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: 15-0006	Period: From 01/01/2020 To 12/31/2020	Worksheet S Parts I-III Date/Time Prepared: 8/2/2021 4:01 pm

PART I - COST REPORT STATUS

Provider use only

1. [X] Electronically prepared cost report — Date: 8/2/2021 Time: 4:01 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 LAPORTE HOSPITAL (15-0006) for the cost reporting period beginning 01/01/2020 and ending 12/31/2020 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

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

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

_____
Title

_____
Date

	Cost Center Description	Title V	Title XVIII Part A	Title XVIII Part B	HIT	Title XIX	
		1.00	2.00	3.00	4.00	5.00	
	PART III - SETTLEMENT SUMMARY						
1.00	Hospital	0	419,135	-33,547	0	0	1.00
2.00	Subprovider - IPF	0	0	0		0	2.00
3.00	Subprovider - IRF	0	0	0		0	3.00
5.00	Swing Bed - SNF	0	0	0		0	5.00
6.00	Swing Bed - NF	0				0	6.00
7.00	SKILLED NURSING FACILITY	0	0	0		0	7.00
200.00	Total	0	419,135	-33,547	0	0	200.00

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 15-0006	Period: From 01/01/2020 To 12/31/2020	Worksheet S-2 Part I Date/Time Prepared: 8/2/2021 4:01 pm

	1.00	2.00	3.00	4.00	
	Hospital and Hospital Health Care Complex Address:				
1.00	Street: STATE & MADISON STREETS	PO Box: 250			1.00
2.00	City: LAPORTE	State: IN	Zip Code: 46350-	County: LA PORTE	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	LAPORTE HOSPITAL	150006	33140	1	07/01/1966	N	P	P	3.00
4.00	Subprovider - IPF									4.00
5.00	Subprovider - IRF									5.00
6.00	Subprovider - (Other)									6.00
7.00	Swing Beds - SNF									7.00
8.00	Swing Beds - NF									8.00
9.00	Hospital-Based SNF									9.00
10.00	Hospital-Based NF									10.00
11.00	Hospital-Based OLTC									11.00
12.00	Hospital-Based HHA									12.00
13.00	Separately Certified ASC									13.00
14.00	Hospital-Based Hospice									14.00
15.00	Hospital-Based Health Clinic - RHC									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)	4		21.00

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

		In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of State Medicaid paid days	Out-of State Medicaid eligible unpaid	Medicaid HMO days	Other Medicaid days	
		1.00	2.00	3.00	4.00	5.00	6.00	
24.00	If this provider is an IPPS hospital, enter the in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.	975	191	0	7	3,657	177	24.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-0006 | Period: From 01/01/2020 To 12/31/2020 | Worksheet S-2 Part I | Date/Time Prepared: 8/2/2021 4:01 pm

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

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

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

		Y/N	Y/N	
		1.00	2.00	
39.00	Does this facility qualify for the inpatient hospital payment adjustment for low volume hospitals in accordance with 42 CFR §412.101(b)(2)(i), (ii), or (iii)? Enter in column 1 “Y” for yes or “N” for no. Does the facility meet the mileage requirements in accordance with 42 CFR 412.101(b)(2)(i), (ii), or (iii)? Enter in column 2 "Y" for yes or "N" for no. (see instructions)	N	N	39.00
40.00	Is this hospital subject to the HAC program reduction adjustment? Enter "Y" for yes or "N" for no in column 1, for discharges prior to October 1. Enter "Y" for yes or "N" for no in column 2, for discharges on or after October 1. (see instructions)	Y	Y	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	Y	N	45.00
46.00	Is this facility eligible for additional payment exception for extraordinary circumstances pursuant to 42 CFR §412.348(f)? If yes, complete Wkst. L, Pt. III and Wkst. L-1, Pt. I through Pt. III.	N	N	N	46.00
47.00	Is this a new hospital under 42 CFR §412.300(b) PPS capital? Enter "Y for yes or "N" for no.	N	N	N	47.00
48.00	Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.	N	N	N	48.00
	Teaching Hospitals				
56.00	Is this a hospital involved in training residents in approved GME programs? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", are you impacted by CR 11642 (or subsequent CR), MA GME payment reduction? Enter "Y" for yes or "N" for no in column 2.	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.	N			58.00
59.00	Are costs claimed on line 100 of Worksheet A? If yes, complete Wkst. D-2, Pt. I.	N			59.00

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-0006 | Period: From 01/01/2020 To 12/31/2020 | Worksheet S-2 Part I | Date/Time Prepared: 8/2/2021 4:01 pm

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

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-0006 | Period: From 01/01/2020 To 12/31/2020 | Worksheet S-2 Part I Date/Time Prepared: 8/2/2021 4:01 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)	N		0.00	0.00	0.000000	65.00

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 15-0006	Period: From 01/01/2020 To 12/31/2020	Worksheet S-2 Part I Date/Time Prepared: 8/2/2021 4:01 pm

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-0006 | Period: From 01/01/2020 To 12/31/2020 | Worksheet S-2 Part I | Date/Time Prepared: 8/2/2021 4:01 pm

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

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

		Premiums	Losses	Insurance	
		1.00	2.00	3.00	
118.01	List amounts of malpractice premiums and paid losses:	45,011	162,452	0	118.01

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-0006 | Period: From 01/01/2020 To 12/31/2020 | Worksheet S-2 Part I | Date/Time Prepared: 8/2/2021 4:01 pm

	1.00	2.00	3.00	
	If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number.			
141.00	Name: COMMUNITY HEALTH SYSTEMS	Contractor's Name: WPS	Contractor's Number: 10101	141.00
142.00	Street: 4000 MERIDIAN BLVD	PO Box:		142.00
143.00	City: FRANKLIN	State: TN	Zip Code: 37067	143.00

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

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

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

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

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

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

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 15-0006 | Period: From 01/01/2020 To 12/31/2020 | Worksheet S-2 Part II | Date/Time Prepared: 8/2/2021 4:01 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.	Y	15.00

		Part A		Part B		
		Y/N	Date	Y/N	Date	
		1.00	2.00	3.00	4.00	
	PS&R Data					
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see instructions)	N		N		16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	Y	04/16/2021	Y	04/16/2021	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: 15-0006 | Period: From 01/01/2020 To 12/31/2020 | Worksheet S-2 Part II Date/Time Prepared: 8/2/2021 4:01 pm

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

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

		Y/N	Date	
		1.00	2.00	
	Home Office Costs			
36.00	Were home office costs claimed on the cost report?	Y		36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.	Y		37.00
38.00	If line 36 is yes , was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.	Y	12/31/2019	38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.	N		39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.	N		40.00

		1.00	2.00	
	Cost Report Preparer Contact Information			
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	KUZIWA	TSIGA	41.00
42.00	Enter the employer/company name of the cost report preparer.	COMMUNITY HEALTH SYSTEMS		42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	615-465-3416	KUZIWA_TSIGA@CHS.NET	43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider CCN: 15-0006	Period: From 01/01/2020 To 12/31/2020	Worksheet S-2 Part II Date/Time Prepared: 8/2/2021 4:01 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.	REVENUE 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: 15-0006 | Period: From 01/01/2020 To 12/31/2020 | Worksheet S-3 Part I Date/Time Prepared: 8/2/2021 4:01 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	99	36,234	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)		99	36,234	0.00	0	7.00
8.00	INTENSIVE CARE UNIT	31.00	18	6,588	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)		117	42,822	0.00	0	14.00
15.00	CAH visits					0	15.00
16.00	SUBPROVIDER - IPF	40.00	0	0		0	16.00
17.00	SUBPROVIDER - IRF	41.00	0	0		0	17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY	44.00	0	0		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)		117				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: 15-0006 | Period: From 01/01/2020 To 12/31/2020 | Worksheet S-3 Part I | Date/Time Prepared: 8/2/2021 4:01 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)	6,504	749	15,665			1.00
2.00	HMO and other (see instructions)	3,370	3,121				2.00
3.00	HMO IPF Subprovider	0	0				3.00
4.00	HMO IRF Subprovider	0	0				4.00
5.00	Hospital Adults & Peds. Swing Bed SNF	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)	6,504	749	15,665			7.00
8.00	INTENSIVE CARE UNIT	1,361	101	2,986			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		859	1,141			13.00
14.00	Total (see instructions)	7,865	1,709	19,792	0.00	566.58	14.00
15.00	CAH visits	0	0	0			15.00
16.00	SUBPROVIDER - IPF	0	0	0	0.00	0.00	16.00
17.00	SUBPROVIDER - IRF	0	0	0	0.00	0.00	17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY	0	0	0	0.00	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)			0			24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0.00	0.00	26.25
27.00	Total (sum of lines 14-26)				0.00	566.58	27.00
28.00	Observation Bed Days		0	1,138			28.00
29.00	Ambulance Trips	0					29.00
30.00	Employee discount days (see instruction)			143			30.00
31.00	Employee discount days - IRF			0			31.00
32.00	Labor & delivery days (see instructions)	0	177	233			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: 15-0006 | Period: From 01/01/2020 To 12/31/2020 | Worksheet S-3 Part I | Date/Time Prepared: 8/2/2021 4:01 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	1,623	1,012	4,072	1.00
2.00	HMO and other (see instructions)			585	0		2.00
3.00	HMO IPF Subprovider				0		3.00
4.00	HMO IRF Subprovider				0		4.00
5.00	Hospital Adults & Peds. Swing Bed SNF						5.00
6.00	Hospital Adults & Peds. Swing Bed NF						6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)						7.00
8.00	INTENSIVE CARE UNIT						8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY						13.00
14.00	Total (see instructions)	0.00	0	1,623	1,012	4,072	14.00
15.00	CAH visits						15.00
16.00	SUBPROVIDER - IPF	0.00	0	0	0	0	16.00
17.00	SUBPROVIDER - IRF	0.00	0	0	0	0	17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY	0.00					19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)						24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0.00					26.25
27.00	Total (sum of lines 14-26)	0.00					27.00
28.00	Observation Bed Days						28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)						32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00	LTCH non-covered days			0			33.00
33.01	LTCH site neutral days and discharges			0			33.01

HOSPITAL WAGE INDEX INFORMATION | Provider CCN: 15-0006 | Period: From 01/01/2020 To 12/31/2020 | Worksheet S-3 Part II Date/Time Prepared: 8/2/2021 4:01 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	39,713,752	0	39,713,752	1,178,496.00	33.70	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		368,862	0	368,862	1,776.00	207.69	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	0	0	0	0.00	0.00	9.00
10.00	Excluded area salaries (see instructions)		209,975	0	209,975	6,173.00	34.02	10.00
	OTHER WAGES & RELATED COSTS							
11.00	Contract labor: Direct Patient Care		1,356,404	0	1,356,404	28,418.00	47.73	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		40,658	0	40,658	225.00	180.70	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		4,711,758	0	4,711,758	156,927.00	30.03	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)		8,182,640	0	8,182,640			17.00
18.00	Wage-related costs (other) (see instructions)							18.00
19.00	Excluded areas		45,096	0	45,096			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		26,762	0	26,762			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)		1,070,897	0	1,070,897			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: 15-0006 | Period: From 01/01/2020 To 12/31/2020 | Worksheet S-3 Part II Date/Time Prepared: 8/2/2021 4:01 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	283,902	0	283,902	8,936.00	31.77	26.00
27.00	Administrative & General	5.00	8,206,387	-297,890	7,908,497	229,702.00	34.43	27.00
28.00	Administrative & General under contract (see inst.)		80,497	0	80,497	855.00	94.15	28.00
29.00	Maintenance & Repairs	6.00	0	0	0	0.00	0.00	29.00
30.00	Operation of Plant	7.00	991,188	0	991,188	39,350.00	25.19	30.00
31.00	Laundry & Linen Service	8.00	0	0	0	0.00	0.00	31.00
32.00	Housekeeping	9.00	0	0	0	0.00	0.00	32.00
33.00	Housekeeping under contract (see instructions)		1,268,158	0	1,268,158	51,645.00	24.56	33.00
34.00	Dietary	10.00	0	0	0	0.00	0.00	34.00
35.00	Dietary under contract (see instructions)		1,527,107	0	1,527,107	56,385.00	27.08	35.00
36.00	Cafeteria	11.00	0	0	0	0.00	0.00	36.00
37.00	Maintenance of Personnel	12.00	0	0	0	0.00	0.00	37.00
38.00	Nursing Administration	13.00	1,689,971	297,890	1,987,861	45,904.00	43.30	38.00
39.00	Central Services and Supply	14.00	491,730	0	491,730	23,016.00	21.36	39.00
40.00	Pharmacy	15.00	1,270,144	0	1,270,144	33,191.00	38.27	40.00
41.00	Medical Records & Medical Records Library	16.00	427,563	0	427,563	17,462.00	24.49	41.00
42.00	Social Service	17.00	417,376	0	417,376	12,657.00	32.98	42.00
43.00	Other General Service	18.00	0	0	0	0.00	0.00	43.00

HOSPITAL WAGE INDEX INFORMATION | Provider CCN: 15-0006 | Period: From 01/01/2020 To 12/31/2020 | Worksheet S-3 Part III Date/Time Prepared: 8/2/2021 4:01 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)		42,589,514	0	42,589,514	1,287,381.00	33.08	1.00
2.00	Excluded area salaries (see instructions)		209,975	0	209,975	6,173.00	34.02	2.00
3.00	Subtotal salaries (line 1 minus line 2)		42,379,539	0	42,379,539	1,281,208.00	33.08	3.00
4.00	Subtotal other wages & related costs (see inst.)		6,108,820	0	6,108,820	185,570.00	32.92	4.00
5.00	Subtotal wage-related costs (see inst.)		9,280,299	0	9,280,299	0.00	21.90	5.00
6.00	Total (sum of lines 3 thru 5)		57,768,658	0	57,768,658	1,466,778.00	39.38	6.00
7.00	Total overhead cost (see instructions)		16,654,023	0	16,654,023	519,103.00	32.08	7.00

HOSPITAL WAGE RELATED COSTS | Provider CCN: 15-0006 | Period: From 01/01/2020 To 12/31/2020 | Worksheet S-3 Part IV Date/Time Prepared: 8/2/2021 4:01 pm

		Amount Reported	
		1.00	
	PART IV - WAGE RELATED COSTS		
	Part A - Core List		
	RETIREMENT COST		
1.00	401K Employer Contributions	743,088	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)	4,249,741	8.02
8.03	Health Insurance (Purchased)	0	8.03
9.00	Prescription Drug Plan	0	9.00
10.00	Dental, Hearing and Vision Plan	101,371	10.00
11.00	Life Insurance (If employee is owner or beneficiary)	32,776	11.00
12.00	Accident Insurance (If employee is owner or beneficiary)	2,605	12.00
13.00	Disability Insurance (If employee is owner or beneficiary)	90,150	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)	0	14.00
15.00	'Workers' Compensation Insurance	233,179	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	2,203,511	17.00
18.00	Medicare Taxes - Employers Portion Only	515,337	18.00
19.00	Unemployment Insurance	0	19.00
20.00	State or Federal Unemployment Taxes	82,740	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)	8,254,498	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: 15-0006 | Period: From 01/01/2020 To 12/31/2020 | Worksheet S-3 Part V | Date/Time Prepared: 8/2/2021 4:01 pm

	Cost Center Description	Contract Labor	Benefit Cost	
		1.00	2.00	
	PART V - Contract Labor and Benefit Cost			
	Hospital and Hospital-Based Component Identification:			
1.00	Total facility's contract labor and benefit cost	1,356,404	8,254,498	1.00
2.00	Hospital	1,356,404	8,254,498	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	0	0	17.00
18.00	Other	0	0	18.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA	Provider CCN: 15-0006	Period: From 01/01/2020 To 12/31/2020	Worksheet S-10 Date/Time Prepared: 8/2/2021 4:01 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)	0.196690	1.00
	Medicaid (see instructions for each line)		
2.00	Net revenue from Medicaid	7,023,480	2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?	Y	3.00
4.00	If line 3 is yes, does line 2 include all DSH and/or supplemental payments from Medicaid?	Y	4.00
5.00	If line 4 is no, then enter DSH and/or supplemental payments from Medicaid	0	5.00
6.00	Medicaid charges	123,015,775	6.00
7.00	Medicaid cost (line 1 times line 6)	24,195,973	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)	17,172,493	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)	17,172,493	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)	5,865,081	0	5,865,081	20.00
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	1,153,603	0	1,153,603	21.00
22.00	Payments received from patients for amounts previously written off as charity care	297	0	297	22.00
23.00	Cost of charity care (line 21 minus line 22)	1,153,306	0	1,153,306	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)	6,410,015	26.00
27.00	Medicare reimbursable bad debts for the entire hospital complex (see instructions)	189,111	27.00
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)	290,940	27.01
28.00	Non-Medicare bad debt expense (see instructions)	6,119,075	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)	1,305,390	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)	2,458,696	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	19,631,189	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 15-0006 | Period: From 01/01/2020 To 12/31/2020 | Worksheet A | Date/Time Prepared: 8/2/2021 4:01 pm

		Cost Center Description	Salaries	Other	Total (col. 1 + col. 2)	Reclassifications (See A-6)	Reclassified Trial Balance (col. 3 +- col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT		2,353,222	2,353,222	4,669,000	7,022,222	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		8,798,782	8,798,782	655,448	9,454,230	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	283,902	86,483	370,385	5,521,471	5,891,856	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	8,206,387	39,643,938	47,850,325	-10,132,126	37,718,199	5.00
7.00	00700	OPERATION OF PLANT	991,188	3,225,092	4,216,280	2,121,520	6,337,800	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	417,897	417,897	0	417,897	8.00
9.00	00900	HOUSEKEEPING	0	1,724,684	1,724,684	-2,969	1,721,715	9.00
10.00	01000	DIETARY	0	2,225,482	2,225,482	-1,363,350	862,132	10.00
11.00	01100	CAFETERIA	0	0	0	1,359,441	1,359,441	11.00
13.00	01300	NURSING ADMINISTRATION	1,689,971	223,400	1,913,371	274,175	2,187,546	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	491,730	6,685,754	7,177,484	-6,099,380	1,078,104	14.00
15.00	01500	PHARMACY	1,270,144	8,254,250	9,524,394	-7,999,808	1,524,586	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	427,563	635,765	1,063,328	-3,214	1,060,114	16.00
17.00	01700	SOCIAL SERVICE	417,376	74,106	491,482	-319	491,163	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	5,438,123	2,920,997	8,359,120	651,399	9,010,519	30.00
31.00	03100	INTENSIVE CARE UNIT	2,216,957	1,290,150	3,507,107	-37,762	3,469,345	31.00
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	0	40.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
43.00	04300	NURSERY	0	0	0	402,277	402,277	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,868,715	3,637,393	5,506,108	-857,326	4,648,782	50.00
51.00	05100	RECOVERY ROOM	1,224,595	234,065	1,458,660	-2,462	1,456,198	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,470,290	284,899	1,755,189	-1,112,664	642,525	52.00
53.00	05300	ANESTHESIOLOGY	48,230	1,857,155	1,905,385	-12,766	1,892,619	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,857,226	968,071	2,825,297	-527,255	2,298,042	54.00
54.01	05401	ULTRASOUND	351,359	59,502	410,861	-18,813	392,048	54.01
56.00	05600	RADIOISOTOPE	281,530	253,291	534,821	-6,701	528,120	56.00
57.00	05700	CT SCAN	505,663	229,201	734,864	-135,254	599,610	57.00
58.00	05800	MRI	197,791	101,778	299,569	-72,923	226,646	58.00
60.00	06000	LABORATORY	2,185,436	2,708,118	4,893,554	-155,312	4,738,242	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	867,357	222,521	1,089,878	-80,270	1,009,608	65.00
66.00	06600	PHYSICAL THERAPY	1,661,006	289,096	1,950,102	-49,513	1,900,589	66.00
67.00	06700	OCCUPATIONAL THERAPY	535,856	90,082	625,938	-99	625,839	67.00
68.00	06800	SPEECH PATHOLOGY	516,161	62,964	579,125	-433	578,692	68.00
69.00	06900	ELECTROCARDIOLOGY	2,378,290	1,699,525	4,077,815	-552,710	3,525,105	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	1,529,833	1,529,833	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	4,402,270	4,402,270	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	7,703,444	7,703,444	73.00
74.00	07400	RENAL DIALYSIS	0	320,819	320,819	0	320,819	74.00
76.00	03950	OTHER ANCILLARY-OTHER	0	0	0	0	0	76.00
76.01	03610	SLEEP LAB	254,628	62,631	317,259	-11,817	305,442	76.01
76.02	03020	ACUPUNCTURE	0	0	0	0	0	76.02
76.03	03040	WOUND CARE	10,961	793,603	804,564	-2,199	802,365	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	4,441,678	4,441,678	0	4,441,678	90.00
91.00	09100	EMERGENCY	1,855,342	666,979	2,522,321	-8,875	2,513,446	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	39,503,777	97,543,373	137,047,150	43,958	137,091,108	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	131,179	-902,782	-771,603	-43,958	-815,561	192.00
194.00	07950	OTHER NONREIMBURSABLE COSTS	78,796	6,422	85,218	0	85,218	194.00
194.01	07951	MARKETING	0	0	0	0	0	194.01
200.00		TOTAL (SUM OF LINES 118 through 199)	39,713,752	96,647,013	136,360,765	0	136,360,765	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 15-0006 | Period: From 01/01/2020 To 12/31/2020 | Worksheet A | Date/Time Prepared: 8/2/2021 4:01 pm

