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: 15-0104	Period: From 01/01/2020 To 12/31/2020	Worksheet S Parts I-III Date/Time Prepared: 8/2/2021 1:50 pm

PART I - COST REPORT STATUS

Provider use only

1. [X] Electronically prepared cost report — Date: 8/2/2021 Time: 1:50 pm
2. [ ] Manually prepared cost report
3. [0] If this is an amended report enter the number of times the provider resubmitted this cost report
4. [F] Medicare Utilization. Enter "F" for full or "L" for low.

Contractor use only

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

PART II - CERTIFICATION

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

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

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by WITHAM MEMORIAL HOSPITAL (15-0104) for the cost reporting period beginning 01/01/2020 and ending 12/31/2020 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

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

(Signed) GEORGE POGAS
Officer or Administrator of Provider(s)

SR VP CFO
Title

(Dated when report is electronically signed.)
Date

	Cost Center Description	Title V	Title XVIII Part A	Title XVIII Part B	HIT	Title XIX	
		1.00	2.00	3.00	4.00	5.00	
	PART III - SETTLEMENT SUMMARY						
1.00	Hospital	0	297,460	122,684	0	542,570	1.00
2.00	Subprovider - IPF	0	4,684	449		0	2.00
3.00	Subprovider - IRF	0	0	0		0	3.00
4.00	SUBPROVIDER I						4.00
5.00	Swing Bed - SNF	0	0	0		0	5.00
6.00	Swing Bed - NF	0				0	6.00
7.00	SKILLED NURSING FACILITY	0	0	588		0	7.00
200.00	Total	0	302,144	123,721	0	542,570	200.00

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-0104 | Period: From 01/01/2020 To 12/31/2020 | Worksheet S-2 Part I Date/Time Prepared: 8/2/2021 1:50 pm

	1.00	2.00	3.00	4.00	
	Hospital and Hospital Health Care Complex Address:				
1.00	Street: 2605 N. LEBANON STREET	PO Box:			1.00
2.00	City: LEBANON	State: IN	Zip Code: 46052-	County: BOONE	2.00

		Component Name	CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N) V	XVIII	XIX	
		1.00	2.00	3.00	4.00	5.00	6.00	7.00	8.00	
	Hospital and Hospital-Based Component Identification:									
3.00	Hospital	WITHAM MEMORIAL HOSPITAL	150104	26900	1	07/01/1966	N	P	O	3.00
4.00	Subprovider - IPF	WITHAM HOSPITAL GEROPSYCH	15S104	26900	4	01/01/2000	N	P	N	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	WITHAM HOSPITAL ECU	155832	26900		05/07/2015	N	P	N	9.00
10.00	Hospital-Based NF									10.00
11.00	Hospital-Based OLTC									11.00
12.00	Hospital-Based HHA									12.00
13.00	Separately Certified ASC									13.00
14.00	Hospital-Based Hospice									14.00
15.00	Hospital-Based Health Clinic - RHC									15.00
16.00	Hospital-Based Health Clinic - FQHC									16.00
17.00	Hospital-Based (CMHC) I									17.00
18.00	Renal Dialysis									18.00
19.00	Other									19.00

		From:	To:	
		1.00	2.00	
20.00	Cost Reporting Period (mm/dd/yyyy)	01/01/2020	12/31/2020	20.00
21.00	Type of Control (see instructions)	9		21.00

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

		In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of State Medicaid paid days	Out-of State Medicaid eligible unpaid	Medicaid HMO days	Other Medicaid days	
		1.00	2.00	3.00	4.00	5.00	6.00	
24.00	If this provider is an IPPS hospital, enter the in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.	312	1,505	0	0	391	0	24.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-0104 | Period: From 01/01/2020 To 12/31/2020 | Worksheet S-2 Part I Date/Time Prepared: 8/2/2021 1:50 pm

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

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

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

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-0104 | Period: From 01/01/2020 To 12/31/2020 | Worksheet S-2 Part I | Date/Time Prepared: 8/2/2021 1:50 pm

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

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-0104 | Period: From 01/01/2020 To 12/31/2020 | Worksheet S-2 Part I Date/Time Prepared: 8/2/2021 1:50 pm

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

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

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

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

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

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

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

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

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

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

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

		Premiums	Losses	Insurance	
		1.00	2.00	3.00	
118.01	List amounts of malpractice premiums and paid losses:	984,175	0	0	118.01

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-0104 | Period: From 01/01/2020 To 12/31/2020 | Worksheet S-2 Part I Date/Time Prepared: 8/2/2021 1:50 pm

		1.00	2.00	
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)	N		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:	Contractor's Name:	Contractor's Number:	141.00
142.00	Street:	PO Box:		142.00
143.00	City:	State:	Zip Code:	143.00

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

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

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

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

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

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

		1.00	
	Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act		
167.00	Is this provider a meaningful user under §1886(n)? Enter "Y" for yes or "N" for no.	Y	167.00
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)		168.00
168.01	If this provider is a CAH and is not a meaningful user, does this provider qualify for a hardship exception under §413.70(a)(6)(ii)? Enter "Y" for yes or "N" for no. (see instructions)		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: 15-0104	Period: From 01/01/2020 To 12/31/2020	Worksheet S-2 Part I Date/Time Prepared: 8/2/2021 1:50 pm

		Beginning	Ending	
		1.00	2.00	
170.00	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)			170.00
		1.00	2.00	
171.00	If line 167 is "Y", does this provider have any days for individuals enrolled in section 1876 Medicare cost plans reported on Wkst. S-3, Pt. I, line 2, col. 6? Enter "Y" for yes and "N" for no in column 1. If column 1 is yes, enter the number of section 1876 Medicare days in column 2. (see instructions)	N	0	171.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 15-0104 | Period: From 01/01/2020 To 12/31/2020 | Worksheet S-2 Part II | Date/Time Prepared: 8/2/2021 1:50 pm

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

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

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

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

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

		Part A		Part B		
		Y/N	Date	Y/N	Date	
		1.00	2.00	3.00	4.00	
	PS&R Data					
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see instructions)	N		N		16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	Y	07/01/2021	Y	07/01/2021	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: 15-0104 | Period: From 01/01/2020 To 12/31/2020 | Worksheet S-2 Part II Date/Time Prepared: 8/2/2021 1:50 pm

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

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

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

		1.00	2.00	
	Cost Report Preparer Contact Information			
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	TINA	SEVERS	41.00
42.00	Enter the employer/company name of the cost report preparer.	BLUE & CO., LLC		42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	317-713-7946	TSEVERS@BLUEANDCO.COM	43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider CCN: 15-0104	Period: From 01/01/2020 To 12/31/2020	Worksheet S-2 Part II Date/Time Prepared: 8/2/2021 1:50 pm

		3.00		
	Cost Report Preparer Contact Information			
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	MANAGER		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: 15-0104 | Period: From 01/01/2020 To 12/31/2020 | Worksheet S-3 Part I Date/Time Prepared: 8/2/2021 1:50 pm

	Component	Worksheet A Line Number	No. of Beds	Bed Days Available	CAH Hours	I/P Days / O/P Visits / Trips Title V	
		1.00	2.00	3.00	4.00	5.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30.00	63	22,408	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)		63	22,408	0.00	0	7.00
8.00	INTENSIVE CARE UNIT	31.00	8	2,928	0.00	0	8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY	43.00				0	13.00
14.00	Total (see instructions)		71	25,336	0.00	0	14.00
15.00	CAH visits					0	15.00
16.00	SUBPROVIDER - IPF	40.00	7	1,548		0	16.00
17.00	SUBPROVIDER - IRF	41.00	0	0		0	17.00
18.00	SUBPROVIDER	42.00	0	0		0	18.00
19.00	SKILLED NURSING FACILITY	44.00	18	6,588		0	19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)	30.00					24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	26.25
27.00	Total (sum of lines 14-26)		96				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: 15-0104 | Period: From 01/01/2020 To 12/31/2020 | Worksheet S-3 Part I | Date/Time Prepared: 8/2/2021 1:50 pm

	Component	I/P Days / O/P Visits / Trips			Full Time Equivalents		
		Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
		6.00	7.00	8.00	9.00	10.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	2,060	141	5,115			1.00
2.00	HMO and other (see instructions)	1,190	1,818				2.00
3.00	HMO IPF Subprovider	67	0				3.00
4.00	HMO IRF Subprovider	0	0				4.00
5.00	Hospital Adults & Peds. Swing Bed SNF	0	0	0			5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	0			6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	2,060	141	5,115			7.00
8.00	INTENSIVE CARE UNIT	1,046	67	2,815			8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY		97	962			13.00
14.00	Total (see instructions)	3,106	305	8,892	0.00	687.00	14.00
15.00	CAH visits	0	0	0			15.00
16.00	SUBPROVIDER - IPF	1,001	0	1,400	0.00	28.16	16.00
17.00	SUBPROVIDER - IRF	0	0	0	0.00	0.00	17.00
18.00	SUBPROVIDER		0	0	0.00	0.00	18.00
19.00	SKILLED NURSING FACILITY	2,342	0	4,039	0.00	31.75	19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)			31			24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0.00	0.00	26.25
27.00	Total (sum of lines 14-26)				0.00	746.91	27.00
28.00	Observation Bed Days		0	2,350			28.00
29.00	Ambulance Trips	1,761					29.00
30.00	Employee discount days (see instruction)			169			30.00
31.00	Employee discount days - IRF			0			31.00
32.00	Labor & delivery days (see instructions)	0	85	147			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: 15-0104 | Period: From 01/01/2020 To 12/31/2020 | Worksheet S-3 Part I | Date/Time Prepared: 8/2/2021 1:50 pm

	Component	Full Time Equivalents	Discharges				
		Nonpaid Workers	Title V	Title XVIII	Title XIX	Total All Patients	
		11.00	12.00	13.00	14.00	15.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)		0	716	55	2,100	1.00
2.00	HMO and other (see instructions)			234	421		2.00
3.00	HMO IPF Subprovider				0		3.00
4.00	HMO IRF Subprovider				0		4.00
5.00	Hospital Adults & Peds. Swing Bed SNF						5.00
6.00	Hospital Adults & Peds. Swing Bed NF						6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)						7.00
8.00	INTENSIVE CARE UNIT						8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY						13.00
14.00	Total (see instructions)	0.00	0	716	55	2,100	14.00
15.00	CAH visits						15.00
16.00	SUBPROVIDER - IPF	0.00	0	74	0	128	16.00
17.00	SUBPROVIDER - IRF	0.00	0	0	0	0	17.00
18.00	SUBPROVIDER	0.00	0		0	0	18.00
19.00	SKILLED NURSING FACILITY	0.00					19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)						24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0.00					26.25
27.00	Total (sum of lines 14-26)	0.00					27.00
28.00	Observation Bed Days						28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)						32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00	LTCH non-covered days			0			33.00
33.01	LTCH site neutral days and discharges			0			33.01

HOSPITAL WAGE INDEX INFORMATION | Provider CCN: 15-0104 | Period: From 01/01/2020 To 12/31/2020 | Worksheet S-3 Part II Date/Time Prepared: 8/2/2021 1:50 pm

		Wkst. A Line Number	Amount Reported	Reclassification of Salaries (from Wkst. A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
	PART II - WAGE DATA							
	SALARIES							
1.00	Total salaries (see instructions)	200.00	69,391,575	1,645,932	71,037,507	2,057,118.00	34.53	1.00
2.00	Non-physician anesthetist Part A		0	0	0	0.00	0.00	2.00
3.00	Non-physician anesthetist Part B		0	0	0	0.00	0.00	3.00
4.00	Physician-Part A - Administrative		0	0	0	0.00	0.00	4.00
4.01	Physicians - Part A - Teaching		0	0	0	0.00	0.00	4.01
5.00	Physician and Non Physician-Part B		0	0	0	0.00	0.00	5.00
6.00	Non-physician-Part B for hospital-based RHC and FQHC services		0	0	0	0.00	0.00	6.00
7.00	Interns & residents (in an approved program)	21.00	0	0	0	0.00	0.00	7.00
7.01	Contracted interns and residents (in an approved programs)		0	0	0	0.00	0.00	7.01
8.00	Home office and/or related organization personnel		0	0	0	0.00	0.00	8.00
9.00	SNF	44.00	1,011,576	39,468	1,051,044	66,032.00	15.92	9.00
10.00	Excluded area salaries (see instructions)		34,490,285	112,112	34,602,397	673,844.00	51.35	10.00
	OTHER WAGES & RELATED COSTS							
11.00	Contract labor: Direct Patient Care		769,367	0	769,367	11,404.00	67.46	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		0	0	0	0.00	0.00	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		0	0	0	0.00	0.00	14.01
14.02	Related organization salaries		0	0	0	0.00	0.00	14.02
15.00	Home office: Physician Part A - Administrative		0	0	0	0.00	0.00	15.00
16.00	Home office and Contract Physicians Part A - Teaching		0	0	0	0.00	0.00	16.00
16.01	Home office Physicians Part A - Teaching		0	0	0	0.00	0.00	16.01
16.02	Home office contract Physicians Part A - Teaching		0	0	0	0.00	0.00	16.02
	WAGE-RELATED COSTS							
17.00	Wage-related costs (core) (see instructions)		12,469,195	0	12,469,195			17.00
18.00	Wage-related costs (other) (see instructions)							18.00
19.00	Excluded areas		8,752,014	0	8,752,014			19.00
20.00	Non-physician anesthetist Part A		0	0	0			20.00
21.00	Non-physician anesthetist Part B		0	0	0			21.00
22.00	Physician Part A - Administrative		0	0	0			22.00
22.01	Physician Part A - Teaching		0	0	0			22.01
23.00	Physician Part B		0	0	0			23.00
24.00	Wage-related costs (RHC/FQHC)		0	0	0			24.00
25.00	Interns & residents (in an approved program)		0	0	0			25.00
25.50	Home office wage-related (core)		0	0	0			25.50
25.51	Related organization wage-related (core)		0	0	0			25.51
25.52	Home office: Physician Part A - Administrative - wage-related (core)		0	0	0			25.52

HOSPITAL WAGE INDEX INFORMATION | Provider CCN: 15-0104 | Period: From 01/01/2020 To 12/31/2020 | Worksheet S-3 Part II Date/Time Prepared: 8/2/2021 1:50 pm

		Wkst. A Line Number	Amount Reported	Reclassification of Salaries (from Wkst. A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
25.53	Home office: Physicians Part A - Teaching - wage-related (core)		0	0	0			25.53
	OVERHEAD COSTS - DIRECT SALARIES							
26.00	Employee Benefits Department	4.00	210,304	0	210,304	11,605.00	18.12	26.00
27.00	Administrative & General	5.00	7,479,547	523,285	8,002,832	225,717.00	35.46	27.00
28.00	Administrative & General under contract (see inst.)		376,920	0	376,920	662.00	569.37	28.00
29.00	Maintenance & Repairs	6.00	0	0	0	0.00	0.00	29.00
30.00	Operation of Plant	7.00	671,946	29,538	701,484	25,510.00	27.50	30.00
31.00	Laundry & Linen Service	8.00	33,387	1,973	35,360	1,963.00	18.01	31.00
32.00	Housekeeping	9.00	509,937	24,156	534,093	43,709.00	12.22	32.00
33.00	Housekeeping under contract (see instructions)		0	0	0	0.00	0.00	33.00
34.00	Dietary	10.00	929,751	-324,627	605,124	35,100.00	17.24	34.00
35.00	Dietary under contract (see instructions)		0	0	0	0.00	0.00	35.00
36.00	Cafeteria	11.00	0	371,105	371,105	29,100.00	12.75	36.00
37.00	Maintenance of Personnel	12.00	0	0	0	0.00	0.00	37.00
38.00	Nursing Administration	13.00	610,807	19,005	629,812	17,219.00	36.58	38.00
39.00	Central Services and Supply	14.00	0	0	0	0.00	0.00	39.00
40.00	Pharmacy	15.00	677,003	20,879	697,882	32,867.00	21.23	40.00
41.00	Medical Records & Medical Records Library	16.00	1,403,258	83,208	1,486,466	41,336.00	35.96	41.00
42.00	Social Service	17.00	0	0	0	0.00	0.00	42.00
43.00	Other General Service	18.00	0	0	0	0.00	0.00	43.00

HOSPITAL WAGE INDEX INFORMATION | Provider CCN: 15-0104 | Period: From 01/01/2020 To 12/31/2020 | Worksheet S-3 Part III Date/Time Prepared: 8/2/2021 1:50 pm

		Worksheet A Line Number	Amount Reported	Reclassification of Salaries (from Worksheet A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
	PART III - HOSPITAL WAGE INDEX SUMMARY							
1.00	Net salaries (see instructions)		69,768,495	1,645,932	71,414,427	2,057,780.00	34.70	1.00
2.00	Excluded area salaries (see instructions)		35,501,861	151,580	35,653,441	739,876.00	48.19	2.00
3.00	Subtotal salaries (line 1 minus line 2)		34,266,634	1,494,352	35,760,986	1,317,904.00	27.13	3.00
4.00	Subtotal other wages & related costs (see inst.)		769,367	0	769,367	11,404.00	67.46	4.00
5.00	Subtotal wage-related costs (see inst.)		12,469,195	0	12,469,195	0.00	34.87	5.00
6.00	Total (sum of lines 3 thru 5)		47,505,196	1,494,352	48,999,548	1,329,308.00	36.86	6.00
7.00	Total overhead cost (see instructions)		12,902,860	748,522	13,651,382	464,788.00	29.37	7.00

HOSPITAL WAGE RELATED COSTS | Provider CCN: 15-0104 | Period: From 01/01/2020 To 12/31/2020 | Worksheet S-3 Part IV Date/Time Prepared: 8/2/2021 1:50 pm

		Amount Reported	
		1.00	
	PART IV - WAGE RELATED COSTS		
	Part A - Core List		
	RETIREMENT COST		
1.00	401K Employer Contributions	3,123,716	1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution	0	2.00
3.00	Nonqualified Defined Benefit Plan Cost (see instructions)	0	3.00
4.00	Qualified Defined Benefit Plan Cost (see instructions)	0	4.00
	PLAN ADMINISTRATIVE COSTS (Paid to External Organization)		
5.00	401K/TSA Plan Administration fees	0	5.00
6.00	Legal/Accounting/Management Fees-Pension Plan	0	6.00
7.00	Employee Managed Care Program Administration Fees	0	7.00
	HEALTH AND INSURANCE COST		
8.00	Health Insurance (Purchased or Self Funded)	0	8.00
8.01	Health Insurance (Self Funded without a Third Party Administrator)	0	8.01
8.02	Health Insurance (Self Funded with a Third Party Administrator)	9,607,022	8.02
8.03	Health Insurance (Purchased)	0	8.03
9.00	Prescription Drug Plan	2,424,629	9.00
10.00	Dental, Hearing and Vision Plan	483,688	10.00
11.00	Life Insurance (If employee is owner or beneficiary)	106,544	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)	286,614	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)	0	14.00
15.00	'Workers' Compensation Insurance	605,206	15.00
16.00	Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. Non cumulative portion)	0	16.00
	TAXES		
17.00	FICA-Employers Portion Only	4,442,208	17.00
18.00	Medicare Taxes - Employers Portion Only	0	18.00
19.00	Unemployment Insurance	141,582	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)	21,221,209	24.00
	Part B - Other than Core Related Cost		
25.00	OTHER WAGE RELATED COSTS (SPECIFY)		25.00

HOSPITAL CONTRACT LABOR AND BENEFIT COST | Provider CCN: 15-0104 | Period: From 01/01/2020 To 12/31/2020 | Worksheet S-3 Part V | Date/Time Prepared: 8/2/2021 1:50 pm

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

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA | Provider CCN: 15-0104 | Period: From 01/01/2020 To 12/31/2020 | Worksheet S-10 | Date/Time Prepared: 8/2/2021 1:50 pm

		1.00	
	Uncompensated and indigent care cost computation		
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided by line 202 column 8)	0.224699	1.00
	Medicaid (see instructions for each line)		
2.00	Net revenue from Medicaid	-3,213,184	2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?	Y	3.00
4.00	If line 3 is yes, does line 2 include all DSH and/or supplemental payments from Medicaid?	N	4.00
5.00	If line 4 is no, then enter DSH and/or supplemental payments from Medicaid	1,724,304	5.00
6.00	Medicaid charges	42,297,081	6.00
7.00	Medicaid cost (line 1 times line 6)	9,504,112	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)	10,992,992	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)	10,992,992	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)	2,540,703	0	2,540,703	20.00
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	570,893	0	570,893	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)	570,893	0	570,893	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)	11,407,563	26.00
27.00	Medicare reimbursable bad debts for the entire hospital complex (see instructions)	148,275	27.00
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)	228,116	27.01
28.00	Non-Medicare bad debt expense (see instructions)	11,179,447	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)	2,591,852	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)	3,162,745	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	14,155,737	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 15-0104 | Period: From 01/01/2020 To 12/31/2020 | Worksheet A | Date/Time Prepared: 8/2/2021 1:50 pm

		Cost Center Description	Salaries	Other	Total (col. 1 + col. 2)	Reclassifications (See A-6)	Reclassified Trial Balance (col. 3 +- col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT		4,473,436	4,473,436	-14,993	4,458,443	1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP		0	0	5,105,187	5,105,187	2.00
3.00	00300	OTHER CAPITAL RELATED COSTS		0	0	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	210,304	16,704,941	16,915,245	-630,358	16,284,887	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	7,479,547	17,945,018	25,424,565	-1,806,536	23,618,029	5.00
7.00	00700	OPERATION OF PLANT	671,946	2,581,244	3,253,190	-126,159	3,127,031	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	33,387	574,968	608,355	1,813	610,168	8.00
9.00	00900	HOUSEKEEPING	509,937	420,904	930,841	20,264	951,105	9.00
10.00	01000	DIETARY	929,751	1,146,923	2,076,674	-841,043	1,235,631	10.00
11.00	01100	CAFETERIA	0	0	0	857,726	857,726	11.00
13.00	01300	NURSING ADMINISTRATION	610,807	77,085	687,892	1,970	689,862	13.00
15.00	01500	PHARMACY	677,003	8,456,431	9,133,434	-7,623,268	1,510,166	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,403,258	303,874	1,707,132	74,393	1,781,525	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	3,812,143	999,201	4,811,344	-264,498	4,546,846	30.00
31.00	03100	INTENSIVE CARE UNIT	1,985,350	605,772	2,591,122	-179,545	2,411,577	31.00
40.00	04000	SUBPROVIDER - IPF	842,876	136,320	979,196	7,363	986,559	40.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	0	42.00
43.00	04300	NURSERY	0	56,752	56,752	0	56,752	43.00
44.00	04400	SKILLED NURSING FACILITY	1,011,576	290,298	1,301,874	-52,601	1,249,273	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,675,554	5,687,656	8,363,210	-4,586,983	3,776,227	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,580,984	4,160,943	5,741,927	-637,361	5,104,566	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	0	55.00
55.01	05501	ULTRA SOUND	427,152	341,402	768,554	-127,582	640,972	55.01
57.00	05700	CT SCAN	193,799	1,140,457	1,334,256	-413,197	921,059	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	359,565	743,234	1,102,799	-70,177	1,032,622	58.00
59.00	05900	CARDIAC CATHETERIZATION	424,771	2,023,146	2,447,917	-972,796	1,475,121	59.00
60.00	06000	LABORATORY	3,195,699	5,258,990	8,454,689	-236,247	8,218,442	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	183,681	183,681	-1,537	182,144	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
66.00	06600	PHYSICAL THERAPY	1,531,855	236,495	1,768,350	30,296	1,798,646	66.00
67.00	06700	OCCUPATIONAL THERAPY	467,834	67,380	535,214	16,125	551,339	67.00
67.01	06701	AUDIOLOGY	208,076	208,545	416,621	-13,696	402,925	67.01
68.00	06800	SPEECH PATHOLOGY	162,795	32,732	195,527	5,490	201,017	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
69.01	06901	CARDIOLOGY	1,308,368	650,103	1,958,471	-272,028	1,686,443	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	52	29,606	29,658	2,605,696	2,635,354	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	3,838,343	3,838,343	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	13,596	13,596	7,249,906	7,263,502	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	OTHER OUTPATIENT SERVICE COST CENTER	140,751	79,373	220,124	856	220,980	90.01
90.02	09002	CLINIC	0	0	0	0	0	90.02
90.03	09003	DERMATOLOGY CLINIC	0	3,035	3,035	0	3,035	90.03
90.04	09004	ENT CLINIC	0	20	20	43	63	90.04
90.05	09005	SURGERY CLINIC	0	889	889	-712	177	90.05
90.07	09007	UROLOGY CLINIC	0	-80	-80	-470	-550	90.07
90.09	09009	GASTROENTEROLOGY CLINIC	254	8,790	9,044	4,014	13,058	90.09
90.11	09011	NEUROLOGY CLINIC	0	7,129	7,129	0	7,129	90.11
90.12	09012	OPTHAMOLOGY CLINIC	0	15,640	15,640	-8,018	7,622	90.12
90.13	09013	ALLERGY CLINIC	69,977	29,109	99,086	916	100,002	90.13
90.14	09014	WOUND CARE	258,552	463,343	721,895	-40,159	681,736	90.14
91.00	09100	EMERGENCY	2,560,243	5,891,921	8,452,164	-383,750	8,068,414	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	2,330,994	475,235	2,806,229	-54,684	2,751,545	95.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	38,075,160	82,525,537	120,600,697	462,003	121,062,700	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	30,962,139	10,177,105	41,139,244	-459,378	40,679,866	192.00
194.00	07950	THORNTOWN OFFICE BUILDING	0	0	0	0	0	194.00
194.01	07951	CAFE/BOUTIQUE	0	0	0	0	0	194.01
194.02	07952	OTHER NONREIMB	72,055	43,159	115,214	-773	114,441	194.02
194.03	07953	RETAIL PHARMACY	282,221	1,987,770	2,269,991	-1,852	2,268,139	194.03
200.00		TOTAL (SUM OF LINES 118 through 199)	69,391,575	94,733,571	164,125,146	0	164,125,146	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 15-0104 | Period: From 01/01/2020 To 12/31/2020 | Worksheet A | Date/Time Prepared: 8/2/2021 1:50 pm

		Cost Center Description	Adjustments (See A-8)	Net Expenses For Allocation		
			6.00	7.00		
		GENERAL SERVICE COST CENTERS				
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT	-272,741	4,185,702		1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP	0	5,105,187		2.00
3.00	00300	OTHER CAPITAL RELATED COSTS	0	0		3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-5,385,670	10,899,217		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-9,182,383	14,435,646		5.00
7.00	00700	OPERATION OF PLANT	375	3,127,406		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	610,168		8.00
9.00	00900	HOUSEKEEPING	-469	950,636		9.00
10.00	01000	DIETARY	-339,078	896,553		10.00
11.00	01100	CAFETERIA	0	857,726		11.00
13.00	01300	NURSING ADMINISTRATION	0	689,862		13.00
15.00	01500	PHARMACY	-11,690	1,498,476		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-53,087	1,728,438		16.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	0	4,546,846		30.00
31.00	03100	INTENSIVE CARE UNIT	0	2,411,577		31.00
40.00	04000	SUBPROVIDER - IPF	0	986,559		40.00
41.00	04100	SUBPROVIDER - IRF	0	0		41.00
42.00	04200	SUBPROVIDER	0	0		42.00
43.00	04300	NURSERY	0	56,752		43.00
44.00	04400	SKILLED NURSING FACILITY	0	1,249,273		44.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	-12,250	3,763,977		50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-379,824	4,724,742		54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0		55.00
55.01	05501	ULTRA SOUND	0	640,972		55.01
57.00	05700	CT SCAN	0	921,059		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	1,032,622		58.00
59.00	05900	CARDIAC CATHETERIZATION	-23,999	1,451,122		59.00
60.00	06000	LABORATORY	-100,000	8,118,442		60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	182,144		63.00
64.00	06400	INTRAVENOUS THERAPY	0	0		64.00
66.00	06600	PHYSICAL THERAPY	0	1,798,646		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	551,339		67.00
67.01	06701	AUDIOLOGY	-229,742	173,183		67.01
68.00	06800	SPEECH PATHOLOGY	0	201,017		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0		69.00
69.01	06901	CARDIOLOGY	0	1,686,443		69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	-5,215	2,630,139		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	3,838,343		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	7,263,502		73.00
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0	0		90.00
90.01	09001	OTHER OUTPATIENT SERVICE COST CENTER	0	220,980		90.01
90.02	09002	CLINIC	0	0		90.02
90.03	09003	DERMATOLOGY CLINIC	-3,035	0		90.03
90.04	09004	ENT CLINIC	-63	0		90.04
90.05	09005	SURGERY CLINIC	-177	0		90.05
90.07	09007	UROLOGY CLINIC	550	0		90.07
90.09	09009	GASTROENTEROLOGY CLINIC	-13,058	0		90.09
90.11	09011	NEUROLOGY CLINIC	0	7,129		90.11
90.12	09012	OPTHAMOLOGY CLINIC	-7,622	0		90.12
90.13	09013	ALLERGY CLINIC	0	100,002		90.13
90.14	09014	WOUND CARE	-105,686	576,050		90.14
91.00	09100	EMERGENCY	-2,602,200	5,466,214		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES	-4,950	2,746,595		95.00
		SPECIAL PURPOSE COST CENTERS				
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-18,732,014	102,330,686		118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	0		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	40,679,866		192.00
194.00	07950	THORNTOWN OFFICE BUILDING	0	0		194.00
194.01	07951	CAFE/BOUTIQUE	0	0		194.01
194.02	07952	OTHER NONREIMB	0	114,441		194.02
194.03	07953	RETAIL PHARMACY	0	2,268,139		194.03
200.00		TOTAL (SUM OF LINES 118 through 199)	-18,732,014	145,393,132		200.00

