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:15-1306	Period: From 01/01/2020 To 12/31/2020	Worksheet S Parts I-III Date/Time Prepared: 7/14/2021 11:21 am

PART I - COST REPORT STATUS

Provider use only

1. [X] Electronically prepared cost report — Date: 7/14/2021 Time: 11:21 am
2. [ ] Manually prepared cost report
3. [0] If this is an amended report enter the number of times the provider resubmitted this cost report
4. [F] Medicare Utilization. Enter "F" for full or "L" for low.

Contractor use only

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

PART II - CERTIFICATION

MISREPRESENTATION OR FALSIFICATION OF ANY INFORMATION CONTAINED IN THIS COST REPORT MAY BE PUNISHABLE BY CRIMINAL, CIVIL AND ADMINISTRATIVE ACTION, FINE AND/OR IMPRISONMENT UNDER FEDERAL LAW. FURTHERMORE, IF SERVICES IDENTIFIED IN THIS REPORT WERE PROVIDED OR PROCURED THROUGH THE PAYMENT DIRECTLY OR INDIRECTLY OF A KICKBACK OR WERE OTHERWISE ILLEGAL, CRIMINAL, CIVIL AND ADMINISTRATIVE ACTIONS, 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 IU HEALTH PAOLI HOSPITAL (15-1306) 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) MICHAEL CRAIG
Officer or Administrator of Provider(s)

CHIEF FINANCIAL OFFICER
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	230,941	-266,952	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	83,309	0		0	5.00
6.00	Swing Bed - NF	0				0	6.00
9.00	HOME HEALTH AGENCY I	0	0	0		0	9.00
10.00	RURAL HEALTH CLINIC I	0		0		0	10.00
11.00	FEDERALLY QUALIFIED HEALTH CENTER I	0		0		0	11.00
200.00	Total	0	314,250	-266,952	0	0	200.00

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN:15-1306 | Period: From 01/01/2020 To 12/31/2020 | Worksheet S-2 Part I | Date/Time Prepared: 7/14/2021 11:21 am

	1.00	2.00	3.00	4.00	
	Hospital and Hospital Health Care Complex Address:				
1.00	Street:642 WEST HOSPITAL ROAD	PO Box:			1.00
2.00	City: PAOLI	State: IN	Zip Code:47454	County: ORANGE	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	IU HEALTH PAOLI HOSPITAL	151306	99915	1	07/01/2001	N	O	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	IUHP SWING BEDS	15Z306	99915		07/01/2001	N	O	N	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	IU HEALTH PAOLI FAMILY AND INTERNAL	158557	99915		12/07/2020	N	O	O	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.	N	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)	N	N		22.01
22.02	Is this a newly merged hospital that requires final uncompensated care payments to be determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1.	N	N		22.02
22.03	Did this hospital receive a geographic reclassification from urban to rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or “N” for no.	N	N	N	22.03
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.	3	N		23.00

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN:15-1306 | Period: From 01/01/2020 To 12/31/2020 | Worksheet S-2 Part I Date/Time Prepared: 7/14/2021 11:21 am

		In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of State Medicaid paid days	Out-of State Medicaid eligible unpaid days	Medicaid HMO days	Other Medicaid days	
		1.00	2.00	3.00	4.00	5.00	6.00	
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 St	Date of Geogra	
		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.	2		27.00
35.00	If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period.	0		35.00

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

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

		V	XVIII	XIX	
		1.00	2.00	3.00	
	Prospective Payment System (PPS)-Capital				
45.00	Does this facility qualify and receive Capital payment for disproportionate share in accordance with 42 CFR Section §412.320? (see instructions)	N	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			56.00
57.00	If line 56 is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y" did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If column 2 is "N", complete Wkst. D, Parts III & IV and D-2, Pt. II, if applicable.				57.00
58.00	If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, chapter 21, §2148? If yes, complete Wkst. D-5.				58.00
59.00	Are costs claimed on line 100 of Worksheet A? If yes, complete Wkst. D-2, Pt. I.	N			59.00

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN:15-1306 | Period: From 01/01/2020 To 12/31/2020 | Worksheet S-2 Part I Date/Time Prepared: 7/14/2021 11:21 am

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

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

ACA Provisions Affecting the Health Resources and Services Administration (HRSA)

62.00	Enter the number of FTE residents that your hospital trained in this cost reporting period for which your hospital received HRSA PCRE funding (see instructions)	0.00	62.00
62.01	Enter the number of FTE residents that rotated from a Teaching Health Center (THC) into your hospital during in this cost reporting period of HRSA THC program. (see instructions)	0.00	62.01

Teaching Hospitals that Claim Residents in Nonprovider Settings

63.00	Has your facility trained residents in nonprovider settings during this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If yes, complete lines 64 through 67. (see instructions)	N	63.00

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN:15-1306 | Period: From 01/01/2020 To 12/31/2020 | Worksheet S-2 Part I Date/Time Prepared: 7/14/2021 11:21 am

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

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

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

		1.00	2.00	3.00	
	Inpatient Psychiatric Facility PPS				
70.00	Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? Enter "Y" for yes or "N" for no.	N			70.00
71.00	If line 70 is yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost report filed on or before November 15, 2004? Enter "Y" for yes or "N" for no. (see 42 CFR 412.424(d)(1)(iii)(c)) Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)			0	71.00
	Inpatient Rehabilitation Facility PPS				
75.00	Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF subprovider? Enter "Y" for yes and "N" for no.	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:15-1306	Period: From 01/01/2020 To 12/31/2020	Worksheet S-2 Part I Date/Time Prepared: 7/14/2021 11:21 am

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

		V	XIX	
		1.00	2.00	
	Title V and XIX Services			
90.00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.	N	Y	90.00
91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.	N	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.	N	Y	98.00
98.01	Does title V or XIX follow Medicare (title XVIII) for the reporting of charges on Wkst. C, Pt. I? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	Y	98.01
98.02	Does title V or XIX follow Medicare (title XVIII) for the calculation of observation bed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	Y	98.02
98.03	Does title V or XIX follow Medicare (title XVIII) for a critical access hospital (CAH) reimbursed 101% of inpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.03
98.04	Does title V or XIX follow Medicare (title XVIII) for a CAH reimbursed 101% of outpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.04
98.05	Does title V or XIX follow Medicare (title XVIII) and add back the RCE disallowance on Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	Y	98.05
98.06	Does title V or XIX follow Medicare (title XVIII) when cost reimbursed for Wkst. D, Pts. I through IV? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	Y	98.06
	Rural Providers			
105.00	Does this hospital qualify as a CAH?	Y		105.00
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)	N		106.00
107.00	Column 1: If line 105 is Y, is this facility eligible for cost reimbursement for I&R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) Column 2: If column 1 is Y and line 70 or line 75 is Y, do you train I&Rs in an approved medical education program in the CAH's excluded IPF and/or IRF unit(s)? Enter "Y" for yes or "N" for no in column 2. (see instructions)	N		107.00
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	Y		108.00

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

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				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
			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.	N			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:	40,724	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.		Y	5.00	122.00
	Transplant Center Information				
125.00	Does this facility operate a transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.		N		125.00
126.00	If this is a Medicare certified kidney transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				126.00
127.00	If this is a Medicare certified heart transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				127.00
128.00	If this is a Medicare certified liver transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				128.00
129.00	If this is a Medicare certified lung transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				129.00
130.00	If this is a Medicare certified pancreas transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				130.00
131.00	If this is a Medicare certified intestinal transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				131.00
132.00	If this is a Medicare certified islet transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				132.00
133.00	Removed and reserved				133.00
134.00	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.				134.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN:15-1306 | Period: From 01/01/2020 To 12/31/2020 | Worksheet S-2 Part I Date/Time Prepared: 7/14/2021 11:21 am

		1.00	2.00	
	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	15H059	140.00

	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: INDIANA UNIVERSITY HEALTH	Contractor's Name: WISCONSIN PHYSICIAN SERVICES	Contractor's Number: 08101	141.00
142.00	Street: 340 WEST TENTH STREET	PO Box:		142.00
143.00	City: INDIANAPOLIS	State: IN	Zip Code: 46204	143.00

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

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

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

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

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

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

		1.00	
	Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act		
167.00	Is this provider a meaningful user under §1886(n)? Enter "Y" for yes or "N" for no.	Y	167.00
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)		168.00
168.01	If this provider is a CAH and is not a meaningful user, does this provider qualify for a hardship exception under §413.70(a)(6)(ii)? Enter "Y" for yes or "N" for no. (see instructions)	N	168.01
169.00	If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)	0.00	169.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN:15-1306	Period: From 01/01/2020 To 12/31/2020	Worksheet S-2 Part I Date/Time Prepared: 7/14/2021 11:21 am

		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)	Y	12	171.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN:15-1306 | Period: From 01/01/2020 To 12/31/2020 | Worksheet S-2 Part II | Date/Time Prepared: 7/14/2021 11:21 am

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

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

		Y/N	Type	Date	
		1.00	2.00	3.00	
	Financial Data and Reports				
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	Y	A	02/25/2021	4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.	N			5.00

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

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

		Part A		Part B		
		Y/N	Date	Y/N	Date	
		1.00	2.00	3.00	4.00	
	PS&R Data					
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see instructions)	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	04/02/2021	Y	04/02/2021	17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N		N		18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		N		19.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN:15-1306 | Period: From 01/01/2020 To 12/31/2020 | Worksheet S-2 Part II | Date/Time Prepared: 7/14/2021 11:21 am

		Description		Y/N	Y/N	
		0		1.00	3.00	
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:			N	N	20.00
		Y/N	Date	Y/N	Date	
		1.00	2.00	3.00	4.00	
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		N		21.00
					1.00	
	COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)					
	Capital Related Cost					
22.00	Have assets been relifed for Medicare purposes? If yes, see instructions				N	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.				N	23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions				N	24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.				N	25.00
26.00	Were assets subject to Sec.2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.				N	26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.				N	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.				N	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				N	29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.				N	30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.				N	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.				N	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.				Y	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.				Y	35.00
				Y/N	Date	
				1.00	2.00	
	Home Office Costs					
36.00	Were home office costs claimed on the cost report?			Y		36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.			Y		37.00
38.00	If line 36 is yes , was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.			N		38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.			N		39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.			N		40.00
		1.00		2.00		
	Cost Report Preparer Contact Information					
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	RHONDA		UTTER		41.00
42.00	Enter the employer/company name of the cost report preparer.	INDIANA UNIVERSITY HEALTH				42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	317-962-1093		RUTTER@IUHEALTH.ORG		43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider CCN:15-1306	Period: From 01/01/2020 To 12/31/2020	Worksheet S-2 Part II Date/Time Prepared: 7/14/2021 11:21 am

		3.00		
	Cost Report Preparer Contact Information			
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	DIRECTOR		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:15-1306 | Period: From 01/01/2020 To 12/31/2020 | Worksheet S-3 Part I Date/Time Prepared: 7/14/2021 11:21 am

	Component	Worksheet A Line Number	No. of Beds	Bed Days Available	CAH Hours	I/P Days / O/P Visits / Trips Title V	
		1.00	2.00	3.00	4.00	5.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30.00	24	8,784	19,200.00	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)		24	8,784	19,200.00	0	7.00
8.00	INTENSIVE CARE UNIT	31.00	0	0	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)		24	8,784	19,200.00	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	101.00				0	22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)	30.00					24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC	88.00				0	26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	26.25
27.00	Total (sum of lines 14-26)		24				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:15-1306 | Period: From 01/01/2020 To 12/31/2020 | Worksheet S-3 Part I | Date/Time Prepared: 7/14/2021 11:21 am

	Component	I/P Days / O/P Visits / Trips			Full Time Equivalents		
		Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
		6.00	7.00	8.00	9.00	10.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	335	11	800			1.00
2.00	HMO and other (see instructions)	137	222				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	163	0	163			5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	100			6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	498	11	1,063			7.00
8.00	INTENSIVE CARE UNIT	0	0	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		25	129			13.00
14.00	Total (see instructions)	498	36	1,192	0.00	134.83	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	0	0	0	0.00	0.00	22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)			30			24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC	0	0	0	0.00	0.00	26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0.00	0.00	26.25
27.00	Total (sum of lines 14-26)				0.00	134.83	27.00
28.00	Observation Bed Days		13	512			28.00
29.00	Ambulance Trips	0					29.00
30.00	Employee discount days (see instruction)			0			30.00
31.00	Employee discount days - IRF			0			31.00
32.00	Labor & delivery days (see instructions)	0	0	0			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:15-1306 | Period: From 01/01/2020 To 12/31/2020 | Worksheet S-3 Part I | Date/Time Prepared: 7/14/2021 11:21 am

	Component	Full Time Equivalents	Discharges				
		Nonpaid Workers	Title V	Title XVIII	Title XIX	Total All Patients	
		11.00	12.00	13.00	14.00	15.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)		0	115	5	292	1.00
2.00	HMO and other (see instructions)			45	99		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	115	5	292	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	0.00					22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)						24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC	0.00					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 UNCOMPENSATED AND INDIGENT CARE DATA | Provider CCN:15-1306 | Period: From 01/01/2020 To 12/31/2020 | Worksheet S-10 | Date/Time Prepared: 7/14/2021 11:21 am

		1.00	
	Uncompensated and indigent care cost computation		
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided by line 202 column 8)	0.406967	1.00
	Medicaid (see instructions for each line)		
2.00	Net revenue from Medicaid	5,913,612	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	0	5.00
6.00	Medicaid charges	16,485,858	6.00
7.00	Medicaid cost (line 1 times line 6)	6,709,200	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)	795,588	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)	1,104	13.00
14.00	Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)	11,915	14.00
15.00	State or local indigent care program cost (line 1 times line 14)	4,849	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)	3,745	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)	799,333	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)	1,447,117	51,883	1,499,000	20.00
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	588,929	51,883	640,812	21.00
22.00	Payments received from patients for amounts previously written off as charity care	0	0	0	22.00
23.00	Cost of charity care (line 21 minus line 22)	588,929	51,883	640,812	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)	2,303,771	26.00
27.00	Medicare reimbursable bad debts for the entire hospital complex (see instructions)	83,015	27.00
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)	127,716	27.01
28.00	Non-Medicare bad debt expense (see instructions)	2,176,055	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)	930,284	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)	1,571,096	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	2,370,429	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN:15-1306 | Period: From 01/01/2020 To 12/31/2020 | Worksheet A | Date/Time Prepared: 7/14/2021 11:21 am

		Cost Center Description	Salaries	Other	Total (col. 1 + col. 2)	Reclassifications (See A-6)	Reclassified Trial Balance (col. 3 +- col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT		0	0	520,655	520,655	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		0	0	1,086,242	1,086,242	2.00
3.00	00300	OTHER CAP REL COSTS		0	0	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	272,954	194,162	467,116	1,595,707	2,062,823	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	836,056	6,671,138	7,507,194	-169,332	7,337,862	5.00
7.00	00700	OPERATION OF PLANT	411,012	1,270,023	1,681,035	-718,222	962,813	7.00
7.01	00701	UTILITIES	0	0	0	375,792	375,792	7.01
8.00	00800	LAUNDRY & LINEN SERVICE	0	38,456	38,456	0	38,456	8.00
9.00	00900	HOUSEKEEPING	223,861	208,696	432,557	-95,416	337,141	9.00
10.00	01000	DIETARY	171,739	220,627	392,366	-248,705	143,661	10.00
11.00	01100	CAFETERIA	0	0	0	172,982	172,982	11.00
13.00	01300	NURSING ADMINISTRATION	605,887	833,226	1,439,113	-267,771	1,171,342	13.00
13.01	01301	HOUSE SUPERVISORS	398,793	99,448	498,241	-69,916	428,325	13.01
14.00	01400	CENTRAL SERVICES & SUPPLY	0	27,550	27,550	165,150	192,700	14.00
15.00	01500	PHARMACY	268,267	1,959,218	2,227,485	-1,668,471	559,014	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	8,127	8,127	-3,539	4,588	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	348,314	7,018	355,332	22,305	377,637	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,144,466	1,354,771	2,499,237	-452,410	2,046,827	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
43.00	04300	NURSERY	166,633	17,855	184,488	-153,268	31,220	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	450,837	279,774	730,611	-178,477	552,134	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	37,488	0	37,488	186,599	224,087	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	891,703	1,182,891	2,074,594	-717,251	1,357,343	54.00
60.00	06000	LABORATORY	0	1,820,685	1,820,685	-1,433	1,819,252	60.00
64.00	06400	INTRAVENOUS THERAPY	76,822	45,146	121,968	-25,822	96,146	64.00
65.00	06500	RESPIRATORY THERAPY	316,657	135,224	451,881	-91,414	360,467	65.00
66.00	06600	PHYSICAL THERAPY	519,913	329,397	849,310	-428,294	421,016	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	93,243	93,243	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	59,995	59,995	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	23,319	23,319	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	10,593	10,593	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	1,588,240	1,588,240	73.00
73.01	07301	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.01
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	0	75.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	37,669	27,407	65,076	-1,576	63,500	90.00
90.01	09001	VISITING SPECIALTY CLINIC	186,842	80,502	267,344	-41,295	226,049	90.01
90.02	09002	PAOLI PRIMARY CARE CLINIC	414,447	261,784	676,231	-131,391	544,840	90.02
91.00	09100	EMERGENCY	1,271,186	1,632,889	2,904,075	-428,367	2,475,708	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE		0	0	0	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	9,051,546	18,706,014	27,757,560	8,452	27,766,012	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
190.01	19001	VISITING SPECIALTY CLINIC	0	0	0	0	0	190.01
190.02	19002	OUTREACH	15,677	6,423	22,100	-3,792	18,308	190.02
190.03	19003	FOUNDATION	0	0	0	0	0	190.03
190.04	19004	SPRING VALLEY FAMILY PRACTICE	0	0	0	0	0	190.04
190.05	19005	PAOLI FAMILY PRACTICE	0	4,147	4,147	-800	3,347	190.05
190.06	19006	OTHER PROPERTY	0	3,886	3,886	-3,860	26	190.06
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
200.00		TOTAL (SUM OF LINES 118 through 199)	9,067,223	18,720,470	27,787,693	0	27,787,693	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN:15-1306 | Period: From 01/01/2020 To 12/31/2020 | Worksheet A | Date/Time Prepared: 7/14/2021 11:21 am

