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: 15-0034	Period: From 07/01/2019 To 06/30/2020	Worksheet S Parts I-III Date/Time Prepared: 11/25/2020 2:58 pm

PART I - COST REPORT STATUS

Provider use only

1. [X] Electronically prepared cost report — Date: 11/25/2020 Time: 2:58 pm
2. [ ] Manually prepared cost report
3. [0] If this is an amended report enter the number of times the provider resubmitted this cost report
4. [F] Medicare Utilization. Enter "F" for full or "L" for low.

Contractor use only

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

PART II - CERTIFICATION

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

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

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by ST. MARY MEDICAL CENTER, INC. (15-0034) for the cost reporting period beginning 07/01/2019 and ending 06/30/2020 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

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

(Signed) MARY F. SUDICKY
Officer or Administrator of Provider(s)

VP OF FINANCE/CFO
Title

11/25/2020 02:58:27 PM
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	162,835	-201,654	0	0	1.00
2.00	Subprovider - IPF	0	0	0		0	2.00
3.00	Subprovider - IRF	0	79,241	0		0	3.00
5.00	Swing Bed - SNF	0	0	0		0	5.00
6.00	Swing Bed - NF	0				0	6.00
9.00	HOME HEALTH AGENCY I	0	0	0		0	9.00
200.00	Total	0	242,076	-201,654	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: 15-0034 | Period: From 07/01/2019 To 06/30/2020 | Worksheet S-2 Part I Date/Time Prepared: 11/25/2020 2:58 pm

	1.00	2.00	3.00	4.00	
	Hospital and Hospital Health Care Complex Address:				
1.00	Street: 1500 SOUTH LAKE AVENUE	PO Box:			1.00
2.00	City: HOBART	State: IN	Zip Code: 46342	County: LAKE	2.00

		Component Name	CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N) V	XVIII	XIX	
		1.00	2.00	3.00	4.00	5.00	6.00	7.00	8.00	
	Hospital and Hospital-Based Component Identification:									
3.00	Hospital	ST. MARY MEDICAL CENTER, INC.	150034	23844	1	07/01/1966	N	P	P	3.00
4.00	Subprovider - IPF									4.00
5.00	Subprovider - IRF	SMMC REHABILITATION UNIT	15T034	23844	5	01/01/2001	N	P	P	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	SMMC HOME HEALTH AGENCY	157313	23844		02/08/1996	N	P	N	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)	07/01/2019	06/30/2020	20.00
21.00	Type of Control (see instructions)	2		21.00

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

		In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of State Medicaid paid days	Out-of State Medicaid eligible unpaid	Medicaid HMO days	Other Medicaid days	
		1.00	2.00	3.00	4.00	5.00	6.00	
24.00	If this provider is an IPPS hospital, enter the in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.	1,610	205	65	3	4,936	0	24.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-0034 | Period: From 07/01/2019 To 06/30/2020 | Worksheet S-2 Part I | Date/Time Prepared: 11/25/2020 2:58 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	449		25.00

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

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

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

		V	XVIII	XIX	
		1.00	2.00	3.00	
	Prospective Payment System (PPS)-Capital				
45.00	Does this facility qualify and receive Capital payment for disproportionate share in accordance with 42 CFR Section §412.320? (see instructions)	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.	Y	Y		60.00
60.01	If line 60 is yes, complete columns 2 and 3 for each program. (see instructions)		23.00	1	60.01

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-0034 | Period: From 07/01/2019 To 06/30/2020 | Worksheet S-2 Part I | Date/Time Prepared: 11/25/2020 2:58 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: 15-0034 | Period: From 07/01/2019 To 06/30/2020 | Worksheet S-2 Part I | Date/Time Prepared: 11/25/2020 2:58 pm

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

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-0034 | Period: From 07/01/2019 To 06/30/2020 | Worksheet S-2 Part I Date/Time Prepared: 11/25/2020 2:58 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	N	91.00
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.		N	92.00
93.00	Does this facility operate an ICF/IID facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.	N	N	93.00
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.	N	N	94.00
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	95.00
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.	N	N	96.00
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	97.00
98.00	Does title V or XIX follow Medicare (title XVIII) for the interns and residents post stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N	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.	N	Y	98.01
98.02	Does title V or XIX follow Medicare (title XVIII) for the calculation of observation bed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	Y	98.02
98.03	Does title V or XIX follow Medicare (title XVIII) for a critical access hospital (CAH) reimbursed 101% of inpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.03
98.04	Does title V or XIX follow Medicare (title XVIII) for a CAH reimbursed 101% of outpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.04
98.05	Does title V or XIX follow Medicare (title XVIII) and add back the RCE disallowance on Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	Y	98.05
98.06	Does title V or XIX follow Medicare (title XVIII) when cost reimbursed for Wkst. D, Pts. I through IV? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N	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	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: 15-0034	Period: From 07/01/2019 To 06/30/2020	Worksheet S-2 Part I Date/Time Prepared: 11/25/2020 2:58 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.	Y			117.00
118.00	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.	1			118.00

		Premiums	Losses	Insurance	
		1.00	2.00	3.00	
118.01	List amounts of malpractice premiums and paid losses:	1	0	0	118.01

		1.00	2.00	
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein.	N		118.02
119.00	DO NOT USE THIS LINE			119.00
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 1, "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2, "Y" for yes or "N" for no.	N	N	120.00
121.00	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter "Y" for yes or "N" for no.	Y		121.00
122.00	Does the cost report contain healthcare related taxes as defined in §1903(w)(3) of the Act?Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2 the Worksheet A line number where these taxes are included.	N		122.00
	Transplant Center Information			
125.00	Does this facility operate a transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.	N		125.00
126.00	If this is a Medicare certified kidney transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			126.00
127.00	If this is a Medicare certified heart transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			127.00
128.00	If this is a Medicare certified liver transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			128.00
129.00	If this is a Medicare certified lung transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			129.00
130.00	If this is a Medicare certified pancreas transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			130.00
131.00	If this is a Medicare certified intestinal transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			131.00
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	15H054	140.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-0034 | Period: From 07/01/2019 To 06/30/2020 | Worksheet S-2 Part I | Date/Time Prepared: 11/25/2020 2:58 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 FOUNDATION OF NW IN, INC.	Contractor's Name: WPS	Contractor's Number: 08001	141.00
142.00	Street: STREET: STREET: 10010 DONALD POWER	PO Box: 201		142.00
143.00	City: MUNSTER	State: IN	Zip Code: 46321	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	N	145.00
146.00	Has the cost allocation methodology changed from the previously filed cost report? Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, chapter 40, §4020) If yes, enter the approval date (mm/dd/yyyy) in column 2.	N		146.00

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

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

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

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

		1.00	
	Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act		
167.00	Is this provider a meaningful user under §1886(n)? Enter "Y" for yes or "N" for no.	Y	167.00
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)		168.00
168.01	If this provider is a CAH and is not a meaningful user, does this provider qualify for a hardship exception under §413.70(a)(6)(ii)? Enter "Y" for yes or "N" for no. (see instructions)		168.01
169.00	If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)	0.00	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: 15-0034 | Period: From 07/01/2019 To 06/30/2020 | Worksheet S-2 Part II | Date/Time Prepared: 11/25/2020 2:58 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)	N			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.	Y		7.00
8.00	Were nursing school and/or allied health programs approved and/or renewed during the cost reporting period? If yes, see instructions.	N		8.00
9.00	Are costs claimed for Interns and Residents in an approved graduate medical education program in the current cost report? If yes, see instructions.	N		9.00
10.00	Was an approved Intern and Resident GME program initiated or renewed in the current cost reporting period? If yes, see instructions.	N		10.00
11.00	Are GME cost directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions.	N		11.00

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

		Part A		Part B		
		Y/N	Date	Y/N	Date	
		1.00	2.00	3.00	4.00	
	PS&R Data					
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see instructions)	N		N		16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	Y	10/12/2020	Y	10/12/2020	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: 15-0034 | Period: From 07/01/2019 To 06/30/2020 | Worksheet S-2 Part II Date/Time Prepared: 11/25/2020 2:58 pm

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

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

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

		1.00	2.00	
	Cost Report Preparer Contact Information			
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	CATHERINE	WOERNER	41.00
42.00	Enter the employer/company name of the cost report preparer.	COMMUNITY HOSPITAL		42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	12197031267	CATHERINE.R.WOERNER@COMHS.ORG	43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider CCN: 15-0034	Period: From 07/01/2019 To 06/30/2020	Worksheet S-2 Part II Date/Time Prepared: 11/25/2020 2:58 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.	REIMBURSEMENT SUPERVISOR		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: 15-0034 | Period: From 07/01/2019 To 06/30/2020 | Worksheet S-3 Part I | Date/Time Prepared: 11/25/2020 2:58 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	160	58,560	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)		160	58,560	0.00	0	7.00
8.00	INTENSIVE CARE UNIT	31.00	20	7,320	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)		180	65,880	0.00	0	14.00
15.00	CAH visits					0	15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF	41.00	20	7,320		0	17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY	101.00				0	22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						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)		200				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: 15-0034 | Period: From 07/01/2019 To 06/30/2020 | Worksheet S-3 Part I | Date/Time Prepared: 11/25/2020 2:58 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)	16,879	1,331	38,387			1.00
2.00	HMO and other (see instructions)	10,234	5,119				2.00
3.00	HMO IPF Subprovider	0	0				3.00
4.00	HMO IRF Subprovider	640	449				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)	16,879	1,331	38,387			7.00
8.00	INTENSIVE CARE UNIT	1,707	38	5,137			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		227	1,417			13.00
14.00	Total (see instructions)	18,586	1,596	44,941	0.00	1,097.99	14.00
15.00	CAH visits	0	0	0			15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF	3,787	0	5,991	0.00	29.33	17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY	14,939	0	25,306	0.00	26.90	22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)			50			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	1,154.22	27.00
28.00	Observation Bed Days		0	5,440			28.00
29.00	Ambulance Trips	0					29.00
30.00	Employee discount days (see instruction)			0			30.00
31.00	Employee discount days - IRF			0			31.00
32.00	Labor & delivery days (see instructions)	0	104	223			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: 15-0034 | Period: From 07/01/2019 To 06/30/2020 | Worksheet S-3 Part I | Date/Time Prepared: 11/25/2020 2:58 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	3,893	278	9,227	1.00
2.00	HMO and other (see instructions)			1,679	1,076		2.00
3.00	HMO IPF Subprovider				0		3.00
4.00	HMO IRF Subprovider				45		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	3,893	278	9,227	14.00
15.00	CAH visits						15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF	0.00	0	350	0	533	17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY	0.00					22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						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: 15-0034 | Period: From 07/01/2019 To 06/30/2020 | Worksheet S-3 Part II | Date/Time Prepared: 11/25/2020 2:58 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	73,311,813	0	73,311,813	2,400,785.00	30.54	1.00
2.00	Non-physician anesthetist Part A		0	0	0	0.00	0.00	2.00
3.00	Non-physician anesthetist Part B		0	0	0	0.00	0.00	3.00
4.00	Physician-Part A - Administrative		0	0	0	0.00	0.00	4.00
4.01	Physicians - Part A - Teaching		0	0	0	0.00	0.00	4.01
5.00	Physician and Non Physician-Part B		191,985	0	191,985	3,975.00	48.30	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)		4,325,440	61,782	4,387,222	125,068.00	35.08	10.00
	OTHER WAGES & RELATED COSTS							
11.00	Contract labor: Direct Patient Care		4,291,840	0	4,291,840	85,368.72	50.27	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		724,878	0	724,878	4,643.00	156.12	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		9,898,955	0	9,898,955	297,284.00	33.30	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)		18,094,712	0	18,094,712			17.00
18.00	Wage-related costs (other) (see instructions)							18.00
19.00	Excluded areas		1,062,423	0	1,062,423			19.00
20.00	Non-physician anesthetist Part A		0	0	0			20.00
21.00	Non-physician anesthetist Part B		0	0	0			21.00
22.00	Physician Part A - Administrative		0	0	0			22.00
22.01	Physician Part A - Teaching		0	0	0			22.01
23.00	Physician Part B		40,714	0	40,714			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)		2,596,422	0	2,596,422			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: 15-0034 | Period: From 07/01/2019 To 06/30/2020 | Worksheet S-3 Part II | Date/Time Prepared: 11/25/2020 2:58 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	1,109,417	0	1,109,417	31,017.00	35.77	26.00
27.00	Administrative & General	5.00	6,442,193	0	6,442,193	222,240.00	28.99	27.00
28.00	Administrative & General under contract (see inst.)		1,460,521	0	1,460,521	11,242.00	129.92	28.00
29.00	Maintenance & Repairs	6.00	1,890,098	0	1,890,098	55,197.00	34.24	29.00
30.00	Operation of Plant	7.00	1,082,079	0	1,082,079	52,870.00	20.47	30.00
31.00	Laundry & Linen Service	8.00	101,542	0	101,542	6,805.00	14.92	31.00
32.00	Housekeeping	9.00	2,070,586	0	2,070,586	132,468.00	15.63	32.00
33.00	Housekeeping under contract (see instructions)		0	0	0	0.00	0.00	33.00
34.00	Dietary	10.00	1,943,452	-756,202	1,187,250	68,835.00	17.25	34.00
35.00	Dietary under contract (see instructions)		0	0	0	0.00	0.00	35.00
36.00	Cafeteria	11.00	0	756,202	756,202	43,844.00	17.25	36.00
37.00	Maintenance of Personnel	12.00	0	0	0	0.00	0.00	37.00
38.00	Nursing Administration	13.00	2,763,078	0	2,763,078	73,116.00	37.79	38.00
39.00	Central Services and Supply	14.00	483,614	0	483,614	19,608.00	24.66	39.00
40.00	Pharmacy	15.00	2,767,043	-467,932	2,299,111	55,975.00	41.07	40.00
41.00	Medical Records & Medical Records Library	16.00	0	0	0	0.00	0.00	41.00
42.00	Social Service	17.00	0	0	0	0.00	0.00	42.00
43.00	Other General Service	18.00	0	0	0	0.00	0.00	43.00

HOSPITAL WAGE INDEX INFORMATION | Provider CCN: 15-0034 | Period: From 07/01/2019 To 06/30/2020 | Worksheet S-3 Part III Date/Time Prepared: 11/25/2020 2:58 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)		74,580,349	0	74,580,349	2,408,052.00	30.97	1.00
2.00	Excluded area salaries (see instructions)		4,325,440	61,782	4,387,222	125,068.00	35.08	2.00
3.00	Subtotal salaries (line 1 minus line 2)		70,254,909	-61,782	70,193,127	2,282,984.00	30.75	3.00
4.00	Subtotal other wages & related costs (see inst.)		14,915,673	0	14,915,673	387,295.72	38.51	4.00
5.00	Subtotal wage-related costs (see inst.)		20,691,134	0	20,691,134	0.00	29.48	5.00
6.00	Total (sum of lines 3 thru 5)		105,861,716	-61,782	105,799,934	2,670,279.72	39.62	6.00
7.00	Total overhead cost (see instructions)		22,113,623	-467,932	21,645,691	773,217.00	27.99	7.00

HOSPITAL WAGE RELATED COSTS | Provider CCN: 15-0034 | Period: From 07/01/2019 To 06/30/2020 | Worksheet S-3 Part IV | Date/Time Prepared: 11/25/2020 2:58 pm

		Amount Reported	
		1.00	
	PART IV - WAGE RELATED COSTS		
	Part A - Core List		
	RETIREMENT COST		
1.00	401K Employer Contributions	0	1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution	2,265,514	2.00
3.00	Nonqualified Defined Benefit Plan Cost (see instructions)	0	3.00
4.00	Qualified Defined Benefit Plan Cost (see instructions)	0	4.00
	PLAN ADMINISTRATIVE COSTS (Paid to External Organization)		
5.00	401K/TSA Plan Administration fees	0	5.00
6.00	Legal/Accounting/Management Fees-Pension Plan	0	6.00
7.00	Employee Managed Care Program Administration Fees	0	7.00
	HEALTH AND INSURANCE COST		
8.00	Health Insurance (Purchased or Self Funded)	0	8.00
8.01	Health Insurance (Self Funded without a Third Party Administrator)	0	8.01
8.02	Health Insurance (Self Funded with a Third Party Administrator)	9,888,146	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	719,542	10.00
11.00	Life Insurance (If employee is owner or beneficiary)	67,781	11.00
12.00	Accident Insurance (If employee is owner or beneficiary)	0	12.00
13.00	Disability Insurance (If employee is owner or beneficiary)	54,472	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)	0	14.00
15.00	'Workers' Compensation Insurance	702,908	15.00
16.00	Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. Non cumulative portion)	0	16.00
	TAXES		
17.00	FICA-Employers Portion Only	4,294,921	17.00
18.00	Medicare Taxes - Employers Portion Only	1,016,464	18.00
19.00	Unemployment Insurance	188,101	19.00
20.00	State or Federal Unemployment Taxes	0	20.00
	OTHER		
21.00	Executive Deferred Compensation (Other Than Retirement Cost Reported on lines 1 through 4 above. (see instructions))	0	21.00
22.00	Day Care Cost and Allowances	0	22.00
23.00	Tuition Reimbursement	0	23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)	19,197,849	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: 15-0034 | Period: From 07/01/2019 To 06/30/2020 | Worksheet S-3 Part V | Date/Time Prepared: 11/25/2020 2:58 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	4,291,840	19,197,849	1.00
2.00	Hospital	4,291,840	19,197,849	2.00
3.00	Subprovider - IPF			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			8.00
9.00	Hospital-Based NF			9.00
10.00	Hospital-Based OLTC			10.00
11.00	Hospital-Based HHA	0	0	11.00
12.00	Separately Certified ASC			12.00
13.00	Hospital-Based Hospice			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

