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: 15-0048	Period: From 01/01/2020 To 12/31/2020	Worksheet S Parts I-III Date/Time Prepared: 7/8/2021 10:37 am

PART I - COST REPORT STATUS

Provider use only

1. [X] Electronically prepared cost report — Date: 7/8/2021 Time: 10:37 am
2. [ ] Manually prepared cost report
3. [0] If this is an amended report enter the number of times the provider resubmitted this cost report
4. [F] Medicare Utilization. Enter "F" for full or "L" for low.

Contractor use only

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

PART II - CERTIFICATION

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

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

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by REID HOSPITAL & HEALTH CARE SERVICES (15-0048) for the cost reporting period beginning 01/01/2020 and ending 12/31/2020 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

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

(Signed)____________________
Officer or Administrator of Provider(s)

____
Title

____
Date

	Cost Center Description	Title V	Title XVIII Part A	Title XVIII Part B	HIT	Title XIX	
		1.00	2.00	3.00	4.00	5.00	
	PART III - SETTLEMENT SUMMARY						
1.00	Hospital	0	-1,197	116,219	0	0	1.00
2.00	Subprovider - IPF	0	-6,037	37		0	2.00
3.00	Subprovider - IRF	0	92,684	6		0	3.00
5.00	Swing Bed - SNF	0	0	0		0	5.00
6.00	Swing Bed - NF	0				0	6.00
200.00	Total	0	85,450	116,262	0	0	200.00

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

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0050. The time required to complete and review the information collection is estimated 673 hours per response, including the time to review instructions, search existing resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving the form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Report Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.
Please do not send applications, claims, payments, medical records or any documents containing sensitive information to the PRA Reports Clearance Office. Please note that any correspondence not pertaining to the information collection burden approved under the associated OMB control number listed on this form will not be reviewed, forwarded, or retained. If you have questions or concerns regarding where to submit your documents , please contact 1-800-MEDICARE.

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-0048 | Period: From 01/01/2020 To 12/31/2020 | Worksheet S-2 Part I Date/Time Prepared: 7/8/2021 10:37 am

	1.00	2.00	3.00	4.00	
	Hospital and Hospital Health Care Complex Address:				
1.00	Street: 1401 CHESTER BOULEVARD	PO Box:			1.00
2.00	City: RICHMOND	State: IN	Zip Code: 47374	County: WAYNE	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	REID HOSPITAL & HEALTH CARE SERVICES	150048	99915	1	07/01/1966	N	P	O	3.00
4.00	Subprovider - IPF	SUBPROVIDER	15S048	99915	4	01/01/2001	N	P	O	4.00
5.00	Subprovider - IRF	REHAB UNIT	15T048	99915	5	01/01/2003	N	P	O	5.00
6.00	Subprovider - (Other)									6.00
7.00	Swing Beds - SNF									7.00
8.00	Swing Beds - NF									8.00
9.00	Hospital-Based SNF									9.00
10.00	Hospital-Based NF									10.00
11.00	Hospital-Based OLTC									11.00
12.00	Hospital-Based HHA									12.00
13.00	Separately Certified ASC									13.00
14.00	Hospital-Based Hospice	HOSPICE	151524	99915		11/03/1993				14.00
15.00	Hospital-Based Health Clinic - RHC									15.00
16.00	Hospital-Based Health Clinic - FQHC									16.00
17.00	Hospital-Based (CMHC) I									17.00
18.00	Renal Dialysis									18.00
19.00	Other									19.00

		From:	To:	
		1.00	2.00	
20.00	Cost Reporting Period (mm/dd/yyyy)	01/01/2020	12/31/2020	20.00
21.00	Type of Control (see instructions)	2		21.00

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

		In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of State Medicaid paid days	Out-of State Medicaid eligible unpaid	Medicaid HMO days	Other Medicaid days	
		1.00	2.00	3.00	4.00	5.00	6.00	
24.00	If this provider is an IPPS hospital, enter the in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.	1,343	4,519	474	118	7,804	99	24.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-0048 | Period: From 01/01/2020 To 12/31/2020 | Worksheet S-2 Part I Date/Time Prepared: 7/8/2021 10:37 am

		In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of State Medicaid paid days	Out-of State Medicaid eligible unpaid	Medicaid HMO days	Other Medicaid days	
		1.00	2.00	3.00	4.00	5.00	6.00	
25.00	If this provider is an IRF, enter the in-state Medicaid paid days in column 1, the in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5.	0	22	0	10	737		25.00

		Urban/Rural S	Date of Geogr	
		1.00	2.00	
26.00	Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter "1" for urban or "2" for rural.	2		26.00
27.00	Enter your standard geographic classification (not wage) status at the end of the cost reporting period. Enter in column 1, "1" for urban or "2" for rural. If applicable, enter the effective date of the geographic reclassification in column 2.	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.	1		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.	01/01/2020	12/31/2020	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	Y		56.00
57.00	If line 56 is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y" did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If column 2 is "N", complete Wkst. D, Parts III & IV and D-2, Pt. II, if applicable.	N			57.00
58.00	If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, chapter 21, §2148? If yes, complete Wkst. D-5.	N			58.00
59.00	Are costs claimed on line 100 of Worksheet A? If yes, complete Wkst. D-2, Pt. I.	N			59.00

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 15-0048	Period: From 01/01/2020 To 12/31/2020	Worksheet S-2 Part I Date/Time Prepared: 7/8/2021 10:37 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: 15-0048	Period: From 01/01/2020 To 12/31/2020	Worksheet S-2 Part I Date/Time Prepared: 7/8/2021 10:37 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.	Y			70.00
71.00	If line 70 is yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost report filed on or before November 15, 2004? Enter "Y" for yes or "N" for no. (see 42 CFR 412.424(d)(1)(iii)(c)) Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)	N	N	0	71.00
	Inpatient Rehabilitation Facility PPS				
75.00	Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF subprovider? Enter "Y" for yes and "N" for no.	Y			75.00

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		1.00	2.00	3.00	
76.00	If line 75 is yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)	N	N	0	76.00

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

		V	XIX	
		1.00	2.00	
	Title V and XIX Services			
90.00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.	N	Y	90.00
91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.	N	Y	91.00
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.		N	92.00
93.00	Does this facility operate an ICF/IID facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.	N	N	93.00
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.	N	N	94.00
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	95.00
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.	N	N	96.00
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	97.00
98.00	Does title V or XIX follow Medicare (title XVIII) for the interns and residents post stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	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.	Y	Y	98.01
98.02	Does title V or XIX follow Medicare (title XVIII) for the calculation of observation bed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.02
98.03	Does title V or XIX follow Medicare (title XVIII) for a critical access hospital (CAH) reimbursed 101% of inpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.03
98.04	Does title V or XIX follow Medicare (title XVIII) for a CAH reimbursed 101% of outpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.04
98.05	Does title V or XIX follow Medicare (title XVIII) and add back the RCE disallowance on Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.05
98.06	Does title V or XIX follow Medicare (title XVIII) when cost reimbursed for Wkst. D, Pts. I through IV? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.06
	Rural Providers			
105.00	Does this hospital qualify as a CAH?	N		105.00
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)	N		106.00
107.00	Column 1: If line 105 is Y, is this facility eligible for cost reimbursement for I&R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) Column 2: If column 1 is Y and line 70 or line 75 is Y, do you train I&Rs in an approved medical education program in the CAH's excluded IPF and/or IRF unit(s)? Enter "Y" for yes or "N" for no in column 2. (see instructions)	N		107.00
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	N		108.00

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		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

		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.	Y			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:	0	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.	Y	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	5.06	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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 15-0048	Period: From 01/01/2020 To 12/31/2020	Worksheet S-2 Part I Date/Time Prepared: 7/8/2021 10:37 am

Line	Description	1.00	2.00	Line
132.00	If this is a Medicare certified islet transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			132.00
133.00	Removed and reserved			133.00
134.00	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.			134.00
	All Providers			
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)	Y		140.00

Line	1.00	2.00	3.00	Line
	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: REID HOME OFFICE	Contractor's Name: WPS	Contractor's Number: 08101	141.00
142.00	Street: 1100 REID PARKWAY	PO Box:		142.00
143.00	City: RICHMOND	State: IN	Zip Code: 47374	143.00

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

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

Line	Description	1.00	Line
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

Line	Description	Part A	Part B	Title V	Title XIX	Line
		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

Line	Description	1.00	Line
	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

Line	Description	Name	County	State	Zip Code	CBSA	FTE/Campus	Line
		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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 15-0048	Period: From 01/01/2020 To 12/31/2020	Worksheet S-2 Part I Date/Time Prepared: 7/8/2021 10:37 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)	N	0	171.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 15-0048 | Period: From 01/01/2020 To 12/31/2020 | Worksheet S-2 Part II Date/Time Prepared: 7/8/2021 10:37 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	04/16/2021	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.	Y		7.00
8.00	Were nursing school and/or allied health programs approved and/or renewed during the cost reporting period? If yes, see instructions.	Y		8.00
9.00	Are costs claimed for Interns and Residents in an approved graduate medical education program in the current cost report? If yes, see instructions.	Y		9.00
10.00	Was an approved Intern and Resident GME program initiated or renewed in the current cost reporting period? If yes, see instructions.	Y		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

		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	Y	29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.	Y	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.	Y	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.	Y	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.	N	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.	N	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.			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.	KERRY	BEJARANO	41.00
42.00	Enter the employer/company name of the cost report preparer.	BKD		42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	3173834000	KBEJARANO@BKD.COM	43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider CCN: 15-0048	Period: From 01/01/2020 To 12/31/2020	Worksheet S-2 Part II Date/Time Prepared: 7/8/2021 10:37 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: 15-0048 | Period: From 01/01/2020 To 12/31/2020 | Worksheet S-3 Part I | Date/Time Prepared: 7/8/2021 10:37 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	193	70,638	0.00	0	1.00
2.00	HMO and other (see instructions)						2.00
3.00	HMO IPF Subprovider						3.00
4.00	HMO IRF Subprovider						4.00
5.00	Hospital Adults & Peds. Swing Bed SNF					0	5.00
6.00	Hospital Adults & Peds. Swing Bed NF					0	6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)		193	70,638	0.00	0	7.00
8.00	INTENSIVE CARE UNIT	31.00	30	10,980	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)		223	81,618	0.00	0	14.00
15.00	CAH visits					0	15.00
16.00	SUBPROVIDER - IPF	40.00	28	10,248		0	16.00
17.00	SUBPROVIDER - IRF	41.00	20	7,320		0	17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE	116.00	0	0			24.00
24.10	HOSPICE (non-distinct part)	30.00					24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	26.25
27.00	Total (sum of lines 14-26)		271				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: 15-0048 | Period: From 01/01/2020 To 12/31/2020 | Worksheet S-3 Part I | Date/Time Prepared: 7/8/2021 10:37 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)	19,417	1,135	44,133			1.00
2.00	HMO and other (see instructions)	4,915	12,915				2.00
3.00	HMO IPF Subprovider	1,037	1,529				3.00
4.00	HMO IRF Subprovider	758	769				4.00
5.00	Hospital Adults & Peds. Swing Bed SNF	0	0	0			5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	0			6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	19,417	1,135	44,133			7.00
8.00	INTENSIVE CARE UNIT	2,778	164	6,349			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		44	1,700			13.00
14.00	Total (see instructions)	22,195	1,343	52,182	16.75	1,559.11	14.00
15.00	CAH visits	0	0	0			15.00
16.00	SUBPROVIDER - IPF	4,421	366	8,484	0.00	55.79	16.00
17.00	SUBPROVIDER - IRF	2,934	0	5,384	0.00	26.90	17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE	1,118	20	1,290	0.00	23.42	24.00
24.10	HOSPICE (non-distinct part)			0			24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0.00	0.00	26.25
27.00	Total (sum of lines 14-26)				16.75	1,665.22	27.00
28.00	Observation Bed Days		296	5,186			28.00
29.00	Ambulance Trips	0					29.00
30.00	Employee discount days (see instruction)			451			30.00
31.00	Employee discount days - IRF			56			31.00
32.00	Labor & delivery days (see instructions)	0	99	99			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: 15-0048 | Period: From 01/01/2020 To 12/31/2020 | Worksheet S-3 Part I Date/Time Prepared: 7/8/2021 10:37 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	5,574	298	11,568	1.00
2.00	HMO and other (see instructions)			1,139	2,863		2.00
3.00	HMO IPF Subprovider				96		3.00
4.00	HMO IRF Subprovider				47		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	5,574	298	11,568	14.00
15.00	CAH visits						15.00
16.00	SUBPROVIDER - IPF	0.00	0	277	0	533	16.00
17.00	SUBPROVIDER - IRF	0.00	0	215	0	325	17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE	0.00					24.00
24.10	HOSPICE (non-distinct part)						24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0.00					26.25
27.00	Total (sum of lines 14-26)	0.00					27.00
28.00	Observation Bed Days						28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)						32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00	LTCH non-covered days			0			33.00
33.01	LTCH site neutral days and discharges			0			33.01

HOSPITAL WAGE INDEX INFORMATION | Provider CCN: 15-0048 | Period: From 01/01/2020 To 12/31/2020 | Worksheet S-3 Part II Date/Time Prepared: 7/8/2021 10:37 am

		Wkst. A Line Number	Amount Reported	Reclassification of Salaries (from Wkst. A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
	PART II - WAGE DATA							
	SALARIES							
1.00	Total salaries (see instructions)	200.00	103,340,784	0	103,340,784	3,502,987.90	29.50	1.00
2.00	Non-physician anesthetist Part A		0	0	0	0.00	0.00	2.00
3.00	Non-physician anesthetist Part B		0	0	0	0.00	0.00	3.00
4.00	Physician-Part A - Administrative		0	0	0	0.00	0.00	4.00
4.01	Physicians - Part A - Teaching		0	0	0	0.00	0.00	4.01
5.00	Physician and Non Physician-Part B		0	0	0	0.00	0.00	5.00
6.00	Non-physician-Part B for hospital-based RHC and FQHC services		0	0	0	0.00	0.00	6.00
7.00	Interns & residents (in an approved program)	21.00	0	1,859,564	1,859,564	39,338.91	47.27	7.00
7.01	Contracted interns and residents (in an approved programs)		0	0	0	0.00	0.00	7.01
8.00	Home office and/or related organization personnel		0	0	0	0.00	0.00	8.00
9.00	SNF	44.00	0	0	0	0.00	0.00	9.00
10.00	Excluded area salaries (see instructions)		7,021,477	695,332	7,716,809	241,746.58	31.92	10.00
	OTHER WAGES & RELATED COSTS							
11.00	Contract labor: Direct Patient Care		8,202,333	0	8,202,333	133,910.36	61.25	11.00
12.00	Contract labor: Top level management and other management and administrative services		0	0	0	0.00	0.00	12.00
13.00	Contract labor: Physician-Part A - Administrative		660,655	0	660,655	4,173.00	158.32	13.00
14.00	Home office and/or related organization salaries and wage-related costs		0	0	0	0.00	0.00	14.00
14.01	Home office salaries		18,094,545	0	18,094,545	634,860.96	28.50	14.01
14.02	Related organization salaries		0	0	0	0.00	0.00	14.02
15.00	Home office: Physician Part A - Administrative		0	0	0	0.00	0.00	15.00
16.00	Home office and Contract Physicians Part A - Teaching		0	0	0	0.00	0.00	16.00
16.01	Home office Physicians Part A - Teaching		0	0	0	0.00	0.00	16.01
16.02	Home office contract Physicians Part A - Teaching		0	0	0	0.00	0.00	16.02
	WAGE-RELATED COSTS							
17.00	Wage-related costs (core) (see instructions)		34,145,309	0	34,145,309			17.00
18.00	Wage-related costs (other) (see instructions)							18.00
19.00	Excluded areas		2,564,278	0	2,564,278			19.00
20.00	Non-physician anesthetist Part A		0	0	0			20.00
21.00	Non-physician anesthetist Part B		0	0	0			21.00
22.00	Physician Part A - Administrative		0	0	0			22.00
22.01	Physician Part A - Teaching		0	0	0			22.01
23.00	Physician Part B		0	0	0			23.00
24.00	Wage-related costs (RHC/FQHC)		0	0	0			24.00
25.00	Interns & residents (in an approved program)		416,935	0	416,935			25.00
25.50	Home office wage-related (core)		3,907,571	0	3,907,571			25.50
25.51	Related organization wage-related (core)		0	0	0			25.51
25.52	Home office: Physician Part A - Administrative - wage-related (core)		0	0	0			25.52

		Wkst. A Line Number	Amount Reported	Reclassification of Salaries (from Wkst. A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
25.53	Home office: Physicians Part A - Teaching - wage-related (core)		0	0	0			25.53
	OVERHEAD COSTS - DIRECT SALARIES							
26.00	Employee Benefits Department	4.00	229,453	0	229,453	8,841.28	25.95	26.00
27.00	Administrative & General	5.00	7,886,293	105,905	7,992,198	363,003.96	22.02	27.00
28.00	Administrative & General under contract (see inst.)		3,373,666	0	3,373,666	71,398.46	47.25	28.00
29.00	Maintenance & Repairs	6.00	0	0	0	0.00	0.00	29.00
30.00	Operation of Plant	7.00	686,763	0	686,763	29,076.03	23.62	30.00
31.00	Laundry & Linen Service	8.00	631,336	-200,403	430,933	24,584.89	17.53	31.00
32.00	Housekeeping	9.00	2,618,845	0	2,618,845	162,058.97	16.16	32.00
33.00	Housekeeping under contract (see instructions)		0	0	0	0.00	0.00	33.00
34.00	Dietary	10.00	3,680,869	-2,489,172	1,191,697	56,504.62	21.09	34.00
35.00	Dietary under contract (see instructions)		129,498	0	129,498	2,180.00	59.40	35.00
36.00	Cafeteria	11.00	0	2,489,172	2,489,172	148,376.87	16.78	36.00
37.00	Maintenance of Personnel	12.00	0	0	0	0.00	0.00	37.00
38.00	Nursing Administration	13.00	0	280,277	280,277	2,080.00	134.75	38.00
39.00	Central Services and Supply	14.00	755,306	0	755,306	43,615.67	17.32	39.00
40.00	Pharmacy	15.00	4,439,147	0	4,439,147	130,994.60	33.89	40.00
41.00	Medical Records & Medical Records Library	16.00	0	0	0	0.00	0.00	41.00
42.00	Social Service	17.00	4,324,114	0	4,324,114	127,303.83	33.97	42.00
43.00	Other General Service	18.00	0	0	0	0.00	0.00	43.00

HOSPITAL WAGE INDEX INFORMATION | Provider CCN: 15-0048 | Period: From 01/01/2020 To 12/31/2020 | Worksheet S-3 Part III Date/Time Prepared: 7/8/2021 10:37 am

		Worksheet A Line Number	Amount Reported	Reclassification of Salaries (from Worksheet A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
	PART III - HOSPITAL WAGE INDEX SUMMARY							
1.00	Net salaries (see instructions)		106,843,948	-1,859,564	104,984,384	3,537,227.45	29.68	1.00
2.00	Excluded area salaries (see instructions)		7,021,477	695,332	7,716,809	241,746.58	31.92	2.00
3.00	Subtotal salaries (line 1 minus line 2)		99,822,471	-2,554,896	97,267,575	3,295,480.87	29.52	3.00
4.00	Subtotal other wages & related costs (see inst.)		26,957,533	0	26,957,533	772,944.32	34.88	4.00
5.00	Subtotal wage-related costs (see inst.)		38,052,880	0	38,052,880	0.00	39.12	5.00
6.00	Total (sum of lines 3 thru 5)		164,832,884	-2,554,896	162,277,988	4,068,425.19	39.89	6.00
7.00	Total overhead cost (see instructions)		28,755,290	185,779	28,941,069	1,170,019.18	24.74	7.00

HOSPITAL WAGE RELATED COSTS	Provider CCN: 15-0048	Period: From 01/01/2020 To 12/31/2020	Worksheet S-3 Part IV Date/Time Prepared: 7/8/2021 10:37 am

		Amount Reported	
		1.00	
	PART IV - WAGE RELATED COSTS		
	Part A - Core List		
	RETIREMENT COST		
1.00	401K Employer Contributions	0	1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution	3,548,162	2.00
3.00	Nonqualified Defined Benefit Plan Cost (see instructions)	0	3.00
4.00	Qualified Defined Benefit Plan Cost (see instructions)	0	4.00
	PLAN ADMINISTRATIVE COSTS (Paid to External Organization)		
5.00	401K/TSA Plan Administration fees	0	5.00
6.00	Legal/Accounting/Management Fees-Pension Plan	0	6.00
7.00	Employee Managed Care Program Administration Fees	0	7.00
	HEALTH AND INSURANCE COST		
8.00	Health Insurance (Purchased or Self Funded)	0	8.00
8.01	Health Insurance (Self Funded without a Third Party Administrator)	0	8.01
8.02	Health Insurance (Self Funded with a Third Party Administrator)	23,705,061	8.02
8.03	Health Insurance (Purchased)	0	8.03
9.00	Prescription Drug Plan	77,858	9.00
10.00	Dental, Hearing and Vision Plan	591,646	10.00
11.00	Life Insurance (If employee is owner or beneficiary)	127,061	11.00
12.00	Accident Insurance (If employee is owner or beneficiary)	0	12.00
13.00	Disability Insurance (If employee is owner or beneficiary)	394,490	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)	0	14.00
15.00	'Workers' Compensation Insurance	550,729	15.00
16.00	Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. Non cumulative portion)	0	16.00
	TAXES		
17.00	FICA-Employers Portion Only	7,668,646	17.00
18.00	Medicare Taxes - Employers Portion Only	0	18.00
19.00	Unemployment Insurance	216,550	19.00
20.00	State or Federal Unemployment Taxes	0	20.00
	OTHER		
21.00	Executive Deferred Compensation (Other Than Retirement Cost Reported on lines 1 through 4 above. (see instructions))	0	21.00
22.00	Day Care Cost and Allowances	0	22.00
23.00	Tuition Reimbursement	246,319	23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)	37,126,522	24.00
	Part B - Other than Core Related Cost		
25.00	OTHER WAGE RELATED COSTS (SPECIFY)		25.00

HOSPITAL CONTRACT LABOR AND BENEFIT COST | Provider CCN: 15-0048 | Period: From 01/01/2020 To 12/31/2020 | Worksheet S-3 Part V Date/Time Prepared: 7/8/2021 10:37 am

	Cost Center Description	Contract Labor	Benefit Cost	
		1.00	2.00	
	PART V - Contract Labor and Benefit Cost			
	Hospital and Hospital-Based Component Identification:			
1.00	Total facility's contract labor and benefit cost	8,202,333	37,126,522	1.00
2.00	Hospital	8,202,333	34,562,244	2.00
3.00	Subprovider - IPF	0	1,071,868	3.00
4.00	Subprovider - IRF	0	608,760	4.00
5.00	Subprovider - (Other)	0	0	5.00
6.00	Swing Beds - SNF	0	0	6.00
7.00	Swing Beds - NF	0	0	7.00
8.00	Hospital-Based SNF			8.00
9.00	Hospital-Based NF			9.00
10.00	Hospital-Based OLTC			10.00
11.00	Hospital-Based HHA			11.00
12.00	Separately Certified ASC			12.00
13.00	Hospital-Based Hospice	0	456,441	13.00
14.00	Hospital-Based Health Clinic RHC			14.00
15.00	Hospital-Based Health Clinic FQHC			15.00
16.00	Hospital-Based-CMHC			16.00
17.00	Renal Dialysis	0	0	17.00
18.00	Other	0	427,209	18.00

HOSPITAL-BASED HOSPICE IDENTIFICATION DATA

Provider CCN: 15-0048 | Hospice CCN: 15-1524 | Period: From 01/01/2020 To 12/31/2020 | Worksheet S-9 PARTS I THROUGH IV | Date/Time Prepared: 7/8/2021 10:37 am

Hospice I

		Unduplicated Days						
		Title XVIII	Title XIX	Title XVIII Skilled Nursing Facility	Title XIX Nursing Facility	All Other	Total (sum of cols. 1, 2 & 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
	PART I - ENROLLMENT DAYS FOR COST REPORTING PERIODS BEGINNING BEFORE OCTOBER 1, 2015							
1.00	Hospice Continuous Home Care							1.00
2.00	Hospice Routine Home Care							2.00
3.00	Hospice Inpatient Respite Care							3.00
4.00	Hospice General Inpatient Care							4.00
5.00	Total Hospice Days							5.00
	Part II - CENSUS DATA FOR COST REPORTING PERIODS BEGINNING BEFORE OCTOBER 1, 2015							
6.00	Number of patients receiving hospice care							6.00
7.00	Total number of unduplicated Continuous Care hours billable to Medicare							7.00
8.00	Average Length of Stay (line 5 / line 6)							8.00
9.00	Unduplicated census count							9.00

NOTE: Parts I and II, columns 1 and 2 also include the days reported in columns 3 and 4.

		Title XVIII	Title XIX	Other	Total (sum of cols. 1 through 3)	
		1.00	2.00	3.00	4.00	
	PART III - ENROLLMENT DAYS FOR COST REPORTING PERIODS BEGINNING ON OR AFTER OCTOBER 1, 2015					
10.00	Hospice Continuous Home Care	0	0	0	0	10.00
11.00	Hospice Routine Home Care	15,687	524	1,553	17,764	11.00
12.00	Hospice Inpatient Respite Care	154	0	6	160	12.00
13.00	Hospice General Inpatient Care	964	20	146	1,130	13.00
14.00	Total Hospice Days	16,805	544	1,705	19,054	14.00
	PART IV - CONTRACTED STATISTICAL DATA FOR COST REPORTING PERIODS BEGINNING ON OR AFTER OCTOBER 1, 2015					
15.00	Hospice Inpatient Respite Care	0	0	0	0	15.00
16.00	Hospice General Inpatient Care	0	0	0	0	16.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA | Provider CCN: 15-0048 | Period: From 01/01/2020 To 12/31/2020 | Worksheet S-10 | Date/Time Prepared: 7/8/2021 10:37 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)	0.299459	1.00
	Medicaid (see instructions for each line)		
2.00	Net revenue from Medicaid	66,509,930	2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?	N	3.00
4.00	If line 3 is yes, does line 2 include all DSH and/or supplemental payments from Medicaid?		4.00
5.00	If line 4 is no, then enter DSH and/or supplemental payments from Medicaid	0	5.00
6.00	Medicaid charges	197,037,208	6.00
7.00	Medicaid cost (line 1 times line 6)	59,004,565	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)	0	8.00
	Children's Health Insurance Program (CHIP) (see instructions for each line)		
9.00	Net revenue from stand-alone CHIP	0	9.00
10.00	Stand-alone CHIP charges	0	10.00
11.00	Stand-alone CHIP cost (line 1 times line 10)	0	11.00
12.00	Difference between net revenue and costs for stand-alone CHIP (line 11 minus line 9; if < zero then enter zero)	0	12.00
	Other state or local government indigent care program (see instructions for each line)		
13.00	Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9)	0	13.00
14.00	Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)	0	14.00
15.00	State or local indigent care program cost (line 1 times line 14)	0	15.00
16.00	Difference between net revenue and costs for state or local indigent care program (line 15 minus line 13; if < zero then enter zero)	0	16.00
	Grants, donations and total unreimbursed cost for Medicaid, CHIP and state/local indigent care programs (see instructions for each line)		
17.00	Private grants, donations, or endowment income restricted to funding charity care	0	17.00
18.00	Government grants, appropriations or transfers for support of hospital operations	0	18.00
19.00	Total unreimbursed cost for Medicaid , CHIP and state and local indigent care programs (sum of lines 8, 12 and 16)	0	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)	1,855,646	2,554,740	4,410,386	20.00
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	555,690	2,554,740	3,110,430	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)	555,690	2,554,740	3,110,430	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)	12,994,210	26.00
27.00	Medicare reimbursable bad debts for the entire hospital complex (see instructions)	1,805,358	27.00
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)	2,777,473	27.01
28.00	Non-Medicare bad debt expense (see instructions)	10,216,737	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)	4,031,609	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)	7,142,039	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	7,142,039	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 15-0048 | Period: From 01/01/2020 To 12/31/2020 | Worksheet A | Date/Time Prepared: 7/8/2021 10:37 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	NEW CAP REL COSTS-BLDG & FIXT		0	0	19,932,360	19,932,360	1.00
1.01	00101	NEW CAP BLDG & FIXT - OFFSITE		0	0	6,707,864	6,707,864	1.01
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP		0	0	0	0	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	229,453	29,363	258,816	-3,113	255,703	4.00
5.01	00540	NONPATIENT TELEPHONES	0	0	0	0	0	5.01
5.02	00550	DATA PROCESSING	298,997	3,458,577	3,757,574	0	3,757,574	5.02
5.03	00560	PURCHASING RECEIVING AND STORES	71,472	23,125	94,597	0	94,597	5.03
5.04	00570	ADMITTING	4,550,289	2,184,460	6,734,749	-15,176	6,719,573	5.04
5.05	00580	CASHIERING/ACCOUNTS RECEIVABLE	0	272,437	272,437	-164,229	108,208	5.05
5.06	00590	OTHER A&G	2,965,535	17,002,542	19,968,077	283,279	20,251,356	5.06
7.00	00700	OPERATION OF PLANT	686,763	177,912	864,675	0	864,675	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	631,336	674,320	1,305,656	-382,879	922,777	8.00
9.00	00900	HOUSEKEEPING	2,618,845	930,571	3,549,416	0	3,549,416	9.00
10.00	01000	DIETARY	3,680,869	3,515,400	7,196,269	-5,234,274	1,961,995	10.00
11.00	01100	CAFETERIA	0	0	0	5,234,274	5,234,274	11.00
13.00	01300	NURSING ADMINISTRATION	0	0	0	280,277	280,277	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	755,306	5,384,936	6,140,242	0	6,140,242	14.00
15.00	01500	PHARMACY	4,439,147	36,056,420	40,495,567	-2,086	40,493,481	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	3,065,023	563,296	3,628,319	0	3,628,319	17.00
17.01	01701	INSERVICE EDUCATION	1,259,091	1,797,815	3,056,906	0	3,056,906	17.01
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	0	0	1,957,778	1,957,778	21.00
22.00	02200	I&R SERVICES-OTHER PRGM. COSTS APPRVD	1,967,984	1,130,578	3,098,562	-1,957,778	1,140,784	22.00
23.00	02300	PARAMED ED PRGM	278,072	34,047	312,119	0	312,119	23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	26,574,395	13,718,252	40,292,647	-644,884	39,647,763	30.00
31.00	03100	INTENSIVE CARE UNIT	4,099,953	2,693,207	6,793,160	0	6,793,160	31.00
40.00	04000	SUBPROVIDER - IPF	3,405,363	510,025	3,915,388	0	3,915,388	40.00
41.00	04100	SUBPROVIDER - IRF	1,933,943	455,181	2,389,124	0	2,389,124	41.00
43.00	04300	NURSERY	813,211	121,743	934,954	-15	934,939	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,632,297	45,263,809	46,896,106	-13,388,873	33,507,233	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	849,531	289,529	1,139,060	-3,760	1,135,300	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	7,717,253	7,795,798	15,513,051	-151,518	15,361,533	54.00
59.00	05900	CARDIAC CATHETERIZATION	1,921,873	8,057,299	9,979,172	-3,219,780	6,759,392	59.00
60.00	06000	LABORATORY	4,558,196	10,383,916	14,942,112	-42,241	14,899,871	60.00
65.00	06500	RESPIRATORY THERAPY	1,868,623	664,416	2,533,039	-922	2,532,117	65.00
66.00	06600	PHYSICAL THERAPY	7,151,580	1,469,411	8,620,991	-247,212	8,373,779	66.00
69.00	06900	ELECTROCARDIOLOGY	1,100,621	900,992	2,001,613	0	2,001,613	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	316,892	88,386	405,278	0	405,278	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	16,634,850	16,634,850	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	1,074	878,851	879,925	0	879,925	74.00
76.00	03950	ANCILLARY - OTHER	0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	422,999	93,536	516,535	-37,560	478,975	76.97
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	7,839,190	7,080,649	14,919,839	-1,200,282	13,719,557	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
93.00	04040	FAMILY PRACTICE	2,028,802	478,485	2,507,287	-151,644	2,355,643	93.00
		OTHER REIMBURSABLE COST CENTERS						
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	202,707	450,290	652,997	-125	652,872	96.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE		8,366,523	8,366,523	-8,366,523	0	113.00
116.00	11600	HOSPICE	1,054,622	1,253,890	2,308,512	556,349	2,864,861	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	102,991,307	184,249,987	287,241,294	16,372,157	303,613,451	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	9,548,133	9,548,133	-6,029,564	3,518,569	192.00
194.00	07950	RENTAL SPACE	32,660	14,737,687	14,770,347	-10,070,660	4,699,687	194.00
194.01	07951	FOUNDATION	167,657	302,611	470,268	0	470,268	194.01
194.02	07952	RETAIL SERVICES	149,160	18,469	167,629	0	167,629	194.02
194.03	07953	REID CONTRACTED SERVICES	0	0	0	382,879	382,879	194.03
194.04	07954	REID PHYSICIAN ASSOC.	0	0	0	0	0	194.04
194.05	07955	CONNERSVILLE LOCATION	0	1,782,899	1,782,899	-378,197	1,404,702	194.05
194.06	07956	VACANT SPACE	0	411,817	411,817	-276,615	135,202	194.06
194.07	07957	HOME OFFICE	0	0	0	0	0	194.07
194.08	07958	CAMBRIDGE RHC	0	0	0	0	0	194.08
200.00		TOTAL (SUM OF LINES 118 through 199)	103,340,784	211,051,603	314,392,387	0	314,392,387	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 15-0048 | Period: From 01/01/2020 To 12/31/2020 | Worksheet A | Date/Time Prepared: 7/8/2021 10:37 am

		Cost Center Description	Adjustments (See A-8)	Net Expenses For Allocation	
			6.00	7.00	
		GENERAL SERVICE COST CENTERS			
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT	1,877,048	21,809,408	1.00
1.01	00101	NEW CAP BLDG & FIXT - OFFSITE	0	6,707,864	1.01
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP	0	0	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	15,897,183	16,152,886	4.00
5.01	00540	NONPATIENT TELEPHONES	0	0	5.01
5.02	00550	DATA PROCESSING	10,566,849	14,324,423	5.02
5.03	00560	PURCHASING RECEIVING AND STORES	-6,684	87,913	5.03
5.04	00570	ADMITTING	-10	6,719,563	5.04
5.05	00580	CASHIERING/ACCOUNTS RECEIVABLE	-230,850	-122,642	5.05
5.06	00590	OTHER A&G	13,396,962	33,648,318	5.06
7.00	00700	OPERATION OF PLANT	0	864,675	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	-364,499	558,278	8.00
9.00	00900	HOUSEKEEPING	0	3,549,416	9.00
10.00	01000	DIETARY	-8,172	1,953,823	10.00
11.00	01100	CAFETERIA	-3,392,654	1,841,620	11.00
13.00	01300	NURSING ADMINISTRATION	0	280,277	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	-9,324	6,130,918	14.00
15.00	01500	PHARMACY	-392,303	40,101,178	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	16.00
17.00	01700	SOCIAL SERVICE	0	3,628,319	17.00
17.01	01701	INSERVICE EDUCATION	-580,688	2,476,218	17.01
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	1,957,778	21.00
22.00	02200	I&R SERVICES-OTHER PRGM. COSTS APPRVD	-668,833	471,951	22.00
23.00	02300	PARAMED ED PRGM	-305	311,814	23.00
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS	-6,692,031	32,955,732	30.00
31.00	03100	INTENSIVE CARE UNIT	0	6,793,160	31.00
40.00	04000	SUBPROVIDER - IPF	-1,508	3,913,880	40.00
41.00	04100	SUBPROVIDER - IRF	-171,422	2,217,702	41.00
43.00	04300	NURSERY	0	934,939	43.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	-10,862,238	22,644,995	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	-140	1,135,160	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-278,368	15,083,165	54.00
59.00	05900	CARDIAC CATHETERIZATION	-1,822	6,757,570	59.00
60.00	06000	LABORATORY	-890,356	14,009,515	60.00
65.00	06500	RESPIRATORY THERAPY	-1,425	2,530,692	65.00
66.00	06600	PHYSICAL THERAPY	-88,332	8,285,447	66.00
69.00	06900	ELECTROCARDIOLOGY	-63,533	1,938,080	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	-73	405,205	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	16,634,850	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	879,925	74.00
76.00	03950	ANCILLARY - OTHER	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	-2,733	476,242	76.97
		OUTPATIENT SERVICE COST CENTERS			
91.00	09100	EMERGENCY	-4,728,082	8,991,475	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)			92.00
93.00	04040	FAMILY PRACTICE	-8,437	2,347,206	93.00
		OTHER REIMBURSABLE COST CENTERS			
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	-412,418	240,454	96.00
		SPECIAL PURPOSE COST CENTERS			
113.00	11300	INTEREST EXPENSE	0	0	113.00
116.00	11600	HOSPICE	-2,370	2,862,491	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	11,878,432	315,491,883	118.00
		NONREIMBURSABLE COST CENTERS			
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	3,518,569	192.00
194.00	07950	RENTAL SPACE	0	4,699,687	194.00
194.01	07951	FOUNDATION	0	470,268	194.01
194.02	07952	RETAIL SERVICES	0	167,629	194.02
194.03	07953	REID CONTRACTED SERVICES	0	382,879	194.03
194.04	07954	REID PHYSICIAN ASSOC.	0	0	194.04
194.05	07955	CONNERSVILLE LOCATION	0	1,404,702	194.05
194.06	07956	VACANT SPACE	0	135,202	194.06
194.07	07957	HOME OFFICE	0	0	194.07
194.08	07958	CAMBRIDGE RHC	0	0	194.08
200.00		TOTAL (SUM OF LINES 118 through 199)	11,878,432	326,270,819	200.00

RECLASSIFICATIONS | Provider CCN: 15-0048 | Period: From 01/01/2020 To 12/31/2020 | Worksheet A-6 | Date/Time Prepared: 7/8/2021 10:37 am

