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: 15-0047	Period: From 06/01/2019 To 05/31/2020	Worksheet S Parts I-III Date/Time Prepared: 11/2/2020 12:13 pm

PART I - COST REPORT STATUS

Provider use only

1. [X] Electronically prepared cost report — Date: 11/2/2020 Time: 12:13 pm
2. [ ] Manually prepared cost report
3. [0] If this is an amended report enter the number of times the provider resubmitted this cost report
4. [F] Medicare Utilization. Enter "F" for full or "L" for low.

Contractor use only

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

PART II - CERTIFICATION

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

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

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by ST JOSEPH MEDICAL CENTER (15-0047) for the cost reporting period beginning 06/01/2019 and ending 05/31/2020 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	149,235	-60,609	0	0	1.00
2.00	Subprovider - IPF	0	3,548	-609		0	2.00
3.00	Subprovider - IRF	0	0	0		0	3.00
5.00	Swing Bed - SNF	0	0	0		0	5.00
6.00	Swing Bed - NF	0				0	6.00
7.00	SKILLED NURSING FACILITY	0	0	-12		7	7.00
200.00	Total	0	152,783	-61,230	0	7	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: 15-0047 | Period: From 06/01/2019 To 05/31/2020 | Worksheet S-2 Part I Date/Time Prepared: 11/2/2020 12:13 pm

	1.00	2.00	3.00	4.00	
	Hospital and Hospital Health Care Complex Address:				
1.00	Street: 700 BROADWAY STREET	PO Box:			1.00
2.00	City: FORT WAYNE	State: IN	Zip Code: 46802	County: ALLEN	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	ST JOSEPH MEDICAL CENTER	150047	23060	1	07/01/1996	N	P	P	3.00
4.00	Subprovider - IPF	ST JOSPEH GENERATIONS	15S047	23060	4	06/01/2003	N	P	P	4.00
5.00	Subprovider - IRF									5.00
6.00	Subprovider - (Other)									6.00
7.00	Swing Beds - SNF									7.00
8.00	Swing Beds - NF									8.00
9.00	Hospital-Based SNF	SKILLED NURSING FACILITY ST JOSEPH	155356	23060		04/01/1990	N	P	P	9.00
10.00	Hospital-Based NF									10.00
11.00	Hospital-Based OLTC									11.00
12.00	Hospital-Based HHA									12.00
13.00	Separately Certified ASC									13.00
14.00	Hospital-Based Hospice									14.00
15.00	Hospital-Based Health Clinic - RHC									15.00
16.00	Hospital-Based Health Clinic - FQHC									16.00
17.00	Hospital-Based (CMHC) I									17.00
18.00	Renal Dialysis									18.00
19.00	Other									19.00

		From:	To:	
		1.00	2.00	
20.00	Cost Reporting Period (mm/dd/yyyy)	06/01/2019	05/31/2020	20.00
21.00	Type of Control (see instructions)	4		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.	1,858	295	25	21	4,112	0	24.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-0047 | Period: From 06/01/2019 To 05/31/2020 | Worksheet S-2 Part I Date/Time Prepared: 11/2/2020 12:13 pm

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

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

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

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-0047 | Period: From 06/01/2019 To 05/31/2020 | Worksheet S-2 Part I | Date/Time Prepared: 11/2/2020 12:13 pm

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

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-0047 | Period: From 06/01/2019 To 05/31/2020 | Worksheet S-2 Part I Date/Time Prepared: 11/2/2020 12:13 pm

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

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

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

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

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				1.00	
	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)				106.00
107.00	Column 1: If line 105 is Y, is this facility eligible for cost reimbursement for I&R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) Column 2: If column 1 is Y and line 70 or line 75 is Y, do you train I&Rs in an approved medical education program in the CAH's excluded IPF and/or IRF unit(s)? Enter "Y" for yes or "N" for no in column 2. (see instructions)				107.00
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.		N		108.00
		Physical	Occupational	Speech	Respiratory	
		1.00	2.00	3.00	4.00	
109.00	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.					109.00
					1.00	
110.00	Did this hospital participate in the Rural Community Hospital Demonstration project (§410A Demonstration)for the current cost reporting period? Enter "Y" for yes or "N" for no. If yes, complete Worksheet E, Part A, lines 200 through 218, and Worksheet E-2, lines 200 through 215, as applicable.				N	110.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-0047 | Period: From 06/01/2019 To 05/31/2020 | Worksheet S-2 Part I | Date/Time Prepared: 11/2/2020 12:13 pm

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

		1.00	2.00	3.00	
112.00	Did this hospital participate in the Pennsylvania Rural Health Model demonstration for any portion of the current cost reporting period? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2, the date the hospital began participating in the demonstration. In column 3, enter the date the hospital ceased participation in the demonstration, if applicable.	N			112.00
	Miscellaneous Cost Reporting Information				
115.00	Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in column 1. If column 1 is yes, enter the method used (A, B, or E only) in column 2. If column 2 is "E", enter in column 3 either "93" percent for short term hospital or "98" percent for long term care (includes psychiatric, rehabilitation and long term hospitals providers) based on the definition in CMS Pub.15-1, chapter 22, §2208.1.	N		0	115.00
116.00	Is this facility classified as a referral center? Enter "Y" for yes or "N" for no.	N			116.00
117.00	Is this facility legally-required to carry malpractice insurance? Enter "Y" for yes or "N" for no.	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:	233,011	207,774	0	118.01

		1.00	2.00	
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein.	N		118.02
119.00	DO NOT USE THIS LINE			119.00
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 1, "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2, "Y" for yes or "N" for no.	N	N	120.00
121.00	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter "Y" for yes or "N" for no.	Y		121.00
122.00	Does the cost report contain healthcare related taxes as defined in §1903(w)(3) of the Act?Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2 the Worksheet A line number where these taxes are included.	N		122.00
	Transplant Center Information			
125.00	Does this facility operate a transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.	N		125.00
126.00	If this is a Medicare certified kidney transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			126.00
127.00	If this is a Medicare certified heart transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			127.00
128.00	If this is a Medicare certified liver transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			128.00
129.00	If this is a Medicare certified lung transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			129.00
130.00	If this is a Medicare certified pancreas transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			130.00
131.00	If this is a Medicare certified intestinal transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			131.00
132.00	If this is a Medicare certified islet transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			132.00
133.00	Removed and reserved			133.00
134.00	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.			134.00
	All Providers			
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)	Y	HB1848	140.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-0047 | Period: From 06/01/2019 To 05/31/2020 | Worksheet S-2 Part I | Date/Time Prepared: 11/2/2020 12:13 pm

	1.00	2.00	3.00	
	If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number.			
141.00	Name: COMMUNITY HEALTH SYSTEMS	Contractor's Name: WPS, INC.	Contractor's Number: 10301	141.00
142.00	Street: 4000 MERIDIAN BLVD	PO Box:		142.00
143.00	City: FRANKLIN	State: TN	Zip Code: 37067	143.00

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

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

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

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

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

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

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 15-0047 | Period: From 06/01/2019 To 05/31/2020 | Worksheet S-2 Part II | Date/Time Prepared: 11/2/2020 12:13 pm

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

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

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

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

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

		Part A		Part B		
		Y/N	Date	Y/N	Date	
		1.00	2.00	3.00	4.00	
	PS&R Data					
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see instructions)	Y	10/19/2020	Y	10/19/2020	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)	N		N		17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N		N		18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		N		19.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 15-0047 | Period: From 06/01/2019 To 05/31/2020 | Worksheet S-2 Part II | Date/Time Prepared: 11/2/2020 12:13 pm

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

		1.00	
	COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)		
	Capital Related Cost		
22.00	Have assets been relifed for Medicare purposes? If yes, see instructions	N	22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.	N	23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions	N	24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.	N	25.00
26.00	Were assets subject to Sec.2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.	N	26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.	N	27.00
	Interest Expense		
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.	N	28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions	N	29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.	N	30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.	N	31.00
	Purchased Services		
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.	N	32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.	N	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.	Y	12/31/2019	38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.	N		39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.	N		40.00

		1.00	2.00	
	Cost Report Preparer Contact Information			
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	VICTORIA	ROMANKO	41.00
42.00	Enter the employer/company name of the cost report preparer.	COMMUNITY HEALTH SYSTEMS		42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	(615) 925-4333	VICTORIA_ROMANKO@CHS.NET	43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 15-0047 | Period: From 06/01/2019 To 05/31/2020 | Worksheet S-2 Part II Date/Time Prepared: 11/2/2020 12:13 pm

		3.00		
	Cost Report Preparer Contact Information			
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	MANGER, REVENUE MANAGEMENT		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: 15-0047 | Period: From 06/01/2019 To 05/31/2020 | Worksheet S-3 Part I | Date/Time Prepared: 11/2/2020 12:13 pm

	Component	Worksheet A Line Number	No. of Beds	Bed Days Available	CAH Hours	I/P Days / O/P Visits / Trips Title V	
		1.00	2.00	3.00	4.00	5.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30.00	76	27,816	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)		76	27,816	0.00	0	7.00
8.00	INTENSIVE CARE UNIT						8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT	33.00	0	4,320	0.00	0	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)		76	32,136	0.00	0	14.00
15.00	CAH visits					0	15.00
16.00	SUBPROVIDER - IPF	40.00	0	5,719		0	16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY	44.00	0	6,360		0	19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)	30.00					24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	26.25
27.00	Total (sum of lines 14-26)		76				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: 15-0047 | Period: From 06/01/2019 To 05/31/2020 | Worksheet S-3 Part I | Date/Time Prepared: 11/2/2020 12:13 pm

	Component	I/P Days / O/P Visits / Trips			Full Time Equivalents		
		Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
		6.00	7.00	8.00	9.00	10.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	2,247	2,052	12,018			1.00
2.00	HMO and other (see instructions)	2,421	4,110				2.00
3.00	HMO IPF Subprovider	1,372	0				3.00
4.00	HMO IRF Subprovider	0	0				4.00
5.00	Hospital Adults & Peds. Swing Bed SNF	0	0	0			5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	0			6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	2,247	2,052	12,018			7.00
8.00	INTENSIVE CARE UNIT						8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT	620	149	976			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)	2,867	2,201	12,994	0.42	358.03	14.00
15.00	CAH visits	0	0	0			15.00
16.00	SUBPROVIDER - IPF	1,972	130	3,859	0.00	19.60	16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY	1,196	63	4,321	0.00	13.55	19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)			17			24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0.00	0.00	26.25
27.00	Total (sum of lines 14-26)				0.42	391.18	27.00
28.00	Observation Bed Days		0	1,258			28.00
29.00	Ambulance Trips	0					29.00
30.00	Employee discount days (see instruction)			65			30.00
31.00	Employee discount days - IRF			0			31.00
32.00	Labor & delivery days (see instructions)	0	0	0			32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)			0			32.01
33.00	LTCH non-covered days	0					33.00
33.01	LTCH site neutral days and discharges	0					33.01

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 15-0047 | Period: From 06/01/2019 To 05/31/2020 | Worksheet S-3 Part I | Date/Time Prepared: 11/2/2020 12:13 pm

	Component	Full Time Equivalents	Discharges				
		Nonpaid Workers	Title V	Title XVIII	Title XIX	Total All Patients	
		11.00	12.00	13.00	14.00	15.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)		0	549	1,357	3,305	1.00
2.00	HMO and other (see instructions)			436	0		2.00
3.00	HMO IPF Subprovider				0		3.00
4.00	HMO IRF Subprovider				0		4.00
5.00	Hospital Adults & Peds. Swing Bed SNF						5.00
6.00	Hospital Adults & Peds. Swing Bed NF						6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)						7.00
8.00	INTENSIVE CARE UNIT						8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY						13.00
14.00	Total (see instructions)	0.00	0	549	1,357	3,305	14.00
15.00	CAH visits						15.00
16.00	SUBPROVIDER - IPF	0.00	0	163	28	321	16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY	0.00					19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)						24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0.00					26.25
27.00	Total (sum of lines 14-26)	0.00					27.00
28.00	Observation Bed Days						28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)						32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00	LTCH non-covered days			0			33.00
33.01	LTCH site neutral days and discharges			0			33.01

HOSPITAL WAGE INDEX INFORMATION | Provider CCN: 15-0047 | Period: From 06/01/2019 To 05/31/2020 | Worksheet S-3 Part II | Date/Time Prepared: 11/2/2020 12:13 pm

		Wkst. A Line Number	Amount Reported	Reclassification of Salaries (from Wkst. A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
	PART II - WAGE DATA							
	SALARIES							
1.00	Total salaries (see instructions)	200.00	25,390,477	0	25,390,477	813,646.00	31.21	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	0	0	0.00	0.00	7.00
7.01	Contracted interns and residents (in an approved programs)		0	0	0	0.00	0.00	7.01
8.00	Home office and/or related organization personnel		0	0	0	0.00	0.00	8.00
9.00	SNF	44.00	975,088	0	975,088	28,184.00	34.60	9.00
10.00	Excluded area salaries (see instructions)		1,110,146	0	1,110,146	40,767.00	27.23	10.00
	OTHER WAGES & RELATED COSTS							
11.00	Contract labor: Direct Patient Care		1,342,031	0	1,342,031	17,281.00	77.66	11.00
12.00	Contract labor: Top level management and other management and administrative services		43,269	0	43,269	437.00	99.01	12.00
13.00	Contract labor: Physician-Part A - Administrative		2,238,534	0	2,238,534	32,185.00	69.55	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		2,993,214	0	2,993,214	93,062.00	32.16	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)		5,836,446	0	5,836,446			17.00
18.00	Wage-related costs (other) (see instructions)							18.00
19.00	Excluded areas		543,448	0	543,448			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)		0	0	0			25.00
25.50	Home office wage-related (core)		655,099	0	655,099			25.50
25.51	Related organization wage-related (core)		0	0	0			25.51
25.52	Home office: Physician Part A - Administrative - wage-related (core)		0	0	0			25.52

HOSPITAL WAGE INDEX INFORMATION | Provider CCN: 15-0047 | Period: From 06/01/2019 To 05/31/2020 | Worksheet S-3 Part II | Date/Time Prepared: 11/2/2020 12:13 pm

		Wkst. A Line Number	Amount Reported	Reclassification of Salaries (from Wkst. A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
25.53	Home office: Physicians Part A - Teaching - wage-related (core)		0	0	0			25.53
	OVERHEAD COSTS - DIRECT SALARIES							
26.00	Employee Benefits Department	4.00	309,370	0	309,370	8,230.00	37.59	26.00
27.00	Administrative & General	5.00	3,382,580	0	3,382,580	110,735.00	30.55	27.00
28.00	Administrative & General under contract (see inst.)		120,850	0	120,850	268.00	450.93	28.00
29.00	Maintenance & Repairs	6.00	0	0	0	0.00	0.00	29.00
30.00	Operation of Plant	7.00	1,001,753	0	1,001,753	41,647.00	24.05	30.00
31.00	Laundry & Linen Service	8.00	0	0	0	0.00	0.00	31.00
32.00	Housekeeping	9.00	521,761	0	521,761	33,707.00	15.48	32.00
33.00	Housekeeping under contract (see instructions)		0	0	0	0.00	0.00	33.00
34.00	Dietary	10.00	0	0	0	0.00	0.00	34.00
35.00	Dietary under contract (see instructions)		710,141	0	710,141	36,612.00	19.40	35.00
36.00	Cafeteria	11.00	0	0	0	0.00	0.00	36.00
37.00	Maintenance of Personnel	12.00	0	0	0	0.00	0.00	37.00
38.00	Nursing Administration	13.00	1,359,730	0	1,359,730	35,340.00	38.48	38.00
39.00	Central Services and Supply	14.00	237,502	0	237,502	13,205.00	17.99	39.00
40.00	Pharmacy	15.00	1,353,575	0	1,353,575	29,105.00	46.51	40.00
41.00	Medical Records & Medical Records Library	16.00	166,562	0	166,562	7,241.00	23.00	41.00
42.00	Social Service	17.00	682,536	0	682,536	18,744.00	36.41	42.00
43.00	Other General Service	18.00	0	0	0	0.00	0.00	43.00

HOSPITAL WAGE INDEX INFORMATION | Provider CCN: 15-0047 | Period: From 06/01/2019 To 05/31/2020 | Worksheet S-3 Part III Date/Time Prepared: 11/2/2020 12:13 pm

		Worksheet A Line Number	Amount Reported	Reclassification of Salaries (from Worksheet A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
	PART III - HOSPITAL WAGE INDEX SUMMARY							
1.00	Net salaries (see instructions)		26,221,468	0	26,221,468	850,526.00	30.83	1.00
2.00	Excluded area salaries (see instructions)		2,085,234	0	2,085,234	68,951.00	30.24	2.00
3.00	Subtotal salaries (line 1 minus line 2)		24,136,234	0	24,136,234	781,575.00	30.88	3.00
4.00	Subtotal other wages & related costs (see inst.)		6,617,048	0	6,617,048	142,965.00	46.28	4.00
5.00	Subtotal wage-related costs (see inst.)		6,491,545	0	6,491,545	0.00	26.90	5.00
6.00	Total (sum of lines 3 thru 5)		37,244,827	0	37,244,827	924,540.00	40.28	6.00
7.00	Total overhead cost (see instructions)		9,846,360	0	9,846,360	334,834.00	29.41	7.00

HOSPITAL WAGE RELATED COSTS | Provider CCN: 15-0047 | Period: From 06/01/2019 To 05/31/2020 | Worksheet S-3 Part IV | Date/Time Prepared: 11/2/2020 12:13 pm

		Amount Reported	
		1.00	
	PART IV - WAGE RELATED COSTS		
	Part A - Core List		
	RETIREMENT COST		
1.00	401K Employer Contributions	504,281	1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution	0	2.00
3.00	Nonqualified Defined Benefit Plan Cost (see instructions)	0	3.00
4.00	Qualified Defined Benefit Plan Cost (see instructions)	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)	3,622,734	8.02
8.03	Health Insurance (Purchased)	0	8.03
9.00	Prescription Drug Plan	0	9.00
10.00	Dental, Hearing and Vision Plan	11,557	10.00
11.00	Life Insurance (If employee is owner or beneficiary)	18,948	11.00
12.00	Accident Insurance (If employee is owner or beneficiary)	-2,829	12.00
13.00	Disability Insurance (If employee is owner or beneficiary)	6,074	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)	0	14.00
15.00	'Workers' Compensation Insurance	330,632	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	1,486,249	17.00
18.00	Medicare Taxes - Employers Portion Only	347,590	18.00
19.00	Unemployment Insurance	0	19.00
20.00	State or Federal Unemployment Taxes	54,658	20.00
	OTHER		
21.00	Executive Deferred Compensation (Other Than Retirement Cost Reported on lines 1 through 4 above. (see instructions))	0	21.00
22.00	Day Care Cost and Allowances	0	22.00
23.00	Tuition Reimbursement	0	23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)	6,379,894	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: 15-0047 | Period: From 06/01/2019 To 05/31/2020 | Worksheet S-3 Part V | Date/Time Prepared: 11/2/2020 12:13 pm

	Cost Center Description	Contract Labor	Benefit Cost	
		1.00	2.00	
	PART V - Contract Labor and Benefit Cost			
	Hospital and Hospital-Based Component Identification:			
1.00	Total facility's contract labor and benefit cost	1,342,031	6,379,894	1.00
2.00	Hospital	1,342,031	6,379,894	2.00
3.00	Subprovider - IPF	0	0	3.00
4.00	Subprovider - IRF			4.00
5.00	Subprovider - (Other)	0	0	5.00
6.00	Swing Beds - SNF	0	0	6.00
7.00	Swing Beds - NF	0	0	7.00
8.00	Hospital-Based SNF	0	0	8.00
9.00	Hospital-Based NF			9.00
10.00	Hospital-Based OLTC			10.00
11.00	Hospital-Based HHA			11.00
12.00	Separately Certified ASC			12.00
13.00	Hospital-Based Hospice			13.00
14.00	Hospital-Based Health Clinic RHC			14.00
15.00	Hospital-Based Health Clinic FQHC			15.00
16.00	Hospital-Based-CMHC			16.00
17.00	Renal Dialysis	0	0	17.00
18.00	Other	0	0	18.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA | Provider CCN: 15-0047 | Period: From 06/01/2019 To 05/31/2020 | Worksheet S-10 | Date/Time Prepared: 11/2/2020 12:13 pm

		1.00	
	Uncompensated and indigent care cost computation		
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided by line 202 column 8)	0.211236	1.00
	Medicaid (see instructions for each line)		
2.00	Net revenue from Medicaid	16,475,602	2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?	Y	3.00
4.00	If line 3 is yes, does line 2 include all DSH and/or supplemental payments from Medicaid?	N	4.00
5.00	If line 4 is no, then enter DSH and/or supplemental payments from Medicaid	1,466,941	5.00
6.00	Medicaid charges	111,574,202	6.00
7.00	Medicaid cost (line 1 times line 6)	23,568,488	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)	5,625,945	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)	5,625,945	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)	13,369,365	0	13,369,365	20.00
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	2,824,091	0	2,824,091	21.00
22.00	Payments received from patients for amounts previously written off as charity care	4,555	0	4,555	22.00
23.00	Cost of charity care (line 21 minus line 22)	2,819,536	0	2,819,536	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)	7,961,818	26.00
27.00	Medicare reimbursable bad debts for the entire hospital complex (see instructions)	245,577	27.00
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)	377,810	27.01
28.00	Non-Medicare bad debt expense (see instructions)	7,584,008	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)	1,734,249	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)	4,553,785	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	10,179,730	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 15-0047 | Period: From 06/01/2019 To 05/31/2020 | Worksheet A | Date/Time Prepared: 11/2/2020 12:13 pm

		Cost Center Description	Salaries	Other	Total (col. 1 + col. 2)	Reclassifications (See A-6)	Reclassified Trial Balance (col. 3 +- col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT		5,563,833	5,563,833	1,499,053	7,062,886	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		3,960,554	3,960,554	909,398	4,869,952	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	309,370	93,614	402,984	4,489,106	4,892,090	4.00
5.01	00590	REVENUE CYCLE	1,430,260	4,675,438	6,105,698	-227,725	5,877,973	5.01
5.02	00560	PURCHASING RECEIVING AND STORES	29,673	136,825	166,498	0	166,498	5.02
5.03	00591	ADMINISTRATIVE AND GENERAL	1,922,647	19,954,128	21,876,775	-5,914,786	15,961,989	5.03
7.00	00700	OPERATION OF PLANT	1,001,753	2,702,756	3,704,509	815,288	4,519,797	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	246,873	246,873	0	246,873	8.00
9.00	00900	HOUSEKEEPING	521,761	292,657	814,418	-771	813,647	9.00
10.00	01000	DIETARY	0	1,801,133	1,801,133	-670,369	1,130,764	10.00
11.00	01100	CAFETERIA	0	0	0	669,049	669,049	11.00
13.00	01300	NURSING ADMINISTRATION	1,359,730	373,200	1,732,930	-462	1,732,468	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	237,502	2,466,433	2,703,935	-2,200,816	503,119	14.00
15.00	01500	PHARMACY	1,353,575	2,273,971	3,627,546	-1,747,521	1,880,025	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	166,562	331,980	498,542	-1	498,541	16.00
17.00	01700	SOCIAL SERVICE	682,536	71,295	753,831	-315	753,516	17.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	98,791	98,791	0	98,791	22.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	4,690,867	2,723,305	7,414,172	-4,238	7,409,934	30.00
33.00	03300	BURN INTENSIVE CARE UNIT	1,816,445	1,844,191	3,660,636	-1,900	3,658,736	33.00
40.00	04000	SUBPROVIDER - IPF	1,110,146	865,126	1,975,272	0	1,975,272	40.00
44.00	04400	SKILLED NURSING FACILITY	975,088	159,212	1,134,300	-5	1,134,295	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	555,445	645,403	1,200,848	108,499	1,309,347	50.00
51.00	05100	RECOVERY ROOM	130,066	86,005	216,071	0	216,071	51.00
53.00	05300	ANESTHESIOLOGY	0	1,232,380	1,232,380	0	1,232,380	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	907,235	915,076	1,822,311	174,790	1,997,101	54.00
54.01	03630	ULTRA SOUND	290,112	54,728	344,840	-344,840	0	54.01
56.00	05600	RADIOISOTOPE	87,322	124,173	211,495	-211,495	0	56.00
57.00	05700	CT SCAN	202,483	59,682	262,165	-262,165	0	57.00
59.00	05900	CARDIAC CATHETERIZATION	600,381	1,286,927	1,887,308	-439,719	1,447,589	59.00
60.00	06000	LABORATORY	1,531,475	968,149	2,499,624	-116,224	2,383,400	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	100,328	100,328	-1,560	98,768	62.00
65.00	06500	RESPIRATORY THERAPY	596,434	119,602	716,036	-13,408	702,628	65.00
66.00	06600	PHYSICAL THERAPY	316,356	29,958	346,314	0	346,314	66.00
67.00	06700	OCCUPATIONAL THERAPY	237,357	19,016	256,373	0	256,373	67.00
68.00	06800	SPEECH PATHOLOGY	14,430	6,527	20,957	0	20,957	68.00
69.00	06900	ELECTROCARDIOLOGY	81,019	8,734	89,753	0	89,753	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	785,904	785,904	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	1,236,582	1,236,582	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	1,475,741	1,475,741	73.00
74.00	07400	RENAL DIALYSIS	0	228,336	228,336	0	228,336	74.00
76.00	03950	MISC ANCILLARY	0	0	0	0	0	76.00
76.01	03951	SLEEP LAB	0	0	0	0	0	76.01
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0	0	0	0	76.02
76.03	03952	WOUND CARE	571,316	295,306	866,622	-2,102	864,520	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	76,106	6,077	82,183	0	82,183	90.00
91.00	09100	EMERGENCY	1,585,025	1,395,938	2,980,963	-2,988	2,977,975	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	25,390,477	58,217,660	83,608,137	0	83,608,137	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	1,758	1,758	0	1,758	192.00
194.00	07950	MEALS ON WHEELS	0	0	0	0	0	194.00
200.00		TOTAL (SUM OF LINES 118 through 199)	25,390,477	58,219,418	83,609,895	0	83,609,895	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 15-0047 | Period: From 06/01/2019 To 05/31/2020 | Worksheet A | Date/Time Prepared: 11/2/2020 12:13 pm