		Cost Center Description	Adjustments (See A-8)	Net Expenses For Allocation		
			6.00	7.00		
		GENERAL SERVICE COST CENTERS				
1.00	00100	CAP REL COSTS-BLDG & FIXT	0	520,655		1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	0	1,086,242		2.00
3.00	00300	OTHER CAP REL COSTS	0	0		3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	150,794	2,213,617		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	146,288	7,484,150		5.00
7.00	00700	OPERATION OF PLANT	-22,888	939,925		7.00
7.01	00701	UTILITIES	0	375,792		7.01
8.00	00800	LAUNDRY & LINEN SERVICE	0	38,456		8.00
9.00	00900	HOUSEKEEPING	0	337,141		9.00
10.00	01000	DIETARY	0	143,661		10.00
11.00	01100	CAFETERIA	-46,020	126,962		11.00
13.00	01300	NURSING ADMINISTRATION	-653,793	517,549		13.00
13.01	01301	HOUSE SUPERVISORS	0	428,325		13.01
14.00	01400	CENTRAL SERVICES & SUPPLY	0	192,700		14.00
15.00	01500	PHARMACY	-24,199	534,815		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-2,928	1,660		16.00
17.00	01700	SOCIAL SERVICE	0	0		17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	-89,698	287,939		19.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	-742,314	1,304,513		30.00
31.00	03100	INTENSIVE CARE UNIT	0	0		31.00
43.00	04300	NURSERY	0	31,220		43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	552,134		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	224,087		52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-706	1,356,637		54.00
60.00	06000	LABORATORY	-43,750	1,775,502		60.00
64.00	06400	INTRAVENOUS THERAPY	0	96,146		64.00
65.00	06500	RESPIRATORY THERAPY	0	360,467		65.00
66.00	06600	PHYSICAL THERAPY	236,842	657,858		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	93,243		67.00
68.00	06800	SPEECH PATHOLOGY	0	59,995		68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	23,319		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	10,593		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	1,588,240		73.00
73.01	07301	DRUGS CHARGED TO PATIENTS	0	0		73.01
74.00	07400	RENAL DIALYSIS	0	0		74.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0		75.00
76.97	07697	CARDIAC REHABILITATION	0	0		76.97
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0	0		88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0		89.00
90.00	09000	CLINIC	6,313	69,813		90.00
90.01	09001	VISITING SPECIALTY CLINIC	-28	226,021		90.01
90.02	09002	PAOLI PRIMARY CARE CLINIC	-349,776	195,064		90.02
91.00	09100	EMERGENCY	-54,547	2,421,161		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES	0	0		95.00
101.00	10100	HOME HEALTH AGENCY	0	0		101.00
		SPECIAL PURPOSE COST CENTERS				
113.00	11300	INTEREST EXPENSE	0	0		113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-1,490,410	26,275,602		118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		190.00
190.01	19001	VISITING SPECIALTY CLINIC	0	0		190.01
190.02	19002	OUTREACH	0	18,308		190.02
190.03	19003	FOUNDATION	0	0		190.03
190.04	19004	SPRING VALLEY FAMILY PRACTICE	0	0		190.04
190.05	19005	PAOLI FAMILY PRACTICE	0	3,347		190.05
190.06	19006	OTHER PROPERTY	0	26		190.06
191.00	19100	RESEARCH	0	0		191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0		192.00
193.00	19300	NONPAID WORKERS	0	0		193.00
200.00		TOTAL (SUM OF LINES 118 through 199)	-1,490,410	26,297,283		200.00

RECLASSIFICATIONS | Provider CCN:15-1306 | Period: From 01/01/2020 To 12/31/2020 | Worksheet A-6 | Date/Time Prepared: 7/14/2021 11:21 am

		Increases				
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
	A - EMPLOYEE BENEFITS					
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	1,596,510		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
	0		0	1,596,510		
	B - BILLABLE DRUGS					
1.00	DRUGS CHARGED TO PATIENTS	73.00		1,588,240		1.00
2.00	OPERATING ROOM	50.00		727		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
	0		0	1,588,967		
	C - BILLABLE SUPPLIES					
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	23,319		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
	0		0	23,319		
	D - IMPLANT SUPPLIES					
1.00	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	10,593		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
	0		0	10,593		
	E - NON-BILLABLE DRUGS					
1.00	PHARMACY	15.00	0	31,629		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
	0		0	31,629		
	F - NON-BILLABLE MED SUPPLIES					
1.00	CENTRAL SERVICES & SUPPLY	14.00		167,562		1.00
2.00	OPERATION OF PLANT	7.00		1,489		2.00
3.00	NURSING ADMINISTRATION	13.00		2,297		3.00
4.00	NONPHYSICIAN ANESTHETISTS	19.00		53,222		4.00
5.00	OPERATING ROOM	50.00		133,230		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

RECLASSIFICATIONS | Provider CCN:15-1306 | Period: From 01/01/2020 To 12/31/2020 | Worksheet A-6 | Date/Time Prepared: 7/14/2021 11:21 am

	Increases					
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
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
	0		0	357,800		
	G - CAPITAL RELATED COSTS					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	350,373		1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	1,086,242		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
	0		0	1,436,615		
	H - LEASE EXPENSE					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	170,282		1.00
	0		0	170,282		
	I - COO/CNO					
1.00	ADMINISTRATIVE & GENERAL	5.00	187,044	0		1.00
	0		187,044	0		
	J - UTILITIES					
1.00	UTILITIES	7.01	0	375,792		1.00
2.00		0.00	0	0		2.00
	0		0	375,792		
	L - OBSTETRICS					
1.00	NURSERY	43.00	0	3,331		1.00
2.00	DELIVERY ROOM & LABOR ROOM	52.00	145,260	41,339		2.00
	0		145,260	44,670		
	M - CAFETERIA					
1.00	CAFETERIA	11.00	93,821	79,161		1.00
	0		93,821	79,161		
	N - OT AND ST					
1.00	OCCUPATIONAL THERAPY	67.00	84,571	8,672		1.00
2.00	SPEECH PATHOLOGY	68.00	54,415	5,580		2.00
	0		138,986	14,252		
	P - MALPRACTICE INSURANCE					
1.00	ADMINISTRATIVE & GENERAL	5.00	0	3,562		1.00
	TOTALS		0	3,562		
500.00	Grand Total: Increases		565,111	5,733,152		500.00

RECLASSIFICATIONS | Provider CCN:15-1306 | Period: From 01/01/2020 To 12/31/2020 | Worksheet A-6 | Date/Time Prepared: 7/14/2021 11:21 am

		Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	A - EMPLOYEE BENEFITS						
1.00	ADMINISTRATIVE & GENERAL	5.00		83,029	0		1.00
2.00	OPERATION OF PLANT	7.00		85,863	0		2.00
3.00	HOUSEKEEPING	9.00		84,550	0		3.00
4.00	DIETARY	10.00		65,820	0		4.00
5.00	NURSING ADMINISTRATION	13.00		77,920	0		5.00
6.00	HOUSE SUPERVISORS	13.01		69,916	0		6.00
7.00	PHARMACY	15.00		61,564	0		7.00
8.00	NONPHYSICIAN ANESTHETISTS	19.00		27,555	0		8.00
9.00	ADULTS & PEDIATRICS	30.00		278,107	0		9.00
10.00	OPERATING ROOM	50.00		106,420	0		10.00
11.00	RADIOLOGY-DIAGNOSTIC	54.00		137,635	0		11.00
12.00	INTRAVENOUS THERAPY	64.00		15,726	0		12.00
13.00	RESPIRATORY THERAPY	65.00		45,153	0		13.00
14.00	PHYSICAL THERAPY	66.00		104,096	0		14.00
15.00	CLINIC	90.00		1,576	0		15.00
16.00	VISITING SPECIALTY CLINIC	90.01		31,910	0		16.00
17.00	PAOLI PRIMARY CARE CLINIC	90.02		59,757	0		17.00
18.00	EMERGENCY	91.00		256,211	0		18.00
19.00	OUTREACH	190.02		3,702	0		19.00
	0		0	1,596,510			
	B - BILLABLE DRUGS						
1.00	DIETARY	10.00		32	0		1.00
2.00	PHARMACY	15.00		1,549,540	0		2.00
3.00	NURSERY	43.00		6	0		3.00
4.00	RADIOLOGY-DIAGNOSTIC	54.00		24,191	0		4.00
5.00	VISITING SPECIALTY CLINIC	90.01		2,203	0		5.00
6.00	PAOLI PRIMARY CARE CLINIC	90.02		12,995	0		6.00
	0		0	1,588,967			
	C - BILLABLE SUPPLIES						
1.00	NURSING ADMINISTRATION	13.00		7	0		1.00
2.00	CENTRAL SERVICES & SUPPLY	14.00		310	0		2.00
3.00	NONPHYSICIAN ANESTHETISTS	19.00		13	0		3.00
4.00	ADULTS & PEDIATRICS	30.00		1,194	0		4.00
5.00	OPERATING ROOM	50.00		15,828	0		5.00
6.00	RADIOLOGY-DIAGNOSTIC	54.00		6	0		6.00
7.00	INTRAVENOUS THERAPY	64.00		51	0		7.00
8.00	RESPIRATORY THERAPY	65.00		247	0		8.00
9.00	PHYSICAL THERAPY	66.00		364	0		9.00
10.00	VISITING SPECIALTY CLINIC	90.01		538	0		10.00
11.00	PAOLI PRIMARY CARE CLINIC	90.02		1,812	0		11.00
12.00	EMERGENCY	91.00		2,949	0		12.00
	0		0	23,319			
	D - IMPLANT SUPPLIES						
1.00	NURSERY	43.00		8	0		1.00
2.00	OPERATING ROOM	50.00		9,904	0		2.00
3.00	VISITING SPECIALTY CLINIC	90.01		38	0		3.00
4.00	PAOLI PRIMARY CARE CLINIC	90.02		53	0		4.00
5.00	EMERGENCY	91.00		590	0		5.00
	0		0	10,593			
	E - NON-BILLABLE DRUGS						
1.00	OPERATION OF PLANT	7.00		3	0		1.00
2.00	CENTRAL SERVICES & SUPPLY	14.00		172	0		2.00
3.00	NONPHYSICIAN ANESTHETISTS	19.00		351	0		3.00
4.00	ADULTS & PEDIATRICS	30.00		4,335	0		4.00
5.00	NURSERY	43.00		136	0		5.00
6.00	OPERATING ROOM	50.00		2,488	0		6.00
7.00	RADIOLOGY-DIAGNOSTIC	54.00		11,930	0		7.00
8.00	INTRAVENOUS THERAPY	64.00		1,337	0		8.00
9.00	RESPIRATORY THERAPY	65.00		206	0		9.00
10.00	PHYSICAL THERAPY	66.00		13	0		10.00
11.00	PAOLI PRIMARY CARE CLINIC	90.02		7	0		11.00
12.00	EMERGENCY	91.00		10,651	0		12.00
	0		0	31,629			
	F - NON-BILLABLE MED SUPPLIES						
1.00	ADMINISTRATIVE & GENERAL	5.00		5,755	0		1.00
2.00	HOUSEKEEPING	9.00		10,706	0		2.00
3.00	DIETARY	10.00		433	0		3.00
4.00	PHARMACY	15.00		27,320	0		4.00
5.00	MEDICAL RECORDS & LIBRARY	16.00		10	0		5.00
6.00	ADULTS & PEDIATRICS	30.00		58,964	0		6.00
7.00	NURSERY	43.00		13,488	0		7.00
8.00	RADIOLOGY-DIAGNOSTIC	54.00		33,300	0		8.00
9.00	INTRAVENOUS THERAPY	64.00		8,708	0		9.00

RECLASSIFICATIONS | Provider CCN:15-1306 | Period: From 01/01/2020 To 12/31/2020 | Worksheet A-6 | Date/Time Prepared: 7/14/2021 11:21 am

		Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
10.00	RESPIRATORY THERAPY	65.00		40,539	0		10.00
11.00	PHYSICAL THERAPY	66.00		15,335	0		11.00
12.00	VISITING SPECIALTY CLINIC	90.01		4,474	0		12.00
13.00	PAOLI PRIMARY CARE CLINIC	90.02		19,207	0		13.00
14.00	EMERGENCY	91.00		119,471	0		14.00
15.00	OUTREACH	190.02		90	0		15.00
	0		0	357,800			
	G - CAPITAL RELATED COSTS						
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	803	9		1.00
2.00	ADMINISTRATIVE & GENERAL	5.00	0	100,872	9		2.00
3.00	OPERATION OF PLANT	7.00	0	272,753	0		3.00
4.00	HOUSEKEEPING	9.00	0	160	0		4.00
5.00	DIETARY	10.00	0	9,438	0		5.00
6.00	NURSING ADMINISTRATION	13.00	0	5,097	0		6.00
7.00	CENTRAL SERVICES & SUPPLY	14.00	0	1,930	0		7.00
8.00	PHARMACY	15.00	0	61,676	0		8.00
9.00	MEDICAL RECORDS & LIBRARY	16.00	0	3,529	0		9.00
10.00	NONPHYSICIAN ANESTHETISTS	19.00	0	2,998	0		10.00
11.00	ADULTS & PEDIATRICS	30.00	0	61,053	0		11.00
12.00	NURSERY	43.00	0	1,788	0		12.00
13.00	OPERATING ROOM	50.00	0	177,794	0		13.00
14.00	RADIOLOGY-DIAGNOSTIC	54.00	0	510,189	0		14.00
15.00	LABORATORY	60.00	0	1,433	0		15.00
16.00	RESPIRATORY THERAPY	65.00	0	5,269	0		16.00
17.00	PHYSICAL THERAPY	66.00	0	155,248	0		17.00
18.00	VISITING SPECIALTY CLINIC	90.01	0	2,132	0		18.00
19.00	PAOLI PRIMARY CARE CLINIC	90.02	0	19,298	0		19.00
20.00	EMERGENCY	91.00	0	38,495	0		20.00
21.00	PAOLI FAMILY PRACTICE	190.05	0	800	0		21.00
22.00	OTHER PROPERTY	190.06	0	3,860	0		22.00
	0		0	1,436,615			
	H - LEASE EXPENSE						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	170,282	10		1.00
	0		0	170,282			
	I - COO/CNO						
1.00	NURSING ADMINISTRATION	13.00	187,044	0	0		1.00
	0		187,044	0			
	J - UTILITIES						
1.00	OPERATION OF PLANT	7.00		361,092	0		1.00
2.00	PAOLI PRIMARY CARE CLINIC	90.02		14,700	0		2.00
	0		0	375,792			
	L - OBSTETRICS						
1.00	ADULTS & PEDIATRICS	30.00	4,087	44,670	0		1.00
2.00	NURSERY	43.00	141,173	0	0		2.00
	0		145,260	44,670			
	M - CAFETERIA						
1.00	DIETARY	10.00	93,821	79,161	0		1.00
	0		93,821	79,161			
	N - OT AND ST						
1.00	PHYSICAL THERAPY	66.00	138,986	14,252	0		1.00
2.00		0.00	0	0	0		2.00
	0		138,986	14,252			
	P - MALPRACTICE INSURANCE						
1.00	PAOLI PRIMARY CARE CLINIC	90.02	0	3,562	0		1.00
	TOTALS		0	3,562			
500.00	Grand Total: Decreases		565,111	5,733,152			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN:15-1306 | Period: From 01/01/2020 To 12/31/2020 | Worksheet A-7 Part I Date/Time Prepared: 7/14/2021 11:21 am

		Beginning Balances	Acquisitions: Purchases	Acquisitions: Donation	Acquisitions: Total	Disposals and Retirements	
		1.00	2.00	3.00	4.00	5.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	148,000	35,505	0	35,505	0	1.00
2.00	Land Improvements	438,464	0	0	0	0	2.00
3.00	Buildings and Fixtures	4,741,722	0	0	0	0	3.00
4.00	Building Improvements	1,939,739	0	0	0	0	4.00
5.00	Fixed Equipment	0	0	0	0	0	5.00
6.00	Movable Equipment	11,334,654	288,480	0	288,480	471,780	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	18,602,579	323,985	0	323,985	471,780	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	18,602,579	323,985	0	323,985	471,780	10.00

		Ending Balance	Fully Depreciated Assets	
		6.00	7.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES			
1.00	Land	183,505	0	1.00
2.00	Land Improvements	438,464	0	2.00
3.00	Buildings and Fixtures	4,741,722	0	3.00
4.00	Building Improvements	1,939,739	0	4.00
5.00	Fixed Equipment	0	0	5.00
6.00	Movable Equipment	11,151,354	0	6.00
7.00	HIT designated Assets	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	18,454,784	0	8.00
9.00	Reconciling Items	0	0	9.00
10.00	Total (line 8 minus line 9)	18,454,784	0	10.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN:15-1306 | Period: From 01/01/2020 To 12/31/2020 | Worksheet A-7 Part II | Date/Time Prepared: 7/14/2021 11:21 am

	Cost Center Description	SUMMARY OF CAPITAL Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	CAP REL COSTS-BLDG & FIXT	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:15-1306 | Period: From 01/01/2020 To 12/31/2020 | Worksheet A-7 Part III Date/Time Prepared: 7/14/2021 11:21 am

	Cost Center Description	COMPUTATION OF RATIOS: Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	ALLOCATION OF OTHER CAPITAL: 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	7,303,430	0	7,303,430	0.395747	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	11,151,354	0	11,151,354	0.604253	0	2.00
3.00	Total (sum of lines 1-2)	18,454,784	0	18,454,784	1.000000	0	3.00

	Cost Center Description	ALLOCATION OF OTHER CAPITAL: Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	SUMMARY OF CAPITAL: 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	503,136	17,519	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	1,086,242	0	2.00
3.00	Total (sum of lines 1-2)	0	0	0	1,589,378	17,519	3.00

	Cost Center Description	SUMMARY OF CAPITAL: Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	0	520,655	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	0	1,086,242	2.00
3.00	Total (sum of lines 1-2)	0	0	0	0	1,606,897	3.00

ADJUSTMENTS TO EXPENSES | Provider CCN:15-1306 | Period: From 01/01/2020 To 12/31/2020 | Worksheet A-8 | Date/Time Prepared: 7/14/2021 11:21 am

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
1.00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)	B	-152,763	CAP REL COSTS-BLDG & FIXT	1.00	10	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	-3,009,050			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	4,307,713			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests	B	-46,020	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	NONPHYSICIAN ANESTHETISTS	19.00		28.00
29.00	Physicians' assistant		0		0.00	0	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	OCCUPATIONAL THERAPY	67.00		30.00
30.99	Hospice (non-distinct) (see instructions)		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	A	0	CAP REL COSTS-MVBLE EQUIP	2.00	9	32.00
33.00	MISCELLANEOUS INCOME	B	-401	ADMINISTRATIVE & GENERAL	5.00	0	33.00

