

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: 15-0162	Period: From 01/01/2020 To 12/31/2020	Worksheet S Parts I-III Date/Time Prepared: 3/30/2021 10:40 am
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PART I - COST REPORT STATUS

Provider use only
 1. Electronically prepared cost report
 2. Manually prepared cost report
 3. If this is an amended report enter the number of times the provider resubmitted this cost report
 4. Medicare Utilization. Enter "F" for Full or "L" for Low.

Contractor use only
 5. Cost Report Status
 (1) As Submitted
 (2) Settled without Audit
 (3) Settled with Audit
 (4) Reopened
 (5) Amended

6. Date Received:
7. Contractor No.
8. Initial Report for this Provider CCN
9. Final Report for this Provider CCN

10. NPR Date:
11. Contractor's Vendor Code: 4
12. If line 5, column 1 is 4: Enter number of times reopened = 0-9.

Date: 3/30/2021 Time: 10:40 am

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. FRANCIS HOSPITAL & HEALTH CENTER (15-0162) for the cost reporting period beginning 01/01/2020 and ending 12/31/2020 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

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

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

Title

Date

Cost Center Description	Title V	Title XVIII		HIT	Title XIX	
		Part A	Part B			
	1.00	2.00	3.00	4.00	5.00	
PART III - SETTLEMENT SUMMARY						
1.00 Hospital	0	1,457,024	-133,676	0	0	1.00
2.00 Subprovider - IPF	0	0	0		0	2.00
3.00 Subprovider - IRF	0	70,850	-28		0	3.00
5.00 Swing Bed - SNF	0	0	0		0	5.00
6.00 Swing Bed - NF	0				0	6.00
9.00 HOME HEALTH AGENCY I	0	0	0		0	9.00
200.00 Total	0	1,527,874	-133,704	0	0	200.00

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 15-0162			Period: From 01/01/2020 To 12/31/2020		Worksheet S-2 Part I Date/Time Prepared: 3/30/2021 10:40 am					
1.00		2.00		3.00		4.00						
Hospital and Hospital Health Care Complex Address:												
1.00	Street: 8111 S. EMERSON AVENUE			PO Box:						1.00		
2.00	City: INDIANAPOLIS			State: IN		Zip Code: 46237		County: MARI ON		2.00		
		Component Name	CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N)					
		1.00	2.00	3.00	4.00	5.00	6.00	7.00	8.00			
Hospital and Hospital -Based Component Identification:												
3.00	Hospital		ST. FRANCIS HOSPITAL & HEALTH CENTER		150162	26900	1	05/01/2006	N	P	P	3.00
4.00	Subprovider - IPF		REHAB UNIT		15T162	26900	5	01/01/2005	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											9.00
10.00	Hospital -Based NF											10.00
11.00	Hospital -Based OLTC											11.00
12.00	Hospital -Based HHA											12.00
13.00	Separately Certified ASC											13.00
14.00	Hospital -Based Hospice		HOSPICE		151523	26900		01/01/2014				14.00
15.00	Hospital -Based Health Clinic - RHC											15.00
16.00	Hospital -Based Health Clinic - FQHC											16.00
17.00	Hospital -Based (CMHC) I											17.00
18.00	Renal Dialysis											18.00
19.00	Other											19.00
						From:		To:				
						1.00		2.00				
20.00	Cost Reporting Period (mm/dd/yyyy)					01/01/2020		12/31/2020		20.00		
21.00	Type of Control (see instructions)					1				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.				Y		N			22.02		
22.03	Did this hospital receive a geographic reclassification from urban to rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no.				N		N		N	22.03		
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.						3		N	23.00		
		In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of-State Medicaid paid days	Out-of-State Medicaid eligible unpaid days	Medicaid HMO days	Other Medicaid days					
		1.00	2.00	3.00	4.00	5.00	6.00					
24.00	If this provider is an IPPS hospital, enter the in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.	837	226	11	113	19,159	398		24.00			

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 15-0162			Period: From 01/01/2020 To 12/31/2020		Worksheet S-2 Part I Date/Time Prepared: 3/30/2021 10:40 am			
		In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of-State Medicaid paid days	Out-of-State Medicaid eligible unpaid	Medicaid HMO days	Other Medicaid days			
		1.00	2.00	3.00	4.00	5.00	6.00			
25.00	If this provider is an IRF, enter the in-state Medicaid paid days in column 1, the in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5.	0	0	0	0	707			25.00	
						Urban/Rural	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.					2	11/13/2020		27.00	
35.00	If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period.					0			35.00	
						Beginning:	Ending:			
						1.00	2.00			
36.00	Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.								36.00	
37.00	If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status is in effect in the cost reporting period.					0			37.00	
37.01	Is this hospital a former MDH that is eligible for the MDH transitional payment in accordance with FY 2016 OPPS final rule? Enter "Y" for yes or "N" for no. (see instructions)								37.01	
38.00	If line 37 is 1, enter the beginning and ending dates of MDH status. If line 37 is greater than 1, subscript this line for the number of periods in excess of one and enter subsequent dates.								38.00	
						Y/N	Y/N			
						1.00	2.00			
39.00	Does this facility qualify for the inpatient hospital payment adjustment for low volume hospitals in accordance with 42 CFR 412.101(b)(2)(i), (ii), or (iii)? Enter in column 1 "Y" for yes or "N" for no. Does the facility meet the mileage requirements in accordance with 42 CFR 412.101(b)(2)(i), (ii), or (iii)? Enter in column 2 "Y" for yes or "N" for no. (see instructions)					N	N		39.00	
40.00	Is this hospital subject to the HAC program reduction adjustment? Enter "Y" for yes or "N" for no in column 1, for discharges prior to October 1. Enter "Y" for yes or "N" for no in column 2, for discharges on or after October 1. (see instructions)					Y	Y		40.00	
						V	XVII	XIX		
						1.00	2.00	3.00		
Prospective Payment System (PPS)-Capital										
45.00	Does this facility qualify and receive Capital payment for disproportionate share in accordance with 42 CFR Section 412.320? (see instructions)					N	Y	N		45.00
46.00	Is this facility eligible for additional payment exception for extraordinary circumstances pursuant to 42 CFR 412.348(f)? If yes, complete Wkst. L, Pt. III and Wkst. L-1, Pt. I through Pt. III.					N	N	N		46.00
47.00	Is this a new hospital under 42 CFR 412.300(b) PPS capital? Enter "Y" for yes or "N" for no.					N	N	N		47.00
48.00	Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.					N	N	N		48.00
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	N			56.00
57.00	If line 56 is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y" did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If column 2 is "N", complete Wkst. D, Parts III & IV and D-2, Pt. II, if applicable.					N			57.00	
58.00	If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, chapter 21, §2148? If yes, complete Wkst. D-5.					N			58.00	
59.00	Are costs claimed on line 100 of Worksheet A? If yes, complete Wkst. D-2, Pt. I.					N			59.00	
				NAHE 413.85 Y/N	Worksheet A Line #	Pass-Through Qualification Criterion Code				
				1.00	2.00	3.00				
60.00	Are you claiming nursing and allied health education (NAHE) costs for any programs that meet the criteria under 42 CFR 413.85? (see instructions) Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", are you impacted by CR 11642 (or subsequent CR) NAHE MA payment adjustment? Enter "Y" for yes or "N" for no in column 2.					Y	Y			60.00
60.01	If line 60 is yes, complete columns 2 and 3 for each program. (see instructions)						23.00	1		60.01

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		NAHE 413.85 Y/N	Worksheet A Line #	Pass-Through Qualification Criteria Code			
		1.00	2.00	3.00			
60.02	If line 60 is yes, complete columns 2 and 3 for each program. (see instructions)		23.01	1		60.02	
60.03	If line 60 is yes, complete columns 2 and 3 for each program. (see instructions)		23.02	1		60.03	
60.04	If line 60 is yes, complete columns 2 and 3 for each program. (see instructions)		23.03	1		60.04	
		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)	Y			0.81	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)					Y	63.00

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			Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col . 1/ (col . 1 + col . 2))			
			1.00	2.00	3.00			
64.00	Section 5504 of the ACA Base Year FTE Residents in Nonprovider Settings--This base year is your cost reporting period that begins on or after July 1, 2009 and before June 30, 2010. Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)		0.00	0.00	0.000000		64.00	
		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)	FAMILY MEDICINE GENERAL	1350	9.00	13.91	0.392842		65.00
			Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col . 1/ (col . 1 + col . 2))			
			1.00	2.00	3.00			
66.00	Section 5504 of the ACA Current Year FTE Residents in Nonprovider Settings--Effective for cost reporting periods beginning on or after July 1, 2010 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)	FAMILY MEDICINE GENERAL	1350	13.45	10.56	0.560183		67.00

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		1.00	2.00	3.00		
Inpatient Psychiatric Facility PPS						
70.00	Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? Enter "Y" for yes or "N" for no.	N				70.00
71.00	If line 70 is yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost report filed on or before November 15, 2004? Enter "Y" for yes or "N" for no. (see 42 CFR 412.424(d)(1)(iii)(c)) Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)			0		71.00
Inpatient Rehabilitation Facility PPS						
75.00	Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF subprovider? Enter "Y" for yes and "N" for no.	Y				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
		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 1.00			XIX 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. 1, col. 25? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N		Y		98.00
98.01	Does title V or XIX follow Medicare (title XVIII) for the reporting of charges on Wkst. C, Pt. 1? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N		Y		98.01
98.02	Does title V or XIX follow Medicare (title XVIII) for the calculation of observation bed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N		Y		98.02
98.03	Does title V or XIX follow Medicare (title XVIII) for a critical access hospital (CAH) reimbursed 101% of inpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N		N		98.03
98.04	Does title V or XIX follow Medicare (title XVIII) for a CAH reimbursed 101% of outpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N		N		98.04
98.05	Does title V or XIX follow Medicare (title XVIII) and add back the RCE disallowance on Wkst. C, Pt. 1, col. 4? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N		Y		98.05
98.06	Does title V or XIX follow Medicare (title XVIII) when cost reimbursed for Wkst. D, Pts. 1 through IV? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N		Y		98.06
Rural Providers						
105.00	Does this hospital qualify as a CAH?	N				105.00
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)	N				106.00
107.00	Column 1: If line 105 is Y, is this facility eligible for cost reimbursement for I&R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) Column 2: If column 1 is Y and line 70 or line 75 is Y, do you train I&Rs in an approved medical education program in the CAH's excluded IPF and/or IRF unit(s)? Enter "Y" for yes or "N" for no in column 2. (see instructions)	N				107.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 15-0162		Period: From 01/01/2020 To 12/31/2020		Worksheet S-2 Part I Date/Time Prepared: 3/30/2021 10:40 am	
				V	XIX		
				1.00	2.00		
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	N				108.00	
				Physical	Occupational	Speech	Respiratory
				1.00	2.00	3.00	4.00
109.00	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.	N	N	N	N	109.00	
						1.00	
110.00	Did this hospital participate in the Rural Community Hospital Demonstration project (\$410A Demonstration) for the current cost reporting period? Enter "Y" for yes or "N" for no. If yes, complete Worksheet E, Part A, lines 200 through 218, and Worksheet E-2, lines 200 through 215, as applicable.	N				110.00	
				1.00	2.00		
111.00	If this facility qualifies as a CAH, did it participate in the Frontier Community Health Integration Project (FCHIP) demonstration for this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If the response to column 1 is Y, enter the integration prong of the FCHIP demo in which this CAH is participating in column 2. Enter all that apply: "A" for Ambulance services; "B" for additional beds; and/or "C" for tele-health services.	N				111.00	
				1.00	2.00	3.00	
112.00	Did this hospital participate in the Pennsylvania Rural Health Model demonstration for any portion of the current cost reporting period? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2, the date the hospital began participating in the demonstration. In column 3, enter the date the hospital ceased participation in the demonstration, if applicable.	N				112.00	
Miscellaneous Cost Reporting Information							
115.00	Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in column 1. If column 1 is yes, enter the method used (A, B, or E only) in column 2. If column 2 is "E", enter in column 3 either "93" percent for short term hospital or "98" percent for long term care (includes psychiatric, rehabilitation and long term hospitals providers) based on the definition in CMS Pub.15-1, chapter 22, §2208.1.	N				115.00	
116.00	Is this facility classified as a referral center? Enter "Y" for yes or "N" for no.	Y				116.00	
117.00	Is this facility legally-required to carry malpractice insurance? Enter "Y" for yes or "N" for no.	N				117.00	
118.00	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.	2				118.00	
				Premiums	Losses	Insurance	
				1.00	2.00	3.00	
118.01	List amounts of malpractice premiums and paid losses:	1,450,776		644,203		961,181	
				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	
DO NOT USE THIS LINE							
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 1, "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2, "Y" for yes or "N" for no.	N		N		120.00	
121.00	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter "Y" for yes or "N" for no.	Y				121.00	
122.00	Does the cost report contain healthcare related taxes as defined in §1903(w)(3) of the Act? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2 the Worksheet A line number where these taxes are included.	Y		5.03		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	

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 15-0162		Period: From 01/01/2020 To 12/31/2020		Worksheet S-2 Part I Date/Time Prepared: 3/30/2021 10:40 am	
		1.00	2.00				
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	158014				140.00
		1.00	2.00	3.00			
If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number.							
141.00	Name: SISTERS OF ST. FRANCIS HEALTH SERVIC	Contractor's Name: WISCONSIN PHYSICIANS SERVICES		Contractor's Number: 08101			141.00
142.00	Street: 1515 W DRAGOON TRL	PO Box: 1290					142.00
143.00	City: MISHAWAKA	State: IN		Zip Code: 46544			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	N	155.00
156.00	Subprovider - IPF	N	N	N	N	N	156.00
157.00	Subprovider - IRF	N	N	N	N	N	157.00
158.00	SUBPROVIDER						158.00
159.00	SNF	N	N	N	N	N	159.00
160.00	HOME HEALTH AGENCY	N	N	N	N	N	160.00
161.00	CMHC		N	N	N	N	161.00
						1.00	
Multi campus							
165.00	Is this hospital part of a Multi campus hospital that has one or more campuses in different CBSAs? Enter "Y" for yes or "N" for no.					N	165.00
		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
							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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 15-0162	Period: From 01/01/2020 To 12/31/2020	Worksheet S-2 Part I Date/Time Prepared: 3/30/2021 10:40 am
			Beginning	Ending
			1.00	2.00
170.00	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)			170.00
			1.00	2.00
171.00	If line 167 is "Y", does this provider have any days for individuals enrolled in section 1876 Medicare cost plans reported on Wkst. S-3, Pt. 1, line 2, col. 6? Enter "Y" for yes and "N" for no in column 1. If column 1 is yes, enter the number of section 1876 Medicare days in column 2. (see instructions)		N	0171.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 15-0162		Period: From 01/01/2020 To 12/31/2020		Worksheet S-2 Part II Date/Time Prepared: 3/30/2021 10:40 am	
		Y/N	Date				
		1.00	2.00				
General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format.							
COMPLETED BY ALL HOSPITALS							
Provider Organization and Operation							
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)	N					1.00
		Y/N	Date				
		1.00	2.00				
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.	N					2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)	Y					3.00
		Y/N	Type				
		1.00	2.00				
Financial Data and Reports							
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	Y	A				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.	Y					8.00
9.00	Are costs claimed for Interns and Residents in an approved graduate medical education program in the current cost report? If yes, see instructions.	Y					9.00
10.00	Was an approved Intern and Resident GME program initiated or renewed in the current cost reporting period? If yes, see instructions.	N					10.00
11.00	Are GME cost directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions.	N					11.00
		Y/N					
		1.00					1.00
Bad Debts							
12.00	Is the provider seeking reimbursement for bad debts? If yes, see instructions.					Y	12.00
13.00	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.					N	13.00
14.00	If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.					N	14.00
Bed Complement							
15.00	Did total beds available change from the prior cost reporting period? If yes, see instructions.					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)	N		N			16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	Y	03/01/2021	Y	03/01/2021		17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N		N			18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		N			19.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 15-0162	Period: From 01/01/2020 To 12/31/2020	Worksheet S-2 Part II Date/Time Prepared: 3/30/2021 10:40 am	
		Description	Y/N	Y/N	
		0	1.00	3.00	
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:		N	N	20.00
		Y/N	Date	Y/N	Date
		1.00	2.00	3.00	4.00
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.		N		21.00
				1.00	
COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)					
Capital Related Cost					
22.00	Have assets been relieved for Medicare purposes? If yes, see instructions			N	22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.			N	23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions			N	24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.			N	25.00
26.00	Were assets subject to Sec. 2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.			N	26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.			N	27.00
Interest Expense					
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.			N	28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions			N	29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.			N	30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.			N	31.00
Purchased Services					
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.			N	32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.				33.00
Provider-Based Physicians					
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.			Y	34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.			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.		N		37.00
38.00	If line 36 is yes, was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.		N		38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.		Y		39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.		Y		40.00
		1.00		2.00	
Cost Report Preparer Contact Information					
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	KERRY		BEJARANO	41.00
42.00	Enter the employer/company name of the cost report preparer.	BKD, LLP			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	317-383-4000		KBEJARANO@BKD.COM	43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 15-0162	Period: From 01/01/2020 To 12/31/2020	Worksheet S-2 Part II Date/Time Prepared: 3/30/2021 10:40 am
		3.00		
Cost Report Preparer Contact Information				
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	DI RECTOR		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: 15-0162

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

Worksheet S-3
Part I
Date/Time Prepared:
3/30/2021 10:40 am

Component	Worksheet A	No. of Beds	Bed Days Available	CAH Hours	I/P Days / O/P Visits / Trips	
	Line Number				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	304	111,264	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)		304	111,264	0.00	0	7.00
8.00 INTENSIVE CARE UNIT	31.00	67	24,522	0.00	0	8.00
8.01 NEONATAL INTENSIVE CARE UNIT	31.01	31	10,742	0.00	0	8.01
9.00 CORONARY CARE UNIT	32.00	66	24,156	0.00	0	9.00
10.00 BURN INTENSIVE CARE UNIT						10.00
11.00 SURGICAL INTENSIVE CARE UNIT	34.00	31	11,346	0.00	0	11.00
12.00 OTHER SPECIAL CARE (SPECIFY)						12.00
13.00 NURSERY	43.00				0	13.00
14.00 Total (see instructions)		499	182,030	0.00	0	14.00
15.00 CAH visits					0	15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF	41.00	20	7,320		0	17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY	101.00				0	22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE	116.00	0	0			24.00
24.10 HOSPICE (non-distinct part)	30.00					24.10
25.00 CMHC - CMHC						25.00
26.00 RURAL HEALTH CLINIC						26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	26.25
27.00 Total (sum of lines 14-26)		519				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: 15-0162

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

Worksheet S-3
Part I
Date/Time Prepared:
3/30/2021 10:40 am

Component	I/P Days / O/P Visits / Trips			Full Time Equivalents		
	Title XVII	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)	22,236	797	52,024			1.00
2.00 HMO and other (see instructions)	22,179	18,941				2.00
3.00 HMO IPF Subprovider	0	0				3.00
4.00 HMO IRF Subprovider	1,253	707				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)	22,236	797	52,024			7.00
8.00 INTENSIVE CARE UNIT	3,568	278	20,500			8.00
8.01 NEONATAL INTENSIVE CARE UNIT	0	45	6,322			8.01
9.00 CORONARY CARE UNIT	5,353	46	12,691			9.00
10.00 BURN INTENSIVE CARE UNIT						10.00
11.00 SURGICAL INTENSIVE CARE UNIT	3,146	67	8,247			11.00
12.00 OTHER SPECIAL CARE (SPECIFY)						12.00
13.00 NURSERY		172	3,738			13.00
14.00 Total (see instructions)	34,303	1,405	103,522	24.01	2,371.22	14.00
15.00 CAH visits	0	0	0			15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF	2,539	25	5,552	0.00	41.15	17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY	0	0	0	0.00	0.36	22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE	498	43	604	0.00	74.14	24.00
24.10 HOSPICE (non-distinct part)			0			24.10
25.00 CMHC - CMHC						25.00
26.00 RURAL HEALTH CLINIC						26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0.00	0.00	26.25
27.00 Total (sum of lines 14-26)				24.01	2,486.87	27.00
28.00 Observation Bed Days		1,947	9,550			28.00
29.00 Ambulance Trips	0					29.00
30.00 Employee discount days (see instruction)			0			30.00
31.00 Employee discount days - IRF			0			31.00
32.00 Labor & delivery days (see instructions)	0	398	874			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: 15-0162

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

Worksheet S-3
Part I
Date/Time Prepared:
3/30/2021 10:40 am

Component	Full Time Equivalents	Discharges			Total All Patients		
		Nonpaid Workers	Title V	Title XVIII			Title XIX
		11.00	12.00	13.00			14.00
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	6,283	372	18,261	1.00
2.00	HMO and other (see instructions)			3,626	1,768		2.00
3.00	HMO IPF Subprovider				0		3.00
4.00	HMO IRF Subprovider				25		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
8.01	NEONATAL INTENSIVE CARE UNIT						8.01
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	6,283	372	18,261	14.00
15.00	CAH visits						15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF	0.00	0	205	2	438	17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY	0.00					22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE	0.00					24.00
24.10	HOSPICE (non-distinct part)						24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0.00					26.25
27.00	Total (sum of lines 14-26)	0.00					27.00
28.00	Observation Bed Days						28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)						32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00	LTCH non-covered days			0			33.00
33.01	LTCH site neutral days and discharges			0			33.01

HOSPITAL WAGE INDEX INFORMATION			Provider CCN: 15-0162		Period: From 01/01/2020 To 12/31/2020		Worksheet S-3 Part II Date/Time Prepared: 3/30/2021 10:40 am	
	Wkst. A Line Number	Amount Reported	Reclassification of Salaries (from Wkst. A-6)	Adjusted Salaries (col. 2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)		
	1.00	2.00	3.00	4.00	5.00	6.00		
PART II - WAGE DATA								
SALARIES								
1.00	Total salaries (see instructions)	200.00	170,985,927	0	170,985,927	5,172,709.40	33.06	1.00
2.00	Non-physician anesthesiologist Part A		0	0	0	0.00	0.00	2.00
3.00	Non-physician anesthesiologist 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		1,550,228	0	1,550,228	12,683.00	122.23	4.01
5.00	Physician and Non-Physician-Part B		2,640,255	0	2,640,255	9,734.14	271.24	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	5,102,949	-2,896,572	2,206,377	55,201.92	39.97	7.00
7.01	Contracted interns and residents (in an approved programs)		0	0	0	0.00	0.00	7.01
8.00	Home office and/or related organization personnel		0	0	0	0.00	0.00	8.00
9.00	SNF	44.00	0	0	0	0.00	0.00	9.00
10.00	Excluded area salaries (see instructions)		20,912,287	143,864	21,056,151	593,463.53	35.48	10.00
OTHER WAGES & RELATED COSTS								
11.00	Contract Labor: Direct Patient Care		6,588,727	0	6,588,727	98,825.00	66.67	11.00
12.00	Contract Labor: Top level management and other management and administrative services		0	0	0	0.00	0.00	12.00
13.00	Contract Labor: Physician-Part A - Administrative		491,243	0	491,243	3,546.00	138.53	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		67,816,794	0	67,816,794	1,815,398.73	37.36	14.01
14.02	Related organization salaries		5,380,592	0	5,380,592	217,882.70	24.69	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)		50,124,421	0	50,124,421			17.00
18.00	Wage-related costs (other) (see instructions)							18.00
19.00	Excluded areas		7,024,419	0	7,024,419			19.00
20.00	Non-physician anesthesiologist Part A		0	0	0			20.00
21.00	Non-physician anesthesiologist Part B		0	0	0			21.00
22.00	Physician Part A - Administrative		0	0	0			22.00
22.01	Physician Part A - Teaching		373,321	0	373,321			22.01
23.00	Physician Part B		1,387,566	0	1,387,566			23.00
24.00	Wage-related costs (RHC/FQHC)		0	0	0			24.00
25.00	Interns & residents (in an approved program)		1,298,313	0	1,298,313			25.00
25.50	Home office wage-related (core)		22,998,791	0	22,998,791			25.50
25.51	Related organization wage-related (core)		1,622,234	0	1,622,234			25.51
25.52	Home office: Physician Part A - Administrative - wage-related (core)		0	0	0			25.52

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 15-0162

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

Worksheet S-3
Part II
Date/Time Prepared:
3/30/2021 10:40 am

	Wkst. A Line Number	Amount Reported	Reclassification of Salaries (from Wkst. A-6)	Adjusted Salaries (col. 2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
	1.00	2.00	3.00	4.00	5.00	6.00	
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	0	0	0	0.00	0.00	26.00
27.00	Administrative & General	1,781,995	0	1,781,995	46,520.00	38.31	27.00
28.00	Administrative & General under contract (see inst.)	2,677,904	0	2,677,904	24,486.81	109.36	28.00
29.00	Maintenance & Repairs	0	0	0	0.00	0.00	29.00
30.00	Operation of Plant	3,779,271	0	3,779,271	130,762.27	28.90	30.00
31.00	Laundry & Linen Service	242,343	0	242,343	14,459.81	16.76	31.00
32.00	Housekeeping	3,991,630	0	3,991,630	233,704.90	17.08	32.00
33.00	Housekeeping under contract (see instructions)	0	0	0	0.00	0.00	33.00
34.00	Dietary	2,337,218	-1,320,042	1,017,176	55,331.00	18.38	34.00
35.00	Dietary under contract (see instructions)	0	0	0	0.00	0.00	35.00
36.00	Cafeteria	695,193	1,320,042	2,015,235	111,330.98	18.10	36.00
37.00	Maintenance of Personnel	0	0	0	0.00	0.00	37.00
38.00	Nursing Administration	4,328,850	0	4,328,850	94,872.95	45.63	38.00
39.00	Central Services and Supply	678,692	0	678,692	31,708.61	21.40	39.00
40.00	Pharmacy	6,800,157	-142,529	6,657,628	161,606.24	41.20	40.00
41.00	Medical Records & Medical Records Library	0	0	0	0.00	0.00	41.00
42.00	Social Service	0	0	0	0.00	0.00	42.00
43.00	Other General Service	0	0	0	0.00	0.00	43.00

HOSPITAL WAGE INDEX INFORMATION			Provider CCN: 15-0162		Period: From 01/01/2020 To 12/31/2020		Worksheet S-3 Part III Date/Time Prepared: 3/30/2021 10:40 am	
	Worksheet A Line Number	Amount Reported	Recl assi fi cat ion of Sal aries (from Worksheet A-6)	Adj uste d Sal aries (col . 2 ± col . 3)	Pai d Hours Rel ated to Sal aries i n 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)	164,370,399	2,896,572	167,266,971	5,119,577.15	32.67		1.00
2.00	Excluded area salaries (see instructions)	20,912,287	143,864	21,056,151	593,463.53	35.48		2.00
3.00	Subtotal salaries (line 1 minus line 2)	143,458,112	2,752,708	146,210,820	4,526,113.62	32.30		3.00
4.00	Subtotal other wages & related costs (see inst.)	80,277,356	0	80,277,356	2,135,652.43	37.59		4.00
5.00	Subtotal wage-related costs (see inst.)	74,745,446	0	74,745,446	0.00	51.12		5.00
6.00	Total (sum of lines 3 thru 5)	298,480,914	2,752,708	301,233,622	6,661,766.05	45.22		6.00
7.00	Total overhead cost (see instructions)	27,313,253	-142,529	27,170,724	904,783.57	30.03		7.00

HOSPITAL WAGE RELATED COSTS		Provider CCN: 15-0162	Period: From 01/01/2020 To 12/31/2020	Worksheet S-3 Part IV Date/Time Prepared: 3/30/2021 10:40 am
				Amount Reported
				1.00
PART IV - WAGE RELATED COSTS				
Part A - Core List				
RETIREMENT COST				
1.00	401K Employer Contributions			3,869,591 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)			16,040,864 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)			24,012,067 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			1,288,258 10.00
11.00	Life Insurance (If employee is owner or beneficiary)			97,765 11.00
12.00	Accident Insurance (If employee is owner or beneficiary)			0 12.00
13.00	Disability Insurance (If employee is owner or beneficiary)			523,325 13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)			0 14.00
15.00	'Workers' Compensation Insurance			1,219,117 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			13,104,597 17.00
18.00	Medicare Taxes - Employers Portion Only			0 18.00
19.00	Unemployment Insurance			52,456 19.00
20.00	State or Federal Unemployment Taxes			0 20.00
OTHER				
21.00	Executive Deferred Compensation (Other Than Retirement Cost Reported on lines 1 through 4 above. (see instructions))			0 21.00
22.00	Day Care Cost and Allowances			0 22.00
23.00	Tuition Reimbursement			0 23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)			60,208,040 24.00
Part B - Other than Core Related Cost				
25.00	OTHER WAGE RELATED COSTS (SPECIFY)			

HOSPITAL CONTRACT LABOR AND BENEFIT COST		Provider CCN: 15-0162	Period: From 01/01/2020 To 12/31/2020	Worksheet S-3 Part V Date/Time Prepared: 3/30/2021 10:40 am
Cost Center Description		Contract Labor	Benefit Cost	
PART V - Contract Labor and Benefit Cost		1.00	2.00	
Hospital and Hospital-Based Component Identification:				
1.00	Total facility's contract labor and benefit cost	6,588,727	60,208,040	1.00
2.00	Hospital	6,588,727	53,183,622	2.00
3.00	Subprovider - IPF			3.00
4.00	Subprovider - IRF	0	975,678	4.00
5.00	Subprovider - (Other)	0	0	5.00
6.00	Swing Beds - SNF	0	0	6.00
7.00	Swing Beds - NF	0	0	7.00
8.00	Hospital-Based SNF			8.00
9.00	Hospital-Based NF			9.00
10.00	Hospital-Based OLTC			10.00
11.00	Hospital-Based HHA	0	0	11.00
12.00	Separately Certified ASC			12.00
13.00	Hospital-Based Hospice	0	1,930,734	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	4,118,006	18.00

HOSPITAL-BASED HOSPICE IDENTIFICATION DATA		Provider CCN: 15-0162 Hospice CCN: 15-1523	Period: From 01/01/2020 To 12/31/2020	Worksheet S-9 PARTS I THROUGH IV Date/Time Prepared: 3/30/2021 10:40 am
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		Hospice I						
		Unduplicated Days						
		Title XVIII	Title XIX	Title XVIII Skilled Nursing Facility	Title XIX Nursing Facility	All Other	Total (sum of cols. 1, 2 & 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
PART I - ENROLLMENT DAYS FOR COST REPORTING PERIODS BEGINNING BEFORE OCTOBER 1, 2015								
1.00	Hospice Continuous Home Care						1.00	
2.00	Hospice Routine Home Care						2.00	
3.00	Hospice Inpatient Respite Care						3.00	
4.00	Hospice General Inpatient Care						4.00	
5.00	Total Hospice Days						5.00	
Part II - CENSUS DATA FOR COST REPORTING PERIODS BEGINNING BEFORE OCTOBER 1, 2015								
6.00	Number of patients receiving hospice care						6.00	
7.00	Total number of unduplicated Continuous Care hours billable to Medicare						7.00	
8.00	Average Length of Stay (line 5 / line 6)						8.00	
9.00	Unduplicated census count						9.00	

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

		Title XVIII	Title XIX	Other	Total (sum of cols. 1 through 3)
		1.00	2.00	3.00	4.00
PART III - ENROLLMENT DAYS FOR COST REPORTING PERIODS BEGINNING ON OR AFTER OCTOBER 1, 2015					
10.00	Hospice Continuous Home Care	0	0	0	0
11.00	Hospice Routine Home Care	25,710	1,784	2,958	30,452
12.00	Hospice Inpatient Respite Care	498	24	31	553
13.00	Hospice General Inpatient Care	0	19	32	51
14.00	Total Hospice Days	26,208	1,827	3,021	31,056
PART IV - CONTRACTED STATISTICAL DATA FOR COST REPORTING PERIODS BEGINNING ON OR AFTER OCTOBER 1, 2015					
15.00	Hospice Inpatient Respite Care	0	0	0	0
16.00	Hospice General Inpatient Care	0	0	0	0

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA		Provider CCN: 15-0162	Period: From 01/01/2020 To 12/31/2020	Worksheet S-10 Date/Time Prepared: 3/30/2021 10:40 am
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				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)			0.196061	1.00	
Medicaid (see instructions for each line)						
2.00	Net revenue from Medicaid			93,502,133	2.00	
3.00	Did you receive DSH or supplemental payments from Medicaid?			N	3.00	
4.00	If line 3 is yes, does line 2 include all DSH and/or supplemental payments from Medicaid?			N	4.00	
5.00	If line 4 is no, then enter DSH and/or supplemental payments from Medicaid			0	5.00	
6.00	Medicaid charges			457,573,025	6.00	
7.00	Medicaid cost (line 1 times line 6)			89,712,225	7.00	
8.00	Difference between net revenue and costs for Medicaid program (line 7 minus sum of lines 2 and 5; if < zero then enter zero)			0	8.00	
Children's Health Insurance Program (CHIP) (see instructions for each line)						
9.00	Net revenue from stand-alone CHIP			0	9.00	
10.00	Stand-alone CHIP charges			0	10.00	
11.00	Stand-alone CHIP cost (line 1 times line 10)			0	11.00	
12.00	Difference between net revenue and costs for stand-alone CHIP (line 11 minus line 9; if < zero then enter zero)			0	12.00	
Other state or local government indigent care program (see instructions for each line)						
13.00	Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9)			0	13.00	
14.00	Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)			0	14.00	
15.00	State or local indigent care program cost (line 1 times line 14)			0	15.00	
16.00	Difference between net revenue and costs for state or local indigent care program (line 15 minus line 13; if < zero then enter zero)			0	16.00	
Grants, donations and total unreimbursed cost for Medicaid, CHIP and state/local indigent care programs (see instructions for each line)						
17.00	Private grants, donations, or endowment income restricted to funding charity care			0	17.00	
18.00	Government grants, appropriations or transfers for support of hospital operations			0	18.00	
19.00	Total unreimbursed cost for Medicaid, CHIP and state and local indigent care programs (sum of lines 8, 12 and 16)			0	19.00	
				Uninsured patients	Insured patients	Total (col. 1 + col. 2)
				1.00	2.00	3.00
Uncompensated Care (see instructions for each line)						
20.00	Charity care charges and uninsured discounts for the entire facility (see instructions)	60,495,215	10,864,207	71,359,422	20.00	
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	11,860,752	10,864,207	22,724,959	21.00	
22.00	Payments received from patients for amounts previously written off as charity care	0	0	0	22.00	
23.00	Cost of charity care (line 21 minus line 22)	11,860,752	10,864,207	22,724,959	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)			56,014,166	26.00	
27.00	Medicare reimbursable bad debts for the entire hospital complex (see instructions)			907,714	27.00	
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)			1,396,483	27.01	
28.00	Non-Medicare bad debt expense (see instructions)			54,617,683	28.00	
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)			11,197,167	29.00	
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)			33,922,126	30.00	
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)			33,922,126	31.00	

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES				Provider CCN: 15-0162	Period: From 01/01/2020 To 12/31/2020	Worksheet A	Date/Time Prepared: 3/30/2021 10:40 am
Cost Center Description	Salaries	Other	Total (col. 1 + col. 2)	Reclassifications (See A-6)	Reclassified Trial Balance (col. 3 +/- col. 4)		
	1.00	2.00	3.00	4.00	5.00		
GENERAL SERVICE COST CENTERS							
1.00 00100	CAP REL COSTS-BLDG & FIXT	0	0	22,221,497	22,221,497	1.00	
2.00 00200	CAP REL COSTS-MVBLE EQUIP		35,440,978	35,440,978	-20,483,843	2.00	14,957,135
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	0	0	50,219,718	50,219,718	4.00	
5.01 00570	ADMINISTRATIVE	0	4,297	4,297	-487	5.01	3,810
5.02 00580	CASHIERING/ACCOUNTS RECEIVABLE	0	0	0	0	5.02	0
5.03 00590	OTHER ADMIN & GENERAL	1,781,995	38,301,447	40,083,442	-555,398	5.03	39,528,044
7.00 00700	OPERATION OF PLANT	3,779,271	11,205,655	14,984,926	-1,169,250	7.00	13,815,676
8.00 00800	LAUNDRY & LINEN SERVICE	242,343	1,667,693	1,910,036	-79,256	8.00	1,830,780
9.00 00900	HOUSEKEEPING	3,991,630	3,993,988	7,985,618	-1,309,201	9.00	6,676,417
10.00 01000	DIETARY	2,337,218	2,246,711	4,583,929	-3,626,983	10.00	956,946
11.00 01100	CAFETERIA	695,193	1,095,764	1,790,957	2,595,391	11.00	4,386,348
13.00 01300	NURSING ADMINISTRATION	4,328,850	1,406,385	5,735,235	-1,263,158	13.00	4,472,077
14.00 01400	CENTRAL SERVICES & SUPPLY	678,692	2,675,409	3,354,101	-1,246,219	14.00	2,107,882
15.00 01500	PHARMACY	6,800,157	29,058,879	35,859,036	-28,873,037	15.00	6,985,999
16.00 01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	16.00	0
21.00 02100	I&R SERVICES-SALARY & FRINGES APPRV	5,102,949	2,410,288	7,513,237	-5,307,104	21.00	2,206,133
22.00 02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	1,869,825	22.00	1,869,825
23.00 02300	MEDICAL LABORATORY SCIENTIST PRGM	86,682	33,606	120,288	-39,817	23.00	80,471
23.01 02302	PHARMACY PRGM	380,879	132,636	513,515	185,499	23.01	699,014
23.02 02301	EMERGENCY MEDICAL SERVICES	996,141	427,542	1,423,683	-1,050,620	23.02	373,063
23.03 02303	PARAMEDIC PRGM	0	0	0	892,627	23.03	892,627
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00 03000	ADULTS & PEDIATRICS	30,234,107	13,207,122	43,441,229	-10,706,277	30.00	32,734,952
31.00 03100	INTENSIVE CARE UNIT	6,580,301	3,655,701	10,236,002	-3,100,284	31.00	7,135,718
31.01 02060	NEONATAL INTENSIVE CARE UNIT	3,395,716	2,470,708	5,866,424	-1,268,561	31.01	4,597,863
32.00 03200	CORONARY CARE UNIT	8,810,548	3,557,263	12,367,811	-3,310,504	32.00	9,057,307
34.00 03400	SURGICAL INTENSIVE CARE UNIT	4,549,979	1,807,691	6,357,670	-1,653,141	34.00	4,704,529
41.00 04100	SUBPROVIDER - IRF	2,928,631	1,043,800	3,972,431	-938,421	41.00	3,034,010
43.00 04300	NURSERY	26,109	109,622	135,731	369,330	43.00	505,061
ANCILLARY SERVICE COST CENTERS							
50.00 05000	OPERATING ROOM	11,771,098	47,107,207	58,878,305	-40,974,133	50.00	17,904,172
52.00 05200	DELIVERY ROOM & LABOR ROOM	2,773,890	1,486,447	4,260,337	-1,443,645	52.00	2,816,692
54.00 05400	RADIOLOGY-DIAGNOSTIC	8,655,969	9,146,127	17,802,096	-4,994,405	54.00	12,807,691
55.00 05500	RADIOLOGY-THERAPEUTIC	1,462,148	8,981,238	10,443,386	-457,440	55.00	9,985,946
56.00 05600	RADIOISOTOPE	201,920	847,632	1,049,552	-81,620	56.00	967,932
59.00 05900	CARDIAC CATHETERIZATION	2,042,559	15,983,089	18,025,648	-15,758,941	59.00	2,266,707
60.00 06000	LABORATORY	647,440	26,300,788	26,948,228	-1,419,329	60.00	25,528,899
64.00 06400	INTRAVENOUS THERAPY	2,544,678	40,368,434	42,913,112	-39,680,435	64.00	3,232,677
65.00 06500	RESPIRATORY THERAPY	5,773,199	4,885,880	10,659,079	-4,094,320	65.00	6,564,759
66.00 06600	PHYSICAL THERAPY	4,417,949	2,433,995	6,851,944	-1,543,689	66.00	5,308,255
67.00 06700	OCCUPATIONAL THERAPY	1,935,182	693,972	2,629,154	-599,011	67.00	2,030,143
68.00 06800	SPEECH PATHOLOGY	759,134	458,264	1,217,398	-241,257	68.00	976,141
69.00 06900	ELECTROCARDIOLOGY	1,369,267	852,183	2,221,450	-661,404	69.00	1,560,046
70.00 07000	ELECTROENCEPHALOGRAPHY	1,499,680	1,181,974	2,681,654	-522,309	70.00	2,159,345
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	37,364,117	71.00	37,364,117
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	28,863,696	72.00	28,863,696
73.00 07300	DRUGS CHARGED TO PATIENTS	0	0	0	64,771,451	73.00	64,771,451
74.00 07400	RENAL DIALYSIS	37,840	987,546	1,025,386	-56,981	74.00	968,405
76.97 07697	CARDIAC REHABILITATION	318,096	172,456	490,552	-98,799	76.97	391,753
OUTPATIENT SERVICE COST CENTERS							
90.00 09000	CLINIC	4,261,748	2,024,766	6,286,514	25,200	90.00	6,311,714
90.01 09001	IBMT JOINT VENTURE	1,583,902	5,951,311	7,535,213	-561,424	90.01	6,973,789
90.05 09005	CV DIAGNOSTIC SERVICES	7,266,290	5,215,130	12,481,420	-2,266,004	90.05	10,215,416
91.00 09100	EMERGENCY	7,416,593	3,939,973	11,356,566	-3,395,319	91.00	7,961,247
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART)					92.00	
OTHER REIMBURSABLE COST CENTERS							
101.00 10100	HOME HEALTH AGENCY	29,894	60,306	90,200	-90,200	101.00	0
SPECIAL PURPOSE COST CENTERS							
113.00 11300	INTEREST EXPENSE		0	0	0	113.00	0
116.00 11600	HOSPICE	5,795,361	3,247,658	9,043,019	-1,743,656	116.00	7,299,363
118.00 11800	SUBTOTALS (SUM OF LINES 1 through 117)	160,291,228	338,279,561	498,570,789	2,712,469	118.00	501,283,258
NONREIMBURSABLE COST CENTERS							
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	254,045	240,896	494,941	-72,582	190.00	422,359
192.00 19200	PHYSICIANS' PRIVATE OFFICES	6,164,834	4,047,025	10,211,859	-1,951,466	192.00	8,260,393
194.00 07955	MARKETING & COMMUNITY RELATIONS	58,565	5,134	63,699	0	194.00	63,699
194.01 07952	WOMEN'S CENTER	96,624	91,974	188,598	-2,529	194.01	186,069
194.02 07950	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	194.02	0
194.04 07954	OTHER NRCC	4,120,631	47,277,162	51,397,793	-685,892	194.04	50,711,901
194.05 07956	FOUNDATION	0	0	0	0	194.05	0
200.00 20000	TOTAL (SUM OF LINES 118 through 199)	170,985,927	389,941,752	560,927,679	0	200.00	560,927,679