		Cost Center Description	Adjustments (See A-8)	Net Expenses For Allocation		
			6.00	7.00		
		GENERAL SERVICE COST CENTERS				
1.00	00100	CAP REL COSTS-BLDG & FIXT	-1,515,600	5,547,286		1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	959,531	5,829,483		2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-4,562	4,887,528		4.00
5.01	00590	REVENUE CYCLE	29,430	5,907,403		5.01
5.02	00560	PURCHASING RECEIVING AND STORES	0	166,498		5.02
5.03	00591	ADMINISTRATIVE AND GENERAL	-2,332,013	13,629,976		5.03
7.00	00700	OPERATION OF PLANT	-35,005	4,484,792		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	-112,739	134,134		8.00
9.00	00900	HOUSEKEEPING	0	813,647		9.00
10.00	01000	DIETARY	0	1,130,764		10.00
11.00	01100	CAFETERIA	0	669,049		11.00
13.00	01300	NURSING ADMINISTRATION	-4,262	1,728,206		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	503,119		14.00
15.00	01500	PHARMACY	0	1,880,025		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-53	498,488		16.00
17.00	01700	SOCIAL SERVICE	0	753,516		17.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	98,791		22.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	-892,040	6,517,894		30.00
33.00	03300	BURN INTENSIVE CARE UNIT	-1,427,430	2,231,306		33.00
40.00	04000	SUBPROVIDER - IPF	-534,043	1,441,229		40.00
44.00	04400	SKILLED NURSING FACILITY	0	1,134,295		44.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	-355,000	954,347		50.00
51.00	05100	RECOVERY ROOM	0	216,071		51.00
53.00	05300	ANESTHESIOLOGY	0	1,232,380		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	1,997,101		54.00
54.01	03630	ULTRA SOUND	0	0		54.01
56.00	05600	RADIOISOTOPE	0	0		56.00
57.00	05700	CT SCAN	0	0		57.00
59.00	05900	CARDIAC CATHETERIZATION	-38,076	1,409,513		59.00
60.00	06000	LABORATORY	0	2,383,400		60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	98,768		62.00
65.00	06500	RESPIRATORY THERAPY	0	702,628		65.00
66.00	06600	PHYSICAL THERAPY	0	346,314		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	256,373		67.00
68.00	06800	SPEECH PATHOLOGY	0	20,957		68.00
69.00	06900	ELECTROCARDIOLOGY	0	89,753		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	785,904		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	1,236,582		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	1,475,741		73.00
74.00	07400	RENAL DIALYSIS	0	228,336		74.00
76.00	03950	MISC ANCILLARY	0	0		76.00
76.01	03951	SLEEP LAB	0	0		76.01
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0		76.02
76.03	03952	WOUND CARE	-12,000	852,520		76.03
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0	82,183		90.00
91.00	09100	EMERGENCY	-596,196	2,381,779		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				92.00
		SPECIAL PURPOSE COST CENTERS				
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-6,870,058	76,738,079		118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	1,758		192.00
194.00	07950	MEALS ON WHEELS	0	0		194.00
200.00		TOTAL (SUM OF LINES 118 through 199)	-6,870,058	76,739,837		200.00

RECLASSIFICATIONS | Provider CCN: 15-0047 | Period: From 06/01/2019 To 05/31/2020 | Worksheet A-6 | Date/Time Prepared: 11/2/2020 12:13 pm

		Increases				
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
	A - EMPLOYEE BENEFITS					
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	4,489,359		1.00
2.00		0.00	0	0		2.00
3.00		0.00	0	0		3.00
	0		0	4,489,359		
	C - LEASE AND RENTAL					
1.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	899,432		1.00
2.00	CAP REL COSTS-BLDG & FIXT	1.00	0	107,610		2.00
3.00		0.00	0	0		3.00
4.00		0.00	0	0		4.00
5.00		0.00	0	0		5.00
6.00		0.00	0	0		6.00
7.00		0.00	0	0		7.00
8.00		0.00	0	0		8.00
9.00		0.00	0	0		9.00
10.00		0.00	0	0		10.00
11.00		0.00	0	0		11.00
12.00		0.00	0	0		12.00
13.00		0.00	0	0		13.00
14.00		0.00	0	0		14.00
	0		0	1,007,042		
	D - OTHER CAPITAL COSTS					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	166,496		1.00
2.00	CAP REL COSTS-BLDG & FIXT	1.00	0	1,224,947		2.00
3.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	9,966		3.00
	0		0	1,401,409		
	E - REPAIRS & MAINTENANCE					
1.00	OPERATION OF PLANT	7.00	0	762,899		1.00
2.00		0.00	0	0		2.00
3.00		0.00	0	0		3.00
4.00		0.00	0	0		4.00
5.00		0.00	0	0		5.00
6.00		0.00	0	0		6.00
7.00		0.00	0	0		7.00
8.00		0.00	0	0		8.00
9.00		0.00	0	0		9.00
10.00		0.00	0	0		10.00
11.00		0.00	0	0		11.00
12.00		0.00	0	0		12.00
13.00		0.00	0	0		13.00
14.00		0.00	0	0		14.00
15.00		0.00	0	0		15.00
16.00		0.00	0	0		16.00
17.00		0.00	0	0		17.00
18.00		0.00	0	0		18.00
19.00		0.00	0	0		19.00
	0		0	762,899		
	G - MEDICAL SUPPLIES					
1.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	785,904		1.00
2.00	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	1,236,582		2.00
3.00	OPERATING ROOM	50.00	0	132,285		3.00
	0		0	2,154,771		
	H - DRUGS AND IV COSTS					
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	1,475,741		1.00
	0		0	1,475,741		
	J - RADIOLOGY					
1.00	RADIOLOGY-DIAGNOSTIC	54.00	579,917	158,270		1.00
2.00		0.00	0	0		2.00
3.00		0.00	0	0		3.00
	0		579,917	158,270		
	K - DIETARY					
1.00	CAFETERIA	11.00	0	669,049		1.00
	0		0	669,049		
	M - UTILITIES RECLASS					
1.00	OPERATION OF PLANT	7.00	0	52,854		1.00
2.00		0.00	0	0		2.00
3.00		0.00	0	0		3.00
	0		0	52,854		
500.00	Grand Total: Increases		579,917	12,171,394		500.00

RECLASSIFICATIONS | Provider CCN: 15-0047 | Period: From 06/01/2019 To 05/31/2020 | Worksheet A-6 | Date/Time Prepared: 11/2/2020 12:13 pm

		Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	A - EMPLOYEE BENEFITS						
1.00	ADMINISTRATIVE AND GENERAL	5.03	0	4,489,116	0		1.00
2.00	REVENUE CYCLE	5.01	0	23	0		2.00
3.00	SOCIAL SERVICE	17.00	0	220	0		3.00
	0		0	4,489,359			
	C - LEASE AND RENTAL						
1.00	ADMINISTRATIVE AND GENERAL	5.03	0	14,067	10		1.00
2.00	OPERATION OF PLANT	7.00	0	465	10		2.00
3.00	DIETARY	10.00	0	1,320	0		3.00
4.00	NURSING ADMINISTRATION	13.00	0	338	0		4.00
5.00	PHARMACY	15.00	0	271,780	0		5.00
6.00	ADULTS & PEDIATRICS	30.00	0	173	0		6.00
7.00	RADIOLOGY-DIAGNOSTIC	54.00	0	342,476	0		7.00
8.00	LABORATORY	60.00	0	90,107	0		8.00
9.00	MEDICAL RECORDS & LIBRARY	16.00	0	1	0		9.00
10.00	WOUND CARE	76.03	0	115	0		10.00
11.00	REVENUE CYCLE	5.01	0	929	0		11.00
12.00	CENTRAL SERVICES & SUPPLY	14.00	0	283,458	0		12.00
13.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	253	0		13.00
14.00	WHOLE BLOOD & PACKED RED BLOOD CELL	62.00	0	1,560	0		14.00
	0		0	1,007,042			
	D - OTHER CAPITAL COSTS						
1.00	ADMINISTRATIVE AND GENERAL	5.03	0	1,401,409	12		1.00
2.00		0.00	0	0	13		2.00
3.00		0.00	0	0	12		3.00
	0		0	1,401,409			
	E - REPAIRS & MAINTENANCE						
1.00	CARDIAC CATHETERIZATION	59.00	0	90,501	0		1.00
2.00	REVENUE CYCLE	5.01	0	211,459	0		2.00
3.00	ADMINISTRATIVE AND GENERAL	5.03	0	5,337	0		3.00
4.00	HOUSEKEEPING	9.00	0	771	0		4.00
5.00	NURSING ADMINISTRATION	13.00	0	124	0		5.00
6.00	CENTRAL SERVICES & SUPPLY	14.00	0	113,896	0		6.00
7.00	ADULTS & PEDIATRICS	30.00	0	4,065	0		7.00
8.00	SKILLED NURSING FACILITY	44.00	0	5	0		8.00
9.00	OPERATING ROOM	50.00	0	23,786	0		9.00
10.00	RADIOLOGY-DIAGNOSTIC	54.00	0	188,238	0		10.00
11.00	ULTRA SOUND	54.01	0	22,741	0		11.00
12.00	RADIOISOTOPE	56.00	0	23,472	0		12.00
13.00	CT SCAN	57.00	0	34,100	0		13.00
14.00	LABORATORY	60.00	0	26,117	0		14.00
15.00	RESPIRATORY THERAPY	65.00	0	11,317	0		15.00
16.00	SOCIAL SERVICE	17.00	0	95	0		16.00
17.00	BURN INTENSIVE CARE UNIT	33.00	0	1,900	0		17.00
18.00	WOUND CARE	76.03	0	1,987	0		18.00
19.00	EMERGENCY	91.00	0	2,988	0		19.00
	0		0	762,899			
	G - MEDICAL SUPPLIES						
1.00	CENTRAL SERVICES & SUPPLY	14.00	0	1,803,462	0		1.00
2.00	RESPIRATORY THERAPY	65.00	0	2,091	0		2.00
3.00	CARDIAC CATHETERIZATION	59.00	0	349,218	0		3.00
	0		0	2,154,771			
	H - DRUGS AND IV COSTS						
1.00	PHARMACY	15.00	0	1,475,741	0		1.00
	0		0	1,475,741			
	J - RADIOLOGY						
1.00	ULTRA SOUND	54.01	290,112	31,987	0		1.00
2.00	RADIOISOTOPE	56.00	87,322	100,701	0		2.00
3.00	CT SCAN	57.00	202,483	25,582	0		3.00
	0		579,917	158,270			
	K - DIETARY						
1.00	DIETARY	10.00	0	669,049	0		1.00
	0		0	669,049			
	M - UTILITIES RECLASS						
1.00	ADMINISTRATIVE AND GENERAL	5.03	0	4,857	0		1.00
2.00	RADIOLOGY-DIAGNOSTIC	54.00	0	32,683	0		2.00
3.00	REVENUE CYCLE	5.01	0	15,314	0		3.00
	0		0	52,854			
500.00	Grand Total: Decreases		579,917	12,171,394			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-0047 | Period: From 06/01/2019 To 05/31/2020 | Worksheet A-7 Part I | Date/Time Prepared: 11/2/2020 12:13 pm

		Beginning Balances	Acquisitions			Disposals and Retirements	
			Purchases	Donation	Total		
		1.00	2.00	3.00	4.00	5.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	9,348,028	0	0	0	0	1.00
2.00	Land Improvements	1,775,835	0	0	0	0	2.00
3.00	Buildings and Fixtures	28,559,649	24,595	0	24,595	0	3.00
4.00	Building Improvements	31,494,835	482,827	0	482,827	35,113	4.00
5.00	Fixed Equipment	18,720,883	0	0	0	147,991	5.00
6.00	Movable Equipment	53,562,600	17,455,710	0	17,455,710	1,602,727	6.00
7.00	HIT designated Assets	2,833,813	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	146,295,643	17,963,132	0	17,963,132	1,785,831	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	146,295,643	17,963,132	0	17,963,132	1,785,831	10.00

		Ending Balance	Fully Depreciated Assets	
		6.00	7.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES			
1.00	Land	9,348,028	0	1.00
2.00	Land Improvements	1,775,835	0	2.00
3.00	Buildings and Fixtures	28,584,244	0	3.00
4.00	Building Improvements	31,942,549	0	4.00
5.00	Fixed Equipment	18,572,892	0	5.00
6.00	Movable Equipment	69,415,583	0	6.00
7.00	HIT designated Assets	2,833,813	0	7.00
8.00	Subtotal (sum of lines 1-7)	162,472,944	0	8.00
9.00	Reconciling Items	0	0	9.00
10.00	Total (line 8 minus line 9)	162,472,944	0	10.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-0047 | Period: From 06/01/2019 To 05/31/2020 | Worksheet A-7 Part II | Date/Time Prepared: 11/2/2020 12:13 pm

	Cost Center Description	SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	CAP REL COSTS-BLDG & FIXT	5,563,833	0	0	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	3,960,554	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	9,524,387	0	0	0	0	3.00

	Cost Center Description	SUMMARY OF CAPITAL			
		Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)		
		14.00	15.00		
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2				
1.00	CAP REL COSTS-BLDG & FIXT	0	5,563,833		1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	3,960,554		2.00
3.00	Total (sum of lines 1-2)	0	9,524,387		3.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-0047 | Period: From 06/01/2019 To 05/31/2020 | Worksheet A-7 Part III Date/Time Prepared: 11/2/2020 12:13 pm

	Cost Center Description	COMPUTATION OF RATIOS: Gross Assets	COMPUTATION OF RATIOS: Capitalized Leases	COMPUTATION OF RATIOS: Gross Assets for Ratio (col. 1 - col. 2)	ALLOCATION OF OTHER CAPITAL: Ratio (see instructions)	ALLOCATION OF OTHER CAPITAL: Insurance	
		1.00	2.00	3.00	4.00	5.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	71,650,656	0	71,650,656	0.441001	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	90,822,288	0	90,822,288	0.558999	0	2.00
3.00	Total (sum of lines 1-2)	162,472,944	0	162,472,944	1.000000	0	3.00

	Cost Center Description	ALLOCATION OF OTHER CAPITAL: Taxes	ALLOCATION OF OTHER CAPITAL: Other Capital-Related Costs	ALLOCATION OF OTHER CAPITAL: Total (sum of cols. 5 through 7)	SUMMARY OF CAPITAL: Depreciation	SUMMARY OF CAPITAL: Lease	
		6.00	7.00	8.00	9.00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	2,980,512	107,610	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	4,936,721	882,796	2.00
3.00	Total (sum of lines 1-2)	0	0	0	7,917,233	990,406	3.00

	Cost Center Description	SUMMARY OF CAPITAL: Interest	SUMMARY OF CAPITAL: Insurance (see instructions)	SUMMARY OF CAPITAL: Taxes (see instructions)	SUMMARY OF CAPITAL: Other Capital-Related Costs (see instructions)	SUMMARY OF CAPITAL: Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	1,067,721	166,496	1,224,947	0	5,547,286	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	9,966	0	0	5,829,483	2.00
3.00	Total (sum of lines 1-2)	1,067,721	176,462	1,224,947	0	11,376,769	3.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 15-0047 | Period: From 06/01/2019 To 05/31/2020 | Worksheet A-8 | Date/Time Prepared: 11/2/2020 12:13 pm

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
1.00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)		0	CAP REL COSTS-BLDG & FIXT	1.00	0	1.00
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
3.00	Investment income - other (chapter 2)		0		0.00	0	3.00
4.00	Trade, quantity, and time discounts (chapter 8)		0		0.00	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)		0		0.00	0	5.00
6.00	Rental of provider space by suppliers (chapter 8)		0		0.00	0	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)	A	-4,685	ADMINISTRATIVE AND GENERAL	5.03	0	7.00
8.00	Television and radio service (chapter 21)	A	-35,005	OPERATION OF PLANT	7.00	0	8.00
9.00	Parking lot (chapter 21)		0		0.00	0	9.00
10.00	Provider-based physician adjustment	A-8-2	-4,635,638			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	170,301			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests		0		0.00	0	14.00
15.00	Rental of quarters to employee and others		0		0.00	0	15.00
16.00	Sale of medical and surgical supplies to other than patients		0		0.00	0	16.00
17.00	Sale of drugs to other than patients		0		0.00	0	17.00
18.00	Sale of medical records and abstracts	B	-53	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	-536	ADMINISTRATIVE AND GENERAL	5.03	0	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	0	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	RESPIRATORY THERAPY	65.00		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	PHYSICAL THERAPY	66.00		24.00
25.00	Utilization review - physicians' compensation (chapter 21)		0	*** Cost Center Deleted ***	114.00		25.00
26.00	Depreciation - CAP REL COSTS-BLDG & FIXT	A	-2,687,545	CAP REL COSTS-BLDG & FIXT	1.00	9	26.00
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP	A	880,667	CAP REL COSTS-MVBLE EQUIP	2.00	9	27.00
28.00	Non-physician Anesthetist		0	*** Cost Center Deleted ***	19.00		28.00
29.00	Physicians' assistant		0		0.00	0	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	OCCUPATIONAL THERAPY	67.00		30.00
30.99	Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS	30.00		30.99
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	SPEECH PATHOLOGY	68.00		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest		0		0.00	0	32.00
33.00	PARKING GARAGE & MISC INCOME	B	-110,368	ADMINISTRATIVE AND GENERAL	5.03	0	33.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 15-0047 | Period: From 06/01/2019 To 05/31/2020 | Worksheet A-8 | Date/Time Prepared: 11/2/2020 12:13 pm

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
33.01	MARKETING & RECRUITING EXPENSE	A	-198,820	ADMINISTRATIVE AND GENERAL	5.03	0	33.01
33.02	PENALTIES	A	-3,750	ADMINISTRATIVE AND GENERAL	5.03	0	33.02
33.03	FITNESS REVENUE	B	-70	ADMINISTRATIVE AND GENERAL	5.03	0	33.03
33.04	SENIOR CIRCLE	A	-2,311	ADMINISTRATIVE AND GENERAL	5.03	0	33.04
33.06	PATIENT PHONE WAGE COSTS	A	-18,155	ADMINISTRATIVE AND GENERAL	5.03	0	33.06
33.07	PATIENT PHONES BENEFITS	A	-4,562	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.07
33.08	PATIENT PHONE DEPRECIATION COST	A	-232	CAP REL COSTS-MVBLE EQUIP	2.00	9	33.08
33.09	PATIENT TV DEPRECIATION	A	-2,290	CAP REL COSTS-MVBLE EQUIP	2.00	9	33.09
33.12	LOBBYING EXPENSE IN DUES	A	-934	ADMINISTRATIVE AND GENERAL	5.03	0	33.12
33.13	CHARITABLE CONTRIBUTIONS	A	-88,057	ADMINISTRATIVE AND GENERAL	5.03	0	33.13
33.15	IMPUTED RENT	A	-17,160	CAP REL COSTS-MVBLE EQUIP	2.00	10	33.15
33.16	NONALLOWABLE LEGAL EXPENSES	A	-110,855	ADMINISTRATIVE AND GENERAL	5.03	0	33.16
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-6,870,058				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: 15-0047 | Period: From 06/01/2019 To 05/31/2020 | Worksheet A-8-1 | Date/Time Prepared: 11/2/2020 12:13 pm

	Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in Wks. A, column 5	
	1.00	2.00	3.00	4.00	5.00	
	A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:					
1.00	1.00	CAP REL COSTS-BLDG & FIXT	CAPITAL-RELATED INTEREST	1,067,721	0	1.00
2.00	1.00	CAP REL COSTS-BLDG & FIXT	PASI CAPITAL COSTS - BLDG &	14,964	0	2.00
3.00	2.00	CAP REL COSTS-MVBLE EQUIP	PASI CAPITAL COSTS - MOVEABL	1,856	0	3.00
4.00	5.01	REVENUE CYCLE	PASI OPERATING COSTS	420,761	0	4.00
4.01	5.03	ADMINISTRATIVE AND GENERAL	SHARED SERVICE CENTER ALLOCA	1,500,913	1,131,763	4.01
4.02	1.00	CAP REL COSTS-BLDG & FIXT	NEW CAPITAL - BUILDING & FIX	89,260	0	4.02
4.03	2.00	CAP REL COSTS-MVBLE EQUIP	NEW CAPITAL - MOVABLE EQUIPM	96,166	0	4.03
4.04	5.03	ADMINISTRATIVE AND GENERAL	NON-CAPITAL HOME OFFICE COST	2,719,118	0	4.04
4.05	5.03	ADMINISTRATIVE AND GENERAL	MALPRACTICE COSTS	440,785	695,745	4.05
4.06	2.00	CAP REL COSTS-MVBLE EQUIP	CIG LEASED EQUIPMENT	272,886	272,362	4.06
4.07	5.03	ADMINISTRATIVE AND GENERAL	MANAGEMENT FEES	0	2,549,103	4.07
4.08	5.03	ADMINISTRATIVE AND GENERAL	401K FEES	0	6,057	4.08
4.09	5.03	ADMINISTRATIVE AND GENERAL	AUDIT FEES	0	47,017	4.09
4.10	5.03	ADMINISTRATIVE AND GENERAL	CORPORATE OVERHEAD ALLOCATIO	0	995,254	4.10
4.11	5.03	ADMINISTRATIVE AND GENERAL	HIIM ALLOCATION	0	247,014	4.11
4.12	5.01	REVENUE CYCLE	PASI COLLECTION FEES	0	391,331	4.12
4.13	5.03	ADMINISTRATIVE AND GENERAL	PASI LIEN UNIT COLLECTION FE	0	5,744	4.13
4.14	8.00	LAUNDRY & LINEN SERVICE	LAUNDRY & LINEN SERVICE	148,755	261,494	4.14
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.			6,773,185	6,602,884	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.

6.00	B		0.00	CHS, INC	100.00	6.00
7.00	B		0.00	PASI	100.00	7.00
8.00	C		33.00	SHARED LAUNDRY	33.00	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: 15-0047 | Period: From 06/01/2019 To 05/31/2020 | Worksheet A-8-1 | Date/Time Prepared: 11/2/2020 12:13 pm

	Net Adjustments (col. 4 minus col. 5)*	Wkst. A-7 Ref.		
	6.00	7.00		
	A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:			
1.00	1,067,721	11		1.00
2.00	14,964	9		2.00
3.00	1,856	9		3.00
4.00	420,761	0		4.00
4.01	369,150	0		4.01
4.02	89,260	9		4.02
4.03	96,166	9		4.03
4.04	2,719,118	0		4.04
4.05	-254,960	0		4.05
4.06	524	10		4.06
4.07	-2,549,103	0		4.07
4.08	-6,057	0		4.08
4.09	-47,017	0		4.09
4.10	-995,254	0		4.10
4.11	-247,014	0		4.11
4.12	-391,331	0		4.12
4.13	-5,744	0		4.13
4.14	-112,739	0		4.14
5.00	170,301			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	OWNER		6.00
7.00	DEBT COLLECTION		7.00
8.00	LAUNDRY		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: 15-0047 | Period: From 06/01/2019 To 05/31/2020 | Worksheet A-8-2 | Date/Time Prepared: 11/2/2020 12:13 pm

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	30.00	ADULTS & PEDIATRICS	892,040	892,040	0	0	0	1.00
2.00	33.00	BURN INTENSIVE CARE UNIT	1,427,430	1,427,430	0	0	0	2.00
3.00	5.03	ADMINISTRATIVE AND GENERAL	776,591	776,591	0	0	0	3.00
4.00	50.00	OPERATING ROOM	355,000	355,000	0	0	0	4.00
5.00	13.00	NURSING ADMINISTRATION	4,262	4,262	0	0	0	5.00
6.00	40.00	SUBPROVIDER - IPF	534,043	534,043	0	0	0	6.00
7.00	59.00	CARDIAC CATHETERIZATION	38,076	38,076	0	0	0	7.00
8.00	76.03	WOUND CARE	12,000	12,000	0	0	0	8.00
9.00	91.00	EMERGENCY	596,196	596,196	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			4,635,638	4,635,638	0		0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	30.00	ADULTS & PEDIATRICS	0	0	0	0	0	1.00
2.00	33.00	BURN INTENSIVE CARE UNIT	0	0	0	0	0	2.00
3.00	5.03	ADMINISTRATIVE AND GENERAL	0	0	0	0	0	3.00
4.00	50.00	OPERATING ROOM	0	0	0	0	0	4.00
5.00	13.00	NURSING ADMINISTRATION	0	0	0	0	0	5.00
6.00	40.00	SUBPROVIDER - IPF	0	0	0	0	0	6.00
7.00	59.00	CARDIAC CATHETERIZATION	0	0	0	0	0	7.00
8.00	76.03	WOUND CARE	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			0	0	0	0	0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment		
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00	30.00	ADULTS & PEDIATRICS	0	0	0	892,040		1.00
2.00	33.00	BURN INTENSIVE CARE UNIT	0	0	0	1,427,430		2.00
3.00	5.03	ADMINISTRATIVE AND GENERAL	0	0	0	776,591		3.00
4.00	50.00	OPERATING ROOM	0	0	0	355,000		4.00
5.00	13.00	NURSING ADMINISTRATION	0	0	0	4,262		5.00
6.00	40.00	SUBPROVIDER - IPF	0	0	0	534,043		6.00
7.00	59.00	CARDIAC CATHETERIZATION	0	0	0	38,076		7.00
8.00	76.03	WOUND CARE	0	0	0	12,000		8.00
9.00	91.00	EMERGENCY	0	0	0	596,196		9.00
10.00	0.00		0	0	0	0		10.00
200.00			0	0	0	4,635,638		200.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-0047 | Period: From 06/01/2019 To 05/31/2020 | Worksheet B Part I | Date/Time Prepared: 11/2/2020 12:13 pm

		Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS BLDG & FIXT	CAPITAL RELATED COSTS MVBLE EQUIP	EMPLOYEE BENEFITS DEPARTMENT	REVENUE CYCLE	
			0	1.00	2.00	4.00	5.01	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	5,547,286	5,547,286				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	5,829,483		5,829,483			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	4,887,528	62,787	65,981	5,016,296		4.00
5.01	00590	REVENUE CYCLE	5,907,403	222,714	234,044	286,056	6,650,217	5.01
5.02	00560	PURCHASING RECEIVING AND STORES	166,498	154,685	162,554	5,935	0	5.02
5.03	00591	ADMINISTRATIVE AND GENERAL	13,629,976	120,345	126,467	384,535	0	5.03
7.00	00700	OPERATION OF PLANT	4,484,792	1,537,431	1,615,641	200,354	0	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	134,134	49,295	51,803	0	0	8.00
9.00	00900	HOUSEKEEPING	813,647	746,337	784,304	104,354	0	9.00
10.00	01000	DIETARY	1,130,764	233,145	245,006	0	0	10.00
11.00	01100	CAFETERIA	669,049	0	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	1,728,206	85,419	89,764	271,950	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	503,119	0	0	47,501	0	14.00
15.00	01500	PHARMACY	1,880,025	0	0	270,719	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	498,488	139,704	146,811	33,313	0	16.00
17.00	01700	SOCIAL SERVICE	753,516	0	0	136,509	0	17.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	98,791	0	0	0	0	22.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	6,517,894	539,775	567,234	938,185	614,333	30.00
33.00	03300	BURN INTENSIVE CARE UNIT	2,231,306	93,309	98,055	363,294	229,417	33.00
40.00	04000	SUBPROVIDER - IPF	1,441,229	59,088	62,094	222,033	264,325	40.00
44.00	04400	SKILLED NURSING FACILITY	1,134,295	114,171	119,979	195,021	70,135	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	954,347	228,595	240,224	111,091	448,038	50.00
51.00	05100	RECOVERY ROOM	216,071	85,751	90,114	26,014	33,190	51.00
53.00	05300	ANESTHESIOLOGY	1,232,380	0	0	0	46,907	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,997,101	219,295	230,451	297,435	1,085,024	54.00
54.01	03630	ULTRA SOUND	0	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
59.00	05900	CARDIAC CATHETERIZATION	1,409,513	24,428	25,671	120,078	263,607	59.00
60.00	06000	LABORATORY	2,383,400	187,695	197,243	306,300	825,417	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	98,768	10,285	10,808	0	15,707	62.00
65.00	06500	RESPIRATORY THERAPY	702,628	76,265	80,145	119,289	189,323	65.00
66.00	06600	PHYSICAL THERAPY	346,314	99,096	104,138	63,272	51,753	66.00
67.00	06700	OCCUPATIONAL THERAPY	256,373	37,933	39,863	47,472	49,471	67.00
68.00	06800	SPEECH PATHOLOGY	20,957	14,609	15,352	2,886	2,686	68.00
69.00	06900	ELECTROCARDIOLOGY	89,753	13,904	14,611	16,204	56,988	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	785,904	0	0	0	91,604	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1,236,582	0	0	0	585,403	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,475,741	32,864	34,535	0	881,853	73.00
74.00	07400	RENAL DIALYSIS	228,336	26,743	28,104	0	13,530	74.00
76.00	03950	MISC ANCILLARY	0	0	0	0	0	76.00
76.01	03951	SLEEP LAB	0	0	0	0	0	76.01
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0	0	0	0	76.02
76.03	03952	WOUND CARE	852,520	114,278	120,091	114,265	39,243	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	82,183	28,287	29,726	15,221	3,006	90.00
91.00	09100	EMERGENCY	2,381,779	175,588	184,520	317,010	789,257	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	76,738,079	5,533,821	5,815,333	5,016,296	6,650,217	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	13,465	14,150	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	1,758	0	0	0	0	192.00
194.00	07950	MEALS ON WHEELS	0	0	0	0	0	194.00
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)	76,739,837	5,547,286	5,829,483	5,016,296	6,650,217	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-0047 | Period: From 06/01/2019 To 05/31/2020 | Worksheet B Part I | Date/Time Prepared: 11/2/2020 12:13 pm