		Cost Center Description	Adjustments (See A-8)	Net Expenses For Allocation		
			6.00	7.00		
		GENERAL SERVICE COST CENTERS				
1.00	00100	CAP REL COSTS-BLDG & FIXT	-2,070,759	4,951,463		1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	-656,725	8,797,505		2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-3,701	5,888,155		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-8,847,481	28,870,718		5.00
7.00	00700	OPERATION OF PLANT	-20,840	6,316,960		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	417,897		8.00
9.00	00900	HOUSEKEEPING	0	1,721,715		9.00
10.00	01000	DIETARY	0	862,132		10.00
11.00	01100	CAFETERIA	0	1,359,441		11.00
13.00	01300	NURSING ADMINISTRATION	-51,904	2,135,642		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	1,078,104		14.00
15.00	01500	PHARMACY	0	1,524,586		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-10,253	1,049,861		16.00
17.00	01700	SOCIAL SERVICE	0	491,163		17.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	0	9,010,519		30.00
31.00	03100	INTENSIVE CARE UNIT	-682,792	2,786,553		31.00
40.00	04000	SUBPROVIDER - IPF	0	0		40.00
41.00	04100	SUBPROVIDER - IRF	0	0		41.00
43.00	04300	NURSERY	0	402,277		43.00
44.00	04400	SKILLED NURSING FACILITY	0	0		44.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	-207,608	4,441,174		50.00
51.00	05100	RECOVERY ROOM	0	1,456,198		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	-42,719	599,806		52.00
53.00	05300	ANESTHESIOLOGY	0	1,892,619		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-967	2,297,075		54.00
54.01	05401	ULTRASOUND	0	392,048		54.01
56.00	05600	RADIOISOTOPE	0	528,120		56.00
57.00	05700	CT SCAN	0	599,610		57.00
58.00	05800	MRI	0	226,646		58.00
60.00	06000	LABORATORY	0	4,738,242		60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0		62.00
65.00	06500	RESPIRATORY THERAPY	0	1,009,608		65.00
66.00	06600	PHYSICAL THERAPY	-24,726	1,875,863		66.00
67.00	06700	OCCUPATIONAL THERAPY	-34,429	591,410		67.00
68.00	06800	SPEECH PATHOLOGY	0	578,692		68.00
69.00	06900	ELECTROCARDIOLOGY	0	3,525,105		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	-38,817	1,491,016		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	4,402,270		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	-19,417	7,684,027		73.00
74.00	07400	RENAL DIALYSIS	0	320,819		74.00
76.00	03950	OTHER ANCILLARY-OTHER	0	0		76.00
76.01	03610	SLEEP LAB	0	305,442		76.01
76.02	03020	ACUPUNCTURE	0	0		76.02
76.03	03040	WOUND CARE	0	802,365		76.03
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	-4,441,678	0		90.00
91.00	09100	EMERGENCY	-159,933	2,353,513		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES	0	0		95.00
		SPECIAL PURPOSE COST CENTERS				
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-17,314,749	119,776,359		118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	1,855,295	1,039,734		192.00
194.00	07950	OTHER NONREIMBURSABLE COSTS	0	85,218		194.00
194.01	07951	MARKETING	0	0		194.01
200.00		TOTAL (SUM OF LINES 118 through 199)	-15,459,454	120,901,311		200.00

RECLASSIFICATIONS | Provider CCN: 15-0006 | Period: From 01/01/2020 To 12/31/2020 | Worksheet A-6 | Date/Time Prepared: 8/2/2021 4:01 pm

		Increases			
	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
	A - EMPLOYEE BENEFITS				
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	5,523,001	1.00
2.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	6,227	2.00
	TOTALS		0	5,529,228	
	B - RENTAL AND LEASE EXPENSES				
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	2,660,507	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	632,966	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
	TOTALS		0	3,293,473	
	C - OTHER CAPITAL COSTS				
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	188,763	1.00
2.00	CAP REL COSTS-BLDG & FIXT	1.00	0	1,819,730	2.00
3.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	22,482	3.00
	TOTALS		0	2,030,975	
	D - REPAIRS AND MAINTENANCE				
1.00	OPERATION OF PLANT	7.00	0	2,195,979	1.00
2.00		0.00	0	0	2.00
3.00		0.00	0	0	3.00
4.00		0.00	0	0	4.00
5.00		0.00	0	0	5.00
6.00		0.00	0	0	6.00
7.00		0.00	0	0	7.00
8.00		0.00	0	0	8.00
9.00		0.00	0	0	9.00
10.00		0.00	0	0	10.00
11.00		0.00	0	0	11.00
12.00		0.00	0	0	12.00
13.00		0.00	0	0	13.00
14.00		0.00	0	0	14.00
15.00		0.00	0	0	15.00
16.00		0.00	0	0	16.00
17.00		0.00	0	0	17.00
18.00		0.00	0	0	18.00
19.00		0.00	0	0	19.00
20.00		0.00	0	0	20.00
21.00		0.00	0	0	21.00
22.00		0.00	0	0	22.00
23.00		0.00	0	0	23.00
24.00		0.00	0	0	24.00
25.00		0.00	0	0	25.00
26.00		0.00	0	0	26.00
27.00		0.00	0	0	27.00
28.00		0.00	0	0	28.00
29.00		0.00	0	0	29.00
	TOTALS		0	2,195,979	
	E - CHIEF NURSING OFFICER COSTS				
1.00	NURSING ADMINISTRATION	13.00	297,890	0	1.00
	TOTALS		297,890	0	
	F - MEDICAL SUPPLIES				
1.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	1,529,833	1.00

RECLASSIFICATIONS | Provider CCN: 15-0006 | Period: From 01/01/2020 To 12/31/2020 | Worksheet A-6 | Date/Time Prepared: 8/2/2021 4:01 pm

	Increases					
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
2.00	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	4,402,270		2.00
	TOTALS		0	5,932,103		
	G - COST OF DRUGS/IV SOLUTIONS					
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	7,703,444		1.00
	TOTALS		0	7,703,444		
	H - LABOR AND DELIVERY COSTS					
1.00	ADULTS & PEDIATRICS	30.00	590,086	113,242		1.00
2.00	NURSERY	43.00	336,628	65,649		2.00
	TOTALS		926,714	178,891		
	I - CAFETERIA RECLASSIFICATION					
1.00	CAFETERIA	11.00	0	1,359,441		1.00
	TOTALS		0	1,359,441		
500.00	Grand Total: Increases		1,224,604	28,223,534		500.00

RECLASSIFICATIONS | Provider CCN: 15-0006 | Period: From 01/01/2020 To 12/31/2020 | Worksheet A-6 | Date/Time Prepared: 8/2/2021 4:01 pm

		Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	A - EMPLOYEE BENEFITS						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	5,524,645	0		1.00
2.00	PHYSICAL THERAPY	66.00	0	4,583	0		2.00
	TOTALS		0	5,529,228			
	B - RENTAL AND LEASE EXPENSES						
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	1,396	11		1.00
2.00	ADMINISTRATIVE & GENERAL	5.00	0	2,135,154	10		2.00
3.00	OPERATION OF PLANT	7.00	0	74,459	0		3.00
4.00	HOUSEKEEPING	9.00	0	953	0		4.00
5.00	DIETARY	10.00	0	954	0		5.00
6.00	NURSING ADMINISTRATION	13.00	0	21,104	0		6.00
7.00	CENTRAL SERVICES & SUPPLY	14.00	0	46,551	0		7.00
8.00	PHARMACY	15.00	0	247,811	0		8.00
9.00	MEDICAL RECORDS & LIBRARY	16.00	0	2,923	0		9.00
10.00	SOCIAL SERVICE	17.00	0	319	0		10.00
11.00	ADULTS & PEDIATRICS	30.00	0	48,087	0		11.00
12.00	INTENSIVE CARE UNIT	31.00	0	21,784	0		12.00
13.00	OPERATING ROOM	50.00	0	397,093	0		13.00
14.00	RECOVERY ROOM	51.00	0	729	0		14.00
15.00	DELIVERY ROOM & LABOR ROOM	52.00	0	1,858	0		15.00
16.00	RADIOLOGY-DIAGNOSTIC	54.00	0	102,826	0		16.00
17.00	CT SCAN	57.00	0	10,813	0		17.00
18.00	LABORATORY	60.00	0	23,412	0		18.00
19.00	RESPIRATORY THERAPY	65.00	0	72,402	0		19.00
20.00	PHYSICAL THERAPY	66.00	0	358	0		20.00
21.00	ELECTROCARDIOLOGY	69.00	0	71,188	0		21.00
22.00	SLEEP LAB	76.01	0	6,042	0		22.00
23.00	WOUND CARE	76.03	0	883	0		23.00
24.00	EMERGENCY	91.00	0	2,214	0		24.00
25.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	2,160	0		25.00
	TOTALS		0	3,293,473			
	C - OTHER CAPITAL COSTS						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	2,030,975	12		1.00
2.00		0.00	0	0	13		2.00
3.00		0.00	0	0	12		3.00
	TOTALS		0	2,030,975			
	D - REPAIRS AND MAINTENANCE						
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	134	0		1.00
2.00	ADMINISTRATIVE & GENERAL	5.00	0	143,462	0		2.00
3.00	HOUSEKEEPING	9.00	0	2,016	0		3.00
4.00	DIETARY	10.00	0	2,955	0		4.00
5.00	NURSING ADMINISTRATION	13.00	0	2,611	0		5.00
6.00	CENTRAL SERVICES & SUPPLY	14.00	0	120,726	0		6.00
7.00	PHARMACY	15.00	0	48,553	0		7.00
8.00	MEDICAL RECORDS & LIBRARY	16.00	0	291	0		8.00
9.00	ADULTS & PEDIATRICS	30.00	0	3,842	0		9.00
10.00	INTENSIVE CARE UNIT	31.00	0	15,978	0		10.00
11.00	OPERATING ROOM	50.00	0	460,233	0		11.00
12.00	RECOVERY ROOM	51.00	0	1,733	0		12.00
13.00	DELIVERY ROOM & LABOR ROOM	52.00	0	5,201	0		13.00
14.00	ANESTHESIOLOGY	53.00	0	12,766	0		14.00
15.00	RADIOLOGY-DIAGNOSTIC	54.00	0	424,429	0		15.00
16.00	ULTRASOUND	54.01	0	18,813	0		16.00
17.00	RADIOISOTOPE	56.00	0	6,701	0		17.00
18.00	CT SCAN	57.00	0	124,441	0		18.00
19.00	MRI	58.00	0	72,923	0		19.00
20.00	LABORATORY	60.00	0	131,900	0		20.00
21.00	RESPIRATORY THERAPY	65.00	0	7,868	0		21.00
22.00	PHYSICAL THERAPY	66.00	0	44,572	0		22.00
23.00	OCCUPATIONAL THERAPY	67.00	0	99	0		23.00
24.00	SPEECH PATHOLOGY	68.00	0	433	0		24.00
25.00	ELECTROCARDIOLOGY	69.00	0	481,522	0		25.00
26.00	SLEEP LAB	76.01	0	5,775	0		26.00
27.00	WOUND CARE	76.03	0	1,316	0		27.00
28.00	EMERGENCY	91.00	0	6,661	0		28.00
29.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	48,025	0		29.00
	TOTALS		0	2,195,979			
	E - CHIEF NURSING OFFICER COSTS						
1.00	ADMINISTRATIVE & GENERAL	5.00	297,890	0	0		1.00
	TOTALS		297,890	0			
	F - MEDICAL SUPPLIES						
1.00	CENTRAL SERVICES & SUPPLY	14.00	0	5,932,103	0		1.00
2.00		0.00	0	0	0		2.00
	TOTALS		0	5,932,103			

RECLASSIFICATIONS | Provider CCN: 15-0006 | Period: From 01/01/2020 To 12/31/2020 | Worksheet A-6 | Date/Time Prepared: 8/2/2021 4:01 pm

		Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	G - COST OF DRUGS/IV SOLUTIONS						
1.00	PHARMACY	15.00	0	7,703,444	0		1.00
	TOTALS		0	7,703,444			
	H - LABOR AND DELIVERY COSTS						
1.00	DELIVERY ROOM & LABOR ROOM	52.00	926,714	178,891	0		1.00
2.00		0.00	0	0	0		2.00
	TOTALS		926,714	178,891			
	I - CAFETERIA RECLASSIFICATION						
1.00	DIETARY	10.00	0	1,359,441	0		1.00
	TOTALS		0	1,359,441			
500.00	Grand Total: Decreases		1,224,604	28,223,534			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-0006 | Period: From 01/01/2020 To 12/31/2020 | Worksheet A-7 Part I | Date/Time Prepared: 8/2/2021 4:01 pm

		Beginning Balances	Acquisitions			Disposals and Retirements	
			Purchases	Donation	Total		
		1.00	2.00	3.00	4.00	5.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	5,512,164	0	0	0	0	1.00
2.00	Land Improvements	2,539,426	0	0	0	0	2.00
3.00	Buildings and Fixtures	50,571,156	186,497	0	186,497	0	3.00
4.00	Building Improvements	41,433,918	0	0	0	67,934	4.00
5.00	Fixed Equipment	26,146,830	0	0	0	0	5.00
6.00	Movable Equipment	88,097,333	64,123	0	64,123	11,480	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	214,300,827	250,620	0	250,620	79,414	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	214,300,827	250,620	0	250,620	79,414	10.00

		Ending Balance	Fully Depreciated Assets	
		6.00	7.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES			
1.00	Land	5,512,164	0	1.00
2.00	Land Improvements	2,539,426	0	2.00
3.00	Buildings and Fixtures	50,757,653	0	3.00
4.00	Building Improvements	41,365,984	0	4.00
5.00	Fixed Equipment	26,146,830	0	5.00
6.00	Movable Equipment	88,149,976	0	6.00
7.00	HIT designated Assets	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	214,472,033	0	8.00
9.00	Reconciling Items	0	0	9.00
10.00	Total (line 8 minus line 9)	214,472,033	0	10.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-0006 | Period: From 01/01/2020 To 12/31/2020 | Worksheet A-7 Part II | Date/Time Prepared: 8/2/2021 4:01 pm

	Cost Center Description	SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	CAP REL COSTS-BLDG & FIXT	2,353,222	0	0	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	8,798,782	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	11,152,004	0	0	0	0	3.00

	Cost Center Description	SUMMARY OF CAPITAL			
		Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)		
		14.00	15.00		
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2				
1.00	CAP REL COSTS-BLDG & FIXT	0	2,353,222		1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	8,798,782		2.00
3.00	Total (sum of lines 1-2)	0	11,152,004		3.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-0006 | Period: From 01/01/2020 To 12/31/2020 | Worksheet A-7 Part III Date/Time Prepared: 8/2/2021 4:01 pm

	Cost Center Description	COMPUTATION OF RATIOS: Gross Assets	COMPUTATION OF RATIOS: Capitalized Leases	COMPUTATION OF RATIOS: Gross Assets for Ratio (col. 1 - col. 2)	ALLOCATION OF OTHER CAPITAL: Ratio (see instructions)	ALLOCATION OF OTHER CAPITAL: Insurance	
		1.00	2.00	3.00	4.00	5.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	126,322,059	0	126,322,059	0.588991	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	88,149,976	0	88,149,976	0.411009	0	2.00
3.00	Total (sum of lines 1-2)	214,472,035	0	214,472,035	1.000000	0	3.00

	Cost Center Description	ALLOCATION OF OTHER CAPITAL: Taxes	ALLOCATION OF OTHER CAPITAL: Other Capital-Related Costs	ALLOCATION OF OTHER CAPITAL: Total (sum of cols. 5 through 7)	SUMMARY OF CAPITAL: Depreciation	SUMMARY OF CAPITAL: Lease	
		6.00	7.00	8.00	9.00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	498,897	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	8,054,456	579,722	2.00
3.00	Total (sum of lines 1-2)	0	0	0	8,553,353	579,722	3.00

	Cost Center Description	SUMMARY OF CAPITAL: Interest	SUMMARY OF CAPITAL: Insurance (see instructions)	SUMMARY OF CAPITAL: Taxes (see instructions)	SUMMARY OF CAPITAL: Other Capital-Related Costs (see instructions)	SUMMARY OF CAPITAL: Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	2,444,073	188,763	1,819,730	0	4,951,463	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	140,845	22,482	0	0	8,797,505	2.00
3.00	Total (sum of lines 1-2)	2,584,918	211,245	1,819,730	0	13,748,968	3.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 15-0006 | Period: From 01/01/2020 To 12/31/2020 | Worksheet A-8 | Date/Time Prepared: 8/2/2021 4:01 pm