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 15-0162

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

Worksheet A
Date/Time Prepared:
3/30/2021 10:40 am

Cost Center Description			Adjustments (See A-8)	Net Expenses For Allocation	
			6.00	7.00	
GENERAL SERVICE COST CENTERS					
1.00	00100	CAP REL COSTS-BLDG & FIXT	10,935,625	33,157,122	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	0	14,957,135	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	20,439,587	70,659,305	4.00
5.01	00570	ADMINISTRATIVE	0	3,810	5.01
5.02	00580	CASHIERING/ACCOUNTS RECEIVABLE	0	0	5.02
5.03	00590	OTHER ADMIN & GENERAL	103,712,877	143,240,921	5.03
7.00	00700	OPERATION OF PLANT	5,253,236	19,068,912	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	1,830,780	8.00
9.00	00900	HOUSEKEEPING	0	6,676,417	9.00
10.00	01000	DIETARY	-280,173	676,773	10.00
11.00	01100	CAFETERIA	-1,853,439	2,532,909	11.00
13.00	01300	NURSING ADMINISTRATION	909,628	5,381,705	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	-659,513	1,448,369	14.00
15.00	01500	PHARMACY	612,020	7,598,019	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	174,487	174,487	16.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	-345,301	1,860,832	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	-618,534	1,251,291	22.00
23.00	02300	MEDICAL LABORATORY SCIENTIST PRGM	-42,139	38,332	23.00
23.01	02302	PHARMACY PRGM	0	699,014	23.01
23.02	02301	EMERGENCY MEDICAL SERVICES	-300,731	72,332	23.02
23.03	02303	PARAMEDIC PRGM	-574,080	318,547	23.03
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	-5,309	32,729,643	30.00
31.00	03100	INTENSIVE CARE UNIT	-16,100	7,119,618	31.00
31.01	02060	NEONATAL INTENSIVE CARE UNIT	-338,363	4,259,500	31.01
32.00	03200	CORONARY CARE UNIT	0	9,057,307	32.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	0	4,704,529	34.00
41.00	04100	SUBPROVIDER - IRF	0	3,034,010	41.00
43.00	04300	NURSERY	0	505,061	43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	-4,622,984	13,281,188	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	2,816,692	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	147,460	12,955,151	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	-3,220,202	6,765,744	55.00
56.00	05600	RADIOISOTOPE	0	967,932	56.00
59.00	05900	CARDIAC CATHETERIZATION	-27,150	2,239,557	59.00
60.00	06000	LABORATORY	-145,305	25,383,594	60.00
64.00	06400	INTRAVENOUS THERAPY	-814,321	2,418,356	64.00
65.00	06500	RESPIRATORY THERAPY	-56,906	6,507,853	65.00
66.00	06600	PHYSICAL THERAPY	0	5,308,255	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	2,030,143	67.00
68.00	06800	SPEECH PATHOLOGY	-4,028	972,113	68.00
69.00	06900	ELECTROCARDIOLOGY	-159,408	1,400,638	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	-264,314	1,895,031	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	37,364,117	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	28,863,696	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	64,771,451	73.00
74.00	07400	RENAL DIALYSIS	0	968,405	74.00
76.97	07697	CARDIAC REHABILITATION	-3,950	387,803	76.97
OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	-1,761,674	4,550,040	90.00
90.01	09001	IBMT JOINT VENTURE	1,239	6,975,028	90.01
90.05	09005	CV DIAGNOSTIC SERVICES	-883,964	9,331,452	90.05
91.00	09100	EMERGENCY	-42,896	7,918,351	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART			92.00
OTHER REIMBURSABLE COST CENTERS					
101.00	10100	HOME HEALTH AGENCY	0	0	101.00
SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE	0	0	113.00
116.00	11600	HOSPICE	0	7,299,363	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	125,145,375	626,428,633	118.00
NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	422,359	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	8,260,393	192.00
194.00	07955	MARKETING & COMMUNITY RELATIONS	37,775	101,474	194.00
194.01	07952	WOMEN'S CENTER	0	186,069	194.01
194.02	07950	OTHER NONREIMBURSABLE COST CENTERS	0	0	194.02
194.04	07954	OTHER NRCC	28,526,980	79,238,881	194.04
194.05	07956	FOUNDATION	1,889	1,889	194.05
200.00		TOTAL (SUM OF LINES 118 through 199)	153,712,019	714,639,698	200.00

Provider CCN: 15-0162

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

Worksheet A-6

Date/Time Prepared:
3/30/2021 10:40 am

		Increases			
	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
A - MEDICAL SUPPLIES					
1.00	RADIOLOGY-THERAPEUTIC	55.00	0	1,731	1.00
2.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	37,364,117	2.00
3.00	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	28,863,696	3.00
4.00		0.00	0	0	4.00
5.00		0.00	0	0	5.00
6.00		0.00	0	0	6.00
7.00		0.00	0	0	7.00
8.00		0.00	0	0	8.00
9.00		0.00	0	0	9.00
10.00		0.00	0	0	10.00
11.00		0.00	0	0	11.00
12.00		0.00	0	0	12.00
13.00		0.00	0	0	13.00
14.00		0.00	0	0	14.00
15.00		0.00	0	0	15.00
16.00		0.00	0	0	16.00
17.00		0.00	0	0	17.00
18.00		0.00	0	0	18.00
19.00		0.00	0	0	19.00
20.00		0.00	0	0	20.00
21.00		0.00	0	0	21.00
22.00		0.00	0	0	22.00
23.00		0.00	0	0	23.00
24.00		0.00	0	0	24.00
25.00		0.00	0	0	25.00
26.00		0.00	0	0	26.00
27.00		0.00	0	0	27.00
28.00		0.00	0	0	28.00
29.00		0.00	0	0	29.00
30.00		0.00	0	0	30.00
31.00		0.00	0	0	31.00
32.00		0.00	0	0	32.00
33.00		0.00	0	0	33.00
34.00		0.00	0	0	34.00
35.00		0.00	0	0	35.00
36.00		0.00	0	0	36.00
37.00		0.00	0	0	37.00
38.00		0.00	0	0	38.00
39.00		0.00	0	0	39.00
0			0	66,229,544	
B - DRUG					
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	64,771,451	1.00
2.00		0.00	0	0	2.00
3.00		0.00	0	0	3.00
4.00		0.00	0	0	4.00
5.00		0.00	0	0	5.00
6.00		0.00	0	0	6.00
7.00		0.00	0	0	7.00
8.00		0.00	0	0	8.00
9.00		0.00	0	0	9.00
10.00		0.00	0	0	10.00
11.00		0.00	0	0	11.00
12.00		0.00	0	0	12.00
13.00		0.00	0	0	13.00
14.00		0.00	0	0	14.00
15.00		0.00	0	0	15.00
16.00		0.00	0	0	16.00
17.00		0.00	0	0	17.00
18.00		0.00	0	0	18.00
19.00		0.00	0	0	19.00
20.00		0.00	0	0	20.00
21.00		0.00	0	0	21.00
22.00		0.00	0	0	22.00
23.00		0.00	0	0	23.00
24.00		0.00	0	0	24.00
25.00		0.00	0	0	25.00
26.00		0.00	0	0	26.00
27.00		0.00	0	0	27.00
28.00		0.00	0	0	28.00
29.00		0.00	0	0	29.00
0			0	64,771,451	

		Increases			
Cost Center		Line #	Salary	Other	
2.00		3.00	4.00	5.00	
C - EQUIPMENT LEASE					
1.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	1,361,330	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
	O		0	1,361,330	
D - DEPRECIATION					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	22,221,497	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	376,324	2.00
3.00		0.00	0	0	3.00
4.00		0.00	0	0	4.00
	O		0	22,597,821	
E - CAFETERIA					
1.00	CAFETERIA	11.00	1,320,042	1,499,795	1.00
	O		1,320,042	1,499,795	
F - PARAMEDICAL ED					
1.00	MEDICAL LABORATORY SCIENTIST PRGM	23.00	81,027	23,318	1.00
	O		81,027	23,318	
G - INTERNS AND RESIDENT					
1.00	I&R SERVICES-OTHER PRGM COSTS APPRV	22.00	1,550,228	319,597	1.00
2.00	CLINIC	90.00	1,346,344	298,431	2.00
	O		2,896,572	618,028	
H - EMPLOYEE BENEFITS					
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	50,219,718	1.00
2.00		0.00	0	0	2.00
3.00		0.00	0	0	3.00
4.00		0.00	0	0	4.00
5.00		0.00	0	0	5.00
6.00		0.00	0	0	6.00
7.00		0.00	0	0	7.00
8.00		0.00	0	0	8.00
9.00		0.00	0	0	9.00
10.00		0.00	0	0	10.00
11.00		0.00	0	0	11.00
12.00		0.00	0	0	12.00
13.00		0.00	0	0	13.00
14.00		0.00	0	0	14.00
15.00		0.00	0	0	15.00
16.00		0.00	0	0	16.00
17.00		0.00	0	0	17.00
18.00		0.00	0	0	18.00
19.00		0.00	0	0	19.00
20.00		0.00	0	0	20.00
21.00		0.00	0	0	21.00
22.00		0.00	0	0	22.00
23.00		0.00	0	0	23.00
24.00		0.00	0	0	24.00
25.00		0.00	0	0	25.00
26.00		0.00	0	0	26.00
27.00		0.00	0	0	27.00
28.00		0.00	0	0	28.00
29.00		0.00	0	0	29.00
30.00		0.00	0	0	30.00
31.00		0.00	0	0	31.00
32.00		0.00	0	0	32.00
33.00		0.00	0	0	33.00
34.00		0.00	0	0	34.00
35.00		0.00	0	0	35.00
36.00		0.00	0	0	36.00

						Increases			
Cost Center		Line #	Salary	Other					
2.00		3.00	4.00	5.00					
37.00		0.00	0	0				37.00	
38.00		0.00	0	0				38.00	
39.00		0.00	0	0				39.00	
40.00		0.00	0	0				40.00	
41.00		0.00	0	0				41.00	
42.00		0.00	0	0				42.00	
43.00		0.00	0	0				43.00	
0			0	50,219,718					
I - PHARMACY RESIDENCY									
1.00	PHARMACY PRGM	23.01	142,529	42,970				1.00	
0			142,529	42,970					
J - EMS & PARAMEDIC RECLASS									
1.00	PARAMEDIC PRGM	23.03	667,414	225,213				1.00	
2.00	EMERGENCY	91.00	79,692	71,649				2.00	
0			747,106	296,862					
K - HOME HEALTH RECLASS									
1.00	OTHER NRCC	194.04	29,894	60,306				1.00	
0			29,894	60,306					
L - NURSERY									
1.00	NURSERY	43.00	356,588	107,601				1.00	
TOTALS			356,588	107,601					
500.00	Grand Total: Increases		5,573,758	207,828,744				500.00	

RECLASSIFICATIONS

Provider CCN: 15-0162

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

Worksheet A-6
Date/Time Prepared:
3/30/2021 10:40 am

Decreases						
Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
6.00	7.00	8.00	9.00	10.00		
A - MEDICAL SUPPLIES						
1.00	ADM ITTING	5.01	0	487	0	1.00
2.00	OTHER ADMIN & GENERAL	5.03	0	9,659	0	2.00
3.00	OPERATION OF PLANT	7.00	0	3,878	0	3.00
4.00	LAUNDRY & LINEN SERVICE	8.00	0	4,348	0	4.00
5.00	HOUSEKEEPING	9.00	0	53,299	0	5.00
6.00	DIETARY	10.00	0	67,469	0	6.00
7.00	CAFETERIA	11.00	0	676	0	7.00
8.00	NURSING ADMINISTRATION	13.00	0	22,242	0	8.00
9.00	CENTRAL SERVICES & SUPPLY	14.00	0	938,259	0	9.00
10.00	PHARMACY	15.00	0	1,192,750	0	10.00
11.00	I&R SERVICES-SALARY & FRINGES APPRV	21.00	0	27,740	0	11.00
12.00	MEDICAL LABORATORY SCIENTIST PRGM	23.00	0	200	0	12.00
13.00	EMERGENCY MEDICAL SERVICES	23.02	0	6,652	0	13.00
14.00	ADULTS & PEDIATRICS	30.00	0	1,617,095	0	14.00
15.00	INTENSIVE CARE UNIT	31.00	0	842,272	0	15.00
16.00	NEONATAL INTENSIVE CARE UNIT	31.01	0	254,871	0	16.00
17.00	CORONARY CARE UNIT	32.00	0	666,706	0	17.00
18.00	SURGICAL INTENSIVE CARE UNIT	34.00	0	299,180	0	18.00
19.00	SUBPROVIDER - IRF	41.00	0	66,821	0	19.00
20.00	NURSERY	43.00	0	82,156	0	20.00
21.00	OPERATING ROOM	50.00	0	36,652,761	0	21.00
22.00	DELIVERY ROOM & LABOR ROOM	52.00	0	591,836	0	22.00
23.00	RADIOLOGY-DIAGNOSTIC	54.00	0	2,356,604	0	23.00
24.00	RADIOISOTOPE	56.00	0	25,378	0	24.00
25.00	CARDIAC CATHETERIZATION LABORATORY	59.00	0	15,132,256	0	25.00
26.00	LABORATORY	60.00	0	671,319	0	26.00
27.00	INTRAVENOUS THERAPY	64.00	0	812,456	0	27.00
28.00	RESPIRATORY THERAPY	65.00	0	1,673,029	0	28.00
29.00	PHYSICAL THERAPY	66.00	0	45,451	0	29.00
30.00	OCCUPATIONAL THERAPY	67.00	0	39,106	0	30.00
31.00	SPEECH PATHOLOGY	68.00	0	17,122	0	31.00
32.00	ELECTROCARDIOLOGY	69.00	0	249,175	0	32.00
33.00	ELECTROENCEPHALOGRAPHY	70.00	0	70,528	0	33.00
34.00	RENAL DIALYSIS	74.00	0	26,690	0	34.00
35.00	CARDIAC REHABILITATION	76.97	0	2,847	0	35.00
36.00	CLINIC	90.00	0	348,997	0	36.00
37.00	IBMT JOINT VENTURE	90.01	0	77,472	0	37.00
38.00	CV DIAGNOSTIC SERVICES	90.05	0	276,560	0	38.00
39.00	EMERGENCY	91.00	0	1,003,197	0	39.00
0			0	66,229,544		
B - DRUG						
1.00	OTHER ADMIN & GENERAL	5.03	0	367	0	1.00
2.00	OPERATION OF PLANT	7.00	0	53	0	2.00
3.00	CENTRAL SERVICES & SUPPLY	14.00	0	1,845	0	3.00
4.00	PHARMACY	15.00	0	25,444,237	0	4.00
5.00	I&R SERVICES-SALARY & FRINGES APPRV	21.00	0	233,966	0	5.00
6.00	ADULTS & PEDIATRICS	30.00	0	25,245	0	6.00
7.00	INTENSIVE CARE UNIT	31.00	0	4,536	0	7.00
8.00	NEONATAL INTENSIVE CARE UNIT	31.01	0	9	0	8.00
9.00	CORONARY CARE UNIT	32.00	0	8,302	0	9.00
10.00	SURGICAL INTENSIVE CARE UNIT	34.00	0	4,427	0	10.00
11.00	SUBPROVIDER - IRF	41.00	0	402	0	11.00
12.00	OPERATING ROOM	50.00	0	148,363	0	12.00
13.00	DELIVERY ROOM & LABOR ROOM	52.00	0	724	0	13.00
14.00	RADIOLOGY-DIAGNOSTIC	54.00	0	12,639	0	14.00
15.00	RADIOISOTOPE	56.00	0	343	0	15.00
16.00	CARDIAC CATHETERIZATION LABORATORY	59.00	0	22,042	0	16.00
17.00	LABORATORY	60.00	0	62,607	0	17.00
18.00	INTRAVENOUS THERAPY	64.00	0	38,215,523	0	18.00
19.00	RESPIRATORY THERAPY	65.00	0	504,966	0	19.00
20.00	PHYSICAL THERAPY	66.00	0	264	0	20.00
21.00	OCCUPATIONAL THERAPY	67.00	0	295	0	21.00
22.00	SPEECH PATHOLOGY	68.00	0	436	0	22.00
23.00	ELECTROCARDIOLOGY	69.00	0	119	0	23.00
24.00	CARDIAC REHABILITATION	76.97	0	2	0	24.00
25.00	RENAL DIALYSIS	74.00	0	9,188	0	25.00
26.00	CLINIC	90.00	0	2,016	0	26.00
27.00	IBMT JOINT VENTURE	90.01	0	1,389	0	27.00
28.00	CV DIAGNOSTIC SERVICES	90.05	0	288	0	28.00
29.00	EMERGENCY	91.00	0	66,858	0	29.00

RECLASSIFICATIONS

Provider CCN: 15-0162

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

Worksheet A-6
Date/Time Prepared:
3/30/2021 10:40 am

Decreases						
Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
6.00	7.00	8.00	9.00	10.00		
0		0	64,771,451			
C - EQUIPMENT LEASE						
1.00	OPERATION OF PLANT	7.00	0	720	10	1.00
2.00	DIETARY	10.00	0	10,095	0	2.00
3.00	CENTRAL SERVICES & SUPPLY	14.00	0	92,945	0	3.00
4.00	PHARMACY	15.00	0	378	0	4.00
5.00	I&R SERVICES-SALARY & FRINGES APPRV	21.00	0	243	0	5.00
6.00	ADULTS & PEDIATRICS	30.00	0	31,660	0	6.00
7.00	INTENSIVE CARE UNIT	31.00	0	311,600	0	7.00
8.00	CORONARY CARE UNIT	32.00	0	10,640	0	8.00
9.00	SURGICAL INTENSIVE CARE UNIT	34.00	0	6,099	0	9.00
10.00	OPERATING ROOM	50.00	0	688,724	0	10.00
11.00	RADIOLOGY-DIAGNOSTIC	54.00	0	239	0	11.00
12.00	LABORATORY	60.00	0	2,028	0	12.00
13.00	INTRAVENOUS THERAPY	64.00	0	8,866	0	13.00
14.00	RESPIRATORY THERAPY	65.00	0	191,183	0	14.00
15.00	RENAL DIALYSIS	74.00	0	2,181	0	15.00
16.00	CLINIC	90.00	0	3,280	0	16.00
17.00	CV DIAGNOSTIC SERVICES	90.05	0	449	0	17.00
0			0	1,361,330		
D - DEPRECIATION						
1.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	22,221,497	9	1.00
2.00	RADIOLOGY-DIAGNOSTIC	54.00	0	369	9	2.00
3.00	LABORATORY	60.00	0	375,399	0	3.00
4.00	CV DIAGNOSTIC SERVICES	90.05	0	556	0	4.00
0			0	22,597,821		
E - CAFETERIA						
1.00	DIETARY	10.00	1,320,042	1,499,795	0	1.00
0			1,320,042	1,499,795		
F - PARAMEDICAL ED						
1.00	LABORATORY	60.00	81,027	23,318	0	1.00
0			81,027	23,318		
G - INTERNS AND RESIDENT						
1.00	I&R SERVICES-SALARY & FRINGES APPRV	21.00	2,896,572	618,028	0	1.00
2.00		0.00	0	0	0	2.00
0			2,896,572	618,028		
H - EMPLOYEE BENEFITS						
1.00	OTHER ADMIN & GENERAL	5.03	0	545,372	0	1.00
2.00	OPERATION OF PLANT	7.00	0	1,164,599	0	2.00
3.00	LAUNDRY & LINEN SERVICE	8.00	0	74,908	0	3.00
4.00	HOUSEKEEPING	9.00	0	1,255,902	0	4.00
5.00	DIETARY	10.00	0	729,582	0	5.00
6.00	CAFETERIA	11.00	0	223,770	0	6.00
7.00	NURSING ADMINISTRATION	13.00	0	1,240,916	0	7.00
8.00	CENTRAL SERVICES & SUPPLY	14.00	0	213,170	0	8.00
9.00	PHARMACY	15.00	0	2,050,173	0	9.00
10.00	I&R SERVICES-SALARY & FRINGES APPRV	21.00	0	1,530,555	0	10.00
11.00	MEDICAL LABORATORY SCIENTIST PRGM	23.00	0	143,962	0	11.00
12.00	ADULTS & PEDIATRICS	30.00	0	8,568,088	0	12.00
13.00	INTENSIVE CARE UNIT	31.00	0	1,941,876	0	13.00
14.00	NEONATAL INTENSIVE CARE UNIT	31.01	0	1,013,681	0	14.00
15.00	CORONARY CARE UNIT	32.00	0	2,624,856	0	15.00
16.00	SURGICAL INTENSIVE CARE UNIT	34.00	0	1,343,435	0	16.00
17.00	SUBPROVIDER - IRF	41.00	0	871,198	0	17.00
18.00	NURSERY	43.00	0	12,703	0	18.00
19.00	OPERATING ROOM	50.00	0	3,484,285	0	19.00
20.00	DELIVERY ROOM & LABOR ROOM	52.00	0	851,085	0	20.00
21.00	RADIOLOGY-DIAGNOSTIC	54.00	0	2,624,554	0	21.00
22.00	RADIOLOGY-THERAPEUTIC	55.00	0	459,171	0	22.00
23.00	RADIOISOTOPE	56.00	0	55,899	0	23.00
24.00	CARDIAC CATHETERIZATION	59.00	0	604,643	0	24.00
25.00	LABORATORY	60.00	0	203,631	0	25.00
26.00	INTRAVENOUS THERAPY	64.00	0	643,590	0	26.00
27.00	RESPIRATORY THERAPY	65.00	0	1,725,142	0	27.00
28.00	PHYSICAL THERAPY	66.00	0	1,497,974	0	28.00
29.00	OCCUPATIONAL THERAPY	67.00	0	559,610	0	29.00
30.00	SPEECH PATHOLOGY	68.00	0	223,699	0	30.00
31.00	ELECTROCARDIOLOGY	69.00	0	412,110	0	31.00
32.00	ELECTROENCEPHALOGRAPHY	70.00	0	451,781	0	32.00
33.00	RENAL DIALYSIS	74.00	0	18,922	0	33.00

Provider CCN: 15-0162

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

Worksheet A-6
Date/Time Prepared:
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Decreases							
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
34.00	CARDIAC REHABILITATION	76.97	0	95,950	0		34.00
35.00	CLINIC	90.00	0	1,265,282	0		35.00
36.00	IBMT JOINT VENTURE	90.01	0	482,563	0		36.00
37.00	CV DIAGNOSTIC SERVICES	90.05	0	1,988,151	0		37.00
38.00	EMERGENCY	91.00	0	2,476,605	0		38.00
39.00	HOSPICE	116.00	0	1,743,656	0		39.00
40.00	GIFT, FLOWER, COFFEE SHOP & CANTEEN	190.00	0	72,582	0		40.00
41.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	1,951,466	0		41.00
42.00	WOMEN'S CENTER	194.01	0	2,529	0		42.00
43.00	OTHER NRCC	194.04	0	776,092	0		43.00
	O		0	50,219,718			
I - PHARMACY RESIDENCY							
1.00	PHARMACY	15.00	142,529	42,970	0		1.00
	O		142,529	42,970			
J - EMS & PARAMEDIC RECLASS							
1.00	EMERGENCY MEDICAL SERVICES	23.02	747,106	296,862	0		1.00
2.00		0.00	0	0	0		2.00
	O		747,106	296,862			
K - HOME HEALTH RECLASS							
1.00	HOME HEALTH AGENCY	101.00	29,894	60,306	0		1.00
	O		29,894	60,306			
L - NURSERY							
1.00	ADULTS & PEDIATRICS	30.00	356,588	107,601	0		1.00
	TOTALS		356,588	107,601			
500.00	Grand Total: Decreases		5,573,758	207,828,744			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 15-0162

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

Worksheet A-7
Part I
Date/Time Prepared:
3/30/2021 10:40 am

		Acquisitions			Disposals and Retirements		
		Beginning Balances	Purchases	Donation			Total
		1.00	2.00	3.00			4.00
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES							
1.00	Land	19,017,757	3,236,647	0	3,236,647	0 1.00	
2.00	Land Improvements	34,837,862	8,349	0	8,349	0 2.00	
3.00	Buildings and Fixtures	245,551,581	1,682,217	0	1,682,217	0 3.00	
4.00	Building Improvements	20,263,122	56,216	0	56,216	0 4.00	
5.00	Fixed Equipment	278,802,400	2,095,995	0	2,095,995	0 5.00	
6.00	Movable Equipment	185,523,687	10,413,051	0	10,413,051	0 6.00	
7.00	HIT designated Assets	0	0	0	0	0 7.00	
8.00	Subtotal (sum of lines 1-7)	783,996,409	17,492,475	0	17,492,475	0 8.00	
9.00	Reconciling Items	0	0	0	0	0 9.00	
10.00	Total (line 8 minus line 9)	783,996,409	17,492,475	0	17,492,475	0 10.00	
		Ending Balance	Fully Depreciated Assets				
		6.00	7.00				
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES							
1.00	Land	22,254,404	0			1.00	
2.00	Land Improvements	34,846,211	5,670,453			2.00	
3.00	Buildings and Fixtures	247,233,798	24,543,991			3.00	
4.00	Building Improvements	20,319,338	3,359,107			4.00	
5.00	Fixed Equipment	280,898,395	30,588,373			5.00	
6.00	Movable Equipment	195,936,738	91,991,425			6.00	
7.00	HIT designated Assets	0	0			7.00	
8.00	Subtotal (sum of lines 1-7)	801,488,884	156,153,349			8.00	
9.00	Reconciling Items	0	0			9.00	
10.00	Total (line 8 minus line 9)	801,488,884	156,153,349			10.00	

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 15-0162

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

Worksheet A-7
Part II
Date/Time Prepared:
3/30/2021 10:40 am

Cost Center Description		SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2							
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	35,440,978	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	35,440,978	0	0	0	0	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)				
		14.00	15.00				
PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2							
1.00	CAP REL COSTS-BLDG & FIXT	0	0	1.00			
2.00	CAP REL COSTS-MVBLE EQUIP	0	35,440,978	2.00			
3.00	Total (sum of lines 1-2)	0	35,440,978	3.00			

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 15-0162

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

Worksheet A-7
Part III
Date/Time Prepared:
3/30/2021 10:40 am

Cost Center Description		COMPUTATION OF RATIOS			ALLOCATION OF OTHER CAPITAL		
		Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	
		1.00	2.00	3.00	4.00	5.00	
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	CAP REL COSTS-BLDG & FIXT	605,552,145	0	605,552,145	0.755526	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	195,945,738	0	195,945,738	0.244474	0	2.00
3.00	Total (sum of lines 1-2)	801,497,883	0	801,497,883	1.000000	0	3.00
Cost Center Description		ALLOCATION OF OTHER CAPITAL			SUMMARY OF CAPITAL		
		Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	Depreciation	Lease	
		6.00	7.00	8.00	9.00	10.00	
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	22,221,497	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	13,595,805	1,361,330	2.00
3.00	Total (sum of lines 1-2)	0	0	0	35,817,302	1,361,330	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	CAP REL COSTS-BLDG & FIXT	10,935,625	0	0	0	33,157,122	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	0	14,957,135	2.00
3.00	Total (sum of lines 1-2)	10,935,625	0	0	0	48,114,257	3.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 15-0162

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

Worksheet A-8

Date/Time Prepared:
3/30/2021 10:40 am

Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted			
			Cost Center	Line #	Wkst. A-7 Ref.	
			3.00	4.00	5.00	
1.00 Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)			0CAP REL COSTS-BLDG & FIXT	1.00	0	1.00
2.00 Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)			0CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
3.00 Investment income - other (chapter 2)		0		0.00	0	3.00
4.00 Trade, quantity, and time discounts (chapter 8)		0		0.00	0	4.00
5.00 Refunds and rebates of expenses (chapter 8)		0		0.00	0	5.00
6.00 Rental of provider space by suppliers (chapter 8)		0		0.00	0	6.00
7.00 Telephone services (pay stations excluded) (chapter 21)		0		0.00	0	7.00
8.00 Television and radio service (chapter 21)		0		0.00	0	8.00
9.00 Parking lot (chapter 21)		0		0.00	0	9.00
10.00 Provider-based physician adjustment	A-8-2	-9,016,392			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	208,150,123			0	12.00
13.00 Laundry and linen service		0		0.00	0	13.00
14.00 Cafeteria-employees and guests	B	-1,807,270	CAFETERIA	11.00	0	14.00
15.00 Rental of quarters to employees and others		0		0.00	0	15.00
16.00 Sale of medical and surgical supplies to other than patients		0		0.00	0	16.00
17.00 Sale of drugs to other than patients		0		0.00	0	17.00
18.00 Sale of medical records and abstracts		0		0.00	0	18.00
19.00 Nursing and allied health education (tuition, fees, books, etc.)		0		0.00	0	19.00
19.01 Nursing and allied health education (tuition, fees, books, etc.)		0		0.00	0	19.01
20.00 Vending machines	B	-46,169	CAFETERIA	11.00	0	20.00
21.00 Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	0	21.00
22.00 Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	0	22.00
23.00 Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3		0RESPIRATORY THERAPY	65.00		23.00
24.00 Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3		0PHYSICAL 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			0CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
27.00 Depreciation - CAP REL COSTS-MVBLE EQUIP			0CAP REL COSTS-MVBLE EQUIP	2.00	0	27.00
28.00 Non-physician Anesthetist			0*** Cost Center Deleted ***	19.00		28.00
29.00 Physicians' assistant			0	0.00	0	29.00
30.00 Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3		0OCCUPATIONAL THERAPY	67.00		30.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 15-0162

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

Worksheet A-8

Date/Time Prepared:
3/30/2021 10:40 am

Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted			Wkst. A-7 Ref.	
			Cost Center	Line #			
			3.00	4.00	5.00		
30.99 Hospice (non-distinct) (see instructions)			0ADULTS & PEDIATRICS	30.00		30.99	
31.00 Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3		0SPEECH PATHOLOGY	68.00		31.00	
32.00 CAH HIT Adjustment for Depreciation and Interest		0		0.00		0 32.00	
33.00 MISCELLANEOUS INCOME	B	-30,757	OTHER ADMIN & GENERAL	5.03		0 33.00	
33.01 MISCELLANEOUS INCOME	B	-280,364	DIETARY	10.00		0 33.01	
33.02 MISCELLANEOUS INCOME	B	-534,107	OPERATION OF PLANT	7.00		0 33.02	
33.03 MISCELLANEOUS INCOME	B	-659,513	CENTRAL SERVICES & SUPPLY	14.00		0 33.03	
33.04 MISCELLANEOUS INCOME	B	-830,032	PHARMACY	15.00		0 33.04	
33.05 MISCELLANEOUS INCOME	B	-76,433	I&R SERVICES-SALARY & FRINGES APPRV	21.00		0 33.05	
33.06 MISCELLANEOUS INCOME	B	-42,139	MEDICAL LABORATORY SCIENTIST PRGM	23.00		0 33.06	
33.07 MISCELLANEOUS INCOME	B	-299,746	EMERGENCY MEDICAL SERVICES	23.02		0 33.07	
33.08 MISCELLANEOUS INCOME	B	-745,133	OPERATING ROOM	50.00		0 33.08	
33.09 MISCELLANEOUS INCOME	B	-196,156	RADIOLOGY-DIAGNOSTIC	54.00		0 33.09	
33.10 MISCELLANEOUS INCOME	B	-3,220,202	RADIOLOGY-THERAPEUTIC	55.00		0 33.10	
33.11 MISCELLANEOUS INCOME	B	-27,150	CARDIAC CATHETERIZATION	59.00		0 33.11	
33.12 MISCELLANEOUS INCOME	B	-70,414	LABORATORY	60.00		0 33.12	
33.13 MISCELLANEOUS INCOME	B	-814,077	INTRAVENOUS THERAPY	64.00		0 33.13	
33.14 MISCELLANEOUS INCOME	B	-42,505	RESPIRATORY THERAPY	65.00		0 33.14	
33.15 MISCELLANEOUS INCOME	B	-236,915	ELECTROENCEPHALOGRAPHY	70.00		0 33.15	
33.16 MISCELLANEOUS INCOME	B	-3,950	CARDIAC REHABILITATION	76.97		0 33.16	
33.17 MISCELLANEOUS INCOME	B	-67,397	CLINIC	90.00		0 33.17	
33.18 MISCELLANEOUS INCOME	B	-126,186	CV DIAGNOSTIC SERVICES	90.05		0 33.18	
33.19 MISCELLANEOUS INCOME	B	-4,028	SPEECH PATHOLOGY	68.00		0 33.19	
33.20 MISCELLANEOUS INCOME	B	-574,080	PARAMEDIC PRGM	23.03		0 33.20	
33.21 MISCELLANEOUS INCOME	B	-27,000	EMERGENCY	91.00		0 33.21	
33.22 ADVERTISING	A	-4,190	CV DIAGNOSTIC SERVICES	90.05		0 33.22	
33.23 ADVERTISING	A	-102	OTHER ADMIN & GENERAL	5.03		0 33.23	
33.24 ADVERTISING	A	-239	RESPIRATORY THERAPY	65.00		0 33.24	
33.25 NON-ALLOWABLE INTEREST	A	-1,145,387	CAP REL COSTS-BLDG & FIXT	1.00		11 33.25	
33.26 PHYSICIAN RECRUITMET	A	-38,947	I&R SERVICES-SALARY & FRINGES APPRV	21.00		0 33.26	
33.27 NEUROLOGY TESTING EXPENSE	A	-768	ELECTROENCEPHALOGRAPHY	70.00		0 33.27	
33.28 ON CALL COVERAGE	A	-33,000	OTHER ADMIN & GENERAL	5.03		0 33.28	
33.29 HAF OFFSET	A	-39,055,209	OTHER ADMIN & GENERAL	5.03		0 33.29	
33.30 PENSION ADJ PER REGS 2142.5	A	5,617,853	EMPLOYEE BENEFITS DEPARTMENT	4.00		0 33.30	
33.31 OTHER ADJUSTMENTS (SPECIFY) (3)	A	0		0.00		0 33.31	
33.32 OTHER ADJUSTMENTS (SPECIFY) (3)	A	0		0.00		0 33.32	
50.00 TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		153,712,019				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: 15-0162

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

Worksheet A-8-1

Date/Time Prepared: 3/30/2021 10:40 am

Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in Wks. A, column 5	
1.00	2.00	3.00	4.00	5.00	
A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:					
1.00	4.00	EMPLOYEE BENEFITS DEPARTMENT	SHARED SERVICE ALLOCATION	14,821,734	0
2.00	5.03	OTHER ADMIN & GENERAL	SHARED SERVICE ALLOCATION	37,664,069	0
3.00	7.00	OPERATION OF PLANT	SHARED SERVICE ALLOCATION	5,787,343	0
4.00	10.00	DIETARY	SHARED SERVICE ALLOCATION	191	0
4.01	13.00	NURSING ADMINISTRATION	SHARED SERVICE ALLOCATION	909,628	0
4.02	16.00	MEDICAL RECORDS & LIBRARY	SHARED SERVICE ALLOCATION	174,487	0
4.03	54.00	RADIOLOGY-DIAGNOSTIC	SHARED SERVICE ALLOCATION	1,310,220	0
4.04	1.00	CAP REL COSTS-BLDG & FIXT	SHARED SERVICE ALLOCATION	208,793	0
4.05	194.00	MARKETING & COMMUNITY RELATI	SHARED SERVICE ALLOCATION	37,775	0
4.06	194.04	OTHER NRCC	SHARED SERVICE ALLOCATION	28,526,980	0
4.07	194.05	FOUNDATION	SHARED SERVICE ALLOCATION	1,889	0
4.08	5.03	OTHER ADMIN & GENERAL	FRANCISCAN HOME OFFICE	8,995,797	0
4.09	1.00	CAP REL COSTS-BLDG & FIXT	FRANCISCAN HOME OFFICE	11,872,219	0
4.10	5.03	OTHER ADMIN & GENERAL	FRANCISCAN HOME OFFICE	91,707,730	0
4.11	5.03	OTHER ADMIN & GENERAL	FRANCISCAN HOME OFFICE	4,734,986	0
4.12	15.00	PHARMACY	FRANCISCAN HOME OFFICE	1,451,390	0
4.13	60.00	LABORATORY	SHARED SERVICE ALLOCATION	21,372,070	21,427,178
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.			229,577,301	21,427,178

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

Symbol (1)	Name	Percentage of Ownership	Related Organization(s) and/or Home Office	
			Name	Percentage of Ownership
1.00	2.00	3.00	4.00	5.00

B. 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	SISTERS	100.00	0.00	6.00
7.00	B	APHL	100.00	0.00	7.00
8.00			0.00	0.00	8.00
9.00			0.00	0.00	9.00
10.00			0.00	0.00	10.00
100.00	G. Other (financial or non-financial) specify:				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: 15-0162

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

Worksheet A-8-1

Date/Time Prepared:
3/30/2021 10:40 am

	Net Adjustments (col. 4 minus col. 5)*	Wkst. A-7 Ref.		
	6.00	7.00		
A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:				
1.00	14,821,734	0		1.00
2.00	37,664,069	0		2.00
3.00	5,787,343	0		3.00
4.00	191	0		4.00
4.01	909,628	0		4.01
4.02	174,487	0		4.02
4.03	1,310,220	0		4.03
4.04	208,793	11		4.04
4.05	37,775	0		4.05
4.06	28,526,980	0		4.06
4.07	1,889	0		4.07
4.08	8,995,797	0		4.08
4.09	11,872,219	11		4.09
4.10	91,707,730	0		4.10
4.11	4,734,986	0		4.11
4.12	1,451,390	0		4.12
4.13	-55,108	0		4.13
5.00	208,150,123			5.00