HOME HEALTH AGENCY STATISTICAL DATA | Provider CCN: 15-0034 | Component CCN: 15-7313 | Period: From 07/01/2019 To 06/30/2020 | Worksheet S-4 | Date/Time Prepared: 11/25/2020 2:58 pm

Home Health Agency I | PPS

					1.00		
0.00	County						0.00
		Title V	Title XVIII	Title XIX	Other	Total	
		1.00	2.00	3.00	4.00	5.00	
	HOME HEALTH AGENCY STATISTICAL DATA						
1.00	Home Health Aide Hours	0	1,255	0	487	1,742	1.00
2.00	Unduplicated Census Count (see instructions)	0.00	584.00	0.00	988.00	1,572.00	2.00
				Number of Employees (Full Time Equivalent)			
		Enter the number of hours in your normal work week		Staff	Contract	Total	
		0		1.00	2.00	3.00	
	HOME HEALTH AGENCY - NUMBER OF EMPLOYEES						
3.00	Administrator and Assistant Administrator(s)		40.00	0.00	0.00	0.00	3.00
4.00	Director(s) and Assistant Director(s)			1.01	0.00	1.01	4.00
5.00	Other Administrative Personnel			10.71	0.00	10.71	5.00
6.00	Direct Nursing Service			7.25	0.00	7.25	6.00
7.00	Nursing Supervisor			0.00	0.00	0.00	7.00
8.00	Physical Therapy Service			4.15	0.16	4.31	8.00
9.00	Physical Therapy Supervisor			0.00	0.00	0.00	9.00
10.00	Occupational Therapy Service			0.69	0.17	0.86	10.00
11.00	Occupational Therapy Supervisor			0.00	0.00	0.00	11.00
12.00	Speech Pathology Service			0.55	0.08	0.63	12.00
13.00	Speech Pathology Supervisor			0.00	0.00	0.00	13.00
14.00	Medical Social Service			0.22	0.00	0.22	14.00
15.00	Medical Social Service Supervisor			0.00	0.00	0.00	15.00
16.00	Home Health Aide			2.60	0.00	2.60	16.00
17.00	Home Health Aide Supervisor			0.00	0.00	0.00	17.00
18.00	Other (specify)			0.00	0.00	0.00	18.00
	HOME HEALTH AGENCY CBSA CODES						
19.00	Enter in column 1 the number of CBSAs where you provided services during the cost reporting period.			1			19.00
20.00	List those CBSA code(s) in column 1 serviced during this cost reporting period (line 20 contains the first code).			23844			20.00
		Full Episodes					
		Without Outliers	With Outliers	LUPA Episodes	PEP Only Episodes	Total (cols. 1-4)	
		1.00	2.00	3.00	4.00	5.00	
	PPS ACTIVITY DATA						
21.00	Skilled Nursing Visits	4,861	1,686	145	132	6,824	21.00
22.00	Skilled Nursing Visit Charges	927,589	323,141	28,002	24,704	1,303,436	22.00
23.00	Physical Therapy Visits	3,615	944	36	82	4,677	23.00
24.00	Physical Therapy Visit Charges	802,146	211,939	7,994	17,969	1,040,048	24.00
25.00	Occupational Therapy Visits	1,257	552	6	39	1,854	25.00
26.00	Occupational Therapy Visit Charges	278,308	124,012	1,336	8,552	412,208	26.00
27.00	Speech Pathology Visits	187	103	14	2	306	27.00
28.00	Speech Pathology Visit Charges	41,272	23,316	449	3,066	68,103	28.00
29.00	Medical Social Service Visits	17	6	0	0	23	29.00
30.00	Medical Social Service Visit Charges	4,259	1,507	0	0	5,766	30.00
31.00	Home Health Aide Visits	677	569	1	8	1,255	31.00
32.00	Home Health Aide Visit Charges	96,355	81,102	140	1,127	178,724	32.00
33.00	Total visits (sum of lines 21, 23, 25, 27, 29, and 31)	10,614	3,860	202	263	14,939	33.00
34.00	Other Charges	0	0	0	0	0	34.00
35.00	Total Charges (sum of lines 22, 24, 26, 28, 30, 32, and 34)	2,149,929	765,017	37,921	55,418	3,008,285	35.00
36.00	Total Number of Episodes (standard/non outlier)	701		87	7	795	36.00
37.00	Total Number of Outlier Episodes		117		7	124	37.00
38.00	Total Non-Routine Medical Supply Charges	134,904	85,108	3,564	942	224,518	38.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA | Provider CCN: 15-0034 | Period: From 07/01/2019 To 06/30/2020 | Worksheet S-10 | Date/Time Prepared: 11/25/2020 2:58 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)	0.200776	1.00
	Medicaid (see instructions for each line)		
2.00	Net revenue from Medicaid	9,724,046	2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?	N	3.00
4.00	If line 3 is yes, does line 2 include all DSH and/or supplemental payments from Medicaid?		4.00
5.00	If line 4 is no, then enter DSH and/or supplemental payments from Medicaid	0	5.00
6.00	Medicaid charges	131,608,408	6.00
7.00	Medicaid cost (line 1 times line 6)	26,423,810	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)	16,699,764	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)	23	13.00
14.00	Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)	66	14.00
15.00	State or local indigent care program cost (line 1 times line 14)	13	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)	16,699,764	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)	8,210,286	1,251,066	9,461,352	20.00
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	1,648,428	1,251,066	2,899,494	21.00
22.00	Payments received from patients for amounts previously written off as charity care	0	0	0	22.00
23.00	Cost of charity care (line 21 minus line 22)	1,648,428	1,251,066	2,899,494	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)	9,007,003	26.00
27.00	Medicare reimbursable bad debts for the entire hospital complex (see instructions)	687,833	27.00
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)	1,058,204	27.01
28.00	Non-Medicare bad debt expense (see instructions)	7,948,799	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)	1,966,299	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)	4,865,793	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	21,565,557	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 15-0034 | Period: From 07/01/2019 To 06/30/2020 | Worksheet A | Date/Time Prepared: 11/25/2020 2:58 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		9,388,955	9,388,955	387,790	9,776,745	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		8,127,951	8,127,951	8,416	8,136,367	2.00
3.00	00300	OTHER CAP REL COSTS		0	0	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	151,458	10,466,446	10,617,904	0	10,617,904	4.00
4.01	00401	MAINTENANCE OF PERSONNEL	957,959	301,616	1,259,575	0	1,259,575	4.01
5.01	00540	NONPATIENT TELEPHONES	0	0	0	0	0	5.01
5.02	00560	PURCHASING RECEIVING AND STORES	398,106	137,456	535,562	0	535,562	5.02
5.03	00570	PATIENT REGISTRATION	1,651,618	287,733	1,939,351	0	1,939,351	5.03
5.04	00580	PATIENT ACCOUNTING	0	-5	-5	0	-5	5.04
5.05	00590	ADMINISTRATIVE & GENERAL	4,392,469	49,667,153	54,059,622	-705,470	53,354,152	5.05
6.00	00600	MAINTENANCE & REPAIRS	1,890,098	3,614,963	5,505,061	0	5,505,061	6.00
7.00	00700	OPERATION OF PLANT	1,082,079	4,038,046	5,120,125	0	5,120,125	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	101,542	720,116	821,658	0	821,658	8.00
9.00	00900	HOUSEKEEPING	2,070,586	796,268	2,866,854	0	2,866,854	9.00
10.00	01000	DIETARY	1,943,452	1,598,705	3,542,157	-1,378,262	2,163,895	10.00
11.00	01100	CAFETERIA	0	0	0	1,378,262	1,378,262	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	2,763,078	2,385,327	5,148,405	0	5,148,405	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	483,614	514,331	997,945	0	997,945	14.00
15.00	01500	PHARMACY	2,767,043	13,975,821	16,742,864	-13,055,357	3,687,507	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
23.00	02300	PARAMEDICAL EDUCATION PROGRAM EMS	234,915	68,872	303,787	0	303,787	23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	16,719,474	4,110,357	20,829,831	-2,244,399	18,585,432	30.00
31.00	03100	INTENSIVE CARE UNIT	3,606,023	1,122,918	4,728,941	106,605	4,835,546	31.00
41.00	04100	SUBPROVIDER - IRF	1,712,441	902,778	2,615,219	68,850	2,684,069	41.00
43.00	04300	NURSERY	0	0	0	1,321,930	1,321,930	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	4,669,120	11,675,672	16,344,792	0	16,344,792	50.00
51.00	05100	RECOVERY ROOM	1,771,353	435,624	2,206,977	23,841	2,230,818	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	1,234,639	1,234,639	52.00
53.00	05300	ANESTHESIOLOGY	0	3,786,306	3,786,306	0	3,786,306	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,193,061	2,863,494	6,056,555	9,593	6,066,148	54.00
54.01	03630	ULTRA SOUND	819,208	478,208	1,297,416	0	1,297,416	54.01
56.00	05600	RADIOISOTOPE	530,126	1,034,307	1,564,433	0	1,564,433	56.00
57.00	05700	CT SCAN	934,160	1,017,121	1,951,281	0	1,951,281	57.00
59.00	05900	CARDIAC CATHETERIZATION	2,415,884	1,547,293	3,963,177	4,346	3,967,523	59.00
60.00	06000	LABORATORY	3,616,484	4,984,392	8,600,876	139,955	8,740,831	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	200,559	1,160,792	1,361,351	0	1,361,351	62.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	2,062,177	585,430	2,647,607	0	2,647,607	65.00
66.00	06600	PHYSICAL THERAPY	0	2,891,018	2,891,018	0	2,891,018	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	1,013,671	1,013,671	0	1,013,671	67.00
68.00	06800	SPEECH PATHOLOGY	0	449,642	449,642	0	449,642	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	584,065	810,216	1,394,281	0	1,394,281	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	8,729,320	8,729,320	0	8,729,320	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	14,414,025	14,414,025	0	14,414,025	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	12,494,405	12,494,405	73.00
74.00	07400	RENAL DIALYSIS	0	874,044	874,044	0	874,044	74.00
76.97	07697	CARDIAC REHABILITATION	539,926	155,727	695,653	-6,666	688,987	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	2,738,274	1,259,671	3,997,945	103,952	4,101,897	90.00
91.00	09100	EMERGENCY	3,933,377	1,547,010	5,480,387	100,904	5,581,291	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	2,378,084	591,378	2,969,462	0	2,969,462	101.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	73,311,813	174,530,168	247,841,981	-6,666	247,835,315	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
191.00	19100	RESEARCH	0	0	0	6,666	6,666	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	3,780	3,780	0	3,780	192.00
194.00	07950	OTHER NON-REIMBURSEABLE COST CENTER	0	961,621	961,621	0	961,621	194.00
194.01	07951	OTHER NONREIMBURSABLE	0	0	0	0	0	194.01
200.00		TOTAL (SUM OF LINES 118 through 199)	73,311,813	175,495,569	248,807,382	0	248,807,382	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 15-0034 | Period: From 07/01/2019 To 06/30/2020 | Worksheet A | Date/Time Prepared: 11/25/2020 2:58 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	-476,540	9,300,205		1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	978,335	9,114,702		2.00
3.00	00300	OTHER CAP REL COSTS	0	0		3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	1,312,970	11,930,874		4.00
4.01	00401	MAINTENANCE OF PERSONNEL	0	1,259,575		4.01
5.01	00540	NONPATIENT TELEPHONES	527,290	527,290		5.01
5.02	00560	PURCHASING RECEIVING AND STORES	0	535,562		5.02
5.03	00570	PATIENT REGISTRATION	0	1,939,351		5.03
5.04	00580	PATIENT ACCOUNTING	3,387,756	3,387,751		5.04
5.05	00590	ADMINISTRATIVE & GENERAL	-28,833,378	24,520,774		5.05
6.00	00600	MAINTENANCE & REPAIRS	0	5,505,061		6.00
7.00	00700	OPERATION OF PLANT	0	5,120,125		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	821,658		8.00
9.00	00900	HOUSEKEEPING	0	2,866,854		9.00
10.00	01000	DIETARY	-3,516	2,160,379		10.00
11.00	01100	CAFETERIA	-272,968	1,105,294		11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0		12.00
13.00	01300	NURSING ADMINISTRATION	-2,015,274	3,133,131		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	997,945		14.00
15.00	01500	PHARMACY	0	3,687,507		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	2,643,574	2,643,574		16.00
17.00	01700	SOCIAL SERVICE	0	0		17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0		19.00
23.00	02300	PARAMEDICAL EDUCATION PROGRAM EMS	-34,734	269,053		23.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	-366,018	18,219,414		30.00
31.00	03100	INTENSIVE CARE UNIT	-9,038	4,826,508		31.00
41.00	04100	SUBPROVIDER - IRF	0	2,684,069		41.00
43.00	04300	NURSERY	0	1,321,930		43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	-75,643	16,269,149		50.00
51.00	05100	RECOVERY ROOM	-8	2,230,810		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	1,234,639		52.00
53.00	05300	ANESTHESIOLOGY	-3,366,586	419,720		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-16,564	6,049,584		54.00
54.01	03630	ULTRA SOUND	0	1,297,416		54.01
56.00	05600	RADIOISOTOPE	0	1,564,433		56.00
57.00	05700	CT SCAN	-175	1,951,106		57.00
59.00	05900	CARDIAC CATHETERIZATION	-6,487	3,961,036		59.00
60.00	06000	LABORATORY	-198,055	8,542,776		60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	1,361,351		62.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0		62.30
65.00	06500	RESPIRATORY THERAPY	-747	2,646,860		65.00
66.00	06600	PHYSICAL THERAPY	0	2,891,018		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	1,013,671		67.00
68.00	06800	SPEECH PATHOLOGY	0	449,642		68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	-14,738	1,379,543		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	8,729,320		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	14,414,025		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	12,494,405		73.00
74.00	07400	RENAL DIALYSIS	0	874,044		74.00
76.97	07697	CARDIAC REHABILITATION	-64,424	624,563		76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0		76.98
76.99	07699	LITHOTRIPSY	0	0		76.99
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	-287,871	3,814,026		90.00
91.00	09100	EMERGENCY	-370	5,580,921		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				92.00
		OTHER REIMBURSABLE COST CENTERS				
101.00	10100	HOME HEALTH AGENCY	-6,472	2,962,990		101.00
		SPECIAL PURPOSE COST CENTERS				
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-27,199,681	220,635,634		118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		190.00
191.00	19100	RESEARCH	0	6,666		191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	3,780		192.00
194.00	07950	OTHER NON-REIMBURSEABLE COST CENTER	0	961,621		194.00
194.01	07951	OTHER NONREIMBURSABLE	0	0		194.01
200.00		TOTAL (SUM OF LINES 118 through 199)	-27,199,681	221,607,701		200.00

RECLASSIFICATIONS | Provider CCN: 15-0034 | Period: From 07/01/2019 To 06/30/2020 | Worksheet A-6 | Date/Time Prepared: 11/25/2020 2:58 pm

		Increases			
	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
	A - RECLASS PROPERTY INSURANCE				
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	159,823	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	8,416	2.00
	TOTALS		0	168,239	
	B - RECLASS DRUG COSTS				
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	12,494,405	1.00
	TOTALS		0	12,494,405	
	C - CAFETERIA EXPENSES RECLASS				
1.00	CAFETERIA	11.00	756,202	622,060	1.00
	TOTALS		756,202	622,060	
	D - RESEARCH RECLASS				
1.00	RESEARCH	191.00	5,799	867	1.00
	TOTALS		5,799	867	
	E - RECLASS FLOAT NURSES				
1.00	INTENSIVE CARE UNIT	31.00	54,629	0	1.00
2.00	SUBPROVIDER - IRF	41.00	33,230	0	2.00
3.00	NURSERY	43.00	15,123	0	3.00
4.00	DELIVERY ROOM & LABOR ROOM	52.00	14,124	0	4.00
5.00	EMERGENCY	91.00	66,493	0	5.00
	TOTALS		183,599	0	
	F - RECLASS LDRP COSTS				
1.00	NURSERY	43.00	935,020	371,787	1.00
2.00	DELIVERY ROOM & LABOR ROOM	52.00	873,278	347,237	2.00
	TOTALS		1,808,298	719,024	
	G - RECLASS IV COSTS				
1.00	ADULTS & PEDIATRICS	30.00	298,000	168,522	1.00
2.00	INTENSIVE CARE UNIT	31.00	33,201	18,775	2.00
3.00	SUBPROVIDER - IRF	41.00	22,753	12,867	3.00
4.00	RECOVERY ROOM	51.00	15,229	8,612	4.00
5.00	RADIOLOGY-DIAGNOSTIC	54.00	6,128	3,465	5.00
6.00	CARDIAC CATHETERIZATION	59.00	2,776	1,570	6.00
7.00	LABORATORY	60.00	1,462	827	7.00
8.00	CLINIC	90.00	66,402	37,550	8.00
9.00	EMERGENCY	91.00	21,981	12,430	9.00
	TOTALS		467,932	264,618	
	H - INTEREST EXPENSE RECLASS				
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	227,967	1.00
	TOTALS		0	227,967	
	I - RECLASS COVID COSTS				
1.00	PHARMACY	15.00	0	171,598	1.00
2.00	LABORATORY	60.00	0	137,666	2.00
	TOTALS		0	309,264	
500.00	Grand Total: Increases		3,221,830	14,806,444	500.00