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
1.00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)		0	CAP REL COSTS-BLDG & FIXT	1.00	0	1.00
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
3.00	Investment income - other (chapter 2)		0		0.00	0	3.00
4.00	Trade, quantity, and time discounts (chapter 8)		0		0.00	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)		0		0.00	0	5.00
6.00	Rental of provider space by suppliers (chapter 8)		0		0.00	0	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)	A	-1,243	ADMINISTRATIVE & GENERAL	5.00	0	7.00
8.00	Television and radio service (chapter 21)	A	-20,840	OPERATION OF PLANT	7.00	0	8.00
9.00	Parking lot (chapter 21)		0		0.00	0	9.00
10.00	Provider-based physician adjustment	A-8-2	-5,831,300			0	10.00
11.00	Sale of scrap, waste, etc. (chapter 23)	B	-967	RADIOLOGY-DIAGNOSTIC	54.00	0	11.00
12.00	Related organization transactions (chapter 10)	A-8-1	-7,343,271			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests		0		0.00	0	14.00
15.00	Rental of quarters to employee and others		0		0.00	0	15.00
16.00	Sale of medical and surgical supplies to other than patients	B	-38,817	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	16.00
17.00	Sale of drugs to other than patients	B	-19,417	DRUGS CHARGED TO PATIENTS	73.00	0	17.00
18.00	Sale of medical records and abstracts	B	-10,253	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		0		0.00	0	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	0	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	RESPIRATORY THERAPY	65.00		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	PHYSICAL THERAPY	66.00		24.00
25.00	Utilization review - physicians' compensation (chapter 21)		0	*** Cost Center Deleted ***	114.00		25.00
26.00	Depreciation - CAP REL COSTS-BLDG & FIXT	A	-1,854,325	CAP REL COSTS-BLDG & FIXT	1.00	9	26.00
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP	A	-744,326	CAP REL COSTS-MVBLE EQUIP	2.00	9	27.00
28.00	Non-physician Anesthetist		0	*** Cost Center Deleted ***	19.00		28.00
29.00	Physicians' assistant		0		0.00	0	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	OCCUPATIONAL THERAPY	67.00		30.00
30.99	Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS	30.00		30.99
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	SPEECH PATHOLOGY	68.00		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest		0		0.00	0	32.00
33.00	TRAINING REVENUE	B	-51,904	NURSING ADMINISTRATION	13.00	0	33.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 15-0006 | Period: From 01/01/2020 To 12/31/2020 | Worksheet A-8 | Date/Time Prepared: 8/2/2021 4:01 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	
34.00	TELEPHONE COMMISSION	B	-47,590	ADMINISTRATIVE & GENERAL	5.00	0	34.00
35.00	OTHER MISCELLANEOUS REVENUE	B	-25,848	ADMINISTRATIVE & GENERAL	5.00	0	35.00
36.00	RENTAL INCOME	B	-360,697	CAP REL COSTS-BLDG & FIXT	1.00	11	36.00
37.00	OTHER MISCELLANEOUS REVENUE	B	-40,081	ADMINISTRATIVE & GENERAL	5.00	0	37.00
38.00	TELEPHONE BENEFIT COST	A	-2,118	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	38.00
39.00	MARKETING DEPARTMENT	A	-452,220	ADMINISTRATIVE & GENERAL	5.00	0	39.00
41.00	MARKETING EXPENSE	A	-8,555	ADMINISTRATIVE & GENERAL	5.00	0	41.00
41.01	RECRUITING FEES - PT	A	-24,726	PHYSICAL THERAPY	66.00	0	41.01
41.02	RECRUITING FEES - OT	A	-34,429	OCCUPATIONAL THERAPY	67.00	0	41.02
41.03	RECRUITING FEES - A & G	A	-56,842	ADMINISTRATIVE & GENERAL	5.00	0	41.03
41.04	RECRUITING FEES - PERSONNEL	A	-1,583	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	41.04
42.00	CHARITABLE CONTRIBUTIONS	A	-35,240	ADMINISTRATIVE & GENERAL	5.00	0	42.00
45.00	ALLOCATED RENT EXPENSE	A	1,854,909	PHYSICIANS' PRIVATE OFFICES	192.00	0	45.00
45.01	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	45.01
45.02	MEMBERSHIP DUES	A	-100,594	ADMINISTRATIVE & GENERAL	5.00	0	45.02
45.04	ACCREDIDATION FEES	A	-10,000	ADMINISTRATIVE & GENERAL	5.00	0	45.04
45.05	DEFERED PHYSICIAN RECRUITING	A	-144,319	ADMINISTRATIVE & GENERAL	5.00	0	45.05
45.09	TELEPHONE DEPRECIATION	A	-893	CAP REL COSTS-MVBLE EQUIP	2.00	10	45.09
45.10	TELEVISION DEPRECIATION	A	-52,351	CAP REL COSTS-MVBLE EQUIP	2.00	10	45.10
45.12	MOB AUTO INSURANCE	A	386	PHYSICIANS' PRIVATE OFFICES	192.00	0	45.12
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-15,459,454				50.00

(1) Description - all chapter references in this column pertain to CMS Pub. 15-1.
(2) Basis for adjustment (see instructions).
A. Costs - if cost, including applicable overhead, can be determined.
B. Amount Received - if cost cannot be determined.
(3) Additional adjustments may be made on lines 33 thru 49 and subscripts thereof.
Note: See instructions for column 5 referencing to Worksheet A-7.

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS | Provider CCN: 15-0006 | Period: From 01/01/2020 To 12/31/2020 | Worksheet A-8-1 | Date/Time Prepared: 8/2/2021 4:01 pm

	Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in Wks. A, column 5	
	1.00	2.00	3.00	4.00	5.00	
	A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:					
1.00	1.00	CAP REL COSTS-BLDG & FIXT	PASI CAPITAL COSTS - BLDG &	15,292	0	1.00
2.00	2.00	CAP REL COSTS-MVBLE EQUIP	PASI CAPITAL COSTS - MOVEABL	1,896	0	2.00
3.00	5.00	ADMINISTRATIVE & GENERAL	PASI OPERATING COSTS	429,990	0	3.00
4.00	5.00	ADMINISTRATIVE & GENERAL	SHARED SERVICE CENTER ALLOCA	2,475,567	1,527,132	4.00
4.01	1.00	CAP REL COSTS-BLDG & FIXT	NEW CAPITAL - BUILDING & FIX	128,971	0	4.01
4.02	2.00	CAP REL COSTS-MVBLE EQUIP	NEW CAPITAL - MOVABLE EQUIPM	138,949	0	4.02
4.03	5.00	ADMINISTRATIVE & GENERAL	NON-CAPITAL HOME OFFICE COST	3,928,838	0	4.03
4.04	5.00	ADMINISTRATIVE & GENERAL	MALPRACTICE COSTS	467,242	870,762	4.04
4.05	5.00	ADMINISTRATIVE & GENERAL	INTEREST EXPENSE	0	5,909,110	4.05
4.06	5.00	ADMINISTRATIVE & GENERAL	MANAGEMENT FEES	0	3,169,917	4.06
4.07	5.00	ADMINISTRATIVE & GENERAL	401K FEES	0	6,756	4.07
4.08	5.00	ADMINISTRATIVE & GENERAL	AUDIT FEES	0	124,173	4.08
4.09	5.00	ADMINISTRATIVE & GENERAL	CORPORATE OVERHEAD ALLOCATIO	0	2,497,975	4.09
4.10	5.00	ADMINISTRATIVE & GENERAL	HIIM ALLOCATION	0	390,968	4.10
4.11	5.00	ADMINISTRATIVE & GENERAL	CONTRACT MANAGEMENT	0	18,000	4.11
4.12	5.00	ADMINISTRATIVE & GENERAL	PASI LIEN UNIT COLLECTION FE	0	1,758	4.12
4.13	5.00	ADMINISTRATIVE & GENERAL	PASI COLLECTION FEES	0	413,465	4.13
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.			7,586,745	14,930,016	5.00

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

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

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

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

6.00	B		0.00	CHS	100.00	6.00
7.00	B		0.00	PASI	100.00	7.00
8.00			0.00		0.00	8.00
9.00			0.00		0.00	9.00
10.00			0.00		0.00	10.00
100.00	G. Other (financial or non-financial) specify:					100.00

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

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

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS | Provider CCN: 15-0006 | Period: From 01/01/2020 To 12/31/2020 | Worksheet A-8-1 | Date/Time Prepared: 8/2/2021 4:01 pm

	Net Adjustments (col. 4 minus col. 5)*	Wkst. A-7 Ref.		
	6.00	7.00		
	A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:			
1.00	15,292	11		1.00
2.00	1,896	11		2.00
3.00	429,990	0		3.00
4.00	948,435	0		4.00
4.01	128,971	11		4.01
4.02	138,949	11		4.02
4.03	3,928,838	0		4.03
4.04	-403,520	0		4.04
4.05	-5,909,110	0		4.05
4.06	-3,169,917	0		4.06
4.07	-6,756	0		4.07
4.08	-124,173	0		4.08
4.09	-2,497,975	0		4.09
4.10	-390,968	0		4.10
4.11	-18,000	0		4.11
4.12	-1,758	0		4.12
4.13	-413,465	0		4.13
5.00	-7,343,271			5.00

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

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

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

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

6.00	HEALTHCARE		6.00
7.00	COLLECTION UNIT		7.00
8.00			8.00
9.00			9.00
10.00			10.00
100.00			100.00

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

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

PROVIDER BASED PHYSICIAN ADJUSTMENT | Provider CCN: 15-0006 | Period: From 01/01/2020 To 12/31/2020 | Worksheet A-8-2 | Date/Time Prepared: 8/2/2021 4:01 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	5.00	ADMINISTRATIVE & GENERAL	296,570	296,570	0	0	211,500	1.00
2.00	31.00	INTENSIVE CARE UNIT	682,792	682,792	0	0	211,500	2.00
3.00	50.00	OPERATING ROOM	207,608	207,608	0	0	211,500	3.00
4.00	52.00	DELIVERY ROOM & LABOR ROOM	42,719	42,719	0	0	211,500	4.00
5.00	90.00	CLINIC	4,441,678	4,441,678	0	0	211,500	5.00
6.00	91.00	EMERGENCY	159,933	159,933	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			5,831,300	5,831,300	0		1,057,500	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	5.00	ADMINISTRATIVE & GENERAL	0	0	0	0	0	1.00
2.00	31.00	INTENSIVE CARE UNIT	0	0	0	0	0	2.00
3.00	50.00	OPERATING ROOM	0	0	0	0	0	3.00
4.00	52.00	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	4.00
5.00	90.00	CLINIC	0	0	0	0	0	5.00
6.00	91.00	EMERGENCY	0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			0	0	0	0	0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment		
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00	5.00	ADMINISTRATIVE & GENERAL	0	0	0	296,570		1.00
2.00	31.00	INTENSIVE CARE UNIT	0	0	0	682,792		2.00
3.00	50.00	OPERATING ROOM	0	0	0	207,608		3.00
4.00	52.00	DELIVERY ROOM & LABOR ROOM	0	0	0	42,719		4.00
5.00	90.00	CLINIC	0	0	0	4,441,678		5.00
6.00	91.00	EMERGENCY	0	0	0	159,933		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	5,831,300		200.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-0006 | Period: From 01/01/2020 To 12/31/2020 | Worksheet B Part I Date/Time Prepared: 8/2/2021 4:01 pm

		Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS BLDG & FIXT	CAPITAL RELATED COSTS MVBLE EQUIP	EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
			0	1.00	2.00	4.00	4A	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	4,951,463	4,951,463				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	8,797,505		8,797,505			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	5,888,155	40,569	72,080	6,000,804		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	28,870,718	521,101	925,865	1,203,601	31,521,285	5.00
7.00	00700	OPERATION OF PLANT	6,316,960	1,956,569	3,476,334	150,848	11,900,711	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	417,897	4,903	8,711	0	431,511	8.00
9.00	00900	HOUSEKEEPING	1,721,715	83,116	147,677	0	1,952,508	9.00
10.00	01000	DIETARY	862,132	81,849	145,425	0	1,089,406	10.00
11.00	01100	CAFETERIA	1,359,441	72,732	129,227	0	1,561,400	11.00
13.00	01300	NURSING ADMINISTRATION	2,135,642	22,458	39,902	302,531	2,500,533	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	1,078,104	35,566	63,191	74,836	1,251,697	14.00
15.00	01500	PHARMACY	1,524,586	34,487	61,275	193,302	1,813,650	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,049,861	38,034	67,577	65,070	1,220,542	16.00
17.00	01700	SOCIAL SERVICE	491,163	16,332	29,018	63,520	600,033	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	9,010,519	300,647	534,173	917,427	10,762,766	30.00
31.00	03100	INTENSIVE CARE UNIT	2,786,553	137,582	244,449	337,396	3,505,980	31.00
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	0	40.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
43.00	04300	NURSERY	402,277	12,941	22,993	51,231	489,442	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	4,441,174	413,270	734,276	284,398	5,873,118	50.00
51.00	05100	RECOVERY ROOM	1,456,198	0	0	186,370	1,642,568	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	599,806	178,840	317,754	82,726	1,179,126	52.00
53.00	05300	ANESTHESIOLOGY	1,892,619	0	0	7,340	1,899,959	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,297,075	132,424	235,284	282,649	2,947,432	54.00
54.01	05401	ULTRASOUND	392,048	8,883	15,783	53,473	470,187	54.01
56.00	05600	RADIOISOTOPE	528,120	0	0	42,846	570,966	56.00
57.00	05700	CT SCAN	599,610	21,880	38,875	76,956	737,321	57.00
58.00	05800	MRI	226,646	94,723	168,300	30,102	519,771	58.00
60.00	06000	LABORATORY	4,738,242	68,597	121,879	332,599	5,261,317	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	15,887	28,228	0	44,115	62.00
65.00	06500	RESPIRATORY THERAPY	1,009,608	25,860	45,947	132,002	1,213,417	65.00
66.00	06600	PHYSICAL THERAPY	1,875,863	350,332	622,452	252,787	3,101,434	66.00
67.00	06700	OCCUPATIONAL THERAPY	591,410	3,825	6,795	81,551	683,581	67.00
68.00	06800	SPEECH PATHOLOGY	578,692	2,257	4,010	78,554	663,513	68.00
69.00	06900	ELECTROCARDIOLOGY	3,525,105	154,504	274,514	361,950	4,316,073	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1,491,016	0	0	0	1,491,016	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	4,402,270	0	0	0	4,402,270	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	7,684,027	0	0	0	7,684,027	73.00
74.00	07400	RENAL DIALYSIS	320,819	0	0	0	320,819	74.00
76.00	03950	OTHER ANCILLARY-OTHER	0	0	0	0	0	76.00
76.01	03610	SLEEP LAB	305,442	0	0	38,752	344,194	76.01
76.02	03020	ACUPUNCTURE	0	0	0	0	0	76.02
76.03	03040	WOUND CARE	802,365	0	0	1,668	804,033	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	2,353,513	111,367	197,871	282,363	2,945,114	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	119,776,359	4,941,535	8,779,865	5,968,848	119,716,835	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	9,928	17,640	0	27,568	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	1,039,734	0	0	19,964	1,059,698	192.00
194.00	07950	OTHER NONREIMBURSABLE COSTS	85,218	0	0	11,992	97,210	194.00
194.01	07951	MARKETING	0	0	0	0	0	194.01
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)	120,901,311	4,951,463	8,797,505	6,000,804	120,901,311	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-0006 | Period: From 01/01/2020 To 12/31/2020 | Worksheet B Part I Date/Time Prepared: 8/2/2021 4:01 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	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	31,521,285					5.00
7.00	00700	OPERATION OF PLANT	4,196,963	16,097,674				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	152,179	32,437	616,127			8.00
9.00	00900	HOUSEKEEPING	688,583	549,880	0	3,190,971		9.00
10.00	01000	DIETARY	384,196	541,495	0	111,367	2,126,464	10.00
11.00	01100	CAFETERIA	550,653	481,182	0	98,962	0	11.00
13.00	01300	NURSING ADMINISTRATION	881,853	148,576	0	30,557	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	441,431	235,295	0	48,392	0	14.00
15.00	01500	PHARMACY	639,613	228,161	0	46,925	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	430,444	251,624	0	51,750	0	16.00
17.00	01700	SOCIAL SERVICE	211,611	108,049	0	22,222	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	3,795,662	1,989,013	246,067	409,071	1,295,903	30.00
31.00	03100	INTENSIVE CARE UNIT	1,236,440	910,215	50,260	187,200	167,405	31.00
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	0	40.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
43.00	04300	NURSERY	172,610	85,615	0	17,608	0	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,071,249	2,734,100	66,981	562,308	0	50.00
51.00	05100	RECOVERY ROOM	579,278	0	29,293	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	415,838	1,183,169	8,642	243,337	0	52.00
53.00	05300	ANESTHESIOLOGY	670,051	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,039,459	876,086	63,687	180,181	0	54.00
54.01	05401	ULTRASOUND	165,819	58,769	0	12,087	0	54.01
56.00	05600	RADIOISOTOPE	201,360	0	0	0	0	56.00
57.00	05700	CT SCAN	260,028	144,752	0	29,770	0	57.00
58.00	05800	MRI	183,306	626,669	0	128,884	0	58.00
60.00	06000	LABORATORY	1,855,488	453,820	5,897	93,335	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	15,558	105,107	0	21,617	0	62.00
65.00	06500	RESPIRATORY THERAPY	427,931	171,084	0	35,186	0	65.00
66.00	06600	PHYSICAL THERAPY	1,093,770	2,317,720	0	476,675	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	241,076	25,302	0	5,204	0	67.00
68.00	06800	SPEECH PATHOLOGY	233,998	14,931	0	3,071	0	68.00
69.00	06900	ELECTROCARDIOLOGY	1,522,132	1,022,162	23,787	210,223	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	525,831	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1,552,531	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,709,895	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	113,142	0	0	0	0	74.00
76.00	03950	OTHER ANCILLARY-OTHER	0	0	0	0	0	76.00
76.01	03610	SLEEP LAB	121,386	0	394	0	0	76.01
76.02	03020	ACUPUNCTURE	0	0	0	0	0	76.02
76.03	03040	WOUND CARE	283,555	0	0	0	0	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	1,038,642	736,778	121,119	151,530	78,961	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	31,103,561	16,031,991	616,127	3,177,462	1,542,269	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	9,722	65,683	0	13,509	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	373,719	0	0	0	584,195	192.00
194.00	07950	OTHER NONREIMBURSABLE COSTS	34,283	0	0	0	0	194.00
194.01	07951	MARKETING	0	0	0	0	0	194.01
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)	31,521,285	16,097,674	616,127	3,190,971	2,126,464	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-0006 | Period: From 01/01/2020 To 12/31/2020 | Worksheet B Part I Date/Time Prepared: 8/2/2021 4:01 pm

		Cost Center Description	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
			11.00	13.00	14.00	15.00	16.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA	2,692,197					11.00
13.00	01300	NURSING ADMINISTRATION	137,231	3,698,750				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	68,833	0	2,045,648			14.00
15.00	01500	PHARMACY	99,239	0	0	2,827,588		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	52,231	0	1,465	0	2,008,056	16.00
17.00	01700	SOCIAL SERVICE	37,867	0	271	0	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	591,889	1,330,270	77,869	0	152,043	30.00
31.00	03100	INTENSIVE CARE UNIT	166,455	553,342	58,396	0	44,283	31.00
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	0	40.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
43.00	04300	NURSERY	27,546	0	0	0	6,326	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	179,886	296,440	180,945	0	298,995	50.00
51.00	05100	RECOVERY ROOM	96,254	327,013	23,603	0	45,914	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	44,459	354,312	21,909	0	10,216	52.00
53.00	05300	ANESTHESIOLOGY	6,964	0	25,582	0	67,837	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	149,107	108,873	17,425	0	29,687	54.00
54.01	05401	ULTRASOUND	21,763	259	2,620	0	21,947	54.01
56.00	05600	RADIOISOTOPE	18,530	0	34,768	0	33,335	56.00
57.00	05700	CT SCAN	46,510	1,326	9,627	0	90,689	57.00
58.00	05800	MRI	14,674	0	1,704	0	30,711	58.00
60.00	06000	LABORATORY	275,643	0	332,544	0	246,317	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0	0	1,864	62.00
65.00	06500	RESPIRATORY THERAPY	82,637	0	11,876	0	31,835	65.00
66.00	06600	PHYSICAL THERAPY	111,799	0	2,843	0	42,339	66.00
67.00	06700	OCCUPATIONAL THERAPY	43,775	0	412	0	19,201	67.00
68.00	06800	SPEECH PATHOLOGY	41,225	0	426	0	12,225	68.00
69.00	06900	ELECTROCARDIOLOGY	186,353	246,958	60,330	0	171,915	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	276,864	0	51,760	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	838,299	0	101,436	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	2,827,588	344,808	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	9,655	74.00
76.00	03950	OTHER ANCILLARY-OTHER	0	0	0	0	0	76.00
76.01	03610	SLEEP LAB	23,877	0	3,887	0	11,798	76.01
76.02	03020	ACUPUNCTURE	0	0	0	0	0	76.02
76.03	03040	WOUND CARE	1,554	282	15,794	0	16,380	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	147,428	444,376	45,653	0	114,540	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	2,673,729	3,663,451	2,045,112	2,827,588	2,008,056	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	10,322	35,299	536	0	0	192.00
194.00	07950	OTHER NONREIMBURSABLE COSTS	8,146	0	0	0	0	194.00
194.01	07951	MARKETING	0	0	0	0	0	194.01
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	2,692,197	3,698,750	2,045,648	2,827,588	2,008,056	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-0006 | Period: From 01/01/2020 To 12/31/2020 | Worksheet B Part I | Date/Time Prepared: 8/2/2021 4:01 pm