ADJUSTMENTS TO EXPENSES | Provider CCN:15-1306 | Period: From 01/01/2020 To 12/31/2020 | Worksheet A-8 | Date/Time Prepared: 7/14/2021 11:21 am

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
33.01	MISCELLANEOUS INCOME	B	-140	NURSING ADMINISTRATION	13.00	0	33.01
33.02	MISCELLANEOUS INCOME	B	-2,928	MEDICAL RECORDS & LIBRARY	16.00	0	33.02
33.03	MISCELLANEOUS INCOME	B	-5,850	PHYSICAL THERAPY	66.00	0	33.03
33.04	MISCELLANEOUS INCOME	B	-28	VISITING SPECIALTY CLINIC	90.01	0	33.04
33.05	HAF	A	-647,598	ADMINISTRATIVE & GENERAL	5.00	0	33.05
33.06	RECRUITING EXPENSE	A	-47,410	ADMINISTRATIVE & GENERAL	5.00	0	33.06
33.07	BENEFITS	A	-1,599,720	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.07
33.08	CRNA	A	-89,698	NONPHYSICIAN ANESTHETISTS	19.00	0	33.08
33.09	MARKETING	A	-3,109	PAOLI PRIMARY CARE CLINIC	90.02	0	33.09
33.10	CLINIC START UP	A	-207,150	PAOLI PRIMARY CARE CLINIC	90.02	0	33.10
33.11	CLINIC START UP AMORTIZIATION	A	13,810	PAOLI PRIMARY CARE CLINIC	90.02	0	33.11
33.12	PENALTY	A	-68	ADMINISTRATIVE & GENERAL	5.00	0	33.12
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-1,490,410				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:15-1306 | Period: From 01/01/2020 To 12/31/2020 | Worksheet A-8-1 | Date/Time Prepared: 7/14/2021 11:21 am

	Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in Wks. A, column 5	
	1.00	2.00	3.00	4.00	5.00	
	A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:					
1.00	1.00	CAP REL COSTS-BLDG & FIXT	HOME OFFICE ALLOCATION	152,763	0	1.00
2.00	4.00	EMPLOYEE BENEFITS DEPARTMENT	HOME OFFICE ALLOCATION	1,794,391	0	2.00
3.00	5.00	ADMINISTRATIVE & GENERAL	HOME OFFICE ALLOCATION	4,799,794	4,271,492	3.00
3.01	5.00	ADMINISTRATIVE & GENERAL	HOME OFFICE ALLOCATION	224,934	0	3.01
3.02	4.00	EMPLOYEE BENEFITS DEPARTMENT	RELATED PARTY	83,402	127,279	3.02
3.03	5.00	ADMINISTRATIVE & GENERAL	RELATED PARTY	1,083,882	878,620	3.03
3.04	7.00	OPERATION OF PLANT	RELATED PARTY	0	22,888	3.04
3.05	13.00	NURSING ADMINISTRATION	RELATED PARTY	48,425	702,078	3.05
3.06	15.00	PHARMACY	RELATED PARTY	185,549	209,748	3.06
3.07	66.00	PHYSICAL THERAPY	RELATED PARTY	242,692	0	3.07
3.08	90.00	CLINIC	RELATED PARTY	29,242	22,929	3.08
3.09	91.00	EMERGENCY	SIP ER ALLOCATION	2,960,590	1,062,917	3.09
3.10	4.00	EMPLOYEE BENEFITS DEPARTMENT	SHARED EMPLOYEES	2,075	2,075	3.10
3.11	5.00	ADMINISTRATIVE & GENERAL	SHARED EMPLOYEES	26,088	26,088	3.11
3.12	10.00	DIETARY	SHARED EMPLOYEES	8,481	8,481	3.12
3.13	30.00	ADULTS & PEDIATRICS	SHARED EMPLOYEES	39,270	39,270	3.13
3.14	54.00	RADIOLOGY-DIAGNOSTIC	SHARED EMPLOYEES	706	706	3.14
3.15	60.00	LABORATORY	SHARED EMPLOYEES	1,710,227	1,710,227	3.15
4.00	65.00	RESPIRATORY THERAPY	SHARED EMPLOYEES	9,000	9,000	4.00
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.			13,401,511	9,093,798	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 h not been posted to Worksheet A, columns 1 and/or 2, the amount allowable should be indicated in column 4 of this part.

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

The Secretary, by virtue of the authority granted under section 1814(b)(1) of the Social Security Act, requires that you furnish t 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 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 request information, the cost report is considered incomplete and not acceptable for purposes of claiming reimbursement under tit XVIII.

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

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

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS | Provider CCN:15-1306 | Period: From 01/01/2020 To 12/31/2020 | Worksheet A-8-1 | Date/Time Prepared: 7/14/2021 11:21 am

	Net Adjustments (col. 4 minus col. 5)*	Wkst. A-7 Ref.		
	6.00	7.00		
	A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:			
1.00	152,763	9		1.00
2.00	1,794,391	9		2.00
3.00	528,302	0		3.00
3.01	224,934	0		3.01
3.02	-43,877	9		3.02
3.03	205,262	0		3.03
3.04	-22,888	0		3.04
3.05	-653,653	0		3.05
3.06	-24,199	0		3.06
3.07	242,692	0		3.07
3.08	6,313	0		3.08
3.09	1,897,673	0		3.09
3.10	0	0		3.10
3.11	0	0		3.11
3.12	0	0		3.12
3.13	0	0		3.13
3.14	0	0		3.14
3.15	0	0		3.15
4.00	0	0		4.00
5.00	4,307,713			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 h 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 t 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 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 request information, the cost report is considered incomplete and not acceptable for purposes of claiming reimbursement under tit XVIII.

6.00	HOSPITAL		6.00
7.00	HOME OFFICE		7.00
8.00	PHYSICIAN GROUP		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:15-1306 | Period: From 01/01/2020 To 12/31/2020 | Worksheet A-8-2 | Date/Time Prepared: 7/14/2021 11:21 am

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	5.00	ADMINISTRATIVE & GENERAL	116,733	116,733	0	0	0	1.00
2.00	30.00	ADULTS & PEDIATRICS	742,314	742,314	0	0	0	2.00
3.00	54.00	RADIOLOGY-DIAGNOSTIC	706	706	0	0	0	3.00
4.00	60.00	LABORATORY	43,750	43,750	0	0	0	4.00
5.00	90.02	PAOLI PRIMARY CARE CLINIC	153,327	153,327	0	0	0	5.00
6.00	91.00	EMERGENCY	2,742,679	1,952,220	790,459	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			3,799,509	3,009,050	790,459		0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	5.00	ADMINISTRATIVE & GENERAL	0	0	0	0	0	1.00
2.00	30.00	ADULTS & PEDIATRICS	0	0	0	0	0	2.00
3.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	3.00
4.00	60.00	LABORATORY	0	0	0	0	0	4.00
5.00	90.02	PAOLI PRIMARY CARE CLINIC	0	0	0	0	0	5.00
6.00	91.00	EMERGENCY	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			0	0	0	0	0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment		
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00	5.00	ADMINISTRATIVE & GENERAL	0	0	0	116,733		1.00
2.00	30.00	ADULTS & PEDIATRICS	0	0	0	742,314		2.00
3.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	706		3.00
4.00	60.00	LABORATORY	0	0	0	43,750		4.00
5.00	90.02	PAOLI PRIMARY CARE CLINIC	0	0	0	153,327		5.00
6.00	91.00	EMERGENCY	0	0	0	1,952,220		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	0	0	3,009,050		200.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN:15-1306 | Period: From 01/01/2020 To 12/31/2020 | Worksheet B Part I Date/Time Prepared: 7/14/2021 11:21 am

		Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS BLDG & FIXT	CAPITAL RELATED COSTS MVBLE EQUIP	EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
			0	1.00	2.00	4.00	4A	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	520,655	520,655				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	1,086,242		1,086,242			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	2,213,617	8,588	18,965	2,241,170		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	7,484,150	32,106	70,901	260,731	7,847,888	5.00
7.00	00700	OPERATION OF PLANT	939,925	38,913	85,934	104,744	1,169,516	7.00
7.01	00701	UTILITIES	375,792	0	0	0	375,792	7.01
8.00	00800	LAUNDRY & LINEN SERVICE	38,456	2,632	5,812	0	46,900	8.00
9.00	00900	HOUSEKEEPING	337,141	8,272	18,268	57,050	420,731	9.00
10.00	01000	DIETARY	143,661	15,860	35,024	19,857	214,402	10.00
11.00	01100	CAFETERIA	126,962	8,816	19,469	23,910	179,157	11.00
13.00	01300	NURSING ADMINISTRATION	517,549	13,571	29,968	106,740	667,828	13.00
13.01	01301	HOUSE SUPERVISORS	428,325	0	0	101,630	529,955	13.01
14.00	01400	CENTRAL SERVICES & SUPPLY	192,700	18,351	40,526	0	251,577	14.00
15.00	01500	PHARMACY	534,815	10,255	22,646	68,366	636,082	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,660	6,605	14,587	0	22,852	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	287,939	0	0	88,766	376,705	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,304,513	64,696	142,868	290,619	1,802,696	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
43.00	04300	NURSERY	31,220	2,193	4,843	6,488	44,744	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	552,134	52,870	116,755	114,893	836,652	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	224,087	5,237	11,565	46,572	287,461	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,356,637	51,186	113,035	227,245	1,748,103	54.00
60.00	06000	LABORATORY	1,775,502	15,421	34,056	0	1,824,979	60.00
64.00	06400	INTRAVENOUS THERAPY	96,146	3,947	8,717	19,578	128,388	64.00
65.00	06500	RESPIRATORY THERAPY	360,467	2,895	6,393	80,698	450,453	65.00
66.00	06600	PHYSICAL THERAPY	657,858	35,948	79,386	97,077	870,269	66.00
67.00	06700	OCCUPATIONAL THERAPY	93,243	7,983	17,628	21,552	140,406	67.00
68.00	06800	SPEECH PATHOLOGY	59,995	5,132	11,333	13,867	90,327	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	23,319	0	0	0	23,319	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	10,593	0	0	0	10,593	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,588,240	0	0	0	1,588,240	73.00
73.01	07301	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.01
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	0	75.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	69,813	333	736	9,600	80,482	90.00
90.01	09001	VISITING SPECIALTY CLINIC	226,021	30,527	67,414	47,616	371,578	90.01
90.02	09002	PAOLI PRIMARY CARE CLINIC	195,064	13,658	30,162	105,619	344,503	90.02
91.00	09100	EMERGENCY	2,421,161	35,887	79,251	323,957	2,860,256	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	26,275,602	491,882	1,086,242	2,237,175	26,242,834	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
190.01	19001	VISITING SPECIALTY CLINIC	0	0	0	0	0	190.01
190.02	19002	OUTREACH	18,308	3,930	0	3,995	26,233	190.02
190.03	19003	FOUNDATION	0	0	0	0	0	190.03
190.04	19004	SPRING VALLEY FAMILY PRACTICE	0	0	0	0	0	190.04
190.05	19005	PAOLI FAMILY PRACTICE	3,347	0	0	0	3,347	190.05
190.06	19006	OTHER PROPERTY	26	24,843	0	0	24,869	190.06
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
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)	26,297,283	520,655	1,086,242	2,241,170	26,297,283	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN:15-1306 | Period: From 01/01/2020 To 12/31/2020 | Worksheet B Part I Date/Time Prepared: 7/14/2021 11:21 am

		Cost Center Description	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	UTILITIES	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
			5.00	7.00	7.01	8.00	9.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	7,847,888					5.00
7.00	00700	OPERATION OF PLANT	497,482	1,666,998				7.00
7.01	00701	UTILITIES	159,852	0	535,644			7.01
8.00	00800	LAUNDRY & LINEN SERVICE	19,950	12,219	3,225	82,294		8.00
9.00	00900	HOUSEKEEPING	178,968	38,407	10,137	0	648,243	9.00
10.00	01000	DIETARY	91,201	73,638	19,435	0	27,293	10.00
11.00	01100	CAFETERIA	76,209	40,933	10,803	0	15,171	11.00
13.00	01300	NURSING ADMINISTRATION	284,077	35,516	16,629	0	23,353	13.00
13.01	01301	HOUSE SUPERVISORS	225,429	0	0	0	0	13.01
14.00	01400	CENTRAL SERVICES & SUPPLY	107,014	85,205	22,488	0	0	14.00
15.00	01500	PHARMACY	270,573	47,612	12,566	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	9,721	30,669	8,094	0	11,367	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	160,241	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	766,820	300,377	79,280	21,953	111,332	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
43.00	04300	NURSERY	19,033	10,182	2,687	0	3,774	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	355,890	245,474	64,787	5,959	90,982	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	122,278	24,315	6,417	1,302	9,012	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	743,598	237,654	62,723	14,618	88,084	54.00
60.00	06000	LABORATORY	776,299	71,602	18,897	0	26,538	60.00
64.00	06400	INTRAVENOUS THERAPY	54,613	18,328	4,837	0	6,793	64.00
65.00	06500	RESPIRATORY THERAPY	191,611	13,441	3,547	0	4,982	65.00
66.00	06600	PHYSICAL THERAPY	370,190	5,946	44,051	2,523	61,863	66.00
67.00	06700	OCCUPATIONAL THERAPY	59,725	1,303	9,782	559	13,737	67.00
68.00	06800	SPEECH PATHOLOGY	38,423	855	6,288	360	8,831	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	9,919	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	4,506	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	675,596	0	0	0	0	73.00
73.01	07301	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.01
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	0	75.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	34,235	1,548	408	0	574	90.00
90.01	09001	VISITING SPECIALTY CLINIC	158,060	141,737	37,408	1,037	52,533	90.01
90.02	09002	PAOLI PRIMARY CARE CLINIC	146,543	63,415	16,737	0	23,504	90.02
91.00	09100	EMERGENCY	1,216,670	166,622	43,976	33,983	61,757	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	7,824,726	1,666,998	505,202	82,294	641,480	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
190.01	19001	VISITING SPECIALTY CLINIC	0	0	0	0	0	190.01
190.02	19002	OUTREACH	11,159	0	0	0	6,763	190.02
190.03	19003	FOUNDATION	0	0	0	0	0	190.03
190.04	19004	SPRING VALLEY FAMILY PRACTICE	0	0	0	0	0	190.04
190.05	19005	PAOLI FAMILY PRACTICE	1,424	0	0	0	0	190.05
190.06	19006	OTHER PROPERTY	10,579	0	30,442	0	0	190.06
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
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)	7,847,888	1,666,998	535,644	82,294	648,243	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN:15-1306 | Period: From 01/01/2020 To 12/31/2020 | Worksheet B Part I | Date/Time Prepared: 7/14/2021 11:21 am

		Cost Center Description	DIETARY	CAFETERIA	NURSING ADMINISTRATION	HOUSE SUPERVISORS	CENTRAL SERVICES & SUPPLY	
			10.00	11.00	13.00	13.01	14.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
7.01	00701	UTILITIES						7.01
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY	425,969					10.00
11.00	01100	CAFETERIA	0	322,273				11.00
13.00	01300	NURSING ADMINISTRATION	0	14,949	1,042,352			13.00
13.01	01301	HOUSE SUPERVISORS	0	14,017	0	769,401		13.01
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	466,284	14.00
15.00	01500	PHARMACY	0	12,673	0	0	35,421	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	13	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	5,946	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	425,969	52,386	414,625	306,050	73,643	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
43.00	04300	NURSERY	0	985	8,157	6,021	17,152	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	17,075	116,777	86,198	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	7,068	58,578	43,239	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	37,814	17,760	13,109	42,020	54.00
60.00	06000	LABORATORY	0	37,535	0	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0	2,717	22,537	16,636	10,812	64.00
65.00	06500	RESPIRATORY THERAPY	0	14,266	0	0	48,766	65.00
66.00	06600	PHYSICAL THERAPY	0	15,759	0	0	13,653	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	3,523	0	0	3,031	67.00
68.00	06800	SPEECH PATHOLOGY	0	2,650	0	0	1,950	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	27,742	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	12,602	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
73.01	07301	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.01
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	0	75.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	0	843	0	0	0	90.00
90.01	09001	VISITING SPECIALTY CLINIC	0	14,114	36,266	26,769	5,813	90.01
90.02	09002	PAOLI PRIMARY CARE CLINIC	0	10,524	27,540	20,329	23,429	90.02
91.00	09100	EMERGENCY	0	56,743	340,112	251,050	150,126	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	425,969	321,587	1,042,352	769,401	466,173	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
190.01	19001	VISITING SPECIALTY CLINIC	0	0	0	0	0	190.01
190.02	19002	OUTREACH	0	686	0	0	111	190.02
190.03	19003	FOUNDATION	0	0	0	0	0	190.03
190.04	19004	SPRING VALLEY FAMILY PRACTICE	0	0	0	0	0	190.04
190.05	19005	PAOLI FAMILY PRACTICE	0	0	0	0	0	190.05
190.06	19006	OTHER PROPERTY	0	0	0	0	0	190.06
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
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)	425,969	322,273	1,042,352	769,401	466,284	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN:15-1306 | Period: From 01/01/2020 To 12/31/2020 | Worksheet B Part I Date/Time Prepared: 7/14/2021 11:21 am