RECLASSIFICATIONS | Provider CCN: 15-0104 | Period: From 01/01/2020 To 12/31/2020 | Worksheet A-6 | Date/Time Prepared: 8/2/2021 1:50 pm

		Increases				
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
	A - EMPLOYEE BENEFITS RECLASS					
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	512,335		1.00
	TOTALS		0	512,335		
	B - INSURANCE RECLASS					
1.00	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	74,826		1.00
2.00	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	122,195		2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	512,335		3.00
	TOTALS		0	709,356		
	C - CAFETERIA RECLASS					
1.00	CAFETERIA	11.00	371,105	486,621		1.00
	TOTALS		371,105	486,621		
	D - MME DEPRECIATION RECLASS					
1.00	NEW CAP REL COSTS-MVBLE EQUIP	2.00	0	5,105,187		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
27.00		0.00	0	0		27.00
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
	TOTALS		0	5,105,187		
	E - DRUGS RECLASS					
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	7,622,710		1.00
	TOTALS		0	7,622,710		
	F - IMPLANTABLES RECLASS					
1.00	IMPL. DEV. CHARGED TO PATIENT	72.00	0	3,838,343		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
	TOTALS		0	3,838,343		
	G - CHARGEABLE SUPPLIES RECLASS					
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	2,605,696		1.00
2.00	ENT CLINIC	90.04	0	43		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

RECLASSIFICATIONS | Provider CCN: 15-0104 | Period: From 01/01/2020 To 12/31/2020 | Worksheet A-6 | Date/Time Prepared: 8/2/2021 1:50 pm

		Increases			
	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
9.00		0.00	0	0	9.00
10.00		0.00	0	0	10.00
11.00		0.00	0	0	11.00
12.00		0.00	0	0	12.00
13.00		0.00	0	0	13.00
14.00		0.00	0	0	14.00
15.00		0.00	0	0	15.00
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
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
	TOTALS		0	2,605,739	
	H - BONUS RECLASS				
1.00	ADMINISTRATIVE & GENERAL	5.00	523,285	0	1.00
2.00	OPERATION OF PLANT	7.00	29,538	0	2.00
3.00	LAUNDRY & LINEN SERVICE	8.00	1,973	0	3.00
4.00	HOUSEKEEPING	9.00	24,156	0	4.00
5.00	DIETARY	10.00	46,478	0	5.00
6.00	NURSING ADMINISTRATION	13.00	19,005	0	6.00
7.00	PHARMACY	15.00	20,879	0	7.00
8.00	MEDICAL RECORDS & LIBRARY	16.00	83,208	0	8.00
9.00	ADULTS & PEDIATRICS	30.00	127,942	0	9.00
10.00	INTENSIVE CARE UNIT	31.00	63,380	0	10.00
11.00	SUBPROVIDER - IPF	40.00	34,913	0	11.00
12.00	SKILLED NURSING FACILITY	44.00	39,468	0	12.00
13.00	OPERATING ROOM	50.00	91,308	0	13.00
14.00	RADIOLOGY-DIAGNOSTIC	54.00	69,555	0	14.00
15.00	ULTRA SOUND	55.01	12,855	0	15.00
16.00	CT SCAN	57.00	7,498	0	16.00
17.00	MAGNETIC RESONANCE IMAGING (MRI)	58.00	11,824	0	17.00
18.00	CARDIAC CATHETERIZATION	59.00	19,600	0	18.00
19.00	LABORATORY	60.00	128,683	0	19.00
20.00	PHYSICAL THERAPY	66.00	48,570	0	20.00
21.00	OCCUPATIONAL THERAPY	67.00	16,530	0	21.00
22.00	AUDIOLOGY	67.01	7,447	0	22.00
23.00	SPEECH PATHOLOGY	68.00	5,490	0	23.00
24.00	CARDIOLOGY	69.01	44,007	0	24.00
25.00	OTHER OUTPATIENT SERVICE COST CENTER	90.01	5,062	0	25.00
26.00	GASTROENTEROLOGY CLINIC	90.09	4,014	0	26.00
27.00	ALLERGY CLINIC	90.13	1,801	0	27.00
28.00	WOUND CARE	90.14	13,454	0	28.00
29.00	EMERGENCY	91.00	66,810	0	29.00
30.00	AMBULANCE SERVICES	95.00	77,199	0	30.00
	TOTALS		1,645,932	0	
500.00	Grand Total: Increases		2,017,037	20,880,291	500.00

RECLASSIFICATIONS | Provider CCN: 15-0104 | Period: From 01/01/2020 To 12/31/2020 | Worksheet A-6 | Date/Time Prepared: 8/2/2021 1:50 pm

		Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	A - EMPLOYEE BENEFITS RECLASS						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	512,335	0		1.00
	TOTALS		0	512,335			
	B - INSURANCE RECLASS						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	709,356	12		1.00
2.00		0.00	0	0	12		2.00
3.00		0.00	0	0	0		3.00
	TOTALS		0	709,356			
	C - CAFETERIA RECLASS						
1.00	DIETARY	10.00	371,105	486,621	0		1.00
	TOTALS		371,105	486,621			
	D - MME DEPRECIATION RECLASS						
1.00	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	212,014	9		1.00
2.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	7,987	0		2.00
3.00	ADMINISTRATIVE & GENERAL	5.00	0	1,097,899	0		3.00
4.00	OPERATION OF PLANT	7.00	0	155,658	0		4.00
5.00	LAUNDRY & LINEN SERVICE	8.00	0	160	0		5.00
6.00	HOUSEKEEPING	9.00	0	3,169	0		6.00
7.00	DIETARY	10.00	0	29,623	0		7.00
8.00	NURSING ADMINISTRATION	13.00	0	17,023	0		8.00
9.00	PHARMACY	15.00	0	4,860	0		9.00
10.00	MEDICAL RECORDS & LIBRARY	16.00	0	8,697	0		10.00
11.00	ADULTS & PEDIATRICS	30.00	0	151,742	0		11.00
12.00	INTENSIVE CARE UNIT	31.00	0	102,089	0		12.00
13.00	SUBPROVIDER - IPF	40.00	0	13,686	0		13.00
14.00	SKILLED NURSING FACILITY	44.00	0	54,675	0		14.00
15.00	OPERATING ROOM	50.00	0	640,527	0		15.00
16.00	RADIOLOGY-DIAGNOSTIC	54.00	0	554,601	0		16.00
17.00	ULTRA SOUND	55.01	0	131,727	0		17.00
18.00	CT SCAN	57.00	0	405,006	0		18.00
19.00	MAGNETIC RESONANCE IMAGING (MRI)	58.00	0	76,134	0		19.00
20.00	CARDIAC CATHETERIZATION	59.00	0	168,832	0		20.00
21.00	LABORATORY	60.00	0	338,684	0		21.00
22.00	BLOOD STORING, PROCESSING & TRANS.	63.00	0	1,537	0		22.00
23.00	PHYSICAL THERAPY	66.00	0	16,924	0		23.00
24.00	OCCUPATIONAL THERAPY	67.00	0	372	0		24.00
25.00	AUDIOLOGY	67.01	0	20,974	0		25.00
27.00	CARDIOLOGY	69.01	0	303,430	0		27.00
29.00	OTHER OUTPATIENT SERVICE COST CENTER	90.01	0	2,170	0		29.00
30.00	SURGERY CLINIC	90.05	0	566	0		30.00
31.00	UROLOGY CLINIC	90.07	0	293	0		31.00
32.00	OPTHAMOLOGY CLINIC	90.12	0	8,018	0		32.00
33.00	ALLERGY CLINIC	90.13	0	701	0		33.00
34.00	WOUND CARE	90.14	0	26,184	0		34.00
35.00	EMERGENCY	91.00	0	124,202	0		35.00
36.00	AMBULANCE SERVICES	95.00	0	115,900	0		36.00
37.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	306,575	0		37.00
38.00	OTHER NONREIMB	194.02	0	771	0		38.00
39.00	RETAIL PHARMACY	194.03	0	1,777	0		39.00
	TOTALS		0	5,105,187			
	E - DRUGS RECLASS						
1.00	PHARMACY	15.00	0	7,622,710	0		1.00
	TOTALS		0	7,622,710			
	F - IMPLANTABLES RECLASS						
1.00	INTENSIVE CARE UNIT	31.00	0	2,825	0		1.00
2.00	OPERATING ROOM	50.00	0	2,554,591	0		2.00
3.00	RADIOLOGY-DIAGNOSTIC	54.00	0	119,571	0		3.00
4.00	CARDIAC CATHETERIZATION	59.00	0	788,552	0		4.00
5.00	DRUGS CHARGED TO PATIENTS	73.00	0	372,804	0		5.00
	TOTALS		0	3,838,343			
	G - CHARGEABLE SUPPLIES RECLASS						
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	1,109	0		1.00
2.00	ADMINISTRATIVE & GENERAL	5.00	0	10,231	0		2.00
3.00	OPERATION OF PLANT	7.00	0	39	0		3.00
4.00	HOUSEKEEPING	9.00	0	723	0		4.00
5.00	DIETARY	10.00	0	172	0		5.00
6.00	NURSING ADMINISTRATION	13.00	0	12	0		6.00
7.00	PHARMACY	15.00	0	16,577	0		7.00
8.00	MEDICAL RECORDS & LIBRARY	16.00	0	118	0		8.00
9.00	ADULTS & PEDIATRICS	30.00	0	240,698	0		9.00

RECLASSIFICATIONS | Provider CCN: 15-0104 | Period: From 01/01/2020 To 12/31/2020 | Worksheet A-6 | Date/Time Prepared: 8/2/2021 1:50 pm

		Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
10.00	INTENSIVE CARE UNIT	31.00	0	138,011	0		10.00
11.00	SUBPROVIDER - IPF	40.00	0	13,864	0		11.00
12.00	SKILLED NURSING FACILITY	44.00	0	37,394	0		12.00
13.00	OPERATING ROOM	50.00	0	1,483,173	0		13.00
14.00	RADIOLOGY-DIAGNOSTIC	54.00	0	32,744	0		14.00
15.00	ULTRA SOUND	55.01	0	8,710	0		15.00
16.00	CT SCAN	57.00	0	15,689	0		16.00
17.00	MAGNETIC RESONANCE IMAGING (MRI)	58.00	0	5,867	0		17.00
18.00	CARDIAC CATHETERIZATION	59.00	0	35,012	0		18.00
19.00	LABORATORY	60.00	0	26,246	0		19.00
20.00	PHYSICAL THERAPY	66.00	0	1,350	0		20.00
21.00	OCCUPATIONAL THERAPY	67.00	0	33	0		21.00
22.00	AUDIOLOGY	67.01	0	169	0		22.00
23.00	CARDIOLOGY	69.01	0	12,605	0		23.00
24.00	OTHER OUTPATIENT SERVICE COST CENTER	90.01	0	2,036	0		24.00
26.00	SURGERY CLINIC	90.05	0	146	0		26.00
27.00	UROLOGY CLINIC	90.07	0	177	0		27.00
28.00	ALLERGY CLINIC	90.13	0	184	0		28.00
29.00	WOUND CARE	90.14	0	27,429	0		29.00
30.00	EMERGENCY	91.00	0	326,358	0		30.00
31.00	AMBULANCE SERVICES	95.00	0	15,983	0		31.00
32.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	152,803	0		32.00
33.00	OTHER NONREIMB	194.02	0	2	0		33.00
34.00	RETAIL PHARMACY	194.03	0	75	0		34.00
	TOTALS		0	2,605,739			
	H - BONUS RECLASS						
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	1,645,932	0		1.00
2.00		0.00	0	0	0		2.00
3.00		0.00	0	0	0		3.00
4.00		0.00	0	0	0		4.00
5.00		0.00	0	0	0		5.00
6.00		0.00	0	0	0		6.00
7.00		0.00	0	0	0		7.00
8.00		0.00	0	0	0		8.00
9.00		0.00	0	0	0		9.00
10.00		0.00	0	0	0		10.00
11.00		0.00	0	0	0		11.00
12.00		0.00	0	0	0		12.00
13.00		0.00	0	0	0		13.00
14.00		0.00	0	0	0		14.00
15.00		0.00	0	0	0		15.00
16.00		0.00	0	0	0		16.00
17.00		0.00	0	0	0		17.00
18.00		0.00	0	0	0		18.00
19.00		0.00	0	0	0		19.00
20.00		0.00	0	0	0		20.00
21.00		0.00	0	0	0		21.00
22.00		0.00	0	0	0		22.00
23.00		0.00	0	0	0		23.00
24.00		0.00	0	0	0		24.00
25.00		0.00	0	0	0		25.00
26.00		0.00	0	0	0		26.00
27.00		0.00	0	0	0		27.00
28.00		0.00	0	0	0		28.00
29.00		0.00	0	0	0		29.00
30.00		0.00	0	0	0		30.00
	TOTALS		0	1,645,932			
500.00	Grand Total: Decreases		371,105	22,526,223			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-0104 | Period: From 01/01/2020 To 12/31/2020 | Worksheet A-7 Part I | Date/Time Prepared: 8/2/2021 1:50 pm

		Beginning Balances	Acquisitions: Purchases	Acquisitions: Donation	Acquisitions: Total	Disposals and Retirements	
		1.00	2.00	3.00	4.00	5.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	2,845,261	0	0	0	0	1.00
2.00	Land Improvements	3,054,058	0	0	0	475	2.00
3.00	Buildings and Fixtures	87,433,726	41,320,158	0	41,320,158	100,614	3.00
4.00	Building Improvements	0	0	0	0	0	4.00
5.00	Fixed Equipment	5,037,483	245,485	0	245,485	290,345	5.00
6.00	Movable Equipment	67,721,331	5,127,546	0	5,127,546	-309,982	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	166,091,859	46,693,189	0	46,693,189	81,452	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	166,091,859	46,693,189	0	46,693,189	81,452	10.00

		Ending Balance	Fully Depreciated Assets	
		6.00	7.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES			
1.00	Land	2,845,261	0	1.00
2.00	Land Improvements	3,053,583	0	2.00
3.00	Buildings and Fixtures	128,653,270	0	3.00
4.00	Building Improvements	0	0	4.00
5.00	Fixed Equipment	4,992,623	0	5.00
6.00	Movable Equipment	73,158,859	0	6.00
7.00	HIT designated Assets	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	212,703,596	0	8.00
9.00	Reconciling Items	0	0	9.00
10.00	Total (line 8 minus line 9)	212,703,596	0	10.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-0104 | Period: From 01/01/2020 To 12/31/2020 | Worksheet A-7 Part II Date/Time Prepared: 8/2/2021 1:50 pm

	Cost Center Description	SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	NEW CAP REL COSTS-BLDG & FIXT	4,473,436	0	0	0	0	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	4,473,436	0	0	0	0	3.00

	Cost Center Description	SUMMARY OF CAPITAL			
		Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)		
		14.00	15.00		
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2				
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	4,473,436		1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0		2.00
3.00	Total (sum of lines 1-2)	0	4,473,436		3.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-0104 | Period: From 01/01/2020 To 12/31/2020 | Worksheet A-7 Part III Date/Time Prepared: 8/2/2021 1:50 pm

	Cost Center Description	COMPUTATION OF RATIOS			ALLOCATION OF OTHER CAPITAL		
		Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	
		1.00	2.00	3.00	4.00	5.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	NEW CAP REL COSTS-BLDG & FIXT	139,544,737	0	139,544,737	0.656053	0	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	73,158,859	0	73,158,859	0.343947	0	2.00
3.00	Total (sum of lines 1-2)	212,703,596	0	212,703,596	1.000000	0	3.00

	Cost Center Description	ALLOCATION OF OTHER CAPITAL			SUMMARY OF CAPITAL		
		Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	Depreciation	Lease	
		6.00	7.00	8.00	9.00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	0	0	4,261,422	-6,034	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0	0	5,105,187	0	2.00
3.00	Total (sum of lines 1-2)	0	0	0	9,366,609	-6,034	3.00

	Cost Center Description	SUMMARY OF CAPITAL					
		Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	NEW CAP REL COSTS-BLDG & FIXT	-266,707	197,021	0	0	4,185,702	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0	0	0	5,105,187	2.00
3.00	Total (sum of lines 1-2)	-266,707	197,021	0	0	9,290,889	3.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 15-0104 | Period: From 01/01/2020 To 12/31/2020 | Worksheet A-8 | Date/Time Prepared: 8/2/2021 1:50 pm

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
1.00	Investment income - NEW CAP REL COSTS-BLDG & FIXT (chapter 2)		0	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	1.00
2.00	Investment income - NEW CAP REL COSTS-MVBLE EQUIP (chapter 2)		0	NEW CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
3.00	Investment income - other (chapter 2)		0		0.00	0	3.00
4.00	Trade, quantity, and time discounts (chapter 8)		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)	B	-4,066	ADMINISTRATIVE & GENERAL	5.00	0	7.00
8.00	Television and radio service (chapter 21)		0		0.00	0	8.00
9.00	Parking lot (chapter 21)		0		0.00	0	9.00
10.00	Provider-based physician adjustment	A-8-2	-3,082,024			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	0			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests	B	-272,222	DIETARY	10.00	0	14.00
15.00	Rental of quarters to employee and others		0		0.00	0	15.00
16.00	Sale of medical and surgical supplies to other than patients		0		0.00	0	16.00
17.00	Sale of drugs to other than patients		0		0.00	0	17.00
18.00	Sale of medical records and abstracts	B	-44,347	MEDICAL RECORDS & LIBRARY	16.00	0	18.00
19.00	Nursing and allied health education (tuition, fees, books, etc.)		0		0.00	0	19.00
20.00	Vending machines	B	-1,706	DIETARY	10.00	0	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	0	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	*** Cost Center Deleted ***	65.00		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	PHYSICAL THERAPY	66.00		24.00
25.00	Utilization review - physicians' compensation (chapter 21)		0	*** Cost Center Deleted ***	114.00		25.00
26.00	Depreciation - NEW CAP REL COSTS-BLDG & FIXT		0	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
27.00	Depreciation - NEW CAP REL COSTS-MVBLE EQUIP		0	NEW CAP REL COSTS-MVBLE EQUIP	2.00	0	27.00
28.00	Non-physician Anesthetist		0	*** Cost Center Deleted ***	19.00		28.00
29.00	Physicians' assistant		0		0.00	0	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	OCCUPATIONAL THERAPY	67.00		30.00
30.99	Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS	30.00		30.99

ADJUSTMENTS TO EXPENSES | Provider CCN: 15-0104 | Period: From 01/01/2020 To 12/31/2020 | Worksheet A-8 | Date/Time Prepared: 8/2/2021 1:50 pm

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	SPEECH PATHOLOGY	68.00		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest		0		0.00	0	32.00
33.00	HOSPITAL ADMINISTRAT SPONSORSHIPS/DO	A	-7,379	ADMINISTRATIVE & GENERAL	5.00	0	33.00
33.01	BANK FEES	A	0	OPERATING ROOM	50.00	0	33.01
33.02	HEARING AID COSTS	A	-229,742	AUDIOLOGY	67.01	0	33.02
33.03	BANK FEES	A	-506,061	ADMINISTRATIVE & GENERAL	5.00	0	33.03
33.04	LOBBYING EXPENSE-IHA DUES	A	-3,420	ADMINISTRATIVE & GENERAL	5.00	0	33.04
33.05	LOBBYING EXPENSE-AHA DUES	A	-5,173	ADMINISTRATIVE & GENERAL	5.00	0	33.05
33.06	NON-REIMBURSABLE ADVERTISING COSTS	A	-141,869	ADMINISTRATIVE & GENERAL	5.00	0	33.06
33.07	SELF INSURANCE CLAIMS PAID	B	-5,081,685	EMPLOYEE BENEFITS DEPARTMENT	4.00	12	33.07
33.08	HAF FEE	A	-8,125,542	ADMINISTRATIVE & GENERAL	5.00	0	33.08
33.09	WIT ADMIN HOSPITAL MEDICAL STAFF FEE	A	-6,060	ADMINISTRATIVE & GENERAL	5.00	0	33.09
33.10	WIT AMBULANCE EDUCATION REIMBURSEM	A	-4,950	AMBULANCE SERVICES	95.00	0	33.10
33.12	WIT DIETARY HOME DELIVERED MEALS	B	-36,083	DIETARY	10.00	0	33.12
33.13	WIT DIETARY HEAD START	B	-26,978	DIETARY	10.00	0	33.13
33.14	WIT DIETARY CICOA MEAL VOUCHERS	B	-2,089	DIETARY	10.00	0	33.14
33.15	WIT PLANT OPERATIONS LB WATER FOUNTA	B	375	OPERATION OF PLANT	7.00	0	33.15
33.16	WIT FINANCE HOSPITAL BIL RETURNED CH	B	-150	ADMINISTRATIVE & GENERAL	5.00	0	33.16
33.17	WIT FINANCE HOSPITAL BIL CASH (SHORT	B	-470	ADMINISTRATIVE & GENERAL	5.00	0	33.17
33.18	WIT FINANCE HOSPITAL BIL COLLECTION	B	-832	ADMINISTRATIVE & GENERAL	5.00	0	33.18
33.19	WIT HEALTH INFORMATION M PHYSICIAN Q	B	-8,740	MEDICAL RECORDS & LIBRARY	16.00	0	33.19
33.20	WIT FINANCE PHYSICIAN BI PHYSICIAN Q	B	-141,506	ADMINISTRATIVE & GENERAL	5.00	0	33.20
33.21	WIT FINANCE HOSPITAL BIL INTEREST IN	B	113	NEW CAP REL COSTS-BLDG & FIXT	1.00	11	33.21
33.22	WIT OPERATING ROOM PURCHASING DISCOU	B	-12,250	OPERATING ROOM	50.00	0	33.22
33.23	WIT PHARMACY LB PURCHASING DISCOUNTS	B	-11,690	PHARMACY	15.00	0	33.23
33.24	WIT CENTRAL SUPPLY PURCHASING DISCOU	B	-5,215	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	33.24
33.25	WIT ENVIRONMENTAL SERVIC PURCHASING	B	-469	HOUSEKEEPING	9.00	0	33.25
33.26	WIT FINANCE MATERIALS MG PURCHASING	B	-104,737	ADMINISTRATIVE & GENERAL	5.00	0	33.26
33.27	WIT CARDIAC CATHETERIZAT PURCHASING	B	-23,999	CARDIAC CATHETERIZATION	59.00	0	33.27
33.28	WIT FINANCE MATERIALS MG PURCHASING	B	-6,476	ADMINISTRATIVE & GENERAL	5.00	0	33.28
33.30	VOL VOLUNTEERS VOLUNTEER MISC REV	B	-1,413	ADMINISTRATIVE & GENERAL	5.00	0	33.30
33.31	WIT DERMATOLOGY CLINIC RENTAL REVENU	A	-3,035	DERMATOLOGY CLINIC	90.03	0	33.31
33.32	WIT EAR NOSE THROAT CLIN RENTAL REVE	A	-63	ENT CLINIC	90.04	0	33.32
33.33	WIT SURGERY CLINIC RENTAL REVENUE	A	-177	SURGERY CLINIC	90.05	0	33.33
33.34	WIT UROLOGY CLINIC RENTAL REVENUE	A	550	UROLOGY CLINIC	90.07	0	33.34
33.35	WIT GASTROENTEROLOGY CLI RENTAL REVE	A	-13,058	GASTROENTEROLOGY CLINIC	90.09	0	33.35
33.36	WIT DIALYSIS CENTER RENTAL REVENUE	A	-105,686	WOUND CARE	90.14	0	33.36

ADJUSTMENTS TO EXPENSES | Provider CCN: 15-0104 | Period: From 01/01/2020 To 12/31/2020 | Worksheet A-8 | Date/Time Prepared: 8/2/2021 1:50 pm

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
33.37	WIT EYE INSTITUTE RENTAL REVENUE	A	-7,622	OPTHAMOLOGY CLINIC	90.12	0	33.37
33.38	WIT PO 1208 N LEBANON BL RENTAL REVE	B	14,450	NEW CAP REL COSTS-BLDG & FIXT	1.00	10	33.38
33.39	WIT ADMIN HOSPITAL LAND LEASE REVENU	B	-20,484	NEW CAP REL COSTS-BLDG & FIXT	1.00	10	33.39
33.40	WIT ADMIN HOSPITAL MANAGEMENT FEE RE	B	-28,947	ADMINISTRATIVE & GENERAL	5.00	0	33.40
33.41	WIT ADMIN HOSPITAL OTHER OPERATING R	B	-199	ADMINISTRATIVE & GENERAL	5.00	0	33.41
33.42	WIT HR WELLNESS PROGRAM OTHER OPERAT	B	-49,289	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.42
33.43	WIT INSURANCE INSURANCE CLAIM PROC	B	-138,701	ADMINISTRATIVE & GENERAL	5.00	12	33.43
33.44	WIT HR EMPLOYEE BENEFITS EMPLOYEE DR	A	-254,696	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.44
33.45	WIT ADMIN HOSPITAL GAIN(LOSS) ON INV	B	40,618	ADMINISTRATIVE & GENERAL	5.00	0	33.45
33.46	WIT ADMIN HOSPITAL INTEREST ON INVES	B	-248,195	NEW CAP REL COSTS-BLDG & FIXT	1.00	11	33.46
33.47	VOL VOLUNTEERS INTEREST ON INVESTME	B	-147	NEW CAP REL COSTS-BLDG & FIXT	1.00	11	33.47
33.48	BCH 2015 BOND INTEREST ON INVESTME	B	-14,742	NEW CAP REL COSTS-BLDG & FIXT	1.00	11	33.48
33.49	BCH 2017 BOND INTEREST ON INVESTME	B	-3,736	NEW CAP REL COSTS-BLDG & FIXT	1.00	11	33.49
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-18,732,014				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.