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

Related Organization(s) and/or Home Office	Type of Business	6.00

B. INTERRELATIONSHIP TO RELATED ORGANIZATION(S) AND/OR HOME OFFICE:

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

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

6.00			6.00
7.00	SHARED LAB		7.00
8.00			8.00
9.00			9.00
10.00			10.00
100.00			100.00

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

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

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 15-0162

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

Worksheet A-8-2
Date/Time Prepared:
3/30/2021 10:40 am

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	5.03	OTHER ADMIN & GENERAL	295,142	258,917	36,225	211,500	241	1.00
2.00	15.00	PHARMACY	18,693	4,893	13,800	211,500	92	2.00
3.00	21.00	I&R SERVICES-SALARY & FRINGES APPRV	229,921	229,921	0	211,500	0	3.00
4.00	22.00	I&R SERVICES-OTHER PRGM COSTS APPRV	1,908,176	0	1,908,176	211,500	12,683	4.00
5.00	23.02	EMERGENCY MEDICAL SERVICES	20,000	-2,000	22,000	211,500	187	5.00
6.00	30.00	ADULTS & PEDIATRICS	14,867	-766	15,633	211,500	94	6.00
7.00	31.00	INTENSIVE CARE UNIT	41,317	4,117	37,200	211,500	248	7.00
8.00	31.01	NEONATAL INTENSIVE CARE UNIT	338,363	338,363	0	211,500	0	8.00
9.00	41.00	SUBPROVIDER - IRF	0	0	0	246,400	0	9.00
10.00	50.00	OPERATING ROOM	3,877,851	3,877,851	0	271,900	0	10.00
11.00	54.00	RADIOLOGY-DIAGNOSTIC	974,604	966,604	8,000	271,900	192	11.00
12.00	59.00	CARDIAC CATHETERIZATION	0	0	0	260,300	0	12.00
13.00	60.00	LABORATORY	87,300	-12,225	99,525	211,500	664	13.00
14.00	64.00	INTRAVENOUS THERAPY	244	244	0	211,500	0	14.00
15.00	65.00	RESPIRATORY THERAPY	20,975	10,925	10,050	211,500	67	15.00
16.00	66.00	PHYSICAL THERAPY	0	0	0	211,500	0	16.00
17.00	69.00	ELECTROCARDIOLOGY	159,408	159,408	0	211,500	0	17.00
18.00	70.00	ELECTROENCEPHALOGRAPHY	31,105	22,745	8,360	211,500	44	18.00
19.00	74.00	RENAL DIALYSIS	0	0	0	211,500	0	19.00
20.00	90.00	CLINIC	1,694,277	1,694,277	0	211,500	0	20.00
21.00	90.01	I/BMT JOINT VENTURE	137,354	-65,096	202,450	211,500	1,363	21.00
22.00	90.05	CV DIAGNOSTIC SERVICES	753,588	753,588	0	211,500	0	22.00
23.00	91.00	EMERGENCY	51,383	13,383	38,000	211,500	349	23.00
200.00			10,654,568	8,255,149	2,399,419		16,224	200.00

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 15-0162

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

Worksheet A-8-2

Date/Time Prepared:
3/30/2021 10:40 am

	Wkst. A Line #	Cost Center/Physician Identifier	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	5.03	OTHER ADMIN & GENERAL	24,505	1,225	0	0	0	1.00
2.00	15.00	PHARMACY	9,355	468	0	0	0	2.00
3.00	21.00	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	0	3.00
4.00	22.00	I&R SERVICES-OTHER PRGM COSTS APPRV	1,289,642	64,482	0	0	0	4.00
5.00	23.02	EMERGENCY MEDICAL SERVICES	19,015	951	0	0	0	5.00
6.00	30.00	ADULTS & PEDIATRICS	9,558	478	0	0	0	6.00
7.00	31.00	INTENSIVE CARE UNIT	25,217	1,261	0	0	0	7.00
8.00	31.01	NEONATAL INTENSIVE CARE UNIT	0	0	0	0	0	8.00
9.00	41.00	SUBPROVIDER - IRF	0	0	0	0	0	9.00
10.00	50.00	OPERATING ROOM	0	0	0	0	0	10.00
11.00	54.00	RADIOLOGY-DIAGNOSTIC	25,099	1,255	0	0	0	11.00
12.00	59.00	CARDIAC CATHETERIZATION	0	0	0	0	0	12.00
13.00	60.00	LABORATORY	67,517	3,376	0	0	0	13.00
14.00	64.00	INTRAVENOUS THERAPY	0	0	0	0	0	14.00
15.00	65.00	RESPIRATORY THERAPY	6,813	341	0	0	0	15.00
16.00	66.00	PHYSICAL THERAPY	0	0	0	0	0	16.00
17.00	69.00	ELECTROCARDIOLOGY	0	0	0	0	0	17.00
18.00	70.00	ELECTROENCEPHALOGRAPHY	4,474	224	0	0	0	18.00
19.00	74.00	RENAL DIALYSIS	0	0	0	0	0	19.00
20.00	90.00	CLINIC	0	0	0	0	0	20.00
21.00	90.01	IBMT JOINT VENTURE	138,593	6,930	0	0	0	21.00
22.00	90.05	CV DIAGNOSTIC SERVICES	0	0	0	0	0	22.00
23.00	91.00	EMERGENCY	35,487	1,774	0	0	0	23.00
200.00			1,655,275	82,765	0	0	0	200.00

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 15-0162

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

Worksheet A-8-2

Date/Time Prepared:
3/30/2021 10:40 am

	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment		
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00	5.03	OTHER ADMIN & GENERAL	0	24,505	11,720	270,637		1.00
2.00	15.00	PHARMACY	0	9,355	4,445	9,338		2.00
3.00	21.00	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	229,921		3.00
4.00	22.00	I&R SERVICES-OTHER PRGM COSTS APPRV	0	1,289,642	618,534	618,534		4.00
5.00	23.02	EMERGENCY MEDICAL SERVICES	0	19,015	2,985	985		5.00
6.00	30.00	ADULTS & PEDIATRICS	0	9,558	6,075	5,309		6.00
7.00	31.00	INTENSIVE CARE UNIT	0	25,217	11,983	16,100		7.00
8.00	31.01	NEONATAL INTENSIVE CARE UNIT	0	0	0	338,363		8.00
9.00	41.00	SUBPROVIDER - IRF	0	0	0	0		9.00
10.00	50.00	OPERATING ROOM	0	0	0	3,877,851		10.00
11.00	54.00	RADIOLOGY-DIAGNOSTIC	0	25,099	0	966,604		11.00
12.00	59.00	CARDIAC CATHETERIZATION	0	0	0	0		12.00
13.00	60.00	LABORATORY	0	67,517	32,008	19,783		13.00
14.00	64.00	INTRAVENOUS THERAPY	0	0	0	244		14.00
15.00	65.00	RESPIRATORY THERAPY	0	6,813	3,237	14,162		15.00
16.00	66.00	PHYSICAL THERAPY	0	0	0	0		16.00
17.00	69.00	ELECTROCARDIOLOGY	0	0	0	159,408		17.00
18.00	70.00	ELECTROENCEPHALOGRAPHY	0	4,474	3,886	26,631		18.00
19.00	74.00	RENAL DIALYSIS	0	0	0	0		19.00
20.00	90.00	CLINIC	0	0	0	1,694,277		20.00
21.00	90.01	I BMT JOINT VENTURE	0	138,593	63,857	-1,239		21.00
22.00	90.05	CV DIAGNOSTIC SERVICES	0	0	0	753,588		22.00
23.00	91.00	EMERGENCY	0	35,487	2,513	15,896		23.00
200.00			0	1,655,275	761,243	9,016,392		200.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 15-0162

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

Worksheet B Part I Date/Time Prepared: 3/30/2021 10:40 am

Table with columns: Cost Center Description, Net Expenses for Cost Allocation (from Wkst A col. 7), CAPITAL RELATED COSTS (BLDG & FIXT, MVBLE EQUIP), EMPLOYEE BENEFITS DEPARTMENT, ADMITTING, and other allocation values. Rows include GENERAL SERVICE COST CENTERS, INPATIENT ROUTINE SERVICE COST CENTERS, ANCILLARY SERVICE COST CENTERS, and SPECIAL PURPOSE COST CENTERS.

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 15-0162

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

Worksheet B
Part I
Date/Time Prepared:
3/30/2021 10:40 am

Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	ADMINISTRATIVE	
		BLDG & FIXT	MVBLE EQUIP			
	0	1.00	2.00	4.00	5.01	
194.05 07956 FOUNDATION	1,889	0	0	0	0	194.05
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)	714,639,698	33,157,122	14,957,135	70,659,305	206,251	202.00

COST ALLOCATION - GENERAL SERVICE COSTS				Provider CCN: 15-0162	Period: From 01/01/2020 To 12/31/2020	Worksheet B Part I Date/Time Prepared: 3/30/2021 10:40 am	
Cost Center	Description	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATIVE	
		8.00	9.00	10.00	11.00	13.00	
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	00570	ADMITTING					5.01
5.02	00580	CASHIERING/ACCOUNTS RECEIVABLE					5.02
5.03	00590	OTHER ADMIN & GENERAL					5.03
7.00	00700	OPERATION OF PLANT					7.00
8.00	00800	LAUNDRY & LINEN SERVICE	3,241,364				8.00
9.00	00900	HOUSEKEEPING	0	11,160,401			9.00
10.00	01000	DIETARY	0	140,537	2,573,876		10.00
11.00	01100	CAFETERIA	0	192,834	0	5,862,029	11.00
13.00	01300	NURSING ADMINISTRATION	0	0	0	121,434	9,103,749
14.00	01400	CENTRAL SERVICES & SUPPLY	11,164	442,881	0	40,586	0
15.00	01500	PHARMACY	0	171,710	0	204,080	0
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	0
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	13,423	0	70,784	0
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	20,134	0
23.00	02300	MEDICAL LABORATORY SCIENTIST PRGM	0	0	0	6,111	0
23.01	02302	PHARMACY PRGM	0	0	0	16,959	0
23.02	02301	EMERGENCY MEDICAL SERVICES	0	0	0	15,174	0
23.03	02303	PARAMEDIC PRGM	0	0	0	35,671	0
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	1,278,346	2,742,270	1,227,637	1,211,102	4,342,131
31.00	03100	INTENSIVE CARE UNIT	226,820	308,491	483,749	253,812	1,711,011
31.01	02060	NEONATAL INTENSIVE CARE UNIT	22,932	208,751	149,184	120,150	527,659
32.00	03200	CORONARY CARE UNIT	232,788	671,965	299,476	339,119	1,059,241
34.00	03400	SURGICAL INTENSIVE CARE UNIT	153,387	380,036	194,609	179,212	688,327
41.00	04100	SUBPROVIDER - IRF	71,580	250,736	131,013	109,565	463,392
43.00	04300	NURSERY	9,863	53,002	88,208	14,237	311,988
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	270,636	1,426,344	0	416,653	0
52.00	05200	DELIVERY ROOM & LABOR ROOM	150,970	381,019	0	100,610	0
54.00	05400	RADIOLOGY-DIAGNOSTIC	166,651	918,652	0	294,004	0
55.00	05500	RADIOLOGY-THERAPEUTIC	0	64,327	0	44,392	0
56.00	05600	RADIOISOTOPE	6,229	12,440	0	5,238	0
59.00	05900	CARDIAC CATHETERIZATION	69,099	356,564	0	63,121	0
60.00	06000	LABORATORY	23	378,569	0	17,004	0
64.00	06400	INTRAVENOUS THERAPY	0	138,248	0	93,632	0
65.00	06500	RESPIRATORY THERAPY	810	123,681	0	216,059	0
66.00	06600	PHYSICAL THERAPY	24,684	162,013	0	145,907	0
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	69,604	0
68.00	06800	SPEECH PATHOLOGY	0	28,738	0	28,105	0
69.00	06900	ELECTROCARDIOLOGY	13,219	201,886	0	53,230	0
70.00	07000	ELECTROENCEPHALOGRAPHY	6,238	0	0	54,522	0
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0
74.00	07400	RENAL DIALYSIS	9,786	58,811	0	1,030	0
76.97	07697	CARDIAC REHABILITATION	0	0	0	14,364	0
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	12,935	274,384	0	227,786	0
90.01	09001	IBMT JOINT VENTURE	9,218	35,075	0	53,977	0
90.05	09005	CV DIAGNOSTIC SERVICES	0	0	0	353,410	0
91.00	09100	EMERGENCY	467,962	706,175	0	296,215	0
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					
OTHER REIMBURSABLE COST CENTERS							
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					
116.00	11600	HOSPICE	0	0	0	197,389	0
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	3,215,340	10,843,562	2,573,876	5,504,382	9,103,749
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	66,689	0	17,855	0
192.00	19200	PHYSICIANS' PRIVATE OFFICES	9,868	95,882	0	165,828	0
194.00	07955	MARKETING & COMMUNITY RELATIONS	0	0	0	2,676	0
194.01	07952	WOMEN'S CENTER	16,156	36,249	0	4,635	0
194.02	07950	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0
194.04	07954	OTHER NRCC	0	118,019	0	166,653	0
194.05	07956	FOUNDATION	0	0	0	0	0
200.00		Cross Foot Adjustments					
201.00		Negative Cost Centers	0	0	0	0	0
202.00		TOTAL (sum lines 118 through 201)	3,241,364	11,160,401	2,573,876	5,862,029	9,103,749

COST ALLOCATION - GENERAL SERVICE COSTS		Provider CCN: 15-0162	Period: From 01/01/2020 To 12/31/2020	Worksheet B Part I Date/Time Prepared: 3/30/2021 10:40 am
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Cost Center Description	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	INTERNS & RESIDENTS		
				SERVICES-SALARY & FRINGES APPRV	SERVICES-OTHER PRGM COSTS APPRV	
				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 00570 ADMITTING						5.01
5.02 00580 CASHIERING/ACCOUNTS RECEIVABLE						5.02
5.03 00590 OTHER ADMIN & 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	5,997,634					14.00
15.00 01500 PHARMACY	9,127	14,642,963				15.00
16.00 01600 MEDICAL RECORDS & LIBRARY	0	0	218,573			16.00
21.00 02100 I&R SERVICES-SALARY & FRINGES APPRV	1,440	0	0	3,659,934		21.00
22.00 02200 I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	2,390,066	22.00
23.00 02300 MEDICAL LABORATORY SCIENTIST PRGM	80	0	0	0		23.00
23.01 02302 PHARMACY PRGM	80	0	0	0		23.01
23.02 02301 EMERGENCY MEDICAL SERVICES	565	0	0	0		23.02
23.03 02303 PARAMEDIC PRGM	277	0	0	0		23.03
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000 ADULTS & PEDIATRICS	15,869	0	14,399	2,533,570	1,654,513	30.00
31.00 03100 INTENSIVE CARE UNIT	2,571	0	2,552	109,051	71,214	31.00
31.01 02060 NEONATAL INTENSIVE CARE UNIT	1,449	0	2,167	0	0	31.01
32.00 03200 CORONARY CARE UNIT	3,360	0	2,444	0	0	32.00
34.00 03400 SURGICAL INTENSIVE CARE UNIT	1,636	0	1,916	0	0	34.00
41.00 04100 SUBPROVIDER - IRF	862	0	1,082	0	0	41.00
43.00 04300 NURSERY	1,202	0	471	0	0	43.00
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	44,085	0	19,339	234,535	153,159	50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	1,611	0	3,231	0	0	52.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	31,741	0	21,595	0	0	54.00
55.00 05500 RADIOLOGY-THERAPEUTIC	35	0	5,933	0	0	55.00
56.00 05600 RADIOISOTOPE	64,392	0	529	0	0	56.00
59.00 05900 CARDIAC CATHETERIZATION	1,378	0	10,738	0	0	59.00
60.00 06000 LABORATORY	920	0	22,472	0	0	60.00
64.00 06400 INTRAVENOUS THERAPY	4,529	0	2,324	0	0	64.00
65.00 06500 RESPIRATORY THERAPY	1,940	0	4,394	34,359	22,437	65.00
66.00 06600 PHYSICAL THERAPY	1,717	0	2,801	256,942	167,792	66.00
67.00 06700 OCCUPATIONAL THERAPY	393	0	1,552	0	0	67.00
68.00 06800 SPEECH PATHOLOGY	282	0	767	0	0	68.00
69.00 06900 ELECTROCARDIOLOGY	2,172	0	2,691	95,606	62,434	69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	585	0	1,446	29,877	19,511	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	3,227,866	0	14,817	0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	2,493,538	0	12,287	0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	14,642,963	36,171	0	0	73.00
74.00 07400 RENAL DIALYSIS	107	0	599	28,383	18,535	74.00
76.97 07697 CARDIAC REHABILITATION	454	0	113	0	0	76.97
OUTPATIENT SERVICE COST CENTERS						
90.00 09000 CLINIC	1,352	0	984	0	0	90.00
90.01 09001 IBMT JOINT VENTURE	524	0	653	0	0	90.01
90.05 09005 CV DIAGNOSTIC SERVICES	21,928	0	4,974	0	0	90.05
91.00 09100 EMERGENCY	5,224	0	21,282	264,412	172,670	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART						92.00
OTHER REIMBURSABLE COST CENTERS						
101.00 10100 HOME HEALTH AGENCY	0	0	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS						
113.00 11300 INTEREST EXPENSE						113.00
116.00 11600 HOSPICE	13,914	0	1,850			116.00
118.00 11800 SUBTOTALS (SUM OF LINES 1 through 117)	5,959,205	14,642,963	218,573	3,586,735	2,342,265	118.00
NONREIMBURSABLE COST CENTERS						
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	11,765	0	0	0	0	190.00
192.00 19200 PHYSICIANS' PRIVATE OFFICES	8,586	0	0	73,199	47,801	192.00
194.00 07955 MARKETING & COMMUNITY RELATIONS	0	0	0	0	0	194.00
194.01 07952 WOMEN'S CENTER	244	0	0	0	0	194.01
194.02 07950 OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.02
194.04 07954 OTHER NRCC	17,834	0	0	0	0	194.04
194.05 07956 FOUNDATION	0	0	0	0	0	194.05
200.00 20000 Cross Foot Adjustments				0	0	200.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 15-0162

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

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Cost Center Description		CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	INTERNS & RESIDENTS		
					SERVICES-SALA RY & FRINGES APPRV	SERVICES-OTHE R PRGM COSTS APPRV	
					14.00	15.00	
201.00	Negative Cost Centers	0	0	0	0	0	201.00
202.00	TOTAL (sum lines 118 through 201)	5,997,634	14,642,963	218,573	3,659,934	2,390,066	202.00

COST ALLOCATION - GENERAL SERVICE COSTS		Provider CCN: 15-0162		Period: From 01/01/2020 To 12/31/2020		Worksheet B Part I Date/Time Prepared: 3/30/2021 10:40 am	
Cost Center Description		MEDICAL LABORATORY SCIENTIST PRGM	PHARMACY PRGM	EMERGENCY MEDICAL SERVICES	PARAMEDIC PRGM	Subtotal	
		23.00	23.01	23.02	23.03	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	00570	ADMITTING					5.01
5.02	00580	CASHIERING/ACCOUNTS RECEIVABLE					5.02
5.03	00590	OTHER ADMIN & 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
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV					21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV					22.00
23.00	02300	MEDICAL LABORATORY SCIENTIST PRGM	141,024				23.00
23.01	02302	PHARMACY PRGM		1,163,613			23.01
23.02	02301	EMERGENCY MEDICAL SERVICES			235,262		23.02
23.03	02303	PARAMEDIC PRGM				780,472	23.03
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	92,178,384 30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	17,825,217 31.00
31.01	02060	NEONATAL INTENSIVE CARE UNIT	0	0	0	0	9,704,382 31.01
32.00	03200	CORONARY CARE UNIT	0	0	0	0	23,584,816 32.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	0	0	0	0	12,716,282 34.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	8,237,029 41.00
43.00	04300	NURSERY	0	0	0	0	1,710,345 43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	0	0	0	36,070,015 50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	8,481,089 52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	29,080,249 54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	9,832,056 55.00
56.00	05600	RADIOISOTOPE	0	0	0	0	1,499,950 56.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	7,061,378 59.00
60.00	06000	LABORATORY	141,024	0	0	0	35,527,785 60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	5,627,859 64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	12,485,807 65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	10,922,770 66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	3,619,035 67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	1,886,323 68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	4,420,504 69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	3,263,205 70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	50,075,701 71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	38,677,602 72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	1,163,613	0	780,472	97,792,385 73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	1,794,562 74.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	665,417 76.97
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0	0	0	0	11,187,932 90.00
90.01	09001	IBMT JOINT VENTURE	0	0	0	0	9,921,120 90.01
90.05	09005	CV DIAGNOSTIC SERVICES	0	0	0	0	15,830,967 90.05
91.00	09100	EMERGENCY	0	0	235,262	0	21,304,752 91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					92.00
OTHER REIMBURSABLE COST CENTERS							
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0 101.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
116.00	11600	HOSPICE	0	0	0	0	12,356,795 116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	141,024	1,163,613	235,262	780,472	595,341,713 118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	1,259,429 190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	14,662,435 192.00
194.00	07955	MARKETING & COMMUNITY RELATIONS	0	0	0	0	160,106 194.00
194.01	07952	WOMEN'S CENTER	0	0	0	0	613,541 194.01
194.02	07950	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0 194.02
194.04	07954	OTHER NRCC	0	0	0	0	102,600,108 194.04
194.05	07956	FOUNDATION	0	0	0	0	2,366 194.05
200.00		Cross Foot Adjustments	0	0	0	0	0 200.00
201.00		Negative Cost Centers	0	0	0	0	0 201.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 15-0162

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

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Cost Center Description	MEDICAL LABORATORY SCIENTIST PRGM	PHARMACY PRGM	EMERGENCY MEDICAL SERVICES	PARAMEDIC PRGM	Subtotal	
	23.00	23.01	23.02	23.03	24.00	
202.00 TOTAL (sum lines 118 through 201)	141,024	1,163,613	235,262	780,472	714,639,698	202.00

COST ALLOCATION - GENERAL SERVICE COSTS		Provider CCN: 15-0162	Period: From 01/01/2020 To 12/31/2020	Worksheet B Part I Date/Time Prepared: 3/30/2021 10:40 am
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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	00570	ADMITTING		5.01
5.02	00580	CASHIERING/ACCOUNTS RECEIVABLE		5.02
5.03	00590	OTHER ADMIN & 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
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV		21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV		22.00
23.00	02300	MEDICAL LABORATORY SCIENTIST PRGM		23.00
23.01	02302	PHARMACY PRGM		23.01
23.02	02301	EMERGENCY MEDICAL SERVICES		23.02
23.03	02303	PARAMEDIC PRGM		23.03
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	-4,188,083	30.00
31.00	03100	INTENSIVE CARE UNIT	-180,265	31.00
31.01	02060	NEONATAL INTENSIVE CARE UNIT	0	31.01
32.00	03200	CORONARY CARE UNIT	0	32.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	0	34.00
41.00	04100	SUBPROVIDER - IRF	0	41.00
43.00	04300	NURSERY	0	43.00
ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	-387,694	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	55.00
56.00	05600	RADIOISOTOPE	0	56.00
59.00	05900	CARDIAC CATHETERIZATION	0	59.00
60.00	06000	LABORATORY	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0	64.00
65.00	06500	RESPIRATORY THERAPY	-56,796	65.00
66.00	06600	PHYSICAL THERAPY	-424,734	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	68.00
69.00	06900	ELECTROCARDIOLOGY	-158,040	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	-49,388	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	73.00
74.00	07400	RENAL DIALYSIS	-46,918	74.00
76.97	07697	CARDIAC REHABILITATION	0	76.97
OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0	90.00
90.01	09001	IBMT JOINT VENTURE	0	90.01
90.05	09005	CV DIAGNOSTIC SERVICES	0	90.05
91.00	09100	EMERGENCY	-437,082	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	92.00
OTHER REIMBURSABLE COST CENTERS				
101.00	10100	HOME HEALTH AGENCY	0	101.00
SPECIAL PURPOSE COST CENTERS				
113.00	11300	INTEREST EXPENSE		113.00
116.00	11600	HOSPICE	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-5,929,000	118.00
NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	-121,000	192.00
194.00	07955	MARKETING & COMMUNITY RELATIONS	0	194.00
194.01	07952	WOMEN'S CENTER	0	194.01
194.02	07950	OTHER NONREIMBURSABLE COST CENTERS	0	194.02
194.04	07954	OTHER NRCC	0	194.04
194.05	07956	FOUNDATION	0	194.05
200.00		Cross Foot Adjustments	0	200.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 15-0162

Period:
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To 12/31/2020

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Cost Center Description		Intern & Residents Cost & Post Stepdown Adjustments	Total	
		25.00	26.00	
201.00	Negative Cost Centers	0	0	201.00
202.00	TOTAL (sum lines 118 through 201)	-6,050,000	708,589,698	202.00

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 15-0162	Period: From 01/01/2020 To 12/31/2020	Worksheet B Part II Date/Time Prepared: 3/30/2021 10:40 am		
Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
		BLDG & FIXT	MVBLE EQUIP			
		0	1.00			2.00
GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	0	0	4.00
5.01	00570	ADMINISTRATIVE	0	139,509	62,932	5.01
5.02	00580	CASHIERING/ACCOUNTS RECEIVABLE	0	41,856	18,881	5.02
5.03	00590	OTHER ADMIN & GENERAL	0	72,184	32,562	5.03
7.00	00700	OPERATION OF PLANT	0	3,712,339	1,674,631	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	280,336	126,459	8.00
9.00	00900	HOUSEKEEPING	0	249,067	112,354	9.00
10.00	01000	DIETARY	0	360,922	162,812	10.00
11.00	01100	CAFETERIA	0	495,232	223,399	11.00
13.00	01300	NURSING ADMINISTRATION	0	0	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	1,137,395	513,077	14.00
15.00	01500	PHARMACY	0	440,981	198,926	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	16.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	34,472	15,550	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	22.00
23.00	02300	MEDICAL LABORATORY SCIENTIST PRGM	0	0	0	23.00
23.01	02302	PHARMACY PRGM	0	0	0	23.01
23.02	02301	EMERGENCY MEDICAL SERVICES	0	0	0	23.02
23.03	02303	PARAMEDIC PRGM	0	0	0	23.03
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	7,042,622	3,176,916	30.00
31.00	03100	INTENSIVE CARE UNIT	0	792,258	357,387	31.00
31.01	02060	NEONATAL INTENSIVE CARE UNIT	0	536,109	241,838	31.01
32.00	03200	CORONARY CARE UNIT	0	1,725,721	778,471	32.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	0	975,997	440,271	34.00
41.00	04100	SUBPROVIDER - IRF	0	643,934	290,478	41.00
43.00	04300	NURSERY	0	136,118	61,403	43.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	3,663,098	1,652,419	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	978,522	441,410	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	2,359,257	1,064,258	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	165,203	74,523	55.00
56.00	05600	RADIOISOTOPE	0	31,948	14,412	56.00
59.00	05900	CARDIAC CATHETERIZATION	0	915,718	413,079	59.00
60.00	06000	LABORATORY	0	972,230	438,572	60.00
64.00	06400	INTRAVENOUS THERAPY	0	355,045	160,160	64.00
65.00	06500	RESPIRATORY THERAPY	0	317,634	143,284	65.00
66.00	06600	PHYSICAL THERAPY	0	416,078	187,692	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	73,804	33,293	68.00
69.00	06900	ELECTROCARDIOLOGY	0	518,477	233,884	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	151,037	68,133	74.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	76.97
OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	704,665	317,874	90.00
90.01	09001	IBMT JOINT VENTURE	0	90,080	40,635	90.01
90.05	09005	CV DIAGNOSTIC SERVICES	0	0	0	90.05
91.00	09100	EMERGENCY	0	1,813,578	818,103	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE	0	0	0	113.00
116.00	11600	HOSPICE	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	32,343,426	14,590,078	118.00
NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	171,269	77,259	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	246,241	111,079	192.00
194.00	07955	MARKETING & COMMUNITY RELATIONS	0	0	0	194.00
194.01	07952	WOMEN'S CENTER	0	93,094	41,995	194.01
194.02	07950	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	194.02
194.04	07954	OTHER NRCC	0	303,092	136,724	194.04
194.05	07956	FOUNDATION	0	0	0	194.05

Cost Center Description		Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
			BLDG & FIXT	MVBLE EQUIP			
		0	1.00	2.00	2A	4.00	
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	33,157,122	14,957,135	48,114,257	0	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 15-0162

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

Worksheet B Part II Date/Time Prepared: 3/30/2021 10:40 am

Table with columns: Cost Center Description, ADMITTING (5.01), CASHIERING/AC COUNTS RECEIVABLE (5.02), OTHER ADMIN & GENERAL (5.03), OPERATION OF PLANT (7.00), LAUNDRY & LINEN SERVICE (8.00), and an unlabeled column for total values. The table lists various cost centers such as 'GENERAL SERVICE COST CENTERS', 'INPATIENT ROUTINE SERVICE COST CENTERS', etc., with their respective values.

ALLOCATION OF CAPITAL RELATED COSTS			Provider CCN: 15-0162	Period: From 01/01/2020 To 12/31/2020	Worksheet B Part II Date/Time Prepared: 3/30/2021 10:40 am			
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	00570	ADMINISTRATION						5.01
5.02	00580	CASHIERING/ACCOUNTS RECEIVABLE						5.02
5.03	00590	OTHER ADMIN & GENERAL						5.03
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	409,967					9.00	
10.00	01000	5,162	596,064				10.00	
11.00	01100	7,084	0	818,418			11.00	
13.00	01300	0	0	16,954	19,033		13.00	
14.00	01400	16,269	0	5,666	0	1,885,159	14.00	
15.00	01500	6,308	0	28,492	0	2,869	15.00	
16.00	01600	0	0	0	0	0	16.00	
21.00	02100	493	0	9,882	0	453	21.00	
22.00	02200	0	0	2,811	0	0	22.00	
23.00	02300	0	0	853	0	25	23.00	
23.01	02302	0	0	2,368	0	25	23.01	
23.02	02301	0	0	2,118	0	178	23.02	
23.03	02303	0	0	4,980	0	87	23.03	
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	100,737	284,300	169,082	9,078	4,988	30.00	
31.00	03100	11,332	112,028	35,436	3,577	808	31.00	
31.01	02060	7,668	34,548	16,775	1,103	455	31.01	
32.00	03200	24,684	69,353	47,346	2,215	1,056	32.00	
34.00	03400	13,960	45,068	25,021	1,439	514	34.00	
41.00	04100	9,211	30,340	15,297	969	271	41.00	
43.00	04300	1,947	20,427	1,988	652	378	43.00	
ANCILLARY SERVICE COST CENTERS								
50.00	05000	52,395	0	58,170	0	13,857	50.00	
52.00	05200	13,996	0	14,047	0	506	52.00	
54.00	05400	33,746	0	41,047	0	9,977	54.00	
55.00	05500	2,363	0	6,198	0	11	55.00	
56.00	05600	457	0	731	0	20,240	56.00	
59.00	05900	13,098	0	8,813	0	433	59.00	
60.00	06000	13,906	0	2,374	0	289	60.00	
64.00	06400	5,078	0	13,072	0	1,424	64.00	
65.00	06500	4,543	0	30,165	0	610	65.00	
66.00	06600	5,951	0	20,371	0	540	66.00	
67.00	06700	0	0	9,718	0	124	67.00	
68.00	06800	1,056	0	3,924	0	89	68.00	
69.00	06900	7,416	0	7,432	0	683	69.00	
70.00	07000	0	0	7,612	0	184	70.00	
71.00	07100	0	0	0	0	1,014,565	71.00	
72.00	07200	0	0	0	0	783,766	72.00	
73.00	07300	0	0	0	0	0	73.00	
74.00	07400	2,160	0	144	0	34	74.00	
76.97	07697	0	0	2,005	0	143	76.97	
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	10,079	0	31,802	0	425	90.00	
90.01	09001	1,288	0	7,536	0	165	90.01	
90.05	09005	0	0	49,341	0	6,892	90.05	
91.00	09100	25,941	0	41,356	0	1,642	91.00	
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
OTHER REIMBURSABLE COST CENTERS								
101.00	10100	0	0	0	0	0	101.00	
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	0	0	27,558	0	4,373	116.00	
118.00		398,328	596,064	768,485	19,033	1,873,079	118.00	
NONREIMBURSABLE COST CENTERS								
190.00	19000	2,450	0	2,493	0	3,698	190.00	
192.00	19200	3,522	0	23,152	0	2,699	192.00	
194.00	07955	0	0	374	0	0	194.00	
194.01	07952	1,332	0	647	0	77	194.01	
194.02	07950	0	0	0	0	0	194.02	
194.04	07954	4,335	0	23,267	0	5,606	194.04	
194.05	07956	0	0	0	0	0	194.05	
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		409,967	596,064	818,418	19,033	1,885,159	202.00	

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 15-0162	Period: From 01/01/2020 To 12/31/2020	Worksheet B Part II Date/Time Prepared: 3/30/2021 10:40 am
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Cost Center Description	PHARMACY	MEDICAL RECORDS & LIBRARY	INTERNS & RESIDENTS		MEDICAL LABORATORY SCIENTIST PRGM	
			SERVICES-SALARY & FRINGES APPRV	SERVICES-OTHER PRGM COSTS APPRV		
	15.00	16.00	21.00	22.00	23.00	
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 00570	ADMINISTRATIVE					5.01
5.02 00580	CASHIERING/ACCOUNTS RECEIVABLE					5.02
5.03 00590	OTHER ADMIN & 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	762,256				15.00
16.00 01600	MEDICAL RECORDS & LIBRARY	0	51			16.00
21.00 02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	68,039		21.00
22.00 02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0		3,360	22.00
23.00 02300	MEDICAL LABORATORY SCIENTIST PRGM	0	0			23.00
23.01 02302	PHARMACY PRGM	0	0			23.01
23.02 02301	EMERGENCY MEDICAL SERVICES	0	0			23.02
23.03 02303	PARAMEDIC PRGM	0	0			23.03
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS	0	0			30.00
31.00 03100	INTENSIVE CARE UNIT	0	0			31.00
31.01 02060	NEONATAL INTENSIVE CARE UNIT	0	0			31.01
32.00 03200	CORONARY CARE UNIT	0	0			32.00
34.00 03400	SURGICAL INTENSIVE CARE UNIT	0	0			34.00
41.00 04100	SUBPROVIDER - IRF	0	0			41.00
43.00 04300	NURSERY	0	0			43.00
ANCILLARY SERVICE COST CENTERS						
50.00 05000	OPERATING ROOM	0	0			50.00
52.00 05200	DELIVERY ROOM & LABOR ROOM	0	0			52.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	0	0			54.00
55.00 05500	RADIOLOGY-THERAPEUTIC	0	0			55.00
56.00 05600	RADIOISOTOPE	0	0			56.00
59.00 05900	CARDIAC CATHETERIZATION	0	0			59.00
60.00 06000	LABORATORY	0	0			60.00
64.00 06400	INTRAVENOUS THERAPY	0	0			64.00
65.00 06500	RESPIRATORY THERAPY	0	0			65.00
66.00 06600	PHYSICAL THERAPY	0	0			66.00
67.00 06700	OCCUPATIONAL THERAPY	0	0			67.00
68.00 06800	SPEECH PATHOLOGY	0	0			68.00
69.00 06900	ELECTROCARDIOLOGY	0	0			69.00
70.00 07000	ELECTROENCEPHALOGRAPHY	0	0			70.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0			71.00
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	0	0			72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	762,256	51			73.00
74.00 07400	RENAL DIALYSIS	0	0			74.00
76.97 07697	CARDIAC REHABILITATION	0	0			76.97
OUTPATIENT SERVICE COST CENTERS						
90.00 09000	CLINIC	0	0			90.00
90.01 09001	IBMT JOINT VENTURE	0	0			90.01
90.05 09005	CV DIAGNOSTIC SERVICES	0	0			90.05
91.00 09100	EMERGENCY	0	0			91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART					92.00
OTHER REIMBURSABLE COST CENTERS						
101.00 10100	HOME HEALTH AGENCY	0	0			101.00
SPECIAL PURPOSE COST CENTERS						
113.00 11300	INTEREST EXPENSE					113.00
116.00 11600	HOSPICE	0	0			116.00
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	762,256	51	0	0	118.00
NONREIMBURSABLE COST CENTERS						
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0			190.00
192.00 19200	PHYSICIANS' PRIVATE OFFICES	0	0			192.00
194.00 07955	MARKETING & COMMUNITY RELATIONS	0	0			194.00
194.01 07952	WOMEN'S CENTER	0	0			194.01
194.02 07950	OTHER NONREIMBURSABLE COST CENTERS	0	0			194.02
194.04 07954	OTHER NRCC	0	0			194.04
194.05 07956	FOUNDATION	0	0			194.05

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 15-0162		Period:		Worksheet B	
				From 01/01/2020	To 12/31/2020	Part II	Date/Time Prepared:
Cost Center Description		PHARMACY	MEDICAL RECORDS & LIBRARY	INTERNS & RESIDENTS		MEDICAL LABORATORY SCIENTIST PRGM	
				SERVICES-SALARY & FRINGES APPRV	SERVICES-OTHER PRGM COSTS APPRV		
		15.00	16.00	21.00	22.00	23.00	
200.00	Cross Foot Adjustments			68,039	3,360	909	200.00
201.00	Negative Cost Centers	0	0	0	0	0	201.00
202.00	TOTAL (sum lines 118 through 201)	762,256	51	68,039	3,360	909	202.00

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 15-0162	Period: From 01/01/2020 To 12/31/2020	Worksheet B Part II Date/Time Prepared: 3/30/2021 10:40 am			
Cost Center Description		PHARMACY PRGM 23.01	EMERGENCY MEDICAL SERVICES 23.02	PARAMEDIC PRGM 23.03	Subtotal 24.00	Intern & Residents Cost & Post Stepdown Adjustments 25.00	
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	00570	ADMITTING				5.01	
5.02	00580	CASHIERING/ACCOUNTS RECEIVABLE				5.02	
5.03	00590	OTHER ADMIN & 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	
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV				21.00	
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV				22.00	
23.00	02300	MEDICAL LABORATORY SCIENTIST PRGM				23.00	
23.01	02302	PHARMACY PRGM	2,659			23.01	
23.02	02301	EMERGENCY MEDICAL SERVICES		2,347		23.02	
23.03	02303	PARAMEDIC PRGM			5,240	23.03	
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS			12,308,780	0 30.00	
31.00	03100	INTENSIVE CARE UNIT			1,499,666	0 31.00	
31.01	02060	NEONATAL INTENSIVE CARE UNIT			947,022	0 31.01	
32.00	03200	CORONARY CARE UNIT			3,010,041	0 32.00	
34.00	03400	SURGICAL INTENSIVE CARE UNIT			1,710,521	0 34.00	
41.00	04100	SUBPROVIDER - IRF			1,123,305	0 41.00	
43.00	04300	NURSERY			250,659	0 43.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM			6,183,085	0 50.00	
52.00	05200	DELIVERY ROOM & LABOR ROOM			1,658,701	0 52.00	
54.00	05400	RADIOLOGY-DIAGNOSTIC			3,986,123	0 54.00	
55.00	05500	RADIOLOGY-THERAPEUTIC			281,467	0 55.00	
56.00	05600	RADIOISOTOPE			75,179	0 56.00	
59.00	05900	CARDIAC CATHETERIZATION			1,539,955	0 59.00	
60.00	06000	LABORATORY			1,634,404	0 60.00	
64.00	06400	INTRAVENOUS THERAPY			602,096	0 64.00	
65.00	06500	RESPIRATORY THERAPY			565,204	0 65.00	
66.00	06600	PHYSICAL THERAPY			716,119	0 66.00	
67.00	06700	OCCUPATIONAL THERAPY			12,746	0 67.00	
68.00	06800	SPEECH PATHOLOGY			127,134	0 68.00	
69.00	06900	ELECTROCARDIOLOGY			869,997	0 69.00	
70.00	07000	ELECTROENCEPHALOGRAPHY			10,097	0 70.00	
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT			1,047,795	0 71.00	
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS			804,218	0 72.00	
73.00	07300	DRUGS CHARGED TO PATIENTS			805,647	0 73.00	
74.00	07400	RENAL DIALYSIS			252,309	0 74.00	
76.97	07697	CARDIAC REHABILITATION			2,326	0 76.97	
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC			1,199,286	0 90.00	
90.01	09001	IBMT JOINT VENTURE			159,980	0 90.01	
90.05	09005	CV DIAGNOSTIC SERVICES			59,855	0 90.05	
91.00	09100	EMERGENCY			3,117,540	0 91.00	
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				0 92.00	
OTHER REIMBURSABLE COST CENTERS							
101.00	10100	HOME HEALTH AGENCY			0	0 101.00	
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE				113.00	
116.00	11600	HOSPICE			34,742	0 116.00	
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	0	0	46,595,999	0 118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN			289,044	0 190.00	
192.00	19200	PHYSICIANS' PRIVATE OFFICES			436,834	0 192.00	
194.00	07955	MARKETING & COMMUNITY RELATIONS			411	0 194.00	
194.01	07952	WOMEN'S CENTER			156,743	0 194.01	
194.02	07950	OTHER NONREIMBURSABLE COST CENTERS			0	0 194.02	
194.04	07954	OTHER NRCC			552,672	0 194.04	
194.05	07956	FOUNDATION			0	0 194.05	
200.00		Cross Foot Adjustments	2,659	2,347	5,240	82,554	0 200.00