		Cost Center Description	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	NONPHYSICIAN ANESTHETISTS	Subtotal	
			15.00	16.00	17.00	19.00	24.00	
		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
7.01	00701	UTILITIES						7.01
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
13.01	01301	HOUSE SUPERVISORS						13.01
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY	1,014,927					15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	82,716				16.00
17.00	01700	SOCIAL SERVICE	0	0	0			17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	220	0	0	543,112		19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,716	6,598	0	0	4,364,445	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
43.00	04300	NURSERY	85	258	0	0	113,078	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,559	6,363	0	543,112	2,370,828	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	1,074	0	0	560,744	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	7,476	14,433	0	0	3,027,392	54.00
60.00	06000	LABORATORY	0	7,236	0	0	2,763,086	60.00
64.00	06400	INTRAVENOUS THERAPY	838	2,803	0	0	269,302	64.00
65.00	06500	RESPIRATORY THERAPY	129	1,213	0	0	728,408	65.00
66.00	06600	PHYSICAL THERAPY	6	1,878	0	0	1,386,138	66.00
67.00	06700	OCCUPATIONAL THERAPY	1	381	0	0	232,448	67.00
68.00	06800	SPEECH PATHOLOGY	1	234	0	0	149,919	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	217	0	0	61,197	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	75	0	0	27,776	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	995,218	13,025	0	0	3,272,079	73.00
73.01	07301	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.01
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	0	75.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	0	82	0	0	118,172	90.00
90.01	09001	VISITING SPECIALTY CLINIC	0	1,209	0	0	846,524	90.01
90.02	09002	PAOLI PRIMARY CARE CLINIC	4	183	0	0	676,711	90.02
91.00	09100	EMERGENCY	6,674	25,454	0	0	5,213,423	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	1,014,927	82,716	0	543,112	26,181,670	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
190.01	19001	VISITING SPECIALTY CLINIC	0	0	0	0	0	190.01
190.02	19002	OUTREACH	0	0	0	0	44,952	190.02
190.03	19003	FOUNDATION	0	0	0	0	0	190.03
190.04	19004	SPRING VALLEY FAMILY PRACTICE	0	0	0	0	0	190.04
190.05	19005	PAOLI FAMILY PRACTICE	0	0	0	0	4,771	190.05
190.06	19006	OTHER PROPERTY	0	0	0	0	65,890	190.06
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
200.00		Cross Foot Adjustments				0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	1,014,927	82,716	0	543,112	26,297,283	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN:15-1306 | Period: From 01/01/2020 To 12/31/2020 | Worksheet B Part I Date/Time Prepared: 7/14/2021 11:21 am

		Cost Center Description	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			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
7.01	00701	UTILITIES				7.01
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
13.01	01301	HOUSE SUPERVISORS				13.01
14.00	01400	CENTRAL SERVICES & SUPPLY				14.00
15.00	01500	PHARMACY				15.00
16.00	01600	MEDICAL RECORDS & LIBRARY				16.00
17.00	01700	SOCIAL SERVICE				17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS				19.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	0	4,364,445		30.00
31.00	03100	INTENSIVE CARE UNIT	0	0		31.00
43.00	04300	NURSERY	0	113,078		43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	2,370,828		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	560,744		52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	3,027,392		54.00
60.00	06000	LABORATORY	0	2,763,086		60.00
64.00	06400	INTRAVENOUS THERAPY	0	269,302		64.00
65.00	06500	RESPIRATORY THERAPY	0	728,408		65.00
66.00	06600	PHYSICAL THERAPY	0	1,386,138		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	232,448		67.00
68.00	06800	SPEECH PATHOLOGY	0	149,919		68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	61,197		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	27,776		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	3,272,079		73.00
73.01	07301	DRUGS CHARGED TO PATIENTS	0	0		73.01
74.00	07400	RENAL DIALYSIS	0	0		74.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0		75.00
76.97	07697	CARDIAC REHABILITATION	0	0		76.97
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0	0		88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0		89.00
90.00	09000	CLINIC	0	118,172		90.00
90.01	09001	VISITING SPECIALTY CLINIC	0	846,524		90.01
90.02	09002	PAOLI PRIMARY CARE CLINIC	0	676,711		90.02
91.00	09100	EMERGENCY	0	5,213,423		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0			92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES	0	0		95.00
101.00	10100	HOME HEALTH AGENCY	0	0		101.00
		SPECIAL PURPOSE COST CENTERS				
113.00	11300	INTEREST EXPENSE				113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	26,181,670		118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		190.00
190.01	19001	VISITING SPECIALTY CLINIC	0	0		190.01
190.02	19002	OUTREACH	0	44,952		190.02
190.03	19003	FOUNDATION	0	0		190.03
190.04	19004	SPRING VALLEY FAMILY PRACTICE	0	0		190.04
190.05	19005	PAOLI FAMILY PRACTICE	0	4,771		190.05
190.06	19006	OTHER PROPERTY	0	65,890		190.06
191.00	19100	RESEARCH	0	0		191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0		192.00
193.00	19300	NONPAID WORKERS	0	0		193.00
200.00		Cross Foot Adjustments	0	0		200.00
201.00		Negative Cost Centers	0	0		201.00
202.00		TOTAL (sum lines 118 through 201)	0	26,297,283		202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN:15-1306 | Period: From 01/01/2020 To 12/31/2020 | Worksheet B Part II Date/Time Prepared: 7/14/2021 11:21 am

		Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS BLDG & FIXT	CAPITAL RELATED COSTS MVBLE EQUIP	Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
			0	1.00	2.00	2A	4.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	8,588	18,965	27,553	27,553	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	224,934	32,106	70,901	327,941	3,205	5.00
7.00	00700	OPERATION OF PLANT	0	38,913	85,934	124,847	1,288	7.00
7.01	00701	UTILITIES	0	0	0	0	0	7.01
8.00	00800	LAUNDRY & LINEN SERVICE	0	2,632	5,812	8,444	0	8.00
9.00	00900	HOUSEKEEPING	0	8,272	18,268	26,540	701	9.00
10.00	01000	DIETARY	0	15,860	35,024	50,884	244	10.00
11.00	01100	CAFETERIA	0	8,816	19,469	28,285	294	11.00
13.00	01300	NURSING ADMINISTRATION	0	13,571	29,968	43,539	1,312	13.00
13.01	01301	HOUSE SUPERVISORS	0	0	0	0	1,249	13.01
14.00	01400	CENTRAL SERVICES & SUPPLY	0	18,351	40,526	58,877	0	14.00
15.00	01500	PHARMACY	0	10,255	22,646	32,901	840	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	6,605	14,587	21,192	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	1,091	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	64,696	142,868	207,564	3,573	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
43.00	04300	NURSERY	0	2,193	4,843	7,036	80	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	52,870	116,755	169,625	1,412	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	5,237	11,565	16,802	573	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	51,186	113,035	164,221	2,794	54.00
60.00	06000	LABORATORY	0	15,421	34,056	49,477	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0	3,947	8,717	12,664	241	64.00
65.00	06500	RESPIRATORY THERAPY	0	2,895	6,393	9,288	992	65.00
66.00	06600	PHYSICAL THERAPY	0	35,948	79,386	115,334	1,193	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	7,983	17,628	25,611	265	67.00
68.00	06800	SPEECH PATHOLOGY	0	5,132	11,333	16,465	170	68.00
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
73.01	07301	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.01
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	0	75.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	0	333	736	1,069	118	90.00
90.01	09001	VISITING SPECIALTY CLINIC	0	30,527	67,414	97,941	585	90.01
90.02	09002	PAOLI PRIMARY CARE CLINIC	0	13,658	30,162	43,820	1,298	90.02
91.00	09100	EMERGENCY	0	35,887	79,251	115,138	3,986	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				0		92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	224,934	491,882	1,086,242	1,803,058	27,504	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
190.01	19001	VISITING SPECIALTY CLINIC	0	0	0	0	0	190.01
190.02	19002	OUTREACH	0	3,930	0	3,930	49	190.02
190.03	19003	FOUNDATION	0	0	0	0	0	190.03
190.04	19004	SPRING VALLEY FAMILY PRACTICE	0	0	0	0	0	190.04
190.05	19005	PAOLI FAMILY PRACTICE	0	0	0	0	0	190.05
190.06	19006	OTHER PROPERTY	0	24,843	0	24,843	0	190.06
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
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)	224,934	520,655	1,086,242	1,831,831	27,553	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN:15-1306 | Period: From 01/01/2020 To 12/31/2020 | Worksheet B Part II Date/Time Prepared: 7/14/2021 11:21 am

		Cost Center Description	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	UTILITIES	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
			5.00	7.00	7.01	8.00	9.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	331,146					5.00
7.00	00700	OPERATION OF PLANT	20,992	147,127				7.00
7.01	00701	UTILITIES	6,745	0	6,745			7.01
8.00	00800	LAUNDRY & LINEN SERVICE	842	1,078	41	10,405		8.00
9.00	00900	HOUSEKEEPING	7,552	3,390	128	0	38,311	9.00
10.00	01000	DIETARY	3,848	6,499	245	0	1,613	10.00
11.00	01100	CAFETERIA	3,216	3,613	136	0	897	11.00
13.00	01300	NURSING ADMINISTRATION	11,987	3,135	209	0	1,380	13.00
13.01	01301	HOUSE SUPERVISORS	9,512	0	0	0	0	13.01
14.00	01400	CENTRAL SERVICES & SUPPLY	4,516	7,520	283	0	0	14.00
15.00	01500	PHARMACY	11,417	4,202	158	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	410	2,707	102	0	672	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	6,761	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	32,357	26,510	997	2,776	6,579	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
43.00	04300	NURSERY	803	899	34	0	223	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	15,017	21,665	816	753	5,377	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	5,160	2,146	81	165	533	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	31,377	20,975	790	1,848	5,206	54.00
60.00	06000	LABORATORY	32,757	6,319	238	0	1,568	60.00
64.00	06400	INTRAVENOUS THERAPY	2,304	1,618	61	0	401	64.00
65.00	06500	RESPIRATORY THERAPY	8,085	1,186	45	0	294	65.00
66.00	06600	PHYSICAL THERAPY	15,620	525	555	319	3,656	66.00
67.00	06700	OCCUPATIONAL THERAPY	2,520	115	123	71	812	67.00
68.00	06800	SPEECH PATHOLOGY	1,621	75	79	46	522	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	419	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	190	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	28,507	0	0	0	0	73.00
73.01	07301	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.01
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	0	75.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	1,445	137	5	0	34	90.00
90.01	09001	VISITING SPECIALTY CLINIC	6,669	12,510	471	131	3,105	90.01
90.02	09002	PAOLI PRIMARY CARE CLINIC	6,183	5,597	211	0	1,389	90.02
91.00	09100	EMERGENCY	51,337	14,706	554	4,296	3,650	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	330,169	147,127	6,362	10,405	37,911	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
190.01	19001	VISITING SPECIALTY CLINIC	0	0	0	0	0	190.01
190.02	19002	OUTREACH	471	0	0	0	400	190.02
190.03	19003	FOUNDATION	0	0	0	0	0	190.03
190.04	19004	SPRING VALLEY FAMILY PRACTICE	0	0	0	0	0	190.04
190.05	19005	PAOLI FAMILY PRACTICE	60	0	0	0	0	190.05
190.06	19006	OTHER PROPERTY	446	0	383	0	0	190.06
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
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)	331,146	147,127	6,745	10,405	38,311	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN:15-1306 | Period: From 01/01/2020 To 12/31/2020 | Worksheet B Part II Date/Time Prepared: 7/14/2021 11:21 am

		Cost Center Description	DIETARY	CAFETERIA	NURSING ADMINISTRATION	HOUSE SUPERVISORS	CENTRAL SERVICES & SUPPLY	
			10.00	11.00	13.00	13.01	14.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
7.01	00701	UTILITIES						7.01
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY	63,333					10.00
11.00	01100	CAFETERIA	0	36,441				11.00
13.00	01300	NURSING ADMINISTRATION	0	1,690	63,252			13.00
13.01	01301	HOUSE SUPERVISORS	0	1,585	0	12,346		13.01
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	71,196	14.00
15.00	01500	PHARMACY	0	1,433	0	0	5,408	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	2	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	672	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	63,333	5,924	25,159	4,911	11,244	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
43.00	04300	NURSERY	0	111	495	97	2,619	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	1,931	7,086	1,383	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	799	3,555	694	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	4,276	1,078	210	6,416	54.00
60.00	06000	LABORATORY	0	4,244	0	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0	307	1,368	267	1,651	64.00
65.00	06500	RESPIRATORY THERAPY	0	1,613	0	0	7,446	65.00
66.00	06600	PHYSICAL THERAPY	0	1,782	0	0	2,085	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	398	0	0	463	67.00
68.00	06800	SPEECH PATHOLOGY	0	300	0	0	298	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	4,236	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	1,924	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
73.01	07301	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.01
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	0	75.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	0	95	0	0	0	90.00
90.01	09001	VISITING SPECIALTY CLINIC	0	1,596	2,201	430	888	90.01
90.02	09002	PAOLI PRIMARY CARE CLINIC	0	1,190	1,671	326	3,577	90.02
91.00	09100	EMERGENCY	0	6,417	20,639	4,028	22,922	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	63,333	36,363	63,252	12,346	71,179	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
190.01	19001	VISITING SPECIALTY CLINIC	0	0	0	0	0	190.01
190.02	19002	OUTREACH	0	78	0	0	17	190.02
190.03	19003	FOUNDATION	0	0	0	0	0	190.03
190.04	19004	SPRING VALLEY FAMILY PRACTICE	0	0	0	0	0	190.04
190.05	19005	PAOLI FAMILY PRACTICE	0	0	0	0	0	190.05
190.06	19006	OTHER PROPERTY	0	0	0	0	0	190.06
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
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)	63,333	36,441	63,252	12,346	71,196	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN:15-1306 | Period: From 01/01/2020 To 12/31/2020 | Worksheet B Part II Date/Time Prepared: 7/14/2021 11:21 am

		Cost Center Description	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	NONPHYSICIAN ANESTHETISTS	Subtotal	
			15.00	16.00	17.00	19.00	24.00	
		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
7.01	00701	UTILITIES						7.01
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
13.01	01301	HOUSE SUPERVISORS						13.01
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY	56,359					15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	25,085				16.00
17.00	01700	SOCIAL SERVICE	0	0	0			17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	12	0	0	8,536		19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	151	2,001	0		393,079	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0		0	31.00
43.00	04300	NURSERY	5	78	0		12,480	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	87	1,930	0		227,082	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	326	0		30,834	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	415	4,377	0		243,983	54.00
60.00	06000	LABORATORY	0	2,194	0		96,797	60.00
64.00	06400	INTRAVENOUS THERAPY	47	850	0		21,779	64.00
65.00	06500	RESPIRATORY THERAPY	7	368	0		29,324	65.00
66.00	06600	PHYSICAL THERAPY	0	570	0		141,639	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	116	0		30,494	67.00
68.00	06800	SPEECH PATHOLOGY	0	71	0		19,647	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	66	0		4,721	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	23	0		2,137	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	55,264	3,950	0		87,721	73.00
73.01	07301	DRUGS CHARGED TO PATIENTS	0	0	0		0	73.01
74.00	07400	RENAL DIALYSIS	0	0	0		0	74.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0		0	75.00
76.97	07697	CARDIAC REHABILITATION	0	0	0		0	76.97
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0		0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0		0	89.00
90.00	09000	CLINIC	0	25	0		2,928	90.00
90.01	09001	VISITING SPECIALTY CLINIC	0	367	0		126,894	90.01
90.02	09002	PAOLI PRIMARY CARE CLINIC	0	56	0		65,318	90.02
91.00	09100	EMERGENCY	371	7,717	0		255,761	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0		0	95.00
101.00	10100	HOME HEALTH AGENCY	0	0	0		0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	56,359	25,085	0	0	1,792,618	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0		0	190.00
190.01	19001	VISITING SPECIALTY CLINIC	0	0	0		0	190.01
190.02	19002	OUTREACH	0	0	0		4,945	190.02
190.03	19003	FOUNDATION	0	0	0		0	190.03
190.04	19004	SPRING VALLEY FAMILY PRACTICE	0	0	0		0	190.04
190.05	19005	PAOLI FAMILY PRACTICE	0	0	0		60	190.05
190.06	19006	OTHER PROPERTY	0	0	0		25,672	190.06
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
200.00		Cross Foot Adjustments				8,536	8,536	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	56,359	25,085	0	8,536	1,831,831	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN:15-1306 | Period: From 01/01/2020 To 12/31/2020 | Worksheet B Part II | Date/Time Prepared: 7/14/2021 11:21 am

		Cost Center Description	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			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
7.01	00701	UTILITIES				7.01
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
13.01	01301	HOUSE SUPERVISORS				13.01
14.00	01400	CENTRAL SERVICES & SUPPLY				14.00
15.00	01500	PHARMACY				15.00
16.00	01600	MEDICAL RECORDS & LIBRARY				16.00
17.00	01700	SOCIAL SERVICE				17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS				19.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	0	393,079		30.00
31.00	03100	INTENSIVE CARE UNIT	0	0		31.00
43.00	04300	NURSERY	0	12,480		43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	227,082		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	30,834		52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	243,983		54.00
60.00	06000	LABORATORY	0	96,797		60.00
64.00	06400	INTRAVENOUS THERAPY	0	21,779		64.00
65.00	06500	RESPIRATORY THERAPY	0	29,324		65.00
66.00	06600	PHYSICAL THERAPY	0	141,639		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	30,494		67.00
68.00	06800	SPEECH PATHOLOGY	0	19,647		68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	4,721		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	2,137		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	87,721		73.00
73.01	07301	DRUGS CHARGED TO PATIENTS	0	0		73.01
74.00	07400	RENAL DIALYSIS	0	0		74.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0		75.00
76.97	07697	CARDIAC REHABILITATION	0	0		76.97
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0	0		88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0		89.00
90.00	09000	CLINIC	0	2,928		90.00
90.01	09001	VISITING SPECIALTY CLINIC	0	126,894		90.01
90.02	09002	PAOLI PRIMARY CARE CLINIC	0	65,318		90.02
91.00	09100	EMERGENCY	0	255,761		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0			92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES	0	0		95.00
101.00	10100	HOME HEALTH AGENCY	0	0		101.00
		SPECIAL PURPOSE COST CENTERS				
113.00	11300	INTEREST EXPENSE				113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	1,792,618		118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		190.00
190.01	19001	VISITING SPECIALTY CLINIC	0	0		190.01
190.02	19002	OUTREACH	0	4,945		190.02
190.03	19003	FOUNDATION	0	0		190.03
190.04	19004	SPRING VALLEY FAMILY PRACTICE	0	0		190.04
190.05	19005	PAOLI FAMILY PRACTICE	0	60		190.05
190.06	19006	OTHER PROPERTY	0	25,672		190.06
191.00	19100	RESEARCH	0	0		191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0		192.00
193.00	19300	NONPAID WORKERS	0	0		193.00
200.00		Cross Foot Adjustments	0	8,536		200.00
201.00		Negative Cost Centers	0	0		201.00
202.00		TOTAL (sum lines 118 through 201)	0	1,831,831		202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN:15-1306 | Period: From 01/01/2020 To 12/31/2020 | Worksheet B-1 | Date/Time Prepared: 7/14/2021 11:21 am