	Increases				
	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
	A - CAPITAL EXPENSE RECLASS				
1.00	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	11,330,937	1.00
2.00	NEW CAP BLDG & FIXT - OFFSITE	1.01	0	6,415,767	2.00
3.00	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	20,280	3.00
4.00	NEW CAP BLDG & FIXT - OFFSITE	1.01	0	285,121	4.00
5.00	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	214,620	5.00
6.00	NEW CAP BLDG & FIXT - OFFSITE	1.01	0	6,976	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
	0		0	18,273,701	
	B - CAFETERIA RECLASS				
1.00	CAFETERIA	11.00	2,489,172	2,745,102	1.00
	0		2,489,172	2,745,102	
	C - LAUNDRY RECLASS				
1.00	REID CONTRACTED SERVICES	194.03	200,403	182,476	1.00
	0		200,403	182,476	
	D - NURSING VP RECLASS				
1.00	NURSING ADMINISTRATION	13.00	280,277	0	1.00
	0		280,277	0	
	E - OCCUPATIONAL MEDICINE RECLASS				
1.00	OTHER A&G	5.06	386,182	814,100	1.00
	0		386,182	814,100	
	F - IMPLANTABLE DEVICES RECLASS				
1.00	IMPL. DEV. CHARGED TO PATIENT	72.00	0	16,634,850	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	16,634,850	
	G - INTEREST RECLASS				
1.00	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	8,366,523	1.00
	0		0	8,366,523	
	J - INTERN AND RESIDENT				
1.00	I&R SERVICES-SALARY & FRINGES APPRVD	21.00	1,859,564	98,214	1.00
	0		1,859,564	98,214	
	N - HOSPICE				
1.00	HOSPICE	116.00	494,929	63,220	1.00
	0		494,929	63,220	
500.00	Grand Total: Increases		5,710,527	47,178,186	500.00

RECLASSIFICATIONS | Provider CCN: 15-0048 | Period: From 01/01/2020 To 12/31/2020 | Worksheet A-6 | Date/Time Prepared: 7/8/2021 10:37 am

	Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.	
	6.00	7.00	8.00	9.00	10.00	
	A - CAPITAL EXPENSE RECLASS					
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	3,113	9	1.00
2.00	ADMITTING	5.04	0	15,176	9	2.00
3.00	CASHIERING/ACCOUNTS RECEIVABLE	5.05	0	164,229	13	3.00
4.00	OTHER A&G	5.06	0	636,726	13	4.00
5.00	PHARMACY	15.00	0	2,086	10	5.00
6.00	ADULTS & PEDIATRICS	30.00	0	86,735	10	6.00
7.00	RADIOLOGY-DIAGNOSTIC	54.00	0	129,096	0	7.00
8.00	LABORATORY	60.00	0	42,241	0	8.00
9.00	RESPIRATORY THERAPY	65.00	0	922	0	9.00
10.00	PHYSICAL THERAPY	66.00	0	247,212	0	10.00
11.00	CARDIAC REHABILITATION	76.97	0	37,560	0	11.00
12.00	FAMILY PRACTICE	93.00	0	151,644	0	12.00
13.00	DURABLE MEDICAL EQUIP-RENTED	96.00	0	125	0	13.00
14.00	HOSPICE	116.00	0	1,800	0	14.00
15.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	6,029,564	0	15.00
16.00	RENTAL SPACE	194.00	0	10,070,660	0	16.00
17.00	CONNERSVILLE LOCATION	194.05	0	378,197	0	17.00
18.00	VACANT SPACE	194.06	0	276,615	0	18.00
	0		0	18,273,701		
	B - CAFETERIA RECLASS					
1.00	DIETARY	10.00	2,489,172	2,745,102	0	1.00
	0		2,489,172	2,745,102		
	C - LAUNDRY RECLASS					
1.00	LAUNDRY & LINEN SERVICE	8.00	200,403	182,476	0	1.00
	0		200,403	182,476		
	D - NURSING VP RECLASS					
1.00	OTHER A&G	5.06	280,277	0	0	1.00
	0		280,277	0		
	E - OCCUPATIONAL MEDICINE RECLASS					
1.00	EMERGENCY	91.00	386,182	814,100	0	1.00
	0		386,182	814,100		
	F - IMPLANTABLE DEVICES RECLASS					
1.00	NURSERY	43.00	0	15	0	1.00
2.00	OPERATING ROOM	50.00	0	13,388,873	0	2.00
3.00	DELIVERY ROOM & LABOR ROOM	52.00	0	3,760	0	3.00
4.00	RADIOLOGY-DIAGNOSTIC	54.00	0	22,422	0	4.00
5.00	CARDIAC CATHETERIZATION	59.00	0	3,219,780	0	5.00
	0		0	16,634,850		
	G - INTEREST RECLASS					
1.00	INTEREST EXPENSE	113.00	0	8,366,523	11	1.00
	0		0	8,366,523		
	J - INTERN AND RESIDENT					
1.00	I&R SERVICES-OTHER PRGM. COSTS APPRVD	22.00	1,859,564	98,214	0	1.00
	0		1,859,564	98,214		
	N - HOSPICE					
1.00	ADULTS & PEDIATRICS	30.00	494,929	63,220	0	1.00
	0		494,929	63,220		
500.00	Grand Total: Decreases		5,710,527	47,178,186		500.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-0048 | Period: From 01/01/2020 To 12/31/2020 | Worksheet A-7 Part I Date/Time Prepared: 7/8/2021 10:37 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	16,281,439	945,728	0	945,728	0	1.00
2.00	Land Improvements	13,517,691	0	0	0	913,620	2.00
3.00	Buildings and Fixtures	311,331,989	9,786,916	0	9,786,916	0	3.00
4.00	Building Improvements	12,979,130	655,930	0	655,930	0	4.00
5.00	Fixed Equipment	2,180,808	15,392	0	15,392	0	5.00
6.00	Movable Equipment	172,254,105	16,590,448	0	16,590,448	0	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	528,545,162	27,994,414	0	27,994,414	913,620	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	528,545,162	27,994,414	0	27,994,414	913,620	10.00

		Ending Balance	Fully Depreciated Assets	
		6.00	7.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES			
1.00	Land	17,227,167	0	1.00
2.00	Land Improvements	12,604,071	0	2.00
3.00	Buildings and Fixtures	321,118,905	0	3.00
4.00	Building Improvements	13,635,060	0	4.00
5.00	Fixed Equipment	2,196,200	0	5.00
6.00	Movable Equipment	188,844,553	0	6.00
7.00	HIT designated Assets	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	555,625,956	0	8.00
9.00	Reconciling Items	0	0	9.00
10.00	Total (line 8 minus line 9)	555,625,956	0	10.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 15-0048 | Period: From 01/01/2020 To 12/31/2020 | Worksheet A-7 Part II | Date/Time Prepared: 7/8/2021 10:37 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	NEW CAP REL COSTS-BLDG & FIXT	0	0	0	0	0	1.00
1.01	NEW CAP BLDG & FIXT - OFFSITE	0	0	0	0	0	1.01
2.00	NEW 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	NEW CAP REL COSTS-BLDG & FIXT	0	0	1.00
1.01	NEW CAP BLDG & FIXT - OFFSITE	0	0	1.01
2.00	NEW 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: 15-0048 | Period: From 01/01/2020 To 12/31/2020 | Worksheet A-7 Part III | Date/Time Prepared: 7/8/2021 10:37 am

	Cost Center Description	COMPUTATION OF RATIOS			ALLOCATION OF OTHER CAPITAL		
		Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	
		1.00	2.00	3.00	4.00	5.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	NEW CAP REL COSTS-BLDG & FIXT	366,781,403	0	366,781,403	0.660123	0	1.00
1.01	NEW CAP BLDG & FIXT - OFFSITE	188,844,553	0	188,844,553	0.339877	0	1.01
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0	0	0.000000	0	2.00
3.00	Total (sum of lines 1-2)	555,625,956	0	555,625,956	1.000000	0	3.00

	Cost Center Description	ALLOCATION OF OTHER CAPITAL			SUMMARY OF CAPITAL		
		Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	Depreciation	Lease	
		6.00	7.00	8.00	9.00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	0	0	21,574,508	214,620	1.00
1.01	NEW CAP BLDG & FIXT - OFFSITE	0	0	0	6,415,767	6,976	1.01
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	0	0	0	27,990,275	221,596	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	NEW CAP REL COSTS-BLDG & FIXT	0	0	20,280	0	21,809,408	1.00
1.01	NEW CAP BLDG & FIXT - OFFSITE	0	0	285,121	0	6,707,864	1.01
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	0	0	305,401	0	28,517,272	3.00

	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 - NEW CAP REL COSTS-BLDG & FIXT (chapter 2)		0	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	1.00
1.01	Investment income - NEW CAP BLDG & FIXT - OFFSITE (chapter 2)		0	NEW CAP BLDG & FIXT - OFFSITE	1.01	0	1.01
2.00	Investment income - NEW CAP REL COSTS-MVBLE EQUIP (chapter 2)		0	NEW 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)	B	0	PURCHASING RECEIVING AND STORES	5.03	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	-17,358,378			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	76,269,074			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests	B	-2,857,422	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	B	0	PURCHASING RECEIVING AND STORES	5.03	0	16.00
17.00	Sale of drugs to other than patients	B	-60,971	PHARMACY	15.00	0	17.00
18.00	Sale of medical records and abstracts	B	0	MEDICAL RECORDS & LIBRARY	16.00	0	18.00
19.00	Nursing and allied health education (tuition, fees, books, etc.)		0		0.00	0	19.00
20.00	Vending machines	B	-6,187	DIETARY	10.00	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 - NEW CAP REL COSTS-BLDG & FIXT		0	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
26.01	Depreciation - NEW CAP BLDG & FIXT - OFFSITE		0	NEW CAP BLDG & FIXT - OFFSITE	1.01	0	26.01
27.00	Depreciation - NEW CAP REL COSTS-MVBLE EQUIP		0	NEW CAP REL COSTS-MVBLE EQUIP	2.00	0	27.00
28.00	Non-physician Anesthetist		0	*** Cost Center Deleted ***	19.00		28.00
29.00	Physicians' assistant		0		0.00	0	29.00

				Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted			
	Cost Center Description	Basis/Code (2)	Amount	Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	*** Cost Center Deleted ***	67.00		30.00
30.99	Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS	30.00		30.99
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	*** Cost Center Deleted ***	68.00		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest		0		0.00	0	32.00
33.00	MISCELLANEOUS INCOME	B	-142,662	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.00
33.01	MISCELLANEOUS INCOME	B	-495,797	DATA PROCESSING	5.02	0	33.01
33.02	MISCELLANEOUS INCOME	B	-6,684	PURCHASING RECEIVING AND STORES	5.03	0	33.02
33.03	MISCELLANEOUS INCOME	B	-10	ADMITTING	5.04	0	33.03
33.04	MISCELLANEOUS INCOME	B	-230,850	CASHIERING/ACCOUNTS RECEIVABLE	5.05	0	33.04
33.05	MISCELLANEOUS INCOME	B	-7,608	OTHER A&G	5.06	0	33.05
33.06	MISCELLANEOUS INCOME	B	-364,499	LAUNDRY & LINEN SERVICE	8.00	0	33.06
33.07	MISCELLANEOUS INCOME	B	-535,232	CAFETERIA	11.00	0	33.07
33.08	MISCELLANEOUS INCOME	B	-9,324	CENTRAL SERVICES & SUPPLY	14.00	0	33.08
33.09	MISCELLANEOUS INCOME	B	-44,105	INSERVICE EDUCATION	17.01	0	33.09
33.10	MISCELLANEOUS INCOME	B	765	I&R SERVICES-OTHER PRGM. COSTS APPRVD	22.00	0	33.10
33.11	MISCELLANEOUS INCOME	B	-4,805	ADULTS & PEDIATRICS	30.00	0	33.11
33.12	MISCELLANEOUS INCOME	B	-6,223	OPERATING ROOM	50.00	0	33.12
33.13	MISCELLANEOUS INCOME	B	-269,204	RADIOLOGY-DIAGNOSTIC	54.00	0	33.13
33.14	MISCELLANEOUS INCOME	B	-55,295	LABORATORY	60.00	0	33.14
33.15	MISCELLANEOUS INCOME	B	-1,425	RESPIRATORY THERAPY	65.00	0	33.15
33.16	MISCELLANEOUS INCOME	B	-77,270	PHYSICAL THERAPY	66.00	0	33.16
33.17	MISCELLANEOUS INCOME	B	-500	EMERGENCY	91.00	0	33.17
33.18	MISCELLANEOUS INCOME	B	-409,955	DURABLE MEDICAL EQUIP-RENTED	96.00	0	33.18
33.19	INTEREST INCOME	B	-3,643,621	NEW CAP REL COSTS-BLDG & FIXT	1.00	11	33.19
33.20	UNNECESSARY BORROWING	A	-4,722,902	NEW CAP REL COSTS-BLDG & FIXT	1.00	11	33.20
33.21	SELF INSURANCE ADJUSTMENT	A	-16,908,465	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.21
33.22	MARKETING/ADVERTISING	A	-54	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.22
33.23	MARKETING/ADVERTISING	A	-28,842	OTHER A&G	5.06	0	33.23
33.24	MARKETING/ADVERTISING	A	-1,970	DIETARY	10.00	0	33.24
33.25	MARKETING/ADVERTISING	A	-4,515	INSERVICE EDUCATION	17.01	0	33.25
33.26	MARKETING/ADVERTISING	A	-98	I&R SERVICES-OTHER PRGM. COSTS APPRVD	22.00	0	33.26
33.27	MARKETING/ADVERTISING	A	-6,074	ADULTS & PEDIATRICS	30.00	0	33.27
33.28	MARKETING/ADVERTISING	A	-1,508	SUBPROVIDER - IPF	40.00	0	33.28
33.29	MARKETING/ADVERTISING	A	-3,927	SUBPROVIDER - IRF	41.00	0	33.29
33.30	MARKETING/ADVERTISING	A	-1,611	OPERATING ROOM	50.00	0	33.30
33.31	MARKETING/ADVERTISING	A	-1,021	RADIOLOGY-DIAGNOSTIC	54.00	0	33.31
33.32	MARKETING/ADVERTISING	A	-1,822	CARDIAC CATHETERIZATION	59.00	0	33.32
33.33	MARKETING/ADVERTISING	A	-9,817	PHYSICAL THERAPY	66.00	0	33.33
33.34	MARKETING/ADVERTISING	A	-73	ELECTROENCEPHALOGRAPHY	70.00	0	33.34
33.35	MARKETING/ADVERTISING	A	-2,690	CARDIAC REHABILITATION	76.97	0	33.35
33.36	MARKETING/ADVERTISING	A	-7,786	EMERGENCY	91.00	0	33.36
33.37	MARKETING/ADVERTISING	A	-8,387	FAMILY PRACTICE	93.00	0	33.37
33.38	MARKETING/ADVERTISING	A	-2,463	DURABLE MEDICAL EQUIP-RENTED	96.00	0	33.38
33.39	MARKETING/ADVERTISING	A	-1,525	HOSPICE	116.00	0	33.39
33.40	NON-ALLOWABLE EXPENSES	A	-900,029	OTHER A&G	5.06	0	33.40
33.41	NON-ALLOWABLE EXPENSES	A	-15	DIETARY	10.00	0	33.41
33.42	NON-ALLOWABLE EXPENSES	A	-3	PHARMACY	15.00	0	33.42
33.43	NON-ALLOWABLE EXPENSES	A	-344,571	INSERVICE EDUCATION	17.01	0	33.43
33.44	NON-ALLOWABLE EXPENSES	A	-305	PARAMED ED PRGM	23.00	0	33.44
33.45	NON-ALLOWABLE EXPENSES	A	-800	ADULTS & PEDIATRICS	30.00	0	33.45
33.46	NON-ALLOWABLE EXPENSES	A	-20	SUBPROVIDER - IRF	41.00	0	33.46
33.47	NON-ALLOWABLE EXPENSES	A	-140	DELIVERY ROOM & LABOR ROOM	52.00	0	33.47
33.48	NON-ALLOWABLE EXPENSES	A	-1,370	RADIOLOGY-DIAGNOSTIC	54.00	0	33.48
33.49	NON-ALLOWABLE EXPENSES	A	-1,245	PHYSICAL THERAPY	66.00	0	33.49

ADJUSTMENTS TO EXPENSES | Provider CCN: 15-0048 | Period: From 01/01/2020 To 12/31/2020 | Worksheet A-8 | Date/Time Prepared: 7/8/2021 10:37 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	
33.50	NON-ALLOWABLE EXPENSES	A	-43	CARDIAC REHABILITATION	76.97	0	33.50
33.51	NON-ALLOWABLE EXPENSES	A	-4,602	EMERGENCY	91.00	0	33.51
33.52	NON-ALLOWABLE EXPENSES	A	-50	FAMILY PRACTICE	93.00	0	33.52
33.53	NON-ALLOWABLE EXPENSES	A	-845	HOSPICE	116.00	0	33.53
33.54	HAF EXPENSE	A	-14,052,483	OTHER A&G	5.06	0	33.54
33.55	BOND REFUNDING - 2015 BONDS	A	-401,531	OTHER A&G	5.06	0	33.55
33.56	BOND REFUNDING - 2016 BONDS	A	-7,737	OTHER A&G	5.06	0	33.56
33.57	OCC MED - EMPLOYEE COST	A	-35,939	OTHER A&G	5.06	0	33.57
33.58	OCC MED - EMPLOYEE COST	A	-331,329	PHARMACY	15.00	0	33.58
33.59	OCC MED - EMPLOYEE COST	A	-4,773	RADIOLOGY-DIAGNOSTIC	54.00	0	33.59
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		11,878,432				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: 15-0048 | Period: From 01/01/2020 To 12/31/2020 | Worksheet A-8-1 | Date/Time Prepared: 7/8/2021 10:37 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	50.00	OPERATING ROOM	REID OUTPATIENT SURGERY	21,242,819	28,059,457	1.00
2.00	1.00	NEW CAP REL COSTS-BLDG & FIX	NEW CAPITAL	10,243,571	0	2.00
3.00	4.00	EMPLOYEE BENEFITS DEPARTMENT	BENEFITS & HR	32,948,364	0	3.00
4.00	5.02	DATA PROCESSING	INFORMATION SYSTEMS	11,062,646	0	4.00
4.01	5.06	OTHER A&G	A&G	28,831,131	0	4.01
4.02	0.00			0	0	4.02
5.00	0		0	104,328,531	28,059,457	5.00

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

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

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

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

	Symbol (1)	Name	Percentage of Ownership	Name	Percentage of Ownership	
6.00	A	REID O/P SURGER	55.00		0.00	6.00
7.00	B		0.00	REID HOME OFFIC	100.00	7.00
8.00			0.00		0.00	8.00
9.00			0.00		0.00	9.00
10.00			0.00		0.00	10.00
100.00	G. Other (financial or non-financial) specify:					100.00

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

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

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

Provider CCN: 15-0048

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

Worksheet A-8-1

Date/Time Prepared: 7/8/2021 10:37 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	-6,816,638	0	1.00
2.00	10,243,571	9	2.00
3.00	32,948,364	0	3.00
4.00	11,062,646	0	4.00
4.01	28,831,131	0	4.01
4.02	0	0	4.02
5.00	76,269,074		5.00

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

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

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

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

6.00		6.00
7.00	HOME OFFICE	7.00
8.00		8.00
9.00		9.00
10.00		10.00
100.00		100.00

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

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

PROVIDER BASED PHYSICIAN ADJUSTMENT | Provider CCN: 15-0048 | Period: From 01/01/2020 To 12/31/2020 | Worksheet A-8-2 | Date/Time Prepared: 7/8/2021 10:37 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	17.01	INSERVICE EDUCATION	325,706	69,230	256,476	179,000	1,606	1.00
2.00	22.00	I&R SERVICES-OTHER PRGM. COSTS APPRVD	669,500	669,500	0	197,500	0	2.00
3.00	30.00	ADULTS & PEDIATRICS	6,766,238	6,607,360	158,878	179,000	998	3.00
4.00	41.00	SUBPROVIDER - IRF	167,475	167,475	0	179,000	0	4.00
5.00	50.00	OPERATING ROOM	4,037,766	4,037,766	0	246,400	0	5.00
6.00	54.00	RADIOLOGY-DIAGNOSTIC	2,000	2,000	0	260,300	0	6.00
7.00	60.00	LABORATORY	835,061	835,061	0	260,300	0	7.00
8.00	69.00	ELECTROCARDIOLOGY	63,533	63,533	0	179,000	0	8.00
9.00	91.00	EMERGENCY	4,715,194	4,715,194	0	179,000	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			17,582,473	17,167,119	415,354		2,604	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	17.01	INSERVICE EDUCATION	138,209	6,910	0	0	0	1.00
2.00	22.00	I&R SERVICES-OTHER PRGM. COSTS APPRVD	0	0	0	0	0	2.00
3.00	30.00	ADULTS & PEDIATRICS	85,886	4,294	0	0	0	3.00
4.00	41.00	SUBPROVIDER - IRF	0	0	0	0	0	4.00
5.00	50.00	OPERATING ROOM	0	0	0	0	0	5.00
6.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	6.00
7.00	60.00	LABORATORY	0	0	0	0	0	7.00
8.00	69.00	ELECTROCARDIOLOGY	0	0	0	0	0	8.00
9.00	91.00	EMERGENCY	0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			224,095	11,204	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	17.01	INSERVICE EDUCATION	0	138,209	118,267	187,497	1.00
2.00	22.00	I&R SERVICES-OTHER PRGM. COSTS APPRVD	0	0	0	669,500	2.00
3.00	30.00	ADULTS & PEDIATRICS	0	85,886	72,992	6,680,352	3.00
4.00	41.00	SUBPROVIDER - IRF	0	0	0	167,475	4.00
5.00	50.00	OPERATING ROOM	0	0	0	4,037,766	5.00
6.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	2,000	6.00
7.00	60.00	LABORATORY	0	0	0	835,061	7.00
8.00	69.00	ELECTROCARDIOLOGY	0	0	0	63,533	8.00
9.00	91.00	EMERGENCY	0	0	0	4,715,194	9.00
10.00	0.00		0	0	0	0	10.00
200.00			0	224,095	191,259	17,358,378	200.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-0048 | Period: From 01/01/2020 To 12/31/2020 | Worksheet B Part I | Date/Time Prepared: 7/8/2021 10:37 am

		Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS			EMPLOYEE BENEFITS DEPARTMENT	
				NEW BLDG & FIXT	NEW CAP BLDG & FIXT - OFFSITE	NEW MVBLE EQUIP		
			0	1.00	1.01	2.00	4.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT	21,809,408	21,809,408				1.00
1.01	00101	NEW CAP BLDG & FIXT - OFFSITE	6,707,864	0	6,707,864			1.01
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP	0			0		2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	16,152,886	0	9,741	0	16,162,627	4.00
5.01	00540	NONPATIENT TELEPHONES	0	0	0	0	0	5.01
5.02	00550	DATA PROCESSING	14,324,423	82,741	26,665	0	46,867	5.02
5.03	00560	PURCHASING RECEIVING AND STORES	87,913	221,549	0	0	11,203	5.03
5.04	00570	ADMITTING	6,719,563	11,538	45,879	0	713,253	5.04
5.05	00580	CASHIERING/ACCOUNTS RECEIVABLE	-122,642	0	190,431	0	0	5.05
5.06	00590	OTHER A&G	33,648,318	95,702	16,657	0	481,445	5.06
7.00	00700	OPERATION OF PLANT	864,675	274,820	37,940	0	107,649	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	558,278	308,061	0	0	67,548	8.00
9.00	00900	HOUSEKEEPING	3,549,416	203,742	0	0	410,501	9.00
10.00	01000	DIETARY	1,953,823	457,284	0	0	186,797	10.00
11.00	01100	CAFETERIA	1,841,620	240,105	0	0	390,175	11.00
13.00	01300	NURSING ADMINISTRATION	280,277	48,825	0	0	43,933	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	6,130,918	210,061	0	0	118,393	14.00
15.00	01500	PHARMACY	40,101,178	246,524	0	0	695,832	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	114,965	0	0	16.00
17.00	01700	SOCIAL SERVICE	3,628,319	30,993	0	0	480,439	17.00
17.01	01701	INSERVICE EDUCATION	2,476,218	259,960	0	0	197,361	17.01
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	1,957,778	0	0	0	291,485	21.00
22.00	02200	I&R SERVICES-OTHER PRGM. COSTS APPRVD	471,951	0	0	0	16,995	22.00
23.00	02300	PARAMED ED PRGM	311,814	26,498	65,263	0	43,588	23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	32,955,732	2,918,623	0	0	4,087,959	30.00
31.00	03100	INTENSIVE CARE UNIT	6,793,160	613,175	0	0	642,664	31.00
40.00	04000	SUBPROVIDER - IPF	3,913,880	557,931	0	0	533,787	40.00
41.00	04100	SUBPROVIDER - IRF	2,217,702	446,994	0	0	303,144	41.00
43.00	04300	NURSERY	934,939	66,957	0	0	127,470	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	22,644,995	1,140,387	318,789	0	255,861	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,135,160	207,688	0	0	133,163	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	15,083,165	1,746,769	38,963	0	1,209,672	54.00
59.00	05900	CARDIAC CATHETERIZATION	6,757,570	339,129	0	0	301,252	59.00
60.00	06000	LABORATORY	14,009,515	726,634	0	0	714,493	60.00
65.00	06500	RESPIRATORY THERAPY	2,530,692	41,133	0	0	292,905	65.00
66.00	06600	PHYSICAL THERAPY	8,285,447	201,894	1,030,469	0	1,121,003	66.00
69.00	06900	ELECTROCARDIOLOGY	1,938,080	195,026	0	0	172,521	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	405,205	0	94,777	0	49,673	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	16,634,850	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	879,925	37,212	0	0	168	74.00
76.00	03950	ANCILLARY - OTHER	0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	476,242	204,417	0	0	66,305	76.97
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	8,991,475	773,261	0	0	1,168,252	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
93.00	04040	FAMILY PRACTICE	2,347,206	0	20,626	0	318,013	93.00
		OTHER REIMBURSABLE COST CENTERS						
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	240,454	44,305	69,938	0	31,774	96.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	2,862,491	11,114	0	0	242,891	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	315,491,883	12,991,052	2,081,103	0	16,076,434	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	3,518,569	0	2,634,202	0	0	192.00
194.00	07950	RENTAL SPACE	4,699,687	0	475,590	0	5,119	194.00
194.01	07951	FOUNDATION	470,268	5,145	0	0	26,280	194.01
194.02	07952	RETAIL SERVICES	167,629	58,440	0	0	23,381	194.02
194.03	07953	REID CONTRACTED SERVICES	382,879	0	0	0	31,413	194.03
194.04	07954	REID PHYSICIAN ASSOC.	0	0	7,598	0	0	194.04
194.05	07955	CONNERSVILLE LOCATION	1,404,702	0	0	0	0	194.05
194.06	07956	VACANT SPACE	135,202	1,767,023	418,071	0	0	194.06
194.07	07957	HOME OFFICE	0	6,987,748	1,091,300	0	0	194.07
194.08	07958	CAMBRIDGE RHC	0	0	0	0	0	194.08

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-0048 | Period: From 01/01/2020 To 12/31/2020 | Worksheet B Part I | Date/Time Prepared: 7/8/2021 10:37 am

		Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS				
				NEW BLDG & FIXT	NEW CAP BLDG & FIXT - OFFSITE	NEW MVBLE EQUIP	EMPLOYEE BENEFITS DEPARTMENT	
			0	1.00	1.01	2.00	4.00	
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	326,270,819	21,809,408	6,707,864	0	16,162,627	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-0048 | Period: From 01/01/2020 To 12/31/2020 | Worksheet B Part I Date/Time Prepared: 7/8/2021 10:37 am

		Cost Center Description	NONPATIENT TELEPHONES	DATA PROCESSING	PURCHASING RECEIVING AND STORES	ADMITTING	CASHIERING/ACCOUNTS RECEIVABLE	
			5.01	5.02	5.03	5.04	5.05	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	NEW CAP BLDG & FIXT - OFFSITE						1.01
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00540	NONPATIENT TELEPHONES	0					5.01
5.02	00550	DATA PROCESSING	0	14,480,696				5.02
5.03	00560	PURCHASING RECEIVING AND STORES	0	0	320,665			5.03
5.04	00570	ADMITTING	0	1,415,236	800	8,906,269		5.04
5.05	00580	CASHIERING/ACCOUNTS RECEIVABLE	0	0	0	0	67,789	5.05
5.06	00590	OTHER A&G	0	849,142	1,454	0	0	5.06
7.00	00700	OPERATION OF PLANT	0	33,966	1,381	0	0	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	22,644	137	0	0	8.00
9.00	00900	HOUSEKEEPING	0	56,609	12,798	0	0	9.00
10.00	01000	DIETARY	0	532,129	5,841	0	0	10.00
11.00	01100	CAFETERIA	0	0	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	0	0	0	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	192,472	38,142	0	0	14.00
15.00	01500	PHARMACY	0	645,348	37,328	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	0	215,116	370	0	0	17.00
17.01	01701	INSERVICE EDUCATION	0	883,107	675	0	0	17.01
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM. COSTS APPRVD	0	271,725	74	0	0	22.00
23.00	02300	PARAMED ED PRGM	0	271,725	115	0	0	23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	1,641,674	37,897	544,595	4,152	30.00
31.00	03100	INTENSIVE CARE UNIT	0	283,047	14,145	103,216	787	31.00
40.00	04000	SUBPROVIDER - IPF	0	169,828	3,417	84,094	641	40.00
41.00	04100	SUBPROVIDER - IRF	0	113,219	2,850	52,827	403	41.00
43.00	04300	NURSERY	0	0	1,757	15,516	118	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	713,279	35,453	1,469,523	11,094	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	56,609	4,625	84,878	647	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	1,879,434	32,978	1,392,378	10,615	54.00
59.00	05900	CARDIAC CATHETERIZATION	0	113,219	23,070	896,105	6,831	59.00
60.00	06000	LABORATORY	0	724,601	5,794	1,001,588	7,636	60.00
65.00	06500	RESPIRATORY THERAPY	0	135,863	14,636	236,089	1,800	65.00
66.00	06600	PHYSICAL THERAPY	0	1,415,236	2,023	200,399	1,528	66.00
69.00	06900	ELECTROCARDIOLOGY	0	215,116	1,781	317,999	2,424	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	90,575	827	41,078	313	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	291,164	2,220	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	1,239,214	9,447	73.00
74.00	07400	RENAL DIALYSIS	0	45,288	811	11,647	89	74.00
76.00	03950	ANCILLARY - OTHER	0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0	67,931	382	8,473	65	76.97
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0	951,039	18,637	804,531	6,133	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
93.00	04040	FAMILY PRACTICE	0	169,828	3,350	57,168	436	93.00
		OTHER REIMBURSABLE COST CENTERS						
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	22,644	6,204	4,575	35	96.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	0	203,794	5,784	49,212	375	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	14,401,443	315,536	8,906,269	67,789	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	11,322	132	0	0	192.00
194.00	07950	RENTAL SPACE	0	0	3,192	0	0	194.00
194.01	07951	FOUNDATION	0	56,609	436	0	0	194.01
194.02	07952	RETAIL SERVICES	0	11,322	60	0	0	194.02
194.03	07953	REID CONTRACTED SERVICES	0	0	0	0	0	194.03
194.04	07954	REID PHYSICIAN ASSOC.	0	0	0	0	0	194.04
194.05	07955	CONNERSVILLE LOCATION	0	0	1,307	0	0	194.05
194.06	07956	VACANT SPACE	0	0	2	0	0	194.06
194.07	07957	HOME OFFICE	0	0	0	0	0	194.07
194.08	07958	CAMBRIDGE RHC	0	0	0	0	0	194.08
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	0	14,480,696	320,665	8,906,269	67,789	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-0048 | Period: From 01/01/2020 To 12/31/2020 | Worksheet B Part I Date/Time Prepared: 7/8/2021 10:37 am

		Cost Center Description	Subtotal	OTHER A&G	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
			5A.05	5.06	7.00	8.00	9.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	NEW CAP BLDG & FIXT - OFFSITE						1.01
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00540	NONPATIENT TELEPHONES						5.01
5.02	00550	DATA PROCESSING						5.02
5.03	00560	PURCHASING RECEIVING AND STORES						5.03
5.04	00570	ADMITTING						5.04
5.05	00580	CASHIERING/ACCOUNTS RECEIVABLE						5.05
5.06	00590	OTHER A&G	35,092,718	35,092,718				5.06
7.00	00700	OPERATION OF PLANT	1,320,431	159,138	1,479,569			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	956,668	115,298	19,122	1,091,088		8.00
9.00	00900	HOUSEKEEPING	4,233,066	510,169	12,203	0	4,755,438	9.00
10.00	01000	DIETARY	3,135,874	377,936	28,384	0	186,571	10.00
11.00	01100	CAFETERIA	2,471,900	297,913	14,666	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	373,035	44,958	3,031	0	3,902	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	6,689,986	806,277	13,039	0	63,136	14.00
15.00	01500	PHARMACY	41,726,210	5,028,843	14,944	0	81,226	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	114,965	13,856	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	4,355,237	524,893	679	0	34,760	17.00
17.01	01701	INSERVICE EDUCATION	3,817,321	460,064	14,451	0	112,439	17.01
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	2,249,263	271,081	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM. COSTS APPRVD	760,745	91,685	0	0	0	22.00
23.00	02300	PARAMED ED PRGM	719,003	86,654	4,351	0	0	23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	42,190,632	5,084,750	179,446	328,287	1,852,942	30.00
31.00	03100	INTENSIVE CARE UNIT	8,450,194	1,018,417	38,060	66,861	314,263	31.00
40.00	04000	SUBPROVIDER - IPF	5,263,578	634,366	34,631	75,713	205,725	40.00
41.00	04100	SUBPROVIDER - IRF	3,137,139	378,088	27,745	31,374	149,683	41.00
43.00	04300	NURSERY	1,146,757	138,207	4,156	0	10,286	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	26,589,381	3,204,552	62,975	166,043	371,369	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,622,770	195,576	12,891	58,676	137,623	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	21,393,974	2,578,402	83,524	106,909	205,370	54.00
59.00	05900	CARDIAC CATHETERIZATION	8,437,176	1,016,848	7,120	0	58,880	59.00
60.00	06000	LABORATORY	17,190,261	2,071,770	31,304	59,185	166,708	60.00
65.00	06500	RESPIRATORY THERAPY	3,253,118	392,066	1,851	0	44,692	65.00
66.00	06600	PHYSICAL THERAPY	12,257,999	1,477,334	74,750	10,416	46,465	66.00
69.00	06900	ELECTROCARDIOLOGY	2,842,947	342,632	863	0	54,624	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	682,448	82,249	8,371	4,419	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	16,928,234	2,040,191	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,248,661	150,489	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	975,140	117,524	2,310	0	55,688	74.00
76.00	03950	ANCILLARY - OTHER	0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	823,815	99,286	5,677	0	14,188	76.97
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	12,713,328	1,532,210	47,997	150,801	344,412	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0					92.00
93.00	04040	FAMILY PRACTICE	2,916,627	351,512	0	32,404	90,803	93.00
		OTHER REIMBURSABLE COST CENTERS						
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	419,929	50,610	5,816	0	0	96.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	3,375,661	406,835	0	0	82,290	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	301,876,191	32,152,679	754,357	1,091,088	4,688,045	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	6,164,225	742,912	167,688	0	53,205	192.00
194.00	07950	RENTAL SPACE	5,183,588	624,726	35,530	0	0	194.00
194.01	07951	FOUNDATION	558,738	67,339	319	0	3,547	194.01
194.02	07952	RETAIL SERVICES	260,832	31,435	1,060	0	10,641	194.02
194.03	07953	REID CONTRACTED SERVICES	414,292	49,930	0	0	0	194.03
194.04	07954	REID PHYSICIAN ASSOC.	7,598	916	0	0	0	194.04
194.05	07955	CONNERSVILLE LOCATION	1,406,009	169,452	0	0	0	194.05
194.06	07956	VACANT SPACE	2,320,298	279,642	144,223	0	0	194.06
194.07	07957	HOME OFFICE	8,079,048	973,687	376,392	0	0	194.07
194.08	07958	CAMBRIDGE RHC	0	0	0	0	0	194.08
200.00		Cross Foot Adjustments	0					200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	326,270,819	35,092,718	1,479,569	1,091,088	4,755,438	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-0048 | Period: From 01/01/2020 To 12/31/2020 | Worksheet B Part I Date/Time Prepared: 7/8/2021 10:37 am

		Cost Center Description	DIETARY	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	
			10.00	11.00	13.00	14.00	15.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	NEW CAP BLDG & FIXT - OFFSITE						1.01
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00540	NONPATIENT TELEPHONES						5.01
5.02	00550	DATA PROCESSING						5.02
5.03	00560	PURCHASING RECEIVING AND STORES						5.03
5.04	00570	ADMITTING						5.04
5.05	00580	CASHIERING/ACCOUNTS RECEIVABLE						5.05
5.06	00590	OTHER A&G						5.06
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY	3,728,765					10.00
11.00	01100	CAFETERIA	0	2,784,479				11.00
13.00	01300	NURSING ADMINISTRATION	0	2,137	427,063			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	44,806	0	7,617,244		14.00
15.00	01500	PHARMACY	0	134,568	0	0	46,985,791	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	0	89,679	0	0	53	17.00
17.01	01701	INSERVICE EDUCATION	0	41,097	0	0	0	17.01
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	40,412	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM. COSTS APPRVD	0	5,353	0	0	0	22.00
23.00	02300	PARAMED ED PRGM	0	7,109	0	0	0	23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,559,517	829,394	196,352	22,813	4,165	30.00
31.00	03100	INTENSIVE CARE UNIT	368,214	118,385	28,027	25,225	830	31.00
40.00	04000	SUBPROVIDER - IPF	492,034	119,213	28,223	1,369	18	40.00
41.00	04100	SUBPROVIDER - IRF	309,000	57,476	13,607	4,777	123	41.00
43.00	04300	NURSERY	0	21,752	5,150	22	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	54,163	12,823	3,983,338	147,999	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	23,246	5,503	11,909	1,057	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	231,954	54,914	56,970	757,955	54.00
59.00	05900	CARDIAC CATHETERIZATION	0	55,025	13,027	2,815,784	2,209	59.00
60.00	06000	LABORATORY	0	183,945	0	524,071	154	60.00
65.00	06500	RESPIRATORY THERAPY	0	55,464	13,131	8,592	997	65.00
66.00	06600	PHYSICAL THERAPY	0	214,403	0	655	133	66.00
69.00	06900	ELECTROCARDIOLOGY	0	36,531	0	49,385	282,700	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	13,318	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	45,616,453	73.00
74.00	07400	RENAL DIALYSIS	0	30	7	31	11	74.00
76.00	03950	ANCILLARY - OTHER	0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0	16,139	3,821	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0	221,667	52,478	24,712	11,123	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
93.00	04040	FAMILY PRACTICE	0	78,465	0	0	1,142	93.00
		OTHER REIMBURSABLE COST CENTERS						
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	11,079	0	87,591	158,669	96.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	0	50,035	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	3,728,765	2,756,845	427,063	7,617,244	46,985,791	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07950	RENTAL SPACE	0	1,380	0	0	0	194.00
194.01	07951	FOUNDATION	0	6,567	0	0	0	194.01
194.02	07952	RETAIL SERVICES	0	7,942	0	0	0	194.02
194.03	07953	REID CONTRACTED SERVICES	0	11,745	0	0	0	194.03
194.04	07954	REID PHYSICIAN ASSOC.	0	0	0	0	0	194.04
194.05	07955	CONNERSVILLE LOCATION	0	0	0	0	0	194.05
194.06	07956	VACANT SPACE	0	0	0	0	0	194.06
194.07	07957	HOME OFFICE	0	0	0	0	0	194.07
194.08	07958	CAMBRIDGE RHC	0	0	0	0	0	194.08
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	3,728,765	2,784,479	427,063	7,617,244	46,985,791	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-0048 | Period: From 01/01/2020 To 12/31/2020 | Worksheet B Part I Date/Time Prepared: 7/8/2021 10:37 am

