194.08
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)	191,100,678	7,711,614	10,344,962	1,872,706	191,100,678	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-0128 | Period: From 01/01/2020 To 12/31/2020 | Worksheet B Part I Date/Time Prepared: 8/2/2021 3:42 pm

		Cost Center Description	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
			5.00	7.00	8.00	9.00	10.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	36,668,038					5.00
7.00	00700	OPERATION OF PLANT	1,620,853	8,447,307				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	161,362	30,481	871,441			8.00
9.00	00900	HOUSEKEEPING	610,717	65,451	0	3,248,291		9.00
10.00	01000	DIETARY	256,411	126,914	0	49,364	1,512,599	10.00
11.00	01100	CAFETERIA	226,640	236,817	0	92,111	0	11.00
13.00	01300	NURSING ADMINISTRATION	578,146	0	0	0	0	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	432,129	0	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	435,912	30,620	0	11,910	0	17.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	188,593	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM. COSTS APPRVD	282,632	17,987	0	6,996	0	22.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	8,047,174	2,816,373	408,818	1,095,435	1,377,504	30.00
31.00	03100	INTENSIVE CARE UNIT	1,157,358	845,341	42,731	328,798	135,095	31.00
43.00	04300	NURSERY	177,011	72,590	8,415	28,234	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,091,485	1,013,807	0	394,323	0	50.00
51.00	05100	RECOVERY ROOM	949,740	237,152	126,533	92,241	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	968,199	335,621	38,922	130,541	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	689,916	341,756	14,402	132,927	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	318,560	0	0	0	0	55.00
57.00	05700	CT SCAN	383,127	41,970	48,452	16,324	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	153,199	46,962	0	18,266	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	872,874	309,268	10,230	120,291	0	59.00
60.00	06000	LABORATORY	1,778,536	143,563	0	55,839	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	654,628	71,726	0	27,898	0	65.00
66.00	06600	PHYSICAL THERAPY	765,317	23,063	0	8,970	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	224,840	7,864	0	3,059	0	67.00
68.00	06800	SPEECH PATHOLOGY	59,531	2,092	0	814	0	68.00
69.00	06900	ELECTROCARDIOLOGY	372,324	174,015	0	67,684	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	179,430	69,774	0	27,139	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	3,595,455	324,801	0	126,332	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	2,178,971	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,874,563	176,609	0	68,693	0	73.00
74.00	07400	RENAL DIALYSIS	134,069	33,799	0	13,146	0	74.00
76.00	03950	ENDOSCOPY	270,980	0	0	0	0	76.00
76.06	03330	IMAGING CENTER	379,347	0	0	0	0	76.06
76.97	07697	CARDIAC REHABILITATION	75,542	0	0	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	04950	DIABETIC CARE CENTER	0	0	0	0	0	90.01
90.02	04951	ANTI-COAGULATION CLINIC	89,959	0	0	0	0	90.02
90.03	04952	PALLIATIVE CARE	0	0	0	0	0	90.03
90.04	04953	SPINE CENTER	71,685	0	0	0	0	90.04
91.00	09100	EMERGENCY	2,095,076	834,521	172,938	324,589	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	36,402,291	8,430,937	871,441	3,241,924	1,512,599	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	28,901	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	LEASED OFFICE SPACE	0	0	0	0	0	194.06
194.08	07958	MISC NONREIMBURSABLE COST CENTERS	236,846	16,370	0	6,367	0	194.08
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	36,668,038	8,447,307	871,441	3,248,291	1,512,599	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-0128 | Period: From 01/01/2020 To 12/31/2020 | Worksheet B Part I Date/Time Prepared: 8/2/2021 3:42 pm

		Cost Center Description	CAFETERIA	NURSING ADMINISTRATION	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	INTERNS & RESIDENTS SERVICES-SALARY & FRINGES	
			11.00	13.00	16.00	17.00	21.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA	1,510,094					11.00
13.00	01300	NURSING ADMINISTRATION	17,258	3,030,349				13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	6,472	0	2,258,574			16.00
17.00	01700	SOCIAL SERVICE	34,516	0	0	2,348,865		17.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	0	0	0	982,879	21.00
22.00	02200	I&R SERVICES-OTHER PRGM. COSTS APPRVD	0	0	0	0		22.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	591,095	2,162,280	283,620	2,017,314	834,534	30.00
31.00	03100	INTENSIVE CARE UNIT	66,876	244,638	30,966	179,540	0	31.00
43.00	04300	NURSERY	12,944	47,349	9,460	152,011	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	103,549	0	285,246	0	25,512	50.00
51.00	05100	RECOVERY ROOM	69,033	0	92,656	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	58,246	0	43,743	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	45,303	0	81,124	0	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	17,258	0	53,157	0	0	55.00
57.00	05700	CT SCAN	25,887	0	156,822	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	10,786	0	31,512	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	34,516	0	189,749	0	0	59.00
60.00	06000	LABORATORY	0	0	182,189	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	51,775	0	40,244	0	0	65.00
66.00	06600	PHYSICAL THERAPY	21,573	0	20,411	0	12,756	66.00
67.00	06700	OCCUPATIONAL THERAPY	17,258	0	7,229	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	4,315	0	1,914	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	38,831	0	60,980	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	10,786	0	10,622	0	8,321	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	21,573	0	74,414	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	77,066	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	69,033	0	145,609	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	6,668	0	0	74.00
76.00	03950	ENDOSCOPY	12,944	0	20,233	0	0	76.00
76.06	03330	IMAGING CENTER	2,157	0	33,378	0	0	76.06
76.97	07697	CARDIAC REHABILITATION	8,629	0	2,956	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	04950	DIABETIC CARE CENTER	0	0	0	0	0	90.01
90.02	04951	ANTI-COAGULATION CLINIC	0	0	3,320	0	0	90.02
90.03	04952	PALLIATIVE CARE	0	0	0	0	0	90.03
90.04	04953	SPINE CENTER	0	0	830	0	0	90.04
91.00	09100	EMERGENCY	157,481	576,082	312,456	0	85,123	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	1,510,094	3,030,349	2,258,574	2,348,865	966,246	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
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	LEASED OFFICE SPACE	0	0	0	0	0	194.06
194.08	07958	MISC NONREIMBURSABLE COST CENTERS	0	0	0	0	16,633	194.08
200.00		Cross Foot Adjustments					0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	1,510,094	3,030,349	2,258,574	2,348,865	982,879	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-0128 | Period: From 01/01/2020 To 12/31/2020 | Worksheet B Part I | Date/Time Prepared: 8/2/2021 3:42 pm

		Cost Center Description	INTERNS & RESIDENTS SERVICES-OTHER PRGM. COSTS	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			22.00	24.00	25.00	26.00		
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION						13.00
16.00	01600	MEDICAL RECORDS & LIBRARY						16.00
17.00	01700	SOCIAL SERVICE						17.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD						21.00
22.00	02200	I&R SERVICES-OTHER PRGM. COSTS APPRVD	1,497,961					22.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,271,875	54,797,784	-2,106,409	52,691,375		30.00
31.00	03100	INTENSIVE CARE UNIT	0	7,905,721	0	7,905,721		31.00
43.00	04300	NURSERY	0	1,253,521	0	1,253,521		43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	38,882	12,761,392	-64,394	12,696,998		50.00
51.00	05100	RECOVERY ROOM	0	5,567,321	0	5,567,321		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	5,652,981	0	5,652,981		52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	4,211,108	0	4,211,108		54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	1,730,637	0	1,730,637		55.00
57.00	05700	CT SCAN	0	2,286,176	0	2,286,176		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	905,944	0	905,944		58.00
59.00	05900	CARDIAC CATHETERIZATION	0	5,213,163	0	5,213,163		59.00
60.00	06000	LABORATORY	0	9,650,688	0	9,650,688		60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0		64.00
65.00	06500	RESPIRATORY THERAPY	0	3,603,332	0	3,603,332		65.00
66.00	06600	PHYSICAL THERAPY	19,441	4,094,774	-32,197	4,062,577		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	1,207,195	0	1,207,195		67.00
68.00	06800	SPEECH PATHOLOGY	0	319,391	0	319,391		68.00
69.00	06900	ELECTROCARDIOLOGY	0	2,281,928	0	2,281,928		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	12,682	1,074,451	-21,003	1,053,448		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	19,285,349	0	19,285,349		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	11,433,085	0	11,433,085		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	15,441,143	0	15,441,143		73.00
74.00	07400	RENAL DIALYSIS	0	752,333	0	752,333		74.00
76.00	03950	ENDOSCOPY	0	1,445,430	0	1,445,430		76.00
76.06	03330	IMAGING CENTER	0	2,012,555	0	2,012,555		76.06
76.97	07697	CARDIAC REHABILITATION	0	405,281	0	405,281		76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0		90.00
90.01	04950	DIABETIC CARE CENTER	0	0	0	0		90.01
90.02	04951	ANTI-COAGULATION CLINIC	0	472,156	0	472,156		90.02
90.03	04952	PALLIATIVE CARE	0	0	0	0		90.03
90.04	04953	SPINE CENTER	0	374,428	0	374,428		90.04
91.00	09100	EMERGENCY	129,732	13,511,713	-214,855	13,296,858		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)			0			92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	1,472,612	189,650,980	-2,438,858	187,212,122		118.00
		NONREIMBURSABLE COST CENTERS						
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	150,620	0	150,620		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	LEASED OFFICE SPACE	0	0	0	0		194.06
194.08	07958	MISC NONREIMBURSABLE COST CENTERS	25,349	1,299,078	-41,982	1,257,096		194.08
200.00		Cross Foot Adjustments	0	0	0	0		200.00
201.00		Negative Cost Centers	0	0	0	0		201.00
202.00		TOTAL (sum lines 118 through 201)	1,497,961	191,100,678	-2,480,840	188,619,838		202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-0128 | Period: From 01/01/2020 To 12/31/2020 | Worksheet B Part II Date/Time Prepared: 8/2/2021 3:42 pm

		Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS BLDG & FIXT	CAPITAL RELATED COSTS MVBLE EQUIP	Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
			0	1.00	2.00	2A	4.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	0	0	0	0	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	10,957	434,437	3,895,474	4,340,868	0	5.00
7.00	00700	OPERATION OF PLANT	0	1,449,452	60,294	1,509,746	0	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	21,028	0	21,028	0	8.00
9.00	00900	HOUSEKEEPING	0	45,154	13,457	58,611	0	9.00
10.00	01000	DIETARY	0	87,557	21,381	108,938	0	10.00
11.00	01100	CAFETERIA	0	163,378	44,017	207,395	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	0	0	0	0	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	0	21,124	1,782	22,906	0	17.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM. COSTS APPRVD	0	12,409	0	12,409	0	22.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	18,640	1,942,993	253,483	2,215,116	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	583,194	159,123	742,317	0	31.00
43.00	04300	NURSERY	0	50,079	8,530	58,609	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	699,417	1,636,129	2,335,546	0	50.00
51.00	05100	RECOVERY ROOM	0	163,609	41,460	205,069	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	231,542	39,442	270,984	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	235,775	249,120	484,895	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	241,813	241,813	0	55.00
57.00	05700	CT SCAN	0	28,955	0	28,955	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	32,399	16,915	49,314	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	213,361	543,459	756,820	0	59.00
60.00	06000	LABORATORY	0	99,043	77	99,120	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	49,483	24,152	73,635	0	65.00
66.00	06600	PHYSICAL THERAPY	0	15,911	565,219	581,130	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	5,425	30,368	35,793	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	1,443	8,040	9,483	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	120,052	54,389	174,441	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	48,136	111,530	159,666	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	224,077	1,195,186	1,419,263	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	121,841	371,739	493,580	0	73.00
74.00	07400	RENAL DIALYSIS	0	23,318	0	23,318	0	74.00
76.00	03950	ENDOSCOPY	0	0	233,419	233,419	0	76.00
76.06	03330	IMAGING CENTER	0	0	371,872	371,872	0	76.06
76.97	07697	CARDIAC REHABILITATION	0	0	11,797	11,797	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	04950	DIABETIC CARE CENTER	0	0	0	0	0	90.01
90.02	04951	ANTI-COAGULATION CLINIC	0	0	2,039	2,039	0	90.02
90.03	04952	PALLIATIVE CARE	0	0	0	0	0	90.03
90.04	04953	SPINE CENTER	0	0	66,824	66,824	0	90.04
91.00	09100	EMERGENCY	0	575,729	61,914	637,643	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				0		92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	29,597	7,700,321	10,334,444	18,064,362	0	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
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	LEASED OFFICE SPACE	0	0	0	0	0	194.06
194.08	07958	MISC NONREIMBURSABLE COST CENTERS	0	11,293	10,518	21,811	0	194.08
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)	29,597	7,711,614	10,344,962	18,086,173	0	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-0128 | Period: From 01/01/2020 To 12/31/2020 | Worksheet B Part II | Date/Time Prepared: 8/2/2021 3:42 pm

		Cost Center Description	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
			5.00	7.00	8.00	9.00	10.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	4,340,868					5.00
7.00	00700	OPERATION OF PLANT	191,878	1,701,624				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	19,102	6,140	46,270			8.00
9.00	00900	HOUSEKEEPING	72,297	13,184	0	144,092		9.00
10.00	01000	DIETARY	30,354	25,566	0	2,190	167,048	10.00
11.00	01100	CAFETERIA	26,830	47,704	0	4,086	0	11.00
13.00	01300	NURSING ADMINISTRATION	68,441	0	0	0	0	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	51,156	0	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	51,604	6,168	0	528	0	17.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	22,326	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM. COSTS APPRVD	33,458	3,623	0	310	0	22.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	952,707	567,332	21,706	48,593	152,128	30.00
31.00	03100	INTENSIVE CARE UNIT	137,009	170,285	2,269	14,585	14,920	31.00
43.00	04300	NURSERY	20,955	14,623	447	1,252	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	247,592	204,221	0	17,492	0	50.00
51.00	05100	RECOVERY ROOM	112,431	47,772	6,718	4,092	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	114,616	67,607	2,067	5,791	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	81,673	68,843	765	5,897	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	37,711	0	0	0	0	55.00
57.00	05700	CT SCAN	45,355	8,454	2,573	724	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	18,136	9,460	0	810	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	103,332	62,299	543	5,336	0	59.00
60.00	06000	LABORATORY	210,545	28,919	0	2,477	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	77,495	14,448	0	1,238	0	65.00
66.00	06600	PHYSICAL THERAPY	90,599	4,646	0	398	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	26,617	1,584	0	136	0	67.00
68.00	06800	SPEECH PATHOLOGY	7,047	421	0	36	0	68.00
69.00	06900	ELECTROCARDIOLOGY	44,076	35,054	0	3,002	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	21,241	14,055	0	1,204	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	425,633	65,428	0	5,604	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	257,948	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	340,293	35,576	0	3,047	0	73.00
74.00	07400	RENAL DIALYSIS	15,871	6,808	0	583	0	74.00
76.00	03950	ENDOSCOPY	32,079	0	0	0	0	76.00
76.06	03330	IMAGING CENTER	44,907	0	0	0	0	76.06
76.97	07697	CARDIAC REHABILITATION	8,943	0	0	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	04950	DIABETIC CARE CENTER	0	0	0	0	0	90.01
90.02	04951	ANTI-COAGULATION CLINIC	10,649	0	0	0	0	90.02
90.03	04952	PALLIATIVE CARE	0	0	0	0	0	90.03
90.04	04953	SPINE CENTER	8,486	0	0	0	0	90.04
91.00	09100	EMERGENCY	248,017	168,106	9,182	14,399	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	4,309,409	1,698,326	46,270	143,810	167,048	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	3,421	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	LEASED OFFICE SPACE	0	0	0	0	0	194.06
194.08	07958	MISC NONREIMBURSABLE COST CENTERS	28,038	3,298	0	282	0	194.08
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	4,340,868	1,701,624	46,270	144,092	167,048	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-0128 | Period: From 01/01/2020 To 12/31/2020 | Worksheet B Part II Date/Time Prepared: 8/2/2021 3:42 pm