PROVIDER BASED PHYSICIAN ADJUSTMENT | Provider CCN: 15-0104 | Period: From 01/01/2020 To 12/31/2020 | Worksheet A-8-2 | Date/Time Prepared: 8/2/2021 1:50 pm

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	54.00	RADIOLOGY-DIAGNOSTIC	379,824	379,824	0	0	0	1.00
2.00	60.00	LABORATORY	100,000	100,000	0	0	0	2.00
3.00	91.00	EMERGENCY	2,602,200	2,602,200	0	0	0	3.00
4.00	0.00		0	0	0	0	0	4.00
5.00	0.00		0	0	0	0	0	5.00
6.00	0.00		0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			3,082,024	3,082,024	0		0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	1.00
2.00	60.00	LABORATORY	0	0	0	0	0	2.00
3.00	91.00	EMERGENCY	0	0	0	0	0	3.00
4.00	0.00		0	0	0	0	0	4.00
5.00	0.00		0	0	0	0	0	5.00
6.00	0.00		0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			0	0	0	0	0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment		
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	379,824		1.00
2.00	60.00	LABORATORY	0	0	0	100,000		2.00
3.00	91.00	EMERGENCY	0	0	0	2,602,200		3.00
4.00	0.00		0	0	0	0		4.00
5.00	0.00		0	0	0	0		5.00
6.00	0.00		0	0	0	0		6.00
7.00	0.00		0	0	0	0		7.00
8.00	0.00		0	0	0	0		8.00
9.00	0.00		0	0	0	0		9.00
10.00	0.00		0	0	0	0		10.00
200.00			0	0	0	3,082,024		200.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-0104 | Period: From 01/01/2020 To 12/31/2020 | Worksheet B Part I | Date/Time Prepared: 8/2/2021 1:50 pm

		Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS NEW BLDG & FIXT	CAPITAL RELATED COSTS NEW MVBLE EQUIP	EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
			0	1.00	2.00	4.00	4A	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT	4,185,702	4,185,702				1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP	5,105,187		5,105,187			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	10,899,217	8,724	10,640	10,918,581		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	14,435,646	278,804	340,050	1,233,701	16,288,201	5.00
7.00	00700	OPERATION OF PLANT	3,127,406	365,263	445,502	108,139	4,046,310	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	610,168	0	0	5,451	615,619	8.00
9.00	00900	HOUSEKEEPING	950,636	42,060	51,300	82,335	1,126,331	9.00
10.00	01000	DIETARY	896,553	94,149	114,831	93,285	1,198,818	10.00
11.00	01100	CAFETERIA	857,726	0	0	57,209	914,935	11.00
13.00	01300	NURSING ADMINISTRATION	689,862	0	0	97,091	786,953	13.00
15.00	01500	PHARMACY	1,498,476	29,065	35,449	107,584	1,670,574	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,728,438	45,913	55,998	229,151	2,059,500	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	4,546,846	305,380	372,464	607,396	5,832,086	30.00
31.00	03100	INTENSIVE CARE UNIT	2,411,577	83,866	102,289	315,828	2,913,560	31.00
40.00	04000	SUBPROVIDER - IPF	986,559	96,022	117,116	135,318	1,335,015	40.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	0	42.00
43.00	04300	NURSERY	56,752	0	0	0	56,752	43.00
44.00	04400	SKILLED NURSING FACILITY	1,249,273	72,714	88,687	162,027	1,572,701	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	3,763,977	243,729	297,269	426,534	4,731,509	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,724,742	298,080	363,561	254,444	5,640,827	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	0	55.00
55.01	05501	ULTRA SOUND	640,972	0	0	67,831	708,803	55.01
57.00	05700	CT SCAN	921,059	0	0	31,032	952,091	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	1,032,622	25,572	31,189	57,253	1,146,636	58.00
59.00	05900	CARDIAC CATHETERIZATION	1,451,122	21,555	26,290	68,503	1,567,470	59.00
60.00	06000	LABORATORY	8,118,442	139,012	169,549	512,480	8,939,483	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	182,144	0	0	0	182,144	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
66.00	06600	PHYSICAL THERAPY	1,798,646	134,545	164,101	243,635	2,340,927	66.00
67.00	06700	OCCUPATIONAL THERAPY	551,339	0	0	74,669	626,008	67.00
67.01	06701	AUDIOLOGY	173,183	0	0	33,225	206,408	67.01
68.00	06800	SPEECH PATHOLOGY	201,017	0	0	25,942	226,959	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
69.01	06901	CARDIOLOGY	1,686,443	13,865	16,911	208,479	1,925,698	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	2,630,139	0	0	8	2,630,147	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	3,838,343	0	0	0	3,838,343	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	7,263,502	0	0	0	7,263,502	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	OTHER OUTPATIENT SERVICE COST CENTER	220,980	57,290	69,875	22,478	370,623	90.01
90.02	09002	CLINIC	0	0	0	0	0	90.02
90.03	09003	DERMATOLOGY CLINIC	0	0	0	0	0	90.03
90.04	09004	ENT CLINIC	0	0	0	0	0	90.04
90.05	09005	SURGERY CLINIC	0	0	0	0	0	90.05
90.07	09007	UROLOGY CLINIC	0	0	0	0	0	90.07
90.09	09009	GASTROENTEROLOGY CLINIC	0	0	0	658	658	90.09
90.11	09011	NEUROLOGY CLINIC	7,129	0	0	0	7,129	90.11
90.12	09012	OPTHAMOLOGY CLINIC	0	0	0	0	0	90.12
90.13	09013	ALLERGY CLINIC	100,002	0	0	11,065	111,067	90.13
90.14	09014	WOUND CARE	576,050	52,523	64,061	41,932	734,566	90.14
91.00	09100	EMERGENCY	5,466,214	368,231	449,121	404,981	6,688,547	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	2,746,595	71,350	87,023	371,242	3,276,210	95.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	102,330,686	2,847,712	3,473,276	6,090,906	94,533,110	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	9,353	11,408	0	20,761	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	40,679,866	993,473	1,211,712	4,773,060	47,658,111	192.00
194.00	07950	THORNTOWN OFFICE BUILDING	0	0	0	0	0	194.00
194.01	07951	CAFE/BOUTIQUE	0	21,225	25,888	0	47,113	194.01
194.02	07952	OTHER NONREIMB	114,441	307,943	375,590	11,108	809,082	194.02
194.03	07953	RETAIL PHARMACY	2,268,139	5,996	7,313	43,507	2,324,955	194.03
200.00		Cross Foot Adjustments					0	200.00
201.00		Negative Cost Centers		0	0	0	0	201.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-0104 | Period: From 01/01/2020 To 12/31/2020 | Worksheet B Part I Date/Time Prepared: 8/2/2021 1:50 pm

	Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
			NEW BLDG & FIXT	NEW MVBLE EQUIP			
		0	1.00	2.00	4.00	4A	
202.00	TOTAL (sum lines 118 through 201)	145,393,132	4,185,702	5,105,187	10,918,581	145,393,132	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-0104 | Period: From 01/01/2020 To 12/31/2020 | Worksheet B Part I Date/Time Prepared: 8/2/2021 1:50 pm

		Cost Center Description	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
			5.00	7.00	8.00	9.00	10.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	16,288,201					5.00
7.00	00700	OPERATION OF PLANT	510,495	4,556,805				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	77,668	0	693,287			8.00
9.00	00900	HOUSEKEEPING	142,101	69,562	0	1,337,994		9.00
10.00	01000	DIETARY	151,246	155,709	0	89,284	1,595,057	10.00
11.00	01100	CAFETERIA	115,431	0	0	29,768	0	11.00
13.00	01300	NURSING ADMINISTRATION	99,284	0	0	13,460	0	13.00
15.00	01500	PHARMACY	210,765	48,069	0	27,180	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	259,833	75,933	0	59,536	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	735,793	505,056	38,513	452,279	963,321	30.00
31.00	03100	INTENSIVE CARE UNIT	367,583	138,703	13,445	120,108	0	31.00
40.00	04000	SUBPROVIDER - IPF	168,429	158,808	3,317	142,825	162,638	40.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	0	42.00
43.00	04300	NURSERY	7,160	0	3,327	0	0	43.00
44.00	04400	SKILLED NURSING FACILITY	198,417	120,258	4,375	0	469,098	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	596,941	403,093	85,433	26,662	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	711,664	492,983	57,986	120,626	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	0	55.00
55.01	05501	ULTRA SOUND	89,425	0	14,742	7,766	0	55.01
57.00	05700	CT SCAN	120,119	0	83,079	11,907	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	144,663	42,292	29,464	11,390	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	197,757	35,649	41,518	0	0	59.00
60.00	06000	LABORATORY	1,127,832	229,907	111,189	50,994	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	22,980	0	1,990	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	6,076	0	0	64.00
66.00	06600	PHYSICAL THERAPY	295,338	222,519	12,015	18,379	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	78,979	0	5,748	8,801	0	67.00
67.01	06701	AUDIOLOGY	26,041	0	1,297	6,471	0	67.01
68.00	06800	SPEECH PATHOLOGY	28,634	0	1,527	3,883	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
69.01	06901	CARDIOLOGY	242,952	22,931	28,556	39,087	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	331,827	0	15,972	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	484,257	0	22,191	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	916,385	0	44,213	28,215	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	OTHER OUTPATIENT SERVICE COST CENTER	46,759	94,749	0	69,373	0	90.01
90.02	09002	CLINIC	0	0	0	0	0	90.02
90.03	09003	DERMATOLOGY CLINIC	0	0	0	0	0	90.03
90.04	09004	ENT CLINIC	0	0	0	0	0	90.04
90.05	09005	SURGERY CLINIC	0	0	0	0	0	90.05
90.07	09007	UROLOGY CLINIC	0	0	185	0	0	90.07
90.09	09009	GASTROENTEROLOGY CLINIC	83	0	0	0	0	90.09
90.11	09011	NEUROLOGY CLINIC	899	0	0	0	0	90.11
90.12	09012	OPTHAMOLOGY CLINIC	0	0	0	0	0	90.12
90.13	09013	ALLERGY CLINIC	14,013	0	564	0	0	90.13
90.14	09014	WOUND CARE	92,675	86,866	9,393	0	0	90.14
91.00	09100	EMERGENCY	843,847	609,002	50,180	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	413,336	43,631	6,992	0	0	95.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	9,871,611	3,555,720	693,287	1,337,994	1,595,057	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	2,619	15,469	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	6,012,628	940,597	0	0	0	192.00
194.00	07950	THORNTOWN OFFICE BUILDING	0	0	0	0	0	194.00
194.01	07951	CAFE/BOUTIQUE	5,944	35,103	0	0	0	194.01
194.02	07952	OTHER NONREIMB	102,076	0	0	0	0	194.02
194.03	07953	RETAIL PHARMACY	293,323	9,916	0	0	0	194.03
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	16,288,201	4,556,805	693,287	1,337,994	1,595,057	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-0104 | Period: From 01/01/2020 To 12/31/2020 | Worksheet B Part I Date/Time Prepared: 8/2/2021 1:50 pm

		Cost Center Description	CAFETERIA	NURSING ADMINISTRATION	PHARMACY	MEDICAL RECORDS & LIBRARY	Subtotal	
			11.00	13.00	15.00	16.00	24.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA	1,060,134					11.00
13.00	01300	NURSING ADMINISTRATION	20,512	920,209				13.00
15.00	01500	PHARMACY	41,024	0	1,997,612			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	83,127	0	0	2,537,929		16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	279,606	194,294	231	623,676	9,624,855	30.00
31.00	03100	INTENSIVE CARE UNIT	22,671	86,779	14	129,675	3,792,538	31.00
40.00	04000	SUBPROVIDER - IPF	35,626	51,802	22	154,375	2,212,857	40.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	0	42.00
43.00	04300	NURSERY	0	0	0	0	67,239	43.00
44.00	04400	SKILLED NURSING FACILITY	0	64,335	30	0	2,429,214	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	24,830	146,205	5,494	223,844	6,244,011	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	30,228	18,174	5,295	598,976	7,676,759	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	0	55.00
55.01	05501	ULTRA SOUND	3,239	0	423	64,838	889,236	55.01
57.00	05700	CT SCAN	4,318	0	8,983	74,100	1,254,597	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	10,796	0	5,311	40,138	1,430,690	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	19,991	0	0	1,862,385	59.00
60.00	06000	LABORATORY	88,524	0	11	61,750	10,609,690	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	207,114	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	601	0	6,677	64.00
66.00	06600	PHYSICAL THERAPY	44,262	65,884	0	120,413	3,119,737	66.00
67.00	06700	OCCUPATIONAL THERAPY	18,353	23,268	0	52,488	813,645	67.00
67.01	06701	AUDIOLOGY	19,432	12,310	0	0	271,959	67.01
68.00	06800	SPEECH PATHOLOGY	20,512	10,321	0	0	291,836	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
69.01	06901	CARDIOLOGY	44,262	65,181	935	115,781	2,485,383	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	22,671	0	0	0	3,000,617	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	4,344,791	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	8,252,315	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	OTHER OUTPATIENT SERVICE COST CENTER	36,705	3,718	5	259,350	881,282	90.01
90.02	09002	CLINIC	0	0	0	0	0	90.02
90.03	09003	DERMATOLOGY CLINIC	0	0	0	0	0	90.03
90.04	09004	ENT CLINIC	0	0	0	0	0	90.04
90.05	09005	SURGERY CLINIC	0	0	0	0	0	90.05
90.07	09007	UROLOGY CLINIC	0	0	0	0	185	90.07
90.09	09009	GASTROENTEROLOGY CLINIC	0	7,221	0	0	7,962	90.09
90.11	09011	NEUROLOGY CLINIC	0	0	2,025	0	10,053	90.11
90.12	09012	OPTHAMOLOGY CLINIC	0	0	0	0	0	90.12
90.13	09013	ALLERGY CLINIC	0	3,536	0	0	129,180	90.13
90.14	09014	WOUND CARE	0	14,753	4,603	0	942,856	90.14
91.00	09100	EMERGENCY	69,092	101,474	687,686	0	9,049,828	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	140,344	0	3,433	0	3,883,946	95.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	1,060,134	889,246	725,102	2,519,404	85,793,437	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	0	0	0	38,849	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	27,502	737,376	18,525	55,394,739	192.00
194.00	07950	THORNTOWN OFFICE BUILDING	0	0	0	0	0	194.00
194.01	07951	CAFE/BOUTIQUE	0	0	0	0	88,160	194.01
194.02	07952	OTHER NONREIMB	0	3,461	0	0	914,619	194.02
194.03	07953	RETAIL PHARMACY	0	0	535,134	0	3,163,328	194.03
200.00		Cross Foot Adjustments					0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	1,060,134	920,209	1,997,612	2,537,929	145,393,132	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-0104 | Period: From 01/01/2020 To 12/31/2020 | Worksheet B Part I | Date/Time Prepared: 8/2/2021 1:50 pm

		Cost Center Description	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			25.00	26.00		
		GENERAL SERVICE COST CENTERS				
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT				1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT				4.00
5.00	00500	ADMINISTRATIVE & GENERAL				5.00
7.00	00700	OPERATION OF PLANT				7.00
8.00	00800	LAUNDRY & LINEN SERVICE				8.00
9.00	00900	HOUSEKEEPING				9.00
10.00	01000	DIETARY				10.00
11.00	01100	CAFETERIA				11.00
13.00	01300	NURSING ADMINISTRATION				13.00
15.00	01500	PHARMACY				15.00
16.00	01600	MEDICAL RECORDS & LIBRARY				16.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	0	9,624,855		30.00
31.00	03100	INTENSIVE CARE UNIT	0	3,792,538		31.00
40.00	04000	SUBPROVIDER - IPF	0	2,212,857		40.00
41.00	04100	SUBPROVIDER - IRF	0	0		41.00
42.00	04200	SUBPROVIDER	0	0		42.00
43.00	04300	NURSERY	0	67,239		43.00
44.00	04400	SKILLED NURSING FACILITY	0	2,429,214		44.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	6,244,011		50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	7,676,759		54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0		55.00
55.01	05501	ULTRA SOUND	0	889,236		55.01
57.00	05700	CT SCAN	0	1,254,597		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	1,430,690		58.00
59.00	05900	CARDIAC CATHETERIZATION	0	1,862,385		59.00
60.00	06000	LABORATORY	0	10,609,690		60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	207,114		63.00
64.00	06400	INTRAVENOUS THERAPY	0	6,677		64.00
66.00	06600	PHYSICAL THERAPY	0	3,119,737		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	813,645		67.00
67.01	06701	AUDIOLOGY	0	271,959		67.01
68.00	06800	SPEECH PATHOLOGY	0	291,836		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0		69.00
69.01	06901	CARDIOLOGY	0	2,485,383		69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	3,000,617		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	4,344,791		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	8,252,315		73.00
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0	0		90.00
90.01	09001	OTHER OUTPATIENT SERVICE COST CENTER	0	881,282		90.01
90.02	09002	CLINIC	0	0		90.02
90.03	09003	DERMATOLOGY CLINIC	0	0		90.03
90.04	09004	ENT CLINIC	0	0		90.04
90.05	09005	SURGERY CLINIC	0	0		90.05
90.07	09007	UROLOGY CLINIC	0	185		90.07
90.09	09009	GASTROENTEROLOGY CLINIC	0	7,962		90.09
90.11	09011	NEUROLOGY CLINIC	0	10,053		90.11
90.12	09012	OPTHAMOLOGY CLINIC	0	0		90.12
90.13	09013	ALLERGY CLINIC	0	129,180		90.13
90.14	09014	WOUND CARE	0	942,856		90.14
91.00	09100	EMERGENCY	0	9,049,828		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0			92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES	0	3,883,946		95.00
		SPECIAL PURPOSE COST CENTERS				
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	85,793,437		118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	38,849		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	55,394,739		192.00
194.00	07950	THORNTOWN OFFICE BUILDING	0	0		194.00
194.01	07951	CAFE/BOUTIQUE	0	88,160		194.01
194.02	07952	OTHER NONREIMB	0	914,619		194.02
194.03	07953	RETAIL PHARMACY	0	3,163,328		194.03
200.00		Cross Foot Adjustments	0	0		200.00
201.00		Negative Cost Centers	0	0		201.00
202.00		TOTAL (sum lines 118 through 201)	0	145,393,132		202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-0104 | Period: From 01/01/2020 To 12/31/2020 | Worksheet B Part II Date/Time Prepared: 8/2/2021 1:50 pm

		Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS NEW BLDG & FIXT	CAPITAL RELATED COSTS NEW MVBLE EQUIP	Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
			0	1.00	2.00	2A	4.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	8,724	10,640	19,364	19,364	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	0	278,804	340,050	618,854	2,185	5.00
7.00	00700	OPERATION OF PLANT	0	365,263	445,502	810,765	192	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0	0	10	8.00
9.00	00900	HOUSEKEEPING	0	42,060	51,300	93,360	146	9.00
10.00	01000	DIETARY	0	94,149	114,831	208,980	165	10.00
11.00	01100	CAFETERIA	0	0	0	0	101	11.00
13.00	01300	NURSING ADMINISTRATION	0	0	0	0	172	13.00
15.00	01500	PHARMACY	0	29,065	35,449	64,514	191	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	45,913	55,998	101,911	406	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	305,380	372,464	677,844	1,076	30.00
31.00	03100	INTENSIVE CARE UNIT	0	83,866	102,289	186,155	559	31.00
40.00	04000	SUBPROVIDER - IPF	0	96,022	117,116	213,138	240	40.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	0	42.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
44.00	04400	SKILLED NURSING FACILITY	0	72,714	88,687	161,401	287	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	243,729	297,269	540,998	755	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	298,080	363,561	661,641	451	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	0	55.00
55.01	05501	ULTRA SOUND	0	0	0	0	120	55.01
57.00	05700	CT SCAN	0	0	0	0	55	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	25,572	31,189	56,761	101	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	21,555	26,290	47,845	121	59.00
60.00	06000	LABORATORY	0	139,012	169,549	308,561	908	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
66.00	06600	PHYSICAL THERAPY	0	134,545	164,101	298,646	431	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	132	67.00
67.01	06701	AUDIOLOGY	0	0	0	0	59	67.01
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	46	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
69.01	06901	CARDIOLOGY	0	13,865	16,911	30,776	369	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	OTHER OUTPATIENT SERVICE COST CENTER	0	57,290	69,875	127,165	40	90.01
90.02	09002	CLINIC	0	0	0	0	0	90.02
90.03	09003	DERMATOLOGY CLINIC	0	0	0	0	0	90.03
90.04	09004	ENT CLINIC	0	0	0	0	0	90.04
90.05	09005	SURGERY CLINIC	0	0	0	0	0	90.05
90.07	09007	UROLOGY CLINIC	0	0	0	0	0	90.07
90.09	09009	GASTROENTEROLOGY CLINIC	0	0	0	0	1	90.09
90.11	09011	NEUROLOGY CLINIC	0	0	0	0	0	90.11
90.12	09012	OPTHAMOLOGY CLINIC	0	0	0	0	0	90.12
90.13	09013	ALLERGY CLINIC	0	0	0	0	20	90.13
90.14	09014	WOUND CARE	0	52,523	64,061	116,584	74	90.14
91.00	09100	EMERGENCY	0	368,231	449,121	817,352	717	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				0		92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	71,350	87,023	158,373	657	95.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	2,847,712	3,473,276	6,320,988	10,787	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	9,353	11,408	20,761	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	993,473	1,211,712	2,205,185	8,480	192.00
194.00	07950	THORNTOWN OFFICE BUILDING	0	0	0	0	0	194.00
194.01	07951	CAFE/BOUTIQUE	0	21,225	25,888	47,113	0	194.01
194.02	07952	OTHER NONREIMB	0	307,943	375,590	683,533	20	194.02
194.03	07953	RETAIL PHARMACY	0	5,996	7,313	13,309	77	194.03
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	4,185,702	5,105,187	9,290,889	19,364	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-0104 | Period: From 01/01/2020 To 12/31/2020 | Worksheet B Part II Date/Time Prepared: 8/2/2021 1:50 pm

		Cost Center Description	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
			5.00	7.00	8.00	9.00	10.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	621,039					5.00
7.00	00700	OPERATION OF PLANT	19,463	830,420				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	2,961	0	2,971			8.00
9.00	00900	HOUSEKEEPING	5,418	12,677	0	111,601		9.00
10.00	01000	DIETARY	5,766	28,376	0	7,447	250,734	10.00
11.00	01100	CAFETERIA	4,401	0	0	2,483	0	11.00
13.00	01300	NURSING ADMINISTRATION	3,785	0	0	1,123	0	13.00
15.00	01500	PHARMACY	8,035	8,760	0	2,267	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	9,906	13,838	0	4,966	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	28,052	92,040	170	37,725	151,428	30.00
31.00	03100	INTENSIVE CARE UNIT	14,014	25,277	59	10,018	0	31.00
40.00	04000	SUBPROVIDER - IPF	6,421	28,941	15	11,913	25,566	40.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	0	42.00
43.00	04300	NURSERY	273	0	15	0	0	43.00
44.00	04400	SKILLED NURSING FACILITY	7,565	21,916	19	0	73,740	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	22,759	73,459	376	2,224	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	27,132	89,840	255	10,061	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	0	55.00
55.01	05501	ULTRA SOUND	3,409	0	65	648	0	55.01
57.00	05700	CT SCAN	4,580	0	366	993	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	5,515	7,707	130	950	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	7,540	6,497	183	0	0	59.00
60.00	06000	LABORATORY	42,999	41,898	406	4,253	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	876	0	9	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	27	0	0	64.00
66.00	06600	PHYSICAL THERAPY	11,260	40,551	53	1,533	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	3,011	0	25	734	0	67.00
67.01	06701	AUDIOLOGY	993	0	6	540	0	67.01
68.00	06800	SPEECH PATHOLOGY	1,092	0	7	324	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
69.01	06901	CARDIOLOGY	9,263	4,179	126	3,260	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	12,651	0	70	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	18,462	0	98	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	34,937	0	195	2,353	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	OTHER OUTPATIENT SERVICE COST CENTER	1,783	17,267	0	5,786	0	90.01
90.02	09002	CLINIC	0	0	0	0	0	90.02
90.03	09003	DERMATOLOGY CLINIC	0	0	0	0	0	90.03
90.04	09004	ENT CLINIC	0	0	0	0	0	90.04
90.05	09005	SURGERY CLINIC	0	0	0	0	0	90.05
90.07	09007	UROLOGY CLINIC	0	0	1	0	0	90.07
90.09	09009	GASTROENTEROLOGY CLINIC	3	0	0	0	0	90.09
90.11	09011	NEUROLOGY CLINIC	34	0	0	0	0	90.11
90.12	09012	OPTHAMOLOGY CLINIC	0	0	0	0	0	90.12
90.13	09013	ALLERGY CLINIC	534	0	2	0	0	90.13
90.14	09014	WOUND CARE	3,533	15,830	41	0	0	90.14
91.00	09100	EMERGENCY	32,172	110,983	221	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	15,759	7,951	31	0	0	95.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	376,357	647,987	2,971	111,601	250,734	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	100	2,819	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	229,280	171,410	0	0	0	192.00
194.00	07950	THORNTOWN OFFICE BUILDING	0	0	0	0	0	194.00
194.01	07951	CAFE/BOUTIQUE	227	6,397	0	0	0	194.01
194.02	07952	OTHER NONREIMB	3,892	0	0	0	0	194.02
194.03	07953	RETAIL PHARMACY	11,183	1,807	0	0	0	194.03
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	621,039	830,420	2,971	111,601	250,734	202.00

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		Cost Center Description	CAFETERIA	NURSING ADMINISTRATION	PHARMACY	MEDICAL RECORDS & LIBRARY	Subtotal	
			11.00	13.00	15.00	16.00	24.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA	6,985					11.00
13.00	01300	NURSING ADMINISTRATION	135	5,215				13.00
15.00	01500	PHARMACY	270	0	84,037			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	548	0	0	131,575		16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,843	1,100	10	32,333	1,023,621	30.00
31.00	03100	INTENSIVE CARE UNIT	149	492	1	6,723	243,447	31.00
40.00	04000	SUBPROVIDER - IPF	235	294	1	8,003	294,767	40.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	0	42.00
43.00	04300	NURSERY	0	0	0	0	288	43.00
44.00	04400	SKILLED NURSING FACILITY	0	365	1	0	265,294	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	164	829	231	11,605	653,400	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	199	103	223	31,053	820,958	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	0	55.00
55.01	05501	ULTRA SOUND	21	0	18	3,361	7,642	55.01
57.00	05700	CT SCAN	28	0	378	3,842	10,242	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	71	0	223	2,081	73,539	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	113	0	0	62,299	59.00
60.00	06000	LABORATORY	583	0	0	3,201	402,809	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	885	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	25	0	52	64.00
66.00	06600	PHYSICAL THERAPY	292	373	0	6,243	359,382	66.00
67.00	06700	OCCUPATIONAL THERAPY	121	132	0	2,721	6,876	67.00
67.01	06701	AUDIOLOGY	128	70	0	0	1,796	67.01
68.00	06800	SPEECH PATHOLOGY	135	58	0	0	1,662	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
69.01	06901	CARDIOLOGY	292	369	39	6,003	54,676	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	149	0	0	0	12,870	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	18,560	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	37,485	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	OTHER OUTPATIENT SERVICE COST CENTER	242	21	0	13,446	165,750	90.01
90.02	09002	CLINIC	0	0	0	0	0	90.02
90.03	09003	DERMATOLOGY CLINIC	0	0	0	0	0	90.03
90.04	09004	ENT CLINIC	0	0	0	0	0	90.04
90.05	09005	SURGERY CLINIC	0	0	0	0	0	90.05
90.07	09007	UROLOGY CLINIC	0	0	0	0	1	90.07
90.09	09009	GASTROENTEROLOGY CLINIC	0	41	0	0	45	90.09
90.11	09011	NEUROLOGY CLINIC	0	0	85	0	119	90.11
90.12	09012	OPTHAMOLOGY CLINIC	0	0	0	0	0	90.12
90.13	09013	ALLERGY CLINIC	0	20	0	0	576	90.13
90.14	09014	WOUND CARE	0	84	194	0	136,340	90.14
91.00	09100	EMERGENCY	455	575	28,931	0	991,406	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	925	0	144	0	183,840	95.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	6,985	5,039	30,504	130,615	5,830,627	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	0	0	0	23,680	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	156	31,020	960	2,646,491	192.00
194.00	07950	THORNTOWN OFFICE BUILDING	0	0	0	0	0	194.00
194.01	07951	CAFE/BOUTIQUE	0	0	0	0	53,737	194.01
194.02	07952	OTHER NONREIMB	0	20	0	0	687,465	194.02
194.03	07953	RETAIL PHARMACY	0	0	22,513	0	48,889	194.03
200.00		Cross Foot Adjustments					0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	6,985	5,215	84,037	131,575	9,290,889	202.00