		Cost Center Description	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	INSERVICE EDUCATION	INTERNS & RESIDENTS SERVICES-SALARY & FRINGES	INTERNS & RESIDENTS SERVICES-OTHER PRGM. COSTS	
			16.00	17.00	17.01	21.00	22.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	NEW CAP BLDG & FIXT - OFFSITE						1.01
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00540	NONPATIENT TELEPHONES						5.01
5.02	00550	DATA PROCESSING						5.02
5.03	00560	PURCHASING RECEIVING AND STORES						5.03
5.04	00570	ADMITTING						5.04
5.05	00580	CASHIERING/ACCOUNTS RECEIVABLE						5.05
5.06	00590	OTHER A&G						5.06
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY						15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	128,821					16.00
17.00	01700	SOCIAL SERVICE	0	5,005,301				17.00
17.01	01701	INSERVICE EDUCATION	0	0	4,445,372			17.01
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	0	0	2,560,756		21.00
22.00	02200	I&R SERVICES-OTHER PRGM. COSTS APPRVD	0	0	0		857,783	22.00
23.00	02300	PARAMED ED PRGM	0	0	10,169			23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	7,882	3,237,858	1,382,613	2,123,255	711,233	30.00
31.00	03100	INTENSIVE CARE UNIT	1,494	290,144	201,421	78,016	26,133	31.00
40.00	04000	SUBPROVIDER - IPF	1,217	0	220,011	0	0	40.00
41.00	04100	SUBPROVIDER - IRF	765	0	78,622	0	0	41.00
43.00	04300	NURSERY	225	0	42,427	0	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	21,184	0	288,463	140,734	47,142	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,228	0	43,958	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	20,153	0	402,077	0	0	54.00
59.00	05900	CARDIAC CATHETERIZATION	12,970	0	102,788	0	0	59.00
60.00	06000	LABORATORY	14,497	0	317,659	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	3,417	0	96,774	12,238	4,099	65.00
66.00	06600	PHYSICAL THERAPY	2,900	0	377,911	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	4,603	0	71,733	38,243	12,810	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	595	0	24,713	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	4,214	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	17,936	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	169	0	0	0	0	74.00
76.00	03950	ANCILLARY - OTHER	0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	123	0	32,149	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	11,644	1,477,299	511,426	168,270	56,366	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
93.00	04040	FAMILY PRACTICE	827	0	133,734	0	0	93.00
		OTHER REIMBURSABLE COST CENTERS						
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	66	0	19,136	0	0	96.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	712	0	62,110			116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	128,821	5,005,301	4,419,894	2,560,756	857,783	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07950	RENTAL SPACE	0	0	0	0	0	194.00
194.01	07951	FOUNDATION	0	0	12,028	0	0	194.01
194.02	07952	RETAIL SERVICES	0	0	13,450	0	0	194.02
194.03	07953	REID CONTRACTED SERVICES	0	0	0	0	0	194.03
194.04	07954	REID PHYSICIAN ASSOC.	0	0	0	0	0	194.04
194.05	07955	CONNERSVILLE LOCATION	0	0	0	0	0	194.05
194.06	07956	VACANT SPACE	0	0	0	0	0	194.06
194.07	07957	HOME OFFICE	0	0	0	0	0	194.07
194.08	07958	CAMBRIDGE RHC	0	0	0	0	0	194.08
200.00		Cross Foot Adjustments				0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00

COST ALLOCATION - GENERAL SERVICE COSTS	Provider CCN: 15-0048	Period: From 01/01/2020 To 12/31/2020	Worksheet B Part I Date/Time Prepared: 7/8/2021 10:37 am

	Cost Center Description				INTERNS & RESIDENTS		
		MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	INSERVICE EDUCATION	SERVICES-SALARY & FRINGES	SERVICES-OTHER PRGM. COSTS	
		16.00	17.00	17.01	21.00	22.00	
202.00	TOTAL (sum lines 118 through 201)	128,821	5,005,301	4,445,372	2,560,756	857,783	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-0048 | Period: From 01/01/2020 To 12/31/2020 | Worksheet B Part I Date/Time Prepared: 7/8/2021 10:37 am

		Cost Center Description	PARAMED ED PRGM	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			23.00	24.00	25.00	26.00		
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	NEW CAP BLDG & FIXT - OFFSITE						1.01
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00540	NONPATIENT TELEPHONES						5.01
5.02	00550	DATA PROCESSING						5.02
5.03	00560	PURCHASING RECEIVING AND STORES						5.03
5.04	00570	ADMITTING						5.04
5.05	00580	CASHIERING/ACCOUNTS RECEIVABLE						5.05
5.06	00590	OTHER A&G						5.06
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY						15.00
16.00	01600	MEDICAL RECORDS & LIBRARY						16.00
17.00	01700	SOCIAL SERVICE						17.00
17.01	01701	INSERVICE EDUCATION						17.01
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD						21.00
22.00	02200	I&R SERVICES-OTHER PRGM. COSTS APPRVD						22.00
23.00	02300	PARAMED ED PRGM	827,286					23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	60,711,139	-2,834,488	57,876,651		30.00
31.00	03100	INTENSIVE CARE UNIT	0	11,025,684	-104,149	10,921,535		31.00
40.00	04000	SUBPROVIDER - IPF	0	7,076,098	0	7,076,098		40.00
41.00	04100	SUBPROVIDER - IRF	0	4,188,399	0	4,188,399		41.00
43.00	04300	NURSERY	0	1,368,982	0	1,368,982		43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	35,090,166	-187,876	34,902,290		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	2,114,437	0	2,114,437		52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	827,286	26,719,488	0	26,719,488		54.00
59.00	05900	CARDIAC CATHETERIZATION	0	12,521,827	0	12,521,827		59.00
60.00	06000	LABORATORY	0	20,559,554	0	20,559,554		60.00
65.00	06500	RESPIRATORY THERAPY	0	3,886,439	-16,337	3,870,102		65.00
66.00	06600	PHYSICAL THERAPY	0	14,462,966	0	14,462,966		66.00
69.00	06900	ELECTROCARDIOLOGY	0	3,737,071	-51,053	3,686,018		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	816,113	0	816,113		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	18,972,639	0	18,972,639		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	47,033,539	0	47,033,539		73.00
74.00	07400	RENAL DIALYSIS	0	1,150,910	0	1,150,910		74.00
76.00	03950	ANCILLARY - OTHER	0	0	0	0		76.00
76.97	07697	CARDIAC REHABILITATION	0	995,198	0	995,198		76.97
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0	17,323,733	-224,636	17,099,097		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)			0			92.00
93.00	04040	FAMILY PRACTICE	0	3,605,514	0	3,605,514		93.00
		OTHER REIMBURSABLE COST CENTERS						
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	752,896	0	752,896		96.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	0	3,977,643	0	3,977,643		116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	827,286	298,090,435	-3,418,539	294,671,896		118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	7,128,030	0	7,128,030		192.00
194.00	07950	RENTAL SPACE	0	5,845,224	0	5,845,224		194.00
194.01	07951	FOUNDATION	0	648,538	0	648,538		194.01
194.02	07952	RETAIL SERVICES	0	325,360	0	325,360		194.02
194.03	07953	REID CONTRACTED SERVICES	0	475,967	0	475,967		194.03
194.04	07954	REID PHYSICIAN ASSOC.	0	8,514	0	8,514		194.04
194.05	07955	CONNERSVILLE LOCATION	0	1,575,461	0	1,575,461		194.05
194.06	07956	VACANT SPACE	0	2,744,163	0	2,744,163		194.06
194.07	07957	HOME OFFICE	0	9,429,127	0	9,429,127		194.07
194.08	07958	CAMBRIDGE RHC	0	0	0	0		194.08
200.00		Cross Foot Adjustments	0	0	0	0		200.00
201.00		Negative Cost Centers	0	0	0	0		201.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-0048 | Period: From 01/01/2020 To 12/31/2020 | Worksheet B Part I Date/Time Prepared: 7/8/2021 10:37 am

	Cost Center Description	PARAMED ED PRGM	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
		23.00	24.00	25.00	26.00		
202.00	TOTAL (sum lines 118 through 201)	827,286	326,270,819	-3,418,539	322,852,280		202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-0048 | Period: From 01/01/2020 To 12/31/2020 | Worksheet B Part II | Date/Time Prepared: 7/8/2021 10:37 am

		Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS NEW BLDG & FIXT	NEW CAP BLDG & FIXT - OFFSITE	NEW MVBLE EQUIP	Subtotal	
			0	1.00	1.01	2.00	2A	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	NEW CAP BLDG & FIXT - OFFSITE						1.01
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	403	0	9,741	0	10,144	4.00
5.01	00540	NONPATIENT TELEPHONES	0	0	0	0	0	5.01
5.02	00550	DATA PROCESSING	223,905	82,741	26,665	0	333,311	5.02
5.03	00560	PURCHASING RECEIVING AND STORES	8,072	221,549	0	0	229,621	5.03
5.04	00570	ADMITTING	48,284	11,538	45,879	0	105,701	5.04
5.05	00580	CASHIERING/ACCOUNTS RECEIVABLE	5,462	0	190,431	0	195,893	5.05
5.06	00590	OTHER A&G	47,974	95,702	16,657	0	160,333	5.06
7.00	00700	OPERATION OF PLANT	45,984	274,820	37,940	0	358,744	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	57,721	308,061	0	0	365,782	8.00
9.00	00900	HOUSEKEEPING	67,224	203,742	0	0	270,966	9.00
10.00	01000	DIETARY	101,232	457,284	0	0	558,516	10.00
11.00	01100	CAFETERIA	0	240,105	0	0	240,105	11.00
13.00	01300	NURSING ADMINISTRATION	0	48,825	0	0	48,825	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	507,907	210,061	0	0	717,968	14.00
15.00	01500	PHARMACY	424,741	246,524	0	0	671,265	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	114,965	0	114,965	16.00
17.00	01700	SOCIAL SERVICE	2,728	30,993	0	0	33,721	17.00
17.01	01701	INSERVICE EDUCATION	22,582	259,960	0	0	282,542	17.01
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM. COSTS APPRVD	21,423	0	0	0	21,423	22.00
23.00	02300	PARAMED ED PRGM	2,970	26,498	65,263	0	94,731	23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	713,816	2,918,623	0	0	3,632,439	30.00
31.00	03100	INTENSIVE CARE UNIT	502,236	613,175	0	0	1,115,411	31.00
40.00	04000	SUBPROVIDER - IPF	26,171	557,931	0	0	584,102	40.00
41.00	04100	SUBPROVIDER - IRF	44,317	446,994	0	0	491,311	41.00
43.00	04300	NURSERY	8,036	66,957	0	0	74,993	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,263,208	1,140,387	318,789	0	2,722,384	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	39,549	207,688	0	0	247,237	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,660,618	1,746,769	38,963	0	3,446,350	54.00
59.00	05900	CARDIAC CATHETERIZATION	237,344	339,129	0	0	576,473	59.00
60.00	06000	LABORATORY	696,001	726,634	0	0	1,422,635	60.00
65.00	06500	RESPIRATORY THERAPY	68,346	41,133	0	0	109,479	65.00
66.00	06600	PHYSICAL THERAPY	101,485	201,894	1,030,469	0	1,333,848	66.00
69.00	06900	ELECTROCARDIOLOGY	147,449	195,026	0	0	342,475	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	33,147	0	94,777	0	127,924	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	10,685	37,212	0	0	47,897	74.00
76.00	03950	ANCILLARY - OTHER	0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	5,850	204,417	0	0	210,267	76.97
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	382,426	773,261	0	0	1,155,687	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					0	92.00
93.00	04040	FAMILY PRACTICE	31,988	0	20,626	0	52,614	93.00
		OTHER REIMBURSABLE COST CENTERS						
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	2,405	44,305	69,938	0	116,648	96.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	222	11,114	0	0	11,336	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	7,563,911	12,991,052	2,081,103	0	22,636,066	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	102,102	0	2,634,202	0	2,736,304	192.00
194.00	07950	RENTAL SPACE	99,513	0	475,590	0	575,103	194.00
194.01	07951	FOUNDATION	1,841	5,145	0	0	6,986	194.01
194.02	07952	RETAIL SERVICES	143	58,440	0	0	58,583	194.02
194.03	07953	REID CONTRACTED SERVICES	0	0	0	0	0	194.03
194.04	07954	REID PHYSICIAN ASSOC.	0	0	7,598	0	7,598	194.04
194.05	07955	CONNERSVILLE LOCATION	87,383	0	0	0	87,383	194.05
194.06	07956	VACANT SPACE	4,932	1,767,023	418,071	0	2,190,026	194.06
194.07	07957	HOME OFFICE	0	6,987,748	1,091,300	0	8,079,048	194.07
194.08	07958	CAMBRIDGE RHC	0	0	0	0	0	194.08
200.00		Cross Foot Adjustments					0	200.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-0048 | Period: From 01/01/2020 To 12/31/2020 | Worksheet B Part II Date/Time Prepared: 7/8/2021 10:37 am

	Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS			Subtotal	
			NEW BLDG & FIXT	NEW CAP BLDG & FIXT - OFFSITE	NEW MVBLE EQUIP		
		0	1.00	1.01	2.00	2A	
201.00	Negative Cost Centers		0	0	0	0	201.00
202.00	TOTAL (sum lines 118 through 201)	7,859,825	21,809,408	6,707,864	0	36,377,097	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-0048 | Period: From 01/01/2020 To 12/31/2020 | Worksheet B Part II Date/Time Prepared: 7/8/2021 10:37 am

		Cost Center Description	EMPLOYEE BENEFITS DEPARTMENT	NONPATIENT TELEPHONES	DATA PROCESSING	PURCHASING RECEIVING AND STORES	ADMITTING	
			4.00	5.01	5.02	5.03	5.04	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	NEW CAP BLDG & FIXT - OFFSITE						1.01
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	10,144					4.00
5.01	00540	NONPATIENT TELEPHONES	0	0				5.01
5.02	00550	DATA PROCESSING	29	0	333,340			5.02
5.03	00560	PURCHASING RECEIVING AND STORES	7	0	0	229,628		5.03
5.04	00570	ADMITTING	446	0	32,578	573	139,298	5.04
5.05	00580	CASHIERING/ACCOUNTS RECEIVABLE	0	0	0	0	0	5.05
5.06	00590	OTHER A&G	301	0	19,547	1,041	0	5.06
7.00	00700	OPERATION OF PLANT	67	0	782	989	0	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	42	0	521	98	0	8.00
9.00	00900	HOUSEKEEPING	257	0	1,303	9,165	0	9.00
10.00	01000	DIETARY	117	0	12,249	4,182	0	10.00
11.00	01100	CAFETERIA	244	0	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	27	0	0	0	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	74	0	4,431	27,312	0	14.00
15.00	01500	PHARMACY	435	0	14,856	26,731	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	300	0	4,952	265	0	17.00
17.01	01701	INSERVICE EDUCATION	123	0	20,329	483	0	17.01
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	182	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM. COSTS APPRVD	11	0	6,255	53	0	22.00
23.00	02300	PARAMED ED PRGM	27	0	6,255	82	0	23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,596	0	37,791	27,138	8,544	30.00
31.00	03100	INTENSIVE CARE UNIT	402	0	6,516	10,129	1,619	31.00
40.00	04000	SUBPROVIDER - IPF	334	0	3,909	2,447	1,319	40.00
41.00	04100	SUBPROVIDER - IRF	190	0	2,606	2,041	829	41.00
43.00	04300	NURSERY	80	0	0	1,259	243	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	160	0	16,419	25,388	22,624	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	83	0	1,303	3,312	1,332	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	756	0	43,263	23,615	21,845	54.00
59.00	05900	CARDIAC CATHETERIZATION	188	0	2,606	16,520	14,059	59.00
60.00	06000	LABORATORY	447	0	16,680	4,149	15,714	60.00
65.00	06500	RESPIRATORY THERAPY	183	0	3,128	10,481	3,704	65.00
66.00	06600	PHYSICAL THERAPY	701	0	32,578	1,448	3,144	66.00
69.00	06900	ELECTROCARDIOLOGY	108	0	4,952	1,276	4,989	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	31	0	2,085	592	644	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	4,568	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	19,442	73.00
74.00	07400	RENAL DIALYSIS	0	0	1,043	581	183	74.00
76.00	03950	ANCILLARY - OTHER	0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	41	0	1,564	274	133	76.97
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	730	0	21,893	13,346	12,622	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
93.00	04040	FAMILY PRACTICE	199	0	3,909	2,399	897	93.00
		OTHER REIMBURSABLE COST CENTERS						
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	20	0	521	4,443	72	96.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	152	0	4,691	4,142	772	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	10,090	0	331,515	225,954	139,298	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	261	95	0	192.00
194.00	07950	RENTAL SPACE	3	0	0	2,286	0	194.00
194.01	07951	FOUNDATION	16	0	1,303	312	0	194.01
194.02	07952	RETAIL SERVICES	15	0	261	43	0	194.02
194.03	07953	REID CONTRACTED SERVICES	20	0	0	0	0	194.03
194.04	07954	REID PHYSICIAN ASSOC.	0	0	0	0	0	194.04
194.05	07955	CONNERSVILLE LOCATION	0	0	0	936	0	194.05
194.06	07956	VACANT SPACE	0	0	0	2	0	194.06
194.07	07957	HOME OFFICE	0	0	0	0	0	194.07
194.08	07958	CAMBRIDGE RHC	0	0	0	0	0	194.08
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	10,144	0	333,340	229,628	139,298	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-0048 | Period: From 01/01/2020 To 12/31/2020 | Worksheet B Part II Date/Time Prepared: 7/8/2021 10:37 am

		Cost Center Description	CASHIERING/ACCOUNTS RECEIVABLE	OTHER A&G	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
			5.05	5.06	7.00	8.00	9.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	NEW CAP BLDG & FIXT - OFFSITE						1.01
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00540	NONPATIENT TELEPHONES						5.01
5.02	00550	DATA PROCESSING						5.02
5.03	00560	PURCHASING RECEIVING AND STORES						5.03
5.04	00570	ADMITTING						5.04
5.05	00580	CASHIERING/ACCOUNTS RECEIVABLE	69,733					5.05
5.06	00590	OTHER A&G	0	181,222				5.06
7.00	00700	OPERATION OF PLANT	0	821	361,403			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	595	4,671	371,709		8.00
9.00	00900	HOUSEKEEPING	0	2,633	2,981	0	287,305	9.00
10.00	01000	DIETARY	0	1,951	6,933	0	11,272	10.00
11.00	01100	CAFETERIA	0	1,538	3,582	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	232	740	0	236	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	4,161	3,185	0	3,814	14.00
15.00	01500	PHARMACY	0	25,954	3,650	0	4,907	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	72	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	0	2,709	166	0	2,100	17.00
17.01	01701	INSERVICE EDUCATION	0	2,374	3,530	0	6,793	17.01
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	1,399	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM. COSTS APPRVD	0	473	0	0	0	22.00
23.00	02300	PARAMED ED PRGM	0	447	1,063	0	0	23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	4,272	26,353	43,832	111,843	111,949	30.00
31.00	03100	INTENSIVE CARE UNIT	810	5,256	9,297	22,778	18,987	31.00
40.00	04000	SUBPROVIDER - IPF	660	3,274	8,459	25,794	12,429	40.00
41.00	04100	SUBPROVIDER - IRF	414	1,951	6,777	10,688	9,043	41.00
43.00	04300	NURSERY	122	713	1,015	0	621	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	11,397	16,539	15,382	56,567	22,437	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	666	1,009	3,149	19,989	8,315	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	10,922	13,307	20,402	36,421	12,408	54.00
59.00	05900	CARDIAC CATHETERIZATION	7,029	5,248	1,739	0	3,557	59.00
60.00	06000	LABORATORY	7,857	10,692	7,646	20,163	10,072	60.00
65.00	06500	RESPIRATORY THERAPY	1,852	2,023	452	0	2,700	65.00
66.00	06600	PHYSICAL THERAPY	1,572	7,624	18,259	3,548	2,807	66.00
69.00	06900	ELECTROCARDIOLOGY	2,495	1,768	211	0	3,300	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	322	424	2,045	1,505	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	2,284	10,529	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	9,721	777	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	91	607	564	0	3,364	74.00
76.00	03950	ANCILLARY - OTHER	0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	66	512	1,387	0	857	76.97
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	6,311	7,908	11,724	51,374	20,808	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
93.00	04040	FAMILY PRACTICE	448	1,814	0	11,039	5,486	93.00
		OTHER REIMBURSABLE COST CENTERS						
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	36	261	1,421	0	0	96.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	386	2,100	0	0	4,972	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	69,733	166,048	184,262	371,709	283,234	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	3,834	40,960	0	3,214	192.00
194.00	07950	RENTAL SPACE	0	3,224	8,679	0	0	194.00
194.01	07951	FOUNDATION	0	348	78	0	214	194.01
194.02	07952	RETAIL SERVICES	0	162	259	0	643	194.02
194.03	07953	REID CONTRACTED SERVICES	0	258	0	0	0	194.03
194.04	07954	REID PHYSICIAN ASSOC.	0	5	0	0	0	194.04
194.05	07955	CONNERSVILLE LOCATION	0	875	0	0	0	194.05
194.06	07956	VACANT SPACE	0	1,443	35,228	0	0	194.06
194.07	07957	HOME OFFICE	0	5,025	91,937	0	0	194.07
194.08	07958	CAMBRIDGE RHC	0	0	0	0	0	194.08
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	126,160	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	195,893	181,222	361,403	371,709	287,305	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-0048 | Period: From 01/01/2020 To 12/31/2020 | Worksheet B Part II Date/Time Prepared: 7/8/2021 10:37 am

		Cost Center Description	DIETARY	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	
			10.00	11.00	13.00	14.00	15.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	NEW CAP BLDG & FIXT - OFFSITE						1.01
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00540	NONPATIENT TELEPHONES						5.01
5.02	00550	DATA PROCESSING						5.02
5.03	00560	PURCHASING RECEIVING AND STORES						5.03
5.04	00570	ADMITTING						5.04
5.05	00580	CASHIERING/ACCOUNTS RECEIVABLE						5.05
5.06	00590	OTHER A&G						5.06
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY	595,220					10.00
11.00	01100	CAFETERIA	0	245,469				11.00
13.00	01300	NURSING ADMINISTRATION	0	188	50,248			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	3,950	0	764,895		14.00
15.00	01500	PHARMACY	0	11,863	0	0	759,661	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	0	7,906	0	0	1	17.00
17.01	01701	INSERVICE EDUCATION	0	3,623	0	0	0	17.01
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	3,563	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM. COSTS APPRVD	0	472	0	0	0	22.00
23.00	02300	PARAMED ED PRGM	0	627	0	0	0	23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	408,574	73,116	23,100	2,291	67	30.00
31.00	03100	INTENSIVE CARE UNIT	58,778	10,436	3,298	2,533	13	31.00
40.00	04000	SUBPROVIDER - IPF	78,543	10,509	3,321	137	0	40.00
41.00	04100	SUBPROVIDER - IRF	49,325	5,067	1,601	480	2	41.00
43.00	04300	NURSERY	0	1,918	606	2	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	4,775	1,509	399,990	2,393	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	2,049	648	1,196	17	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	20,448	6,461	5,721	12,254	54.00
59.00	05900	CARDIAC CATHETERIZATION	0	4,851	1,533	282,752	36	59.00
60.00	06000	LABORATORY	0	16,216	0	52,625	2	60.00
65.00	06500	RESPIRATORY THERAPY	0	4,889	1,545	863	16	65.00
66.00	06600	PHYSICAL THERAPY	0	18,901	0	66	2	66.00
69.00	06900	ELECTROCARDIOLOGY	0	3,220	0	4,959	4,571	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	1,174	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	737,524	73.00
74.00	07400	RENAL DIALYSIS	0	3	1	3	0	74.00
76.00	03950	ANCILLARY - OTHER	0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0	1,423	450	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0	19,541	6,175	2,481	180	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
93.00	04040	FAMILY PRACTICE	0	6,917	0	0	18	93.00
		OTHER REIMBURSABLE COST CENTERS						
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	977	0	8,796	2,565	96.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	0	4,411	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	595,220	243,033	50,248	764,895	759,661	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07950	RENTAL SPACE	0	122	0	0	0	194.00
194.01	07951	FOUNDATION	0	579	0	0	0	194.01
194.02	07952	RETAIL SERVICES	0	700	0	0	0	194.02
194.03	07953	REID CONTRACTED SERVICES	0	1,035	0	0	0	194.03
194.04	07954	REID PHYSICIAN ASSOC.	0	0	0	0	0	194.04
194.05	07955	CONNERSVILLE LOCATION	0	0	0	0	0	194.05
194.06	07956	VACANT SPACE	0	0	0	0	0	194.06
194.07	07957	HOME OFFICE	0	0	0	0	0	194.07
194.08	07958	CAMBRIDGE RHC	0	0	0	0	0	194.08
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	595,220	245,469	50,248	764,895	759,661	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-0048 | Period: From 01/01/2020 To 12/31/2020 | Worksheet B Part II | Date/Time Prepared: 7/8/2021 10:37 am

		Cost Center Description	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	INSERVICE EDUCATION	INTERNS & RESIDENTS SERVICES-SALARY & FRINGES	INTERNS & RESIDENTS SERVICES-OTHER PRGM. COSTS	
			16.00	17.00	17.01	21.00	22.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	NEW CAP BLDG & FIXT - OFFSITE						1.01
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00540	NONPATIENT TELEPHONES						5.01
5.02	00550	DATA PROCESSING						5.02
5.03	00560	PURCHASING RECEIVING AND STORES						5.03
5.04	00570	ADMITTING						5.04
5.05	00580	CASHIERING/ACCOUNTS RECEIVABLE						5.05
5.06	00590	OTHER A&G						5.06
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY						15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	115,037					16.00
17.00	01700	SOCIAL SERVICE	0	52,120				17.00
17.01	01701	INSERVICE EDUCATION	0	0	319,797			17.01
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	0	0	5,144		21.00
22.00	02200	I&R SERVICES-OTHER PRGM. COSTS APPRVD	0	0	0		28,687	22.00
23.00	02300	PARAMED ED PRGM	0	0	732			23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	7,040	33,716	99,463			30.00
31.00	03100	INTENSIVE CARE UNIT	1,334	3,021	14,490			31.00
40.00	04000	SUBPROVIDER - IPF	1,087	0	15,827			40.00
41.00	04100	SUBPROVIDER - IRF	683	0	5,656			41.00
43.00	04300	NURSERY	201	0	3,052			43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	18,902	0	20,752			50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,097	0	3,162			52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	17,999	0	28,925			54.00
59.00	05900	CARDIAC CATHETERIZATION	11,584	0	7,395			59.00
60.00	06000	LABORATORY	12,947	0	22,852			60.00
65.00	06500	RESPIRATORY THERAPY	3,052	0	6,962			65.00
66.00	06600	PHYSICAL THERAPY	2,591	0	27,187			66.00
69.00	06900	ELECTROCARDIOLOGY	4,111	0	5,160			69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	531	0	1,778			70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0			71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	3,764	0	0			72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	16,019	0	0			73.00
74.00	07400	RENAL DIALYSIS	151	0	0			74.00
76.00	03950	ANCILLARY - OTHER	0	0	0			76.00
76.97	07697	CARDIAC REHABILITATION	110	0	2,313			76.97
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	10,400	15,383	36,792			91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
93.00	04040	FAMILY PRACTICE	739	0	9,621			93.00
		OTHER REIMBURSABLE COST CENTERS						
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	59	0	1,377			96.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	636	0	4,468			116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	115,037	52,120	317,964	0	0	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0			190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0			192.00
194.00	07950	RENTAL SPACE	0	0	0			194.00
194.01	07951	FOUNDATION	0	0	865			194.01
194.02	07952	RETAIL SERVICES	0	0	968			194.02
194.03	07953	REID CONTRACTED SERVICES	0	0	0			194.03
194.04	07954	REID PHYSICIAN ASSOC.	0	0	0			194.04
194.05	07955	CONNERSVILLE LOCATION	0	0	0			194.05
194.06	07956	VACANT SPACE	0	0	0			194.06
194.07	07957	HOME OFFICE	0	0	0			194.07
194.08	07958	CAMBRIDGE RHC	0	0	0			194.08
200.00		Cross Foot Adjustments				5,144	28,687	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-0048 | Period: From 01/01/2020 To 12/31/2020 | Worksheet B Part II Date/Time Prepared: 7/8/2021 10:37 am

	Cost Center Description	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	INSERVICE EDUCATION	INTERNS & RESIDENTS SERVICES-SALARY & FRINGES	INTERNS & RESIDENTS SERVICES-OTHER PRGM. COSTS	
		16.00	17.00	17.01	21.00	22.00	
202.00	TOTAL (sum lines 118 through 201)	115,037	52,120	319,797	5,144	28,687	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-0048 | Period: From 01/01/2020 To 12/31/2020 | Worksheet B Part II Date/Time Prepared: 7/8/2021 10:37 am

		Cost Center Description	PARAMED ED PRGM	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			23.00	24.00	25.00	26.00		
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	NEW CAP BLDG & FIXT - OFFSITE						1.01
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00540	NONPATIENT TELEPHONES						5.01
5.02	00550	DATA PROCESSING						5.02
5.03	00560	PURCHASING RECEIVING AND STORES						5.03
5.04	00570	ADMITTING						5.04
5.05	00580	CASHIERING/ACCOUNTS RECEIVABLE						5.05
5.06	00590	OTHER A&G						5.06
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY						15.00
16.00	01600	MEDICAL RECORDS & LIBRARY						16.00
17.00	01700	SOCIAL SERVICE						17.00
17.01	01701	INSERVICE EDUCATION						17.01
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD						21.00
22.00	02200	I&R SERVICES-OTHER PRGM. COSTS APPRVD						22.00
23.00	02300	PARAMED ED PRGM	103,964					23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS		4,654,124	0	4,654,124		30.00
31.00	03100	INTENSIVE CARE UNIT		1,285,108	0	1,285,108		31.00
40.00	04000	SUBPROVIDER - IPF		752,151	0	752,151		40.00
41.00	04100	SUBPROVIDER - IRF		588,664	0	588,664		41.00
43.00	04300	NURSERY		84,825	0	84,825		43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM		3,357,618	0	3,357,618		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM		294,564	0	294,564		52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC		3,721,097	0	3,721,097		54.00
59.00	05900	CARDIAC CATHETERIZATION		935,570	0	935,570		59.00
60.00	06000	LABORATORY		1,620,697	0	1,620,697		60.00
65.00	06500	RESPIRATORY THERAPY		151,329	0	151,329		65.00
66.00	06600	PHYSICAL THERAPY		1,454,276	0	1,454,276		66.00
69.00	06900	ELECTROCARDIOLOGY		383,595	0	383,595		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY		139,055	0	139,055		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS		0	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT		21,145	0	21,145		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS		783,483	0	783,483		73.00
74.00	07400	RENAL DIALYSIS		54,488	0	54,488		74.00
76.00	03950	ANCILLARY - OTHER		0	0	0		76.00
76.97	07697	CARDIAC REHABILITATION		219,397	0	219,397		76.97
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY		1,393,355	0	1,393,355		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)			0			92.00
93.00	04040	FAMILY PRACTICE		96,100	0	96,100		93.00
		OTHER REIMBURSABLE COST CENTERS						
96.00	09600	DURABLE MEDICAL EQUIP-RENTED		137,196	0	137,196		96.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE		38,066	0	38,066		116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	22,165,903	0	22,165,903		118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN		0	0	0		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES		2,784,668	0	2,784,668		192.00
194.00	07950	RENTAL SPACE		589,417	0	589,417		194.00
194.01	07951	FOUNDATION		10,701	0	10,701		194.01
194.02	07952	RETAIL SERVICES		61,634	0	61,634		194.02
194.03	07953	REID CONTRACTED SERVICES		1,313	0	1,313		194.03
194.04	07954	REID PHYSICIAN ASSOC.		7,603	0	7,603		194.04
194.05	07955	CONNERSVILLE LOCATION		89,194	0	89,194		194.05
194.06	07956	VACANT SPACE		2,226,699	0	2,226,699		194.06
194.07	07957	HOME OFFICE		8,176,010	0	8,176,010		194.07
194.08	07958	CAMBRIDGE RHC		0	0	0		194.08
200.00		Cross Foot Adjustments	103,964	137,795	0	137,795		200.00
201.00		Negative Cost Centers	0	126,160	0	126,160		201.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-0048 | Period: From 01/01/2020 To 12/31/2020 | Worksheet B Part II Date/Time Prepared: 7/8/2021 10:37 am

	Cost Center Description	PARAMED ED PRGM	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
		23.00	24.00	25.00	26.00		
202.00	TOTAL (sum lines 118 through 201)	103,964	36,377,097	0	36,377,097		202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-0048 | Period: From 01/01/2020 To 12/31/2020 | Worksheet B-1 | Date/Time Prepared: 7/8/2021 10:37 am

		Cost Center Description	CAPITAL RELATED COSTS					
			NEW BLDG & FIXT (SQUARE FEET)	NEW CAP BLDG & FIXT - OFFSITE (SQUARE FEET)	NEW MVBLE EQUIP (SQUARE FEET)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	NONPATIENT TELEPHONES (PHONES)	
			1.00	1.01	2.00	4.00	5.01	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT	873,266					1.00
1.01	00101	NEW CAP BLDG & FIXT - OFFSITE	0	275,457				1.01
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP			0			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	400	0	103,111,331		4.00
5.01	00540	NONPATIENT TELEPHONES	0	0	0	0	0	5.01
5.02	00550	DATA PROCESSING	3,313	1,095	0	298,997	0	5.02
5.03	00560	PURCHASING RECEIVING AND STORES	8,871	0	0	71,472	0	5.03
5.04	00570	ADMITTING	462	1,884	0	4,550,289	0	5.04
5.05	00580	CASHIERING/ACCOUNTS RECEIVABLE	0	7,820	0	0	0	5.05
5.06	00590	OTHER A&G	3,832	684	0	3,071,440	0	5.06
7.00	00700	OPERATION OF PLANT	11,004	1,558	0	686,763	0	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	12,335	0	0	430,933	0	8.00
9.00	00900	HOUSEKEEPING	8,158	0	0	2,618,845	0	9.00
10.00	01000	DIETARY	18,310	0	0	1,191,697	0	10.00
11.00	01100	CAFETERIA	9,614	0	0	2,489,172	0	11.00
13.00	01300	NURSING ADMINISTRATION	1,955	0	0	280,277	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	8,411	0	0	755,306	0	14.00
15.00	01500	PHARMACY	9,871	0	0	4,439,147	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	4,721	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	1,241	0	0	3,065,023	0	17.00
17.01	01701	INSERVICE EDUCATION	10,409	0	0	1,259,091	0	17.01
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	0	0	1,859,564	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM. COSTS APPRVD	0	0	0	108,420	0	22.00
23.00	02300	PARAMED ED PRGM	1,061	2,680	0	278,072	0	23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	116,864	0	0	26,079,466	0	30.00
31.00	03100	INTENSIVE CARE UNIT	24,552	0	0	4,099,953	0	31.00
40.00	04000	SUBPROVIDER - IPF	22,340	0	0	3,405,363	0	40.00
41.00	04100	SUBPROVIDER - IRF	17,898	0	0	1,933,943	0	41.00
43.00	04300	NURSERY	2,681	0	0	813,211	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	45,662	13,091	0	1,632,297	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	8,316	0	0	849,531	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	69,942	1,600	0	7,717,253	0	54.00
59.00	05900	CARDIAC CATHETERIZATION	13,579	0	0	1,921,873	0	59.00
60.00	06000	LABORATORY	29,095	0	0	4,558,196	0	60.00
65.00	06500	RESPIRATORY THERAPY	1,647	0	0	1,868,623	0	65.00
66.00	06600	PHYSICAL THERAPY	8,084	42,316	0	7,151,580	0	66.00
69.00	06900	ELECTROCARDIOLOGY	7,809	0	0	1,100,621	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	3,892	0	316,892	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	1,490	0	0	1,074	0	74.00
76.00	03950	ANCILLARY - OTHER	0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	8,185	0	0	422,999	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	30,962	0	0	7,453,008	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
93.00	04040	FAMILY PRACTICE	0	847	0	2,028,802	0	93.00
		OTHER REIMBURSABLE COST CENTERS						
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	1,774	2,872	0	202,707	0	96.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	445	0	0	1,549,551	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	520,172	85,460	0	102,561,451	0	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	108,173	0	0	0	192.00
194.00	07950	RENTAL SPACE	0	19,530	0	32,660	0	194.00
194.01	07951	FOUNDATION	206	0	0	167,657	0	194.01
194.02	07952	RETAIL SERVICES	2,340	0	0	149,160	0	194.02
194.03	07953	REID CONTRACTED SERVICES	0	0	0	200,403	0	194.03
194.04	07954	REID PHYSICIAN ASSOC.	0	312	0	0	0	194.04
194.05	07955	CONNERSVILLE LOCATION	0	0	0	0	0	194.05
194.06	07956	VACANT SPACE	70,753	17,168	0	0	0	194.06
194.07	07957	HOME OFFICE	279,795	44,814	0	0	0	194.07
194.08	07958	CAMBRIDGE RHC	0	0	0	0	0	194.08