		Cost Center Description	CAFETERIA	NURSING ADMINISTRATION	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	INTERNS & RESIDENTS SERVICES-SALARY & FRINGES	
			11.00	13.00	16.00	17.00	21.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
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	286,015					11.00
13.00	01300	NURSING ADMINISTRATION	3,269	71,710				13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,226	0	52,382			16.00
17.00	01700	SOCIAL SERVICE	6,537	0	0	87,743		17.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	0	0	0	22,326	21.00
22.00	02200	I&R SERVICES-OTHER PRGM. COSTS APPRVD	0	0	0	0		22.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	111,955	51,169	6,614	75,358		30.00
31.00	03100	INTENSIVE CARE UNIT	12,666	5,789	722	6,707		31.00
43.00	04300	NURSERY	2,452	1,120	221	5,678		43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	19,612	0	6,652	0		50.00
51.00	05100	RECOVERY ROOM	13,075	0	2,161	0		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	11,032	0	1,020	0		52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	8,580	0	1,892	0		54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	3,269	0	1,240	0		55.00
57.00	05700	CT SCAN	4,903	0	3,657	0		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	2,043	0	735	0		58.00
59.00	05900	CARDIAC CATHETERIZATION	6,537	0	4,425	0		59.00
60.00	06000	LABORATORY	0	0	4,249	0		60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0		64.00
65.00	06500	RESPIRATORY THERAPY	9,806	0	939	0		65.00
66.00	06600	PHYSICAL THERAPY	4,086	0	476	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	3,269	0	169	0		67.00
68.00	06800	SPEECH PATHOLOGY	817	0	45	0		68.00
69.00	06900	ELECTROCARDIOLOGY	7,355	0	1,422	0		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	2,043	0	248	0		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	4,086	0	1,735	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	1,797	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	13,075	0	3,396	0		73.00
74.00	07400	RENAL DIALYSIS	0	0	156	0		74.00
76.00	03950	ENDOSCOPY	2,452	0	472	0		76.00
76.06	03330	IMAGING CENTER	409	0	778	0		76.06
76.97	07697	CARDIAC REHABILITATION	1,634	0	69	0		76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0		90.00
90.01	04950	DIABETIC CARE CENTER	0	0	0	0		90.01
90.02	04951	ANTI-COAGULATION CLINIC	0	0	77	0		90.02
90.03	04952	PALLIATIVE CARE	0	0	0	0		90.03
90.04	04953	SPINE CENTER	0	0	19	0		90.04
91.00	09100	EMERGENCY	29,827	13,632	6,996	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	286,015	71,710	52,382	87,743	0	118.00
		NONREIMBURSABLE COST CENTERS						
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	LEASED OFFICE SPACE	0	0	0	0		194.06
194.08	07958	MISC NONREIMBURSABLE COST CENTERS	0	0	0	0		194.08
200.00		Cross Foot Adjustments					22,326	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	286,015	71,710	52,382	87,743	22,326	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-0128 | Period: From 01/01/2020 To 12/31/2020 | Worksheet B Part II | Date/Time Prepared: 8/2/2021 3:42 pm

		Cost Center Description	INTERNS & RESIDENTS SERVICES-OTHER PRGM. COSTS	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			22.00	24.00	25.00	26.00		
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION						13.00
16.00	01600	MEDICAL RECORDS & LIBRARY						16.00
17.00	01700	SOCIAL SERVICE						17.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD						21.00
22.00	02200	I&R SERVICES-OTHER PRGM. COSTS APPRVD	49,800					22.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS		4,202,678	0	4,202,678		30.00
31.00	03100	INTENSIVE CARE UNIT		1,107,269	0	1,107,269		31.00
43.00	04300	NURSERY		105,357	0	105,357		43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM		2,831,115	0	2,831,115		50.00
51.00	05100	RECOVERY ROOM		391,318	0	391,318		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM		473,117	0	473,117		52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC		652,545	0	652,545		54.00
55.00	05500	RADIOLOGY-THERAPEUTIC		284,033	0	284,033		55.00
57.00	05700	CT SCAN		94,621	0	94,621		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)		80,498	0	80,498		58.00
59.00	05900	CARDIAC CATHETERIZATION		939,292	0	939,292		59.00
60.00	06000	LABORATORY		345,310	0	345,310		60.00
64.00	06400	INTRAVENOUS THERAPY		0	0	0		64.00
65.00	06500	RESPIRATORY THERAPY		177,561	0	177,561		65.00
66.00	06600	PHYSICAL THERAPY		681,335	0	681,335		66.00
67.00	06700	OCCUPATIONAL THERAPY		67,568	0	67,568		67.00
68.00	06800	SPEECH PATHOLOGY		17,849	0	17,849		68.00
69.00	06900	ELECTROCARDIOLOGY		265,350	0	265,350		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY		198,457	0	198,457		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS		1,921,749	0	1,921,749		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS		259,745	0	259,745		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS		888,967	0	888,967		73.00
74.00	07400	RENAL DIALYSIS		46,736	0	46,736		74.00
76.00	03950	ENDOSCOPY		268,422	0	268,422		76.00
76.06	03330	IMAGING CENTER		417,966	0	417,966		76.06
76.97	07697	CARDIAC REHABILITATION		22,443	0	22,443		76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC		0	0	0		90.00
90.01	04950	DIABETIC CARE CENTER		0	0	0		90.01
90.02	04951	ANTI-COAGULATION CLINIC		12,765	0	12,765		90.02
90.03	04952	PALLIATIVE CARE		0	0	0		90.03
90.04	04953	SPINE CENTER		75,329	0	75,329		90.04
91.00	09100	EMERGENCY		1,127,802	0	1,127,802		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)			0			92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	17,957,197	0	17,957,197		118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN		0	0	0		190.00
191.00	19100	RESEARCH		0	0	0		191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES		3,421	0	3,421		192.00
193.00	19300	NONPAID WORKERS		0	0	0		193.00
194.00	07950	HOME OFFICE		0	0	0		194.00
194.06	07956	LEASED OFFICE SPACE		0	0	0		194.06
194.08	07958	MISC NONREIMBURSABLE COST CENTERS		53,429	0	53,429		194.08
200.00		Cross Foot Adjustments	49,800	72,126	0	72,126		200.00
201.00		Negative Cost Centers	0	0	0	0		201.00
202.00		TOTAL (sum lines 118 through 201)	49,800	18,086,173	0	18,086,173		202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-0128 | Period: From 01/01/2020 To 12/31/2020 | Worksheet B-1 | Date/Time Prepared: 8/2/2021 3:42 pm

		Cost Center Description	CAPITAL RELATED COSTS BLDG & FIXT (SQUARE FEET)	CAPITAL RELATED COSTS MVBLE EQUIP (DOLLAR VALUE)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
			1.00	2.00	4.00	5A	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	400,831					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		10,689,680				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	0	67,840,947			4.00
5.00	00500	ADMINISTRATIVE & GENERAL	22,581	4,025,279	7,216,299	-36,668,038	154,432,640	5.00
7.00	00700	OPERATION OF PLANT	75,339	62,303	1,524,668	0	6,826,454	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	1,093	0	0	0	679,598	8.00
9.00	00900	HOUSEKEEPING	2,347	13,905	1,442,420	0	2,572,123	9.00
10.00	01000	DIETARY	4,551	22,093	425,520	0	1,079,910	10.00
11.00	01100	CAFETERIA	8,492	45,484	815,781	0	954,526	11.00
13.00	01300	NURSING ADMINISTRATION	0	0	267,067	0	2,434,945	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	285,422	0	1,819,973	16.00
17.00	01700	SOCIAL SERVICE	1,098	1,841	1,400,787	0	1,835,907	17.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	0	0	0	794,286	21.00
22.00	02200	I&R SERVICES-OTHER PRGM. COSTS APPRVD	645	0	0	0	1,190,346	22.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	100,992	261,930	19,923,144	0	33,891,762	30.00
31.00	03100	INTENSIVE CARE UNIT	30,313	164,425	3,082,722	0	4,874,378	31.00
43.00	04300	NURSERY	2,603	8,814	475,047	0	745,507	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	36,354	1,690,649	3,195,763	0	8,808,588	50.00
51.00	05100	RECOVERY ROOM	8,504	42,842	2,689,087	0	3,999,966	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	12,035	40,756	2,784,251	0	4,077,709	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	12,255	257,421	1,583,550	0	2,905,680	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	249,871	687,065	0	1,341,662	55.00
57.00	05700	CT SCAN	1,505	0	875,927	0	1,613,594	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	1,684	17,479	395,897	0	645,219	58.00
59.00	05900	CARDIAC CATHETERIZATION	11,090	561,568	1,371,509	0	3,676,235	59.00
60.00	06000	LABORATORY	5,148	80	0	0	7,490,561	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	2,572	24,957	1,928,833	0	2,757,061	65.00
66.00	06600	PHYSICAL THERAPY	827	584,054	1,990,713	0	3,223,243	66.00
67.00	06700	OCCUPATIONAL THERAPY	282	31,380	687,307	0	946,945	67.00
68.00	06800	SPEECH PATHOLOGY	75	8,308	181,976	0	250,725	68.00
69.00	06900	ELECTROCARDIOLOGY	6,240	56,201	935,384	0	1,568,094	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	2,502	115,246	364,731	0	755,697	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	11,647	1,235,013	418,465	0	15,142,774	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	9,177,048	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	6,333	384,126	2,955,569	0	12,106,636	73.00
74.00	07400	RENAL DIALYSIS	1,212	0	0	0	564,651	74.00
76.00	03950	ENDOSCOPY	0	241,197	541,222	0	1,141,273	76.00
76.06	03330	IMAGING CENTER	0	384,264	875,692	0	1,597,673	76.06
76.97	07697	CARDIAC REHABILITATION	0	12,190	225,715	0	318,154	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	04950	DIABETIC CARE CENTER	0	0	0	0	0	90.01
90.02	04951	ANTI-COAGULATION CLINIC	0	2,107	517,020	0	378,877	90.02
90.03	04952	PALLIATIVE CARE	0	0	0	0	0	90.03
90.04	04953	SPINE CENTER	0	69,051	160,973	0	301,913	90.04
91.00	09100	EMERGENCY	29,925	63,977	5,239,358	0	8,823,715	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	400,244	10,678,811	67,464,884	-36,668,038	153,313,408	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	121,719	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	LEASED OFFICE SPACE	0	0	0	0	0	194.06
194.08	07958	MISC NONREIMBURSABLE COST CENTERS	587	10,869	376,063	0	997,513	194.08
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)	7,711,614	10,344,962	1,872,706		36,668,038	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	19.239066	0.967752	0.027604		0.237437	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)			0		4,340,868	204.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-0128 | Period: From 01/01/2020 To 12/31/2020 | Worksheet B-1 | Date/Time Prepared: 8/2/2021 3:42 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	4.00	5A	5.00	
205.00		Unit cost multiplier (Wkst. B, Part II)			0.000000		0.028108	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: 15-0128 | Period: From 01/01/2020 To 12/31/2020 | Worksheet B-1 | Date/Time Prepared: 8/2/2021 3:42 pm

		Cost Center Description	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (PATIENT DAYS)	CAFETERIA (MEALS SERVED)	
			7.00	8.00	9.00	10.00	11.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT	302,911					7.00
8.00	00800	LAUNDRY & LINEN SERVICE	1,093	146,853				8.00
9.00	00900	HOUSEKEEPING	2,347	0	299,471			9.00
10.00	01000	DIETARY	4,551	0	4,551	33,444		10.00
11.00	01100	CAFETERIA	8,492	0	8,492	0	700	11.00
13.00	01300	NURSING ADMINISTRATION	0	0	0	0	8	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	3	16.00
17.00	01700	SOCIAL SERVICE	1,098	0	1,098	0	16	17.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM. COSTS APPRVD	645	0	645	0	0	22.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	100,992	68,893	100,992	30,457	274	30.00
31.00	03100	INTENSIVE CARE UNIT	30,313	7,201	30,313	2,987	31	31.00
43.00	04300	NURSERY	2,603	1,418	2,603	0	6	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	36,354	0	36,354	0	48	50.00
51.00	05100	RECOVERY ROOM	8,504	21,323	8,504	0	32	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	12,035	6,559	12,035	0	27	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	12,255	2,427	12,255	0	21	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	8	55.00
57.00	05700	CT SCAN	1,505	8,165	1,505	0	12	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	1,684	0	1,684	0	5	58.00
59.00	05900	CARDIAC CATHETERIZATION	11,090	1,724	11,090	0	16	59.00
60.00	06000	LABORATORY	5,148	0	5,148	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	2,572	0	2,572	0	24	65.00
66.00	06600	PHYSICAL THERAPY	827	0	827	0	10	66.00
67.00	06700	OCCUPATIONAL THERAPY	282	0	282	0	8	67.00
68.00	06800	SPEECH PATHOLOGY	75	0	75	0	2	68.00
69.00	06900	ELECTROCARDIOLOGY	6,240	0	6,240	0	18	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	2,502	0	2,502	0	5	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	11,647	0	11,647	0	10	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	6,333	0	6,333	0	32	73.00
74.00	07400	RENAL DIALYSIS	1,212	0	1,212	0	0	74.00
76.00	03950	ENDOSCOPY	0	0	0	0	6	76.00
76.06	03330	IMAGING CENTER	0	0	0	0	1	76.06
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	4	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	04950	DIABETIC CARE CENTER	0	0	0	0	0	90.01
90.02	04951	ANTI-COAGULATION CLINIC	0	0	0	0	0	90.02
90.03	04952	PALLIATIVE CARE	0	0	0	0	0	90.03
90.04	04953	SPINE CENTER	0	0	0	0	0	90.04
91.00	09100	EMERGENCY	29,925	29,143	29,925	0	73	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	302,324	146,853	298,884	33,444	700	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
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	LEASED OFFICE SPACE	0	0	0	0	0	194.06
194.08	07958	MISC NONREIMBURSABLE COST CENTERS	587	0	587	0	0	194.08
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)	8,447,307	871,441	3,248,291	1,512,599	1,510,094	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	27.887092	5.934104	10.846763	45.227814	2,157.277143	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	1,701,624	46,270	144,092	167,048	286,015	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	5.617571	0.315077	0.481155	4.994857	408.592857	205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)						206.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-0128 | Period: From 01/01/2020 To 12/31/2020 | Worksheet B-1 | Date/Time Prepared: 8/2/2021 3:42 pm