		Cost Center Description	SOCIAL SERVICE	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			17.00	24.00	25.00	26.00		
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY						15.00
16.00	01600	MEDICAL RECORDS & LIBRARY						16.00
17.00	01700	SOCIAL SERVICE	980,053					17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	775,693	21,426,246	0	21,426,246		30.00
31.00	03100	INTENSIVE CARE UNIT	147,860	7,027,836	0	7,027,836		31.00
40.00	04000	SUBPROVIDER - IPF	0	0	0	0		40.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0		41.00
43.00	04300	NURSERY	56,500	855,647	0	855,647		43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0		44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	12,264,022	0	12,264,022		50.00
51.00	05100	RECOVERY ROOM	0	2,743,923	0	2,743,923		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	3,461,008	0	3,461,008		52.00
53.00	05300	ANESTHESIOLOGY	0	2,670,393	0	2,670,393		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	5,411,937	0	5,411,937		54.00
54.01	05401	ULTRASOUND	0	753,451	0	753,451		54.01
56.00	05600	RADIOISOTOPE	0	858,959	0	858,959		56.00
57.00	05700	CT SCAN	0	1,320,023	0	1,320,023		57.00
58.00	05800	MRI	0	1,505,719	0	1,505,719		58.00
60.00	06000	LABORATORY	0	8,524,361	0	8,524,361		60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	188,261	0	188,261		62.00
65.00	06500	RESPIRATORY THERAPY	0	1,973,966	0	1,973,966		65.00
66.00	06600	PHYSICAL THERAPY	0	7,146,580	0	7,146,580		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	1,018,551	0	1,018,551		67.00
68.00	06800	SPEECH PATHOLOGY	0	969,389	0	969,389		68.00
69.00	06900	ELECTROCARDIOLOGY	0	7,759,933	0	7,759,933		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	2,345,471	0	2,345,471		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	6,894,536	0	6,894,536		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	13,566,318	0	13,566,318		73.00
74.00	07400	RENAL DIALYSIS	0	443,616	0	443,616		74.00
76.00	03950	OTHER ANCILLARY-OTHER	0	0	0	0		76.00
76.01	03610	SLEEP LAB	0	505,536	0	505,536		76.01
76.02	03020	ACUPUNCTURE	0	0	0	0		76.02
76.03	03040	WOUND CARE	0	1,121,598	0	1,121,598		76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0		90.00
91.00	09100	EMERGENCY	0	5,824,141	0	5,824,141		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART			0			92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0		95.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	980,053	118,581,421	0	118,581,421		118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	116,482	0	116,482		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	2,063,769	0	2,063,769		192.00
194.00	07950	OTHER NONREIMBURSABLE COSTS	0	139,639	0	139,639		194.00
194.01	07951	MARKETING	0	0	0	0		194.01
200.00		Cross Foot Adjustments		0	0	0		200.00
201.00		Negative Cost Centers	0	0	0	0		201.00
202.00		TOTAL (sum lines 118 through 201)	980,053	120,901,311	0	120,901,311		202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-0006 | Period: From 01/01/2020 To 12/31/2020 | Worksheet B Part II Date/Time Prepared: 8/2/2021 4:01 pm

		Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS BLDG & FIXT	CAPITAL RELATED COSTS MVBLE EQUIP	Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
			0	1.00	2.00	2A	4.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	40,569	72,080	112,649	112,649	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	0	521,101	925,865	1,446,966	22,591	5.00
7.00	00700	OPERATION OF PLANT	0	1,956,569	3,476,334	5,432,903	2,832	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	4,903	8,711	13,614	0	8.00
9.00	00900	HOUSEKEEPING	0	83,116	147,677	230,793	0	9.00
10.00	01000	DIETARY	0	81,849	145,425	227,274	0	10.00
11.00	01100	CAFETERIA	0	72,732	129,227	201,959	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	22,458	39,902	62,360	5,679	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	35,566	63,191	98,757	1,405	14.00
15.00	01500	PHARMACY	0	34,487	61,275	95,762	3,629	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	38,034	67,577	105,611	1,222	16.00
17.00	01700	SOCIAL SERVICE	0	16,332	29,018	45,350	1,192	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	300,647	534,173	834,820	17,223	30.00
31.00	03100	INTENSIVE CARE UNIT	0	137,582	244,449	382,031	6,334	31.00
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	0	40.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
43.00	04300	NURSERY	0	12,941	22,993	35,934	962	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	413,270	734,276	1,147,546	5,339	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	3,499	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	178,840	317,754	496,594	1,553	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	138	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	132,424	235,284	367,708	5,306	54.00
54.01	05401	ULTRASOUND	0	8,883	15,783	24,666	1,004	54.01
56.00	05600	RADIOISOTOPE	0	0	0	0	804	56.00
57.00	05700	CT SCAN	0	21,880	38,875	60,755	1,445	57.00
58.00	05800	MRI	0	94,723	168,300	263,023	565	58.00
60.00	06000	LABORATORY	0	68,597	121,879	190,476	6,244	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	15,887	28,228	44,115	0	62.00
65.00	06500	RESPIRATORY THERAPY	0	25,860	45,947	71,807	2,478	65.00
66.00	06600	PHYSICAL THERAPY	0	350,332	622,452	972,784	4,745	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	3,825	6,795	10,620	1,531	67.00
68.00	06800	SPEECH PATHOLOGY	0	2,257	4,010	6,267	1,475	68.00
69.00	06900	ELECTROCARDIOLOGY	0	154,504	274,514	429,018	6,795	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.00	03950	OTHER ANCILLARY-OTHER	0	0	0	0	0	76.00
76.01	03610	SLEEP LAB	0	0	0	0	727	76.01
76.02	03020	ACUPUNCTURE	0	0	0	0	0	76.02
76.03	03040	WOUND CARE	0	0	0	0	31	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	111,367	197,871	309,238	5,301	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				0		92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	4,941,535	8,779,865	13,721,400	112,049	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	9,928	17,640	27,568	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	375	192.00
194.00	07950	OTHER NONREIMBURSABLE COSTS	0	0	0	0	225	194.00
194.01	07951	MARKETING	0	0	0	0	0	194.01
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	4,951,463	8,797,505	13,748,968	112,649	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-0006 | Period: From 01/01/2020 To 12/31/2020 | Worksheet B Part II Date/Time Prepared: 8/2/2021 4:01 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	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	1,469,557					5.00
7.00	00700	OPERATION OF PLANT	195,643	5,631,378				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	7,095	11,347	32,056			8.00
9.00	00900	HOUSEKEEPING	32,103	192,362	0	455,258		9.00
10.00	01000	DIETARY	17,912	189,429	0	15,889	450,504	10.00
11.00	01100	CAFETERIA	25,673	168,330	0	14,119	0	11.00
13.00	01300	NURSING ADMINISTRATION	41,114	51,976	0	4,360	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	20,580	82,312	0	6,904	0	14.00
15.00	01500	PHARMACY	29,820	79,816	0	6,695	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	20,068	88,024	0	7,383	0	16.00
17.00	01700	SOCIAL SERVICE	9,866	37,798	0	3,170	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	176,961	695,807	12,801	58,362	274,545	30.00
31.00	03100	INTENSIVE CARE UNIT	57,645	318,416	2,615	26,708	35,466	31.00
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	0	40.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
43.00	04300	NURSERY	8,047	29,950	0	2,512	0	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	96,566	956,462	3,485	80,228	0	50.00
51.00	05100	RECOVERY ROOM	27,007	0	1,524	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	19,387	413,903	450	34,717	0	52.00
53.00	05300	ANESTHESIOLOGY	31,239	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	48,462	306,477	3,314	25,706	0	54.00
54.01	05401	ULTRASOUND	7,731	20,559	0	1,724	0	54.01
56.00	05600	RADIOISOTOPE	9,388	0	0	0	0	56.00
57.00	05700	CT SCAN	12,123	50,638	0	4,247	0	57.00
58.00	05800	MRI	8,546	219,225	0	18,388	0	58.00
60.00	06000	LABORATORY	86,507	158,758	307	13,316	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	725	36,769	0	3,084	0	62.00
65.00	06500	RESPIRATORY THERAPY	19,951	59,849	0	5,020	0	65.00
66.00	06600	PHYSICAL THERAPY	50,994	810,798	0	68,007	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	11,239	8,851	0	742	0	67.00
68.00	06800	SPEECH PATHOLOGY	10,909	5,223	0	438	0	68.00
69.00	06900	ELECTROCARDIOLOGY	70,965	357,578	1,238	29,993	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	24,515	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	72,382	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	126,341	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	5,275	0	0	0	0	74.00
76.00	03950	OTHER ANCILLARY-OTHER	0	0	0	0	0	76.00
76.01	03610	SLEEP LAB	5,659	0	20	0	0	76.01
76.02	03020	ACUPUNCTURE	0	0	0	0	0	76.02
76.03	03040	WOUND CARE	13,220	0	0	0	0	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	48,424	257,744	6,302	21,619	16,728	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	1,450,082	5,608,401	32,056	453,331	326,739	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	453	22,977	0	1,927	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	17,424	0	0	0	123,765	192.00
194.00	07950	OTHER NONREIMBURSABLE COSTS	1,598	0	0	0	0	194.00
194.01	07951	MARKETING	0	0	0	0	0	194.01
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)	1,469,557	5,631,378	32,056	455,258	450,504	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-0006 | Period: From 01/01/2020 To 12/31/2020 | Worksheet B Part II | Date/Time Prepared: 8/2/2021 4:01 pm

		Cost Center Description	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
			11.00	13.00	14.00	15.00	16.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA	410,081					11.00
13.00	01300	NURSING ADMINISTRATION	20,903	186,392				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	10,485	0	220,443			14.00
15.00	01500	PHARMACY	15,116	0	0	230,838		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	7,956	0	158	0	230,422	16.00
17.00	01700	SOCIAL SERVICE	5,768	0	29	0	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	90,157	67,040	8,391	0	17,436	30.00
31.00	03100	INTENSIVE CARE UNIT	25,355	27,884	6,293	0	5,078	31.00
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	0	40.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
43.00	04300	NURSERY	4,196	0	0	0	726	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	27,401	14,938	19,499	0	34,289	50.00
51.00	05100	RECOVERY ROOM	14,662	16,479	2,543	0	5,265	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	6,772	17,854	2,361	0	1,172	52.00
53.00	05300	ANESTHESIOLOGY	1,061	0	2,757	0	7,780	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	22,712	5,486	1,878	0	3,405	54.00
54.01	05401	ULTRASOUND	3,315	13	282	0	2,517	54.01
56.00	05600	RADIOISOTOPE	2,822	0	3,747	0	3,823	56.00
57.00	05700	CT SCAN	7,085	67	1,037	0	10,400	57.00
58.00	05800	MRI	2,235	0	184	0	3,522	58.00
60.00	06000	LABORATORY	41,986	0	35,835	0	28,248	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0	0	214	62.00
65.00	06500	RESPIRATORY THERAPY	12,587	0	1,280	0	3,651	65.00
66.00	06600	PHYSICAL THERAPY	17,029	0	306	0	4,855	66.00
67.00	06700	OCCUPATIONAL THERAPY	6,668	0	44	0	2,202	67.00
68.00	06800	SPEECH PATHOLOGY	6,280	0	46	0	1,402	68.00
69.00	06900	ELECTROCARDIOLOGY	28,386	12,445	6,501	0	19,715	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	29,835	0	5,936	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	90,338	0	11,633	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	230,838	39,679	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	1,107	74.00
76.00	03950	OTHER ANCILLARY-OTHER	0	0	0	0	0	76.00
76.01	03610	SLEEP LAB	3,637	0	419	0	1,353	76.01
76.02	03020	ACUPUNCTURE	0	0	0	0	0	76.02
76.03	03040	WOUND CARE	237	14	1,702	0	1,878	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	22,457	22,393	4,920	0	13,136	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	407,268	184,613	220,385	230,838	230,422	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	1,572	1,779	58	0	0	192.00
194.00	07950	OTHER NONREIMBURSABLE COSTS	1,241	0	0	0	0	194.00
194.01	07951	MARKETING	0	0	0	0	0	194.01
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)	410,081	186,392	220,443	230,838	230,422	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-0006 | Period: From 01/01/2020 To 12/31/2020 | Worksheet B Part II | Date/Time Prepared: 8/2/2021 4:01 pm

		Cost Center Description	SOCIAL SERVICE	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			17.00	24.00	25.00	26.00		
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY						15.00
16.00	01600	MEDICAL RECORDS & LIBRARY						16.00
17.00	01700	SOCIAL SERVICE	103,173					17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	81,659	2,335,202	0	2,335,202		30.00
31.00	03100	INTENSIVE CARE UNIT	15,566	909,391	0	909,391		31.00
40.00	04000	SUBPROVIDER - IPF	0	0	0	0		40.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0		41.00
43.00	04300	NURSERY	5,948	88,275	0	88,275		43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0		44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	2,385,753	0	2,385,753		50.00
51.00	05100	RECOVERY ROOM	0	70,979	0	70,979		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	994,763	0	994,763		52.00
53.00	05300	ANESTHESIOLOGY	0	42,975	0	42,975		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	790,454	0	790,454		54.00
54.01	05401	ULTRASOUND	0	61,811	0	61,811		54.01
56.00	05600	RADIOISOTOPE	0	20,584	0	20,584		56.00
57.00	05700	CT SCAN	0	147,797	0	147,797		57.00
58.00	05800	MRI	0	515,688	0	515,688		58.00
60.00	06000	LABORATORY	0	561,677	0	561,677		60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	84,907	0	84,907		62.00
65.00	06500	RESPIRATORY THERAPY	0	176,623	0	176,623		65.00
66.00	06600	PHYSICAL THERAPY	0	1,929,518	0	1,929,518		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	41,897	0	41,897		67.00
68.00	06800	SPEECH PATHOLOGY	0	32,040	0	32,040		68.00
69.00	06900	ELECTROCARDIOLOGY	0	962,634	0	962,634		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	60,286	0	60,286		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	174,353	0	174,353		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	396,858	0	396,858		73.00
74.00	07400	RENAL DIALYSIS	0	6,382	0	6,382		74.00
76.00	03950	OTHER ANCILLARY-OTHER	0	0	0	0		76.00
76.01	03610	SLEEP LAB	0	11,815	0	11,815		76.01
76.02	03020	ACUPUNCTURE	0	0	0	0		76.02
76.03	03040	WOUND CARE	0	17,082	0	17,082		76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0		90.00
91.00	09100	EMERGENCY	0	728,262	0	728,262		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART			0			92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0		95.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	103,173	13,548,006	0	13,548,006		118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	52,925	0	52,925		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	144,973	0	144,973		192.00
194.00	07950	OTHER NONREIMBURSABLE COSTS	0	3,064	0	3,064		194.00
194.01	07951	MARKETING	0	0	0	0		194.01
200.00		Cross Foot Adjustments		0	0	0		200.00
201.00		Negative Cost Centers	0	0	0	0		201.00
202.00		TOTAL (sum lines 118 through 201)	103,173	13,748,968	0	13,748,968		202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-0006 | Period: From 01/01/2020 To 12/31/2020 | Worksheet B-1 | Date/Time Prepared: 8/2/2021 4:01 pm

		Cost Center Description	CAPITAL RELATED COSTS BLDG & FIXT (SQUARE FEET)	CAPITAL RELATED COSTS MVBLE EQUIP (SQUARE FEET)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
			1.00	2.00	4.00	5A	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	445,365					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		445,365				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	3,649	3,649	39,429,848			4.00
5.00	00500	ADMINISTRATIVE & GENERAL	46,871	46,871	7,908,496	-31,521,285	89,380,026	5.00
7.00	00700	OPERATION OF PLANT	175,986	175,986	991,188	0	11,900,711	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	441	441	0	0	431,511	8.00
9.00	00900	HOUSEKEEPING	7,476	7,476	0	0	1,952,508	9.00
10.00	01000	DIETARY	7,362	7,362	0	0	1,089,406	10.00
11.00	01100	CAFETERIA	6,542	6,542	0	0	1,561,400	11.00
13.00	01300	NURSING ADMINISTRATION	2,020	2,020	1,987,861	0	2,500,533	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	3,199	3,199	491,730	0	1,251,697	14.00
15.00	01500	PHARMACY	3,102	3,102	1,270,144	0	1,813,650	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	3,421	3,421	427,563	0	1,220,542	16.00
17.00	01700	SOCIAL SERVICE	1,469	1,469	417,376	0	600,033	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	27,042	27,042	6,028,208	0	10,762,766	30.00
31.00	03100	INTENSIVE CARE UNIT	12,375	12,375	2,216,957	0	3,505,980	31.00
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	0	40.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
43.00	04300	NURSERY	1,164	1,164	336,628	0	489,442	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	37,172	37,172	1,868,715	0	5,873,118	50.00
51.00	05100	RECOVERY ROOM	0	0	1,224,595	0	1,642,568	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	16,086	16,086	543,576	0	1,179,126	52.00
53.00	05300	ANESTHESIOLOGY	0	0	48,230	0	1,899,959	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	11,911	11,911	1,857,226	0	2,947,432	54.00
54.01	05401	ULTRASOUND	799	799	351,359	0	470,187	54.01
56.00	05600	RADIOISOTOPE	0	0	281,530	0	570,966	56.00
57.00	05700	CT SCAN	1,968	1,968	505,663	0	737,321	57.00
58.00	05800	MRI	8,520	8,520	197,791	0	519,771	58.00
60.00	06000	LABORATORY	6,170	6,170	2,185,436	0	5,261,317	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	1,429	1,429	0	0	44,115	62.00
65.00	06500	RESPIRATORY THERAPY	2,326	2,326	867,357	0	1,213,417	65.00
66.00	06600	PHYSICAL THERAPY	31,511	31,511	1,661,006	0	3,101,434	66.00
67.00	06700	OCCUPATIONAL THERAPY	344	344	535,856	0	683,581	67.00
68.00	06800	SPEECH PATHOLOGY	203	203	516,161	0	663,513	68.00
69.00	06900	ELECTROCARDIOLOGY	13,897	13,897	2,378,290	0	4,316,073	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	1,491,016	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	4,402,270	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	7,684,027	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	320,819	74.00
76.00	03950	OTHER ANCILLARY-OTHER	0	0	0	0	0	76.00
76.01	03610	SLEEP LAB	0	0	254,628	0	344,194	76.01
76.02	03020	ACUPUNCTURE	0	0	0	0	0	76.02
76.03	03040	WOUND CARE	0	0	10,961	0	804,033	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	10,017	10,017	1,855,342	0	2,945,114	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	444,472	444,472	39,219,873	-31,521,285	88,195,550	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	893	893	0	0	27,568	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	131,179	0	1,059,698	192.00
194.00	07950	OTHER NONREIMBURSABLE COSTS	0	0	78,796	0	97,210	194.00
194.01	07951	MARKETING	0	0	0	0	0	194.01
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	4,951,463	8,797,505	6,000,804		31,521,285	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	11.117764	19.753472	0.152189		0.352666	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)			112,649		1,469,557	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)			0.002857		0.016442	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-0006 | Period: From 01/01/2020 To 12/31/2020 | Worksheet B-1 | Date/Time Prepared: 8/2/2021 4:01 pm

		Cost Center Description	CAPITAL RELATED COSTS					
			BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (SQUARE FEET)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
			1.00	2.00	4.00	5A	5.00	
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: 15-0006 | Period: From 01/01/2020 To 12/31/2020 | Worksheet B-1 | Date/Time Prepared: 8/2/2021 4:01 pm