		Cost Center Description	CAPITAL RELATED COSTS					
			BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (SQUARE FEET)	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	59,353					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		56,073				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	979	979	8,794,269			4.00
5.00	00500	ADMINISTRATIVE & GENERAL	3,660	3,660	1,023,100	-7,847,888	18,449,395	5.00
7.00	00700	OPERATION OF PLANT	4,436	4,436	411,012	0	1,169,516	7.00
7.01	00701	UTILITIES	0	0	0	0	375,792	7.01
8.00	00800	LAUNDRY & LINEN SERVICE	300	300	0	0	46,900	8.00
9.00	00900	HOUSEKEEPING	943	943	223,861	0	420,731	9.00
10.00	01000	DIETARY	1,808	1,808	77,918	0	214,402	10.00
11.00	01100	CAFETERIA	1,005	1,005	93,821	0	179,157	11.00
13.00	01300	NURSING ADMINISTRATION	1,547	1,547	418,843	0	667,828	13.00
13.01	01301	HOUSE SUPERVISORS	0	0	398,793	0	529,955	13.01
14.00	01400	CENTRAL SERVICES & SUPPLY	2,092	2,092	0	0	251,577	14.00
15.00	01500	PHARMACY	1,169	1,169	268,267	0	636,082	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	753	753	0	0	22,852	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	348,314	0	376,705	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	7,375	7,375	1,140,379	0	1,802,696	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
43.00	04300	NURSERY	250	250	25,460	0	44,744	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	6,027	6,027	450,837	0	836,652	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	597	597	182,748	0	287,461	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	5,835	5,835	891,703	0	1,748,103	54.00
60.00	06000	LABORATORY	1,758	1,758	0	0	1,824,979	60.00
64.00	06400	INTRAVENOUS THERAPY	450	450	76,822	0	128,388	64.00
65.00	06500	RESPIRATORY THERAPY	330	330	316,657	0	450,453	65.00
66.00	06600	PHYSICAL THERAPY	4,098	4,098	380,927	0	870,269	66.00
67.00	06700	OCCUPATIONAL THERAPY	910	910	84,571	0	140,406	67.00
68.00	06800	SPEECH PATHOLOGY	585	585	54,415	0	90,327	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	23,319	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	10,593	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	1,588,240	73.00
73.01	07301	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.01
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	0	75.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	38	38	37,669	0	80,482	90.00
90.01	09001	VISITING SPECIALTY CLINIC	3,480	3,480	186,842	0	371,578	90.01
90.02	09002	PAOLI PRIMARY CARE CLINIC	1,557	1,557	414,447	0	344,503	90.02
91.00	09100	EMERGENCY	4,091	4,091	1,271,186	0	2,860,256	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	56,073	56,073	8,778,592	-7,847,888	18,394,946	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
190.01	19001	VISITING SPECIALTY CLINIC	0	0	0	0	0	190.01
190.02	19002	OUTREACH	448	0	15,677	0	26,233	190.02
190.03	19003	FOUNDATION	0	0	0	0	0	190.03
190.04	19004	SPRING VALLEY FAMILY PRACTICE	0	0	0	0	0	190.04
190.05	19005	PAOLI FAMILY PRACTICE	0	0	0	0	3,347	190.05
190.06	19006	OTHER PROPERTY	2,832	0	0	0	24,869	190.06
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
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)	520,655	1,086,242	2,241,170		7,847,888	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	8.772177	19.371926	0.254844		0.425374	203.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN:15-1306 | Period: From 01/01/2020 To 12/31/2020 | Worksheet B-1 | Date/Time Prepared: 7/14/2021 11:21 am

	Cost Center Description	CAPITAL RELATED COSTS					
		BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (SQUARE FEET)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
		1.00	2.00	4.00	5A	5.00	
204.00	Cost to be allocated (per Wkst. B, Part II)			27,553		331,146	204.00
205.00	Unit cost multiplier (Wkst. B, Part II)			0.003133		0.017949	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:15-1306 | Period: From 01/01/2020 To 12/31/2020 | Worksheet B-1 | Date/Time Prepared: 7/14/2021 11:21 am

		Cost Center Description	OPERATION OF PLANT (SQUARE FEET)	UTILITIES (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	
			7.00	7.01	8.00	9.00	10.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT	40,929					7.00
7.01	00701	UTILITIES	0	49,830				7.01
8.00	00800	LAUNDRY & LINEN SERVICE	300	300	11,186			8.00
9.00	00900	HOUSEKEEPING	943	943	0	42,942		9.00
10.00	01000	DIETARY	1,808	1,808	0	1,808	4,602	10.00
11.00	01100	CAFETERIA	1,005	1,005	0	1,005	0	11.00
13.00	01300	NURSING ADMINISTRATION	872	1,547	0	1,547	0	13.00
13.01	01301	HOUSE SUPERVISORS	0	0	0	0	0	13.01
14.00	01400	CENTRAL SERVICES & SUPPLY	2,092	2,092	0	0	0	14.00
15.00	01500	PHARMACY	1,169	1,169	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	753	753	0	753	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	7,375	7,375	2,984	7,375	4,602	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
43.00	04300	NURSERY	250	250	0	250	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	6,027	6,027	810	6,027	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	597	597	177	597	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	5,835	5,835	1,987	5,835	0	54.00
60.00	06000	LABORATORY	1,758	1,758	0	1,758	0	60.00
64.00	06400	INTRAVENOUS THERAPY	450	450	0	450	0	64.00
65.00	06500	RESPIRATORY THERAPY	330	330	0	330	0	65.00
66.00	06600	PHYSICAL THERAPY	146	4,098	343	4,098	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	32	910	76	910	0	67.00
68.00	06800	SPEECH PATHOLOGY	21	585	49	585	0	68.00
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
73.01	07301	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.01
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	0	75.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	38	38	0	38	0	90.00
90.01	09001	VISITING SPECIALTY CLINIC	3,480	3,480	141	3,480	0	90.01
90.02	09002	PAOLI PRIMARY CARE CLINIC	1,557	1,557	0	1,557	0	90.02
91.00	09100	EMERGENCY	4,091	4,091	4,619	4,091	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	40,929	46,998	11,186	42,494	4,602	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
190.01	19001	VISITING SPECIALTY CLINIC	0	0	0	0	0	190.01
190.02	19002	OUTREACH	0	0	0	448	0	190.02
190.03	19003	FOUNDATION	0	0	0	0	0	190.03
190.04	19004	SPRING VALLEY FAMILY PRACTICE	0	0	0	0	0	190.04
190.05	19005	PAOLI FAMILY PRACTICE	0	0	0	0	0	190.05
190.06	19006	OTHER PROPERTY	0	2,832	0	0	0	190.06
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
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)	1,666,998	535,644	82,294	648,243	425,969	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	40.729019	10.749428	7.356875	15.095780	92.561712	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	147,127	6,745	10,405	38,311	63,333	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	3.594688	0.135360	0.930181	0.892157	13.762060	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN:15-1306 | Period: From 01/01/2020 To 12/31/2020 | Worksheet B-1 | Date/Time Prepared: 7/14/2021 11:21 am

	Cost Center Description	OPERATION OF PLANT (SQUARE FEET)	UTILITIES (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	
		7.00	7.01	8.00	9.00	10.00	
206.00	NAHE adjustment amount to be allocated (per Wkst. B-2)						206.00
207.00	NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN:15-1306 | Period: From 01/01/2020 To 12/31/2020 | Worksheet B-1 | Date/Time Prepared: 7/14/2021 11:21 am

		Cost Center Description	CAFETERIA (MAN HOURS)	NURSING ADMINISTRATION (DIRECT NRSING HRS)	HOUSE SUPERVISORS (DIRECT NRSING HRS)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	
			11.00	13.00	13.01	14.00	15.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
7.01	00701	UTILITIES						7.01
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA	225,481					11.00
13.00	01300	NURSING ADMINISTRATION	10,459	87,921				13.00
13.01	01301	HOUSE SUPERVISORS	9,807	0	87,921			13.01
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	391,923		14.00
15.00	01500	PHARMACY	8,867	0	0	29,772	1,619,693	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	11	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	4,160	0	0	0	351	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	36,652	34,973	34,973	61,899	4,335	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
43.00	04300	NURSERY	689	688	688	14,417	136	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	11,947	9,850	9,850	0	2,488	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	4,945	4,941	4,941	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	26,457	1,498	1,498	35,319	11,930	54.00
60.00	06000	LABORATORY	26,262	0	0	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY	1,901	1,901	1,901	9,088	1,337	64.00
65.00	06500	RESPIRATORY THERAPY	9,981	0	0	40,989	206	65.00
66.00	06600	PHYSICAL THERAPY	11,026	0	0	11,476	9	66.00
67.00	06700	OCCUPATIONAL THERAPY	2,465	0	0	2,548	2	67.00
68.00	06800	SPEECH PATHOLOGY	1,854	0	0	1,639	1	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	23,318	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	10,592	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	1,588,240	73.00
73.01	07301	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.01
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	0	75.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	590	0	0	0	0	90.00
90.01	09001	VISITING SPECIALTY CLINIC	9,875	3,059	3,059	4,886	0	90.01
90.02	09002	PAOLI PRIMARY CARE CLINIC	7,363	2,323	2,323	19,693	7	90.02
91.00	09100	EMERGENCY	39,701	28,688	28,688	126,183	10,651	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	225,001	87,921	87,921	391,830	1,619,693	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
190.01	19001	VISITING SPECIALTY CLINIC	0	0	0	0	0	190.01
190.02	19002	OUTREACH	480	0	0	93	0	190.02
190.03	19003	FOUNDATION	0	0	0	0	0	190.03
190.04	19004	SPRING VALLEY FAMILY PRACTICE	0	0	0	0	0	190.04
190.05	19005	PAOLI FAMILY PRACTICE	0	0	0	0	0	190.05
190.06	19006	OTHER PROPERTY	0	0	0	0	0	190.06
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
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)	322,273	1,042,352	769,401	466,284	1,014,927	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	1.429269	11.855552	8.751049	1.189734	0.626617	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	36,441	63,252	12,346	71,196	56,359	204.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN:15-1306 | Period: From 01/01/2020 To 12/31/2020 | Worksheet B-1 | Date/Time Prepared: 7/14/2021 11:21 am

	Cost Center Description	CAFETERIA (MAN HOURS)	NURSING ADMINISTRATION (DIRECT NRSING HRS)	HOUSE SUPERVISORS (DIRECT NRSING HRS)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	
		11.00	13.00	13.01	14.00	15.00	
205.00	Unit cost multiplier (Wkst. B, Part II)	0.161615	0.719419	0.140422	0.181658	0.034796	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:15-1306 | Period: From 01/01/2020 To 12/31/2020 | Worksheet B-1 | Date/Time Prepared: 7/14/2021 11:21 am

		Cost Center Description	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)	SOCIAL SERVICE (TIME SPENT)	NONPHYSICIAN ANESTHETISTS (ASSIGNED TIME)		
			16.00	17.00	19.00		
		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
7.01	00701	UTILITIES					7.01
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
13.01	01301	HOUSE SUPERVISORS					13.01
14.00	01400	CENTRAL SERVICES & SUPPLY					14.00
15.00	01500	PHARMACY					15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	64,333,698				16.00
17.00	01700	SOCIAL SERVICE	0	0			17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	100		19.00
		INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	5,130,583	0	0		30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0		31.00
43.00	04300	NURSERY	200,764	0	0		43.00
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	4,948,039	0	100		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	835,249	0	0		52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	11,222,796	0	0		54.00
60.00	06000	LABORATORY	5,626,497	0	0		60.00
64.00	06400	INTRAVENOUS THERAPY	2,179,291	0	0		64.00
65.00	06500	RESPIRATORY THERAPY	943,060	0	0		65.00
66.00	06600	PHYSICAL THERAPY	1,460,695	0	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	296,321	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	181,690	0	0		68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	168,512	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	58,535	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	10,128,041	0	0		73.00
73.01	07301	DRUGS CHARGED TO PATIENTS	0	0	0		73.01
74.00	07400	RENAL DIALYSIS	0	0	0		74.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0		75.00
76.97	07697	CARDIAC REHABILITATION	0	0	0		76.97
		OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	0	0	0		88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0		89.00
90.00	09000	CLINIC	63,498	0	0		90.00
90.01	09001	VISITING SPECIALTY CLINIC	940,484	0	0		90.01
90.02	09002	PAOLI PRIMARY CARE CLINIC	142,597	0	0		90.02
91.00	09100	EMERGENCY	19,807,046	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					92.00
		OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES	0	0	0		95.00
101.00	10100	HOME HEALTH AGENCY	0	0	0		101.00
		SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	64,333,698	0	100		118.00
		NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0		190.00
190.01	19001	VISITING SPECIALTY CLINIC	0	0	0		190.01
190.02	19002	OUTREACH	0	0	0		190.02
190.03	19003	FOUNDATION	0	0	0		190.03
190.04	19004	SPRING VALLEY FAMILY PRACTICE	0	0	0		190.04
190.05	19005	PAOLI FAMILY PRACTICE	0	0	0		190.05
190.06	19006	OTHER PROPERTY	0	0	0		190.06
191.00	19100	RESEARCH	0	0	0		191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0		192.00
193.00	19300	NONPAID WORKERS	0	0	0		193.00
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)	82,716	0	543,112		202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.001286	0.000000	5,431.120000		203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	25,085	0	8,536		204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.000390	0.000000	85.360000		205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN:15-1306 | Period: From 01/01/2020 To 12/31/2020 | Worksheet B-1 | Date/Time Prepared: 7/14/2021 11:21 am

		Cost Center Description	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)	SOCIAL SERVICE (TIME SPENT)	NONPHYSICIAN ANESTHETISTS (ASSIGNED TIME)		
			16.00	17.00	19.00		
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:15-1306 | Period: From 01/01/2020 To 12/31/2020 | Worksheet C Part I Date/Time Prepared: 7/14/2021 11:21 am

Title XVIII | Hospital | Cost

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	RCE Disallowance	Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	4,364,445		4,364,445	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0		0	0	0	31.00
43.00	04300	NURSERY	113,078		113,078	0	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,370,828		2,370,828	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	560,744		560,744	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,027,392		3,027,392	0	0	54.00
60.00	06000	LABORATORY	2,763,086		2,763,086	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY	269,302		269,302	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	728,408	0	728,408	0	0	65.00
66.00	06600	PHYSICAL THERAPY	1,386,138	0	1,386,138	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	232,448	0	232,448	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	149,919	0	149,919	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	61,197		61,197	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	27,776		27,776	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	3,272,079		3,272,079	0	0	73.00
73.01	07301	DRUGS CHARGED TO PATIENTS	0		0	0	0	73.01
74.00	07400	RENAL DIALYSIS	0		0	0	0	74.00
75.00	07500	ASC (NON-DISTINCT PART)	0		0	0	0	75.00
76.97	07697	CARDIAC REHABILITATION	0		0	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0		0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0		0	0	0	89.00
90.00	09000	CLINIC	118,172		118,172	0	0	90.00
90.01	09001	VISITING SPECIALTY CLINIC	846,524		846,524	0	0	90.01
90.02	09002	PAOLI PRIMARY CARE CLINIC	676,711		676,711	0	0	90.02
91.00	09100	EMERGENCY	5,213,423		5,213,423	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1,507,451		1,507,451		0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0		0	0	0	95.00
101.00	10100	HOME HEALTH AGENCY	0		0		0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	27,689,121	0	27,689,121	0	0	200.00
201.00		Less Observation Beds	1,507,451		1,507,451		0	201.00
202.00		Total (see instructions)	26,181,670	0	26,181,670	0	0	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN:15-1306 | Period: From 01/01/2020 To 12/31/2020 | Worksheet C Part I Date/Time Prepared: 7/14/2021 11:21 am

Title XVIII | Hospital | Cost

		Cost Center Description	Charges Inpatient	Charges Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,003,131		2,003,131			30.00
31.00	03100	INTENSIVE CARE UNIT	0		0			31.00
43.00	04300	NURSERY	200,764		200,764			43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	436,055	4,511,984	4,948,039	0.479145	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	502,944	332,305	835,249	0.671350	0.000000	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	244,494	10,978,302	11,222,796	0.269754	0.000000	54.00
60.00	06000	LABORATORY	489,887	5,136,610	5,626,497	0.491085	0.000000	60.00
64.00	06400	INTRAVENOUS THERAPY	0	2,179,291	2,179,291	0.123573	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	221,470	721,590	943,060	0.772388	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	216,591	1,244,104	1,460,695	0.948958	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	49,286	247,035	296,321	0.784447	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	6,820	174,870	181,690	0.825136	0.000000	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	9,765	158,747	168,512	0.363161	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	58,535	58,535	0.474520	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,481,643	8,646,398	10,128,041	0.323071	0.000000	73.00
73.01	07301	DRUGS CHARGED TO PATIENTS	0	0	0	0.000000	0.000000	73.01
74.00	07400	RENAL DIALYSIS	0	0	0	0.000000	0.000000	74.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0.000000	0.000000	75.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0.000000	0.000000	76.97
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0			88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0			89.00
90.00	09000	CLINIC	0	63,498	63,498	1.861035	0.000000	90.00
90.01	09001	VISITING SPECIALTY CLINIC	0	940,484	940,484	0.900094	0.000000	90.01
90.02	09002	PAOLI PRIMARY CARE CLINIC	0	142,597	142,597	4.745619	0.000000	90.02
91.00	09100	EMERGENCY	226,271	19,580,775	19,807,046	0.263211	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	9,077	3,118,375	3,127,452	0.482006	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0.000000	0.000000	95.00
101.00	10100	HOME HEALTH AGENCY	0	0	0			101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	6,098,198	58,235,500	64,333,698			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	6,098,198	58,235,500	64,333,698			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN:15-1306 | Period: From 01/01/2020 To 12/31/2020 | Worksheet C Part I Date/Time Prepared: 7/14/2021 11:21 am