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

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-0128 | Period: From 01/01/2020 To 12/31/2020 | Worksheet B-1 | Date/Time Prepared: 8/2/2021 3:42 pm

		Cost Center Description	NURSING ADMINISTRATION (DIRECT NURS. HRS.)	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)	SOCIAL SERVICE (TOTAL PATIENT DAYS)	INTERNS & RESIDENTS SERVICES-SALARY & FRINGES (ASSIGNED TIME)	INTERNS & RESIDENTS SERVICES-OTHER PRGM. COSTS (ASSIGNED TIME)	
			13.00	16.00	17.00	21.00	22.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
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	384					13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	908,031,675				16.00
17.00	01700	SOCIAL SERVICE	0	0	39,078			17.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	0	0	96,853		21.00
22.00	02200	I&R SERVICES-OTHER PRGM. COSTS APPRVD	0	0	0		96,853	22.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	274	114,040,907	33,562	82,235	82,235	30.00
31.00	03100	INTENSIVE CARE UNIT	31	12,451,172	2,987	0	0	31.00
43.00	04300	NURSERY	6	3,803,616	2,529	0	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	114,694,681	0	2,514	2,514	50.00
51.00	05100	RECOVERY ROOM	0	37,256,221	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	17,588,748	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	32,619,326	0	0	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	21,373,916	0	0	0	55.00
57.00	05700	CT SCAN	0	63,056,681	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	12,670,661	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	76,296,215	0	0	0	59.00
60.00	06000	LABORATORY	0	73,256,365	0	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	16,181,858	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	8,207,032	0	1,257	1,257	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	2,906,540	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	769,406	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	24,519,368	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	4,271,005	0	820	820	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	29,921,007	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	30,987,651	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	58,548,204	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	2,681,063	0	0	0	74.00
76.00	03950	ENDOSCOPY	0	8,135,444	0	0	0	76.00
76.06	03330	IMAGING CENTER	0	13,421,152	0	0	0	76.06
76.97	07697	CARDIAC REHABILITATION	0	1,188,629	0	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	04950	DIABETIC CARE CENTER	0	0	0	0	0	90.01
90.02	04951	ANTI-COAGULATION CLINIC	0	1,335,072	0	0	0	90.02
90.03	04952	PALLIATIVE CARE	0	0	0	0	0	90.03
90.04	04953	SPINE CENTER	0	333,915	0	0	0	90.04
91.00	09100	EMERGENCY	73	125,515,820	0	8,388	8,388	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	384	908,031,675	39,078	95,214	95,214	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
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	LEASED OFFICE SPACE	0	0	0	0	0	194.06
194.08	07958	MISC NONREIMBURSABLE COST CENTERS	0	0	0	1,639	1,639	194.08
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	3,030,349	2,258,574	2,348,865	982,879	1,497,961	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	7,891.533854	0.002487	60.107094	10.148152	15.466336	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	71,710	52,382	87,743	22,326	49,800	204.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-0128 | Period: From 01/01/2020 To 12/31/2020 | Worksheet B-1 | Date/Time Prepared: 8/2/2021 3:42 pm

		Cost Center Description	NURSING ADMINISTRATION (DIRECT NURS. HRS.)	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)	SOCIAL SERVICE (TOTAL PATIENT DAYS)	INTERNS & RESIDENTS SERVICES-SALARY & FRINGES (ASSIGNED TIME)	INTERNS & RESIDENTS SERVICES-OTHER PRGM. COSTS (ASSIGNED TIME)	
			13.00	16.00	17.00	21.00	22.00	
205.00		Unit cost multiplier (Wkst. B, Part II)	186.744792	0.000058	2.245330	0.230514	0.514181	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: 15-0128 | Period: From 01/01/2020 To 12/31/2020 | Worksheet C Part I Date/Time Prepared: 8/2/2021 3:42 pm

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		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	Costs RCE Disallowance	Costs Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	52,691,375		52,691,375	0	52,691,375	30.00
31.00	03100	INTENSIVE CARE UNIT	7,905,721		7,905,721	0	7,905,721	31.00
43.00	04300	NURSERY	1,253,521		1,253,521	0	1,253,521	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	12,696,998		12,696,998	0	12,696,998	50.00
51.00	05100	RECOVERY ROOM	5,567,321		5,567,321	0	5,567,321	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	5,652,981		5,652,981	0	5,652,981	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,211,108		4,211,108	0	4,211,108	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	1,730,637		1,730,637	0	1,730,637	55.00
57.00	05700	CT SCAN	2,286,176		2,286,176	0	2,286,176	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	905,944		905,944	0	905,944	58.00
59.00	05900	CARDIAC CATHETERIZATION	5,213,163		5,213,163	0	5,213,163	59.00
60.00	06000	LABORATORY	9,650,688		9,650,688	0	9,650,688	60.00
64.00	06400	INTRAVENOUS THERAPY	0		0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	3,603,332	0	3,603,332	0	3,603,332	65.00
66.00	06600	PHYSICAL THERAPY	4,062,577	0	4,062,577	0	4,062,577	66.00
67.00	06700	OCCUPATIONAL THERAPY	1,207,195	0	1,207,195	0	1,207,195	67.00
68.00	06800	SPEECH PATHOLOGY	319,391	0	319,391	0	319,391	68.00
69.00	06900	ELECTROCARDIOLOGY	2,281,928		2,281,928	0	2,281,928	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	1,053,448		1,053,448	0	1,053,448	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	19,285,349		19,285,349	0	19,285,349	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	11,433,085		11,433,085	0	11,433,085	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	15,441,143		15,441,143	0	15,441,143	73.00
74.00	07400	RENAL DIALYSIS	752,333		752,333	0	752,333	74.00
76.00	03950	ENDOSCOPY	1,445,430		1,445,430	0	1,445,430	76.00
76.06	03330	IMAGING CENTER	2,012,555		2,012,555	0	2,012,555	76.06
76.97	07697	CARDIAC REHABILITATION	405,281		405,281	0	405,281	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0		0	0	0	90.00
90.01	04950	DIABETIC CARE CENTER	0		0	0	0	90.01
90.02	04951	ANTI-COAGULATION CLINIC	472,156		472,156	0	472,156	90.02
90.03	04952	PALLIATIVE CARE	0		0	0	0	90.03
90.04	04953	SPINE CENTER	374,428		374,428	0	374,428	90.04
91.00	09100	EMERGENCY	13,296,858		13,296,858	0	13,296,858	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	5,688,709		5,688,709		5,688,709	92.00
200.00		Subtotal (see instructions)	192,900,831	0	192,900,831	0	192,900,831	200.00
201.00		Less Observation Beds	5,688,709		5,688,709		5,688,709	201.00
202.00		Total (see instructions)	187,212,122	0	187,212,122	0	187,212,122	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-0128 | Period: From 01/01/2020 To 12/31/2020 | Worksheet C Part I Date/Time Prepared: 8/2/2021 3:42 pm

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		Cost Center Description	Charges Inpatient	Charges Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	107,351,007		107,351,007			30.00
31.00	03100	INTENSIVE CARE UNIT	12,451,172		12,451,172			31.00
43.00	04300	NURSERY	3,803,616		3,803,616			43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	59,293,364	55,401,317	114,694,681	0.110703	0.000000	50.00
51.00	05100	RECOVERY ROOM	14,002,999	23,253,222	37,256,221	0.149433	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	17,588,748	0	17,588,748	0.321398	0.000000	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	7,034,972	25,584,354	32,619,326	0.129099	0.000000	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	7,329,313	14,044,603	21,373,916	0.080970	0.000000	55.00
57.00	05700	CT SCAN	17,852,352	45,204,329	63,056,681	0.036256	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	3,416,443	9,254,218	12,670,661	0.071499	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	30,073,404	46,222,811	76,296,215	0.068328	0.000000	59.00
60.00	06000	LABORATORY	44,646,834	28,609,531	73,256,365	0.131739	0.000000	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0.000000	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	14,804,722	1,377,136	16,181,858	0.222677	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	2,878,086	5,328,946	8,207,032	0.495012	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	2,165,720	740,820	2,906,540	0.415337	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	598,680	170,726	769,406	0.415114	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	7,137,524	17,381,844	24,519,368	0.093066	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	324,932	3,946,073	4,271,005	0.246651	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	15,761,035	14,159,972	29,921,007	0.644542	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	17,564,300	13,423,351	30,987,651	0.368956	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	42,905,288	15,642,916	58,548,204	0.263734	0.000000	73.00
74.00	07400	RENAL DIALYSIS	2,681,063	0	2,681,063	0.280610	0.000000	74.00
76.00	03950	ENDOSCOPY	2,124,648	6,010,796	8,135,444	0.177671	0.000000	76.00
76.06	03330	IMAGING CENTER	141,028	13,280,124	13,421,152	0.149954	0.000000	76.06
76.97	07697	CARDIAC REHABILITATION	3,054	1,185,575	1,188,629	0.340965	0.000000	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0.000000	0.000000	90.00
90.01	04950	DIABETIC CARE CENTER	0	0	0	0.000000	0.000000	90.01
90.02	04951	ANTI-COAGULATION CLINIC	7,525	1,327,547	1,335,072	0.353656	0.000000	90.02
90.03	04952	PALLIATIVE CARE	0	0	0	0.000000	0.000000	90.03
90.04	04953	SPINE CENTER	0	333,915	333,915	1.121327	0.000000	90.04
91.00	09100	EMERGENCY	28,668,624	96,847,196	125,515,820	0.105938	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	2,318,605	4,371,295	6,689,900	0.850343	0.000000	92.00
200.00		Subtotal (see instructions)	464,929,058	443,102,617	908,031,675			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	464,929,058	443,102,617	908,031,675			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-0128 | Period: From 01/01/2020 To 12/31/2020 | Worksheet C Part I Date/Time Prepared: 8/2/2021 3:42 pm

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		Cost Center Description	PPS Inpatient Ratio	
			11.00	
		INPATIENT ROUTINE SERVICE COST CENTERS		
30.00	03000	ADULTS & PEDIATRICS		30.00
31.00	03100	INTENSIVE CARE UNIT		31.00
43.00	04300	NURSERY		43.00
		ANCILLARY SERVICE COST CENTERS		
50.00	05000	OPERATING ROOM	0.110703	50.00
51.00	05100	RECOVERY ROOM	0.149433	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.321398	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.129099	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.080970	55.00
57.00	05700	CT SCAN	0.036256	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.071499	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.068328	59.00
60.00	06000	LABORATORY	0.131739	60.00
64.00	06400	INTRAVENOUS THERAPY	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	0.222677	65.00
66.00	06600	PHYSICAL THERAPY	0.495012	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.415337	67.00
68.00	06800	SPEECH PATHOLOGY	0.415114	68.00
69.00	06900	ELECTROCARDIOLOGY	0.093066	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.246651	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.644542	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.368956	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.263734	73.00
74.00	07400	RENAL DIALYSIS	0.280610	74.00
76.00	03950	ENDOSCOPY	0.177671	76.00
76.06	03330	IMAGING CENTER	0.149954	76.06
76.97	07697	CARDIAC REHABILITATION	0.340965	76.97
		OUTPATIENT SERVICE COST CENTERS		
90.00	09000	CLINIC	0.000000	90.00
90.01	04950	DIABETIC CARE CENTER	0.000000	90.01
90.02	04951	ANTI-COAGULATION CLINIC	0.353656	90.02
90.03	04952	PALLIATIVE CARE	0.000000	90.03
90.04	04953	SPINE CENTER	1.121327	90.04
91.00	09100	EMERGENCY	0.105938	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.850343	92.00
200.00		Subtotal (see instructions)		200.00
201.00		Less Observation Beds		201.00
202.00		Total (see instructions)		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-0128 | Period: From 01/01/2020 To 12/31/2020 | Worksheet C Part I Date/Time Prepared: 8/2/2021 3:42 pm