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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	NEW CAP REL COSTS-BLDG & FIXT				1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT				4.00
5.00	00500	ADMINISTRATIVE & GENERAL				5.00
7.00	00700	OPERATION OF PLANT				7.00
8.00	00800	LAUNDRY & LINEN SERVICE				8.00
9.00	00900	HOUSEKEEPING				9.00
10.00	01000	DIETARY				10.00
11.00	01100	CAFETERIA				11.00
13.00	01300	NURSING ADMINISTRATION				13.00
15.00	01500	PHARMACY				15.00
16.00	01600	MEDICAL RECORDS & LIBRARY				16.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	0	1,023,621		30.00
31.00	03100	INTENSIVE CARE UNIT	0	243,447		31.00
40.00	04000	SUBPROVIDER - IPF	0	294,767		40.00
41.00	04100	SUBPROVIDER - IRF	0	0		41.00
42.00	04200	SUBPROVIDER	0	0		42.00
43.00	04300	NURSERY	0	288		43.00
44.00	04400	SKILLED NURSING FACILITY	0	265,294		44.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	653,400		50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	820,958		54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0		55.00
55.01	05501	ULTRA SOUND	0	7,642		55.01
57.00	05700	CT SCAN	0	10,242		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	73,539		58.00
59.00	05900	CARDIAC CATHETERIZATION	0	62,299		59.00
60.00	06000	LABORATORY	0	402,809		60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	885		63.00
64.00	06400	INTRAVENOUS THERAPY	0	52		64.00
66.00	06600	PHYSICAL THERAPY	0	359,382		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	6,876		67.00
67.01	06701	AUDIOLOGY	0	1,796		67.01
68.00	06800	SPEECH PATHOLOGY	0	1,662		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0		69.00
69.01	06901	CARDIOLOGY	0	54,676		69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	12,870		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	18,560		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	37,485		73.00
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0	0		90.00
90.01	09001	OTHER OUTPATIENT SERVICE COST CENTER	0	165,750		90.01
90.02	09002	CLINIC	0	0		90.02
90.03	09003	DERMATOLOGY CLINIC	0	0		90.03
90.04	09004	ENT CLINIC	0	0		90.04
90.05	09005	SURGERY CLINIC	0	0		90.05
90.07	09007	UROLOGY CLINIC	0	1		90.07
90.09	09009	GASTROENTEROLOGY CLINIC	0	45		90.09
90.11	09011	NEUROLOGY CLINIC	0	119		90.11
90.12	09012	OPTHAMOLOGY CLINIC	0	0		90.12
90.13	09013	ALLERGY CLINIC	0	576		90.13
90.14	09014	WOUND CARE	0	136,340		90.14
91.00	09100	EMERGENCY	0	991,406		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0			92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES	0	183,840		95.00
		SPECIAL PURPOSE COST CENTERS				
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	5,830,627		118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	23,680		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	2,646,491		192.00
194.00	07950	THORNTOWN OFFICE BUILDING	0	0		194.00
194.01	07951	CAFE/BOUTIQUE	0	53,737		194.01
194.02	07952	OTHER NONREIMB	0	687,465		194.02
194.03	07953	RETAIL PHARMACY	0	48,889		194.03
200.00		Cross Foot Adjustments	0	0		200.00
201.00		Negative Cost Centers	0	0		201.00
202.00		TOTAL (sum lines 118 through 201)	0	9,290,889		202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-0104 | Period: From 01/01/2020 To 12/31/2020 | Worksheet B-1 | Date/Time Prepared: 8/2/2021 1:50 pm

		Cost Center Description	CAPITAL RELATED COSTS					
			NEW BLDG & FIXT (SQUARE FEET)	NEW MVBLE EQUIP (SQUARE FEET)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
			1.00	2.00	4.00	5A	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT	279,243					1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP		279,243				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	582	582	70,827,203			4.00
5.00	00500	ADMINISTRATIVE & GENERAL	18,600	18,600	8,002,832	-16,288,201	129,104,931	5.00
7.00	00700	OPERATION OF PLANT	24,368	24,368	701,484	0	4,046,310	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	35,360	0	615,619	8.00
9.00	00900	HOUSEKEEPING	2,806	2,806	534,093	0	1,126,331	9.00
10.00	01000	DIETARY	6,281	6,281	605,124	0	1,198,818	10.00
11.00	01100	CAFETERIA	0	0	371,105	0	914,935	11.00
13.00	01300	NURSING ADMINISTRATION	0	0	629,812	0	786,953	13.00
15.00	01500	PHARMACY	1,939	1,939	697,882	0	1,670,574	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	3,063	3,063	1,486,466	0	2,059,500	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	20,373	20,373	3,940,085	0	5,832,086	30.00
31.00	03100	INTENSIVE CARE UNIT	5,595	5,595	2,048,730	0	2,913,560	31.00
40.00	04000	SUBPROVIDER - IPF	6,406	6,406	877,789	0	1,335,015	40.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	0	42.00
43.00	04300	NURSERY	0	0	0	0	56,752	43.00
44.00	04400	SKILLED NURSING FACILITY	4,851	4,851	1,051,044	0	1,572,701	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	16,260	16,260	2,766,862	0	4,731,509	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	19,886	19,886	1,650,539	0	5,640,827	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	0	55.00
55.01	05501	ULTRA SOUND	0	0	440,007	0	708,803	55.01
57.00	05700	CT SCAN	0	0	201,297	0	952,091	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	1,706	1,706	371,389	0	1,146,636	58.00
59.00	05900	CARDIAC CATHETERIZATION	1,438	1,438	444,371	0	1,567,470	59.00
60.00	06000	LABORATORY	9,274	9,274	3,324,382	0	8,939,483	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	182,144	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
66.00	06600	PHYSICAL THERAPY	8,976	8,976	1,580,425	0	2,340,927	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	484,364	0	626,008	67.00
67.01	06701	AUDIOLOGY	0	0	215,523	0	206,408	67.01
68.00	06800	SPEECH PATHOLOGY	0	0	168,285	0	226,959	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
69.01	06901	CARDIOLOGY	925	925	1,352,375	0	1,925,698	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	52	0	2,630,147	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	3,838,343	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	7,263,502	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	OTHER OUTPATIENT SERVICE COST CENTER	3,822	3,822	145,813	0	370,623	90.01
90.02	09002	CLINIC	0	0	0	0	0	90.02
90.03	09003	DERMATOLOGY CLINIC	0	0	0	0	0	90.03
90.04	09004	ENT CLINIC	0	0	0	0	0	90.04
90.05	09005	SURGERY CLINIC	0	0	0	0	0	90.05
90.07	09007	UROLOGY CLINIC	0	0	0	0	0	90.07
90.09	09009	GASTROENTEROLOGY CLINIC	0	0	4,268	0	658	90.09
90.11	09011	NEUROLOGY CLINIC	0	0	0	0	7,129	90.11
90.12	09012	OPTHAMOLOGY CLINIC	0	0	0	0	0	90.12
90.13	09013	ALLERGY CLINIC	0	0	71,778	0	111,067	90.13
90.14	09014	WOUND CARE	3,504	3,504	272,006	0	734,566	90.14
91.00	09100	EMERGENCY	24,566	24,566	2,627,053	0	6,688,547	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	4,760	4,760	2,408,193	0	3,276,210	95.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	189,981	189,981	39,510,788	-16,288,201	78,244,909	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	624	624	0	0	20,761	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	66,278	66,278	30,962,139	0	47,658,111	192.00
194.00	07950	THORNTOWN OFFICE BUILDING	0	0	0	0	0	194.00
194.01	07951	CAFE/BOUTIQUE	1,416	1,416	0	0	47,113	194.01
194.02	07952	OTHER NONREIMB	20,544	20,544	72,055	0	809,082	194.02
194.03	07953	RETAIL PHARMACY	400	400	282,221	0	2,324,955	194.03
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-0104 | Period: From 01/01/2020 To 12/31/2020 | Worksheet B-1 | Date/Time Prepared: 8/2/2021 1:50 pm

		Cost Center Description	CAPITAL RELATED COSTS					
			NEW BLDG & FIXT (SQUARE FEET)	NEW MVBLE EQUIP (SQUARE FEET)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
			1.00	2.00	4.00	5A	5.00	
202.00		Cost to be allocated (per Wkst. B, Part I)	4,185,702	5,105,187	10,918,581		16,288,201	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	14.989461	18.282238	0.154158		0.126163	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)			19,364		621,039	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)			0.000273		0.004810	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: 15-0104 | Period: From 01/01/2020 To 12/31/2020 | Worksheet B-1 | Date/Time Prepared: 8/2/2021 1:50 pm

		Cost Center Description	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (GROSS CHARGES)	HOUSEKEEPING (HOURS OF SERVICE)	DIETARY (MEALS SERVED)	CAFETERIA (MEALS SERVED)	
			7.00	8.00	9.00	10.00	11.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT	183,813					7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	381,815,298				8.00
9.00	00900	HOUSEKEEPING	2,806	0	129,223			9.00
10.00	01000	DIETARY	6,281	0	8,623	41,201		10.00
11.00	01100	CAFETERIA	0	0	2,875	0	982	11.00
13.00	01300	NURSING ADMINISTRATION	0	0	1,300	0	19	13.00
15.00	01500	PHARMACY	1,939	0	2,625	0	38	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	3,063	0	5,750	0	77	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	20,373	21,207,725	43,681	24,883	259	30.00
31.00	03100	INTENSIVE CARE UNIT	5,595	7,403,536	11,600	0	21	31.00
40.00	04000	SUBPROVIDER - IPF	6,406	1,826,667	13,794	4,201	33	40.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	0	42.00
43.00	04300	NURSERY	0	1,831,818	0	0	0	43.00
44.00	04400	SKILLED NURSING FACILITY	4,851	2,409,282	0	12,117	0	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	16,260	47,044,449	2,575	0	23	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	19,886	31,930,414	11,650	0	28	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	0	55.00
55.01	05501	ULTRA SOUND	0	8,117,740	750	0	3	55.01
57.00	05700	CT SCAN	0	45,748,168	1,150	0	4	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	1,706	16,224,511	1,100	0	10	58.00
59.00	05900	CARDIAC CATHETERIZATION	1,438	22,862,080	0	0	0	59.00
60.00	06000	LABORATORY	9,274	61,277,688	4,925	0	82	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	1,095,920	0	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0	3,345,949	0	0	0	64.00
66.00	06600	PHYSICAL THERAPY	8,976	6,616,141	1,775	0	41	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	3,165,281	850	0	17	67.00
67.01	06701	AUDIOLOGY	0	714,269	625	0	18	67.01
68.00	06800	SPEECH PATHOLOGY	0	840,897	375	0	19	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
69.01	06901	CARDIOLOGY	925	15,724,680	3,775	0	41	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	8,795,355	0	0	21	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	12,219,567	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	24,346,119	2,725	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	OTHER OUTPATIENT SERVICE COST CENTER	3,822	0	6,700	0	34	90.01
90.02	09002	CLINIC	0	0	0	0	0	90.02
90.03	09003	DERMATOLOGY CLINIC	0	0	0	0	0	90.03
90.04	09004	ENT CLINIC	0	0	0	0	0	90.04
90.05	09005	SURGERY CLINIC	0	0	0	0	0	90.05
90.07	09007	UROLOGY CLINIC	0	101,957	0	0	0	90.07
90.09	09009	GASTROENTEROLOGY CLINIC	0	0	0	0	0	90.09
90.11	09011	NEUROLOGY CLINIC	0	0	0	0	0	90.11
90.12	09012	OPTHAMOLOGY CLINIC	0	0	0	0	0	90.12
90.13	09013	ALLERGY CLINIC	0	310,424	0	0	0	90.13
90.14	09014	WOUND CARE	3,504	5,172,180	0	0	0	90.14
91.00	09100	EMERGENCY	24,566	27,632,063	0	0	64	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	1,760	3,850,418	0	0	130	95.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	143,431	381,815,298	129,223	41,201	982	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	624	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	37,942	0	0	0	0	192.00
194.00	07950	THORNTOWN OFFICE BUILDING	0	0	0	0	0	194.00
194.01	07951	CAFE/BOUTIQUE	1,416	0	0	0	0	194.01
194.02	07952	OTHER NONREIMB	0	0	0	0	0	194.02
194.03	07953	RETAIL PHARMACY	400	0	0	0	0	194.03
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)	4,556,805	693,287	1,337,994	1,595,057	1,060,134	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	24.790439	0.001816	10.354147	38.714036	1,079.566191	203.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-0104 | Period: From 01/01/2020 To 12/31/2020 | Worksheet B-1 | Date/Time Prepared: 8/2/2021 1:50 pm

	Cost Center Description	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (GROSS CHARGES)	HOUSEKEEPING (HOURS OF SERVICE)	DIETARY (MEALS SERVED)	CAFETERIA (MEALS SERVED)	
		7.00	8.00	9.00	10.00	11.00	
204.00	Cost to be allocated (per Wkst. B, Part II)	830,420	2,971	111,601	250,734	6,985	204.00
205.00	Unit cost multiplier (Wkst. B, Part II)	4.517744	0.000008	0.863631	6.085629	7.113035	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: 15-0104 | Period: From 01/01/2020 To 12/31/2020 | Worksheet B-1 | Date/Time Prepared: 8/2/2021 1:50 pm

		Cost Center Description	NURSING ADMINISTRATION (DIRECT NRSING HRS)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (TIME SPENT)		
			13.00	15.00	16.00		
		GENERAL SERVICE COST CENTERS					
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500	ADMINISTRATIVE & GENERAL					5.00
7.00	00700	OPERATION OF PLANT					7.00
8.00	00800	LAUNDRY & LINEN SERVICE					8.00
9.00	00900	HOUSEKEEPING					9.00
10.00	01000	DIETARY					10.00
11.00	01100	CAFETERIA					11.00
13.00	01300	NURSING ADMINISTRATION	490,747				13.00
15.00	01500	PHARMACY	0	7,034,265			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	41,100		16.00
		INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	103,616	815	10,100		30.00
31.00	03100	INTENSIVE CARE UNIT	46,279	48	2,100		31.00
40.00	04000	SUBPROVIDER - IPF	27,626	77	2,500		40.00
41.00	04100	SUBPROVIDER - IRF	0	0	0		41.00
42.00	04200	SUBPROVIDER	0	0	0		42.00
43.00	04300	NURSERY	0	0	0		43.00
44.00	04400	SKILLED NURSING FACILITY	34,310	104	0		44.00
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	77,971	19,346	3,625		50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	9,692	18,645	9,700		54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0		55.00
55.01	05501	ULTRA SOUND	0	1,489	1,050		55.01
57.00	05700	CT SCAN	0	31,632	1,200		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	18,702	650		58.00
59.00	05900	CARDIAC CATHETERIZATION	10,661	0	0		59.00
60.00	06000	LABORATORY	0	39	1,000		60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0		63.00
64.00	06400	INTRAVENOUS THERAPY	0	2,117	0		64.00
66.00	06600	PHYSICAL THERAPY	35,136	0	1,950		66.00
67.00	06700	OCCUPATIONAL THERAPY	12,409	0	850		67.00
67.01	06701	AUDIOLOGY	6,565	0	0		67.01
68.00	06800	SPEECH PATHOLOGY	5,504	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0		69.00
69.01	06901	CARDIOLOGY	34,761	3,293	1,875		69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0		73.00
		OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	0	0	0		90.00
90.01	09001	OTHER OUTPATIENT SERVICE COST CENTER	1,983	16	4,200		90.01
90.02	09002	CLINIC	0	0	0		90.02
90.03	09003	DERMATOLOGY CLINIC	0	0	0		90.03
90.04	09004	ENT CLINIC	0	0	0		90.04
90.05	09005	SURGERY CLINIC	0	0	0		90.05
90.07	09007	UROLOGY CLINIC	0	0	0		90.07
90.09	09009	GASTROENTEROLOGY CLINIC	3,851	0	0		90.09
90.11	09011	NEUROLOGY CLINIC	0	7,129	0		90.11
90.12	09012	OPTHAMOLOGY CLINIC	0	0	0		90.12
90.13	09013	ALLERGY CLINIC	1,886	0	0		90.13
90.14	09014	WOUND CARE	7,868	16,209	0		90.14
91.00	09100	EMERGENCY	54,116	2,421,576	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					92.00
		OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES	0	12,090	0		95.00
		SPECIAL PURPOSE COST CENTERS					
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	474,234	2,553,327	40,800		118.00
		NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	0	0		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	14,667	2,596,551	300		192.00
194.00	07950	THORNTOWN OFFICE BUILDING	0	0	0		194.00
194.01	07951	CAFE/BOUTIQUE	0	0	0		194.01
194.02	07952	OTHER NONREIMB	1,846	0	0		194.02
194.03	07953	RETAIL PHARMACY	0	1,884,387	0		194.03
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)	920,209	1,997,612	2,537,929		202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-0104 | Period: From 01/01/2020 To 12/31/2020 | Worksheet B-1 | Date/Time Prepared: 8/2/2021 1:50 pm

		Cost Center Description	NURSING ADMINISTRATION (DIRECT NRSING HRS)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (TIME SPENT)		
			13.00	15.00	16.00		
203.00		Unit cost multiplier (Wkst. B, Part I)	1.875119	0.283983	61.750097		203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	5,215	84,037	131,575		204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.010627	0.011947	3.201338		205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)					206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)					207.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-0104 | Period: From 01/01/2020 To 12/31/2020 | Worksheet C Part I Date/Time Prepared: 8/2/2021 1:50 pm

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		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	RCE Disallowance	Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	9,624,855		9,624,855	0	9,624,855	30.00
31.00	03100	INTENSIVE CARE UNIT	3,792,538		3,792,538	0	3,792,538	31.00
40.00	04000	SUBPROVIDER - IPF	2,212,857		2,212,857	0	2,212,857	40.00
41.00	04100	SUBPROVIDER - IRF	0		0	0	0	41.00
42.00	04200	SUBPROVIDER	0		0	0	0	42.00
43.00	04300	NURSERY	67,239		67,239	0	67,239	43.00
44.00	04400	SKILLED NURSING FACILITY	2,429,214		2,429,214	0	2,429,214	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	6,244,011		6,244,011	0	6,244,011	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	7,676,759		7,676,759	0	7,676,759	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0		0	0	0	55.00
55.01	05501	ULTRA SOUND	889,236		889,236	0	889,236	55.01
57.00	05700	CT SCAN	1,254,597		1,254,597	0	1,254,597	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	1,430,690		1,430,690	0	1,430,690	58.00
59.00	05900	CARDIAC CATHETERIZATION	1,862,385		1,862,385	0	1,862,385	59.00
60.00	06000	LABORATORY	10,609,690		10,609,690	0	10,609,690	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	207,114		207,114	0	207,114	63.00
64.00	06400	INTRAVENOUS THERAPY	6,677		6,677	0	6,677	64.00
66.00	06600	PHYSICAL THERAPY	3,119,737	0	3,119,737	0	3,119,737	66.00
67.00	06700	OCCUPATIONAL THERAPY	813,645	0	813,645	0	813,645	67.00
67.01	06701	AUDIOLOGY	271,959	0	271,959	0	271,959	67.01
68.00	06800	SPEECH PATHOLOGY	291,836	0	291,836	0	291,836	68.00
69.00	06900	ELECTROCARDIOLOGY	0		0	0	0	69.00
69.01	06901	CARDIOLOGY	2,485,383		2,485,383	0	2,485,383	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	3,000,617		3,000,617	0	3,000,617	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	4,344,791		4,344,791	0	4,344,791	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	8,252,315		8,252,315	0	8,252,315	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0		0	0	0	90.00
90.01	09001	OTHER OUTPATIENT SERVICE COST CENTER	881,282		881,282	0	881,282	90.01
90.02	09002	CLINIC	0		0	0	0	90.02
90.03	09003	DERMATOLOGY CLINIC	0		0	0	0	90.03
90.04	09004	ENT CLINIC	0		0	0	0	90.04
90.05	09005	SURGERY CLINIC	0		0	0	0	90.05
90.07	09007	UROLOGY CLINIC	185		185	0	185	90.07
90.09	09009	GASTROENTEROLOGY CLINIC	7,962		7,962	0	7,962	90.09
90.11	09011	NEUROLOGY CLINIC	10,053		10,053	0	10,053	90.11
90.12	09012	OPTHAMOLOGY CLINIC	0		0	0	0	90.12
90.13	09013	ALLERGY CLINIC	129,180		129,180	0	129,180	90.13
90.14	09014	WOUND CARE	942,856		942,856	0	942,856	90.14
91.00	09100	EMERGENCY	9,049,828		9,049,828	0	9,049,828	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	3,029,926		3,029,926		3,029,926	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	3,883,946		3,883,946	0	3,883,946	95.00
200.00		Subtotal (see instructions)	88,823,363	0	88,823,363	0	88,823,363	200.00
201.00		Less Observation Beds	3,029,926		3,029,926		3,029,926	201.00
202.00		Total (see instructions)	85,793,437	0	85,793,437	0	85,793,437	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-0104 | Period: From 01/01/2020 To 12/31/2020 | Worksheet C Part I Date/Time Prepared: 8/2/2021 1:50 pm

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		Cost Center Description	Charges Inpatient	Charges Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	15,374,575		15,374,575			30.00
31.00	03100	INTENSIVE CARE UNIT	7,403,536		7,403,536			31.00
40.00	04000	SUBPROVIDER - IPF	1,826,667		1,826,667			40.00
41.00	04100	SUBPROVIDER - IRF	0		0			41.00
42.00	04200	SUBPROVIDER	0		0			42.00
43.00	04300	NURSERY	1,831,818		1,831,818			43.00
44.00	04400	SKILLED NURSING FACILITY	2,409,282		2,409,282			44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	7,569,747	39,474,702	47,044,449	0.132726	0.000000	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,694,536	30,235,878	31,930,414	0.240422	0.000000	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0.000000	0.000000	55.00
55.01	05501	ULTRA SOUND	544,387	7,573,353	8,117,740	0.109542	0.000000	55.01
57.00	05700	CT SCAN	5,469,210	40,278,958	45,748,168	0.027424	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	797,436	15,427,075	16,224,511	0.088181	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	5,752,693	17,109,387	22,862,080	0.081462	0.000000	59.00
60.00	06000	LABORATORY	10,689,162	50,588,526	61,277,688	0.173141	0.000000	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	555,199	540,721	1,095,920	0.188986	0.000000	63.00
64.00	06400	INTRAVENOUS THERAPY	1,489,630	1,856,319	3,345,949	0.001996	0.000000	64.00
66.00	06600	PHYSICAL THERAPY	2,256,532	4,359,609	6,616,141	0.471534	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	2,150,403	1,014,878	3,165,281	0.257053	0.000000	67.00
67.01	06701	AUDIOLOGY	398	713,871	714,269	0.380752	0.000000	67.01
68.00	06800	SPEECH PATHOLOGY	175,668	665,229	840,897	0.347053	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0.000000	0.000000	69.00
69.01	06901	CARDIOLOGY	5,698,406	10,026,274	15,724,680	0.158056	0.000000	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	3,449,995	5,345,360	8,795,355	0.341159	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	3,218,589	9,000,978	12,219,567	0.355560	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	9,544,936	14,801,183	24,346,119	0.338958	0.000000	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0.000000	0.000000	90.00
90.01	09001	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0.000000	0.000000	90.01
90.02	09002	CLINIC	0	0	0	0.000000	0.000000	90.02
90.03	09003	DERMATOLOGY CLINIC	0	0	0	0.000000	0.000000	90.03
90.04	09004	ENT CLINIC	0	0	0	0.000000	0.000000	90.04
90.05	09005	SURGERY CLINIC	0	0	0	0.000000	0.000000	90.05
90.07	09007	UROLOGY CLINIC	1,267	100,690	101,957	0.001814	0.000000	90.07
90.09	09009	GASTROENTEROLOGY CLINIC	0	0	0	0.000000	0.000000	90.09
90.11	09011	NEUROLOGY CLINIC	0	0	0	0.000000	0.000000	90.11
90.12	09012	OPTHAMOLOGY CLINIC	0	0	0	0.000000	0.000000	90.12
90.13	09013	ALLERGY CLINIC	0	310,424	310,424	0.416141	0.000000	90.13
90.14	09014	WOUND CARE	22,593	5,149,587	5,172,180	0.182294	0.000000	90.14
91.00	09100	EMERGENCY	3,566,773	24,065,290	27,632,063	0.327512	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	407,724	5,425,426	5,833,150	0.519432	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	1,057	3,849,361	3,850,418	1.008708	0.000000	95.00
200.00		Subtotal (see instructions)	93,902,219	287,913,079	381,815,298			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	93,902,219	287,913,079	381,815,298			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-0104 | Period: From 01/01/2020 To 12/31/2020 | Worksheet C Part I Date/Time Prepared: 8/2/2021 1:50 pm

Title XVIII | Hospital | PPS

		Cost Center Description	PPS Inpatient Ratio		
			11.00		
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS			30.00
31.00	03100	INTENSIVE CARE UNIT			31.00
40.00	04000	SUBPROVIDER - IPF			40.00
41.00	04100	SUBPROVIDER - IRF			41.00
42.00	04200	SUBPROVIDER			42.00
43.00	04300	NURSERY			43.00
44.00	04400	SKILLED NURSING FACILITY			44.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0.132726		50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.240422		54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.000000		55.00
55.01	05501	ULTRA SOUND	0.109542		55.01
57.00	05700	CT SCAN	0.027424		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.088181		58.00
59.00	05900	CARDIAC CATHETERIZATION	0.081462		59.00
60.00	06000	LABORATORY	0.173141		60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.188986		63.00
64.00	06400	INTRAVENOUS THERAPY	0.001996		64.00
66.00	06600	PHYSICAL THERAPY	0.471534		66.00
67.00	06700	OCCUPATIONAL THERAPY	0.257053		67.00
67.01	06701	AUDIOLOGY	0.380752		67.01
68.00	06800	SPEECH PATHOLOGY	0.347053		68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000		69.00
69.01	06901	CARDIOLOGY	0.158056		69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.341159		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.355560		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.338958		73.00
		OUTPATIENT SERVICE COST CENTERS			
90.00	09000	CLINIC	0.000000		90.00
90.01	09001	OTHER OUTPATIENT SERVICE COST CENTER	0.000000		90.01
90.02	09002	CLINIC	0.000000		90.02
90.03	09003	DERMATOLOGY CLINIC	0.000000		90.03
90.04	09004	ENT CLINIC	0.000000		90.04
90.05	09005	SURGERY CLINIC	0.000000		90.05
90.07	09007	UROLOGY CLINIC	0.001814		90.07
90.09	09009	GASTROENTEROLOGY CLINIC	0.000000		90.09
90.11	09011	NEUROLOGY CLINIC	0.000000		90.11
90.12	09012	OPTHAMOLOGY CLINIC	0.000000		90.12
90.13	09013	ALLERGY CLINIC	0.416141		90.13
90.14	09014	WOUND CARE	0.182294		90.14
91.00	09100	EMERGENCY	0.327512		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.519432		92.00
		OTHER REIMBURSABLE COST CENTERS			
95.00	09500	AMBULANCE SERVICES	1.008708		95.00
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: 15-0104 | Period: From 01/01/2020 To 12/31/2020 | Worksheet C Part I Date/Time Prepared: 8/2/2021 1:50 pm