		Cost Center Description	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	CAFETERIA (HOURS)	
			7.00	8.00	9.00	10.00	11.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT	218,859					7.00
8.00	00800	LAUNDRY & LINEN SERVICE	441	398,892				8.00
9.00	00900	HOUSEKEEPING	7,476	0	210,942			9.00
10.00	01000	DIETARY	7,362	0	7,362	90,137		10.00
11.00	01100	CAFETERIA	6,542	0	6,542	0	43,297	11.00
13.00	01300	NURSING ADMINISTRATION	2,020	0	2,020	0	2,207	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	3,199	0	3,199	0	1,107	14.00
15.00	01500	PHARMACY	3,102	0	3,102	0	1,596	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	3,421	0	3,421	0	840	16.00
17.00	01700	SOCIAL SERVICE	1,469	0	1,469	0	609	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	27,042	159,308	27,042	54,931	9,519	30.00
31.00	03100	INTENSIVE CARE UNIT	12,375	32,539	12,375	7,096	2,677	31.00
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	0	40.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
43.00	04300	NURSERY	1,164	0	1,164	0	443	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	37,172	43,365	37,172	0	2,893	50.00
51.00	05100	RECOVERY ROOM	0	18,965	0	0	1,548	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	16,086	5,595	16,086	0	715	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	112	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	11,911	41,232	11,911	0	2,398	54.00
54.01	05401	ULTRASOUND	799	0	799	0	350	54.01
56.00	05600	RADIOISOTOPE	0	0	0	0	298	56.00
57.00	05700	CT SCAN	1,968	0	1,968	0	748	57.00
58.00	05800	MRI	8,520	0	8,520	0	236	58.00
60.00	06000	LABORATORY	6,170	3,818	6,170	0	4,433	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	1,429	0	1,429	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	2,326	0	2,326	0	1,329	65.00
66.00	06600	PHYSICAL THERAPY	31,511	0	31,511	0	1,798	66.00
67.00	06700	OCCUPATIONAL THERAPY	344	0	344	0	704	67.00
68.00	06800	SPEECH PATHOLOGY	203	0	203	0	663	68.00
69.00	06900	ELECTROCARDIOLOGY	13,897	15,400	13,897	0	2,997	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.00	03950	OTHER ANCILLARY-OTHER	0	0	0	0	0	76.00
76.01	03610	SLEEP LAB	0	255	0	0	384	76.01
76.02	03020	ACUPUNCTURE	0	0	0	0	0	76.02
76.03	03040	WOUND CARE	0	0	0	0	25	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	10,017	78,415	10,017	3,347	2,371	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	217,966	398,892	210,049	65,374	43,000	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	893	0	893	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	24,763	166	192.00
194.00	07950	OTHER NONREIMBURSABLE COSTS	0	0	0	0	131	194.00
194.01	07951	MARKETING	0	0	0	0	0	194.01
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	16,097,674	616,127	3,190,971	2,126,464	2,692,197	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	73.552717	1.544596	15.127244	23.591466	62.179758	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	5,631,378	32,056	455,258	450,504	410,081	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	25.730621	0.080363	2.158214	4.997992	9.471349	205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)						206.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-0006 | Period: From 01/01/2020 To 12/31/2020 | Worksheet B-1 | Date/Time Prepared: 8/2/2021 4:01 pm

	Cost Center Description	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	CAFETERIA (HOURS)	
		7.00	8.00	9.00	10.00	11.00	
207.00	NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-0006 | Period: From 01/01/2020 To 12/31/2020 | Worksheet B-1 | Date/Time Prepared: 8/2/2021 4:01 pm

		Cost Center Description	NURSING ADMINISTRATION (DIRECT NRSING)	CENTRAL SERVICES & SUPPLY (BILLABLE SUPPLIE)	PHARMACY (100% ALLOCAT)	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)	SOCIAL SERVICE (TOTAL PATIENT DAYS)	
			13.00	14.00	15.00	16.00	17.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
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	13,886,548					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	11,570,904				14.00
15.00	01500	PHARMACY	0	0	7,703,444			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	8,287	0	602,885,687		16.00
17.00	01700	SOCIAL SERVICE	0	1,534	0	0	19,792	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	4,994,354	440,457	0	45,644,991	15,665	30.00
31.00	03100	INTENSIVE CARE UNIT	2,077,460	330,309	0	13,294,251	2,986	31.00
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	0	40.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
43.00	04300	NURSERY	0	0	0	1,899,260	1,141	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,112,950	1,023,491	0	89,761,407	0	50.00
51.00	05100	RECOVERY ROOM	1,227,735	133,505	0	13,783,943	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,330,224	123,925	0	3,066,858	0	52.00
53.00	05300	ANESTHESIOLOGY	0	144,703	0	20,365,406	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	408,752	98,560	0	8,912,344	0	54.00
54.01	05401	ULTRASOUND	974	14,822	0	6,588,703	0	54.01
56.00	05600	RADIOISOTOPE	0	196,661	0	10,007,453	0	56.00
57.00	05700	CT SCAN	4,977	54,454	0	27,225,824	0	57.00
58.00	05800	MRI	0	9,638	0	9,219,864	0	58.00
60.00	06000	LABORATORY	0	1,880,990	0	73,946,727	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0	559,634	0	62.00
65.00	06500	RESPIRATORY THERAPY	0	67,174	0	9,557,329	0	65.00
66.00	06600	PHYSICAL THERAPY	0	16,079	0	12,710,568	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	2,332	0	5,764,483	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	2,411	0	3,670,158	0	68.00
69.00	06900	ELECTROCARDIOLOGY	927,175	341,251	0	51,610,515	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	1,566,045	0	15,538,978	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	4,741,694	0	30,452,217	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	7,703,444	103,560,716	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	2,898,415	0	74.00
76.00	03950	OTHER ANCILLARY-OTHER	0	0	0	0	0	76.00
76.01	03610	SLEEP LAB	0	21,984	0	3,542,009	0	76.01
76.02	03020	ACUPUNCTURE	0	0	0	0	0	76.02
76.03	03040	WOUND CARE	1,060	89,335	0	4,917,462	0	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	1,668,361	258,231	0	34,386,172	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	13,754,022	11,567,872	7,703,444	602,885,687	19,792	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	132,526	3,032	0	0	0	192.00
194.00	07950	OTHER NONREIMBURSABLE COSTS	0	0	0	0	0	194.00
194.01	07951	MARKETING	0	0	0	0	0	194.01
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	3,698,750	2,045,648	2,827,588	2,008,056	980,053	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.266355	0.176792	0.367055	0.003331	49.517633	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	186,392	220,443	230,838	230,422	103,173	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.013422	0.019051	0.029966	0.000382	5.212864	205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)						206.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-0006 | Period: From 01/01/2020 To 12/31/2020 | Worksheet B-1 | Date/Time Prepared: 8/2/2021 4:01 pm

		Cost Center Description	NURSING ADMINISTRATION (DIRECT NRSING)	CENTRAL SERVICES & SUPPLY (BILLABLE SUPPLIE)	PHARMACY (100% ALLOCAT)	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)	SOCIAL SERVICE (TOTAL PATIENT DAYS)	
			13.00	14.00	15.00	16.00	17.00	
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-0006 | Period: From 01/01/2020 To 12/31/2020 | Worksheet C Part I Date/Time Prepared: 8/2/2021 4:01 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	RCE Disallowance	Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	21,426,246		21,426,246	0	21,426,246	30.00
31.00	03100	INTENSIVE CARE UNIT	7,027,836		7,027,836	0	7,027,836	31.00
40.00	04000	SUBPROVIDER - IPF	0		0	0	0	40.00
41.00	04100	SUBPROVIDER - IRF	0		0	0	0	41.00
43.00	04300	NURSERY	855,647		855,647	0	855,647	43.00
44.00	04400	SKILLED NURSING FACILITY	0		0	0	0	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	12,264,022		12,264,022	0	12,264,022	50.00
51.00	05100	RECOVERY ROOM	2,743,923		2,743,923	0	2,743,923	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	3,461,008		3,461,008	0	3,461,008	52.00
53.00	05300	ANESTHESIOLOGY	2,670,393		2,670,393	0	2,670,393	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	5,411,937		5,411,937	0	5,411,937	54.00
54.01	05401	ULTRASOUND	753,451		753,451	0	753,451	54.01
56.00	05600	RADIOISOTOPE	858,959		858,959	0	858,959	56.00
57.00	05700	CT SCAN	1,320,023		1,320,023	0	1,320,023	57.00
58.00	05800	MRI	1,505,719		1,505,719	0	1,505,719	58.00
60.00	06000	LABORATORY	8,524,361		8,524,361	0	8,524,361	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	188,261		188,261	0	188,261	62.00
65.00	06500	RESPIRATORY THERAPY	1,973,966	0	1,973,966	0	1,973,966	65.00
66.00	06600	PHYSICAL THERAPY	7,146,580	0	7,146,580	0	7,146,580	66.00
67.00	06700	OCCUPATIONAL THERAPY	1,018,551	0	1,018,551	0	1,018,551	67.00
68.00	06800	SPEECH PATHOLOGY	969,389	0	969,389	0	969,389	68.00
69.00	06900	ELECTROCARDIOLOGY	7,759,933		7,759,933	0	7,759,933	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	2,345,471		2,345,471	0	2,345,471	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	6,894,536		6,894,536	0	6,894,536	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	13,566,318		13,566,318	0	13,566,318	73.00
74.00	07400	RENAL DIALYSIS	443,616		443,616	0	443,616	74.00
76.00	03950	OTHER ANCILLARY-OTHER	0		0	0	0	76.00
76.01	03610	SLEEP LAB	505,536		505,536	0	505,536	76.01
76.02	03020	ACUPUNCTURE	0		0	0	0	76.02
76.03	03040	WOUND CARE	1,121,598		1,121,598	0	1,121,598	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0		0	0	0	90.00
91.00	09100	EMERGENCY	5,824,141		5,824,141	0	5,824,141	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1,451,109		1,451,109		1,451,109	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0		0	0	0	95.00
200.00		Subtotal (see instructions)	120,032,530	0	120,032,530	0	120,032,530	200.00
201.00		Less Observation Beds	1,451,109		1,451,109		1,451,109	201.00
202.00		Total (see instructions)	118,581,421	0	118,581,421	0	118,581,421	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-0006 | Period: From 01/01/2020 To 12/31/2020 | Worksheet C Part I Date/Time Prepared: 8/2/2021 4:01 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Charges Inpatient	Charges Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	41,389,552		41,389,552			30.00
31.00	03100	INTENSIVE CARE UNIT	13,294,251		13,294,251			31.00
40.00	04000	SUBPROVIDER - IPF	0		0			40.00
41.00	04100	SUBPROVIDER - IRF	0		0			41.00
43.00	04300	NURSERY	1,899,260		1,899,260			43.00
44.00	04400	SKILLED NURSING FACILITY	0		0			44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	25,260,825	64,500,582	89,761,407	0.136629	0.000000	50.00
51.00	05100	RECOVERY ROOM	2,818,869	10,965,074	13,783,943	0.199067	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	2,952,844	114,014	3,066,858	1.128519	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	6,489,999	13,875,407	20,365,406	0.131124	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,618,889	7,293,455	8,912,344	0.607241	0.000000	54.00
54.01	05401	ULTRASOUND	1,067,441	5,521,262	6,588,703	0.114355	0.000000	54.01
56.00	05600	RADIOISOTOPE	1,030,029	8,977,424	10,007,453	0.085832	0.000000	56.00
57.00	05700	CT SCAN	8,065,320	19,160,504	27,225,824	0.048484	0.000000	57.00
58.00	05800	MRI	1,866,850	7,353,014	9,219,864	0.163312	0.000000	58.00
60.00	06000	LABORATORY	28,240,192	45,706,535	73,946,727	0.115277	0.000000	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	414,342	145,292	559,634	0.336400	0.000000	62.00
65.00	06500	RESPIRATORY THERAPY	8,704,865	852,464	9,557,329	0.206540	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	3,417,608	9,292,960	12,710,568	0.562255	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	3,315,022	2,449,461	5,764,483	0.176694	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	1,258,306	2,411,852	3,670,158	0.264127	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	16,452,624	35,157,891	51,610,515	0.150356	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	6,731,736	8,807,242	15,538,978	0.150941	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	13,106,520	17,345,697	30,452,217	0.226405	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	48,159,383	55,401,333	103,560,716	0.130999	0.000000	73.00
74.00	07400	RENAL DIALYSIS	2,898,415	0	2,898,415	0.153055	0.000000	74.00
76.00	03950	OTHER ANCILLARY-OTHER	0	0	0	0.000000	0.000000	76.00
76.01	03610	SLEEP LAB	195,245	3,346,764	3,542,009	0.142726	0.000000	76.01
76.02	03020	ACUPUNCTURE	0	0	0	0.000000	0.000000	76.02
76.03	03040	WOUND CARE	57,276	4,860,186	4,917,462	0.228085	0.000000	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0.000000	0.000000	90.00
91.00	09100	EMERGENCY	9,667,396	24,718,776	34,386,172	0.169375	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1,334,499	2,920,940	4,255,439	0.341001	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0.000000	0.000000	95.00
200.00		Subtotal (see instructions)	251,707,558	351,178,129	602,885,687			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	251,707,558	351,178,129	602,885,687			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-0006 | Period: From 01/01/2020 To 12/31/2020 | Worksheet C Part I Date/Time Prepared: 8/2/2021 4:01 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
43.00	04300	NURSERY		43.00
44.00	04400	SKILLED NURSING FACILITY		44.00
		ANCILLARY SERVICE COST CENTERS		
50.00	05000	OPERATING ROOM	0.136629	50.00
51.00	05100	RECOVERY ROOM	0.199067	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1.128519	52.00
53.00	05300	ANESTHESIOLOGY	0.131124	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.607241	54.00
54.01	05401	ULTRASOUND	0.114355	54.01
56.00	05600	RADIOISOTOPE	0.085832	56.00
57.00	05700	CT SCAN	0.048484	57.00
58.00	05800	MRI	0.163312	58.00
60.00	06000	LABORATORY	0.115277	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0.336400	62.00
65.00	06500	RESPIRATORY THERAPY	0.206540	65.00
66.00	06600	PHYSICAL THERAPY	0.562255	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.176694	67.00
68.00	06800	SPEECH PATHOLOGY	0.264127	68.00
69.00	06900	ELECTROCARDIOLOGY	0.150356	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.150941	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.226405	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.130999	73.00
74.00	07400	RENAL DIALYSIS	0.153055	74.00
76.00	03950	OTHER ANCILLARY-OTHER	0.000000	76.00
76.01	03610	SLEEP LAB	0.142726	76.01
76.02	03020	ACUPUNCTURE	0.000000	76.02
76.03	03040	WOUND CARE	0.228085	76.03
		OUTPATIENT SERVICE COST CENTERS		
90.00	09000	CLINIC	0.000000	90.00
91.00	09100	EMERGENCY	0.169375	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.341001	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

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-0006 | Period: From 01/01/2020 To 12/31/2020 | Worksheet C Part I Date/Time Prepared: 8/2/2021 4:01 pm

Title XIX | Hospital | PPS

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	RCE Disallowance	Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	21,426,246		21,426,246	0	21,426,246	30.00
31.00	03100	INTENSIVE CARE UNIT	7,027,836		7,027,836	0	7,027,836	31.00
40.00	04000	SUBPROVIDER - IPF	0		0	0	0	40.00
41.00	04100	SUBPROVIDER - IRF	0		0	0	0	41.00
43.00	04300	NURSERY	855,647		855,647	0	855,647	43.00
44.00	04400	SKILLED NURSING FACILITY	0		0	0	0	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	12,264,022		12,264,022	0	12,264,022	50.00
51.00	05100	RECOVERY ROOM	2,743,923		2,743,923	0	2,743,923	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	3,461,008		3,461,008	0	3,461,008	52.00
53.00	05300	ANESTHESIOLOGY	2,670,393		2,670,393	0	2,670,393	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	5,411,937		5,411,937	0	5,411,937	54.00
54.01	05401	ULTRASOUND	753,451		753,451	0	753,451	54.01
56.00	05600	RADIOISOTOPE	858,959		858,959	0	858,959	56.00
57.00	05700	CT SCAN	1,320,023		1,320,023	0	1,320,023	57.00
58.00	05800	MRI	1,505,719		1,505,719	0	1,505,719	58.00
60.00	06000	LABORATORY	8,524,361		8,524,361	0	8,524,361	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	188,261		188,261	0	188,261	62.00
65.00	06500	RESPIRATORY THERAPY	1,973,966	0	1,973,966	0	1,973,966	65.00
66.00	06600	PHYSICAL THERAPY	7,146,580	0	7,146,580	0	7,146,580	66.00
67.00	06700	OCCUPATIONAL THERAPY	1,018,551	0	1,018,551	0	1,018,551	67.00
68.00	06800	SPEECH PATHOLOGY	969,389	0	969,389	0	969,389	68.00
69.00	06900	ELECTROCARDIOLOGY	7,759,933		7,759,933	0	7,759,933	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	2,345,471		2,345,471	0	2,345,471	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	6,894,536		6,894,536	0	6,894,536	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	13,566,318		13,566,318	0	13,566,318	73.00
74.00	07400	RENAL DIALYSIS	443,616		443,616	0	443,616	74.00
76.00	03950	OTHER ANCILLARY-OTHER	0		0	0	0	76.00
76.01	03610	SLEEP LAB	505,536		505,536	0	505,536	76.01
76.02	03020	ACUPUNCTURE	0		0	0	0	76.02
76.03	03040	WOUND CARE	1,121,598		1,121,598	0	1,121,598	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0		0	0	0	90.00
91.00	09100	EMERGENCY	5,824,141		5,824,141	0	5,824,141	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1,451,109		1,451,109		1,451,109	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0		0	0	0	95.00
200.00		Subtotal (see instructions)	120,032,530	0	120,032,530	0	120,032,530	200.00
201.00		Less Observation Beds	1,451,109		1,451,109		1,451,109	201.00
202.00		Total (see instructions)	118,581,421	0	118,581,421	0	118,581,421	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-0006 | Period: From 01/01/2020 To 12/31/2020 | Worksheet C Part I Date/Time Prepared: 8/2/2021 4:01 pm

Title XIX | Hospital | PPS

		Cost Center Description	Charges Inpatient	Charges Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	41,389,552		41,389,552			30.00
31.00	03100	INTENSIVE CARE UNIT	13,294,251		13,294,251			31.00
40.00	04000	SUBPROVIDER - IPF	0		0			40.00
41.00	04100	SUBPROVIDER - IRF	0		0			41.00
43.00	04300	NURSERY	1,899,260		1,899,260			43.00
44.00	04400	SKILLED NURSING FACILITY	0		0			44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	25,260,825	64,500,582	89,761,407	0.136629	0.000000	50.00
51.00	05100	RECOVERY ROOM	2,818,869	10,965,074	13,783,943	0.199067	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	2,952,844	114,014	3,066,858	1.128519	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	6,489,999	13,875,407	20,365,406	0.131124	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,618,889	7,293,455	8,912,344	0.607241	0.000000	54.00
54.01	05401	ULTRASOUND	1,067,441	5,521,262	6,588,703	0.114355	0.000000	54.01
56.00	05600	RADIOISOTOPE	1,030,029	8,977,424	10,007,453	0.085832	0.000000	56.00
57.00	05700	CT SCAN	8,065,320	19,160,504	27,225,824	0.048484	0.000000	57.00
58.00	05800	MRI	1,866,850	7,353,014	9,219,864	0.163312	0.000000	58.00
60.00	06000	LABORATORY	28,240,192	45,706,535	73,946,727	0.115277	0.000000	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	414,342	145,292	559,634	0.336400	0.000000	62.00
65.00	06500	RESPIRATORY THERAPY	8,704,865	852,464	9,557,329	0.206540	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	3,417,608	9,292,960	12,710,568	0.562255	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	3,315,022	2,449,461	5,764,483	0.176694	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	1,258,306	2,411,852	3,670,158	0.264127	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	16,452,624	35,157,891	51,610,515	0.150356	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	6,731,736	8,807,242	15,538,978	0.150941	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	13,106,520	17,345,697	30,452,217	0.226405	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	48,159,383	55,401,333	103,560,716	0.130999	0.000000	73.00
74.00	07400	RENAL DIALYSIS	2,898,415	0	2,898,415	0.153055	0.000000	74.00
76.00	03950	OTHER ANCILLARY-OTHER	0	0	0	0.000000	0.000000	76.00
76.01	03610	SLEEP LAB	195,245	3,346,764	3,542,009	0.142726	0.000000	76.01
76.02	03020	ACUPUNCTURE	0	0	0	0.000000	0.000000	76.02
76.03	03040	WOUND CARE	57,276	4,860,186	4,917,462	0.228085	0.000000	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0.000000	0.000000	90.00
91.00	09100	EMERGENCY	9,667,396	24,718,776	34,386,172	0.169375	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1,334,499	2,920,940	4,255,439	0.341001	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0.000000	0.000000	95.00
200.00		Subtotal (see instructions)	251,707,558	351,178,129	602,885,687			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	251,707,558	351,178,129	602,885,687			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-0006 | Period: From 01/01/2020 To 12/31/2020 | Worksheet C Part I Date/Time Prepared: 8/2/2021 4:01 pm