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		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	RCE Disallowance	Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	54,797,784		54,797,784	0	54,797,784	30.00
31.00	03100	INTENSIVE CARE UNIT	7,905,721		7,905,721	0	7,905,721	31.00
43.00	04300	NURSERY	1,253,521		1,253,521	0	1,253,521	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	12,761,392		12,761,392	0	12,761,392	50.00
51.00	05100	RECOVERY ROOM	5,567,321		5,567,321	0	5,567,321	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	5,652,981		5,652,981	0	5,652,981	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,211,108		4,211,108	0	4,211,108	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	1,730,637		1,730,637	0	1,730,637	55.00
57.00	05700	CT SCAN	2,286,176		2,286,176	0	2,286,176	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	905,944		905,944	0	905,944	58.00
59.00	05900	CARDIAC CATHETERIZATION	5,213,163		5,213,163	0	5,213,163	59.00
60.00	06000	LABORATORY	9,650,688		9,650,688	0	9,650,688	60.00
64.00	06400	INTRAVENOUS THERAPY	0		0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	3,603,332	0	3,603,332	0	3,603,332	65.00
66.00	06600	PHYSICAL THERAPY	4,094,774	0	4,094,774	0	4,094,774	66.00
67.00	06700	OCCUPATIONAL THERAPY	1,207,195	0	1,207,195	0	1,207,195	67.00
68.00	06800	SPEECH PATHOLOGY	319,391	0	319,391	0	319,391	68.00
69.00	06900	ELECTROCARDIOLOGY	2,281,928		2,281,928	0	2,281,928	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	1,074,451		1,074,451	0	1,074,451	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	19,285,349		19,285,349	0	19,285,349	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	11,433,085		11,433,085	0	11,433,085	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	15,441,143		15,441,143	0	15,441,143	73.00
74.00	07400	RENAL DIALYSIS	752,333		752,333	0	752,333	74.00
76.00	03950	ENDOSCOPY	1,445,430		1,445,430	0	1,445,430	76.00
76.06	03330	IMAGING CENTER	2,012,555		2,012,555	0	2,012,555	76.06
76.97	07697	CARDIAC REHABILITATION	405,281		405,281	0	405,281	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0		0	0	0	90.00
90.01	04950	DIABETIC CARE CENTER	0		0	0	0	90.01
90.02	04951	ANTI-COAGULATION CLINIC	472,156		472,156	0	472,156	90.02
90.03	04952	PALLIATIVE CARE	0		0	0	0	90.03
90.04	04953	SPINE CENTER	374,428		374,428	0	374,428	90.04
91.00	09100	EMERGENCY	13,511,713		13,511,713	0	13,511,713	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	5,688,709		5,688,709		5,688,709	92.00
200.00		Subtotal (see instructions)	195,339,689	0	195,339,689	0	195,339,689	200.00
201.00		Less Observation Beds	5,688,709		5,688,709		5,688,709	201.00
202.00		Total (see instructions)	189,650,980	0	189,650,980	0	189,650,980	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-0128 | Period: From 01/01/2020 To 12/31/2020 | Worksheet C Part I Date/Time Prepared: 8/2/2021 3:42 pm

Title XIX | Hospital | PPS

		Cost Center Description	Charges Inpatient	Charges Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	107,351,007		107,351,007			30.00
31.00	03100	INTENSIVE CARE UNIT	12,451,172		12,451,172			31.00
43.00	04300	NURSERY	3,803,616		3,803,616			43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	59,293,364	55,401,317	114,694,681	0.111264	0.000000	50.00
51.00	05100	RECOVERY ROOM	14,002,999	23,253,222	37,256,221	0.149433	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	17,588,748	0	17,588,748	0.321398	0.000000	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	7,034,972	25,584,354	32,619,326	0.129099	0.000000	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	7,329,313	14,044,603	21,373,916	0.080970	0.000000	55.00
57.00	05700	CT SCAN	17,852,352	45,204,329	63,056,681	0.036256	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	3,416,443	9,254,218	12,670,661	0.071499	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	30,073,404	46,222,811	76,296,215	0.068328	0.000000	59.00
60.00	06000	LABORATORY	44,646,834	28,609,531	73,256,365	0.131739	0.000000	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0.000000	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	14,804,722	1,377,136	16,181,858	0.222677	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	2,878,086	5,328,946	8,207,032	0.498935	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	2,165,720	740,820	2,906,540	0.415337	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	598,680	170,726	769,406	0.415114	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	7,137,524	17,381,844	24,519,368	0.093066	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	324,932	3,946,073	4,271,005	0.251569	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	15,761,035	14,159,972	29,921,007	0.644542	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	17,564,300	13,423,351	30,987,651	0.368956	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	42,905,288	15,642,916	58,548,204	0.263734	0.000000	73.00
74.00	07400	RENAL DIALYSIS	2,681,063	0	2,681,063	0.280610	0.000000	74.00
76.00	03950	ENDOSCOPY	2,124,648	6,010,796	8,135,444	0.177671	0.000000	76.00
76.06	03330	IMAGING CENTER	141,028	13,280,124	13,421,152	0.149954	0.000000	76.06
76.97	07697	CARDIAC REHABILITATION	3,054	1,185,575	1,188,629	0.340965	0.000000	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0.000000	0.000000	90.00
90.01	04950	DIABETIC CARE CENTER	0	0	0	0.000000	0.000000	90.01
90.02	04951	ANTI-COAGULATION CLINIC	7,525	1,327,547	1,335,072	0.353656	0.000000	90.02
90.03	04952	PALLIATIVE CARE	0	0	0	0.000000	0.000000	90.03
90.04	04953	SPINE CENTER	0	333,915	333,915	1.121327	0.000000	90.04
91.00	09100	EMERGENCY	28,668,624	96,847,196	125,515,820	0.107649	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	2,318,605	4,371,295	6,689,900	0.850343	0.000000	92.00
200.00		Subtotal (see instructions)	464,929,058	443,102,617	908,031,675			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	464,929,058	443,102,617	908,031,675			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-0128 | Period: From 01/01/2020 To 12/31/2020 | Worksheet C Part I Date/Time Prepared: 8/2/2021 3:42 pm

Title XIX | Hospital | PPS

		Cost Center Description	PPS Inpatient Ratio		
			11.00		
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS			30.00
31.00	03100	INTENSIVE CARE UNIT			31.00
43.00	04300	NURSERY			43.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0.111264		50.00
51.00	05100	RECOVERY ROOM	0.149433		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.321398		52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.129099		54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.080970		55.00
57.00	05700	CT SCAN	0.036256		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.071499		58.00
59.00	05900	CARDIAC CATHETERIZATION	0.068328		59.00
60.00	06000	LABORATORY	0.131739		60.00
64.00	06400	INTRAVENOUS THERAPY	0.000000		64.00
65.00	06500	RESPIRATORY THERAPY	0.222677		65.00
66.00	06600	PHYSICAL THERAPY	0.498935		66.00
67.00	06700	OCCUPATIONAL THERAPY	0.415337		67.00
68.00	06800	SPEECH PATHOLOGY	0.415114		68.00
69.00	06900	ELECTROCARDIOLOGY	0.093066		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.251569		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.644542		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.368956		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.263734		73.00
74.00	07400	RENAL DIALYSIS	0.280610		74.00
76.00	03950	ENDOSCOPY	0.177671		76.00
76.06	03330	IMAGING CENTER	0.149954		76.06
76.97	07697	CARDIAC REHABILITATION	0.340965		76.97
		OUTPATIENT SERVICE COST CENTERS			
90.00	09000	CLINIC	0.000000		90.00
90.01	04950	DIABETIC CARE CENTER	0.000000		90.01
90.02	04951	ANTI-COAGULATION CLINIC	0.353656		90.02
90.03	04952	PALLIATIVE CARE	0.000000		90.03
90.04	04953	SPINE CENTER	1.121327		90.04
91.00	09100	EMERGENCY	0.107649		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.850343		92.00
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: 15-0128 | Period: From 01/01/2020 To 12/31/2020 | Worksheet C Part II | Date/Time Prepared: 8/2/2021 3:42 pm

Title XIX | Hospital | PPS

		Cost Center Description	Total Cost (Wkst. B, Part I, col. 26)	Capital Cost (Wkst. B, Part II col. 26)	Operating Cost Net of Capital Cost (col. 1 - col. 2)	Capital Reduction	Operating Cost Reduction Amount	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	12,761,392	2,831,115	9,930,277	0	0	50.00
51.00	05100	RECOVERY ROOM	5,567,321	391,318	5,176,003	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	5,652,981	473,117	5,179,864	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,211,108	652,545	3,558,563	0	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	1,730,637	284,033	1,446,604	0	0	55.00
57.00	05700	CT SCAN	2,286,176	94,621	2,191,555	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	905,944	80,498	825,446	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	5,213,163	939,292	4,273,871	0	0	59.00
60.00	06000	LABORATORY	9,650,688	345,310	9,305,378	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	3,603,332	177,561	3,425,771	0	0	65.00
66.00	06600	PHYSICAL THERAPY	4,094,774	681,335	3,413,439	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	1,207,195	67,568	1,139,627	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	319,391	17,849	301,542	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	2,281,928	265,350	2,016,578	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	1,074,451	198,457	875,994	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	19,285,349	1,921,749	17,363,600	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	11,433,085	259,745	11,173,340	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	15,441,143	888,967	14,552,176	0	0	73.00
74.00	07400	RENAL DIALYSIS	752,333	46,736	705,597	0	0	74.00
76.00	03950	ENDOSCOPY	1,445,430	268,422	1,177,008	0	0	76.00
76.06	03330	IMAGING CENTER	2,012,555	417,966	1,594,589	0	0	76.06
76.97	07697	CARDIAC REHABILITATION	405,281	22,443	382,838	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	04950	DIABETIC CARE CENTER	0	0	0	0	0	90.01
90.02	04951	ANTI-COAGULATION CLINIC	472,156	12,765	459,391	0	0	90.02
90.03	04952	PALLIATIVE CARE	0	0	0	0	0	90.03
90.04	04953	SPINE CENTER	374,428	75,329	299,099	0	0	90.04
91.00	09100	EMERGENCY	13,511,713	1,127,802	12,383,911	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	5,688,709	453,731	5,234,978	0	0	92.00
200.00		Subtotal (sum of lines 50 thru 199)	131,382,663	12,995,624	118,387,039	0	0	200.00
201.00		Less Observation Beds	5,688,709	453,731	5,234,978	0	0	201.00
202.00		Total (line 200 minus line 201)	125,693,954	12,541,893	113,152,061	0	0	202.00

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

Provider CCN: 15-0128 | Period: From 01/01/2020 To 12/31/2020 | Worksheet C Part II | Date/Time Prepared: 8/2/2021 3:42 pm

Title XIX | Hospital | PPS

		Cost Center Description	Cost Net of Capital and Operating Cost Reduction	Total Charges (Worksheet C, Part I, column 8)	Outpatient Cost to Charge Ratio (col. 6 / col. 7)		
			6.00	7.00	8.00		
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	12,761,392	114,694,681	0.111264		50.00
51.00	05100	RECOVERY ROOM	5,567,321	37,256,221	0.149433		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	5,652,981	17,588,748	0.321398		52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,211,108	32,619,326	0.129099		54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	1,730,637	21,373,916	0.080970		55.00
57.00	05700	CT SCAN	2,286,176	63,056,681	0.036256		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	905,944	12,670,661	0.071499		58.00
59.00	05900	CARDIAC CATHETERIZATION	5,213,163	76,296,215	0.068328		59.00
60.00	06000	LABORATORY	9,650,688	73,256,365	0.131739		60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0.000000		64.00
65.00	06500	RESPIRATORY THERAPY	3,603,332	16,181,858	0.222677		65.00
66.00	06600	PHYSICAL THERAPY	4,094,774	8,207,032	0.498935		66.00
67.00	06700	OCCUPATIONAL THERAPY	1,207,195	2,906,540	0.415337		67.00
68.00	06800	SPEECH PATHOLOGY	319,391	769,406	0.415114		68.00
69.00	06900	ELECTROCARDIOLOGY	2,281,928	24,519,368	0.093066		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	1,074,451	4,271,005	0.251569		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	19,285,349	29,921,007	0.644542		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	11,433,085	30,987,651	0.368956		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	15,441,143	58,548,204	0.263734		73.00
74.00	07400	RENAL DIALYSIS	752,333	2,681,063	0.280610		74.00
76.00	03950	ENDOSCOPY	1,445,430	8,135,444	0.177671		76.00
76.06	03330	IMAGING CENTER	2,012,555	13,421,152	0.149954		76.06
76.97	07697	CARDIAC REHABILITATION	405,281	1,188,629	0.340965		76.97
		OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	0	0	0.000000		90.00
90.01	04950	DIABETIC CARE CENTER	0	0	0.000000		90.01
90.02	04951	ANTI-COAGULATION CLINIC	472,156	1,335,072	0.353656		90.02
90.03	04952	PALLIATIVE CARE	0	0	0.000000		90.03
90.04	04953	SPINE CENTER	374,428	333,915	1.121327		90.04
91.00	09100	EMERGENCY	13,511,713	125,515,820	0.107649		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	5,688,709	6,689,900	0.850343		92.00
200.00		Subtotal (sum of lines 50 thru 199)	131,382,663	784,425,880			200.00
201.00		Less Observation Beds	5,688,709	0			201.00
202.00		Total (line 200 minus line 201)	125,693,954	784,425,880			202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS | Provider CCN: 15-0128 | Period: From 01/01/2020 To 12/31/2020 | Worksheet D Part I Date/Time Prepared: 8/2/2021 3:42 pm

Title XVIII | Hospital | PPS

	Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	4,202,678	0	4,202,678	37,624	111.70	30.00
31.00	INTENSIVE CARE UNIT	1,107,269		1,107,269	2,987	370.70	31.00
43.00	NURSERY	105,357		105,357	2,529	41.66	43.00
200.00	Total (lines 30 through 199)	5,415,304		5,415,304	43,140		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	10,425	1,164,473				30.00
31.00	INTENSIVE CARE UNIT	1,040	385,528				31.00
43.00	NURSERY	0	0				43.00
200.00	Total (lines 30 through 199)	11,465	1,550,001				200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS | Provider CCN: 15-0128 | Period: From 01/01/2020 To 12/31/2020 | Worksheet D Part II Date/Time Prepared: 8/2/2021 3:42 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,831,115	114,694,681	0.024684	17,567,431	433,634	50.00
51.00	05100	RECOVERY ROOM	391,318	37,256,221	0.010503	3,695,862	38,818	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	473,117	17,588,748	0.026899	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	652,545	32,619,326	0.020005	2,524,948	50,512	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	284,033	21,373,916	0.013289	3,066,616	40,752	55.00
57.00	05700	CT SCAN	94,621	63,056,681	0.001501	6,396,512	9,601	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	80,498	12,670,661	0.006353	1,228,952	7,808	58.00
59.00	05900	CARDIAC CATHETERIZATION	939,292	76,296,215	0.012311	9,958,823	122,603	59.00
60.00	06000	LABORATORY	345,310	73,256,365	0.004714	15,874,383	74,832	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0.000000	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	177,561	16,181,858	0.010973	4,512,276	49,513	65.00
66.00	06600	PHYSICAL THERAPY	681,335	8,207,032	0.083018	1,083,209	89,926	66.00
67.00	06700	OCCUPATIONAL THERAPY	67,568	2,906,540	0.023247	888,386	20,652	67.00
68.00	06800	SPEECH PATHOLOGY	17,849	769,406	0.023198	232,176	5,386	68.00
69.00	06900	ELECTROCARDIOLOGY	265,350	24,519,368	0.010822	2,833,245	30,661	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	198,457	4,271,005	0.046466	141,263	6,564	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,921,749	29,921,007	0.064227	4,273,738	274,489	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	259,745	30,987,651	0.008382	6,019,410	50,455	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	888,967	58,548,204	0.015184	13,241,482	201,059	73.00
74.00	07400	RENAL DIALYSIS	46,736	2,681,063	0.017432	1,446,217	25,210	74.00
76.00	03950	ENDOSCOPY	268,422	8,135,444	0.032994	68,867	2,272	76.00
76.06	03330	IMAGING CENTER	417,966	13,421,152	0.031142	22,560	703	76.06
76.97	07697	CARDIAC REHABILITATION	22,443	1,188,629	0.018881	337	6	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0.000000	0	0	90.00
90.01	04950	DIABETIC CARE CENTER	0	0	0.000000	0	0	90.01
90.02	04951	ANTI-COAGULATION CLINIC	12,765	1,335,072	0.009561	0	0	90.02
90.03	04952	PALLIATIVE CARE	0	0	0.000000	0	0	90.03
90.04	04953	SPINE CENTER	75,329	333,915	0.225593	0	0	90.04
91.00	09100	EMERGENCY	1,127,802	125,515,820	0.008985	9,859,772	88,590	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	453,731	6,689,900	0.067823	1,038,855	70,458	92.00
200.00		Total (lines 50 through 199)	12,995,624	784,425,880		105,975,320	1,694,504	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 15-0128 | Period: From 01/01/2020 To 12/31/2020 | Worksheet D Part III Date/Time Prepared: 8/2/2021 3:42 pm