Title XIX | Hospital | Cost

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	RCE Disallowance	Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	9,624,855		9,624,855	0	9,624,855	30.00
31.00	03100	INTENSIVE CARE UNIT	3,792,538		3,792,538	0	3,792,538	31.00
40.00	04000	SUBPROVIDER - IPF	2,212,857		2,212,857	0	2,212,857	40.00
41.00	04100	SUBPROVIDER - IRF	0		0	0	0	41.00
42.00	04200	SUBPROVIDER	0		0	0	0	42.00
43.00	04300	NURSERY	67,239		67,239	0	67,239	43.00
44.00	04400	SKILLED NURSING FACILITY	2,429,214		2,429,214	0	2,429,214	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	6,244,011		6,244,011	0	6,244,011	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	7,676,759		7,676,759	0	7,676,759	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0		0	0	0	55.00
55.01	05501	ULTRA SOUND	889,236		889,236	0	889,236	55.01
57.00	05700	CT SCAN	1,254,597		1,254,597	0	1,254,597	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	1,430,690		1,430,690	0	1,430,690	58.00
59.00	05900	CARDIAC CATHETERIZATION	1,862,385		1,862,385	0	1,862,385	59.00
60.00	06000	LABORATORY	10,609,690		10,609,690	0	10,609,690	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	207,114		207,114	0	207,114	63.00
64.00	06400	INTRAVENOUS THERAPY	6,677		6,677	0	6,677	64.00
66.00	06600	PHYSICAL THERAPY	3,119,737	0	3,119,737	0	3,119,737	66.00
67.00	06700	OCCUPATIONAL THERAPY	813,645	0	813,645	0	813,645	67.00
67.01	06701	AUDIOLOGY	271,959	0	271,959	0	271,959	67.01
68.00	06800	SPEECH PATHOLOGY	291,836	0	291,836	0	291,836	68.00
69.00	06900	ELECTROCARDIOLOGY	0		0	0	0	69.00
69.01	06901	CARDIOLOGY	2,485,383		2,485,383	0	2,485,383	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	3,000,617		3,000,617	0	3,000,617	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	4,344,791		4,344,791	0	4,344,791	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	8,252,315		8,252,315	0	8,252,315	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0		0	0	0	90.00
90.01	09001	OTHER OUTPATIENT SERVICE COST CENTER	881,282		881,282	0	881,282	90.01
90.02	09002	CLINIC	0		0	0	0	90.02
90.03	09003	DERMATOLOGY CLINIC	0		0	0	0	90.03
90.04	09004	ENT CLINIC	0		0	0	0	90.04
90.05	09005	SURGERY CLINIC	0		0	0	0	90.05
90.07	09007	UROLOGY CLINIC	185		185	0	185	90.07
90.09	09009	GASTROENTEROLOGY CLINIC	7,962		7,962	0	7,962	90.09
90.11	09011	NEUROLOGY CLINIC	10,053		10,053	0	10,053	90.11
90.12	09012	OPTHAMOLOGY CLINIC	0		0	0	0	90.12
90.13	09013	ALLERGY CLINIC	129,180		129,180	0	129,180	90.13
90.14	09014	WOUND CARE	942,856		942,856	0	942,856	90.14
91.00	09100	EMERGENCY	9,049,828		9,049,828	0	9,049,828	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	3,029,926		3,029,926		3,029,926	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	3,883,946		3,883,946	0	3,883,946	95.00
200.00		Subtotal (see instructions)	88,823,363	0	88,823,363	0	88,823,363	200.00
201.00		Less Observation Beds	3,029,926		3,029,926		3,029,926	201.00
202.00		Total (see instructions)	85,793,437	0	85,793,437	0	85,793,437	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-0104 | Period: From 01/01/2020 To 12/31/2020 | Worksheet C Part I Date/Time Prepared: 8/2/2021 1:50 pm

Title XIX | Hospital | Cost

		Cost Center Description	Charges Inpatient	Charges Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	15,374,575		15,374,575			30.00
31.00	03100	INTENSIVE CARE UNIT	7,403,536		7,403,536			31.00
40.00	04000	SUBPROVIDER - IPF	1,826,667		1,826,667			40.00
41.00	04100	SUBPROVIDER - IRF	0		0			41.00
42.00	04200	SUBPROVIDER	0		0			42.00
43.00	04300	NURSERY	1,831,818		1,831,818			43.00
44.00	04400	SKILLED NURSING FACILITY	2,409,282		2,409,282			44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	7,569,747	39,474,702	47,044,449	0.132726	0.000000	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,694,536	30,235,878	31,930,414	0.240422	0.000000	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0.000000	0.000000	55.00
55.01	05501	ULTRA SOUND	544,387	7,573,353	8,117,740	0.109542	0.000000	55.01
57.00	05700	CT SCAN	5,469,210	40,278,958	45,748,168	0.027424	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	797,436	15,427,075	16,224,511	0.088181	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	5,752,693	17,109,387	22,862,080	0.081462	0.000000	59.00
60.00	06000	LABORATORY	10,689,162	50,588,526	61,277,688	0.173141	0.000000	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	555,199	540,721	1,095,920	0.188986	0.000000	63.00
64.00	06400	INTRAVENOUS THERAPY	1,489,630	1,856,319	3,345,949	0.001996	0.000000	64.00
66.00	06600	PHYSICAL THERAPY	2,256,532	4,359,609	6,616,141	0.471534	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	2,150,403	1,014,878	3,165,281	0.257053	0.000000	67.00
67.01	06701	AUDIOLOGY	398	713,871	714,269	0.380752	0.000000	67.01
68.00	06800	SPEECH PATHOLOGY	175,668	665,229	840,897	0.347053	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0.000000	0.000000	69.00
69.01	06901	CARDIOLOGY	5,698,406	10,026,274	15,724,680	0.158056	0.000000	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	3,449,995	5,345,360	8,795,355	0.341159	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	3,218,589	9,000,978	12,219,567	0.355560	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	9,544,936	14,801,183	24,346,119	0.338958	0.000000	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0.000000	0.000000	90.00
90.01	09001	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0.000000	0.000000	90.01
90.02	09002	CLINIC	0	0	0	0.000000	0.000000	90.02
90.03	09003	DERMATOLOGY CLINIC	0	0	0	0.000000	0.000000	90.03
90.04	09004	ENT CLINIC	0	0	0	0.000000	0.000000	90.04
90.05	09005	SURGERY CLINIC	0	0	0	0.000000	0.000000	90.05
90.07	09007	UROLOGY CLINIC	1,267	100,690	101,957	0.001814	0.000000	90.07
90.09	09009	GASTROENTEROLOGY CLINIC	0	0	0	0.000000	0.000000	90.09
90.11	09011	NEUROLOGY CLINIC	0	0	0	0.000000	0.000000	90.11
90.12	09012	OPTHAMOLOGY CLINIC	0	0	0	0.000000	0.000000	90.12
90.13	09013	ALLERGY CLINIC	0	310,424	310,424	0.416141	0.000000	90.13
90.14	09014	WOUND CARE	22,593	5,149,587	5,172,180	0.182294	0.000000	90.14
91.00	09100	EMERGENCY	3,566,773	24,065,290	27,632,063	0.327512	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	407,724	5,425,426	5,833,150	0.519432	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	1,057	3,849,361	3,850,418	1.008708	0.000000	95.00
200.00		Subtotal (see instructions)	93,902,219	287,913,079	381,815,298			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	93,902,219	287,913,079	381,815,298			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-0104 | Period: From 01/01/2020 To 12/31/2020 | Worksheet C Part I Date/Time Prepared: 8/2/2021 1:50 pm

Title XIX | Hospital | Cost

		Cost Center Description	PPS Inpatient Ratio		
			11.00		
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS			30.00
31.00	03100	INTENSIVE CARE UNIT			31.00
40.00	04000	SUBPROVIDER - IPF			40.00
41.00	04100	SUBPROVIDER - IRF			41.00
42.00	04200	SUBPROVIDER			42.00
43.00	04300	NURSERY			43.00
44.00	04400	SKILLED NURSING FACILITY			44.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0.000000		50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000		54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.000000		55.00
55.01	05501	ULTRA SOUND	0.000000		55.01
57.00	05700	CT SCAN	0.000000		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000		58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000		59.00
60.00	06000	LABORATORY	0.000000		60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.000000		63.00
64.00	06400	INTRAVENOUS THERAPY	0.000000		64.00
66.00	06600	PHYSICAL THERAPY	0.000000		66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000		67.00
67.01	06701	AUDIOLOGY	0.000000		67.01
68.00	06800	SPEECH PATHOLOGY	0.000000		68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000		69.00
69.01	06901	CARDIOLOGY	0.000000		69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.000000		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000		73.00
		OUTPATIENT SERVICE COST CENTERS			
90.00	09000	CLINIC	0.000000		90.00
90.01	09001	OTHER OUTPATIENT SERVICE COST CENTER	0.000000		90.01
90.02	09002	CLINIC	0.000000		90.02
90.03	09003	DERMATOLOGY CLINIC	0.000000		90.03
90.04	09004	ENT CLINIC	0.000000		90.04
90.05	09005	SURGERY CLINIC	0.000000		90.05
90.07	09007	UROLOGY CLINIC	0.000000		90.07
90.09	09009	GASTROENTEROLOGY CLINIC	0.000000		90.09
90.11	09011	NEUROLOGY CLINIC	0.000000		90.11
90.12	09012	OPTHAMOLOGY CLINIC	0.000000		90.12
90.13	09013	ALLERGY CLINIC	0.000000		90.13
90.14	09014	WOUND CARE	0.000000		90.14
91.00	09100	EMERGENCY	0.000000		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000		92.00
		OTHER REIMBURSABLE COST CENTERS			
95.00	09500	AMBULANCE SERVICES	0.000000		95.00
200.00		Subtotal (see instructions)			200.00
201.00		Less Observation Beds			201.00
202.00		Total (see instructions)			202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS | Provider CCN: 15-0104 | Period: From 01/01/2020 To 12/31/2020 | Worksheet D Part I Date/Time Prepared: 8/2/2021 1:50 pm

Title XVIII | Hospital | PPS

	Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	1,023,621	0	1,023,621	7,465	137.12	30.00
31.00	INTENSIVE CARE UNIT	243,447		243,447	2,815	86.48	31.00
40.00	SUBPROVIDER - IPF	294,767	0	294,767	1,400	210.55	40.00
41.00	SUBPROVIDER - IRF	0	0	0	0	0.00	41.00
42.00	SUBPROVIDER	0	0	0	0	0.00	42.00
43.00	NURSERY	288		288	962	0.30	43.00
44.00	SKILLED NURSING FACILITY	265,294		265,294	4,039	65.68	44.00
200.00	Total (lines 30 through 199)	1,827,417		1,827,417	16,681		200.00

	Cost Center Description	Inpatient Program days	Inpatient Program Capital Cost (col. 5 x col. 6)	
		6.00	7.00	
	INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	ADULTS & PEDIATRICS	2,060	282,467	30.00
31.00	INTENSIVE CARE UNIT	1,046	90,458	31.00
40.00	SUBPROVIDER - IPF	1,001	210,761	40.00
41.00	SUBPROVIDER - IRF	0	0	41.00
42.00	SUBPROVIDER	0	0	42.00
43.00	NURSERY	0	0	43.00
44.00	SKILLED NURSING FACILITY	2,342	153,823	44.00
200.00	Total (lines 30 through 199)	6,449	737,509	200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS | Provider CCN: 15-0104 | Period: From 01/01/2020 To 12/31/2020 | Worksheet D Part II Date/Time Prepared: 8/2/2021 1:50 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	653,400	47,044,449	0.013889	3,092,957	42,958	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	820,958	31,930,414	0.025711	1,009,855	25,964	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0.000000	0	0	55.00
55.01	05501	ULTRA SOUND	7,642	8,117,740	0.000941	42,334	40	55.01
57.00	05700	CT SCAN	10,242	45,748,168	0.000224	1,732,141	388	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	73,539	16,224,511	0.004533	288,272	1,307	58.00
59.00	05900	CARDIAC CATHETERIZATION	62,299	22,862,080	0.002725	401,701	1,095	59.00
60.00	06000	LABORATORY	402,809	61,277,688	0.006574	3,275,552	21,533	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	885	1,095,920	0.000808	105,683	85	63.00
64.00	06400	INTRAVENOUS THERAPY	52	3,345,949	0.000016	385,974	6	64.00
66.00	06600	PHYSICAL THERAPY	359,382	6,616,141	0.054319	315,861	17,157	66.00
67.00	06700	OCCUPATIONAL THERAPY	6,876	3,165,281	0.002172	248,795	540	67.00
67.01	06701	AUDIOLOGY	1,796	714,269	0.002514	0	0	67.01
68.00	06800	SPEECH PATHOLOGY	1,662	840,897	0.001976	50,179	99	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0.000000	0	0	69.00
69.01	06901	CARDIOLOGY	54,676	15,724,680	0.003477	3,525,246	12,257	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	12,870	8,795,355	0.001463	856,125	1,253	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	18,560	12,219,567	0.001519	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	37,485	24,346,119	0.001540	2,390,895	3,682	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0.000000	0	0	90.00
90.01	09001	OTHER OUTPATIENT SERVICE COST CENTER	165,750	0	0.000000	0	0	90.01
90.02	09002	CLINIC	0	0	0.000000	0	0	90.02
90.03	09003	DERMATOLOGY CLINIC	0	0	0.000000	0	0	90.03
90.04	09004	ENT CLINIC	0	0	0.000000	0	0	90.04
90.05	09005	SURGERY CLINIC	0	0	0.000000	0	0	90.05
90.07	09007	UROLOGY CLINIC	1	101,957	0.000010	0	0	90.07
90.09	09009	GASTROENTEROLOGY CLINIC	45	0	0.000000	0	0	90.09
90.11	09011	NEUROLOGY CLINIC	119	0	0.000000	0	0	90.11
90.12	09012	OPTHAMOLOGY CLINIC	0	0	0.000000	0	0	90.12
90.13	09013	ALLERGY CLINIC	576	310,424	0.001856	0	0	90.13
90.14	09014	WOUND CARE	136,340	5,172,180	0.026360	2,220	59	90.14
91.00	09100	EMERGENCY	991,406	27,632,063	0.035879	1,308,244	46,938	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	322,239	5,833,150	0.055243	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)	4,141,609	349,119,002		19,032,034	175,361	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 15-0104 | Period: From 01/01/2020 To 12/31/2020 | Worksheet D Part III Date/Time Prepared: 8/2/2021 1:50 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health Cost	All Other Medical Education Cost	
			1A	1.00	2A	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	0	40.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	0	42.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0		44.00
200.00		Total (lines 30 through 199)	0	0	0	0	0	200.00

		Cost Center Description	Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days	
			4.00	5.00	6.00	7.00	8.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	0	7,465	0.00	2,060	30.00
31.00	03100	INTENSIVE CARE UNIT		0	2,815	0.00	1,046	31.00
40.00	04000	SUBPROVIDER - IPF	0	0	1,400	0.00	1,001	40.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0.00	0	41.00
42.00	04200	SUBPROVIDER	0	0	0	0.00	0	42.00
43.00	04300	NURSERY		0	962	0.00	0	43.00
44.00	04400	SKILLED NURSING FACILITY		0	4,039	0.00	2,342	44.00
200.00		Total (lines 30 through 199)		0	16,681		6,449	200.00

		Cost Center Description	Inpatient Program Pass-Through Cost (col. 7 x col. 8)	
			9.00	
		INPATIENT ROUTINE SERVICE COST CENTERS		
30.00	03000	ADULTS & PEDIATRICS	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	31.00
40.00	04000	SUBPROVIDER - IPF	0	40.00
41.00	04100	SUBPROVIDER - IRF	0	41.00
42.00	04200	SUBPROVIDER	0	42.00
43.00	04300	NURSERY	0	43.00
44.00	04400	SKILLED NURSING FACILITY	0	44.00
200.00		Total (lines 30 through 199)	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 15-0104 | Period: From 01/01/2020 To 12/31/2020 | Worksheet D Part IV Date/Time Prepared: 8/2/2021 1:50 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health	
			1.00	2A	2.00	3A	3.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	0	55.00
55.01	05501	ULTRA SOUND	0	0	0	0	0	55.01
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
67.01	06701	AUDIOLOGY	0	0	0	0	0	67.01
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
69.01	06901	CARDIOLOGY	0	0	0	0	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	0	90.01
90.02	09002	CLINIC	0	0	0	0	0	90.02
90.03	09003	DERMATOLOGY CLINIC	0	0	0	0	0	90.03
90.04	09004	ENT CLINIC	0	0	0	0	0	90.04
90.05	09005	SURGERY CLINIC	0	0	0	0	0	90.05
90.07	09007	UROLOGY CLINIC	0	0	0	0	0	90.07
90.09	09009	GASTROENTEROLOGY CLINIC	0	0	0	0	0	90.09
90.11	09011	NEUROLOGY CLINIC	0	0	0	0	0	90.11
90.12	09012	OPTHAMOLOGY CLINIC	0	0	0	0	0	90.12
90.13	09013	ALLERGY CLINIC	0	0	0	0	0	90.13
90.14	09014	WOUND CARE	0	0	0	0	0	90.14
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0		0		0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-0104 | Period: From 01/01/2020 To 12/31/2020 | Worksheet D Part IV Date/Time Prepared: 8/2/2021 1:50 pm

Title XVIII | Hospital | PPS

		Cost Center Description	All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7) (see instructions)	
			4.00	5.00	6.00	7.00	8.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	47,044,449	0.000000	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	31,930,414	0.000000	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	0.000000	55.00
55.01	05501	ULTRA SOUND	0	0	0	8,117,740	0.000000	55.01
57.00	05700	CT SCAN	0	0	0	45,748,168	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	16,224,511	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	22,862,080	0.000000	59.00
60.00	06000	LABORATORY	0	0	0	61,277,688	0.000000	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	1,095,920	0.000000	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	3,345,949	0.000000	64.00
66.00	06600	PHYSICAL THERAPY	0	0	0	6,616,141	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	3,165,281	0.000000	67.00
67.01	06701	AUDIOLOGY	0	0	0	714,269	0.000000	67.01
68.00	06800	SPEECH PATHOLOGY	0	0	0	840,897	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0.000000	69.00
69.01	06901	CARDIOLOGY	0	0	0	15,724,680	0.000000	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	8,795,355	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	12,219,567	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	24,346,119	0.000000	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0.000000	90.00
90.01	09001	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	0.000000	90.01
90.02	09002	CLINIC	0	0	0	0	0.000000	90.02
90.03	09003	DERMATOLOGY CLINIC	0	0	0	0	0.000000	90.03
90.04	09004	ENT CLINIC	0	0	0	0	0.000000	90.04
90.05	09005	SURGERY CLINIC	0	0	0	0	0.000000	90.05
90.07	09007	UROLOGY CLINIC	0	0	0	101,957	0.000000	90.07
90.09	09009	GASTROENTEROLOGY CLINIC	0	0	0	0	0.000000	90.09
90.11	09011	NEUROLOGY CLINIC	0	0	0	0	0.000000	90.11
90.12	09012	OPTHAMOLOGY CLINIC	0	0	0	0	0.000000	90.12
90.13	09013	ALLERGY CLINIC	0	0	0	310,424	0.000000	90.13
90.14	09014	WOUND CARE	0	0	0	5,172,180	0.000000	90.14
91.00	09100	EMERGENCY	0	0	0	27,632,063	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	5,833,150	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)	0	0	0	349,119,002		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-0104 | Period: From 01/01/2020 To 12/31/2020 | Worksheet D Part IV Date/Time Prepared: 8/2/2021 1:50 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
			9.00	10.00	11.00	12.00	13.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.000000	3,092,957	0	12,405,947	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	1,009,855	0	9,847,585	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.000000	0	0	0	0	55.00
55.01	05501	ULTRA SOUND	0.000000	42,334	0	825,606	0	55.01
57.00	05700	CT SCAN	0.000000	1,732,141	0	9,765,359	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000	288,272	0	4,969,547	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	401,701	0	2,019,049	0	59.00
60.00	06000	LABORATORY	0.000000	3,275,552	0	5,197,901	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.000000	105,683	0	237,129	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0.000000	385,974	0	435,367	0	64.00
66.00	06600	PHYSICAL THERAPY	0.000000	315,861	0	37,726	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	248,795	0	18,185	0	67.00
67.01	06701	AUDIOLOGY	0.000000	0	0	0	0	67.01
68.00	06800	SPEECH PATHOLOGY	0.000000	50,179	0	73,737	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	0	0	0	0	69.00
69.01	06901	CARDIOLOGY	0.000000	3,525,246	0	7,660,551	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	856,125	0	935,740	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.000000	0	0	19,620	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	2,390,895	0	10,148,756	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.000000	0	0	0	0	90.00
90.01	09001	OTHER OUTPATIENT SERVICE COST CENTER	0.000000	0	0	0	0	90.01
90.02	09002	CLINIC	0.000000	0	0	0	0	90.02
90.03	09003	DERMATOLOGY CLINIC	0.000000	0	0	0	0	90.03
90.04	09004	ENT CLINIC	0.000000	0	0	0	0	90.04
90.05	09005	SURGERY CLINIC	0.000000	0	0	0	0	90.05
90.07	09007	UROLOGY CLINIC	0.000000	0	0	0	0	90.07
90.09	09009	GASTROENTEROLOGY CLINIC	0.000000	0	0	0	0	90.09
90.11	09011	NEUROLOGY CLINIC	0.000000	0	0	0	0	90.11
90.12	09012	OPTHAMOLOGY CLINIC	0.000000	0	0	0	0	90.12
90.13	09013	ALLERGY CLINIC	0.000000	0	0	0	0	90.13
90.14	09014	WOUND CARE	0.000000	2,220	0	1,792,477	0	90.14
91.00	09100	EMERGENCY	0.000000	1,308,244	0	3,949,080	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	0	0	2,644,316	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)		19,032,034	0	72,983,678	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-0104 | Period: From 01/01/2020 To 12/31/2020 | Worksheet D Part V Date/Time Prepared: 8/2/2021 1:50 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.132726	12,405,947	0	0	1,646,592	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.240422	9,847,585	383	374	2,367,576	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.000000	0	0	0	0	55.00
55.01	05501	ULTRA SOUND	0.109542	825,606	0	0	90,439	55.01
57.00	05700	CT SCAN	0.027424	9,765,359	0	6,623	267,805	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.088181	4,969,547	0	8	438,220	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.081462	2,019,049	0	0	164,476	59.00
60.00	06000	LABORATORY	0.173141	5,197,901	13,980	0	899,970	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.188986	237,129	0	0	44,814	63.00
64.00	06400	INTRAVENOUS THERAPY	0.001996	435,367	0	0	869	64.00
66.00	06600	PHYSICAL THERAPY	0.471534	37,726	0	0	17,789	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.257053	18,185	0	0	4,675	67.00
67.01	06701	AUDIOLOGY	0.380752	0	0	0	0	67.01
68.00	06800	SPEECH PATHOLOGY	0.347053	73,737	0	0	25,591	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	0	0	0	0	69.00
69.01	06901	CARDIOLOGY	0.158056	7,660,551	0	107	1,210,796	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.341159	935,740	0	0	319,236	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.355560	19,620	0	0	6,976	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.338958	10,148,756	0	39,881	3,440,002	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.000000	0	0	0	0	90.00
90.01	09001	OTHER OUTPATIENT SERVICE COST CENTER	0.000000	0	0	0	0	90.01
90.02	09002	CLINIC	0.000000	0	0	0	0	90.02
90.03	09003	DERMATOLOGY CLINIC	0.000000	0	0	0	0	90.03
90.04	09004	ENT CLINIC	0.000000	0	0	0	0	90.04
90.05	09005	SURGERY CLINIC	0.000000	0	0	0	0	90.05
90.07	09007	UROLOGY CLINIC	0.001814	0	0	0	0	90.07
90.09	09009	GASTROENTEROLOGY CLINIC	0.000000	0	0	0	0	90.09
90.11	09011	NEUROLOGY CLINIC	0.000000	0	0	0	0	90.11
90.12	09012	OPTHAMOLOGY CLINIC	0.000000	0	0	0	0	90.12
90.13	09013	ALLERGY CLINIC	0.416141	0	0	0	0	90.13
90.14	09014	WOUND CARE	0.182294	1,792,477	0	6,959	326,758	90.14
91.00	09100	EMERGENCY	0.327512	3,949,080	0	0	1,293,371	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.519432	2,644,316	0	0	1,373,542	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	1.008708		0			95.00
200.00		Subtotal (see instructions)		72,983,678	14,363	53,952	13,939,497	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 - line 201)		72,983,678	14,363	53,952	13,939,497	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-0104 | Period: From 01/01/2020 To 12/31/2020 | Worksheet D Part V Date/Time Prepared: 8/2/2021 1:50 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Costs: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	0		50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	92	90		54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0		55.00
55.01	05501	ULTRA SOUND	0	0		55.01
57.00	05700	CT SCAN	0	182		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	1		58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0		59.00
60.00	06000	LABORATORY	2,421	0		60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0		63.00
64.00	06400	INTRAVENOUS THERAPY	0	0		64.00
66.00	06600	PHYSICAL THERAPY	0	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0		67.00
67.01	06701	AUDIOLOGY	0	0		67.01
68.00	06800	SPEECH PATHOLOGY	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0		69.00
69.01	06901	CARDIOLOGY	0	17		69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	13,518		73.00
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0	0		90.00
90.01	09001	OTHER OUTPATIENT SERVICE COST CENTER	0	0		90.01
90.02	09002	CLINIC	0	0		90.02
90.03	09003	DERMATOLOGY CLINIC	0	0		90.03
90.04	09004	ENT CLINIC	0	0		90.04
90.05	09005	SURGERY CLINIC	0	0		90.05
90.07	09007	UROLOGY CLINIC	0	0		90.07
90.09	09009	GASTROENTEROLOGY CLINIC	0	0		90.09
90.11	09011	NEUROLOGY CLINIC	0	0		90.11
90.12	09012	OPTHAMOLOGY CLINIC	0	0		90.12
90.13	09013	ALLERGY CLINIC	0	0		90.13
90.14	09014	WOUND CARE	0	1,269		90.14
91.00	09100	EMERGENCY	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0		92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES	0			95.00
200.00		Subtotal (see instructions)	2,513	15,077		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	2,513	15,077		202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 15-0104 | Component CCN: 15-S104 | Period: From 01/01/2020 To 12/31/2020 | Worksheet D Part II Date/Time Prepared: 8/2/2021 1:50 pm

Title XVIII | Subprovider - IPF | PPS

		Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	653,400	47,044,449	0.013889	4,555	63	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	820,958	31,930,414	0.025711	19,214	494	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0.000000	0	0	55.00
55.01	05501	ULTRA SOUND	7,642	8,117,740	0.000941	1,310	1	55.01
57.00	05700	CT SCAN	10,242	45,748,168	0.000224	43,948	10	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	73,539	16,224,511	0.004533	7,941	36	58.00
59.00	05900	CARDIAC CATHETERIZATION	62,299	22,862,080	0.002725	3,006	8	59.00
60.00	06000	LABORATORY	402,809	61,277,688	0.006574	275,406	1,811	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	885	1,095,920	0.000808	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	52	3,345,949	0.000016	3,017	0	64.00
66.00	06600	PHYSICAL THERAPY	359,382	6,616,141	0.054319	16,124	876	66.00
67.00	06700	OCCUPATIONAL THERAPY	6,876	3,165,281	0.002172	268	1	67.00
67.01	06701	AUDIOLOGY	1,796	714,269	0.002514	0	0	67.01
68.00	06800	SPEECH PATHOLOGY	1,662	840,897	0.001976	874	2	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0.000000	0	0	69.00
69.01	06901	CARDIOLOGY	54,676	15,724,680	0.003477	26,375	92	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	12,870	8,795,355	0.001463	16,124	24	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	18,560	12,219,567	0.001519	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	37,485	24,346,119	0.001540	280,392	432	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0.000000	0	0	90.00
90.01	09001	OTHER OUTPATIENT SERVICE COST CENTER	165,750	0	0.000000	0	0	90.01
90.02	09002	CLINIC	0	0	0.000000	0	0	90.02
90.03	09003	DERMATOLOGY CLINIC	0	0	0.000000	0	0	90.03
90.04	09004	ENT CLINIC	0	0	0.000000	0	0	90.04
90.05	09005	SURGERY CLINIC	0	0	0.000000	0	0	90.05
90.07	09007	UROLOGY CLINIC	1	101,957	0.000010	0	0	90.07
90.09	09009	GASTROENTEROLOGY CLINIC	45	0	0.000000	0	0	90.09
90.11	09011	NEUROLOGY CLINIC	119	0	0.000000	0	0	90.11
90.12	09012	OPTHAMOLOGY CLINIC	0	0	0.000000	0	0	90.12
90.13	09013	ALLERGY CLINIC	576	310,424	0.001856	0	0	90.13
90.14	09014	WOUND CARE	136,340	5,172,180	0.026360	31	1	90.14
91.00	09100	EMERGENCY	991,406	27,632,063	0.035879	20,040	719	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	5,833,150	0.000000	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)	3,819,370	349,119,002		718,625	4,570	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-0104 | Component CCN: 15-S104 | Period: From 01/01/2020 To 12/31/2020 | Worksheet D Part IV Date/Time Prepared: 8/2/2021 1:50 pm