Title XIX | Hospital | PPS

		Cost Center Description	PPS Inpatient Ratio	
			11.00	
		INPATIENT ROUTINE SERVICE COST CENTERS		
30.00	03000	ADULTS & PEDIATRICS		30.00
31.00	03100	INTENSIVE CARE UNIT		31.00
40.00	04000	SUBPROVIDER - IPF		40.00
41.00	04100	SUBPROVIDER - IRF		41.00
43.00	04300	NURSERY		43.00
44.00	04400	SKILLED NURSING FACILITY		44.00
		ANCILLARY SERVICE COST CENTERS		
50.00	05000	OPERATING ROOM	0.136629	50.00
51.00	05100	RECOVERY ROOM	0.199067	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1.128519	52.00
53.00	05300	ANESTHESIOLOGY	0.131124	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.607241	54.00
54.01	05401	ULTRASOUND	0.114355	54.01
56.00	05600	RADIOISOTOPE	0.085832	56.00
57.00	05700	CT SCAN	0.048484	57.00
58.00	05800	MRI	0.163312	58.00
60.00	06000	LABORATORY	0.115277	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0.336400	62.00
65.00	06500	RESPIRATORY THERAPY	0.206540	65.00
66.00	06600	PHYSICAL THERAPY	0.562255	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.176694	67.00
68.00	06800	SPEECH PATHOLOGY	0.264127	68.00
69.00	06900	ELECTROCARDIOLOGY	0.150356	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.150941	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.226405	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.130999	73.00
74.00	07400	RENAL DIALYSIS	0.153055	74.00
76.00	03950	OTHER ANCILLARY-OTHER	0.000000	76.00
76.01	03610	SLEEP LAB	0.142726	76.01
76.02	03020	ACUPUNCTURE	0.000000	76.02
76.03	03040	WOUND CARE	0.228085	76.03
		OUTPATIENT SERVICE COST CENTERS		
90.00	09000	CLINIC	0.000000	90.00
91.00	09100	EMERGENCY	0.169375	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.341001	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

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

Provider CCN: 15-0006 | Period: From 01/01/2020 To 12/31/2020 | Worksheet C Part II | Date/Time Prepared: 8/2/2021 4:01 pm

Title XIX | Hospital | PPS

		Cost Center Description	Total Cost (Wkst. B, Part I, col. 26)	Capital Cost (Wkst. B, Part II col. 26)	Operating Cost Net of Capital Cost (col. 1 - col. 2)	Capital Reduction	Operating Cost Reduction Amount	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	12,264,022	2,385,753	9,878,269	0	0	50.00
51.00	05100	RECOVERY ROOM	2,743,923	70,979	2,672,944	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	3,461,008	994,763	2,466,245	0	0	52.00
53.00	05300	ANESTHESIOLOGY	2,670,393	42,975	2,627,418	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	5,411,937	790,454	4,621,483	0	0	54.00
54.01	05401	ULTRASOUND	753,451	61,811	691,640	0	0	54.01
56.00	05600	RADIOISOTOPE	858,959	20,584	838,375	0	0	56.00
57.00	05700	CT SCAN	1,320,023	147,797	1,172,226	0	0	57.00
58.00	05800	MRI	1,505,719	515,688	990,031	0	0	58.00
60.00	06000	LABORATORY	8,524,361	561,677	7,962,684	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	188,261	84,907	103,354	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	1,973,966	176,623	1,797,343	0	0	65.00
66.00	06600	PHYSICAL THERAPY	7,146,580	1,929,518	5,217,062	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	1,018,551	41,897	976,654	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	969,389	32,040	937,349	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	7,759,933	962,634	6,797,299	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	2,345,471	60,286	2,285,185	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	6,894,536	174,353	6,720,183	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	13,566,318	396,858	13,169,460	0	0	73.00
74.00	07400	RENAL DIALYSIS	443,616	6,382	437,234	0	0	74.00
76.00	03950	OTHER ANCILLARY-OTHER	0	0	0	0	0	76.00
76.01	03610	SLEEP LAB	505,536	11,815	493,721	0	0	76.01
76.02	03020	ACUPUNCTURE	0	0	0	0	0	76.02
76.03	03040	WOUND CARE	1,121,598	17,082	1,104,516	0	0	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	5,824,141	728,262	5,095,879	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1,451,109	158,153	1,292,956	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
200.00		Subtotal (sum of lines 50 thru 199)	90,722,801	10,373,291	80,349,510	0	0	200.00
201.00		Less Observation Beds	1,451,109	158,153	1,292,956	0	0	201.00
202.00		Total (line 200 minus line 201)	89,271,692	10,215,138	79,056,554	0	0	202.00

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

Provider CCN: 15-0006 | Period: From 01/01/2020 To 12/31/2020 | Worksheet C Part II Date/Time Prepared: 8/2/2021 4:01 pm

Title XIX | Hospital | PPS

		Cost Center Description	Cost Net of Capital and Operating Cost Reduction	Total Charges (Worksheet C, Part I, column 8)	Outpatient Cost to Charge Ratio (col. 6 / col. 7)		
			6.00	7.00	8.00		
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	12,264,022	89,761,407	0.136629		50.00
51.00	05100	RECOVERY ROOM	2,743,923	13,783,943	0.199067		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	3,461,008	3,066,858	1.128519		52.00
53.00	05300	ANESTHESIOLOGY	2,670,393	20,365,406	0.131124		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	5,411,937	8,912,344	0.607241		54.00
54.01	05401	ULTRASOUND	753,451	6,588,703	0.114355		54.01
56.00	05600	RADIOISOTOPE	858,959	10,007,453	0.085832		56.00
57.00	05700	CT SCAN	1,320,023	27,225,824	0.048484		57.00
58.00	05800	MRI	1,505,719	9,219,864	0.163312		58.00
60.00	06000	LABORATORY	8,524,361	73,946,727	0.115277		60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	188,261	559,634	0.336400		62.00
65.00	06500	RESPIRATORY THERAPY	1,973,966	9,557,329	0.206540		65.00
66.00	06600	PHYSICAL THERAPY	7,146,580	12,710,568	0.562255		66.00
67.00	06700	OCCUPATIONAL THERAPY	1,018,551	5,764,483	0.176694		67.00
68.00	06800	SPEECH PATHOLOGY	969,389	3,670,158	0.264127		68.00
69.00	06900	ELECTROCARDIOLOGY	7,759,933	51,610,515	0.150356		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	2,345,471	15,538,978	0.150941		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	6,894,536	30,452,217	0.226405		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	13,566,318	103,560,716	0.130999		73.00
74.00	07400	RENAL DIALYSIS	443,616	2,898,415	0.153055		74.00
76.00	03950	OTHER ANCILLARY-OTHER	0	0	0.000000		76.00
76.01	03610	SLEEP LAB	505,536	3,542,009	0.142726		76.01
76.02	03020	ACUPUNCTURE	0	0	0.000000		76.02
76.03	03040	WOUND CARE	1,121,598	4,917,462	0.228085		76.03
		OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	0	0	0.000000		90.00
91.00	09100	EMERGENCY	5,824,141	34,386,172	0.169375		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1,451,109	4,255,439	0.341001		92.00
		OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES	0	0	0.000000		95.00
200.00		Subtotal (sum of lines 50 thru 199)	90,722,801	546,302,624			200.00
201.00		Less Observation Beds	1,451,109	0			201.00
202.00		Total (line 200 minus line 201)	89,271,692	546,302,624			202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS | Provider CCN: 15-0006 | Period: From 01/01/2020 To 12/31/2020 | Worksheet D Part I Date/Time Prepared: 8/2/2021 4:01 pm

Title XVIII | Hospital | PPS

	Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	2,335,202	0	2,335,202	16,803	138.98	30.00
31.00	INTENSIVE CARE UNIT	909,391		909,391	2,986	304.55	31.00
40.00	SUBPROVIDER - IPF	0	0	0	0	0.00	40.00
41.00	SUBPROVIDER - IRF	0	0	0	0	0.00	41.00
43.00	NURSERY	88,275		88,275	1,141	77.37	43.00
44.00	SKILLED NURSING FACILITY	0		0	0	0.00	44.00
200.00	Total (lines 30 through 199)	3,332,868		3,332,868	20,930		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	6,504	903,926	30.00
31.00	INTENSIVE CARE UNIT	1,361	414,493	31.00
40.00	SUBPROVIDER - IPF	0	0	40.00
41.00	SUBPROVIDER - IRF	0	0	41.00
43.00	NURSERY	0	0	43.00
44.00	SKILLED NURSING FACILITY	0	0	44.00
200.00	Total (lines 30 through 199)	7,865	1,318,419	200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS | Provider CCN: 15-0006 | Period: From 01/01/2020 To 12/31/2020 | Worksheet D Part II Date/Time Prepared: 8/2/2021 4:01 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	2,385,753	89,761,407	0.026579	8,524,690	226,578	50.00
51.00	05100	RECOVERY ROOM	70,979	13,783,943	0.005149	1,011,316	5,207	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	994,763	3,066,858	0.324359	0	0	52.00
53.00	05300	ANESTHESIOLOGY	42,975	20,365,406	0.002110	2,193,937	4,629	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	790,454	8,912,344	0.088692	1,212,860	107,571	54.00
54.01	05401	ULTRASOUND	61,811	6,588,703	0.009381	417,005	3,912	54.01
56.00	05600	RADIOISOTOPE	20,584	10,007,453	0.002057	257,878	530	56.00
57.00	05700	CT SCAN	147,797	27,225,824	0.005429	3,441,739	18,685	57.00
58.00	05800	MRI	515,688	9,219,864	0.055932	703,781	39,364	58.00
60.00	06000	LABORATORY	561,677	73,946,727	0.007596	12,185,126	92,558	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	84,907	559,634	0.151719	318,572	48,333	62.00
65.00	06500	RESPIRATORY THERAPY	176,623	9,557,329	0.018480	4,087,345	75,534	65.00
66.00	06600	PHYSICAL THERAPY	1,929,518	12,710,568	0.151804	1,722,239	261,443	66.00
67.00	06700	OCCUPATIONAL THERAPY	41,897	5,764,483	0.007268	1,635,599	11,888	67.00
68.00	06800	SPEECH PATHOLOGY	32,040	3,670,158	0.008730	707,018	6,172	68.00
69.00	06900	ELECTROCARDIOLOGY	962,634	51,610,515	0.018652	6,747,146	125,848	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	60,286	15,538,978	0.003880	2,800,142	10,865	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	174,353	30,452,217	0.005725	6,189,112	35,433	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	396,858	103,560,716	0.003832	20,515,233	78,614	73.00
74.00	07400	RENAL DIALYSIS	6,382	2,898,415	0.002202	1,830,287	4,030	74.00
76.00	03950	OTHER ANCILLARY-OTHER	0	0	0.000000	0	0	76.00
76.01	03610	SLEEP LAB	11,815	3,542,009	0.003336	97,632	326	76.01
76.02	03020	ACUPUNCTURE	0	0	0.000000	0	0	76.02
76.03	03040	WOUND CARE	17,082	4,917,462	0.003474	4,507	16	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0.000000	0	0	90.00
91.00	09100	EMERGENCY	728,262	34,386,172	0.021179	4,014,879	85,031	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	158,153	4,255,439	0.037165	278,531	10,352	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)	10,373,291	546,302,624		80,896,574	1,252,919	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 15-0006 | Period: From 01/01/2020 To 12/31/2020 | Worksheet D Part III Date/Time Prepared: 8/2/2021 4:01 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
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	16,803	0.00	6,504	30.00
31.00	03100	INTENSIVE CARE UNIT		0	2,986	0.00	1,361	31.00
40.00	04000	SUBPROVIDER - IPF	0	0	0	0.00	0	40.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0.00	0	41.00
43.00	04300	NURSERY		0	1,141	0.00	0	43.00
44.00	04400	SKILLED NURSING FACILITY		0	0	0.00	0	44.00
200.00		Total (lines 30 through 199)		0	20,930		7,865	200.00

		Cost Center Description	Inpatient Program Pass-Through Cost (col. 7 x col. 8)	
			9.00	
		INPATIENT ROUTINE SERVICE COST CENTERS		
30.00	03000	ADULTS & PEDIATRICS	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	31.00
40.00	04000	SUBPROVIDER - IPF	0	40.00
41.00	04100	SUBPROVIDER - IRF	0	41.00
43.00	04300	NURSERY	0	43.00
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: 15-0006 | Period: From 01/01/2020 To 12/31/2020 | Worksheet D Part IV | Date/Time Prepared: 8/2/2021 4:01 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health	
			1.00	2A	2.00	3A	3.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
54.01	05401	ULTRASOUND	0	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.00	03950	OTHER ANCILLARY-OTHER	0	0	0	0	0	76.00
76.01	03610	SLEEP LAB	0	0	0	0	0	76.01
76.02	03020	ACUPUNCTURE	0	0	0	0	0	76.02
76.03	03040	WOUND CARE	0	0	0	0	0	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0		0		0	92.00
		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: 15-0006 | Period: From 01/01/2020 To 12/31/2020 | Worksheet D Part IV | Date/Time Prepared: 8/2/2021 4:01 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	89,761,407	0.000000	50.00
51.00	05100	RECOVERY ROOM	0	0	0	13,783,943	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	3,066,858	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	20,365,406	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	8,912,344	0.000000	54.00
54.01	05401	ULTRASOUND	0	0	0	6,588,703	0.000000	54.01
56.00	05600	RADIOISOTOPE	0	0	0	10,007,453	0.000000	56.00
57.00	05700	CT SCAN	0	0	0	27,225,824	0.000000	57.00
58.00	05800	MRI	0	0	0	9,219,864	0.000000	58.00
60.00	06000	LABORATORY	0	0	0	73,946,727	0.000000	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0	559,634	0.000000	62.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	9,557,329	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	12,710,568	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	5,764,483	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	3,670,158	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	51,610,515	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	15,538,978	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	30,452,217	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	103,560,716	0.000000	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	2,898,415	0.000000	74.00
76.00	03950	OTHER ANCILLARY-OTHER	0	0	0	0	0.000000	76.00
76.01	03610	SLEEP LAB	0	0	0	3,542,009	0.000000	76.01
76.02	03020	ACUPUNCTURE	0	0	0	0	0.000000	76.02
76.03	03040	WOUND CARE	0	0	0	4,917,462	0.000000	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0.000000	90.00
91.00	09100	EMERGENCY	0	0	0	34,386,172	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	4,255,439	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	546,302,624		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 15-0006 | Period: From 01/01/2020 To 12/31/2020 | Worksheet D Part IV Date/Time Prepared: 8/2/2021 4:01 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	8,524,690	0	20,494,884	0	50.00
51.00	05100	RECOVERY ROOM	0.000000	1,011,316	0	2,662,891	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	2,193,937	0	3,570,488	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	1,212,860	0	2,225,826	0	54.00
54.01	05401	ULTRASOUND	0.000000	417,005	0	983,414	0	54.01
56.00	05600	RADIOISOTOPE	0.000000	257,878	0	3,282,008	0	56.00
57.00	05700	CT SCAN	0.000000	3,441,739	0	5,405,014	0	57.00
58.00	05800	MRI	0.000000	703,781	0	1,992,059	0	58.00
60.00	06000	LABORATORY	0.000000	12,185,126	0	4,251,861	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0.000000	318,572	0	53,718	0	62.00
65.00	06500	RESPIRATORY THERAPY	0.000000	4,087,345	0	281,878	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	1,722,239	0	28,084	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	1,635,599	0	17,281	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	707,018	0	15,943	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	6,747,146	0	12,268,529	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	2,800,142	0	2,424,929	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	6,189,112	0	7,539,579	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	20,515,233	0	18,620,524	0	73.00
74.00	07400	RENAL DIALYSIS	0.000000	1,830,287	0	0	0	74.00
76.00	03950	OTHER ANCILLARY-OTHER	0.000000	0	0	0	0	76.00
76.01	03610	SLEEP LAB	0.000000	97,632	0	779,642	0	76.01
76.02	03020	ACUPUNCTURE	0.000000	0	0	0	0	76.02
76.03	03040	WOUND CARE	0.000000	4,507	0	572,614	0	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.000000	0	0	0	0	90.00
91.00	09100	EMERGENCY	0.000000	4,014,879	0	4,193,527	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	278,531	0	772,413	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)		80,896,574	0	92,437,106	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-0006 | Period: From 01/01/2020 To 12/31/2020 | Worksheet D Part V Date/Time Prepared: 8/2/2021 4:01 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	0.136629	20,494,884	30,769	0	2,800,196	50.00
51.00	05100	RECOVERY ROOM	0.199067	2,662,891	0	0	530,094	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1.128519	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.131124	3,570,488	0	0	468,177	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.607241	2,225,826	0	0	1,351,613	54.00
54.01	05401	ULTRASOUND	0.114355	983,414	0	0	112,458	54.01
56.00	05600	RADIOISOTOPE	0.085832	3,282,008	0	0	281,701	56.00
57.00	05700	CT SCAN	0.048484	5,405,014	0	0	262,057	57.00
58.00	05800	MRI	0.163312	1,992,059	0	0	325,327	58.00
60.00	06000	LABORATORY	0.115277	4,251,861	9,628	0	490,142	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0.336400	53,718	0	0	18,071	62.00
65.00	06500	RESPIRATORY THERAPY	0.206540	281,878	0	0	58,219	65.00
66.00	06600	PHYSICAL THERAPY	0.562255	28,084	0	0	15,790	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.176694	17,281	0	0	3,053	67.00
68.00	06800	SPEECH PATHOLOGY	0.264127	15,943	0	0	4,211	68.00
69.00	06900	ELECTROCARDIOLOGY	0.150356	12,268,529	0	0	1,844,647	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.150941	2,424,929	0	0	366,021	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.226405	7,539,579	0	0	1,706,998	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.130999	18,620,524	0	22,253	2,439,270	73.00
74.00	07400	RENAL DIALYSIS	0.153055	0	0	0	0	74.00
76.00	03950	OTHER ANCILLARY-OTHER	0.000000	0	0	0	0	76.00
76.01	03610	SLEEP LAB	0.142726	779,642	0	0	111,275	76.01
76.02	03020	ACUPUNCTURE	0.000000	0	0	0	0	76.02
76.03	03040	WOUND CARE	0.228085	572,614	0	0	130,605	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.000000	0	0	0	0	90.00
91.00	09100	EMERGENCY	0.169375	4,193,527	0	0	710,279	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.341001	772,413	0	0	263,394	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0.000000		0			95.00
200.00		Subtotal (see instructions)		92,437,106	40,397	22,253	14,293,598	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 - line 201)		92,437,106	40,397	22,253	14,293,598	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-0006 | Period: From 01/01/2020 To 12/31/2020 | Worksheet D Part V Date/Time Prepared: 8/2/2021 4:01 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	4,204	0		50.00
51.00	05100	RECOVERY ROOM	0	0		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0		52.00
53.00	05300	ANESTHESIOLOGY	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0		54.00
54.01	05401	ULTRASOUND	0	0		54.01
56.00	05600	RADIOISOTOPE	0	0		56.00
57.00	05700	CT SCAN	0	0		57.00
58.00	05800	MRI	0	0		58.00
60.00	06000	LABORATORY	1,110	0		60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0		62.00
65.00	06500	RESPIRATORY THERAPY	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	2,915		73.00
74.00	07400	RENAL DIALYSIS	0	0		74.00
76.00	03950	OTHER ANCILLARY-OTHER	0	0		76.00
76.01	03610	SLEEP LAB	0	0		76.01
76.02	03020	ACUPUNCTURE	0	0		76.02
76.03	03040	WOUND CARE	0	0		76.03
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0	0		90.00
91.00	09100	EMERGENCY	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0		92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES	0			95.00
200.00		Subtotal (see instructions)	5,314	2,915		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	5,314	2,915		202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS | Provider CCN: 15-0006 | Period: From 01/01/2020 To 12/31/2020 | Worksheet D Part I Date/Time Prepared: 8/2/2021 4:01 pm