Title XVIII | Hospital | PPS

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

		Cost Center Description	Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days	
			4.00	5.00	6.00	7.00	8.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	0	37,624	0.00	10,425	30.00
31.00	03100	INTENSIVE CARE UNIT		0	2,987	0.00	1,040	31.00
43.00	04300	NURSERY		0	2,529	0.00	0	43.00
200.00		Total (lines 30 through 199)		0	43,140		11,465	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
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: 15-0128 | Period: From 01/01/2020 To 12/31/2020 | Worksheet D Part IV | Date/Time Prepared: 8/2/2021 3:42 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health	
			1.00	2A	2.00	3A	3.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
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	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
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 PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.00	03950	ENDOSCOPY	0	0	0	0	0	76.00
76.06	03330	IMAGING CENTER	0	0	0	0	0	76.06
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	04950	DIABETIC CARE CENTER	0	0	0	0	0	90.01
90.02	04951	ANTI-COAGULATION CLINIC	0	0	0	0	0	90.02
90.03	04952	PALLIATIVE CARE	0	0	0	0	0	90.03
90.04	04953	SPINE CENTER	0	0	0	0	0	90.04
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0		0		0	92.00
200.00		Total (lines 50 through 199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-0128 | Period: From 01/01/2020 To 12/31/2020 | Worksheet D Part IV | Date/Time Prepared: 8/2/2021 3:42 pm

Title XVIII | Hospital | PPS

		Cost Center Description	All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7) (see instructions)	
			4.00	5.00	6.00	7.00	8.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	114,694,681	0.000000	50.00
51.00	05100	RECOVERY ROOM	0	0	0	37,256,221	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	17,588,748	0.000000	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	32,619,326	0.000000	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	21,373,916	0.000000	55.00
57.00	05700	CT SCAN	0	0	0	63,056,681	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	12,670,661	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	76,296,215	0.000000	59.00
60.00	06000	LABORATORY	0	0	0	73,256,365	0.000000	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	16,181,858	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	8,207,032	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	2,906,540	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	769,406	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	24,519,368	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	4,271,005	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	29,921,007	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	30,987,651	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	58,548,204	0.000000	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	2,681,063	0.000000	74.00
76.00	03950	ENDOSCOPY	0	0	0	8,135,444	0.000000	76.00
76.06	03330	IMAGING CENTER	0	0	0	13,421,152	0.000000	76.06
76.97	07697	CARDIAC REHABILITATION	0	0	0	1,188,629	0.000000	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0.000000	90.00
90.01	04950	DIABETIC CARE CENTER	0	0	0	0	0.000000	90.01
90.02	04951	ANTI-COAGULATION CLINIC	0	0	0	1,335,072	0.000000	90.02
90.03	04952	PALLIATIVE CARE	0	0	0	0	0.000000	90.03
90.04	04953	SPINE CENTER	0	0	0	333,915	0.000000	90.04
91.00	09100	EMERGENCY	0	0	0	125,515,820	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	6,689,900	0.000000	92.00
200.00		Total (lines 50 through 199)	0	0	0	784,425,880		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-0128 | Period: From 01/01/2020 To 12/31/2020 | Worksheet D Part IV | Date/Time Prepared: 8/2/2021 3:42 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
			9.00	10.00	11.00	12.00	13.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.000000	17,567,431	0	9,554,818	0	50.00
51.00	05100	RECOVERY ROOM	0.000000	3,695,862	0	4,755,861	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	2,524,948	0	5,528,213	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.000000	3,066,616	0	6,323,332	0	55.00
57.00	05700	CT SCAN	0.000000	6,396,512	0	8,822,153	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000	1,228,952	0	2,145,716	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	9,958,823	0	16,398,336	0	59.00
60.00	06000	LABORATORY	0.000000	15,874,383	0	4,806,647	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0.000000	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.000000	4,512,276	0	275,554	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	1,083,209	0	54,984	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	888,386	0	12,265	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	232,176	0	3,644	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	2,833,245	0	5,032,334	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	141,263	0	596,634	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	4,273,738	0	3,676,122	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	6,019,410	0	4,431,101	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	13,241,482	0	4,368,297	0	73.00
74.00	07400	RENAL DIALYSIS	0.000000	1,446,217	0	0	0	74.00
76.00	03950	ENDOSCOPY	0.000000	68,867	0	1,341,956	0	76.00
76.06	03330	IMAGING CENTER	0.000000	22,560	0	2,592,690	0	76.06
76.97	07697	CARDIAC REHABILITATION	0.000000	337	0	440,621	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.000000	0	0	0	0	90.00
90.01	04950	DIABETIC CARE CENTER	0.000000	0	0	0	0	90.01
90.02	04951	ANTI-COAGULATION CLINIC	0.000000	0	0	423,781	0	90.02
90.03	04952	PALLIATIVE CARE	0.000000	0	0	0	0	90.03
90.04	04953	SPINE CENTER	0.000000	0	0	0	0	90.04
91.00	09100	EMERGENCY	0.000000	9,859,772	0	11,696,991	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	1,038,855	0	2,650,791	0	92.00
200.00		Total (lines 50 through 199)		105,975,320	0	95,932,841	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-0128 | Period: From 01/01/2020 To 12/31/2020 | Worksheet D Part V Date/Time Prepared: 8/2/2021 3:42 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.110703	9,554,818	10,602	0	1,057,747	50.00
51.00	05100	RECOVERY ROOM	0.149433	4,755,861	1,223	0	710,683	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.321398	0	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.129099	5,528,213	0	0	713,687	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.080970	6,323,332	0	0	512,000	55.00
57.00	05700	CT SCAN	0.036256	8,822,153	0	0	319,856	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.071499	2,145,716	0	0	153,417	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.068328	16,398,336	0	0	1,120,466	59.00
60.00	06000	LABORATORY	0.131739	4,806,647	0	0	633,223	60.00
64.00	06400	INTRAVENOUS THERAPY	0.000000	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.222677	275,554	0	0	61,360	65.00
66.00	06600	PHYSICAL THERAPY	0.495012	54,984	0	0	27,218	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.415337	12,265	0	0	5,094	67.00
68.00	06800	SPEECH PATHOLOGY	0.415114	3,644	0	0	1,513	68.00
69.00	06900	ELECTROCARDIOLOGY	0.093066	5,032,334	0	0	468,339	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.246651	596,634	0	0	147,160	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.644542	3,676,122	0	0	2,369,415	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.368956	4,431,101	0	0	1,634,881	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.263734	4,368,297	0	73,450	1,152,068	73.00
74.00	07400	RENAL DIALYSIS	0.280610	0	0	0	0	74.00
76.00	03950	ENDOSCOPY	0.177671	1,341,956	1,767	0	238,427	76.00
76.06	03330	IMAGING CENTER	0.149954	2,592,690	0	0	388,784	76.06
76.97	07697	CARDIAC REHABILITATION	0.340965	440,621	0	0	150,236	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.000000	0	0	0	0	90.00
90.01	04950	DIABETIC CARE CENTER	0.000000	0	0	0	0	90.01
90.02	04951	ANTI-COAGULATION CLINIC	0.353656	423,781	0	0	149,873	90.02
90.03	04952	PALLIATIVE CARE	0.000000	0	0	0	0	90.03
90.04	04953	SPINE CENTER	1.121327	0	0	0	0	90.04
91.00	09100	EMERGENCY	0.105938	11,696,991	0	0	1,239,156	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.850343	2,650,791	0	0	2,254,082	92.00
200.00		Subtotal (see instructions)		95,932,841	13,592	73,450	15,508,685	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 - line 201)		95,932,841	13,592	73,450	15,508,685	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-0128 | Period: From 01/01/2020 To 12/31/2020 | Worksheet D Part V Date/Time Prepared: 8/2/2021 3:42 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Costs: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	1,174	0		50.00
51.00	05100	RECOVERY ROOM	183	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	MAGNETIC RESONANCE IMAGING (MRI)	0	0		58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0		59.00
60.00	06000	LABORATORY	0	0		60.00
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 PATIENTS	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	19,371		73.00
74.00	07400	RENAL DIALYSIS	0	0		74.00
76.00	03950	ENDOSCOPY	314	0		76.00
76.06	03330	IMAGING CENTER	0	0		76.06
76.97	07697	CARDIAC REHABILITATION	0	0		76.97
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0	0		90.00
90.01	04950	DIABETIC CARE CENTER	0	0		90.01
90.02	04951	ANTI-COAGULATION CLINIC	0	0		90.02
90.03	04952	PALLIATIVE CARE	0	0		90.03
90.04	04953	SPINE CENTER	0	0		90.04
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)	1,671	19,371		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	1,671	19,371		202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS | Provider CCN: 15-0128 | Period: From 01/01/2020 To 12/31/2020 | Worksheet D Part I Date/Time Prepared: 8/2/2021 3:42 pm

Title XIX | Hospital | PPS

	Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	4,202,678	0	4,202,678	37,624	111.70	30.00
31.00	INTENSIVE CARE UNIT	1,107,269		1,107,269	2,987	370.70	31.00
43.00	NURSERY	105,357		105,357	2,529	41.66	43.00
200.00	Total (lines 30 through 199)	5,415,304		5,415,304	43,140		200.00

	Cost Center Description	Inpatient Program days	Inpatient Program Capital Cost (col. 5 x col. 6)				
		6.00	7.00				
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	1,586	177,156				30.00
31.00	INTENSIVE CARE UNIT	0	0				31.00
43.00	NURSERY	1,308	54,491				43.00
200.00	Total (lines 30 through 199)	2,894	231,647				200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS | Provider CCN: 15-0128 | Period: From 01/01/2020 To 12/31/2020 | Worksheet D Part II Date/Time Prepared: 8/2/2021 3:42 pm

Title XIX | Hospital | PPS

		Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,831,115	114,694,681	0.024684	766,023	18,909	50.00
51.00	05100	RECOVERY ROOM	391,318	37,256,221	0.010503	350,863	3,685	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	473,117	17,588,748	0.026899	248,251	6,678	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	652,545	32,619,326	0.020005	260,465	5,211	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	284,033	21,373,916	0.013289	332,642	4,420	55.00
57.00	05700	CT SCAN	94,621	63,056,681	0.001501	653,638	981	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	80,498	12,670,661	0.006353	134,211	853	58.00
59.00	05900	CARDIAC CATHETERIZATION	939,292	76,296,215	0.012311	670,809	8,258	59.00
60.00	06000	LABORATORY	345,310	73,256,365	0.004714	1,867,054	8,801	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0.000000	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	177,561	16,181,858	0.010973	770,721	8,457	65.00
66.00	06600	PHYSICAL THERAPY	681,335	8,207,032	0.083018	100,710	8,361	66.00
67.00	06700	OCCUPATIONAL THERAPY	67,568	2,906,540	0.023247	54,731	1,272	67.00
68.00	06800	SPEECH PATHOLOGY	17,849	769,406	0.023198	23,856	553	68.00
69.00	06900	ELECTROCARDIOLOGY	265,350	24,519,368	0.010822	218,940	2,369	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	198,457	4,271,005	0.046466	15,195	706	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,921,749	29,921,007	0.064227	499,862	32,105	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	259,745	30,987,651	0.008382	219,815	1,842	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	888,967	58,548,204	0.015184	2,051,098	31,144	73.00
74.00	07400	RENAL DIALYSIS	46,736	2,681,063	0.017432	20,554	358	74.00
76.00	03950	ENDOSCOPY	268,422	8,135,444	0.032994	49,622	1,637	76.00
76.06	03330	IMAGING CENTER	417,966	13,421,152	0.031142	0	0	76.06
76.97	07697	CARDIAC REHABILITATION	22,443	1,188,629	0.018881	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0.000000	0	0	90.00
90.01	04950	DIABETIC CARE CENTER	0	0	0.000000	0	0	90.01
90.02	04951	ANTI-COAGULATION CLINIC	12,765	1,335,072	0.009561	0	0	90.02
90.03	04952	PALLIATIVE CARE	0	0	0.000000	0	0	90.03
90.04	04953	SPINE CENTER	75,329	333,915	0.225593	0	0	90.04
91.00	09100	EMERGENCY	1,127,802	125,515,820	0.008985	959,016	8,617	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	453,731	6,689,900	0.067823	21,532	1,460	92.00
200.00		Total (lines 50 through 199)	12,995,624	784,425,880		10,289,608	156,677	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 15-0128 | Period: From 01/01/2020 To 12/31/2020 | Worksheet D Part III Date/Time Prepared: 8/2/2021 3:42 pm

Title XIX | Hospital | PPS

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

		Cost Center Description	Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days	
			4.00	5.00	6.00	7.00	8.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	0	37,624	0.00	1,586	30.00
31.00	03100	INTENSIVE CARE UNIT		0	2,987	0.00	0	31.00
43.00	04300	NURSERY		0	2,529	0.00	1,308	43.00
200.00		Total (lines 30 through 199)		0	43,140		2,894	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
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: 15-0128 | Period: From 01/01/2020 To 12/31/2020 | Worksheet D Part IV Date/Time Prepared: 8/2/2021 3:42 pm