Title XVIII | Subprovider - IPF | PPS

		Cost Center Description	Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health	
			1.00	2A	2.00	3A	3.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	0	55.00
55.01	05501	ULTRA SOUND	0	0	0	0	0	55.01
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
67.01	06701	AUDIOLOGY	0	0	0	0	0	67.01
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
69.01	06901	CARDIOLOGY	0	0	0	0	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	0	90.01
90.02	09002	CLINIC	0	0	0	0	0	90.02
90.03	09003	DERMATOLOGY CLINIC	0	0	0	0	0	90.03
90.04	09004	ENT CLINIC	0	0	0	0	0	90.04
90.05	09005	SURGERY CLINIC	0	0	0	0	0	90.05
90.07	09007	UROLOGY CLINIC	0	0	0	0	0	90.07
90.09	09009	GASTROENTEROLOGY CLINIC	0	0	0	0	0	90.09
90.11	09011	NEUROLOGY CLINIC	0	0	0	0	0	90.11
90.12	09012	OPTHAMOLOGY CLINIC	0	0	0	0	0	90.12
90.13	09013	ALLERGY CLINIC	0	0	0	0	0	90.13
90.14	09014	WOUND CARE	0	0	0	0	0	90.14
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0		0		0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-0104
Component CCN: 15-S104

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

Worksheet D
Part IV
Date/Time Prepared: 8/2/2021 1:50 pm

Title XVIII

Subprovider - IPF

PPS

		Cost Center Description	All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7) (see instructions)	
			4.00	5.00	6.00	7.00	8.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	47,044,449	0.000000	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	31,930,414	0.000000	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	0.000000	55.00
55.01	05501	ULTRA SOUND	0	0	0	8,117,740	0.000000	55.01
57.00	05700	CT SCAN	0	0	0	45,748,168	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	16,224,511	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	22,862,080	0.000000	59.00
60.00	06000	LABORATORY	0	0	0	61,277,688	0.000000	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	1,095,920	0.000000	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	3,345,949	0.000000	64.00
66.00	06600	PHYSICAL THERAPY	0	0	0	6,616,141	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	3,165,281	0.000000	67.00
67.01	06701	AUDIOLOGY	0	0	0	714,269	0.000000	67.01
68.00	06800	SPEECH PATHOLOGY	0	0	0	840,897	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0.000000	69.00
69.01	06901	CARDIOLOGY	0	0	0	15,724,680	0.000000	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	8,795,355	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	12,219,567	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	24,346,119	0.000000	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0.000000	90.00
90.01	09001	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	0.000000	90.01
90.02	09002	CLINIC	0	0	0	0	0.000000	90.02
90.03	09003	DERMATOLOGY CLINIC	0	0	0	0	0.000000	90.03
90.04	09004	ENT CLINIC	0	0	0	0	0.000000	90.04
90.05	09005	SURGERY CLINIC	0	0	0	0	0.000000	90.05
90.07	09007	UROLOGY CLINIC	0	0	0	101,957	0.000000	90.07
90.09	09009	GASTROENTEROLOGY CLINIC	0	0	0	0	0.000000	90.09
90.11	09011	NEUROLOGY CLINIC	0	0	0	0	0.000000	90.11
90.12	09012	OPTHAMOLOGY CLINIC	0	0	0	0	0.000000	90.12
90.13	09013	ALLERGY CLINIC	0	0	0	310,424	0.000000	90.13
90.14	09014	WOUND CARE	0	0	0	5,172,180	0.000000	90.14
91.00	09100	EMERGENCY	0	0	0	27,632,063	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	5,833,150	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)	0	0	0	349,119,002		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-0104 | Component CCN: 15-S104 | Period: From 01/01/2020 To 12/31/2020 | Worksheet D Part IV Date/Time Prepared: 8/2/2021 1:50 pm

Title XVIII | Subprovider - IPF | PPS

		Cost Center Description	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
			9.00	10.00	11.00	12.00	13.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.000000	4,555	0	0	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	19,214	0	50	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.000000	0	0	0	0	55.00
55.01	05501	ULTRA SOUND	0.000000	1,310	0	0	0	55.01
57.00	05700	CT SCAN	0.000000	43,948	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000	7,941	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	3,006	0	0	0	59.00
60.00	06000	LABORATORY	0.000000	275,406	0	0	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.000000	0	0	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0.000000	3,017	0	0	0	64.00
66.00	06600	PHYSICAL THERAPY	0.000000	16,124	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	268	0	0	0	67.00
67.01	06701	AUDIOLOGY	0.000000	0	0	0	0	67.01
68.00	06800	SPEECH PATHOLOGY	0.000000	874	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	0	0	0	0	69.00
69.01	06901	CARDIOLOGY	0.000000	26,375	0	0	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	16,124	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.000000	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	280,392	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.000000	0	0	0	0	90.00
90.01	09001	OTHER OUTPATIENT SERVICE COST CENTER	0.000000	0	0	0	0	90.01
90.02	09002	CLINIC	0.000000	0	0	0	0	90.02
90.03	09003	DERMATOLOGY CLINIC	0.000000	0	0	0	0	90.03
90.04	09004	ENT CLINIC	0.000000	0	0	0	0	90.04
90.05	09005	SURGERY CLINIC	0.000000	0	0	0	0	90.05
90.07	09007	UROLOGY CLINIC	0.000000	0	0	0	0	90.07
90.09	09009	GASTROENTEROLOGY CLINIC	0.000000	0	0	0	0	90.09
90.11	09011	NEUROLOGY CLINIC	0.000000	0	0	0	0	90.11
90.12	09012	OPTHAMOLOGY CLINIC	0.000000	0	0	0	0	90.12
90.13	09013	ALLERGY CLINIC	0.000000	0	0	0	0	90.13
90.14	09014	WOUND CARE	0.000000	31	0	0	0	90.14
91.00	09100	EMERGENCY	0.000000	20,040	0	951	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	0	0	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)		718,625	0	1,001	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 15-0104 | Component CCN: 15-S104 | Period: From 01/01/2020 To 12/31/2020 | Worksheet D Part V | Date/Time Prepared: 8/2/2021 1:50 pm

Title XVIII | Subprovider - IPF | PPS

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.132726	0	0	0	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.240422	50	0	39	12	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.000000	0	0	0	0	55.00
55.01	05501	ULTRA SOUND	0.109542	0	0	0	0	55.01
57.00	05700	CT SCAN	0.027424	0	0	698	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.088181	0	0	1	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.081462	0	0	0	0	59.00
60.00	06000	LABORATORY	0.173141	0	0	0	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.188986	0	0	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0.001996	0	0	0	0	64.00
66.00	06600	PHYSICAL THERAPY	0.471534	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.257053	0	0	0	0	67.00
67.01	06701	AUDIOLOGY	0.380752	0	0	0	0	67.01
68.00	06800	SPEECH PATHOLOGY	0.347053	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	0	0	0	0	69.00
69.01	06901	CARDIOLOGY	0.158056	0	0	11	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.341159	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.355560	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.338958	0	0	4,206	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.000000	0	0	0	0	90.00
90.01	09001	OTHER OUTPATIENT SERVICE COST CENTER	0.000000	0	0	0	0	90.01
90.02	09002	CLINIC	0.000000	0	0	0	0	90.02
90.03	09003	DERMATOLOGY CLINIC	0.000000	0	0	0	0	90.03
90.04	09004	ENT CLINIC	0.000000	0	0	0	0	90.04
90.05	09005	SURGERY CLINIC	0.000000	0	0	0	0	90.05
90.07	09007	UROLOGY CLINIC	0.001814	0	0	0	0	90.07
90.09	09009	GASTROENTEROLOGY CLINIC	0.000000	0	0	0	0	90.09
90.11	09011	NEUROLOGY CLINIC	0.000000	0	0	0	0	90.11
90.12	09012	OPTHAMOLOGY CLINIC	0.000000	0	0	0	0	90.12
90.13	09013	ALLERGY CLINIC	0.416141	0	0	0	0	90.13
90.14	09014	WOUND CARE	0.182294	0	0	734	0	90.14
91.00	09100	EMERGENCY	0.327512	951	0	0	311	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.519432	0	0	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	1.008708		0			95.00
200.00		Subtotal (see instructions)		1,001	0	5,689	323	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 - line 201)		1,001	0	5,689	323	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 15-0104 | Component CCN: 15-S104 | Period: From 01/01/2020 To 12/31/2020 | Worksheet D Part V | Date/Time Prepared: 8/2/2021 1:50 pm

Title XVIII | Subprovider - IPF | PPS

		Cost Center Description	Costs: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	0		50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	9		54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0		55.00
55.01	05501	ULTRA SOUND	0	0		55.01
57.00	05700	CT SCAN	0	19		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0		58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0		59.00
60.00	06000	LABORATORY	0	0		60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0		63.00
64.00	06400	INTRAVENOUS THERAPY	0	0		64.00
66.00	06600	PHYSICAL THERAPY	0	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0		67.00
67.01	06701	AUDIOLOGY	0	0		67.01
68.00	06800	SPEECH PATHOLOGY	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0		69.00
69.01	06901	CARDIOLOGY	0	2		69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	1,426		73.00
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0	0		90.00
90.01	09001	OTHER OUTPATIENT SERVICE COST CENTER	0	0		90.01
90.02	09002	CLINIC	0	0		90.02
90.03	09003	DERMATOLOGY CLINIC	0	0		90.03
90.04	09004	ENT CLINIC	0	0		90.04
90.05	09005	SURGERY CLINIC	0	0		90.05
90.07	09007	UROLOGY CLINIC	0	0		90.07
90.09	09009	GASTROENTEROLOGY CLINIC	0	0		90.09
90.11	09011	NEUROLOGY CLINIC	0	0		90.11
90.12	09012	OPTHAMOLOGY CLINIC	0	0		90.12
90.13	09013	ALLERGY CLINIC	0	0		90.13
90.14	09014	WOUND CARE	0	134		90.14
91.00	09100	EMERGENCY	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0		92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES	0			95.00
200.00		Subtotal (see instructions)	0	1,590		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	0	1,590		202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 15-0104 | Component CCN: 15-5832 | Period: From 01/01/2020 To 12/31/2020 | Worksheet D Part V | Date/Time Prepared: 8/2/2021 1:50 pm

Title XVIII | Skilled Nursing Facility | PPS

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.132726	0	0	0	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.240422	0	0	30	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.000000	0	0	0	0	55.00
55.01	05501	ULTRA SOUND	0.109542	0	0	0	0	55.01
57.00	05700	CT SCAN	0.027424	0	0	744	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.088181	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.081462	0	0	0	0	59.00
60.00	06000	LABORATORY	0.173141	0	0	0	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.188986	0	0	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0.001996	0	0	0	0	64.00
66.00	06600	PHYSICAL THERAPY	0.471534	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.257053	0	0	0	0	67.00
67.01	06701	AUDIOLOGY	0.380752	0	0	0	0	67.01
68.00	06800	SPEECH PATHOLOGY	0.347053	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	0	0	0	0	69.00
69.01	06901	CARDIOLOGY	0.158056	0	0	31	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.341159	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.355560	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.338958	0	0	5,220	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.000000	0	0	0	0	90.00
90.01	09001	OTHER OUTPATIENT SERVICE COST CENTER	0.000000	0	0	0	0	90.01
90.02	09002	CLINIC	0.000000	0	0	0	0	90.02
90.03	09003	DERMATOLOGY CLINIC	0.000000	0	0	0	0	90.03
90.04	09004	ENT CLINIC	0.000000	0	0	0	0	90.04
90.05	09005	SURGERY CLINIC	0.000000	0	0	0	0	90.05
90.07	09007	UROLOGY CLINIC	0.001814	0	0	0	0	90.07
90.09	09009	GASTROENTEROLOGY CLINIC	0.000000	0	0	0	0	90.09
90.11	09011	NEUROLOGY CLINIC	0.000000	0	0	0	0	90.11
90.12	09012	OPTHAMOLOGY CLINIC	0.000000	0	0	0	0	90.12
90.13	09013	ALLERGY CLINIC	0.416141	0	0	0	0	90.13
90.14	09014	WOUND CARE	0.182294	0	0	0	0	90.14
91.00	09100	EMERGENCY	0.327512	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.519432	0	0	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	1.008708		0			95.00
200.00		Subtotal (see instructions)		0	0	6,025	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 - line 201)		0	0	6,025	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 15-0104 | Component CCN: 15-5832 | Period: From 01/01/2020 To 12/31/2020 | Worksheet D Part V | Date/Time Prepared: 8/2/2021 1:50 pm

Title XVIII | Skilled Nursing Facility | PPS

		Cost Center Description	Costs: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	0		50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	7		54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0		55.00
55.01	05501	ULTRA SOUND	0	0		55.01
57.00	05700	CT SCAN	0	20		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0		58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0		59.00
60.00	06000	LABORATORY	0	0		60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0		63.00
64.00	06400	INTRAVENOUS THERAPY	0	0		64.00
66.00	06600	PHYSICAL THERAPY	0	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0		67.00
67.01	06701	AUDIOLOGY	0	0		67.01
68.00	06800	SPEECH PATHOLOGY	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0		69.00
69.01	06901	CARDIOLOGY	0	5		69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	1,769		73.00
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0	0		90.00
90.01	09001	OTHER OUTPATIENT SERVICE COST CENTER	0	0		90.01
90.02	09002	CLINIC	0	0		90.02
90.03	09003	DERMATOLOGY CLINIC	0	0		90.03
90.04	09004	ENT CLINIC	0	0		90.04
90.05	09005	SURGERY CLINIC	0	0		90.05
90.07	09007	UROLOGY CLINIC	0	0		90.07
90.09	09009	GASTROENTEROLOGY CLINIC	0	0		90.09
90.11	09011	NEUROLOGY CLINIC	0	0		90.11
90.12	09012	OPTHAMOLOGY CLINIC	0	0		90.12
90.13	09013	ALLERGY CLINIC	0	0		90.13
90.14	09014	WOUND CARE	0	0		90.14
91.00	09100	EMERGENCY	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0		92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES	0			95.00
200.00		Subtotal (see instructions)	0	1,801		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	0	1,801		202.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-0104 | Period: From 01/01/2020 To 12/31/2020 | Worksheet D-1 | Date/Time Prepared: 8/2/2021 1:50 pm

Title XVIII | Hospital | PPS

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	7,465	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	7,465	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)	5,115	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)	2,060	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)	9,624,855	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)	9,624,855	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)	9,624,855	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)	1,289.33	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	2,656,020	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)	0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)	2,656,020	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-0104 | Period: From 01/01/2020 To 12/31/2020 | Worksheet D-1 | Date/Time Prepared: 8/2/2021 1:50 pm

Title XVIII | Hospital | PPS

	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)	0	0	0.00	0	0	42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	3,792,538	2,815	1,347.26	1,046	1,409,234	43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	3,670,317	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	7,735,571	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)	372,925	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	175,361	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	548,286	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	7,187,285	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)	2,350	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	1,289.33	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	3,029,926	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-0104 | Period: From 01/01/2020 To 12/31/2020 | Worksheet D-1 | Date/Time Prepared: 8/2/2021 1:50 pm

Title XVIII | Hospital | PPS

	Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	1,023,621	9,624,855	0.106352	3,029,926	322,239	90.00
91.00	Nursing School cost	0	9,624,855	0.000000	3,029,926	0	91.00
92.00	Allied health cost	0	9,624,855	0.000000	3,029,926	0	92.00
93.00	All other Medical Education	0	9,624,855	0.000000	3,029,926	0	93.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 15-0104 Component CCN: 15-S104	Period: From 01/01/2020 To 12/31/2020	Worksheet D-1 Date/Time Prepared: 8/2/2021 1:50 pm
	Title XVIII	Subprovider - IPF	PPS

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	1,400	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	1,400	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)	1,400	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions)	1,001	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)	2,212,857	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)	2,212,857	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)	2,212,857	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)	1,580.61	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	1,582,191	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)	1,582,191	41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 15-0104 | Component CCN: 15-S104 | Period: From 01/01/2020 To 12/31/2020 | Worksheet D-1 | Date/Time Prepared: 8/2/2021 1:50 pm

Title XVIII | Subprovider - IPF | PPS

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

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	174,463	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	1,756,654	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)	210,761	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	4,570	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	215,331	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	1,541,323	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: 15-0104
Component CCN: 15-S104
Period: From 01/01/2020 To 12/31/2020
Worksheet D-1
Date/Time Prepared: 8/2/2021 1:50 pm
Title XVIII
Subprovider - IPF
PPS

	Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	294,767	2,212,857	0.133207	0	0	90.00
91.00	Nursing School cost	0	2,212,857	0.000000	0	0	91.00
92.00	Allied health cost	0	2,212,857	0.000000	0	0	92.00
93.00	All other Medical Education	0	2,212,857	0.000000	0	0	93.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 15-0104 Component CCN: 15-5832	Period: From 01/01/2020 To 12/31/2020	Worksheet D-1 Date/Time Prepared: 8/2/2021 1:50 pm
	Title XVIII	Skilled Nursing Facility	PPS

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	4,039	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	4,039	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.	0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)	4,039	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)	2,342	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)	2,429,214	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)	2,429,214	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)	2,429,214	37.00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY		
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS		
38.00	Adjusted general inpatient routine service cost per diem (see instructions)		38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)		40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)		41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 15-0104 | Component CCN: 15-5832 | Period: From 01/01/2020 To 12/31/2020 | Worksheet D-1 | Date/Time Prepared: 8/2/2021 1:50 pm

Title XVIII | Skilled Nursing Facility | PPS

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

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)		48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)		49.00
	PASS THROUGH COST ADJUSTMENTS		
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)		50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)		51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)		52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)		53.00
	TARGET AMOUNT AND LIMIT COMPUTATION		
54.00	Program discharges		54.00
55.00	Target amount per discharge		55.00
56.00	Target amount (line 54 x line 55)		56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)		57.00
58.00	Bonus payment (see instructions)		58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket		59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket		60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)		61.00
62.00	Relief payment (see instructions)		62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)		63.00
	PROGRAM INPATIENT ROUTINE SWING BED COST		
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)		64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)		65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)		66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)		67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)		68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)		69.00
	PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY		
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)	2,429,214	70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)	601.44	71.00
72.00	Program routine service cost (line 9 x line 71)	1,408,572	72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)	0	73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)	1,408,572	74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)	0	75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)	0.00	76.00
77.00	Program capital-related costs (line 9 x line 76)	0	77.00
78.00	Inpatient routine service cost (line 74 minus line 77)	0	78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)	0	79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)	0	80.00
81.00	Inpatient routine service cost per diem limitation	0.00	81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)	0	82.00
83.00	Reasonable inpatient routine service costs (see instructions)	1,408,572	83.00
84.00	Program inpatient ancillary services (see instructions)	1,057,324	84.00
85.00	Utilization review - physician compensation (see instructions)	0	85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)	2,465,896	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: 15-0104 Component CCN: 15-5832	Period: From 01/01/2020 To 12/31/2020	Worksheet D-1 Date/Time Prepared: 8/2/2021 1:50 pm
	Title XVIII	Skilled Nursing Facility	PPS

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

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-0104 | Period: From 01/01/2020 To 12/31/2020 | Worksheet D-1 | Date/Time Prepared: 8/2/2021 1:50 pm

Title XIX | Hospital | Cost

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	7,465	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	7,465	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)	5,115	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)	141	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)	962	15.00
16.00	Nursery days (title V or XIX only)	97	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)	9,624,855	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)	9,624,855	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)	9,624,855	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)	1,289.33	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	181,796	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)	181,796	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-0104 | Period: From 01/01/2020 To 12/31/2020 | Worksheet D-1 | Date/Time Prepared: 8/2/2021 1:50 pm

Title XIX | Hospital | Cost

	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)	67,239	962	69.90	97	6,780	42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	3,792,538	2,815	1,347.26	67	90,266	43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	263,728	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	542,570	49.00
	PASS THROUGH COST ADJUSTMENTS		
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)	0	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	0	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	0	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	0	53.00
	TARGET AMOUNT AND LIMIT COMPUTATION		
54.00	Program discharges	0	54.00
55.00	Target amount per discharge	0.00	55.00
56.00	Target amount (line 54 x line 55)	0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)	0	57.00
58.00	Bonus payment (see instructions)	0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket	0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket	0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)	0	61.00
62.00	Relief payment (see instructions)	0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)	0	63.00
	PROGRAM INPATIENT ROUTINE SWING BED COST		
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)	0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)	0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)	0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)	0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)	0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)	0	69.00
	PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY		
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)		70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)		71.00
72.00	Program routine service cost (line 9 x line 71)		72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)		73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)		74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)		75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)		76.00
77.00	Program capital-related costs (line 9 x line 76)		77.00
78.00	Inpatient routine service cost (line 74 minus line 77)		78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)		79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)		80.00
81.00	Inpatient routine service cost per diem limitation		81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)		82.00
83.00	Reasonable inpatient routine service costs (see instructions)		83.00
84.00	Program inpatient ancillary services (see instructions)		84.00
85.00	Utilization review - physician compensation (see instructions)		85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)		86.00
	PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST		
87.00	Total observation bed days (see instructions)	2,350	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	1,289.33	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	3,029,926	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-0104 | Period: From 01/01/2020 To 12/31/2020 | Worksheet D-1 | Date/Time Prepared: 8/2/2021 1:50 pm

Title XIX | Hospital | Cost

	Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	1,023,621	9,624,855	0.106352	3,029,926	322,239	90.00
91.00	Nursing School cost	0	9,624,855	0.000000	3,029,926	0	91.00
92.00	Allied health cost	0	9,624,855	0.000000	3,029,926	0	92.00
93.00	All other Medical Education	0	9,624,855	0.000000	3,029,926	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 15-0104 | Period: From 01/01/2020 To 12/31/2020 | Worksheet D-3 | Date/Time Prepared: 8/2/2021 1:50 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		1,918,242		30.00
31.00	03100	INTENSIVE CARE UNIT		1,878,341		31.00
40.00	04000	SUBPROVIDER - IPF		2,562		40.00
41.00	04100	SUBPROVIDER - IRF		0		41.00
42.00	04200	SUBPROVIDER		0		42.00
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.132726	3,092,957	410,516	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.240422	1,009,855	242,791	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.000000	0	0	55.00
55.01	05501	ULTRA SOUND	0.109542	42,334	4,637	55.01
57.00	05700	CT SCAN	0.027424	1,732,141	47,502	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.088181	288,272	25,420	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.081462	401,701	32,723	59.00
60.00	06000	LABORATORY	0.173141	3,275,552	567,132	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.188986	105,683	19,973	63.00
64.00	06400	INTRAVENOUS THERAPY	0.001996	385,974	770	64.00
66.00	06600	PHYSICAL THERAPY	0.471534	315,861	148,939	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.257053	248,795	63,954	67.00
67.01	06701	AUDIOLOGY	0.380752	0	0	67.01
68.00	06800	SPEECH PATHOLOGY	0.347053	50,179	17,415	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	0	0	69.00
69.01	06901	CARDIOLOGY	0.158056	3,525,246	557,186	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.341159	856,125	292,075	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.355560	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.338958	2,390,895	810,413	73.00
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0.000000	0	0	90.00
90.01	09001	OTHER OUTPATIENT SERVICE COST CENTER	0.000000	0	0	90.01
90.02	09002	CLINIC	0.000000	0	0	90.02
90.03	09003	DERMATOLOGY CLINIC	0.000000	0	0	90.03
90.04	09004	ENT CLINIC	0.000000	0	0	90.04
90.05	09005	SURGERY CLINIC	0.000000	0	0	90.05
90.07	09007	UROLOGY CLINIC	0.001814	0	0	90.07
90.09	09009	GASTROENTEROLOGY CLINIC	0.000000	0	0	90.09
90.11	09011	NEUROLOGY CLINIC	0.000000	0	0	90.11
90.12	09012	OPTHAMOLOGY CLINIC	0.000000	0	0	90.12
90.13	09013	ALLERGY CLINIC	0.416141	0	0	90.13
90.14	09014	WOUND CARE	0.182294	2,220	405	90.14
91.00	09100	EMERGENCY	0.327512	1,308,244	428,466	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.519432	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES				95.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		19,032,034	3,670,317	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)		19,032,034		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

Provider CCN: 15-0104 | Component CCN: 15-S104 | Period: From 01/01/2020 To 12/31/2020 | Worksheet D-3 | Date/Time Prepared: 8/2/2021 1:50 pm

Title XVIII | Subprovider - IPF | PPS

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		0		30.00
31.00	03100	INTENSIVE CARE UNIT		0		31.00
40.00	04000	SUBPROVIDER - IPF		1,314,398		40.00
41.00	04100	SUBPROVIDER - IRF		0		41.00
42.00	04200	SUBPROVIDER		0		42.00
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.132726	4,555	605	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.240422	19,214	4,619	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.000000	0	0	55.00
55.01	05501	ULTRA SOUND	0.109542	1,310	144	55.01
57.00	05700	CT SCAN	0.027424	43,948	1,205	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.088181	7,941	700	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.081462	3,006	245	59.00
60.00	06000	LABORATORY	0.173141	275,406	47,684	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.188986	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0.001996	3,017	6	64.00
66.00	06600	PHYSICAL THERAPY	0.471534	16,124	7,603	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.257053	268	69	67.00
67.01	06701	AUDIOLOGY	0.380752	0	0	67.01
68.00	06800	SPEECH PATHOLOGY	0.347053	874	303	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	0	0	69.00
69.01	06901	CARDIOLOGY	0.158056	26,375	4,169	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.341159	16,124	5,501	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.355560	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.338958	280,392	95,041	73.00
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0.000000	0	0	90.00
90.01	09001	OTHER OUTPATIENT SERVICE COST CENTER	0.000000	0	0	90.01
90.02	09002	CLINIC	0.000000	0	0	90.02
90.03	09003	DERMATOLOGY CLINIC	0.000000	0	0	90.03
90.04	09004	ENT CLINIC	0.000000	0	0	90.04
90.05	09005	SURGERY CLINIC	0.000000	0	0	90.05
90.07	09007	UROLOGY CLINIC	0.001814	0	0	90.07
90.09	09009	GASTROENTEROLOGY CLINIC	0.000000	0	0	90.09
90.11	09011	NEUROLOGY CLINIC	0.000000	0	0	90.11
90.12	09012	OPTHAMOLOGY CLINIC	0.000000	0	0	90.12
90.13	09013	ALLERGY CLINIC	0.416141	0	0	90.13
90.14	09014	WOUND CARE	0.182294	31	6	90.14
91.00	09100	EMERGENCY	0.327512	20,040	6,563	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.519432	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES				95.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		718,625	174,463	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)		718,625		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

Provider CCN: 15-0104 | Component CCN: 15-5832 | Period: From 01/01/2020 To 12/31/2020 | Worksheet D-3 | Date/Time Prepared: 8/2/2021 1:50 pm

Title XVIII | Skilled Nursing Facility | PPS

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		0		30.00
31.00	03100	INTENSIVE CARE UNIT		0		31.00
40.00	04000	SUBPROVIDER - IPF		0		40.00
41.00	04100	SUBPROVIDER - IRF		0		41.00
42.00	04200	SUBPROVIDER		0		42.00
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.132726	40,851	5,422	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.240422	43,980	10,574	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.000000	0	0	55.00
55.01	05501	ULTRA SOUND	0.109542	4,162	456	55.01
57.00	05700	CT SCAN	0.027424	6,749	185	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.088181	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.081462	29,528	2,405	59.00
60.00	06000	LABORATORY	0.173141	235,155	40,715	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.188986	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0.001996	17,037	34	64.00
66.00	06600	PHYSICAL THERAPY	0.471534	883,413	416,559	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.257053	970,642	249,506	67.00
67.01	06701	AUDIOLOGY	0.380752	0	0	67.01
68.00	06800	SPEECH PATHOLOGY	0.347053	28,411	9,860	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	0	0	69.00
69.01	06901	CARDIOLOGY	0.158056	213,325	33,717	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.341159	108,197	36,912	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.355560	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.338958	738,840	250,436	73.00
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0.000000	0	0	90.00
90.01	09001	OTHER OUTPATIENT SERVICE COST CENTER	0.000000	0	0	90.01
90.02	09002	CLINIC	0.000000	0	0	90.02
90.03	09003	DERMATOLOGY CLINIC	0.000000	0	0	90.03
90.04	09004	ENT CLINIC	0.000000	0	0	90.04
90.05	09005	SURGERY CLINIC	0.000000	0	0	90.05
90.07	09007	UROLOGY CLINIC	0.001814	0	0	90.07
90.09	09009	GASTROENTEROLOGY CLINIC	0.000000	0	0	90.09
90.11	09011	NEUROLOGY CLINIC	0.000000	0	0	90.11
90.12	09012	OPTHAMOLOGY CLINIC	0.000000	0	0	90.12
90.13	09013	ALLERGY CLINIC	0.416141	0	0	90.13
90.14	09014	WOUND CARE	0.182294	132	24	90.14
91.00	09100	EMERGENCY	0.327512	1,585	519	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.519432	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES				95.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		3,322,007	1,057,324	200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0		201.00
202.00		Net charges (line 200 minus line 201)		3,322,007		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 15-0104 | Period: From 01/01/2020 To 12/31/2020 | Worksheet D-3 | Date/Time Prepared: 8/2/2021 1:50 pm