		Cost Center Description	PURCHASING RECEIVING AND STORES	Subtotal	ADMINISTRATIVE AND GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	
			5.02	5A.02	5.03	7.00	8.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00590	REVENUE CYCLE						5.01
5.02	00560	PURCHASING RECEIVING AND STORES	489,672					5.02
5.03	00591	ADMINISTRATIVE AND GENERAL	8,062	14,269,385	14,269,385			5.03
7.00	00700	OPERATION OF PLANT	1,230	7,839,448	1,790,671	9,630,119		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	11,036	246,268	56,252	137,627	440,147	8.00
9.00	00900	HOUSEKEEPING	6,136	2,454,778	560,715	2,083,687	0	9.00
10.00	01000	DIETARY	72,605	1,681,520	384,089	650,916	0	10.00
11.00	01100	CAFETERIA	0	669,049	152,823	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	468	2,175,807	496,993	238,480	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	12,192	562,812	128,556	0	0	14.00
15.00	01500	PHARMACY	1,774	2,152,518	491,674	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	64	818,380	186,933	390,037	0	16.00
17.00	01700	SOCIAL SERVICE	11	890,036	203,300	0	0	17.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	98,791	22,566	0	0	22.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	16,554	9,193,975	2,100,080	1,506,991	103,284	30.00
33.00	03300	BURN INTENSIVE CARE UNIT	14,483	3,029,864	692,075	260,507	50,319	33.00
40.00	04000	SUBPROVIDER - IPF	3,026	2,051,795	468,667	164,967	44,360	40.00
44.00	04400	SKILLED NURSING FACILITY	4,976	1,638,577	374,280	318,753	36,024	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	29,758	2,012,053	459,589	638,212	18,447	50.00
51.00	05100	RECOVERY ROOM	0	451,140	103,048	239,408	7,849	51.00
53.00	05300	ANESTHESIOLOGY	5	1,279,292	292,213	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	8,185	3,837,491	876,552	612,246	33,588	54.00
54.01	03630	ULTRA SOUND	0	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
59.00	05900	CARDIAC CATHETERIZATION	15,958	1,859,255	424,687	68,201	22,256	59.00
60.00	06000	LABORATORY	43,035	3,943,090	900,673	524,024	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	8,916	144,484	33,003	28,714	0	62.00
65.00	06500	RESPIRATORY THERAPY	5,672	1,173,322	268,008	212,923	0	65.00
66.00	06600	PHYSICAL THERAPY	286	664,859	151,866	276,666	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	9	431,121	98,476	105,904	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	56,490	12,903	40,787	0	68.00
69.00	06900	ELECTROCARDIOLOGY	231	191,691	43,786	38,818	1,601	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	61,578	939,086	214,504	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	121,198	1,943,183	443,858	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	2,424,993	553,912	91,752	0	73.00
74.00	07400	RENAL DIALYSIS	243	296,956	67,830	74,664	0	74.00
76.00	03950	MISC ANCILLARY	0	0	0	0	0	76.00
76.01	03951	SLEEP LAB	0	0	0	0	0	76.01
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0	0	0	0	76.02
76.03	03952	WOUND CARE	12,455	1,252,852	286,174	319,050	0	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	14	158,437	36,190	78,973	19,282	90.00
91.00	09100	EMERGENCY	29,512	3,877,666	885,729	490,220	103,137	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART		0				92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	489,672	76,710,464	14,262,675	9,592,527	440,147	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	27,615	6,308	37,592	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	1,758	402	0	0	192.00
194.00	07950	MEALS ON WHEELS	0	0	0	0	0	194.00
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)	489,672	76,739,837	14,269,385	9,630,119	440,147	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-0047 | Period: From 06/01/2019 To 05/31/2020 | Worksheet B Part I | Date/Time Prepared: 11/2/2020 12:13 pm

		Cost Center Description	HOUSEKEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	
			9.00	10.00	11.00	13.00	14.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00590	REVENUE CYCLE						5.01
5.02	00560	PURCHASING RECEIVING AND STORES						5.02
5.03	00591	ADMINISTRATIVE AND GENERAL						5.03
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING	5,099,180					9.00
10.00	01000	DIETARY	447,999	3,164,524				10.00
11.00	01100	CAFETERIA	0	0	821,872			11.00
13.00	01300	NURSING ADMINISTRATION	164,136	0	46,897	3,122,313		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	17,528	0	708,896	14.00
15.00	01500	PHARMACY	0	0	38,616	52,567	3,327	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	268,447	0	9,606	0	121	16.00
17.00	01700	SOCIAL SERVICE	0	0	24,870	171,617	21	17.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0	22.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,037,200	1,117,786	213,368	1,113,925	31,049	30.00
33.00	03300	BURN INTENSIVE CARE UNIT	179,297	193,032	63,818	480,826	27,166	33.00
40.00	04000	SUBPROVIDER - IPF	113,540	337,045	54,101	256,614	5,677	40.00
44.00	04400	SKILLED NURSING FACILITY	219,385	377,400	37,402	271,363	9,333	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	439,255	0	19,212	92,812	55,816	50.00
51.00	05100	RECOVERY ROOM	164,775	0	3,699	30,719	0	51.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	10	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	421,384	0	60,698	0	15,353	54.00
54.01	03630	ULTRA SOUND	0	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
59.00	05900	CARDIAC CATHETERIZATION	46,940	0	21,944	71,901	29,932	59.00
60.00	06000	LABORATORY	360,664	0	73,975	0	80,718	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	19,763	0	0	0	16,724	62.00
65.00	06500	RESPIRATORY THERAPY	146,546	0	23,904	0	10,639	65.00
66.00	06600	PHYSICAL THERAPY	190,418	0	11,428	0	536	66.00
67.00	06700	OCCUPATIONAL THERAPY	72,890	0	7,260	0	17	67.00
68.00	06800	SPEECH PATHOLOGY	28,072	0	469	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	26,717	0	2,898	0	433	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	115,499	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	227,327	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	63,149	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	51,388	0	0	0	455	74.00
76.00	03950	MISC ANCILLARY	0	0	0	0	0	76.00
76.01	03951	SLEEP LAB	0	0	0	0	0	76.01
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0	0	0	0	76.02
76.03	03952	WOUND CARE	219,589	0	24,070	121,816	23,362	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	54,354	0	2,650	18,383	27	90.00
91.00	09100	EMERGENCY	337,399	0	63,459	439,770	55,354	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	5,073,307	2,025,263	821,872	3,122,313	708,896	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	25,873	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	767,156	0	0	0	192.00
194.00	07950	MEALS ON WHEELS	0	372,105	0	0	0	194.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	5,099,180	3,164,524	821,872	3,122,313	708,896	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-0047 | Period: From 06/01/2019 To 05/31/2020 | Worksheet B Part I | Date/Time Prepared: 11/2/2020 12:13 pm

		Cost Center Description	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	INTERNS & RESIDENTS SERVICES-OTHER PRGM COSTS APPRV	Subtotal	
			15.00	16.00	17.00	22.00	24.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00590	REVENUE CYCLE						5.01
5.02	00560	PURCHASING RECEIVING AND STORES						5.02
5.03	00591	ADMINISTRATIVE AND GENERAL						5.03
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	2,738,702					15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	1,673,524				16.00
17.00	01700	SOCIAL SERVICE	0	0	1,289,844			17.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	121,357		22.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	154,605	732,094	121,357	17,425,714	30.00
33.00	03300	BURN INTENSIVE CARE UNIT	0	57,736	59,454	0	5,094,094	33.00
40.00	04000	SUBPROVIDER - IPF	0	66,521	235,076	0	3,798,363	40.00
44.00	04400	SKILLED NURSING FACILITY	0	17,650	263,220	0	3,563,387	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	112,755	0	0	3,848,151	50.00
51.00	05100	RECOVERY ROOM	0	8,353	0	0	1,008,991	51.00
53.00	05300	ANESTHESIOLOGY	0	11,805	0	0	1,583,320	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	272,968	0	0	6,130,280	54.00
54.01	03630	ULTRA SOUND	0	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
59.00	05900	CARDIAC CATHETERIZATION	0	66,340	0	0	2,611,456	59.00
60.00	06000	LABORATORY	0	207,727	0	0	6,090,871	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	3,953	0	0	246,641	62.00
65.00	06500	RESPIRATORY THERAPY	0	47,646	0	0	1,882,988	65.00
66.00	06600	PHYSICAL THERAPY	0	13,024	0	0	1,308,797	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	12,450	0	0	728,118	67.00
68.00	06800	SPEECH PATHOLOGY	0	676	0	0	139,397	68.00
69.00	06900	ELECTROCARDIOLOGY	0	14,342	0	0	320,286	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	23,053	0	0	1,292,142	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	147,325	0	0	2,761,693	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,738,702	221,930	0	0	6,094,438	73.00
74.00	07400	RENAL DIALYSIS	0	3,405	0	0	494,698	74.00
76.00	03950	MISC ANCILLARY	0	0	0	0	0	76.00
76.01	03951	SLEEP LAB	0	0	0	0	0	76.01
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0	0	0	0	76.02
76.03	03952	WOUND CARE	0	9,876	0	0	2,256,789	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	757	0	0	369,053	90.00
91.00	09100	EMERGENCY	0	198,627	0	0	6,451,361	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	2,738,702	1,673,524	1,289,844	121,357	75,501,028	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	97,388	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	769,316	192.00
194.00	07950	MEALS ON WHEELS	0	0	0	0	372,105	194.00
200.00		Cross Foot Adjustments				0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	2,738,702	1,673,524	1,289,844	121,357	76,739,837	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-0047 | Period: From 06/01/2019 To 05/31/2020 | Worksheet B Part I | Date/Time Prepared: 11/2/2020 12:13 pm

		Cost Center Description	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			25.00	26.00		
		GENERAL SERVICE COST CENTERS				
1.00	00100	CAP REL COSTS-BLDG & FIXT				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT				4.00
5.01	00590	REVENUE CYCLE				5.01
5.02	00560	PURCHASING RECEIVING AND STORES				5.02
5.03	00591	ADMINISTRATIVE AND GENERAL				5.03
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
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV				22.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	-121,357	17,304,357		30.00
33.00	03300	BURN INTENSIVE CARE UNIT	0	5,094,094		33.00
40.00	04000	SUBPROVIDER - IPF	0	3,798,363		40.00
44.00	04400	SKILLED NURSING FACILITY	0	3,563,387		44.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	3,848,151		50.00
51.00	05100	RECOVERY ROOM	0	1,008,991		51.00
53.00	05300	ANESTHESIOLOGY	0	1,583,320		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	6,130,280		54.00
54.01	03630	ULTRA SOUND	0	0		54.01
56.00	05600	RADIOISOTOPE	0	0		56.00
57.00	05700	CT SCAN	0	0		57.00
59.00	05900	CARDIAC CATHETERIZATION	0	2,611,456		59.00
60.00	06000	LABORATORY	0	6,090,871		60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	246,641		62.00
65.00	06500	RESPIRATORY THERAPY	0	1,882,988		65.00
66.00	06600	PHYSICAL THERAPY	0	1,308,797		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	728,118		67.00
68.00	06800	SPEECH PATHOLOGY	0	139,397		68.00
69.00	06900	ELECTROCARDIOLOGY	0	320,286		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	1,292,142		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	2,761,693		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	6,094,438		73.00
74.00	07400	RENAL DIALYSIS	0	494,698		74.00
76.00	03950	MISC ANCILLARY	0	0		76.00
76.01	03951	SLEEP LAB	0	0		76.01
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0		76.02
76.03	03952	WOUND CARE	0	2,256,789		76.03
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0	369,053		90.00
91.00	09100	EMERGENCY	0	6,451,361		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0			92.00
		SPECIAL PURPOSE COST CENTERS				
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-121,357	75,379,671		118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	97,388		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	769,316		192.00
194.00	07950	MEALS ON WHEELS	0	372,105		194.00
200.00		Cross Foot Adjustments	0	0		200.00
201.00		Negative Cost Centers	0	0		201.00
202.00		TOTAL (sum lines 118 through 201)	-121,357	76,618,480		202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-0047 | Period: From 06/01/2019 To 05/31/2020 | Worksheet B Part II Date/Time Prepared: 11/2/2020 12:13 pm

		Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS BLDG & FIXT	CAPITAL RELATED COSTS MVBLE EQUIP	Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
			0	1.00	2.00	2A	4.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	62,787	65,981	128,768	128,768	4.00
5.01	00590	REVENUE CYCLE	0	222,714	234,044	456,758	7,343	5.01
5.02	00560	PURCHASING RECEIVING AND STORES	0	154,685	162,554	317,239	152	5.02
5.03	00591	ADMINISTRATIVE AND GENERAL	0	120,345	126,467	246,812	9,871	5.03
7.00	00700	OPERATION OF PLANT	0	1,537,431	1,615,641	3,153,072	5,143	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	49,295	51,803	101,098	0	8.00
9.00	00900	HOUSEKEEPING	0	746,337	784,304	1,530,641	2,679	9.00
10.00	01000	DIETARY	0	233,145	245,006	478,151	0	10.00
11.00	01100	CAFETERIA	0	0	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	85,419	89,764	175,183	6,981	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	1,219	14.00
15.00	01500	PHARMACY	0	0	0	0	6,949	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	139,704	146,811	286,515	855	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	3,504	17.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0	22.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	539,775	567,234	1,107,009	24,084	30.00
33.00	03300	BURN INTENSIVE CARE UNIT	0	93,309	98,055	191,364	9,326	33.00
40.00	04000	SUBPROVIDER - IPF	0	59,088	62,094	121,182	5,699	40.00
44.00	04400	SKILLED NURSING FACILITY	0	114,171	119,979	234,150	5,006	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	228,595	240,224	468,819	2,852	50.00
51.00	05100	RECOVERY ROOM	0	85,751	90,114	175,865	668	51.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	219,295	230,451	449,746	7,635	54.00
54.01	03630	ULTRA SOUND	0	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
59.00	05900	CARDIAC CATHETERIZATION	0	24,428	25,671	50,099	3,082	59.00
60.00	06000	LABORATORY	0	187,695	197,243	384,938	7,863	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	10,285	10,808	21,093	0	62.00
65.00	06500	RESPIRATORY THERAPY	0	76,265	80,145	156,410	3,062	65.00
66.00	06600	PHYSICAL THERAPY	0	99,096	104,138	203,234	1,624	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	37,933	39,863	77,796	1,219	67.00
68.00	06800	SPEECH PATHOLOGY	0	14,609	15,352	29,961	74	68.00
69.00	06900	ELECTROCARDIOLOGY	0	13,904	14,611	28,515	416	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	32,864	34,535	67,399	0	73.00
74.00	07400	RENAL DIALYSIS	0	26,743	28,104	54,847	0	74.00
76.00	03950	MISC ANCILLARY	0	0	0	0	0	76.00
76.01	03951	SLEEP LAB	0	0	0	0	0	76.01
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0	0	0	0	76.02
76.03	03952	WOUND CARE	0	114,278	120,091	234,369	2,933	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	28,287	29,726	58,013	391	90.00
91.00	09100	EMERGENCY	0	175,588	184,520	360,108	8,138	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				0		92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	5,533,821	5,815,333	11,349,154	128,768	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	13,465	14,150	27,615	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07950	MEALS ON WHEELS	0	0	0	0	0	194.00
200.00		Cross Foot Adjustments				0		200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	0	5,547,286	5,829,483	11,376,769	128,768	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-0047 | Period: From 06/01/2019 To 05/31/2020 | Worksheet B Part II | Date/Time Prepared: 11/2/2020 12:13 pm

		Cost Center Description	REVENUE CYCLE	PURCHASING RECEIVING AND STORES	ADMINISTRATIVE AND GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	
			5.01	5.02	5.03	7.00	8.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00590	REVENUE CYCLE	464,101					5.01
5.02	00560	PURCHASING RECEIVING AND STORES	0	317,391				5.02
5.03	00591	ADMINISTRATIVE AND GENERAL	0	5,225	261,908			5.03
7.00	00700	OPERATION OF PLANT	0	797	32,871	3,191,883		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	7,153	1,033	45,616	154,900	8.00
9.00	00900	HOUSEKEEPING	0	3,977	10,293	690,633	0	9.00
10.00	01000	DIETARY	0	47,060	7,051	215,745	0	10.00
11.00	01100	CAFETERIA	0	0	2,805	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	304	9,123	79,044	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	7,903	2,360	0	0	14.00
15.00	01500	PHARMACY	0	1,150	9,026	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	42	3,431	129,277	0	16.00
17.00	01700	SOCIAL SERVICE	0	7	3,732	0	0	17.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	414	0	0	22.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	42,887	10,730	38,517	499,489	36,348	30.00
33.00	03300	BURN INTENSIVE CARE UNIT	16,016	9,388	12,704	86,345	17,709	33.00
40.00	04000	SUBPROVIDER - IPF	18,453	1,962	8,603	54,678	15,611	40.00
44.00	04400	SKILLED NURSING FACILITY	4,896	3,225	6,871	105,650	12,678	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	31,278	19,288	8,437	211,534	6,492	50.00
51.00	05100	RECOVERY ROOM	2,317	0	1,892	79,351	2,762	51.00
53.00	05300	ANESTHESIOLOGY	3,275	3	5,364	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	75,587	5,306	16,091	202,928	11,821	54.00
54.01	03630	ULTRA SOUND	0	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
59.00	05900	CARDIAC CATHETERIZATION	18,403	10,343	7,796	22,605	7,832	59.00
60.00	06000	LABORATORY	57,623	27,894	16,533	173,687	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	1,096	5,779	606	9,517	0	62.00
65.00	06500	RESPIRATORY THERAPY	13,217	3,677	4,920	70,573	0	65.00
66.00	06600	PHYSICAL THERAPY	3,613	185	2,788	91,700	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	3,454	6	1,808	35,102	0	67.00
68.00	06800	SPEECH PATHOLOGY	188	0	237	13,519	0	68.00
69.00	06900	ELECTROCARDIOLOGY	3,978	150	804	12,866	564	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	6,395	39,913	3,938	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	40,868	78,556	8,148	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	61,563	0	10,168	30,411	0	73.00
74.00	07400	RENAL DIALYSIS	945	157	1,245	24,747	0	74.00
76.00	03950	MISC ANCILLARY	0	0	0	0	0	76.00
76.01	03951	SLEEP LAB	0	0	0	0	0	76.01
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0	0	0	0	76.02
76.03	03952	WOUND CARE	2,740	8,073	5,253	105,748	0	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	210	9	664	26,175	6,786	90.00
91.00	09100	EMERGENCY	55,099	19,129	16,259	162,483	36,297	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	464,101	317,391	261,785	3,179,423	154,900	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	116	12,460	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	7	0	0	192.00
194.00	07950	MEALS ON WHEELS	0	0	0	0	0	194.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	464,101	317,391	261,908	3,191,883	154,900	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-0047 | Period: From 06/01/2019 To 05/31/2020 | Worksheet B Part II | Date/Time Prepared: 11/2/2020 12:13 pm

		Cost Center Description	HOUSEKEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	
			9.00	10.00	11.00	13.00	14.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00590	REVENUE CYCLE						5.01
5.02	00560	PURCHASING RECEIVING AND STORES						5.02
5.03	00591	ADMINISTRATIVE AND GENERAL						5.03
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING	2,238,223					9.00
10.00	01000	DIETARY	196,644	944,651				10.00
11.00	01100	CAFETERIA	0	0	2,805			11.00
13.00	01300	NURSING ADMINISTRATION	72,045	0	160	342,840		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	60	0	11,542	14.00
15.00	01500	PHARMACY	0	0	132	5,772	54	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	117,831	0	33	0	2	16.00
17.00	01700	SOCIAL SERVICE	0	0	85	18,844	0	17.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0	22.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	455,266	333,673	725	122,314	506	30.00
33.00	03300	BURN INTENSIVE CARE UNIT	78,700	57,623	218	52,796	442	33.00
40.00	04000	SUBPROVIDER - IPF	49,837	100,612	185	28,177	92	40.00
44.00	04400	SKILLED NURSING FACILITY	96,296	112,659	128	29,796	152	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	192,806	0	66	10,191	909	50.00
51.00	05100	RECOVERY ROOM	72,326	0	13	3,373	0	51.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	184,962	0	207	0	250	54.00
54.01	03630	ULTRA SOUND	0	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
59.00	05900	CARDIAC CATHETERIZATION	20,604	0	75	7,895	487	59.00
60.00	06000	LABORATORY	158,309	0	252	0	1,314	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	8,675	0	0	0	272	62.00
65.00	06500	RESPIRATORY THERAPY	64,325	0	82	0	173	65.00
66.00	06600	PHYSICAL THERAPY	83,582	0	39	0	9	66.00
67.00	06700	OCCUPATIONAL THERAPY	31,994	0	25	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	12,322	0	2	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	11,727	0	10	0	7	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	1,881	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	3,704	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	27,718	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	22,556	0	0	0	7	74.00
76.00	03950	MISC ANCILLARY	0	0	0	0	0	76.00
76.01	03951	SLEEP LAB	0	0	0	0	0	76.01
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0	0	0	0	76.02
76.03	03952	WOUND CARE	96,386	0	82	13,376	380	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	23,858	0	9	2,018	0	90.00
91.00	09100	EMERGENCY	148,097	0	217	48,288	901	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	2,226,866	604,567	2,805	342,840	11,542	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	11,357	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	229,006	0	0	0	192.00
194.00	07950	MEALS ON WHEELS	0	111,078	0	0	0	194.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	2,238,223	944,651	2,805	342,840	11,542	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-0047 | Period: From 06/01/2019 To 05/31/2020 | Worksheet B Part II | Date/Time Prepared: 11/2/2020 12:13 pm

		Cost Center Description	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	INTERNS & RESIDENTS SERVICES-OTHER PRGM COSTS APPRV	Subtotal	
			15.00	16.00	17.00	22.00	24.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00590	REVENUE CYCLE						5.01
5.02	00560	PURCHASING RECEIVING AND STORES						5.02
5.03	00591	ADMINISTRATIVE AND GENERAL						5.03
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	23,083					15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	537,986				16.00
17.00	01700	SOCIAL SERVICE	0	0	26,172			17.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	414		22.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	49,711	14,855		2,736,114	30.00
33.00	03300	BURN INTENSIVE CARE UNIT	0	18,564	1,206		552,401	33.00
40.00	04000	SUBPROVIDER - IPF	0	21,389	4,770		431,250	40.00
44.00	04400	SKILLED NURSING FACILITY	0	5,675	5,341		622,523	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	36,255	0		988,927	50.00
51.00	05100	RECOVERY ROOM	0	2,686	0		341,253	51.00
53.00	05300	ANESTHESIOLOGY	0	3,796	0		12,438	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	87,658	0		1,042,191	54.00
54.01	03630	ULTRA SOUND	0	0	0		0	54.01
56.00	05600	RADIOISOTOPE	0	0	0		0	56.00
57.00	05700	CT SCAN	0	0	0		0	57.00
59.00	05900	CARDIAC CATHETERIZATION	0	21,331	0		170,552	59.00
60.00	06000	LABORATORY	0	66,792	0		895,205	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	1,271	0		48,309	62.00
65.00	06500	RESPIRATORY THERAPY	0	15,320	0		331,759	65.00
66.00	06600	PHYSICAL THERAPY	0	4,188	0		390,962	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	4,003	0		155,407	67.00
68.00	06800	SPEECH PATHOLOGY	0	217	0		56,520	68.00
69.00	06900	ELECTROCARDIOLOGY	0	4,611	0		63,648	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	7,412	0		59,539	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	47,370	0		178,646	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	23,083	71,358	0		291,700	73.00
74.00	07400	RENAL DIALYSIS	0	1,095	0		105,599	74.00
76.00	03950	MISC ANCILLARY	0	0	0		0	76.00
76.01	03951	SLEEP LAB	0	0	0		0	76.01
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0	0		0	76.02
76.03	03952	WOUND CARE	0	3,175	0		472,515	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	243	0		118,376	90.00
91.00	09100	EMERGENCY	0	63,866	0		918,882	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	23,083	537,986	26,172	0	10,984,716	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0		51,548	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0		229,013	192.00
194.00	07950	MEALS ON WHEELS	0	0	0		111,078	194.00
200.00		Cross Foot Adjustments				414	414	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	23,083	537,986	26,172	414	11,376,769	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-0047 | Period: From 06/01/2019 To 05/31/2020 | Worksheet B Part II | Date/Time Prepared: 11/2/2020 12:13 pm

		Cost Center Description	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			25.00	26.00		
		GENERAL SERVICE COST CENTERS				
1.00	00100	CAP REL COSTS-BLDG & FIXT				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT				4.00
5.01	00590	REVENUE CYCLE				5.01
5.02	00560	PURCHASING RECEIVING AND STORES				5.02
5.03	00591	ADMINISTRATIVE AND GENERAL				5.03
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
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV				22.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	0	2,736,114		30.00
33.00	03300	BURN INTENSIVE CARE UNIT	0	552,401		33.00
40.00	04000	SUBPROVIDER - IPF	0	431,250		40.00
44.00	04400	SKILLED NURSING FACILITY	0	622,523		44.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	988,927		50.00
51.00	05100	RECOVERY ROOM	0	341,253		51.00
53.00	05300	ANESTHESIOLOGY	0	12,438		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	1,042,191		54.00
54.01	03630	ULTRA SOUND	0	0		54.01
56.00	05600	RADIOISOTOPE	0	0		56.00
57.00	05700	CT SCAN	0	0		57.00
59.00	05900	CARDIAC CATHETERIZATION	0	170,552		59.00
60.00	06000	LABORATORY	0	895,205		60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	48,309		62.00
65.00	06500	RESPIRATORY THERAPY	0	331,759		65.00
66.00	06600	PHYSICAL THERAPY	0	390,962		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	155,407		67.00
68.00	06800	SPEECH PATHOLOGY	0	56,520		68.00
69.00	06900	ELECTROCARDIOLOGY	0	63,648		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	59,539		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	178,646		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	291,700		73.00
74.00	07400	RENAL DIALYSIS	0	105,599		74.00
76.00	03950	MISC ANCILLARY	0	0		76.00
76.01	03951	SLEEP LAB	0	0		76.01
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0		76.02
76.03	03952	WOUND CARE	0	472,515		76.03
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0	118,376		90.00
91.00	09100	EMERGENCY	0	918,882		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0			92.00
		SPECIAL PURPOSE COST CENTERS				
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	10,984,716		118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	51,548		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	229,013		192.00
194.00	07950	MEALS ON WHEELS	0	111,078		194.00
200.00		Cross Foot Adjustments	0	414		200.00
201.00		Negative Cost Centers	0	0		201.00
202.00		TOTAL (sum lines 118 through 201)	0	11,376,769		202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-0047 | Period: From 06/01/2019 To 05/31/2020 | Worksheet B-1 | Date/Time Prepared: 11/2/2020 12:13 pm