Title XIX | Hospital | PPS

		Cost Center Description	Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health	
			1.00	2A	2.00	3A	3.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
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	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
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 PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.00	03950	ENDOSCOPY	0	0	0	0	0	76.00
76.06	03330	IMAGING CENTER	0	0	0	0	0	76.06
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	04950	DIABETIC CARE CENTER	0	0	0	0	0	90.01
90.02	04951	ANTI-COAGULATION CLINIC	0	0	0	0	0	90.02
90.03	04952	PALLIATIVE CARE	0	0	0	0	0	90.03
90.04	04953	SPINE CENTER	0	0	0	0	0	90.04
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0		0		0	92.00
200.00		Total (lines 50 through 199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-0128 | Period: From 01/01/2020 To 12/31/2020 | Worksheet D Part IV Date/Time Prepared: 8/2/2021 3:42 pm

Title XIX | Hospital | PPS

		Cost Center Description	All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7) (see instructions)	
			4.00	5.00	6.00	7.00	8.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	114,694,681	0.000000	50.00
51.00	05100	RECOVERY ROOM	0	0	0	37,256,221	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	17,588,748	0.000000	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	32,619,326	0.000000	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	21,373,916	0.000000	55.00
57.00	05700	CT SCAN	0	0	0	63,056,681	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	12,670,661	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	76,296,215	0.000000	59.00
60.00	06000	LABORATORY	0	0	0	73,256,365	0.000000	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	16,181,858	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	8,207,032	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	2,906,540	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	769,406	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	24,519,368	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	4,271,005	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	29,921,007	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	30,987,651	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	58,548,204	0.000000	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	2,681,063	0.000000	74.00
76.00	03950	ENDOSCOPY	0	0	0	8,135,444	0.000000	76.00
76.06	03330	IMAGING CENTER	0	0	0	13,421,152	0.000000	76.06
76.97	07697	CARDIAC REHABILITATION	0	0	0	1,188,629	0.000000	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0.000000	90.00
90.01	04950	DIABETIC CARE CENTER	0	0	0	0	0.000000	90.01
90.02	04951	ANTI-COAGULATION CLINIC	0	0	0	1,335,072	0.000000	90.02
90.03	04952	PALLIATIVE CARE	0	0	0	0	0.000000	90.03
90.04	04953	SPINE CENTER	0	0	0	333,915	0.000000	90.04
91.00	09100	EMERGENCY	0	0	0	125,515,820	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	6,689,900	0.000000	92.00
200.00		Total (lines 50 through 199)	0	0	0	784,425,880		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-0128 | Period: From 01/01/2020 To 12/31/2020 | Worksheet D Part IV | Date/Time Prepared: 8/2/2021 3:42 pm

Title XIX | Hospital | PPS

		Cost Center Description	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
			9.00	10.00	11.00	12.00	13.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.000000	766,023	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0.000000	350,863	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	248,251	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	260,465	0	0	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.000000	332,642	0	0	0	55.00
57.00	05700	CT SCAN	0.000000	653,638	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000	134,211	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	670,809	0	0	0	59.00
60.00	06000	LABORATORY	0.000000	1,867,054	0	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0.000000	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.000000	770,721	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	100,710	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	54,731	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	23,856	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	218,940	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	15,195	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	499,862	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	219,815	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	2,051,098	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0.000000	20,554	0	0	0	74.00
76.00	03950	ENDOSCOPY	0.000000	49,622	0	0	0	76.00
76.06	03330	IMAGING CENTER	0.000000	0	0	0	0	76.06
76.97	07697	CARDIAC REHABILITATION	0.000000	0	0	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.000000	0	0	0	0	90.00
90.01	04950	DIABETIC CARE CENTER	0.000000	0	0	0	0	90.01
90.02	04951	ANTI-COAGULATION CLINIC	0.000000	0	0	0	0	90.02
90.03	04952	PALLIATIVE CARE	0.000000	0	0	0	0	90.03
90.04	04953	SPINE CENTER	0.000000	0	0	0	0	90.04
91.00	09100	EMERGENCY	0.000000	959,016	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	21,532	0	0	0	92.00
200.00		Total (lines 50 through 199)		10,289,608	0	0	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-0128 | Period: From 01/01/2020 To 12/31/2020 | Worksheet D Part V Date/Time Prepared: 8/2/2021 3:42 pm

Title XIX | Hospital | PPS

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.111264	0	973,189	0	0	50.00
51.00	05100	RECOVERY ROOM	0.149433	0	358,819	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.321398	0	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.129099	0	796,937	0	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.080970	0	234,781	0	0	55.00
57.00	05700	CT SCAN	0.036256	0	1,803,940	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.071499	0	215,898	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.068328	0	536,498	0	0	59.00
60.00	06000	LABORATORY	0.131739	0	1,214,809	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0.000000	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.222677	0	48,201	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.498935	0	73,532	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.415337	0	9,952	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.415114	0	1,461	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.093066	0	221,423	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.251569	0	44,770	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.644542	0	360,447	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.368956	0	96,658	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.263734	0	267,651	0	0	73.00
74.00	07400	RENAL DIALYSIS	0.280610	0	0	0	0	74.00
76.00	03950	ENDOSCOPY	0.177671	0	40,979	0	0	76.00
76.06	03330	IMAGING CENTER	0.149954	0	124,458	0	0	76.06
76.97	07697	CARDIAC REHABILITATION	0.340965	0	0	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.000000	0	0	0	0	90.00
90.01	04950	DIABETIC CARE CENTER	0.000000	0	0	0	0	90.01
90.02	04951	ANTI-COAGULATION CLINIC	0.353656	0	12,270	0	0	90.02
90.03	04952	PALLIATIVE CARE	0.000000	0	0	0	0	90.03
90.04	04953	SPINE CENTER	1.121327	0	0	0	0	90.04
91.00	09100	EMERGENCY	0.107649	0	6,067,861	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.850343	0	0	0	0	92.00
200.00		Subtotal (see instructions)		0	13,504,534	0	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 - line 201)		0	13,504,534	0	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-0128 | Period: From 01/01/2020 To 12/31/2020 | Worksheet D Part V Date/Time Prepared: 8/2/2021 3:42 pm

Title XIX | Hospital | PPS

		Cost Center Description	Costs: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	
			6.00	7.00	
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	108,281	0	50.00
51.00	05100	RECOVERY ROOM	53,619	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	102,884	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	19,010	0	55.00
57.00	05700	CT SCAN	65,404	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	15,436	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	36,658	0	59.00
60.00	06000	LABORATORY	160,038	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	10,733	0	65.00
66.00	06600	PHYSICAL THERAPY	36,688	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	4,133	0	67.00
68.00	06800	SPEECH PATHOLOGY	606	0	68.00
69.00	06900	ELECTROCARDIOLOGY	20,607	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	11,263	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	232,323	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	35,663	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	70,589	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	74.00
76.00	03950	ENDOSCOPY	7,281	0	76.00
76.06	03330	IMAGING CENTER	18,663	0	76.06
76.97	07697	CARDIAC REHABILITATION	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS			
90.00	09000	CLINIC	0	0	90.00
90.01	04950	DIABETIC CARE CENTER	0	0	90.01
90.02	04951	ANTI-COAGULATION CLINIC	4,339	0	90.02
90.03	04952	PALLIATIVE CARE	0	0	90.03
90.04	04953	SPINE CENTER	0	0	90.04
91.00	09100	EMERGENCY	653,199	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	92.00
200.00		Subtotal (see instructions)	1,667,417	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0		201.00
202.00		Net Charges (line 200 - line 201)	1,667,417	0	202.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-0128 | Period: From 01/01/2020 To 12/31/2020 | Worksheet D-1 | Date/Time Prepared: 8/2/2021 3:42 pm

Title XVIII | Hospital | PPS

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	37,624	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	37,624	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)	33,562	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)	10,425	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)	0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period	0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15.00	Total nursery days (title V or XIX only)	0	15.00
16.00	Nursery days (title V or XIX only)	0	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period	0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period	0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)	52,691,375	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)	52,691,375	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	28.00
29.00	Private room charges (excluding swing-bed charges)	0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)	0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)	0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)	0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	52,691,375	37.00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY		
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS		
38.00	Adjusted general inpatient routine service cost per diem (see instructions)	1,400.47	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	14,599,900	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)	14,599,900	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-0128 | Period: From 01/01/2020 To 12/31/2020 | Worksheet D-1 | Date/Time Prepared: 8/2/2021 3:42 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	7,905,721	2,987	2,646.71	1,040	2,752,578	43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	19,284,903	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	36,637,381	49.00
	PASS THROUGH COST ADJUSTMENTS		
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)	1,550,001	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	1,694,504	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	3,244,505	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	33,392,876	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)	4,062	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	1,400.47	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	5,688,709	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-0128 | Period: From 01/01/2020 To 12/31/2020 | Worksheet D-1 | Date/Time Prepared: 8/2/2021 3:42 pm

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	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	4,202,678	52,691,375	0.079760	5,688,709	453,731	90.00
91.00	Nursing School cost	0	52,691,375	0.000000	5,688,709	0	91.00
92.00	Allied health cost	0	52,691,375	0.000000	5,688,709	0	92.00
93.00	All other Medical Education	0	52,691,375	0.000000	5,688,709	0	93.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-0128 | Period: From 01/01/2020 To 12/31/2020 | Worksheet D-1 | Date/Time Prepared: 8/2/2021 3:42 pm

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	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	37,624	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	37,624	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)	33,562	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions)	1,586	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)	0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period	0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15.00	Total nursery days (title V or XIX only)	2,529	15.00
16.00	Nursery days (title V or XIX only)	1,308	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period	0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period	0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)	54,797,784	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)	54,797,784	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	28.00
29.00	Private room charges (excluding swing-bed charges)	0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)	0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)	0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)	0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	54,797,784	37.00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY		
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS		
38.00	Adjusted general inpatient routine service cost per diem (see instructions)	1,456.46	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	2,309,946	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)	0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)	2,309,946	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-0128 | Period: From 01/01/2020 To 12/31/2020 | Worksheet D-1 | Date/Time Prepared: 8/2/2021 3:42 pm

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	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)	1,253,521	2,529	495.66	1,308	648,323	42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	7,905,721	2,987	2,646.71	0	0	43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	1,962,165	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	4,920,434	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)	231,647	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	156,677	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	388,324	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	4,532,110	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)	4,062	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	1,456.46	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	5,916,141	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-0128 | Period: From 01/01/2020 To 12/31/2020 | Worksheet D-1 | Date/Time Prepared: 8/2/2021 3:42 pm

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	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	4,202,678	54,797,784	0.076694	5,916,141	453,733	90.00
91.00	Nursing School cost	0	54,797,784	0.000000	5,916,141	0	91.00
92.00	Allied health cost	0	54,797,784	0.000000	5,916,141	0	92.00
93.00	All other Medical Education	0	54,797,784	0.000000	5,916,141	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 15-0128 | Period: From 01/01/2020 To 12/31/2020 | Worksheet D-3 | Date/Time Prepared: 8/2/2021 3:42 pm

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		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		22,786,645		30.00
31.00	03100	INTENSIVE CARE UNIT		4,072,557		31.00
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.110703	17,567,431	1,944,767	50.00
51.00	05100	RECOVERY ROOM	0.149433	3,695,862	552,284	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.321398	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.129099	2,524,948	325,968	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.080970	3,066,616	248,304	55.00
57.00	05700	CT SCAN	0.036256	6,396,512	231,912	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.071499	1,228,952	87,869	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.068328	9,958,823	680,466	59.00
60.00	06000	LABORATORY	0.131739	15,874,383	2,091,275	60.00
64.00	06400	INTRAVENOUS THERAPY	0.000000	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.222677	4,512,276	1,004,780	65.00
66.00	06600	PHYSICAL THERAPY	0.495012	1,083,209	536,201	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.415337	888,386	368,980	67.00
68.00	06800	SPEECH PATHOLOGY	0.415114	232,176	96,380	68.00
69.00	06900	ELECTROCARDIOLOGY	0.093066	2,833,245	263,679	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.246651	141,263	34,843	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.644542	4,273,738	2,754,604	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.368956	6,019,410	2,220,897	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.263734	13,241,482	3,492,229	73.00
74.00	07400	RENAL DIALYSIS	0.280610	1,446,217	405,823	74.00
76.00	03950	ENDOSCOPY	0.177671	68,867	12,236	76.00
76.06	03330	IMAGING CENTER	0.149954	22,560	3,383	76.06
76.97	07697	CARDIAC REHABILITATION	0.340965	337	115	76.97
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0.000000	0	0	90.00
90.01	04950	DIABETIC CARE CENTER	0.000000	0	0	90.01
90.02	04951	ANTI-COAGULATION CLINIC	0.353656	0	0	90.02
90.03	04952	PALLIATIVE CARE	0.000000	0	0	90.03
90.04	04953	SPINE CENTER	1.121327	0	0	90.04
91.00	09100	EMERGENCY	0.105938	9,859,772	1,044,525	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.850343	1,038,855	883,383	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		105,975,320	19,284,903	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)		105,975,320		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 15-0128 | Period: From 01/01/2020 To 12/31/2020 | Worksheet D-3 | Date/Time Prepared: 8/2/2021 3:42 pm

Title XIX | Hospital | PPS

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		5,910,273		30.00
31.00	03100	INTENSIVE CARE UNIT		839,855		31.00
43.00	04300	NURSERY		308,842		43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.111264	766,023	85,231	50.00
51.00	05100	RECOVERY ROOM	0.149433	350,863	52,431	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.321398	248,251	79,787	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.129099	260,465	33,626	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.080970	332,642	26,934	55.00
57.00	05700	CT SCAN	0.036256	653,638	23,698	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.071499	134,211	9,596	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.068328	670,809	45,835	59.00
60.00	06000	LABORATORY	0.131739	1,867,054	245,964	60.00
64.00	06400	INTRAVENOUS THERAPY	0.000000	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.222677	770,721	171,622	65.00
66.00	06600	PHYSICAL THERAPY	0.498935	100,710	50,248	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.415337	54,731	22,732	67.00
68.00	06800	SPEECH PATHOLOGY	0.415114	23,856	9,903	68.00
69.00	06900	ELECTROCARDIOLOGY	0.093066	218,940	20,376	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.251569	15,195	3,823	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.644542	499,862	322,182	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.368956	219,815	81,102	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.263734	2,051,098	540,944	73.00
74.00	07400	RENAL DIALYSIS	0.280610	20,554	5,768	74.00
76.00	03950	ENDOSCOPY	0.177671	49,622	8,816	76.00
76.06	03330	IMAGING CENTER	0.149954	0	0	76.06
76.97	07697	CARDIAC REHABILITATION	0.340965	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0.000000	0	0	90.00
90.01	04950	DIABETIC CARE CENTER	0.000000	0	0	90.01
90.02	04951	ANTI-COAGULATION CLINIC	0.353656	0	0	90.02
90.03	04952	PALLIATIVE CARE	0.000000	0	0	90.03
90.04	04953	SPINE CENTER	1.121327	0	0	90.04
91.00	09100	EMERGENCY	0.107649	959,016	103,237	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.850343	21,532	18,310	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		10,289,608	1,962,165	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)		10,289,608		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT | Provider CCN: 15-0128 | Period: From 01/01/2020 To 12/31/2020 | Worksheet E Part A Date/Time Prepared: 8/2/2021 3:42 pm