RECLASSIFICATIONS | Provider CCN: 15-0034 | Period: From 07/01/2019 To 06/30/2020 | Worksheet A-6 | Date/Time Prepared: 11/25/2020 2:58 pm

		Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	A - RECLASS PROPERTY INSURANCE						
1.00	ADMINISTRATIVE & GENERAL	5.05	0	168,239	12		1.00
2.00		0.00	0	0	12		2.00
	TOTALS		0	168,239			
	B - RECLASS DRUG COSTS						
1.00	PHARMACY	15.00	0	12,494,405	0		1.00
	TOTALS		0	12,494,405			
	C - CAFETERIA EXPENSES RECLASS						
1.00	DIETARY	10.00	756,202	622,060	0		1.00
	TOTALS		756,202	622,060			
	D - RESEARCH RECLASS						
1.00	CARDIAC REHABILITATION	76.97	5,799	867	0		1.00
	TOTALS		5,799	867			
	E - RECLASS FLOAT NURSES						
1.00	ADULTS & PEDIATRICS	30.00	183,599	0	0		1.00
2.00		0.00	0	0	0		2.00
3.00		0.00	0	0	0		3.00
4.00		0.00	0	0	0		4.00
5.00		0.00	0	0	0		5.00
	TOTALS		183,599	0			
	F - RECLASS LDRP COSTS						
1.00	ADULTS & PEDIATRICS	30.00	935,020	371,787	0		1.00
2.00	ADULTS & PEDIATRICS	30.00	873,278	347,237	0		2.00
	TOTALS		1,808,298	719,024			
	G - RECLASS IV COSTS						
1.00	PHARMACY	15.00	467,932	264,618	0		1.00
2.00		0.00	0	0	0		2.00
3.00		0.00	0	0	0		3.00
4.00		0.00	0	0	0		4.00
5.00		0.00	0	0	0		5.00
6.00		0.00	0	0	0		6.00
7.00		0.00	0	0	0		7.00
8.00		0.00	0	0	0		8.00
9.00		0.00	0	0	0		9.00
	TOTALS		467,932	264,618			
	H - INTEREST EXPENSE RECLASS						
1.00	ADMINISTRATIVE & GENERAL	5.05	0	227,967	11		1.00
	TOTALS		0	227,967			
	I - RECLASS COVID COSTS						
1.00	ADMINISTRATIVE & GENERAL	5.05	0	171,598	0		1.00
2.00	ADMINISTRATIVE & GENERAL	5.05	0	137,666	0		2.00
	TOTALS		0	309,264			
500.00	Grand Total: Decreases		3,221,830	14,806,444			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-0034 | Period: From 07/01/2019 To 06/30/2020 | Worksheet A-7 Part I | Date/Time Prepared: 11/25/2020 2:58 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	11,734,736	1,302,739	0	1,302,739	0	1.00
2.00	Land Improvements	7,644,673	219,050	0	219,050	0	2.00
3.00	Buildings and Fixtures	124,547,835	4,590,543	0	4,590,543	0	3.00
4.00	Building Improvements	66,601,754	7,300,626	0	7,300,626	0	4.00
5.00	Fixed Equipment	0	0	0	0	0	5.00
6.00	Movable Equipment	71,405,857	6,710,302	0	6,710,302	0	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	281,934,855	20,123,260	0	20,123,260	0	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	281,934,855	20,123,260	0	20,123,260	0	10.00

		Ending Balance	Fully Depreciated Assets	
		6.00	7.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES			
1.00	Land	13,037,475	0	1.00
2.00	Land Improvements	7,863,723	0	2.00
3.00	Buildings and Fixtures	129,138,378	0	3.00
4.00	Building Improvements	73,902,380	0	4.00
5.00	Fixed Equipment	0	0	5.00
6.00	Movable Equipment	78,116,159	0	6.00
7.00	HIT designated Assets	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	302,058,115	0	8.00
9.00	Reconciling Items	0	0	9.00
10.00	Total (line 8 minus line 9)	302,058,115	0	10.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-0034 | Period: From 07/01/2019 To 06/30/2020 | Worksheet A-7 Part II | Date/Time Prepared: 11/25/2020 2:58 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	8,257,626	1,131,329	0	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	6,104,716	2,023,235	0	0	0	2.00
3.00	Total (sum of lines 1-2)	14,362,342	3,154,564	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	9,388,955	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	8,127,951	2.00
3.00	Total (sum of lines 1-2)	0	17,516,906	3.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-0034 | Period: From 07/01/2019 To 06/30/2020 | Worksheet A-7 Part III Date/Time Prepared: 11/25/2020 2:58 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	223,941,956	0	223,941,956	0.741387	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	78,116,158	0	78,116,158	0.258613	0	2.00
3.00	Total (sum of lines 1-2)	302,058,114	0	302,058,114	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	8,009,053	1,131,329	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	7,083,051	2,023,235	2.00
3.00	Total (sum of lines 1-2)	0	0	0	15,092,104	3,154,564	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	0	159,823	0	0	9,300,205	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	8,416	0	0	9,114,702	2.00
3.00	Total (sum of lines 1-2)	0	168,239	0	0	18,414,907	3.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 15-0034 | Period: From 07/01/2019 To 06/30/2020 | Worksheet A-8 | Date/Time Prepared: 11/25/2020 2:58 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	-121,549	NONPATIENT TELEPHONES	5.01	0	7.00
8.00	Television and radio service (chapter 21)	A	-11,008	CAP REL COSTS-MVBLE EQUIP	2.00	9	8.00
9.00	Parking lot (chapter 21)		0		0.00	0	9.00
10.00	Provider-based physician adjustment	A-8-2	-246,972			0	10.00
11.00	Sale of scrap, waste, etc. (chapter 23)		0		0.00	0	11.00
12.00	Related organization transactions (chapter 10)	A-8-1	-3,471,254			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests	B	-272,968	CAFETERIA	11.00	0	14.00
15.00	Rental of quarters to employee and others		0		0.00	0	15.00
16.00	Sale of medical and surgical supplies to other than patients		0		0.00	0	16.00
17.00	Sale of drugs to other than patients		0		0.00	0	17.00
18.00	Sale of medical records and abstracts		0		0.00	0	18.00
19.00	Nursing and allied health education (tuition, fees, books, etc.)		0		0.00	0	19.00
20.00	Vending machines	B	-3,127	DIETARY	10.00	0	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	0	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	RESPIRATORY THERAPY	65.00		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	PHYSICAL THERAPY	66.00		24.00
25.00	Utilization review - physicians' compensation (chapter 21)		0	*** Cost Center Deleted ***	114.00		25.00
26.00	Depreciation - CAP REL COSTS-BLDG & FIXT	A	-349,988	CAP REL COSTS-BLDG & FIXT	1.00	9	26.00
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	27.00
28.00	Non-physician Anesthetist		0	NONPHYSICIAN ANESTHETISTS	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

ADJUSTMENTS TO EXPENSES | Provider CCN: 15-0034 | Period: From 07/01/2019 To 06/30/2020 | Worksheet A-8 | Date/Time Prepared: 11/25/2020 2:58 pm

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
33.00	OFFSET CRNA/ANESTHESIOLOGIST FE	A	-3,366,586	ANESTHESIOLOGY	53.00	0	33.00
33.01	AHA LIFE 1991 PHILLIPS EQ	A	5,750	CAP REL COSTS-MVBLE EQUIP	2.00	9	33.01
33.07	1990 ASSETS-INSTALLMENTS	A	-1,397	CAP REL COSTS-MVBLE EQUIP	2.00	9	33.07
34.00	PHOTOGRAPHIC FEES	B	-1,390	RADIOLOGY-DIAGNOSTIC	54.00	0	34.00
34.01	POST ANESTHESIA INCOME	B	-8	RECOVERY ROOM	51.00	0	34.01
34.03	OFFSET OTHER OP REV	B	-34,734	PARAMEDICAL EDUCATION PROGRAM EMS	23.00	0	34.03
34.04	OFFSET OTHER INCOME	B	-476	ADULTS & PEDIATRICS	30.00	0	34.04
35.00	ADVERTISING OFFSET	A	-732,298	ADMINISTRATIVE & GENERAL	5.05	0	35.00
35.03	OFFSET NP SALARIES	A	-191,985	CLINIC	90.00	0	35.03
35.09	OFFSET PHYSICIAN FEES	A	-345,000	ADULTS & PEDIATRICS	30.00	0	35.09
35.10	OFFSET HOSPITALISTS	A	-2,136,110	NURSING ADMINISTRATION	13.00	0	35.10
35.12	OTHER INCOME ADD BACK FOR 2020	A	64,125	ADMINISTRATIVE & GENERAL	5.05	0	35.12
37.00	OTHER OP REV/EP	B	-886	ELECTROENCEPHALOGRAPHY	70.00	0	37.00
38.00	OFFSET LAB INCOME	B	-163,218	LABORATORY	60.00	0	38.00
39.00	OFFSET HHA PR COSTS	A	-4,986	HOME HEALTH AGENCY	101.00	0	39.00
39.01	RELEASED TEMPORARY ASSET INCOME	B	-472	CARDIAC REHABILITATION	76.97	0	39.01
39.02	RELEASED TEMPORARY ASSET INCOME	B	-11,054	ELECTROENCEPHALOGRAPHY	70.00	0	39.02
39.03	RELEASED TEMPORARY ASSET INCOME	B	-48,626	ADMINISTRATIVE & GENERAL	5.05	0	39.03
39.04	RELEASED TEMPORARY ASSET INCOME	B	-985	NURSING ADMINISTRATION	13.00	0	39.04
39.05	RELEASED TEMPORARY ASSET INCOME	B	-183	CLINIC	90.00	0	39.05
39.06	RELEASED TEMPORARY ASSET INCOME	B	-1,486	HOME HEALTH AGENCY	101.00	0	39.06
41.03	OFFSET OTHER INCOME	B	-520	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	41.03
42.01	OFFSET PHO REVENUE	B	-14,000	ADMINISTRATIVE & GENERAL	5.05	0	42.01
42.03	OTHER INCOME	B	-49,772	ADMINISTRATIVE & GENERAL	5.05	0	42.03
42.05	OFFSET DIETARY INCOME	B	-389	DIETARY	10.00	0	42.05
42.06	OFFSET OTHER INCOME	B	-9	INTENSIVE CARE UNIT	31.00	0	42.06
43.00	OFFSET OTHER INCOME	B	-370	EMERGENCY	91.00	0	43.00
43.03	OFFSET CONTRIBUTION EXPENSE	A	-33,700	ADMINISTRATIVE & GENERAL	5.05	0	43.03
43.04	OFFSET CONTRIBUTION EXPENSE	A	-28	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	43.04
43.05	OFFSET CONTRIBUTION EXPENSE	A	-645	NURSING ADMINISTRATION	13.00	0	43.05
44.00	PHONE OFFSET	A	-13,983	NONPATIENT TELEPHONES	5.01	0	44.00
46.00	OTHER INCOME RESP THERAPY	B	-263	RESPIRATORY THERAPY	65.00	0	46.00
46.01	OFFSET CARDIAC INCOME	B	-46,640	CARDIAC REHABILITATION	76.97	0	46.01
47.00	OFFSET INTEREST EXPENSE	A	-227,967	CAP REL COSTS-BLDG & FIXT	1.00	11	47.00
47.01	BARIATRIC COSTS/DEPT 4266	A	-57,710	CLINIC	90.00	0	47.01
47.02	OFFSET PHYSICIAN FEES	A	-17,312	CARDIAC REHABILITATION	76.97	0	47.02
47.03	OFFSET PHYSICIAN FEES	A	-71,505	OPERATING ROOM	50.00	0	47.03
47.04	OFFSET PHYSICIAN FEES	A	-3,900	RADIOLOGY-DIAGNOSTIC	54.00	0	47.04
47.05	OFFSET PHYSICIAN FEES	A	-175	CT SCAN	57.00	0	47.05
49.01	OFFSET PHYSICIAN CORP ALLOCATIO	A	-15,211,922	ADMINISTRATIVE & GENERAL	5.05	0	49.01
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-27,199,681				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: 15-0034 | Period: From 07/01/2019 To 06/30/2020 | Worksheet A-8-1 | Date/Time Prepared: 11/25/2020 2:58 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	5.05	ADMINISTRATIVE & GENERAL	OTHER NONCAPITAL COSTS	8,181,260	27,390,399	1.00
2.00	1.00	CAP REL COSTS-BLDG & FIXT	BLDG DEPR	101,415	0	2.00
3.00	2.00	CAP REL COSTS-MVBLE EQUIP	EQ DEPR	984,990	0	3.00
3.01	5.01	NONPATIENT TELEPHONES	TELECOMMUNICATIONS	662,822	0	3.01
3.02	16.00	MEDICAL RECORDS & LIBRARY	MEDICAL RECORDS	2,643,574	0	3.02
3.03	5.04	PATIENT ACCOUNTING	PATIENT ACCTING	3,387,756	0	3.03
3.04	13.00	NURSING ADMINISTRATION	CANCER REGISTRY COSTS	145,801	0	3.04
3.05	4.00	EMPLOYEE BENEFITS DEPARTMENT	ALLOCATED FRINGE BENEFITS CO	1,313,518	0	3.05
4.00	5.05	ADMINISTRATIVE & GENERAL	ALLOCATED SALARY COSTS	6,498,009	0	4.00
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.			23,919,145	27,390,399	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	CFNI	100.00		0.00	6.00
7.00			0.00		0.00	7.00
8.00			0.00		0.00	8.00
9.00			0.00		0.00	9.00
10.00			0.00		0.00	10.00
100.00	G. Other (financial or non-financial) specify:					100.00

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

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

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS	Provider CCN: 15-0034	Period: From 07/01/2019 To 06/30/2020	Worksheet A-8-1 Date/Time Prepared: 11/25/2020 2:58 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	-19,209,139	0		1.00
2.00	101,415	9		2.00
3.00	984,990	9		3.00
3.01	662,822	0		3.01
3.02	2,643,574	0		3.02
3.03	3,387,756	0		3.03
3.04	145,801	0		3.04
3.05	1,313,518	0		3.05
4.00	6,498,009	0		4.00
5.00	-3,471,254			5.00

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

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

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

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

6.00			6.00
7.00			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: 15-0034 | Period: From 07/01/2019 To 06/30/2020 | Worksheet A-8-2 | Date/Time Prepared: 11/25/2020 2:58 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	4.01	AGGREGATE-MAINTENANCE OF PERSONNEL	12,500	0	12,500	211,500	125	1.00
2.00	5.05	AGGREGATE-ADMINISTRATIVE & GENERAL	318,333	0	318,333	211,500	2,186	2.00
3.00	13.00	AGGREGATE-NURSING ADMINISTRATION	50,688	0	50,688	211,500	269	3.00
4.00	30.00	AGGREGATE-ADULTS & PEDIATRICS	34,167	0	34,167	211,500	134	4.00
5.00	31.00	AGGREGATE-INTENSIVE CARE UNIT	37,500	0	37,500	211,500	280	5.00
6.00	50.00	AGGREGATE-OPERATING ROOM	10,417	0	10,417	246,400	53	6.00
7.00	54.00	AGGREGATE-RADIOLOGY-DIAGNOSTIC	25,000	0	25,000	271,900	105	7.00
8.00	59.00	AGGREGATE-CARDIAC CATHETERIZATION	17,500	0	17,500	260,300	88	8.00
9.00	60.00	AGGREGATE-LABORATORY	70,833	0	70,833	211,500	354	9.00
10.00	65.00	AGGREGATE-RESPIRATORY THERAPY	7,500	0	7,500	211,500	69	10.00
11.00	70.00	AGGREGATE-ELECTROENCEPHALOGRAPHY	15,000	0	15,000	211,500	120	11.00
12.00	90.00	AGGREGATE-CLINIC	125,440	0	125,440	211,500	860	12.00
200.00			724,878	0	724,878		4,643	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	4.01	AGGREGATE-MAINTENANCE OF PERSONNEL	12,710	636	0	0	0	1.00
2.00	5.05	AGGREGATE-ADMINISTRATIVE & GENERAL	222,278	11,114	0	0	0	2.00
3.00	13.00	AGGREGATE-NURSING ADMINISTRATION	27,353	1,368	0	0	0	3.00
4.00	30.00	AGGREGATE-ADULTS & PEDIATRICS	13,625	681	0	0	0	4.00
5.00	31.00	AGGREGATE-INTENSIVE CARE UNIT	28,471	1,424	0	0	0	5.00
6.00	50.00	AGGREGATE-OPERATING ROOM	6,279	314	0	0	0	6.00
7.00	54.00	AGGREGATE-RADIOLOGY-DIAGNOSTIC	13,726	686	0	0	0	7.00
8.00	59.00	AGGREGATE-CARDIAC CATHETERIZATION	11,013	551	0	0	0	8.00
9.00	60.00	AGGREGATE-LABORATORY	35,996	1,800	0	0	0	9.00
10.00	65.00	AGGREGATE-RESPIRATORY THERAPY	7,016	351	0	0	0	10.00
11.00	70.00	AGGREGATE-ELECTROENCEPHALOGRAPHY	12,202	610	0	0	0	11.00
12.00	90.00	AGGREGATE-CLINIC	87,447	4,372	0	0	0	12.00
200.00			478,116	23,907	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	4.01	AGGREGATE-MAINTENANCE OF PERSONNEL	0	12,710	0	0		1.00
2.00	5.05	AGGREGATE-ADMINISTRATIVE & GENERAL	0	222,278	96,055	96,055		2.00
3.00	13.00	AGGREGATE-NURSING ADMINISTRATION	0	27,353	23,335	23,335		3.00
4.00	30.00	AGGREGATE-ADULTS & PEDIATRICS	0	13,625	20,542	20,542		4.00
5.00	31.00	AGGREGATE-INTENSIVE CARE UNIT	0	28,471	9,029	9,029		5.00
6.00	50.00	AGGREGATE-OPERATING ROOM	0	6,279	4,138	4,138		6.00
7.00	54.00	AGGREGATE-RADIOLOGY-DIAGNOSTIC	0	13,726	11,274	11,274		7.00
8.00	59.00	AGGREGATE-CARDIAC CATHETERIZATION	0	11,013	6,487	6,487		8.00
9.00	60.00	AGGREGATE-LABORATORY	0	35,996	34,837	34,837		9.00
10.00	65.00	AGGREGATE-RESPIRATORY THERAPY	0	7,016	484	484		10.00
11.00	70.00	AGGREGATE-ELECTROENCEPHALOGRAPHY	0	12,202	2,798	2,798		11.00
12.00	90.00	AGGREGATE-CLINIC	0	87,447	37,993	37,993		12.00