COST ALLOCATION - STATISTICAL BASIS	Provider CCN: 15-0048	Period: From 01/01/2020 To 12/31/2020	Worksheet B-1 Date/Time Prepared: 7/8/2021 10:37 am

	Cost Center Description	CAPITAL RELATED COSTS					
		NEW BLDG & FIXT (SQUARE FEET)	NEW CAP BLDG & FIXT - OFFSITE (SQUARE FEET)	NEW MVBLE EQUIP (SQUARE FEET)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	NONPATIENT TELEPHONES (PHONES)	
		1.00	1.01	2.00	4.00	5.01	
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)	21,809,408	6,707,864	0	16,162,627	0	202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	24.974530	24.351765	0.000000	0.156749	0.000000	203.00
204.00	Cost to be allocated (per Wkst. B, Part II)				10,144	0	204.00
205.00	Unit cost multiplier (Wkst. B, Part II)				0.000098	0.000000	205.00
206.00	NAHE adjustment amount to be allocated (per Wkst. B-2)						206.00
207.00	NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-0048 | Period: From 01/01/2020 To 12/31/2020 | Worksheet B-1 | Date/Time Prepared: 7/8/2021 10:37 am

		Cost Center Description	DATA PROCESSING (TERMINALS)	PURCHASING RECEIVING AND STORES (SUPPLY EXPENSE)	ADMITTING (TOTAL REVENUE)	CASHIERING/ACCOUNTS RECEIVABLE (TOTAL REVENUE)	Reconciliation	
			5.02	5.03	5.04	5.05	5A.06	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	NEW CAP BLDG & FIXT - OFFSITE						1.01
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00540	NONPATIENT TELEPHONES						5.01
5.02	00550	DATA PROCESSING	1,279					5.02
5.03	00560	PURCHASING RECEIVING AND STORES	0	8,492,387				5.03
5.04	00570	ADMITTING	125	21,182	984,014,640			5.04
5.05	00580	CASHIERING/ACCOUNTS RECEIVABLE	0	0	0	984,014,640		5.05
5.06	00590	OTHER A&G	75	38,509	0	0	-35,092,718	5.06
7.00	00700	OPERATION OF PLANT	3	36,564	0	0	0	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	2	3,627	0	0	0	8.00
9.00	00900	HOUSEKEEPING	5	338,937	0	0	0	9.00
10.00	01000	DIETARY	47	154,680	0	0	0	10.00
11.00	01100	CAFETERIA	0	0	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	0	0	0	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	17	1,010,106	0	0	0	14.00
15.00	01500	PHARMACY	57	988,595	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	19	9,788	0	0	0	17.00
17.01	01701	INSERVICE EDUCATION	78	17,875	0	0	0	17.01
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM. COSTS APPRVD	24	1,952	0	0	0	22.00
23.00	02300	PARAMED ED PRGM	24	3,038	0	0	0	23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	145	1,003,654	60,169,616	60,169,616	0	30.00
31.00	03100	INTENSIVE CARE UNIT	25	374,603	11,403,776	11,403,776	0	31.00
40.00	04000	SUBPROVIDER - IPF	15	90,494	9,291,130	9,291,130	0	40.00
41.00	04100	SUBPROVIDER - IRF	10	75,472	5,836,638	5,836,638	0	41.00
43.00	04300	NURSERY	0	46,544	1,714,258	1,714,258	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	63	938,939	162,365,438	162,365,438	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	5	122,485	9,377,711	9,377,711	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	166	873,374	153,836,943	153,836,943	0	54.00
59.00	05900	CARDIAC CATHETERIZATION	10	610,974	99,006,132	99,006,132	0	59.00
60.00	06000	LABORATORY	64	153,459	110,660,526	110,660,526	0	60.00
65.00	06500	RESPIRATORY THERAPY	12	387,627	26,084,310	26,084,310	0	65.00
66.00	06600	PHYSICAL THERAPY	125	53,567	22,141,113	22,141,113	0	66.00
69.00	06900	ELECTROCARDIOLOGY	19	47,180	35,134,132	35,134,132	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	8	21,908	4,538,492	4,538,492	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	32,169,316	32,169,316	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	136,914,597	136,914,597	0	73.00
74.00	07400	RENAL DIALYSIS	4	21,485	1,286,781	1,286,781	0	74.00
76.00	03950	ANCILLARY - OTHER	0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	6	10,130	936,186	936,186	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	84	493,580	88,888,587	88,888,587	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
93.00	04040	FAMILY PRACTICE	15	88,713	6,316,224	6,316,224	0	93.00
		OTHER REIMBURSABLE COST CENTERS						
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	2	164,315	505,498	505,498	0	96.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	18	153,192	5,437,236	5,437,236	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	1,272	8,356,548	984,014,640	984,014,640	-35,092,718	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	1	3,496	0	0	0	192.00
194.00	07950	RENTAL SPACE	0	84,532	0	0	0	194.00
194.01	07951	FOUNDATION	5	11,546	0	0	0	194.01
194.02	07952	RETAIL SERVICES	1	1,581	0	0	0	194.02
194.03	07953	REID CONTRACTED SERVICES	0	0	0	0	0	194.03
194.04	07954	REID PHYSICIAN ASSOC.	0	0	0	0	0	194.04
194.05	07955	CONNERSVILLE LOCATION	0	34,626	0	0	0	194.05
194.06	07956	VACANT SPACE	0	58	0	0	0	194.06
194.07	07957	HOME OFFICE	0	0	0	0	0	194.07
194.08	07958	CAMBRIDGE RHC	0	0	0	0	0	194.08
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-0048 | Period: From 01/01/2020 To 12/31/2020 | Worksheet B-1 | Date/Time Prepared: 7/8/2021 10:37 am

		Cost Center Description	DATA PROCESSING (TERMINALS)	PURCHASING RECEIVING AND STORES (SUPPLY EXPENSE)	ADMITTING (TOTAL REVENUE)	CASHIERING/ACCOUNTS RECEIVABLE (TOTAL REVENUE)	Reconciliation	
			5.02	5.03	5.04	5.05	5A.06	
202.00		Cost to be allocated (per Wkst. B, Part I)	14,480,696	320,665	8,906,269	67,789		202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	11,321.888976	0.037759	0.009051	0.000069		203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	333,340	229,628	139,298	195,893		204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	260.625489	0.027039	0.000142	0.000071		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: 15-0048 | Period: From 01/01/2020 To 12/31/2020 | Worksheet B-1 | Date/Time Prepared: 7/8/2021 10:37 am

		Cost Center Description	OTHER A&G (ACCUM. COST)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (HOURS OF SERVICE)	DIETARY (MEALS SERVED)	
			5.06	7.00	8.00	9.00	10.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	NEW CAP BLDG & FIXT - OFFSITE						1.01
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00540	NONPATIENT TELEPHONES						5.01
5.02	00550	DATA PROCESSING						5.02
5.03	00560	PURCHASING RECEIVING AND STORES						5.03
5.04	00570	ADMITTING						5.04
5.05	00580	CASHIERING/ACCOUNTS RECEIVABLE						5.05
5.06	00590	OTHER A&G	291,178,101					5.06
7.00	00700	OPERATION OF PLANT	1,320,431	954,446				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	956,668	12,335	2,296,990			8.00
9.00	00900	HOUSEKEEPING	4,233,066	7,872	0	13,407		9.00
10.00	01000	DIETARY	3,135,874	18,310	0	526	64,294	10.00
11.00	01100	CAFETERIA	2,471,900	9,461	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	373,035	1,955	0	11	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	6,689,986	8,411	0	178	0	14.00
15.00	01500	PHARMACY	41,726,210	9,640	0	229	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	114,965	0	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	4,355,237	438	0	98	0	17.00
17.01	01701	INSERVICE EDUCATION	3,817,321	9,322	0	317	0	17.01
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	2,249,263	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM. COSTS APPRVD	760,745	0	0	0	0	22.00
23.00	02300	PARAMED ED PRGM	719,003	2,807	0	0	0	23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	42,190,632	115,758	691,121	5,224	44,133	30.00
31.00	03100	INTENSIVE CARE UNIT	8,450,194	24,552	140,758	886	6,349	31.00
40.00	04000	SUBPROVIDER - IPF	5,263,578	22,340	159,393	580	8,484	40.00
41.00	04100	SUBPROVIDER - IRF	3,137,139	17,898	66,050	422	5,328	41.00
43.00	04300	NURSERY	1,146,757	2,681	0	29	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	26,589,381	40,624	349,559	1,047	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,622,770	8,316	123,526	388	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	21,393,974	53,880	225,068	579	0	54.00
59.00	05900	CARDIAC CATHETERIZATION	8,437,176	4,593	0	166	0	59.00
60.00	06000	LABORATORY	17,190,261	20,194	124,597	470	0	60.00
65.00	06500	RESPIRATORY THERAPY	3,253,118	1,194	0	126	0	65.00
66.00	06600	PHYSICAL THERAPY	12,257,999	48,220	21,928	131	0	66.00
69.00	06900	ELECTROCARDIOLOGY	2,842,947	557	0	154	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	682,448	5,400	9,302	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	16,928,234	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,248,661	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	975,140	1,490	0	157	0	74.00
76.00	03950	ANCILLARY - OTHER	0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	823,815	3,662	0	40	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	12,713,328	30,962	317,470	971	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
93.00	04040	FAMILY PRACTICE	2,916,627	0	68,218	256	0	93.00
		OTHER REIMBURSABLE COST CENTERS						
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	419,929	3,752	0	0	0	96.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	3,375,661	0	0	232	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	266,783,473	486,624	2,296,990	13,217	64,294	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	6,164,225	108,173	0	150	0	192.00
194.00	07950	RENTAL SPACE	5,183,588	22,920	0	0	0	194.00
194.01	07951	FOUNDATION	558,738	206	0	10	0	194.01
194.02	07952	RETAIL SERVICES	260,832	684	0	30	0	194.02
194.03	07953	REID CONTRACTED SERVICES	414,292	0	0	0	0	194.03
194.04	07954	REID PHYSICIAN ASSOC.	7,598	0	0	0	0	194.04
194.05	07955	CONNERSVILLE LOCATION	1,406,009	0	0	0	0	194.05
194.06	07956	VACANT SPACE	2,320,298	93,036	0	0	0	194.06
194.07	07957	HOME OFFICE	8,079,048	242,803	0	0	0	194.07
194.08	07958	CAMBRIDGE RHC	0	0	0	0	0	194.08
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-0048 | Period: From 01/01/2020 To 12/31/2020 | Worksheet B-1 | Date/Time Prepared: 7/8/2021 10:37 am

	Cost Center Description	OTHER A&G (ACCUM. COST)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (HOURS OF SERVICE)	DIETARY (MEALS SERVED)	
		5.06	7.00	8.00	9.00	10.00	
202.00	Cost to be allocated (per Wkst. B, Part I)	35,092,718	1,479,569	1,091,088	4,755,438	3,728,765	202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	0.120520	1.550186	0.475008	354.698143	57.995536	203.00
204.00	Cost to be allocated (per Wkst. B, Part II)	181,222	361,403	371,709	287,305	595,220	204.00
205.00	Unit cost multiplier (Wkst. B, Part II)	0.000622	0.378652	0.161824	21.429477	9.257785	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: 15-0048 | Period: From 01/01/2020 To 12/31/2020 | Worksheet B-1 | Date/Time Prepared: 7/8/2021 10:37 am

		Cost Center Description	CAFETERIA (MANHOURS)	NURSING ADMINISTRATION (DIRECT NURSING HRS)	CENTRAL SERVICES & SUPPLY (MED SUPPLIES)	PHARMACY (DRUGS)	MEDICAL RECORDS & LIBRARY (TOTAL REVENUE)	
			11.00	13.00	14.00	15.00	16.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	NEW CAP BLDG & FIXT - OFFSITE						1.01
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00540	NONPATIENT TELEPHONES						5.01
5.02	00550	DATA PROCESSING						5.02
5.03	00560	PURCHASING RECEIVING AND STORES						5.03
5.04	00570	ADMITTING						5.04
5.05	00580	CASHIERING/ACCOUNTS RECEIVABLE						5.05
5.06	00590	OTHER A&G						5.06
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA	2,710,541					11.00
13.00	01300	NURSING ADMINISTRATION	2,080	1,756,008				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	43,616	0	18,617,019			14.00
15.00	01500	PHARMACY	130,995	0	0	34,879,872		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	984,014,640	16.00
17.00	01700	SOCIAL SERVICE	87,298	0	0	39	0	17.00
17.01	01701	INSERVICE EDUCATION	40,006	0	0	0	0	17.01
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	39,339	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM. COSTS APPRVD	5,211	0	0	0	0	22.00
23.00	02300	PARAMED ED PRGM	6,920	0	0	0	0	23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	807,372	807,372	55,757	3,092	60,169,616	30.00
31.00	03100	INTENSIVE CARE UNIT	115,241	115,241	61,651	616	11,403,776	31.00
40.00	04000	SUBPROVIDER - IPF	116,047	116,047	3,346	13	9,291,130	40.00
41.00	04100	SUBPROVIDER - IRF	55,950	55,950	11,675	91	5,836,638	41.00
43.00	04300	NURSERY	21,174	21,174	53	0	1,714,258	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	52,725	52,725	9,735,532	109,867	162,365,438	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	22,629	22,629	29,106	785	9,377,711	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	225,795	225,795	139,237	562,667	153,836,943	54.00
59.00	05900	CARDIAC CATHETERIZATION	53,564	53,564	6,881,950	1,640	99,006,132	59.00
60.00	06000	LABORATORY	179,061	0	1,280,862	114	110,660,526	60.00
65.00	06500	RESPIRATORY THERAPY	53,991	53,991	21,000	740	26,084,310	65.00
66.00	06600	PHYSICAL THERAPY	208,710	0	1,601	99	22,141,113	66.00
69.00	06900	ELECTROCARDIOLOGY	35,561	0	120,700	209,862	35,134,132	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	12,964	0	0	0	4,538,492	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	32,169,316	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	33,863,346	136,914,597	73.00
74.00	07400	RENAL DIALYSIS	29	29	75	8	1,286,781	74.00
76.00	03950	ANCILLARY - OTHER	0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	15,710	15,710	0	0	936,186	76.97
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	215,781	215,781	60,397	8,257	88,888,587	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
93.00	04040	FAMILY PRACTICE	76,381	0	0	848	6,316,224	93.00
		OTHER REIMBURSABLE COST CENTERS						
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	10,785	0	214,077	117,788	505,498	96.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	48,706	0	0	0	5,437,236	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	2,683,641	1,756,008	18,617,019	34,879,872	984,014,640	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07950	RENTAL SPACE	1,343	0	0	0	0	194.00
194.01	07951	FOUNDATION	6,393	0	0	0	0	194.01
194.02	07952	RETAIL SERVICES	7,731	0	0	0	0	194.02
194.03	07953	REID CONTRACTED SERVICES	11,433	0	0	0	0	194.03
194.04	07954	REID PHYSICIAN ASSOC.	0	0	0	0	0	194.04
194.05	07955	CONNERSVILLE LOCATION	0	0	0	0	0	194.05
194.06	07956	VACANT SPACE	0	0	0	0	0	194.06
194.07	07957	HOME OFFICE	0	0	0	0	0	194.07
194.08	07958	CAMBRIDGE RHC	0	0	0	0	0	194.08
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-0048 | Period: From 01/01/2020 To 12/31/2020 | Worksheet B-1 | Date/Time Prepared: 7/8/2021 10:37 am

	Cost Center Description	CAFETERIA (MANHOURS)	NURSING ADMINISTRATION (DIRECT NURSING HRS)	CENTRAL SERVICES & SUPPLY (MED SUPPLIES)	PHARMACY (DRUGS)	MEDICAL RECORDS & LIBRARY (TOTAL REVENUE)	
		11.00	13.00	14.00	15.00	16.00	
202.00	Cost to be allocated (per Wkst. B, Part I)	2,784,479	427,063	7,617,244	46,985,791	128,821	202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	1.027278	0.243201	0.409155	1.347075	0.000131	203.00
204.00	Cost to be allocated (per Wkst. B, Part II)	245,469	50,248	764,895	759,661	115,037	204.00
205.00	Unit cost multiplier (Wkst. B, Part II)	0.090561	0.028615	0.041086	0.021779	0.000117	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: 15-0048 | Period: From 01/01/2020 To 12/31/2020 | Worksheet B-1 | Date/Time Prepared: 7/8/2021 10:37 am

		Cost Center Description	SOCIAL SERVICE (TIME SPENT)	INSERVICE EDUCATION (IN HOUSE ED)	INTERNS & RESIDENTS		PARAMED ED PRGM (TIME SPENT)	
					SERVICES-SALARY & FRINGES (ASSIGNED TIME)	SERVICES-OTHER PRGM. COSTS (ASSIGNED TIME)		
			17.00	17.01	21.00	22.00	23.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	NEW CAP BLDG & FIXT - OFFSITE						1.01
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00540	NONPATIENT TELEPHONES						5.01
5.02	00550	DATA PROCESSING						5.02
5.03	00560	PURCHASING RECEIVING AND STORES						5.03
5.04	00570	ADMITTING						5.04
5.05	00580	CASHIERING/ACCOUNTS RECEIVABLE						5.05
5.06	00590	OTHER A&G						5.06
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY						15.00
16.00	01600	MEDICAL RECORDS & LIBRARY						16.00
17.00	01700	SOCIAL SERVICE	47,268					17.00
17.01	01701	INSERVICE EDUCATION	0	40,653				17.01
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	0	1,674			21.00
22.00	02200	I&R SERVICES-OTHER PRGM. COSTS APPRVD	0	0		1,674		22.00
23.00	02300	PARAMED ED PRGM	0	93			100	23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	30,577	12,644	1,388	1,388	0	30.00
31.00	03100	INTENSIVE CARE UNIT	2,740	1,842	51	51	0	31.00
40.00	04000	SUBPROVIDER - IPF	0	2,012	0	0	0	40.00
41.00	04100	SUBPROVIDER - IRF	0	719	0	0	0	41.00
43.00	04300	NURSERY	0	388	0	0	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	2,638	92	92	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	402	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	3,677	0	0	100	54.00
59.00	05900	CARDIAC CATHETERIZATION	0	940	0	0	0	59.00
60.00	06000	LABORATORY	0	2,905	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	885	8	8	0	65.00
66.00	06600	PHYSICAL THERAPY	0	3,456	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	656	25	25	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	226	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.00	03950	ANCILLARY - OTHER	0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0	294	0	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	13,951	4,677	110	110	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
93.00	04040	FAMILY PRACTICE	0	1,223	0	0	0	93.00
		OTHER REIMBURSABLE COST CENTERS						
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	175	0	0	0	96.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	0	568			0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	47,268	40,420	1,674	1,674	100	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07950	RENTAL SPACE	0	0	0	0	0	194.00
194.01	07951	FOUNDATION	0	110	0	0	0	194.01
194.02	07952	RETAIL SERVICES	0	123	0	0	0	194.02
194.03	07953	REID CONTRACTED SERVICES	0	0	0	0	0	194.03
194.04	07954	REID PHYSICIAN ASSOC.	0	0	0	0	0	194.04
194.05	07955	CONNERSVILLE LOCATION	0	0	0	0	0	194.05
194.06	07956	VACANT SPACE	0	0	0	0	0	194.06
194.07	07957	HOME OFFICE	0	0	0	0	0	194.07
194.08	07958	CAMBRIDGE RHC	0	0	0	0	0	194.08
200.00		Cross Foot Adjustments						200.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-0048 | Period: From 01/01/2020 To 12/31/2020 | Worksheet B-1 | Date/Time Prepared: 7/8/2021 10:37 am

		Cost Center Description	SOCIAL SERVICE (TIME SPENT)	INSERVICE EDUCATION (IN HOUSE ED)	INTERNS & RESIDENTS		PARAMED ED PRGM (TIME SPENT)	
					SERVICES-SALARY & FRINGES (ASSIGNED TIME)	SERVICES-OTHER PRGM. COSTS (ASSIGNED TIME)		
			17.00	17.01	21.00	22.00	23.00	
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	5,005,301	4,445,372	2,560,756	857,783	827,286	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	105.891957	109.349175	1,529.722820	512.415173	8,272.860000	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	52,120	319,797	5,144	28,687	103,964	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	1.102649	7.866504	3.072879	17.136798	1,039.640000	205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)					0	206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)					0.000000	207.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-0048 | Period: From 01/01/2020 To 12/31/2020 | Worksheet C Part I Date/Time Prepared: 7/8/2021 10:37 am

Title XVIII | Hospital | PPS

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	RCE Disallowance	Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	57,876,651		57,876,651	72,992	57,949,643	30.00
31.00	03100	INTENSIVE CARE UNIT	10,921,535		10,921,535	0	10,921,535	31.00
40.00	04000	SUBPROVIDER - IPF	7,076,098		7,076,098	0	7,076,098	40.00
41.00	04100	SUBPROVIDER - IRF	4,188,399		4,188,399	0	4,188,399	41.00
43.00	04300	NURSERY	1,368,982		1,368,982	0	1,368,982	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	34,902,290		34,902,290	0	34,902,290	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	2,114,437		2,114,437	0	2,114,437	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	26,719,488		26,719,488	0	26,719,488	54.00
59.00	05900	CARDIAC CATHETERIZATION	12,521,827		12,521,827	0	12,521,827	59.00
60.00	06000	LABORATORY	20,559,554		20,559,554	0	20,559,554	60.00
65.00	06500	RESPIRATORY THERAPY	3,870,102	0	3,870,102	0	3,870,102	65.00
66.00	06600	PHYSICAL THERAPY	14,462,966	0	14,462,966	0	14,462,966	66.00
69.00	06900	ELECTROCARDIOLOGY	3,686,018		3,686,018	0	3,686,018	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	816,113		816,113	0	816,113	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0		0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	18,972,639		18,972,639	0	18,972,639	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	47,033,539		47,033,539	0	47,033,539	73.00
74.00	07400	RENAL DIALYSIS	1,150,910		1,150,910	0	1,150,910	74.00
76.00	03950	ANCILLARY - OTHER	0		0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	995,198		995,198	0	995,198	76.97
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	17,099,097		17,099,097	0	17,099,097	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	6,093,550		6,093,550		6,093,550	92.00
93.00	04040	FAMILY PRACTICE	3,605,514		3,605,514	0	3,605,514	93.00
		OTHER REIMBURSABLE COST CENTERS						
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	752,896		752,896	0	752,896	96.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	3,977,643		3,977,643		3,977,643	116.00
200.00		Subtotal (see instructions)	300,765,446	0	300,765,446	72,992	300,838,438	200.00
201.00		Less Observation Beds	6,093,550		6,093,550		6,093,550	201.00
202.00		Total (see instructions)	294,671,896	0	294,671,896	72,992	294,744,888	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-0048 | Period: From 01/01/2020 To 12/31/2020 | Worksheet C Part I Date/Time Prepared: 7/8/2021 10:37 am

Title XVIII | Hospital | PPS

		Cost Center Description	Charges Inpatient	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	49,405,519		49,405,519			30.00
31.00	03100	INTENSIVE CARE UNIT	11,403,776		11,403,776			31.00
40.00	04000	SUBPROVIDER - IPF	9,291,130		9,291,130			40.00
41.00	04100	SUBPROVIDER - IRF	5,836,638		5,836,638			41.00
43.00	04300	NURSERY	1,714,258		1,714,258			43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	47,582,446	114,782,992	162,365,438	0.214961	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	8,456,537	921,174	9,377,711	0.225475	0.000000	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	40,118,828	113,718,115	153,836,943	0.173687	0.000000	54.00
59.00	05900	CARDIAC CATHETERIZATION	35,148,973	63,857,159	99,006,132	0.126475	0.000000	59.00
60.00	06000	LABORATORY	42,217,615	68,442,911	110,660,526	0.185789	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	22,974,892	3,109,418	26,084,310	0.148369	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	9,699,736	12,441,377	22,141,113	0.653218	0.000000	66.00
69.00	06900	ELECTROCARDIOLOGY	16,044,429	19,089,703	35,134,132	0.104913	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	5,665	4,532,827	4,538,492	0.179820	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0.000000	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	15,861,161	16,308,155	32,169,316	0.589774	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	55,069,614	81,844,983	136,914,597	0.343525	0.000000	73.00
74.00	07400	RENAL DIALYSIS	1,212,150	74,631	1,286,781	0.894410	0.000000	74.00
76.00	03950	ANCILLARY - OTHER	0	0	0	0.000000	0.000000	76.00
76.97	07697	CARDIAC REHABILITATION	658	935,528	936,186	1.063034	0.000000	76.97
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	27,494,350	61,394,237	88,888,587	0.192365	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	3,184,813	7,579,284	10,764,097	0.566100	0.000000	92.00
93.00	04040	FAMILY PRACTICE	15,252	6,300,972	6,316,224	0.570834	0.000000	93.00
		OTHER REIMBURSABLE COST CENTERS						
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	505,498	505,498	1.489414	0.000000	96.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	1,385,764	4,051,472	5,437,236			116.00
200.00		Subtotal (see instructions)	404,124,204	579,890,436	984,014,640			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	404,124,204	579,890,436	984,014,640			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-0048 | Period: From 01/01/2020 To 12/31/2020 | Worksheet C Part I Date/Time Prepared: 7/8/2021 10:37 am

Title XVIII | 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
40.00	04000	SUBPROVIDER - IPF		40.00
41.00	04100	SUBPROVIDER - IRF		41.00
43.00	04300	NURSERY		43.00
		ANCILLARY SERVICE COST CENTERS		
50.00	05000	OPERATING ROOM	0.214961	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.225475	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.173687	54.00
59.00	05900	CARDIAC CATHETERIZATION	0.126475	59.00
60.00	06000	LABORATORY	0.185789	60.00
65.00	06500	RESPIRATORY THERAPY	0.148369	65.00
66.00	06600	PHYSICAL THERAPY	0.653218	66.00
69.00	06900	ELECTROCARDIOLOGY	0.104913	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.179820	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.589774	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.343525	73.00
74.00	07400	RENAL DIALYSIS	0.894410	74.00
76.00	03950	ANCILLARY - OTHER	0.000000	76.00
76.97	07697	CARDIAC REHABILITATION	1.063034	76.97
		OUTPATIENT SERVICE COST CENTERS		
91.00	09100	EMERGENCY	0.192365	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.566100	92.00
93.00	04040	FAMILY PRACTICE	0.570834	93.00
		OTHER REIMBURSABLE COST CENTERS		
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	1.489414	96.00
		SPECIAL PURPOSE COST CENTERS		
113.00	11300	INTEREST EXPENSE		113.00
116.00	11600	HOSPICE		116.00
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: 15-0048 | Period: From 01/01/2020 To 12/31/2020 | Worksheet C Part I | Date/Time Prepared: 7/8/2021 10:37 am

Title XIX | Hospital | Cost

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	RCE Disallowance	Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	57,876,651		57,876,651	72,992	57,949,643	30.00
31.00	03100	INTENSIVE CARE UNIT	10,921,535		10,921,535	0	10,921,535	31.00
40.00	04000	SUBPROVIDER - IPF	7,076,098		7,076,098	0	7,076,098	40.00
41.00	04100	SUBPROVIDER - IRF	4,188,399		4,188,399	0	4,188,399	41.00
43.00	04300	NURSERY	1,368,982		1,368,982	0	1,368,982	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	34,902,290		34,902,290	0	34,902,290	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	2,114,437		2,114,437	0	2,114,437	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	26,719,488		26,719,488	0	26,719,488	54.00
59.00	05900	CARDIAC CATHETERIZATION	12,521,827		12,521,827	0	12,521,827	59.00
60.00	06000	LABORATORY	20,559,554		20,559,554	0	20,559,554	60.00
65.00	06500	RESPIRATORY THERAPY	3,870,102	0	3,870,102	0	3,870,102	65.00
66.00	06600	PHYSICAL THERAPY	14,462,966	0	14,462,966	0	14,462,966	66.00
69.00	06900	ELECTROCARDIOLOGY	3,686,018		3,686,018	0	3,686,018	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	816,113		816,113	0	816,113	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0		0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	18,972,639		18,972,639	0	18,972,639	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	47,033,539		47,033,539	0	47,033,539	73.00
74.00	07400	RENAL DIALYSIS	1,150,910		1,150,910	0	1,150,910	74.00
76.00	03950	ANCILLARY - OTHER	0		0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	995,198		995,198	0	995,198	76.97
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	17,099,097		17,099,097	0	17,099,097	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	6,093,550		6,093,550		6,093,550	92.00
93.00	04040	FAMILY PRACTICE	3,605,514		3,605,514	0	3,605,514	93.00
		OTHER REIMBURSABLE COST CENTERS						
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	752,896		752,896	0	752,896	96.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	3,977,643		3,977,643		3,977,643	116.00
200.00		Subtotal (see instructions)	300,765,446	0	300,765,446	72,992	300,838,438	200.00
201.00		Less Observation Beds	6,093,550		6,093,550		6,093,550	201.00
202.00		Total (see instructions)	294,671,896	0	294,671,896	72,992	294,744,888	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-0048 | Period: From 01/01/2020 To 12/31/2020 | Worksheet C Part I Date/Time Prepared: 7/8/2021 10:37 am

Title XIX | Hospital | Cost

		Cost Center Description	Charges Inpatient	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	49,405,519		49,405,519			30.00
31.00	03100	INTENSIVE CARE UNIT	11,403,776		11,403,776			31.00
40.00	04000	SUBPROVIDER - IPF	9,291,130		9,291,130			40.00
41.00	04100	SUBPROVIDER - IRF	5,836,638		5,836,638			41.00
43.00	04300	NURSERY	1,714,258		1,714,258			43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	47,582,446	114,782,992	162,365,438	0.214961	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	8,456,537	921,174	9,377,711	0.225475	0.000000	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	40,118,828	113,718,115	153,836,943	0.173687	0.000000	54.00
59.00	05900	CARDIAC CATHETERIZATION	35,148,973	63,857,159	99,006,132	0.126475	0.000000	59.00
60.00	06000	LABORATORY	42,217,615	68,442,911	110,660,526	0.185789	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	22,974,892	3,109,418	26,084,310	0.148369	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	9,699,736	12,441,377	22,141,113	0.653218	0.000000	66.00
69.00	06900	ELECTROCARDIOLOGY	16,044,429	19,089,703	35,134,132	0.104913	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	5,665	4,532,827	4,538,492	0.179820	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0.000000	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	15,861,161	16,308,155	32,169,316	0.589774	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	55,069,614	81,844,983	136,914,597	0.343525	0.000000	73.00
74.00	07400	RENAL DIALYSIS	1,212,150	74,631	1,286,781	0.894410	0.000000	74.00
76.00	03950	ANCILLARY - OTHER	0	0	0	0.000000	0.000000	76.00
76.97	07697	CARDIAC REHABILITATION	658	935,528	936,186	1.063034	0.000000	76.97
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	27,494,350	61,394,237	88,888,587	0.192365	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	3,184,813	7,579,284	10,764,097	0.566100	0.000000	92.00
93.00	04040	FAMILY PRACTICE	15,252	6,300,972	6,316,224	0.570834	0.000000	93.00
		OTHER REIMBURSABLE COST CENTERS						
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	505,498	505,498	1.489414	0.000000	96.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	1,385,764	4,051,472	5,437,236			116.00
200.00		Subtotal (see instructions)	404,124,204	579,890,436	984,014,640			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	404,124,204	579,890,436	984,014,640			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 15-0048 | Period: From 01/01/2020 To 12/31/2020 | Worksheet C Part I | Date/Time Prepared: 7/8/2021 10:37 am

Title XIX | Hospital | Cost

		Cost Center Description	PPS Inpatient Ratio	
			11.00	
		INPATIENT ROUTINE SERVICE COST CENTERS		
30.00	03000	ADULTS & PEDIATRICS		30.00
31.00	03100	INTENSIVE CARE UNIT		31.00
40.00	04000	SUBPROVIDER - IPF		40.00
41.00	04100	SUBPROVIDER - IRF		41.00
43.00	04300	NURSERY		43.00
		ANCILLARY SERVICE COST CENTERS		
50.00	05000	OPERATING ROOM	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	54.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	59.00
60.00	06000	LABORATORY	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	66.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	73.00
74.00	07400	RENAL DIALYSIS	0.000000	74.00
76.00	03950	ANCILLARY - OTHER	0.000000	76.00
76.97	07697	CARDIAC REHABILITATION	0.000000	76.97
		OUTPATIENT SERVICE COST CENTERS		
91.00	09100	EMERGENCY	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	92.00
93.00	04040	FAMILY PRACTICE	0.000000	93.00
		OTHER REIMBURSABLE COST CENTERS		
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0.000000	96.00
		SPECIAL PURPOSE COST CENTERS		
113.00	11300	INTEREST EXPENSE		113.00
116.00	11600	HOSPICE		116.00
200.00		Subtotal (see instructions)		200.00
201.00		Less Observation Beds		201.00
202.00		Total (see instructions)		202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS | Provider CCN: 15-0048 | Period: From 01/01/2020 To 12/31/2020 | Worksheet D Part I Date/Time Prepared: 7/8/2021 10:37 am

Title XVIII | Hospital | PPS

	Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	4,654,124	0	4,654,124	49,319	94.37	30.00
31.00	INTENSIVE CARE UNIT	1,285,108		1,285,108	6,349	202.41	31.00
40.00	SUBPROVIDER - IPF	752,151	0	752,151	8,484	88.66	40.00
41.00	SUBPROVIDER - IRF	588,664	0	588,664	5,384	109.34	41.00
43.00	NURSERY	84,825		84,825	1,700	49.90	43.00
200.00	Total (lines 30 through 199)	7,364,872		7,364,872	71,236		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	19,417	1,832,382	30.00
31.00	INTENSIVE CARE UNIT	2,778	562,295	31.00
40.00	SUBPROVIDER - IPF	4,421	391,966	40.00
41.00	SUBPROVIDER - IRF	2,934	320,804	41.00
43.00	NURSERY	0	0	43.00
200.00	Total (lines 30 through 199)	29,550	3,107,447	200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS | Provider CCN: 15-0048 | Period: From 01/01/2020 To 12/31/2020 | Worksheet D Part II Date/Time Prepared: 7/8/2021 10:37 am

Title XVIII | Hospital | PPS

		Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	3,357,618	162,365,438	0.020679	27,363,876	565,858	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	294,564	9,377,711	0.031411	21,718	682	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,721,097	153,836,943	0.024189	22,095,813	534,476	54.00
59.00	05900	CARDIAC CATHETERIZATION	935,570	99,006,132	0.009450	17,527,225	165,632	59.00
60.00	06000	LABORATORY	1,620,697	110,660,526	0.014646	20,998,863	307,549	60.00
65.00	06500	RESPIRATORY THERAPY	151,329	26,084,310	0.005802	9,960,288	57,790	65.00
66.00	06600	PHYSICAL THERAPY	1,454,276	22,141,113	0.065682	2,803,474	184,138	66.00
69.00	06900	ELECTROCARDIOLOGY	383,595	35,134,132	0.010918	3,782,695	41,299	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	139,055	4,538,492	0.030639	5,664	174	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0.000000	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	21,145	32,169,316	0.000657	9,282,558	6,099	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	783,483	136,914,597	0.005722	25,888,855	148,136	73.00
74.00	07400	RENAL DIALYSIS	54,488	1,286,781	0.042344	771,867	32,684	74.00
76.00	03950	ANCILLARY - OTHER	0	0	0.000000	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	219,397	936,186	0.234352	83	19	76.97
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	1,393,355	88,888,587	0.015675	14,855,787	232,864	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	489,391	10,764,097	0.045465	923,763	41,999	92.00
93.00	04040	FAMILY PRACTICE	96,100	6,316,224	0.015215	15,227	232	93.00
		OTHER REIMBURSABLE COST CENTERS						
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	137,196	505,498	0.271408	0	0	96.00
200.00		Total (lines 50 through 199)	15,252,356	900,926,083		156,297,756	2,319,631	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 15-0048 | Period: From 01/01/2020 To 12/31/2020 | Worksheet D Part III Date/Time Prepared: 7/8/2021 10:37 am

Title XVIII | Hospital | PPS

		Cost Center Description	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health Cost	All Other Medical Education Cost	
			1A	1.00	2A	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	0	40.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
200.00		Total (lines 30 through 199)	0	0	0	0	0	200.00

		Cost Center Description	Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days	
			4.00	5.00	6.00	7.00	8.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	0	49,319	0.00	19,417	30.00
31.00	03100	INTENSIVE CARE UNIT		0	6,349	0.00	2,778	31.00
40.00	04000	SUBPROVIDER - IPF	0	0	8,484	0.00	4,421	40.00
41.00	04100	SUBPROVIDER - IRF	0	0	5,384	0.00	2,934	41.00
43.00	04300	NURSERY		0	1,700	0.00	0	43.00
200.00		Total (lines 30 through 199)		0	71,236		29,550	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
40.00	04000	SUBPROVIDER - IPF	0	40.00
41.00	04100	SUBPROVIDER - IRF	0	41.00
43.00	04300	NURSERY	0	43.00
200.00		Total (lines 30 through 199)	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-0048

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

Worksheet D Part IV

Date/Time Prepared: 7/8/2021 10:37 am

Title XVIII | Hospital | PPS

		Cost Center Description	Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health	
			1.00	2A	2.00	3A	3.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	827,286	54.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.00	03950	ANCILLARY - OTHER	0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0		0		0	92.00
93.00	04040	FAMILY PRACTICE	0	0	0	0	0	93.00
		OTHER REIMBURSABLE COST CENTERS						
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	0	96.00
200.00		Total (lines 50 through 199)	0	0	0	0	827,286	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-0048 | Period: From 01/01/2020 To 12/31/2020 | Worksheet D Part IV | Date/Time Prepared: 7/8/2021 10:37 am