Title XVIII | Hospital | Cost

		Cost Center Description	PPS Inpatient Ratio		
			11.00		
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS			30.00
31.00	03100	INTENSIVE CARE UNIT			31.00
43.00	04300	NURSERY			43.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0.000000		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000		52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000		54.00
60.00	06000	LABORATORY	0.000000		60.00
64.00	06400	INTRAVENOUS THERAPY	0.000000		64.00
65.00	06500	RESPIRATORY THERAPY	0.000000		65.00
66.00	06600	PHYSICAL THERAPY	0.000000		66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000		67.00
68.00	06800	SPEECH PATHOLOGY	0.000000		68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000		73.00
73.01	07301	DRUGS CHARGED TO PATIENTS	0.000000		73.01
74.00	07400	RENAL DIALYSIS	0.000000		74.00
75.00	07500	ASC (NON-DISTINCT PART)	0.000000		75.00
76.97	07697	CARDIAC REHABILITATION	0.000000		76.97
		OUTPATIENT SERVICE COST CENTERS			
88.00	08800	RURAL HEALTH CLINIC			88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER			89.00
90.00	09000	CLINIC	0.000000		90.00
90.01	09001	VISITING SPECIALTY CLINIC	0.000000		90.01
90.02	09002	PAOLI PRIMARY CARE CLINIC	0.000000		90.02
91.00	09100	EMERGENCY	0.000000		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000		92.00
		OTHER REIMBURSABLE COST CENTERS			
95.00	09500	AMBULANCE SERVICES	0.000000		95.00
101.00	10100	HOME HEALTH AGENCY			101.00
		SPECIAL PURPOSE COST CENTERS			
113.00	11300	INTEREST EXPENSE			113.00
200.00		Subtotal (see instructions)			200.00
201.00		Less Observation Beds			201.00
202.00		Total (see instructions)			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN:15-1306 | Period: From 01/01/2020 To 12/31/2020 | Worksheet C Part I Date/Time Prepared: 7/14/2021 11:21 am

Title XIX | Hospital | PPS

		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	4,364,445		4,364,445	0	4,364,445	30.00
31.00	03100	INTENSIVE CARE UNIT	0		0	0	0	31.00
43.00	04300	NURSERY	113,078		113,078	0	113,078	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,370,828		2,370,828	0	2,370,828	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	560,744		560,744	0	560,744	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,027,392		3,027,392	0	3,027,392	54.00
60.00	06000	LABORATORY	2,763,086		2,763,086	0	2,763,086	60.00
64.00	06400	INTRAVENOUS THERAPY	269,302		269,302	0	269,302	64.00
65.00	06500	RESPIRATORY THERAPY	728,408	0	728,408	0	728,408	65.00
66.00	06600	PHYSICAL THERAPY	1,386,138	0	1,386,138	0	1,386,138	66.00
67.00	06700	OCCUPATIONAL THERAPY	232,448	0	232,448	0	232,448	67.00
68.00	06800	SPEECH PATHOLOGY	149,919	0	149,919	0	149,919	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	61,197		61,197	0	61,197	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	27,776		27,776	0	27,776	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	3,272,079		3,272,079	0	3,272,079	73.00
73.01	07301	DRUGS CHARGED TO PATIENTS	0		0	0	0	73.01
74.00	07400	RENAL DIALYSIS	0		0	0	0	74.00
75.00	07500	ASC (NON-DISTINCT PART)	0		0	0	0	75.00
76.97	07697	CARDIAC REHABILITATION	0		0	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0		0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0		0	0	0	89.00
90.00	09000	CLINIC	118,172		118,172	0	118,172	90.00
90.01	09001	VISITING SPECIALTY CLINIC	846,524		846,524	0	846,524	90.01
90.02	09002	PAOLI PRIMARY CARE CLINIC	676,711		676,711	0	676,711	90.02
91.00	09100	EMERGENCY	5,213,423		5,213,423	0	5,213,423	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1,507,451		1,507,451		1,507,451	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0		0	0	0	95.00
101.00	10100	HOME HEALTH AGENCY	0		0		0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	27,689,121	0	27,689,121	0	27,689,121	200.00
201.00		Less Observation Beds	1,507,451		1,507,451		1,507,451	201.00
202.00		Total (see instructions)	26,181,670	0	26,181,670	0	26,181,670	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN:15-1306 | Period: From 01/01/2020 To 12/31/2020 | Worksheet C Part I Date/Time Prepared: 7/14/2021 11:21 am

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	2,003,131		2,003,131			30.00
31.00	03100	INTENSIVE CARE UNIT	0		0			31.00
43.00	04300	NURSERY	200,764		200,764			43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	436,055	4,511,984	4,948,039	0.479145	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	502,944	332,305	835,249	0.671350	0.000000	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	244,494	10,978,302	11,222,796	0.269754	0.000000	54.00
60.00	06000	LABORATORY	489,887	5,136,610	5,626,497	0.491085	0.000000	60.00
64.00	06400	INTRAVENOUS THERAPY	0	2,179,291	2,179,291	0.123573	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	221,470	721,590	943,060	0.772388	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	216,591	1,244,104	1,460,695	0.948958	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	49,286	247,035	296,321	0.784447	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	6,820	174,870	181,690	0.825136	0.000000	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	9,765	158,747	168,512	0.363161	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	58,535	58,535	0.474520	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,481,643	8,646,398	10,128,041	0.323071	0.000000	73.00
73.01	07301	DRUGS CHARGED TO PATIENTS	0	0	0	0.000000	0.000000	73.01
74.00	07400	RENAL DIALYSIS	0	0	0	0.000000	0.000000	74.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0.000000	0.000000	75.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0.000000	0.000000	76.97
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0.000000	0.000000	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0.000000	0.000000	89.00
90.00	09000	CLINIC	0	63,498	63,498	1.861035	0.000000	90.00
90.01	09001	VISITING SPECIALTY CLINIC	0	940,484	940,484	0.900094	0.000000	90.01
90.02	09002	PAOLI PRIMARY CARE CLINIC	0	142,597	142,597	4.745619	0.000000	90.02
91.00	09100	EMERGENCY	226,271	19,580,775	19,807,046	0.263211	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	9,077	3,118,375	3,127,452	0.482006	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0.000000	0.000000	95.00
101.00	10100	HOME HEALTH AGENCY	0	0	0			101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	6,098,198	58,235,500	64,333,698			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	6,098,198	58,235,500	64,333,698			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN:15-1306 | Period: From 01/01/2020 To 12/31/2020 | Worksheet C Part I Date/Time Prepared: 7/14/2021 11:21 am

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	0.479145	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.671350	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.269754	54.00
60.00	06000	LABORATORY	0.491085	60.00
64.00	06400	INTRAVENOUS THERAPY	0.123573	64.00
65.00	06500	RESPIRATORY THERAPY	0.772388	65.00
66.00	06600	PHYSICAL THERAPY	0.948958	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.784447	67.00
68.00	06800	SPEECH PATHOLOGY	0.825136	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.363161	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.474520	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.323071	73.00
73.01	07301	DRUGS CHARGED TO PATIENTS	0.000000	73.01
74.00	07400	RENAL DIALYSIS	0.000000	74.00
75.00	07500	ASC (NON-DISTINCT PART)	0.000000	75.00
76.97	07697	CARDIAC REHABILITATION	0.000000	76.97
		OUTPATIENT SERVICE COST CENTERS		
88.00	08800	RURAL HEALTH CLINIC	0.000000	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0.000000	89.00
90.00	09000	CLINIC	1.861035	90.00
90.01	09001	VISITING SPECIALTY CLINIC	0.900094	90.01
90.02	09002	PAOLI PRIMARY CARE CLINIC	4.745619	90.02
91.00	09100	EMERGENCY	0.263211	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.482006	92.00
		OTHER REIMBURSABLE COST CENTERS		
95.00	09500	AMBULANCE SERVICES	0.000000	95.00
101.00	10100	HOME HEALTH AGENCY		101.00
		SPECIAL PURPOSE COST CENTERS		
113.00	11300	INTEREST EXPENSE		113.00
200.00		Subtotal (see instructions)		200.00
201.00		Less Observation Beds		201.00
202.00		Total (see instructions)		202.00

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

Provider CCN:15-1306 | Period: From 01/01/2020 To 12/31/2020 | Worksheet C Part II Date/Time Prepared: 7/14/2021 11:21 am

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	2,370,828	227,082	2,143,746	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	560,744	30,834	529,910	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,027,392	243,983	2,783,409	0	0	54.00
60.00	06000	LABORATORY	2,763,086	96,797	2,666,289	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY	269,302	21,779	247,523	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	728,408	29,324	699,084	0	0	65.00
66.00	06600	PHYSICAL THERAPY	1,386,138	141,639	1,244,499	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	232,448	30,494	201,954	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	149,919	19,647	130,272	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	61,197	4,721	56,476	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	27,776	2,137	25,639	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	3,272,079	87,721	3,184,358	0	0	73.00
73.01	07301	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.01
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	0	75.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	118,172	2,928	115,244	0	0	90.00
90.01	09001	VISITING SPECIALTY CLINIC	846,524	126,894	719,630	0	0	90.01
90.02	09002	PAOLI PRIMARY CARE CLINIC	676,711	65,318	611,393	0	0	90.02
91.00	09100	EMERGENCY	5,213,423	255,761	4,957,662	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1,507,451	135,767	1,371,684	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (sum of lines 50 thru 199)	23,211,598	1,522,826	21,688,772	0	0	200.00
201.00		Less Observation Beds	1,507,451	135,767	1,371,684	0	0	201.00
202.00		Total (line 200 minus line 201)	21,704,147	1,387,059	20,317,088	0	0	202.00

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

Provider CCN:15-1306 | Period: From 01/01/2020 To 12/31/2020 | Worksheet C Part II | Date/Time Prepared: 7/14/2021 11:21 am

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	2,370,828	4,948,039	0.479145		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	560,744	835,249	0.671350		52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,027,392	11,222,796	0.269754		54.00
60.00	06000	LABORATORY	2,763,086	5,626,497	0.491085		60.00
64.00	06400	INTRAVENOUS THERAPY	269,302	2,179,291	0.123573		64.00
65.00	06500	RESPIRATORY THERAPY	728,408	943,060	0.772388		65.00
66.00	06600	PHYSICAL THERAPY	1,386,138	1,460,695	0.948958		66.00
67.00	06700	OCCUPATIONAL THERAPY	232,448	296,321	0.784447		67.00
68.00	06800	SPEECH PATHOLOGY	149,919	181,690	0.825136		68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	61,197	168,512	0.363161		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	27,776	58,535	0.474520		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	3,272,079	10,128,041	0.323071		73.00
73.01	07301	DRUGS CHARGED TO PATIENTS	0	0	0.000000		73.01
74.00	07400	RENAL DIALYSIS	0	0	0.000000		74.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0.000000		75.00
76.97	07697	CARDIAC REHABILITATION	0	0	0.000000		76.97
		OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	0	0	0.000000		88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0.000000		89.00
90.00	09000	CLINIC	118,172	63,498	1.861035		90.00
90.01	09001	VISITING SPECIALTY CLINIC	846,524	940,484	0.900094		90.01
90.02	09002	PAOLI PRIMARY CARE CLINIC	676,711	142,597	4.745619		90.02
91.00	09100	EMERGENCY	5,213,423	19,807,046	0.263211		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1,507,451	3,127,452	0.482006		92.00
		OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES	0	0	0.000000		95.00
101.00	10100	HOME HEALTH AGENCY	0	0	0.000000		101.00
		SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE					113.00
200.00		Subtotal (sum of lines 50 thru 199)	23,211,598	62,129,803			200.00
201.00		Less Observation Beds	1,507,451	0			201.00
202.00		Total (line 200 minus line 201)	21,704,147	62,129,803			202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS | Provider CCN:15-1306 | Period: From 01/01/2020 To 12/31/2020 | Worksheet D Part II Date/Time Prepared: 7/14/2021 11:21 am

Title XVIII | Hospital | Cost

		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	227,082	4,948,039	0.045893	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	30,834	835,249	0.036916	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	243,983	11,222,796	0.021740	76,935	1,673	54.00
60.00	06000	LABORATORY	96,797	5,626,497	0.017204	151,707	2,610	60.00
64.00	06400	INTRAVENOUS THERAPY	21,779	2,179,291	0.009994	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	29,324	943,060	0.031095	107,757	3,351	65.00
66.00	06600	PHYSICAL THERAPY	141,639	1,460,695	0.096967	41,216	3,997	66.00
67.00	06700	OCCUPATIONAL THERAPY	30,494	296,321	0.102909	10,995	1,131	67.00
68.00	06800	SPEECH PATHOLOGY	19,647	181,690	0.108135	1,706	184	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	4,721	168,512	0.028016	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	2,137	58,535	0.036508	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	87,721	10,128,041	0.008661	605,433	5,244	73.00
73.01	07301	DRUGS CHARGED TO PATIENTS	0	0	0.000000	0	0	73.01
74.00	07400	RENAL DIALYSIS	0	0	0.000000	0	0	74.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0.000000	0	0	75.00
76.97	07697	CARDIAC REHABILITATION	0	0	0.000000	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0.000000	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0.000000	0	0	89.00
90.00	09000	CLINIC	2,928	63,498	0.046112	0	0	90.00
90.01	09001	VISITING SPECIALTY CLINIC	126,894	940,484	0.134924	0	0	90.01
90.02	09002	PAOLI PRIMARY CARE CLINIC	65,318	142,597	0.458060	0	0	90.02
91.00	09100	EMERGENCY	255,761	19,807,046	0.012913	20,860	269	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	135,767	3,127,452	0.043411	1,050	46	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)	1,522,826	62,129,803		1,017,659	18,505	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS | Provider CCN:15-1306 | Period: From 01/01/2020 To 12/31/2020 | Worksheet D Part IV Date/Time Prepared: 7/14/2021 11:21 am

Title XVIII | Hospital | Cost

		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	543,112	0	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
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
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
73.01	07301	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.01
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	0	75.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	VISITING SPECIALTY CLINIC	0	0	0	0	0	90.01
90.02	09002	PAOLI PRIMARY CARE CLINIC	0	0	0	0	0	90.02
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0		0		0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)	543,112	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS | Provider CCN:15-1306 | Period: From 01/01/2020 To 12/31/2020 | Worksheet D Part IV Date/Time Prepared: 7/14/2021 11:21 am

Title XVIII | Hospital | Cost

		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	543,112	0	4,948,039	0.109763	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	835,249	0.000000	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	11,222,796	0.000000	54.00
60.00	06000	LABORATORY	0	0	0	5,626,497	0.000000	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	2,179,291	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	943,060	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	1,460,695	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	296,321	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	181,690	0.000000	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	168,512	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	58,535	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	10,128,041	0.000000	73.00
73.01	07301	DRUGS CHARGED TO PATIENTS	0	0	0	0	0.000000	73.01
74.00	07400	RENAL DIALYSIS	0	0	0	0	0.000000	74.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	0.000000	75.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0.000000	76.97
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0.000000	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0.000000	89.00
90.00	09000	CLINIC	0	0	0	63,498	0.000000	90.00
90.01	09001	VISITING SPECIALTY CLINIC	0	0	0	940,484	0.000000	90.01
90.02	09002	PAOLI PRIMARY CARE CLINIC	0	0	0	142,597	0.000000	90.02
91.00	09100	EMERGENCY	0	0	0	19,807,046	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	3,127,452	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)	0	543,112	0	62,129,803		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS | Provider CCN:15-1306 | Period: From 01/01/2020 To 12/31/2020 | Worksheet D Part IV | Date/Time Prepared: 7/14/2021 11:21 am

Title XVIII | Hospital | Cost

		Cost Center Description	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
			9.00	10.00	11.00	12.00	13.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.000000	0	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	76,935	0	0	0	54.00
60.00	06000	LABORATORY	0.000000	151,707	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	107,757	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	41,216	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	10,995	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	1,706	0	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	605,433	0	0	0	73.00
73.01	07301	DRUGS CHARGED TO PATIENTS	0.000000	0	0	0	0	73.01
74.00	07400	RENAL DIALYSIS	0.000000	0	0	0	0	74.00
75.00	07500	ASC (NON-DISTINCT PART)	0.000000	0	0	0	0	75.00
76.97	07697	CARDIAC REHABILITATION	0.000000	0	0	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0.000000	0	0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0.000000	0	0	0	0	89.00
90.00	09000	CLINIC	0.000000	0	0	0	0	90.00
90.01	09001	VISITING SPECIALTY CLINIC	0.000000	0	0	0	0	90.01
90.02	09002	PAOLI PRIMARY CARE CLINIC	0.000000	0	0	0	0	90.02
91.00	09100	EMERGENCY	0.000000	20,860	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	1,050	0	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)		1,017,659	0	0	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN:15-1306 | Period: From 01/01/2020 To 12/31/2020 | Worksheet D Part V Date/Time Prepared: 7/14/2021 11:21 am

Title XVIII | Hospital | Cost

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.479145	0	1,033,854	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.671350	0	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.269754	0	3,111,209	0	0	54.00
60.00	06000	LABORATORY	0.491085	0	1,279,168	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0.123573	0	562,895	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.772388	0	217,478	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.948958	0	377,198	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.784447	0	54,738	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.825136	0	7,237	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.363161	0	37,728	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.474520	0	17,278	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.323071	0	3,406,873	2,350	0	73.00
73.01	07301	DRUGS CHARGED TO PATIENTS	0.000000	0	0	0	0	73.01
74.00	07400	RENAL DIALYSIS	0.000000	0	0	0	0	74.00
75.00	07500	ASC (NON-DISTINCT PART)	0.000000	0	0	0	0	75.00
76.97	07697	CARDIAC REHABILITATION	0.000000	0	0	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC						88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER						89.00
90.00	09000	CLINIC	1.861035	0	32,341	0	0	90.00
90.01	09001	VISITING SPECIALTY CLINIC	0.900094	0	394,941	0	0	90.01
90.02	09002	PAOLI PRIMARY CARE CLINIC	4.745619	0	13,276	0	0	90.02
91.00	09100	EMERGENCY	0.263211	0	4,762,977	2,047	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.482006	0	1,101,456	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0.000000		0			95.00
200.00		Subtotal (see instructions)		0	16,410,647	4,397	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	16,410,647	4,397	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN:15-1306 | Period: From 01/01/2020 To 12/31/2020 | Worksheet D Part V Date/Time Prepared: 7/14/2021 11:21 am

Title XVIII | Hospital | Cost

		Cost Center Description	Costs: Cost Reimbursed Services Subject To Ded & Coins. (see inst.)	Costs: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	495,366	0		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0		52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	839,261	0		54.00
60.00	06000	LABORATORY	628,180	0		60.00
64.00	06400	INTRAVENOUS THERAPY	69,559	0		64.00
65.00	06500	RESPIRATORY THERAPY	167,977	0		65.00
66.00	06600	PHYSICAL THERAPY	357,945	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	42,939	0		67.00
68.00	06800	SPEECH PATHOLOGY	5,972	0		68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	13,701	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	8,199	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,100,662	759		73.00
73.01	07301	DRUGS CHARGED TO PATIENTS	0	0		73.01
74.00	07400	RENAL DIALYSIS	0	0		74.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0		75.00
76.97	07697	CARDIAC REHABILITATION	0	0		76.97
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC				88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER				89.00
90.00	09000	CLINIC	60,188	0		90.00
90.01	09001	VISITING SPECIALTY CLINIC	355,484	0		90.01
90.02	09002	PAOLI PRIMARY CARE CLINIC	63,003	0		90.02
91.00	09100	EMERGENCY	1,253,668	539		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	530,908	0		92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES	0			95.00
200.00		Subtotal (see instructions)	5,993,012	1,298		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	5,993,012	1,298		202.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN:15-1306 | Component CCN:15-Z306 | Period: From 01/01/2020 To 12/31/2020 | Worksheet D Part IV | Date/Time Prepared: 7/14/2021 11:21 am