Title XIX | Hospital | PPS

	Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	2,335,202	0	2,335,202	16,803	138.98	30.00
31.00	INTENSIVE CARE UNIT	909,391		909,391	2,986	304.55	31.00
40.00	SUBPROVIDER - IPF	0	0	0	0	0.00	40.00
41.00	SUBPROVIDER - IRF	0	0	0	0	0.00	41.00
43.00	NURSERY	88,275		88,275	1,141	77.37	43.00
44.00	SKILLED NURSING FACILITY	0		0	0	0.00	44.00
200.00	Total (lines 30 through 199)	3,332,868		3,332,868	20,930		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	749	104,096	30.00
31.00	INTENSIVE CARE UNIT	101	30,760	31.00
40.00	SUBPROVIDER - IPF	0	0	40.00
41.00	SUBPROVIDER - IRF	0	0	41.00
43.00	NURSERY	859	66,461	43.00
44.00	SKILLED NURSING FACILITY	0	0	44.00
200.00	Total (lines 30 through 199)	1,709	201,317	200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS | Provider CCN: 15-0006 | Period: From 01/01/2020 To 12/31/2020 | Worksheet D Part II Date/Time Prepared: 8/2/2021 4:01 pm

Title XIX | Hospital | PPS

		Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,385,753	89,761,407	0.026579	893,151	23,739	50.00
51.00	05100	RECOVERY ROOM	70,979	13,783,943	0.005149	121,807	627	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	994,763	3,066,858	0.324359	197,370	64,019	52.00
53.00	05300	ANESTHESIOLOGY	42,975	20,365,406	0.002110	245,125	517	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	790,454	8,912,344	0.088692	112,575	9,985	54.00
54.01	05401	ULTRASOUND	61,811	6,588,703	0.009381	77,221	724	54.01
56.00	05600	RADIOISOTOPE	20,584	10,007,453	0.002057	23,811	49	56.00
57.00	05700	CT SCAN	147,797	27,225,824	0.005429	376,298	2,043	57.00
58.00	05800	MRI	515,688	9,219,864	0.055932	137,590	7,696	58.00
60.00	06000	LABORATORY	561,677	73,946,727	0.007596	1,415,790	10,754	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	84,907	559,634	0.151719	26,020	3,948	62.00
65.00	06500	RESPIRATORY THERAPY	176,623	9,557,329	0.018480	435,099	8,041	65.00
66.00	06600	PHYSICAL THERAPY	1,929,518	12,710,568	0.151804	147,683	22,419	66.00
67.00	06700	OCCUPATIONAL THERAPY	41,897	5,764,483	0.007268	134,286	976	67.00
68.00	06800	SPEECH PATHOLOGY	32,040	3,670,158	0.008730	67,456	589	68.00
69.00	06900	ELECTROCARDIOLOGY	962,634	51,610,515	0.018652	388,804	7,252	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	60,286	15,538,978	0.003880	257,869	1,001	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	174,353	30,452,217	0.005725	152,763	875	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	396,858	103,560,716	0.003832	2,137,530	8,191	73.00
74.00	07400	RENAL DIALYSIS	6,382	2,898,415	0.002202	53,048	117	74.00
76.00	03950	OTHER ANCILLARY-OTHER	0	0	0.000000	0	0	76.00
76.01	03610	SLEEP LAB	11,815	3,542,009	0.003336	22,062	74	76.01
76.02	03020	ACUPUNCTURE	0	0	0.000000	0	0	76.02
76.03	03040	WOUND CARE	17,082	4,917,462	0.003474	2,578	9	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0.000000	0	0	90.00
91.00	09100	EMERGENCY	728,262	34,386,172	0.021179	480,630	10,179	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	158,153	4,255,439	0.037165	40,802	1,516	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)	10,373,291	546,302,624		7,947,368	185,340	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 15-0006 | Period: From 01/01/2020 To 12/31/2020 | Worksheet D Part III Date/Time Prepared: 8/2/2021 4:01 pm

Title XIX | Hospital | PPS

		Cost Center Description	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health Cost	All Other Medical Education Cost	
			1A	1.00	2A	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	0	40.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
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	16,803	0.00	749	30.00
31.00	03100	INTENSIVE CARE UNIT		0	2,986	0.00	101	31.00
40.00	04000	SUBPROVIDER - IPF	0	0	0	0.00	0	40.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0.00	0	41.00
43.00	04300	NURSERY		0	1,141	0.00	859	43.00
44.00	04400	SKILLED NURSING FACILITY		0	0	0.00	0	44.00
200.00		Total (lines 30 through 199)		0	20,930		1,709	200.00

		Cost Center Description	Inpatient Program Pass-Through Cost (col. 7 x col. 8)	
			9.00	
		INPATIENT ROUTINE SERVICE COST CENTERS		
30.00	03000	ADULTS & PEDIATRICS	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	31.00
40.00	04000	SUBPROVIDER - IPF	0	40.00
41.00	04100	SUBPROVIDER - IRF	0	41.00
43.00	04300	NURSERY	0	43.00
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: 15-0006 | Period: From 01/01/2020 To 12/31/2020 | Worksheet D Part IV | Date/Time Prepared: 8/2/2021 4:01 pm

Title XIX | Hospital | PPS

		Cost Center Description	Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health	
			1.00	2A	2.00	3A	3.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
54.01	05401	ULTRASOUND	0	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.00	03950	OTHER ANCILLARY-OTHER	0	0	0	0	0	76.00
76.01	03610	SLEEP LAB	0	0	0	0	0	76.01
76.02	03020	ACUPUNCTURE	0	0	0	0	0	76.02
76.03	03040	WOUND CARE	0	0	0	0	0	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0		0		0	92.00
		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: 15-0006 | Period: From 01/01/2020 To 12/31/2020 | Worksheet D Part IV Date/Time Prepared: 8/2/2021 4:01 pm

Title XIX | Hospital | PPS

		Cost Center Description	All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7) (see instructions)	
			4.00	5.00	6.00	7.00	8.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	89,761,407	0.000000	50.00
51.00	05100	RECOVERY ROOM	0	0	0	13,783,943	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	3,066,858	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	20,365,406	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	8,912,344	0.000000	54.00
54.01	05401	ULTRASOUND	0	0	0	6,588,703	0.000000	54.01
56.00	05600	RADIOISOTOPE	0	0	0	10,007,453	0.000000	56.00
57.00	05700	CT SCAN	0	0	0	27,225,824	0.000000	57.00
58.00	05800	MRI	0	0	0	9,219,864	0.000000	58.00
60.00	06000	LABORATORY	0	0	0	73,946,727	0.000000	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0	559,634	0.000000	62.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	9,557,329	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	12,710,568	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	5,764,483	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	3,670,158	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	51,610,515	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	15,538,978	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	30,452,217	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	103,560,716	0.000000	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	2,898,415	0.000000	74.00
76.00	03950	OTHER ANCILLARY-OTHER	0	0	0	0	0.000000	76.00
76.01	03610	SLEEP LAB	0	0	0	3,542,009	0.000000	76.01
76.02	03020	ACUPUNCTURE	0	0	0	0	0.000000	76.02
76.03	03040	WOUND CARE	0	0	0	4,917,462	0.000000	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0.000000	90.00
91.00	09100	EMERGENCY	0	0	0	34,386,172	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	4,255,439	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	546,302,624		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 15-0006 | Period: From 01/01/2020 To 12/31/2020 | Worksheet D Part IV Date/Time Prepared: 8/2/2021 4:01 pm

Title XIX | Hospital | PPS

		Cost Center Description	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
			9.00	10.00	11.00	12.00	13.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.000000	893,151	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0.000000	121,807	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	197,370	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	245,125	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	112,575	0	0	0	54.00
54.01	05401	ULTRASOUND	0.000000	77,221	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0.000000	23,811	0	0	0	56.00
57.00	05700	CT SCAN	0.000000	376,298	0	0	0	57.00
58.00	05800	MRI	0.000000	137,590	0	0	0	58.00
60.00	06000	LABORATORY	0.000000	1,415,790	0	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0.000000	26,020	0	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	0.000000	435,099	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	147,683	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	134,286	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	67,456	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	388,804	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	257,869	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	152,763	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	2,137,530	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0.000000	53,048	0	0	0	74.00
76.00	03950	OTHER ANCILLARY-OTHER	0.000000	0	0	0	0	76.00
76.01	03610	SLEEP LAB	0.000000	22,062	0	0	0	76.01
76.02	03020	ACUPUNCTURE	0.000000	0	0	0	0	76.02
76.03	03040	WOUND CARE	0.000000	2,578	0	0	0	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.000000	0	0	0	0	90.00
91.00	09100	EMERGENCY	0.000000	480,630	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	40,802	0	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)		7,947,368	0	0	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-0006 | Period: From 01/01/2020 To 12/31/2020 | Worksheet D Part V Date/Time Prepared: 8/2/2021 4:01 pm

Title XIX | Hospital | PPS

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.136629	0	0	1,251,921	0	50.00
51.00	05100	RECOVERY ROOM	0.199067	0	0	247,667	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1.128519	0	0	171	0	52.00
53.00	05300	ANESTHESIOLOGY	0.131124	0	0	280,181	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.607241	0	0	246,000	0	54.00
54.01	05401	ULTRASOUND	0.114355	0	0	179,241	0	54.01
56.00	05600	RADIOISOTOPE	0.085832	0	0	79,768	0	56.00
57.00	05700	CT SCAN	0.048484	0	0	711,946	0	57.00
58.00	05800	MRI	0.163312	0	0	136,760	0	58.00
60.00	06000	LABORATORY	0.115277	0	0	1,545,035	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0.336400	0	0	20,144	0	62.00
65.00	06500	RESPIRATORY THERAPY	0.206540	0	0	17,358	0	65.00
66.00	06600	PHYSICAL THERAPY	0.562255	0	0	43,087	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.176694	0	0	30,299	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.264127	0	0	33,115	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.150356	0	0	291,324	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.150941	0	0	114,821	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.226405	0	0	189,298	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.130999	0	0	973,424	0	73.00
74.00	07400	RENAL DIALYSIS	0.153055	0	0	0	0	74.00
76.00	03950	OTHER ANCILLARY-OTHER	0.000000	0	0	0	0	76.00
76.01	03610	SLEEP LAB	0.142726	0	0	49,933	0	76.01
76.02	03020	ACUPUNCTURE	0.000000	0	0	0	0	76.02
76.03	03040	WOUND CARE	0.228085	0	0	36,632	0	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.000000	0	0	0	0	90.00
91.00	09100	EMERGENCY	0.169375	0	0	1,677,991	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.341001	0	0	109,178	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0.000000	0	0			95.00
200.00		Subtotal (see instructions)		0	0	8,265,294	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	8,265,294	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-0006 | Period: From 01/01/2020 To 12/31/2020 | Worksheet D Part V Date/Time Prepared: 8/2/2021 4:01 pm

Title XIX | Hospital | PPS

		Cost Center Description	Costs: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	171,049		50.00
51.00	05100	RECOVERY ROOM	0	49,302		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	193		52.00
53.00	05300	ANESTHESIOLOGY	0	36,738		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	149,381		54.00
54.01	05401	ULTRASOUND	0	20,497		54.01
56.00	05600	RADIOISOTOPE	0	6,847		56.00
57.00	05700	CT SCAN	0	34,518		57.00
58.00	05800	MRI	0	22,335		58.00
60.00	06000	LABORATORY	0	178,107		60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	6,776		62.00
65.00	06500	RESPIRATORY THERAPY	0	3,585		65.00
66.00	06600	PHYSICAL THERAPY	0	24,226		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	5,354		67.00
68.00	06800	SPEECH PATHOLOGY	0	8,747		68.00
69.00	06900	ELECTROCARDIOLOGY	0	43,802		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	17,331		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	42,858		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	127,518		73.00
74.00	07400	RENAL DIALYSIS	0	0		74.00
76.00	03950	OTHER ANCILLARY-OTHER	0	0		76.00
76.01	03610	SLEEP LAB	0	7,127		76.01
76.02	03020	ACUPUNCTURE	0	0		76.02
76.03	03040	WOUND CARE	0	8,355		76.03
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0	0		90.00
91.00	09100	EMERGENCY	0	284,210		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	37,230		92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES	0			95.00
200.00		Subtotal (see instructions)	0	1,286,086		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	0	1,286,086		202.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-0006 | Period: From 01/01/2020 To 12/31/2020 | Worksheet D-1 | Date/Time Prepared: 8/2/2021 4:01 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)	16,803	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	16,803	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)	15,665	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)	6,504	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)	21,426,246	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)	21,426,246	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)	21,426,246	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)	1,275.14	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	8,293,511	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)	8,293,511	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-0006 | Period: From 01/01/2020 To 12/31/2020 | Worksheet D-1 | Date/Time Prepared: 8/2/2021 4:01 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	7,027,836	2,986	2,353.60	1,361	3,203,250	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)	13,137,904	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	24,634,665	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)	1,318,419	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	1,252,919	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	2,571,338	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	22,063,327	53.00
	TARGET AMOUNT AND LIMIT COMPUTATION		
54.00	Program discharges	0	54.00
55.00	Target amount per discharge	0.00	55.00
56.00	Target amount (line 54 x line 55)	0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)	0	57.00
58.00	Bonus payment (see instructions)	0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket	0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket	0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)	0	61.00
62.00	Relief payment (see instructions)	0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)	0	63.00
	PROGRAM INPATIENT ROUTINE SWING BED COST		
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)	0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)	0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)	0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)	0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)	0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)	0	69.00
	PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY		
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)		70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)		71.00
72.00	Program routine service cost (line 9 x line 71)		72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)		73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)		74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)		75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)		76.00
77.00	Program capital-related costs (line 9 x line 76)		77.00
78.00	Inpatient routine service cost (line 74 minus line 77)		78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)		79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)		80.00
81.00	Inpatient routine service cost per diem limitation		81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)		82.00
83.00	Reasonable inpatient routine service costs (see instructions)		83.00
84.00	Program inpatient ancillary services (see instructions)		84.00
85.00	Utilization review - physician compensation (see instructions)		85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)		86.00
	PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST		
87.00	Total observation bed days (see instructions)	1,138	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	1,275.14	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	1,451,109	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-0006 | Period: From 01/01/2020 To 12/31/2020 | Worksheet D-1 | Date/Time Prepared: 8/2/2021 4:01 pm

Title XVIII | Hospital | PPS

	Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	2,335,202	21,426,246	0.108988	1,451,109	158,153	90.00
91.00	Nursing School cost	0	21,426,246	0.000000	1,451,109	0	91.00
92.00	Allied health cost	0	21,426,246	0.000000	1,451,109	0	92.00
93.00	All other Medical Education	0	21,426,246	0.000000	1,451,109	0	93.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 15-0006	Period: From 01/01/2020 To 12/31/2020	Worksheet D-1 Date/Time Prepared: 8/2/2021 4:01 pm
	Title XIX	Hospital	PPS

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	16,803	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	16,803	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)	15,665	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)	749	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)	0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period	0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15.00	Total nursery days (title V or XIX only)	1,141	15.00
16.00	Nursery days (title V or XIX only)	859	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)	21,426,246	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)	21,426,246	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)	21,426,246	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)	1,275.14	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	955,080	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)	955,080	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-0006 | Period: From 01/01/2020 To 12/31/2020 | Worksheet D-1 | Date/Time Prepared: 8/2/2021 4:01 pm

Title XIX | Hospital | PPS

	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)	855,647	1,141	749.91	859	644,173	42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	7,027,836	2,986	2,353.60	101	237,714	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)	1,426,671	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	3,263,638	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)	201,317	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	185,340	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	386,657	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	2,876,981	53.00
	TARGET AMOUNT AND LIMIT COMPUTATION		
54.00	Program discharges	0	54.00
55.00	Target amount per discharge	0.00	55.00
56.00	Target amount (line 54 x line 55)	0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)	0	57.00
58.00	Bonus payment (see instructions)	0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket	0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket	0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)	0	61.00
62.00	Relief payment (see instructions)	0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)	0	63.00
	PROGRAM INPATIENT ROUTINE SWING BED COST		
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)	0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)	0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)	0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)	0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)	0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)	0	69.00
	PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY		
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)		70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)		71.00
72.00	Program routine service cost (line 9 x line 71)		72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)		73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)		74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)		75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)		76.00
77.00	Program capital-related costs (line 9 x line 76)		77.00
78.00	Inpatient routine service cost (line 74 minus line 77)		78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)		79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)		80.00
81.00	Inpatient routine service cost per diem limitation		81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)		82.00
83.00	Reasonable inpatient routine service costs (see instructions)		83.00
84.00	Program inpatient ancillary services (see instructions)		84.00
85.00	Utilization review - physician compensation (see instructions)		85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)		86.00
	PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST		
87.00	Total observation bed days (see instructions)	1,138	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	1,275.14	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	1,451,109	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-0006 | Period: From 01/01/2020 To 12/31/2020 | Worksheet D-1 | Date/Time Prepared: 8/2/2021 4:01 pm

Title XIX | Hospital | PPS

	Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	2,335,202	21,426,246	0.108988	1,451,109	158,153	90.00
91.00	Nursing School cost	0	21,426,246	0.000000	1,451,109	0	91.00
92.00	Allied health cost	0	21,426,246	0.000000	1,451,109	0	92.00
93.00	All other Medical Education	0	21,426,246	0.000000	1,451,109	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 15-0006 | Period: From 01/01/2020 To 12/31/2020 | Worksheet D-3 | Date/Time Prepared: 8/2/2021 4:01 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		17,849,264		30.00
31.00	03100	INTENSIVE CARE UNIT		5,563,981		31.00
40.00	04000	SUBPROVIDER - IPF		0		40.00
41.00	04100	SUBPROVIDER - IRF		0		41.00
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.136629	8,524,690	1,164,720	50.00
51.00	05100	RECOVERY ROOM	0.199067	1,011,316	201,320	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1.128519	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.131124	2,193,937	287,678	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.607241	1,212,860	736,498	54.00
54.01	05401	ULTRASOUND	0.114355	417,005	47,687	54.01
56.00	05600	RADIOISOTOPE	0.085832	257,878	22,134	56.00
57.00	05700	CT SCAN	0.048484	3,441,739	166,869	57.00
58.00	05800	MRI	0.163312	703,781	114,936	58.00
60.00	06000	LABORATORY	0.115277	12,185,126	1,404,665	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0.336400	318,572	107,168	62.00
65.00	06500	RESPIRATORY THERAPY	0.206540	4,087,345	844,200	65.00
66.00	06600	PHYSICAL THERAPY	0.562255	1,722,239	968,337	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.176694	1,635,599	289,001	67.00
68.00	06800	SPEECH PATHOLOGY	0.264127	707,018	186,743	68.00
69.00	06900	ELECTROCARDIOLOGY	0.150356	6,747,146	1,014,474	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.150941	2,800,142	422,656	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.226405	6,189,112	1,401,246	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.130999	20,515,233	2,687,475	73.00
74.00	07400	RENAL DIALYSIS	0.153055	1,830,287	280,135	74.00
76.00	03950	OTHER ANCILLARY-OTHER	0.000000	0	0	76.00
76.01	03610	SLEEP LAB	0.142726	97,632	13,935	76.01
76.02	03020	ACUPUNCTURE	0.000000	0	0	76.02
76.03	03040	WOUND CARE	0.228085	4,507	1,028	76.03
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0.000000	0	0	90.00
91.00	09100	EMERGENCY	0.169375	4,014,879	680,020	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.341001	278,531	94,979	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)		80,896,574	13,137,904	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)		80,896,574		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 15-0006 | Period: From 01/01/2020 To 12/31/2020 | Worksheet D-3 | Date/Time Prepared: 8/2/2021 4:01 pm