Title XVIII | Hospital | PPS

		Cost Center Description	All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7) (see instructions)	
			4.00	5.00	6.00	7.00	8.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	162,365,438	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	9,377,711	0.000000	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	827,286	827,286	153,836,943	0.005378	54.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	99,006,132	0.000000	59.00
60.00	06000	LABORATORY	0	0	0	110,660,526	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	26,084,310	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	22,141,113	0.000000	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	35,134,132	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	4,538,492	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	32,169,316	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	136,914,597	0.000000	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	1,286,781	0.000000	74.00
76.00	03950	ANCILLARY - OTHER	0	0	0	0	0.000000	76.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	936,186	0.000000	76.97
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0	0	0	88,888,587	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	10,764,097	0.000000	92.00
93.00	04040	FAMILY PRACTICE	0	0	0	6,316,224	0.000000	93.00
		OTHER REIMBURSABLE COST CENTERS						
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	0	505,498	0.000000	96.00
200.00		Total (lines 50 through 199)	0	827,286	827,286	900,926,083		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-0048 | Period: From 01/01/2020 To 12/31/2020 | Worksheet D Part IV | Date/Time Prepared: 7/8/2021 10:37 am

Title XVIII | Hospital | PPS

		Cost Center Description	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
			9.00	10.00	11.00	12.00	13.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.000000	27,363,876	0	41,449,664	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	21,718	0	84	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.005378	22,095,813	118,831	45,640,004	245,452	54.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	17,527,225	0	32,250,451	0	59.00
60.00	06000	LABORATORY	0.000000	20,998,863	0	10,041,372	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.000000	9,960,288	0	1,231,022	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	2,803,474	0	79,588	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	3,782,695	0	9,728,145	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	5,664	0	1,631,676	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.000000	9,282,558	0	7,033,411	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	25,888,855	0	34,349,941	0	73.00
74.00	07400	RENAL DIALYSIS	0.000000	771,867	0	49,599	0	74.00
76.00	03950	ANCILLARY - OTHER	0.000000	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0.000000	83	0	571,534	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0.000000	14,855,787	0	15,270,122	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	923,763	0	1,731,443	0	92.00
93.00	04040	FAMILY PRACTICE	0.000000	15,227	0	2,834,807	0	93.00
		OTHER REIMBURSABLE COST CENTERS						
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0.000000	0	0	0	0	96.00
200.00		Total (lines 50 through 199)		156,297,756	118,831	203,892,863	245,452	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-0048 | Period: From 01/01/2020 To 12/31/2020 | Worksheet D Part V Date/Time Prepared: 7/8/2021 10:37 am

Title XVIII | Hospital | PPS

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.214961	41,449,664	0	0	8,910,061	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.225475	84	0	0	19	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.173687	45,640,004	0	0	7,927,075	54.00
59.00	05900	CARDIAC CATHETERIZATION	0.126475	32,250,451	0	0	4,078,876	59.00
60.00	06000	LABORATORY	0.185789	10,041,372	0	0	1,865,576	60.00
65.00	06500	RESPIRATORY THERAPY	0.148369	1,231,022	0	0	182,646	65.00
66.00	06600	PHYSICAL THERAPY	0.653218	79,588	0	0	51,988	66.00
69.00	06900	ELECTROCARDIOLOGY	0.104913	9,728,145	0	0	1,020,609	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.179820	1,631,676	0	0	293,408	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.589774	7,033,411	0	0	4,148,123	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.343525	34,349,941	0	39,270	11,800,063	73.00
74.00	07400	RENAL DIALYSIS	0.894410	49,599	0	0	44,362	74.00
76.00	03950	ANCILLARY - OTHER	0.000000	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	1.063034	571,534	0	0	607,560	76.97
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0.192365	15,270,122	0	1,201	2,937,437	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.566100	1,731,443	0	0	980,170	92.00
93.00	04040	FAMILY PRACTICE	0.570834	2,834,807	0	696	1,618,204	93.00
		OTHER REIMBURSABLE COST CENTERS						
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	1.489414	0	0	0	0	96.00
200.00		Subtotal (see instructions)		203,892,863	0	41,167	46,466,177	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 - line 201)		203,892,863	0	41,167	46,466,177	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-0048 | Period: From 01/01/2020 To 12/31/2020 | Worksheet D Part V Date/Time Prepared: 7/8/2021 10:37 am

Title XVIII | Hospital | PPS

		Cost Center Description	Costs: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	
			6.00	7.00	
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	54.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	59.00
60.00	06000	LABORATORY	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	13,490	73.00
74.00	07400	RENAL DIALYSIS	0	0	74.00
76.00	03950	ANCILLARY - OTHER	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS			
91.00	09100	EMERGENCY	0	231	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	92.00
93.00	04040	FAMILY PRACTICE	0	397	93.00
		OTHER REIMBURSABLE COST CENTERS			
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	96.00
200.00		Subtotal (see instructions)	0	14,118	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0		201.00
202.00		Net Charges (line 200 - line 201)	0	14,118	202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 15-0048 | Period: From 01/01/2020 To 12/31/2020 | Worksheet D Part II
Component CCN: 15-S048 | Date/Time Prepared: 7/8/2021 10:37 am

Title XVIII | Subprovider - IPF | PPS

		Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	3,357,618	162,365,438	0.020679	86,781	1,795	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	294,564	9,377,711	0.031411	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,721,097	153,836,943	0.024189	346,532	8,382	54.00
59.00	05900	CARDIAC CATHETERIZATION	935,570	99,006,132	0.009450	530	5	59.00
60.00	06000	LABORATORY	1,620,697	110,660,526	0.014646	708,041	10,370	60.00
65.00	06500	RESPIRATORY THERAPY	151,329	26,084,310	0.005802	388,534	2,254	65.00
66.00	06600	PHYSICAL THERAPY	1,454,276	22,141,113	0.065682	276,350	18,151	66.00
69.00	06900	ELECTROCARDIOLOGY	383,595	35,134,132	0.010918	23,163	253	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	139,055	4,538,492	0.030639	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0.000000	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	21,145	32,169,316	0.000657	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	783,483	136,914,597	0.005722	1,076,669	6,161	73.00
74.00	07400	RENAL DIALYSIS	54,488	1,286,781	0.042344	3,250	138	74.00
76.00	03950	ANCILLARY - OTHER	0	0	0.000000	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	219,397	936,186	0.234352	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	1,393,355	88,888,587	0.015675	444,502	6,968	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	10,764,097	0.000000	0	0	92.00
93.00	04040	FAMILY PRACTICE	96,100	6,316,224	0.015215	0	0	93.00
		OTHER REIMBURSABLE COST CENTERS						
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	137,196	505,498	0.271408	0	0	96.00
200.00		Total (lines 50 through 199)	14,762,965	900,926,083		3,354,352	54,477	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-0048 | Component CCN: 15-S048 | Period: From 01/01/2020 To 12/31/2020 | Worksheet D Part IV | Date/Time Prepared: 7/8/2021 10:37 am

Title XVIII | Subprovider - IPF | PPS

		Cost Center Description	Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health	
			1.00	2A	2.00	3A	3.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	827,286	54.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.00	03950	ANCILLARY - OTHER	0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0		0		0	92.00
93.00	04040	FAMILY PRACTICE	0	0	0	0	0	93.00
		OTHER REIMBURSABLE COST CENTERS						
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	0	96.00
200.00		Total (lines 50 through 199)	0	0	0	0	827,286	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-0048 | Component CCN: 15-S048 | Period: From 01/01/2020 To 12/31/2020 | Worksheet D Part IV | Date/Time Prepared: 7/8/2021 10:37 am

Title XVIII | Subprovider - IPF | PPS

		Cost Center Description	All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7) (see instructions)	
			4.00	5.00	6.00	7.00	8.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	162,365,438	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	9,377,711	0.000000	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	827,286	827,286	153,836,943	0.005378	54.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	99,006,132	0.000000	59.00
60.00	06000	LABORATORY	0	0	0	110,660,526	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	26,084,310	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	22,141,113	0.000000	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	35,134,132	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	4,538,492	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	32,169,316	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	136,914,597	0.000000	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	1,286,781	0.000000	74.00
76.00	03950	ANCILLARY - OTHER	0	0	0	0	0.000000	76.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	936,186	0.000000	76.97
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0	0	0	88,888,587	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	10,764,097	0.000000	92.00
93.00	04040	FAMILY PRACTICE	0	0	0	6,316,224	0.000000	93.00
		OTHER REIMBURSABLE COST CENTERS						
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	0	505,498	0.000000	96.00
200.00		Total (lines 50 through 199)	0	827,286	827,286	900,926,083		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-0048 | Period: From 01/01/2020 To 12/31/2020 | Worksheet D Part IV | Date/Time Prepared: 7/8/2021 10:37 am

Component CCN: 15-S048

Title XVIII | Subprovider - IPF | 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	86,781	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	0.005378	346,532	1,864	4,353	23	54.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	530	0	0	0	59.00
60.00	06000	LABORATORY	0.000000	708,041	0	9,601	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.000000	388,534	0	444	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	276,350	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	23,163	0	179	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.000000	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	1,076,669	0	1,889	0	73.00
74.00	07400	RENAL DIALYSIS	0.000000	3,250	0	0	0	74.00
76.00	03950	ANCILLARY - OTHER	0.000000	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0.000000	0	0	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0.000000	444,502	0	84	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	0	0	0	0	92.00
93.00	04040	FAMILY PRACTICE	0.000000	0	0	0	0	93.00
		OTHER REIMBURSABLE COST CENTERS						
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0.000000	0	0	0	0	96.00
200.00		Total (lines 50 through 199)		3,354,352	1,864	16,550	23	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 15-0048 | Component CCN: 15-S048 | Period: From 01/01/2020 To 12/31/2020 | Worksheet D Part V | Date/Time Prepared: 7/8/2021 10:37 am

Title XVIII | Subprovider - IPF | PPS

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.214961	0	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.225475	0	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.173687	4,353	0	0	756	54.00
59.00	05900	CARDIAC CATHETERIZATION	0.126475	0	0	0	0	59.00
60.00	06000	LABORATORY	0.185789	9,601	0	0	1,784	60.00
65.00	06500	RESPIRATORY THERAPY	0.148369	444	0	0	66	65.00
66.00	06600	PHYSICAL THERAPY	0.653218	0	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0.104913	179	0	0	19	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.179820	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.589774	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.343525	1,889	0	2,336	649	73.00
74.00	07400	RENAL DIALYSIS	0.894410	0	0	0	0	74.00
76.00	03950	ANCILLARY - OTHER	0.000000	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	1.063034	0	0	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0.192365	84	0	0	16	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.566100	0	0	0	0	92.00
93.00	04040	FAMILY PRACTICE	0.570834	0	0	0	0	93.00
		OTHER REIMBURSABLE COST CENTERS						
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	1.489414	0	0	0	0	96.00
200.00		Subtotal (see instructions)		16,550	0	2,336	3,290	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 - line 201)		16,550	0	2,336	3,290	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-0048 | Component CCN: 15-S048 | Period: From 01/01/2020 To 12/31/2020 | Worksheet D Part V | Date/Time Prepared: 7/8/2021 10:37 am

Title XVIII | Subprovider - IPF | PPS

		Cost Center Description	Costs		
			Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	
			6.00	7.00	
		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
59.00	05900	CARDIAC CATHETERIZATION	0	0	59.00
60.00	06000	LABORATORY	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	802	73.00
74.00	07400	RENAL DIALYSIS	0	0	74.00
76.00	03950	ANCILLARY - OTHER	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS			
91.00	09100	EMERGENCY	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	92.00
93.00	04040	FAMILY PRACTICE	0	0	93.00
		OTHER REIMBURSABLE COST CENTERS			
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	96.00
200.00		Subtotal (see instructions)	0	802	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0		201.00
202.00		Net Charges (line 200 - line 201)	0	802	202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 15-0048 | Component CCN: 15-T048 | Period: From 01/01/2020 To 12/31/2020 | Worksheet D Part II | Date/Time Prepared: 7/8/2021 10:37 am

Title XVIII | Subprovider - IRF | PPS

		Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	3,357,618	162,365,438	0.020679	85,513	1,768	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	294,564	9,377,711	0.031411	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,721,097	153,836,943	0.024189	115,451	2,793	54.00
59.00	05900	CARDIAC CATHETERIZATION	935,570	99,006,132	0.009450	8,370	79	59.00
60.00	06000	LABORATORY	1,620,697	110,660,526	0.014646	480,494	7,037	60.00
65.00	06500	RESPIRATORY THERAPY	151,329	26,084,310	0.005802	261,278	1,516	65.00
66.00	06600	PHYSICAL THERAPY	1,454,276	22,141,113	0.065682	2,537,241	166,651	66.00
69.00	06900	ELECTROCARDIOLOGY	383,595	35,134,132	0.010918	7,197	79	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	139,055	4,538,492	0.030639	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0.000000	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	21,145	32,169,316	0.000657	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	783,483	136,914,597	0.005722	717,752	4,107	73.00
74.00	07400	RENAL DIALYSIS	54,488	1,286,781	0.042344	24,700	1,046	74.00
76.00	03950	ANCILLARY - OTHER	0	0	0.000000	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	219,397	936,186	0.234352	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	1,393,355	88,888,587	0.015675	10,661	167	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	10,764,097	0.000000	0	0	92.00
93.00	04040	FAMILY PRACTICE	96,100	6,316,224	0.015215	0	0	93.00
		OTHER REIMBURSABLE COST CENTERS						
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	137,196	505,498	0.271408	0	0	96.00
200.00		Total (lines 50 through 199)	14,762,965	900,926,083		4,248,657	185,243	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-0048 | Component CCN: 15-T048 | Period: From 01/01/2020 To 12/31/2020 | Worksheet D Part IV | Date/Time Prepared: 7/8/2021 10:37 am

Title XVIII | Subprovider - IRF | PPS

		Cost Center Description	Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health	
			1.00	2A	2.00	3A	3.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	827,286	54.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.00	03950	ANCILLARY - OTHER	0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0		0		0	92.00
93.00	04040	FAMILY PRACTICE	0	0	0	0	0	93.00
		OTHER REIMBURSABLE COST CENTERS						
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	0	96.00
200.00		Total (lines 50 through 199)	0	0	0	0	827,286	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-0048 | Component CCN: 15-T048 | Period: From 01/01/2020 To 12/31/2020 | Worksheet D Part IV | Date/Time Prepared: 7/8/2021 10:37 am

Title XVIII | Subprovider - IRF | PPS

		Cost Center Description	All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7) (see instructions)	
			4.00	5.00	6.00	7.00	8.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	162,365,438	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	9,377,711	0.000000	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	827,286	827,286	153,836,943	0.005378	54.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	99,006,132	0.000000	59.00
60.00	06000	LABORATORY	0	0	0	110,660,526	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	26,084,310	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	22,141,113	0.000000	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	35,134,132	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	4,538,492	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	32,169,316	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	136,914,597	0.000000	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	1,286,781	0.000000	74.00
76.00	03950	ANCILLARY - OTHER	0	0	0	0	0.000000	76.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	936,186	0.000000	76.97
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0	0	0	88,888,587	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	10,764,097	0.000000	92.00
93.00	04040	FAMILY PRACTICE	0	0	0	6,316,224	0.000000	93.00
		OTHER REIMBURSABLE COST CENTERS						
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	0	505,498	0.000000	96.00
200.00		Total (lines 50 through 199)	0	827,286	827,286	900,926,083		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-0048 | Component CCN: 15-T048 | Period: From 01/01/2020 To 12/31/2020 | Worksheet D Part IV | Date/Time Prepared: 7/8/2021 10:37 am

Title XVIII | Subprovider - IRF | PPS

		Cost Center Description	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
			9.00	10.00	11.00	12.00	13.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.000000	85,513	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	0.005378	115,451	621	0	0	54.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	8,370	0	0	0	59.00
60.00	06000	LABORATORY	0.000000	480,494	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.000000	261,278	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	2,537,241	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	7,197	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.000000	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	717,752	0	1,279	0	73.00
74.00	07400	RENAL DIALYSIS	0.000000	24,700	0	0	0	74.00
76.00	03950	ANCILLARY - OTHER	0.000000	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0.000000	0	0	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0.000000	10,661	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	0	0	0	0	92.00
93.00	04040	FAMILY PRACTICE	0.000000	0	0	0	0	93.00
		OTHER REIMBURSABLE COST CENTERS						
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0.000000	0	0	0	0	96.00
200.00		Total (lines 50 through 199)		4,248,657	621	1,279	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-0048 | Component CCN: 15-T048 | Period: From 01/01/2020 To 12/31/2020 | Worksheet D Part V | Date/Time Prepared: 7/8/2021 10:37 am

Title XVIII | Subprovider - IRF | PPS

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges			Costs	
				PPS Reimbursed Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.214961	0	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.225475	0	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.173687	0	0	0	0	54.00
59.00	05900	CARDIAC CATHETERIZATION	0.126475	0	0	0	0	59.00
60.00	06000	LABORATORY	0.185789	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.148369	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.653218	0	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0.104913	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.179820	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.589774	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.343525	1,279	0	1,869	439	73.00
74.00	07400	RENAL DIALYSIS	0.894410	0	0	0	0	74.00
76.00	03950	ANCILLARY - OTHER	0.000000	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	1.063034	0	0	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0.192365	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.566100	0	0	0	0	92.00
93.00	04040	FAMILY PRACTICE	0.570834	0	0	0	0	93.00
		OTHER REIMBURSABLE COST CENTERS						
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	1.489414	0	0	0	0	96.00
200.00		Subtotal (see instructions)		1,279	0	1,869	439	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 - line 201)		1,279	0	1,869	439	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 15-0048 | Component CCN: 15-T048 | Period: From 01/01/2020 To 12/31/2020 | Worksheet D Part V | Date/Time Prepared: 7/8/2021 10:37 am

Title XVIII | Subprovider - IRF | PPS

		Cost Center Description	Costs: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	
			6.00	7.00	
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	54.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	59.00
60.00	06000	LABORATORY	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	642	73.00
74.00	07400	RENAL DIALYSIS	0	0	74.00
76.00	03950	ANCILLARY - OTHER	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS			
91.00	09100	EMERGENCY	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	92.00
93.00	04040	FAMILY PRACTICE	0	0	93.00
		OTHER REIMBURSABLE COST CENTERS			
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	96.00
200.00		Subtotal (see instructions)	0	642	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0		201.00
202.00		Net Charges (line 200 - line 201)	0	642	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-0048 | Period: From 01/01/2020 To 12/31/2020 | Worksheet D Part V Date/Time Prepared: 7/8/2021 10:37 am

Title XIX | Hospital | Cost

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.214961	0	2,314,592	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.225475	0	55,450	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.173687	0	2,897,756	0	0	54.00
59.00	05900	CARDIAC CATHETERIZATION	0.126475	0	578,949	0	0	59.00
60.00	06000	LABORATORY	0.185789	0	1,893,321	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.148369	0	83,346	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.653218	0	735,729	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0.104913	0	308,055	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.179820	0	71,409	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.589774	0	180,218	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.343525	0	1,829,244	0	0	73.00
74.00	07400	RENAL DIALYSIS	0.894410	0	0	0	0	74.00
76.00	03950	ANCILLARY - OTHER	0.000000	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	1.063034	0	3,881	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0.192365	0	3,348,909	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.566100	0	401,202	0	0	92.00
93.00	04040	FAMILY PRACTICE	0.570834	0	120,627	0	0	93.00
		OTHER REIMBURSABLE COST CENTERS						
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	1.489414	0	0	0	0	96.00
200.00		Subtotal (see instructions)		0	14,822,688	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	14,822,688	0	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-0048 | Period: From 01/01/2020 To 12/31/2020 | Worksheet D Part V Date/Time Prepared: 7/8/2021 10:37 am

Title XIX | Hospital | Cost

		Cost Center Description	Costs		
			Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	
			6.00	7.00	
	ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	497,547	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	12,503	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	503,303	0	54.00
59.00	05900	CARDIAC CATHETERIZATION	73,223	0	59.00
60.00	06000	LABORATORY	351,758	0	60.00
65.00	06500	RESPIRATORY THERAPY	12,366	0	65.00
66.00	06600	PHYSICAL THERAPY	480,591	0	66.00
69.00	06900	ELECTROCARDIOLOGY	32,319	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	12,841	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	106,288	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	628,391	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	74.00
76.00	03950	ANCILLARY - OTHER	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	4,126	0	76.97
	OUTPATIENT SERVICE COST CENTERS				
91.00	09100	EMERGENCY	644,213	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	227,120	0	92.00
93.00	04040	FAMILY PRACTICE	68,858	0	93.00
	OTHER REIMBURSABLE COST CENTERS				
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	96.00
200.00		Subtotal (see instructions)	3,655,447	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0		201.00
202.00		Net Charges (line 200 - line 201)	3,655,447	0	202.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-0048 | Period: From 01/01/2020 To 12/31/2020 | Worksheet D-1 | Date/Time Prepared: 7/8/2021 10:37 am

Title XVIII | Hospital | PPS

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	49,319	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	49,319	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)	44,133	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions)	19,417	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)	0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period	0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15.00	Total nursery days (title V or XIX only)	0	15.00
16.00	Nursery days (title V or XIX only)	0	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period	0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period	0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)	57,949,643	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)	0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)	0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)	0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)	0	25.00
26.00	Total swing-bed cost (see instructions)	0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	57,949,643	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)	57,949,643	37.00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY		
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS		
38.00	Adjusted general inpatient routine service cost per diem (see instructions)	1,175.00	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	22,814,975	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)	22,814,975	41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 15-0048 | Period: From 01/01/2020 To 12/31/2020 | Worksheet D-1 | Date/Time Prepared: 7/8/2021 10:37 am

Title XVIII | Hospital | PPS

	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)	0	0	0.00	0	0	42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	10,921,535	6,349	1,720.20	2,778	4,778,716	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)	37,997,784	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	65,591,475	49.00
	PASS THROUGH COST ADJUSTMENTS		
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)	2,394,677	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	2,438,462	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	4,833,139	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	60,758,336	53.00
	TARGET AMOUNT AND LIMIT COMPUTATION		
54.00	Program discharges	0	54.00
55.00	Target amount per discharge	0.00	55.00
56.00	Target amount (line 54 x line 55)	0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)	0	57.00
58.00	Bonus payment (see instructions)	0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket	0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket	0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)	0	61.00
62.00	Relief payment (see instructions)	0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)	0	63.00
	PROGRAM INPATIENT ROUTINE SWING BED COST		
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)	0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)	0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)	0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)	0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)	0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)	0	69.00
	PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY		
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)		70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)		71.00
72.00	Program routine service cost (line 9 x line 71)		72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)		73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)		74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)		75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)		76.00
77.00	Program capital-related costs (line 9 x line 76)		77.00
78.00	Inpatient routine service cost (line 74 minus line 77)		78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)		79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)		80.00
81.00	Inpatient routine service cost per diem limitation		81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)		82.00
83.00	Reasonable inpatient routine service costs (see instructions)		83.00
84.00	Program inpatient ancillary services (see instructions)		84.00
85.00	Utilization review - physician compensation (see instructions)		85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)		86.00
	PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST		
87.00	Total observation bed days (see instructions)	5,186	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	1,175.00	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	6,093,550	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-0048 | Period: From 01/01/2020 To 12/31/2020 | Worksheet D-1 | Date/Time Prepared: 7/8/2021 10:37 am

Title XVIII | Hospital | PPS

	Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	4,654,124	57,949,643	0.080313	6,093,550	489,391	90.00
91.00	Nursing School cost	0	57,949,643	0.000000	6,093,550	0	91.00
92.00	Allied health cost	0	57,949,643	0.000000	6,093,550	0	92.00
93.00	All other Medical Education	0	57,949,643	0.000000	6,093,550	0	93.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 15-0048 Component CCN: 15-S048	Period: From 01/01/2020 To 12/31/2020	Worksheet D-1 Date/Time Prepared: 7/8/2021 10:37 am
	Title XVIII	Subprovider - IPF	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)	8,484	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	8,484	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)	8,484	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions)	4,421	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)	0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period	0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15.00	Total nursery days (title V or XIX only)	0	15.00
16.00	Nursery days (title V or XIX only)	0	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period	0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period	0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)	7,076,098	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)	0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)	0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)	0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)	0	25.00
26.00	Total swing-bed cost (see instructions)	0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	7,076,098	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)	7,076,098	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)	834.05	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	3,687,335	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)	0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)	3,687,335	41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 15-0048 | Component CCN: 15-S048 | Period: From 01/01/2020 To 12/31/2020 | Worksheet D-1 | Date/Time Prepared: 7/8/2021 10:37 am

Title XVIII | Subprovider - IPF | PPS

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

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	909,326	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	4,596,661	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)	391,966	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	56,341	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	448,307	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	4,148,354	53.00
	TARGET AMOUNT AND LIMIT COMPUTATION		
54.00	Program discharges	0	54.00
55.00	Target amount per discharge	0.00	55.00
56.00	Target amount (line 54 x line 55)	0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)	0	57.00
58.00	Bonus payment (see instructions)	0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket	0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket	0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)	0	61.00
62.00	Relief payment (see instructions)	0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)	0	63.00
	PROGRAM INPATIENT ROUTINE SWING BED COST		
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)	0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)	0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)	0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)	0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)	0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)	0	69.00
	PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY		
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)		70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)		71.00
72.00	Program routine service cost (line 9 x line 71)		72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)		73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)		74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)		75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)		76.00
77.00	Program capital-related costs (line 9 x line 76)		77.00
78.00	Inpatient routine service cost (line 74 minus line 77)		78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)		79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)		80.00
81.00	Inpatient routine service cost per diem limitation		81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)		82.00
83.00	Reasonable inpatient routine service costs (see instructions)		83.00
84.00	Program inpatient ancillary services (see instructions)		84.00
85.00	Utilization review - physician compensation (see instructions)		85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)		86.00
	PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST		
87.00	Total observation bed days (see instructions)	0	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	0.00	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	0	89.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 15-0048 | Period: From 01/01/2020 To 12/31/2020 | Worksheet D-1

Component CCN: 15-S048 | Date/Time Prepared: 7/8/2021 10:37 am

Title XVIII | Subprovider - IPF | PPS

	Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	752,151	7,076,098	0.106295	0	0	90.00
91.00	Nursing School cost	0	7,076,098	0.000000	0	0	91.00
92.00	Allied health cost	0	7,076,098	0.000000	0	0	92.00
93.00	All other Medical Education	0	7,076,098	0.000000	0	0	93.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 15-0048 | Component CCN: 15-T048 | Period: From 01/01/2020 To 12/31/2020 | Worksheet D-1 | Date/Time Prepared: 7/8/2021 10:37 am

Title XVIII | Subprovider - IRF | PPS

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	5,384	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	5,384	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)	5,384	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions)	2,934	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)	0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period	0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15.00	Total nursery days (title V or XIX only)	0	15.00
16.00	Nursery days (title V or XIX only)	0	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period	0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period	0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)	4,188,399	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)	0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)	0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)	0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)	0	25.00
26.00	Total swing-bed cost (see instructions)	0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	4,188,399	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)	4,188,399	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)	777.93	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	2,282,447	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)	0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)	2,282,447	41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 15-0048 | Period: From 01/01/2020 To 12/31/2020 | Worksheet D-1
Component CCN: 15-T048 | Date/Time Prepared: 7/8/2021 10:37 am

Title XVIII | Subprovider - IRF | PPS

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

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	2,096,364	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	4,378,811	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)	320,804	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	185,864	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	506,668	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	3,872,143	53.00
	TARGET AMOUNT AND LIMIT COMPUTATION		
54.00	Program discharges	0	54.00
55.00	Target amount per discharge	0.00	55.00
56.00	Target amount (line 54 x line 55)	0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)	0	57.00
58.00	Bonus payment (see instructions)	0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket	0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket	0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)	0	61.00
62.00	Relief payment (see instructions)	0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)	0	63.00
	PROGRAM INPATIENT ROUTINE SWING BED COST		
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)	0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)	0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)	0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)	0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)	0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)	0	69.00
	PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY		
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)		70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)		71.00
72.00	Program routine service cost (line 9 x line 71)		72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)		73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)		74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)		75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)		76.00
77.00	Program capital-related costs (line 9 x line 76)		77.00
78.00	Inpatient routine service cost (line 74 minus line 77)		78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)		79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)		80.00
81.00	Inpatient routine service cost per diem limitation		81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)		82.00
83.00	Reasonable inpatient routine service costs (see instructions)		83.00
84.00	Program inpatient ancillary services (see instructions)		84.00
85.00	Utilization review - physician compensation (see instructions)		85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)		86.00
	PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST		
87.00	Total observation bed days (see instructions)	0	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	0.00	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	0	89.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 15-0048 | Period: From 01/01/2020 To 12/31/2020 | Worksheet D-1

Component CCN: 15-T048 | Date/Time Prepared: 7/8/2021 10:37 am

Title XVIII | Subprovider - IRF | PPS

	Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	588,664	4,188,399	0.140546	0	0	90.00
91.00	Nursing School cost	0	4,188,399	0.000000	0	0	91.00
92.00	Allied health cost	0	4,188,399	0.000000	0	0	92.00
93.00	All other Medical Education	0	4,188,399	0.000000	0	0	93.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-0048 | Period: From 01/01/2020 To 12/31/2020 | Worksheet D-1 Date/Time Prepared: 7/8/2021 10:37 am

Title XIX | Hospital | Cost

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	49,319	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	49,319	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)	44,133	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions)	1,135	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)	0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period	0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15.00	Total nursery days (title V or XIX only)	1,700	15.00
16.00	Nursery days (title V or XIX only)	44	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period	0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period	0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)	57,876,651	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)	0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)	0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)	0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)	0	25.00
26.00	Total swing-bed cost (see instructions)	0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	57,876,651	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)	57,876,651	37.00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY		
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS		
38.00	Adjusted general inpatient routine service cost per diem (see instructions)	1,173.52	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	1,331,945	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)	0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)	1,331,945	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-0048 | Period: From 01/01/2020 To 12/31/2020 | Worksheet D-1 Date/Time Prepared: 7/8/2021 10:37 am

Title XIX | Hospital | Cost

	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)	1,368,982	1,700	805.28	44	35,432	42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	10,921,535	6,349	1,720.20	164	282,113	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)	2,172,372	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	3,821,862	49.00
	PASS THROUGH COST ADJUSTMENTS		
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)	0	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	0	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	0	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	0	53.00
	TARGET AMOUNT AND LIMIT COMPUTATION		
54.00	Program discharges	0	54.00
55.00	Target amount per discharge	0.00	55.00
56.00	Target amount (line 54 x line 55)	0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)	0	57.00
58.00	Bonus payment (see instructions)	0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket	0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket	0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)	0	61.00
62.00	Relief payment (see instructions)	0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)	0	63.00
	PROGRAM INPATIENT ROUTINE SWING BED COST		
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)	0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)	0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)	0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)	0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)	0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)	0	69.00
	PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY		
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)		70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)		71.00
72.00	Program routine service cost (line 9 x line 71)		72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)		73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)		74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)		75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)		76.00
77.00	Program capital-related costs (line 9 x line 76)		77.00
78.00	Inpatient routine service cost (line 74 minus line 77)		78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)		79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)		80.00
81.00	Inpatient routine service cost per diem limitation		81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)		82.00
83.00	Reasonable inpatient routine service costs (see instructions)		83.00
84.00	Program inpatient ancillary services (see instructions)		84.00
85.00	Utilization review - physician compensation (see instructions)		85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)		86.00
	PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST		
87.00	Total observation bed days (see instructions)	5,186	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	1,173.52	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	6,085,875	89.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 15-0048	Period: From 01/01/2020 To 12/31/2020	Worksheet D-1 Date/Time Prepared: 7/8/2021 10:37 am
	Title XIX	Hospital	Cost

	Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	4,654,124	57,876,651	0.080415	6,085,875	489,396	90.00
91.00	Nursing School cost	0	57,876,651	0.000000	6,085,875	0	91.00
92.00	Allied health cost	0	57,876,651	0.000000	6,085,875	0	92.00
93.00	All other Medical Education	0	57,876,651	0.000000	6,085,875	0	93.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 15-0048 Component CCN: 15-S048	Period: From 01/01/2020 To 12/31/2020	Worksheet D-1 Date/Time Prepared: 7/8/2021 10:37 am
	Title XIX	Subprovider - IPF	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)	8,484	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	8,484	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)	8,484	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions)	366	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)	0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period	0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15.00	Total nursery days (title V or XIX only)	1,700	15.00
16.00	Nursery days (title V or XIX only)	44	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period	0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period	0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)	7,076,098	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)	0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)	0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)	0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)	0	25.00
26.00	Total swing-bed cost (see instructions)	0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	7,076,098	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)	7,076,098	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)	834.05	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	305,262	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)	305,262	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-0048 | Component CCN: 15-S048 | Period: From 01/01/2020 To 12/31/2020 | Worksheet D-1 | Date/Time Prepared: 7/8/2021 10:37 am

Title XIX | Subprovider - IPF | 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)	0	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	305,262	49.00
	PASS THROUGH COST ADJUSTMENTS		
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)	0	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	0	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	0	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	0	53.00
	TARGET AMOUNT AND LIMIT COMPUTATION		
54.00	Program discharges	0	54.00
55.00	Target amount per discharge	0.00	55.00
56.00	Target amount (line 54 x line 55)	0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)	0	57.00
58.00	Bonus payment (see instructions)	0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket	0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket	0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)	0	61.00
62.00	Relief payment (see instructions)	0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)	0	63.00
	PROGRAM INPATIENT ROUTINE SWING BED COST		
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)	0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)	0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)	0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)	0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)	0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)	0	69.00
	PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY		
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)		70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)		71.00
72.00	Program routine service cost (line 9 x line 71)		72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)		73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)		74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)		75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)		76.00
77.00	Program capital-related costs (line 9 x line 76)		77.00
78.00	Inpatient routine service cost (line 74 minus line 77)		78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)		79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)		80.00
81.00	Inpatient routine service cost per diem limitation		81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)		82.00
83.00	Reasonable inpatient routine service costs (see instructions)		83.00
84.00	Program inpatient ancillary services (see instructions)		84.00
85.00	Utilization review - physician compensation (see instructions)		85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)		86.00
	PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST		
87.00	Total observation bed days (see instructions)	0	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	0.00	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	0	89.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 15-0048 | Component CCN: 15-S048 | Period: From 01/01/2020 To 12/31/2020 | Worksheet D-1 | Date/Time Prepared: 7/8/2021 10:37 am

Title XIX | Subprovider - IPF | 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	752,151	7,076,098	0.106295	0	0	90.00
91.00	Nursing School cost	0	7,076,098	0.000000	0	0	91.00
92.00	Allied health cost	0	7,076,098	0.000000	0	0	92.00
93.00	All other Medical Education	0	7,076,098	0.000000	0	0	93.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 15-0048 Component CCN: 15-T048	Period: From 01/01/2020 To 12/31/2020	Worksheet D-1 Date/Time Prepared: 7/8/2021 10:37 am
	Title XIX	Subprovider - IRF	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)	5,384	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	5,384	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)	5,384	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions)	0	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)	0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period	0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15.00	Total nursery days (title V or XIX only)	1,700	15.00
16.00	Nursery days (title V or XIX only)	44	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period	0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period	0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)	4,188,399	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)	0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)	0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)	0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)	0	25.00
26.00	Total swing-bed cost (see instructions)	0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	4,188,399	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)	4,188,399	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)	777.93	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	0	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)	0	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-0048 | Component CCN: 15-T048 | Period: From 01/01/2020 To 12/31/2020 | Worksheet D-1 | Date/Time Prepared: 7/8/2021 10:37 am

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

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 15-0048 | Period: From 01/01/2020 To 12/31/2020 | Worksheet D-1
Component CCN: 15-T048 | Date/Time Prepared: 7/8/2021 10:37 am

Title XIX | Subprovider - IRF | 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	588,664	4,188,399	0.140546	0	0	90.00
91.00	Nursing School cost	0	4,188,399	0.000000	0	0	91.00
92.00	Allied health cost	0	4,188,399	0.000000	0	0	92.00
93.00	All other Medical Education	0	4,188,399	0.000000	0	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provider CCN: 15-0048	Period: From 01/01/2020 To 12/31/2020	Worksheet D-3 Date/Time Prepared: 7/8/2021 10:37 am
	Title XVIII	Hospital	PPS

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		28,012,538		30.00
31.00	03100	INTENSIVE CARE UNIT		5,245,117		31.00
40.00	04000	SUBPROVIDER - IPF		0		40.00
41.00	04100	SUBPROVIDER - IRF		0		41.00
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.214961	27,363,876	5,882,166	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.225475	21,718	4,897	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.173687	22,095,813	3,837,755	54.00
59.00	05900	CARDIAC CATHETERIZATION	0.126475	17,527,225	2,216,756	59.00
60.00	06000	LABORATORY	0.185789	20,998,863	3,901,358	60.00
65.00	06500	RESPIRATORY THERAPY	0.148369	9,960,288	1,477,798	65.00
66.00	06600	PHYSICAL THERAPY	0.653218	2,803,474	1,831,280	66.00
69.00	06900	ELECTROCARDIOLOGY	0.104913	3,782,695	396,854	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.179820	5,664	1,019	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.589774	9,282,558	5,474,611	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.343525	25,888,855	8,893,469	73.00
74.00	07400	RENAL DIALYSIS	0.894410	771,867	690,366	74.00
76.00	03950	ANCILLARY - OTHER	0.000000	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	1.063034	83	88	76.97
		OUTPATIENT SERVICE COST CENTERS				
91.00	09100	EMERGENCY	0.192365	14,855,787	2,857,733	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.566100	923,763	522,942	92.00
93.00	04040	FAMILY PRACTICE	0.570834	15,227	8,692	93.00
		OTHER REIMBURSABLE COST CENTERS				
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	1.489414	0	0	96.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		156,297,756	37,997,784	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)		156,297,756		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

Provider CCN: 15-0048 | Component CCN: 15-S048 | Period: From 01/01/2020 To 12/31/2020 | Worksheet D-3 | Date/Time Prepared: 7/8/2021 10:37 am