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 15-0162			Period: From 01/01/2020 To 12/31/2020	Worksheet B Part II Date/Time Prepared: 3/30/2021 10:40 am	
Cost Center Description		PHARMACY PRGM	EMERGENCY MEDICAL SERVICES	PARAMEDIC PRGM	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	
		23.01	23.02	23.03	24.00	25.00	
201.00	Negative Cost Centers	0	0	0	0		0 201.00
202.00	TOTAL (sum lines 118 through 201)	2,659	2,347	5,240	48,114,257		0 202.00

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 15-0162	Period: From 01/01/2020 To 12/31/2020	Worksheet B Part II Date/Time Prepared: 3/30/2021 10:40 am
Cost Center Description		Total		
		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	00570	ADMITTING		5.01
5.02	00580	CASHIERING/ACCOUNTS RECEIVABLE		5.02
5.03	00590	OTHER ADMIN & 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
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV		21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV		22.00
23.00	02300	MEDICAL LABORATORY SCIENTIST PRGM		23.00
23.01	02302	PHARMACY PRGM		23.01
23.02	02301	EMERGENCY MEDICAL SERVICES		23.02
23.03	02303	PARAMEDIC PRGM		23.03
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	12,308,780	30.00
31.00	03100	INTENSIVE CARE UNIT	1,499,666	31.00
31.01	02060	NEONATAL INTENSIVE CARE UNIT	947,022	31.01
32.00	03200	CORONARY CARE UNIT	3,010,041	32.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	1,710,521	34.00
41.00	04100	SUBPROVIDER - IRF	1,123,305	41.00
43.00	04300	NURSERY	250,659	43.00
ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	6,183,085	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,658,701	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,986,123	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	281,467	55.00
56.00	05600	RADIOISOTOPE	75,179	56.00
59.00	05900	CARDIAC CATHETERIZATION	1,539,955	59.00
60.00	06000	LABORATORY	1,634,404	60.00
64.00	06400	INTRAVENOUS THERAPY	602,096	64.00
65.00	06500	RESPIRATORY THERAPY	565,204	65.00
66.00	06600	PHYSICAL THERAPY	716,119	66.00
67.00	06700	OCCUPATIONAL THERAPY	12,746	67.00
68.00	06800	SPEECH PATHOLOGY	127,134	68.00
69.00	06900	ELECTROCARDIOLOGY	869,997	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	10,097	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1,047,795	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	804,218	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	805,647	73.00
74.00	07400	RENAL DIALYSIS	252,309	74.00
76.97	07697	CARDIAC REHABILITATION	2,326	76.97
OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	1,199,286	90.00
90.01	09001	IBMT JOINT VENTURE	159,980	90.01
90.05	09005	CV DIAGNOSTIC SERVICES	59,855	90.05
91.00	09100	EMERGENCY	3,117,540	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART		92.00
OTHER REIMBURSABLE COST CENTERS				
101.00	10100	HOME HEALTH AGENCY	0	101.00
SPECIAL PURPOSE COST CENTERS				
113.00	11300	INTEREST EXPENSE		113.00
116.00	11600	HOSPICE	34,742	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	46,595,999	118.00
NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	289,044	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	436,834	192.00
194.00	07955	MARKETING & COMMUNITY RELATIONS	411	194.00
194.01	07952	WOMEN'S CENTER	156,743	194.01
194.02	07950	OTHER NONREIMBURSABLE COST CENTERS	0	194.02
194.04	07954	OTHER NRCC	552,672	194.04
194.05	07956	FOUNDATION	0	194.05
200.00		Cross Foot Adjustments	82,554	200.00
201.00		Negative Cost Centers	0	201.00
202.00		TOTAL (sum lines 118 through 201)	48,114,257	202.00

COST ALLOCATION - STATISTICAL BASIS		Provider CCN: 15-0162	Period: From 01/01/2020 To 12/31/2020	Worksheet B-1 Date/Time Prepared: 3/30/2021 10:40 am
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Cost Center Description	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	ADMITTING (INPATIENT CHARGES)	Reconciliation	
	BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (SQUARE FEET)				
	1.00	2.00				
GENERAL SERVICE COST CENTERS						
1.00 00100	CAP REL COSTS-BLDG & FIXT	880,093				1.00
2.00 00200	CAP REL COSTS-MVBLE EQUIP		880,093			2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	0	0	170,985,927		4.00
5.01 00570	ADMITTING	3,703	3,703	0	1,389,261,404	5.01
5.02 00580	CASHIERING/ACCOUNTS RECEIVABLE	1,111	1,111	0	0	5.02
5.03 00590	OTHER ADMIN & GENERAL	1,916	1,916	1,781,995	0	5.03
7.00 00700	OPERATION OF PLANT	98,537	98,537	3,779,271	0	7.00
8.00 00800	LAUNDRY & LINEN SERVICE	7,441	7,441	242,343	0	8.00
9.00 00900	HOUSEKEEPING	6,611	6,611	3,991,630	0	9.00
10.00 01000	DIETARY	9,580	9,580	1,017,176	0	10.00
11.00 01100	CAFETERIA	13,145	13,145	2,015,235	0	11.00
13.00 01300	NURSING ADMINISTRATION	0	0	4,328,850	0	13.00
14.00 01400	CENTRAL SERVICES & SUPPLY	30,190	30,190	678,692	0	14.00
15.00 01500	PHARMACY	11,705	11,705	6,657,628	0	15.00
16.00 01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	16.00
21.00 02100	I&R SERVICES-SALARY & FRINGES APPRV	915	915	2,206,377	0	21.00
22.00 02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	1,550,228	0	22.00
23.00 02300	MEDICAL LABORATORY SCIENTIST PRGM	0	0	167,709	0	23.00
23.01 02302	PHARMACY PRGM	0	0	523,408	0	23.01
23.02 02301	EMERGENCY MEDICAL SERVICES	0	0	249,035	0	23.02
23.03 02303	PARAMEDIC PRGM	0	0	667,414	0	23.03
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS	186,933	186,933	29,877,519	153,517,968	30.00
31.00 03100	INTENSIVE CARE UNIT	21,029	21,029	6,580,301	34,959,936	31.00
31.01 02060	NEONATAL INTENSIVE CARE UNIT	14,230	14,230	3,395,716	29,689,793	31.01
32.00 03200	CORONARY CARE UNIT	45,806	45,806	8,810,548	33,477,904	32.00
34.00 03400	SURGICAL INTENSIVE CARE UNIT	25,906	25,906	4,549,979	26,244,402	34.00
41.00 04100	SUBPROVIDER - IRF	17,092	17,092	2,928,631	14,817,214	41.00
43.00 04300	NURSERY	3,613	3,613	382,697	6,456,336	43.00
ANCILLARY SERVICE COST CENTERS						
50.00 05000	OPERATING ROOM	97,230	97,230	11,771,098	144,187,696	50.00
52.00 05200	DELIVERY ROOM & LABOR ROOM	25,973	25,973	2,773,890	44,083,876	52.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	62,622	62,622	8,655,969	85,242,123	54.00
55.00 05500	RADIOLOGY-THERAPEUTIC	4,385	4,385	1,462,148	2,968,046	55.00
56.00 05600	RADIOISOTOPE	848	848	201,920	1,960,555	56.00
59.00 05900	CARDIAC CATHETERIZATION	24,306	24,306	2,042,559	58,337,731	59.00
60.00 06000	LABORATORY	25,806	25,806	566,413	133,693,180	60.00
64.00 06400	INTRAVENOUS THERAPY	9,424	9,424	2,544,678	3,757,530	64.00
65.00 06500	RESPIRATORY THERAPY	8,431	8,431	5,773,199	50,953,990	65.00
66.00 06600	PHYSICAL THERAPY	11,044	11,044	4,417,949	19,538,129	66.00
67.00 06700	OCCUPATIONAL THERAPY	0	0	1,935,182	14,258,454	67.00
68.00 06800	SPEECH PATHOLOGY	1,959	1,959	759,134	6,337,786	68.00
69.00 06900	ELECTROCARDIOLOGY	13,762	13,762	1,369,267	24,859,377	69.00
70.00 07000	ELECTROENCEPHALOGRAPHY	0	0	1,499,680	4,706,509	70.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	153,335,853	71.00
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	82,727,769	72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	0	0	0	170,802,832	73.00
74.00 07400	RENAL DIALYSIS	4,009	4,009	37,840	7,896,114	74.00
76.97 07697	CARDIAC REHABILITATION	0	0	318,096	189,051	76.97
OUTPATIENT SERVICE COST CENTERS						
90.00 09000	CLINIC	18,704	18,704	5,608,092	662,591	90.00
90.01 09001	IBMT JOINT VENTURE	2,391	2,391	1,583,902	495,465	90.01
90.05 09005	CV DIAGNOSTIC SERVICES	0	0	7,266,290	309,254	90.05
91.00 09100	EMERGENCY	48,138	48,138	7,496,285	78,793,940	91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART					92.00
OTHER REIMBURSABLE COST CENTERS						
101.00 10100	HOME HEALTH AGENCY	0	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS						
113.00 11300	INTEREST EXPENSE					113.00
116.00 11600	HOSPICE	0	0	5,795,361	0	116.00
118.00 11800	SUBTOTALS (SUM OF LINES 1 through 117)	858,495	858,495	160,261,334	1,389,261,404	-60,737
NONREIMBURSABLE COST CENTERS						
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	4,546	4,546	254,045	0	190.00
192.00 19200	PHYSICIANS' PRIVATE OFFICES	6,536	6,536	6,164,834	0	192.00
194.00 07955	MARKETING & COMMUNITY RELATIONS	0	0	58,565	0	194.00
194.01 07952	WOMEN'S CENTER	2,471	2,471	96,624	0	194.01
194.02 07950	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	194.02
194.04 07954	OTHER NRCC	8,045	8,045	4,150,525	0	194.04

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 15-0162

Period:
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Date/Time Prepared:
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Cost Center Description	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	ADMITTING (INPATIENT CHARGES)	Reconciliation	
	BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (SQUARE FEET)				
	1.00	2.00				
194.05 07956 FOUNDATION	0	0	0	0	0	194.05
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)	33,157,122	14,957,135	70,659,305	206,251		202.00
203.00 Unit cost multiplier (Wkst. B, Part I)	37.674566	16.994948	0.413246	0.000148		203.00
204.00 Cost to be allocated (per Wkst. B, Part II)			0	202,441		204.00
205.00 Unit cost multiplier (Wkst. B, Part II)			0.000000	0.000146		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: 15-0162

Period:
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Date/Time Prepared:
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Cost Center Description		CASHIERING/AC COUNTS RECEIVABLE (ACCUM. COST)	Reconciliation	OTHER ADMIN & GENERAL (ACCUM. COST)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	
		5.02	5A.03	5.03	7.00	8.00	
202.00	Cost to be allocated (per Wkst. B, Part I)	60,737		144,094,315	32,591,309	3,241,364	202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	0.000085		0.252555	42.062746	1.141870	203.00
204.00	Cost to be allocated (per Wkst. B, Part II)	60,737		116,992	5,394,516	459,279	204.00
205.00	Unit cost multiplier (Wkst. B, Part II)	0.000085		0.000205	6.962229	0.161795	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: 15-0162

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

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Table with columns: Cost Center Description, HOUSEKEEPING (SQUARE FEET), DIETARY (TOTAL PATIENT DAYS), CAFETERIA (FTES), NURSING ADMINISTRATION (TOTAL PATIENT DAYS), CENTRAL SERVICES & SUPPLY (COSTED REQUIS.), and a final column for totals. Rows include categories like GENERAL SERVICE COST CENTERS, INPATIENT ROUTINE SERVICE COST CENTERS, ANCILLARY SERVICE COST CENTERS, and OUTPATIENT SERVICE COST CENTERS.

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 15-0162

Period:
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Cost Center Description		HOUSEKEEPING (SQUARE FEET)	DIETARY (TOTAL PATIENT DAYS)	CAFETERIA (FTES)	NURSING ADMINISTRATION (TOTAL PATIENT DAYS)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	
		9.00	10.00	11.00	13.00	14.00	
201.00	Negative Cost Centers						201.00
202.00	Cost to be allocated (per Wkst. B, Part I)	11,160,401	2,573,876	5,862,029	9,103,749	5,997,634	202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	14.669798	23.597521	1.279961	83.463969	0.086390	203.00
204.00	Cost to be allocated (per Wkst. B, Part II)	409,967	596,064	818,418	19,033	1,885,159	204.00
205.00	Unit cost multiplier (Wkst. B, Part II)	0.538881	5.464767	0.178700	0.174496	0.027154	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: 15-0162	Period: From 01/01/2020 To 12/31/2020	Worksheet B-1 Date/Time Prepared: 3/30/2021 10:40 am
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Cost Center Description	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)	INTERNS & RESIDENTS		MEDICAL LABORATORY SCIENTIST PRGM (ASSIGNED TIME)
			SERVICES-SALARY & FRINGES APPRV (ASSIGNED TIME)	SERVICES-OTHER PRGM COSTS APPRV (ASSIGNED TIME)	
	15.00	16.00	21.00	22.00	23.00
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 00570 ADMITTING					5.01
5.02 00580 CASHIERING/ACCOUNTS RECEIVABLE					5.02
5.03 00590 OTHER ADMIN & 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	100				15.00
16.00 01600 MEDICAL RECORDS & LIBRARY	0	3,006,278,609			16.00
21.00 02100 I&R SERVICES-SALARY & FRINGES APPRV	0	0	2,450		21.00
22.00 02200 I&R SERVICES-OTHER PRGM COSTS APPRV	0	0		2,450	22.00
23.00 02300 MEDICAL LABORATORY SCIENTIST PRGM	0	0			100 23.00
23.01 02302 PHARMACY PRGM	0	0			23.01
23.02 02301 EMERGENCY MEDICAL SERVICES	0	0			23.02
23.03 02303 PARAMEDIC PRGM	0	0			23.03
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00 03000 ADULTS & PEDIATRICS	0	197,244,567	1,696	1,696	0 30.00
31.00 03100 INTENSIVE CARE UNIT	0	34,959,936	73	73	0 31.00
31.01 02060 NEONATAL INTENSIVE CARE UNIT	0	29,689,793	0	0	0 31.01
32.00 03200 CORONARY CARE UNIT	0	33,477,904	0	0	0 32.00
34.00 03400 SURGICAL INTENSIVE CARE UNIT	0	26,244,402	0	0	0 34.00
41.00 04100 SUBPROVIDER - IRF	0	14,817,214	0	0	0 41.00
43.00 04300 NURSERY	0	6,456,336	0	0	0 43.00
ANCILLARY SERVICE COST CENTERS					
50.00 05000 OPERATING ROOM	0	264,914,869	157	157	0 50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	44,259,677	0	0	0 52.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	0	295,826,730	0	0	0 54.00
55.00 05500 RADIOLOGY-THERAPEUTIC	0	81,279,420	0	0	0 55.00
56.00 05600 RADIOISOTOPE	0	7,243,622	0	0	0 56.00
59.00 05900 CARDIAC CATHETERIZATION	0	147,100,158	0	0	0 59.00
60.00 06000 LABORATORY	0	307,838,767	0	0	100 60.00
64.00 06400 INTRAVENOUS THERAPY	0	31,834,595	0	0	0 64.00
65.00 06500 RESPIRATORY THERAPY	0	60,186,493	23	23	0 65.00
66.00 06600 PHYSICAL THERAPY	0	38,371,939	172	172	0 66.00
67.00 06700 OCCUPATIONAL THERAPY	0	21,266,221	0	0	0 67.00
68.00 06800 SPEECH PATHOLOGY	0	10,511,216	0	0	0 68.00
69.00 06900 ELECTROCARDIOLOGY	0	36,866,750	64	64	0 69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	0	19,812,117	20	20	0 70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	202,976,423	0	0	0 71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	168,318,773	0	0	0 72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	100	507,587,955	0	0	0 73.00
74.00 07400 RENAL DIALYSIS	0	8,199,678	19	19	0 74.00
76.97 07697 CARDIAC REHABILITATION	0	1,547,213	0	0	0 76.97
OUTPATIENT SERVICE COST CENTERS					
90.00 09000 CLINIC	0	13,478,991	0	0	0 90.00
90.01 09001 IBMT JOINT VENTURE	0	8,948,827	0	0	0 90.01
90.05 09005 CV DIAGNOSTIC SERVICES	0	68,142,020	0	0	0 90.05
91.00 09100 EMERGENCY	0	291,532,173	177	177	0 91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART					0 92.00
OTHER REIMBURSABLE COST CENTERS					
101.00 10100 HOME HEALTH AGENCY	0	0	0	0	0 101.00
SPECIAL PURPOSE COST CENTERS					
113.00 11300 INTEREST EXPENSE					113.00
116.00 11600 HOSPICE	0	25,343,830			0 116.00
118.00 11800 SUBTOTALS (SUM OF LINES 1 through 117)	100	3,006,278,609	2,401	2,401	100 118.00
NONREIMBURSABLE COST CENTERS					
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEN	0	0	0	0	0 190.00
192.00 19200 PHYSICIANS' PRIVATE OFFICES	0	0	49	49	0 192.00
194.00 07955 MARKETING & COMMUNITY RELATIONS	0	0	0	0	0 194.00
194.01 07952 WOMEN'S CENTER	0	0	0	0	0 194.01
194.02 07950 OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0 194.02

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 15-0162

Period:
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To 12/31/2020

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Cost Center Description	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)	INTERNS & RESIDENTS		MEDICAL LABORATORY SCIENTIST PRGM (ASSIGNED TIME)	
			SERVICES-SALA RY & FRINGES APPRV (ASSIGNED TIME)	SERVICES-OTHE R PRGM COSTS APPRV (ASSIGNED TIME)		
194.04 07954 OTHER NRCC	15.00	16.00	21.00	22.00	23.00	0
194.05 07956 FOUNDATION	0	0	0	0	0	0
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)	14,642,963	218,573	3,659,934	2,390,066	141,024	202.00
203.00 Unit cost multiplier (Wkst. B, Part I)	146,429.630000	0.000073	1,493.850612	975.537143	1,410.240000	203.00
204.00 Cost to be allocated (per Wkst. B, Part II)	762,256	51	68,039	3,360	909	204.00
205.00 Unit cost multiplier (Wkst. B, Part II)	7,622.560000	0.000000	27.771020	1.371429	9.090000	205.00
206.00 NAHE adjustment amount to be allocated (per Wkst. B-2)						0
207.00 NAHE unit cost multiplier (Wkst. D, Parts III and IV)					0.000000	207.00

COST ALLOCATION - STATISTICAL BASIS		Provider CCN: 15-0162	Period: From 01/01/2020 To 12/31/2020	Worksheet B-1 Date/Time Prepared: 3/30/2021 10:40 am	
Cost Center Description		PHARMACY PRGM (ASSIGNED TIME)	EMERGENCY MEDICAL SERVICES (ASSIGNED TIME)	PARAMEDIC PRGM (ASSIGNED TIME)	
		23.01	23.02	23.03	
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	00570	ADMITTING			5.01
5.02	00580	CASHIERING/ACCOUNTS RECEIVABLE			5.02
5.03	00590	OTHER ADMIN & 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
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV			21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV			22.00
23.00	02300	MEDICAL LABORATORY SCIENTIST PRGM			23.00
23.01	02302	PHARMACY PRGM	100		23.01
23.02	02301	EMERGENCY MEDICAL SERVICES		100	23.02
23.03	02303	PARAMEDIC PRGM		100	23.03
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	31.00
31.01	02060	NEONATAL INTENSIVE CARE UNIT	0	0	31.01
32.00	03200	CORONARY CARE UNIT	0	0	32.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	0	0	34.00
41.00	04100	SUBPROVIDER - IRF	0	0	41.00
43.00	04300	NURSERY	0	0	43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	55.00
56.00	05600	RADIOISOTOPE	0	0	56.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	59.00
60.00	06000	LABORATORY	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	100	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	74.00
76.97	07697	CARDIAC REHABILITATION	0	0	76.97
OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	0	0	90.00
90.01	09001	IBMT JOINT VENTURE	0	0	90.01
90.05	09005	CV DIAGNOSTIC SERVICES	0	0	90.05
91.00	09100	EMERGENCY	0	100	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART			92.00
OTHER REIMBURSABLE COST CENTERS					
101.00	10100	HOME HEALTH AGENCY	0	0	101.00
SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE			113.00
116.00	11600	HOSPICE	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	100	100	118.00
NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	192.00
194.00	07955	MARKETING & COMMUNITY RELATIONS	0	0	194.00
194.01	07952	WOMEN'S CENTER	0	0	194.01
194.02	07950	OTHER NONREIMBURSABLE COST CENTERS	0	0	194.02
194.04	07954	OTHER NRCC	0	0	194.04
194.05	07956	FOUNDATION	0	0	194.05
200.00		Cross Foot Adjustments			200.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 15-0162

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

Worksheet B-1
Date/Time Prepared:
3/30/2021 10:40 am

Cost Center Description		PHARMACY PRGM (ASSIGNED TIME)	EMERGENCY MEDICAL SERVICES (ASSIGNED TIME)	PARAMEDIC PRGM (ASSIGNED TIME)	
		23.01	23.02	23.03	
201.00	Negative Cost Centers				201.00
202.00	Cost to be allocated (per Wkst. B, Part I)	1,163,613	235,262	780,472	202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	11,636.130000	2,352.620000	7,804.720000	203.00
204.00	Cost to be allocated (per Wkst. B, Part II)	2,659	2,347	5,240	204.00
205.00	Unit cost multiplier (Wkst. B, Part II)	26.590000	23.470000	52.400000	205.00
206.00	NAHE adjustment amount to be allocated (per Wkst. B-2)	0	0	0	206.00
207.00	NAHE unit cost multiplier (Wkst. D, Parts III and IV)	0.000000	0.000000	0.000000	207.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 15-0162

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

Worksheet C
Part I
Date/Time Prepared:
3/30/2021 10:40 am

		Title XVIII		Hospital		PPS		
Cost Center Description		Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs		Total Costs		
				Total Costs	RCE Disallowance			
		1.00	2.00	3.00	4.00	5.00		
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	87,990,301		87,990,301	6,075	87,996,376	30.00
31.00	03100	INTENSIVE CARE UNIT	17,644,952		17,644,952	11,983	17,656,935	31.00
31.01	02060	NEONATAL INTENSIVE CARE UNIT	9,704,382		9,704,382	0	9,704,382	31.01
32.00	03200	CORONARY CARE UNIT	23,584,816		23,584,816	0	23,584,816	32.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	12,716,282		12,716,282	0	12,716,282	34.00
41.00	04100	SUBPROVIDER - IRF	8,237,029		8,237,029	0	8,237,029	41.00
43.00	04300	NURSERY	1,710,345		1,710,345	0	1,710,345	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	35,682,321		35,682,321	0	35,682,321	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	8,481,089		8,481,089	0	8,481,089	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	29,080,249		29,080,249	0	29,080,249	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	9,832,056		9,832,056	0	9,832,056	55.00
56.00	05600	RADIO SOTOPE	1,499,950		1,499,950	0	1,499,950	56.00
59.00	05900	CARDIAC CATHETERIZATION	7,061,378		7,061,378	0	7,061,378	59.00
60.00	06000	LABORATORY	35,527,785		35,527,785	32,008	35,559,793	60.00
64.00	06400	INTRAVENOUS THERAPY	5,627,859		5,627,859	0	5,627,859	64.00
65.00	06500	RESPIRATORY THERAPY	12,429,011	0	12,429,011	3,237	12,432,248	65.00
66.00	06600	PHYSICAL THERAPY	10,498,036	0	10,498,036	0	10,498,036	66.00
67.00	06700	OCCUPATIONAL THERAPY	3,619,035	0	3,619,035	0	3,619,035	67.00
68.00	06800	SPEECH PATHOLOGY	1,886,323	0	1,886,323	0	1,886,323	68.00
69.00	06900	ELECTROCARDIOLOGY	4,262,464		4,262,464	0	4,262,464	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	3,213,817		3,213,817	3,886	3,217,703	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	50,075,701		50,075,701	0	50,075,701	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	38,677,602		38,677,602	0	38,677,602	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	97,792,385		97,792,385	0	97,792,385	73.00
74.00	07400	RENAL DIALYSIS	1,747,644		1,747,644	0	1,747,644	74.00
76.97	07697	CARDIAC REHABILITATION	665,417		665,417	0	665,417	76.97
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	11,187,932		11,187,932	0	11,187,932	90.00
90.01	09001	IBMT JOINT VENTURE	9,921,120		9,921,120	63,857	9,984,977	90.01
90.05	09005	CV DIAGNOSTIC SERVICES	15,830,967		15,830,967	0	15,830,967	90.05
91.00	09100	EMERGENCY	20,867,670		20,867,670	2,513	20,870,183	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	13,648,096		13,648,096	0	13,648,096	92.00
OTHER REIMBURSABLE COST CENTERS								
101.00	10100	HOME HEALTH AGENCY	0		0	0	0	101.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	12,356,795		12,356,795		12,356,795	116.00
200.00		Subtotal (see instructions)	603,060,809	0	603,060,809	123,559	603,184,368	200.00
201.00		Less Observation Beds	13,648,096		13,648,096		13,648,096	201.00
202.00		Total (see instructions)	589,412,713	0	589,412,713	123,559	589,536,272	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES			Provider CCN: 15-0162		Period: From 01/01/2020 To 12/31/2020		Worksheet C Part I Date/Time Prepared: 3/30/2021 10:40 am	
			Title XVIII		Hospital		PPS	
Cost Center Description			Charges			Cost or Other Ratio	TEFRA Inpatient Ratio	
			Inpatient	Outpatient	Total (col. 6 + col. 7)			
			6.00	7.00	8.00	9.00	10.00	
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	146,396,820		146,396,820			30.00
31.00	03100	INTENSIVE CARE UNIT	34,959,936		34,959,936			31.00
31.01	02060	NEONATAL INTENSIVE CARE UNIT	29,689,793		29,689,793			31.01
32.00	03200	CORONARY CARE UNIT	33,477,904		33,477,904			32.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	26,244,402		26,244,402			34.00
41.00	04100	SUBPROVIDER - IRF	14,817,214		14,817,214			41.00
43.00	04300	NURSERY	6,456,336		6,456,336			43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	144,187,696	120,727,173	264,914,869	0.134694	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	44,083,876	175,801	44,259,677	0.191621	0.000000	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	85,242,123	210,584,607	295,826,730	0.098302	0.000000	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	2,968,046	78,311,374	81,279,420	0.120966	0.000000	55.00
56.00	05600	RADIOISOTOPE	1,960,555	5,283,067	7,243,622	0.207072	0.000000	56.00
59.00	05900	CARDIAC CATHETERIZATION	58,337,731	88,762,427	147,100,158	0.048004	0.000000	59.00
60.00	06000	LABORATORY	133,693,180	174,145,587	307,838,767	0.115410	0.000000	60.00
64.00	06400	INTRAVENOUS THERAPY	3,757,530	28,077,065	31,834,595	0.176784	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	50,953,990	9,232,503	60,186,493	0.206508	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	19,538,129	18,833,810	38,371,939	0.273586	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	14,258,454	7,007,767	21,266,221	0.170178	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	6,337,786	4,173,430	10,511,216	0.179458	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	24,859,377	12,007,373	36,866,750	0.115618	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	4,706,509	15,105,608	19,812,117	0.162215	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	153,335,853	49,640,570	202,976,423	0.246707	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	82,727,769	85,591,004	168,318,773	0.229788	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	170,802,832	336,785,123	507,587,955	0.192661	0.000000	73.00
74.00	07400	RENAL DIALYSIS	7,896,114	303,564	8,199,678	0.213136	0.000000	74.00
76.97	07697	CARDIAC REHABILITATION	189,051	1,358,162	1,547,213	0.430075	0.000000	76.97
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	662,591	12,816,400	13,478,991	0.830027	0.000000	90.00
90.01	09001	IBMT JOINT VENTURE	495,465	8,453,362	8,948,827	1.108650	0.000000	90.01
90.05	09005	CV DIAGNOSTIC SERVICES	309,254	67,832,766	68,142,020	0.232323	0.000000	90.05
91.00	09100	EMERGENCY	78,793,940	212,738,233	291,532,173	0.071579	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	7,121,148	43,726,599	50,847,747	0.268411	0.000000	92.00
OTHER REIMBURSABLE COST CENTERS								
101.00	10100	HOME HEALTH AGENCY	0	0	0			101.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	0	25,343,830	25,343,830			116.00
200.00		Subtotal (see instructions)	1,389,261,404	1,617,017,205	3,006,278,609			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	1,389,261,404	1,617,017,205	3,006,278,609			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 15-0162	Period: From 01/01/2020 To 12/31/2020	Worksheet C Part I Date/Time Prepared: 3/30/2021 10:40 am
		Title XVIII	Hospital	PPS

Cost Center Description		PPS Inpatient Ratio		
		11.00		
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000 ADULTS & PEDIATRICS			30.00
31.00	03100 INTENSIVE CARE UNIT			31.00
31.01	02060 NEONATAL INTENSIVE CARE UNIT			31.01
32.00	03200 CORONARY CARE UNIT			32.00
34.00	03400 SURGICAL INTENSIVE CARE UNIT			34.00
41.00	04100 SUBPROVIDER - IRF			41.00
43.00	04300 NURSERY			43.00
ANCILLARY SERVICE COST CENTERS				
50.00	05000 OPERATING ROOM	0.134694		50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.191621		52.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.098302		54.00
55.00	05500 RADIOLOGY-THERAPEUTIC	0.120966		55.00
56.00	05600 RADIO SOTOPE	0.207072		56.00
59.00	05900 CARDIAC CATHETERIZATION	0.048004		59.00
60.00	06000 LABORATORY	0.115514		60.00
64.00	06400 INTRAVENOUS THERAPY	0.176784		64.00
65.00	06500 RESPIRATORY THERAPY	0.206562		65.00
66.00	06600 PHYSICAL THERAPY	0.273586		66.00
67.00	06700 OCCUPATIONAL THERAPY	0.170178		67.00
68.00	06800 SPEECH PATHOLOGY	0.179458		68.00
69.00	06900 ELECTROCARDIOLOGY	0.115618		69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0.162411		70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.246707		71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.229788		72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.192661		73.00
74.00	07400 RENAL DIALYSIS	0.213136		74.00
76.97	07697 CARDIAC REHABILITATION	0.430075		76.97
OUTPATIENT SERVICE COST CENTERS				
90.00	09000 CLINIC	0.830027		90.00
90.01	09001 IBMT JOINT VENTURE	1.115786		90.01
90.05	09005 CV DIAGNOSTIC SERVICES	0.232323		90.05
91.00	09100 EMERGENCY	0.071588		91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0.268411		92.00
OTHER REIMBURSABLE COST CENTERS				
101.00	10100 HOME HEALTH AGENCY			101.00
SPECIAL PURPOSE COST CENTERS				
113.00	11300 INTEREST EXPENSE			113.00
116.00	11600 HOSPICE			116.00
200.00	Subtotal (see instructions)			200.00
201.00	Less Observation Beds			201.00
202.00	Total (see instructions)			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES			Provider CCN: 15-0162	Period: From 01/01/2020 To 12/31/2020	Worksheet C Part I Date/Time Prepared: 3/30/2021 10:40 am		
			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	87,990,301	87,990,301	6,075	87,996,376	30.00
31.00	03100	INTENSIVE CARE UNIT	17,644,952	17,644,952	11,983	17,656,935	31.00
31.01	02060	NEONATAL INTENSIVE CARE UNIT	9,704,382	9,704,382	0	9,704,382	31.01
32.00	03200	CORONARY CARE UNIT	23,584,816	23,584,816	0	23,584,816	32.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	12,716,282	12,716,282	0	12,716,282	34.00
41.00	04100	SUBPROVIDER - IRF	8,237,029	8,237,029	0	8,237,029	41.00
43.00	04300	NURSERY	1,710,345	1,710,345	0	1,710,345	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	35,682,321	35,682,321	0	35,682,321	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	8,481,089	8,481,089	0	8,481,089	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	29,080,249	29,080,249	0	29,080,249	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	9,832,056	9,832,056	0	9,832,056	55.00
56.00	05600	RADIO SOTOPE	1,499,950	1,499,950	0	1,499,950	56.00
59.00	05900	CARDIAC CATHETERIZATION	7,061,378	7,061,378	0	7,061,378	59.00
60.00	06000	LABORATORY	35,527,785	35,527,785	32,008	35,559,793	60.00
64.00	06400	INTRAVENOUS THERAPY	5,627,859	5,627,859	0	5,627,859	64.00
65.00	06500	RESPIRATORY THERAPY	12,429,011	12,429,011	3,237	12,432,248	65.00
66.00	06600	PHYSICAL THERAPY	10,498,036	10,498,036	0	10,498,036	66.00
67.00	06700	OCCUPATIONAL THERAPY	3,619,035	3,619,035	0	3,619,035	67.00
68.00	06800	SPEECH PATHOLOGY	1,886,323	1,886,323	0	1,886,323	68.00
69.00	06900	ELECTROCARDIOLOGY	4,262,464	4,262,464	0	4,262,464	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	3,213,817	3,213,817	3,886	3,217,703	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	50,075,701	50,075,701	0	50,075,701	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	38,677,602	38,677,602	0	38,677,602	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	97,792,385	97,792,385	0	97,792,385	73.00
74.00	07400	RENAL DIALYSIS	1,747,644	1,747,644	0	1,747,644	74.00
76.97	07697	CARDIAC REHABILITATION	665,417	665,417	0	665,417	76.97
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	11,187,932	11,187,932	0	11,187,932	90.00
90.01	09001	IBMT JOINT VENTURE	9,921,120	9,921,120	63,857	9,984,977	90.01
90.05	09005	CV DIAGNOSTIC SERVICES	15,830,967	15,830,967	0	15,830,967	90.05
91.00	09100	EMERGENCY	20,867,670	20,867,670	2,513	20,870,183	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	13,648,096	13,648,096	0	13,648,096	92.00
OTHER REIMBURSABLE COST CENTERS							
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
116.00	11600	HOSPICE	12,356,795	12,356,795		12,356,795	116.00
200.00		Subtotal (see instructions)	603,060,809	603,060,809	123,559	603,184,368	200.00
201.00		Less Observation Beds	13,648,096	13,648,096		13,648,096	201.00
202.00		Total (see instructions)	589,412,713	589,412,713	123,559	589,536,272	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES			Provider CCN: 15-0162		Period: From 01/01/2020 To 12/31/2020		Worksheet C Part I Date/Time Prepared: 3/30/2021 10:40 am	
			Title XIX		Hospital		PPS	
Cost Center Description	Charges			Cost or Other Ratio	TEFRA Inpatient Ratio			
	Inpatient	Outpatient	Total (col. 6 + col. 7)					
	6.00	7.00	8.00	9.00	10.00			
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	146,396,820		146,396,820		30.00	
31.00	03100	INTENSIVE CARE UNIT	34,959,936		34,959,936		31.00	
31.01	02060	NEONATAL INTENSIVE CARE UNIT	29,689,793		29,689,793		31.01	
32.00	03200	CORONARY CARE UNIT	33,477,904		33,477,904		32.00	
34.00	03400	SURGICAL INTENSIVE CARE UNIT	26,244,402		26,244,402		34.00	
41.00	04100	SUBPROVIDER - IRF	14,817,214		14,817,214		41.00	
43.00	04300	NURSERY	6,456,336		6,456,336		43.00	
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	144,187,696	120,727,173	264,914,869	0.134694	50.00	
52.00	05200	DELIVERY ROOM & LABOR ROOM	44,083,876	175,801	44,259,677	0.191621	52.00	
54.00	05400	RADIOLOGY-DIAGNOSTIC	85,242,123	210,584,607	295,826,730	0.098302	54.00	
55.00	05500	RADIOLOGY-THERAPEUTIC	2,968,046	78,311,374	81,279,420	0.120966	55.00	
56.00	05600	RADIOISOTOPE	1,960,555	5,283,067	7,243,622	0.207072	56.00	
59.00	05900	CARDIAC CATHETERIZATION	58,337,731	88,762,427	147,100,158	0.048004	59.00	
60.00	06000	LABORATORY	133,693,180	174,145,587	307,838,767	0.115410	60.00	
64.00	06400	INTRAVENOUS THERAPY	3,757,530	28,077,065	31,834,595	0.176784	64.00	
65.00	06500	RESPIRATORY THERAPY	50,953,990	9,232,503	60,186,493	0.206508	65.00	
66.00	06600	PHYSICAL THERAPY	19,538,129	18,833,810	38,371,939	0.273586	66.00	
67.00	06700	OCCUPATIONAL THERAPY	14,258,454	7,007,767	21,266,221	0.170178	67.00	
68.00	06800	SPEECH PATHOLOGY	6,337,786	4,173,430	10,511,216	0.179458	68.00	
69.00	06900	ELECTROCARDIOLOGY	24,859,377	12,007,373	36,866,750	0.115618	69.00	
70.00	07000	ELECTROENCEPHALOGRAPHY	4,706,509	15,105,608	19,812,117	0.162215	70.00	
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	153,335,853	49,640,570	202,976,423	0.246707	71.00	
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	82,727,769	85,591,004	168,318,773	0.229788	72.00	
73.00	07300	DRUGS CHARGED TO PATIENTS	170,802,832	336,785,123	507,587,955	0.192661	73.00	
74.00	07400	RENAL DIALYSIS	7,896,114	303,564	8,199,678	0.213136	74.00	
76.97	07697	CARDIAC REHABILITATION	189,051	1,358,162	1,547,213	0.430075	76.97	
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	662,591	12,816,400	13,478,991	0.830027	90.00	
90.01	09001	IBMT JOINT VENTURE	495,465	8,453,362	8,948,827	1.108650	90.01	
90.05	09005	CV DIAGNOSTIC SERVICES	309,254	67,832,766	68,142,020	0.232323	90.05	
91.00	09100	EMERGENCY	78,793,940	212,738,233	291,532,173	0.071579	91.00	
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	7,121,148	43,726,599	50,847,747	0.268411	92.00	
OTHER REIMBURSABLE COST CENTERS								
101.00	10100	HOME HEALTH AGENCY	0	0	0		101.00	
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE					113.00	
116.00	11600	HOSPICE	0	25,343,830	25,343,830		116.00	
200.00		Subtotal (see instructions)	1,389,261,404	1,617,017,205	3,006,278,609		200.00	
201.00		Less Observation Beds					201.00	
202.00		Total (see instructions)	1,389,261,404	1,617,017,205	3,006,278,609		202.00	

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 15-0162	Period: From 01/01/2020 To 12/31/2020	Worksheet C Part I Date/Time Prepared: 3/30/2021 10:40 am
		Title XIX	Hospital	PPS