PROVIDER BASED PHYSICIAN ADJUSTMENT | Provider CCN: 15-0034 | Period: From 07/01/2019 To 06/30/2020 | Worksheet A-8-2 | Date/Time Prepared: 11/25/2020 2:58 pm

	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		
200.00			0	478,116	246,972	246,972		200.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-0034 | Period: From 07/01/2019 To 06/30/2020 | Worksheet B Part I Date/Time Prepared: 11/25/2020 2:58 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	MAINTENANCE OF PERSONNEL	
			0	1.00	2.00	4.00	4.01	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	9,300,205	9,300,205				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	9,114,702		9,114,702			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	11,930,874	7,211	7,068	11,945,153		4.00
4.01	00401	MAINTENANCE OF PERSONNEL	1,259,575	62,358	61,114	156,410	1,539,457	4.01
5.01	00540	NONPATIENT TELEPHONES	527,290	35,096	34,396	0	0	5.01
5.02	00560	PURCHASING RECEIVING AND STORES	535,562	76,831	75,299	65,000	15,580	5.02
5.03	00570	PATIENT REGISTRATION	1,939,351	49,688	48,697	269,666	52,901	5.03
5.04	00580	PATIENT ACCOUNTING	3,387,751	11,912	11,675	0	0	5.04
5.05	00590	ADMINISTRATIVE & GENERAL	24,520,774	477,786	468,256	717,176	75,899	5.05
6.00	00600	MAINTENANCE & REPAIRS	5,505,061	881,049	863,475	308,604	35,862	6.00
7.00	00700	OPERATION OF PLANT	5,120,125	392,985	385,147	176,675	34,348	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	821,658	16,428	16,100	16,579	4,419	8.00
9.00	00900	HOUSEKEEPING	2,866,854	72,130	70,692	338,073	86,060	9.00
10.00	01000	DIETARY	2,160,379	121,144	118,728	193,847	44,712	10.00
11.00	01100	CAFETERIA	1,105,294	81,600	79,972	123,468	28,484	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	3,133,131	69,435	68,050	451,139	47,496	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	997,945	67,227	65,886	78,962	12,742	14.00
15.00	01500	PHARMACY	3,687,507	74,321	72,838	375,385	36,362	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	2,643,574	35,602	34,892	0	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
23.00	02300	PARAMEDICAL EDUCATION PROGRAM EMS	269,053	7,481	7,332	38,356	5,081	23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	18,219,414	1,535,412	1,504,787	2,453,254	328,750	30.00
31.00	03100	INTENSIVE CARE UNIT	4,826,508	221,378	216,963	603,110	65,089	31.00
41.00	04100	SUBPROVIDER - IRF	2,684,069	184,344	180,668	288,738	39,632	41.00
43.00	04300	NURSERY	1,321,930	82,728	81,078	155,134	17,877	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	16,269,149	549,141	538,188	762,346	93,829	50.00
51.00	05100	RECOVERY ROOM	2,230,810	107,075	104,939	291,702	31,078	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,234,639	77,269	75,728	144,890	16,701	52.00
53.00	05300	ANESTHESIOLOGY	419,720	5,594	5,482	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	6,049,584	299,642	293,665	522,344	66,278	54.00
54.01	03630	ULTRA SOUND	1,297,416	47,750	46,798	133,755	13,283	54.01
56.00	05600	RADIOISOTOPE	1,564,433	98,516	96,551	86,556	7,486	56.00
57.00	05700	CT SCAN	1,951,106	54,961	53,865	152,524	17,107	57.00
59.00	05900	CARDIAC CATHETERIZATION	3,961,036	177,133	173,600	394,904	40,456	59.00
60.00	06000	LABORATORY	8,542,776	189,652	185,869	590,717	88,411	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	1,361,351	15,029	14,729	32,746	4,027	62.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	2,646,860	61,600	60,371	336,700	40,253	65.00
66.00	06600	PHYSICAL THERAPY	2,891,018	290,661	284,864	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	1,013,671	13,361	13,095	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	449,642	3,976	3,897	0	0	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	1,379,543	56,225	55,104	95,363	11,269	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	8,729,320	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	14,414,025	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	12,494,405	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	874,044	0	0	0	0	74.00
76.97	07697	CARDIAC REHABILITATION	624,563	132,045	129,412	87,209	9,702	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	3,814,026	447,609	438,681	457,931	52,820	90.00
91.00	09100	EMERGENCY	5,580,921	313,778	307,520	656,664	78,939	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	2,962,990	0	0	388,279	36,348	101.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	220,635,634	7,505,163	7,355,471	11,944,206	1,539,281	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	11,996	11,757	0	0	190.00
191.00	19100	RESEARCH	6,666	0	0	947	176	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	3,780	1,598,196	1,566,311	0	0	192.00
194.00	07950	OTHER NON-REIMBURSEABLE COST CENTER	961,621	184,850	181,163	0	0	194.00
194.01	07951	OTHER NONREIMBURSABLE	0	0	0	0	0	194.01
200.00		Cross Foot Adjustments						200.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-0034 | Period: From 07/01/2019 To 06/30/2020 | Worksheet B Part I Date/Time Prepared: 11/25/2020 2:58 pm

	Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	MAINTENANCE OF PERSONNEL	
			BLDG & FIXT	MVBLE EQUIP			
		0	1.00	2.00	4.00	4.01	
201.00	Negative Cost Centers		0	0	0	0	201.00
202.00	TOTAL (sum lines 118 through 201)	221,607,701	9,300,205	9,114,702	11,945,153	1,539,457	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-0034 | Period: From 07/01/2019 To 06/30/2020 | Worksheet B Part I | Date/Time Prepared: 11/25/2020 2:58 pm

		Cost Center Description	NONPATIENT TELEPHONES	PURCHASING RECEIVING AND STORES	PATIENT REGISTRATION	PATIENT ACCOUNTING	Subtotal	
			5.01	5.02	5.03	5.04	5A.04	
		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
4.01	00401	MAINTENANCE OF PERSONNEL						4.01
5.01	00540	NONPATIENT TELEPHONES	596,782					5.01
5.02	00560	PURCHASING RECEIVING AND STORES	0	768,272				5.02
5.03	00570	PATIENT REGISTRATION	11,276	976	2,372,555			5.03
5.04	00580	PATIENT ACCOUNTING	0	0	0	3,411,338		5.04
5.05	00590	ADMINISTRATIVE & GENERAL	121,872	1,546	0	0	26,383,309	5.05
6.00	00600	MAINTENANCE & REPAIRS	10,843	623	0	0	7,605,517	6.00
7.00	00700	OPERATION OF PLANT	5,204	134	0	0	6,114,618	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	434	28	0	0	875,646	8.00
9.00	00900	HOUSEKEEPING	9,108	2,276	0	0	3,445,193	9.00
10.00	01000	DIETARY	6,506	5,655	0	0	2,650,971	10.00
11.00	01100	CAFETERIA	0	0	0	0	1,418,818	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	3,470	205	0	0	3,772,926	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	4,771	7,868	0	0	1,235,401	14.00
15.00	01500	PHARMACY	8,674	13,128	0	0	4,268,215	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	2,714,068	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
23.00	02300	PARAMEDICAL EDUCATION PROGRAM EMS	867	1,356	0	0	329,526	23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	154,399	63,566	169,204	243,320	24,672,106	30.00
31.00	03100	INTENSIVE CARE UNIT	19,517	24,888	29,784	42,830	6,050,067	31.00
41.00	04100	SUBPROVIDER - IRF	16,915	4,856	17,098	24,587	3,440,907	41.00
43.00	04300	NURSERY	0	0	9,091	13,074	1,680,912	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	32,094	321,983	272,533	391,911	19,231,174	50.00
51.00	05100	RECOVERY ROOM	3,903	9,263	33,529	48,216	2,860,515	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	8,514	12,243	1,569,984	52.00
53.00	05300	ANESTHESIOLOGY	867	14,247	54,573	78,477	578,960	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	19,517	13,569	196,445	282,493	7,743,537	54.00
54.01	03630	ULTRA SOUND	4,771	9,438	47,174	67,838	1,668,223	54.01
56.00	05600	RADIOISOTOPE	9,542	1,093	40,559	58,325	1,963,061	56.00
57.00	05700	CT SCAN	5,204	8,908	170,916	245,782	2,660,373	57.00
59.00	05900	CARDIAC CATHETERIZATION	13,879	28,233	206,230	296,564	5,292,035	59.00
60.00	06000	LABORATORY	12,578	119,708	287,424	412,863	10,429,998	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	1,735	7,586	12,613	18,137	1,467,953	62.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	1,735	12,430	46,177	66,404	3,272,530	65.00
66.00	06600	PHYSICAL THERAPY	10,843	2,633	36,938	53,118	3,570,075	66.00
67.00	06700	OCCUPATIONAL THERAPY	3,903	377	16,061	23,096	1,083,564	67.00
68.00	06800	SPEECH PATHOLOGY	1,301	95	3,027	4,353	466,291	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	6,506	29,489	49,737	71,524	1,754,760	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	59,754	85,927	8,875,001	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	80,350	115,546	14,609,921	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	248,157	356,856	13,099,418	73.00
74.00	07400	RENAL DIALYSIS	0	0	8,979	12,912	895,935	74.00
76.97	07697	CARDIAC REHABILITATION	7,373	373	4,635	6,665	1,001,977	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	42,070	16,318	37,240	53,552	5,360,247	90.00
91.00	09100	EMERGENCY	26,022	44,980	215,059	309,260	7,533,143	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					0	92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	11,710	117	10,754	15,465	3,425,663	101.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	589,409	767,945	2,372,555	3,411,338	217,072,538	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	23,753	190.00
191.00	19100	RESEARCH	0	0	0	0	7,789	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	3,168,287	192.00
194.00	07950	OTHER NON-REIMBURSEABLE COST CENTER	7,373	327	0	0	1,335,334	194.00
194.01	07951	OTHER NONREIMBURSABLE	0	0	0	0	0	194.01
200.00		Cross Foot Adjustments					0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	596,782	768,272	2,372,555	3,411,338	221,607,701	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-0034 | Period: From 07/01/2019 To 06/30/2020 | Worksheet B Part I | Date/Time Prepared: 11/25/2020 2:58 pm

		Cost Center Description	ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
			5.05	6.00	7.00	8.00	9.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
4.01	00401	MAINTENANCE OF PERSONNEL						4.01
5.01	00540	NONPATIENT TELEPHONES						5.01
5.02	00560	PURCHASING RECEIVING AND STORES						5.02
5.03	00570	PATIENT REGISTRATION						5.03
5.04	00580	PATIENT ACCOUNTING						5.04
5.05	00590	ADMINISTRATIVE & GENERAL	26,383,309					5.05
6.00	00600	MAINTENANCE & REPAIRS	1,027,840	8,633,357				6.00
7.00	00700	OPERATION OF PLANT	826,354	440,720	7,381,692			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	118,338	18,423	16,600	1,029,007		8.00
9.00	00900	HOUSEKEEPING	465,597	80,892	72,885	0	4,064,567	9.00
10.00	01000	DIETARY	358,263	135,859	122,411	0	68,230	10.00
11.00	01100	CAFETERIA	191,745	91,511	82,453	0	45,958	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	509,888	77,869	70,161	0	39,107	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	166,957	75,393	67,930	0	37,863	14.00
15.00	01500	PHARMACY	576,824	83,348	75,098	0	41,859	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	366,790	39,926	35,974	0	20,051	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
23.00	02300	PARAMEDICAL EDUCATION PROGRAM EMS	44,533	8,390	7,559	0	4,213	23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	3,334,193	1,721,913	1,551,471	372,844	864,766	30.00
31.00	03100	INTENSIVE CARE UNIT	817,630	248,269	223,694	49,857	124,684	31.00
41.00	04100	SUBPROVIDER - IRF	465,018	206,736	186,272	45,972	103,825	41.00
43.00	04300	NURSERY	227,165	92,777	83,594	8,201	46,594	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,598,978	615,844	554,885	145,000	309,284	50.00
51.00	05100	RECOVERY ROOM	386,581	120,081	108,195	0	60,306	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	212,174	86,655	78,077	9,623	43,519	52.00
53.00	05300	ANESTHESIOLOGY	78,243	6,273	5,652	0	3,151	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,046,493	336,038	302,776	67,397	168,763	54.00
54.01	03630	ULTRA SOUND	225,450	53,550	48,249	19,077	26,893	54.01
56.00	05600	RADIOISOTOPE	265,296	110,482	99,546	8,594	55,486	56.00
57.00	05700	CT SCAN	359,533	61,637	55,536	20,581	30,955	57.00
59.00	05900	CARDIAC CATHETERIZATION	715,187	198,649	178,986	35,162	99,764	59.00
60.00	06000	LABORATORY	1,409,552	212,688	191,635	6,353	106,815	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	198,385	16,855	15,186	0	8,465	62.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	442,263	69,082	62,244	0	34,694	65.00
66.00	06600	PHYSICAL THERAPY	482,474	325,967	293,701	19,449	163,705	66.00
67.00	06700	OCCUPATIONAL THERAPY	146,437	14,984	13,501	6,437	7,525	67.00
68.00	06800	SPEECH PATHOLOGY	63,016	4,459	4,018	1,474	2,240	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	237,145	63,054	56,813	0	31,667	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1,199,403	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1,974,443	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,770,308	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	121,080	0	0	0	0	74.00
76.97	07697	CARDIAC REHABILITATION	135,411	148,084	133,426	945	74,370	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	724,405	501,979	452,291	31,539	252,100	90.00
91.00	09100	EMERGENCY	1,018,059	351,892	317,060	178,894	176,724	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	462,958	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	25,770,409	6,620,279	5,567,879	1,027,399	3,053,576	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	3,210	13,454	12,122	0	6,757	190.00
191.00	19100	RESEARCH	1,053	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	428,175	1,792,321	1,614,908	1,608	900,124	192.00
194.00	07950	OTHER NON-REIMBURSEABLE COST CENTER	180,462	207,303	186,783	0	104,110	194.00
194.01	07951	OTHER NONREIMBURSABLE	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)	26,383,309	8,633,357	7,381,692	1,029,007	4,064,567	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-0034 | Period: From 07/01/2019 To 06/30/2020 | Worksheet B Part I | Date/Time Prepared: 11/25/2020 2:58 pm

		Cost Center Description	DIETARY	CAFETERIA	MAINTENANCE OF PERSONNEL	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	
			10.00	11.00	12.00	13.00	14.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
4.01	00401	MAINTENANCE OF PERSONNEL						4.01
5.01	00540	NONPATIENT TELEPHONES						5.01
5.02	00560	PURCHASING RECEIVING AND STORES						5.02
5.03	00570	PATIENT REGISTRATION						5.03
5.04	00580	PATIENT ACCOUNTING						5.04
5.05	00590	ADMINISTRATIVE & GENERAL						5.05
6.00	00600	MAINTENANCE & REPAIRS						6.00
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	3,335,734					10.00
11.00	01100	CAFETERIA	0	1,830,485				11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0			12.00
13.00	01300	NURSING ADMINISTRATION	0	74,871	0	4,544,822		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	20,086	0	0	1,603,630	14.00
15.00	01500	PHARMACY	0	57,320	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
23.00	02300	PARAMEDICAL EDUCATION PROGRAM EMS	0	8,009	0	0	0	23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,721,771	518,241	0	2,192,059	0	30.00
31.00	03100	INTENSIVE CARE UNIT	192,463	102,605	0	433,993	0	31.00
41.00	04100	SUBPROVIDER - IRF	353,480	62,475	0	264,256	0	41.00
43.00	04300	NURSERY	0	28,181	0	119,205	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	147,911	0	625,661	0	50.00
51.00	05100	RECOVERY ROOM	0	48,991	0	207,248	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	26,327	0	111,330	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	104,479	0	0	0	54.00
54.01	03630	ULTRA SOUND	0	20,938	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0	11,801	0	0	0	56.00
57.00	05700	CT SCAN	0	26,967	0	0	0	57.00
59.00	05900	CARDIAC CATHETERIZATION	0	63,774	0	0	0	59.00
60.00	06000	LABORATORY	0	139,370	0	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	6,348	0	0	0	62.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0	63,454	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
70.00	07000	ELECTROENCEPHALOGRAPHY	0	17,765	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	604,863	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	998,767	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
76.97	07697	CARDIAC REHABILITATION	0	15,294	0	64,701	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	83,264	0	0	0	90.00
91.00	09100	EMERGENCY	68,020	124,438	0	526,369	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	57,299	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	3,335,734	1,830,208	0	4,544,822	1,603,630	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
191.00	19100	RESEARCH	0	277	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07950	OTHER NON-REIMBURSEABLE COST CENTER	0	0	0	0	0	194.00
194.01	07951	OTHER NONREIMBURSABLE	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)	3,335,734	1,830,485	0	4,544,822	1,603,630	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-0034 | Period: From 07/01/2019 To 06/30/2020 | Worksheet B Part I | Date/Time Prepared: 11/25/2020 2:58 pm