Title XVIII | Subprovider - IPF | PPS

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		0		30.00
31.00	03100	INTENSIVE CARE UNIT		0		31.00
40.00	04000	SUBPROVIDER - IPF		4,843,161		40.00
41.00	04100	SUBPROVIDER - IRF		0		41.00
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.214961	86,781	18,655	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.225475	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.173687	346,532	60,188	54.00
59.00	05900	CARDIAC CATHETERIZATION	0.126475	530	67	59.00
60.00	06000	LABORATORY	0.185789	708,041	131,546	60.00
65.00	06500	RESPIRATORY THERAPY	0.148369	388,534	57,646	65.00
66.00	06600	PHYSICAL THERAPY	0.653218	276,350	180,517	66.00
69.00	06900	ELECTROCARDIOLOGY	0.104913	23,163	2,430	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.179820	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.589774	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.343525	1,076,669	369,863	73.00
74.00	07400	RENAL DIALYSIS	0.894410	3,250	2,907	74.00
76.00	03950	ANCILLARY - OTHER	0.000000	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	1.063034	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS				
91.00	09100	EMERGENCY	0.192365	444,502	85,507	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.566100	0	0	92.00
93.00	04040	FAMILY PRACTICE	0.570834	0	0	93.00
		OTHER REIMBURSABLE COST CENTERS				
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	1.489414	0	0	96.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		3,354,352	909,326	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)		3,354,352		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provider CCN: 15-0048 Component CCN: 15-T048	Period: From 01/01/2020 To 12/31/2020	Worksheet D-3 Date/Time Prepared: 7/8/2021 10:37 am
	Title XVIII	Subprovider - IRF	PPS

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		0		30.00
31.00	03100	INTENSIVE CARE UNIT		0		31.00
40.00	04000	SUBPROVIDER - IPF		0		40.00
41.00	04100	SUBPROVIDER - IRF		3,214,168		41.00
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.214961	85,513	18,382	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.225475	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.173687	115,451	20,052	54.00
59.00	05900	CARDIAC CATHETERIZATION	0.126475	8,370	1,059	59.00
60.00	06000	LABORATORY	0.185789	480,494	89,270	60.00
65.00	06500	RESPIRATORY THERAPY	0.148369	261,278	38,766	65.00
66.00	06600	PHYSICAL THERAPY	0.653218	2,537,241	1,657,371	66.00
69.00	06900	ELECTROCARDIOLOGY	0.104913	7,197	755	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.179820	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.589774	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.343525	717,752	246,566	73.00
74.00	07400	RENAL DIALYSIS	0.894410	24,700	22,092	74.00
76.00	03950	ANCILLARY - OTHER	0.000000	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	1.063034	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS				
91.00	09100	EMERGENCY	0.192365	10,661	2,051	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.566100	0	0	92.00
93.00	04040	FAMILY PRACTICE	0.570834	0	0	93.00
		OTHER REIMBURSABLE COST CENTERS				
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	1.489414	0	0	96.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		4,248,657	2,096,364	200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0		201.00
202.00		Net charges (line 200 minus line 201)		4,248,657		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 15-0048 | Period: From 01/01/2020 To 12/31/2020 | Worksheet D-3 | Date/Time Prepared: 7/8/2021 10:37 am

Title XIX | Hospital | Cost

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		1,801,202		30.00
31.00	03100	INTENSIVE CARE UNIT		528,301		31.00
40.00	04000	SUBPROVIDER - IPF		510,088		40.00
41.00	04100	SUBPROVIDER - IRF		85,448		41.00
43.00	04300	NURSERY		274,614		43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.214961	1,105,604	237,662	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.225475	436,282	98,371	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.173687	1,369,650	237,890	54.00
59.00	05900	CARDIAC CATHETERIZATION	0.126475	402,624	50,922	59.00
60.00	06000	LABORATORY	0.185789	1,476,994	274,409	60.00
65.00	06500	RESPIRATORY THERAPY	0.148369	733,512	108,830	65.00
66.00	06600	PHYSICAL THERAPY	0.653218	204,840	133,805	66.00
69.00	06900	ELECTROCARDIOLOGY	0.104913	193,042	20,253	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.179820	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.589774	236,195	139,302	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.343525	1,928,177	662,377	73.00
74.00	07400	RENAL DIALYSIS	0.894410	31,200	27,906	74.00
76.00	03950	ANCILLARY - OTHER	0.000000	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	1.063034	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS				
91.00	09100	EMERGENCY	0.192365	939,000	180,631	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.566100	0	0	92.00
93.00	04040	FAMILY PRACTICE	0.570834	25	14	93.00
		OTHER REIMBURSABLE COST CENTERS				
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	1.489414	0	0	96.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		9,057,145	2,172,372	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)		9,057,145		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provider CCN: 15-0048 Component CCN: 15-S048	Period: From 01/01/2020 To 12/31/2020	Worksheet D-3 Date/Time Prepared: 7/8/2021 10:37 am
	Title XIX	Subprovider - IPF	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
40.00	04000	SUBPROVIDER - IPF		510,622		40.00
41.00	04100	SUBPROVIDER - IRF		0		41.00
43.00	04300	NURSERY		0		43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.214961	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.225475	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.173687	0	0	54.00
59.00	05900	CARDIAC CATHETERIZATION	0.126475	0	0	59.00
60.00	06000	LABORATORY	0.185789	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.148369	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.653218	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0.104913	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.179820	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.589774	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.343525	0	0	73.00
74.00	07400	RENAL DIALYSIS	0.894410	0	0	74.00
76.00	03950	ANCILLARY - OTHER	0.000000	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	1.063034	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS				
91.00	09100	EMERGENCY	0.192365	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.566100	0	0	92.00
93.00	04040	FAMILY PRACTICE	0.570834	0	0	93.00
		OTHER REIMBURSABLE COST CENTERS				
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	1.489414	0	0	96.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		0	0	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)		0		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

Provider CCN: 15-0048 | Component CCN: 15-T048 | Period: From 01/01/2020 To 12/31/2020 | Worksheet D-3 | Date/Time Prepared: 7/8/2021 10:37 am

Title XIX | Subprovider - IRF | Cost

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
	INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS		0		30.00
31.00	03100	INTENSIVE CARE UNIT		0		31.00
40.00	04000	SUBPROVIDER - IPF		0		40.00
41.00	04100	SUBPROVIDER - IRF		85,448		41.00
43.00	04300	NURSERY		0		43.00
	ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0.214961	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.225475	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.173687	0	0	54.00
59.00	05900	CARDIAC CATHETERIZATION	0.126475	0	0	59.00
60.00	06000	LABORATORY	0.185789	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.148369	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.653218	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0.104913	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.179820	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.589774	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.343525	0	0	73.00
74.00	07400	RENAL DIALYSIS	0.894410	0	0	74.00
76.00	03950	ANCILLARY - OTHER	0.000000	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	1.063034	0	0	76.97
	OUTPATIENT SERVICE COST CENTERS					
91.00	09100	EMERGENCY	0.192365	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.566100	0	0	92.00
93.00	04040	FAMILY PRACTICE	0.570834	0	0	93.00
	OTHER REIMBURSABLE COST CENTERS					
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	1.489414	0	0	96.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		0	0	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)		0		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT | Provider CCN: 15-0048 | Period: From 01/01/2020 To 12/31/2020 | Worksheet E Part A | Date/Time Prepared: 7/8/2021 10:37 am

Title XVIII | Hospital | PPS

		1.00	
	PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS		
1.00	DRG Amounts Other than Outlier Payments	0	1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1 (see instructions)	36,167,946	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1 (see instructions)	16,349,890	1.02
1.03	DRG for federal specific operating payment for Model 4 BPCI for discharges occurring prior to October 1 (see instructions)	0	1.03
1.04	DRG for federal specific operating payment for Model 4 BPCI for discharges occurring on or after October 1 (see instructions)	0	1.04
2.00	Outlier payments for discharges. (see instructions)		2.00
2.01	Outlier reconciliation amount	0	2.01
2.02	Outlier payment for discharges for Model 4 BPCI (see instructions)	0	2.02
2.03	Outlier payments for discharges occurring prior to October 1 (see instructions)	502,320	2.03
2.04	Outlier payments for discharges occurring on or after October 1 (see instructions)	86,215	2.04
3.00	Managed Care Simulated Payments	10,955,664	3.00
4.00	Bed days available divided by number of days in the cost reporting period (see instructions)	208.83	4.00
	Indirect Medical Education Adjustment		
5.00	FTE count for allopathic and osteopathic programs for the most recent cost reporting period ending on or before 12/31/1996.(see instructions)	0.00	5.00
6.00	FTE count for allopathic and osteopathic programs that meet the criteria for an add-on to the cap for new programs in accordance with 42 CFR 413.79(e)	0.00	6.00
7.00	MMA Section 422 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(1)	0.00	7.00
7.01	ACA § 5503 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(2) If the cost report straddles July 1, 2011 then see instructions.	0.00	7.01
8.00	Adjustment (increase or decrease) to the FTE count for allopathic and osteopathic programs for affiliated programs in accordance with 42 CFR 413.75(b), 413.79(c)(2)(iv), 64 FR 26340 (May 12, 1998), and 67 FR 50069 (August 1, 2002).	0.00	8.00
8.01	The amount of increase if the hospital was awarded FTE cap slots under § 5503 of the ACA. If the cost report straddles July 1, 2011, see instructions.	0.00	8.01
8.02	The amount of increase if the hospital was awarded FTE cap slots from a closed teaching hospital under § 5506 of ACA. (see instructions)	0.00	8.02
9.00	Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus lines (8, 8,01 and 8,02) (see instructions)	0.00	9.00
10.00	FTE count for allopathic and osteopathic programs in the current year from your records	0.00	10.00
11.00	FTE count for residents in dental and podiatric programs.	0.00	11.00
12.00	Current year allowable FTE (see instructions)	0.00	12.00
13.00	Total allowable FTE count for the prior year.	0.00	13.00
14.00	Total allowable FTE count for the penultimate year if that year ended on or after September 30, 1997, otherwise enter zero.	0.00	14.00
15.00	Sum of lines 12 through 14 divided by 3.	0.00	15.00
16.00	Adjustment for residents in initial years of the program	16.75	16.00
17.00	Adjustment for residents displaced by program or hospital closure	0.00	17.00
18.00	Adjusted rolling average FTE count	16.75	18.00
19.00	Current year resident to bed ratio (line 18 divided by line 4).	0.080209	19.00
20.00	Prior year resident to bed ratio (see instructions)	0.111622	20.00
21.00	Enter the lesser of lines 19 or 20 (see instructions)	0.080209	21.00
22.00	IME payment adjustment (see instructions)	2,250,389	22.00
22.01	IME payment adjustment - Managed Care (see instructions)	469,450	22.01
	Indirect Medical Education Adjustment for the Add-on for § 422 of the MMA		
23.00	Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 CFR 412.105 (f)(1)(iv)(C).	0.00	23.00
24.00	IME FTE Resident Count Over Cap (see instructions)	0.00	24.00
25.00	If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see instructions)	0.00	25.00
26.00	Resident to bed ratio (divide line 25 by line 4)	0.000000	26.00
27.00	IME payments adjustment factor. (see instructions)	0.000000	27.00
28.00	IME add-on adjustment amount (see instructions)	0	28.00
28.01	IME add-on adjustment amount - Managed Care (see instructions)	0	28.01
29.00	Total IME payment (sum of lines 22 and 28)	2,250,389	29.00
29.01	Total IME payment - Managed Care (sum of lines 22.01 and 28.01)	469,450	29.01
	Disproportionate Share Adjustment		
30.00	Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)	5.42	30.00
31.00	Percentage of Medicaid patient days (see instructions)	27.23	31.00
32.00	Sum of lines 30 and 31	32.65	32.00
33.00	Allowable disproportionate share percentage (see instructions)	16.15	33.00
34.00	Disproportionate share adjustment (see instructions)	2,120,408	34.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0048	Period: From 01/01/2020 To 12/31/2020	Worksheet E Part A Date/Time Prepared: 7/8/2021 10:37 am
	Title XVIII	Hospital	PPS

		Prior to 10/1	On/After 10/1	
		1.00	2.00	
	Uncompensated Care Adjustment			
35.00	Total uncompensated care amount (see instructions)	8,350,599,096	8,290,014,521	35.00
35.01	Factor 3 (see instructions)	0.000106761	0.000540925	35.01
35.02	Hospital uncompensated care payment (If line 34 is zero, enter zero on this line) (see instructions)	655,168	1,158,162	35.02
35.03	Pro rata share of the hospital uncompensated care payment amount (see instructions)	490,481	291,921	35.03
36.00	Total uncompensated care (sum of columns 1 and 2 on line 35.03)	782,402		36.00
	Additional payment for high percentage of ESRD beneficiary discharges (lines 40 through 46)			
40.00	Total Medicare discharges, excluding MS-DRGs 652, 682, 683, 684 and 685. (see instructions)	0		40.00
41.00	Total ESRD Medicare discharges excluding MS-DRGs 652, 682, 683, 684 an 685. (see instructions)	0		41.00
41.01	Total ESRD Medicare covered and paid discharges excluding MS-DRGs 652, 682, 683, 684 an 685. (see instructions)	0		41.01
42.00	Divide line 41 by line 40 (if less than 10%, you do not qualify for adjustment)	0.00		42.00
43.00	Total Medicare ESRD inpatient days excluding MS-DRGs 652, 682, 683, 684 an 685. (see instructions)	0		43.00
44.00	Ratio of average length of stay to one week (line 43 divided by line 41 divided by 7 days)	0.000000		44.00
45.00	Average weekly cost for dialysis treatments (see instructions)	0.00		45.00
46.00	Total additional payment (line 45 times line 44 times line 41.01)	0		46.00
47.00	Subtotal (see instructions)	58,259,570		47.00
48.00	Hospital specific payments (to be completed by SCH and MDH, small rural hospitals only.(see instructions)	70,031,474		48.00

		Amount	
		1.00	
49.00	Total payment for inpatient operating costs (see instructions)	70,500,924	49.00
50.00	Payment for inpatient program capital (from Wkst. L, Pt. I and Pt. II, as applicable)	4,246,576	50.00
51.00	Exception payment for inpatient program capital (Wkst. L, Pt. III, see instructions)	0	51.00
52.00	Direct graduate medical education payment (from Wkst. E-4, line 49 see instructions).	486,987	52.00
53.00	Nursing and Allied Health Managed Care payment	165,142	53.00
54.00	Special add-on payments for new technologies	180,092	54.00
54.01	Islet isolation add-on payment	0	54.01
55.00	Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line 69)	0	55.00
56.00	Cost of physicians' services in a teaching hospital (see intructions)	0	56.00
57.00	Routine service other pass through costs (from Wkst. D, Pt. III, column 9, lines 30 through 35).	0	57.00
58.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 11 line 200)	118,831	58.00
59.00	Total (sum of amounts on lines 49 through 58)	75,698,552	59.00
60.00	Primary payer payments	27,983	60.00
61.00	Total amount payable for program beneficiaries (line 59 minus line 60)	75,670,569	61.00
62.00	Deductibles billed to program beneficiaries	5,540,744	62.00
63.00	Coinsurance billed to program beneficiaries	160,820	63.00
64.00	Allowable bad debts (see instructions)	1,017,709	64.00
65.00	Adjusted reimbursable bad debts (see instructions)	661,511	65.00
66.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	424,062	66.00
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)	70,630,516	67.00
68.00	Credits received from manufacturers for replaced devices for applicable to MS-DRGs (see instructions)	0	68.00
69.00	Outlier payments reconciliation (sum of lines 93, 95 and 96).(For SCH see instructions)	0	69.00
70.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	70.00
70.50	Rural Community Hospital Demonstration Project (§410A Demonstration) adjustment (see instructions)	0	70.50
70.87	Demonstration payment adjustment amount before sequestration	0	70.87
70.88	SCH or MDH volume decrease adjustment (contractor use only)	0	70.88
70.89	Pioneer ACO demonstration payment adjustment amount (see instructions)		70.89
70.90	HSP bonus payment HVBP adjustment amount (see instructions)	0	70.90
70.91	HSP bonus payment HRR adjustment amount (see instructions)	0	70.91
70.92	Bundled Model 1 discount amount (see instructions)	0	70.92
70.93	HVBP payment adjustment amount (see instructions)	-184,922	70.93
70.94	HRR adjustment amount (see instructions)	-57,793	70.94
70.95	Recovery of accelerated depreciation	0	70.95

CALCULATION OF REIMBURSEMENT SETTLEMENT | Provider CCN: 15-0048 | Period: From 01/01/2020 To 12/31/2020 | Worksheet E Part A Date/Time Prepared: 7/8/2021 10:37 am

Title XVIII | Hospital | PPS

		FFY (yyyy)	Amount	
		0	1.00	
70.96	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period prior to 10/1)	0	0	70.96
70.97	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period ending on or after 10/1)	0	0	70.97
70.98	Low Volume Payment-3		0	70.98
70.99	HAC adjustment amount (see instructions)		0	70.99
71.00	Amount due provider (line 67 minus lines 68 plus/minus lines 69 & 70)		70,387,801	71.00
71.01	Sequestration adjustment (see instructions)		464,559	71.01
71.02	Demonstration payment adjustment amount after sequestration		0	71.02
71.03	Sequestration adjustment-PARHM pass-throughs			71.03
72.00	Interim payments		69,924,439	72.00
72.01	Interim payments-PARHM			72.01
73.00	Tentative settlement (for contractor use only)		0	73.00
73.01	Tentative settlement-PARHM (for contractor use only)			73.01
74.00	Balance due provider/program (line 71 minus lines 71.01, 71.02, 72, and 73)		-1,197	74.00
74.01	Balance due provider/program-PARHM (see instructions)			74.01
75.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		0	75.00
	TO BE COMPLETED BY CONTRACTOR (lines 90 through 96)			
90.00	Operating outlier amount from Wkst. E, Pt. A, line 2, or sum of 2.03 plus 2.04 (see instructions)		0	90.00
91.00	Capital outlier from Wkst. L, Pt. I, line 2		0	91.00
92.00	Operating outlier reconciliation adjustment amount (see instructions)		0	92.00
93.00	Capital outlier reconciliation adjustment amount (see instructions)		0	93.00
94.00	The rate used to calculate the time value of money (see instructions)		0.00	94.00
95.00	Time value of money for operating expenses (see instructions)		0	95.00
96.00	Time value of money for capital related expenses (see instructions)		0	96.00

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

CALCULATION OF REIMBURSEMENT SETTLEMENT | Provider CCN: 15-0048 | Period: From 01/01/2020 To 12/31/2020 | Worksheet E Part B Date/Time Prepared: 7/8/2021 10:37 am

Title XVIII | Hospital | PPS

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	14,118	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)	46,220,725	2.00
3.00	OPPS payments	51,405,984	3.00
4.00	Outlier payment (see instructions)	58,034	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	245,452	9.00
10.00	Organ acquisitions	0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)	14,118	11.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
12.00	Ancillary service charges	41,167	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)	41,167	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)	41,167	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)	27,049	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)	14,118	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)	51,709,470	24.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
25.00	Deductibles and coinsurance amounts (for CAH, see instructions)	399	25.00
26.00	Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)	9,020,899	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)	42,702,290	27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 50)	303,660	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)	43,005,950	30.00
31.00	Primary payer payments	10,212	31.00
32.00	Subtotal (line 30 minus line 31)	42,995,738	32.00
	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)		
33.00	Composite rate ESRD (from Wkst. I-5, line 11)	0	33.00
34.00	Allowable bad debts (see instructions)	1,647,874	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	1,071,118	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	1,036,889	36.00
37.00	Subtotal (see instructions)	44,066,856	37.00
38.00	MSP-LCC reconciliation amount from PS&R	-6	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)	44,066,862	40.00
40.01	Sequestration adjustment (see instructions)	290,841	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	43,659,802	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)	116,219	43.00
43.01	Balance due provider/program-PARHM (see instructions)		43.01
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	44.00
	TO BE COMPLETED BY CONTRACTOR		
90.00	Original outlier amount (see instructions)	0	90.00
91.00	Outlier reconciliation adjustment amount (see instructions)	0	91.00
92.00	The rate used to calculate the Time Value of Money	0.00	92.00
93.00	Time Value of Money (see instructions)	0	93.00
94.00	Total (sum of lines 91 and 93)	0	94.00

CALCULATION OF REIMBURSEMENT SETTLEMENT

Provider CCN: 15-0048 | Component CCN: 15-S048 | Period: From 01/01/2020 To 12/31/2020 | Worksheet E Part B | Date/Time Prepared: 7/8/2021 10:37 am

Title XVIII | Subprovider - IPF | PPS

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	802	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)	3,267	2.00
3.00	OPPS payments	1,278	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	23	9.00
10.00	Organ acquisitions	0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)	802	11.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
12.00	Ancillary service charges	2,336	12.00
13.00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, line 69)	0	13.00
14.00	Total reasonable charges (sum of lines 12 and 13)	2,336	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)	2,336	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)	1,534	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)	802	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)	1,301	24.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
25.00	Deductibles and coinsurance amounts (for CAH, see instructions)	0	25.00
26.00	Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)	118	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)	1,985	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)	1,985	30.00
31.00	Primary payer payments	0	31.00
32.00	Subtotal (line 30 minus line 31)	1,985	32.00
	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)		
33.00	Composite rate ESRD (from Wkst. I-5, line 11)	0	33.00
34.00	Allowable bad debts (see instructions)	0	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	0	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	0	36.00
37.00	Subtotal (see instructions)	1,985	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)	1,985	40.00
40.01	Sequestration adjustment (see instructions)	13	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	1,935	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)	37	43.00
43.01	Balance due provider/program-PARHM (see instructions)		43.01
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	44.00
	TO BE COMPLETED BY CONTRACTOR		
90.00	Original outlier amount (see instructions)	0	90.00
91.00	Outlier reconciliation adjustment amount (see instructions)	0	91.00
92.00	The rate used to calculate the Time Value of Money	0.00	92.00
93.00	Time Value of Money (see instructions)	0	93.00
94.00	Total (sum of lines 91 and 93)	0	94.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0048 Component CCN: 15-T048	Period: From 01/01/2020 To 12/31/2020	Worksheet E Part B Date/Time Prepared: 7/8/2021 10:37 am
	Title XVIII	Subprovider - IRF	PPS

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	642	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)	439	2.00
3.00	OPPS payments	550	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)	642	11.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
12.00	Ancillary service charges	1,869	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)	1,869	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)	1,869	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)	1,227	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)	642	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)	550	24.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
25.00	Deductibles and coinsurance amounts (for CAH, see instructions)	0	25.00
26.00	Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)	0	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)	1,192	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)	1,192	30.00
31.00	Primary payer payments	0	31.00
32.00	Subtotal (line 30 minus line 31)	1,192	32.00
	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)		
33.00	Composite rate ESRD (from Wkst. I-5, line 11)	0	33.00
34.00	Allowable bad debts (see instructions)	0	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	0	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	0	36.00
37.00	Subtotal (see instructions)	1,192	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)	1,192	40.00
40.01	Sequestration adjustment (see instructions)	8	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	1,178	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)	6	43.00
43.01	Balance due provider/program-PARHM (see instructions)		43.01
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	44.00
	TO BE COMPLETED BY CONTRACTOR		
90.00	Original outlier amount (see instructions)	0	90.00
91.00	Outlier reconciliation adjustment amount (see instructions)	0	91.00
92.00	The rate used to calculate the Time Value of Money	0.00	92.00
93.00	Time Value of Money (see instructions)	0	93.00
94.00	Total (sum of lines 91 and 93)	0	94.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED | Provider CCN: 15-0048 | Period: From 01/01/2020 To 12/31/2020 | Worksheet E-1 Part I Date/Time Prepared: 7/8/2021 10:37 am

Title XVIII | Hospital | PPS

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		69,883,639		43,659,802	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	07/08/2020	40,800		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)		40,800		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)		69,924,439		43,659,802	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		0		116,219	6.01
6.02	SETTLEMENT TO PROGRAM		1,197		0	6.02
7.00	Total Medicare program liability (see instructions)		69,923,242		43,776,021	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: 15-0048 | Component CCN: 15-S048 | Period: From 01/01/2020 To 12/31/2020 | Worksheet E-1 Part I | Date/Time Prepared: 7/8/2021 10:37 am

Title XVIII | Subprovider - IPF | PPS

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		4,179,137		1,935	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	07/08/2020	31,800		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)		31,800		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		4,210,937		1,935	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		0		37	6.01
6.02	SETTLEMENT TO PROGRAM		6,037		0	6.02
7.00	Total Medicare program liability (see instructions)		4,204,900		1,972	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: 15-0048 | Component CCN: 15-T048 | Period: From 01/01/2020 To 12/31/2020 | Worksheet E-1 Part I | Date/Time Prepared: 7/8/2021 10:37 am

Title XVIII | Subprovider - IRF | PPS

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		4,824,044		1,178	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
	Program to Provider					
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
	Provider to Program					
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		4,824,044		1,178	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		92,684		6	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		4,916,728		1,184	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: 15-0048	Period: From 01/01/2020 To 12/31/2020	Worksheet E-1 Part II Date/Time Prepared: 7/8/2021 10:37 am
	Title XVIII	Hospital	PPS

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

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0048 Component CCN: 15-S048	Period: From 01/01/2020 To 12/31/2020	Worksheet E-3 Part II Date/Time Prepared: 7/8/2021 10:37 am
	Title XVIII	Subprovider - IPF	PPS

		1.00	
	PART II - MEDICARE PART A SERVICES - IPF PPS		
1.00	Net Federal IPF PPS Payments (excluding outlier, ECT, and medical education payments)	4,581,011	1.00
2.00	Net IPF PPS Outlier Payments	12,461	2.00
3.00	Net IPF PPS ECT Payments	0	3.00
4.00	Unweighted intern and resident FTE count in the most recent cost report filed on or before November 15, 2004. (see instructions)	0.00	4.00
4.01	Cap increases for the unweighted intern and resident FTE count for residents that were displaced by program or hospital closure, that would not be counted without a temporary cap adjustment under 42 CFR §412.424(d)(1)(iii)(F)(1) or (2) (see instructions)	0.00	4.01
5.00	New Teaching program adjustment. (see instructions)	0.00	5.00
6.00	Current year's unweighted FTE count of I&R excluding FTEs in the new program growth period of a "new teaching program" (see instuctions)	0.00	6.00
7.00	Current year's unweighted I&R FTE count for residents within the new program growth period of a "new teaching program" (see instuctions)	0.00	7.00
8.00	Intern and resident count for IPF PPS medical education adjustment (see instructions)	0.00	8.00
9.00	Average Daily Census (see instructions)	23.180328	9.00
10.00	Teaching Adjustment Factor {((1 + (line 8/line 9)) raised to the power of .5150 -1}.	0.000000	10.00
11.00	Teaching Adjustment (line 1 multiplied by line 10).	0	11.00
12.00	Adjusted Net IPF PPS Payments (sum of lines 1, 2, 3 and 11)	4,593,472	12.00
13.00	Nursing and Allied Health Managed Care payment (see instruction)	0	13.00
14.00	Organ acquisition (DO NOT USE THIS LINE)		14.00
15.00	Cost of physicians' services in a teaching hospital (see instructions)	0	15.00
16.00	Subtotal (see instructions)	4,593,472	16.00
17.00	Primary payer payments	300	17.00
18.00	Subtotal (line 16 less line 17).	4,593,172	18.00
19.00	Deductibles	238,920	19.00
20.00	Subtotal (line 18 minus line 19)	4,354,252	20.00
21.00	Coinsurance	180,708	21.00
22.00	Subtotal (line 20 minus line 21)	4,173,544	22.00
23.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)	88,352	23.00
24.00	Adjusted reimbursable bad debts (see instructions)	57,429	24.00
25.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	53,627	25.00
26.00	Subtotal (sum of lines 22 and 24)	4,230,973	26.00
27.00	Direct graduate medical education payments (see instructions)	0	27.00
28.00	Other pass through costs (see instructions)	1,864	28.00
29.00	Outlier payments reconciliation	0	29.00
30.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	30.00
30.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	30.50
30.99	Demonstration payment adjustment amount before sequestration	0	30.99
31.00	Total amount payable to the provider (see instructions)	4,232,837	31.00
31.01	Sequestration adjustment (see instructions)	27,937	31.01
31.02	Demonstration payment adjustment amount after sequestration	0	31.02
32.00	Interim payments	4,210,937	32.00
33.00	Tentative settlement (for contractor use only)	0	33.00
34.00	Balance due provider/program (line 31 minus lines 31.01, 31.02, 32 and 33)	-6,037	34.00
35.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	35.00
	TO BE COMPLETED BY CONTRACTOR		
50.00	Original outlier amount from Worksheet E-3, Part II, line 2	12,461	50.00
51.00	Outlier reconciliation adjustment amount (see instructions)	0	51.00
52.00	The rate used to calculate the Time Value of Money	0.00	52.00
53.00	Time Value of Money (see instructions)	0	53.00

CALCULATION OF REIMBURSEMENT SETTLEMENT

Provider CCN: 15-0048 | Component CCN: 15-T048 | Period: From 01/01/2020 To 12/31/2020 | Worksheet E-3 Part III | Date/Time Prepared: 7/8/2021 10:37 am

Title XVIII | Subprovider - IRF | PPS

		1.00	
	PART III - MEDICARE PART A SERVICES - IRF PPS		
1.00	Net Federal PPS Payment (see instructions)	4,682,087	1.00
2.00	Medicare SSI ratio (IRF PPS only) (see instructions)	0.0175	2.00
3.00	Inpatient Rehabilitation LIP Payments (see instructions)	224,740	3.00
4.00	Outlier Payments	97,712	4.00
5.00	Unweighted intern and resident FTE count in the most recent cost reporting period ending on or prior to November 15, 2004 (see instructions)	0.00	5.00
5.01	Cap increases for the unweighted intern and resident FTE count for residents that were displaced by program or hospital closure, that would not be counted without a temporary cap adjustment under 42 CFR §412.424(d)(1)(iii)(F)(1) or (2) (see instructions)	0.00	5.01
6.00	New Teaching program adjustment. (see instructions)	0.00	6.00
7.00	Current year's unweighted FTE count of I&R excluding FTEs in the new program growth period of a "new teaching program" (see instructions)	0.00	7.00
8.00	Current year's unweighted I&R FTE count for residents within the new program growth period of a "new teaching program" (see instructions)	0.00	8.00
9.00	Intern and resident count for IRF PPS medical education adjustment (see instructions)	0.00	9.00
10.00	Average Daily Census (see instructions)	14.710383	10.00
11.00	Teaching Adjustment Factor (see instructions)	0.000000	11.00
12.00	Teaching Adjustment (see instructions)	0	12.00
13.00	Total PPS Payment (see instructions)	5,004,539	13.00
14.00	Nursing and Allied Health Managed Care payments (see instruction)	0	14.00
15.00	Organ acquisition (DO NOT USE THIS LINE)		15.00
16.00	Cost of physicians' services in a teaching hospital (see instructions)	0	16.00
17.00	Subtotal (see instructions)	5,004,539	17.00
18.00	Primary payer payments	5,000	18.00
19.00	Subtotal (line 17 less line 18).	4,999,539	19.00
20.00	Deductibles	26,752	20.00
21.00	Subtotal (line 19 minus line 20)	4,972,787	21.00
22.00	Coinsurance	39,314	22.00
23.00	Subtotal (line 21 minus line 22)	4,933,473	23.00
24.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)	23,538	24.00
25.00	Adjusted reimbursable bad debts (see instructions)	15,300	25.00
26.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	4,092	26.00
27.00	Subtotal (sum of lines 23 and 25)	4,948,773	27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 49)	0	28.00
29.00	Other pass through costs (see instructions)	621	29.00
30.00	Outlier payments reconciliation	0	30.00
31.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	31.00
31.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	31.50
31.99	Demonstration payment adjustment amount before sequestration	0	31.99
32.00	Total amount payable to the provider (see instructions)	4,949,394	32.00
32.01	Sequestration adjustment (see instructions)	32,666	32.01
32.02	Demonstration payment adjustment amount after sequestration	0	32.02
33.00	Interim payments	4,824,044	33.00
34.00	Tentative settlement (for contractor use only)	0	34.00
35.00	Balance due provider/program (line 32 minus lines 32.01, 32.02, 33, and 34)	92,684	35.00
36.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	36.00
	TO BE COMPLETED BY CONTRACTOR		
50.00	Original outlier amount from Wkst. E-3, Pt. III, line 4	97,712	50.00
51.00	Outlier reconciliation adjustment amount (see instructions)	0	51.00
52.00	The rate used to calculate the Time Value of Money	0.00	52.00
53.00	Time Value of Money (see instructions)	0	53.00

CALCULATION OF REIMBURSEMENT SETTLEMENT | Provider CCN: 15-0048 | Period: From 01/01/2020 To 12/31/2020 | Worksheet E-3 Part VII Date/Time Prepared: 7/8/2021 10:37 am

Title XIX | Hospital | Cost

		Inpatient	Outpatient	
		1.00	2.00	
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR XIX SERVICES			
	COMPUTATION OF NET COST OF COVERED SERVICES			
1.00	Inpatient hospital/SNF/NF services	3,821,862		1.00
2.00	Medical and other services		3,655,447	2.00
3.00	Organ acquisition (certified transplant centers only)	0		3.00
4.00	Subtotal (sum of lines 1, 2 and 3)	3,821,862	3,655,447	4.00
5.00	Inpatient primary payer payments	0		5.00
6.00	Outpatient primary payer payments		0	6.00
7.00	Subtotal (line 4 less sum of lines 5 and 6)	3,821,862	3,655,447	7.00
	COMPUTATION OF LESSER OF COST OR CHARGES			
	Reasonable Charges			
8.00	Routine service charges	0		8.00
9.00	Ancillary service charges	9,057,145	14,822,688	9.00
10.00	Organ acquisition charges, net of revenue	0		10.00
11.00	Incentive from target amount computation	0		11.00
12.00	Total reasonable charges (sum of lines 8 through 11)	9,057,145	14,822,688	12.00
	CUSTOMARY CHARGES			
13.00	Amount actually collected from patients liable for payment for services on a charge basis	0	0	13.00
14.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)	0	0	14.00
15.00	Ratio of line 13 to line 14 (not to exceed 1.000000)	0.000000	0.000000	15.00
16.00	Total customary charges (see instructions)	9,057,145	14,822,688	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)	5,235,283	11,167,241	17.00
18.00	Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 16) (see instructions)	0	0	18.00
19.00	Interns and Residents (see instructions)	0	0	19.00
20.00	Cost of physicians' services in a teaching hospital (see instructions)	0	0	20.00
21.00	Cost of covered services (enter the lesser of line 4 or line 16)	3,821,862	3,655,447	21.00
	PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be completed for PPS providers.			
22.00	Other than outlier payments	0	0	22.00
23.00	Outlier payments	0	0	23.00
24.00	Program capital payments	0		24.00
25.00	Capital exception payments (see instructions)	0		25.00
26.00	Routine and Ancillary service other pass through costs	0	0	26.00
27.00	Subtotal (sum of lines 22 through 26)	0	0	27.00
28.00	Customary charges (title V or XIX PPS covered services only)	0	0	28.00
29.00	Titles V or XIX (sum of lines 21 and 27)	3,821,862	3,655,447	29.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT			
30.00	Excess of reasonable cost (from line 18)	0	0	30.00
31.00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)	3,821,862	3,655,447	31.00
32.00	Deductibles	0	0	32.00
33.00	Coinsurance	0	0	33.00
34.00	Allowable bad debts (see instructions)	0	0	34.00
35.00	Utilization review	0		35.00
36.00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)	3,821,862	3,655,447	36.00
37.00	TO ZERO OUT MEDICAID	-3,821,862	-3,655,447	37.00
38.00	Subtotal (line 36 ± line 37)	0	0	38.00
39.00	Direct graduate medical education payments (from Wkst. E-4)	0		39.00
40.00	Total amount payable to the provider (sum of lines 38 and 39)	0	0	40.00
41.00	Interim payments	0	0	41.00
42.00	Balance due provider/program (line 40 minus line 41)	0	0	42.00
43.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, chapter 1, §115.2	0	0	43.00

CALCULATION OF REIMBURSEMENT SETTLEMENT | Provider CCN: 15-0048 | Component CCN: 15-S048 | Period: From 01/01/2020 To 12/31/2020 | Worksheet E-3 Part VII | Date/Time Prepared: 7/8/2021 10:37 am

Title XIX | Subprovider - IPF | Cost

		Inpatient	Outpatient	
		1.00	2.00	
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR XIX SERVICES			
	COMPUTATION OF NET COST OF COVERED SERVICES			
1.00	Inpatient hospital/SNF/NF services	305,262		1.00
2.00	Medical and other services		0	2.00
3.00	Organ acquisition (certified transplant centers only)	0		3.00
4.00	Subtotal (sum of lines 1, 2 and 3)	305,262	0	4.00
5.00	Inpatient primary payer payments	0		5.00
6.00	Outpatient primary payer payments		0	6.00
7.00	Subtotal (line 4 less sum of lines 5 and 6)	305,262	0	7.00
	COMPUTATION OF LESSER OF COST OR CHARGES			
	Reasonable Charges			
8.00	Routine service charges	0		8.00
9.00	Ancillary service charges	0	0	9.00
10.00	Organ acquisition charges, net of revenue	0		10.00
11.00	Incentive from target amount computation	0		11.00
12.00	Total reasonable charges (sum of lines 8 through 11)	0	0	12.00
	CUSTOMARY CHARGES			
13.00	Amount actually collected from patients liable for payment for services on a charge basis	0	0	13.00
14.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)	0	0	14.00
15.00	Ratio of line 13 to line 14 (not to exceed 1.000000)	0.000000	0.000000	15.00
16.00	Total customary charges (see instructions)	0	0	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)	0	0	17.00
18.00	Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 16) (see instructions)	305,262	0	18.00
19.00	Interns and Residents (see instructions)	0	0	19.00
20.00	Cost of physicians' services in a teaching hospital (see instructions)	0	0	20.00
21.00	Cost of covered services (enter the lesser of line 4 or line 16)	0	0	21.00
	PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be completed for PPS providers.			
22.00	Other than outlier payments	0	0	22.00
23.00	Outlier payments	0	0	23.00
24.00	Program capital payments	0		24.00
25.00	Capital exception payments (see instructions)	0		25.00
26.00	Routine and Ancillary service other pass through costs	0	0	26.00
27.00	Subtotal (sum of lines 22 through 26)	0	0	27.00
28.00	Customary charges (title V or XIX PPS covered services only)	0	0	28.00
29.00	Titles V or XIX (sum of lines 21 and 27)	0	0	29.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT			
30.00	Excess of reasonable cost (from line 18)	305,262	0	30.00
31.00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)	0	0	31.00
32.00	Deductibles	0	0	32.00
33.00	Coinsurance	0	0	33.00
34.00	Allowable bad debts (see instructions)	0	0	34.00
35.00	Utilization review	0		35.00
36.00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)	0	0	36.00
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	37.00
38.00	Subtotal (line 36 ± line 37)	0	0	38.00
39.00	Direct graduate medical education payments (from Wkst. E-4)	0		39.00
40.00	Total amount payable to the provider (sum of lines 38 and 39)	0	0	40.00
41.00	Interim payments	0	0	41.00
42.00	Balance due provider/program (line 40 minus line 41)	0	0	42.00
43.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, chapter 1, §115.2	0	0	43.00