Title XIX | Hospital | Cost

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		1,071,168		30.00
31.00	03100	INTENSIVE CARE UNIT		83,194		31.00
40.00	04000	SUBPROVIDER - IPF		4,252		40.00
41.00	04100	SUBPROVIDER - IRF		0		41.00
42.00	04200	SUBPROVIDER		0		42.00
43.00	04300	NURSERY		0		43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.132726	308,582	40,957	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.240422	20,597	4,952	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.000000	0	0	55.00
55.01	05501	ULTRA SOUND	0.109542	0	0	55.01
57.00	05700	CT SCAN	0.027424	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.088181	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.081462	0	0	59.00
60.00	06000	LABORATORY	0.173141	353,695	61,239	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.188986	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0.001996	0	0	64.00
66.00	06600	PHYSICAL THERAPY	0.471534	11,123	5,245	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.257053	7,216	1,855	67.00
67.01	06701	AUDIOLOGY	0.380752	0	0	67.01
68.00	06800	SPEECH PATHOLOGY	0.347053	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	0	0	69.00
69.01	06901	CARDIOLOGY	0.158056	0	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.341159	118,173	40,316	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.355560	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.338958	255,240	86,516	73.00
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0.000000	0	0	90.00
90.01	09001	OTHER OUTPATIENT SERVICE COST CENTER	0.000000	0	0	90.01
90.02	09002	CLINIC	0.000000	0	0	90.02
90.03	09003	DERMATOLOGY CLINIC	0.000000	0	0	90.03
90.04	09004	ENT CLINIC	0.000000	0	0	90.04
90.05	09005	SURGERY CLINIC	0.000000	0	0	90.05
90.07	09007	UROLOGY CLINIC	0.001814	0	0	90.07
90.09	09009	GASTROENTEROLOGY CLINIC	0.000000	0	0	90.09
90.11	09011	NEUROLOGY CLINIC	0.000000	0	0	90.11
90.12	09012	OPTHAMOLOGY CLINIC	0.000000	0	0	90.12
90.13	09013	ALLERGY CLINIC	0.416141	0	0	90.13
90.14	09014	WOUND CARE	0.182294	0	0	90.14
91.00	09100	EMERGENCY	0.327512	69,151	22,648	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.519432	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES				95.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		1,143,777	263,728	200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0		201.00
202.00		Net charges (line 200 minus line 201)		1,143,777		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0104	Period: From 01/01/2020 To 12/31/2020	Worksheet E Part A Date/Time Prepared: 8/2/2021 1:50 pm
	Title XVIII	Hospital	PPS

		1.00	
	PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS		
1.00	DRG Amounts Other than Outlier Payments	0	1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1 (see instructions)	4,681,954	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1 (see instructions)	1,566,393	1.02
1.03	DRG for federal specific operating payment for Model 4 BPCI for discharges occurring prior to October 1 (see instructions)	0	1.03
1.04	DRG for federal specific operating payment for Model 4 BPCI for discharges occurring on or after October 1 (see instructions)	0	1.04
2.00	Outlier payments for discharges. (see instructions)		2.00
2.01	Outlier reconciliation amount	0	2.01
2.02	Outlier payment for discharges for Model 4 BPCI (see instructions)	0	2.02
2.03	Outlier payments for discharges occurring prior to October 1 (see instructions)	3,496	2.03
2.04	Outlier payments for discharges occurring on or after October 1 (see instructions)	6,116	2.04
3.00	Managed Care Simulated Payments	0	3.00
4.00	Bed days available divided by number of days in the cost reporting period (see instructions)	62.72	4.00
	Indirect Medical Education Adjustment		
5.00	FTE count for allopathic and osteopathic programs for the most recent cost reporting period ending on or before 12/31/1996.(see instructions)	0.00	5.00
6.00	FTE count for allopathic and osteopathic programs that meet the criteria for an add-on to the cap for new programs in accordance with 42 CFR 413.79(e)	0.00	6.00
7.00	MMA Section 422 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(1)	0.00	7.00
7.01	ACA § 5503 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(2) If the cost report straddles July 1, 2011 then see instructions.	0.00	7.01
8.00	Adjustment (increase or decrease) to the FTE count for allopathic and osteopathic programs for affiliated programs in accordance with 42 CFR 413.75(b), 413.79(c)(2)(iv), 64 FR 26340 (May 12, 1998), and 67 FR 50069 (August 1, 2002).	0.00	8.00
8.01	The amount of increase if the hospital was awarded FTE cap slots under § 5503 of the ACA. If the cost report straddles July 1, 2011, see instructions.	0.00	8.01
8.02	The amount of increase if the hospital was awarded FTE cap slots from a closed teaching hospital under § 5506 of ACA. (see instructions)	0.00	8.02
9.00	Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus lines (8, 8,01 and 8,02) (see instructions)	0.00	9.00
10.00	FTE count for allopathic and osteopathic programs in the current year from your records	0.00	10.00
11.00	FTE count for residents in dental and podiatric programs.	0.00	11.00
12.00	Current year allowable FTE (see instructions)	0.00	12.00
13.00	Total allowable FTE count for the prior year.	0.00	13.00
14.00	Total allowable FTE count for the penultimate year if that year ended on or after September 30, 1997, otherwise enter zero.	0.00	14.00
15.00	Sum of lines 12 through 14 divided by 3.	0.00	15.00
16.00	Adjustment for residents in initial years of the program	0.00	16.00
17.00	Adjustment for residents displaced by program or hospital closure	0.00	17.00
18.00	Adjusted rolling average FTE count	0.00	18.00
19.00	Current year resident to bed ratio (line 18 divided by line 4).	0.000000	19.00
20.00	Prior year resident to bed ratio (see instructions)	0.000000	20.00
21.00	Enter the lesser of lines 19 or 20 (see instructions)	0.000000	21.00
22.00	IME payment adjustment (see instructions)	0	22.00
22.01	IME payment adjustment - Managed Care (see instructions)	0	22.01
	Indirect Medical Education Adjustment for the Add-on for § 422 of the MMA		
23.00	Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 CFR 412.105 (f)(1)(iv)(C).	0.00	23.00
24.00	IME FTE Resident Count Over Cap (see instructions)	0.00	24.00
25.00	If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see instructions)	0.00	25.00
26.00	Resident to bed ratio (divide line 25 by line 4)	0.000000	26.00
27.00	IME payments adjustment factor. (see instructions)	0.000000	27.00
28.00	IME add-on adjustment amount (see instructions)	0	28.00
28.01	IME add-on adjustment amount - Managed Care (see instructions)	0	28.01
29.00	Total IME payment (sum of lines 22 and 28)	0	29.00
29.01	Total IME payment - Managed Care (sum of lines 22.01 and 28.01)	0	29.01
	Disproportionate Share Adjustment		
30.00	Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)	3.37	30.00
31.00	Percentage of Medicaid patient days (see instructions)	23.98	31.00
32.00	Sum of lines 30 and 31	27.35	32.00
33.00	Allowable disproportionate share percentage (see instructions)	11.78	33.00
34.00	Disproportionate share adjustment (see instructions)	184,014	34.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0104	Period: From 01/01/2020 To 12/31/2020	Worksheet E Part A Date/Time Prepared: 8/2/2021 1:50 pm
	Title XVIII	Hospital	PPS

		Prior to 10/1	On/After 10/1	
		1.00	2.00	
	Uncompensated Care Adjustment			
35.00	Total uncompensated care amount (see instructions)	0	0	35.00
35.01	Factor 3 (see instructions)	0.000000000	0.000000000	35.01
35.02	Hospital uncompensated care payment (If line 34 is zero, enter zero on this line) (see instructions)	950,269	991,071	35.02
35.03	Pro rata share of the hospital uncompensated care payment amount (see instructions)	711,404	249,804	35.03
36.00	Total uncompensated care (sum of columns 1 and 2 on line 35.03)	961,208		36.00
	Additional payment for high percentage of ESRD beneficiary discharges (lines 40 through 46)			
40.00	Total Medicare discharges, excluding MS-DRGs 652, 682, 683, 684 and 685. (see instructions)	0		40.00
41.00	Total ESRD Medicare discharges excluding MS-DRGs 652, 682, 683, 684 an 685. (see instructions)	0		41.00
41.01	Total ESRD Medicare covered and paid discharges excluding MS-DRGs 652, 682, 683, 684 an 685. (see instructions)	0		41.01
42.00	Divide line 41 by line 40 (if less than 10%, you do not qualify for adjustment)	0.00		42.00
43.00	Total Medicare ESRD inpatient days excluding MS-DRGs 652, 682, 683, 684 an 685. (see instructions)	0		43.00
44.00	Ratio of average length of stay to one week (line 43 divided by line 41 divided by 7 days)	0.000000		44.00
45.00	Average weekly cost for dialysis treatments (see instructions)	0.00		45.00
46.00	Total additional payment (line 45 times line 44 times line 41.01)	0		46.00
47.00	Subtotal (see instructions)	7,403,181		47.00
48.00	Hospital specific payments (to be completed by SCH and MDH, small rural hospitals only.(see instructions)	0		48.00

		Amount	
		1.00	
49.00	Total payment for inpatient operating costs (see instructions)	7,403,181	49.00
50.00	Payment for inpatient program capital (from Wkst. L, Pt. I and Pt. II, as applicable)	483,405	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).	0	52.00
53.00	Nursing and Allied Health Managed Care payment	0	53.00
54.00	Special add-on payments for new technologies	0	54.00
54.01	Islet isolation add-on payment	0	54.01
55.00	Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line 69)	0	55.00
56.00	Cost of physicians' services in a teaching hospital (see intructions)	0	56.00
57.00	Routine service other pass through costs (from Wkst. D, Pt. III, column 9, lines 30 through 35).	0	57.00
58.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 11 line 200)	0	58.00
59.00	Total (sum of amounts on lines 49 through 58)	7,886,586	59.00
60.00	Primary payer payments	0	60.00
61.00	Total amount payable for program beneficiaries (line 59 minus line 60)	7,886,586	61.00
62.00	Deductibles billed to program beneficiaries	727,584	62.00
63.00	Coinsurance billed to program beneficiaries	3,872	63.00
64.00	Allowable bad debts (see instructions)	52,057	64.00
65.00	Adjusted reimbursable bad debts (see instructions)	33,837	65.00
66.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	52,057	66.00
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)	7,188,967	67.00
68.00	Credits received from manufacturers for replaced devices for applicable to MS-DRGs (see instructions)	0	68.00
69.00	Outlier payments reconciliation (sum of lines 93, 95 and 96).(For SCH see instructions)	0	69.00
70.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	70.00
70.50	Rural Community Hospital Demonstration Project (§410A Demonstration) adjustment (see instructions)	0	70.50
70.87	Demonstration payment adjustment amount before sequestration	0	70.87
70.88	SCH or MDH volume decrease adjustment (contractor use only)	0	70.88
70.89	Pioneer ACO demonstration payment adjustment amount (see instructions)		70.89
70.90	HSP bonus payment HVBP adjustment amount (see instructions)	0	70.90
70.91	HSP bonus payment HRR adjustment amount (see instructions)	0	70.91
70.92	Bundled Model 1 discount amount (see instructions)	0	70.92
70.93	HVBP payment adjustment amount (see instructions)	11,262	70.93
70.94	HRR adjustment amount (see instructions)	-61,110	70.94
70.95	Recovery of accelerated depreciation	0	70.95

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0104	Period: From 01/01/2020 To 12/31/2020	Worksheet E Part A Date/Time Prepared: 8/2/2021 1:50 pm
	Title XVIII	Hospital	PPS

		FFY (yyyy)	Amount	
		0	1.00	
70.96	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period prior to 10/1)	2020	692,276	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)	2021	232,821	70.97
70.98	Low Volume Payment-3		0	70.98
70.99	HAC adjustment amount (see instructions)		0	70.99
71.00	Amount due provider (line 67 minus lines 68 plus/minus lines 69 & 70)		8,064,216	71.00
71.01	Sequestration adjustment (see instructions)		53,224	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		7,713,532	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)		297,460	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		172,104	75.00
	TO BE COMPLETED BY CONTRACTOR (lines 90 through 96)			
90.00	Operating outlier amount from Wkst. E, Pt. A, line 2, or sum of 2.03 plus 2.04 (see instructions)		0	90.00
91.00	Capital outlier from Wkst. L, Pt. I, line 2		0	91.00
92.00	Operating outlier reconciliation adjustment amount (see instructions)		0	92.00
93.00	Capital outlier reconciliation adjustment amount (see instructions)		0	93.00
94.00	The rate used to calculate the time value of money (see instructions)		0.00	94.00
95.00	Time value of money for operating expenses (see instructions)		0	95.00
96.00	Time value of money for capital related expenses (see instructions)		0	96.00

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

LOW VOLUME CALCULATION EXHIBIT 4 | Provider CCN: 15-0104 | Period: From 01/01/2020 To 12/31/2020 | Worksheet E Part A Exhibit 4 Date/Time Prepared: 8/2/2021 1:50 pm

Title XVIII | Hospital | PPS

		W/S E, Part A line	Amounts (from E, Part A)	Pre/Post Entitlement	Period Prior to 10/01	Period On/After 10/01	Total (Col 2 through 4)	
		0	1.00	2.00	3.00	4.00	5.00	
1.00	DRG amounts other than outlier payments	1.00	0	0	0	0	0	1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1	1.01	4,681,954	0	4,681,954		4,681,954	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	1,566,393	0		1,566,393	1,566,393	1.02
1.03	DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October 1	1.03	0	0	0		0	1.03
1.04	DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1	1.04	0	0		0	0	1.04
2.00	Outlier payments for discharges (see instructions)	2.00						2.00
2.01	Outlier payments for discharges for Model 4 BPCI	2.02	0	0	0	0	0	2.01
2.02	Outlier payments for discharges occurring prior to October 1 (see instructions)	2.03	3,496	0	3,496		3,496	2.02
2.03	Outlier payments for discharges occurring on or after October 1 (see instructions)	2.04	6,116	0		6,116	6,116	2.03
3.00	Operating outlier reconciliation	2.01	0	0	0	0	0	3.00
4.00	Managed care simulated payments	3.00	0	0	0	0	0	4.00
	Indirect Medical Education Adjustment							
5.00	Amount from Worksheet E, Part A, line 21 (see instructions)	21.00	0.000000	0.000000	0.000000	0.000000		5.00
6.00	IME payment adjustment (see instructions)	22.00	0	0	0	0	0	6.00
6.01	IME payment adjustment for managed care (see instructions)	22.01	0	0	0	0	0	6.01
	Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA							
7.00	IME payment adjustment factor (see instructions)	27.00	0.000000	0.000000	0.000000	0.000000		7.00
8.00	IME adjustment (see instructions)	28.00	0	0	0	0	0	8.00
8.01	IME payment adjustment add on for managed care (see instructions)	28.01	0	0	0	0	0	8.01
9.00	Total IME payment (sum of lines 6 and 8)	29.00	0	0	0	0	0	9.00
9.01	Total IME payment for managed care (sum of lines 6.01 and 8.01)	29.01	0	0	0	0	0	9.01
	Disproportionate Share Adjustment							
10.00	Allowable disproportionate share percentage (see instructions)	33.00	0.1178	0.1178	0.1178	0.1178		10.00
11.00	Disproportionate share adjustment (see instructions)	34.00	184,014	0	137,884	46,130	184,014	11.00
11.01	Uncompensated care payments	36.00	961,208	0	711,404	249,804	961,208	11.01
	Additional payment for high percentage of ESRD beneficiary discharges							
12.00	Total ESRD additional payment (see instructions)	46.00	0	0	0	0	0	12.00
13.00	Subtotal (see instructions)	47.00	7,403,181	0	5,534,738	1,868,443	7,403,181	13.00
14.00	Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see instructions)	48.00	0	0	0	0	0	14.00
15.00	Total payment for inpatient operating costs (see instructions)	49.00	7,403,181	0	5,534,738	1,868,443	7,403,181	15.00

LOW VOLUME CALCULATION EXHIBIT 4 | Provider CCN: 15-0104 | Period: From 01/01/2020 To 12/31/2020 | Worksheet E Part A Exhibit 4 Date/Time Prepared: 8/2/2021 1:50 pm

Title XVIII | Hospital | PPS

		W/S E, Part A line	Amounts (from E, Part A)	Pre/Post Entitlement	Period Prior to 10/01	Period On/After 10/01	Total (Col 2 through 4)	
		0	1.00	2.00	3.00	4.00	5.00	
16.00	Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable)	50.00	483,405	0	367,014	116,391	483,405	16.00
17.00	Special add-on payments for new technologies	54.00	0	0	0	0	0	17.00
17.01	Net organ aquisition cost							17.01
17.02	Credits received from manufacturers for replaced devices for applicable MS-DRGs	68.00	0	0	0	0	0	17.02
18.00	Capital outlier reconciliation adjustment amount (see instructions)	93.00	0	0	0	0	0	18.00
19.00	SUBTOTAL			0	5,901,752	1,984,834	7,886,586	19.00
		W/S L, line	(Amounts from L)					
		0	1.00	2.00	3.00	4.00	5.00	
20.00	Capital DRG other than outlier	1.00	482,768	0	366,734	116,034	482,768	20.00
20.01	Model 4 BPCI Capital DRG other than outlier	1.01	0	0	0	0	0	20.01
21.00	Capital DRG outlier payments	2.00	637	0	280	357	637	21.00
21.01	Model 4 BPCI Capital DRG outlier payments	2.01	0	0	0	0	0	21.01
22.00	Indirect medical education percentage (see instructions)	5.00	0.0000	0.0000	0.0000	0.0000		22.00
23.00	Indirect medical education adjustment (see instructions)	6.00	0	0	0	0	0	23.00
24.00	Allowable disproportionate share percentage (see instructions)	10.00	0.0000	0.0000	0.0000	0.0000		24.00
25.00	Disproportionate share adjustment (see instructions)	11.00	0	0	0	0	0	25.00
26.00	Total prospective capital payments (see instructions)	12.00	483,405	0	367,014	116,391	483,405	26.00
		W/S E, Part A line	(Amounts to E, Part A)					
		0	1.00	2.00	3.00	4.00	5.00	
27.00	Low volume adjustment factor				0.117300	0.117300		27.00
28.00	Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)	70.96			692,276		692,276	28.00
29.00	Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)	70.97				232,821	232,821	29.00
100.00	Transfer low volume adjustments to Wkst. E, Pt. A.		Y					100.00

HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULATION EXHIBIT 5 | Provider CCN: 15-0104 | Period: From 01/01/2020 To 12/31/2020 | Worksheet E Part A Exhibit 5 Date/Time Prepared: 8/2/2021 1:50 pm

Title XVIII | Hospital | PPS

		Wkst. E, Pt. A, line	Amt. from Wkst. E, Pt. A)	Period to 10/01	Period on after 10/01	Total (cols. 2 and 3)	
		0	1.00	2.00	3.00	4.00	
1.00	DRG amounts other than outlier payments	1.00					1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1	1.01	4,681,954	4,681,954		4,681,954	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	1,566,393		1,566,393	1,566,393	1.02
1.03	DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October 1	1.03	0	0		0	1.03
1.04	DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1	1.04	0		0	0	1.04
2.00	Outlier payments for discharges (see instructions)	2.00					2.00
2.01	Outlier payments for discharges for Model 4 BPCI	2.02	0	0	0	0	2.01
2.02	Outlier payments for discharges occurring prior to October 1 (see instructions)	2.03	3,496	3,496		3,496	2.02
2.03	Outlier payments for discharges occurring on or after October 1 (see instructions)	2.04	6,116		6,116	6,116	2.03
3.00	Operating outlier reconciliation	2.01	0	0	0	0	3.00
4.00	Managed care simulated payments	3.00	0	0	0	0	4.00
	Indirect Medical Education Adjustment						
5.00	Amount from Worksheet E, Part A, line 21 (see instructions)	21.00	0.000000	0.000000	0.000000		5.00
6.00	IME payment adjustment (see instructions)	22.00	0	0	0	0	6.00
6.01	IME payment adjustment for managed care (see instructions)	22.01	0	0	0	0	6.01
	Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA						
7.00	IME payment adjustment factor (see instructions)	27.00	0.000000	0.000000	0.000000		7.00
8.00	IME adjustment (see instructions)	28.00	0	0	0	0	8.00
8.01	IME payment adjustment add on for managed care (see instructions)	28.01	0	0	0	0	8.01
9.00	Total IME payment (sum of lines 6 and 8)	29.00	0	0	0	0	9.00
9.01	Total IME payment for managed care (sum of lines 6.01 and 8.01)	29.01	0	0	0	0	9.01
	Disproportionate Share Adjustment						
10.00	Allowable disproportionate share percentage (see instructions)	33.00	0.1178	0.1178	0.1178		10.00
11.00	Disproportionate share adjustment (see instructions)	34.00	184,014	137,884	46,130	184,014	11.00
11.01	Uncompensated care payments	36.00	961,208	711,404	249,804	961,208	11.01
	Additional payment for high percentage of ESRD beneficiary discharges						
12.00	Total ESRD additional payment (see instructions)	46.00	0	0	0	0	12.00
13.00	Subtotal (see instructions)	47.00	7,403,181	5,534,738	1,868,443	7,403,181	13.00
14.00	Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see instructions)	48.00	0	0	0	0	14.00
15.00	Total payment for inpatient operating costs (see instructions)	49.00	7,403,181	5,534,738	1,868,443	7,403,181	15.00
16.00	Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable)	50.00	483,405	367,014	116,391	483,405	16.00
17.00	Special add-on payments for new technologies	54.00	0	0	0	0	17.00
17.01	Net organ acquisition cost						17.01
17.02	Credits received from manufacturers for replaced devices for applicable MS-DRGs	68.00	0	0	0	0	17.02
18.00	Capital outlier reconciliation adjustment amount (see instructions)	93.00	0	0	0	0	18.00
19.00	SUBTOTAL			5,901,752	1,984,834	7,886,586	19.00

HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULATION EXHIBIT 5 | Provider CCN: 15-0104 | Period: From 01/01/2020 To 12/31/2020 | Worksheet E Part A Exhibit 5 Date/Time Prepared: 8/2/2021 1:50 pm

Title XVIII | Hospital | PPS

		Wkst. L, line	(Amt. from Wkst. L)				
		0	1.00	2.00	3.00	4.00	
20.00	Capital DRG other than outlier	1.00	482,768	366,734	116,034	482,768	20.00
20.01	Model 4 BPCI Capital DRG other than outlier	1.01	0	0	0	0	20.01
21.00	Capital DRG outlier payments	2.00	637	280	357	637	21.00
21.01	Model 4 BPCI Capital DRG outlier payments	2.01	0	0	0	0	21.01
22.00	Indirect medical education percentage (see instructions)	5.00	0.0000	0.0000	0.0000		22.00
23.00	Indirect medical education adjustment (see instructions)	6.00	0	0	0	0	23.00
24.00	Allowable disproportionate share percentage (see instructions)	10.00	0.0000	0.0000	0.0000		24.00
25.00	Disproportionate share adjustment (see instructions)	11.00	0	0	0	0	25.00
26.00	Total prospective capital payments (see instructions)	12.00	483,405	367,014	116,391	483,405	26.00
		Wkst. E, Pt. A, line	(Amt. from Wkst. E, Pt. A)				
		0	1.00	2.00	3.00	4.00	
27.00							27.00
28.00	Low volume adjustment prior to October 1	70.96	692,276	692,276		692,276	28.00
29.00	Low volume adjustment on or after October 1	70.97	232,821		232,821	232,821	29.00
30.00	HVBP payment adjustment (see instructions)	70.93	11,262	17,802	-6,540	11,262	30.00
30.01	HVBP payment adjustment for HSP bonus payment (see instructions)	70.90	0	0	0	0	30.01
31.00	HRR adjustment (see instructions)	70.94	-61,110	-36,987	-24,123	-61,110	31.00
31.01	HRR adjustment for HSP bonus payment (see instructions)	70.91	0	0	0	0	31.01
						(Amt. to Wkst. E, Pt. A)	
		0	1.00	2.00	3.00	4.00	
32.00	HAC Reduction Program adjustment (see instructions)	70.99		0	0	0	32.00
100.00	Transfer HAC Reduction Program adjustment to Wkst. E, Pt. A.		N				100.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0104	Period: From 01/01/2020 To 12/31/2020	Worksheet E Part B Date/Time Prepared: 8/2/2021 1:50 pm
	Title XVIII	Hospital	PPS

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	17,590	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)	13,939,497	2.00
3.00	OPPS payments	12,121,593	3.00
4.00	Outlier payment (see instructions)	34,586	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)	17,590	11.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
12.00	Ancillary service charges	68,315	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)	68,315	14.00
	Customary charges		
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis	0	15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a chargebasis had such payment been made in accordance with 42 CFR §413.13(e)	0	16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)	0.000000	17.00
18.00	Total customary charges (see instructions)	68,315	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)	50,725	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)	17,590	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)	12,156,179	24.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
25.00	Deductibles and coinsurance amounts (for CAH, see instructions)	235	25.00
26.00	Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)	2,156,030	26.00
27.00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions)	10,017,504	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)	10,017,504	30.00
31.00	Primary payer payments	3,753	31.00
32.00	Subtotal (line 30 minus line 31)	10,013,751	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)	176,059	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	114,438	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	176,059	36.00
37.00	Subtotal (see instructions)	10,128,189	37.00
38.00	MSP-LCC reconciliation amount from PS&R	-9	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)	10,128,198	40.00
40.01	Sequestration adjustment (see instructions)	66,846	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	9,938,668	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)	122,684	43.00
43.01	Balance due provider/program-PARHM (see instructions)		43.01
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	44.00
	TO BE COMPLETED BY CONTRACTOR		
90.00	Original outlier amount (see instructions)	0	90.00
91.00	Outlier reconciliation adjustment amount (see instructions)	0	91.00
92.00	The rate used to calculate the Time Value of Money	0.00	92.00
93.00	Time Value of Money (see instructions)	0	93.00
94.00	Total (sum of lines 91 and 93)	0	94.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0104 Component CCN: 15-S104	Period: From 01/01/2020 To 12/31/2020	Worksheet E Part B Date/Time Prepared: 8/2/2021 1:50 pm
	Title XVIII	Subprovider - IPF	PPS