		Cost Center Description	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	NONPHYSICIAN ANESTHETISTS	PARAMEDICAL EDUCATION PROGRAM EMS	
			15.00	16.00	17.00	19.00	23.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
4.01	00401	MAINTENANCE OF PERSONNEL						4.01
5.01	00540	NONPATIENT TELEPHONES						5.01
5.02	00560	PURCHASING RECEIVING AND STORES						5.02
5.03	00570	PATIENT REGISTRATION						5.03
5.04	00580	PATIENT ACCOUNTING						5.04
5.05	00590	ADMINISTRATIVE & GENERAL						5.05
6.00	00600	MAINTENANCE & REPAIRS						6.00
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
12.00	01200	MAINTENANCE OF PERSONNEL						12.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY	5,102,664					15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	3,176,809				16.00
17.00	01700	SOCIAL SERVICE	0	0	0			17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0		19.00
23.00	02300	PARAMEDICAL EDUCATION PROGRAM EMS	0	0	0		402,230	23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	226,557	0	0	44,031	30.00
31.00	03100	INTENSIVE CARE UNIT	0	39,879	0	0	21,421	31.00
41.00	04100	SUBPROVIDER - IRF	0	22,893	0	0	0	41.00
43.00	04300	NURSERY	0	12,173	0	0	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	364,912	0	0	42,841	50.00
51.00	05100	RECOVERY ROOM	0	44,894	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	11,400	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	73,071	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	263,032	0	0	0	54.00
54.01	03630	ULTRA SOUND	0	63,164	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0	54,307	0	0	0	56.00
57.00	05700	CT SCAN	0	228,849	0	0	0	57.00
59.00	05900	CARDIAC CATHETERIZATION	0	276,133	0	0	0	59.00
60.00	06000	LABORATORY	0	384,903	0	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	16,888	0	0	0	62.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0	61,829	0	0	23,801	65.00
66.00	06600	PHYSICAL THERAPY	0	49,459	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	21,505	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	4,053	0	0	0	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	66,597	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	80,008	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	107,586	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	5,102,664	332,272	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	12,022	0	0	0	74.00
76.97	07697	CARDIAC REHABILITATION	0	6,206	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	49,863	0	0	0	90.00
91.00	09100	EMERGENCY	0	287,955	0	0	270,136	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	14,399	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	5,102,664	3,176,809	0	0	402,230	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07950	OTHER NON-REIMBURSEABLE COST CENTER	0	0	0	0	0	194.00
194.01	07951	OTHER NONREIMBURSABLE	0	0	0	0	0	194.01
200.00		Cross Foot Adjustments				0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	5,102,664	3,176,809	0	0	402,230	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-0034 | Period: From 07/01/2019 To 06/30/2020 | Worksheet B Part I | Date/Time Prepared: 11/25/2020 2:58 pm

		Cost Center Description	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			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
4.01	00401	MAINTENANCE OF PERSONNEL					4.01
5.01	00540	NONPATIENT TELEPHONES					5.01
5.02	00560	PURCHASING RECEIVING AND STORES					5.02
5.03	00570	PATIENT REGISTRATION					5.03
5.04	00580	PATIENT ACCOUNTING					5.04
5.05	00590	ADMINISTRATIVE & GENERAL					5.05
6.00	00600	MAINTENANCE & REPAIRS					6.00
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
12.00	01200	MAINTENANCE OF PERSONNEL					12.00
13.00	01300	NURSING ADMINISTRATION					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY					14.00
15.00	01500	PHARMACY					15.00
16.00	01600	MEDICAL RECORDS & LIBRARY					16.00
17.00	01700	SOCIAL SERVICE					17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS					19.00
23.00	02300	PARAMEDICAL EDUCATION PROGRAM EMS					23.00
		INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	38,219,952	0	38,219,952		30.00
31.00	03100	INTENSIVE CARE UNIT	8,304,562	0	8,304,562		31.00
41.00	04100	SUBPROVIDER - IRF	5,151,834	0	5,151,834		41.00
43.00	04300	NURSERY	2,298,802	0	2,298,802		43.00
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	24,636,490	0	24,636,490		50.00
51.00	05100	RECOVERY ROOM	3,836,811	0	3,836,811		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	2,149,089	0	2,149,089		52.00
53.00	05300	ANESTHESIOLOGY	745,350	0	745,350		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	10,032,515	0	10,032,515		54.00
54.01	03630	ULTRA SOUND	2,125,544	0	2,125,544		54.01
56.00	05600	RADIOISOTOPE	2,568,573	0	2,568,573		56.00
57.00	05700	CT SCAN	3,444,431	0	3,444,431		57.00
59.00	05900	CARDIAC CATHETERIZATION	6,859,690	0	6,859,690		59.00
60.00	06000	LABORATORY	12,881,314	0	12,881,314		60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	1,730,080	0	1,730,080		62.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0		62.30
65.00	06500	RESPIRATORY THERAPY	4,029,897	0	4,029,897		65.00
66.00	06600	PHYSICAL THERAPY	4,904,830	0	4,904,830		66.00
67.00	06700	OCCUPATIONAL THERAPY	1,293,953	0	1,293,953		67.00
68.00	06800	SPEECH PATHOLOGY	545,551	0	545,551		68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	2,227,801	0	2,227,801		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	10,759,275	0	10,759,275		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	17,690,717	0	17,690,717		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	20,304,662	0	20,304,662		73.00
74.00	07400	RENAL DIALYSIS	1,029,037	0	1,029,037		74.00
76.97	07697	CARDIAC REHABILITATION	1,580,414	0	1,580,414		76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0		76.98
76.99	07699	LITHOTRIPSY	0	0	0		76.99
		OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	7,455,688	0	7,455,688		90.00
91.00	09100	EMERGENCY	10,852,690	0	10,852,690		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART		0			92.00
		OTHER REIMBURSABLE COST CENTERS					
101.00	10100	HOME HEALTH AGENCY	3,960,319	0	3,960,319		101.00
		SPECIAL PURPOSE COST CENTERS					
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	211,619,871	0	211,619,871		118.00
		NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	59,296	0	59,296		190.00
191.00	19100	RESEARCH	9,119	0	9,119		191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	7,905,423	0	7,905,423		192.00
194.00	07950	OTHER NON-REIMBURSEABLE COST CENTER	2,013,992	0	2,013,992		194.00
194.01	07951	OTHER NONREIMBURSABLE	0	0	0		194.01
200.00		Cross Foot Adjustments	0	0	0		200.00
201.00		Negative Cost Centers	0	0	0		201.00
202.00		TOTAL (sum lines 118 through 201)	221,607,701	0	221,607,701		202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-0034 | Period: From 07/01/2019 To 06/30/2020 | Worksheet B Part II Date/Time Prepared: 11/25/2020 2:58 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	7,211	7,068	14,279	14,279	4.00
4.01	00401	MAINTENANCE OF PERSONNEL	0	62,358	61,114	123,472	187	4.01
5.01	00540	NONPATIENT TELEPHONES	0	35,096	34,396	69,492	0	5.01
5.02	00560	PURCHASING RECEIVING AND STORES	0	76,831	75,299	152,130	78	5.02
5.03	00570	PATIENT REGISTRATION	0	49,688	48,697	98,385	322	5.03
5.04	00580	PATIENT ACCOUNTING	0	11,912	11,675	23,587	0	5.04
5.05	00590	ADMINISTRATIVE & GENERAL	0	477,786	468,256	946,042	857	5.05
6.00	00600	MAINTENANCE & REPAIRS	0	881,049	863,475	1,744,524	369	6.00
7.00	00700	OPERATION OF PLANT	0	392,985	385,147	778,132	211	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	16,428	16,100	32,528	20	8.00
9.00	00900	HOUSEKEEPING	0	72,130	70,692	142,822	404	9.00
10.00	01000	DIETARY	0	121,144	118,728	239,872	232	10.00
11.00	01100	CAFETERIA	0	81,600	79,972	161,572	147	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	0	69,435	68,050	137,485	539	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	67,227	65,886	133,113	94	14.00
15.00	01500	PHARMACY	0	74,321	72,838	147,159	448	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	35,602	34,892	70,494	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
23.00	02300	PARAMEDICAL EDUCATION PROGRAM EMS	0	7,481	7,332	14,813	46	23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	1,535,412	1,504,787	3,040,199	2,943	30.00
31.00	03100	INTENSIVE CARE UNIT	0	221,378	216,963	438,341	720	31.00
41.00	04100	SUBPROVIDER - IRF	0	184,344	180,668	365,012	345	41.00
43.00	04300	NURSERY	0	82,728	81,078	163,806	185	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	549,141	538,188	1,087,329	910	50.00
51.00	05100	RECOVERY ROOM	0	107,075	104,939	212,014	348	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	77,269	75,728	152,997	173	52.00
53.00	05300	ANESTHESIOLOGY	0	5,594	5,482	11,076	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	299,642	293,665	593,307	624	54.00
54.01	03630	ULTRA SOUND	0	47,750	46,798	94,548	160	54.01
56.00	05600	RADIOISOTOPE	0	98,516	96,551	195,067	103	56.00
57.00	05700	CT SCAN	0	54,961	53,865	108,826	182	57.00
59.00	05900	CARDIAC CATHETERIZATION	0	177,133	173,600	350,733	472	59.00
60.00	06000	LABORATORY	0	189,652	185,869	375,521	705	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	15,029	14,729	29,758	39	62.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0	61,600	60,371	121,971	402	65.00
66.00	06600	PHYSICAL THERAPY	0	290,661	284,864	575,525	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	13,361	13,095	26,456	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	3,976	3,897	7,873	0	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	56,225	55,104	111,329	114	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.97	07697	CARDIAC REHABILITATION	0	132,045	129,412	261,457	104	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	447,609	438,681	886,290	547	90.00
91.00	09100	EMERGENCY	0	313,778	307,520	621,298	784	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				0		92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	464	101.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	7,505,163	7,355,471	14,860,634	14,278	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	11,996	11,757	23,753	0	190.00
191.00	19100	RESEARCH	0	0	0	0	1	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	1,598,196	1,566,311	3,164,507	0	192.00
194.00	07950	OTHER NON-REIMBURSEABLE COST CENTER	0	184,850	181,163	366,013	0	194.00
194.01	07951	OTHER NONREIMBURSABLE	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

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-0034 | Period: From 07/01/2019 To 06/30/2020 | Worksheet B Part II Date/Time Prepared: 11/25/2020 2:58 pm

	Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
			BLDG & FIXT	MVBLE EQUIP			
		0	1.00	2.00	2A	4.00	
202.00	TOTAL (sum lines 118 through 201)	0	9,300,205	9,114,702	18,414,907	14,279	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-0034 | Period: From 07/01/2019 To 06/30/2020 | Worksheet B Part II Date/Time Prepared: 11/25/2020 2:58 pm

		Cost Center Description	MAINTENANCE OF PERSONNEL	NONPATIENT TELEPHONES	PURCHASING RECEIVING AND STORES	PATIENT REGISTRATION	PATIENT ACCOUNTING	
			4.01	5.01	5.02	5.03	5.04	
		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
4.01	00401	MAINTENANCE OF PERSONNEL	123,659					4.01
5.01	00540	NONPATIENT TELEPHONES	0	69,492				5.01
5.02	00560	PURCHASING RECEIVING AND STORES	1,251	0	153,459			5.02
5.03	00570	PATIENT REGISTRATION	4,249	1,313	195	104,464		5.03
5.04	00580	PATIENT ACCOUNTING	0	0	0	0	23,587	5.04
5.05	00590	ADMINISTRATIVE & GENERAL	6,097	14,191	309	0	0	5.05
6.00	00600	MAINTENANCE & REPAIRS	2,881	1,263	124	0	0	6.00
7.00	00700	OPERATION OF PLANT	2,759	606	27	0	0	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	355	51	6	0	0	8.00
9.00	00900	HOUSEKEEPING	6,913	1,061	455	0	0	9.00
10.00	01000	DIETARY	3,592	758	1,130	0	0	10.00
11.00	01100	CAFETERIA	2,288	0	0	0	0	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	3,815	404	41	0	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	1,024	556	1,572	0	0	14.00
15.00	01500	PHARMACY	2,921	1,010	2,622	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
23.00	02300	PARAMEDICAL EDUCATION PROGRAM EMS	408	101	271	0	0	23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	26,408	17,972	12,697	7,442	1,654	30.00
31.00	03100	INTENSIVE CARE UNIT	5,228	2,273	4,971	1,310	291	31.00
41.00	04100	SUBPROVIDER - IRF	3,183	1,970	970	752	167	41.00
43.00	04300	NURSERY	1,436	0	0	400	89	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	7,537	3,737	64,316	11,986	2,664	50.00
51.00	05100	RECOVERY ROOM	2,496	455	1,850	1,475	328	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,342	0	0	374	83	52.00
53.00	05300	ANESTHESIOLOGY	0	101	2,846	2,400	533	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	5,324	2,273	2,710	8,640	1,920	54.00
54.01	03630	ULTRA SOUND	1,067	556	1,885	2,075	461	54.01
56.00	05600	RADIOISOTOPE	601	1,111	218	1,784	396	56.00
57.00	05700	CT SCAN	1,374	606	1,779	7,517	1,670	57.00
59.00	05900	CARDIAC CATHETERIZATION	3,250	1,616	5,639	9,070	2,016	59.00
60.00	06000	LABORATORY	7,102	1,465	23,911	12,758	3,209	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	323	202	1,515	555	123	62.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	3,233	202	2,483	2,031	451	65.00
66.00	06600	PHYSICAL THERAPY	0	1,263	526	1,625	361	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	455	75	706	157	67.00
68.00	06800	SPEECH PATHOLOGY	0	152	19	133	30	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	905	758	5,890	2,187	486	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	2,628	584	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	3,534	785	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	10,914	2,425	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	395	88	74.00
76.97	07697	CARDIAC REHABILITATION	779	859	75	204	45	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	4,243	4,899	3,259	1,638	364	90.00
91.00	09100	EMERGENCY	6,341	3,030	8,985	9,458	2,102	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	2,920	1,364	23	473	105	101.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	123,645	68,633	153,394	104,464	23,587	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
191.00	19100	RESEARCH	14	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07950	OTHER NON-REIMBURSEABLE COST CENTER	0	859	65	0	0	194.00
194.01	07951	OTHER NONREIMBURSABLE	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)	123,659	69,492	153,459	104,464	23,587	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-0034 | Period: From 07/01/2019 To 06/30/2020 | Worksheet B Part II | Date/Time Prepared: 11/25/2020 2:58 pm