CALCULATION OF REIMBURSEMENT SETTLEMENT

Provider CCN: 15-0048 | Component CCN: 15-T048 | Period: From 01/01/2020 To 12/31/2020 | Worksheet E-3 Part VII | Date/Time Prepared: 7/8/2021 10:37 am

Title XIX | Subprovider - IRF | Cost

		Inpatient	Outpatient	
		1.00	2.00	
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR XIX SERVICES			
	COMPUTATION OF NET COST OF COVERED SERVICES			
1.00	Inpatient hospital/SNF/NF services	0		1.00
2.00	Medical and other services		0	2.00
3.00	Organ acquisition (certified transplant centers only)	0		3.00
4.00	Subtotal (sum of lines 1, 2 and 3)	0	0	4.00
5.00	Inpatient primary payer payments	0		5.00
6.00	Outpatient primary payer payments		0	6.00
7.00	Subtotal (line 4 less sum of lines 5 and 6)	0	0	7.00
	COMPUTATION OF LESSER OF COST OR CHARGES			
	Reasonable Charges			
8.00	Routine service charges	0		8.00
9.00	Ancillary service charges	0	0	9.00
10.00	Organ acquisition charges, net of revenue	0		10.00
11.00	Incentive from target amount computation	0		11.00
12.00	Total reasonable charges (sum of lines 8 through 11)	0	0	12.00
	CUSTOMARY CHARGES			
13.00	Amount actually collected from patients liable for payment for services on a charge basis	0	0	13.00
14.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)	0	0	14.00
15.00	Ratio of line 13 to line 14 (not to exceed 1.000000)	0.000000	0.000000	15.00
16.00	Total customary charges (see instructions)	0	0	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)	0	0	17.00
18.00	Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 16) (see instructions)	0	0	18.00
19.00	Interns and Residents (see instructions)	0	0	19.00
20.00	Cost of physicians' services in a teaching hospital (see instructions)	0	0	20.00
21.00	Cost of covered services (enter the lesser of line 4 or line 16)	0	0	21.00
	PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be completed for PPS providers.			
22.00	Other than outlier payments	0	0	22.00
23.00	Outlier payments	0	0	23.00
24.00	Program capital payments	0		24.00
25.00	Capital exception payments (see instructions)	0		25.00
26.00	Routine and Ancillary service other pass through costs	0	0	26.00
27.00	Subtotal (sum of lines 22 through 26)	0	0	27.00
28.00	Customary charges (title V or XIX PPS covered services only)	0	0	28.00
29.00	Titles V or XIX (sum of lines 21 and 27)	0	0	29.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT			
30.00	Excess of reasonable cost (from line 18)	0	0	30.00
31.00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)	0	0	31.00
32.00	Deductibles	0	0	32.00
33.00	Coinsurance	0	0	33.00
34.00	Allowable bad debts (see instructions)	0	0	34.00
35.00	Utilization review	0		35.00
36.00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)	0	0	36.00
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	37.00
38.00	Subtotal (line 36 ± line 37)	0	0	38.00
39.00	Direct graduate medical education payments (from Wkst. E-4)	0		39.00
40.00	Total amount payable to the provider (sum of lines 38 and 39)	0	0	40.00
41.00	Interim payments	0	0	41.00
42.00	Balance due provider/program (line 40 minus line 41)	0	0	42.00
43.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, chapter 1, §115.2	0	0	43.00

DIRECT GRADUATE MEDICAL EDUCATION (GME) & ESRD OUTPATIENT DIRECT MEDICAL EDUCATION COSTS	Provider CCN: 15-0048	Period: From 01/01/2020 To 12/31/2020	Worksheet E-4 Date/Time Prepared: 7/8/2021 10:37 am
	Title XVIII	Hospital	PPS

		1.00	
	COMPUTATION OF TOTAL DIRECT GME AMOUNT		
1.00	Unweighted resident FTE count for allopathic and osteopathic programs for cost reporting periods ending on or before December 31, 1996.	0.00	1.00
2.00	Unweighted FTE resident cap add-on for new programs per 42 CFR 413.79(e)(1) (see instructions)	0.00	2.00
3.00	Amount of reduction to Direct GME cap under section 422 of MMA	0.00	3.00
3.01	Direct GME cap reduction amount under ACA §5503 in accordance with 42 CFR §413.79 (m). (see instructions for cost reporting periods straddling 7/1/2011)	0.00	3.01
4.00	Adjustment (plus or minus) to the FTE cap for allopathic and osteopathic programs due to a Medicare GME affiliation agreement (42 CFR §413.75(b) and § 413.79 (f))	0.00	4.00
4.01	ACA Section 5503 increase to the Direct GME FTE Cap (see instructions for cost reporting periods straddling 7/1/2011)	0.00	4.01
4.02	ACA Section 5506 number of additional direct GME FTE cap slots (see instructions for cost reporting periods straddling 7/1/2011)	0.00	4.02
5.00	FTE adjusted cap (line 1 plus line 2 minus line 3 and 3.01 plus or minus line 4 plus lines 4.01 and 4.02 plus applicable subscripts	0.00	5.00
6.00	Unweighted resident FTE count for allopathic and osteopathic programs for the current year from your records (see instructions)	16.75	6.00
7.00	Enter the lesser of line 5 or line 6	0.00	7.00

		Primary Care	Other	Total	
		1.00	2.00	3.00	
8.00	Weighted FTE count for physicians in an allopathic and osteopathic program for the current year.	15.47	0.00	15.47	8.00
9.00	If line 6 is less than 5 enter the amount from line 8, otherwise multiply line 8 times the result of line 5 divided by the amount on line 6.	0.00	0.00	0.00	9.00
10.00	Weighted dental and podiatric resident FTE count for the current year		0.00		10.00
10.01	Unweighted dental and podiatric resident FTE count for the current year		0.00		10.01
11.00	Total weighted FTE count	0.00	0.00		11.00
12.00	Total weighted resident FTE count for the prior cost reporting year (see instructions)	0.00	0.00		12.00
13.00	Total weighted resident FTE count for the penultimate cost reporting year (see instructions)	0.00	0.00		13.00
14.00	Rolling average FTE count (sum of lines 11 through 13 divided by 3).	0.00	0.00		14.00
15.00	Adjustment for residents in initial years of new programs	16.75	0.00		15.00
15.01	Unweighted adjustment for residents in initial years of new programs	16.75	0.00		15.01
16.00	Adjustment for residents displaced by program or hospital closure	0.00	0.00		16.00
16.01	Unweighted adjustment for residents displaced by program or hospital closure	0.00	0.00		16.01
17.00	Adjusted rolling average FTE count	16.75	0.00		17.00
18.00	Per resident amount	85,000.00	0.00		18.00
19.00	Approved amount for resident costs	1,423,750	0	1,423,750	19.00

		1.00	
20.00	Additional unweighted allopathic and osteopathic direct GME FTE resident cap slots received under 42 Sec. 413.79(c)(4)	0.00	20.00
21.00	Direct GME FTE unweighted resident count over cap (see instructions)	16.75	21.00
22.00	Allowable additional direct GME FTE Resident Count (see instructions)	0.00	22.00
23.00	Enter the locality adjustment national average per resident amount (see instructions)	85,000.00	23.00
24.00	Multiply line 22 time line 23	0	24.00
25.00	Total direct GME amount (sum of lines 19 and 24)	1,423,750	25.00

		Inpatient Part A	Managed Care	Total	
		1.00	2.00	3.00	
	COMPUTATION OF PROGRAM PATIENT LOAD				
26.00	Inpatient Days (see instructions) (Title XIX - see S-2 Part IX, line 3.02, column 2)	29,550	6,710		26.00
27.00	Total Inpatient Days (see instructions)	64,449	64,449		27.00
28.00	Ratio of inpatient days to total inpatient days	0.458502	0.104113		28.00
29.00	Program direct GME amount	652,792	148,231	801,023	29.00
29.01	Percent reduction for MA DGME		7.00		29.01
30.00	Reduction for direct GME payments for Medicare Advantage		10,376	10,376	30.00
31.00	Net Program direct GME amount			790,647	31.00

DIRECT GRADUATE MEDICAL EDUCATION (GME) & ESRD OUTPATIENT DIRECT MEDICAL EDUCATION COSTS	Provider CCN: 15-0048	Period: From 01/01/2020 To 12/31/2020	Worksheet E-4 Date/Time Prepared: 7/8/2021 10:37 am
	Title XVIII	Hospital	PPS

		1.00	
	DIRECT MEDICAL EDUCATION COSTS FOR ESRD COMPOSITE RATE - TITLE XVIII ONLY (NURSING SCHOOL AND PARAMEDICAL EDUCATION COSTS)		
32.00	Renal dialysis direct medical education costs (from Wkst. B, Pt. I, sum of col. 20 and 23, lines 74 and 94)	0	32.00
33.00	Renal dialysis and home dialysis total charges (Wkst. C, Pt. I, col. 8, sum of lines 74 and 94)	1,286,781	33.00
34.00	Ratio of direct medical education costs to total charges (line 32 ÷ line 33)	0.000000	34.00
35.00	Medicare outpatient ESRD charges (see instructions)	0	35.00
36.00	Medicare outpatient ESRD direct medical education costs (line 34 x line 35)	0	36.00
	APPORTIONMENT BASED ON MEDICARE REASONABLE COST - TITLE XVIII ONLY		
	Part A Reasonable Cost		
37.00	Reasonable cost (see instructions)	74,566,947	37.00
38.00	Organ acquisition costs (Wkst. D-4, Pt. III, col. 1, line 69)	0	38.00
39.00	Cost of physicians' services in a teaching hospital (see instructions)	0	39.00
40.00	Primary payer payments (see instructions)	33,283	40.00
41.00	Total Part A reasonable cost (sum of lines 37 through 39 minus line 40)	74,533,664	41.00
	Part B Reasonable Cost		
42.00	Reasonable cost (see instructions)	46,485,468	42.00
43.00	Primary payer payments (see instructions)	10,212	43.00
44.00	Total Part B reasonable cost (line 42 minus line 43)	46,475,256	44.00
45.00	Total reasonable cost (sum of lines 41 and 44)	121,008,920	45.00
46.00	Ratio of Part A reasonable cost to total reasonable cost (line 41 ÷ line 45)	0.615935	46.00
47.00	Ratio of Part B reasonable cost to total reasonable cost (line 44 ÷ line 45)	0.384065	47.00
	ALLOCATION OF MEDICARE DIRECT GME COSTS BETWEEN PART A AND PART B		
48.00	Total program GME payment (line 31)	790,647	48.00
49.00	Part A Medicare GME payment (line 46 x 48) (title XVIII only) (see instructions)	486,987	49.00
50.00	Part B Medicare GME payment (line 47 x 48) (title XVIII only) (see instructions)	303,660	50.00

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

Provider CCN: 15-0048 | Period: From 01/01/2020 To 12/31/2020 | Worksheet G | Date/Time Prepared: 7/8/2021 10:37 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	38,552,847	0	0	0	1.00
2.00	Temporary investments	420,663,653	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	134,894,274	0	0	0	4.00
5.00	Other receivable	512,464,495	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-66,622,834	0	0	0	6.00
7.00	Inventory	8,471,964	0	0	0	7.00
8.00	Prepaid expenses	6,050,374	0	0	0	8.00
9.00	Other current assets	0	0	0	0	9.00
10.00	Due from other funds	100	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	1,054,474,873	0	0	0	11.00
	FIXED ASSETS					
12.00	Land	17,227,167	0	0	0	12.00
13.00	Land improvements	12,604,071	0	0	0	13.00
14.00	Accumulated depreciation	0	0	0	0	14.00
15.00	Buildings	321,118,905	0	0	0	15.00
16.00	Accumulated depreciation	-170,804,939	0	0	0	16.00
17.00	Leasehold improvements	13,635,060	0	0	0	17.00
18.00	Accumulated depreciation	-7,143,355	0	0	0	18.00
19.00	Fixed equipment	2,196,200	0	0	0	19.00
20.00	Accumulated depreciation	-1,752,392	0	0	0	20.00
21.00	Automobiles and trucks	0	0	0	0	21.00
22.00	Accumulated depreciation	0	0	0	0	22.00
23.00	Major movable equipment	188,844,553	0	0	0	23.00
24.00	Accumulated depreciation	-146,760,930	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)	229,164,340	0	0	0	30.00
	OTHER ASSETS					
31.00	Investments	0	0	0	0	31.00
32.00	Deposits on leases	0	0	0	0	32.00
33.00	Due from owners/officers	0	0	0	0	33.00
34.00	Other assets	82,832,195	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	82,832,195	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	1,366,471,408	0	0	0	36.00
	CURRENT LIABILITIES					
37.00	Accounts payable	36,701,381	0	0	0	37.00
38.00	Salaries, wages, and fees payable	12,456,535	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	10,544,319	0	0	0	40.00
41.00	Deferred income	63,948,026	0	0	0	41.00
42.00	Accelerated payments	0				42.00
43.00	Due to other funds	0	0	0	0	43.00
44.00	Other current liabilities	0	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	123,650,261	0	0	0	45.00
	LONG TERM LIABILITIES					
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	224,029,110	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	3,434,596	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	227,463,706	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	351,113,967	0	0	0	51.00
	CAPITAL ACCOUNTS					
52.00	General fund balance	1,015,357,441				52.00
53.00	Specific purpose fund		0			53.00
54.00	Donor created - endowment fund balance - restricted			0		54.00
55.00	Donor created - endowment fund balance - unrestricted			0		55.00
56.00	Governing body created - endowment fund balance			0		56.00
57.00	Plant fund balance - invested in plant				0	57.00
58.00	Plant fund balance - reserve for plant improvement, replacement, and expansion				0	58.00
59.00	Total fund balances (sum of lines 52 thru 58)	1,015,357,441	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	1,366,471,408	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES | Provider CCN: 15-0048 | Period: From 01/01/2020 To 12/31/2020 | Worksheet G-1 | Date/Time Prepared: 7/8/2021 10:37 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		901,029,581		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		182,680,706				2.00
3.00	Total (sum of line 1 and line 2)		1,083,710,287		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)		1,083,710,287		0		11.00
12.00	AMOUNTS INCLUDED ON HO COST REPORT	68,352,846		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)		68,352,846		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		1,015,357,441		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	AMOUNTS INCLUDED ON HO COST REPORT		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: 15-0048 | Period: From 01/01/2020 To 12/31/2020 | Worksheet G-2 Parts I & II Date/Time Prepared: 7/8/2021 10:37 am

	Cost Center Description	Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospital	71,153,560		71,153,560	1.00
2.00	SUBPROVIDER - IPF	9,445,240		9,445,240	2.00
3.00	SUBPROVIDER - IRF	5,913,649		5,913,649	3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	0		0	5.00
6.00	Swing bed - NF	0		0	6.00
7.00	SKILLED NURSING FACILITY				7.00
8.00	NURSING FACILITY				8.00
9.00	OTHER LONG TERM CARE				9.00
10.00	Total general inpatient care services (sum of lines 1-9)	86,512,449		86,512,449	10.00
	Intensive Care Type Inpatient Hospital Services				
11.00	INTENSIVE CARE UNIT	13,958,519		13,958,519	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)	13,958,519		13,958,519	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	100,470,968		100,470,968	17.00
18.00	Ancillary services	286,429,380	519,828,869	806,258,249	18.00
19.00	Outpatient services	26,997,543	68,757,365	95,754,908	19.00
20.00	RURAL HEALTH CLINIC	0	0	0	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY				22.00
23.00	AMBULANCE SERVICES				23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE	0	5,447,047	5,447,047	26.00
27.00	OTHER	2,902,605	1,451,508	4,354,113	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	416,800,496	595,484,789	1,012,285,285	28.00
	PART II - OPERATING EXPENSES				
29.00	Operating expenses (per Wkst. A, column 3, line 200)		314,392,387		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)		314,392,387		43.00

STATEMENT OF REVENUES AND EXPENSES | Provider CCN: 15-0048 | Period: From 01/01/2020 To 12/31/2020 | Worksheet G-3 | Date/Time Prepared: 7/8/2021 10:37 am

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	1,012,285,285	1.00
2.00	Less contractual allowances and discounts on patients' accounts	569,348,232	2.00
3.00	Net patient revenues (line 1 minus line 2)	442,937,053	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	314,392,387	4.00
5.00	Net income from service to patients (line 3 minus line 4)	128,544,666	5.00
	OTHER INCOME		
6.00	Contributions, donations, bequests, etc	0	6.00
7.00	Income from investments	38,424,437	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	364,409	13.00
14.00	Revenue from meals sold to employees and guests	3,386,926	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	8,500	17.00
18.00	Revenue from sale of medical records and abstracts	349	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	61,874	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	0	20.00
21.00	Rental of vending machines	6,132	21.00
22.00	Rental of hospital space	6,748,637	22.00
23.00	Governmental appropriations	0	23.00
24.00	OTHER	5,134,776	24.00
24.50	COVID-19 PHE Funding	0	24.50
25.00	Total other income (sum of lines 6-24)	54,136,040	25.00
26.00	Total (line 5 plus line 25)	182,680,706	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)	182,680,706	29.00

ANALYSIS OF HOSPITAL-BASED HOSPICE COSTS

Provider CCN: 15-0048 | Period: From 01/01/2020 To 12/31/2020 | Worksheet O

Hospice CCN: 15-1524 | Date/Time Prepared: 7/8/2021 10:37 am

Hospice I

		SALARIES	OTHER	SUBTOTAL (col. 1 plus col. 2)	RECLASSIFI-CATIONS	SUBTOTAL	
		1.00	2.00	3.00	4.00	5.00	
	GENERAL SERVICE COST CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT*		1,800	1,800	-1,800	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP*		864	864	0	864	2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT*	0	80,202	80,202	36,130	116,332	3.00
4.00	ADMINISTRATIVE & GENERAL*	130,893	31,176	162,069	15,162	177,231	4.00
5.00	PLANT OPERATION & MAINTENANCE*	0	0	0	0	0	5.00
6.00	LAUNDRY & LINEN SERVICE*	0	0	0	0	0	6.00
7.00	HOUSEKEEPING*	0	0	0	0	0	7.00
8.00	DIETARY*	0	1,615	1,615	0	1,615	8.00
9.00	NURSING ADMINISTRATION*	0	0	0	0	0	9.00
10.00	ROUTINE MEDICAL SUPPLIES*	0	0	0	0	0	10.00
11.00	MEDICAL RECORDS*	0	0	0	0	0	11.00
12.00	STAFF TRANSPORTATION*	0	95,841	95,841	0	95,841	12.00
13.00	VOLUNTEER SERVICE COORDINATION*	0	0	0	0	0	13.00
14.00	PHARMACY*	0	117,788	117,788	0	117,788	14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES*	0	0	0	0	0	15.00
16.00	OTHER GENERAL SERVICE*	0	0	0	0	0	16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES						17.00
	DIRECT PATIENT CARE SERVICE COST CENTERS						
25.00	INPATIENT CARE-CONTRACTED**		0	0	0	0	25.00
26.00	PHYSICIAN SERVICES**	0	196,819	196,819	0	196,819	26.00
27.00	NURSE PRACTITIONER**	0	0	0	0	0	27.00
28.00	REGISTERED NURSE**	761,460	0	761,460	375,663	1,137,123	28.00
29.00	LPN/LVN**	88,818	0	88,818	18,760	107,578	29.00
30.00	PHYSICAL THERAPY**	0	0	0	0	0	30.00
31.00	OCCUPATIONAL THERAPY**	0	0	0	0	0	31.00
32.00	SPEECH/LANGUAGE PATHOLOGY**	0	0	0	0	0	32.00
33.00	MEDICAL SOCIAL SERVICES**	0	0	0	0	0	33.00
34.00	SPIRITUAL COUNSELING**	0	0	0	0	0	34.00
35.00	DIETARY COUNSELING**	0	0	0	0	0	35.00
36.00	COUNSELING - OTHER**	0	0	0	0	0	36.00
37.00	HOSPICE AIDE & HOMEMAKER SERVICES**	73,451	0	73,451	85,344	158,795	37.00
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN**	0	0	0	0	0	38.00
39.00	PATIENT TRANSPORTATION**	0	0	0	0	0	39.00
40.00	IMAGING SERVICES**	0	0	0	0	0	40.00
41.00	LABS & DIAGNOSTICS**	0	0	0	0	0	41.00
42.00	MEDICAL SUPPLIES-NON-ROUTINE**	0	147,417	147,417	27,090	174,507	42.00
42.50	DRUGS CHARGED TO PATIENTS**	0	0	0	0	0	42.50
43.00	OUTPATIENT SERVICES**	0	0	0	0	0	43.00
44.00	PALLIATIVE RADIATION THERAPY**	0	0	0	0	0	44.00
45.00	PALLIATIVE CHEMOTHERAPY**	0	0	0	0	0	45.00
46.00	OTHER PATIENT CARE SERVICES (SPECIFY)**	0	580,368	580,368	0	580,368	46.00
	NONREIMBURSABLE COST CENTERS						
60.00	BEREAVEMENT PROGRAM *	0	0	0	0	0	60.00
61.00	VOLUNTEER PROGRAM *	0	0	0	0	0	61.00
62.00	FUNDRAISING*	0	0	0	0	0	62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS*	0	0	0	0	0	63.00
64.00	PALLIATIVE CARE PROGRAM*	0	0	0	0	0	64.00
65.00	OTHER PHYSICIAN SERVICES*	0	0	0	0	0	65.00
66.00	RESIDENTIAL CARE*	0	0	0	0	0	66.00
67.00	ADVERTISING*	0	0	0	0	0	67.00
68.00	TELEHEALTH/TELEMONITORING*	0	0	0	0	0	68.00
69.00	THRIFT STORE*	0	0	0	0	0	69.00
70.00	NURSING FACILITY ROOM & BOARD*	0	0	0	0	0	70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)*	0	0	0	0	0	71.00
100.00	TOTAL	1,054,622	1,253,890	2,308,512	556,349	2,864,861	100.00

* Transfer the amounts in column 7 to Wkst. O-5, column 1, line as appropriate.
** See instructions. Do not transfer the amounts in column 7 to Wkst. O-5.

ANALYSIS OF HOSPITAL-BASED HOSPICE COSTS

Provider CCN: 15-0048 | Hospice CCN: 15-1524

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

Worksheet O

Date/Time Prepared: 7/8/2021 10:37 am

Hospice I

		ADJUSTMENTS	TOTAL (col. 5 ± col. 6)	
		6.00	7.00	
	GENERAL SERVICE COST CENTERS			
1.00	CAP REL COSTS-BLDG & FIXT*	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP*	0	864	2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT*	-845	115,487	3.00
4.00	ADMINISTRATIVE & GENERAL*	-1,525	175,706	4.00
5.00	PLANT OPERATION & MAINTENANCE*	0	0	5.00
6.00	LAUNDRY & LINEN SERVICE*	0	0	6.00
7.00	HOUSEKEEPING*	0	0	7.00
8.00	DIETARY*	0	1,615	8.00
9.00	NURSING ADMINISTRATION*	0	0	9.00
10.00	ROUTINE MEDICAL SUPPLIES*	0	0	10.00
11.00	MEDICAL RECORDS*	0	0	11.00
12.00	STAFF TRANSPORTATION*	0	95,841	12.00
13.00	VOLUNTEER SERVICE COORDINATION*	0	0	13.00
14.00	PHARMACY*	0	117,788	14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES*	0	0	15.00
16.00	OTHER GENERAL SERVICE*	0	0	16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES			17.00
	DIRECT PATIENT CARE SERVICE COST CENTERS			
25.00	INPATIENT CARE-CONTRACTED**	0	0	25.00
26.00	PHYSICIAN SERVICES**	0	196,819	26.00
27.00	NURSE PRACTITIONER**	0	0	27.00
28.00	REGISTERED NURSE**	0	1,137,123	28.00
29.00	LPN/LVN**	0	107,578	29.00
30.00	PHYSICAL THERAPY**	0	0	30.00
31.00	OCCUPATIONAL THERAPY**	0	0	31.00
32.00	SPEECH/LANGUAGE PATHOLOGY**	0	0	32.00
33.00	MEDICAL SOCIAL SERVICES**	0	0	33.00
34.00	SPIRITUAL COUNSELING**	0	0	34.00
35.00	DIETARY COUNSELING**	0	0	35.00
36.00	COUNSELING - OTHER**	0	0	36.00
37.00	HOSPICE AIDE & HOMEMAKER SERVICES**	0	158,795	37.00
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN**	0	0	38.00
39.00	PATIENT TRANSPORTATION**	0	0	39.00
40.00	IMAGING SERVICES**	0	0	40.00
41.00	LABS & DIAGNOSTICS**	0	0	41.00
42.00	MEDICAL SUPPLIES-NON-ROUTINE**	0	174,507	42.00
42.50	DRUGS CHARGED TO PATIENTS**	0	0	42.50
43.00	OUTPATIENT SERVICES**	0	0	43.00
44.00	PALLIATIVE RADIATION THERAPY**	0	0	44.00
45.00	PALLIATIVE CHEMOTHERAPY**	0	0	45.00
46.00	OTHER PATIENT CARE SERVICES (SPECIFY)**	0	580,368	46.00
	NONREIMBURSABLE COST CENTERS			
60.00	BEREAVEMENT PROGRAM *	0	0	60.00
61.00	VOLUNTEER PROGRAM *	0	0	61.00
62.00	FUNDRAISING*	0	0	62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS*	0	0	63.00
64.00	PALLIATIVE CARE PROGRAM*	0	0	64.00
65.00	OTHER PHYSICIAN SERVICES*	0	0	65.00
66.00	RESIDENTIAL CARE*	0	0	66.00
67.00	ADVERTISING*	0	0	67.00
68.00	TELEHEALTH/TELEMONITORING*	0	0	68.00
69.00	THRIFT STORE*	0	0	69.00
70.00	NURSING FACILITY ROOM & BOARD*	0	0	70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)*	0	0	71.00
100.00	TOTAL	-2,370	2,862,491	100.00

* Transfer the amounts in column 7 to Wkst. O-5, column 1, line as appropriate.
** See instructions. Do not transfer the amounts in column 7 to Wkst. O-5.

ANALYSIS OF HOSPITAL-BASED HOSPICE COSTS FOR HOSPICE ROUTINE HOME CARE | Provider CCN: 15-0048 | Hospice CCN: 15-1524 | Period: From 01/01/2020 To 12/31/2020 | Worksheet O-2 | Date/Time Prepared: 7/8/2021 10:37 am

Hospice I

		SALARIES	OTHER	SUBTOTAL (col. 1 + col. 2)	RECLASSIFI-CATIONS	SUBTOTAL	
		1.00	2.00	3.00	4.00	5.00	
	DIRECT PATIENT CARE SERVICE COST CENTERS						
25.00	INPATIENT CARE-CONTRACTED						25.00
26.00	PHYSICIAN SERVICES	0	196,819	196,819	0	196,819	26.00
27.00	NURSE PRACTITIONER	0	0	0	0	0	27.00
28.00	REGISTERED NURSE	761,460	0	761,460	0	761,460	28.00
29.00	LPN/LVN	88,818	0	88,818	0	88,818	29.00
30.00	PHYSICAL THERAPY	0	0	0	0	0	30.00
31.00	OCCUPATIONAL THERAPY	0	0	0	0	0	31.00
32.00	SPEECH/LANGUAGE PATHOLOGY	0	0	0	0	0	32.00
33.00	MEDICAL SOCIAL SERVICES	0	0	0	0	0	33.00
34.00	SPIRITUAL COUNSELING	0	0	0	0	0	34.00
35.00	DIETARY COUNSELING	0	0	0	0	0	35.00
36.00	COUNSELING - OTHER	0	0	0	0	0	36.00
37.00	HOSPICE AIDE & HOMEMAKER SERVICES	73,451	0	73,451	0	73,451	37.00
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN	0	0	0	0	0	38.00
39.00	PATIENT TRANSPORTATION	0	0	0	0	0	39.00
40.00	IMAGING SERVICES	0	0	0	0	0	40.00
41.00	LABS & DIAGNOSTICS	0	0	0	0	0	41.00
42.00	MEDICAL SUPPLIES-NON-ROUTINE	0	147,417	147,417	0	147,417	42.00
42.50	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	42.50
43.00	OUTPATIENT SERVICES	0	0	0	0	0	43.00
44.00	PALLIATIVE RADIATION THERAPY	0	0	0	0	0	44.00
45.00	PALLIATIVE CHEMOTHERAPY	0	0	0	0	0	45.00
46.00	OTHER PATIENT CARE SERVICES (SPECIFY)	0	580,368	580,368	0	580,368	46.00
100.00	TOTAL *	923,729	924,604	1,848,333	0	1,848,333	100.00

* Transfer the amount in column 7 to Wkst. O-5, column 1, line 51.

		ADJUSTMENTS	TOTAL (col. 5 ± col. 6)	
		6.00	7.00	
	DIRECT PATIENT CARE SERVICE COST CENTERS			
25.00	INPATIENT CARE-CONTRACTED			25.00
26.00	PHYSICIAN SERVICES	0	196,819	26.00
27.00	NURSE PRACTITIONER	0	0	27.00
28.00	REGISTERED NURSE	0	761,460	28.00
29.00	LPN/LVN	0	88,818	29.00
30.00	PHYSICAL THERAPY	0	0	30.00
31.00	OCCUPATIONAL THERAPY	0	0	31.00
32.00	SPEECH/LANGUAGE PATHOLOGY	0	0	32.00
33.00	MEDICAL SOCIAL SERVICES	0	0	33.00
34.00	SPIRITUAL COUNSELING	0	0	34.00
35.00	DIETARY COUNSELING	0	0	35.00
36.00	COUNSELING - OTHER	0	0	36.00
37.00	HOSPICE AIDE & HOMEMAKER SERVICES	0	73,451	37.00
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN	0	0	38.00
39.00	PATIENT TRANSPORTATION	0	0	39.00
40.00	IMAGING SERVICES	0	0	40.00
41.00	LABS & DIAGNOSTICS	0	0	41.00
42.00	MEDICAL SUPPLIES-NON-ROUTINE	0	147,417	42.00
42.50	DRUGS CHARGED TO PATIENTS	0	0	42.50
43.00	OUTPATIENT SERVICES	0	0	43.00
44.00	PALLIATIVE RADIATION THERAPY	0	0	44.00
45.00	PALLIATIVE CHEMOTHERAPY	0	0	45.00
46.00	OTHER PATIENT CARE SERVICES (SPECIFY)	0	580,368	46.00
100.00	TOTAL *	0	1,848,333	100.00

* Transfer the amount in column 7 to Wkst. O-5, column 1, line 51.

ANALYSIS OF HOSPITAL-BASED HOSPICE COSTS FOR HOSPICE INPATIENT RESPITE CARE

Provider CCN: 15-0048 | Hospice CCN: 15-1524 | Period: From 01/01/2020 To 12/31/2020 | Worksheet O-3 | Date/Time Prepared: 7/8/2021 10:37 am

Hospice I

		SALARIES	OTHER	SUBTOTAL (col. 1 + col. 2)	RECLASSIFICATIONS	SUBTOTAL	
		1.00	2.00	3.00	4.00	5.00	
	DIRECT PATIENT CARE SERVICE COST CENTERS						
25.00	INPATIENT CARE-CONTRACTED		0	0	0	0	25.00
26.00	PHYSICIAN SERVICES	0	0	0	0	0	26.00
27.00	NURSE PRACTITIONER	0	0	0	0	0	27.00
28.00	REGISTERED NURSE	0	0	0	46,582	46,582	28.00
29.00	LPN/LVN	0	0	0	2,326	2,326	29.00
30.00	PHYSICAL THERAPY	0	0	0	0	0	30.00
31.00	OCCUPATIONAL THERAPY	0	0	0	0	0	31.00
32.00	SPEECH/LANGUAGE PATHOLOGY	0	0	0	0	0	32.00
33.00	MEDICAL SOCIAL SERVICES	0	0	0	0	0	33.00
34.00	SPIRITUAL COUNSELING	0	0	0	0	0	34.00
35.00	DIETARY COUNSELING	0	0	0	0	0	35.00
36.00	COUNSELING - OTHER	0	0	0	0	0	36.00
37.00	HOSPICE AIDE & HOMEMAKER SERVICES	0	0	0	10,583	10,583	37.00
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN	0	0	0	0	0	38.00
39.00	PATIENT TRANSPORTATION	0	0	0	0	0	39.00
40.00	IMAGING SERVICES	0	0	0	0	0	40.00
41.00	LABS & DIAGNOSTICS	0	0	0	0	0	41.00
42.00	MEDICAL SUPPLIES-NON-ROUTINE	0	0	0	3,359	3,359	42.00
42.50	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	42.50
43.00	OUTPATIENT SERVICES	0	0	0	0	0	43.00
44.00	PALLIATIVE RADIATION THERAPY	0	0	0	0	0	44.00
45.00	PALLIATIVE CHEMOTHERAPY	0	0	0	0	0	45.00
46.00	OTHER PATIENT CARE SERVICES (SPECIFY)	0	0	0	0	0	46.00
100.00	TOTAL *	0	0	0	62,850	62,850	100.00

* Transfer the amount in column 7 to Wkst. O-5, column 1, line 52.

		ADJUSTMENTS	TOTAL (col. 5 ± col. 6)	
		6.00	7.00	
	DIRECT PATIENT CARE SERVICE COST CENTERS			
25.00	INPATIENT CARE-CONTRACTED	0	0	25.00
26.00	PHYSICIAN SERVICES	0	0	26.00
27.00	NURSE PRACTITIONER	0	0	27.00
28.00	REGISTERED NURSE	0	46,582	28.00
29.00	LPN/LVN	0	2,326	29.00
30.00	PHYSICAL THERAPY	0	0	30.00
31.00	OCCUPATIONAL THERAPY	0	0	31.00
32.00	SPEECH/LANGUAGE PATHOLOGY	0	0	32.00
33.00	MEDICAL SOCIAL SERVICES	0	0	33.00
34.00	SPIRITUAL COUNSELING	0	0	34.00
35.00	DIETARY COUNSELING	0	0	35.00
36.00	COUNSELING - OTHER	0	0	36.00
37.00	HOSPICE AIDE & HOMEMAKER SERVICES	0	10,583	37.00
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN	0	0	38.00
39.00	PATIENT TRANSPORTATION	0	0	39.00
40.00	IMAGING SERVICES	0	0	40.00
41.00	LABS & DIAGNOSTICS	0	0	41.00
42.00	MEDICAL SUPPLIES-NON-ROUTINE	0	3,359	42.00
42.50	DRUGS CHARGED TO PATIENTS	0	0	42.50
43.00	OUTPATIENT SERVICES	0	0	43.00
44.00	PALLIATIVE RADIATION THERAPY	0	0	44.00
45.00	PALLIATIVE CHEMOTHERAPY	0	0	45.00
46.00	OTHER PATIENT CARE SERVICES (SPECIFY)	0	0	46.00
100.00	TOTAL *	0	62,850	100.00

* Transfer the amount in column 7 to Wkst. O-5, column 1, line 52.

ANALYSIS OF HOSPITAL-BASED HOSPICE COSTS FOR HOSPICE GENERAL INPATIENT CARE

Provider CCN: 15-0048 | Hospice CCN: 15-1524 | Period: From 01/01/2020 To 12/31/2020 | Worksheet O-4 | Date/Time Prepared: 7/8/2021 10:37 am

Hospice I

		SALARIES	OTHER	SUBTOTAL (col. 1 + col. 2)	RECLASSIFI-CATIONS	SUBTOTAL	
		1.00	2.00	3.00	4.00	5.00	
	DIRECT PATIENT CARE SERVICE COST CENTERS						
25.00	INPATIENT CARE-CONTRACTED		0	0	0	0	25.00
26.00	PHYSICIAN SERVICES	0	0	0	0	0	26.00
27.00	NURSE PRACTITIONER	0	0	0	0	0	27.00
28.00	REGISTERED NURSE	0	0	0	329,081	329,081	28.00
29.00	LPN/LVN	0	0	0	16,434	16,434	29.00
30.00	PHYSICAL THERAPY	0	0	0	0	0	30.00
31.00	OCCUPATIONAL THERAPY	0	0	0	0	0	31.00
32.00	SPEECH/LANGUAGE PATHOLOGY	0	0	0	0	0	32.00
33.00	MEDICAL SOCIAL SERVICES	0	0	0	0	0	33.00
34.00	SPIRITUAL COUNSELING	0	0	0	0	0	34.00
35.00	DIETARY COUNSELING	0	0	0	0	0	35.00
36.00	COUNSELING - OTHER	0	0	0	0	0	36.00
37.00	HOSPICE AIDE & HOMEMAKER SERVICES	0	0	0	74,761	74,761	37.00
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN	0	0	0	0	0	38.00
39.00	PATIENT TRANSPORTATION	0	0	0	0	0	39.00
40.00	IMAGING SERVICES	0	0	0	0	0	40.00
41.00	LABS & DIAGNOSTICS	0	0	0	0	0	41.00
42.00	MEDICAL SUPPLIES-NON-ROUTINE	0	0	0	23,731	23,731	42.00
42.50	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	42.50
43.00	OUTPATIENT SERVICES	0	0	0	0	0	43.00
44.00	PALLIATIVE RADIATION THERAPY	0	0	0	0	0	44.00
45.00	PALLIATIVE CHEMOTHERAPY	0	0	0	0	0	45.00
46.00	OTHER PATIENT CARE SERVICES (SPECIFY)	0	0	0	0	0	46.00
100.00	TOTAL *	0	0	0	444,007	444,007	100.00

* Transfer the amount in column 7 to Wkst. O-5, column 1, line 53.