Cost Center Description		PPS Inpatient Ratio		
		11.00		
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000 ADULTS & PEDIATRICS			30.00
31.00	03100 INTENSIVE CARE UNIT			31.00
31.01	02060 NEONATAL INTENSIVE CARE UNIT			31.01
32.00	03200 CORONARY CARE UNIT			32.00
34.00	03400 SURGICAL INTENSIVE CARE UNIT			34.00
41.00	04100 SUBPROVIDER - IRF			41.00
43.00	04300 NURSERY			43.00
ANCILLARY SERVICE COST CENTERS				
50.00	05000 OPERATING ROOM	0.134694		50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.191621		52.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.098302		54.00
55.00	05500 RADIOLOGY-THERAPEUTIC	0.120966		55.00
56.00	05600 RADIO SOTOP	0.207072		56.00
59.00	05900 CARDIAC CATHETERIZATION	0.048004		59.00
60.00	06000 LABORATORY	0.115514		60.00
64.00	06400 INTRAVENOUS THERAPY	0.176784		64.00
65.00	06500 RESPIRATORY THERAPY	0.206562		65.00
66.00	06600 PHYSICAL THERAPY	0.273586		66.00
67.00	06700 OCCUPATIONAL THERAPY	0.170178		67.00
68.00	06800 SPEECH PATHOLOGY	0.179458		68.00
69.00	06900 ELECTROCARDIOLOGY	0.115618		69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0.162411		70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.246707		71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.229788		72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.192661		73.00
74.00	07400 RENAL DIALYSIS	0.213136		74.00
76.97	07697 CARDIAC REHABILITATION	0.430075		76.97
OUTPATIENT SERVICE COST CENTERS				
90.00	09000 CLINIC	0.830027		90.00
90.01	09001 IBMT JOINT VENTURE	1.115786		90.01
90.05	09005 CV DIAGNOSTIC SERVICES	0.232323		90.05
91.00	09100 EMERGENCY	0.071588		91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0.268411		92.00
OTHER REIMBURSABLE COST CENTERS				
101.00	10100 HOME HEALTH AGENCY			101.00
SPECIAL PURPOSE COST CENTERS				
113.00	11300 INTEREST EXPENSE			113.00
116.00	11600 HOSPICE			116.00
200.00	Subtotal (see instructions)			200.00
201.00	Less Observation Beds			201.00
202.00	Total (see instructions)			202.00

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

Provider CCN: 15-0162

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

Worksheet C
Part II
Date/Time Prepared:
3/30/2021 10:40 am

Cost Center Description		Title XIX			Hospital		PPS	
		Total Cost (Wkst. B, Part I, col. 26)	Capital Cost (Wkst. B, Part II col. 26)	Operating Cost Net of Capital Cost (col. 1 - col. 2)	Capital Reduction	Operating Cost Reduction Amount		
		1.00	2.00	3.00	4.00	5.00		
ANCILLARY SERVICE COST CENTERS								
50.00	05000 OPERATING ROOM	35,682,321	6,183,085	29,499,236	0	0	0	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	8,481,089	1,658,701	6,822,388	0	0	0	52.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	29,080,249	3,986,123	25,094,126	0	0	0	54.00
55.00	05500 RADIOLOGY-THERAPEUTIC	9,832,056	281,467	9,550,589	0	0	0	55.00
56.00	05600 RADIOISOTOPE	1,499,950	75,179	1,424,771	0	0	0	56.00
59.00	05900 CARDIAC CATHETERIZATION	7,061,378	1,539,955	5,521,423	0	0	0	59.00
60.00	06000 LABORATORY	35,527,785	1,634,404	33,893,381	0	0	0	60.00
64.00	06400 INTRAVENOUS THERAPY	5,627,859	602,096	5,025,763	0	0	0	64.00
65.00	06500 RESPIRATORY THERAPY	12,429,011	565,204	11,863,807	0	0	0	65.00
66.00	06600 PHYSICAL THERAPY	10,498,036	716,119	9,781,917	0	0	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	3,619,035	12,746	3,606,289	0	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	1,886,323	127,134	1,759,189	0	0	0	68.00
69.00	06900 ELECTROCARDIOLOGY	4,262,464	869,997	3,392,467	0	0	0	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	3,213,817	10,097	3,203,720	0	0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	50,075,701	1,047,795	49,027,906	0	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	38,677,602	804,218	37,873,384	0	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	97,792,385	805,647	96,986,738	0	0	0	73.00
74.00	07400 RENAL DIALYSIS	1,747,644	252,309	1,495,335	0	0	0	74.00
76.97	07697 CARDIAC REHABILITATION	665,417	2,326	663,091	0	0	0	76.97
OUTPATIENT SERVICE COST CENTERS								
90.00	09000 CLINIC	11,187,932	1,199,286	9,988,646	0	0	0	90.00
90.01	09001 IBMT JOINT VENTURE	9,921,120	159,980	9,761,140	0	0	0	90.01
90.05	09005 CV DIAGNOSTIC SERVICES	15,830,967	59,855	15,771,112	0	0	0	90.05
91.00	09100 EMERGENCY	20,867,670	3,117,540	17,750,130	0	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	13,648,096	1,909,068	11,739,028	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS								
101.00	10100 HOME HEALTH AGENCY	0	0	0	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300 INTEREST EXPENSE							113.00
116.00	11600 HOSPICE	12,356,795	34,742	12,322,053	0	0	0	116.00
200.00	Subtotal (sum of lines 50 thru 199)	441,472,702	27,655,073	413,817,629	0	0	0	200.00
201.00	Less Observation Beds	13,648,096	1,909,068	11,739,028	0	0	0	201.00
202.00	Total (line 200 minus line 201)	427,824,606	25,746,005	402,078,601	0	0	0	202.00

CALCULATION OF OUTPATIENT SERVICE COST TO CHARGE RATIOS NET OF REDUCTIONS FOR MEDICAID ONLY		Provider CCN: 15-0162	Period: From 01/01/2020 To 12/31/2020	Worksheet C Part II Date/Time Prepared: 3/30/2021 10:40 am
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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)	Hospital	PPS
		6.00	7.00	8.00		
ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	35,682,321	264,914,869	0.134694		50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	8,481,089	44,259,677	0.191621		52.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	29,080,249	295,826,730	0.098302		54.00
55.00	05500 RADIOLOGY-THERAPEUTIC	9,832,056	81,279,420	0.120966		55.00
56.00	05600 RADIOISOTOPE	1,499,950	7,243,622	0.207072		56.00
59.00	05900 CARDIAC CATHETERIZATION	7,061,378	147,100,158	0.048004		59.00
60.00	06000 LABORATORY	35,527,785	307,838,767	0.115410		60.00
64.00	06400 INTRAVENOUS THERAPY	5,627,859	31,834,595	0.176784		64.00
65.00	06500 RESPIRATORY THERAPY	12,429,011	60,186,493	0.206508		65.00
66.00	06600 PHYSICAL THERAPY	10,498,036	38,371,939	0.273586		66.00
67.00	06700 OCCUPATIONAL THERAPY	3,619,035	21,266,221	0.170178		67.00
68.00	06800 SPEECH PATHOLOGY	1,886,323	10,511,216	0.179458		68.00
69.00	06900 ELECTROCARDIOLOGY	4,262,464	36,866,750	0.115618		69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	3,213,817	19,812,117	0.162215		70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	50,075,701	202,976,423	0.246707		71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	38,677,602	168,318,773	0.229788		72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	97,792,385	507,587,955	0.192661		73.00
74.00	07400 RENAL DIALYSIS	1,747,644	8,199,678	0.213136		74.00
76.97	07697 CARDIAC REHABILITATION	665,417	1,547,213	0.430075		76.97
OUTPATIENT SERVICE COST CENTERS						
90.00	09000 CLINIC	11,187,932	13,478,991	0.830027		90.00
90.01	09001 IBMT JOINT VENTURE	9,921,120	8,948,827	1.108650		90.01
90.05	09005 CV DIAGNOSTIC SERVICES	15,830,967	68,142,020	0.232323		90.05
91.00	09100 EMERGENCY	20,867,670	291,532,173	0.071579		91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	13,648,096	50,847,747	0.268411		92.00
OTHER REIMBURSABLE COST CENTERS						
101.00	10100 HOME HEALTH AGENCY	0	0	0.000000		101.00
SPECIAL PURPOSE COST CENTERS						
113.00	11300 INTEREST EXPENSE					113.00
116.00	11600 HOSPICE	12,356,795	25,343,830	0.487566		116.00
200.00	Subtotal (sum of lines 50 thru 199)	441,472,702	2,714,236,204			200.00
201.00	Less Observation Beds	13,648,096	0			201.00
202.00	Total (line 200 minus line 201)	427,824,606	2,714,236,204			202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS		Provider CCN: 15-0162	Period: From 01/01/2020 To 12/31/2020	Worksheet D Part I Date/Time Prepared: 3/30/2021 10:40 am
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Cost Center Description		Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)	
		1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	ADULTS & PEDIATRICS	12,308,780	0	12,308,780	61,574	199.90	30.00
31.00	INTENSIVE CARE UNIT	1,499,666		1,499,666	20,500	73.15	31.00
31.01	NEONATAL INTENSIVE CARE UNIT	947,022		947,022	6,322	149.80	31.01
32.00	CORONARY CARE UNIT	3,010,041		3,010,041	12,691	237.18	32.00
34.00	SURGICAL INTENSIVE CARE UNIT	1,710,521		1,710,521	8,247	207.41	34.00
41.00	SUBPROVIDER - IRF	1,123,305	0	1,123,305	5,552	202.32	41.00
43.00	NURSERY	250,659		250,659	3,738	67.06	43.00
200.00	Total (lines 30 through 199)	20,849,994		20,849,994	118,624		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	22,236	4,444,976				
31.00	INTENSIVE CARE UNIT	3,568	260,999				
31.01	NEONATAL INTENSIVE CARE UNIT	0	0				
32.00	CORONARY CARE UNIT	5,353	1,269,625				
34.00	SURGICAL INTENSIVE CARE UNIT	3,146	652,512				
41.00	SUBPROVIDER - IRF	2,539	513,690				
43.00	NURSERY	0	0				
200.00	Total (lines 30 through 199)	36,842	7,141,802				

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS		Provider CCN: 15-0162	Period: From 01/01/2020 To 12/31/2020	Worksheet D Part II Date/Time Prepared: 3/30/2021 10:40 am
Title XVIII			Hospital	PPS

Cost Center Description		Capital Related Cost (from Wkst. C, 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	6,183,085	264,914,869	0.023340	43,621,216	1,018,119	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	1,658,701	44,259,677	0.037477	126,200	4,730	52.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	3,986,123	295,826,730	0.013475	30,083,379	405,374	54.00
55.00	05500 RADIOLOGY-THERAPEUTIC	281,467	81,279,420	0.003463	0	0	55.00
56.00	05600 RADIOISOTOPE	75,179	7,243,622	0.010379	803,469	8,339	56.00
59.00	05900 CARDIAC CATHETERIZATION	1,539,955	147,100,158	0.010469	17,303,066	181,146	59.00
60.00	06000 LABORATORY	1,634,404	307,838,767	0.005309	40,240,264	213,636	60.00
64.00	06400 INTRAVENOUS THERAPY	602,096	31,834,595	0.018913	1,142,351	21,605	64.00
65.00	06500 RESPIRATORY THERAPY	565,204	60,186,493	0.009391	13,769,203	129,307	65.00
66.00	06600 PHYSICAL THERAPY	716,119	38,371,939	0.018663	5,651,407	105,472	66.00
67.00	06700 OCCUPATIONAL THERAPY	12,746	21,266,221	0.000599	3,820,792	2,289	67.00
68.00	06800 SPEECH PATHOLOGY	127,134	10,511,216	0.012095	1,278,921	15,469	68.00
69.00	06900 ELECTROCARDIOLOGY	869,997	36,866,750	0.023598	8,249,959	194,683	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	10,097	19,812,117	0.000510	1,297,519	662	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	1,047,795	202,976,423	0.005162	44,803,258	231,274	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	804,218	168,318,773	0.004778	33,231,644	158,781	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	805,647	507,587,955	0.001587	43,732,002	69,403	73.00
74.00	07400 RENAL DIALYSIS	252,309	8,199,678	0.030771	3,159,086	97,208	74.00
76.97	07697 CARDIAC REHABILITATION	2,326	1,547,213	0.001503	52,166	78	76.97
OUTPATIENT SERVICE COST CENTERS							
90.00	09000 CLINIC	1,199,286	13,478,991	0.088974	90,847	8,083	90.00
90.01	09001 IBMT JOINT VENTURE	159,980	8,948,827	0.017877	13,115	234	90.01
90.05	09005 CV DIAGNOSTIC SERVICES	59,855	68,142,020	0.000878	50,428	44	90.05
91.00	09100 EMERGENCY	3,117,540	291,532,173	0.010694	27,893,183	298,290	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	1,909,068	50,847,747	0.037545	2,768,958	103,961	92.00
200.00	Total (lines 50 through 199)	27,620,331	2,688,892,374		323,182,433	3,268,187	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS		Provider CCN: 15-0162	Period: From 01/01/2020 To 12/31/2020	Worksheet D Part III Date/Time Prepared: 3/30/2021 10:40 am
Title XVIII			Hospital	PPS

Cost Center Description		Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health Cost	All Other Medical Education Cost	
		1A	1.00	2A	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	31.00
31.01	02060	NEONATAL INTENSIVE CARE UNIT	0	0	0	0	31.01
32.00	03200	CORONARY CARE UNIT	0	0	0	0	32.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	0	0	0	0	34.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	41.00
43.00	04300	NURSERY	0	0	0	0	43.00
200.00		Total (lines 30 through 199)	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	61,574	0.00	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	20,500	0.00	31.00
31.01	02060	NEONATAL INTENSIVE CARE UNIT	0	0	6,322	0.00	31.01
32.00	03200	CORONARY CARE UNIT	0	0	12,691	0.00	32.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	0	0	8,247	0.00	34.00
41.00	04100	SUBPROVIDER - IRF	0	0	5,552	0.00	41.00
43.00	04300	NURSERY	0	0	3,738	0.00	43.00
200.00		Total (lines 30 through 199)	0	0	118,624		200.00
Cost Center Description		Inpatient Program Pass-Through Cost (col. 7 x col. 8)					
		9.00					
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	0				30.00
31.00	03100	INTENSIVE CARE UNIT	0				31.00
31.01	02060	NEONATAL INTENSIVE CARE UNIT	0				31.01
32.00	03200	CORONARY CARE UNIT	0				32.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	0				34.00
41.00	04100	SUBPROVIDER - IRF	0				41.00
43.00	04300	NURSERY	0				43.00
200.00		Total (lines 30 through 199)	0				200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 15-0162	Period: From 01/01/2020 To 12/31/2020	Worksheet D Part IV Date/Time Prepared: 3/30/2021 10:40 am
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Cost Center Description	Title XVIII			Hospital		Allied Health Post-Stepdown Adjustments	Allied Health PPS	
	Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School					
	1.00	2A	2.00	3A	3.00			
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	0	55.00
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0	0	0	0	141,024	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	1,944,085	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	IBMT JOINT VENTURE	0	0	0	0	0	90.01
90.05	09005	CV DIAGNOSTIC SERVICES	0	0	0	0	0	90.05
91.00	09100	EMERGENCY	0	0	0	0	235,262	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	0	92.00
200.00		Total (lines 50 through 199)	0	0	0	0	2,320,371	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 15-0162	Period: From 01/01/2020 To 12/31/2020	Worksheet D Part IV Date/Time Prepared: 3/30/2021 10:40 am
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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
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	0	0	0	264,914,869	0.000000	50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0	0	44,259,677	0.000000	52.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	0	0	0	295,826,730	0.000000	54.00
55.00 05500 RADIOLOGY-THERAPEUTIC	0	0	0	81,279,420	0.000000	55.00
56.00 05600 RADIOISOTOPE	0	0	0	7,243,622	0.000000	56.00
59.00 05900 CARDIAC CATHETERIZATION	0	0	0	147,100,158	0.000000	59.00
60.00 06000 LABORATORY	0	141,024	141,024	307,838,767	0.000458	60.00
64.00 06400 INTRAVENOUS THERAPY	0	0	0	31,834,595	0.000000	64.00
65.00 06500 RESPIRATORY THERAPY	0	0	0	60,186,493	0.000000	65.00
66.00 06600 PHYSICAL THERAPY	0	0	0	38,371,939	0.000000	66.00
67.00 06700 OCCUPATIONAL THERAPY	0	0	0	21,266,221	0.000000	67.00
68.00 06800 SPEECH PATHOLOGY	0	0	0	10,511,216	0.000000	68.00
69.00 06900 ELECTROCARDIOLOGY	0	0	0	36,866,750	0.000000	69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	0	0	0	19,812,117	0.000000	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	202,976,423	0.000000	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	168,318,773	0.000000	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	1,944,085	1,944,085	507,587,955	0.003830	73.00
74.00 07400 RENAL DIALYSIS	0	0	0	8,199,678	0.000000	74.00
76.97 07697 CARDIAC REHABILITATION	0	0	0	1,547,213	0.000000	76.97
OUTPATIENT SERVICE COST CENTERS						
90.00 09000 CLINIC	0	0	0	13,478,991	0.000000	90.00
90.01 09001 IBMT JOINT VENTURE	0	0	0	8,948,827	0.000000	90.01
90.05 09005 CV DIAGNOSTIC SERVICES	0	0	0	68,142,020	0.000000	90.05
91.00 09100 EMERGENCY	0	235,262	235,262	291,532,173	0.000807	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	50,847,747	0.000000	92.00
200.00 Total (lines 50 through 199)	0	2,320,371	2,320,371	2,688,892,374		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 15-0162	Period: From 01/01/2020 To 12/31/2020	Worksheet D Part IV Date/Time Prepared: 3/30/2021 10:40 am
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Cost Center Description	Title XVIII				Hospital		PPS
	Outpatient Ratio of Cost to Charges (col. 6 + col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges before Geographical Reclassification	Outpatient Program Charges on/after Geographical Reclassification		
	9.00	10.00	11.00	12.00	12.01		
ANCILLARY SERVICE COST CENTERS							
50.00 05000 OPERATING ROOM	0.000000	43,621,216	0	23,642,661	0	50.00	
52.00 05200 DELIVERY ROOM & LABOR ROOM	0.000000	126,200	0	0	0	52.00	
54.00 05400 RADIOLOGY-DIAGNOSTIC	0.000000	30,083,379	0	64,957,682	0	54.00	
55.00 05500 RADIOLOGY-THERAPEUTIC	0.000000	0	0	198,489	0	55.00	
56.00 05600 RADIOISOTOPE	0.000000	803,469	0	1,093,642	0	56.00	
59.00 05900 CARDIAC CATHETERIZATION	0.000000	17,303,066	0	26,804,662	0	59.00	
60.00 06000 LABORATORY	0.000458	40,240,264	18,430	7,478,398	0	60.00	
64.00 06400 INTRAVENOUS THERAPY	0.000000	1,142,351	0	9,839,348	0	64.00	
65.00 06500 RESPIRATORY THERAPY	0.000000	13,769,203	0	1,903,275	0	65.00	
66.00 06600 PHYSICAL THERAPY	0.000000	5,651,407	0	157,974	0	66.00	
67.00 06700 OCCUPATIONAL THERAPY	0.000000	3,820,792	0	18,403	0	67.00	
68.00 06800 SPEECH PATHOLOGY	0.000000	1,278,921	0	24,147	0	68.00	
69.00 06900 ELECTROCARDIOLOGY	0.000000	8,249,959	0	1,943,512	0	69.00	
70.00 07000 ELECTROENCEPHALOGRAPHY	0.000000	1,297,519	0	1,188,389	0	70.00	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	44,803,258	0	21,436,492	0	71.00	
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0.000000	33,231,644	0	12,936,539	0	72.00	
73.00 07300 DRUGS CHARGED TO PATIENTS	0.003830	43,732,002	167,494	102,465,482	0	73.00	
74.00 07400 RENAL DIALYSIS	0.000000	3,159,086	0	162,075	0	74.00	
76.97 07697 CARDIAC REHABILITATION	0.000000	52,166	0	359,708	0	76.97	
OUTPATIENT SERVICE COST CENTERS							
90.00 09000 CLINIC	0.000000	90,847	0	2,696,523	0	90.00	
90.01 09001 IBMT JOINT VENTURE	0.000000	13,115	0	694,994	0	90.01	
90.05 09005 CV DIAGNOSTIC SERVICES	0.000000	50,428	0	20,082,779	0	90.05	
91.00 09100 EMERGENCY	0.000807	27,893,183	22,510	33,114,823	0	91.00	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0.000000	2,768,958	0	1,617,017	0	92.00	
200.00 Total (lines 50 through 199)		323,182,433	208,434	334,817,014	0	200.00	

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 15-0162	Period: From 01/01/2020 To 12/31/2020	Worksheet D Part IV Date/Time Prepared: 3/30/2021 10:40 am
	Title XVIII		Hospital
			PPS

Cost Center Description			Outpatient Program Pass-Through Costs (col. 9 x col. 12) before Recl assi fi cat ion	Outpatient Program Pass-Through Costs (col. 9 x col. 12) on/after Geo Recl assi fi cat ion	
			13.00	13.01	
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	55.00
56.00	05600	RADIOISOTOPE	0	0	56.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	59.00
60.00	06000	LABORATORY	3,425	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	392,443	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	74.00
76.97	07697	CARDIAC REHABILITATION	0	0	76.97
OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	0	0	90.00
90.01	09001	IBMT JOINT VENTURE	0	0	90.01
90.05	09005	CV DIAGNOSTIC SERVICES	0	0	90.05
91.00	09100	EMERGENCY	26,724	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	92.00
200.00		Total (lines 50 through 199)	422,592	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 15-0162	Period: From 01/01/2020 To 12/31/2020	Worksheet D Part V Date/Time Prepared: 3/30/2021 10:40 am
	Title XVIII	Hospital	PPS

Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges			Costs	
		PPS Reimbursed Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	PPS Services (see inst.)	
	1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	0.134694	23,642,661	5,922	0	3,184,525	50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0.191621	0	0	0	0	52.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	0.098302	64,957,682	0	0	6,385,470	54.00
55.00 05500 RADIOLOGY-THERAPEUTIC	0.120966	198,489	0	0	24,010	55.00
56.00 05600 RADIOISOTOPE	0.207072	1,093,642	0	0	226,463	56.00
59.00 05900 CARDIAC CATHETERIZATION	0.048004	26,804,662	0	0	1,286,731	59.00
60.00 06000 LABORATORY	0.115410	7,478,398	0	0	863,082	60.00
64.00 06400 INTRAVENOUS THERAPY	0.176784	9,839,348	0	0	1,739,439	64.00
65.00 06500 RESPIRATORY THERAPY	0.206508	1,903,275	0	0	393,042	65.00
66.00 06600 PHYSICAL THERAPY	0.273586	157,974	0	0	43,219	66.00
67.00 06700 OCCUPATIONAL THERAPY	0.170178	18,403	0	0	3,132	67.00
68.00 06800 SPEECH PATHOLOGY	0.179458	24,147	0	0	4,333	68.00
69.00 06900 ELECTROCARDIOLOGY	0.115618	1,943,512	0	0	224,705	69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	0.162215	1,188,389	0	0	192,775	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.246707	21,436,492	2,000	0	5,288,533	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0.229788	12,936,539	0	0	2,972,661	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0.192661	102,465,482	72,346	0	19,741,102	73.00
74.00 07400 RENAL DIALYSIS	0.213136	162,075	0	0	34,544	74.00
76.97 07697 CARDIAC REHABILITATION	0.430075	359,708	0	0	154,701	76.97
OUTPATIENT SERVICE COST CENTERS						
90.00 09000 CLINIC	0.830027	2,696,523	0	0	2,238,187	90.00
90.01 09001 IBMT JOINT VENTURE	1.108650	694,994	0	0	770,505	90.01
90.05 09005 CV DIAGNOSTIC SERVICES	0.232323	20,082,779	0	0	4,665,691	90.05
91.00 09100 EMERGENCY	0.071579	33,114,823	13,518	0	2,370,326	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0.268411	1,617,017	0	0	434,025	92.00
200.00 Subtotal (see instructions)		334,817,014	93,786	0	53,241,201	200.00
201.00 Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00 Net Charges (line 200 - line 201)		334,817,014	93,786	0	53,241,201	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 15-0162	Period: From 01/01/2020 To 12/31/2020	Worksheet D Part V Date/Time Prepared: 3/30/2021 10:40 am
	Title XVIII	Hospital	PPS

Cost Center Description	Costs			
	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
	6.00	7.00		
ANCILLARY SERVICE COST CENTERS				
50.00 05000 OPERATING ROOM	798	0		50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0		52.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	0	0		54.00
55.00 05500 RADIOLOGY-THERAPEUTIC	0	0		55.00
56.00 05600 RADIOISOTOPE	0	0		56.00
59.00 05900 CARDIAC CATHETERIZATION	0	0		59.00
60.00 06000 LABORATORY	0	0		60.00
64.00 06400 INTRAVENOUS THERAPY	0	0		64.00
65.00 06500 RESPIRATORY THERAPY	0	0		65.00
66.00 06600 PHYSICAL THERAPY	0	0		66.00
67.00 06700 OCCUPATIONAL THERAPY	0	0		67.00
68.00 06800 SPEECH PATHOLOGY	0	0		68.00
69.00 06900 ELECTROCARDIOLOGY	0	0		69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	0	0		70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	493	0		71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0		72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	13,938	0		73.00
74.00 07400 RENAL DIALYSIS	0	0		74.00
76.97 07697 CARDIAC REHABILITATION	0	0		76.97
OUTPATIENT SERVICE COST CENTERS				
90.00 09000 CLINIC	0	0		90.00
90.01 09001 IBMT JOINT VENTURE	0	0		90.01
90.05 09005 CV DIAGNOSTIC SERVICES	0	0		90.05
91.00 09100 EMERGENCY	968	0		91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0		92.00
200.00 Subtotal (see instructions)	16,197	0		200.00
201.00 Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00 Net Charges (line 200 - line 201)	16,197	0		202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS			Provider CCN: 15-0162 Component CCN: 15-T162		Period: From 01/01/2020 To 12/31/2020		Worksheet D Part II Date/Time Prepared: 3/30/2021 10:40 am	
			Title XVIII		Subprovider - IRF		PPS	
Cost Center Description			Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 + col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	6,183,085	264,914,869	0.023340	29,550	690	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,658,701	44,259,677	0.037477	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,986,123	295,826,730	0.013475	340,798	4,592	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	281,467	81,279,420	0.003463	0	0	55.00
56.00	05600	RADIOISOTOPE	75,179	7,243,622	0.010379	3,657	38	56.00
59.00	05900	CARDIAC CATHETERIZATION	1,539,955	147,100,158	0.010469	0	0	59.00
60.00	06000	LABORATORY	1,634,404	307,838,767	0.005309	659,963	3,504	60.00
64.00	06400	INTRAVENOUS THERAPY	602,096	31,834,595	0.018913	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	565,204	60,186,493	0.009391	402,339	3,778	65.00
66.00	06600	PHYSICAL THERAPY	716,119	38,371,939	0.018663	1,546,066	28,854	66.00
67.00	06700	OCCUPATIONAL THERAPY	12,746	21,266,221	0.000599	1,400,444	839	67.00
68.00	06800	SPEECH PATHOLOGY	127,134	10,511,216	0.012095	694,918	8,405	68.00
69.00	06900	ELECTROCARDIOLOGY	869,997	36,866,750	0.023598	23,769	561	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	10,097	19,812,117	0.000510	28,159	14	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1,047,795	202,976,423	0.005162	833,430	4,302	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	804,218	168,318,773	0.004778	863	4	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	805,647	507,587,955	0.001587	539,652	856	73.00
74.00	07400	RENAL DIALYSIS	252,309	8,199,678	0.030771	105,290	3,240	74.00
76.97	07697	CARDIAC REHABILITATION	2,326	1,547,213	0.001503	0	0	76.97
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	1,199,286	13,478,991	0.088974	0	0	90.00
90.01	09001	IBMT JOINT VENTURE	159,980	8,948,827	0.017877	0	0	90.01
90.05	09005	CV DIAGNOSTIC SERVICES	59,855	68,142,020	0.000878	0	0	90.05
91.00	09100	EMERGENCY	3,117,540	291,532,173	0.010694	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	50,847,747	0.000000	0	0	92.00
200.00		Total (lines 50 through 199)	25,711,263	2,688,892,374		6,608,898	59,677	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 15-0162 Component CCN: 15-T162	Period: From 01/01/2020 To 12/31/2020	Worksheet D Part IV Date/Time Prepared: 3/30/2021 10:40 am
Title XVIII		Subprovider - IRF	PPS

Cost Center Description			Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health	
			1.00	2A	2.00	3A	3.00	
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	0	55.00
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0	0	0	0	141,024	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	1,944,085	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	IBMT JOINT VENTURE	0	0	0	0	0	90.01
90.05	09005	CV DIAGNOSTIC SERVICES	0	0	0	0	0	90.05
91.00	09100	EMERGENCY	0	0	0	0	235,262	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	0	92.00
200.00		Total (lines 50 through 199)	0	0	0	0	2,320,371	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 15-0162 Component CCN: 15-T162	Period: From 01/01/2020 To 12/31/2020	Worksheet D Part IV Date/Time Prepared: 3/30/2021 10:40 am
Title XVIII		Subprovider - IRF	PPS

Cost Center Description		All Other Medical Education Cost	Total Cost (sum of col s. 1, 2, 3, and 4)	Total Outpatient Cost (sum of col s. 2, 3, and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7) (see instructions)	
		4.00	5.00	6.00	7.00	8.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	0	0	0	264,914,869	0.000000	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	0	44,259,677	0.000000	52.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	0	0	295,826,730	0.000000	54.00
55.00	05500 RADIOLOGY-THERAPEUTIC	0	0	0	81,279,420	0.000000	55.00
56.00	05600 RADIOISOTOPE	0	0	0	7,243,622	0.000000	56.00
59.00	05900 CARDIAC CATHETERIZATION	0	0	0	147,100,158	0.000000	59.00
60.00	06000 LABORATORY	0	141,024	141,024	307,838,767	0.000458	60.00
64.00	06400 INTRAVENOUS THERAPY	0	0	0	31,834,595	0.000000	64.00
65.00	06500 RESPIRATORY THERAPY	0	0	0	60,186,493	0.000000	65.00
66.00	06600 PHYSICAL THERAPY	0	0	0	38,371,939	0.000000	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	0	0	21,266,221	0.000000	67.00
68.00	06800 SPEECH PATHOLOGY	0	0	0	10,511,216	0.000000	68.00
69.00	06900 ELECTROCARDIOLOGY	0	0	0	36,866,750	0.000000	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0	0	19,812,117	0.000000	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	202,976,423	0.000000	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	168,318,773	0.000000	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	1,944,085	1,944,085	507,587,955	0.003830	73.00
74.00	07400 RENAL DIALYSIS	0	0	0	8,199,678	0.000000	74.00
76.97	07697 CARDIAC REHABILITATION	0	0	0	1,547,213	0.000000	76.97
OUTPATIENT SERVICE COST CENTERS							
90.00	09000 CLINIC	0	0	0	13,478,991	0.000000	90.00
90.01	09001 IBMT JOINT VENTURE	0	0	0	8,948,827	0.000000	90.01
90.05	09005 CV DIAGNOSTIC SERVICES	0	0	0	68,142,020	0.000000	90.05
91.00	09100 EMERGENCY	0	235,262	235,262	291,532,173	0.000807	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	50,847,747	0.000000	92.00
200.00	Total (lines 50 through 199)	0	2,320,371	2,320,371	2,688,892,374		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 15-0162 Component CCN: 15-T162	Period: From 01/01/2020 To 12/31/2020	Worksheet D Part IV Date/Time Prepared: 3/30/2021 10:40 am
Title XVIII		Subprovider - IRF	PPS

Cost Center Description			Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges before Geographical Reclassification	Outpatient Program Charges on/after Geographical Reclassification	
			9.00	10.00	11.00	12.00	12.01	
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0.000000	29,550	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	340,798	0	0	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.000000	0	0	0	0	55.00
56.00	05600	RADIOISOTOPE	0.000000	3,657	0	0	0	56.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	0	0	0	0	59.00
60.00	06000	LABORATORY	0.000458	659,963	302	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0.000000	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.000000	402,339	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	1,546,066	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	1,400,444	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	694,918	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	23,769	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	28,159	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	833,430	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	863	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.003830	539,652	2,067	0	0	73.00
74.00	07400	RENAL DIALYSIS	0.000000	105,290	0	0	0	74.00
76.97	07697	CARDIAC REHABILITATION	0.000000	0	0	0	0	76.97
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0.000000	0	0	0	0	90.00
90.01	09001	IBMT JOINT VENTURE	0.000000	0	0	0	0	90.01
90.05	09005	CV DIAGNOSTIC SERVICES	0.000000	0	0	0	0	90.05
91.00	09100	EMERGENCY	0.000807	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)		6,608,898	2,369	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 15-0162 Component CCN: 15-T162	Period: From 01/01/2020 To 12/31/2020	Worksheet D Part IV Date/Time Prepared: 3/30/2021 10:40 am
Title XVIII		Subprovider - IRF	PPS

Cost Center Description		Outpatient Program Pass-Through Costs (col. 9 x col. 12) before Geographical Reclassification	Outpatient Program Pass-Through Costs (col. 9 x col. 12) on/after Geographical Reclassification	
		13.00	13.01	
ANCILLARY SERVICE COST CENTERS				
50.00	05000 OPERATING ROOM	0	0	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	52.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	0	54.00
55.00	05500 RADIOLOGY-THERAPEUTIC	0	0	55.00
56.00	05600 RADIOISOTOPE	0	0	56.00
59.00	05900 CARDIAC CATHETERIZATION	0	0	59.00
60.00	06000 LABORATORY	0	0	60.00
64.00	06400 INTRAVENOUS THERAPY	0	0	64.00
65.00	06500 RESPIRATORY THERAPY	0	0	65.00
66.00	06600 PHYSICAL THERAPY	0	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0	0	68.00
69.00	06900 ELECTROCARDIOLOGY	0	0	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	73.00
74.00	07400 RENAL DIALYSIS	0	0	74.00
76.97	07697 CARDIAC REHABILITATION	0	0	76.97
OUTPATIENT SERVICE COST CENTERS				
90.00	09000 CLINIC	0	0	90.00
90.01	09001 IBMT JOINT VENTURE	0	0	90.01
90.05	09005 CV DIAGNOSTIC SERVICES	0	0	90.05
91.00	09100 EMERGENCY	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0	92.00
200.00	Total (lines 50 through 199)	0	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 15-0162 Component CCN: 15-T162	Period: From 01/01/2020 To 12/31/2020	Worksheet D Part V Date/Time Prepared: 3/30/2021 10:40 am
	Title XVIII	Subprovider - IRF	PPS

Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges			Costs	PPS Services (see inst.)
		PPS Reimbursed Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	PPS Services (see inst.)	
		1.00	2.00	3.00	4.00	
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	0.134694	0	0	0	0	50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0.191621	0	0	0	0	52.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	0.098302	0	0	0	0	54.00
55.00 05500 RADIOLOGY-THERAPEUTIC	0.120966	0	0	0	0	55.00
56.00 05600 RADIOISOTOPE	0.207072	0	0	0	0	56.00
59.00 05900 CARDIAC CATHETERIZATION	0.048004	0	0	0	0	59.00
60.00 06000 LABORATORY	0.115410	0	0	0	0	60.00
64.00 06400 INTRAVENOUS THERAPY	0.176784	0	0	0	0	64.00
65.00 06500 RESPIRATORY THERAPY	0.206508	0	0	0	0	65.00
66.00 06600 PHYSICAL THERAPY	0.273586	0	0	0	0	66.00
67.00 06700 OCCUPATIONAL THERAPY	0.170178	0	0	0	0	67.00
68.00 06800 SPEECH PATHOLOGY	0.179458	0	0	0	0	68.00
69.00 06900 ELECTROCARDIOLOGY	0.115618	0	0	0	0	69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	0.162215	0	0	0	0	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.246707	0	0	0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0.229788	0	0	0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0.192661	0	0	680	0	73.00
74.00 07400 RENAL DIALYSIS	0.213136	0	0	0	0	74.00
76.97 07697 CARDIAC REHABILITATION	0.430075	0	0	0	0	76.97
OUTPATIENT SERVICE COST CENTERS						
90.00 09000 CLINIC	0.830027	0	0	0	0	90.00
90.01 09001 IBMT JOINT VENTURE	1.108650	0	0	0	0	90.01
90.05 09005 CV DIAGNOSTIC SERVICES	0.232323	0	0	0	0	90.05
91.00 09100 EMERGENCY	0.071579	0	1,020	0	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0.268411	0	0	0	0	92.00
200.00 Subtotal (see instructions)		0	1,020	680	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	1,020	680	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 15-0162 Component CCN: 15-T162	Period: From 01/01/2020 To 12/31/2020	Worksheet D Part V Date/Time Prepared: 3/30/2021 10:40 am
Title XVIII		Subprovider - IRF	PPS

Cost Center Description	Costs			
	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
	6.00	7.00		
ANCILLARY SERVICE COST CENTERS				
50.00 05000 OPERATING ROOM	0	0		50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0		52.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	0	0		54.00
55.00 05500 RADIOLOGY-THERAPEUTIC	0	0		55.00
56.00 05600 RADIOISOTOPE	0	0		56.00
59.00 05900 CARDIAC CATHETERIZATION	0	0		59.00
60.00 06000 LABORATORY	0	0		60.00
64.00 06400 INTRAVENOUS THERAPY	0	0		64.00
65.00 06500 RESPIRATORY THERAPY	0	0		65.00
66.00 06600 PHYSICAL THERAPY	0	0		66.00
67.00 06700 OCCUPATIONAL THERAPY	0	0		67.00
68.00 06800 SPEECH PATHOLOGY	0	0		68.00
69.00 06900 ELECTROCARDIOLOGY	0	0		69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	0	0		70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0		72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	131		73.00
74.00 07400 RENAL DIALYSIS	0	0		74.00
76.97 07697 CARDIAC REHABILITATION	0	0		76.97
OUTPATIENT SERVICE COST CENTERS				
90.00 09000 CLINIC	0	0		90.00
90.01 09001 IBMT JOINT VENTURE	0	0		90.01
90.05 09005 CV DIAGNOSTIC SERVICES	0	0		90.05
91.00 09100 EMERGENCY	73	0		91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0		92.00
200.00 Subtotal (see instructions)	73	131		200.00
201.00 Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00 Net Charges (line 200 - line 201)	73	131		202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS		Provider CCN: 15-0162	Period: From 01/01/2020 To 12/31/2020	Worksheet D Part I Date/Time Prepared: 3/30/2021 10:40 am
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Cost Center Description		Title XIX			Hospital	PPS
		Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)
		1.00	2.00	3.00	4.00	5.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	12,308,780	0	12,308,780	61,574	199.90
31.00	INTENSIVE CARE UNIT	1,499,666		1,499,666	20,500	73.15
31.01	NEONATAL INTENSIVE CARE UNIT	947,022		947,022	6,322	149.80
32.00	CORONARY CARE UNIT	3,010,041		3,010,041	12,691	237.18
34.00	SURGICAL INTENSIVE CARE UNIT	1,710,521		1,710,521	8,247	207.41
41.00	SUBPROVIDER - IRF	1,123,305	0	1,123,305	5,552	202.32
43.00	NURSERY	250,659		250,659	3,738	67.06
200.00	Total (lines 30 through 199)	20,849,994		20,849,994	118,624	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	797	159,320			30.00
31.00	INTENSIVE CARE UNIT	278	20,336			31.00
31.01	NEONATAL INTENSIVE CARE UNIT	45	6,741			31.01
32.00	CORONARY CARE UNIT	46	10,910			32.00
34.00	SURGICAL INTENSIVE CARE UNIT	67	13,896			34.00
41.00	SUBPROVIDER - IRF	25	5,058			41.00
43.00	NURSERY	172	11,534			43.00
200.00	Total (lines 30 through 199)	1,430	227,795			200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS		Provider CCN: 15-0162	Period: From 01/01/2020 To 12/31/2020	Worksheet D Part II Date/Time Prepared: 3/30/2021 10:40 am
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Cost Center Description		Title XIX			Hospital	PPS		
		Capital Related Cost (from Wkst. C, Part I, 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	6,183,085	264,914,869	0.023340	13,276,856	309,882	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,658,701	44,259,677	0.037477	11,282,631	422,839	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,986,123	295,826,730	0.013475	9,516,862	128,240	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	281,467	81,279,420	0.003463	0	0	55.00
56.00	05600	RADIOISOTOPE	75,179	7,243,622	0.010379	155,873	1,618	56.00
59.00	05900	CARDIAC CATHETERIZATION	1,539,955	147,100,158	0.010469	3,054,824	31,981	59.00
60.00	06000	LABORATORY	1,634,404	307,838,767	0.005309	15,028,810	79,788	60.00
64.00	06400	INTRAVENOUS THERAPY	602,096	31,834,595	0.018913	548,884	10,381	64.00
65.00	06500	RESPIRATORY THERAPY	565,204	60,186,493	0.009391	5,740,252	53,907	65.00
66.00	06600	PHYSICAL THERAPY	716,119	38,371,939	0.018663	198,046	3,696	66.00
67.00	06700	OCCUPATIONAL THERAPY	12,746	21,266,221	0.000599	1,014,258	608	67.00
68.00	06800	SPEECH PATHOLOGY	127,134	10,511,216	0.012095	285,542	3,454	68.00
69.00	06900	ELECTROCARDIOLOGY	869,997	36,866,750	0.023598	2,636,525	62,217	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	10,097	19,812,117	0.000510	917,860	468	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1,047,795	202,976,423	0.005162	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	804,218	168,318,773	0.004778	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	805,647	507,587,955	0.001587	19,652,123	31,188	73.00
74.00	07400	RENAL DIALYSIS	252,309	8,199,678	0.030771	0	0	74.00
76.97	07697	CARDIAC REHABILITATION	2,326	1,547,213	0.001503	8,700	13	76.97
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	1,199,286	13,478,991	0.088974	138,853	12,354	90.00
90.01	09001	IBMT JOINT VENTURE	159,980	8,948,827	0.017877	1,634	29	90.01
90.05	09005	CV DIAGNOSTIC SERVICES	59,855	68,142,020	0.000878	13,726	12	90.05
91.00	09100	EMERGENCY	3,117,540	291,532,173	0.010694	8,294,479	88,701	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1,909,068	50,847,747	0.037545	0	0	92.00
200.00		Total (lines 50 through 199)	27,620,331	2,688,892,374		91,766,738	1,241,376	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS		Provider CCN: 15-0162	Period: From 01/01/2020 To 12/31/2020	Worksheet D Part III Date/Time Prepared: 3/30/2021 10:40 am
Title XIX			Hospital	PPS