		Cost Center Description	ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
			5.05	6.00	7.00	8.00	9.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
4.01	00401	MAINTENANCE OF PERSONNEL						4.01
5.01	00540	NONPATIENT TELEPHONES						5.01
5.02	00560	PURCHASING RECEIVING AND STORES						5.02
5.03	00570	PATIENT REGISTRATION						5.03
5.04	00580	PATIENT ACCOUNTING						5.04
5.05	00590	ADMINISTRATIVE & GENERAL	967,496					5.05
6.00	00600	MAINTENANCE & REPAIRS	37,693	1,786,854				6.00
7.00	00700	OPERATION OF PLANT	30,304	91,216	903,255			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	4,340	3,813	2,031	43,144		8.00
9.00	00900	HOUSEKEEPING	17,074	16,742	8,918	0	194,389	9.00
10.00	01000	DIETARY	13,138	28,119	14,979	0	3,263	10.00
11.00	01100	CAFETERIA	7,032	18,940	10,089	0	2,198	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	18,699	16,117	8,585	0	1,870	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	6,123	15,604	8,312	0	1,811	14.00
15.00	01500	PHARMACY	21,153	17,251	9,189	0	2,002	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	13,451	8,264	4,402	0	959	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
23.00	02300	PARAMEDICAL EDUCATION PROGRAM EMS	1,633	1,736	925	0	202	23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	122,236	356,386	189,845	15,633	41,358	30.00
31.00	03100	INTENSIVE CARE UNIT	29,984	51,384	27,372	2,090	5,963	31.00
41.00	04100	SUBPROVIDER - IRF	17,053	42,788	22,793	1,928	4,965	41.00
43.00	04300	NURSERY	8,331	19,202	10,229	344	2,228	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	95,310	127,462	67,898	6,080	14,792	50.00
51.00	05100	RECOVERY ROOM	14,177	24,853	13,239	0	2,884	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	7,781	17,935	9,554	403	2,081	52.00
53.00	05300	ANESTHESIOLOGY	2,869	1,298	692	0	151	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	38,377	69,550	37,049	2,826	8,071	54.00
54.01	03630	ULTRA SOUND	8,268	11,083	5,904	800	1,286	54.01
56.00	05600	RADIOISOTOPE	9,729	22,867	12,181	360	2,654	56.00
57.00	05700	CT SCAN	13,185	12,757	6,796	863	1,480	57.00
59.00	05900	CARDIAC CATHETERIZATION	26,227	41,115	21,901	1,474	4,771	59.00
60.00	06000	LABORATORY	51,691	44,020	23,449	266	5,108	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	7,275	3,488	1,858	0	405	62.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	16,219	14,298	7,616	0	1,659	65.00
66.00	06600	PHYSICAL THERAPY	17,693	67,466	35,939	815	7,829	66.00
67.00	06700	OCCUPATIONAL THERAPY	5,370	3,101	1,652	270	360	67.00
68.00	06800	SPEECH PATHOLOGY	2,311	923	492	62	107	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	8,697	13,050	6,952	0	1,514	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	43,985	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	72,407	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	64,921	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	4,440	0	0	0	0	74.00
76.97	07697	CARDIAC REHABILITATION	4,966	30,649	16,327	40	3,557	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	26,565	103,895	55,344	1,322	12,057	90.00
91.00	09100	EMERGENCY	37,334	72,831	38,797	7,501	8,452	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	16,978	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	945,019	1,370,203	681,309	43,077	146,037	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	118	2,785	1,483	0	323	190.00
191.00	19100	RESEARCH	39	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	15,702	370,960	197,607	67	43,050	192.00
194.00	07950	OTHER NON-REIMBURSEABLE COST CENTER	6,618	42,906	22,856	0	4,979	194.00
194.01	07951	OTHER NONREIMBURSABLE	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)	967,496	1,786,854	903,255	43,144	194,389	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-0034 | Period: From 07/01/2019 To 06/30/2020 | Worksheet B Part II | Date/Time Prepared: 11/25/2020 2:58 pm

		Cost Center Description	DIETARY	CAFETERIA	MAINTENANCE OF PERSONNEL	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	
			10.00	11.00	12.00	13.00	14.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
4.01	00401	MAINTENANCE OF PERSONNEL						4.01
5.01	00540	NONPATIENT TELEPHONES						5.01
5.02	00560	PURCHASING RECEIVING AND STORES						5.02
5.03	00570	PATIENT REGISTRATION						5.03
5.04	00580	PATIENT ACCOUNTING						5.04
5.05	00590	ADMINISTRATIVE & GENERAL						5.05
6.00	00600	MAINTENANCE & REPAIRS						6.00
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	305,083					10.00
11.00	01100	CAFETERIA	0	202,266				11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0			12.00
13.00	01300	NURSING ADMINISTRATION	0	8,273	0	195,828		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	2,220	0	0	170,429	14.00
15.00	01500	PHARMACY	0	6,334	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
23.00	02300	PARAMEDICAL EDUCATION PROGRAM EMS	0	885	0	0	0	23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	248,931	57,264	0	94,452	0	30.00
31.00	03100	INTENSIVE CARE UNIT	17,602	11,338	0	18,700	0	31.00
41.00	04100	SUBPROVIDER - IRF	32,329	6,903	0	11,386	0	41.00
43.00	04300	NURSERY	0	3,114	0	5,136	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	16,344	0	26,959	0	50.00
51.00	05100	RECOVERY ROOM	0	5,413	0	8,930	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	2,909	0	4,797	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	11,545	0	0	0	54.00
54.01	03630	ULTRA SOUND	0	2,314	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0	1,304	0	0	0	56.00
57.00	05700	CT SCAN	0	2,980	0	0	0	57.00
59.00	05900	CARDIAC CATHETERIZATION	0	7,047	0	0	0	59.00
60.00	06000	LABORATORY	0	15,400	0	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	701	0	0	0	62.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0	7,012	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
70.00	07000	ELECTROENCEPHALOGRAPHY	0	1,963	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	64,283	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	106,146	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
76.97	07697	CARDIAC REHABILITATION	0	1,690	0	2,788	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	9,201	0	0	0	90.00
91.00	09100	EMERGENCY	6,221	13,750	0	22,680	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	6,331	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	305,083	202,235	0	195,828	170,429	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
191.00	19100	RESEARCH	0	31	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07950	OTHER NON-REIMBURSEABLE COST CENTER	0	0	0	0	0	194.00
194.01	07951	OTHER NONREIMBURSABLE	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)	305,083	202,266	0	195,828	170,429	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-0034 | Period: From 07/01/2019 To 06/30/2020 | Worksheet B Part II Date/Time Prepared: 11/25/2020 2:58 pm

		Cost Center Description	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	NONPHYSICIAN ANESTHETISTS	PARAMEDICAL EDUCATION PROGRAM EMS	
			15.00	16.00	17.00	19.00	23.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
4.01	00401	MAINTENANCE OF PERSONNEL						4.01
5.01	00540	NONPATIENT TELEPHONES						5.01
5.02	00560	PURCHASING RECEIVING AND STORES						5.02
5.03	00570	PATIENT REGISTRATION						5.03
5.04	00580	PATIENT ACCOUNTING						5.04
5.05	00590	ADMINISTRATIVE & GENERAL						5.05
6.00	00600	MAINTENANCE & REPAIRS						6.00
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
12.00	01200	MAINTENANCE OF PERSONNEL						12.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY	210,089					15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	97,570				16.00
17.00	01700	SOCIAL SERVICE	0	0	0			17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0		19.00
23.00	02300	PARAMEDICAL EDUCATION PROGRAM EMS	0	0	0		21,020	23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	6,991	0			30.00
31.00	03100	INTENSIVE CARE UNIT	0	1,231	0			31.00
41.00	04100	SUBPROVIDER - IRF	0	706	0			41.00
43.00	04300	NURSERY	0	376	0			43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	11,260	0			50.00
51.00	05100	RECOVERY ROOM	0	1,385	0			51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	352	0			52.00
53.00	05300	ANESTHESIOLOGY	0	2,255	0			53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	8,116	0			54.00
54.01	03630	ULTRA SOUND	0	1,949	0			54.01
56.00	05600	RADIOISOTOPE	0	1,676	0			56.00
57.00	05700	CT SCAN	0	7,061	0			57.00
59.00	05900	CARDIAC CATHETERIZATION	0	8,520	0			59.00
60.00	06000	LABORATORY	0	11,421	0			60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	521	0			62.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0			62.30
65.00	06500	RESPIRATORY THERAPY	0	1,908	0			65.00
66.00	06600	PHYSICAL THERAPY	0	1,526	0			66.00
67.00	06700	OCCUPATIONAL THERAPY	0	664	0			67.00
68.00	06800	SPEECH PATHOLOGY	0	125	0			68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	2,055	0			70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	2,469	0			71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	3,320	0			72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	210,089	10,253	0			73.00
74.00	07400	RENAL DIALYSIS	0	371	0			74.00
76.97	07697	CARDIAC REHABILITATION	0	191	0			76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0			76.98
76.99	07699	LITHOTRIPSY	0	0	0			76.99
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	1,539	0			90.00
91.00	09100	EMERGENCY	0	8,885	0			91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	444	0			101.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	210,089	97,570	0	0	0	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0			190.00
191.00	19100	RESEARCH	0	0	0			191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0			192.00
194.00	07950	OTHER NON-REIMBURSEABLE COST CENTER	0	0	0			194.00
194.01	07951	OTHER NONREIMBURSABLE	0	0	0			194.01
200.00		Cross Foot Adjustments				0	21,020	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	210,089	97,570	0	0	21,020	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-0034 | Period: From 07/01/2019 To 06/30/2020 | Worksheet B Part II | Date/Time Prepared: 11/25/2020 2:58 pm

		Cost Center Description	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			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
4.01	00401	MAINTENANCE OF PERSONNEL					4.01
5.01	00540	NONPATIENT TELEPHONES					5.01
5.02	00560	PURCHASING RECEIVING AND STORES					5.02
5.03	00570	PATIENT REGISTRATION					5.03
5.04	00580	PATIENT ACCOUNTING					5.04
5.05	00590	ADMINISTRATIVE & GENERAL					5.05
6.00	00600	MAINTENANCE & REPAIRS					6.00
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
12.00	01200	MAINTENANCE OF PERSONNEL					12.00
13.00	01300	NURSING ADMINISTRATION					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY					14.00
15.00	01500	PHARMACY					15.00
16.00	01600	MEDICAL RECORDS & LIBRARY					16.00
17.00	01700	SOCIAL SERVICE					17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS					19.00
23.00	02300	PARAMEDICAL EDUCATION PROGRAM EMS					23.00
		INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	4,242,411	0	4,242,411		30.00
31.00	03100	INTENSIVE CARE UNIT	618,798	0	618,798		31.00
41.00	04100	SUBPROVIDER - IRF	513,250	0	513,250		41.00
43.00	04300	NURSERY	214,876	0	214,876		43.00
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	1,544,584	0	1,544,584		50.00
51.00	05100	RECOVERY ROOM	289,847	0	289,847		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	200,781	0	200,781		52.00
53.00	05300	ANESTHESIOLOGY	24,221	0	24,221		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	790,332	0	790,332		54.00
54.01	03630	ULTRA SOUND	132,356	0	132,356		54.01
56.00	05600	RADIOISOTOPE	250,051	0	250,051		56.00
57.00	05700	CT SCAN	167,076	0	167,076		57.00
59.00	05900	CARDIAC CATHETERIZATION	483,851	0	483,851		59.00
60.00	06000	LABORATORY	576,026	0	576,026		60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	46,763	0	46,763		62.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0		62.30
65.00	06500	RESPIRATORY THERAPY	179,485	0	179,485		65.00
66.00	06600	PHYSICAL THERAPY	710,568	0	710,568		66.00
67.00	06700	OCCUPATIONAL THERAPY	39,266	0	39,266		67.00
68.00	06800	SPEECH PATHOLOGY	12,227	0	12,227		68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	155,900	0	155,900		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	113,949	0	113,949		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	186,192	0	186,192		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	298,602	0	298,602		73.00
74.00	07400	RENAL DIALYSIS	5,294	0	5,294		74.00
76.97	07697	CARDIAC REHABILITATION	323,731	0	323,731		76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0		76.98
76.99	07699	LITHOTRIPSY	0	0	0		76.99
		OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	1,111,163	0	1,111,163		90.00
91.00	09100	EMERGENCY	868,449	0	868,449		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART		0			92.00
		OTHER REIMBURSABLE COST CENTERS					
101.00	10100	HOME HEALTH AGENCY	29,102	0	29,102		101.00
		SPECIAL PURPOSE COST CENTERS					
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	14,129,151	0	14,129,151		118.00
		NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	28,462	0	28,462		190.00
191.00	19100	RESEARCH	85	0	85		191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	3,791,893	0	3,791,893		192.00
194.00	07950	OTHER NON-REIMBURSEABLE COST CENTER	444,296	0	444,296		194.00
194.01	07951	OTHER NONREIMBURSABLE	0	0	0		194.01
200.00		Cross Foot Adjustments	21,020	0	21,020		200.00
201.00		Negative Cost Centers	0	0	0		201.00
202.00		TOTAL (sum lines 118 through 201)	18,414,907	0	18,414,907		202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-0034 | Period: From 07/01/2019 To 06/30/2020 | Worksheet B-1 | Date/Time Prepared: 11/25/2020 2:58 pm

		Cost Center Description	CAPITAL RELATED COSTS					
			BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (SQUARE FEET)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	MAINTENANCE OF PERSONNEL (NUMBER OF FTES)	NONPATIENT TELEPHONES (NUMBER OF PHONES)	
			1.00	2.00	4.00	4.01	5.01	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	551,975					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		551,975				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	428	428	73,160,355			4.00
4.01	00401	MAINTENANCE OF PERSONNEL	3,701	3,701	957,959	113,930		4.01
5.01	00540	NONPATIENT TELEPHONES	2,083	2,083	0	0	1,376	5.01
5.02	00560	PURCHASING RECEIVING AND STORES	4,560	4,560	398,106	1,153	0	5.02
5.03	00570	PATIENT REGISTRATION	2,949	2,949	1,651,618	3,915	26	5.03
5.04	00580	PATIENT ACCOUNTING	707	707	0	0	0	5.04
5.05	00590	ADMINISTRATIVE & GENERAL	28,357	28,357	4,392,469	5,617	281	5.05
6.00	00600	MAINTENANCE & REPAIRS	52,291	52,291	1,890,098	2,654	25	6.00
7.00	00700	OPERATION OF PLANT	23,324	23,324	1,082,079	2,542	12	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	975	975	101,542	327	1	8.00
9.00	00900	HOUSEKEEPING	4,281	4,281	2,070,586	6,369	21	9.00
10.00	01000	DIETARY	7,190	7,190	1,187,250	3,309	15	10.00
11.00	01100	CAFETERIA	4,843	4,843	756,202	2,108	0	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	4,121	4,121	2,763,078	3,515	8	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	3,990	3,990	483,614	943	11	14.00
15.00	01500	PHARMACY	4,411	4,411	2,299,111	2,691	20	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	2,113	2,113	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
23.00	02300	PARAMEDICAL EDUCATION PROGRAM EMS	444	444	234,915	376	2	23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	91,128	91,128	15,025,577	24,330	356	30.00
31.00	03100	INTENSIVE CARE UNIT	13,139	13,139	3,693,853	4,817	45	31.00
41.00	04100	SUBPROVIDER - IRF	10,941	10,941	1,768,424	2,933	39	41.00
43.00	04300	NURSERY	4,910	4,910	950,143	1,323	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	32,592	32,592	4,669,120	6,944	74	50.00
51.00	05100	RECOVERY ROOM	6,355	6,355	1,786,582	2,300	9	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	4,586	4,586	887,402	1,236	0	52.00
53.00	05300	ANESTHESIOLOGY	332	332	0	0	2	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	17,784	17,784	3,199,189	4,905	45	54.00
54.01	03630	ULTRA SOUND	2,834	2,834	819,208	983	11	54.01
56.00	05600	RADIOISOTOPE	5,847	5,847	530,126	554	22	56.00
57.00	05700	CT SCAN	3,262	3,262	934,160	1,266	12	57.00
59.00	05900	CARDIAC CATHETERIZATION	10,513	10,513	2,418,660	2,994	32	59.00
60.00	06000	LABORATORY	11,256	11,256	3,617,946	6,543	29	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	892	892	200,559	298	4	62.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	3,656	3,656	2,062,177	2,979	4	65.00
66.00	06600	PHYSICAL THERAPY	17,251	17,251	0	0	25	66.00
67.00	06700	OCCUPATIONAL THERAPY	793	793	0	0	9	67.00
68.00	06800	SPEECH PATHOLOGY	236	236	0	0	3	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	3,337	3,337	584,065	834	15	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.97	07697	CARDIAC REHABILITATION	7,837	7,837	534,127	718	17	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	26,566	26,566	2,804,676	3,909	97	90.00
91.00	09100	EMERGENCY	18,623	18,623	4,021,851	5,842	60	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	2,378,084	2,690	27	101.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	445,438	445,438	73,154,556	113,917	1,359	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	712	712	0	0	0	190.00
191.00	19100	RESEARCH	0	0	5,799	13	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	94,854	94,854	0	0	0	192.00
194.00	07950	OTHER NON-REIMBURSEABLE COST CENTER	10,971	10,971	0	0	17	194.00
194.01	07951	OTHER NONREIMBURSABLE	0	0	0	0	0	194.01
200.00		Cross Foot Adjustments						200.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-0034 | Period: From 07/01/2019 To 06/30/2020 | Worksheet B-1 | Date/Time Prepared: 11/25/2020 2:58 pm

	Cost Center Description	CAPITAL RELATED COSTS					
		BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (SQUARE FEET)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	MAINTENANCE OF PERSONNEL (NUMBER OF FTES)	NONPATIENT TELEPHONES (NUMBER OF PHONES)	
		1.00	2.00	4.00	4.01	5.01	
201.00	Negative Cost Centers						201.00
202.00	Cost to be allocated (per Wkst. B, Part I)	9,300,205	9,114,702	11,945,153	1,539,457	596,782	202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	16.848961	16.512889	0.163274	13.512306	433.707849	203.00
204.00	Cost to be allocated (per Wkst. B, Part II)			14,279	123,659	69,492	204.00
205.00	Unit cost multiplier (Wkst. B, Part II)			0.000195	1.085395	50.502907	205.00
206.00	NAHE adjustment amount to be allocated (per Wkst. B-2)						206.00
207.00	NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-0034 | Period: From 07/01/2019 To 06/30/2020 | Worksheet B-1 | Date/Time Prepared: 11/25/2020 2:58 pm