Title XVIII | Hospital | PPS

		Before GEO Reclass	On/After GEO Reclass	
		1.00	1.01	
	PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS			
1.00	DRG Amounts Other than Outlier Payments	0	0	1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1 (see instructions)	18,099,437	0	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1 (see instructions)	0	7,129,987	1.02
1.03	DRG for federal specific operating payment for Model 4 BPCI for discharges occurring prior to October 1 (see instructions)	0	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	0	1.04
2.00	Outlier payments for discharges. (see instructions)			2.00
2.01	Outlier reconciliation amount	0	0	2.01
2.02	Outlier payment for discharges for Model 4 BPCI (see instructions)	0	0	2.02
2.03	Outlier payments for discharges occurring prior to October 1 (see instructions)	356,286	0	2.03
2.04	Outlier payments for discharges occurring on or after October 1 (see instructions)	0	69,297	2.04
3.00	Managed Care Simulated Payments	11,848,718	5,935,005	3.00
4.00	Bed days available divided by number of days in the cost reporting period (see instructions)	157.31		4.00
	Indirect Medical Education Adjustment			
5.00	FTE count for allopathic and osteopathic programs for the most recent cost reporting period ending on or before 12/31/1996.(see instructions)	0.00		5.00
6.00	FTE count for allopathic and osteopathic programs that meet the criteria for an add-on to the cap for new programs in accordance with 42 CFR 413.79(e)	0.00		6.00
7.00	MMA Section 422 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(1)	0.00		7.00
7.01	ACA § 5503 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(2) If the cost report straddles July 1, 2011 then see instructions.	0.00		7.01
8.00	Adjustment (increase or decrease) to the FTE count for allopathic and osteopathic programs for affiliated programs in accordance with 42 CFR 413.75(b), 413.79(c)(2)(iv), 64 FR 26340 (May 12, 1998), and 67 FR 50069 (August 1, 2002).	6.95		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)	6.95		9.00
10.00	FTE count for allopathic and osteopathic programs in the current year from your records	8.25		10.00
11.00	FTE count for residents in dental and podiatric programs.	1.44		11.00
12.00	Current year allowable FTE (see instructions)	8.39		12.00
13.00	Total allowable FTE count for the prior year.	7.57		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.	7.54		14.00
15.00	Sum of lines 12 through 14 divided by 3.	7.83		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	7.83		18.00
19.00	Current year resident to bed ratio (line 18 divided by line 4).	0.049774		19.00
20.00	Prior year resident to bed ratio (see instructions)	0.049464		20.00
21.00	Enter the lesser of lines 19 or 20 (see instructions)	0.049464		21.00
22.00	IME payment adjustment (see instructions)	482,477	190,064	22.00
22.01	IME payment adjustment - Managed Care (see instructions)	315,851	158,209	22.01
	Indirect Medical Education Adjustment for the Add-on for § 422 of the MMA			
23.00	Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 CFR 412.105 (f)(1)(iv)(C).	0.00		23.00
24.00	IME FTE Resident Count Over Cap (see instructions)	1.30		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	0	28.00
28.01	IME add-on adjustment amount - Managed Care (see instructions)	0	0	28.01
29.00	Total IME payment (sum of lines 22 and 28)	482,477	190,064	29.00
29.01	Total IME payment - Managed Care (sum of lines 22.01 and 28.01)	315,851	158,209	29.01
	Disproportionate Share Adjustment			
30.00	Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)	2.64		30.00
31.00	Percentage of Medicaid patient days (see instructions)	23.49		31.00
32.00	Sum of lines 30 and 31	26.13		32.00
33.00	Allowable disproportionate share percentage (see instructions)	10.77	10.77	33.00
34.00	Disproportionate share adjustment (see instructions)	487,327	191,975	34.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0128	Period: From 01/01/2020 To 12/31/2020	Worksheet E Part A Date/Time Prepared: 8/2/2021 3:42 pm
	Title XVIII	Hospital	PPS

		Prior to 10/1	On/After 10/1	
		1.00	2.00	
	Uncompensated Care Adjustment			
35.00	Total uncompensated care amount (see instructions)	8,350,599,096	8,290,014,521	35.00
35.01	Factor 3 (see instructions)	0.000168507	0.000397191	35.01
35.02	Hospital uncompensated care payment (If line 34 is zero, enter zero on this line) (see instructions)	1,407,133	3,292,717	35.02
35.03	Pro rata share of the hospital uncompensated care payment amount (see instructions)	1,053,428	829,946	35.03
36.00	Total uncompensated care (sum of columns 1 and 2 on line 35.03)	1,883,374		36.00
	Additional payment for high percentage of ESRD beneficiary discharges (lines 40 through 46)			
40.00	Total Medicare discharges, excluding MS-DRGs 652, 682, 683, 684 and 685. (see instructions)	0		40.00

		Before GEO Reclass	On/After GEO Reclass	
		1.00	1.01	
41.00	Total ESRD Medicare discharges excluding MS-DRGs 652, 682, 683, 684 an 685. (see instructions)	0	0	41.00
41.01	Total ESRD Medicare covered and paid discharges excluding MS-DRGs 652, 682, 683, 684 an 685. (see instructions)	0	0	41.01
42.00	Divide line 41 by line 40 (if less than 10%, you do not qualify for adjustment)	0.00		42.00
43.00	Total Medicare ESRD inpatient days excluding MS-DRGs 652, 682, 683, 684 an 685. (see instructions)	0		43.00
44.00	Ratio of average length of stay to one week (line 43 divided by line 41 divided by 7 days)	0.000000		44.00
45.00	Average weekly cost for dialysis treatments (see instructions)	0.00	0.00	45.00
46.00	Total additional payment (line 45 times line 44 times line 41.01)	0		46.00
47.00	Subtotal (see instructions)	20,835,485	8,054,739	47.00
48.00	Hospital specific payments (to be completed by SCH and MDH, small rural hospitals only.(see instructions)	0	0	48.00

		Amount	
		1.00	
49.00	Total payment for inpatient operating costs (see instructions)	29,364,284	49.00
50.00	Payment for inpatient program capital (from Wkst. L, Pt. I and Pt. II, as applicable)	2,057,469	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).	245,386	52.00
53.00	Nursing and Allied Health Managed Care payment	0	53.00
54.00	Special add-on payments for new technologies	82,602	54.00
54.01	Islet isolation add-on payment	0	54.01
55.00	Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line 69)	0	55.00
56.00	Cost of physicians' services in a teaching hospital (see intructions)	0	56.00
57.00	Routine service other pass through costs (from Wkst. D, Pt. III, column 9, lines 30 through 35).	0	57.00
58.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 11 line 200)	0	58.00
59.00	Total (sum of amounts on lines 49 through 58)	31,749,741	59.00
60.00	Primary payer payments	17,383	60.00
61.00	Total amount payable for program beneficiaries (line 59 minus line 60)	31,732,358	61.00
62.00	Deductibles billed to program beneficiaries	2,477,112	62.00
63.00	Coinsurance billed to program beneficiaries	83,776	63.00
64.00	Allowable bad debts (see instructions)	161,762	64.00
65.00	Adjusted reimbursable bad debts (see instructions)	105,145	65.00
66.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	69,356	66.00
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)	29,276,615	67.00
68.00	Credits received from manufacturers for replaced devices for applicable to MS-DRGs (see instructions)	0	68.00
69.00	Outlier payments reconciliation (sum of lines 93, 95 and 96).(For SCH see instructions)	0	69.00
70.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	70.00
70.50	Rural Community Hospital Demonstration Project (§410A Demonstration) adjustment (see instructions)	0	70.50
70.87	Demonstration payment adjustment amount before sequestration	0	70.87
70.88	SCH or MDH volume decrease adjustment (contractor use only)	0	70.88
70.89	Pioneer ACO demonstration payment adjustment amount (see instructions)		70.89
70.90	HSP bonus payment HVBP adjustment amount (see instructions)	0	70.90
70.91	HSP bonus payment HRR adjustment amount (see instructions)	0	70.91
70.92	Bundled Model 1 discount amount (see instructions)	0	70.92
70.93	HVBP payment adjustment amount (see instructions)	-119,224	70.93
70.94	HRR adjustment amount (see instructions)	-130,915	70.94
70.95	Recovery of accelerated depreciation	0	70.95

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0128	Period: From 01/01/2020 To 12/31/2020	Worksheet E Part A Date/Time Prepared: 8/2/2021 3:42 pm
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		FFY (yyyy)	Amount	
		0	1.00	
70.96	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period prior to 10/1)	0	0	70.96
70.97	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period ending on or after 10/1)	0	0	70.97
70.98	Low Volume Payment-3		0	70.98
70.99	HAC adjustment amount (see instructions)		301,399	70.99
71.00	Amount due provider (line 67 minus lines 68 plus/minus lines 69 & 70)		28,725,077	71.00
71.01	Sequestration adjustment (see instructions)		189,586	71.01
71.02	Demonstration payment adjustment amount after sequestration		0	71.02
71.03	Sequestration adjustment-PARHM pass-throughs			71.03
72.00	Interim payments		27,845,895	72.00
72.01	Interim payments-PARHM			72.01
73.00	Tentative settlement (for contractor use only)		0	73.00
73.01	Tentative settlement-PARHM (for contractor use only)			73.01
74.00	Balance due provider/program (line 71 minus lines 71.01, 71.02, 72, and 73)		689,596	74.00
74.01	Balance due provider/program-PARHM (see instructions)			74.01
75.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		624,729	75.00
	TO BE COMPLETED BY CONTRACTOR (lines 90 through 96)			
90.00	Operating outlier amount from Wkst. E, Pt. A, line 2, or sum of 2.03 plus 2.04 (see instructions)		0	90.00
91.00	Capital outlier from Wkst. L, Pt. I, line 2		0	91.00
92.00	Operating outlier reconciliation adjustment amount (see instructions)		0	92.00
93.00	Capital outlier reconciliation adjustment amount (see instructions)		0	93.00
94.00	The rate used to calculate the time value of money (see instructions)		0.00	94.00
95.00	Time value of money for operating expenses (see instructions)		0	95.00
96.00	Time value of money for capital related expenses (see instructions)		0	96.00

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

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0128	Period: From 01/01/2020 To 12/31/2020	Worksheet E Part B Date/Time Prepared: 8/2/2021 3:42 pm
	Title XVIII	Hospital	PPS

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	21,042	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)	15,508,685	2.00
3.00	OPPS payments	13,189,227	3.00
4.00	Outlier payment (see instructions)	47,551	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)	21,042	11.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
12.00	Ancillary service charges	87,042	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)	87,042	14.00
	Customary charges		
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis	0	15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a chargebasis had such payment been made in accordance with 42 CFR §413.13(e)	0	16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)	0.000000	17.00
18.00	Total customary charges (see instructions)	87,042	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)	66,000	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)	21,042	21.00
22.00	Interns and residents (see instructions)	0	22.00
23.00	Cost of physicians' services in a teaching hospital (see instructions)	0	23.00
24.00	Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)	13,236,778	24.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
25.00	Deductibles and coinsurance amounts (for CAH, see instructions)	2,718	25.00
26.00	Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)	2,264,622	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)	10,990,480	27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 50)	104,031	28.00
29.00	ESRD direct medical education costs (from Wkst. E-4, line 36)	0	29.00
30.00	Subtotal (sum of lines 27 through 29)	11,094,511	30.00
31.00	Primary payer payments	4,791	31.00
32.00	Subtotal (line 30 minus line 31)	11,089,720	32.00
	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)		
33.00	Composite rate ESRD (from Wkst. I-5, line 11)	0	33.00
34.00	Allowable bad debts (see instructions)	275,983	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	179,389	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	245,926	36.00
37.00	Subtotal (see instructions)	11,269,109	37.00
38.00	MSP-LCC reconciliation amount from PS&R	-169	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	39.00
39.50	Pioneer ACO demonstration payment adjustment (see instructions)		39.50
39.97	Demonstration payment adjustment amount before sequestration	0	39.97
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)	0	39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION	0	39.99
40.00	Subtotal (see instructions)	11,269,278	40.00
40.01	Sequestration adjustment (see instructions)	74,377	40.01
40.02	Demonstration payment adjustment amount after sequestration	0	40.02
40.03	Sequestration adjustment-PARHM pass-throughs		40.03
41.00	Interim payments	11,305,415	41.00
41.01	Interim payments-PARHM		41.01
42.00	Tentative settlement (for contractors use only)	0	42.00
42.01	Tentative settlement-PARHM (for contractor use only)		42.01
43.00	Balance due provider/program (see instructions)	-110,514	43.00
43.01	Balance due provider/program-PARHM (see instructions)		43.01
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	44.00
	TO BE COMPLETED BY CONTRACTOR		
90.00	Original outlier amount (see instructions)	0	90.00
91.00	Outlier reconciliation adjustment amount (see instructions)	0	91.00
92.00	The rate used to calculate the Time Value of Money	0.00	92.00
93.00	Time Value of Money (see instructions)	0	93.00
94.00	Total (sum of lines 91 and 93)	0	94.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 15-0128 | Period: From 01/01/2020 To 12/31/2020 | Worksheet E-1 Part I | Date/Time Prepared: 8/2/2021 3:42 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		27,796,895		11,207,815	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	09/25/2020	49,000	09/25/2020	97,600	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)		49,000		97,600	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)		27,845,895		11,305,415	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		689,596		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		110,514	6.02
7.00	Total Medicare program liability (see instructions)		28,535,491		11,194,901	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: 15-0128	Period: From 01/01/2020 To 12/31/2020	Worksheet E-1 Part II Date/Time Prepared: 8/2/2021 3:42 pm
	Title XVIII	Hospital	PPS