		Cost Center Description	CAPITAL RELATED COSTS					
			BLDG & FIXT (SQUARE FOOTAGE)	MVBLE EQUIP (SQUARE FOOTAGE)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	REVENUE CYCLE (GROSS CHARGES)	PURCHASING RECEIVING AND STORES (COSTED REQUIS.)	
			1.00	2.00	4.00	5.01	5.02	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	416,929					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		416,929				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	4,719	4,719	25,081,107			4.00
5.01	00590	REVENUE CYCLE	16,739	16,739	1,430,260	356,850,088		5.01
5.02	00560	PURCHASING RECEIVING AND STORES	11,626	11,626	29,673	0	5,418,429	5.02
5.03	00591	ADMINISTRATIVE AND GENERAL	9,045	9,045	1,922,647	0	89,206	5.03
7.00	00700	OPERATION OF PLANT	115,552	115,552	1,001,753	0	13,614	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	3,705	3,705	0	0	122,120	8.00
9.00	00900	HOUSEKEEPING	56,094	56,094	521,761	0	67,898	9.00
10.00	01000	DIETARY	17,523	17,523	0	0	803,397	10.00
11.00	01100	CAFETERIA	0	0	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	6,420	6,420	1,359,730	0	5,182	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	237,502	0	134,912	14.00
15.00	01500	PHARMACY	0	0	1,353,575	0	19,630	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	10,500	10,500	166,562	0	713	16.00
17.00	01700	SOCIAL SERVICE	0	0	682,536	0	124	17.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0	22.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	40,569	40,569	4,690,867	32,964,842	183,173	30.00
33.00	03300	BURN INTENSIVE CARE UNIT	7,013	7,013	1,816,445	12,310,408	160,265	33.00
40.00	04000	SUBPROVIDER - IPF	4,441	4,441	1,110,146	14,183,573	33,489	40.00
44.00	04400	SKILLED NURSING FACILITY	8,581	8,581	975,088	3,763,427	55,059	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	17,181	17,181	555,445	24,041,550	329,282	50.00
51.00	05100	RECOVERY ROOM	6,445	6,445	130,066	1,780,968	0	51.00
53.00	05300	ANESTHESIOLOGY	0	0	0	2,517,036	58	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	16,482	16,482	1,487,152	58,224,083	90,575	54.00
54.01	03630	ULTRA SOUND	0	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
59.00	05900	CARDIAC CATHETERIZATION	1,836	1,836	600,381	14,145,023	176,582	59.00
60.00	06000	LABORATORY	14,107	14,107	1,531,475	44,291,530	476,195	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	773	773	0	842,806	98,663	62.00
65.00	06500	RESPIRATORY THERAPY	5,732	5,732	596,434	10,158,998	62,766	65.00
66.00	06600	PHYSICAL THERAPY	7,448	7,448	316,356	2,777,068	3,162	66.00
67.00	06700	OCCUPATIONAL THERAPY	2,851	2,851	237,357	2,654,583	99	67.00
68.00	06800	SPEECH PATHOLOGY	1,098	1,098	14,430	144,152	0	68.00
69.00	06900	ELECTROCARDIOLOGY	1,045	1,045	81,019	3,057,976	2,555	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	4,915,444	681,380	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	31,412,498	1,341,106	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,470	2,470	0	47,319,867	0	73.00
74.00	07400	RENAL DIALYSIS	2,010	2,010	0	725,995	2,685	74.00
76.00	03950	MISC ANCILLARY	0	0	0	0	0	76.00
76.01	03951	SLEEP LAB	0	0	0	0	0	76.01
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0	0	0	0	76.02
76.03	03952	WOUND CARE	8,589	8,589	571,316	2,105,748	137,823	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	2,126	2,126	76,106	161,302	157	90.00
91.00	09100	EMERGENCY	13,197	13,197	1,585,025	42,351,211	326,559	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	415,917	415,917	25,081,107	356,850,088	5,418,429	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	1,012	1,012	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07950	MEALS ON WHEELS	0	0	0	0	0	194.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	5,547,286	5,829,483	5,016,296	6,650,217	489,672	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	13.305110	13.981956	0.200003	0.018636	0.090372	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)			128,768	464,101	317,391	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)			0.005134	0.001301	0.058576	205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)						206.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-0047 | Period: From 06/01/2019 To 05/31/2020 | Worksheet B-1 | Date/Time Prepared: 11/2/2020 12:13 pm

	Cost Center Description	CAPITAL RELATED COSTS					
		BLDG & FIXT (SQUARE FOOTAGE)	MVBLE EQUIP (SQUARE FOOTAGE)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	REVENUE CYCLE (GROSS CHARGES)	PURCHASING RECEIVING AND STORES (COSTED REQUIS.)	
		1.00	2.00	4.00	5.01	5.02	
207.00	NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-0047 | Period: From 06/01/2019 To 05/31/2020 | Worksheet B-1 | Date/Time Prepared: 11/2/2020 12:13 pm

		Cost Center Description	Reconciliation	ADMINISTRATIVE AND GENERAL (ACCUM.COST)	OPERATION OF PLANT (SQUARE FOOTAGE)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FOOTAGE)	
			5A.03	5.03	7.00	8.00	9.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00590	REVENUE CYCLE						5.01
5.02	00560	PURCHASING RECEIVING AND STORES						5.02
5.03	00591	ADMINISTRATIVE AND GENERAL	-14,269,385	62,470,452				5.03
7.00	00700	OPERATION OF PLANT	0	7,839,448	259,248			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	246,268	3,705	516,727		8.00
9.00	00900	HOUSEKEEPING	0	2,454,778	56,094	0	199,449	9.00
10.00	01000	DIETARY	0	1,681,520	17,523	0	17,523	10.00
11.00	01100	CAFETERIA	0	669,049	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	2,175,807	6,420	0	6,420	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	562,812	0	0	0	14.00
15.00	01500	PHARMACY	0	2,152,518	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	818,380	10,500	0	10,500	16.00
17.00	01700	SOCIAL SERVICE	0	890,036	0	0	0	17.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	98,791	0	0	0	22.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	9,193,975	40,569	121,252	40,569	30.00
33.00	03300	BURN INTENSIVE CARE UNIT	0	3,029,864	7,013	59,074	7,013	33.00
40.00	04000	SUBPROVIDER - IPF	0	2,051,795	4,441	52,078	4,441	40.00
44.00	04400	SKILLED NURSING FACILITY	0	1,638,577	8,581	42,292	8,581	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	2,012,053	17,181	21,657	17,181	50.00
51.00	05100	RECOVERY ROOM	0	451,140	6,445	9,215	6,445	51.00
53.00	05300	ANESTHESIOLOGY	0	1,279,292	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	3,837,491	16,482	39,432	16,482	54.00
54.01	03630	ULTRA SOUND	0	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
59.00	05900	CARDIAC CATHETERIZATION	0	1,859,255	1,836	26,128	1,836	59.00
60.00	06000	LABORATORY	0	3,943,090	14,107	0	14,107	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	144,484	773	0	773	62.00
65.00	06500	RESPIRATORY THERAPY	0	1,173,322	5,732	0	5,732	65.00
66.00	06600	PHYSICAL THERAPY	0	664,859	7,448	0	7,448	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	431,121	2,851	0	2,851	67.00
68.00	06800	SPEECH PATHOLOGY	0	56,490	1,098	0	1,098	68.00
69.00	06900	ELECTROCARDIOLOGY	0	191,691	1,045	1,880	1,045	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	939,086	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	1,943,183	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	2,424,993	2,470	0	2,470	73.00
74.00	07400	RENAL DIALYSIS	0	296,956	2,010	0	2,010	74.00
76.00	03950	MISC ANCILLARY	0	0	0	0	0	76.00
76.01	03951	SLEEP LAB	0	0	0	0	0	76.01
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0	0	0	0	76.02
76.03	03952	WOUND CARE	0	1,252,852	8,589	0	8,589	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	158,437	2,126	22,637	2,126	90.00
91.00	09100	EMERGENCY	0	3,877,666	13,197	121,082	13,197	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-14,269,385	62,441,079	258,236	516,727	198,437	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	27,615	1,012	0	1,012	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	1,758	0	0	0	192.00
194.00	07950	MEALS ON WHEELS	0	0	0	0	0	194.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)		14,269,385	9,630,119	440,147	5,099,180	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)		0.228418	37.146358	0.851798	25.566335	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)		261,908	3,191,883	154,900	2,238,223	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)		0.004193	12.312083	0.299771	11.222032	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: 15-0047 | Period: From 06/01/2019 To 05/31/2020 | Worksheet B-1 | Date/Time Prepared: 11/2/2020 12:13 pm

		Cost Center Description	DIETARY (MEALS SERVED)	CAFETERIA (FTE'S)	NURSING ADMINISTRATION (GROSS SALARIES)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	
			10.00	11.00	13.00	14.00	15.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00590	REVENUE CYCLE						5.01
5.02	00560	PURCHASING RECEIVING AND STORES						5.02
5.03	00591	ADMINISTRATIVE AND GENERAL						5.03
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	118,330					10.00
11.00	01100	CAFETERIA	0	29,775				11.00
13.00	01300	NURSING ADMINISTRATION	0	1,699	8,268,503			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	635	0	4,182,100		14.00
15.00	01500	PHARMACY	0	1,399	139,207	19,630	1,876,230	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	348	0	713	0	16.00
17.00	01700	SOCIAL SERVICE	0	901	454,477	124	0	17.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0	22.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	41,797	7,730	2,949,894	183,173	0	30.00
33.00	03300	BURN INTENSIVE CARE UNIT	7,218	2,312	1,273,323	160,265	0	33.00
40.00	04000	SUBPROVIDER - IPF	12,603	1,960	679,564	33,489	0	40.00
44.00	04400	SKILLED NURSING FACILITY	14,112	1,355	718,623	55,059	0	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	696	245,785	329,282	0	50.00
51.00	05100	RECOVERY ROOM	0	134	81,350	0	0	51.00
53.00	05300	ANESTHESIOLOGY	0	0	0	58	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	2,199	0	90,575	0	54.00
54.01	03630	ULTRA SOUND	0	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
59.00	05900	CARDIAC CATHETERIZATION	0	795	190,407	176,582	0	59.00
60.00	06000	LABORATORY	0	2,680	0	476,195	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0	98,663	0	62.00
65.00	06500	RESPIRATORY THERAPY	0	866	0	62,766	0	65.00
66.00	06600	PHYSICAL THERAPY	0	414	0	3,162	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	263	0	99	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	17	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	105	0	2,555	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	681,380	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	1,341,106	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	1,876,230	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	2,685	0	74.00
76.00	03950	MISC ANCILLARY	0	0	0	0	0	76.00
76.01	03951	SLEEP LAB	0	0	0	0	0	76.01
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0	0	0	0	76.02
76.03	03952	WOUND CARE	0	872	322,594	137,823	0	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	96	48,681	157	0	90.00
91.00	09100	EMERGENCY	0	2,299	1,164,598	326,559	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	75,730	29,775	8,268,503	4,182,100	1,876,230	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	28,686	0	0	0	0	192.00
194.00	07950	MEALS ON WHEELS	13,914	0	0	0	0	194.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	3,164,524	821,872	3,122,313	708,896	2,738,702	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	26.743210	27.602754	0.377615	0.169507	1.459684	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	944,651	2,805	342,840	11,542	23,083	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	7.983191	0.094207	0.041463	0.002760	0.012303	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

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		Cost Center Description	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)	SOCIAL SERVICE (TOTAL PATIENT DAYS)	INTERNS & RESIDENTS SERVICES-OTHER PRGM COSTS APPRV (ROTATIONS)		
			16.00	17.00	22.00		
		GENERAL SERVICE COST CENTERS					
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.01	00590	REVENUE CYCLE					5.01
5.02	00560	PURCHASING RECEIVING AND STORES					5.02
5.03	00591	ADMINISTRATIVE AND GENERAL					5.03
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	356,850,088				16.00
17.00	01700	SOCIAL SERVICE	0	21,174			17.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	100		22.00
		INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	32,964,842	12,018	100		30.00
33.00	03300	BURN INTENSIVE CARE UNIT	12,310,408	976	0		33.00
40.00	04000	SUBPROVIDER - IPF	14,183,573	3,859	0		40.00
44.00	04400	SKILLED NURSING FACILITY	3,763,427	4,321	0		44.00
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	24,041,550	0	0		50.00
51.00	05100	RECOVERY ROOM	1,780,968	0	0		51.00
53.00	05300	ANESTHESIOLOGY	2,517,036	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	58,224,083	0	0		54.00
54.01	03630	ULTRA SOUND	0	0	0		54.01
56.00	05600	RADIOISOTOPE	0	0	0		56.00
57.00	05700	CT SCAN	0	0	0		57.00
59.00	05900	CARDIAC CATHETERIZATION	14,145,023	0	0		59.00
60.00	06000	LABORATORY	44,291,530	0	0		60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	842,806	0	0		62.00
65.00	06500	RESPIRATORY THERAPY	10,158,998	0	0		65.00
66.00	06600	PHYSICAL THERAPY	2,777,068	0	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	2,654,583	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	144,152	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	3,057,976	0	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	4,915,444	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	31,412,498	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	47,319,867	0	0		73.00
74.00	07400	RENAL DIALYSIS	725,995	0	0		74.00
76.00	03950	MISC ANCILLARY	0	0	0		76.00
76.01	03951	SLEEP LAB	0	0	0		76.01
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0	0		76.02
76.03	03952	WOUND CARE	2,105,748	0	0		76.03
		OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	161,302	0	0		90.00
91.00	09100	EMERGENCY	42,351,211	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					92.00
		SPECIAL PURPOSE COST CENTERS					
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	356,850,088	21,174	100		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	MEALS ON WHEELS	0	0	0		194.00
200.00		Cross Foot Adjustments					200.00
201.00		Negative Cost Centers					201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	1,673,524	1,289,844	121,357		202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.004690	60.916407	1,213.570000		203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	537,986	26,172	414		204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.001508	1.236044	4.140000		205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)					206.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-0047 | Period: From 06/01/2019 To 05/31/2020 | Worksheet B-1 | Date/Time Prepared: 11/2/2020 12:13 pm

	Cost Center Description	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)	SOCIAL SERVICE (TOTAL PATIENT DAYS)	INTERNS & RESIDENTS SERVICES-OTHER PRGM COSTS APPRV (ROTATIONS)		
		16.00	17.00	22.00		
207.00	NAHE unit cost multiplier (Wkst. D, Parts III and IV)					207.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-0047 | Period: From 06/01/2019 To 05/31/2020 | Worksheet C Part I Date/Time Prepared: 11/2/2020 12:13 pm

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		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	RCE Disallowance	Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	17,304,357		17,304,357	0	17,304,357	30.00
33.00	03300	BURN INTENSIVE CARE UNIT	5,094,094		5,094,094	0	5,094,094	33.00
40.00	04000	SUBPROVIDER - IPF	3,798,363		3,798,363	0	3,798,363	40.00
44.00	04400	SKILLED NURSING FACILITY	3,563,387		3,563,387	0	3,563,387	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	3,848,151		3,848,151	0	3,848,151	50.00
51.00	05100	RECOVERY ROOM	1,008,991		1,008,991	0	1,008,991	51.00
53.00	05300	ANESTHESIOLOGY	1,583,320		1,583,320	0	1,583,320	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	6,130,280		6,130,280	0	6,130,280	54.00
54.01	03630	ULTRA SOUND	0		0	0	0	54.01
56.00	05600	RADIOISOTOPE	0		0	0	0	56.00
57.00	05700	CT SCAN	0		0	0	0	57.00
59.00	05900	CARDIAC CATHETERIZATION	2,611,456		2,611,456	0	2,611,456	59.00
60.00	06000	LABORATORY	6,090,871		6,090,871	0	6,090,871	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	246,641		246,641	0	246,641	62.00
65.00	06500	RESPIRATORY THERAPY	1,882,988	0	1,882,988	0	1,882,988	65.00
66.00	06600	PHYSICAL THERAPY	1,308,797	0	1,308,797	0	1,308,797	66.00
67.00	06700	OCCUPATIONAL THERAPY	728,118	0	728,118	0	728,118	67.00
68.00	06800	SPEECH PATHOLOGY	139,397	0	139,397	0	139,397	68.00
69.00	06900	ELECTROCARDIOLOGY	320,286		320,286	0	320,286	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1,292,142		1,292,142	0	1,292,142	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	2,761,693		2,761,693	0	2,761,693	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	6,094,438		6,094,438	0	6,094,438	73.00
74.00	07400	RENAL DIALYSIS	494,698		494,698	0	494,698	74.00
76.00	03950	MISC ANCILLARY	0		0	0	0	76.00
76.01	03951	SLEEP LAB	0		0	0	0	76.01
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0		0	0	0	76.02
76.03	03952	WOUND CARE	2,256,789		2,256,789	0	2,256,789	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	369,053		369,053	0	369,053	90.00
91.00	09100	EMERGENCY	6,451,361		6,451,361	0	6,451,361	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1,639,715		1,639,715		1,639,715	92.00
200.00		Subtotal (see instructions)	77,019,386	0	77,019,386	0	77,019,386	200.00
201.00		Less Observation Beds	1,639,715		1,639,715		1,639,715	201.00
202.00		Total (see instructions)	75,379,671	0	75,379,671	0	75,379,671	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-0047 | Period: From 06/01/2019 To 05/31/2020 | Worksheet C Part I Date/Time Prepared: 11/2/2020 12:13 pm

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		Cost Center Description	Charges Inpatient	Charges Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	29,027,916		29,027,916			30.00
33.00	03300	BURN INTENSIVE CARE UNIT	12,310,408		12,310,408			33.00
40.00	04000	SUBPROVIDER - IPF	14,183,573		14,183,573			40.00
44.00	04400	SKILLED NURSING FACILITY	3,763,427		3,763,427			44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	10,367,163	13,674,387	24,041,550	0.160063	0.000000	50.00
51.00	05100	RECOVERY ROOM	229,674	1,551,294	1,780,968	0.566541	0.000000	51.00
53.00	05300	ANESTHESIOLOGY	1,167,823	1,349,213	2,517,036	0.629041	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	15,310,150	42,913,933	58,224,083	0.105288	0.000000	54.00
54.01	03630	ULTRA SOUND	0	0	0	0.000000	0.000000	54.01
56.00	05600	RADIOISOTOPE	0	0	0	0.000000	0.000000	56.00
57.00	05700	CT SCAN	0	0	0	0.000000	0.000000	57.00
59.00	05900	CARDIAC CATHETERIZATION	5,738,611	8,406,412	14,145,023	0.184620	0.000000	59.00
60.00	06000	LABORATORY	17,994,411	26,297,119	44,291,530	0.137518	0.000000	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	662,931	179,875	842,806	0.292643	0.000000	62.00
65.00	06500	RESPIRATORY THERAPY	8,902,086	1,256,912	10,158,998	0.185352	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	2,721,508	55,560	2,777,068	0.471287	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	2,609,666	44,917	2,654,583	0.274287	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	128,167	15,985	144,152	0.967014	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	931,148	2,126,828	3,057,976	0.104738	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	2,887,550	2,027,894	4,915,444	0.262874	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	13,692,630	17,719,868	31,412,498	0.087917	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	32,194,477	15,125,390	47,319,867	0.128792	0.000000	73.00
74.00	07400	RENAL DIALYSIS	625,747	100,248	725,995	0.681407	0.000000	74.00
76.00	03950	MISC ANCILLARY	0	0	0	0.000000	0.000000	76.00
76.01	03951	SLEEP LAB	0	0	0	0.000000	0.000000	76.01
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0	0	0.000000	0.000000	76.02
76.03	03952	WOUND CARE	169,625	1,936,123	2,105,748	1.071728	0.000000	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	46,695	114,607	161,302	2.287963	0.000000	90.00
91.00	09100	EMERGENCY	7,693,369	34,657,842	42,351,211	0.152330	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1,167,361	2,769,565	3,936,926	0.416496	0.000000	92.00
200.00		Subtotal (see instructions)	184,526,116	172,323,972	356,850,088			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	184,526,116	172,323,972	356,850,088			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-0047 | Period: From 06/01/2019 To 05/31/2020 | Worksheet C Part I Date/Time Prepared: 11/2/2020 12:13 pm

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		Cost Center Description	PPS Inpatient Ratio	
			11.00	
		INPATIENT ROUTINE SERVICE COST CENTERS		
30.00	03000	ADULTS & PEDIATRICS		30.00
33.00	03300	BURN INTENSIVE CARE UNIT		33.00
40.00	04000	SUBPROVIDER - IPF		40.00
44.00	04400	SKILLED NURSING FACILITY		44.00
		ANCILLARY SERVICE COST CENTERS		
50.00	05000	OPERATING ROOM	0.160063	50.00
51.00	05100	RECOVERY ROOM	0.566541	51.00
53.00	05300	ANESTHESIOLOGY	0.629041	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.105288	54.00
54.01	03630	ULTRA SOUND	0.000000	54.01
56.00	05600	RADIOISOTOPE	0.000000	56.00
57.00	05700	CT SCAN	0.000000	57.00
59.00	05900	CARDIAC CATHETERIZATION	0.184620	59.00
60.00	06000	LABORATORY	0.137518	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0.292643	62.00
65.00	06500	RESPIRATORY THERAPY	0.185352	65.00
66.00	06600	PHYSICAL THERAPY	0.471287	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.274287	67.00
68.00	06800	SPEECH PATHOLOGY	0.967014	68.00
69.00	06900	ELECTROCARDIOLOGY	0.104738	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.262874	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.087917	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.128792	73.00
74.00	07400	RENAL DIALYSIS	0.681407	74.00
76.00	03950	MISC ANCILLARY	0.000000	76.00
76.01	03951	SLEEP LAB	0.000000	76.01
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0.000000	76.02
76.03	03952	WOUND CARE	1.071728	76.03
		OUTPATIENT SERVICE COST CENTERS		
90.00	09000	CLINIC	2.287963	90.00
91.00	09100	EMERGENCY	0.152330	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.416496	92.00
200.00		Subtotal (see instructions)		200.00
201.00		Less Observation Beds		201.00
202.00		Total (see instructions)		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-0047 | Period: From 06/01/2019 To 05/31/2020 | Worksheet C Part I Date/Time Prepared: 11/2/2020 12:13 pm

Title XIX | Hospital | PPS

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	RCE Disallowance	Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	17,304,357		17,304,357	0	17,304,357	30.00
33.00	03300	BURN INTENSIVE CARE UNIT	5,094,094		5,094,094	0	5,094,094	33.00
40.00	04000	SUBPROVIDER - IPF	3,798,363		3,798,363	0	3,798,363	40.00
44.00	04400	SKILLED NURSING FACILITY	3,563,387		3,563,387	0	3,563,387	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	3,848,151		3,848,151	0	3,848,151	50.00
51.00	05100	RECOVERY ROOM	1,008,991		1,008,991	0	1,008,991	51.00
53.00	05300	ANESTHESIOLOGY	1,583,320		1,583,320	0	1,583,320	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	6,130,280		6,130,280	0	6,130,280	54.00
54.01	03630	ULTRA SOUND	0		0	0	0	54.01
56.00	05600	RADIOISOTOPE	0		0	0	0	56.00
57.00	05700	CT SCAN	0		0	0	0	57.00
59.00	05900	CARDIAC CATHETERIZATION	2,611,456		2,611,456	0	2,611,456	59.00
60.00	06000	LABORATORY	6,090,871		6,090,871	0	6,090,871	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	246,641		246,641	0	246,641	62.00
65.00	06500	RESPIRATORY THERAPY	1,882,988	0	1,882,988	0	1,882,988	65.00
66.00	06600	PHYSICAL THERAPY	1,308,797	0	1,308,797	0	1,308,797	66.00
67.00	06700	OCCUPATIONAL THERAPY	728,118	0	728,118	0	728,118	67.00
68.00	06800	SPEECH PATHOLOGY	139,397	0	139,397	0	139,397	68.00
69.00	06900	ELECTROCARDIOLOGY	320,286		320,286	0	320,286	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1,292,142		1,292,142	0	1,292,142	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	2,761,693		2,761,693	0	2,761,693	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	6,094,438		6,094,438	0	6,094,438	73.00
74.00	07400	RENAL DIALYSIS	494,698		494,698	0	494,698	74.00
76.00	03950	MISC ANCILLARY	0		0	0	0	76.00
76.01	03951	SLEEP LAB	0		0	0	0	76.01
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0		0	0	0	76.02
76.03	03952	WOUND CARE	2,256,789		2,256,789	0	2,256,789	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	369,053		369,053	0	369,053	90.00
91.00	09100	EMERGENCY	6,451,361		6,451,361	0	6,451,361	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1,639,715		1,639,715		1,639,715	92.00
200.00		Subtotal (see instructions)	77,019,386	0	77,019,386	0	77,019,386	200.00
201.00		Less Observation Beds	1,639,715		1,639,715		1,639,715	201.00
202.00		Total (see instructions)	75,379,671	0	75,379,671	0	75,379,671	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-0047 | Period: From 06/01/2019 To 05/31/2020 | Worksheet C Part I Date/Time Prepared: 11/2/2020 12:13 pm

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		Cost Center Description	Charges Inpatient	Charges Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	29,027,916		29,027,916			30.00
33.00	03300	BURN INTENSIVE CARE UNIT	12,310,408		12,310,408			33.00
40.00	04000	SUBPROVIDER - IPF	14,183,573		14,183,573			40.00
44.00	04400	SKILLED NURSING FACILITY	3,763,427		3,763,427			44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	10,367,163	13,674,387	24,041,550	0.160063	0.000000	50.00
51.00	05100	RECOVERY ROOM	229,674	1,551,294	1,780,968	0.566541	0.000000	51.00
53.00	05300	ANESTHESIOLOGY	1,167,823	1,349,213	2,517,036	0.629041	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	15,310,150	42,913,933	58,224,083	0.105288	0.000000	54.00
54.01	03630	ULTRA SOUND	0	0	0	0.000000	0.000000	54.01
56.00	05600	RADIOISOTOPE	0	0	0	0.000000	0.000000	56.00
57.00	05700	CT SCAN	0	0	0	0.000000	0.000000	57.00
59.00	05900	CARDIAC CATHETERIZATION	5,738,611	8,406,412	14,145,023	0.184620	0.000000	59.00
60.00	06000	LABORATORY	17,994,411	26,297,119	44,291,530	0.137518	0.000000	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	662,931	179,875	842,806	0.292643	0.000000	62.00
65.00	06500	RESPIRATORY THERAPY	8,902,086	1,256,912	10,158,998	0.185352	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	2,721,508	55,560	2,777,068	0.471287	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	2,609,666	44,917	2,654,583	0.274287	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	128,167	15,985	144,152	0.967014	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	931,148	2,126,828	3,057,976	0.104738	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	2,887,550	2,027,894	4,915,444	0.262874	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	13,692,630	17,719,868	31,412,498	0.087917	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	32,194,477	15,125,390	47,319,867	0.128792	0.000000	73.00
74.00	07400	RENAL DIALYSIS	625,747	100,248	725,995	0.681407	0.000000	74.00
76.00	03950	MISC ANCILLARY	0	0	0	0.000000	0.000000	76.00
76.01	03951	SLEEP LAB	0	0	0	0.000000	0.000000	76.01
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0	0	0.000000	0.000000	76.02
76.03	03952	WOUND CARE	169,625	1,936,123	2,105,748	1.071728	0.000000	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	46,695	114,607	161,302	2.287963	0.000000	90.00
91.00	09100	EMERGENCY	7,693,369	34,657,842	42,351,211	0.152330	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1,167,361	2,769,565	3,936,926	0.416496	0.000000	92.00
200.00		Subtotal (see instructions)	184,526,116	172,323,972	356,850,088			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	184,526,116	172,323,972	356,850,088			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-0047 | Period: From 06/01/2019 To 05/31/2020 | Worksheet C Part I Date/Time Prepared: 11/2/2020 12:13 pm