		Cost Center Description	PURCHASING RECEIVING AND STORES (SUPPLY EXPENSE)	PATIENT REGISTRATION (GROSS REVENUE)	PATIENT ACCOUNTING (GROSS REVENUE)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
			5.02	5.03	5.04	5A.05	5.05	
		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
4.01	00401	MAINTENANCE OF PERSONNEL						4.01
5.01	00540	NONPATIENT TELEPHONES						5.01
5.02	00560	PURCHASING RECEIVING AND STORES	800,284					5.02
5.03	00570	PATIENT REGISTRATION	1,017	1,054,011,441				5.03
5.04	00580	PATIENT ACCOUNTING	0	0	1,054,011,441			5.04
5.05	00590	ADMINISTRATIVE & GENERAL	1,610	0	0	-26,383,309	195,224,392	5.05
6.00	00600	MAINTENANCE & REPAIRS	649	0	0	0	7,605,517	6.00
7.00	00700	OPERATION OF PLANT	140	0	0	0	6,114,618	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	29	0	0	0	875,646	8.00
9.00	00900	HOUSEKEEPING	2,371	0	0	0	3,445,193	9.00
10.00	01000	DIETARY	5,891	0	0	0	2,650,971	10.00
11.00	01100	CAFETERIA	0	0	0	0	1,418,818	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	214	0	0	0	3,772,926	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	8,196	0	0	0	1,235,401	14.00
15.00	01500	PHARMACY	13,675	0	0	0	4,268,215	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	2,714,068	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
23.00	02300	PARAMEDICAL EDUCATION PROGRAM EMS	1,412	0	0	0	329,526	23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	66,215	75,168,380	75,168,380	0	24,672,106	30.00
31.00	03100	INTENSIVE CARE UNIT	25,925	13,231,282	13,231,282	0	6,050,067	31.00
41.00	04100	SUBPROVIDER - IRF	5,058	7,595,715	7,595,715	0	3,440,907	41.00
43.00	04300	NURSERY	0	4,038,816	4,038,816	0	1,680,912	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	335,397	121,072,178	121,072,178	0	19,231,174	50.00
51.00	05100	RECOVERY ROOM	9,649	14,895,166	14,895,166	0	2,860,515	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	3,782,209	3,782,209	0	1,569,984	52.00
53.00	05300	ANESTHESIOLOGY	14,841	24,243,755	24,243,755	0	578,960	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	14,134	87,269,983	87,269,983	0	7,743,537	54.00
54.01	03630	ULTRA SOUND	9,831	20,956,930	20,956,930	0	1,668,223	54.01
56.00	05600	RADIOISOTOPE	1,139	18,018,157	18,018,157	0	1,963,061	56.00
57.00	05700	CT SCAN	9,279	75,928,829	75,928,829	0	2,660,373	57.00
59.00	05900	CARDIAC CATHETERIZATION	29,409	91,616,864	91,616,864	0	5,292,035	59.00
60.00	06000	LABORATORY	124,696	127,698,865	127,698,865	0	10,429,998	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	7,902	5,603,104	5,603,104	0	1,467,953	62.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	12,948	20,514,071	20,514,071	0	3,272,530	65.00
66.00	06600	PHYSICAL THERAPY	2,743	16,409,705	16,409,705	0	3,570,075	66.00
67.00	06700	OCCUPATIONAL THERAPY	393	7,134,946	7,134,946	0	1,083,564	67.00
68.00	06800	SPEECH PATHOLOGY	99	1,344,715	1,344,715	0	466,291	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	30,718	22,095,722	22,095,722	0	1,754,760	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	26,545,380	26,545,380	0	8,875,001	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	35,695,354	35,695,354	0	14,609,921	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	110,242,958	110,242,958	0	13,099,418	73.00
74.00	07400	RENAL DIALYSIS	0	3,988,736	3,988,736	0	895,935	74.00
76.97	07697	CARDIAC REHABILITATION	389	2,059,117	2,059,117	0	1,001,977	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	16,998	16,543,866	16,543,866	0	5,360,247	90.00
91.00	09100	EMERGENCY	46,854	95,539,169	95,539,169	0	7,533,143	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	122	4,777,469	4,777,469	0	3,425,663	101.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	799,943	1,054,011,441	1,054,011,441	-26,383,309	190,689,229	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	23,753	190.00
191.00	19100	RESEARCH	0	0	0	0	7,789	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	3,168,287	192.00
194.00	07950	OTHER NON-REIMBURSEABLE COST CENTER	341	0	0	0	1,335,334	194.00
194.01	07951	OTHER NONREIMBURSABLE	0	0	0	0	0	194.01
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-0034 | Period: From 07/01/2019 To 06/30/2020 | Worksheet B-1 | Date/Time Prepared: 11/25/2020 2:58 pm

		Cost Center Description	PURCHASING RECEIVING AND STORES (SUPPLY EXPENSE)	PATIENT REGISTRATION (GROSS REVENUE)	PATIENT ACCOUNTING (GROSS REVENUE)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
			5.02	5.03	5.04	5A.05	5.05	
202.00		Cost to be allocated (per Wkst. B, Part I)	768,272	2,372,555	3,411,338		26,383,309	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.959999	0.002251	0.003237		0.135144	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	153,459	104,464	23,587		967,496	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.191756	0.000099	0.000022		0.004956	205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)						206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-0034 | Period: From 07/01/2019 To 06/30/2020 | Worksheet B-1 | Date/Time Prepared: 11/25/2020 2:58 pm

		Cost Center Description	MAINTENANCE & REPAIRS (SQUARE FEET)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	
			6.00	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
4.01	00401	MAINTENANCE OF PERSONNEL						4.01
5.01	00540	NONPATIENT TELEPHONES						5.01
5.02	00560	PURCHASING RECEIVING AND STORES						5.02
5.03	00570	PATIENT REGISTRATION						5.03
5.04	00580	PATIENT ACCOUNTING						5.04
5.05	00590	ADMINISTRATIVE & GENERAL						5.05
6.00	00600	MAINTENANCE & REPAIRS	456,899					6.00
7.00	00700	OPERATION OF PLANT	23,324	433,575				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	975	975	1,491,526			8.00
9.00	00900	HOUSEKEEPING	4,281	4,281	0	428,319		9.00
10.00	01000	DIETARY	7,190	7,190	0	7,190	171,741	10.00
11.00	01100	CAFETERIA	4,843	4,843	0	4,843	0	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	4,121	4,121	0	4,121	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	3,990	3,990	0	3,990	0	14.00
15.00	01500	PHARMACY	4,411	4,411	0	4,411	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	2,113	2,113	0	2,113	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
23.00	02300	PARAMEDICAL EDUCATION PROGRAM EMS	444	444	0	444	0	23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	91,128	91,128	540,427	91,128	140,131	30.00
31.00	03100	INTENSIVE CARE UNIT	13,139	13,139	72,267	13,139	9,909	31.00
41.00	04100	SUBPROVIDER - IRF	10,941	10,941	66,636	10,941	18,199	41.00
43.00	04300	NURSERY	4,910	4,910	11,887	4,910	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	32,592	32,592	210,175	32,592	0	50.00
51.00	05100	RECOVERY ROOM	6,355	6,355	0	6,355	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	4,586	4,586	13,948	4,586	0	52.00
53.00	05300	ANESTHESIOLOGY	332	332	0	332	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	17,784	17,784	97,691	17,784	0	54.00
54.01	03630	ULTRA SOUND	2,834	2,834	27,652	2,834	0	54.01
56.00	05600	RADIOISOTOPE	5,847	5,847	12,457	5,847	0	56.00
57.00	05700	CT SCAN	3,262	3,262	29,832	3,262	0	57.00
59.00	05900	CARDIAC CATHETERIZATION	10,513	10,513	50,967	10,513	0	59.00
60.00	06000	LABORATORY	11,256	11,256	9,208	11,256	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	892	892	0	892	0	62.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	3,656	3,656	0	3,656	0	65.00
66.00	06600	PHYSICAL THERAPY	17,251	17,251	28,191	17,251	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	793	793	9,331	793	0	67.00
68.00	06800	SPEECH PATHOLOGY	236	236	2,137	236	0	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	3,337	3,337	0	3,337	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.97	07697	CARDIAC REHABILITATION	7,837	7,837	1,370	7,837	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	26,566	26,566	45,715	26,566	0	90.00
91.00	09100	EMERGENCY	18,623	18,623	259,304	18,623	3,502	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	350,362	327,038	1,489,195	321,782	171,741	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	712	712	0	712	0	190.00
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	94,854	94,854	2,331	94,854	0	192.00
194.00	07950	OTHER NON-REIMBURSEABLE COST CENTER	10,971	10,971	0	10,971	0	194.00
194.01	07951	OTHER NONREIMBURSABLE	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)	8,633,357	7,381,692	1,029,007	4,064,567	3,335,734	202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-0034 | Period: From 07/01/2019 To 06/30/2020 | Worksheet B-1 | Date/Time Prepared: 11/25/2020 2:58 pm

		Cost Center Description	MAINTENANCE & REPAIRS (SQUARE FEET)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	
			6.00	7.00	8.00	9.00	10.00	
203.00		Unit cost multiplier (Wkst. B, Part I)	18.895548	17.025179	0.689902	9.489579	19.423050	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	1,786,854	903,255	43,144	194,389	305,083	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	3.910829	2.083273	0.028926	0.453842	1.776413	205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)						206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-0034 | Period: From 07/01/2019 To 06/30/2020 | Worksheet B-1 | Date/Time Prepared: 11/25/2020 2:58 pm

		Cost Center Description	CAFETERIA (NUMBER OF FTES)	MAINTENANCE OF PERSONNEL (NUMBER HOUSED)	NURSING ADMINISTRATION (NURSING HOURS)	CENTRAL SERVICES & SUPPLY (SUPPLY EXPENSE)	PHARMACY (COSTED REQUIS.)	
			11.00	12.00	13.00	14.00	15.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
4.01	00401	MAINTENANCE OF PERSONNEL						4.01
5.01	00540	NONPATIENT TELEPHONES						5.01
5.02	00560	PURCHASING RECEIVING AND STORES						5.02
5.03	00570	PATIENT REGISTRATION						5.03
5.04	00580	PATIENT ACCOUNTING						5.04
5.05	00590	ADMINISTRATIVE & GENERAL						5.05
6.00	00600	MAINTENANCE & REPAIRS						6.00
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	85,936					11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0				12.00
13.00	01300	NURSING ADMINISTRATION	3,515	0	1,049,231			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	943	0	0	23,143,345		14.00
15.00	01500	PHARMACY	2,691	0	0	0	10,000	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
23.00	02300	PARAMEDICAL EDUCATION PROGRAM EMS	376	0	0	0	0	23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	24,330	0	506,065	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	4,817	0	100,193	0	0	31.00
41.00	04100	SUBPROVIDER - IRF	2,933	0	61,007	0	0	41.00
43.00	04300	NURSERY	1,323	0	27,520	0	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	6,944	0	144,442	0	0	50.00
51.00	05100	RECOVERY ROOM	2,300	0	47,846	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,236	0	25,702	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,905	0	0	0	0	54.00
54.01	03630	ULTRA SOUND	983	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	554	0	0	0	0	56.00
57.00	05700	CT SCAN	1,266	0	0	0	0	57.00
59.00	05900	CARDIAC CATHETERIZATION	2,994	0	0	0	0	59.00
60.00	06000	LABORATORY	6,543	0	0	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	298	0	0	0	0	62.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	2,979	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
70.00	07000	ELECTROENCEPHALOGRAPHY	834	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	8,729,320	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	14,414,025	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	10,000	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.97	07697	CARDIAC REHABILITATION	718	0	14,937	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	3,909	0	0	0	0	90.00
91.00	09100	EMERGENCY	5,842	0	121,519	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	2,690	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	85,923	0	1,049,231	23,143,345	10,000	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
191.00	19100	RESEARCH	13	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07950	OTHER NON-REIMBURSEABLE COST CENTER	0	0	0	0	0	194.00
194.01	07951	OTHER NONREIMBURSABLE	0	0	0	0	0	194.01
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-0034 | Period: From 07/01/2019 To 06/30/2020 | Worksheet B-1 | Date/Time Prepared: 11/25/2020 2:58 pm

		Cost Center Description	CAFETERIA (NUMBER OF FTES)	MAINTENANCE OF PERSONNEL (NUMBER HOUSED)	NURSING ADMINISTRATION (NURSING HOURS)	CENTRAL SERVICES & SUPPLY (SUPPLY EXPENSE)	PHARMACY (COSTED REQUIS.)	
			11.00	12.00	13.00	14.00	15.00	
202.00		Cost to be allocated (per Wkst. B, Part I)	1,830,485	0	4,544,822	1,603,630	5,102,664	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	21.300561	0.000000	4.331574	0.069291	510.266400	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	202,266	0	195,828	170,429	210,089	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	2.353682	0.000000	0.186640	0.007364	21.008900	205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)						206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-0034 | Period: From 07/01/2019 To 06/30/2020 | Worksheet B-1 | Date/Time Prepared: 11/25/2020 2:58 pm

		Cost Center Description	MEDICAL RECORDS & LIBRARY (GROSS REVENUE)	SOCIAL SERVICE (TIME SPENT)	NONPHYSICIAN ANESTHETISTS (ASSIGNED TIME)	PARAMEDICAL EDUCATION PROGRAM EMS (ASSIGNED TIME)		
			16.00	17.00	19.00	23.00		
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
4.01	00401	MAINTENANCE OF PERSONNEL						4.01
5.01	00540	NONPATIENT TELEPHONES						5.01
5.02	00560	PURCHASING RECEIVING AND STORES						5.02
5.03	00570	PATIENT REGISTRATION						5.03
5.04	00580	PATIENT ACCOUNTING						5.04
5.05	00590	ADMINISTRATIVE & GENERAL						5.05
6.00	00600	MAINTENANCE & REPAIRS						6.00
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
12.00	01200	MAINTENANCE OF PERSONNEL						12.00
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	1,054,011,441					16.00
17.00	01700	SOCIAL SERVICE	0	0				17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0			19.00
23.00	02300	PARAMEDICAL EDUCATION PROGRAM EMS	0	0		1,352		23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	75,168,380	0	0	148		30.00
31.00	03100	INTENSIVE CARE UNIT	13,231,282	0	0	72		31.00
41.00	04100	SUBPROVIDER - IRF	7,595,715	0	0	0		41.00
43.00	04300	NURSERY	4,038,816	0	0	0		43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	121,072,178	0	0	144		50.00
51.00	05100	RECOVERY ROOM	14,895,166	0	0	0		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	3,782,209	0	0	0		52.00
53.00	05300	ANESTHESIOLOGY	24,243,755	0	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	87,269,983	0	0	0		54.00
54.01	03630	ULTRA SOUND	20,956,930	0	0	0		54.01
56.00	05600	RADIOISOTOPE	18,018,157	0	0	0		56.00
57.00	05700	CT SCAN	75,928,829	0	0	0		57.00
59.00	05900	CARDIAC CATHETERIZATION	91,616,864	0	0	0		59.00
60.00	06000	LABORATORY	127,698,865	0	0	0		60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	5,603,104	0	0	0		62.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0		62.30
65.00	06500	RESPIRATORY THERAPY	20,514,071	0	0	80		65.00
66.00	06600	PHYSICAL THERAPY	16,409,705	0	0	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	7,134,946	0	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	1,344,715	0	0	0		68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	22,095,722	0	0	0		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	26,545,380	0	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	35,695,354	0	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	110,242,958	0	0	0		73.00
74.00	07400	RENAL DIALYSIS	3,988,736	0	0	0		74.00
76.97	07697	CARDIAC REHABILITATION	2,059,117	0	0	0		76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0		76.98
76.99	07699	LITHOTRIPSY	0	0	0	0		76.99
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	16,543,866	0	0	0		90.00
91.00	09100	EMERGENCY	95,539,169	0	0	908		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	4,777,469	0	0	0		101.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	1,054,011,441	0	0	1,352		118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0		190.00
191.00	19100	RESEARCH	0	0	0	0		191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0		192.00
194.00	07950	OTHER NON-REIMBURSEABLE COST CENTER	0	0	0	0		194.00
194.01	07951	OTHER NONREIMBURSABLE	0	0	0	0		194.01
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-0034 | Period: From 07/01/2019 To 06/30/2020 | Worksheet B-1 | Date/Time Prepared: 11/25/2020 2:58 pm

		Cost Center Description	MEDICAL RECORDS & LIBRARY (GROSS REVENUE)	SOCIAL SERVICE (TIME SPENT)	NONPHYSICIAN ANESTHETISTS (ASSIGNED TIME)	PARAMEDICAL EDUCATION PROGRAM EMS (ASSIGNED TIME)		
			16.00	17.00	19.00	23.00		
202.00		Cost to be allocated (per Wkst. B, Part I)	3,176,809	0	0	402,230		202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.003014	0.000000	0.000000	297.507396		203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	97,570	0	0	21,020		204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.000093	0.000000	0.000000	15.547337		205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)				0		206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)				0.000000		207.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-0034 | Period: From 07/01/2019 To 06/30/2020 | Worksheet C Part I Date/Time Prepared: 11/25/2020 2:58 pm