		ADJUSTMENTS	TOTAL (col. 5 ± col. 6)	
		6.00	7.00	
	DIRECT PATIENT CARE SERVICE COST CENTERS			
25.00	INPATIENT CARE-CONTRACTED	0	0	25.00
26.00	PHYSICIAN SERVICES	0	0	26.00
27.00	NURSE PRACTITIONER	0	0	27.00
28.00	REGISTERED NURSE	0	329,081	28.00
29.00	LPN/LVN	0	16,434	29.00
30.00	PHYSICAL THERAPY	0	0	30.00
31.00	OCCUPATIONAL THERAPY	0	0	31.00
32.00	SPEECH/LANGUAGE PATHOLOGY	0	0	32.00
33.00	MEDICAL SOCIAL SERVICES	0	0	33.00
34.00	SPIRITUAL COUNSELING	0	0	34.00
35.00	DIETARY COUNSELING	0	0	35.00
36.00	COUNSELING - OTHER	0	0	36.00
37.00	HOSPICE AIDE & HOMEMAKER SERVICES	0	74,761	37.00
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN	0	0	38.00
39.00	PATIENT TRANSPORTATION	0	0	39.00
40.00	IMAGING SERVICES	0	0	40.00
41.00	LABS & DIAGNOSTICS	0	0	41.00
42.00	MEDICAL SUPPLIES-NON-ROUTINE	0	23,731	42.00
42.50	DRUGS CHARGED TO PATIENTS	0	0	42.50
43.00	OUTPATIENT SERVICES	0	0	43.00
44.00	PALLIATIVE RADIATION THERAPY	0	0	44.00
45.00	PALLIATIVE CHEMOTHERAPY	0	0	45.00
46.00	OTHER PATIENT CARE SERVICES (SPECIFY)	0	0	46.00
100.00	TOTAL *	0	444,007	100.00

* Transfer the amount in column 7 to Wkst. O-5, column 1, line 53.

COST ALLOCATION - DETERMINATION OF HOSPITAL-BASED HOSPICE NET EXPENSES FOR ALLOCATION

Provider CCN: 15-0048 | Hospice CCN: 15-1524 | Period: From 01/01/2020 To 12/31/2020 | Worksheet O-5 | Date/Time Prepared: 7/8/2021 10:37 am

Hospice I

	Descriptions	HOSPICE DIRECT EXPENSES (see instructions)	GENERAL SERVICE EXPENSES FROM WKST B PART I (see instructions)	TOTAL EXPENSES (sum of cols. 1 + 2)	
		1.00	2.00	3.00	
	GENERAL SERVICE COST CENTERS				
1.00	CAP REL COSTS-BLDG & FIXT	0	11,114	11,114	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	864	0	864	2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT	115,487	242,891	358,378	3.00
4.00	ADMINISTRATIVE & GENERAL	175,706	716,035	891,741	4.00
5.00	PLANT OPERATION & MAINTENANCE	0	0	0	5.00
6.00	LAUNDRY & LINEN SERVICE	0	0	0	6.00
7.00	HOUSEKEEPING	0	82,290	82,290	7.00
8.00	DIETARY	1,615	0	1,615	8.00
9.00	NURSING ADMINISTRATION	0	0	0	9.00
10.00	ROUTINE MEDICAL SUPPLIES	0	0	0	10.00
11.00	MEDICAL RECORDS	0	712	712	11.00
12.00	STAFF TRANSPORTATION	95,841		95,841	12.00
13.00	VOLUNTEER SERVICE COORDINATION	0		0	13.00
14.00	PHARMACY	117,788	0	117,788	14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES	0		0	15.00
16.00	OTHER GENERAL SERVICE	0	0	0	16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES		62,110	62,110	17.00
	LEVEL OF CARE				
50.00	HOSPICE CONTINUOUS HOME CARE	0		0	50.00
51.00	HOSPICE ROUTINE HOME CARE	1,848,333		1,848,333	51.00
52.00	HOSPICE INPATIENT RESPITE CARE	62,850		62,850	52.00
53.00	HOSPICE GENERAL INPATIENT CARE	444,007		444,007	53.00
	NONREIMBURSABLE COST CENTERS				
60.00	BEREAVEMENT PROGRAM	0		0	60.00
61.00	VOLUNTEER PROGRAM	0		0	61.00
62.00	FUNDRAISING	0		0	62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS	0		0	63.00
64.00	PALLIATIVE CARE PROGRAM	0		0	64.00
65.00	OTHER PHYSICIAN SERVICES	0		0	65.00
66.00	RESIDENTIAL CARE	0		0	66.00
67.00	ADVERTISING	0		0	67.00
68.00	TELEHEALTH/TELEMONITORING	0		0	68.00
69.00	THRIFT STORE	0		0	69.00
70.00	NURSING FACILITY ROOM & BOARD	0		0	70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)	0		0	71.00
99.00	NEGATIVE COST CENTER	0		0	99.00
100.00	TOTAL	2,862,491	1,115,152	3,977,643	100.00

COST ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL SERVICE COSTS | Provider CCN: 15-0048 | Hospice CCN: 15-1524 | Period: From 01/01/2020 To 12/31/2020 | Worksheet O-6 Part I | Date/Time Prepared: 7/8/2021 10:37 am

Hospice I

	Descriptions	TOTAL EXPENSES	CAP REL BLDG & FIX	CAP REL MVBLE EQUIP	EMPLOYEE BENEFITS DEPARTMENT	SUBTOTAL	
		0	1.00	2.00	3.00	3A	
	GENERAL SERVICE COST CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	11,114	11,114				1.00
2.00	CAP REL COSTS-MVBLE EQUIP	864		864			2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT	358,378	0	0	358,378		3.00
4.00	ADMINISTRATIVE & GENERAL	891,741	11,114	0	33,199	936,054	4.00
5.00	PLANT OPERATION & MAINTENANCE	0	0	0	0	0	5.00
6.00	LAUNDRY & LINEN SERVICE	0	0	0	0	0	6.00
7.00	HOUSEKEEPING	82,290	0	0	0	82,290	7.00
8.00	DIETARY	1,615	0	0	0	1,615	8.00
9.00	NURSING ADMINISTRATION	0	0	0	0	0	9.00
10.00	ROUTINE MEDICAL SUPPLIES	0	0	0	0	0	10.00
11.00	MEDICAL RECORDS	712	0	0	0	712	11.00
12.00	STAFF TRANSPORTATION	95,841	0	0	0	95,841	12.00
13.00	VOLUNTEER SERVICE COORDINATION	0	0	0	0	0	13.00
14.00	PHARMACY	117,788	0	0	0	117,788	14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES	0	0	0	0	0	15.00
16.00	OTHER GENERAL SERVICE	0	0	0	0	0	16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES		0	0		62,110	17.00
	LEVEL OF CARE						
50.00	HOSPICE CONTINUOUS HOME CARE	0			0	0	50.00
51.00	HOSPICE ROUTINE HOME CARE	1,848,333			209,968	2,058,301	51.00
52.00	HOSPICE INPATIENT RESPITE CARE	62,850	0	107	14,286	77,243	52.00
53.00	HOSPICE GENERAL INPATIENT CARE	444,007	0	757	100,925	545,689	53.00
	NONREIMBURSABLE COST CENTERS						
60.00	BEREAVEMENT PROGRAM	0	0	0	0	0	60.00
61.00	VOLUNTEER PROGRAM	0	0	0	0	0	61.00
62.00	FUNDRAISING	0	0	0	0	0	62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS	0	0	0	0	0	63.00
64.00	PALLIATIVE CARE PROGRAM	0	0	0	0	0	64.00
65.00	OTHER PHYSICIAN SERVICES	0	0	0	0	0	65.00
66.00	RESIDENTIAL CARE	0	0	0	0	0	66.00
67.00	ADVERTISING	0	0	0	0	0	67.00
68.00	TELEHEALTH/TELEMONITORING	0	0	0	0	0	68.00
69.00	THRIFT STORE	0	0	0	0	0	69.00
70.00	NURSING FACILITY ROOM & BOARD	0				0	70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)	0	0	0	0	0	71.00
99.00	NEGATIVE COST CENTER	0	0	0	0		99.00
100.00	TOTAL	3,977,643	11,114	864	358,378	3,977,643	100.00

COST ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL SERVICE COSTS | Provider CCN: 15-0048 | Hospice CCN: 15-1524 | Period: From 01/01/2020 To 12/31/2020 | Worksheet O-6 Part I | Date/Time Prepared: 7/8/2021 10:37 am

Hospice I

	Descriptions	ADMINISTRATIVE & GENERAL	PLANT OPERATION & MAINTENANCE	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
		4.00	5.00	6.00	7.00	8.00	
	GENERAL SERVICE COST CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT						1.00
2.00	CAP REL COSTS-MVBLE EQUIP						2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT						3.00
4.00	ADMINISTRATIVE & GENERAL	936,054					4.00
5.00	PLANT OPERATION & MAINTENANCE	0	0				5.00
6.00	LAUNDRY & LINEN SERVICE	0	0	0			6.00
7.00	HOUSEKEEPING	25,325	0		107,615		7.00
8.00	DIETARY	497	0		0	2,112	8.00
9.00	NURSING ADMINISTRATION	0	0		0		9.00
10.00	ROUTINE MEDICAL SUPPLIES	0	0		0		10.00
11.00	MEDICAL RECORDS	219	0		0		11.00
12.00	STAFF TRANSPORTATION	29,495	0		0		12.00
13.00	VOLUNTEER SERVICE COORDINATION	0	0		0		13.00
14.00	PHARMACY	36,249	0		0		14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES	0	0		0		15.00
16.00	OTHER GENERAL SERVICE	0	0		0		16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES	19,114	0		0		17.00
	LEVEL OF CARE						
50.00	HOSPICE CONTINUOUS HOME CARE	0					50.00
51.00	HOSPICE ROUTINE HOME CARE	633,446					51.00
52.00	HOSPICE INPATIENT RESPITE CARE	23,772	0	0	13,301	262	52.00
53.00	HOSPICE GENERAL INPATIENT CARE	167,937	0	0	94,314	1,850	53.00
	NONREIMBURSABLE COST CENTERS						
60.00	BEREAVEMENT PROGRAM	0	0		0		60.00
61.00	VOLUNTEER PROGRAM	0	0		0		61.00
62.00	FUNDRAISING	0	0		0		62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS	0	0		0		63.00
64.00	PALLIATIVE CARE PROGRAM	0	0		0		64.00
65.00	OTHER PHYSICIAN SERVICES	0	0		0		65.00
66.00	RESIDENTIAL CARE	0	0	0	0	0	66.00
67.00	ADVERTISING	0	0		0		67.00
68.00	TELEHEALTH/TELEMONITORING	0	0		0		68.00
69.00	THRIFT STORE	0	0		0		69.00
70.00	NURSING FACILITY ROOM & BOARD						70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)	0	0	0	0	0	71.00
99.00	NEGATIVE COST CENTER	0	0	0	0	0	99.00
100.00	TOTAL	936,054	0	0	107,615	2,112	100.00

COST ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL SERVICE COSTS | Provider CCN: 15-0048 | Hospice CCN: 15-1524 | Period: From 01/01/2020 To 12/31/2020 | Worksheet O-6 Part I | Date/Time Prepared: 7/8/2021 10:37 am

Hospice I

	Descriptions	NURSING ADMINISTRATION	ROUTINE MEDICAL SUPPLIES	MEDICAL RECORDS	STAFF TRANSPORTATION	VOLUNTEER SERVICE COORDINATION	
		9.00	10.00	11.00	12.00	13.00	
	GENERAL SERVICE COST CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT						1.00
2.00	CAP REL COSTS-MVBLE EQUIP						2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT						3.00
4.00	ADMINISTRATIVE & GENERAL						4.00
5.00	PLANT OPERATION & MAINTENANCE						5.00
6.00	LAUNDRY & LINEN SERVICE						6.00
7.00	HOUSEKEEPING						7.00
8.00	DIETARY						8.00
9.00	NURSING ADMINISTRATION	0					9.00
10.00	ROUTINE MEDICAL SUPPLIES	0	0				10.00
11.00	MEDICAL RECORDS	0		931			11.00
12.00	STAFF TRANSPORTATION	0			125,336		12.00
13.00	VOLUNTEER SERVICE COORDINATION	0			0	0	13.00
14.00	PHARMACY	0			0	0	14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES	0			0	0	15.00
16.00	OTHER GENERAL SERVICE	0			0	0	16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES						17.00
	LEVEL OF CARE						
50.00	HOSPICE CONTINUOUS HOME CARE	0	0	0	125,336	0	50.00
51.00	HOSPICE ROUTINE HOME CARE	0	0	868	0	0	51.00
52.00	HOSPICE INPATIENT RESPITE CARE	0	0	8	0	0	52.00
53.00	HOSPICE GENERAL INPATIENT CARE	0	0	55	0	0	53.00
	NONREIMBURSABLE COST CENTERS						
60.00	BEREAVEMENT PROGRAM	0			0	0	60.00
61.00	VOLUNTEER PROGRAM	0			0	0	61.00
62.00	FUNDRAISING	0			0	0	62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS	0			0	0	63.00
64.00	PALLIATIVE CARE PROGRAM	0			0	0	64.00
65.00	OTHER PHYSICIAN SERVICES	0			0	0	65.00
66.00	RESIDENTIAL CARE	0			0	0	66.00
67.00	ADVERTISING	0			0	0	67.00
68.00	TELEHEALTH/TELEMONITORING	0			0	0	68.00
69.00	THRIFT STORE	0			0	0	69.00
70.00	NURSING FACILITY ROOM & BOARD						70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)	0			0	0	71.00
99.00	NEGATIVE COST CENTER	0	0	0	0	0	99.00
100.00	TOTAL	0	0	931	125,336	0	100.00

COST ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL SERVICE COSTS | Provider CCN: 15-0048 | Hospice CCN: 15-1524 | Period: From 01/01/2020 To 12/31/2020 | Worksheet O-6 Part I | Date/Time Prepared: 7/8/2021 10:37 am

Hospice I

	Descriptions	PHARMACY	PHYSICIAN ADMINISTRATIVE SERVICES	OTHER GENERAL SERVICE	PATIENT/ RESIDENTIAL CARE SERVICES	TOTAL	
		14.00	15.00	16.00	17.00	18.00	
	GENERAL SERVICE COST CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT						1.00
2.00	CAP REL COSTS-MVBLE EQUIP						2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT						3.00
4.00	ADMINISTRATIVE & GENERAL						4.00
5.00	PLANT OPERATION & MAINTENANCE						5.00
6.00	LAUNDRY & LINEN SERVICE						6.00
7.00	HOUSEKEEPING						7.00
8.00	DIETARY						8.00
9.00	NURSING ADMINISTRATION						9.00
10.00	ROUTINE MEDICAL SUPPLIES						10.00
11.00	MEDICAL RECORDS						11.00
12.00	STAFF TRANSPORTATION						12.00
13.00	VOLUNTEER SERVICE COORDINATION						13.00
14.00	PHARMACY	154,037					14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES	0	0				15.00
16.00	OTHER GENERAL SERVICE	0		0			16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES				81,224		17.00
	LEVEL OF CARE						
50.00	HOSPICE CONTINUOUS HOME CARE	0	0	0		125,336	50.00
51.00	HOSPICE ROUTINE HOME CARE	143,609	0	0		2,836,224	51.00
52.00	HOSPICE INPATIENT RESPITE CARE	1,293	0	0	10,074	125,953	52.00
53.00	HOSPICE GENERAL INPATIENT CARE	9,135	0	0	71,150	890,130	53.00
	NONREIMBURSABLE COST CENTERS						
60.00	BEREAVEMENT PROGRAM	0		0		0	60.00
61.00	VOLUNTEER PROGRAM	0		0		0	61.00
62.00	FUNDRAISING	0		0		0	62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS	0		0		0	63.00
64.00	PALLIATIVE CARE PROGRAM	0		0		0	64.00
65.00	OTHER PHYSICIAN SERVICES	0		0		0	65.00
66.00	RESIDENTIAL CARE	0	0	0	0	0	66.00
67.00	ADVERTISING	0		0		0	67.00
68.00	TELEHEALTH/TELEMONITORING	0		0		0	68.00
69.00	THRIFT STORE	0		0		0	69.00
70.00	NURSING FACILITY ROOM & BOARD					0	70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)	0	0	0	0	0	71.00
99.00	NEGATIVE COST CENTER	0	0	0	0	0	99.00
100.00	TOTAL	154,037	0	0	81,224	3,977,643	100.00

COST ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL SERVICE COSTS STATISTICAL BASIS

Provider CCN: 15-0048 | Hospice CCN: 15-1524 | Period: From 01/01/2020 To 12/31/2020 | Worksheet O-6 Part II | Date/Time Prepared: 7/8/2021 10:37 am

Hospice I

	Cost Center Descriptions	CAP REL BLDG & FIX (SQUARE FEET)	CAP REL MVBLE EQUIP (DOLLAR VALUE)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	RECONCILIATION	ADMINISTRATIVE & GENERAL (ACCUMULATED COSTS)	
		1.00	2.00	3.00	4A	4.00	
	GENERAL SERVICE COST CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	400					1.00
2.00	CAP REL COSTS-MVBLE EQUIP		445				2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT	0	0	1,576,641			3.00
4.00	ADMINISTRATIVE & GENERAL	400	0	146,055	-936,054	3,041,589	4.00
5.00	PLANT OPERATION & MAINTENANCE	0	0	0	0	0	5.00
6.00	LAUNDRY & LINEN SERVICE	0	0	0	0	0	6.00
7.00	HOUSEKEEPING	0	0	0	0	82,290	7.00
8.00	DIETARY	0	0	0	0	1,615	8.00
9.00	NURSING ADMINISTRATION	0	0	0	0	0	9.00
10.00	ROUTINE MEDICAL SUPPLIES	0	0	0	0	0	10.00
11.00	MEDICAL RECORDS	0	0	0	0	712	11.00
12.00	STAFF TRANSPORTATION	0	0	0	0	95,841	12.00
13.00	VOLUNTEER SERVICE COORDINATION	0	0	0	0	0	13.00
14.00	PHARMACY	0	0	0	0	117,788	14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES	0	0	0	0	0	15.00
16.00	OTHER GENERAL SERVICE	0	0	0	0	0	16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES	0	0		0	62,110	17.00
	LEVEL OF CARE						
50.00	HOSPICE CONTINUOUS HOME CARE			0	0	0	50.00
51.00	HOSPICE ROUTINE HOME CARE			923,729	0	2,058,301	51.00
52.00	HOSPICE INPATIENT RESPITE CARE	0	55	62,850	0	77,243	52.00
53.00	HOSPICE GENERAL INPATIENT CARE	0	390	444,007	0	545,689	53.00
	NONREIMBURSABLE COST CENTERS						
60.00	BEREAVEMENT PROGRAM	0	0	0	0	0	60.00
61.00	VOLUNTEER PROGRAM	0	0	0	0	0	61.00
62.00	FUNDRAISING	0	0	0	0	0	62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS	0	0	0	0	0	63.00
64.00	PALLIATIVE CARE PROGRAM	0	0	0	0	0	64.00
65.00	OTHER PHYSICIAN SERVICES	0	0	0	0	0	65.00
66.00	RESIDENTIAL CARE	0	0	0	0	0	66.00
67.00	ADVERTISING	0	0	0	0	0	67.00
68.00	TELEHEALTH/TELEMONITORING	0	0	0	0	0	68.00
69.00	THRIFT STORE	0	0	0	0	0	69.00
70.00	NURSING FACILITY ROOM & BOARD				0		70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)	0	0	0	0	0	71.00
99.00	NEGATIVE COST CENTER						99.00
100.00	COST TO BE ALLOCATED (per Wkst. O-6, Part I)	11,114	864	358,378		936,054	100.00
101.00	UNIT COST MULTIPLIER	27.785000	1.941573	0.227305		0.307752	101.00

COST ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL SERVICE COSTS STATISTICAL BASIS

Provider CCN: 15-0048 | Hospice CCN: 15-1524 | Period: From 01/01/2020 To 12/31/2020 | Worksheet O-6 Part II | Date/Time Prepared: 7/8/2021 10:37 am

Hospice I

	Cost Center Descriptions	PLANT OPERATION & MAINTENANCE (SQUARE FEET)	LAUNDRY & LINEN SERVICE (IN-FACILITY DAYS)	HOUSEKEEPING (SQUARE FEET)	DIETARY (IN-FACILITY DAYS)	NURSING ADMINISTRATION (DIRECT NURS. HRS.)	
		5.00	6.00	7.00	8.00	9.00	
	GENERAL SERVICE COST CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT						1.00
2.00	CAP REL COSTS-MVBLE EQUIP						2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT						3.00
4.00	ADMINISTRATIVE & GENERAL						4.00
5.00	PLANT OPERATION & MAINTENANCE	445					5.00
6.00	LAUNDRY & LINEN SERVICE	0	0				6.00
7.00	HOUSEKEEPING	0		445			7.00
8.00	DIETARY	0		0	1,290		8.00
9.00	NURSING ADMINISTRATION	0		0		0	9.00
10.00	ROUTINE MEDICAL SUPPLIES	0		0		0	10.00
11.00	MEDICAL RECORDS	0		0		0	11.00
12.00	STAFF TRANSPORTATION	0		0		0	12.00
13.00	VOLUNTEER SERVICE COORDINATION	0		0		0	13.00
14.00	PHARMACY	0		0		0	14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES	0		0		0	15.00
16.00	OTHER GENERAL SERVICE	0		0		0	16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES	0		0			17.00
	LEVEL OF CARE						
50.00	HOSPICE CONTINUOUS HOME CARE					0	50.00
51.00	HOSPICE ROUTINE HOME CARE					0	51.00
52.00	HOSPICE INPATIENT RESPITE CARE	55	0	55	160	0	52.00
53.00	HOSPICE GENERAL INPATIENT CARE	390	0	390	1,130	0	53.00
	NONREIMBURSABLE COST CENTERS						
60.00	BEREAVEMENT PROGRAM	0		0		0	60.00
61.00	VOLUNTEER PROGRAM	0		0		0	61.00
62.00	FUNDRAISING	0		0		0	62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS	0		0		0	63.00
64.00	PALLIATIVE CARE PROGRAM	0		0		0	64.00
65.00	OTHER PHYSICIAN SERVICES	0		0		0	65.00
66.00	RESIDENTIAL CARE	0	0	0	0	0	66.00
67.00	ADVERTISING	0		0		0	67.00
68.00	TELEHEALTH/TELEMONITORING	0		0		0	68.00
69.00	THRIFT STORE	0		0		0	69.00
70.00	NURSING FACILITY ROOM & BOARD						70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)	0	0	0	0	0	71.00
99.00	NEGATIVE COST CENTER						99.00
100.00	COST TO BE ALLOCATED (per Wkst. O-6, Part I)	0	0	107,615	2,112	0	100.00
101.00	UNIT COST MULTIPLIER	0.000000	0.000000	241.831461	1.637209	0.000000	101.00

COST ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL SERVICE COSTS STATISTICAL BASIS

Provider CCN: 15-0048 | Hospice CCN: 15-1524 | Period: From 01/01/2020 To 12/31/2020 | Worksheet O-6 Part II | Date/Time Prepared: 7/8/2021 10:37 am

Hospice I

	Cost Center Descriptions	ROUTINE MEDICAL SUPPLIES (PATIENT DAYS)	MEDICAL RECORDS (PATIENT DAYS)	STAFF TRANSPORTATION (MILEAGE)	VOLUNTEER SERVICE COORDINATION (HOURS OF SERVICE)	PHARMACY (CHARGES)	
		10.00	11.00	12.00	13.00	14.00	
	GENERAL SERVICE COST CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT						1.00
2.00	CAP REL COSTS-MVBLE EQUIP						2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT						3.00
4.00	ADMINISTRATIVE & GENERAL						4.00
5.00	PLANT OPERATION & MAINTENANCE						5.00
6.00	LAUNDRY & LINEN SERVICE						6.00
7.00	HOUSEKEEPING						7.00
8.00	DIETARY						8.00
9.00	NURSING ADMINISTRATION						9.00
10.00	ROUTINE MEDICAL SUPPLIES	19,054					10.00
11.00	MEDICAL RECORDS		19,054				11.00
12.00	STAFF TRANSPORTATION			1,000			12.00
13.00	VOLUNTEER SERVICE COORDINATION			0	19,054		13.00
14.00	PHARMACY			0	0	19,054	14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES			0	0	0	15.00
16.00	OTHER GENERAL SERVICE			0	0	0	16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES						17.00
	LEVEL OF CARE						
50.00	HOSPICE CONTINUOUS HOME CARE	0	0	1,000	0	0	50.00
51.00	HOSPICE ROUTINE HOME CARE	17,764	17,764	0	17,764	17,764	51.00
52.00	HOSPICE INPATIENT RESPITE CARE	160	160	0	160	160	52.00
53.00	HOSPICE GENERAL INPATIENT CARE	1,130	1,130	0	1,130	1,130	53.00
	NONREIMBURSABLE COST CENTERS						
60.00	BEREAVEMENT PROGRAM			0	0	0	60.00
61.00	VOLUNTEER PROGRAM			0	0	0	61.00
62.00	FUNDRAISING			0	0	0	62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS			0	0	0	63.00
64.00	PALLIATIVE CARE PROGRAM			0	0	0	64.00
65.00	OTHER PHYSICIAN SERVICES			0	0	0	65.00
66.00	RESIDENTIAL CARE			0	0	0	66.00
67.00	ADVERTISING			0	0	0	67.00
68.00	TELEHEALTH/TELEMONITORING			0	0	0	68.00
69.00	THRIFT STORE			0	0	0	69.00
70.00	NURSING FACILITY ROOM & BOARD						70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)			0	0	0	71.00
99.00	NEGATIVE COST CENTER						99.00
100.00	COST TO BE ALLOCATED (per Wkst. O-6, Part I)	0	931	125,336	0	154,037	100.00
101.00	UNIT COST MULTIPLIER	0.000000	0.048861	125.336000	0.000000	8.084234	101.00

COST ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL SERVICE COSTS STATISTICAL BASIS

Provider CCN: 15-0048 | Hospice CCN: 15-1524 | Period: From 01/01/2020 To 12/31/2020 | Worksheet O-6 Part II | Date/Time Prepared: 7/8/2021 10:37 am

Hospice I

	Cost Center Descriptions	PHYSICIAN ADMINISTRATIVE SERVICES (PATIENT DAYS)	OTHER GENERAL SERVICE (SPECIFY BASIS)	PATIENT/ RESIDENTIAL CARE SERVICES (IN-FACILITY DAYS)		
		15.00	16.00	17.00		
	GENERAL SERVICE COST CENTERS					
1.00	CAP REL COSTS-BLDG & FIXT					1.00
2.00	CAP REL COSTS-MVBLE EQUIP					2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT					3.00
4.00	ADMINISTRATIVE & GENERAL					4.00
5.00	PLANT OPERATION & MAINTENANCE					5.00
6.00	LAUNDRY & LINEN SERVICE					6.00
7.00	HOUSEKEEPING					7.00
8.00	DIETARY					8.00
9.00	NURSING ADMINISTRATION					9.00
10.00	ROUTINE MEDICAL SUPPLIES					10.00
11.00	MEDICAL RECORDS					11.00
12.00	STAFF TRANSPORTATION					12.00
13.00	VOLUNTEER SERVICE COORDINATION					13.00
14.00	PHARMACY					14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES	19,054				15.00
16.00	OTHER GENERAL SERVICE		0			16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES			1,290		17.00
	LEVEL OF CARE					
50.00	HOSPICE CONTINUOUS HOME CARE	0	0			50.00
51.00	HOSPICE ROUTINE HOME CARE	17,764	0			51.00
52.00	HOSPICE INPATIENT RESPITE CARE	160	0	160		52.00
53.00	HOSPICE GENERAL INPATIENT CARE	1,130	0	1,130		53.00
	NONREIMBURSABLE COST CENTERS					
60.00	BEREAVEMENT PROGRAM		0			60.00
61.00	VOLUNTEER PROGRAM		0			61.00
62.00	FUNDRAISING		0			62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS		0			63.00
64.00	PALLIATIVE CARE PROGRAM		0			64.00
65.00	OTHER PHYSICIAN SERVICES		0			65.00
66.00	RESIDENTIAL CARE	0	0	0		66.00
67.00	ADVERTISING		0			67.00
68.00	TELEHEALTH/TELEMONITORING		0			68.00
69.00	THRIFT STORE		0			69.00
70.00	NURSING FACILITY ROOM & BOARD					70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)	0	0	0		71.00
99.00	NEGATIVE COST CENTER					99.00
100.00	COST TO BE ALLOCATED (per Wkst. O-6, Part I)	0	0	81,224		100.00
101.00	UNIT COST MULTIPLIER	0.000000	0.000000	62.964341		101.00

APPORTIONMENT OF HOSPITAL-BASED HOSPICE SHARED SERVICE COSTS BY LEVEL OF CARE

Provider CCN: 15-0048 | Period: From 01/01/2020 To 12/31/2020 | Worksheet O-7
Hospice CCN: 15-1524 | Date/Time Prepared: 7/8/2021 10:37 am

Hospice I

	Cost Center Descriptions	From Wkst. C, Part I, Col. 9 line	Cost to Charge Ratio	Charges by LOC (from Provider Records) HCHC	HRHC	HIRC	
		0	1.00	2.00	3.00	4.00	
	ANCILLARY SERVICE COST CENTERS						
1.00	PHYSICAL THERAPY	66.00	0.653218	0	0	0	1.00
2.00	OCCUPATIONAL THERAPY	67.00					2.00
3.00	SPEECH PATHOLOGY	68.00					3.00
4.00	DRUGS CHARGED TO PATIENTS	73.00	0.343525	0	0	0	4.00
5.00	DURABLE MEDICAL EQUIP-RENTED	96.00	1.489414	0	0	0	5.00
6.00	LABORATORY	60.00	0.185789	0	0	0	6.00
7.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0.000000	0	0	0	7.00
8.00	FAMILY PRACTICE	93.00	0.570834	0	0	0	8.00
9.00	RADIOLOGY-THERAPEUTIC	55.00					9.00
10.00	ANCILLARY - OTHER	76.00	0.000000	0	0	0	10.00
10.97	CARDIAC REHABILITATION	76.97	1.063034	0	0	0	10.97
11.00	Totals (sum of lines 1-11)						11.00

	Cost Center Descriptions	Charges by LOC (from Provider Records) HGIP	Shared Service Costs by LOC HCHC (col. 1 x col. 2)	HRHC (col. 1 x col. 3)	HIRC (col. 1 x col. 4)	HGIP (col. 1 x col. 5)	
		5.00	6.00	7.00	8.00	9.00	
	ANCILLARY SERVICE COST CENTERS						
1.00	PHYSICAL THERAPY	0	0	0	0	0	1.00
2.00	OCCUPATIONAL THERAPY						2.00
3.00	SPEECH PATHOLOGY						3.00
4.00	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	4.00
5.00	DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	0	5.00
6.00	LABORATORY	0	0	0	0	0	6.00
7.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	7.00
8.00	FAMILY PRACTICE	0	0	0	0	0	8.00
9.00	RADIOLOGY-THERAPEUTIC						9.00
10.00	ANCILLARY - OTHER	0	0	0	0	0	10.00
10.97	CARDIAC REHABILITATION	0	0	0	0	0	10.97
11.00	Totals (sum of lines 1-11)		0	0	0	0	11.00

CALCULATION OF HOSPITAL-BASED HOSPICE PER DIEM COST

Provider CCN: 15-0048 | Hospice CCN: 15-1524 | Period: From 01/01/2020 To 12/31/2020 | Worksheet O-8 | Date/Time Prepared: 7/8/2021 10:37 am

Hospice I

		TITLE XVIII MEDICARE	TITLE XIX MEDICAID	TOTAL	
		1.00	2.00	3.00	
	HOSPICE CONTINUOUS HOME CARE				
1.00	Total cost (Wkst. O-6, Part I, col. 18, line 50 plus Wkst. O-7, col. 6, line 11)			125,336	1.00
2.00	Total unduplicated days (Wkst. S-9, col. 4, line 10)			0	2.00
3.00	Total average cost per diem (line 1 divided by line 2)			0.00	3.00
4.00	Unduplicated program days (Wkst. S-9 col. as appropriate, line 10)	0	0		4.00
5.00	Program cost (line 3 times line 4)	0	0		5.00
	HOSPICE ROUTINE HOME CARE				
6.00	Total cost (Wkst. O-6, Part I, col. 18, line 51 plus Wkst. O-7, col. 7, line 11)			2,836,224	6.00
7.00	Total unduplicated days (Wkst. S-9, col. 4, line 11)			17,764	7.00
8.00	Total average cost per diem (line 6 divided by line 7)			159.66	8.00
9.00	Unduplicated program days (Wkst. S-9, col. as appropriate, line 11)	15,687	524		9.00
10.00	Program cost (line 8 times line 9)	2,504,586	83,662		10.00
	HOSPICE INPATIENT RESPITE CARE				
11.00	Total cost (Wkst. O-6, Part I, col. 18, line 52 plus Wkst. O-7, col. 8, line 11)			125,953	11.00
12.00	Total unduplicated days (Wkst. S-9, col. 4, line 12)			160	12.00
13.00	Total average cost per diem (line 11 divided by line 12)			787.21	13.00
14.00	Unduplicated program days (Wkst. S-9, col. as appropriate, line 12)	154	0		14.00
15.00	Program cost (line 13 times line 14)	121,230	0		15.00
	HOSPICE GENERAL INPATIENT CARE				
16.00	Total cost (Wkst. O-6, Part I, col. 18, line 53 plus Wkst. O-7, col. 9, line 11)			890,130	16.00
17.00	Total unduplicated days (Wkst. S-9, col. 4, line 13)			1,130	17.00
18.00	Total average cost per diem (line 16 divided by line 17)			787.73	18.00
19.00	Unduplicated program days (Wkst. S-9, col. as appropriate, line 13)	964	20		19.00
20.00	Program cost (line 18 times line 19)	759,372	15,755		20.00
	TOTAL HOSPICE CARE				
21.00	Total cost (sum of line 1 + line 6 + line 11 + line 16)			3,977,643	21.00
22.00	Total unduplicated days (Wkst. S-9, col. 4, line 14)			19,054	22.00
23.00	Average cost per diem (line 21 divided by line 22)			208.76	23.00

CALCULATION OF CAPITAL PAYMENT	Provider CCN: 15-0048	Period: From 01/01/2020 To 12/31/2020	Worksheet L Parts I-III Date/Time Prepared: 7/8/2021 10:37 am
	Title XVIII	Hospital	PPS

		1.00	
	PART I - FULLY PROSPECTIVE METHOD		
	CAPITAL FEDERAL AMOUNT		
1.00	Capital DRG other than outlier	4,044,987	1.00
1.01	Model 4 BPCI Capital DRG other than outlier	0	1.01
2.00	Capital DRG outlier payments	62,037	2.00
2.01	Model 4 BPCI Capital DRG outlier payments	0	2.01
3.00	Total inpatient days divided by number of days in the cost reporting period (see instructions)	139.43	3.00
4.00	Number of interns & residents (see instructions)	16.75	4.00
5.00	Indirect medical education percentage (see instructions)	3.45	5.00
6.00	Indirect medical education adjustment (multiply line 5 by the sum of lines 1 and 1.01, columns 1 and 1.01)(see instructions)	139,552	6.00
7.00	Percentage of SSI recipient patient days to Medicare Part A patient days (Worksheet E, part A line 30) (see instructions)	0.00	7.00
8.00	Percentage of Medicaid patient days to total days (see instructions)	0.00	8.00
9.00	Sum of lines 7 and 8	0.00	9.00
10.00	Allowable disproportionate share percentage (see instructions)	0.00	10.00
11.00	Disproportionate share adjustment (see instructions)	0	11.00
12.00	Total prospective capital payments (see instructions)	4,246,576	12.00

		1.00	
	PART II - PAYMENT UNDER REASONABLE COST		
1.00	Program inpatient routine capital cost (see instructions)	0	1.00
2.00	Program inpatient ancillary capital cost (see instructions)	0	2.00
3.00	Total inpatient program capital cost (line 1 plus line 2)	0	3.00
4.00	Capital cost payment factor (see instructions)	0	4.00
5.00	Total inpatient program capital cost (line 3 x line 4)	0	5.00

		1.00	
	PART III - COMPUTATION OF EXCEPTION PAYMENTS		
1.00	Program inpatient capital costs (see instructions)	0	1.00
2.00	Program inpatient capital costs for extraordinary circumstances (see instructions)	0	2.00
3.00	Net program inpatient capital costs (line 1 minus line 2)	0	3.00
4.00	Applicable exception percentage (see instructions)	0.00	4.00
5.00	Capital cost for comparison to payments (line 3 x line 4)	0	5.00
6.00	Percentage adjustment for extraordinary circumstances (see instructions)	0.00	6.00
7.00	Adjustment to capital minimum payment level for extraordinary circumstances (line 2 x line 6)	0	7.00
8.00	Capital minimum payment level (line 5 plus line 7)	0	8.00
9.00	Current year capital payments (from Part I, line 12, as applicable)	0	9.00
10.00	Current year comparison of capital minimum payment level to capital payments (line 8 less line 9)	0	10.00
11.00	Carryover of accumulated capital minimum payment level over capital payment (from prior year Worksheet L, Part III, line 14)	0	11.00
12.00	Net comparison of capital minimum payment level to capital payments (line 10 plus line 11)	0	12.00
13.00	Current year exception payment (if line 12 is positive, enter the amount on this line)	0	13.00
14.00	Carryover of accumulated capital minimum payment level over capital payment for the following period (if line 12 is negative, enter the amount on this line)	0	14.00
15.00	Current year allowable operating and capital payment (see instructions)	0	15.00
16.00	Current year operating and capital costs (see instructions)	0	16.00
17.00	Current year exception offset amount (see instructions)	0	17.00