Title XIX | Hospital | PPS

		Cost Center Description	PPS Inpatient Ratio	
			11.00	
		INPATIENT ROUTINE SERVICE COST CENTERS		
30.00	03000	ADULTS & PEDIATRICS		30.00
33.00	03300	BURN INTENSIVE CARE UNIT		33.00
40.00	04000	SUBPROVIDER - IPF		40.00
44.00	04400	SKILLED NURSING FACILITY		44.00
		ANCILLARY SERVICE COST CENTERS		
50.00	05000	OPERATING ROOM	0.160063	50.00
51.00	05100	RECOVERY ROOM	0.566541	51.00
53.00	05300	ANESTHESIOLOGY	0.629041	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.105288	54.00
54.01	03630	ULTRA SOUND	0.000000	54.01
56.00	05600	RADIOISOTOPE	0.000000	56.00
57.00	05700	CT SCAN	0.000000	57.00
59.00	05900	CARDIAC CATHETERIZATION	0.184620	59.00
60.00	06000	LABORATORY	0.137518	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0.292643	62.00
65.00	06500	RESPIRATORY THERAPY	0.185352	65.00
66.00	06600	PHYSICAL THERAPY	0.471287	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.274287	67.00
68.00	06800	SPEECH PATHOLOGY	0.967014	68.00
69.00	06900	ELECTROCARDIOLOGY	0.104738	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.262874	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.087917	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.128792	73.00
74.00	07400	RENAL DIALYSIS	0.681407	74.00
76.00	03950	MISC ANCILLARY	0.000000	76.00
76.01	03951	SLEEP LAB	0.000000	76.01
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0.000000	76.02
76.03	03952	WOUND CARE	1.071728	76.03
		OUTPATIENT SERVICE COST CENTERS		
90.00	09000	CLINIC	2.287963	90.00
91.00	09100	EMERGENCY	0.152330	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.416496	92.00
200.00		Subtotal (see instructions)		200.00
201.00		Less Observation Beds		201.00
202.00		Total (see instructions)		202.00

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

Provider CCN: 15-0047 | Period: From 06/01/2019 To 05/31/2020 | Worksheet C Part II | Date/Time Prepared: 11/2/2020 12:13 pm

Title XIX | Hospital | PPS

		Cost Center Description	Total Cost (Wkst. B, Part I, col. 26)	Capital Cost (Wkst. B, Part II col. 26)	Operating Cost Net of Capital Cost (col. 1 - col. 2)	Capital Reduction	Operating Cost Reduction Amount	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	3,848,151	988,927	2,859,224	0	0	50.00
51.00	05100	RECOVERY ROOM	1,008,991	341,253	667,738	0	0	51.00
53.00	05300	ANESTHESIOLOGY	1,583,320	12,438	1,570,882	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	6,130,280	1,042,191	5,088,089	0	0	54.00
54.01	03630	ULTRA SOUND	0	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
59.00	05900	CARDIAC CATHETERIZATION	2,611,456	170,552	2,440,904	0	0	59.00
60.00	06000	LABORATORY	6,090,871	895,205	5,195,666	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	246,641	48,309	198,332	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	1,882,988	331,759	1,551,229	0	0	65.00
66.00	06600	PHYSICAL THERAPY	1,308,797	390,962	917,835	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	728,118	155,407	572,711	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	139,397	56,520	82,877	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	320,286	63,648	256,638	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1,292,142	59,539	1,232,603	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	2,761,693	178,646	2,583,047	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	6,094,438	291,700	5,802,738	0	0	73.00
74.00	07400	RENAL DIALYSIS	494,698	105,599	389,099	0	0	74.00
76.00	03950	MISC ANCILLARY	0	0	0	0	0	76.00
76.01	03951	SLEEP LAB	0	0	0	0	0	76.01
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0	0	0	0	76.02
76.03	03952	WOUND CARE	2,256,789	472,515	1,784,274	0	0	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	369,053	118,376	250,677	0	0	90.00
91.00	09100	EMERGENCY	6,451,361	918,882	5,532,479	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1,639,715	259,267	1,380,448	0	0	92.00
200.00		Subtotal (sum of lines 50 thru 199)	47,259,185	6,901,695	40,357,490	0	0	200.00
201.00		Less Observation Beds	1,639,715	259,267	1,380,448	0	0	201.00
202.00		Total (line 200 minus line 201)	45,619,470	6,642,428	38,977,042	0	0	202.00

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

Provider CCN: 15-0047 | Period: From 06/01/2019 To 05/31/2020 | Worksheet C Part II Date/Time Prepared: 11/2/2020 12:13 pm

Title XIX | Hospital | PPS

		Cost Center Description	Cost Net of Capital and Operating Cost Reduction	Total Charges (Worksheet C, Part I, column 8)	Outpatient Cost to Charge Ratio (col. 6 / col. 7)		
			6.00	7.00	8.00		
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	3,848,151	24,041,550	0.160063		50.00
51.00	05100	RECOVERY ROOM	1,008,991	1,780,968	0.566541		51.00
53.00	05300	ANESTHESIOLOGY	1,583,320	2,517,036	0.629041		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	6,130,280	58,224,083	0.105288		54.00
54.01	03630	ULTRA SOUND	0	0	0.000000		54.01
56.00	05600	RADIOISOTOPE	0	0	0.000000		56.00
57.00	05700	CT SCAN	0	0	0.000000		57.00
59.00	05900	CARDIAC CATHETERIZATION	2,611,456	14,145,023	0.184620		59.00
60.00	06000	LABORATORY	6,090,871	44,291,530	0.137518		60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	246,641	842,806	0.292643		62.00
65.00	06500	RESPIRATORY THERAPY	1,882,988	10,158,998	0.185352		65.00
66.00	06600	PHYSICAL THERAPY	1,308,797	2,777,068	0.471287		66.00
67.00	06700	OCCUPATIONAL THERAPY	728,118	2,654,583	0.274287		67.00
68.00	06800	SPEECH PATHOLOGY	139,397	144,152	0.967014		68.00
69.00	06900	ELECTROCARDIOLOGY	320,286	3,057,976	0.104738		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1,292,142	4,915,444	0.262874		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	2,761,693	31,412,498	0.087917		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	6,094,438	47,319,867	0.128792		73.00
74.00	07400	RENAL DIALYSIS	494,698	725,995	0.681407		74.00
76.00	03950	MISC ANCILLARY	0	0	0.000000		76.00
76.01	03951	SLEEP LAB	0	0	0.000000		76.01
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0	0.000000		76.02
76.03	03952	WOUND CARE	2,256,789	2,105,748	1.071728		76.03
		OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	369,053	161,302	2.287963		90.00
91.00	09100	EMERGENCY	6,451,361	42,351,211	0.152330		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1,639,715	3,936,926	0.416496		92.00
200.00		Subtotal (sum of lines 50 thru 199)	47,259,185	297,564,764			200.00
201.00		Less Observation Beds	1,639,715	0			201.00
202.00		Total (line 200 minus line 201)	45,619,470	297,564,764			202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

Provider CCN: 15-0047 | Period: From 06/01/2019 To 05/31/2020 | Worksheet D Part I | Date/Time Prepared: 11/2/2020 12:13 pm

Title XVIII | Hospital | PPS

	Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	2,736,114	0	2,736,114	13,276	206.09	30.00
33.00	BURN INTENSIVE CARE UNIT	552,401		552,401	976	565.98	33.00
40.00	SUBPROVIDER - IPF	431,250	0	431,250	3,859	111.75	40.00
44.00	SKILLED NURSING FACILITY	622,523		622,523	4,321	144.07	44.00
200.00	Total (lines 30 through 199)	4,342,288		4,342,288	22,432		200.00

	Cost Center Description	Inpatient Program days	Inpatient Program Capital Cost (col. 5 x col. 6)				
		6.00	7.00				
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	2,247	463,084				30.00
33.00	BURN INTENSIVE CARE UNIT	620	350,908				33.00
40.00	SUBPROVIDER - IPF	1,972	220,371				40.00
44.00	SKILLED NURSING FACILITY	1,196	172,308				44.00
200.00	Total (lines 30 through 199)	6,035	1,206,671				200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS | Provider CCN: 15-0047 | Period: From 06/01/2019 To 05/31/2020 | Worksheet D Part II Date/Time Prepared: 11/2/2020 12:13 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	988,927	24,041,550	0.041134	1,965,122	80,833	50.00
51.00	05100	RECOVERY ROOM	341,253	1,780,968	0.191611	154,093	29,526	51.00
53.00	05300	ANESTHESIOLOGY	12,438	2,517,036	0.004942	196,643	972	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,042,191	58,224,083	0.017900	3,479,730	62,287	54.00
54.01	03630	ULTRA SOUND	0	0	0.000000	0	0	54.01
56.00	05600	RADIOISOTOPE	0	0	0.000000	0	0	56.00
57.00	05700	CT SCAN	0	0	0.000000	0	0	57.00
59.00	05900	CARDIAC CATHETERIZATION	170,552	14,145,023	0.012057	1,479,413	17,837	59.00
60.00	06000	LABORATORY	895,205	44,291,530	0.020212	3,257,060	65,832	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	48,309	842,806	0.057319	128,936	7,390	62.00
65.00	06500	RESPIRATORY THERAPY	331,759	10,158,998	0.032657	2,097,208	68,489	65.00
66.00	06600	PHYSICAL THERAPY	390,962	2,777,068	0.140782	186,993	26,325	66.00
67.00	06700	OCCUPATIONAL THERAPY	155,407	2,654,583	0.058543	164,716	9,643	67.00
68.00	06800	SPEECH PATHOLOGY	56,520	144,152	0.392086	26,713	10,474	68.00
69.00	06900	ELECTROCARDIOLOGY	63,648	3,057,976	0.020814	207,141	4,311	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	59,539	4,915,444	0.012113	623,461	7,552	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	178,646	31,412,498	0.005687	3,205,640	18,230	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	291,700	47,319,867	0.006164	6,104,822	37,630	73.00
74.00	07400	RENAL DIALYSIS	105,599	725,995	0.145454	537,775	78,222	74.00
76.00	03950	MISC ANCILLARY	0	0	0.000000	0	0	76.00
76.01	03951	SLEEP LAB	0	0	0.000000	0	0	76.01
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0	0.000000	0	0	76.02
76.03	03952	WOUND CARE	472,515	2,105,748	0.224393	3,514	789	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	118,376	161,302	0.733878	0	0	90.00
91.00	09100	EMERGENCY	918,882	42,351,211	0.021697	1,276,886	27,705	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	259,267	3,936,926	0.065855	186,782	12,301	92.00
200.00		Total (lines 50 through 199)	6,901,695	297,564,764		25,282,648	566,348	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 15-0047 | Period: From 06/01/2019 To 05/31/2020 | Worksheet D Part III Date/Time Prepared: 11/2/2020 12:13 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health Cost	All Other Medical Education Cost	
			1A	1.00	2A	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	0	30.00
33.00	03300	BURN INTENSIVE CARE UNIT	0	0	0	0	0	33.00
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	0	40.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0		44.00
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	13,276	0.00	2,247	30.00
33.00	03300	BURN INTENSIVE CARE UNIT		0	976	0.00	620	33.00
40.00	04000	SUBPROVIDER - IPF	0	0	3,859	0.00	1,972	40.00
44.00	04400	SKILLED NURSING FACILITY		0	4,321	0.00	1,196	44.00
200.00		Total (lines 30 through 199)		0	22,432		6,035	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
33.00	03300	BURN INTENSIVE CARE UNIT	0	33.00
40.00	04000	SUBPROVIDER - IPF	0	40.00
44.00	04400	SKILLED NURSING FACILITY	0	44.00
200.00		Total (lines 30 through 199)	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-0047 | Period: From 06/01/2019 To 05/31/2020 | Worksheet D Part IV | Date/Time Prepared: 11/2/2020 12:13 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health	
			1.00	2A	2.00	3A	3.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
54.01	03630	ULTRA SOUND	0	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.00	03950	MISC ANCILLARY	0	0	0	0	0	76.00
76.01	03951	SLEEP LAB	0	0	0	0	0	76.01
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0	0	0	0	76.02
76.03	03952	WOUND CARE	0	0	0	0	0	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0		0		0	92.00
200.00		Total (lines 50 through 199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-0047 | Period: From 06/01/2019 To 05/31/2020 | Worksheet D Part IV Date/Time Prepared: 11/2/2020 12:13 pm

Title XVIII | Hospital | PPS

		Cost Center Description	All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7) (see instructions)	
			4.00	5.00	6.00	7.00	8.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	24,041,550	0.000000	50.00
51.00	05100	RECOVERY ROOM	0	0	0	1,780,968	0.000000	51.00
53.00	05300	ANESTHESIOLOGY	0	0	0	2,517,036	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	58,224,083	0.000000	54.00
54.01	03630	ULTRA SOUND	0	0	0	0	0.000000	54.01
56.00	05600	RADIOISOTOPE	0	0	0	0	0.000000	56.00
57.00	05700	CT SCAN	0	0	0	0	0.000000	57.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	14,145,023	0.000000	59.00
60.00	06000	LABORATORY	0	0	0	44,291,530	0.000000	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0	842,806	0.000000	62.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	10,158,998	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	2,777,068	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	2,654,583	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	144,152	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	3,057,976	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	4,915,444	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	31,412,498	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	47,319,867	0.000000	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	725,995	0.000000	74.00
76.00	03950	MISC ANCILLARY	0	0	0	0	0.000000	76.00
76.01	03951	SLEEP LAB	0	0	0	0	0.000000	76.01
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0	0	0	0.000000	76.02
76.03	03952	WOUND CARE	0	0	0	2,105,748	0.000000	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	161,302	0.000000	90.00
91.00	09100	EMERGENCY	0	0	0	42,351,211	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	3,936,926	0.000000	92.00
200.00		Total (lines 50 through 199)	0	0	0	297,564,764		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-0047 | Period: From 06/01/2019 To 05/31/2020 | Worksheet D Part IV Date/Time Prepared: 11/2/2020 12:13 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
			9.00	10.00	11.00	12.00	13.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.000000	1,965,122	0	2,664,806	0	50.00
51.00	05100	RECOVERY ROOM	0.000000	154,093	0	205,044	0	51.00
53.00	05300	ANESTHESIOLOGY	0.000000	196,643	0	223,018	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	3,479,730	0	5,150,793	0	54.00
54.01	03630	ULTRA SOUND	0.000000	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0.000000	0	0	0	0	56.00
57.00	05700	CT SCAN	0.000000	0	0	0	0	57.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	1,479,413	0	2,285,444	0	59.00
60.00	06000	LABORATORY	0.000000	3,257,060	0	1,372,263	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0.000000	128,936	0	35,040	0	62.00
65.00	06500	RESPIRATORY THERAPY	0.000000	2,097,208	0	163,163	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	186,993	0	238	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	164,716	0	209	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	26,713	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	207,141	0	291,783	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	623,461	0	386,066	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	3,205,640	0	5,398,814	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	6,104,822	0	3,224,085	0	73.00
74.00	07400	RENAL DIALYSIS	0.000000	537,775	0	52,081	0	74.00
76.00	03950	MISC ANCILLARY	0.000000	0	0	0	0	76.00
76.01	03951	SLEEP LAB	0.000000	0	0	0	0	76.01
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0.000000	0	0	0	0	76.02
76.03	03952	WOUND CARE	0.000000	3,514	0	704,208	0	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.000000	0	0	14,339	0	90.00
91.00	09100	EMERGENCY	0.000000	1,276,886	0	2,790,718	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	186,782	0	407,640	0	92.00
200.00		Total (lines 50 through 199)		25,282,648	0	25,369,752	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-0047 | Period: From 06/01/2019 To 05/31/2020 | Worksheet D Part V Date/Time Prepared: 11/2/2020 12:13 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.160063	2,664,806	0	0	426,537	50.00
51.00	05100	RECOVERY ROOM	0.566541	205,044	0	0	116,166	51.00
53.00	05300	ANESTHESIOLOGY	0.629041	223,018	0	0	140,287	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.105288	5,150,793	0	0	542,317	54.00
54.01	03630	ULTRA SOUND	0.000000	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0.000000	0	0	0	0	56.00
57.00	05700	CT SCAN	0.000000	0	0	0	0	57.00
59.00	05900	CARDIAC CATHETERIZATION	0.184620	2,285,444	32,188	0	421,939	59.00
60.00	06000	LABORATORY	0.137518	1,372,263	0	0	188,711	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0.292643	35,040	0	0	10,254	62.00
65.00	06500	RESPIRATORY THERAPY	0.185352	163,163	0	0	30,243	65.00
66.00	06600	PHYSICAL THERAPY	0.471287	238	0	0	112	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.274287	209	0	0	57	67.00
68.00	06800	SPEECH PATHOLOGY	0.967014	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.104738	291,783	0	0	30,561	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.262874	386,066	0	0	101,487	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.087917	5,398,814	0	0	474,648	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.128792	3,224,085	0	49,618	415,236	73.00
74.00	07400	RENAL DIALYSIS	0.681407	52,081	0	0	35,488	74.00
76.00	03950	MISC ANCILLARY	0.000000	0	0	0	0	76.00
76.01	03951	SLEEP LAB	0.000000	0	0	0	0	76.01
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0.000000	0	0	0	0	76.02
76.03	03952	WOUND CARE	1.071728	704,208	0	0	754,719	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	2.287963	14,339	0	0	32,807	90.00
91.00	09100	EMERGENCY	0.152330	2,790,718	0	0	425,110	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.416496	407,640	0	0	169,780	92.00
200.00		Subtotal (see instructions)		25,369,752	32,188	49,618	4,316,459	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 - line 201)		25,369,752	32,188	49,618	4,316,459	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-0047 | Period: From 06/01/2019 To 05/31/2020 | Worksheet D Part V Date/Time Prepared: 11/2/2020 12:13 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Costs: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	0		50.00
51.00	05100	RECOVERY ROOM	0	0		51.00
53.00	05300	ANESTHESIOLOGY	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0		54.00
54.01	03630	ULTRA SOUND	0	0		54.01
56.00	05600	RADIOISOTOPE	0	0		56.00
57.00	05700	CT SCAN	0	0		57.00
59.00	05900	CARDIAC CATHETERIZATION	5,943	0		59.00
60.00	06000	LABORATORY	0	0		60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0		62.00
65.00	06500	RESPIRATORY THERAPY	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	6,390		73.00
74.00	07400	RENAL DIALYSIS	0	0		74.00
76.00	03950	MISC ANCILLARY	0	0		76.00
76.01	03951	SLEEP LAB	0	0		76.01
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0		76.02
76.03	03952	WOUND CARE	0	0		76.03
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0	0		90.00
91.00	09100	EMERGENCY	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0		92.00
200.00		Subtotal (see instructions)	5,943	6,390		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	5,943	6,390		202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 15-0047 | Component CCN: 15-S047 | Period: From 06/01/2019 To 05/31/2020 | Worksheet D Part II Date/Time Prepared: 11/2/2020 12:13 pm

Title XVIII | Subprovider - IPF | PPS

		Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	988,927	24,041,550	0.041134	43,842	1,803	50.00
51.00	05100	RECOVERY ROOM	341,253	1,780,968	0.191611	0	0	51.00
53.00	05300	ANESTHESIOLOGY	12,438	2,517,036	0.004942	1,103	5	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,042,191	58,224,083	0.017900	462,902	8,286	54.00
54.01	03630	ULTRA SOUND	0	0	0.000000	0	0	54.01
56.00	05600	RADIOISOTOPE	0	0	0.000000	0	0	56.00
57.00	05700	CT SCAN	0	0	0.000000	0	0	57.00
59.00	05900	CARDIAC CATHETERIZATION	170,552	14,145,023	0.012057	0	0	59.00
60.00	06000	LABORATORY	895,205	44,291,530	0.020212	934,258	18,883	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	48,309	842,806	0.057319	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	331,759	10,158,998	0.032657	131,724	4,302	65.00
66.00	06600	PHYSICAL THERAPY	390,962	2,777,068	0.140782	133,527	18,798	66.00
67.00	06700	OCCUPATIONAL THERAPY	155,407	2,654,583	0.058543	147,603	8,641	67.00
68.00	06800	SPEECH PATHOLOGY	56,520	144,152	0.392086	21,304	8,353	68.00
69.00	06900	ELECTROCARDIOLOGY	63,648	3,057,976	0.020814	47,961	998	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	59,539	4,915,444	0.012113	11,793	143	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	178,646	31,412,498	0.005687	135,437	770	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	291,700	47,319,867	0.006164	824,909	5,085	73.00
74.00	07400	RENAL DIALYSIS	105,599	725,995	0.145454	0	0	74.00
76.00	03950	MISC ANCILLARY	0	0	0.000000	0	0	76.00
76.01	03951	SLEEP LAB	0	0	0.000000	0	0	76.01
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0	0.000000	0	0	76.02
76.03	03952	WOUND CARE	472,515	2,105,748	0.224393	205	46	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	118,376	161,302	0.733878	0	0	90.00
91.00	09100	EMERGENCY	918,882	42,351,211	0.021697	260,315	5,648	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	3,936,926	0.000000	0	0	92.00
200.00		Total (lines 50 through 199)	6,642,428	297,564,764		3,156,883	81,761	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-0047
Component CCN: 15-S047
Period: From 06/01/2019 To 05/31/2020
Worksheet D Part IV
Date/Time Prepared: 11/2/2020 12:13 pm
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
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
54.01	03630	ULTRA SOUND	0	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.00	03950	MISC ANCILLARY	0	0	0	0	0	76.00
76.01	03951	SLEEP LAB	0	0	0	0	0	76.01
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0	0	0	0	76.02
76.03	03952	WOUND CARE	0	0	0	0	0	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0		0		0	92.00
200.00		Total (lines 50 through 199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-0047 | Component CCN: 15-S047 | Period: From 06/01/2019 To 05/31/2020 | Worksheet D Part IV Date/Time Prepared: 11/2/2020 12:13 pm

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	24,041,550	0.000000	50.00
51.00	05100	RECOVERY ROOM	0	0	0	1,780,968	0.000000	51.00
53.00	05300	ANESTHESIOLOGY	0	0	0	2,517,036	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	58,224,083	0.000000	54.00
54.01	03630	ULTRA SOUND	0	0	0	0	0.000000	54.01
56.00	05600	RADIOISOTOPE	0	0	0	0	0.000000	56.00
57.00	05700	CT SCAN	0	0	0	0	0.000000	57.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	14,145,023	0.000000	59.00
60.00	06000	LABORATORY	0	0	0	44,291,530	0.000000	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0	842,806	0.000000	62.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	10,158,998	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	2,777,068	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	2,654,583	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	144,152	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	3,057,976	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	4,915,444	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	31,412,498	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	47,319,867	0.000000	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	725,995	0.000000	74.00
76.00	03950	MISC ANCILLARY	0	0	0	0	0.000000	76.00
76.01	03951	SLEEP LAB	0	0	0	0	0.000000	76.01
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0	0	0	0.000000	76.02
76.03	03952	WOUND CARE	0	0	0	2,105,748	0.000000	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	161,302	0.000000	90.00
91.00	09100	EMERGENCY	0	0	0	42,351,211	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	3,936,926	0.000000	92.00
200.00		Total (lines 50 through 199)	0	0	0	297,564,764		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-0047 | Component CCN: 15-S047 | Period: From 06/01/2019 To 05/31/2020 | Worksheet D Part IV Date/Time Prepared: 11/2/2020 12:13 pm

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	43,842	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0.000000	0	0	0	0	51.00
53.00	05300	ANESTHESIOLOGY	0.000000	1,103	0	306	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	462,902	0	17,947	0	54.00
54.01	03630	ULTRA SOUND	0.000000	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0.000000	0	0	0	0	56.00
57.00	05700	CT SCAN	0.000000	0	0	0	0	57.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	0	0	0	0	59.00
60.00	06000	LABORATORY	0.000000	934,258	0	3,877	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0.000000	0	0	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	0.000000	131,724	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	133,527	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	147,603	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	21,304	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	47,961	0	584	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	11,793	0	9,052	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	135,437	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	824,909	0	180	0	73.00
74.00	07400	RENAL DIALYSIS	0.000000	0	0	0	0	74.00
76.00	03950	MISC ANCILLARY	0.000000	0	0	0	0	76.00
76.01	03951	SLEEP LAB	0.000000	0	0	0	0	76.01
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0.000000	0	0	0	0	76.02
76.03	03952	WOUND CARE	0.000000	205	0	0	0	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.000000	0	0	1,710	0	90.00
91.00	09100	EMERGENCY	0.000000	260,315	0	5,616	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	0	0	0	0	92.00
200.00		Total (lines 50 through 199)		3,156,883	0	39,272	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 15-0047 | Component CCN: 15-S047 | Period: From 06/01/2019 To 05/31/2020 | Worksheet D Part V Date/Time Prepared: 11/2/2020 12:13 pm

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	0.160063	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0.566541	0	0	0	0	51.00
53.00	05300	ANESTHESIOLOGY	0.629041	306	0	0	192	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.105288	17,947	0	0	1,890	54.00
54.01	03630	ULTRA SOUND	0.000000	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0.000000	0	0	0	0	56.00
57.00	05700	CT SCAN	0.000000	0	0	0	0	57.00
59.00	05900	CARDIAC CATHETERIZATION	0.184620	0	0	0	0	59.00
60.00	06000	LABORATORY	0.137518	3,877	0	0	533	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0.292643	0	0	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	0.185352	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.471287	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.274287	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.967014	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.104738	584	0	0	61	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.262874	9,052	0	0	2,380	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.087917	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.128792	180	0	8,813	23	73.00
74.00	07400	RENAL DIALYSIS	0.681407	0	0	0	0	74.00
76.00	03950	MISC ANCILLARY	0.000000	0	0	0	0	76.00
76.01	03951	SLEEP LAB	0.000000	0	0	0	0	76.01
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0.000000	0	0	0	0	76.02
76.03	03952	WOUND CARE	1.071728	0	0	0	0	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	2.287963	1,710	0	0	3,912	90.00
91.00	09100	EMERGENCY	0.152330	5,616	0	0	855	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.416496	0	0	0	0	92.00
200.00		Subtotal (see instructions)		39,272	0	8,813	9,846	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 - line 201)		39,272	0	8,813	9,846	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 15-0047 | Component CCN: 15-S047 | Period: From 06/01/2019 To 05/31/2020 | Worksheet D Part V | Date/Time Prepared: 11/2/2020 12:13 pm