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

DIRECT GRADUATE MEDICAL EDUCATION (GME) & ESRD OUTPATIENT DIRECT MEDICAL EDUCATION COSTS | Provider CCN: 15-0128 | Period: From 01/01/2020 To 12/31/2020 | Worksheet E-4 | Date/Time Prepared: 8/2/2021 3:42 pm

Title XVIII | Hospital | PPS

				1.00	
	COMPUTATION OF TOTAL DIRECT GME AMOUNT				
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))			6.95	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			6.95	5.00
6.00	Unweighted resident FTE count for allopathic and osteopathic programs for the current year from your records (see instructions)			8.25	6.00
7.00	Enter the lesser of line 5 or line 6			6.95	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.	7.58	0.67	8.25	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.	6.39	0.56	6.95	9.00
10.00	Weighted dental and podiatric resident FTE count for the current year		1.44		10.00
10.01	Unweighted dental and podiatric resident FTE count for the current year		1.44		10.01
11.00	Total weighted FTE count	6.39	2.00		11.00
12.00	Total weighted resident FTE count for the prior cost reporting year (see instructions)	5.56	2.01		12.00
13.00	Total weighted resident FTE count for the penultimate cost reporting year (see instructions)	5.45	0.64		13.00
14.00	Rolling average FTE count (sum of lines 11 through 13 divided by 3).	5.80	1.55		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	5.80	1.55		17.00
18.00	Per resident amount	92,653.98	92,653.98		18.00
19.00	Approved amount for resident costs	537,393	143,614	681,007	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)			1.30	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)			681,007	25.00
		Inpatient Part A	Managed Care	Total	
		1.00	2.00	3.00	
	COMPUTATION OF PROGRAM PATIENT LOAD				
26.00	Inpatient Days (see instructions) (Title XIX - see S-2 Part IX, line 3.02, column 2)	11,465	8,173		26.00
27.00	Total Inpatient Days (see instructions)	37,159	37,159		27.00
28.00	Ratio of inpatient days to total inpatient days	0.308539	0.219947		28.00
29.00	Program direct GME amount	210,117	149,785	359,902	29.00
29.01	Percent reduction for MA DGME		7.00		29.01
30.00	Reduction for direct GME payments for Medicare Advantage		10,485	10,485	30.00
31.00	Net Program direct GME amount			349,417	31.00

DIRECT GRADUATE MEDICAL EDUCATION (GME) & ESRD OUTPATIENT DIRECT MEDICAL EDUCATION COSTS

Provider CCN: 15-0128 | Period: From 01/01/2020 To 12/31/2020 | Worksheet E-4 | Date/Time Prepared: 8/2/2021 3:42 pm

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		1.00	
	DIRECT MEDICAL EDUCATION COSTS FOR ESRD COMPOSITE RATE - TITLE XVIII ONLY (NURSING SCHOOL AND PARAMEDICAL EDUCATION COSTS)		
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)	2,681,063	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
	APPORTIONMENT BASED ON MEDICARE REASONABLE COST - TITLE XVIII ONLY		
	Part A Reasonable Cost		
37.00	Reasonable cost (see instructions)	36,637,381	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)	17,383	40.00
41.00	Total Part A reasonable cost (sum of lines 37 through 39 minus line 40)	36,619,998	41.00
	Part B Reasonable Cost		
42.00	Reasonable cost (see instructions)	15,529,727	42.00
43.00	Primary payer payments (see instructions)	4,791	43.00
44.00	Total Part B reasonable cost (line 42 minus line 43)	15,524,936	44.00
45.00	Total reasonable cost (sum of lines 41 and 44)	52,144,934	45.00
46.00	Ratio of Part A reasonable cost to total reasonable cost (line 41 ÷ line 45)	0.702273	46.00
47.00	Ratio of Part B reasonable cost to total reasonable cost (line 44 ÷ line 45)	0.297727	47.00
	ALLOCATION OF MEDICARE DIRECT GME COSTS BETWEEN PART A AND PART B		
48.00	Total program GME payment (line 31)	349,417	48.00
49.00	Part A Medicare GME payment (line 46 x 48) (title XVIII only) (see instructions)	245,386	49.00
50.00	Part B Medicare GME payment (line 47 x 48) (title XVIII only) (see instructions)	104,031	50.00

BALANCE SHEET (If you are nonproprietary and do not maintain fund-type accounting records, complete the General Fund column only) | Provider CCN: 15-0128 | Period: From 01/01/2020 To 12/31/2020 | Worksheet G | Date/Time Prepared: 8/2/2021 3:42 pm

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
	CURRENT ASSETS					
1.00	Cash on hand in banks	5,849	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	201,097,458	0	0	0	4.00
5.00	Other receivable	-154,759,471	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	521,717	0	0	0	6.00
7.00	Inventory	4,080,470	0	0	0	7.00
8.00	Prepaid expenses	100,000	0	0	0	8.00
9.00	Other current assets	0	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)	51,046,023	0	0	0	11.00
	FIXED ASSETS					
12.00	Land	1,821,632	0	0	0	12.00
13.00	Land improvements	2,722,362	0	0	0	13.00
14.00	Accumulated depreciation	0	0	0	0	14.00
15.00	Buildings	185,616,539	0	0	0	15.00
16.00	Accumulated depreciation	0	0	0	0	16.00
17.00	Leasehold improvements	1,737,035	0	0	0	17.00
18.00	Accumulated depreciation	0	0	0	0	18.00
19.00	Fixed equipment	83,879,806	0	0	0	19.00
20.00	Accumulated depreciation	0	0	0	0	20.00
21.00	Automobiles and trucks	59,805	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	-145,610,138	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	115,657	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	130,342,698	0	0	0	30.00
	OTHER ASSETS					
31.00	Investments	0	0	0	0	31.00
32.00	Deposits on leases	0	0	0	0	32.00
33.00	Due from owners/officers	0	0	0	0	33.00
34.00	Other assets	513,497,149	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	513,497,149	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	694,885,870	0	0	0	36.00
	CURRENT LIABILITIES					
37.00	Accounts payable	728,836	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				42.00
43.00	Due to other funds	0	0	0	0	43.00
44.00	Other current liabilities	10,074,177	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	10,803,013	0	0	0	45.00
	LONG TERM LIABILITIES					
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	0	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	15,390,422	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	15,390,422	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	26,193,435	0	0	0	51.00
	CAPITAL ACCOUNTS					
52.00	General fund balance	668,692,435				52.00
53.00	Specific purpose fund		0			53.00
54.00	Donor created - endowment fund balance - restricted			0		54.00
55.00	Donor created - endowment fund balance - unrestricted			0		55.00
56.00	Governing body created - endowment fund balance			0		56.00
57.00	Plant fund balance - invested in plant				0	57.00
58.00	Plant fund balance - reserve for plant improvement, replacement, and expansion				0	58.00
59.00	Total fund balances (sum of lines 52 thru 58)	668,692,435	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	694,885,870	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES | Provider CCN: 15-0128 | Period: From 01/01/2020 To 12/31/2020 | Worksheet G-1 | Date/Time Prepared: 8/2/2021 3:42 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		602,188,657		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		66,503,778				2.00
3.00	Total (sum of line 1 and line 2)		668,692,435		0		3.00
4.00	Additions (credit adjustments) (specify)	0		0		0	4.00
5.00		0		0		0	5.00
6.00		0		0		0	6.00
7.00		0		0		0	7.00
8.00		0		0		0	8.00
9.00		0		0		0	9.00
10.00	Total additions (sum of line 4-9)		0		0		10.00
11.00	Subtotal (line 3 plus line 10)		668,692,435		0		11.00
12.00	Deductions (debit adjustments) (specify)	0		0		0	12.00
13.00		0		0		0	13.00
14.00		0		0		0	14.00
15.00		0		0		0	15.00
16.00		0		0		0	16.00
17.00		0		0		0	17.00
18.00	Total deductions (sum of lines 12-17)		0		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		668,692,435		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: 15-0128 | Period: From 01/01/2020 To 12/31/2020 | Worksheet G-2 Parts I & II Date/Time Prepared: 8/2/2021 3:42 pm

	Cost Center Description	Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospital	116,692,677		116,692,677	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	0		0	5.00
6.00	Swing bed - NF	0		0	6.00
7.00	SKILLED NURSING FACILITY				7.00
8.00	NURSING FACILITY				8.00
9.00	OTHER LONG TERM CARE				9.00
10.00	Total general inpatient care services (sum of lines 1-9)	116,692,677		116,692,677	10.00
	Intensive Care Type Inpatient Hospital Services				
11.00	INTENSIVE CARE UNIT	12,440,977		12,440,977	11.00
12.00	CORONARY CARE UNIT				12.00
13.00	BURN INTENSIVE CARE UNIT				13.00
14.00	SURGICAL INTENSIVE CARE UNIT				14.00
15.00	OTHER SPECIAL CARE (SPECIFY)				15.00
16.00	Total intensive care type inpatient hospital services (sum of lines 11-15)	12,440,977		12,440,977	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	129,133,654		129,133,654	17.00
18.00	Ancillary services	324,345,747	468,700,282	793,046,029	18.00
19.00	Outpatient services	0	0	0	19.00
20.00	RURAL HEALTH CLINIC	0	0	0	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY				22.00
23.00	AMBULANCE SERVICES				23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	OTHER (SPECIFY)	0	51,686	51,686	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	453,479,401	468,751,968	922,231,369	28.00
	PART II - OPERATING EXPENSES				
29.00	Operating expenses (per Wkst. A, column 3, line 200)		230,568,659		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)		230,568,659		43.00

STATEMENT OF REVENUES AND EXPENSES	Provider CCN: 15-0128	Period: From 01/01/2020 To 12/31/2020	Worksheet G-3 Date/Time Prepared: 8/2/2021 3:42 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	922,231,369	1.00
2.00	Less contractual allowances and discounts on patients' accounts	648,190,918	2.00
3.00	Net patient revenues (line 1 minus line 2)	274,040,451	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	230,568,659	4.00
5.00	Net income from service to patients (line 3 minus line 4)	43,471,792	5.00
	OTHER INCOME		
6.00	Contributions, donations, bequests, etc	0	6.00
7.00	Income from investments	8,521,863	7.00
8.00	Revenues from telephone and other miscellaneous communication services	0	8.00
9.00	Revenue from television and radio service	0	9.00
10.00	Purchase discounts	0	10.00
11.00	Rebates and refunds of expenses	0	11.00
12.00	Parking lot receipts	0	12.00
13.00	Revenue from laundry and linen service	0	13.00
14.00	Revenue from meals sold to employees and guests	998,116	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	8,224	16.00
17.00	Revenue from sale of drugs to other than patients	46,800	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	698,410	22.00
23.00	Governmental appropriations	0	23.00
24.00	MISC REVENUE	913,168	24.00
24.50	COVID-19 PHE Funding	11,845,405	24.50
25.00	Total other income (sum of lines 6-24)	23,031,986	25.00
26.00	Total (line 5 plus line 25)	66,503,778	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)	66,503,778	29.00

CALCULATION OF CAPITAL PAYMENT	Provider CCN: 15-0128	Period: From 01/01/2020 To 12/31/2020	Worksheet L Parts I-III Date/Time Prepared: 8/2/2021 3:42 pm
	Title XVIII	Hospital	PPS

		Urban	Rural	
		1.00	1.01	
	PART I - FULLY PROSPECTIVE METHOD			
	CAPITAL FEDERAL AMOUNT			
1.00	Capital DRG other than outlier	1,425,704	537,823	1.00
1.01	Model 4 BPCI Capital DRG other than outlier	0	0	1.01
2.00	Capital DRG outlier payments	51,333		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)	102.87		3.00
4.00	Number of interns & residents (see instructions)	7.83		4.00
5.00	Indirect medical education percentage (see instructions)	2.17		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)	42,609		6.00
7.00	Percentage of SSI recipient patient days to Medicare Part A patient days (Worksheet E, part A line 30) (see instructions)	0.00		7.00
8.00	Percentage of Medicaid patient days to total days (see instructions)	0.00		8.00
9.00	Sum of lines 7 and 8	0.00		9.00
10.00	Allowable disproportionate share percentage (see instructions)	0.00		10.00
11.00	Disproportionate share adjustment (see instructions)	0		11.00
12.00	Total prospective capital payments (see instructions)	2,057,469		12.00
			1.00	
	PART II - PAYMENT UNDER REASONABLE COST			
1.00	Program inpatient routine capital cost (see instructions)		0	1.00
2.00	Program inpatient ancillary capital cost (see instructions)		0	2.00
3.00	Total inpatient program capital cost (line 1 plus line 2)		0	3.00
4.00	Capital cost payment factor (see instructions)		0	4.00
5.00	Total inpatient program capital cost (line 3 x line 4)		0	5.00
			1.00	
	PART III - COMPUTATION OF EXCEPTION PAYMENTS			
1.00	Program inpatient capital costs (see instructions)		0	1.00
2.00	Program inpatient capital costs for extraordinary circumstances (see instructions)		0	2.00
3.00	Net program inpatient capital costs (line 1 minus line 2)		0	3.00
4.00	Applicable exception percentage (see instructions)		0.00	4.00
5.00	Capital cost for comparison to payments (line 3 x line 4)		0	5.00
6.00	Percentage adjustment for extraordinary circumstances (see instructions)		0.00	6.00
7.00	Adjustment to capital minimum payment level for extraordinary circumstances (line 2 x line 6)		0	7.00
8.00	Capital minimum payment level (line 5 plus line 7)		0	8.00
9.00	Current year capital payments (from Part I, line 12, as applicable)		0	9.00
10.00	Current year comparison of capital minimum payment level to capital payments (line 8 less line 9)		0	10.00
11.00	Carryover of accumulated capital minimum payment level over capital payment (from prior year Worksheet L, Part III, line 14)		0	11.00
12.00	Net comparison of capital minimum payment level to capital payments (line 10 plus line 11)		0	12.00
13.00	Current year exception payment (if line 12 is positive, enter the amount on this line)		0	13.00
14.00	Carryover of accumulated capital minimum payment level over capital payment for the following period (if line 12 is negative, enter the amount on this line)		0	14.00
15.00	Current year allowable operating and capital payment (see instructions)		0	15.00
16.00	Current year operating and capital costs (see instructions)		0	16.00
17.00	Current year exception offset amount (see instructions)		0	17.00