Title XVIII | Swing Beds - SNF | Cost

		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	543,112	0	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
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
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
73.01	07301	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.01
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	0	75.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	VISITING SPECIALTY CLINIC	0	0	0	0	0	90.01
90.02	09002	PAOLI PRIMARY CARE CLINIC	0	0	0	0	0	90.02
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0		0		0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)	543,112	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN:15-1306 | Component CCN:15-Z306 | Period: From 01/01/2020 To 12/31/2020 | Worksheet D Part IV | Date/Time Prepared: 7/14/2021 11:21 am

Title XVIII | Swing Beds - SNF | Cost

		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	543,112	0	4,948,039	0.109763	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	835,249	0.000000	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	11,222,796	0.000000	54.00
60.00	06000	LABORATORY	0	0	0	5,626,497	0.000000	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	2,179,291	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	943,060	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	1,460,695	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	296,321	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	181,690	0.000000	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	168,512	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	58,535	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	10,128,041	0.000000	73.00
73.01	07301	DRUGS CHARGED TO PATIENTS	0	0	0	0	0.000000	73.01
74.00	07400	RENAL DIALYSIS	0	0	0	0	0.000000	74.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	0.000000	75.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0.000000	76.97
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0.000000	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0.000000	89.00
90.00	09000	CLINIC	0	0	0	63,498	0.000000	90.00
90.01	09001	VISITING SPECIALTY CLINIC	0	0	0	940,484	0.000000	90.01
90.02	09002	PAOLI PRIMARY CARE CLINIC	0	0	0	142,597	0.000000	90.02
91.00	09100	EMERGENCY	0	0	0	19,807,046	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	3,127,452	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)	0	543,112	0	62,129,803		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN:15-1306 | Component CCN:15-Z306 | Period: From 01/01/2020 To 12/31/2020 | Worksheet D Part IV | Date/Time Prepared: 7/14/2021 11:21 am

Title XVIII | Swing Beds - SNF | Cost

		Cost Center Description	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
			9.00	10.00	11.00	12.00	13.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.000000	0	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	14,754	0	0	0	54.00
60.00	06000	LABORATORY	0.000000	21,161	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	20,732	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	83,391	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	16,201	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	1,748	0	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	57,590	0	0	0	73.00
73.01	07301	DRUGS CHARGED TO PATIENTS	0.000000	0	0	0	0	73.01
74.00	07400	RENAL DIALYSIS	0.000000	0	0	0	0	74.00
75.00	07500	ASC (NON-DISTINCT PART)	0.000000	0	0	0	0	75.00
76.97	07697	CARDIAC REHABILITATION	0.000000	0	0	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0.000000	0	0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0.000000	0	0	0	0	89.00
90.00	09000	CLINIC	0.000000	0	0	0	0	90.00
90.01	09001	VISITING SPECIALTY CLINIC	0.000000	0	0	0	0	90.01
90.02	09002	PAOLI PRIMARY CARE CLINIC	0.000000	0	0	0	0	90.02
91.00	09100	EMERGENCY	0.000000	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	0	0	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)		215,577	0	0	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN:15-1306 | Component CCN:15-Z306 | Period: From 01/01/2020 To 12/31/2020 | Worksheet D Part V | Date/Time Prepared: 7/14/2021 11:21 am

Title XVIII | Swing Beds - SNF | Cost

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.479145	0	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.671350	0	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.269754	0	0	0	0	54.00
60.00	06000	LABORATORY	0.491085	0	0	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0.123573	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.772388	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.948958	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.784447	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.825136	0	0	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.363161	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.474520	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.323071	0	0	0	0	73.00
73.01	07301	DRUGS CHARGED TO PATIENTS	0.000000	0	0	0	0	73.01
74.00	07400	RENAL DIALYSIS	0.000000	0	0	0	0	74.00
75.00	07500	ASC (NON-DISTINCT PART)	0.000000	0	0	0	0	75.00
76.97	07697	CARDIAC REHABILITATION	0.000000	0	0	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC						88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER						89.00
90.00	09000	CLINIC	1.861035	0	0	0	0	90.00
90.01	09001	VISITING SPECIALTY CLINIC	0.900094	0	0	0	0	90.01
90.02	09002	PAOLI PRIMARY CARE CLINIC	4.745619	0	0	0	0	90.02
91.00	09100	EMERGENCY	0.263211	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.482006	0	0	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0.000000		0			95.00
200.00		Subtotal (see instructions)		0	0	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	0	0	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN:15-1306 | Component CCN:15-Z306 | Period: From 01/01/2020 To 12/31/2020 | Worksheet D Part V | Date/Time Prepared: 7/14/2021 11:21 am

Title XVIII | Swing Beds - SNF | Cost

		Cost Center Description	Costs Cost Reimbursed Services Subject To Ded & Coins. (see inst.)	Costs Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	0		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0		52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0		54.00
60.00	06000	LABORATORY	0	0		60.00
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
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	0		73.00
73.01	07301	DRUGS CHARGED TO PATIENTS	0	0		73.01
74.00	07400	RENAL DIALYSIS	0	0		74.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0		75.00
76.97	07697	CARDIAC REHABILITATION	0	0		76.97
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC				88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER				89.00
90.00	09000	CLINIC	0	0		90.00
90.01	09001	VISITING SPECIALTY CLINIC	0	0		90.01
90.02	09002	PAOLI PRIMARY CARE CLINIC	0	0		90.02
91.00	09100	EMERGENCY	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0		92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES	0			95.00
200.00		Subtotal (see instructions)	0	0		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	0	0		202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS | Provider CCN:15-1306 | Period: From 01/01/2020 To 12/31/2020 | Worksheet D Part I Date/Time Prepared: 7/14/2021 11:21 am

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	393,079	45,177	347,902	1,312	265.17	30.00
31.00	INTENSIVE CARE UNIT	0		0	0	0.00	31.00
43.00	NURSERY	12,480		12,480	129	96.74	43.00
200.00	Total (lines 30 through 199)	405,559		360,382	1,441		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	11	2,917				30.00
31.00	INTENSIVE CARE UNIT	0	0				31.00
43.00	NURSERY	25	2,419				43.00
200.00	Total (lines 30 through 199)	36	5,336				200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS | Provider CCN:15-1306 | Period: From 01/01/2020 To 12/31/2020 | Worksheet D Part II Date/Time Prepared: 7/14/2021 11:21 am

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	227,082	4,948,039	0.045893	28,405	1,304	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	30,834	835,249	0.036916	31,525	1,164	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	243,983	11,222,796	0.021740	494	11	54.00
60.00	06000	LABORATORY	96,797	5,626,497	0.017204	12,347	212	60.00
64.00	06400	INTRAVENOUS THERAPY	21,779	2,179,291	0.009994	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	29,324	943,060	0.031095	551	17	65.00
66.00	06600	PHYSICAL THERAPY	141,639	1,460,695	0.096967	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	30,494	296,321	0.102909	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	19,647	181,690	0.108135	554	60	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	4,721	168,512	0.028016	1,181	33	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	2,137	58,535	0.036508	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	87,721	10,128,041	0.008661	12,008	104	73.00
73.01	07301	DRUGS CHARGED TO PATIENTS	0	0	0.000000	0	0	73.01
74.00	07400	RENAL DIALYSIS	0	0	0.000000	0	0	74.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0.000000	0	0	75.00
76.97	07697	CARDIAC REHABILITATION	0	0	0.000000	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0.000000	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0.000000	0	0	89.00
90.00	09000	CLINIC	2,928	63,498	0.046112	0	0	90.00
90.01	09001	VISITING SPECIALTY CLINIC	126,894	940,484	0.134924	0	0	90.01
90.02	09002	PAOLI PRIMARY CARE CLINIC	65,318	142,597	0.458060	0	0	90.02
91.00	09100	EMERGENCY	255,761	19,807,046	0.012913	6,504	84	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	135,767	3,127,452	0.043411	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)	1,522,826	62,129,803		93,569	2,989	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS | Provider CCN:15-1306 | Period: From 01/01/2020 To 12/31/2020 | Worksheet D Part III Date/Time Prepared: 7/14/2021 11:21 am

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	1,312	0.00	11	30.00
31.00	03100	INTENSIVE CARE UNIT		0	0	0.00	0	31.00
43.00	04300	NURSERY		0	129	0.00	25	43.00
200.00		Total (lines 30 through 199)		0	1,441		36	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:15-1306 | Period: From 01/01/2020 To 12/31/2020 | Worksheet D Part IV Date/Time Prepared: 7/14/2021 11:21 am

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	543,112	0	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
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
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
73.01	07301	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.01
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	0	75.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	VISITING SPECIALTY CLINIC	0	0	0	0	0	90.01
90.02	09002	PAOLI PRIMARY CARE CLINIC	0	0	0	0	0	90.02
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0		0		0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)	543,112	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS | Provider CCN:15-1306 | Period: From 01/01/2020 To 12/31/2020 | Worksheet D Part IV Date/Time Prepared: 7/14/2021 11:21 am

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	543,112	0	4,948,039	0.109763	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	835,249	0.000000	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	11,222,796	0.000000	54.00
60.00	06000	LABORATORY	0	0	0	5,626,497	0.000000	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	2,179,291	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	943,060	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	1,460,695	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	296,321	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	181,690	0.000000	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	168,512	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	58,535	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	10,128,041	0.000000	73.00
73.01	07301	DRUGS CHARGED TO PATIENTS	0	0	0	0	0.000000	73.01
74.00	07400	RENAL DIALYSIS	0	0	0	0	0.000000	74.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	0.000000	75.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0.000000	76.97
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0.000000	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0.000000	89.00
90.00	09000	CLINIC	0	0	0	63,498	0.000000	90.00
90.01	09001	VISITING SPECIALTY CLINIC	0	0	0	940,484	0.000000	90.01
90.02	09002	PAOLI PRIMARY CARE CLINIC	0	0	0	142,597	0.000000	90.02
91.00	09100	EMERGENCY	0	0	0	19,807,046	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	3,127,452	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)	0	543,112	0	62,129,803		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS | Provider CCN:15-1306 | Period: From 01/01/2020 To 12/31/2020 | Worksheet D Part IV | Date/Time Prepared: 7/14/2021 11:21 am

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	28,405	3,118	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	31,525	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	494	0	0	0	54.00
60.00	06000	LABORATORY	0.000000	12,347	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	551	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	554	0	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	1,181	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	12,008	0	0	0	73.00
73.01	07301	DRUGS CHARGED TO PATIENTS	0.000000	0	0	0	0	73.01
74.00	07400	RENAL DIALYSIS	0.000000	0	0	0	0	74.00
75.00	07500	ASC (NON-DISTINCT PART)	0.000000	0	0	0	0	75.00
76.97	07697	CARDIAC REHABILITATION	0.000000	0	0	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0.000000	0	0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0.000000	0	0	0	0	89.00
90.00	09000	CLINIC	0.000000	0	0	0	0	90.00
90.01	09001	VISITING SPECIALTY CLINIC	0.000000	0	0	0	0	90.01
90.02	09002	PAOLI PRIMARY CARE CLINIC	0.000000	0	0	0	0	90.02
91.00	09100	EMERGENCY	0.000000	6,504	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	0	0	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)		93,569	3,118	0	0	200.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN:15-1306 | Period: From 01/01/2020 To 12/31/2020 | Worksheet D-1 | Date/Time Prepared: 7/14/2021 11:21 am

Title XVIII | Hospital | Cost

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	1,575	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	1,312	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)	800	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	163	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	100	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)	335	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)	163	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		17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	216.95	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)	4,364,445	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)	21,695	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)	501,606	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	3,862,839	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	28.00
29.00	Private room charges (excluding swing-bed charges)	0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)	0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)	0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)	0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	3,862,839	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)	2,944.24	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	986,320	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)	986,320	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN:15-1306 | Period: From 01/01/2020 To 12/31/2020 | Worksheet D-1 | Date/Time Prepared: 7/14/2021 11:21 am

Title XVIII | Hospital | Cost

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

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	429,225	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	1,415,545	49.00
	PASS THROUGH COST ADJUSTMENTS		
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)	0	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	0	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	0	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	0	53.00
	TARGET AMOUNT AND LIMIT COMPUTATION		
54.00	Program discharges	0	54.00
55.00	Target amount per discharge	0.00	55.00
56.00	Target amount (line 54 x line 55)	0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)	0	57.00
58.00	Bonus payment (see instructions)	0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket	0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket	0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)	0	61.00
62.00	Relief payment (see instructions)	0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)	0	63.00
	PROGRAM INPATIENT ROUTINE SWING BED COST		
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)	479,911	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)	479,911	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)	512	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	2,944.24	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	1,507,451	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN:15-1306 | Period: From 01/01/2020 To 12/31/2020 | Worksheet D-1 | Date/Time Prepared: 7/14/2021 11:21 am

Title XVIII | Hospital | Cost

	Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	393,079	4,364,445	0.090064	1,507,451	135,767	90.00
91.00	Nursing School cost	0	4,364,445	0.000000	1,507,451	0	91.00
92.00	Allied health cost	0	4,364,445	0.000000	1,507,451	0	92.00
93.00	All other Medical Education	0	4,364,445	0.000000	1,507,451	0	93.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN:15-1306 | Period: From 01/01/2020 To 12/31/2020 | Worksheet D-1 | Date/Time Prepared: 7/14/2021 11:21 am

Title XIX | Hospital | PPS

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	1,575	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	1,312	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)	800	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	163	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	100	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)	11	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)	129	15.00
16.00	Nursery days (title V or XIX only)	25	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		17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	216.95	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)	4,364,445	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)	21,695	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)	501,606	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	3,862,839	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	28.00
29.00	Private room charges (excluding swing-bed charges)	0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)	0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)	0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)	0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	3,862,839	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)	2,944.24	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	32,387	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)	32,387	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN:15-1306 | Period: From 01/01/2020 To 12/31/2020 | Worksheet D-1 | Date/Time Prepared: 7/14/2021 11:21 am

Title XIX | Hospital | PPS

	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)	113,078	129	876.57	25	21,914	42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	0	0	0.00	0	0	43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	47,873	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	102,174	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)	5,336	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	6,107	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	11,443	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	90,731	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)	512	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	2,944.24	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	1,507,451	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN:15-1306 | Period: From 01/01/2020 To 12/31/2020 | Worksheet D-1 | Date/Time Prepared: 7/14/2021 11:21 am

Title XIX | Hospital | PPS

	Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	393,079	4,364,445	0.090064	1,507,451	135,767	90.00
91.00	Nursing School cost	0	4,364,445	0.000000	1,507,451	0	91.00
92.00	Allied health cost	0	4,364,445	0.000000	1,507,451	0	92.00
93.00	All other Medical Education	0	4,364,445	0.000000	1,507,451	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN:15-1306 | Period: From 01/01/2020 To 12/31/2020 | Worksheet D-3 | Date/Time Prepared: 7/14/2021 11:21 am

Title XVIII | Hospital | Cost

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		668,777		30.00
31.00	03100	INTENSIVE CARE UNIT		0		31.00
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.479145	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.671350	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.269754	76,935	20,754	54.00
60.00	06000	LABORATORY	0.491085	151,707	74,501	60.00
64.00	06400	INTRAVENOUS THERAPY	0.123573	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.772388	107,757	83,230	65.00
66.00	06600	PHYSICAL THERAPY	0.948958	41,216	39,112	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.784447	10,995	8,625	67.00
68.00	06800	SPEECH PATHOLOGY	0.825136	1,706	1,408	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.363161	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.474520	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.323071	605,433	195,598	73.00
73.01	07301	DRUGS CHARGED TO PATIENTS	0.000000	0	0	73.01
74.00	07400	RENAL DIALYSIS	0.000000	0	0	74.00
75.00	07500	ASC (NON-DISTINCT PART)	0.000000	0	0	75.00
76.97	07697	CARDIAC REHABILITATION	0.000000	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0.000000		0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0.000000		0	89.00
90.00	09000	CLINIC	1.861035	0	0	90.00
90.01	09001	VISITING SPECIALTY CLINIC	0.900094	0	0	90.01
90.02	09002	PAOLI PRIMARY CARE CLINIC	4.745619	0	0	90.02
91.00	09100	EMERGENCY	0.263211	20,860	5,491	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.482006	1,050	506	92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES				95.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		1,017,659	429,225	200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0		201.00
202.00		Net charges (line 200 minus line 201)		1,017,659		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN:15-1306 | Component CCN:15-Z306 | Period: From 01/01/2020 To 12/31/2020 | Worksheet D-3 | Date/Time Prepared: 7/14/2021 11:21 am

Title XVIII | Swing Beds - SNF | Cost

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		0		30.00
31.00	03100	INTENSIVE CARE UNIT		0		31.00
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.479145	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.671350	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.269754	14,754	3,980	54.00
60.00	06000	LABORATORY	0.491085	21,161	10,392	60.00
64.00	06400	INTRAVENOUS THERAPY	0.123573	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.772388	20,732	16,013	65.00
66.00	06600	PHYSICAL THERAPY	0.948958	83,391	79,135	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.784447	16,201	12,709	67.00
68.00	06800	SPEECH PATHOLOGY	0.825136	1,748	1,442	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.363161	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.474520	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.323071	57,590	18,606	73.00
73.01	07301	DRUGS CHARGED TO PATIENTS	0.000000	0	0	73.01
74.00	07400	RENAL DIALYSIS	0.000000	0	0	74.00
75.00	07500	ASC (NON-DISTINCT PART)	0.000000	0	0	75.00
76.97	07697	CARDIAC REHABILITATION	0.000000	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0.000000		0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0.000000		0	89.00
90.00	09000	CLINIC	1.861035	0	0	90.00
90.01	09001	VISITING SPECIALTY CLINIC	0.900094	0	0	90.01
90.02	09002	PAOLI PRIMARY CARE CLINIC	4.745619	0	0	90.02
91.00	09100	EMERGENCY	0.263211	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.482006	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES				95.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		215,577	142,277	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)		215,577		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN:15-1306 | Period: From 01/01/2020 To 12/31/2020 | Worksheet D-3 | Date/Time Prepared: 7/14/2021 11:21 am