Title XVIII | Subprovider - IPF | 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
51.00	05100	RECOVERY ROOM	0	0		51.00
53.00	05300	ANESTHESIOLOGY	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0		54.00
54.01	03630	ULTRA SOUND	0	0		54.01
56.00	05600	RADIOISOTOPE	0	0		56.00
57.00	05700	CT SCAN	0	0		57.00
59.00	05900	CARDIAC CATHETERIZATION	0	0		59.00
60.00	06000	LABORATORY	0	0		60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0		62.00
65.00	06500	RESPIRATORY THERAPY	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	1,135		73.00
74.00	07400	RENAL DIALYSIS	0	0		74.00
76.00	03950	MISC ANCILLARY	0	0		76.00
76.01	03951	SLEEP LAB	0	0		76.01
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0		76.02
76.03	03952	WOUND CARE	0	0		76.03
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0	0		90.00
91.00	09100	EMERGENCY	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0		92.00
200.00		Subtotal (see instructions)	0	1,135		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	0	1,135		202.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-0047
Component CCN: 15-5356

Period:
From 06/01/2019
To 05/31/2020

Worksheet D
Part IV
Date/Time Prepared:
11/2/2020 12:13 pm

Title XVIII | Skilled Nursing Facility | PPS

		Cost Center Description	Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health	
			1.00	2A	2.00	3A	3.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
54.01	03630	ULTRA SOUND	0	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.00	03950	MISC ANCILLARY	0	0	0	0	0	76.00
76.01	03951	SLEEP LAB	0	0	0	0	0	76.01
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0	0	0	0	76.02
76.03	03952	WOUND CARE	0	0	0	0	0	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0		0		0	92.00
200.00		Total (lines 50 through 199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-0047 | Component CCN: 15-5356 | Period: From 06/01/2019 To 05/31/2020 | Worksheet D Part IV Date/Time Prepared: 11/2/2020 12:13 pm

Title XVIII | Skilled Nursing Facility | 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	24,041,550	0.000000	50.00
51.00	05100	RECOVERY ROOM	0	0	0	1,780,968	0.000000	51.00
53.00	05300	ANESTHESIOLOGY	0	0	0	2,517,036	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	58,224,083	0.000000	54.00
54.01	03630	ULTRA SOUND	0	0	0	0	0.000000	54.01
56.00	05600	RADIOISOTOPE	0	0	0	0	0.000000	56.00
57.00	05700	CT SCAN	0	0	0	0	0.000000	57.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	14,145,023	0.000000	59.00
60.00	06000	LABORATORY	0	0	0	44,291,530	0.000000	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0	842,806	0.000000	62.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	10,158,998	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	2,777,068	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	2,654,583	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	144,152	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	3,057,976	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	4,915,444	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	31,412,498	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	47,319,867	0.000000	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	725,995	0.000000	74.00
76.00	03950	MISC ANCILLARY	0	0	0	0	0.000000	76.00
76.01	03951	SLEEP LAB	0	0	0	0	0.000000	76.01
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0	0	0	0.000000	76.02
76.03	03952	WOUND CARE	0	0	0	2,105,748	0.000000	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	161,302	0.000000	90.00
91.00	09100	EMERGENCY	0	0	0	42,351,211	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	3,936,926	0.000000	92.00
200.00		Total (lines 50 through 199)	0	0	0	297,564,764		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-0047
Component CCN: 15-5356
Period: From 06/01/2019 To 05/31/2020
Worksheet D Part IV
Date/Time Prepared: 11/2/2020 12:13 pm

Title XVIII | Skilled Nursing Facility | PPS

		Cost Center Description	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
			9.00	10.00	11.00	12.00	13.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.000000	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0.000000	0	0	0	0	51.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	79,682	0	0	0	54.00
54.01	03630	ULTRA SOUND	0.000000	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0.000000	0	0	0	0	56.00
57.00	05700	CT SCAN	0.000000	0	0	0	0	57.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	0	0	0	0	59.00
60.00	06000	LABORATORY	0.000000	312,060	0	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0.000000	0	0	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	0.000000	420,604	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	440,935	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	454,907	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	5,847	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	3,825	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	43,733	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	994,191	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0.000000	0	0	0	0	74.00
76.00	03950	MISC ANCILLARY	0.000000	0	0	0	0	76.00
76.01	03951	SLEEP LAB	0.000000	0	0	0	0	76.01
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0.000000	0	0	0	0	76.02
76.03	03952	WOUND CARE	0.000000	58,042	0	0	0	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.000000	0	0	0	0	90.00
91.00	09100	EMERGENCY	0.000000	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	0	0	0	0	92.00
200.00		Total (lines 50 through 199)		2,813,826	0	0	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 15-0047 | Component CCN: 15-5356 | Period: From 06/01/2019 To 05/31/2020 | Worksheet D Part V Date/Time Prepared: 11/2/2020 12:13 pm

Title XVIII | Skilled Nursing Facility | 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	0.160063	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0.566541	0	0	0	0	51.00
53.00	05300	ANESTHESIOLOGY	0.629041	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.105288	0	0	0	0	54.00
54.01	03630	ULTRA SOUND	0.000000	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0.000000	0	0	0	0	56.00
57.00	05700	CT SCAN	0.000000	0	0	0	0	57.00
59.00	05900	CARDIAC CATHETERIZATION	0.184620	0	0	0	0	59.00
60.00	06000	LABORATORY	0.137518	0	0	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0.292643	0	0	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	0.185352	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.471287	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.274287	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.967014	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.104738	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.262874	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.087917	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.128792	0	0	184	0	73.00
74.00	07400	RENAL DIALYSIS	0.681407	0	0	0	0	74.00
76.00	03950	MISC ANCILLARY	0.000000	0	0	0	0	76.00
76.01	03951	SLEEP LAB	0.000000	0	0	0	0	76.01
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0.000000	0	0	0	0	76.02
76.03	03952	WOUND CARE	1.071728	0	0	0	0	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	2.287963	0	0	0	0	90.00
91.00	09100	EMERGENCY	0.152330	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.416496	0	0	0	0	92.00
200.00		Subtotal (see instructions)		0	0	184	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 - line 201)		0	0	184	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 15-0047 | Component CCN: 15-5356 | Period: From 06/01/2019 To 05/31/2020 | Worksheet D Part V Date/Time Prepared: 11/2/2020 12:13 pm

Title XVIII | Skilled Nursing Facility | 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
51.00	05100	RECOVERY ROOM	0	0		51.00
53.00	05300	ANESTHESIOLOGY	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0		54.00
54.01	03630	ULTRA SOUND	0	0		54.01
56.00	05600	RADIOISOTOPE	0	0		56.00
57.00	05700	CT SCAN	0	0		57.00
59.00	05900	CARDIAC CATHETERIZATION	0	0		59.00
60.00	06000	LABORATORY	0	0		60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0		62.00
65.00	06500	RESPIRATORY THERAPY	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	24		73.00
74.00	07400	RENAL DIALYSIS	0	0		74.00
76.00	03950	MISC ANCILLARY	0	0		76.00
76.01	03951	SLEEP LAB	0	0		76.01
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0		76.02
76.03	03952	WOUND CARE	0	0		76.03
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0	0		90.00
91.00	09100	EMERGENCY	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0		92.00
200.00		Subtotal (see instructions)	0	24		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	0	24		202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS | Provider CCN: 15-0047 | Period: From 06/01/2019 To 05/31/2020 | Worksheet D Part I Date/Time Prepared: 11/2/2020 12:13 pm

Title XIX | Hospital | PPS

	Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	2,736,114	0	2,736,114	13,276	206.09	30.00
33.00	BURN INTENSIVE CARE UNIT	552,401		552,401	976	565.98	33.00
40.00	SUBPROVIDER - IPF	431,250	0	431,250	3,859	111.75	40.00
44.00	SKILLED NURSING FACILITY	622,523		622,523	4,321	144.07	44.00
200.00	Total (lines 30 through 199)	4,342,288		4,342,288	22,432		200.00

	Cost Center Description	Inpatient Program days	Inpatient Program Capital Cost (col. 5 x col. 6)				
		6.00	7.00				
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	2,052	422,897				30.00
33.00	BURN INTENSIVE CARE UNIT	149	84,331				33.00
40.00	SUBPROVIDER - IPF	130	14,528				40.00
44.00	SKILLED NURSING FACILITY	63	9,076				44.00
200.00	Total (lines 30 through 199)	2,394	530,832				200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS | Provider CCN: 15-0047 | Period: From 06/01/2019 To 05/31/2020 | Worksheet D Part II Date/Time Prepared: 11/2/2020 12:13 pm

Title XIX | Hospital | PPS

		Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	988,927	24,041,550	0.041134	817,329	33,620	50.00
51.00	05100	RECOVERY ROOM	341,253	1,780,968	0.191611	75,577	14,481	51.00
53.00	05300	ANESTHESIOLOGY	12,438	2,517,036	0.004942	133,822	661	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,042,191	58,224,083	0.017900	1,639,980	29,356	54.00
54.01	03630	ULTRA SOUND	0	0	0.000000	0	0	54.01
56.00	05600	RADIOISOTOPE	0	0	0.000000	0	0	56.00
57.00	05700	CT SCAN	0	0	0.000000	0	0	57.00
59.00	05900	CARDIAC CATHETERIZATION	170,552	14,145,023	0.012057	615,304	7,419	59.00
60.00	06000	LABORATORY	895,205	44,291,530	0.020212	2,001,646	40,457	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	48,309	842,806	0.057319	105,551	6,050	62.00
65.00	06500	RESPIRATORY THERAPY	331,759	10,158,998	0.032657	820,445	26,793	65.00
66.00	06600	PHYSICAL THERAPY	390,962	2,777,068	0.140782	73,872	10,400	66.00
67.00	06700	OCCUPATIONAL THERAPY	155,407	2,654,583	0.058543	62,269	3,645	67.00
68.00	06800	SPEECH PATHOLOGY	56,520	144,152	0.392086	10,135	3,974	68.00
69.00	06900	ELECTROCARDIOLOGY	63,648	3,057,976	0.020814	111,388	2,318	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	59,539	4,915,444	0.012113	255,228	3,092	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	178,646	31,412,498	0.005687	1,041,457	5,923	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	291,700	47,319,867	0.006164	2,937,839	18,109	73.00
74.00	07400	RENAL DIALYSIS	105,599	725,995	0.145454	62,084	9,030	74.00
76.00	03950	MISC ANCILLARY	0	0	0.000000	0	0	76.00
76.01	03951	SLEEP LAB	0	0	0.000000	0	0	76.01
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0	0.000000	0	0	76.02
76.03	03952	WOUND CARE	472,515	2,105,748	0.224393	1,784	400	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	118,376	161,302	0.733878	5,512	4,045	90.00
91.00	09100	EMERGENCY	918,882	42,351,211	0.021697	903,723	19,608	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	259,267	3,936,926	0.065855	160,417	10,564	92.00
200.00		Total (lines 50 through 199)	6,901,695	297,564,764		11,835,362	249,945	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 15-0047 | Period: From 06/01/2019 To 05/31/2020 | Worksheet D Part III Date/Time Prepared: 11/2/2020 12:13 pm

Title XIX | Hospital | PPS

		Cost Center Description	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health Cost	All Other Medical Education Cost	
			1A	1.00	2A	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	0	30.00
33.00	03300	BURN INTENSIVE CARE UNIT	0	0	0	0	0	33.00
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	0	40.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0		44.00
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	13,276	0.00	2,052	30.00
33.00	03300	BURN INTENSIVE CARE UNIT		0	976	0.00	149	33.00
40.00	04000	SUBPROVIDER - IPF	0	0	3,859	0.00	130	40.00
44.00	04400	SKILLED NURSING FACILITY		0	4,321	0.00	63	44.00
200.00		Total (lines 30 through 199)		0	22,432		2,394	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
33.00	03300	BURN INTENSIVE CARE UNIT	0	33.00
40.00	04000	SUBPROVIDER - IPF	0	40.00
44.00	04400	SKILLED NURSING FACILITY	0	44.00
200.00		Total (lines 30 through 199)	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-0047 | Period: From 06/01/2019 To 05/31/2020 | Worksheet D Part IV | Date/Time Prepared: 11/2/2020 12:13 pm

Title XIX | Hospital | PPS

		Cost Center Description	Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health	
			1.00	2A	2.00	3A	3.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
54.01	03630	ULTRA SOUND	0	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.00	03950	MISC ANCILLARY	0	0	0	0	0	76.00
76.01	03951	SLEEP LAB	0	0	0	0	0	76.01
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0	0	0	0	76.02
76.03	03952	WOUND CARE	0	0	0	0	0	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0		0		0	92.00
200.00		Total (lines 50 through 199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-0047 | Period: From 06/01/2019 To 05/31/2020 | Worksheet D Part IV Date/Time Prepared: 11/2/2020 12:13 pm

Title XIX | Hospital | PPS

		Cost Center Description	All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7) (see instructions)	
			4.00	5.00	6.00	7.00	8.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	24,041,550	0.000000	50.00
51.00	05100	RECOVERY ROOM	0	0	0	1,780,968	0.000000	51.00
53.00	05300	ANESTHESIOLOGY	0	0	0	2,517,036	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	58,224,083	0.000000	54.00
54.01	03630	ULTRA SOUND	0	0	0	0	0.000000	54.01
56.00	05600	RADIOISOTOPE	0	0	0	0	0.000000	56.00
57.00	05700	CT SCAN	0	0	0	0	0.000000	57.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	14,145,023	0.000000	59.00
60.00	06000	LABORATORY	0	0	0	44,291,530	0.000000	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0	842,806	0.000000	62.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	10,158,998	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	2,777,068	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	2,654,583	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	144,152	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	3,057,976	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	4,915,444	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	31,412,498	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	47,319,867	0.000000	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	725,995	0.000000	74.00
76.00	03950	MISC ANCILLARY	0	0	0	0	0.000000	76.00
76.01	03951	SLEEP LAB	0	0	0	0	0.000000	76.01
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0	0	0	0.000000	76.02
76.03	03952	WOUND CARE	0	0	0	2,105,748	0.000000	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	161,302	0.000000	90.00
91.00	09100	EMERGENCY	0	0	0	42,351,211	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	3,936,926	0.000000	92.00
200.00		Total (lines 50 through 199)	0	0	0	297,564,764		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-0047 | Period: From 06/01/2019 To 05/31/2020 | Worksheet D Part IV | Date/Time Prepared: 11/2/2020 12:13 pm

Title XIX | Hospital | PPS

		Cost Center Description	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
			9.00	10.00	11.00	12.00	13.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.000000	817,329	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0.000000	75,577	0	0	0	51.00
53.00	05300	ANESTHESIOLOGY	0.000000	133,822	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	1,639,980	0	0	0	54.00
54.01	03630	ULTRA SOUND	0.000000	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0.000000	0	0	0	0	56.00
57.00	05700	CT SCAN	0.000000	0	0	0	0	57.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	615,304	0	0	0	59.00
60.00	06000	LABORATORY	0.000000	2,001,646	0	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0.000000	105,551	0	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	0.000000	820,445	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	73,872	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	62,269	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	10,135	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	111,388	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	255,228	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	1,041,457	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	2,937,839	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0.000000	62,084	0	0	0	74.00
76.00	03950	MISC ANCILLARY	0.000000	0	0	0	0	76.00
76.01	03951	SLEEP LAB	0.000000	0	0	0	0	76.01
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0.000000	0	0	0	0	76.02
76.03	03952	WOUND CARE	0.000000	1,784	0	0	0	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.000000	5,512	0	0	0	90.00
91.00	09100	EMERGENCY	0.000000	903,723	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	160,417	0	0	0	92.00
200.00		Total (lines 50 through 199)		11,835,362	0	0	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-0047 | Period: From 06/01/2019 To 05/31/2020 | Worksheet D Part V Date/Time Prepared: 11/2/2020 12:13 pm

Title XIX | Hospital | PPS

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.160063	0	0	853,589	0	50.00
51.00	05100	RECOVERY ROOM	0.566541	0	0	171,689	0	51.00
53.00	05300	ANESTHESIOLOGY	0.629041	0	0	113,429	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.105288	0	0	3,910,139	0	54.00
54.01	03630	ULTRA SOUND	0.000000	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0.000000	0	0	0	0	56.00
57.00	05700	CT SCAN	0.000000	0	0	0	0	57.00
59.00	05900	CARDIAC CATHETERIZATION	0.184620	0	0	150,777	0	59.00
60.00	06000	LABORATORY	0.137518	0	0	1,921,275	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0.292643	0	0	11,902	0	62.00
65.00	06500	RESPIRATORY THERAPY	0.185352	0	0	134,436	0	65.00
66.00	06600	PHYSICAL THERAPY	0.471287	0	0	4,871	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.274287	0	0	3,612	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.967014	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.104738	0	0	181,460	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.262874	0	0	98,889	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.087917	0	0	334,846	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.128792	0	0	1,068,828	0	73.00
74.00	07400	RENAL DIALYSIS	0.681407	0	0	10,212	0	74.00
76.00	03950	MISC ANCILLARY	0.000000	0	0	0	0	76.00
76.01	03951	SLEEP LAB	0.000000	0	0	0	0	76.01
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0.000000	0	0	0	0	76.02
76.03	03952	WOUND CARE	1.071728	0	0	91,791	0	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	2.287963	0	0	9,214	0	90.00
91.00	09100	EMERGENCY	0.152330	0	0	4,148,473	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.416496	0	0	216,481	0	92.00
200.00		Subtotal (see instructions)		0	0	13,435,913	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 - line 201)		0	0	13,435,913	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-0047 | Period: From 06/01/2019 To 05/31/2020 | Worksheet D Part V Date/Time Prepared: 11/2/2020 12:13 pm

Title XIX | Hospital | PPS

		Cost Center Description	Costs: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	136,628		50.00
51.00	05100	RECOVERY ROOM	0	97,269		51.00
53.00	05300	ANESTHESIOLOGY	0	71,351		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	411,691		54.00
54.01	03630	ULTRA SOUND	0	0		54.01
56.00	05600	RADIOISOTOPE	0	0		56.00
57.00	05700	CT SCAN	0	0		57.00
59.00	05900	CARDIAC CATHETERIZATION	0	27,836		59.00
60.00	06000	LABORATORY	0	264,210		60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	3,483		62.00
65.00	06500	RESPIRATORY THERAPY	0	24,918		65.00
66.00	06600	PHYSICAL THERAPY	0	2,296		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	991		67.00
68.00	06800	SPEECH PATHOLOGY	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	19,006		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	25,995		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	29,439		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	137,656		73.00
74.00	07400	RENAL DIALYSIS	0	6,959		74.00
76.00	03950	MISC ANCILLARY	0	0		76.00
76.01	03951	SLEEP LAB	0	0		76.01
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0		76.02
76.03	03952	WOUND CARE	0	98,375		76.03
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0	21,081		90.00
91.00	09100	EMERGENCY	0	631,937		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	90,163		92.00
200.00		Subtotal (see instructions)	0	2,101,284		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	0	2,101,284		202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 15-0047 | Component CCN: 15-S047 | Period: From 06/01/2019 To 05/31/2020 | Worksheet D Part II | Date/Time Prepared: 11/2/2020 12:13 pm

Title XIX | 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	988,927	24,041,550	0.041134	0	0	50.00
51.00	05100	RECOVERY ROOM	341,253	1,780,968	0.191611	0	0	51.00
53.00	05300	ANESTHESIOLOGY	12,438	2,517,036	0.004942	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,042,191	58,224,083	0.017900	17,003	304	54.00
54.01	03630	ULTRA SOUND	0	0	0.000000	0	0	54.01
56.00	05600	RADIOISOTOPE	0	0	0.000000	0	0	56.00
57.00	05700	CT SCAN	0	0	0.000000	0	0	57.00
59.00	05900	CARDIAC CATHETERIZATION	170,552	14,145,023	0.012057	0	0	59.00
60.00	06000	LABORATORY	895,205	44,291,530	0.020212	76,948	1,555	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	48,309	842,806	0.057319	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	331,759	10,158,998	0.032657	0	0	65.00
66.00	06600	PHYSICAL THERAPY	390,962	2,777,068	0.140782	8,959	1,261	66.00
67.00	06700	OCCUPATIONAL THERAPY	155,407	2,654,583	0.058543	1,377	81	67.00
68.00	06800	SPEECH PATHOLOGY	56,520	144,152	0.392086	788	309	68.00
69.00	06900	ELECTROCARDIOLOGY	63,648	3,057,976	0.020814	2,964	62	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	59,539	4,915,444	0.012113	155	2	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	178,646	31,412,498	0.005687	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	291,700	47,319,867	0.006164	3,753	23	73.00
74.00	07400	RENAL DIALYSIS	105,599	725,995	0.145454	0	0	74.00
76.00	03950	MISC ANCILLARY	0	0	0.000000	0	0	76.00
76.01	03951	SLEEP LAB	0	0	0.000000	0	0	76.01
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0	0.000000	0	0	76.02
76.03	03952	WOUND CARE	472,515	2,105,748	0.224393	0	0	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	118,376	161,302	0.733878	246	181	90.00
91.00	09100	EMERGENCY	918,882	42,351,211	0.021697	46,646	1,012	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	3,936,926	0.000000	0	0	92.00
200.00		Total (lines 50 through 199)	6,642,428	297,564,764		158,839	4,790	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-0047
Component CCN: 15-S047

Period:
From 06/01/2019
To 05/31/2020

Worksheet D
Part IV
Date/Time Prepared:
11/2/2020 12:13 pm

Title XIX | 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
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
54.01	03630	ULTRA SOUND	0	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.00	03950	MISC ANCILLARY	0	0	0	0	0	76.00
76.01	03951	SLEEP LAB	0	0	0	0	0	76.01
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0	0	0	0	76.02
76.03	03952	WOUND CARE	0	0	0	0	0	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0		0		0	92.00
200.00		Total (lines 50 through 199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-0047
Component CCN: 15-S047

Period:
From 06/01/2019
To 05/31/2020

Worksheet D
Part IV
Date/Time Prepared:
11/2/2020 12:13 pm

Title XIX | 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	24,041,550	0.000000	50.00
51.00	05100	RECOVERY ROOM	0	0	0	1,780,968	0.000000	51.00
53.00	05300	ANESTHESIOLOGY	0	0	0	2,517,036	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	58,224,083	0.000000	54.00
54.01	03630	ULTRA SOUND	0	0	0	0	0.000000	54.01
56.00	05600	RADIOISOTOPE	0	0	0	0	0.000000	56.00
57.00	05700	CT SCAN	0	0	0	0	0.000000	57.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	14,145,023	0.000000	59.00
60.00	06000	LABORATORY	0	0	0	44,291,530	0.000000	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0	842,806	0.000000	62.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	10,158,998	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	2,777,068	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	2,654,583	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	144,152	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	3,057,976	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	4,915,444	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	31,412,498	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	47,319,867	0.000000	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	725,995	0.000000	74.00
76.00	03950	MISC ANCILLARY	0	0	0	0	0.000000	76.00
76.01	03951	SLEEP LAB	0	0	0	0	0.000000	76.01
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0	0	0	0.000000	76.02
76.03	03952	WOUND CARE	0	0	0	2,105,748	0.000000	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	161,302	0.000000	90.00
91.00	09100	EMERGENCY	0	0	0	42,351,211	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	3,936,926	0.000000	92.00
200.00		Total (lines 50 through 199)	0	0	0	297,564,764		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-0047
Component CCN: 15-S047

Period:
From 06/01/2019
To 05/31/2020

Worksheet D
Part IV
Date/Time Prepared:
11/2/2020 12:13 pm

Title XIX | 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	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0.000000	0	0	0	0	51.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	17,003	0	0	0	54.00
54.01	03630	ULTRA SOUND	0.000000	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0.000000	0	0	0	0	56.00
57.00	05700	CT SCAN	0.000000	0	0	0	0	57.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	0	0	0	0	59.00
60.00	06000	LABORATORY	0.000000	76,948	0	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0.000000	0	0	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	0.000000	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	8,959	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	1,377	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	788	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	2,964	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	155	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	3,753	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0.000000	0	0	0	0	74.00
76.00	03950	MISC ANCILLARY	0.000000	0	0	0	0	76.00
76.01	03951	SLEEP LAB	0.000000	0	0	0	0	76.01
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0.000000	0	0	0	0	76.02
76.03	03952	WOUND CARE	0.000000	0	0	0	0	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.000000	246	0	0	0	90.00
91.00	09100	EMERGENCY	0.000000	46,646	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	0	0	0	0	92.00
200.00		Total (lines 50 through 199)		158,839	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-0047
Component CCN: 15-5356

Period:
From 06/01/2019
To 05/31/2020

Worksheet D
Part IV
Date/Time Prepared:
11/2/2020 12:13 pm

Title XIX | Skilled Nursing Facility | PPS

		Cost Center Description	Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health	
			1.00	2A	2.00	3A	3.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
54.01	03630	ULTRA SOUND	0	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.00	03950	MISC ANCILLARY	0	0	0	0	0	76.00
76.01	03951	SLEEP LAB	0	0	0	0	0	76.01
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0	0	0	0	76.02
76.03	03952	WOUND CARE	0	0	0	0	0	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0		0		0	92.00
200.00		Total (lines 50 through 199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-0047
Component CCN: 15-5356

Period: From 06/01/2019 To 05/31/2020

Worksheet D
Part IV
Date/Time Prepared: 11/2/2020 12:13 pm

Title XIX | Skilled Nursing Facility | 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	24,041,550	0.000000	50.00
51.00	05100	RECOVERY ROOM	0	0	0	1,780,968	0.000000	51.00
53.00	05300	ANESTHESIOLOGY	0	0	0	2,517,036	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	58,224,083	0.000000	54.00
54.01	03630	ULTRA SOUND	0	0	0	0	0.000000	54.01
56.00	05600	RADIOISOTOPE	0	0	0	0	0.000000	56.00
57.00	05700	CT SCAN	0	0	0	0	0.000000	57.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	14,145,023	0.000000	59.00
60.00	06000	LABORATORY	0	0	0	44,291,530	0.000000	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0	842,806	0.000000	62.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	10,158,998	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	2,777,068	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	2,654,583	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	144,152	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	3,057,976	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	4,915,444	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	31,412,498	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	47,319,867	0.000000	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	725,995	0.000000	74.00
76.00	03950	MISC ANCILLARY	0	0	0	0	0.000000	76.00
76.01	03951	SLEEP LAB	0	0	0	0	0.000000	76.01
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0	0	0	0.000000	76.02
76.03	03952	WOUND CARE	0	0	0	2,105,748	0.000000	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	161,302	0.000000	90.00
91.00	09100	EMERGENCY	0	0	0	42,351,211	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	3,936,926	0.000000	92.00
200.00		Total (lines 50 through 199)	0	0	0	297,564,764		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-0047
Component CCN: 15-5356

Period: From 06/01/2019 To 05/31/2020

Worksheet D
Part IV
Date/Time Prepared: 11/2/2020 12:13 pm

Title XIX | Skilled Nursing Facility | PPS

		Cost Center Description	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
			9.00	10.00	11.00	12.00	13.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.000000	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0.000000	0	0	0	0	51.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	3,439	0	0	0	54.00
54.01	03630	ULTRA SOUND	0.000000	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0.000000	0	0	0	0	56.00
57.00	05700	CT SCAN	0.000000	0	0	0	0	57.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	0	0	0	0	59.00
60.00	06000	LABORATORY	0.000000	6,706	0	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0.000000	0	0	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	0.000000	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	21,634	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	19,546	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	2,436	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	21,081	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0.000000	0	0	0	0	74.00
76.00	03950	MISC ANCILLARY	0.000000	0	0	0	0	76.00
76.01	03951	SLEEP LAB	0.000000	0	0	0	0	76.01
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0.000000	0	0	0	0	76.02
76.03	03952	WOUND CARE	0.000000	0	0	0	0	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.000000	0	0	0	0	90.00
91.00	09100	EMERGENCY	0.000000	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	0	0	0	0	92.00
200.00		Total (lines 50 through 199)		74,842	0	0	0	200.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-0047 | Period: From 06/01/2019 To 05/31/2020 | Worksheet D-1 | Date/Time Prepared: 11/2/2020 12:13 pm