Cost Center Description		Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health Cost	All Other Medical Education Cost	
		1A	1.00	2A	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	31.00
31.01	02060	NEONATAL INTENSIVE CARE UNIT	0	0	0	0	31.01
32.00	03200	CORONARY CARE UNIT	0	0	0	0	32.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	0	0	0	0	34.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	41.00
43.00	04300	NURSERY	0	0	0	0	43.00
200.00		Total (lines 30 through 199)	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	61,574	0.00	797 30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	20,500	0.00	278 31.00
31.01	02060	NEONATAL INTENSIVE CARE UNIT	0	0	6,322	0.00	45 31.01
32.00	03200	CORONARY CARE UNIT	0	0	12,691	0.00	46 32.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	0	0	8,247	0.00	67 34.00
41.00	04100	SUBPROVIDER - IRF	0	0	5,552	0.00	25 41.00
43.00	04300	NURSERY	0	0	3,738	0.00	172 43.00
200.00		Total (lines 30 through 199)	0	0	118,624		1,430 200.00
Cost Center Description		Inpatient Program Pass-Through Cost (col. 7 x col. 8)					
		9.00					
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	0				30.00
31.00	03100	INTENSIVE CARE UNIT	0				31.00
31.01	02060	NEONATAL INTENSIVE CARE UNIT	0				31.01
32.00	03200	CORONARY CARE UNIT	0				32.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	0				34.00
41.00	04100	SUBPROVIDER - IRF	0				41.00
43.00	04300	NURSERY	0				43.00
200.00		Total (lines 30 through 199)	0				200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 15-0162	Period: From 01/01/2020 To 12/31/2020	Worksheet D Part IV Date/Time Prepared: 3/30/2021 10:40 am
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Cost Center Description	Title XIX			Hospital		Allied Health Post-Stepdown Adjustments	Allied Health PPS	
	Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School					
	1.00	2A	2.00	3A	3.00			
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	0	55.00
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0	0	0	0	141,024	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	1,944,085	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	IBMT JOINT VENTURE	0	0	0	0	0	90.01
90.05	09005	CV DIAGNOSTIC SERVICES	0	0	0	0	0	90.05
91.00	09100	EMERGENCY	0	0	0	0	235,262	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	0	92.00
200.00		Total (lines 50 through 199)	0	0	0	0	2,320,371	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 15-0162	Period: From 01/01/2020 To 12/31/2020	Worksheet D Part IV Date/Time Prepared: 3/30/2021 10:40 am
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Cost Center Description	Title XIX		Hospital		Ratio of Cost to Charges (col. 5 ÷ col. 7) (see instructions)	
	All Other Medical Education Cost	Total Cost (sum of col. 1, 2, 3, and 4)	Total Outpatient Cost (sum of col. 2, 3, and 4)	Total Charges (from Wkst. C, Part I, col. 8)		
	4.00	5.00	6.00	7.00	8.00	
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	0	0	0	264,914,869	0.000000	50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0	0	44,259,677	0.000000	52.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	0	0	0	295,826,730	0.000000	54.00
55.00 05500 RADIOLOGY-THERAPEUTIC	0	0	0	81,279,420	0.000000	55.00
56.00 05600 RADIOISOTOPE	0	0	0	7,243,622	0.000000	56.00
59.00 05900 CARDIAC CATHETERIZATION	0	0	0	147,100,158	0.000000	59.00
60.00 06000 LABORATORY	0	141,024	141,024	307,838,767	0.000458	60.00
64.00 06400 INTRAVENOUS THERAPY	0	0	0	31,834,595	0.000000	64.00
65.00 06500 RESPIRATORY THERAPY	0	0	0	60,186,493	0.000000	65.00
66.00 06600 PHYSICAL THERAPY	0	0	0	38,371,939	0.000000	66.00
67.00 06700 OCCUPATIONAL THERAPY	0	0	0	21,266,221	0.000000	67.00
68.00 06800 SPEECH PATHOLOGY	0	0	0	10,511,216	0.000000	68.00
69.00 06900 ELECTROCARDIOLOGY	0	0	0	36,866,750	0.000000	69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	0	0	0	19,812,117	0.000000	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	202,976,423	0.000000	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	168,318,773	0.000000	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	1,944,085	1,944,085	507,587,955	0.003830	73.00
74.00 07400 RENAL DIALYSIS	0	0	0	8,199,678	0.000000	74.00
76.97 07697 CARDIAC REHABILITATION	0	0	0	1,547,213	0.000000	76.97
OUTPATIENT SERVICE COST CENTERS						
90.00 09000 CLINIC	0	0	0	13,478,991	0.000000	90.00
90.01 09001 IBMT JOINT VENTURE	0	0	0	8,948,827	0.000000	90.01
90.05 09005 CV DIAGNOSTIC SERVICES	0	0	0	68,142,020	0.000000	90.05
91.00 09100 EMERGENCY	0	235,262	235,262	291,532,173	0.000807	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	50,847,747	0.000000	92.00
200.00 Total (lines 50 through 199)	0	2,320,371	2,320,371	2,688,892,374		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 15-0162	Period: From 01/01/2020 To 12/31/2020	Worksheet D Part IV Date/Time Prepared: 3/30/2021 10:40 am
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Cost Center Description	Title XIX				Hospital		PPS
	Outpatient Ratio of Cost to Charges (col. 6 + col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges before Geographical Reclassification	Outpatient Program Charges on/after Geographical Reclassification		
	9.00	10.00	11.00	12.00	12.01		
ANCILLARY SERVICE COST CENTERS							
50.00 05000 OPERATING ROOM	0.000000	13,276,856	0	0	0	50.00	
52.00 05200 DELIVERY ROOM & LABOR ROOM	0.000000	11,282,631	0	0	0	52.00	
54.00 05400 RADIOLOGY-DIAGNOSTIC	0.000000	9,516,862	0	0	0	54.00	
55.00 05500 RADIOLOGY-THERAPEUTIC	0.000000	0	0	0	0	55.00	
56.00 05600 RADIOISOTOPE	0.000000	155,873	0	0	0	56.00	
59.00 05900 CARDIAC CATHETERIZATION	0.000000	3,054,824	0	0	0	59.00	
60.00 06000 LABORATORY	0.000458	15,028,810	6,883	0	0	60.00	
64.00 06400 INTRAVENOUS THERAPY	0.000000	548,884	0	0	0	64.00	
65.00 06500 RESPIRATORY THERAPY	0.000000	5,740,252	0	0	0	65.00	
66.00 06600 PHYSICAL THERAPY	0.000000	198,046	0	0	0	66.00	
67.00 06700 OCCUPATIONAL THERAPY	0.000000	1,014,258	0	0	0	67.00	
68.00 06800 SPEECH PATHOLOGY	0.000000	285,542	0	0	0	68.00	
69.00 06900 ELECTROCARDIOLOGY	0.000000	2,636,525	0	0	0	69.00	
70.00 07000 ELECTROENCEPHALOGRAPHY	0.000000	917,860	0	0	0	70.00	
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	0.003830	19,652,123	75,268	0	0	73.00	
74.00 07400 RENAL DIALYSIS	0.000000	0	0	0	0	74.00	
76.97 07697 CARDIAC REHABILITATION	0.000000	8,700	0	0	0	76.97	
OUTPATIENT SERVICE COST CENTERS							
90.00 09000 CLINIC	0.000000	138,853	0	0	0	90.00	
90.01 09001 IBMT JOINT VENTURE	0.000000	1,634	0	0	0	90.01	
90.05 09005 CV DIAGNOSTIC SERVICES	0.000000	13,726	0	0	0	90.05	
91.00 09100 EMERGENCY	0.000807	8,294,479	6,694	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)		91,766,738	88,845	0	0	200.00	

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 15-0162	Period: From 01/01/2020 To 12/31/2020	Worksheet D Part IV Date/Time Prepared: 3/30/2021 10:40 am
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Cost Center Description		Outpatient Program Pass-Through Costs (col. 9 x col. 12) before Geographical Reclassification	Outpatient Program Pass-Through Costs (col. 9 x col. 12) on/after Geographical Reclassification	Title XIX	Hospital	PPS
		13.00	13.01			
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0		52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0		54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0		55.00
56.00	05600	RADIOISOTOPE	0	0		56.00
59.00	05900	CARDIAC CATHETERIZATION	0	0		59.00
60.00	06000	LABORATORY	0	0		60.00
64.00	06400	INTRAVENOUS THERAPY	0	0		64.00
65.00	06500	RESPIRATORY THERAPY	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0		73.00
74.00	07400	RENAL DIALYSIS	0	0		74.00
76.97	07697	CARDIAC REHABILITATION	0	0		76.97
OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0		90.00
90.01	09001	IBMT JOINT VENTURE	0	0		90.01
90.05	09005	CV DIAGNOSTIC SERVICES	0	0		90.05
91.00	09100	EMERGENCY	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0		92.00
200.00		Total (lines 50 through 199)	0	0		200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS				Provider CCN: 15-0162 Component CCN: 15-T162	Period: From 01/01/2020 To 12/31/2020	Worksheet D Part II Date/Time Prepared: 3/30/2021 10:40 am
				Title XIX	Subprovider - IRF	PPS
Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 + col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
	1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	6,183,085	264,914,869	0.023340	232,719	5,432	50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	1,658,701	44,259,677	0.037477	0	0	52.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	3,986,123	295,826,730	0.013475	148,540	2,002	54.00
55.00 05500 RADIOLOGY-THERAPEUTIC	281,467	81,279,420	0.003463	0	0	55.00
56.00 05600 RADIOISOTOPE	75,179	7,243,622	0.010379	18,649	194	56.00
59.00 05900 CARDIAC CATHETERIZATION	1,539,955	147,100,158	0.010469	0	0	59.00
60.00 06000 LABORATORY	1,634,404	307,838,767	0.005309	330,348	1,754	60.00
64.00 06400 INTRAVENOUS THERAPY	602,096	31,834,595	0.018913	23,260	440	64.00
65.00 06500 RESPIRATORY THERAPY	565,204	60,186,493	0.009391	86,035	808	65.00
66.00 06600 PHYSICAL THERAPY	716,119	38,371,939	0.018663	1,132,955	21,144	66.00
67.00 06700 OCCUPATIONAL THERAPY	12,746	21,266,221	0.000599	14,140	8	67.00
68.00 06800 SPEECH PATHOLOGY	127,134	10,511,216	0.012095	14,483	175	68.00
69.00 06900 ELECTROCARDIOLOGY	869,997	36,866,750	0.023598	23,432	553	69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	10,097	19,812,117	0.000510	50,463	26	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	1,047,795	202,976,423	0.005162	80,352	415	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	804,218	168,318,773	0.004778	293,393	1,402	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	805,647	507,587,955	0.001587	479,800	761	73.00
74.00 07400 RENAL DIALYSIS	252,309	8,199,678	0.030771	0	0	74.00
76.97 07697 CARDIAC REHABILITATION	2,326	1,547,213	0.001503	0	0	76.97
OUTPATIENT SERVICE COST CENTERS						
90.00 09000 CLINIC	1,199,286	13,478,991	0.088974	21,783	1,938	90.00
90.01 09001 IBMT JOINT VENTURE	159,980	8,948,827	0.017877	0	0	90.01
90.05 09005 CV DIAGNOSTIC SERVICES	59,855	68,142,020	0.000878	0	0	90.05
91.00 09100 EMERGENCY	3,117,540	291,532,173	0.010694	0	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0	50,847,747	0.000000	0	0	92.00
200.00 Total (lines 50 through 199)	25,711,263	2,688,892,374		2,950,352	37,052	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 15-0162 Component CCN: 15-T162	Period: From 01/01/2020 To 12/31/2020	Worksheet D Part IV Date/Time Prepared: 3/30/2021 10:40 am
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Cost Center Description			Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health	
			1.00	2A	2.00	3A	3.00	
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	0	55.00
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0	0	0	0	141,024	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	1,944,085	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	IBMT JOINT VENTURE	0	0	0	0	0	90.01
90.05	09005	CV DIAGNOSTIC SERVICES	0	0	0	0	0	90.05
91.00	09100	EMERGENCY	0	0	0	0	235,262	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	0	92.00
200.00		Total (lines 50 through 199)	0	0	0	0	2,320,371	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 15-0162 Component CCN: 15-T162	Period: From 01/01/2020 To 12/31/2020	Worksheet D Part IV Date/Time Prepared: 3/30/2021 10:40 am
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Cost Center Description		All Other Medical Education Cost	Total Cost (sum of col s. 1, 2, 3, and 4)	Total Outpatient Cost (sum of col s. 2, 3, and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7) (see instructions)	
		4.00	5.00	6.00	7.00	8.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	0	0	0	264,914,869	0.000000	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	0	44,259,677	0.000000	52.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	0	0	295,826,730	0.000000	54.00
55.00	05500 RADIOLOGY-THERAPEUTIC	0	0	0	81,279,420	0.000000	55.00
56.00	05600 RADIOISOTOPE	0	0	0	7,243,622	0.000000	56.00
59.00	05900 CARDIAC CATHETERIZATION	0	0	0	147,100,158	0.000000	59.00
60.00	06000 LABORATORY	0	141,024	141,024	307,838,767	0.000458	60.00
64.00	06400 INTRAVENOUS THERAPY	0	0	0	31,834,595	0.000000	64.00
65.00	06500 RESPIRATORY THERAPY	0	0	0	60,186,493	0.000000	65.00
66.00	06600 PHYSICAL THERAPY	0	0	0	38,371,939	0.000000	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	0	0	21,266,221	0.000000	67.00
68.00	06800 SPEECH PATHOLOGY	0	0	0	10,511,216	0.000000	68.00
69.00	06900 ELECTROCARDIOLOGY	0	0	0	36,866,750	0.000000	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0	0	19,812,117	0.000000	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	202,976,423	0.000000	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	168,318,773	0.000000	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	1,944,085	1,944,085	507,587,955	0.003830	73.00
74.00	07400 RENAL DIALYSIS	0	0	0	8,199,678	0.000000	74.00
76.97	07697 CARDIAC REHABILITATION	0	0	0	1,547,213	0.000000	76.97
OUTPATIENT SERVICE COST CENTERS							
90.00	09000 CLINIC	0	0	0	13,478,991	0.000000	90.00
90.01	09001 IBMT JOINT VENTURE	0	0	0	8,948,827	0.000000	90.01
90.05	09005 CV DIAGNOSTIC SERVICES	0	0	0	68,142,020	0.000000	90.05
91.00	09100 EMERGENCY	0	235,262	235,262	291,532,173	0.000807	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	50,847,747	0.000000	92.00
200.00	Total (lines 50 through 199)	0	2,320,371	2,320,371	2,688,892,374		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 15-0162 Component CCN: 15-T162	Period: From 01/01/2020 To 12/31/2020	Worksheet D Part IV Date/Time Prepared: 3/30/2021 10:40 am
	Title XIX	Subprovider - IRF	PPS

Cost Center Description		Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges before Geographical Reclassification	Outpatient Program Charges on/after Geographical Reclassification	
		9.00	10.00	11.00	12.00	12.01	
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	0.000000	232,719	0	0	0	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.000000	0	0	0	0	52.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.000000	148,540	0	0	0	54.00
55.00	05500 RADIOLOGY-THERAPEUTIC	0.000000	0	0	0	0	55.00
56.00	05600 RADIOISOTOPE	0.000000	18,649	0	0	0	56.00
59.00	05900 CARDIAC CATHETERIZATION	0.000000	0	0	0	0	59.00
60.00	06000 LABORATORY	0.000458	330,348	151	0	0	60.00
64.00	06400 INTRAVENOUS THERAPY	0.000000	23,260	0	0	0	64.00
65.00	06500 RESPIRATORY THERAPY	0.000000	86,035	0	0	0	65.00
66.00	06600 PHYSICAL THERAPY	0.000000	1,132,955	0	0	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.000000	14,140	0	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0.000000	14,483	0	0	0	68.00
69.00	06900 ELECTROCARDIOLOGY	0.000000	23,432	0	0	0	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0.000000	50,463	0	0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	80,352	0	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.000000	293,393	0	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.003830	479,800	1,838	0	0	73.00
74.00	07400 RENAL DIALYSIS	0.000000	0	0	0	0	74.00
76.97	07697 CARDIAC REHABILITATION	0.000000	0	0	0	0	76.97
OUTPATIENT SERVICE COST CENTERS							
90.00	09000 CLINIC	0.000000	21,783	0	0	0	90.00
90.01	09001 IBMT JOINT VENTURE	0.000000	0	0	0	0	90.01
90.05	09005 CV DIAGNOSTIC SERVICES	0.000000	0	0	0	0	90.05
91.00	09100 EMERGENCY	0.000807	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)		2,950,352	1,989	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 15-0162 Component CCN: 15-T162	Period: From 01/01/2020 To 12/31/2020	Worksheet D Part IV Date/Time Prepared: 3/30/2021 10:40 am
Title XIX		Subprovider - IRF	PPS

Cost Center Description		Outpatient Program Pass-Through Costs (col. 9 x col. 12) before Geographical Reclassification	Outpatient Program Pass-Through Costs (col. 9 x col. 12) on/after Geographical Reclassification	
		13.00	13.01	
ANCILLARY SERVICE COST CENTERS				
50.00	05000 OPERATING ROOM	0	0	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	52.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	0	54.00
55.00	05500 RADIOLOGY-THERAPEUTIC	0	0	55.00
56.00	05600 RADIOISOTOPE	0	0	56.00
59.00	05900 CARDIAC CATHETERIZATION	0	0	59.00
60.00	06000 LABORATORY	0	0	60.00
64.00	06400 INTRAVENOUS THERAPY	0	0	64.00
65.00	06500 RESPIRATORY THERAPY	0	0	65.00
66.00	06600 PHYSICAL THERAPY	0	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0	0	68.00
69.00	06900 ELECTROCARDIOLOGY	0	0	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	73.00
74.00	07400 RENAL DIALYSIS	0	0	74.00
76.97	07697 CARDIAC REHABILITATION	0	0	76.97
OUTPATIENT SERVICE COST CENTERS				
90.00	09000 CLINIC	0	0	90.00
90.01	09001 IBMT JOINT VENTURE	0	0	90.01
90.05	09005 CV DIAGNOSTIC SERVICES	0	0	90.05
91.00	09100 EMERGENCY	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0	92.00
200.00	Total (lines 50 through 199)	0	0	200.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 15-0162	Period: From 01/01/2020 To 12/31/2020	Worksheet D-1 Date/Time Prepared: 3/30/2021 10:40 am
Cost Center Description		Title XVIII	Hospital	PPS
		1.00		
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		61,574	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		61,574	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)		52,024	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)		22,236	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)		87,996,376	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)		87,996,376	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)		87,996,376	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)		1,429.12	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		31,777,912	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)		31,777,912	41.00

COMPUTATION OF INPATIENT OPERATING COST			Provider CCN: 15-0162	Period: From 01/01/2020 To 12/31/2020	Worksheet D-1 Date/Time Prepared: 3/30/2021 10:40 am	
Title XVIII			Hospital		PPS	
Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
	1.00	2.00	3.00	4.00	5.00	
42.00 NURSERY (title V & XIX only)	0	0	0.00	0	0	42.00
Intensive Care Type Inpatient Hospital Units						
43.00 INTENSIVE CARE UNIT	17,656,935	20,500	861.31	3,568	3,073,154	43.00
43.01 NEONATAL INTENSIVE CARE UNIT	9,704,382	6,322	1,535.02	0	0	43.01
44.00 CORONARY CARE UNIT	23,584,816	12,691	1,858.39	5,353	9,947,962	44.00
45.00 BURN INTENSIVE CARE UNIT						45.00
46.00 SURGICAL INTENSIVE CARE UNIT	12,716,282	8,247	1,541.93	3,146	4,850,912	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)					51,791,355	48.00
49.00 Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					101,441,295	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)					6,628,112	50.00
51.00 Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					3,476,621	51.00
52.00 Total Program excludable cost (sum of lines 50 and 51)					10,104,733	52.00
53.00 Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					91,336,562	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)					9,550	87.00
88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					1,429.12	88.00
89.00 Observation bed cost (line 87 x line 88) (see instructions)					13,648,096	89.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 15-0162		Period: From 01/01/2020 To 12/31/2020		Worksheet D-1 Date/Time Prepared: 3/30/2021 10:40 am	
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	12,308,780	87,996,376	0.139878	13,648,096	1,909,068	90.00
91.00	Nursing School cost	0	87,996,376	0.000000	13,648,096	0	91.00
92.00	Allied health cost	0	87,996,376	0.000000	13,648,096	0	92.00
93.00	All other Medical Education	0	87,996,376	0.000000	13,648,096	0	93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 15-0162 Component CCN: 15-T162	Period: From 01/01/2020 To 12/31/2020	Worksheet D-1 Date/Time Prepared: 3/30/2021 10:40 am
		Title XVIII	Subprovider - IRF	PPS
Cost Center Description				1.00
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		5,552	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		5,552	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.		0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)		5,552	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)		2,539	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)		8,237,029	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)		8,237,029	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)		8,237,029	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)		1,483.61	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		3,766,886	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)		0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)		3,766,886	41.00

COMPUTATION OF INPATIENT OPERATING COST				Provider CCN: 15-0162	Period: From 01/01/2020 To 12/31/2020	Worksheet D-1	
				Component CCN: 15-T162		Date/Time Prepared: 3/30/2021 10:40 am	
				Title XVIII	Subprovider - IRF	PPS	
Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)		
	1.00	2.00	3.00	4.00	5.00		
42.00 NURSERY (title V & XIX only)	0	0	0.00	0	0	0	42.00
Intensive Care Type Inpatient Hospital Units							
43.00 INTENSIVE CARE UNIT	0	0	0.00	0	0	0	43.00
43.01 NEONATAL INTENSIVE CARE UNIT	0	0	0.00	0	0	0	43.01
44.00 CORONARY CARE UNIT	0	0	0.00	0	0	0	44.00
45.00 BURN INTENSIVE CARE UNIT							45.00
46.00 SURGICAL INTENSIVE CARE UNIT	0	0	0.00	0	0	0	46.00
47.00 OTHER SPECIAL CARE (SPECIFY)							47.00
Cost Center Description							
48.00 Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					1,323,140		48.00
49.00 Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					5,090,026		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)					513,690		50.00
51.00 Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					62,046		51.00
52.00 Total Program excludable cost (sum of lines 50 and 51)					575,736		52.00
53.00 Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					4,514,290		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: 15-0162 Component CCN: 15-T162		Period: From 01/01/2020 To 12/31/2020		Worksheet D-1 Date/Time Prepared: 3/30/2021 10:40 am	
		Title XVIII		Subprovider - IRF		PPS	
Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)		
	1.00	2.00	3.00	4.00	5.00		
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00	Capital-related cost	1,123,305	8,237,029	0.136373	0	0	90.00
91.00	Nursing School cost	0	8,237,029	0.000000	0	0	91.00
92.00	Allied health cost	0	8,237,029	0.000000	0	0	92.00
93.00	All other Medical Education	0	8,237,029	0.000000	0	0	93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 15-0162	Period: From 01/01/2020 To 12/31/2020	Worksheet D-1 Date/Time Prepared: 3/30/2021 10:40 am
Cost Center Description		Title XIX	Hospital	PPS
				1.00
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)			61,574 1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)			61,574 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)			52,024 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)			797 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)			3,738 15.00
16.00	Nursery days (title V or XIX only)			172 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)			87,996,376 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)			87,996,376 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)			87,996,376 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)			1,429.12 38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)			1,139,009 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)			1,139,009 41.00

COMPUTATION OF INPATIENT OPERATING COST			Provider CCN: 15-0162	Period: From 01/01/2020 To 12/31/2020	Worksheet D-1 Date/Time Prepared: 3/30/2021 10:40 am	
			Title XIX		Hospital	PPS
Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
	1.00	2.00	3.00	4.00	5.00	
42.00 NURSERY (title V & XIX only)	1,710,345	3,738	457.56	172	78,700	42.00
Intensive Care Type Inpatient Hospital Units						
43.00 INTENSIVE CARE UNIT	17,656,935	20,500	861.31	278	239,444	43.00
43.01 NEONATAL INTENSIVE CARE UNIT	9,704,382	6,322	1,535.02	45	69,076	43.01
44.00 CORONARY CARE UNIT	23,584,816	12,691	1,858.39	46	85,486	44.00
45.00 BURN INTENSIVE CARE UNIT						45.00
46.00 SURGICAL INTENSIVE CARE UNIT	12,716,282	8,247	1,541.93	67	103,309	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)					13,319,460	48.00
49.00 Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					15,034,484	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)					222,737	50.00
51.00 Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					1,330,221	51.00
52.00 Total Program excludable cost (sum of lines 50 and 51)					1,552,958	52.00
53.00 Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					13,481,526	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)					9,550	87.00
88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					1,429.12	88.00
89.00 Observation bed cost (line 87 x line 88) (see instructions)					13,648,096	89.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 15-0162		Period: From 01/01/2020 To 12/31/2020		Worksheet D-1 Date/Time Prepared: 3/30/2021 10:40 am	
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	12,308,780	87,996,376	0.139878	13,648,096	1,909,068	90.00
91.00	Nursing School cost	0	87,996,376	0.000000	13,648,096	0	91.00
92.00	Allied health cost	0	87,996,376	0.000000	13,648,096	0	92.00
93.00	All other Medical Education	0	87,996,376	0.000000	13,648,096	0	93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 15-0162 Component CCN: 15-T162	Period: From 01/01/2020 To 12/31/2020	Worksheet D-1 Date/Time Prepared: 3/30/2021 10:40 am
		Title XIX	Subprovider - IRF	PPS
Cost Center Description				1.00
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		5,552	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		5,552	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.		0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)		5,552	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)		25	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)		3,738	15.00
16.00	Nursery days (title V or XIX only)		172	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)		8,237,029	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)		8,237,029	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)		8,237,029	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)		1,483.61	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		37,090	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)		37,090	41.00

COMPUTATION OF INPATIENT OPERATING COST				Provider CCN: 15-0162	Period: From 01/01/2020 To 12/31/2020	Worksheet D-1	
				Component CCN: 15-T162	Date/Time Prepared: 3/30/2021 10:40 am		
				Title XIX	Subprovider - IRF	PPS	
Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)		
	1.00	2.00	3.00	4.00	5.00		
42.00 NURSERY (title V & XIX only)	0	0	0.00	0	0	0	42.00
Intensive Care Type Inpatient Hospital Units							
43.00 INTENSIVE CARE UNIT	0	0	0.00	0	0	0	43.00
43.01 NEONATAL INTENSIVE CARE UNIT	0	0	0.00	0	0	0	43.01
44.00 CORONARY CARE UNIT	0	0	0.00	0	0	0	44.00
45.00 BURN INTENSIVE CARE UNIT							45.00
46.00 SURGICAL INTENSIVE CARE UNIT	0	0	0.00	0	0	0	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)					633,485		48.00
49.00 Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					670,575		49.00
PASS THROUGH COST ADJUSTMENTS							
50.00 Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)					5,058		50.00
51.00 Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					39,041		51.00
52.00 Total Program excludable cost (sum of lines 50 and 51)					44,099		52.00
53.00 Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					626,476		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: 15-0162 Component CCN: 15-T162		Period: From 01/01/2020 To 12/31/2020		Worksheet D-1 Date/Time Prepared: 3/30/2021 10:40 am	
		Title XIX		Subprovider - IRF		PPS	
Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)		
	1.00	2.00	3.00	4.00	5.00		
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00	Capital-related cost	1,123,305	8,237,029	0.136373	0	0	90.00
91.00	Nursing School cost	0	8,237,029	0.000000	0	0	91.00
92.00	Allied health cost	0	8,237,029	0.000000	0	0	92.00
93.00	All other Medical Education	0	8,237,029	0.000000	0	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 15-0162	Period: From 01/01/2020 To 12/31/2020	Worksheet D-3	
		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		45,113,725	30.00
31.00	03100	INTENSIVE CARE UNIT		11,957,052	31.00
31.01	02060	NEONATAL INTENSIVE CARE UNIT		0	31.01
32.00	03200	CORONARY CARE UNIT		12,061,518	32.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT		8,208,874	34.00
41.00	04100	SUBPROVIDER - IRF		0	41.00
43.00	04300	NURSERY			43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0.134694	43,621,216	5,875,516 50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.191621	126,200	24,183 52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.098302	30,083,379	2,957,256 54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.120966	0	0 55.00
56.00	05600	RADIOISOTOPE	0.207072	803,469	166,376 56.00
59.00	05900	CARDIAC CATHETERIZATION	0.048004	17,303,066	830,616 59.00
60.00	06000	LABORATORY	0.115514	40,240,264	4,648,314 60.00
64.00	06400	INTRAVENOUS THERAPY	0.176784	1,142,351	201,949 64.00
65.00	06500	RESPIRATORY THERAPY	0.206562	13,769,203	2,844,194 65.00
66.00	06600	PHYSICAL THERAPY	0.273586	5,651,407	1,546,146 66.00
67.00	06700	OCCUPATIONAL THERAPY	0.170178	3,820,792	650,215 67.00
68.00	06800	SPEECH PATHOLOGY	0.179458	1,278,921	229,513 68.00
69.00	06900	ELECTROCARDIOLOGY	0.115618	8,249,959	953,844 69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.162411	1,297,519	210,731 70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.246707	44,803,258	11,053,277 71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.229788	33,231,644	7,636,233 72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.192661	43,732,002	8,425,451 73.00
74.00	07400	RENAL DIALYSIS	0.213136	3,159,086	673,315 74.00
76.97	07697	CARDIAC REHABILITATION	0.430075	52,166	22,435 76.97
OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	0.830027	90,847	75,405 90.00
90.01	09001	IBMT JOINT VENTURE	1.115786	13,115	14,634 90.01
90.05	09005	CV DIAGNOSTIC SERVICES	0.232323	50,428	11,716 90.05
91.00	09100	EMERGENCY	0.071588	27,893,183	1,996,817 91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.268411	2,768,958	743,219 92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		323,182,433	51,791,355 200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0	0 201.00
202.00		Net charges (line 200 minus line 201)		323,182,433	202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 15-0162 Component CCN: 15-T162	Period: From 01/01/2020 To 12/31/2020	Worksheet D-3 Date/Time Prepared: 3/30/2021 10:40 am	
Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDIATRICS		0		30.00
31.00	03100 INTENSIVE CARE UNIT		0		31.00
31.01	02060 NEONATAL INTENSIVE CARE UNIT		0		31.01
32.00	03200 CORONARY CARE UNIT		0		32.00
34.00	03400 SURGICAL INTENSIVE CARE UNIT		0		34.00
41.00	04100 SUBPROVIDER - IRF		5,929,744		41.00
43.00	04300 NURSERY				43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.134694	29,550	3,980	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.191621	0	0	52.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.098302	340,798	33,501	54.00
55.00	05500 RADIOLOGY-THERAPEUTIC	0.120966	0	0	55.00
56.00	05600 RADIOISOTOPE	0.207072	3,657	757	56.00
59.00	05900 CARDIAC CATHETERIZATION	0.048004	0	0	59.00
60.00	06000 LABORATORY	0.115514	659,963	76,235	60.00
64.00	06400 INTRAVENOUS THERAPY	0.176784	0	0	64.00
65.00	06500 RESPIRATORY THERAPY	0.206562	402,339	83,108	65.00
66.00	06600 PHYSICAL THERAPY	0.273586	1,546,066	422,982	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.170178	1,400,444	238,325	67.00
68.00	06800 SPEECH PATHOLOGY	0.179458	694,918	124,709	68.00
69.00	06900 ELECTROCARDIOLOGY	0.115618	23,769	2,748	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0.162411	28,159	4,573	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.246707	833,430	205,613	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.229788	863	198	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.192661	539,652	103,970	73.00
74.00	07400 RENAL DIALYSIS	0.213136	105,290	22,441	74.00
76.97	07697 CARDIAC REHABILITATION	0.430075	0	0	76.97
OUTPATIENT SERVICE COST CENTERS					
90.00	09000 CLINIC	0.830027	0	0	90.00
90.01	09001 IBMT JOINT VENTURE	1.115786	0	0	90.01
90.05	09005 CV DIAGNOSTIC SERVICES	0.232323	0	0	90.05
91.00	09100 EMERGENCY	0.071588	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.268411	0	0	92.00
200.00	Total (sum of lines 50 through 94 and 96 through 98)		6,608,898	1,323,140	200.00
201.00	Less PBP Clinic Laboratory Services-Program only charges (line 61)		0	0	201.00
202.00	Net charges (line 200 minus line 201)		6,608,898		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 15-0162	Period: From 01/01/2020 To 12/31/2020	Worksheet D-3 Date/Time Prepared: 3/30/2021 10:40 am	
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		21,281,223	30.00
31.00	03100	INTENSIVE CARE UNIT		4,895,836	31.00
31.01	02060	NEONATAL INTENSIVE CARE UNIT		10,196,322	31.01
32.00	03200	CORONARY CARE UNIT		2,262,889	32.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT		1,980,881	34.00
41.00	04100	SUBPROVIDER - IRF		0	41.00
43.00	04300	NURSERY		3,152,325	43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0.134694	13,276,856	1,788,313 50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.191621	11,282,631	2,161,989 52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.098302	9,516,862	935,527 54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.120966	0	0 55.00
56.00	05600	RADIOISOTOPE	0.207072	155,873	32,277 56.00
59.00	05900	CARDIAC CATHETERIZATION	0.048004	3,054,824	146,644 59.00
60.00	06000	LABORATORY	0.115514	15,028,810	1,736,038 60.00
64.00	06400	INTRAVENOUS THERAPY	0.176784	548,884	97,034 64.00
65.00	06500	RESPIRATORY THERAPY	0.206562	5,740,252	1,185,718 65.00
66.00	06600	PHYSICAL THERAPY	0.273586	198,046	54,183 66.00
67.00	06700	OCCUPATIONAL THERAPY	0.170178	1,014,258	172,604 67.00
68.00	06800	SPEECH PATHOLOGY	0.179458	285,542	51,243 68.00
69.00	06900	ELECTROCARDIOLOGY	0.115618	2,636,525	304,830 69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.162411	917,860	149,071 70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.246707	0	0 71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.229788	0	0 72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.192661	19,652,123	3,786,198 73.00
74.00	07400	RENAL DIALYSIS	0.213136	0	0 74.00
76.97	07697	CARDIAC REHABILITATION	0.430075	8,700	3,742 76.97
OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	0.830027	138,853	115,252 90.00
90.01	09001	IBMT JOINT VENTURE	1.115786	1,634	1,823 90.01
90.05	09005	CV DIAGNOSTIC SERVICES	0.232323	13,726	3,189 90.05
91.00	09100	EMERGENCY	0.071588	8,294,479	593,785 91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.268411	0	0 92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		91,766,738	13,319,460 200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0	0 201.00
202.00		Net charges (line 200 minus line 201)		91,766,738	202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 15-0162 Component CCN: 15-T162	Period: From 01/01/2020 To 12/31/2020	Worksheet D-3 Date/Time Prepared: 3/30/2021 10:40 am	
		Title XIX	Subprovider - IRF	PPS	
Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS		0	30.00
31.00	03100	INTENSIVE CARE UNIT		0	31.00
31.01	02060	NEONATAL INTENSIVE CARE UNIT		0	31.01
32.00	03200	CORONARY CARE UNIT		0	32.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT		0	34.00
41.00	04100	SUBPROVIDER - IRF		1,675,584	41.00
43.00	04300	NURSERY		0	43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0.134694	232,719	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.191621	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.098302	148,540	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.120966	0	55.00
56.00	05600	RADIOISOTOPE	0.207072	18,649	56.00
59.00	05900	CARDIAC CATHETERIZATION	0.048004	0	59.00
60.00	06000	LABORATORY	0.115514	330,348	60.00
64.00	06400	INTRAVENOUS THERAPY	0.176784	23,260	64.00
65.00	06500	RESPIRATORY THERAPY	0.206562	86,035	65.00
66.00	06600	PHYSICAL THERAPY	0.273586	1,132,955	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.170178	14,140	67.00
68.00	06800	SPEECH PATHOLOGY	0.179458	14,483	68.00
69.00	06900	ELECTROCARDIOLOGY	0.115618	23,432	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.162411	50,463	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.246707	80,352	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.229788	293,393	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.192661	479,800	73.00
74.00	07400	RENAL DIALYSIS	0.213136	0	74.00
76.97	07697	CARDIAC REHABILITATION	0.430075	0	76.97
OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	0.830027	21,783	90.00
90.01	09001	IBMT JOINT VENTURE	1.115786	0	90.01
90.05	09005	CV DIAGNOSTIC SERVICES	0.232323	0	90.05
91.00	09100	EMERGENCY	0.071588	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.268411	0	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		2,950,352	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)		2,950,352	202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 15-0162	Period: From 01/01/2020 To 12/31/2020	Worksheet E Part A Date/Time Prepared: 3/30/2021 10:40 am	
		Title XVIII	Hospital	PPS	
		Before GEO Reclass	1.00	On/After GEO Reclass	1.01
PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS					
1.00	DRG Amounts Other than Outlier Payments		0	0	1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1 (see instructions)		55,125,858	0	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1 (see instructions)		9,580,256	11,325,990	1.02
1.03	DRG for federal specific operating payment for Model 4 BPCI for discharges occurring prior to October 1 (see instructions)		0	0	1.03
1.04	DRG for federal specific operating payment for Model 4 BPCI for discharges occurring on or after October 1 (see instructions)		0	0	1.04
2.00	Outlier payments for discharges. (see instructions)				2.00
2.01	Outlier reconciliation amount		0	0	2.01
2.02	Outlier payment for discharges for Model 4 BPCI (see instructions)		0	0	2.02
2.03	Outlier payments for discharges occurring prior to October 1 (see instructions)		2,486,555	0	2.03
2.04	Outlier payments for discharges occurring on or after October 1 (see instructions)		580,277	431,062	2.04
3.00	Managed Care Simulated Payments		38,677,035	7,121,964	3.00
4.00	Bed days available divided by number of days in the cost reporting period (see instructions)		471.26		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)		17.43		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)		0.32		7.00
7.01	ACA § 5503 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(2) If the cost report straddles July 1, 2011 then see instructions.		0.00		7.01
8.00	Adjustment (increase or decrease) to the FTE count for allopathic and osteopathic programs for affiliated programs in accordance with 42 CFR 413.75(b), 413.79(c)(2)(iv), 64 FR 26340 (May 12, 1998), and 67 FR 50069 (August 1, 2002).		-0.05		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.		0.81		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)		17.87		9.00
10.00	FTE count for allopathic and osteopathic programs in the current year from your records		24.01		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)		17.87		12.00
13.00	Total allowable FTE count for the prior year.		22.68		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.		17.14		14.00
15.00	Sum of lines 12 through 14 divided by 3.		19.23		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		19.23		18.00
19.00	Current year resident to bed ratio (line 18 divided by line 4).		0.040806		19.00
20.00	Prior year resident to bed ratio (see instructions)		0.042470		20.00
21.00	Enter the lesser of lines 19 or 20 (see instructions)		0.040806		21.00
22.00	IME payment adjustment (see instructions)		1,426,511	249,693	22.00
22.01	IME payment adjustment - Managed Care (see instructions)		852,674	157,011	22.01
Indirect Medical Education Adjustment for the Add-on for § 422 of the MMA					
23.00	Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 CFR 412.105 (f)(1)(iv)(C).		0.00		23.00
24.00	IME FTE Resident Count Over Cap (see instructions)		6.14		24.00
25.00	If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see instructions)		0.00		25.00
26.00	Resident to bed ratio (divide line 25 by line 4)		0.000000		26.00
27.00	IME payments adjustment factor. (see instructions)		0.000000		27.00
28.00	IME add-on adjustment amount (see instructions)		0	0	28.00
28.01	IME add-on adjustment amount - Managed Care (see instructions)		0	0	28.01
29.00	Total IME payment (sum of lines 22 and 28)		1,426,511	249,693	29.00
29.01	Total IME payment - Managed Care (sum of lines 22.01 and 28.01)		852,674	157,011	29.01
Disproportionate Share Adjustment					
30.00	Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)		3.09		30.00
31.00	Percentage of Medicaid patient days (see instructions)		19.87		31.00
32.00	Sum of lines 30 and 31		22.96		32.00
33.00	Allowable disproportionate share percentage (see instructions)		8.16	8.16	33.00
34.00	Disproportionate share adjustment (see instructions)		1,320,005	231,050	34.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 15-0162	Period: From 01/01/2020 To 12/31/2020	Worksheet E Part A Date/Time Prepared: 3/30/2021 10:40 am	
		Title XVIII	Hospital	PPS	
			Prior to 10/1	On/After 10/1	
			1.00	2.00	
Uncompensated Care Adjustment					
35.00	Total uncompensated care amount (see instructions)		8,350,599,096	8,290,014,521	35.00
35.01	Factor 3 (see instructions)		0.000896187	0.001080121	35.01
35.02	Hospital uncompensated care payment (If line 34 is zero, enter zero on this line) (see instructions)		7,483,699	8,954,215	35.02
35.03	Pro rata share of the hospital uncompensated care payment amount (see instructions)		5,602,552	2,256,955	35.03
36.00	Total uncompensated care (sum of columns 1 and 2 on line 35.03)		7,859,507		36.00
Additional payment for high percentage of ESRD beneficiary discharges (lines 40 through 46)					
40.00	Total Medicare discharges, excluding MS-DRGs 652, 682, 683, 684 and 685. (see instructions)		0		40.00
			Before GEO Recl ass	On/After GEO Recl ass	
			1.00	1.01	
41.00	Total ESRD Medicare discharges excluding MS-DRGs 652, 682, 683, 684 and 685. (see instructions)		0	0	41.00
41.01	Total ESRD Medicare covered and paid discharges excluding MS-DRGs 652, 682, 683, 684 and 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 and 685. (see instructions)		0		43.00
44.00	Ratio of average length of stay to one week (line 43 divided by line 41 divided by 7 days)		0.000000		44.00
45.00	Average weekly cost for dialysis treatments (see instructions)		0.00	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)		77,326,738	13,290,026	47.00
48.00	Hospital specific payments (to be completed by SCH and MDH, small rural hospitals only. (see instructions)		0	0	48.00
			Amount		
			1.00		
49.00	Total payment for inpatient operating costs (see instructions)			91,626,449	49.00
50.00	Payment for inpatient program capital (from Wkst. L, Pt. I and Pt. II, as applicable)			6,855,539	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).			805,359	52.00
53.00	Nursing and Allied Health Managed Care payment			165,142	53.00
54.00	Special add-on payments for new technologies			169,754	54.00
54.01	Islet isolation add-on payment			0	54.01
55.00	Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line 69)			0	55.00
56.00	Cost of physicians' services in a teaching hospital (see instructions)			0	56.00
57.00	Routine service other pass through costs (from Wkst. D, Pt. III, column 9, lines 30 through 35).			0	57.00
58.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 11 line 200)			208,434	58.00
59.00	Total (sum of amounts on lines 49 through 58)			99,830,677	59.00
60.00	Primary payer payments			14,948	60.00
61.00	Total amount payable for program beneficiaries (line 59 minus line 60)			99,815,729	61.00
62.00	Deductibles billed to program beneficiaries			6,299,744	62.00
63.00	Coinurance billed to program beneficiaries			254,848	63.00
64.00	Allowable bad debts (see instructions)			444,119	64.00
65.00	Adjusted reimbursable bad debts (see instructions)			288,677	65.00
66.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			139,325	66.00
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)			93,549,814	67.00
68.00	Credits received from manufacturers for replaced devices for applicable to MS-DRGs (see instructions)			0	68.00
69.00	Outlier payments reconciliation (sum of lines 93, 95 and 96). (For SCH see instructions)			0	69.00
70.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	70.00
70.50	Rural Community Hospital Demonstration Project (\$410A Demonstration) adjustment (see instructions)			0	70.50
70.87	Demonstration payment adjustment amount before sequestration			0	70.87
70.88	SCH or MDH volume decrease adjustment (contractor use only)			0	70.88
70.89	Pioneer ACO demonstration payment adjustment amount (see instructions)			0	70.89
70.90	HSP bonus payment HVBP adjustment amount (see instructions)			0	70.90
70.91	HSP bonus payment HRR adjustment amount (see instructions)			0	70.91
70.92	Bundled Model 1 discount amount (see instructions)			0	70.92
70.93	HVBP payment adjustment amount (see instructions)			-218,161	70.93
70.94	HRR adjustment amount (see instructions)			-114,791	70.94
70.95	Recovery of accelerated depreciation			0	70.95