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		19,856		30.00
31.00	03100	INTENSIVE CARE UNIT		0		31.00
43.00	04300	NURSERY		34,785		43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.479145	28,405	13,610	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.671350	31,525	21,164	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.269754	494	133	54.00
60.00	06000	LABORATORY	0.491085	12,347	6,063	60.00
64.00	06400	INTRAVENOUS THERAPY	0.123573	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.772388	551	426	65.00
66.00	06600	PHYSICAL THERAPY	0.948958	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.784447	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.825136	554	457	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.363161	1,181	429	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.474520	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.323071	12,008	3,879	73.00
73.01	07301	DRUGS CHARGED TO PATIENTS	0.000000	0	0	73.01
74.00	07400	RENAL DIALYSIS	0.000000	0	0	74.00
75.00	07500	ASC (NON-DISTINCT PART)	0.000000	0	0	75.00
76.97	07697	CARDIAC REHABILITATION	0.000000	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0.000000	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0.000000	0	0	89.00
90.00	09000	CLINIC	1.861035	0	0	90.00
90.01	09001	VISITING SPECIALTY CLINIC	0.900094	0	0	90.01
90.02	09002	PAOLI PRIMARY CARE CLINIC	4.745619	0	0	90.02
91.00	09100	EMERGENCY	0.263211	6,504	1,712	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.482006	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES				95.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		93,569	47,873	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)		93,569		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT | Provider CCN:15-1306 | Period: From 01/01/2020 To 12/31/2020 | Worksheet E Part B Date/Time Prepared: 7/14/2021 11:21 am

Title XVIII | Hospital | Cost

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	5,994,310	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)	0	2.00
3.00	OPPS payments	0	3.00
4.00	Outlier payment (see instructions)	0	4.00
4.01	Outlier reconciliation amount (see instructions)	0	4.01
5.00	Enter the hospital specific payment to cost ratio (see instructions)	0.000	5.00
6.00	Line 2 times line 5	0	6.00
7.00	Sum of lines 3, 4, and 4.01, divided by line 6	0.00	7.00
8.00	Transitional corridor payment (see instructions)	0	8.00
9.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200	0	9.00
10.00	Organ acquisitions	0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)	5,994,310	11.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
12.00	Ancillary service charges	0	12.00
13.00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, line 69)	0	13.00
14.00	Total reasonable charges (sum of lines 12 and 13)	0	14.00
	Customary charges		
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis	0	15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a chargebasis had such payment been made in accordance with 42 CFR §413.13(e)	0	16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)	0.000000	17.00
18.00	Total customary charges (see instructions)	0	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)	0	19.00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)	0	20.00
21.00	Lesser of cost or charges (see instructions)	6,054,253	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)	0	24.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
25.00	Deductibles and coinsurance amounts (for CAH, see instructions)	74,290	25.00
26.00	Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)	2,899,967	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)	3,079,996	27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 50)	0	28.00
29.00	ESRD direct medical education costs (from Wkst. E-4, line 36)	0	29.00
30.00	Subtotal (sum of lines 27 through 29)	3,079,996	30.00
31.00	Primary payer payments	1,282	31.00
32.00	Subtotal (line 30 minus line 31)	3,078,714	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)	110,948	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	72,116	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	-61,329	36.00
37.00	Subtotal (see instructions)	3,150,830	37.00
38.00	MSP-LCC reconciliation amount from PS&R	0	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	39.00
39.50	Pioneer ACO demonstration payment adjustment (see instructions)		39.50
39.97	Demonstration payment adjustment amount before sequestration	0	39.97
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)	0	39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION	0	39.99
40.00	Subtotal (see instructions)	3,150,830	40.00
40.01	Sequestration adjustment (see instructions)	20,795	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	3,396,987	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)	-266,952	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	148,171	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:15-1306 | Period: From 01/01/2020 To 12/31/2020 | Worksheet E-1 Part I | Date/Time Prepared: 7/14/2021 11:21 am

Title XVIII | Hospital | Cost

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		1,084,057		3,396,987	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
	Program to Provider					
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
	Provider to Program					
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		1,084,057		3,396,987	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		230,941		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		266,952	6.02
7.00	Total Medicare program liability (see instructions)		1,314,998		3,130,035	7.00

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

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN:15-1306 | Component CCN:15-Z306 | Period: From 01/01/2020 To 12/31/2020 | Worksheet E-1 Part I | Date/Time Prepared: 7/14/2021 11:21 am

Title XVIII | Swing Beds - SNF | Cost

		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		539,904		0	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
	Program to Provider					
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
	Provider to Program					
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		539,904		0	4.00
	TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
	Program to Provider					
5.01	TENTATIVE TO PROVIDER		0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
	Provider to Program					
5.50	TENTATIVE TO PROGRAM		0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		83,309		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		623,213		0	7.00
				Contractor Number	NPR Date (Mo/Day/Yr)	
		0		1.00	2.00	
8.00	Name of Contractor					8.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT	Provider CCN:15-1306	Period: From 01/01/2020 To 12/31/2020	Worksheet E-1 Part II Date/Time Prepared: 7/14/2021 11:21 am
	Title XVIII	Hospital	Cost

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

CALCULATION OF REIMBURSEMENT SETTLEMENT - SWING BEDS

Provider CCN:15-1306 | Component CCN:15-Z306 | Period: From 01/01/2020 To 12/31/2020 | Worksheet E-2 | Date/Time Prepared: 7/14/2021 11:21 am

Title XVIII | Swing Beds - SNF | Cost

		Part A	Part B	
		1.00	2.00	
	COMPUTATION OF NET COST OF COVERED SERVICES			
1.00	Inpatient routine services - swing bed-SNF (see instructions)	484,710	0	1.00
2.00	Inpatient routine services - swing bed-NF (see instructions)			2.00
3.00	Ancillary services (from Wkst. D-3, col. 3, line 200, for Part A, and sum of Wkst. D, Part V, cols. 6 and 7, line 202, for Part B) (For CAH and swing-bed pass-through, see instructions)	143,700	0	3.00
3.01	Nursing and allied health payment-PARHM (see instructions)			3.01
4.00	Per diem cost for interns and residents not in approved teaching program (see instructions)		0.00	4.00
5.00	Program days	163	0	5.00
6.00	Interns and residents not in approved teaching program (see instructions)		0	6.00
7.00	Utilization review - physician compensation - SNF optional method only	0		7.00
8.00	Subtotal (sum of lines 1 through 3 plus lines 6 and 7)	628,410	0	8.00
9.00	Primary payer payments (see instructions)	0	0	9.00
10.00	Subtotal (line 8 minus line 9)	628,410	0	10.00
11.00	Deductibles billed to program patients (exclude amounts applicable to physician professional services)	0	0	11.00
12.00	Subtotal (line 10 minus line 11)	628,410	0	12.00
13.00	Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)	1,056	0	13.00
14.00	80% of Part B costs (line 12 x 80%)		0	14.00
15.00	Subtotal (see instructions)	627,354	0	15.00
16.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	16.00
16.50	Pioneer ACO demonstration payment adjustment (see instructions)			16.50
16.55	Rural community hospital demonstration project (§410A Demonstration) payment adjustment (see instructions)	0		16.55
16.99	Demonstration payment adjustment amount before sequestration	0	0	16.99
17.00	Allowable bad debts (see instructions)	0	0	17.00
17.01	Adjusted reimbursable bad debts (see instructions)	0	0	17.01
18.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	0	0	18.00
19.00	Total (see instructions)	627,354	0	19.00
19.01	Sequestration adjustment (see instructions)	4,141	0	19.01
19.02	Demonstration payment adjustment amount after sequestration)	0	0	19.02
19.03	Sequestration adjustment-PARHM pass-throughs			19.03
20.00	Interim payments	539,904	0	20.00
20.01	Interim payments-PARHM			20.01
21.00	Tentative settlement (for contractor use only)	0	0	21.00
21.01	Tentative settlement-PARHM (for contractor use only)			21.01
22.00	Balance due provider/program (line 19 minus lines 19.01, 20, and 21)	83,309	0	22.00
22.01	Balance due provider/program-PARHM (see instructions)			22.01
23.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	15,431	0	23.00
	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 swing-bed SNF inpatient routine service costs (from Wkst. D-1, Pt. II, line 66 (title XVIII hospital))			201.00
202.00	Medicare swing-bed SNF inpatient ancillary service costs (from Wkst. D-3, col. 3, line 200 (title XVIII swing-bed SNF))			202.00
203.00	Total (sum of lines 201 and 202)			203.00
204.00	Medicare swing-bed SNF discharges (see instructions)			204.00
	Computation of Demonstration Target Amount Limitation (N/A in first year of the current 5-year demonstration period)			
205.00	Medicare swing-bed SNF target amount			205.00
206.00	Medicare swing-bed SNF inpatient routine cost cap (line 205 times line 204)			206.00
	Adjustment to Medicare Part A Swing-Bed SNF Inpatient Reimbursement			
207.00	Program reimbursement under the §410A Demonstration (see instructions)			207.00
208.00	Medicare swing-bed SNF inpatient service costs (from Wkst. E-2, col. 1, sum of lines 1 and 3)			208.00
209.00	Adjustment to Medicare swing-bed SNF PPS payments (see instructions)			209.00
210.00	Reserved for future use			210.00
	Comparision of PPS versus Cost Reimbursement			
215.00	Total adjustment to Medicare swing-bed SNF PPS payment (line 209 plus line 210) (see instructions)			215.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN:15-1306	Period: From 01/01/2020 To 12/31/2020	Worksheet E-3 Part V Date/Time Prepared: 7/14/2021 11:21 am
	Title XVIII	Hospital	Cost

		1.00	
	PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PART A SERVICES - COST REIMBURSEMENT		
1.00	Inpatient services	1,415,545	1.00
2.00	Nursing and Allied Health Managed Care payment (see instructions)	0	2.00
3.00	Organ acquisition	0	3.00
4.00	Subtotal (sum of lines 1 through 3)	1,415,545	4.00
5.00	Primary payer payments	0	5.00
6.00	Total cost (line 4 less line 5). For CAH (see instructions)	1,429,700	6.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
7.00	Routine service charges	0	7.00
8.00	Ancillary service charges	0	8.00
9.00	Organ acquisition charges, net of revenue	0	9.00
10.00	Total reasonable charges	0	10.00
	Customary charges		
11.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis	0	11.00
12.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR 413.13(e)	0	12.00
13.00	Ratio of line 11 to line 12 (not to exceed 1.000000)	0.000000	13.00
14.00	Total customary charges (see instructions)	0	14.00
15.00	Excess of customary charges over reasonable cost (complete only if line 14 exceeds line 6) (see instructions)	0	15.00
16.00	Excess of reasonable cost over customary charges (complete only if line 6 exceeds line 14) (see instructions)	0	16.00
17.00	Cost of physicians' services in a teaching hospital (see instructions)	0	17.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
18.00	Direct graduate medical education payments (from Worksheet E-4, line 49)	0	18.00
19.00	Cost of covered services (sum of lines 6, 17 and 18)	1,429,700	19.00
20.00	Deductibles (exclude professional component)	116,864	20.00
21.00	Excess reasonable cost (from line 16)	0	21.00
22.00	Subtotal (line 19 minus line 20 and 21)	1,312,836	22.00
23.00	Coinsurance	0	23.00
24.00	Subtotal (line 22 minus line 23)	1,312,836	24.00
25.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)	16,768	25.00
26.00	Adjusted reimbursable bad debts (see instructions)	10,899	26.00
27.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	12,772	27.00
28.00	Subtotal (sum of lines 24 and 25, or line 26)	1,323,735	28.00
29.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	29.00
29.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	29.50
29.99	Demonstration payment adjustment amount before sequestration	0	29.99
30.00	Subtotal (see instructions)	1,323,735	30.00
30.01	Sequestration adjustment (see instructions)	8,737	30.01
30.02	Demonstration payment adjustment amount after sequestration	0	30.02
30.03	Sequestration adjustment-PARHM		30.03
31.00	Interim payments	1,084,057	31.00
31.01	Interim payments-PARHM		31.01
32.00	Tentative settlement (for contractor use only)	0	32.00
32.01	Tentative settlement-PARHM (for contractor use only)		32.01
33.00	Balance due provider/program (line 30 minus lines 30.01, 30.02, 31, and 32)	230,941	33.00
33.01	Balance due provider/program-PARHM (lines 2, 3, 18, and 26, minus lines 30.03, 31.01, and 32.01)		33.01
34.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	35,095	34.00

BALANCE SHEET (If you are nonproprietary and do not maintain fund-type accounting records, complete the General Fund column only) | Provider CCN:15-1306 | Period: From 01/01/2020 To 12/31/2020 | Worksheet G | Date/Time Prepared: 7/14/2021 11:21 am

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
	CURRENT ASSETS					
1.00	Cash on hand in banks	15,402,319	0	0	0	1.00
2.00	Temporary investments	0	0	0	0	2.00
3.00	Notes receivable	88,636	0	0	0	3.00
4.00	Accounts receivable	3,378,143	0	0	0	4.00
5.00	Other receivable	-721,528	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	0	0	0	0	6.00
7.00	Inventory	760,633	0	0	0	7.00
8.00	Prepaid expenses	121,498	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)	19,029,701	0	0	0	11.00
	FIXED ASSETS					
12.00	Land	183,505	0	0	0	12.00
13.00	Land improvements	438,464	0	0	0	13.00
14.00	Accumulated depreciation	-388,211	0	0	0	14.00
15.00	Buildings	6,984,220	0	0	0	15.00
16.00	Accumulated depreciation	-3,722,418	0	0	0	16.00
17.00	Leasehold improvements	791,602	0	0	0	17.00
18.00	Accumulated depreciation	-657,524	0	0	0	18.00
19.00	Fixed equipment	0	0	0	0	19.00
20.00	Accumulated depreciation	0	0	0	0	20.00
21.00	Automobiles and trucks	13,607	0	0	0	21.00
22.00	Accumulated depreciation	0	0	0	0	22.00
23.00	Major movable equipment	11,110,417	0	0	0	23.00
24.00	Accumulated depreciation	-7,423,046	0	0	0	24.00
25.00	Minor equipment depreciable	0	0	0	0	25.00
26.00	Accumulated depreciation	0	0	0	0	26.00
27.00	HIT designated Assets	0	0	0	0	27.00
28.00	Accumulated depreciation	0	0	0	0	28.00
29.00	Minor equipment-nondepreciable	0	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	7,330,616	0	0	0	30.00
	OTHER ASSETS					
31.00	Investments	1,225,259	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	12,257,905	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	13,483,164	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	39,843,481	0	0	0	36.00
	CURRENT LIABILITIES					
37.00	Accounts payable	845,204	0	0	0	37.00
38.00	Salaries, wages, and fees payable	1,181,299	0	0	0	38.00
39.00	Payroll taxes payable	271	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	7,353,915				42.00
43.00	Due to other funds	0	0	0	0	43.00
44.00	Other current liabilities	2,767,725	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	12,148,414	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	32,963	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	32,963	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	12,181,377	0	0	0	51.00
	CAPITAL ACCOUNTS					
52.00	General fund balance	27,662,104				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)	27,662,104	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	39,843,481	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES | Provider CCN:15-1306 | Period: From 01/01/2020 To 12/31/2020 | Worksheet G-1 | Date/Time Prepared: 7/14/2021 11:21 am

		General Fund		Special Purpose Fund		Endowment Fund	
		1.00	2.00	3.00	4.00	5.00	
1.00	Fund balances at beginning of period		25,302,249		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		2,359,858				2.00
3.00	Total (sum of line 1 and line 2)		27,662,107		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)		27,662,107		0		11.00
12.00	ROUNDING	3		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)		3		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		27,662,104		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	ROUNDING		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:15-1306 | Period: From 01/01/2020 To 12/31/2020 | Worksheet G-2 Parts I & II | Date/Time Prepared: 7/14/2021 11:21 am

	Cost Center Description	Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospital	2,100,771		2,100,771	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	103,124		103,124	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)	2,203,895		2,203,895	10.00
	Intensive Care Type Inpatient Hospital Services				
11.00	INTENSIVE CARE UNIT	0		0	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)	0		0	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	2,203,895		2,203,895	17.00
18.00	Ancillary services	3,658,954	34,389,771	38,048,725	18.00
19.00	Outpatient services	235,348	23,845,729	24,081,077	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		0	0	22.00
23.00	AMBULANCE SERVICES	0	0	0	23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	OTHER NRCC	0	259,482	259,482	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	6,098,197	58,494,982	64,593,179	28.00
	PART II - OPERATING EXPENSES				
29.00	Operating expenses (per Wkst. A, column 3, line 200)		27,787,693		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)		27,787,693		43.00

STATEMENT OF REVENUES AND EXPENSES	Provider CCN:15-1306	Period: From 01/01/2020 To 12/31/2020	Worksheet G-3 Date/Time Prepared: 7/14/2021 11:21 am

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	64,593,179	1.00
2.00	Less contractual allowances and discounts on patients' accounts	36,065,431	2.00
3.00	Net patient revenues (line 1 minus line 2)	28,527,748	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	27,787,693	4.00
5.00	Net income from service to patients (line 3 minus line 4)	740,055	5.00
	OTHER INCOME		
6.00	Contributions, donations, bequests, etc	0	6.00
7.00	Income from investments	0	7.00
8.00	Revenues from telephone and other miscellaneous communication services	0	8.00
9.00	Revenue from television and radio service	0	9.00
10.00	Purchase discounts	0	10.00
11.00	Rebates and refunds of expenses	0	11.00
12.00	Parking lot receipts	0	12.00
13.00	Revenue from laundry and linen service	0	13.00
14.00	Revenue from meals sold to employees and guests	0	14.00
15.00	Revenue from rental of living quarters	0	15.00
16.00	Revenue from sale of medical and surgical supplies to other than patients	0	16.00
17.00	Revenue from sale of drugs to other than patients	0	17.00
18.00	Revenue from sale of medical records and abstracts	0	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	0	20.00
21.00	Rental of vending machines	0	21.00
22.00	Rental of hospital space	0	22.00
23.00	Governmental appropriations	0	23.00
24.00	MISCELLANEOUS INCOME	1,392,590	24.00
24.50	COVID-19 PHE Funding	227,213	24.50
25.00	Total other income (sum of lines 6-24)	1,619,803	25.00
26.00	Total (line 5 plus line 25)	2,359,858	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)	2,359,858	29.00