Title XVIII | Hospital | PPS

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	13,276	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	13,276	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)	12,018	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)	2,247	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)	17,304,357	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)	17,304,357	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)	17,304,357	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)	1,303.43	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	2,928,807	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)	2,928,807	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-0047 | Period: From 06/01/2019 To 05/31/2020 | Worksheet D-1 | Date/Time Prepared: 11/2/2020 12:13 pm

Title XVIII | Hospital | PPS

	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)						42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT						43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT	5,094,094	976	5,219.36	620	3,236,003	45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	4,094,721	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	10,259,531	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)	813,992	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	566,348	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	1,380,340	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	8,879,191	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)	1,258	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	1,303.43	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	1,639,715	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-0047 | Period: From 06/01/2019 To 05/31/2020 | Worksheet D-1 | Date/Time Prepared: 11/2/2020 12:13 pm

Title XVIII | Hospital | PPS

	Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	2,736,114	17,304,357	0.158117	1,639,715	259,267	90.00
91.00	Nursing School cost	0	17,304,357	0.000000	1,639,715	0	91.00
92.00	Allied health cost	0	17,304,357	0.000000	1,639,715	0	92.00
93.00	All other Medical Education	0	17,304,357	0.000000	1,639,715	0	93.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 15-0047 Component CCN: 15-S047	Period: From 06/01/2019 To 05/31/2020	Worksheet D-1 Date/Time Prepared: 11/2/2020 12:13 pm
	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)	3,859	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	3,859	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)	3,859	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)	1,972	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)	3,798,363	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)	0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)	0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)	0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)	0	25.00
26.00	Total swing-bed cost (see instructions)	0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	3,798,363	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	28.00
29.00	Private room charges (excluding swing-bed charges)	0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)	0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)	0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)	0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	3,798,363	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)	984.29	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	1,941,020	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)	1,941,020	41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 15-0047 | Component CCN: 15-S047 | Period: From 06/01/2019 To 05/31/2020 | Worksheet D-1 | Date/Time Prepared: 11/2/2020 12:13 pm

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)						42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT						43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT	0	0	0.00	0	0	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)	499,504	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	2,440,524	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)	220,371	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	81,761	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	302,132	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	2,138,392	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: 15-0047
Component CCN: 15-S047

Period:
From 06/01/2019
To 05/31/2020

Worksheet D-1
Date/Time Prepared:
11/2/2020 12:13 pm

Title XVIII | Subprovider - IPF | PPS

	Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	431,250	3,798,363	0.113536	0	0	90.00
91.00	Nursing School cost	0	3,798,363	0.000000	0	0	91.00
92.00	Allied health cost	0	3,798,363	0.000000	0	0	92.00
93.00	All other Medical Education	0	3,798,363	0.000000	0	0	93.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 15-0047 Component CCN: 15-5356	Period: From 06/01/2019 To 05/31/2020	Worksheet D-1 Date/Time Prepared: 11/2/2020 12:13 pm
	Title XVIII	Skilled Nursing Facility	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)	4,321	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	4,321	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.	0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)	4,321	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)	1,196	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)	3,563,387	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)	0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)	0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)	0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)	0	25.00
26.00	Total swing-bed cost (see instructions)	0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	3,563,387	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	28.00
29.00	Private room charges (excluding swing-bed charges)	0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)	0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)	0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)	0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	3,563,387	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)		38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)		40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)		41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 15-0047 | Component CCN: 15-5356 | Period: From 06/01/2019 To 05/31/2020 | Worksheet D-1 | Date/Time Prepared: 11/2/2020 12:13 pm

Title XVIII | Skilled Nursing Facility | 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)						42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT						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)		48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)		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)		50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)		51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)		52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)		53.00
	TARGET AMOUNT AND LIMIT COMPUTATION		
54.00	Program discharges		54.00
55.00	Target amount per discharge		55.00
56.00	Target amount (line 54 x line 55)		56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)		57.00
58.00	Bonus payment (see instructions)		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		59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket		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)		61.00
62.00	Relief payment (see instructions)		62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)		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)		64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)		65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)		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)		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)		68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)		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)	3,563,387	70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)	824.67	71.00
72.00	Program routine service cost (line 9 x line 71)	986,305	72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)	0	73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)	986,305	74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)	0	75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)	0.00	76.00
77.00	Program capital-related costs (line 9 x line 76)	0	77.00
78.00	Inpatient routine service cost (line 74 minus line 77)	0	78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)	0	79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)	0	80.00
81.00	Inpatient routine service cost per diem limitation	0.00	81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)	0	82.00
83.00	Reasonable inpatient routine service costs (see instructions)	986,305	83.00
84.00	Program inpatient ancillary services (see instructions)	669,646	84.00
85.00	Utilization review - physician compensation (see instructions)	0	85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)	1,655,951	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: 15-0047 | Period: From 06/01/2019 To 05/31/2020 | Worksheet D-1

Component CCN: 15-5356 | Date/Time Prepared: 11/2/2020 12:13 pm

Title XVIII | Skilled Nursing Facility | 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	0	0	0.000000	0	0	90.00
91.00	Nursing School cost	0	0	0.000000	0	0	91.00
92.00	Allied health cost	0	0	0.000000	0	0	92.00
93.00	All other Medical Education	0	0	0.000000	0	0	93.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-0047 | Period: From 06/01/2019 To 05/31/2020 | Worksheet D-1 | Date/Time Prepared: 11/2/2020 12:13 pm

Title XIX | Hospital | PPS

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	13,276	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	13,276	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)	12,018	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)	2,052	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)	17,304,357	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)	17,304,357	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)	17,304,357	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)	1,303.43	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	2,674,638	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)	2,674,638	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-0047 | Period: From 06/01/2019 To 05/31/2020 | Worksheet D-1 | Date/Time Prepared: 11/2/2020 12:13 pm

Title XIX | Hospital | PPS

	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)						42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT						43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT	5,094,094	976	5,219.36	149	777,685	45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	1,874,002	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	5,326,325	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)	507,228	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	249,945	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	757,173	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	4,569,152	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)	1,258	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	1,303.43	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	1,639,715	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-0047 | Period: From 06/01/2019 To 05/31/2020 | Worksheet D-1 | Date/Time Prepared: 11/2/2020 12:13 pm

Title XIX | Hospital | PPS

	Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	2,736,114	17,304,357	0.158117	1,639,715	259,267	90.00
91.00	Nursing School cost	0	17,304,357	0.000000	1,639,715	0	91.00
92.00	Allied health cost	0	17,304,357	0.000000	1,639,715	0	92.00
93.00	All other Medical Education	0	17,304,357	0.000000	1,639,715	0	93.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 15-0047 Component CCN: 15-S047	Period: From 06/01/2019 To 05/31/2020	Worksheet D-1 Date/Time Prepared: 11/2/2020 12:13 pm
	Title XIX	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)	3,859	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	3,859	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)	3,859	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)	130	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)	3,798,363	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)	0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)	0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)	0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)	0	25.00
26.00	Total swing-bed cost (see instructions)	0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	3,798,363	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	28.00
29.00	Private room charges (excluding swing-bed charges)	0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)	0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)	0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)	0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	3,798,363	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)	984.29	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	127,958	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)	127,958	41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 15-0047 | Component CCN: 15-S047 | Period: From 06/01/2019 To 05/31/2020 | Worksheet D-1 | Date/Time Prepared: 11/2/2020 12:13 pm

Title XIX | 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)						42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT						43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT	0	0	0.00	0	0	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)	26,237	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	154,195	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)	14,528	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	4,790	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	19,318	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	134,877	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: 15-0047
Component CCN: 15-S047

Period:
From 06/01/2019
To 05/31/2020

Worksheet D-1
Date/Time Prepared:
11/2/2020 12:13 pm

Title XIX | 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	431,250	3,798,363	0.113536	0	0	90.00
91.00	Nursing School cost	0	3,798,363	0.000000	0	0	91.00
92.00	Allied health cost	0	3,798,363	0.000000	0	0	92.00
93.00	All other Medical Education	0	3,798,363	0.000000	0	0	93.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 15-0047 Component CCN: 15-5356	Period: From 06/01/2019 To 05/31/2020	Worksheet D-1 Date/Time Prepared: 11/2/2020 12:13 pm
	Title XIX	Skilled Nursing Facility	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)	4,321	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	4,321	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.	0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)	4,321	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)	63	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)	3,563,387	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)	0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)	0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)	0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)	0	25.00
26.00	Total swing-bed cost (see instructions)	0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	3,563,387	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	28.00
29.00	Private room charges (excluding swing-bed charges)	0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)	0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)	0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)	0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	3,563,387	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)		38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)		40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)		41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 15-0047 | Component CCN: 15-5356 | Period: From 06/01/2019 To 05/31/2020 | Worksheet D-1 | Date/Time Prepared: 11/2/2020 12:13 pm

Title XIX | Skilled Nursing Facility | 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)						42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT						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)		48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)		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)		50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)		51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)		52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)		53.00
	TARGET AMOUNT AND LIMIT COMPUTATION		
54.00	Program discharges		54.00
55.00	Target amount per discharge		55.00
56.00	Target amount (line 54 x line 55)		56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)		57.00
58.00	Bonus payment (see instructions)		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		59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket		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)		61.00
62.00	Relief payment (see instructions)		62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)		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)		64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)		65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)		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)		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)		68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)		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)	3,563,387	70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)	824.67	71.00
72.00	Program routine service cost (line 9 x line 71)	51,954	72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)	0	73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)	51,954	74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)	622,523	75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)	144.07	76.00
77.00	Program capital-related costs (line 9 x line 76)	9,076	77.00
78.00	Inpatient routine service cost (line 74 minus line 77)	42,878	78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)	0	79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)	42,878	80.00
81.00	Inpatient routine service cost per diem limitation	0.00	81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)	0	82.00
83.00	Reasonable inpatient routine service costs (see instructions)	9,076	83.00
84.00	Program inpatient ancillary services (see instructions)	21,912	84.00
85.00	Utilization review - physician compensation (see instructions)	0	85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)	30,988	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: 15-0047 Component CCN: 15-5356	Period: From 06/01/2019 To 05/31/2020	Worksheet D-1 Date/Time Prepared: 11/2/2020 12:13 pm
	Title XIX	Skilled Nursing Facility	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	0	0	0.000000	0	0	90.00
91.00	Nursing School cost	0	0	0.000000	0	0	91.00
92.00	Allied health cost	0	0	0.000000	0	0	92.00
93.00	All other Medical Education	0	0	0.000000	0	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 15-0047 | Period: From 06/01/2019 To 05/31/2020 | Worksheet D-3 | Date/Time Prepared: 11/2/2020 12:13 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		5,573,239		30.00
33.00	03300	BURN INTENSIVE CARE UNIT		3,164,640		33.00
40.00	04000	SUBPROVIDER - IPF		0		40.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.160063	1,965,122	314,543	50.00
51.00	05100	RECOVERY ROOM	0.566541	154,093	87,300	51.00
53.00	05300	ANESTHESIOLOGY	0.629041	196,643	123,697	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.105288	3,479,730	366,374	54.00
54.01	03630	ULTRA SOUND	0.000000	0	0	54.01
56.00	05600	RADIOISOTOPE	0.000000	0	0	56.00
57.00	05700	CT SCAN	0.000000	0	0	57.00
59.00	05900	CARDIAC CATHETERIZATION	0.184620	1,479,413	273,129	59.00
60.00	06000	LABORATORY	0.137518	3,257,060	447,904	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0.292643	128,936	37,732	62.00
65.00	06500	RESPIRATORY THERAPY	0.185352	2,097,208	388,722	65.00
66.00	06600	PHYSICAL THERAPY	0.471287	186,993	88,127	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.274287	164,716	45,179	67.00
68.00	06800	SPEECH PATHOLOGY	0.967014	26,713	25,832	68.00
69.00	06900	ELECTROCARDIOLOGY	0.104738	207,141	21,696	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.262874	623,461	163,892	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.087917	3,205,640	281,830	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.128792	6,104,822	786,252	73.00
74.00	07400	RENAL DIALYSIS	0.681407	537,775	366,444	74.00
76.00	03950	MISC ANCILLARY	0.000000	0	0	76.00
76.01	03951	SLEEP LAB	0.000000	0	0	76.01
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0.000000	0	0	76.02
76.03	03952	WOUND CARE	1.071728	3,514	3,766	76.03
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	2.287963	0	0	90.00
91.00	09100	EMERGENCY	0.152330	1,276,886	194,508	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.416496	186,782	77,794	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		25,282,648	4,094,721	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)		25,282,648		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

Provider CCN: 15-0047 | Component CCN: 15-S047 | Period: From 06/01/2019 To 05/31/2020 | Worksheet D-3 | Date/Time Prepared: 11/2/2020 12:13 pm

Title XVIII | Subprovider - IPF | PPS

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		0		30.00
33.00	03300	BURN INTENSIVE CARE UNIT		0		33.00
40.00	04000	SUBPROVIDER - IPF		7,258,635		40.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.160063	43,842	7,017	50.00
51.00	05100	RECOVERY ROOM	0.566541	0	0	51.00
53.00	05300	ANESTHESIOLOGY	0.629041	1,103	694	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.105288	462,902	48,738	54.00
54.01	03630	ULTRA SOUND	0.000000	0	0	54.01
56.00	05600	RADIOISOTOPE	0.000000	0	0	56.00
57.00	05700	CT SCAN	0.000000	0	0	57.00
59.00	05900	CARDIAC CATHETERIZATION	0.184620	0	0	59.00
60.00	06000	LABORATORY	0.137518	934,258	128,477	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0.292643	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	0.185352	131,724	24,415	65.00
66.00	06600	PHYSICAL THERAPY	0.471287	133,527	62,930	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.274287	147,603	40,486	67.00
68.00	06800	SPEECH PATHOLOGY	0.967014	21,304	20,601	68.00
69.00	06900	ELECTROCARDIOLOGY	0.104738	47,961	5,023	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.262874	11,793	3,100	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.087917	135,437	11,907	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.128792	824,909	106,242	73.00
74.00	07400	RENAL DIALYSIS	0.681407	0	0	74.00
76.00	03950	MISC ANCILLARY	0.000000	0	0	76.00
76.01	03951	SLEEP LAB	0.000000	0	0	76.01
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0.000000	0	0	76.02
76.03	03952	WOUND CARE	1.071728	205	220	76.03
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	2.287963	0	0	90.00
91.00	09100	EMERGENCY	0.152330	260,315	39,654	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.416496	0	0	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		3,156,883	499,504	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)		3,156,883		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 15-0047 | Component CCN: 15-5356 | Period: From 06/01/2019 To 05/31/2020 | Worksheet D-3 | Date/Time Prepared: 11/2/2020 12:13 pm

Title XVIII | Skilled Nursing Facility | 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
33.00	03300	BURN INTENSIVE CARE UNIT		0		33.00
40.00	04000	SUBPROVIDER - IPF		0		40.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.160063	0	0	50.00
51.00	05100	RECOVERY ROOM	0.566541	0	0	51.00
53.00	05300	ANESTHESIOLOGY	0.629041	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.105288	79,682	8,390	54.00
54.01	03630	ULTRA SOUND	0.000000	0	0	54.01
56.00	05600	RADIOISOTOPE	0.000000	0	0	56.00
57.00	05700	CT SCAN	0.000000	0	0	57.00
59.00	05900	CARDIAC CATHETERIZATION	0.184620	0	0	59.00
60.00	06000	LABORATORY	0.137518	312,060	42,914	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0.292643	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	0.185352	420,604	77,960	65.00
66.00	06600	PHYSICAL THERAPY	0.471287	440,935	207,807	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.274287	454,907	124,775	67.00
68.00	06800	SPEECH PATHOLOGY	0.967014	5,847	5,654	68.00
69.00	06900	ELECTROCARDIOLOGY	0.104738	3,825	401	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.262874	43,733	11,496	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.087917	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.128792	994,191	128,044	73.00
74.00	07400	RENAL DIALYSIS	0.681407	0	0	74.00
76.00	03950	MISC ANCILLARY	0.000000	0	0	76.00
76.01	03951	SLEEP LAB	0.000000	0	0	76.01
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0.000000	0	0	76.02
76.03	03952	WOUND CARE	1.071728	58,042	62,205	76.03
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	2.287963	0	0	90.00
91.00	09100	EMERGENCY	0.152330	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.416496	0	0	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		2,813,826	669,646	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)		2,813,826		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 15-0047 | Period: From 06/01/2019 To 05/31/2020 | Worksheet D-3 | Date/Time Prepared: 11/2/2020 12:13 pm

Title XIX | Hospital | PPS

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		4,779,722		30.00
33.00	03300	BURN INTENSIVE CARE UNIT		774,791		33.00
40.00	04000	SUBPROVIDER - IPF		0		40.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.160063	817,329	130,824	50.00
51.00	05100	RECOVERY ROOM	0.566541	75,577	42,817	51.00
53.00	05300	ANESTHESIOLOGY	0.629041	133,822	84,180	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.105288	1,639,980	172,670	54.00
54.01	03630	ULTRA SOUND	0.000000	0	0	54.01
56.00	05600	RADIOISOTOPE	0.000000	0	0	56.00
57.00	05700	CT SCAN	0.000000	0	0	57.00
59.00	05900	CARDIAC CATHETERIZATION	0.184620	615,304	113,597	59.00
60.00	06000	LABORATORY	0.137518	2,001,646	275,262	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0.292643	105,551	30,889	62.00
65.00	06500	RESPIRATORY THERAPY	0.185352	820,445	152,071	65.00
66.00	06600	PHYSICAL THERAPY	0.471287	73,872	34,815	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.274287	62,269	17,080	67.00
68.00	06800	SPEECH PATHOLOGY	0.967014	10,135	9,801	68.00
69.00	06900	ELECTROCARDIOLOGY	0.104738	111,388	11,667	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.262874	255,228	67,093	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.087917	1,041,457	91,562	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.128792	2,937,839	378,370	73.00
74.00	07400	RENAL DIALYSIS	0.681407	62,084	42,304	74.00
76.00	03950	MISC ANCILLARY	0.000000	0	0	76.00
76.01	03951	SLEEP LAB	0.000000	0	0	76.01
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0.000000	0	0	76.02
76.03	03952	WOUND CARE	1.071728	1,784	1,912	76.03
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	2.287963	5,512	12,611	90.00
91.00	09100	EMERGENCY	0.152330	903,723	137,664	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.416496	160,417	66,813	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		11,835,362	1,874,002	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)		11,835,362		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

Provider CCN: 15-0047 | Component CCN: 15-S047 | Period: From 06/01/2019 To 05/31/2020 | Worksheet D-3 | Date/Time Prepared: 11/2/2020 12:13 pm

Title XIX | 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
33.00	03300	BURN INTENSIVE CARE UNIT		0		33.00
40.00	04000	SUBPROVIDER - IPF		290,231		40.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.160063	0	0	50.00
51.00	05100	RECOVERY ROOM	0.566541	0	0	51.00
53.00	05300	ANESTHESIOLOGY	0.629041	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.105288	17,003	1,790	54.00
54.01	03630	ULTRA SOUND	0.000000	0	0	54.01
56.00	05600	RADIOISOTOPE	0.000000	0	0	56.00
57.00	05700	CT SCAN	0.000000	0	0	57.00
59.00	05900	CARDIAC CATHETERIZATION	0.184620	0	0	59.00
60.00	06000	LABORATORY	0.137518	76,948	10,582	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0.292643	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	0.185352	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.471287	8,959	4,222	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.274287	1,377	378	67.00
68.00	06800	SPEECH PATHOLOGY	0.967014	788	762	68.00
69.00	06900	ELECTROCARDIOLOGY	0.104738	2,964	310	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.262874	155	41	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.087917	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.128792	3,753	483	73.00
74.00	07400	RENAL DIALYSIS	0.681407	0	0	74.00
76.00	03950	MISC ANCILLARY	0.000000	0	0	76.00
76.01	03951	SLEEP LAB	0.000000	0	0	76.01
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0.000000	0	0	76.02
76.03	03952	WOUND CARE	1.071728	0	0	76.03
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	2.287963	246	563	90.00
91.00	09100	EMERGENCY	0.152330	46,646	7,106	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.416496	0	0	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		158,839	26,237	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)		158,839		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

Provider CCN: 15-0047 | Component CCN: 15-5356 | Period: From 06/01/2019 To 05/31/2020 | Worksheet D-3 | Date/Time Prepared: 11/2/2020 12:13 pm

Title XIX | Skilled Nursing Facility | 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
33.00	03300	BURN INTENSIVE CARE UNIT		0		33.00
40.00	04000	SUBPROVIDER - IPF		0		40.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.160063	0	0	50.00
51.00	05100	RECOVERY ROOM	0.566541	0	0	51.00
53.00	05300	ANESTHESIOLOGY	0.629041	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.105288	3,439	362	54.00
54.01	03630	ULTRA SOUND	0.000000	0	0	54.01
56.00	05600	RADIOISOTOPE	0.000000	0	0	56.00
57.00	05700	CT SCAN	0.000000	0	0	57.00
59.00	05900	CARDIAC CATHETERIZATION	0.184620	0	0	59.00
60.00	06000	LABORATORY	0.137518	6,706	922	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0.292643	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	0.185352	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.471287	21,634	10,196	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.274287	19,546	5,361	67.00
68.00	06800	SPEECH PATHOLOGY	0.967014	2,436	2,356	68.00
69.00	06900	ELECTROCARDIOLOGY	0.104738	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.262874	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.087917	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.128792	21,081	2,715	73.00
74.00	07400	RENAL DIALYSIS	0.681407	0	0	74.00
76.00	03950	MISC ANCILLARY	0.000000	0	0	76.00
76.01	03951	SLEEP LAB	0.000000	0	0	76.01
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0.000000	0	0	76.02
76.03	03952	WOUND CARE	1.071728	0	0	76.03
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	2.287963	0	0	90.00
91.00	09100	EMERGENCY	0.152330	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.416496	0	0	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		74,842	21,912	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)		74,842		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0047	Period: From 06/01/2019 To 05/31/2020	Worksheet E Part A Date/Time Prepared: 11/2/2020 12:13 pm
	Title XVIII	Hospital	PPS

		1.00	
	PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS		
1.00	DRG Amounts Other than Outlier Payments	0	1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1 (see instructions)	1,646,510	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1 (see instructions)	2,737,934	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)	97,833	2.03
2.04	Outlier payments for discharges occurring on or after October 1 (see instructions)	152,570	2.04
3.00	Managed Care Simulated Payments	3,882,555	3.00
4.00	Bed days available divided by number of days in the cost reporting period (see instructions)	84.32	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)	8.95	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.	1.89	7.01
8.00	Adjustment (increase or decrease) to the FTE count for allopathic and osteopathic programs for affiliated programs in accordance with 42 CFR 413.75(b), 413.79(c)(2)(iv), 64 FR 26340 (May 12, 1998), and 67 FR 50069 (August 1, 2002).	-6.37	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)	0.69	9.00
10.00	FTE count for allopathic and osteopathic programs in the current year from your records	0.42	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)	0.42	12.00
13.00	Total allowable FTE count for the prior year.	0.50	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.	0.69	14.00
15.00	Sum of lines 12 through 14 divided by 3.	0.54	15.00
16.00	Adjustment for residents in initial years of the program	0.00	16.00
17.00	Adjustment for residents displaced by program or hospital closure	0.00	17.00
18.00	Adjusted rolling average FTE count	0.54	18.00
19.00	Current year resident to bed ratio (line 18 divided by line 4).	0.006404	19.00
20.00	Prior year resident to bed ratio (see instructions)	0.004162	20.00
21.00	Enter the lesser of lines 19 or 20 (see instructions)	0.004162	21.00
22.00	IME payment adjustment (see instructions)	9,966	22.00
22.01	IME payment adjustment - Managed Care (see instructions)	8,825	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).	4.00	23.00
24.00	IME FTE Resident Count Over Cap (see instructions)	-0.27	24.00
25.00	If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see instructions)	0.00	25.00
26.00	Resident to bed ratio (divide line 25 by line 4)	0.000000	26.00
27.00	IME payments adjustment factor. (see instructions)	0.000000	27.00
28.00	IME add-on adjustment amount (see instructions)	0	28.00
28.01	IME add-on adjustment amount - Managed Care (see instructions)	0	28.01
29.00	Total IME payment (sum of lines 22 and 28)	9,966	29.00
29.01	Total IME payment - Managed Care (sum of lines 22.01 and 28.01)	8,825	29.01
	Disproportionate Share Adjustment		
30.00	Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)	13.86	30.00
31.00	Percentage of Medicaid patient days (see instructions)	48.33	31.00
32.00	Sum of lines 30 and 31	62.19	32.00
33.00	Allowable disproportionate share percentage (see instructions)	12.00	33.00
34.00	Disproportionate share adjustment (see instructions)	131,533	34.00

CALCULATION OF REIMBURSEMENT SETTLEMENT | Provider CCN: 15-0047 | Period: From 06/01/2019 To 05/31/2020 | Worksheet E Part A Date/Time Prepared: 11/2/2020 12:13 pm

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		Prior to 10/1	On/After 10/1	
		1.00	2.00	
	Uncompensated Care Adjustment			
35.00	Total uncompensated care amount (see instructions)	0	0	35.00
35.01	Factor 3 (see instructions)	0.000000000	0.000000000	35.01
35.02	Hospital uncompensated care payment (If line 34 is zero, enter zero on this line) (see instructions)	1,655,129	1,305,861	35.02
35.03	Pro rata share of the hospital uncompensated care payment amount (see instructions)	553,222	870,574	35.03
36.00	Total uncompensated care (sum of columns 1 and 2 on line 35.03)	1,423,796		36.00
	Additional payment for high percentage of ESRD beneficiary discharges (lines 40 through 46)			
40.00	Total Medicare discharges on Worksheet S-3, Part I excluding discharges for MS-DRGs 652, 682, 683, 684 and 685 (see instructions)	0		40.00
		Before 1/1	On/After 1/1	
		1.00	1.01	
41.00	Total ESRD Medicare discharges excluding MS-DRGs 652, 682, 683, 684 an 685. (see instructions)	0	0	41.00
41.01	Total ESRD Medicare covered and paid discharges excluding MS-DRGs 652, 682, 683, 684 an 685. (see instructions)	0	0	41.01
42.00	Divide line 41 by line 40 (if less than 10%, you do not qualify for adjustment)	0.00		42.00
43.00	Total Medicare ESRD inpatient days excluding MS-DRGs 652, 682, 683, 684 an 685. (see instructions)	0		43.00
44.00	Ratio of average length of stay to one week (line 43 divided by line 41 divided by 7 days)	0.000000		44.00
45.00	Average weekly cost for dialysis treatments (see instructions)	0.00	0.00	45.00
46.00	Total additional payment (line 45 times line 44 times line 41.01)	0		46.00
47.00	Subtotal (see instructions)	6,200,142		47.00
48.00	Hospital specific payments (to be completed by SCH and MDH, small rural hospitals only.(see instructions)	0		48.00
			Amount	
			1.00	
49.00	Total payment for inpatient operating costs (see instructions)		6,208,967	49.00
50.00	Payment for inpatient program capital (from Wkst. L, Pt. I and Pt. II, as applicable)		389,188	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).		21,441	52.00
53.00	Nursing and Allied Health Managed Care payment		0	53.00
54.00	Special add-on payments for new technologies		0	54.00
54.01	Islet isolation add-on payment		0	54.01
55.00	Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line 69)		0	55.00
56.00	Cost of physicians' services in a teaching hospital (see intructions)		0	56.00
57.00	Routine service other pass through costs (from Wkst. D, Pt. III, column 9, lines 30 through 35).		0	57.00
58.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 11 line 200)		0	58.00
59.00	Total (sum of amounts on lines 49 through 58)		6,619,596	59.00
60.00	Primary payer payments		8,748	60.00
61.00	Total amount payable for program beneficiaries (line 59 minus line 60)		6,610,848	61.00
62.00	Deductibles billed to program beneficiaries		477,180	62.00
63.00	Coinsurance billed to program beneficiaries		17,930	63.00
64.00	Allowable bad debts (see instructions)		181,158	64.00
65.00	Adjusted reimbursable bad debts (see instructions)		117,753	65.00
66.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		91,637	66.00
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)		6,233,491	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)		17,131	70.93
70.94	HRR adjustment amount (see instructions)		-494	70.94
70.95	Recovery of accelerated depreciation		0	70.95