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 15-0162	Period: From 01/01/2020 To 12/31/2020	Worksheet E Part A Date/Time Prepared: 3/30/2021 10:40 am	
		Title XVIII	Hospital	PPS	
		FFY (yyyy)	Amount		
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	1.00	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)			1,101,604	70.99
71.00	Amount due provider (line 67 minus lines 68 plus/minus lines 69 & 70)			92,115,258	71.00
71.01	Sequestration adjustment (see instructions)			607,961	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			90,050,273	72.00
72.01	Interim payments-PARHM				72.01
73.00	Tentative settlement (for contractor use only)			0	73.00
73.01	Tentative settlement-PARHM (for contractor use only)				73.01
74.00	Balance due provider/program (line 71 minus lines 71.01, 71.02, 72, and 73)			1,457,024	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			973,211	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	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	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	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
Comparison 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: 15-0162	Period: From 01/01/2020 To 12/31/2020	Worksheet E Part B Date/Time Prepared: 3/30/2021 10:40 am
		Title XVIII	Hospital	PPS
				1.00
PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)		16,197	1.00
2.00	Medical and other services reimbursed under OPPTS (see instructions)		52,818,609	2.00
3.00	OPPS payments		47,959,948	3.00
4.00	Outlier payment (see instructions)		311,190	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		422,592	9.00
10.00	Organ acquisitions		0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)		16,197	11.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
12.00	Ancillary service charges		93,786	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)		93,786	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 charge basis had such payment been made in accordance with 42 CFR §413.13(e)		0	16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)		0.000000	17.00
18.00	Total customary charges (see instructions)		93,786	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)		77,589	19.00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)		0	20.00
21.00	Lesser of cost or charges (see instructions)		16,197	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)		48,693,730	24.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25.00	Deductibles and coinsurance amounts (for CAH, see instructions)		1,595	25.00
26.00	Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)		8,314,139	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)		40,394,193	27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 50)		402,705	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)		40,796,898	30.00
31.00	Primary payer payments		5,713	31.00
32.00	Subtotal (line 30 minus line 31)		40,791,185	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)		952,364	34.00
35.00	Adjusted reimbursable bad debts (see instructions)		619,037	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		496,843	36.00
37.00	Subtotal (see instructions)		41,410,222	37.00
38.00	MSP-LCC reconciliation amount from PS&R		208	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	39.00
39.50	Pioneer ACO demonstration payment adjustment (see instructions)		0	39.50
39.97	Demonstration payment adjustment amount before sequestration		0	39.97
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)		0	39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION		0	39.99
40.00	Subtotal (see instructions)		41,410,014	40.00
40.01	Sequestration adjustment (see instructions)		273,306	40.01
40.02	Demonstration payment adjustment amount after sequestration		0	40.02
40.03	Sequestration adjustment-PARHM pass-throughs		0	40.03
41.00	Interim payments		41,270,384	41.00
41.01	Interim payments-PARHM		0	41.01
42.00	Tentative settlement (for contractors use only)		0	42.00
42.01	Tentative settlement-PARHM (for contractor use only)		0	42.01
43.00	Balance due provider/program (see instructions)		-133,676	43.00
43.01	Balance due provider/program-PARHM (see instructions)		0	43.01
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		0	44.00
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: 15-0162 Component CCN: 15-T162	Period: From 01/01/2020 To 12/31/2020	Worksheet E Part B Date/Time Prepared: 3/30/2021 10:40 am
		Title XVIII	Subprovider - IRF	PPS
				1.00
PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)		204	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)		0	2.00
3.00	OPPS payments		537	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)		204	11.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
12.00	Ancillary service charges		1,700	12.00
13.00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, line 69)		0	13.00
14.00	Total reasonable charges (sum of lines 12 and 13)		1,700	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 charge basis had such payment been made in accordance with 42 CFR §413.13(e)		0	16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)		0.000000	17.00
18.00	Total customary charges (see instructions)		1,700	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)		1,496	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)		204	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)		537	24.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25.00	Deductibles and coinsurance amounts (for CAH, see instructions)		0	25.00
26.00	Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)		0	26.00
27.00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions)		741	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)		741	30.00
31.00	Primary payer payments		0	31.00
32.00	Subtotal (line 30 minus line 31)		741	32.00
ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)				
33.00	Composite rate ESRD (from Wkst. 1-5, 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)		741	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)		741	40.00
40.01	Sequestration adjustment (see instructions)		5	40.01
40.02	Demonstration payment adjustment amount after sequestration		0	40.02
40.03	Sequestration adjustment-PARHM pass-throughs			40.03
41.00	Interim payments		764	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)		-28	43.00
43.01	Balance due provider/program-PARHM (see instructions)			43.01
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		0	44.00
TO BE COMPLETED BY CONTRACTOR				
90.00	Original outlier amount (see instructions)		0	90.00
91.00	Outlier reconciliation adjustment amount (see instructions)		0	91.00
92.00	The rate used to calculate the Time Value of Money		0.00	92.00
93.00	Time Value of Money (see instructions)		0	93.00
94.00	Total (sum of lines 91 and 93)		0	94.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED		Provider CCN: 15-0162		Period: From 01/01/2020 To 12/31/2020		Worksheet E-1 Part I Date/Time Prepared: 3/30/2021 10:40 am	
		Title XVIII		Hospital		PPS	
		Inpatient Part A		Part B			
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount		
		1.00	2.00	3.00	4.00		
1.00	Total interim payments paid to provider		90,050,273		41,270,384	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)		90,050,273		41,270,384	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		1,457,024		0	6.01	
6.02	SETTLEMENT TO PROGRAM		0		133,676	6.02	
7.00	Total Medicare program liability (see instructions)		91,507,297		41,136,708	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: 15-0162 Component CCN: 15-T162	Period: From 01/01/2020 To 12/31/2020	Worksheet E-1 Part I Date/Time Prepared: 3/30/2021 10:40 am	
		Title XVIII	Subprovider - IRF	PPS	
		Inpatient Part A		Part B	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount
		1.00	2.00	3.00	4.00
1.00	Total interim payments paid to provider				764 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		4,648,399		0 2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)				3.00
Program to Provider					
3.01	ADJUSTMENTS TO PROVIDER		0		0 3.01
3.02			0		0 3.02
3.03			0		0 3.03
3.04			0		0 3.04
3.05			0		0 3.05
Provider to Program					
3.50	ADJUSTMENTS TO PROGRAM		0		0 3.50
3.51			0		0 3.51
3.52			0		0 3.52
3.53			0		0 3.53
3.54			0		0 3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0 3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		4,648,399		764 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		70,850		0 6.01
6.02	SETTLEMENT TO PROGRAM		0		28 6.02
7.00	Total Medicare program liability (see instructions)		4,719,249		736 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: 15-0162

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

Worksheet E-1
Part II
Date/Time Prepared:
3/30/2021 10:40 am

Title XVIII		Hospital	PPS
			1.00

TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS
HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION

1.00	Total hospital discharges as defined in AARA §4102 from Wkst. S-3, Pt. I col. 15 line 14	1.00
2.00	Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, 8-12	2.00
3.00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2	3.00
4.00	Total inpatient days from S-3, Pt. I col. 8 sum of lines 1, 8-12	4.00
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200	5.00
6.00	Total hospital charity care charges from Wkst. S-10, col. 3 line 20	6.00
7.00	CAH only - The reasonable cost incurred for the purchase of certified HIT technology Wkst. S-2, Pt. I line 168	7.00
8.00	Calculation of the HIT incentive payment (see instructions)	8.00
9.00	Sequestration adjustment amount (see instructions)	9.00
10.00	Calculation of the HIT incentive payment after sequestration (see instructions)	10.00
INPATIENT HOSPITAL SERVICES UNDER THE IPSS & 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: 15-0162 Component CCN: 15-T162	Period: From 01/01/2020 To 12/31/2020	Worksheet E-3 Part III Date/Time Prepared: 3/30/2021 10:40 am
		Title XVIII	Subprovider - IRF	PPS
				1.00
PART III - MEDICARE PART A SERVICES - IRF PPS				
1.00	Net Federal PPS Payment (see instructions)			4,493,627 1.00
2.00	Medicare SSI ratio (IRF PPS only) (see instructions)			0.0309 2.00
3.00	Inpatient Rehabilitation LIP Payments (see instructions)			214,795 3.00
4.00	Outlier Payments			92,166 4.00
5.00	Unweighted intern and resident FTE count in the most recent cost reporting period ending on or prior to November 15, 2004 (see instructions)			0.00 5.00
5.01	Cap increases for the unweighted intern and resident FTE count for residents that were displaced by program or hospital closure, that would not be counted without a temporary cap adjustment under 42 CFR §412.424(d)(1)(iii)(F)(1) or (2) (see instructions)			0.00 5.01
6.00	New Teaching program adjustment. (see instructions)			0.00 6.00
7.00	Current year's unweighted FTE count of I&R excluding FTEs in the new program growth period of a "new teaching program" (see instructions)			0.00 7.00
8.00	Current year's unweighted I&R FTE count for residents within the new program growth period of a "new teaching program" (see instructions)			0.00 8.00
9.00	Intern and resident count for IRF PPS medical education adjustment (see instructions)			0.00 9.00
10.00	Average Daily Census (see instructions)			15.169399 10.00
11.00	Teaching Adjustment Factor (see instructions)			0.000000 11.00
12.00	Teaching Adjustment (see instructions)			0 12.00
13.00	Total PPS Payment (see instructions)			4,800,588 13.00
14.00	Nursing and Allied Health Managed Care payments (see instruction)			0 14.00
15.00	Organ acquisition (DO NOT USE THIS LINE)			0 15.00
16.00	Cost of physicians' services in a teaching hospital (see instructions)			0 16.00
17.00	Subtotal (see instructions)			4,800,588 17.00
18.00	Primary payer payments			19,266 18.00
19.00	Subtotal (line 17 less line 18).			4,781,322 19.00
20.00	Deductibles			15,488 20.00
21.00	Subtotal (line 19 minus line 20)			4,765,834 21.00
22.00	Coinurance			17,600 22.00
23.00	Subtotal (line 21 minus line 22)			4,748,234 23.00
24.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)			0 24.00
25.00	Adjusted reimbursable bad debts (see instructions)			0 25.00
26.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			0 26.00
27.00	Subtotal (sum of lines 23 and 25)			4,748,234 27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 49)			0 28.00
29.00	Other pass through costs (see instructions)			2,369 29.00
30.00	Outlier payments reconciliation			0 30.00
31.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0 31.00
31.50	Pioneer ACO demonstration payment adjustment (see instructions)			0 31.50
31.99	Demonstration payment adjustment amount before sequestration			0 31.99
32.00	Total amount payable to the provider (see instructions)			4,750,603 32.00
32.01	Sequestration adjustment (see instructions)			31,354 32.01
32.02	Demonstration payment adjustment amount after sequestration			0 32.02
33.00	Interim payments			4,648,399 33.00
34.00	Tentative settlement (for contractor use only)			0 34.00
35.00	Balance due provider/program (line 32 minus lines 32.01, 32.02, 33, and 34)			70,850 35.00
36.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2			0 36.00
TO BE COMPLETED BY CONTRACTOR				
50.00	Original outlier amount from Wkst. E-3, Pt. III, line 4			92,166 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: 15-0162	Period: From 01/01/2020 To 12/31/2020	Worksheet E-3 Part VII Date/Time Prepared: 3/30/2021 10:40 am	
		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			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		91,766,738	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)		91,766,738	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)		91,766,738	0	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)		91,766,738	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		88,845	0	26.00
27.00	Subtotal (sum of lines 22 through 26)		88,845	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)		88,845	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)		88,845	0	31.00
32.00	Deductibles		0		32.00
33.00	Coinurance		0		33.00
34.00	Allowable bad debts (see instructions)		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)		88,845	0	36.00
37.00	TO ZERO OUT MEDICAID		-88,845	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: 15-0162 Component CCN: 15-T162	Period: From 01/01/2020 To 12/31/2020	Worksheet E-3 Part VII Date/Time Prepared: 3/30/2021 10:40 am
		Title XIX	Subprovider - IRF	PPS
			Inpatient 1.00	Outpatient 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	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	7.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable Charges				
8.00	Routine service charges		0	8.00
9.00	Ancillary service charges		2,950,352	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)		2,950,352	12.00
CUSTOMARY CHARGES				
13.00	Amount actually collected from patients liable for payment for services on a charge basis		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	14.00
15.00	Ratio of line 13 to line 14 (not to exceed 1.000000)		0.000000	15.00
16.00	Total customary charges (see instructions)		2,950,352	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)		2,950,352	17.00
18.00	Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 16) (see instructions)		0	18.00
19.00	Interns and Residents (see instructions)		0	19.00
20.00	Cost of physicians' services in a teaching hospital (see instructions)		0	20.00
21.00	Cost of covered services (enter the lesser of line 4 or line 16)		0	21.00
PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be completed for PPS providers.				
22.00	Other than outlier payments		0	22.00
23.00	Outlier payments		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		1,989	26.00
27.00	Subtotal (sum of lines 22 through 26)		1,989	27.00
28.00	Customary charges (title V or XIX PPS covered services only)		0	28.00
29.00	Titles V or XIX (sum of lines 21 and 27)		1,989	29.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT				
30.00	Excess of reasonable cost (from line 18)		0	30.00
31.00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)		1,989	31.00
32.00	Deductibles		0	32.00
33.00	Coinurance		0	33.00
34.00	Allowable bad debts (see instructions)		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)		1,989	36.00
37.00	TO ZERO OUT MEDICAID		-1,989	37.00
38.00	Subtotal (line 36 ± line 37)		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	40.00
41.00	Interim payments		0	41.00
42.00	Balance due provider/program (line 40 minus line 41)		0	42.00
43.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, chapter 1, §115.2		0	43.00

DIRECT GRADUATE MEDICAL EDUCATION (GME) & ESRD OUTPATIENT DIRECT MEDICAL EDUCATION COSTS		Provider CCN: 15-0162	Period: From 01/01/2020 To 12/31/2020	Worksheet E-4	
		Title XVIII	Hospital	Date/Time Prepared: 3/30/2021 10:40 am	
				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.			19.50	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			0.94	3.00
3.01	Direct GME cap reduction amount under ACA §5503 in accordance with 42 CFR §413.79 (m). (see instructions for cost reporting periods straddling 7/1/2011)			0.00	3.01
4.00	Adjustment (plus or minus) to the FTE cap for allopathic and osteopathic programs due to a Medicare GME affiliation agreement (42 CFR §413.75(b) and § 413.79 (f))			-0.05	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)			18.51	5.00
6.00	Unweighted resident FTE count for allopathic and osteopathic programs for the current year from your records (see instructions)			24.01	6.00
7.00	Enter the lesser of line 5 or line 6			18.51	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.	24.01	0.00	24.01	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.	18.51	0.00	18.51	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	18.51	0.00		11.00
12.00	Total weighted resident FTE count for the prior cost reporting year (see instructions)	18.46	0.00		12.00
13.00	Total weighted resident FTE count for the penultimate cost reporting year (see instructions)	18.46	0.00		13.00
14.00	Rolling average FTE count (sum of lines 11 through 13 divided by 3).	18.48	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	18.48	0.00		17.00
18.00	Per resident amount	121,887.58	121,887.58		18.00
19.00	Approved amount for resident costs	2,252,482	0	2,252,482	19.00
				1.00	
20.00	Additional unweighted allopathic and osteopathic direct GME FTE resident cap slots received under 42 Sec. 413.79(c)(4)			0.00	20.00
21.00	Direct GME FTE unweighted resident count over cap (see instructions)			5.50	21.00
22.00	Allowable additional direct GME FTE Resident Count (see instructions)			0.00	22.00
23.00	Enter the locality adjustment national average per resident amount (see instructions)			0.00	23.00
24.00	Multiply line 22 time line 23			0	24.00
25.00	Total direct GME amount (sum of lines 19 and 24)			2,252,482	25.00
		Inpatient Part A	Managed Care	Total	
		1.00	2.00	3.00	
COMPUTATION OF PROGRAM PATIENT LOAD					
26.00	Inpatient Days (see instructions)	36,842	23,432		26.00
27.00	Total Inpatient Days (see instructions)	106,210	106,210		27.00
28.00	Ratio of inpatient days to total inpatient days	0.346879	0.220620		28.00
29.00	Program direct GME amount	781,339	496,943	1,278,282	29.00
29.01	Percent reduction for MA DGME				29.01
30.00	Reduction for direct GME payments for Medicare Advantage		70,218	70,218	30.00
31.00	Net Program direct GME amount			1,208,064	31.00

DIRECT GRADUATE MEDICAL EDUCATION (GME) & ESRD OUTPATIENT DIRECT MEDICAL EDUCATION COSTS		Provider CCN: 15-0162	Period: From 01/01/2020 To 12/31/2020	Worksheet E-4 Date/Time Prepared: 3/30/2021 10:40 am
		Title XVIII	Hospital	PPS
		1.00		
DIRECT MEDICAL EDUCATION COSTS FOR ESRD COMPOSITE RATE - TITLE XVIII ONLY (NURSING SCHOOL AND PARAMEDICAL EDUCATION COSTS)				
32.00	Renal dialysis direct medical education costs (from Wkst. B, Pt. I, sum of col. 20 and 23, lines 74 and 94)		0	32.00
33.00	Renal dialysis and home dialysis total charges (Wkst. C, Pt. I, col. 8, sum of lines 74 and 94)		8,199,678	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)		106,531,321	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)		34,214	40.00
41.00	Total Part A reasonable cost (sum of lines 37 through 39 minus line 40)		106,497,107	41.00
Part B Reasonable Cost				
42.00	Reasonable cost (see instructions)		53,257,602	42.00
43.00	Primary payer payments (see instructions)		5,713	43.00
44.00	Total Part B reasonable cost (line 42 minus line 43)		53,251,889	44.00
45.00	Total reasonable cost (sum of lines 41 and 44)		159,748,996	45.00
46.00	Ratio of Part A reasonable cost to total reasonable cost (line 41 ÷ line 45)		0.666653	46.00
47.00	Ratio of Part B reasonable cost to total reasonable cost (line 44 ÷ line 45)		0.333347	47.00
ALLOCATION OF MEDICARE DIRECT GME COSTS BETWEEN PART A AND PART B				
48.00	Total program GME payment (line 31)		1,208,064	48.00
49.00	Part A Medicare GME payment (line 46 x 48) (title XVIII only) (see instructions)		805,359	49.00
50.00	Part B Medicare GME payment (line 47 x 48) (title XVIII only) (see instructions)		402,705	50.00

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

Provider CCN: 15-0162

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

Worksheet G
Date/Time Prepared:
3/30/2021 10:40 am

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
CURRENT ASSETS						
1.00	Cash on hand in banks	97,239,452	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	503,731,585	0	0	0	4.00
5.00	Other receivable	-964,146	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-370,158,667	0	0	0	6.00
7.00	Inventory	13,598,507	0	0	0	7.00
8.00	Prepaid expenses	1,867,972	0	0	0	8.00
9.00	Other current assets	0	0	0	0	9.00
10.00	Due from other funds	18,007,626	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	263,322,329	0	0	0	11.00
FIXED ASSETS						
12.00	Land	0	0	0	0	12.00
13.00	Land improvements	57,100,615	0	0	0	13.00
14.00	Accumulated depreciation	-26,785,035	0	0	0	14.00
15.00	Buildings	528,132,193	0	0	0	15.00
16.00	Accumulated depreciation	-227,558,626	0	0	0	16.00
17.00	Leasehold improvements	17,574,309	0	0	0	17.00
18.00	Accumulated depreciation	-14,397,410	0	0	0	18.00
19.00	Fixed equipment	0	0	0	0	19.00
20.00	Accumulated depreciation	0	0	0	0	20.00
21.00	Automobiles and trucks	0	0	0	0	21.00
22.00	Accumulated depreciation	0	0	0	0	22.00
23.00	Major movable equipment	198,690,765	0	0	0	23.00
24.00	Accumulated depreciation	-148,350,314	0	0	0	24.00
25.00	Minor equipment depreciable	0	0	0	0	25.00
26.00	Accumulated depreciation	0	0	0	0	26.00
27.00	HIT designated Assets	0	0	0	0	27.00
28.00	Accumulated depreciation	0	0	0	0	28.00
29.00	Minor equipment-nondepreciable	0	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	384,406,497	0	0	0	30.00
OTHER ASSETS						
31.00	Investments	19,421,096	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	60,700,199	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	80,121,295	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	727,850,121	0	0	0	36.00
CURRENT LIABILITIES						
37.00	Accounts payable	44,976,582	0	0	0	37.00
38.00	Salaries, wages, and fees payable	0	0	0	0	38.00
39.00	Payroll taxes payable	28,842,959	0	0	0	39.00
40.00	Notes and loans payable (short term)	918,648	0	0	0	40.00
41.00	Deferred income	0	0	0	0	41.00
42.00	Accelerated payments	0	0	0	0	42.00
43.00	Due to other funds	0	0	0	0	43.00
44.00	Other current liabilities	115,625,103	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	190,363,292	0	0	0	45.00
LONG TERM LIABILITIES						
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	0	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	-28,438,299	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	-28,438,299	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	161,924,993	0	0	0	51.00
CAPITAL ACCOUNTS						
52.00	General fund balance	565,925,128				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)	565,925,128	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	727,850,121	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 15-0162

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

Worksheet G-1

Date/Time Prepared:
3/30/2021 10:40 am

		General Fund		Special Purpose Fund		Endowment Fund	
		1.00	2.00	3.00	4.00	5.00	
1.00	Fund balances at beginning of period		576,296,353			0	1.00
2.00	Net income (loss) (From Wkst. G-3, line 29)		274,177,769				2.00
3.00	Total (sum of line 1 and line 2)		850,474,122			0	3.00
4.00	FUND EQUITY CHANGES	21,398,775		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)		21,398,775			0	10.00
11.00	Subtotal (line 3 plus line 10)		871,872,897			0	11.00
12.00	SHARED SERVICES	305,947,769		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)		305,947,769			0	18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		565,925,128			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	FUND EQUITY CHANGES		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	SHARED SERVICES		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: 15-0162

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

Worksheet G-2
Parts I & II
Date/Time Prepared:
3/30/2021 10:40 am

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
PART I - PATIENT REVENUES					
General Inpatient Routine Services					
1.00	Hospital	194,831,364		194,831,364	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF	23,982,164		23,982,164	3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	0		0	5.00
6.00	Swing bed - NF	0		0	6.00
7.00	SKILLED NURSING FACILITY				7.00
8.00	NURSING FACILITY				8.00
9.00	OTHER LONG TERM CARE				9.00
10.00	Total general inpatient care services (sum of lines 1-9)	218,813,528		218,813,528	10.00
Intensive Care Type Inpatient Hospital Services					
11.00	INTENSIVE CARE UNIT	37,011,910		37,011,910	11.00
11.01	NEONATAL INTENSIVE CARE UNIT	42,353,072		42,353,072	11.01
12.00	CORONARY CARE UNIT	0		0	12.00
13.00	BURN INTENSIVE CARE UNIT				13.00
14.00	SURGICAL INTENSIVE CARE UNIT	59,489,434		59,489,434	14.00
15.00	OTHER SPECIAL CARE (SPECIFY)				15.00
16.00	Total intensive care type inpatient hospital services (sum of lines 11-15)	138,854,416		138,854,416	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	357,667,944		357,667,944	17.00
18.00	Ancillary services	983,372,251	1,239,499,281	2,222,871,532	18.00
19.00	Outpatient services	80,216,011	306,684,384	386,900,395	19.00
20.00	RURAL HEALTH CLINIC	0	0	0	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY		0	0	22.00
23.00	AMBULANCE SERVICES				23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE	0	25,343,830	25,343,830	26.00
27.00	OTHER REVENUE	14,789,789	122,928,801	137,718,590	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	1,436,045,995	1,694,456,296	3,130,502,291	28.00
PART II - OPERATING EXPENSES					
29.00	Operating expenses (per Wkst. A, column 3, line 200)		560,927,679		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)		560,927,679		43.00

STATEMENT OF REVENUES AND EXPENSES	Provider CCN: 15-0162	Period: From 01/01/2020 To 12/31/2020	Worksheet G-3 Date/Time Prepared: 3/30/2021 10:40 am
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		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	3,130,502,291	1.00
2.00	Less contractual allowances and discounts on patients' accounts	2,327,753,031	2.00
3.00	Net patient revenues (line 1 minus line 2)	802,749,260	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	560,927,679	4.00
5.00	Net income from service to patients (line 3 minus line 4)	241,821,581	5.00
OTHER INCOME			
6.00	Contributions, donations, bequests, etc	152,322	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	3,730,242	10.00
11.00	Rebates and refunds of expenses	0	11.00
12.00	Parking lot receipts	50	12.00
13.00	Revenue from laundry and linen service	0	13.00
14.00	Revenue from meals sold to employees and guests	2,053,373	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	227,366	20.00
21.00	Rental of vending machines	47,334	21.00
22.00	Rental of hospital space	4,066,085	22.00
23.00	Governmental appropriations	0	23.00
24.00	IDENTIFIED ON TRIAL BALANCE	22,079,416	24.00
24.50	COVID-19 PHE Funding	0	24.50
25.00	Total other income (sum of lines 6-24)	32,356,188	25.00
26.00	Total (line 5 plus line 25)	274,177,769	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)	274,177,769	29.00

ANALYSIS OF HOSPITAL-BASED HOSPICE COSTS		Provider CCN: 15-0162 Hospice CCN: 15-1523		Period: From 01/01/2020 To 12/31/2020		Worksheet 0 Date/Time Prepared: 3/30/2021 10:40 am	
		SALARIES	OTHER	SUBTOTAL (col. 1 plus col. 2)	Hospice I RECLASSIFI- CATIONS	SUBTOTAL	
		1.00	2.00	3.00	4.00	5.00	
GENERAL SERVICE COST CENTERS							
1.00	CAP REL COSTS-BLDG & FIXT*		0	0	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP*		0	0	0	0	2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT*	0	1,743,656	1,743,656	-1,743,656	0	3.00
4.00	ADMINISTRATIVE & GENERAL*	3,243,569	237,380	3,480,949	-2,756,603	724,346	4.00
5.00	PLANT OPERATION & MAINTENANCE*	0	0	0	0	0	5.00
6.00	LAUNDRY & LINEN SERVICE*	0	17,352	17,352	0	17,352	6.00
7.00	HOUSEKEEPING*	0	0	0	0	0	7.00
8.00	DIETARY*	0	21,507	21,507	0	21,507	8.00
9.00	NURSING ADMINISTRATION*	0	0	0	0	0	9.00
10.00	ROUTINE MEDICAL SUPPLIES*	0	0	0	0	0	10.00
11.00	MEDICAL RECORDS*	0	0	0	0	0	11.00
12.00	STAFF TRANSPORTATION*	0	74,384	74,384	0	74,384	12.00
13.00	VOLUNTEER SERVICE COORDINATION*	0	0	0	48,128	48,128	13.00
14.00	PHARMACY*	0	319,580	319,580	0	319,580	14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES*	0	0	0	0	0	15.00
16.00	OTHER GENERAL SERVICE*	0	0	0	0	0	16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES						17.00
DIRECT PATIENT CARE SERVICE COST CENTERS							
25.00	INPATIENT CARE-CONTRACTED**		0	0	0	0	25.00
26.00	PHYSICIAN SERVICES**	0	0	0	0	0	26.00
27.00	NURSE PRACTITIONER**	0	0	0	0	0	27.00
28.00	REGISTERED NURSE**	0	27,986	27,986	1,784,983	1,812,969	28.00
29.00	LPN/LVN**	0	0	0	0	0	29.00
30.00	PHYSICAL THERAPY**	0	0	0	0	0	30.00
31.00	OCCUPATIONAL THERAPY**	0	0	0	0	0	31.00
32.00	SPEECH/LANGUAGE PATHOLOGY**	0	0	0	0	0	32.00
33.00	MEDICAL SOCIAL SERVICES**	0	0	0	322,729	322,729	33.00
34.00	SPIRITUAL COUNSELING**	0	0	0	147,442	147,442	34.00
35.00	DIETARY COUNSELING**	0	0	0	0	0	35.00
36.00	COUNSELING - OTHER**	0	0	0	0	0	36.00
37.00	HOSPICE AIDE & HOME MAKER SERVICES**	0	0	0	390,646	390,646	37.00
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN**	0	219,386	219,386	0	219,386	38.00
39.00	PATIENT TRANSPORTATION**	0	0	0	0	0	39.00
40.00	IMAGING SERVICES**	0	0	0	0	0	40.00
41.00	LABS & DIAGNOSTICS**	0	0	0	0	0	41.00
42.00	MEDICAL SUPPLIES-NON-ROUTINE**	0	133,572	133,572	0	133,572	42.00
42.50	DRUGS CHARGED TO PATIENTS**	0	0	0	0	0	42.50
43.00	OUTPATIENT SERVICES**	0	377,959	377,959	0	377,959	43.00
44.00	PALLIATIVE RADIATION THERAPY**	0	0	0	0	0	44.00
45.00	PALLIATIVE CHEMOTHERAPY**	0	0	0	0	0	45.00
46.00	OTHER PATIENT CARE SERVICES (SPECIFY)**	0	0	0	0	0	46.00
NONREIMBURSABLE COST CENTERS							
60.00	BEREAVEMENT PROGRAM *	0	0	0	62,675	62,675	60.00
61.00	VOLUNTEER PROGRAM *	0	0	0	0	0	61.00
62.00	FUNDRAISING*	0	0	0	0	0	62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS*	0	0	0	0	0	63.00
64.00	PALLIATIVE CARE PROGRAM*	2,551,792	74,896	2,626,688	0	2,626,688	64.00
65.00	OTHER PHYSICIAN SERVICES*	0	0	0	0	0	65.00
66.00	RESIDENTIAL CARE*	0	0	0	0	0	66.00
67.00	ADVERTISING*	0	0	0	0	0	67.00
68.00	TELEHEALTH/TELEMONITORING*	0	0	0	0	0	68.00
69.00	THRIFT STORE*	0	0	0	0	0	69.00
70.00	NURSING FACILITY ROOM & BOARD*	0	0	0	0	0	70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)*	0	0	0	0	0	71.00
100.00	TOTAL	5,795,361	3,247,658	9,043,019	-1,743,656	7,299,363	100.00

* Transfer the amounts in column 7 to Wkst. 0-5, column 1, line as appropriate.

** See instructions. Do not transfer the amounts in column 7 to Wkst. 0-5.

ANALYSIS OF HOSPITAL-BASED HOSPICE COSTS		Provider CCN: 15-0162	Period: From 01/01/2020 To 12/31/2020	Worksheet 0
		Hospice CCN: 15-1523		Date/Time Prepared: 3/30/2021 10:40 am
		Hospice I		

		ADJUSTMENTS	TOTAL (col. 5 ± col. 6)	
		6.00	7.00	
GENERAL SERVICE COST CENTERS				
1.00	CAP REL COSTS-BLDG & FIXT*	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP*	0	0	2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT*	0	0	3.00
4.00	ADMINISTRATIVE & GENERAL*	0	724,346	4.00
5.00	PLANT OPERATION & MAINTENANCE*	0	0	5.00
6.00	LAUNDRY & LINEN SERVICE*	0	17,352	6.00
7.00	HOUSEKEEPING*	0	0	7.00
8.00	DIETARY*	0	21,507	8.00
9.00	NURSING ADMINISTRATION*	0	0	9.00
10.00	ROUTINE MEDICAL SUPPLIES*	0	0	10.00
11.00	MEDICAL RECORDS*	0	0	11.00
12.00	STAFF TRANSPORTATION*	0	74,384	12.00
13.00	VOLUNTEER SERVICE COORDINATION*	0	48,128	13.00
14.00	PHARMACY*	0	319,580	14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES*	0	0	15.00
16.00	OTHER GENERAL SERVICE*	0	0	16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES			17.00
DIRECT PATIENT CARE SERVICE COST CENTERS				
25.00	INPATIENT CARE-CONTRACTED**	0	0	25.00
26.00	PHYSICIAN SERVICES**	0	0	26.00
27.00	NURSE PRACTITIONER**	0	0	27.00
28.00	REGISTERED NURSE**	0	1,812,969	28.00
29.00	LPN/LVN**	0	0	29.00
30.00	PHYSICAL THERAPY**	0	0	30.00
31.00	OCCUPATIONAL THERAPY**	0	0	31.00
32.00	SPEECH/LANGUAGE PATHOLOGY**	0	0	32.00
33.00	MEDICAL SOCIAL SERVICES**	0	322,729	33.00
34.00	SPIRITUAL COUNSELING**	0	147,442	34.00
35.00	DIETARY COUNSELING**	0	0	35.00
36.00	COUNSELING - OTHER**	0	0	36.00
37.00	HOSPICE AIDE & HOME MAKER SERVICES**	0	390,646	37.00
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN**	0	219,386	38.00
39.00	PATIENT TRANSPORTATION**	0	0	39.00
40.00	IMAGING SERVICES**	0	0	40.00
41.00	LABS & DIAGNOSTICS**	0	0	41.00
42.00	MEDICAL SUPPLIES-NON-ROUTINE**	0	133,572	42.00
42.50	DRUGS CHARGED TO PATIENTS**	0	0	42.50
43.00	OUTPATIENT SERVICES**	0	377,959	43.00
44.00	PALLIATIVE RADIATION THERAPY**	0	0	44.00
45.00	PALLIATIVE CHEMOTHERAPY**	0	0	45.00
46.00	OTHER PATIENT CARE SERVICES (SPECIFY)**	0	0	46.00
NONREIMBURSABLE COST CENTERS				
60.00	BEREAVEMENT PROGRAM *	0	62,675	60.00
61.00	VOLUNTEER PROGRAM *	0	0	61.00
62.00	FUNDRAISING*	0	0	62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS*	0	0	63.00
64.00	PALLIATIVE CARE PROGRAM*	0	2,626,688	64.00
65.00	OTHER PHYSICIAN SERVICES*	0	0	65.00
66.00	RESIDENTIAL CARE*	0	0	66.00
67.00	ADVERTISING*	0	0	67.00
68.00	TELEHEALTH/TELEMONITORING*	0	0	68.00
69.00	THRIFT STORE*	0	0	69.00
70.00	NURSING FACILITY ROOM & BOARD*	0	0	70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)*	0	0	71.00
100.00	TOTAL	0	7,299,363	100.00

* Transfer the amounts in column 7 to Wkst. 0-5, column 1, line as appropriate.