Title XIX | Hospital | PPS

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		1,944,709		30.00
31.00	03100	INTENSIVE CARE UNIT		749,348		31.00
40.00	04000	SUBPROVIDER - IPF		0		40.00
41.00	04100	SUBPROVIDER - IRF		0		41.00
43.00	04300	NURSERY		195,687		43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.136629	893,151	122,030	50.00
51.00	05100	RECOVERY ROOM	0.199067	121,807	24,248	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1.128519	197,370	222,736	52.00
53.00	05300	ANESTHESIOLOGY	0.131124	245,125	32,142	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.607241	112,575	68,360	54.00
54.01	05401	ULTRASOUND	0.114355	77,221	8,831	54.01
56.00	05600	RADIOISOTOPE	0.085832	23,811	2,044	56.00
57.00	05700	CT SCAN	0.048484	376,298	18,244	57.00
58.00	05800	MRI	0.163312	137,590	22,470	58.00
60.00	06000	LABORATORY	0.115277	1,415,790	163,208	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0.336400	26,020	8,753	62.00
65.00	06500	RESPIRATORY THERAPY	0.206540	435,099	89,865	65.00
66.00	06600	PHYSICAL THERAPY	0.562255	147,683	83,036	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.176694	134,286	23,728	67.00
68.00	06800	SPEECH PATHOLOGY	0.264127	67,456	17,817	68.00
69.00	06900	ELECTROCARDIOLOGY	0.150356	388,804	58,459	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.150941	257,869	38,923	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.226405	152,763	34,586	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.130999	2,137,530	280,014	73.00
74.00	07400	RENAL DIALYSIS	0.153055	53,048	8,119	74.00
76.00	03950	OTHER ANCILLARY-OTHER	0.000000	0	0	76.00
76.01	03610	SLEEP LAB	0.142726	22,062	3,149	76.01
76.02	03020	ACUPUNCTURE	0.000000	0	0	76.02
76.03	03040	WOUND CARE	0.228085	2,578	588	76.03
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0.000000	0	0	90.00
91.00	09100	EMERGENCY	0.169375	480,630	81,407	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.341001	40,802	13,914	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)		7,947,368	1,426,671	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)		7,947,368		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0006	Period: From 01/01/2020 To 12/31/2020	Worksheet E Part A Date/Time Prepared: 8/2/2021 4:01 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)	10,931,396	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1 (see instructions)	5,072,796	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)	839,796	2.03
2.04	Outlier payments for discharges occurring on or after October 1 (see instructions)	751,950	2.04
3.00	Managed Care Simulated Payments	5,501,052	3.00
4.00	Bed days available divided by number of days in the cost reporting period (see instructions)	113.89	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)	4.75	30.00
31.00	Percentage of Medicaid patient days (see instructions)	24.83	31.00
32.00	Sum of lines 30 and 31	29.58	32.00
33.00	Allowable disproportionate share percentage (see instructions)	13.62	33.00
34.00	Disproportionate share adjustment (see instructions)	544,943	34.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0006	Period: From 01/01/2020 To 12/31/2020	Worksheet E Part A Date/Time Prepared: 8/2/2021 4:01 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)	1,777,013	1,257,607	35.02
35.03	Pro rata share of the hospital uncompensated care payment amount (see instructions)	1,330,332	316,986	35.03
36.00	Total uncompensated care (sum of columns 1 and 2 on line 35.03)	1,647,318		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)	19,788,199		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)	19,788,199	49.00
50.00	Payment for inpatient program capital (from Wkst. L, Pt. I and Pt. II, as applicable)	1,471,733	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	227,904	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)	21,487,836	59.00
60.00	Primary payer payments	15,539	60.00
61.00	Total amount payable for program beneficiaries (line 59 minus line 60)	21,472,297	61.00
62.00	Deductibles billed to program beneficiaries	1,568,952	62.00
63.00	Coinsurance billed to program beneficiaries	37,312	63.00
64.00	Allowable bad debts (see instructions)	76,889	64.00
65.00	Adjusted reimbursable bad debts (see instructions)	49,978	65.00
66.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	56,074	66.00
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)	19,916,011	67.00
68.00	Credits received from manufacturers for replaced devices for applicable to MS-DRGs (see instructions)	275	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 PER PS&R	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)	-103,028	70.93
70.94	HRR adjustment amount (see instructions)	-160,929	70.94
70.95	Recovery of accelerated depreciation	0	70.95

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0006	Period: From 01/01/2020 To 12/31/2020	Worksheet E Part A Date/Time Prepared: 8/2/2021 4:01 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)	0	0	70.96
70.97	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period ending on or after 10/1)	0	0	70.97
70.98	Low Volume Payment-3		0	70.98
70.99	HAC adjustment amount (see instructions)		212,241	70.99
71.00	Amount due provider (line 67 minus lines 68 plus/minus lines 69 & 70)		19,439,538	71.00
71.01	Sequestration adjustment (see instructions)		128,301	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		18,892,102	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)		419,135	74.00
74.01	Balance due provider/program-PARHM (see instructions)			74.01
75.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		1,666,193	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

HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULATION EXHIBIT 5 | Provider CCN: 15-0006 | Period: From 01/01/2020 To 12/31/2020 | Worksheet E Part A Exhibit 5 Date/Time Prepared: 8/2/2021 4:01 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	10,931,396	10,931,396		10,931,396	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	5,072,796		5,072,796	5,072,796	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	839,796	839,796		839,796	2.02
2.03	Outlier payments for discharges occurring on or after October 1 (see instructions)	2.04	751,950		751,950	751,950	2.03
3.00	Operating outlier reconciliation	2.01	0	0	0	0	3.00
4.00	Managed care simulated payments	3.00	5,501,052	3,336,250	2,164,802	5,501,052	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	0.1362	0.1362	0.1362		10.00
11.00	Disproportionate share adjustment (see instructions)	34.00	544,943	372,214	172,729	544,943	11.00
11.01	Uncompensated care payments	36.00	1,647,318	1,330,332	316,986	1,647,318	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	19,788,199	13,473,738	6,314,461	19,788,199	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	19,788,199	13,473,738	6,314,461	19,788,199	15.00
16.00	Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable)	50.00	1,471,733	1,115,978	355,755	1,471,733	16.00
17.00	Special add-on payments for new technologies	54.00	227,904	170,617	57,287	227,904	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	275	206	69	275	17.02
18.00	Capital outlier reconciliation adjustment amount (see instructions)	93.00	0	0	0	0	18.00
19.00	SUBTOTAL			14,760,539	6,727,572	21,488,111	19.00

HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULATION EXHIBIT 5 | Provider CCN: 15-0006 | Period: From 01/01/2020 To 12/31/2020 | Worksheet E Part A Exhibit 5 Date/Time Prepared: 8/2/2021 4:01 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	1,234,189	908,839	325,350	1,234,189	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	161,395	151,064	10,331	161,395	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	0.0617	0.0617	0.0617		24.00
25.00	Disproportionate share adjustment (see instructions)	11.00	76,149	56,075	20,074	76,149	25.00
26.00	Total prospective capital payments (see instructions)	12.00	1,471,733	1,115,978	355,755	1,471,733	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	0	0		0	28.00
29.00	Low volume adjustment on or after October 1	70.97	0		0	0	29.00
30.00	HVBP payment adjustment (see instructions)	70.93	-103,028	-75,355	-27,673	-103,028	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	-160,929	-125,665	-35,264	-160,929	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		145,595	66,646	212,241	32.00
100.00	Transfer HAC Reduction Program adjustment to Wkst. E, Pt. A.		Y				100.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0006	Period: From 01/01/2020 To 12/31/2020	Worksheet E Part B Date/Time Prepared: 8/2/2021 4:01 pm
	Title XVIII	Hospital	PPS

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	8,229	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)	14,293,598	2.00
3.00	OPPS payments	12,583,421	3.00
4.00	Outlier payment (see instructions)	155,384	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)	8,229	11.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
12.00	Ancillary service charges	62,650	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)	62,650	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)	62,650	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)	54,421	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)	8,229	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)	12,738,805	24.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
25.00	Deductibles and coinsurance amounts (for CAH, see instructions)	12,943	25.00
26.00	Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)	2,242,900	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)	10,491,191	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)	10,491,191	30.00
31.00	Primary payer payments	409	31.00
32.00	Subtotal (line 30 minus line 31)	10,490,782	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)	214,051	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	139,133	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	201,136	36.00
37.00	Subtotal (see instructions)	10,629,915	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)	10,629,915	40.00
40.01	Sequestration adjustment (see instructions)	70,157	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	10,593,305	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)	-33,547	43.00
43.01	Balance due provider/program-PARHM (see instructions)		43.01
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	44.00
	TO BE COMPLETED BY CONTRACTOR		
90.00	Original outlier amount (see instructions)	0	90.00
91.00	Outlier reconciliation adjustment amount (see instructions)	0	91.00
92.00	The rate used to calculate the Time Value of Money	0.00	92.00
93.00	Time Value of Money (see instructions)	0	93.00
94.00	Total (sum of lines 91 and 93)	0	94.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 15-0006 | Period: From 01/01/2020 To 12/31/2020 | Worksheet E-1 Part I | Date/Time Prepared: 8/2/2021 4:01 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		18,892,102		10,549,105	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	11/17/2020	44,200	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		44,200	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)		18,892,102		10,593,305	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		419,135		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		33,547	6.02
7.00	Total Medicare program liability (see instructions)		19,311,237		10,559,758	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: 15-0006	Period: From 01/01/2020 To 12/31/2020	Worksheet E-1 Part II Date/Time Prepared: 8/2/2021 4:01 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: 15-0006 | Period: From 01/01/2020 To 12/31/2020 | Worksheet E-3 Part VII Date/Time Prepared: 8/2/2021 4:01 pm

Title XIX | Hospital | PPS

		Inpatient	Outpatient	
		1.00	2.00	
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR XIX SERVICES			
	COMPUTATION OF NET COST OF COVERED SERVICES			
1.00	Inpatient hospital/SNF/NF services	0		1.00
2.00	Medical and other services		1,286,086	2.00
3.00	Organ acquisition (certified transplant centers only)	0		3.00
4.00	Subtotal (sum of lines 1, 2 and 3)	0	1,286,086	4.00
5.00	Inpatient primary payer payments	0		5.00
6.00	Outpatient primary payer payments		0	6.00
7.00	Subtotal (line 4 less sum of lines 5 and 6)	0	1,286,086	7.00
	COMPUTATION OF LESSER OF COST OR CHARGES			
	Reasonable Charges			
8.00	Routine service charges	0		8.00
9.00	Ancillary service charges	7,947,368	8,265,294	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)	7,947,368	8,265,294	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)	7,947,368	8,265,294	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)	7,947,368	6,979,208	17.00
18.00	Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 16) (see instructions)	0	0	18.00
19.00	Interns and Residents (see instructions)	0	0	19.00
20.00	Cost of physicians' services in a teaching hospital (see instructions)	0	0	20.00
21.00	Cost of covered services (enter the lesser of line 4 or line 16)	0	1,286,086	21.00
	PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be completed for PPS providers.			
22.00	Other than outlier payments	0	0	22.00
23.00	Outlier payments	0	0	23.00
24.00	Program capital payments	0		24.00
25.00	Capital exception payments (see instructions)	0		25.00
26.00	Routine and Ancillary service other pass through costs	0	0	26.00
27.00	Subtotal (sum of lines 22 through 26)	0	0	27.00
28.00	Customary charges (title V or XIX PPS covered services only)	0	0	28.00
29.00	Titles V or XIX (sum of lines 21 and 27)	0	1,286,086	29.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT			
30.00	Excess of reasonable cost (from line 18)	0	0	30.00
31.00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)	0	1,286,086	31.00
32.00	Deductibles	0	0	32.00
33.00	Coinsurance	0	0	33.00
34.00	Allowable bad debts (see instructions)	0	0	34.00
35.00	Utilization review	0		35.00
36.00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)	0	1,286,086	36.00
37.00	REMOVE SETTLEMENT	0	-1,286,086	37.00
38.00	Subtotal (line 36 ± line 37)	0	0	38.00
39.00	Direct graduate medical education payments (from Wkst. E-4)	0		39.00
40.00	Total amount payable to the provider (sum of lines 38 and 39)	0	0	40.00
41.00	Interim payments	0	0	41.00
42.00	Balance due provider/program (line 40 minus line 41)	0	0	42.00
43.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, chapter 1, §115.2	0	0	43.00

BALANCE SHEET (If you are nonproprietary and do not maintain fund-type accounting records, complete the General Fund column only) | Provider CCN: 15-0006 | Period: From 01/01/2020 To 12/31/2020 | Worksheet G | Date/Time Prepared: 8/2/2021 4:01 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	-144,097	0	0	0	1.00
2.00	Temporary investments	0	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	34,359,530	0	0	0	4.00
5.00	Other receivable	0	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-15,593,949	0	0	0	6.00
7.00	Inventory	3,009,738	0	0	0	7.00
8.00	Prepaid expenses	924,935	0	0	0	8.00
9.00	Other current assets	145,220	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)	22,701,377	0	0	0	11.00
	FIXED ASSETS					
12.00	Land	2,963,232	0	0	0	12.00
13.00	Land improvements	1,881,247	0	0	0	13.00
14.00	Accumulated depreciation	-847,619	0	0	0	14.00
15.00	Buildings	128,860,132	0	0	0	15.00
16.00	Accumulated depreciation	-19,193,172	0	0	0	16.00
17.00	Leasehold improvements	1,235,940	0	0	0	17.00
18.00	Accumulated depreciation	-511,371	0	0	0	18.00
19.00	Fixed equipment	3,428,884	0	0	0	19.00
20.00	Accumulated depreciation	-2,008,893	0	0	0	20.00
21.00	Automobiles and trucks	111,420	0	0	0	21.00
22.00	Accumulated depreciation	-111,420	0	0	0	22.00
23.00	Major movable equipment	41,188,811	0	0	0	23.00
24.00	Accumulated depreciation	-11,532,438	0	0	0	24.00
25.00	Minor equipment depreciable	9,574,073	0	0	0	25.00
26.00	Accumulated depreciation	-5,222,639	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)	149,816,187	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	14,020,838	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	14,020,838	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	186,538,402	0	0	0	36.00
	CURRENT LIABILITIES					
37.00	Accounts payable	6,009,814	0	0	0	37.00
38.00	Salaries, wages, and fees payable	5,631,012	0	0	0	38.00
39.00	Payroll taxes payable	-1,722	0	0	0	39.00
40.00	Notes and loans payable (short term)	1,176,540	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	115,647,909	0	0	0	43.00
44.00	Other current liabilities	18,046,203	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	146,509,756	0	0	0	45.00
	LONG TERM LIABILITIES					
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	0	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	9,450,130	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	9,450,130	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	155,959,886	0	0	0	51.00
	CAPITAL ACCOUNTS					
52.00	General fund balance	30,578,516				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)	30,578,516	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	186,538,402	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES | Provider CCN: 15-0006 | Period: From 01/01/2020 To 12/31/2020 | Worksheet G-1 | Date/Time Prepared: 8/2/2021 4:01 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		10,415,397		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		19,152,454				2.00
3.00	Total (sum of line 1 and line 2)		29,567,851		0		3.00
4.00	FUND BALANCE TIE	1,010,665		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)		1,010,665		0		10.00
11.00	Subtotal (line 3 plus line 10)		30,578,516		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)		30,578,516		0		19.00

		Endowment Fund	Plant Fund			
		6.00	7.00	8.00		
1.00	Fund balances at beginning of period	0		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)					2.00
3.00	Total (sum of line 1 and line 2)	0		0		3.00
4.00	FUND BALANCE TIE		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: 15-0006 | Period: From 01/01/2020 To 12/31/2020 | Worksheet G-2 Parts I & II | Date/Time Prepared: 8/2/2021 4:01 pm

	Cost Center Description	Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospital	43,288,812		43,288,812	1.00
2.00	SUBPROVIDER - IPF	0		0	2.00
3.00	SUBPROVIDER - IRF	0		0	3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	0		0	5.00
6.00	Swing bed - NF	0		0	6.00
7.00	SKILLED NURSING FACILITY	0		0	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)	43,288,812		43,288,812	10.00
	Intensive Care Type Inpatient Hospital Services				
11.00	INTENSIVE CARE UNIT	13,294,251		13,294,251	11.00
12.00	CORONARY CARE UNIT				12.00
13.00	BURN INTENSIVE CARE UNIT				13.00
14.00	SURGICAL INTENSIVE CARE UNIT				14.00
15.00	OTHER SPECIAL CARE (SPECIFY)				15.00
16.00	Total intensive care type inpatient hospital services (sum of lines 11-15)	13,294,251		13,294,251	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	56,583,063		56,583,063	17.00
18.00	Ancillary services	184,122,601	323,538,413	507,661,014	18.00
19.00	Outpatient services	11,001,895	27,639,716	38,641,611	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	0	0	0	23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	OTHER (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)	251,707,559	351,178,129	602,885,688	28.00
	PART II - OPERATING EXPENSES				
29.00	Operating expenses (per Wkst. A, column 3, line 200)		136,360,765		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)		136,360,765		43.00

STATEMENT OF REVENUES AND EXPENSES	Provider CCN: 15-0006	Period: From 01/01/2020 To 12/31/2020	Worksheet G-3 Date/Time Prepared: 8/2/2021 4:01 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	602,885,688	1.00
2.00	Less contractual allowances and discounts on patients' accounts	449,742,756	2.00
3.00	Net patient revenues (line 1 minus line 2)	153,142,932	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	136,360,765	4.00
5.00	Net income from service to patients (line 3 minus line 4)	16,782,167	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	47,590	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	38,817	16.00
17.00	Revenue from sale of drugs to other than patients	19,417	17.00
18.00	Revenue from sale of medical records and abstracts	10,253	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	360,697	22.00
23.00	Governmental appropriations	0	23.00
24.00	TRAINING REVENUE	51,904	24.00
24.01	MISCELLANEOUS NON-PATIENT REVENUE	41,048	24.01
24.02	GAIN/(LOSS) ON THE DISPOSAL OF FA	12,076	24.02
24.03	OTHER MISCELLANEOUS REVENUE	25,848	24.03
24.04	GRANT INCOME	375,644	24.04
24.50	COVID-19 PHE Funding	1,386,993	24.50
25.00	Total other income (sum of lines 6-24)	2,370,287	25.00
26.00	Total (line 5 plus line 25)	19,152,454	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)	19,152,454	29.00

CALCULATION OF CAPITAL PAYMENT	Provider CCN: 15-0006	Period: From 01/01/2020 To 12/31/2020	Worksheet L Parts I-III Date/Time Prepared: 8/2/2021 4:01 pm
	Title XVIII	Hospital	PPS

		1.00	
	PART I - FULLY PROSPECTIVE METHOD		
	CAPITAL FEDERAL AMOUNT		
1.00	Capital DRG other than outlier	1,234,189	1.00
1.01	Model 4 BPCI Capital DRG other than outlier	0	1.01
2.00	Capital DRG outlier payments	161,395	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)	51.99	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)	4.75	7.00
8.00	Percentage of Medicaid patient days to total days (see instructions)	24.83	8.00
9.00	Sum of lines 7 and 8	29.58	9.00
10.00	Allowable disproportionate share percentage (see instructions)	6.17	10.00
11.00	Disproportionate share adjustment (see instructions)	76,149	11.00
12.00	Total prospective capital payments (see instructions)	1,471,733	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