CALCULATION OF REIMBURSEMENT SETTLEMENT | Provider CCN: 15-0047 | Period: From 06/01/2019 To 05/31/2020 | Worksheet E Part A Date/Time Prepared: 11/2/2020 12:13 pm

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		FFY (yyyy)	Amount	
		0	1.00	
70.96	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period prior to 10/1)	0	0	70.96
70.97	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period ending on or after 10/1)	0	0	70.97
70.98	Low Volume Payment-3		0	70.98
70.99	HAC adjustment amount (see instructions)		0	70.99
71.00	Amount due provider (line 67 minus lines 68 plus/minus lines 69 & 70)		6,250,128	71.00
71.01	Sequestration adjustment (see instructions)		114,377	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		5,986,516	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)		149,235	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		1,284,645	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: 15-0047	Period: From 06/01/2019 To 05/31/2020	Worksheet E Part B Date/Time Prepared: 11/2/2020 12:13 pm
	Title XVIII	Hospital	PPS

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	12,333	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)	4,316,459	2.00
3.00	OPPS payments	2,635,588	3.00
4.00	Outlier payment (see instructions)	54,918	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)	12,333	11.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
12.00	Ancillary service charges	81,806	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)	81,806	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)	81,806	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)	69,473	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)	12,333	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)	2,690,506	24.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
25.00	Deductibles and coinsurance amounts (for CAH, see instructions)	2,487	25.00
26.00	Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)	472,023	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)	2,228,329	27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 50)	6,532	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)	2,234,861	30.00
31.00	Primary payer payments	24	31.00
32.00	Subtotal (line 30 minus line 31)	2,234,837	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)	195,468	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	127,054	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	129,279	36.00
37.00	Subtotal (see instructions)	2,361,891	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)	2,361,891	40.00
40.01	Sequestration adjustment (see instructions)	43,223	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	2,379,277	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)	-60,609	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: 15-0047 Component CCN: 15-S047	Period: From 06/01/2019 To 05/31/2020	Worksheet E Part B Date/Time Prepared: 11/2/2020 12:13 pm
	Title XVIII	Subprovider - IPF	PPS

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	1,135	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)	9,846	2.00
3.00	OPPS payments	2,645	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)	1,135	11.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
12.00	Ancillary service charges	8,813	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)	8,813	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)	8,813	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)	7,678	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)	1,135	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)	2,645	24.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
25.00	Deductibles and coinsurance amounts (for CAH, see instructions)	212	25.00
26.00	Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)	226	26.00
27.00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions)	3,342	27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 50)	0	28.00
29.00	ESRD direct medical education costs (from Wkst. E-4, line 36)	0	29.00
30.00	Subtotal (sum of lines 27 through 29)	3,342	30.00
31.00	Primary payer payments	0	31.00
32.00	Subtotal (line 30 minus line 31)	3,342	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)	3,342	37.00
38.00	MSP-LCC reconciliation amount from PS&R	0	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	39.00
39.50	Pioneer ACO demonstration payment adjustment (see instructions)		39.50
39.97	Demonstration payment adjustment amount before sequestration	0	39.97
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)	0	39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION	0	39.99
40.00	Subtotal (see instructions)	3,342	40.00
40.01	Sequestration adjustment (see instructions)	61	40.01
40.02	Demonstration payment adjustment amount after sequestration	0	40.02
40.03	Sequestration adjustment-PARHM pass-throughs		40.03
41.00	Interim payments	3,890	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)	-609	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: 15-0047 Component CCN: 15-5356	Period: From 06/01/2019 To 05/31/2020	Worksheet E Part B Date/Time Prepared: 11/2/2020 12:13 pm
	Title XVIII	Skilled Nursing Facility	PPS

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	24	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)	0	2.00
3.00	OPPS payments		3.00
4.00	Outlier payment (see instructions)		4.00
4.01	Outlier reconciliation amount (see instructions)		4.01
5.00	Enter the hospital specific payment to cost ratio (see instructions)		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)	24	11.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
12.00	Ancillary service charges	184	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)	184	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)	184	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)	160	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)	24	21.00
22.00	Interns and residents (see instructions)	0	22.00
23.00	Cost of physicians' services in a teaching hospital (see instructions)	0	23.00
24.00	Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)	0	24.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
25.00	Deductibles and coinsurance amounts (for CAH, see instructions)	0	25.00
26.00	Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)		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)	24	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)	24	30.00
31.00	Primary payer payments	0	31.00
32.00	Subtotal (line 30 minus line 31)	24	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)	24	37.00
38.00	MSP-LCC reconciliation amount from PS&R		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)	24	40.00
40.01	Sequestration adjustment (see instructions)	0	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	36	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)	-12	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)		90.00
91.00	Outlier reconciliation adjustment amount (see instructions)		91.00
92.00	The rate used to calculate the Time Value of Money		92.00
93.00	Time Value of Money (see instructions)		93.00
94.00	Total (sum of lines 91 and 93)		94.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 15-0047 | Period: From 06/01/2019 To 05/31/2020 | Worksheet E-1 Part I | Date/Time Prepared: 11/2/2020 12:13 pm

Title XVIII | Hospital | PPS

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		5,986,516		2,379,277	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)		5,986,516		2,379,277	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		149,235		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		60,609	6.02
7.00	Total Medicare program liability (see instructions)		6,135,751		2,318,668	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: 15-0047 | Component CCN: 15-S047 | Period: From 06/01/2019 To 05/31/2020 | Worksheet E-1 Part I | Date/Time Prepared: 11/2/2020 12:13 pm

Title XVIII | Subprovider - IPF | PPS

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		1,609,605		3,890	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
	Program to Provider					
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
	Provider to Program					
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		1,609,605		3,890	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		3,548		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		609	6.02
7.00	Total Medicare program liability (see instructions)		1,613,153		3,281	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: 15-0047 | Component CCN: 15-5356 | Period: From 06/01/2019 To 05/31/2020 | Worksheet E-1 Part I | Date/Time Prepared: 11/2/2020 12:13 pm

Title XVIII | Skilled Nursing Facility | 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		460,120		36	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)		460,120		36	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		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		12	6.02
7.00	Total Medicare program liability (see instructions)		460,120		24	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: 15-0047	Period: From 06/01/2019 To 05/31/2020	Worksheet E-1 Part II Date/Time Prepared: 11/2/2020 12:13 pm
	Title XVIII	Hospital	PPS

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

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0047 Component CCN: 15-S047	Period: From 06/01/2019 To 05/31/2020	Worksheet E-3 Part II Date/Time Prepared: 11/2/2020 12:13 pm
	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)	1,791,773	1.00
2.00	Net IPF PPS Outlier Payments	24,910	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)	10.543716	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)	1,816,683	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)	1,816,683	16.00
17.00	Primary payer payments	0	17.00
18.00	Subtotal (line 16 less line 17).	1,816,683	18.00
19.00	Deductibles	128,040	19.00
20.00	Subtotal (line 18 minus line 19)	1,688,643	20.00
21.00	Coinsurance	46,189	21.00
22.00	Subtotal (line 20 minus line 21)	1,642,454	22.00
23.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)	1,184	23.00
24.00	Adjusted reimbursable bad debts (see instructions)	770	24.00
25.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	0	25.00
26.00	Subtotal (sum of lines 22 and 24)	1,643,224	26.00
27.00	Direct graduate medical education payments (see instructions)	0	27.00
28.00	Other pass through costs (see instructions)	0	28.00
29.00	Outlier payments reconciliation	0	29.00
30.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	30.00
30.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	30.50
30.99	Demonstration payment adjustment amount before sequestration	0	30.99
31.00	Total amount payable to the provider (see instructions)	1,643,224	31.00
31.01	Sequestration adjustment (see instructions)	30,071	31.01
31.02	Demonstration payment adjustment amount after sequestration	0	31.02
32.00	Interim payments	1,609,605	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)	3,548	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	24,910	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: 15-0047 Component CCN: 15-5356	Period: From 06/01/2019 To 05/31/2020	Worksheet E-3 Part VI Date/Time Prepared: 11/2/2020 12:13 pm
	Title XVIII	Skilled Nursing Facility	PPS

		1.00	
	PART VI - CALCULATION OF REIMBURSEMENT SETTLEMEMENT - ALL OTHER HEALTH SERVICES FOR TITLE XVIII PART A PPS SNF SERVICES		
	PROSPECTIVE PAYMENT AMOUNT (SEE INSTRUCTIONS)		
1.00	Resource Utilization Group Payment (RUGS)	568,505	1.00
2.00	Routine service other pass through costs	0	2.00
3.00	Ancillary service other pass through costs	0	3.00
4.00	Subtotal (sum of lines 1 through 3)	568,505	4.00
	COMPUTATION OF NET COST OF COVERED SERVICES		
5.00	Medical and other services (Do not use this line as vaccine costs are included in line 1 of W/S E, Part B. This line is now shaded.)		5.00
6.00	Deductible	0	6.00
7.00	Coinsurance	98,995	7.00
8.00	Allowable bad debts (see instructions)	0	8.00
9.00	Reimbursable bad debts for dual eligible beneficiaries (see instructions)	0	9.00
10.00	Adjusted reimbursable bad debts (see instructions)	0	10.00
11.00	Utilization review	0	11.00
12.00	Subtotal (sum of lines 4, 5 minus lines 6 and 7, plus lines 10 and 11)(see instructions)	469,510	12.00
13.00	Inpatient primary payer payments	0	13.00
14.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	14.00
14.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	14.50
14.99	Demonstration payment adjustment amount before sequestration	0	14.99
15.00	Subtotal (see instructions	469,510	15.00
15.01	Sequestration adjustment (see instructions)	9,390	15.01
15.02	Demonstration payment adjustment amount after sequestration	0	15.02
15.75	Sequestration for non-claims based amounts (see instructions)	0	15.75
16.00	Interim payments	460,120	16.00
17.00	Tentative settlement (for contractor use only)	0	17.00
18.00	Balance due provider/program (line 15 minus lines 15.01, 15.02, 15.75, 16, and 17)	0	18.00
19.00	Protested amounts (nonallowable cost report items) in accordance with CMS 19 Pub. 15-2, chapter 1, §115.2	0	19.00

CALCULATION OF REIMBURSEMENT SETTLEMENT | Provider CCN: 15-0047 | Period: From 06/01/2019 To 05/31/2020 | Worksheet E-3 Part VII Date/Time Prepared: 11/2/2020 12:13 pm

Title XIX | Hospital | PPS

		Inpatient	Outpatient	
		1.00	2.00	
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR XIX SERVICES			
	COMPUTATION OF NET COST OF COVERED SERVICES			
1.00	Inpatient hospital/SNF/NF services	0		1.00
2.00	Medical and other services		2,101,284	2.00
3.00	Organ acquisition (certified transplant centers only)	0		3.00
4.00	Subtotal (sum of lines 1, 2 and 3)	0	2,101,284	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	2,101,284	7.00
	COMPUTATION OF LESSER OF COST OR CHARGES			
	Reasonable Charges			
8.00	Routine service charges	0		8.00
9.00	Ancillary service charges	11,835,362	13,435,913	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)	11,835,362	13,435,913	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)	11,835,362	13,435,913	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)	11,835,362	11,334,629	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	2,101,284	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	2,101,284	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	2,101,284	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	2,101,284	36.00
37.00	ELIMINATE SETTLEMENT	0	-2,101,284	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: 15-0047 Component CCN: 15-S047	Period: From 06/01/2019 To 05/31/2020	Worksheet E-3 Part VII Date/Time Prepared: 11/2/2020 12:13 pm
	Title XIX	Subprovider - IPF	PPS

		Inpatient	Outpatient	
		1.00	2.00	
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR XIX SERVICES			
	COMPUTATION OF NET COST OF COVERED SERVICES			
1.00	Inpatient hospital/SNF/NF services	0		1.00
2.00	Medical and other services		0	2.00
3.00	Organ acquisition (certified transplant centers only)	0		3.00
4.00	Subtotal (sum of lines 1, 2 and 3)	0	0	4.00
5.00	Inpatient primary payer payments	0		5.00
6.00	Outpatient primary payer payments		0	6.00
7.00	Subtotal (line 4 less sum of lines 5 and 6)	0	0	7.00
	COMPUTATION OF LESSER OF COST OR CHARGES			
	Reasonable Charges			
8.00	Routine service charges	0		8.00
9.00	Ancillary service charges	158,839	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)	158,839	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)	158,839	0	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)	158,839	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

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0047 Component CCN: 15-5356	Period: From 06/01/2019 To 05/31/2020	Worksheet E-3 Part VII Date/Time Prepared: 11/2/2020 12:13 pm
	Title XIX	Skilled Nursing Facility	PPS

		Inpatient	Outpatient	
		1.00	2.00	
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR XIX SERVICES			
	COMPUTATION OF NET COST OF COVERED SERVICES			
1.00	Inpatient hospital/SNF/NF services	30,988		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)	30,988	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)	30,988	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	74,842	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)	74,842	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)	74,842	0	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)	43,854	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)	30,988	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)	30,988	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)	30,988	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)	30,988	0	36.00
37.00	ELIMINATE SETTLEMENT	-30,981	0	37.00
38.00	Subtotal (line 36 ± line 37)	7	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)	7	0	40.00
41.00	Interim payments	0	0	41.00
42.00	Balance due provider/program (line 40 minus line 41)	7	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: 15-0047 | Period: From 06/01/2019 To 05/31/2020 | Worksheet E-4 | Date/Time Prepared: 11/2/2020 12:13 pm

Title XVIII | Hospital | PPS

		1.00	
	COMPUTATION OF TOTAL DIRECT GME AMOUNT		
1.00	Unweighted resident FTE count for allopathic and osteopathic programs for cost reporting periods ending on or before December 31, 1996.	7.63	1.00
2.00	Unweighted FTE resident cap add-on for new programs per 42 CFR 413.79(e)(1) (see instructions)	0.00	2.00
3.00	Amount of reduction to Direct GME cap under section 422 of MMA	0.00	3.00
3.01	Direct GME cap reduction amount under ACA §5503 in accordance with 42 CFR §413.79 (m). (see instructions for cost reporting periods straddling 7/1/2011)	0.00	3.01
4.00	Adjustment (plus or minus) to the FTE cap for allopathic and osteopathic programs due to a Medicare GME affiliation agreement (42 CFR §413.75(b) and § 413.79 (f))	-6.94	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	0.69	5.00
6.00	Unweighted resident FTE count for allopathic and osteopathic programs for the current year from your records (see instructions)	0.42	6.00
7.00	Enter the lesser of line 5 or line 6	0.42	7.00

		Primary Care	Other	Total	
		1.00	2.00	3.00	
8.00	Weighted FTE count for physicians in an allopathic and osteopathic program for the current year.	0.42	0.00	0.42	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.	0.42	0.00	0.42	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	0.42	0.00		11.00
12.00	Total weighted resident FTE count for the prior cost reporting year (see instructions)	0.50	0.00		12.00
13.00	Total weighted resident FTE count for the penultimate cost reporting year (see instructions)	0.69	0.00		13.00
14.00	Rolling average FTE count (sum of lines 11 through 13 divided by 3).	0.54	0.00		14.00
15.00	Adjustment for residents in initial years of new programs	0.00	0.00		15.00
15.01	Unweighted adjustment for residents in initial years of new programs	0.00	0.00		15.01
16.00	Adjustment for residents displaced by program or hospital closure	0.00	0.00		16.00
16.01	Unweighted adjustment for residents displaced by program or hospital closure	0.00	0.00		16.01
17.00	Adjusted rolling average FTE count	0.54	0.00		17.00
18.00	Per resident amount	104,350.89	98,663.16		18.00
19.00	Approved amount for resident costs	56,349	0	56,349	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)	5.00	20.00
21.00	Direct GME FTE unweighted resident count over cap (see instructions)	0.00	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)	103,709.75	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)	56,349	25.00

		Inpatient Part A	Managed Care Prior to 1/1	Managed Care On or after 1/1	Total	
		1.00	2.00	2.01	3.00	
	COMPUTATION OF PROGRAM PATIENT LOAD					
26.00	Inpatient Days (see instructions)	4,839	1,516	2,277		26.00
27.00	Total Inpatient Days (see instructions)	16,853	16,853	16,853		27.00
28.00	Ratio of inpatient days to total inpatient days	0.287130	0.089954	0.135109		28.00
29.00	Program direct GME amount	16,179	5,069	7,613	28,861	29.00
29.01	Percent reduction for MA DGME		7.00	7.00		29.01
30.00	Reduction for direct GME payments for Medicare Advantage		355	533	888	30.00
31.00	Net Program direct GME amount				27,973	31.00

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

Provider CCN: 15-0047 | Period: From 06/01/2019 To 05/31/2020 | Worksheet E-4 | Date/Time Prepared: 11/2/2020 12:13 pm

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)	725,995	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)	14,254,865	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)	8,748	40.00
41.00	Total Part A reasonable cost (sum of lines 37 through 39 minus line 40)	14,246,117	41.00
	Part B Reasonable Cost		
42.00	Reasonable cost (see instructions)	4,339,797	42.00
43.00	Primary payer payments (see instructions)	24	43.00
44.00	Total Part B reasonable cost (line 42 minus line 43)	4,339,773	44.00
45.00	Total reasonable cost (sum of lines 41 and 44)	18,585,890	45.00
46.00	Ratio of Part A reasonable cost to total reasonable cost (line 41 ÷ line 45)	0.766502	46.00
47.00	Ratio of Part B reasonable cost to total reasonable cost (line 44 ÷ line 45)	0.233498	47.00
	ALLOCATION OF MEDICARE DIRECT GME COSTS BETWEEN PART A AND PART B		
48.00	Total program GME payment (line 31)	27,973	48.00
49.00	Part A Medicare GME payment (line 46 x 48) (title XVIII only) (see instructions)	21,441	49.00
50.00	Part B Medicare GME payment (line 47 x 48) (title XVIII only) (see instructions)	6,532	50.00

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

Provider CCN: 15-0047 | Period: From 06/01/2019 To 05/31/2020 | Worksheet G | Date/Time Prepared: 11/2/2020 12:13 pm

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
	CURRENT ASSETS					
1.00	Cash on hand in banks	-447,039	0	0	0	1.00
2.00	Temporary investments	0	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	27,861,383	0	0	0	4.00
5.00	Other receivable	0	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-15,330,143	0	0	0	6.00
7.00	Inventory	2,631,734	0	0	0	7.00
8.00	Prepaid expenses	1,093,660	0	0	0	8.00
9.00	Other current assets	597,898	0	0	0	9.00
10.00	Due from other funds	0	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	16,407,493	0	0	0	11.00
	FIXED ASSETS					
12.00	Land	1,010,000	0	0	0	12.00
13.00	Land improvements	412,126	0	0	0	13.00
14.00	Accumulated depreciation	-316,600	0	0	0	14.00
15.00	Buildings	28,388,394	0	0	0	15.00
16.00	Accumulated depreciation	-25,675,972	0	0	0	16.00
17.00	Leasehold improvements	23,524,288	0	0	0	17.00
18.00	Accumulated depreciation	-9,904,432	0	0	0	18.00
19.00	Fixed equipment	1,509,768	0	0	0	19.00
20.00	Accumulated depreciation	0	0	0	0	20.00
21.00	Automobiles and trucks	0	0	0	0	21.00
22.00	Accumulated depreciation	0	0	0	0	22.00
23.00	Major movable equipment	21,068,138	0	0	0	23.00
24.00	Accumulated depreciation	-16,996,143	0	0	0	24.00
25.00	Minor equipment depreciable	8,212,683	0	0	0	25.00
26.00	Accumulated depreciation	-7,695,982	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)	23,536,268	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	18,902,897	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	18,902,897	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	58,846,658	0	0	0	36.00
	CURRENT LIABILITIES					
37.00	Accounts payable	1,259,058	0	0	0	37.00
38.00	Salaries, wages, and fees payable	1,479,127	0	0	0	38.00
39.00	Payroll taxes payable	149,533	0	0	0	39.00
40.00	Notes and loans payable (short term)	0	0	0	0	40.00
41.00	Deferred income	0	0	0	0	41.00
42.00	Accelerated payments	0				42.00
43.00	Due to other funds	59,398,481	0	0	0	43.00
44.00	Other current liabilities	7,065,498	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	69,351,697	0	0	0	45.00
	LONG TERM LIABILITIES					
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	-1	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	0	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	-1	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	69,351,696	0	0	0	51.00
	CAPITAL ACCOUNTS					
52.00	General fund balance	-10,505,038				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)	-10,505,038	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	58,846,658	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES | Provider CCN: 15-0047 | Period: From 06/01/2019 To 05/31/2020 | Worksheet G-1 | Date/Time Prepared: 11/2/2020 12:13 pm

		General Fund		Special Purpose Fund		Endowment Fund	
		1.00	2.00	3.00	4.00	5.00	
1.00	Fund balances at beginning of period		19,085,283		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		-29,590,321				2.00
3.00	Total (sum of line 1 and line 2)		-10,505,038		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)		-10,505,038		0		11.00
12.00	Deductions (debit adjustments) (specify)	0		0		0	12.00
13.00		0		0		0	13.00
14.00		0		0		0	14.00
15.00		0		0		0	15.00
16.00		0		0		0	16.00
17.00		0		0		0	17.00
18.00	Total deductions (sum of lines 12-17)		0		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		-10,505,038		0		19.00

		Endowment Fund	Plant Fund		
		6.00	7.00	8.00	
1.00	Fund balances at beginning of period	0		0	1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)				2.00
3.00	Total (sum of line 1 and line 2)	0		0	3.00
4.00	Additions (credit adjustments) (specify)		0		4.00
5.00			0		5.00
6.00			0		6.00
7.00			0		7.00
8.00			0		8.00
9.00			0		9.00
10.00	Total additions (sum of line 4-9)	0		0	10.00
11.00	Subtotal (line 3 plus line 10)	0		0	11.00
12.00	Deductions (debit adjustments) (specify)		0		12.00
13.00			0		13.00
14.00			0		14.00
15.00			0		15.00
16.00			0		16.00
17.00			0		17.00
18.00	Total deductions (sum of lines 12-17)	0		0	18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)	0		0	19.00

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES | Provider CCN: 15-0047 | Period: From 06/01/2019 To 05/31/2020 | Worksheet G-2 Parts I & II | Date/Time Prepared: 11/2/2020 12:13 pm

	Cost Center Description	Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospital	29,027,916		29,027,916	1.00
2.00	SUBPROVIDER - IPF	14,183,573		14,183,573	2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	0		0	5.00
6.00	Swing bed - NF	0		0	6.00
7.00	SKILLED NURSING FACILITY	3,763,427		3,763,427	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)	46,974,916		46,974,916	10.00
	Intensive Care Type Inpatient Hospital Services				
11.00	INTENSIVE CARE UNIT				11.00
12.00	CORONARY CARE UNIT				12.00
13.00	BURN INTENSIVE CARE UNIT	12,310,408		12,310,408	13.00
14.00	SURGICAL INTENSIVE CARE UNIT				14.00
15.00	OTHER SPECIAL CARE (SPECIFY)				15.00
16.00	Total intensive care type inpatient hospital services (sum of lines 11-15)	12,310,408		12,310,408	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	59,285,324		59,285,324	17.00
18.00	Ancillary services	116,333,367	134,781,958	251,115,325	18.00
19.00	Outpatient services	8,907,425	37,542,014	46,449,439	19.00
20.00	RURAL HEALTH CLINIC	0	0	0	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY				22.00
23.00	AMBULANCE SERVICES				23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	OTHER (SPECIFY)	0	0	0	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	184,526,116	172,323,972	356,850,088	28.00
	PART II - OPERATING EXPENSES				
29.00	Operating expenses (per Wkst. A, column 3, line 200)		83,609,895		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)		83,609,895		43.00

STATEMENT OF REVENUES AND EXPENSES | Provider CCN: 15-0047 | Period: From 06/01/2019 To 05/31/2020 | Worksheet G-3 | Date/Time Prepared: 11/2/2020 12:13 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	356,850,088	1.00
2.00	Less contractual allowances and discounts on patients' accounts	304,407,359	2.00
3.00	Net patient revenues (line 1 minus line 2)	52,442,729	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	83,609,895	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-31,167,166	5.00
	OTHER INCOME		
6.00	Contributions, donations, bequests, etc	0	6.00
7.00	Income from investments	0	7.00
8.00	Revenues from telephone and other miscellaneous communication services	0	8.00
9.00	Revenue from television and radio service	0	9.00
10.00	Purchase discounts	0	10.00
11.00	Rebates and refunds of expenses	0	11.00
12.00	Parking lot receipts	0	12.00
13.00	Revenue from laundry and linen service	0	13.00
14.00	Revenue from meals sold to employees and guests	0	14.00
15.00	Revenue from rental of living quarters	0	15.00
16.00	Revenue from sale of medical and surgical supplies to other than patients	0	16.00
17.00	Revenue from sale of drugs to other than patients	0	17.00
18.00	Revenue from sale of medical records and abstracts	0	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	0	20.00
21.00	Rental of vending machines	0	21.00
22.00	Rental of hospital space	0	22.00
23.00	Governmental appropriations	0	23.00
24.00	COVID-19 GRANT	1,511,850	24.00
24.01	OTHER MISC INCOME	64,995	24.01
24.50	COVID-19 PHE Funding	0	24.50
25.00	Total other income (sum of lines 6-24)	1,576,845	25.00
26.00	Total (line 5 plus line 25)	-29,590,321	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)	-29,590,321	29.00

CALCULATION OF CAPITAL PAYMENT | Provider CCN: 15-0047 | Period: From 06/01/2019 To 05/31/2020 | Worksheet L Parts I-III Date/Time Prepared: 11/2/2020 12:13 pm

Title XVIII | Hospital | PPS

		1.00	
	PART I - FULLY PROSPECTIVE METHOD		
	CAPITAL FEDERAL AMOUNT		
1.00	Capital DRG other than outlier	347,653	1.00
1.01	Model 4 BPCI Capital DRG other than outlier	0	1.01
2.00	Capital DRG outlier payments	40,040	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)	35.68	3.00
4.00	Number of interns & residents (see instructions)	0.54	4.00
5.00	Indirect medical education percentage (see instructions)	0.43	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)	1,495	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)	389,188	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