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	1,590	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)	323	2.00
3.00	OPPS payments	268	3.00
4.00	Outlier payment (see instructions)	0	4.00
4.01	Outlier reconciliation amount (see instructions)	0	4.01
5.00	Enter the hospital specific payment to cost ratio (see instructions)	0.000	5.00
6.00	Line 2 times line 5	0	6.00
7.00	Sum of lines 3, 4, and 4.01, divided by line 6	0.00	7.00
8.00	Transitional corridor payment (see instructions)	0	8.00
9.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200	0	9.00
10.00	Organ acquisitions	0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)	1,590	11.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
12.00	Ancillary service charges	5,689	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)	5,689	14.00
	Customary charges		
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis	0	15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a chargebasis had such payment been made in accordance with 42 CFR §413.13(e)	0	16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)	0.000000	17.00
18.00	Total customary charges (see instructions)	5,689	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)	4,099	19.00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)	0	20.00
21.00	Lesser of cost or charges (see instructions)	1,590	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)	268	24.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
25.00	Deductibles and coinsurance amounts (for CAH, see instructions)	0	25.00
26.00	Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)	0	26.00
27.00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions)	1,858	27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 50)	0	28.00
29.00	ESRD direct medical education costs (from Wkst. E-4, line 36)	0	29.00
30.00	Subtotal (sum of lines 27 through 29)	1,858	30.00
31.00	Primary payer payments	0	31.00
32.00	Subtotal (line 30 minus line 31)	1,858	32.00
	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)		
33.00	Composite rate ESRD (from Wkst. I-5, line 11)	0	33.00
34.00	Allowable bad debts (see instructions)	0	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	0	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	0	36.00
37.00	Subtotal (see instructions)	1,858	37.00
38.00	MSP-LCC reconciliation amount from PS&R	0	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	39.00
39.50	Pioneer ACO demonstration payment adjustment (see instructions)		39.50
39.97	Demonstration payment adjustment amount before sequestration	0	39.97
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)	0	39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION	0	39.99
40.00	Subtotal (see instructions)	1,858	40.00
40.01	Sequestration adjustment (see instructions)	12	40.01
40.02	Demonstration payment adjustment amount after sequestration	0	40.02
40.03	Sequestration adjustment-PARHM pass-throughs		40.03
41.00	Interim payments	1,397	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)	449	43.00
43.01	Balance due provider/program-PARHM (see instructions)		43.01
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	44.00
	TO BE COMPLETED BY CONTRACTOR		
90.00	Original outlier amount (see instructions)	0	90.00
91.00	Outlier reconciliation adjustment amount (see instructions)	0	91.00
92.00	The rate used to calculate the Time Value of Money	0.00	92.00
93.00	Time Value of Money (see instructions)	0	93.00
94.00	Total (sum of lines 91 and 93)	0	94.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0104 Component CCN: 15-5832	Period: From 01/01/2020 To 12/31/2020	Worksheet E Part B Date/Time Prepared: 8/2/2021 1:50 pm
	Title XVIII	Skilled Nursing Facility	PPS

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	1,801	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)	0	2.00
3.00	OPPS payments		3.00
4.00	Outlier payment (see instructions)		4.00
4.01	Outlier reconciliation amount (see instructions)		4.01
5.00	Enter the hospital specific payment to cost ratio (see instructions)		5.00
6.00	Line 2 times line 5	0	6.00
7.00	Sum of lines 3, 4, and 4.01, divided by line 6	0.00	7.00
8.00	Transitional corridor payment (see instructions)	0	8.00
9.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200	0	9.00
10.00	Organ acquisitions	0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)	1,801	11.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
12.00	Ancillary service charges	6,025	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)	6,025	14.00
	Customary charges		
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis	0	15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a chargebasis had such payment been made in accordance with 42 CFR §413.13(e)	0	16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)	0.000000	17.00
18.00	Total customary charges (see instructions)	6,025	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)	4,224	19.00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)	0	20.00
21.00	Lesser of cost or charges (see instructions)	1,801	21.00
22.00	Interns and residents (see instructions)	0	22.00
23.00	Cost of physicians' services in a teaching hospital (see instructions)	0	23.00
24.00	Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)	0	24.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
25.00	Deductibles and coinsurance amounts (for CAH, see instructions)	0	25.00
26.00	Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)		26.00
27.00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions)	1,801	27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 50)	0	28.00
29.00	ESRD direct medical education costs (from Wkst. E-4, line 36)	0	29.00
30.00	Subtotal (sum of lines 27 through 29)	1,801	30.00
31.00	Primary payer payments	0	31.00
32.00	Subtotal (line 30 minus line 31)	1,801	32.00
	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)		
33.00	Composite rate ESRD (from Wkst. I-5, line 11)	0	33.00
34.00	Allowable bad debts (see instructions)	0	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	0	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	0	36.00
37.00	Subtotal (see instructions)	1,801	37.00
38.00	MSP-LCC reconciliation amount from PS&R		38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	39.00
39.50	Pioneer ACO demonstration payment adjustment (see instructions)		39.50
39.97	Demonstration payment adjustment amount before sequestration	0	39.97
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)	0	39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION	0	39.99
40.00	Subtotal (see instructions)	1,801	40.00
40.01	Sequestration adjustment (see instructions)	12	40.01
40.02	Demonstration payment adjustment amount after sequestration	0	40.02
40.03	Sequestration adjustment-PARHM pass-throughs		40.03
41.00	Interim payments	1,201	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)	588	43.00
43.01	Balance due provider/program-PARHM (see instructions)		43.01
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	44.00
	TO BE COMPLETED BY CONTRACTOR		
90.00	Original outlier amount (see instructions)		90.00
91.00	Outlier reconciliation adjustment amount (see instructions)		91.00
92.00	The rate used to calculate the Time Value of Money		92.00
93.00	Time Value of Money (see instructions)		93.00
94.00	Total (sum of lines 91 and 93)		94.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED | Provider CCN: 15-0104 | Period: From 01/01/2020 To 12/31/2020 | Worksheet E-1 Part I | Date/Time Prepared: 8/2/2021 1:50 pm

Title XVIII | Hospital | PPS

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		7,713,532		9,938,668	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)		7,713,532		9,938,668	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		297,460		122,684	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		8,010,992		10,061,352	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: 15-0104 | Component CCN: 15-S104 | Period: From 01/01/2020 To 12/31/2020 | Worksheet E-1 Part I | Date/Time Prepared: 8/2/2021 1:50 pm

Title XVIII | Subprovider - IPF | PPS

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		932,467		1,397	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)		932,467		1,397	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		4,684		449	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		937,151		1,846	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: 15-0104 | Component CCN: 15-5832 | Period: From 01/01/2020 To 12/31/2020 | Worksheet E-1 Part I | Date/Time Prepared: 8/2/2021 1:50 pm

Title XVIII | Skilled Nursing Facility | PPS

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		1,156,789		1,201	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
	Program to Provider					
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
	Provider to Program					
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		1,156,789		1,201	4.00
	TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
	Program to Provider					
5.01	TENTATIVE TO PROVIDER		0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
	Provider to Program					
5.50	TENTATIVE TO PROGRAM		0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		0		588	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		1,156,789		1,789	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: 15-0104	Period: From 01/01/2020 To 12/31/2020	Worksheet E-1 Part II Date/Time Prepared: 8/2/2021 1:50 pm
	Title XVIII	Hospital	PPS

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

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0104 Component CCN: 15-S104	Period: From 01/01/2020 To 12/31/2020	Worksheet E-3 Part II Date/Time Prepared: 8/2/2021 1:50 pm
	Title XVIII	Subprovider - IPF	PPS

		1.00	
	PART II - MEDICARE PART A SERVICES - IPF PPS		
1.00	Net Federal IPF PPS Payments (excluding outlier, ECT, and medical education payments)	1,020,905	1.00
2.00	Net IPF PPS Outlier Payments	0	2.00
3.00	Net IPF PPS ECT Payments	0	3.00
4.00	Unweighted intern and resident FTE count in the most recent cost report filed on or before November 15, 2004. (see instructions)	0.00	4.00
4.01	Cap increases for the unweighted intern and resident FTE count for residents that were displaced by program or hospital closure, that would not be counted without a temporary cap adjustment under 42 CFR §412.424(d)(1)(iii)(F)(1) or (2) (see instructions)	0.00	4.01
5.00	New Teaching program adjustment. (see instructions)	0.00	5.00
6.00	Current year's unweighted FTE count of I&R excluding FTEs in the new program growth period of a "new teaching program" (see instuctions)	0.00	6.00
7.00	Current year's unweighted I&R FTE count for residents within the new program growth period of a "new teaching program" (see instuctions)	0.00	7.00
8.00	Intern and resident count for IPF PPS medical education adjustment (see instructions)	0.00	8.00
9.00	Average Daily Census (see instructions)	3.825137	9.00
10.00	Teaching Adjustment Factor {((1 + (line 8/line 9)) raised to the power of .5150 -1}.	0.000000	10.00
11.00	Teaching Adjustment (line 1 multiplied by line 10).	0	11.00
12.00	Adjusted Net IPF PPS Payments (sum of lines 1, 2, 3 and 11)	1,020,905	12.00
13.00	Nursing and Allied Health Managed Care payment (see instruction)	0	13.00
14.00	Organ acquisition (DO NOT USE THIS LINE)		14.00
15.00	Cost of physicians' services in a teaching hospital (see instructions)	0	15.00
16.00	Subtotal (see instructions)	1,020,905	16.00
17.00	Primary payer payments	0	17.00
18.00	Subtotal (line 16 less line 17).	1,020,905	18.00
19.00	Deductibles	75,768	19.00
20.00	Subtotal (line 18 minus line 19)	945,137	20.00
21.00	Coinsurance	1,760	21.00
22.00	Subtotal (line 20 minus line 21)	943,377	22.00
23.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)	0	23.00
24.00	Adjusted reimbursable bad debts (see instructions)	0	24.00
25.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	0	25.00
26.00	Subtotal (sum of lines 22 and 24)	943,377	26.00
27.00	Direct graduate medical education payments (see instructions)	0	27.00
28.00	Other pass through costs (see instructions)	0	28.00
29.00	Outlier payments reconciliation	0	29.00
30.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	30.00
30.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	30.50
30.99	Demonstration payment adjustment amount before sequestration	0	30.99
31.00	Total amount payable to the provider (see instructions)	943,377	31.00
31.01	Sequestration adjustment (see instructions)	6,226	31.01
31.02	Demonstration payment adjustment amount after sequestration	0	31.02
32.00	Interim payments	932,467	32.00
33.00	Tentative settlement (for contractor use only)	0	33.00
34.00	Balance due provider/program (line 31 minus lines 31.01, 31.02, 32 and 33)	4,684	34.00
35.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	35.00
	TO BE COMPLETED BY CONTRACTOR		
50.00	Original outlier amount from Worksheet E-3, Part II, line 2	0	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: 15-0104 Component CCN: 15-5832	Period: From 01/01/2020 To 12/31/2020	Worksheet E-3 Part VI Date/Time Prepared: 8/2/2021 1:50 pm
	Title XVIII	Skilled Nursing Facility	PPS

		1.00	
	PART VI - CALCULATION OF REIMBURSEMENT SETTLEMEMENT - ALL OTHER HEALTH SERVICES FOR TITLE XVIII PART A PPS SNF SERVICES		
	PROSPECTIVE PAYMENT AMOUNT (SEE INSTRUCTIONS)		
1.00	Resource Utilization Group Payment (RUGS)	1,311,926	1.00
2.00	Routine service other pass through costs	0	2.00
3.00	Ancillary service other pass through costs	0	3.00
4.00	Subtotal (sum of lines 1 through 3)	1,311,926	4.00
	COMPUTATION OF NET COST OF COVERED SERVICES		
5.00	Medical and other services (Do not use this line as vaccine costs are included in line 1 of W/S E, Part B. This line is now shaded.)		5.00
6.00	Deductible	0	6.00
7.00	Coinsurance	144,848	7.00
8.00	Allowable bad debts (see instructions)	0	8.00
9.00	Reimbursable bad debts for dual eligible beneficiaries (see instructions)	0	9.00
10.00	Adjusted reimbursable bad debts (see instructions)	0	10.00
11.00	Utilization review	0	11.00
12.00	Subtotal (sum of lines 4, 5 minus lines 6 and 7, plus lines 10 and 11)(see instructions)	1,167,078	12.00
13.00	Inpatient primary payer payments	0	13.00
14.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	14.00
14.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	14.50
14.99	Demonstration payment adjustment amount before sequestration	0	14.99
15.00	Subtotal (see instructions	1,167,078	15.00
15.01	Sequestration adjustment (see instructions)	10,289	15.01
15.02	Demonstration payment adjustment amount after sequestration	0	15.02
15.75	Sequestration for non-claims based amounts (see instructions)	0	15.75
16.00	Interim payments	1,156,789	16.00
17.00	Tentative settlement (for contractor use only)	0	17.00
18.00	Balance due provider/program (line 15 minus lines 15.01, 15.02, 15.75, 16, and 17)	0	18.00
19.00	Protested amounts (nonallowable cost report items) in accordance with CMS 19 Pub. 15-2, chapter 1, §115.2	0	19.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0104	Period: From 01/01/2020 To 12/31/2020	Worksheet E-3 Part VII Date/Time Prepared: 8/2/2021 1:50 pm
	Title XIX	Hospital	Cost

		Inpatient	Outpatient	
		1.00	2.00	
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR XIX SERVICES			
	COMPUTATION OF NET COST OF COVERED SERVICES			
1.00	Inpatient hospital/SNF/NF services	542,570		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)	542,570	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)	542,570	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	1,143,777	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)	1,143,777	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)	1,143,777	0	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)	601,207	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)	542,570	0	21.00
	PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be completed for PPS providers.			
22.00	Other than outlier payments	0	0	22.00
23.00	Outlier payments	0	0	23.00
24.00	Program capital payments	0		24.00
25.00	Capital exception payments (see instructions)	0		25.00
26.00	Routine and Ancillary service other pass through costs	0	0	26.00
27.00	Subtotal (sum of lines 22 through 26)	0	0	27.00
28.00	Customary charges (title V or XIX PPS covered services only)	0	0	28.00
29.00	Titles V or XIX (sum of lines 21 and 27)	542,570	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)	542,570	0	31.00
32.00	Deductibles	0	0	32.00
33.00	Coinsurance	0	0	33.00
34.00	Allowable bad debts (see instructions)	0	0	34.00
35.00	Utilization review	0		35.00
36.00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)	542,570	0	36.00
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	37.00
38.00	Subtotal (line 36 ± line 37)	542,570	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)	542,570	0	40.00
41.00	Interim payments	0	0	41.00
42.00	Balance due provider/program (line 40 minus line 41)	542,570	0	42.00
43.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, chapter 1, §115.2	0	0	43.00

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

Provider CCN: 15-0104 | Period: From 01/01/2020 To 12/31/2020 | Worksheet E-4 | Date/Time Prepared: 8/2/2021 1:50 pm

Title XVIII | Hospital | PPS

				1.00	
	COMPUTATION OF TOTAL DIRECT GME AMOUNT				
1.00	Unweighted resident FTE count for allopathic and osteopathic programs for cost reporting periods ending on or before December 31, 1996.			0.00	1.00
2.00	Unweighted FTE resident cap add-on for new programs per 42 CFR 413.79(e)(1) (see instructions)			0.00	2.00
3.00	Amount of reduction to Direct GME cap under section 422 of MMA			0.00	3.00
3.01	Direct GME cap reduction amount under ACA §5503 in accordance with 42 CFR §413.79 (m). (see instructions for cost reporting periods straddling 7/1/2011)			0.00	3.01
4.00	Adjustment (plus or minus) to the FTE cap for allopathic and osteopathic programs due to a Medicare GME affiliation agreement (42 CFR §413.75(b) and § 413.79 (f))			0.00	4.00
4.01	ACA Section 5503 increase to the Direct GME FTE Cap (see instructions for cost reporting periods straddling 7/1/2011)			0.00	4.01
4.02	ACA Section 5506 number of additional direct GME FTE cap slots (see instructions for cost reporting periods straddling 7/1/2011)			0.00	4.02
5.00	FTE adjusted cap (line 1 plus line 2 minus line 3 and 3.01 plus or minus line 4 plus lines 4.01 and 4.02 plus applicable subscripts			0.00	5.00
6.00	Unweighted resident FTE count for allopathic and osteopathic programs for the current year from your records (see instructions)			0.00	6.00
7.00	Enter the lesser of line 5 or line 6			0.00	7.00
		Primary Care	Other	Total	
		1.00	2.00	3.00	
8.00	Weighted FTE count for physicians in an allopathic and osteopathic program for the current year.	0.00	0.00	0.00	8.00
9.00	If line 6 is less than 5 enter the amount from line 8, otherwise multiply line 8 times the result of line 5 divided by the amount on line 6.	0.00	0.00	0.00	9.00
10.00	Weighted dental and podiatric resident FTE count for the current year		0.00		10.00
10.01	Unweighted dental and podiatric resident FTE count for the current year		0.00		10.01
11.00	Total weighted FTE count	0.00	0.00		11.00
12.00	Total weighted resident FTE count for the prior cost reporting year (see instructions)	0.00	0.00		12.00
13.00	Total weighted resident FTE count for the penultimate cost reporting year (see instructions)	0.00	0.00		13.00
14.00	Rolling average FTE count (sum of lines 11 through 13 divided by 3).	0.00	0.00		14.00
15.00	Adjustment for residents in initial years of new programs	0.00	0.00		15.00
15.01	Unweighted adjustment for residents in initial years of new programs	0.00	0.00		15.01
16.00	Adjustment for residents displaced by program or hospital closure	0.00	0.00		16.00
16.01	Unweighted adjustment for residents displaced by program or hospital closure	0.00	0.00		16.01
17.00	Adjusted rolling average FTE count	0.00	0.00		17.00
18.00	Per resident amount	0.00	0.00		18.00
19.00	Approved amount for resident costs	0	0	0	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)			0.00	21.00
22.00	Allowable additional direct GME FTE Resident Count (see instructions)			0.00	22.00
23.00	Enter the locality adjustment national average per resident amount (see instructions)			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)			0	25.00
		Inpatient Part A	Managed Care	Total	
		1.00	2.00	3.00	
	COMPUTATION OF PROGRAM PATIENT LOAD				
26.00	Inpatient Days (see instructions) (Title XIX - see S-2 Part IX, line 3.02, column 2)	4,107	1,257		26.00
27.00	Total Inpatient Days (see instructions)	9,477	9,477		27.00
28.00	Ratio of inpatient days to total inpatient days	0.433365	0.132637		28.00
29.00	Program direct GME amount	0	0	0	29.00
29.01	Percent reduction for MA DGME				29.01
30.00	Reduction for direct GME payments for Medicare Advantage		0	0	30.00
31.00	Net Program direct GME amount			0	31.00

DIRECT GRADUATE MEDICAL EDUCATION (GME) & ESRD OUTPATIENT DIRECT MEDICAL EDUCATION COSTS	Provider CCN: 15-0104	Period: From 01/01/2020 To 12/31/2020	Worksheet E-4 Date/Time Prepared: 8/2/2021 1:50 pm
	Title XVIII	Hospital	PPS

		1.00	
	DIRECT MEDICAL EDUCATION COSTS FOR ESRD COMPOSITE RATE - TITLE XVIII ONLY (NURSING SCHOOL AND PARAMEDICAL EDUCATION COSTS)		
32.00	Renal dialysis direct medical education costs (from Wkst. B, Pt. I, sum of col. 20 and 23, lines 74 and 94)	0	32.00
33.00	Renal dialysis and home dialysis total charges (Wkst. C, Pt. I, col. 8, sum of lines 74 and 94)	0	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)	12,212,723	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)	0	40.00
41.00	Total Part A reasonable cost (sum of lines 37 through 39 minus line 40)	12,212,723	41.00
	Part B Reasonable Cost		
42.00	Reasonable cost (see instructions)	13,960,801	42.00
43.00	Primary payer payments (see instructions)	3,753	43.00
44.00	Total Part B reasonable cost (line 42 minus line 43)	13,957,048	44.00
45.00	Total reasonable cost (sum of lines 41 and 44)	26,169,771	45.00
46.00	Ratio of Part A reasonable cost to total reasonable cost (line 41 ÷ line 45)	0.466673	46.00
47.00	Ratio of Part B reasonable cost to total reasonable cost (line 44 ÷ line 45)	0.533327	47.00
	ALLOCATION OF MEDICARE DIRECT GME COSTS BETWEEN PART A AND PART B		
48.00	Total program GME payment (line 31)	0	48.00
49.00	Part A Medicare GME payment (line 46 x 48) (title XVIII only) (see instructions)	0	49.00
50.00	Part B Medicare GME payment (line 47 x 48) (title XVIII only) (see instructions)	0	50.00

BALANCE SHEET (If you are nonproprietary and do not maintain fund-type accounting records, complete the General Fund column only) | Provider CCN: 15-0104 | Period: From 01/01/2020 To 12/31/2020 | Worksheet G | Date/Time Prepared: 8/2/2021 1:50 pm

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
	CURRENT ASSETS					
1.00	Cash on hand in banks	50,065,375	0	0	0	1.00
2.00	Temporary investments	2,965,591	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	26,869,530	0	0	0	4.00
5.00	Other receivable	1,925,644	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	0	0	0	0	6.00
7.00	Inventory	3,662,369	0	0	0	7.00
8.00	Prepaid expenses	0	0	0	0	8.00
9.00	Other current assets	2,350,984	0	0	0	9.00
10.00	Due from other funds	0	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	87,839,493	0	0	0	11.00
	FIXED ASSETS					
12.00	Land	0	0	0	0	12.00
13.00	Land improvements	5,898,844	0	0	0	13.00
14.00	Accumulated depreciation	0	0	0	0	14.00
15.00	Buildings	3,704,163	0	0	0	15.00
16.00	Accumulated depreciation	0	0	0	0	16.00
17.00	Leasehold improvements	0	0	0	0	17.00
18.00	Accumulated depreciation	0	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	206,804,752	0	0	0	23.00
24.00	Accumulated depreciation	-94,643,851	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)	121,763,908	0	0	0	30.00
	OTHER ASSETS					
31.00	Investments	0	0	0	0	31.00
32.00	Deposits on leases	0	0	0	0	32.00
33.00	Due from owners/officers	0	0	0	0	33.00
34.00	Other assets	32,150,024	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	32,150,024	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	241,753,425	0	0	0	36.00
	CURRENT LIABILITIES					
37.00	Accounts payable	4,508,821	0	0	0	37.00
38.00	Salaries, wages, and fees payable	12,489,222	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	68,258	0	0	0	40.00
41.00	Deferred income	0	0	0	0	41.00
42.00	Accelerated payments	0				42.00
43.00	Due to other funds	0	0	0	0	43.00
44.00	Other current liabilities	20,869,815	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	37,936,116	0	0	0	45.00
	LONG TERM LIABILITIES					
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	83,664	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	31,364,439	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	31,448,103	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	69,384,219	0	0	0	51.00
	CAPITAL ACCOUNTS					
52.00	General fund balance	172,369,206				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)	172,369,206	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	241,753,425	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES | Provider CCN: 15-0104 | Period: From 01/01/2020 To 12/31/2020 | Worksheet G-1 | Date/Time Prepared: 8/2/2021 1:50 pm

		General Fund		Special Purpose Fund		Endowment Fund	
		1.00	2.00	3.00	4.00	5.00	
1.00	Fund balances at beginning of period		165,849,096		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		2,925,281				2.00
3.00	Total (sum of line 1 and line 2)		168,774,377		0		3.00
4.00	Additions (credit adjustments) (specify)	0		0		0	4.00
5.00		0		0		0	5.00
6.00		0		0		0	6.00
7.00		0		0		0	7.00
8.00		0		0		0	8.00
9.00		0		0		0	9.00
10.00	Total additions (sum of line 4-9)		0		0		10.00
11.00	Subtotal (line 3 plus line 10)		168,774,377		0		11.00
12.00	Deductions (debit adjustments) (specify)	0		0		0	12.00
13.00		0		0		0	13.00
14.00		0		0		0	14.00
15.00		0		0		0	15.00
16.00		0		0		0	16.00
17.00		0		0		0	17.00
18.00	Total deductions (sum of lines 12-17)		0		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		168,774,377		0		19.00

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

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES | Provider CCN: 15-0104 | Period: From 01/01/2020 To 12/31/2020 | Worksheet G-2 Parts I & II Date/Time Prepared: 8/2/2021 1:50 pm

	Cost Center Description	Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospital	13,369,063		13,369,063	1.00
2.00	SUBPROVIDER - IPF	-1,826,667		-1,826,667	2.00
3.00	SUBPROVIDER - IRF	0		0	3.00
4.00	SUBPROVIDER	0		0	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	-2,418,222		-2,418,222	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)	9,124,174		9,124,174	10.00
	Intensive Care Type Inpatient Hospital Services				
11.00	INTENSIVE CARE UNIT	6,897,877		6,897,877	11.00
12.00	CORONARY CARE UNIT				12.00
13.00	BURN INTENSIVE CARE UNIT				13.00
14.00	SURGICAL INTENSIVE CARE UNIT				14.00
15.00	OTHER SPECIAL CARE (SPECIFY)				15.00
16.00	Total intensive care type inpatient hospital services (sum of lines 11-15)	6,897,877		6,897,877	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	16,022,051		16,022,051	17.00
18.00	Ancillary services	75,892,809	367,646,448	443,539,257	18.00
19.00	Outpatient services	1,463	58,989	60,452	19.00
20.00	RURAL HEALTH CLINIC	0	0	0	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY				22.00
23.00	AMBULANCE SERVICES	1,057	3,868,371	3,869,428	23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	OTHER (SPECIFY)	0	0	0	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	91,917,380	371,573,808	463,491,188	28.00
	PART II - OPERATING EXPENSES				
29.00	Operating expenses (per Wkst. A, column 3, line 200)		164,125,146		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)		164,125,146		43.00

STATEMENT OF REVENUES AND EXPENSES | Provider CCN: 15-0104 | Period: From 01/01/2020 To 12/31/2020 | Worksheet G-3 | Date/Time Prepared: 8/2/2021 1:50 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	463,491,188	1.00
2.00	Less contractual allowances and discounts on patients' accounts	314,744,968	2.00
3.00	Net patient revenues (line 1 minus line 2)	148,746,220	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	164,125,146	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-15,378,926	5.00
	OTHER INCOME		
6.00	Contributions, donations, bequests, etc	0	6.00
7.00	Income from investments	0	7.00
8.00	Revenues from telephone and other miscellaneous communication services	0	8.00
9.00	Revenue from television and radio service	0	9.00
10.00	Purchase discounts	0	10.00
11.00	Rebates and refunds of expenses	0	11.00
12.00	Parking lot receipts	0	12.00
13.00	Revenue from laundry and linen service	0	13.00
14.00	Revenue from meals sold to employees and guests	0	14.00
15.00	Revenue from rental of living quarters	0	15.00
16.00	Revenue from sale of medical and surgical supplies to other than patients	0	16.00
17.00	Revenue from sale of drugs to other than patients	0	17.00
18.00	Revenue from sale of medical records and abstracts	0	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	0	20.00
21.00	Rental of vending machines	0	21.00
22.00	Rental of hospital space	0	22.00
23.00	Governmental appropriations	0	23.00
24.00	OTHER OPERATING INCOME	4,030,965	24.00
24.01	NON-OPERATING INCOME	5,875,836	24.01
24.50	COVID-19 PHE Funding	8,397,406	24.50
25.00	Total other income (sum of lines 6-24)	18,304,207	25.00
26.00	Total (line 5 plus line 25)	2,925,281	26.00
27.00	OTHER EXPENSES (SPECIFY)	0	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	0	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	2,925,281	29.00

CALCULATION OF CAPITAL PAYMENT	Provider CCN: 15-0104	Period: From 01/01/2020 To 12/31/2020	Worksheet L Parts I-III Date/Time Prepared: 8/2/2021 1:50 pm
	Title XVIII	Hospital	PPS

			1.00	
	PART I - FULLY PROSPECTIVE METHOD			
	CAPITAL FEDERAL AMOUNT			
1.00	Capital DRG other than outlier		482,768	1.00
1.01	Model 4 BPCI Capital DRG other than outlier		0	1.01
2.00	Capital DRG outlier payments		637	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)		22.53	3.00
4.00	Number of interns & residents (see instructions)		0.00	4.00
5.00	Indirect medical education percentage (see instructions)		0.00	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)		0	6.00
7.00	Percentage of SSI recipient patient days to Medicare Part A patient days (Worksheet E, part A line 30) (see instructions)		0.00	7.00
8.00	Percentage of Medicaid patient days to total days (see instructions)		0.00	8.00
9.00	Sum of lines 7 and 8		0.00	9.00
10.00	Allowable disproportionate share percentage (see instructions)		0.00	10.00
11.00	Disproportionate share adjustment (see instructions)		0	11.00
12.00	Total prospective capital payments (see instructions)		483,405	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