** See instructions. Do not transfer the amounts in column 7 to Wkst. 0-5.

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

Provider CCN: 15-0162

Period: From 01/01/2020

Worksheet 0-3

Hospice CCN: 15-1523

To 12/31/2020

Date/Time Prepared: 3/30/2021 10:40 am

		Hospice I				
		SALARIES	OTHER	SUBTOTAL (col. 1 + col. 2)	RECLASSIFI - CATIONS	SUBTOTAL
		1.00	2.00	3.00	4.00	5.00
DI RECT PATIENT CARE SERVICE COST CENTERS						
25.00	INPATIENT CARE-CONTRACTED		0	0	0	25.00
26.00	PHYSICIAN SERVICES	0	0	0	0	26.00
27.00	NURSE PRACTITIONER	0	0	0	0	27.00
28.00	REGISTERED NURSE	0	610	610	170,789	28.00
29.00	LPN/LVN	0	0	0	0	29.00
30.00	PHYSICAL THERAPY	0	0	0	0	30.00
31.00	OCCUPATIONAL THERAPY	0	0	0	0	31.00
32.00	SPEECH/LANGUAGE PATHOLOGY	0	0	0	0	32.00
33.00	MEDICAL SOCIAL SERVICES	0	0	0	0	33.00
34.00	SPIRITUAL COUNSELING	0	0	0	0	34.00
35.00	DIETARY COUNSELING	0	0	0	0	35.00
36.00	COUNSELING - OTHER	0	0	0	0	36.00
37.00	HOSPICE AIDE & HOME MAKER SERVICES	0	0	0	2,159	37.00
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN	0	4,791	4,791	0	38.00
39.00	PATIENT TRANSPORTATION	0	0	0	0	39.00
40.00	IMAGING SERVICES	0	0	0	0	40.00
41.00	LABS & DIAGNOSTICS	0	0	0	0	41.00
42.00	MEDICAL SUPPLIES-NON-ROUTINE	0	2,912	2,912	0	42.00
42.50	DRUGS CHARGED TO PATIENTS	0	0	0	0	42.50
43.00	OUTPATIENT SERVICES	0	8,231	8,231	0	43.00
44.00	PALLIATIVE RADIATION THERAPY	0	0	0	0	44.00
45.00	PALLIATIVE CHEMOTHERAPY	0	0	0	0	45.00
46.00	OTHER PATIENT CARE SERVICES (SPECIFY)	0	0	0	0	46.00
100.00	TOTAL *	0	16,544	16,544	172,948	189,492

* Transfer the amount in column 7 to Wkst. 0-5, column 1, line 52.

		ADJUSTMENTS	TOTAL (col. 5 ± col. 6)	
		6.00	7.00	
DI RECT PATIENT CARE SERVICE COST CENTERS				
25.00	INPATIENT CARE-CONTRACTED	0	0	25.00
26.00	PHYSICIAN SERVICES	0	0	26.00
27.00	NURSE PRACTITIONER	0	0	27.00
28.00	REGISTERED NURSE	0	171,399	28.00
29.00	LPN/LVN	0	0	29.00
30.00	PHYSICAL THERAPY	0	0	30.00
31.00	OCCUPATIONAL THERAPY	0	0	31.00
32.00	SPEECH/LANGUAGE PATHOLOGY	0	0	32.00
33.00	MEDICAL SOCIAL SERVICES	0	0	33.00
34.00	SPIRITUAL COUNSELING	0	0	34.00
35.00	DIETARY COUNSELING	0	0	35.00
36.00	COUNSELING - OTHER	0	0	36.00
37.00	HOSPICE AIDE & HOME MAKER SERVICES	0	2,159	37.00
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN	0	4,791	38.00
39.00	PATIENT TRANSPORTATION	0	0	39.00
40.00	IMAGING SERVICES	0	0	40.00
41.00	LABS & DIAGNOSTICS	0	0	41.00
42.00	MEDICAL SUPPLIES-NON-ROUTINE	0	2,912	42.00
42.50	DRUGS CHARGED TO PATIENTS	0	0	42.50
43.00	OUTPATIENT SERVICES	0	8,231	43.00
44.00	PALLIATIVE RADIATION THERAPY	0	0	44.00
45.00	PALLIATIVE CHEMOTHERAPY	0	0	45.00
46.00	OTHER PATIENT CARE SERVICES (SPECIFY)	0	0	46.00
100.00	TOTAL *	0	189,492	189,492

* Transfer the amount in column 7 to Wkst. 0-5, column 1, line 52.

ANALYSIS OF HOSPITAL-BASED HOSPICE COSTS FOR HOSPICE GENERAL
 INPATIENT CARE
 Provider CCN: 15-0162
 Hospice CCN: 15-1523
 Period: From 01/01/2020 To 12/31/2020
 Worksheet 0-4
 Date/Time Prepared: 3/30/2021 10:40 am

		Hospice I				
		SALARIES	OTHER	SUBTOTAL (col. 1 + col. 2)	RECLASSIFICATIONS	SUBTOTAL
		1.00	2.00	3.00	4.00	5.00
DI RECT PATIENT CARE SERVICE COST CENTERS						
25.00	INPATIENT CARE-CONTRACTED		0	0	0	25.00
26.00	PHYSICIAN SERVICES	0	0	0	0	26.00
27.00	NURSE PRACTITIONER	0	0	0	0	27.00
28.00	REGISTERED NURSE	0	48	48	1,535,175	28.00
29.00	LPN/LVN	0	0	0	0	29.00
30.00	PHYSICAL THERAPY	0	0	0	0	30.00
31.00	OCCUPATIONAL THERAPY	0	0	0	0	31.00
32.00	SPEECH/LANGUAGE PATHOLOGY	0	0	0	0	32.00
33.00	MEDICAL SOCIAL SERVICES	0	0	0	0	33.00
34.00	SPIRITUAL COUNSELING	0	0	0	0	34.00
35.00	DIETARY COUNSELING	0	0	0	0	35.00
36.00	COUNSELING - OTHER	0	0	0	0	36.00
37.00	HOSPICE AIDE & HOME MAKER SERVICES	0	0	0	19,406	37.00
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN	0	0	0	0	38.00
39.00	PATIENT TRANSPORTATION	0	0	0	0	39.00
40.00	IMAGING SERVICES	0	0	0	0	40.00
41.00	LABS & DIAGNOSTICS	0	0	0	0	41.00
42.00	MEDICAL SUPPLIES-NON-ROUTINE	0	227	227	0	42.00
42.50	DRUGS CHARGED TO PATIENTS	0	0	0	0	42.50
43.00	OUTPATIENT SERVICES	0	1,015	1,015	0	43.00
44.00	PALLIATIVE RADIATION THERAPY	0	0	0	0	44.00
45.00	PALLIATIVE CHEMOTHERAPY	0	0	0	0	45.00
46.00	OTHER PATIENT CARE SERVICES (SPECIFY)	0	0	0	0	46.00
100.00	TOTAL *	0	1,290	1,290	1,554,581	100.00

* Transfer the amount in column 7 to Wkst. 0-5, column 1, line 53.

		ADJUSTMENTS	TOTAL (col. 5 ± col. 6)	
		6.00	7.00	
DI RECT PATIENT CARE SERVICE COST CENTERS				
25.00	INPATIENT CARE-CONTRACTED	0	0	25.00
26.00	PHYSICIAN SERVICES	0	0	26.00
27.00	NURSE PRACTITIONER	0	0	27.00
28.00	REGISTERED NURSE	0	1,535,223	28.00
29.00	LPN/LVN	0	0	29.00
30.00	PHYSICAL THERAPY	0	0	30.00
31.00	OCCUPATIONAL THERAPY	0	0	31.00
32.00	SPEECH/LANGUAGE PATHOLOGY	0	0	32.00
33.00	MEDICAL SOCIAL SERVICES	0	0	33.00
34.00	SPIRITUAL COUNSELING	0	0	34.00
35.00	DIETARY COUNSELING	0	0	35.00
36.00	COUNSELING - OTHER	0	0	36.00
37.00	HOSPICE AIDE & HOME MAKER SERVICES	0	19,406	37.00
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN	0	0	38.00
39.00	PATIENT TRANSPORTATION	0	0	39.00
40.00	IMAGING SERVICES	0	0	40.00
41.00	LABS & DIAGNOSTICS	0	0	41.00
42.00	MEDICAL SUPPLIES-NON-ROUTINE	0	227	42.00
42.50	DRUGS CHARGED TO PATIENTS	0	0	42.50
43.00	OUTPATIENT SERVICES	0	1,015	43.00
44.00	PALLIATIVE RADIATION THERAPY	0	0	44.00
45.00	PALLIATIVE CHEMOTHERAPY	0	0	45.00
46.00	OTHER PATIENT CARE SERVICES (SPECIFY)	0	0	46.00
100.00	TOTAL *	0	1,555,871	100.00

* Transfer the amount in column 7 to Wkst. 0-5, column 1, line 53.

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

Provider CCN: 15-0162

Period: From 01/01/2020

Worksheet 0-5

Hospice CCN: 15-1523

To 12/31/2020

Date/Time Prepared: 3/30/2021 10:40 am

Descriptions		Hospice I		TOTAL EXPENSES (sum of col s. 1 + 2)	
		HOSPICE DIRECT EXPENSES (see instructions)	GENERAL SERVICE EXPENSES FROM WKST B PART I (see instructions)		
		1.00	2.00	3.00	
GENERAL SERVICE COST CENTERS					
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT	0	2,394,910	2,394,910	3.00
4.00	ADMINISTRATIVE & GENERAL	724,346	2,646,758	3,371,104	4.00
5.00	PLANT OPERATION & MAINTENANCE	0	0	0	5.00
6.00	LAUNDRY & LINEN SERVICE	17,352	0	17,352	6.00
7.00	HOUSEKEEPING	0	0	0	7.00
8.00	DIETARY	21,507	0	21,507	8.00
9.00	NURSING ADMINISTRATION	0	0	0	9.00
10.00	ROUTINE MEDICAL SUPPLIES	0	13,914	13,914	10.00
11.00	MEDICAL RECORDS	0	1,850	1,850	11.00
12.00	STAFF TRANSPORTATION	74,384	0	74,384	12.00
13.00	VOLUNTEER SERVICE COORDINATION	48,128	0	48,128	13.00
14.00	PHARMACY	319,580	0	319,580	14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES	0	0	0	15.00
16.00	OTHER GENERAL SERVICE	0	0	0	16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES	0	0	0	17.00
LEVEL OF CARE					
50.00	HOSPICE CONTINUOUS HOME CARE	0	0	0	50.00
51.00	HOSPICE ROUTINE HOME CARE	1,659,340	0	1,659,340	51.00
52.00	HOSPICE INPATIENT RESPIRE CARE	189,492	0	189,492	52.00
53.00	HOSPICE GENERAL INPATIENT CARE	1,555,871	0	1,555,871	53.00
NONREIMBURSABLE COST CENTERS					
60.00	BEREAVEMENT PROGRAM	62,675	0	62,675	60.00
61.00	VOLUNTEER PROGRAM	0	0	0	61.00
62.00	FUNDRAISING	0	0	0	62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS	0	0	0	63.00
64.00	PALLIATIVE CARE PROGRAM	2,626,688	0	2,626,688	64.00
65.00	OTHER PHYSICIAN SERVICES	0	0	0	65.00
66.00	RESIDENTIAL CARE	0	0	0	66.00
67.00	ADVERTISING	0	0	0	67.00
68.00	TELEHEALTH/TELEMONITORING	0	0	0	68.00
69.00	THRIFT STORE	0	0	0	69.00
70.00	NURSING FACILITY ROOM & BOARD	0	0	0	70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)	0	0	0	71.00
99.00	NEGATIVE COST CENTER	0	0	0	99.00
100.00	TOTAL	7,299,363	5,057,432	12,356,795	100.00

COST ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL SERVICE COSTS		Provider CCN: 15-0162	Period: From 01/01/2020	Worksheet 0-6
		Hospice CCN: 15-1523	To 12/31/2020	Part I
				Date/Time Prepared: 3/30/2021 10:40 am

Descriptions	TOTAL EXPENSES	CAP REL BLDG & FIX	CAP REL MVBLE EQUIP	EMPLOYEE BENEFITS DEPARTMENT	SUBTOTAL	
	0	1.00	2.00	3.00	3A	
GENERAL SERVICE COST CENTERS						
1.00	CAP REL COSTS-BLDG & FIX	0	0			1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0		2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT	2,394,910	0	0	2,394,910	3.00
4.00	ADMINISTRATIVE & GENERAL	3,371,104	0	0	240,925	3,612,029
5.00	PLANT OPERATION & MAINTENANCE	0	0	0	0	0
6.00	LAUNDRY & LINEN SERVICE	17,352	0	0	0	17,352
7.00	HOUSEKEEPING	0	0	0	0	0
8.00	DIETARY	21,507	0	0	0	21,507
9.00	NURSING ADMINISTRATION	0	0	0	0	0
10.00	ROUTINE MEDICAL SUPPLIES	13,914	0	0	0	13,914
11.00	MEDICAL RECORDS	1,850	0	0	0	1,850
12.00	STAFF TRANSPORTATION	74,384	0	0	0	74,384
13.00	VOLUNTEER SERVICE COORDINATION	48,128	0	0	19,762	67,890
14.00	PHARMACY	319,580	0	0	0	319,580
15.00	PHYSICIAN ADMINISTRATIVE SERVICES	0	0	0	0	0
16.00	OTHER GENERAL SERVICE	0	0	0	0	0
17.00	PATIENT/RESIDENTIAL CARE SERVICES	0	0	0	0	0
LEVEL OF CARE						
50.00	HOSPICE CONTINUOUS HOME CARE	0			0	0
51.00	HOSPICE ROUTINE HOME CARE	1,659,340			377,059	2,036,399
52.00	HOSPICE INPATIENT RESPIRE CARE	189,492	0	0	71,016	260,508
53.00	HOSPICE GENERAL INPATIENT CARE	1,555,871	0	0	638,339	2,194,210
NONREIMBURSABLE COST CENTERS						
60.00	BEREAVEMENT PROGRAM	62,675	0	0	0	62,675
61.00	VOLUNTEER PROGRAM	0	0	0	0	0
62.00	FUNDRAISING	0	0	0	0	0
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS	0	0	0	0	0
64.00	PALLIATIVE CARE PROGRAM	2,626,688	0	0	1,047,809	3,674,497
65.00	OTHER PHYSICIAN SERVICES	0	0	0	0	0
66.00	RESIDENTIAL CARE	0	0	0	0	0
67.00	ADVERTISING	0	0	0	0	0
68.00	TELEHEALTH/TELEMONITORING	0	0	0	0	0
69.00	THRIFT STORE	0	0	0	0	0
70.00	NURSING FACILITY ROOM & BOARD	0				0
71.00	OTHER NONREIMBURSABLE (SPECIFY)	0	0	0	0	0
99.00	NEGATIVE COST CENTER	0	0	0	0	0
100.00	TOTAL	12,356,795	0	0	2,394,910	12,356,795

COST ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL SERVICE COSTS		Provider CCN: 15-0162	Period: From 01/01/2020	Worksheet 0-6
		Hospice CCN: 15-1523	To 12/31/2020	Part I
				Date/Time Prepared: 3/30/2021 10:40 am

Descriptions	Hospice I					
	ADMINISTRATIVE & GENERAL	PLANT OPERATION & MAINTENANCE	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
	4.00	5.00	6.00	7.00	8.00	
GENERAL SERVICE COST CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT					1.00
2.00	CAP REL COSTS-MVBLE EQUIP					2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT					3.00
4.00	ADMINISTRATIVE & GENERAL	3,612,029				4.00
5.00	PLANT OPERATION & MAINTENANCE	0	0			5.00
6.00	LAUNDRY & LINEN SERVICE	7,167	0	24,519		6.00
7.00	HOUSEKEEPING	0	0		0	7.00
8.00	DIETARY	8,883	0		0	30,390
9.00	NURSING ADMINISTRATION	0	0		0	9.00
10.00	ROUTINE MEDICAL SUPPLIES	5,747	0		0	10.00
11.00	MEDICAL RECORDS	764	0		0	11.00
12.00	STAFF TRANSPORTATION	30,724	0		0	12.00
13.00	VOLUNTEER SERVICE COORDINATION	28,042	0		0	13.00
14.00	PHARMACY	132,003	0		0	14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES	0	0		0	15.00
16.00	OTHER GENERAL SERVICE	0	0		0	16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES	0	0		0	17.00
LEVEL OF CARE						
50.00	HOSPICE CONTINUOUS HOME CARE	0				50.00
51.00	HOSPICE ROUTINE HOME CARE	841,135				51.00
52.00	HOSPICE INPATIENT RESPIRE CARE	107,603	0	22,449	0	27,824
53.00	HOSPICE GENERAL INPATIENT CARE	906,318	0	2,070	0	2,566
NONREIMBURSABLE COST CENTERS						
60.00	BEREAVEMENT PROGRAM	25,888	0		0	60.00
61.00	VOLUNTEER PROGRAM	0	0		0	61.00
62.00	FUNDRAISING	0	0		0	62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS	0	0		0	63.00
64.00	PALLIATIVE CARE PROGRAM	1,517,755	0		0	64.00
65.00	OTHER PHYSICIAN SERVICES	0	0		0	65.00
66.00	RESIDENTIAL CARE	0	0	0	0	0
67.00	ADVERTISING	0	0		0	67.00
68.00	TELEHEALTH/TELEMONITORING	0	0		0	68.00
69.00	THRIFT STORE	0	0		0	69.00
70.00	NURSING FACILITY ROOM & BOARD					70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)	0	0	0	0	0
99.00	NEGATIVE COST CENTER	0	0	0	0	0
100.00	TOTAL	3,612,029	0	24,519	0	30,390

COST ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL SERVICE COSTS		Provider CCN: 15-0162	Period: From 01/01/2020	Worksheet 0-6
		Hospice CCN: 15-1523	To 12/31/2020	Part I
				Date/Time Prepared: 3/30/2021 10:40 am

Descriptions	Hospice I					
	NURSING ADMINISTRATIVE	ROUTINE MEDICAL SUPPLIES	MEDICAL RECORDS	STAFF TRANSPORTATION	VOLUNTEER SERVICE COORDINATION	
	9.00	10.00	11.00	12.00	13.00	
GENERAL SERVICE COST CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT					1.00
2.00	CAP REL COSTS-MVBLE EQUIP					2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT					3.00
4.00	ADMINISTRATIVE & GENERAL					4.00
5.00	PLANT OPERATION & MAINTENANCE					5.00
6.00	LAUNDRY & LINEN SERVICE					6.00
7.00	HOUSEKEEPING					7.00
8.00	DIETARY					8.00
9.00	NURSING ADMINISTRATION	0				9.00
10.00	ROUTINE MEDICAL SUPPLIES	0	19,661			10.00
11.00	MEDICAL RECORDS	0		2,614		11.00
12.00	STAFF TRANSPORTATION	0			105,108	12.00
13.00	VOLUNTEER SERVICE COORDINATION	0			0	95,932
14.00	PHARMACY	0			0	0
15.00	PHYSICIAN ADMINISTRATIVE SERVICES	0			0	0
16.00	OTHER GENERAL SERVICE	0			0	0
17.00	PATIENT/RESIDENTIAL CARE SERVICES	0			0	0
LEVEL OF CARE						
50.00	HOSPICE CONTINUOUS HOME CARE	0	0	0	0	0
51.00	HOSPICE ROUTINE HOME CARE	0	19,279	2,563	105,108	94,066
52.00	HOSPICE INPATIENT RESPIRE CARE	0	350	47	0	1,708
53.00	HOSPICE GENERAL INPATIENT CARE	0	32	4	0	158
NONREIMBURSABLE COST CENTERS						
60.00	BEREAVEMENT PROGRAM	0			0	0
61.00	VOLUNTEER PROGRAM	0			0	0
62.00	FUNDRAISING	0			0	0
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS	0			0	0
64.00	PALLIATIVE CARE PROGRAM	0			0	0
65.00	OTHER PHYSICIAN SERVICES	0			0	0
66.00	RESIDENTIAL CARE	0			0	0
67.00	ADVERTISING	0			0	0
68.00	TELEHEALTH/TELEMONITORING	0			0	0
69.00	THRIFT STORE	0			0	0
70.00	NURSING FACILITY ROOM & BOARD					70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)	0			0	0
99.00	NEGATIVE COST CENTER	0	0	0	0	0
100.00	TOTAL	0	19,661	2,614	105,108	95,932

COST ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL SERVICE COSTS

Provider CCN: 15-0162

Period: From 01/01/2020

Worksheet 0-6

Hospice CCN: 15-1523

To 12/31/2020

Part I
Date/Time Prepared:
3/30/2021 10:40 am

Descriptions	Hospice I				TOTAL	
	PHARMACY	PHYSICIAN ADMINISTRATIVE SERVICES	OTHER GENERAL SERVICE	PATIENT/ RESIDENTIAL CARE SERVICES		
	14.00	15.00	16.00	17.00	18.00	
GENERAL SERVICE COST CENTERS						
1.00						1.00
2.00						2.00
3.00						3.00
4.00						4.00
5.00						5.00
6.00						6.00
7.00						7.00
8.00						8.00
9.00						9.00
10.00						10.00
11.00						11.00
12.00						12.00
13.00						13.00
14.00	451,583					14.00
15.00	0	0				15.00
16.00	0		0			16.00
17.00				0		17.00
LEVEL OF CARE						
50.00	0	0	0		0	50.00
51.00	442,800	0	0		3,541,350	51.00
52.00	8,041	0	0	0	428,530	52.00
53.00	742	0	0	0	3,106,100	53.00
NONREIMBURSABLE COST CENTERS						
60.00	0		0		88,563	60.00
61.00	0		0		0	61.00
62.00	0		0		0	62.00
63.00	0		0		0	63.00
64.00	0		0		5,192,252	64.00
65.00	0		0		0	65.00
66.00	0	0	0	0	0	66.00
67.00	0		0		0	67.00
68.00	0		0		0	68.00
69.00	0		0		0	69.00
70.00	0		0		0	70.00
71.00	0	0	0	0	0	71.00
99.00	0	0	0	0	0	99.00
100.00	451,583	0	0	0	12,356,795	100.00

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

Provider CCN: 15-0162

Period: From 01/01/2020

Worksheet 0-6

Hospice CCN: 15-1523

To 12/31/2020

Part II
Date/Time Prepared:
3/30/2021 10:40 am

Cost Center Descriptions		CAP REL BLDG & FIX (SQUARE FEET)	CAP REL MVBLE EQUIP (DOLLAR VALUE)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	RECONCILIATION	ADMINISTRATIVE & GENERAL (ACCUMULATED COSTS)	
		1.00	2.00	3.00	4A	4.00	
GENERAL SERVICE COST CENTERS							
1.00	CAP REL COSTS-BLDG & FIXT	0					1.00
2.00	CAP REL COSTS-MVBLE EQUIP		0				2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT			5,832,459			3.00
4.00	ADMINISTRATIVE & GENERAL			586,738	-3,612,029	8,744,766	4.00
5.00	PLANT OPERATION & MAINTENANCE			0	0	0	5.00
6.00	LAUNDRY & LINEN SERVICE			0		17,352	6.00
7.00	HOUSEKEEPING			0		0	7.00
8.00	DIETARY			0		21,507	8.00
9.00	NURSING ADMINISTRATION			0		0	9.00
10.00	ROUTINE MEDICAL SUPPLIES			0		13,914	10.00
11.00	MEDICAL RECORDS			0		1,850	11.00
12.00	STAFF TRANSPORTATION			0		74,384	12.00
13.00	VOLUNTEER SERVICE COORDINATION			48,128		67,890	13.00
14.00	PHARMACY			0		319,580	14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES			0		0	15.00
16.00	OTHER GENERAL SERVICE			0		0	16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES			0		0	17.00
LEVEL OF CARE							
50.00	HOSPICE CONTINUOUS HOME CARE			0	0	0	50.00
51.00	HOSPICE ROUTINE HOME CARE			918,271		2,036,399	51.00
52.00	HOSPICE INPATIENT RESPIRE CARE	0	0	172,948	0	260,508	52.00
53.00	HOSPICE GENERAL INPATIENT CARE	0	0	1,554,581	0	2,194,210	53.00
NONREIMBURSABLE COST CENTERS							
60.00	BEREAVEMENT PROGRAM	0	0	0	0	62,675	60.00
61.00	VOLUNTEER PROGRAM	0	0	0	0	0	61.00
62.00	FUNDRAISING	0	0	0	0	0	62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS	0	0	0	0	0	63.00
64.00	PALLIATIVE CARE PROGRAM	0	0	2,551,793	0	3,674,497	64.00
65.00	OTHER PHYSICIAN SERVICES	0	0	0	0	0	65.00
66.00	RESIDENTIAL CARE	0	0	0	0	0	66.00
67.00	ADVERTISING	0	0	0	0	0	67.00
68.00	TELEHEALTH/TELEMONITORING	0	0	0	0	0	68.00
69.00	THRIFT STORE	0	0	0	0	0	69.00
70.00	NURSING FACILITY ROOM & BOARD	0	0	0	0	0	70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)	0	0	0	0	0	71.00
99.00	NEGATIVE COST CENTER						99.00
100.00	COST TO BE ALLOCATED (per Wkst. 0-6, Part I)			2,394,910		3,612,029	100.00
101.00	UNIT COST MULTIPLIER	0.000000	0.000000	0.410618		0.413050	101.00

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

Provider CCN: 15-0162
Hospice CCN: 15-1523

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

Worksheet 0-6
Part II
Date/Time Prepared:
3/30/2021 10:40 am

Cost Center Descriptions		Hospice I					
		PLANT OPERATION & MAINTENANCE (SQUARE FEET)	LAUNDRY & LINEN SERVICE (IN-FACILITY DAYS)	HOUSEKEEPING (SQUARE FEET)	DIETARY (IN-FACILITY DAYS)	NURSING ADMINISTRATION (DIRECT NURS. HRS.)	
		5.00	6.00	7.00	8.00	9.00	
GENERAL SERVICE COST CENTERS							
1.00	CAP REL COSTS-BLDG & FIXT						1.00
2.00	CAP REL COSTS-MVBLE EQUIP						2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT						3.00
4.00	ADMINISTRATIVE & GENERAL						4.00
5.00	PLANT OPERATION & MAINTENANCE	0					5.00
6.00	LAUNDRY & LINEN SERVICE	0	604				6.00
7.00	HOUSEKEEPING	0		0			7.00
8.00	DIETARY	0		0	604		8.00
9.00	NURSING ADMINISTRATION	0		0		31,056	9.00
10.00	ROUTINE MEDICAL SUPPLIES	0		0		0	10.00
11.00	MEDICAL RECORDS	0		0		0	11.00
12.00	STAFF TRANSPORTATION	0		0		0	12.00
13.00	VOLUNTEER SERVICE COORDINATION	0		0		0	13.00
14.00	PHARMACY	0		0		0	14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES	0		0		0	15.00
16.00	OTHER GENERAL SERVICE	0		0		0	16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES	0		0		0	17.00
LEVEL OF CARE							
50.00	HOSPICE CONTINUOUS HOME CARE					0	50.00
51.00	HOSPICE ROUTINE HOME CARE					30,452	51.00
52.00	HOSPICE INPATIENT RESPIRE CARE	0	553	0	553	553	52.00
53.00	HOSPICE GENERAL INPATIENT CARE	0	51	0	51	51	53.00
NONREIMBURSABLE COST CENTERS							
60.00	BEREAVEMENT PROGRAM	0		0		0	60.00
61.00	VOLUNTEER PROGRAM	0		0		0	61.00
62.00	FUNDRAISING	0		0		0	62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS	0		0		0	63.00
64.00	PALLIATIVE CARE PROGRAM	0		0		0	64.00
65.00	OTHER PHYSICIAN SERVICES	0		0		0	65.00
66.00	RESIDENTIAL CARE	0	0	0	0	0	66.00
67.00	ADVERTISING	0		0		0	67.00
68.00	TELEHEALTH/TELEMONITORING	0		0		0	68.00
69.00	THRIFT STORE	0		0		0	69.00
70.00	NURSING FACILITY ROOM & BOARD	0		0		0	70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)	0	0	0	0	0	71.00
99.00	NEGATIVE COST CENTER						99.00
100.00	COST TO BE ALLOCATED (per Wkst. 0-6, Part I)		24,519	0	30,390	0	100.00
101.00	UNIT COST MULTIPLIER	0.000000	40.594371	0.000000	50.314570	0.000000	101.00

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

Provider CCN: 15-0162

Hospice CCN: 15-1523

Period:

From 01/01/2020
To 12/31/2020

Worksheet 0-6

Part II
Date/Time Prepared:
3/30/2021 10:40 am

Cost Center Descriptions		Hospice I					
		ROUTINE MEDICAL SUPPLIES (PATIENT DAYS)	MEDICAL RECORDS (PATIENT DAYS)	STAFF TRANSPORTATION (MILEAGE)	VOLUNTEER SERVICE COORDINATION (HOURS OF SERVICE)	PHARMACY (CHARGES)	
		10.00	11.00	12.00	13.00	14.00	
GENERAL SERVICE COST CENTERS							
1.00	CAP REL COSTS-BLDG & FIXT						1.00
2.00	CAP REL COSTS-MVBLE EQUIP						2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT						3.00
4.00	ADMINISTRATIVE & GENERAL						4.00
5.00	PLANT OPERATION & MAINTENANCE						5.00
6.00	LAUNDRY & LINEN SERVICE						6.00
7.00	HOUSEKEEPING						7.00
8.00	DIETARY						8.00
9.00	NURSING ADMINISTRATION						9.00
10.00	ROUTINE MEDICAL SUPPLIES	31,056					10.00
11.00	MEDICAL RECORDS		31,056				11.00
12.00	STAFF TRANSPORTATION			100			12.00
13.00	VOLUNTEER SERVICE COORDINATION				31,056		13.00
14.00	PHARMACY					31,056	14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES						15.00
16.00	OTHER GENERAL SERVICE						16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES						17.00
LEVEL OF CARE							
50.00	HOSPICE CONTINUOUS HOME CARE	0	0	0	0	0	50.00
51.00	HOSPICE ROUTINE HOME CARE	30,452	30,452	100	30,452	30,452	51.00
52.00	HOSPICE INPATIENT RESPIRE CARE	553	553	0	553	553	52.00
53.00	HOSPICE GENERAL INPATIENT CARE	51	51	0	51	51	53.00
NONREIMBURSABLE COST CENTERS							
60.00	BEREAVEMENT PROGRAM			0	0	0	60.00
61.00	VOLUNTEER PROGRAM			0	0	0	61.00
62.00	FUNDRAISING			0	0	0	62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS			0	0	0	63.00
64.00	PALLIATIVE CARE PROGRAM			0	0	0	64.00
65.00	OTHER PHYSICIAN SERVICES			0	0	0	65.00
66.00	RESIDENTIAL CARE			0	0	0	66.00
67.00	ADVERTISING			0	0	0	67.00
68.00	TELEHEALTH/TELEMONITORING			0	0	0	68.00
69.00	THRIFT STORE			0	0	0	69.00
70.00	NURSING FACILITY ROOM & BOARD			0	0	0	70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)			0	0	0	71.00
99.00	NEGATIVE COST CENTER						99.00
100.00	COST TO BE ALLOCATED (per Wkst. 0-6, Part I)	19,661	2,614	105,108	95,932	451,583	100.00
101.00	UNIT COST MULTIPLIER	0.633082	0.084171	1.051080000	3.089001	14.540926	101.00

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

Provider CCN: 15-0162
Hospice CCN: 15-1523

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

Worksheet 0-6
Part II
Date/Time Prepared:
3/30/2021 10:40 am

Cost Center Descriptions		PHYSICIAN ADMINISTRATIVE SERVICES (PATIENT DAYS)	OTHER GENERAL SERVICE (SPECIFY BASIS)	PATIENT/ RESIDENTIAL CARE SERVICES (IN-FACILITY DAYS)	Hospice I	
		15.00	16.00	17.00		
GENERAL SERVICE COST CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT					1.00
2.00	CAP REL COSTS-MVBLE EQUIP					2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT					3.00
4.00	ADMINISTRATIVE & GENERAL					4.00
5.00	PLANT OPERATION & MAINTENANCE					5.00
6.00	LAUNDRY & LINEN SERVICE					6.00
7.00	HOUSEKEEPING					7.00
8.00	DIETARY					8.00
9.00	NURSING ADMINISTRATION					9.00
10.00	ROUTINE MEDICAL SUPPLIES					10.00
11.00	MEDICAL RECORDS					11.00
12.00	STAFF TRANSPORTATION					12.00
13.00	VOLUNTEER SERVICE COORDINATION					13.00
14.00	PHARMACY					14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES	31,056				15.00
16.00	OTHER GENERAL SERVICE		0			16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES			0		17.00
LEVEL OF CARE						
50.00	HOSPICE CONTINUOUS HOME CARE	0	0			50.00
51.00	HOSPICE ROUTINE HOME CARE	30,452	0			51.00
52.00	HOSPICE INPATIENT RESPIRE CARE	553	0	0		52.00
53.00	HOSPICE GENERAL INPATIENT CARE	51	0	0		53.00
NONREIMBURSABLE COST CENTERS						
60.00	BEREAVEMENT PROGRAM		0			60.00
61.00	VOLUNTEER PROGRAM		0			61.00
62.00	FUNDRAISING		0			62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS		0			63.00
64.00	PALLIATIVE CARE PROGRAM		0			64.00
65.00	OTHER PHYSICIAN SERVICES		0			65.00
66.00	RESIDENTIAL CARE	0	0	0		66.00
67.00	ADVERTISING		0			67.00
68.00	TELEHEALTH/TELEMONITORING		0			68.00
69.00	THRIFT STORE		0			69.00
70.00	NURSING FACILITY ROOM & BOARD		0			70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)	0	0	0		71.00
99.00	NEGATIVE COST CENTER		0			99.00
100.00	COST TO BE ALLOCATED (per Wkst. 0-6, Part I)		0			100.00
101.00	UNIT COST MULTIPLIER	0.000000	0.000000	0.000000		101.00

APPORTIONMENT OF HOSPITAL-BASED HOSPICE SHARED SERVICE COSTS BY LEVEL OF CARE	Provider CCN: 15-0162 Hospice CCN: 15-1523	Period: From 01/01/2020 To 12/31/2020	Worksheet 0-7 Date/Time Prepared: 3/30/2021 10:40 am
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Cost Center Descriptions	From Wkst. C, Part I, Col. 9 line	Cost to Charge Ratio	Charges by LOC (from Provider Records)			
			HCHC	HRHC	HIRC	
			0	1.00	2.00	
ANCILLARY SERVICE COST CENTERS						
1.00 PHYSICAL THERAPY	66.00	0.273586	0	0	0	1.00
2.00 OCCUPATIONAL THERAPY	67.00	0.170178	0	0	0	2.00
3.00 SPEECH PATHOLOGY	68.00	0.179458	0	0	0	3.00
4.00 DRUGS CHARGED TO PATIENTS	73.00	0.192661	0	0	0	4.00
5.00 DURABLE MEDICAL EQUIP-RENTED	96.00					5.00
6.00 LABORATORY	60.00	0.115410	0	0	0	6.00
7.00 MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0.246707	0	0	0	7.00
8.00 OTHER OUTPATIENT SERVICE COST CENTER	93.00					8.00
9.00 RADIOLOGY-THERAPEUTIC	55.00	0.120966	0	0	0	9.00
10.97 CARDIAC REHABILITATION	76.97	0.430075	0	0	0	10.97
11.00 Totals (sum of lines 1-11)						11.00
Cost Center Descriptions	Charges by LOC (from Provider Records)	Shared Service Costs by LOC				
	HGIP	HCHC (col. 1 x col. 2)	HRHC (col. 1 x col. 3)	HIRC (col. 1 x col. 4)	HGIP (col. 1 x col. 5)	
	5.00	6.00	7.00	8.00	9.00	
ANCILLARY SERVICE COST CENTERS						
1.00 PHYSICAL THERAPY	0	0	0	0	0	1.00
2.00 OCCUPATIONAL THERAPY	0	0	0	0	0	2.00
3.00 SPEECH PATHOLOGY	0	0	0	0	0	3.00
4.00 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	4.00
5.00 DURABLE MEDICAL EQUIP-RENTED						5.00
6.00 LABORATORY	0	0	0	0	0	6.00
7.00 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	7.00
8.00 OTHER OUTPATIENT SERVICE COST CENTER						8.00
9.00 RADIOLOGY-THERAPEUTIC	0	0	0	0	0	9.00
10.97 CARDIAC REHABILITATION	0	0	0	0	0	10.97
11.00 Totals (sum of lines 1-11)		0	0	0	0	11.00

CALCULATION OF HOSPITAL-BASED HOSPICE PER DIEM COST

Provider CCN: 15-0162

Period: From 01/01/2020

Worksheet 0-8

Hospice CCN: 15-1523

To 12/31/2020

Date/Time Prepared: 3/30/2021 10:40 am

		Hospice I		TOTAL	
		TITLE XVII MEDI CARE	TITLE XIX MEDI CAID		
		1.00	2.00	3.00	
HOSPICE CONTINUOUS HOME CARE					
1.00	Total cost (Wkst. 0-6, Part I, col. 18, line 50 plus Wkst. 0-7, col. 6, line 11)			0	1.00
2.00	Total unduplicated days (Wkst. S-9, col. 4, line 10)			0	2.00
3.00	Total average cost per diem (line 1 divided by line 2)			0.00	3.00
4.00	Unduplicated program days (Wkst. S-9 col. as appropriate, line 10)				4.00
5.00	Program cost (line 3 times line 4)	0	0	0	5.00
HOSPICE ROUTINE HOME CARE					
6.00	Total cost (Wkst. 0-6, Part I, col. 18, line 51 plus Wkst. 0-7, col. 7, line 11)			3,541,350	6.00
7.00	Total unduplicated days (Wkst. S-9, col. 4, line 11)			30,452	7.00
8.00	Total average cost per diem (line 6 divided by line 7)			116.29	8.00
9.00	Unduplicated program days (Wkst. S-9, col. as appropriate, line 11)	25,710	1,784		9.00
10.00	Program cost (line 8 times line 9)	2,989,816	207,461		10.00
HOSPICE INPATIENT RESPITE CARE					
11.00	Total cost (Wkst. 0-6, Part I, col. 18, line 52 plus Wkst. 0-7, col. 8, line 11)			428,530	11.00
12.00	Total unduplicated days (Wkst. S-9, col. 4, line 12)			553	12.00
13.00	Total average cost per diem (line 11 divided by line 12)			774.92	13.00
14.00	Unduplicated program days (Wkst. S-9, col. as appropriate, line 12)	498	24		14.00
15.00	Program cost (line 13 times line 14)	385,910	18,598		15.00
HOSPICE GENERAL INPATIENT CARE					
16.00	Total cost (Wkst. 0-6, Part I, col. 18, line 53 plus Wkst. 0-7, col. 9, line 11)			3,106,100	16.00
17.00	Total unduplicated days (Wkst. S-9, col. 4, line 13)			51	17.00
18.00	Total average cost per diem (line 16 divided by line 17)			60,903.92	18.00
19.00	Unduplicated program days (Wkst. S-9, col. as appropriate, line 13)	0	19		19.00
20.00	Program cost (line 18 times line 19)	0	1,157,174		20.00
TOTAL HOSPICE CARE					
21.00	Total cost (sum of line 1 + line 6 + line 11 + line 16)			7,075,980	21.00
22.00	Total unduplicated days (Wkst. S-9, col. 4, line 14)			31,056	22.00
23.00	Average cost per diem (line 21 divided by line 22)			227.85	23.00

CALCULATION OF CAPITAL PAYMENT		Provider CCN: 15-0162	Period: From 01/01/2020 To 12/31/2020	Worksheet L Parts I-III Date/Time Prepared: 3/30/2021 10:40 am	
		Title XVIII	Hospital	PPS	
			Urban	Rural	
			1.00	1.01	
PART I - FULLY PROSPECTIVE METHOD					
CAPITAL FEDERAL AMOUNT					
1.00	Capital DRG other than outlier		5,095,241	847,846	1.00
1.01	Model 4 BPCI Capital DRG other than outlier		0	0	1.01
2.00	Capital DRG outlier payments		551,652		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)		275.02		3.00
4.00	Number of interns & residents (see instructions)		19.23		4.00
5.00	Indirect medical education percentage (see instructions)		1.99		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)		118,267		6.00
7.00	Percentage of SSI recipient patient days to Medicare Part A patient days (Worksheet E, part A line 30) (see instructions)		3.09		7.00
8.00	Percentage of Medicaid patient days to total days (see instructions)		19.87		8.00
9.00	Sum of lines 7 and 8		22.96		9.00
10.00	Allowable disproportionate share percentage (see instructions)		4.76		10.00
11.00	Disproportionate share adjustment (see instructions)		242,533		11.00
12.00	Total prospective capital payments (see instructions)		6,855,539		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