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		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	RCE Disallowance	Costs Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	38,219,952		38,219,952	20,542	38,240,494	30.00
31.00	03100	INTENSIVE CARE UNIT	8,304,562		8,304,562	9,029	8,313,591	31.00
41.00	04100	SUBPROVIDER - IRF	5,151,834		5,151,834	0	5,151,834	41.00
43.00	04300	NURSERY	2,298,802		2,298,802	0	2,298,802	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	24,636,490		24,636,490	4,138	24,640,628	50.00
51.00	05100	RECOVERY ROOM	3,836,811		3,836,811	0	3,836,811	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	2,149,089		2,149,089	0	2,149,089	52.00
53.00	05300	ANESTHESIOLOGY	745,350		745,350	0	745,350	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	10,032,515		10,032,515	11,274	10,043,789	54.00
54.01	03630	ULTRA SOUND	2,125,544		2,125,544	0	2,125,544	54.01
56.00	05600	RADIOISOTOPE	2,568,573		2,568,573	0	2,568,573	56.00
57.00	05700	CT SCAN	3,444,431		3,444,431	0	3,444,431	57.00
59.00	05900	CARDIAC CATHETERIZATION	6,859,690		6,859,690	6,487	6,866,177	59.00
60.00	06000	LABORATORY	12,881,314		12,881,314	34,837	12,916,151	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	1,730,080		1,730,080	0	1,730,080	62.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0		0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	4,029,897	0	4,029,897	484	4,030,381	65.00
66.00	06600	PHYSICAL THERAPY	4,904,830	0	4,904,830	0	4,904,830	66.00
67.00	06700	OCCUPATIONAL THERAPY	1,293,953	0	1,293,953	0	1,293,953	67.00
68.00	06800	SPEECH PATHOLOGY	545,551	0	545,551	0	545,551	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	2,227,801		2,227,801	2,798	2,230,599	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	10,759,275		10,759,275	0	10,759,275	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	17,690,717		17,690,717	0	17,690,717	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	20,304,662		20,304,662	0	20,304,662	73.00
74.00	07400	RENAL DIALYSIS	1,029,037		1,029,037	0	1,029,037	74.00
76.97	07697	CARDIAC REHABILITATION	1,580,414		1,580,414	0	1,580,414	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0		0	0	0	76.98
76.99	07699	LITHOTRIPSY	0		0	0	0	76.99
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	7,455,688		7,455,688	37,993	7,493,681	90.00
91.00	09100	EMERGENCY	10,852,690		10,852,690	0	10,852,690	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	4,746,563		4,746,563		4,746,563	92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	3,960,319		3,960,319		3,960,319	101.00
200.00		Subtotal (see instructions)	216,366,434	0	216,366,434	127,582	216,494,016	200.00
201.00		Less Observation Beds	4,746,563		4,746,563		4,746,563	201.00
202.00		Total (see instructions)	211,619,871	0	211,619,871	127,582	211,747,453	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-0034 | Period: From 07/01/2019 To 06/30/2020 | Worksheet C Part I Date/Time Prepared: 11/25/2020 2:58 pm

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		Cost Center Description	Charges Inpatient	Charges Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	60,944,567		60,944,567			30.00
31.00	03100	INTENSIVE CARE UNIT	13,231,282		13,231,282			31.00
41.00	04100	SUBPROVIDER - IRF	7,595,715		7,595,715			41.00
43.00	04300	NURSERY	4,038,816		4,038,816			43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	40,709,070	80,363,108	121,072,178	0.203486	0.000000	50.00
51.00	05100	RECOVERY ROOM	4,784,466	10,110,700	14,895,166	0.257588	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	2,823,209	959,000	3,782,209	0.568210	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	8,130,154	16,113,601	24,243,755	0.030744	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	12,408,566	74,861,417	87,269,983	0.114960	0.000000	54.00
54.01	03630	ULTRA SOUND	3,459,481	17,497,449	20,956,930	0.101424	0.000000	54.01
56.00	05600	RADIOISOTOPE	2,796,812	15,221,345	18,018,157	0.142555	0.000000	56.00
57.00	05700	CT SCAN	21,503,978	54,424,851	75,928,829	0.045364	0.000000	57.00
59.00	05900	CARDIAC CATHETERIZATION	30,596,949	61,019,915	91,616,864	0.074874	0.000000	59.00
60.00	06000	LABORATORY	39,466,545	88,232,320	127,698,865	0.100873	0.000000	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	3,508,059	2,095,045	5,603,104	0.308772	0.000000	62.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0.000000	0.000000	62.30
65.00	06500	RESPIRATORY THERAPY	18,678,345	1,835,726	20,514,071	0.196446	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	6,269,243	10,140,462	16,409,705	0.298898	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	4,909,231	2,225,715	7,134,946	0.181354	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	963,782	380,933	1,344,715	0.405700	0.000000	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	4,207,224	17,888,498	22,095,722	0.100825	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	11,694,793	14,850,587	26,545,380	0.405316	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	19,394,383	16,300,971	35,695,354	0.495603	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	52,238,494	58,004,464	110,242,958	0.184181	0.000000	73.00
74.00	07400	RENAL DIALYSIS	3,790,508	198,228	3,988,736	0.257986	0.000000	74.00
76.97	07697	CARDIAC REHABILITATION	370,636	1,688,481	2,059,117	0.767520	0.000000	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0.000000	0.000000	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0.000000	0.000000	76.99
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	807,119	15,736,747	16,543,866	0.450662	0.000000	90.00
91.00	09100	EMERGENCY	29,878,918	65,660,251	95,539,169	0.113594	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	2,479,772	11,744,041	14,223,813	0.333705	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	4,777,469	4,777,469			101.00
200.00		Subtotal (see instructions)	411,680,117	642,331,324	1,054,011,441			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	411,680,117	642,331,324	1,054,011,441			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-0034 | Period: From 07/01/2019 To 06/30/2020 | Worksheet C Part I Date/Time Prepared: 11/25/2020 2:58 pm

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		Cost Center Description	PPS Inpatient Ratio	
			11.00	
		INPATIENT ROUTINE SERVICE COST CENTERS		
30.00	03000	ADULTS & PEDIATRICS		30.00
31.00	03100	INTENSIVE CARE UNIT		31.00
41.00	04100	SUBPROVIDER - IRF		41.00
43.00	04300	NURSERY		43.00
		ANCILLARY SERVICE COST CENTERS		
50.00	05000	OPERATING ROOM	0.203520	50.00
51.00	05100	RECOVERY ROOM	0.257588	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.568210	52.00
53.00	05300	ANESTHESIOLOGY	0.030744	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.115089	54.00
54.01	03630	ULTRA SOUND	0.101424	54.01
56.00	05600	RADIOISOTOPE	0.142555	56.00
57.00	05700	CT SCAN	0.045364	57.00
59.00	05900	CARDIAC CATHETERIZATION	0.074944	59.00
60.00	06000	LABORATORY	0.101145	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0.308772	62.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0.000000	62.30
65.00	06500	RESPIRATORY THERAPY	0.196469	65.00
66.00	06600	PHYSICAL THERAPY	0.298898	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.181354	67.00
68.00	06800	SPEECH PATHOLOGY	0.405700	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.100952	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.405316	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.495603	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.184181	73.00
74.00	07400	RENAL DIALYSIS	0.257986	74.00
76.97	07697	CARDIAC REHABILITATION	0.767520	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0.000000	76.98
76.99	07699	LITHOTRIPSY	0.000000	76.99
		OUTPATIENT SERVICE COST CENTERS		
90.00	09000	CLINIC	0.452958	90.00
91.00	09100	EMERGENCY	0.113594	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.333705	92.00
		OTHER REIMBURSABLE COST CENTERS		
101.00	10100	HOME HEALTH AGENCY		101.00
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: 15-0034 | Period: From 07/01/2019 To 06/30/2020 | Worksheet C Part I Date/Time Prepared: 11/25/2020 2:58 pm

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		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	Costs RCE Disallowance	Costs Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	38,219,952		38,219,952	20,542	38,240,494	30.00
31.00	03100	INTENSIVE CARE UNIT	8,304,562		8,304,562	9,029	8,313,591	31.00
41.00	04100	SUBPROVIDER - IRF	5,151,834		5,151,834	0	5,151,834	41.00
43.00	04300	NURSERY	2,298,802		2,298,802	0	2,298,802	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	24,636,490		24,636,490	4,138	24,640,628	50.00
51.00	05100	RECOVERY ROOM	3,836,811		3,836,811	0	3,836,811	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	2,149,089		2,149,089	0	2,149,089	52.00
53.00	05300	ANESTHESIOLOGY	745,350		745,350	0	745,350	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	10,032,515		10,032,515	11,274	10,043,789	54.00
54.01	03630	ULTRA SOUND	2,125,544		2,125,544	0	2,125,544	54.01
56.00	05600	RADIOISOTOPE	2,568,573		2,568,573	0	2,568,573	56.00
57.00	05700	CT SCAN	3,444,431		3,444,431	0	3,444,431	57.00
59.00	05900	CARDIAC CATHETERIZATION	6,859,690		6,859,690	6,487	6,866,177	59.00
60.00	06000	LABORATORY	12,881,314		12,881,314	34,837	12,916,151	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	1,730,080		1,730,080	0	1,730,080	62.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0		0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	4,029,897	0	4,029,897	484	4,030,381	65.00
66.00	06600	PHYSICAL THERAPY	4,904,830	0	4,904,830	0	4,904,830	66.00
67.00	06700	OCCUPATIONAL THERAPY	1,293,953	0	1,293,953	0	1,293,953	67.00
68.00	06800	SPEECH PATHOLOGY	545,551	0	545,551	0	545,551	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	2,227,801		2,227,801	2,798	2,230,599	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	10,759,275		10,759,275	0	10,759,275	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	17,690,717		17,690,717	0	17,690,717	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	20,304,662		20,304,662	0	20,304,662	73.00
74.00	07400	RENAL DIALYSIS	1,029,037		1,029,037	0	1,029,037	74.00
76.97	07697	CARDIAC REHABILITATION	1,580,414		1,580,414	0	1,580,414	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0		0	0	0	76.98
76.99	07699	LITHOTRIPSY	0		0	0	0	76.99
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	7,455,688		7,455,688	37,993	7,493,681	90.00
91.00	09100	EMERGENCY	10,852,690		10,852,690	0	10,852,690	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	4,746,563		4,746,563		4,746,563	92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	3,960,319		3,960,319		3,960,319	101.00
200.00		Subtotal (see instructions)	216,366,434	0	216,366,434	127,582	216,494,016	200.00
201.00		Less Observation Beds	4,746,563		4,746,563		4,746,563	201.00
202.00		Total (see instructions)	211,619,871	0	211,619,871	127,582	211,747,453	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-0034 | Period: From 07/01/2019 To 06/30/2020 | Worksheet C Part I Date/Time Prepared: 11/25/2020 2:58 pm

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		Cost Center Description	Charges Inpatient	Charges Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	60,944,567		60,944,567			30.00
31.00	03100	INTENSIVE CARE UNIT	13,231,282		13,231,282			31.00
41.00	04100	SUBPROVIDER - IRF	7,595,715		7,595,715			41.00
43.00	04300	NURSERY	4,038,816		4,038,816			43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	40,709,070	80,363,108	121,072,178	0.203486	0.000000	50.00
51.00	05100	RECOVERY ROOM	4,784,466	10,110,700	14,895,166	0.257588	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	2,823,209	959,000	3,782,209	0.568210	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	8,130,154	16,113,601	24,243,755	0.030744	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	12,408,566	74,861,417	87,269,983	0.114960	0.000000	54.00
54.01	03630	ULTRA SOUND	3,459,481	17,497,449	20,956,930	0.101424	0.000000	54.01
56.00	05600	RADIOISOTOPE	2,796,812	15,221,345	18,018,157	0.142555	0.000000	56.00
57.00	05700	CT SCAN	21,503,978	54,424,851	75,928,829	0.045364	0.000000	57.00
59.00	05900	CARDIAC CATHETERIZATION	30,596,949	61,019,915	91,616,864	0.074874	0.000000	59.00
60.00	06000	LABORATORY	39,466,545	88,232,320	127,698,865	0.100873	0.000000	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	3,508,059	2,095,045	5,603,104	0.308772	0.000000	62.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0.000000	0.000000	62.30
65.00	06500	RESPIRATORY THERAPY	18,678,345	1,835,726	20,514,071	0.196446	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	6,269,243	10,140,462	16,409,705	0.298898	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	4,909,231	2,225,715	7,134,946	0.181354	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	963,782	380,933	1,344,715	0.405700	0.000000	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	4,207,224	17,888,498	22,095,722	0.100825	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	11,694,793	14,850,587	26,545,380	0.405316	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	19,394,383	16,300,971	35,695,354	0.495603	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	52,238,494	58,004,464	110,242,958	0.184181	0.000000	73.00
74.00	07400	RENAL DIALYSIS	3,790,508	198,228	3,988,736	0.257986	0.000000	74.00
76.97	07697	CARDIAC REHABILITATION	370,636	1,688,481	2,059,117	0.767520	0.000000	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0.000000	0.000000	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0.000000	0.000000	76.99
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	807,119	15,736,747	16,543,866	0.450662	0.000000	90.00
91.00	09100	EMERGENCY	29,878,918	65,660,251	95,539,169	0.113594	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	2,479,772	11,744,041	14,223,813	0.333705	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	4,777,469	4,777,469			101.00
200.00		Subtotal (see instructions)	411,680,117	642,331,324	1,054,011,441			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	411,680,117	642,331,324	1,054,011,441			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-0034 | Period: From 07/01/2019 To 06/30/2020 | Worksheet C Part I Date/Time Prepared: 11/25/2020 2:58 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
41.00	04100	SUBPROVIDER - IRF		41.00
43.00	04300	NURSERY		43.00
		ANCILLARY SERVICE COST CENTERS		
50.00	05000	OPERATING ROOM	0.203520	50.00
51.00	05100	RECOVERY ROOM	0.257588	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.568210	52.00
53.00	05300	ANESTHESIOLOGY	0.030744	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.115089	54.00
54.01	03630	ULTRA SOUND	0.101424	54.01
56.00	05600	RADIOISOTOPE	0.142555	56.00
57.00	05700	CT SCAN	0.045364	57.00
59.00	05900	CARDIAC CATHETERIZATION	0.074944	59.00
60.00	06000	LABORATORY	0.101145	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0.308772	62.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0.000000	62.30
65.00	06500	RESPIRATORY THERAPY	0.196469	65.00
66.00	06600	PHYSICAL THERAPY	0.298898	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.181354	67.00
68.00	06800	SPEECH PATHOLOGY	0.405700	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.100952	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.405316	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.495603	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.184181	73.00
74.00	07400	RENAL DIALYSIS	0.257986	74.00
76.97	07697	CARDIAC REHABILITATION	0.767520	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0.000000	76.98
76.99	07699	LITHOTRIPSY	0.000000	76.99
		OUTPATIENT SERVICE COST CENTERS		
90.00	09000	CLINIC	0.452958	90.00
91.00	09100	EMERGENCY	0.113594	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.333705	92.00
		OTHER REIMBURSABLE COST CENTERS		
101.00	10100	HOME HEALTH AGENCY		101.00
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: 15-0034 | Period: From 07/01/2019 To 06/30/2020 | Worksheet C Part II Date/Time Prepared: 11/25/2020 2:58 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	24,636,490	1,544,584	23,091,906	0	0	50.00
51.00	05100	RECOVERY ROOM	3,836,811	289,847	3,546,964	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	2,149,089	200,781	1,948,308	0	0	52.00
53.00	05300	ANESTHESIOLOGY	745,350	24,221	721,129	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	10,032,515	790,332	9,242,183	0	0	54.00
54.01	03630	ULTRA SOUND	2,125,544	132,356	1,993,188	0	0	54.01
56.00	05600	RADIOISOTOPE	2,568,573	250,051	2,318,522	0	0	56.00
57.00	05700	CT SCAN	3,444,431	167,076	3,277,355	0	0	57.00
59.00	05900	CARDIAC CATHETERIZATION	6,859,690	483,851	6,375,839	0	0	59.00
60.00	06000	LABORATORY	12,881,314	576,026	12,305,288	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	1,730,080	46,763	1,683,317	0	0	62.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	4,029,897	179,485	3,850,412	0	0	65.00
66.00	06600	PHYSICAL THERAPY	4,904,830	710,568	4,194,262	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	1,293,953	39,266	1,254,687	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	545,551	12,227	533,324	0	0	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	2,227,801	155,900	2,071,901	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	10,759,275	113,949	10,645,326	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	17,690,717	186,192	17,504,525	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	20,304,662	298,602	20,006,060	0	0	73.00
74.00	07400	RENAL DIALYSIS	1,029,037	5,294	1,023,743	0	0	74.00
76.97	07697	CARDIAC REHABILITATION	1,580,414	323,731	1,256,683	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	7,455,688	1,111,163	6,344,525	0	0	90.00
91.00	09100	EMERGENCY	10,852,690	868,449	9,984,241	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	4,746,563	526,584	4,219,979	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	3,960,319	29,102	3,931,217	0	0	101.00
200.00		Subtotal (sum of lines 50 thru 199)	162,391,284	9,066,400	153,324,884	0	0	200.00
201.00		Less Observation Beds	4,746,563	526,584	4,219,979	0	0	201.00
202.00		Total (line 200 minus line 201)	157,644,721	8,539,816	149,104,905	0	0	202.00

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

Provider CCN: 15-0034 | Period: From 07/01/2019 To 06/30/2020 | Worksheet C Part II Date/Time Prepared: 11/25/2020 2:58 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	24,636,490	121,072,178	0.203486		50.00
51.00	05100	RECOVERY ROOM	3,836,811	14,895,166	0.257588		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	2,149,089	3,782,209	0.568210		52.00
53.00	05300	ANESTHESIOLOGY	745,350	24,243,755	0.030744		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	10,032,515	87,269,983	0.114960		54.00
54.01	03630	ULTRA SOUND	2,125,544	20,956,930	0.101424		54.01
56.00	05600	RADIOISOTOPE	2,568,573	18,018,157	0.142555		56.00
57.00	05700	CT SCAN	3,444,431	75,928,829	0.045364		57.00
59.00	05900	CARDIAC CATHETERIZATION	6,859,690	91,616,864	0.074874		59.00
60.00	06000	LABORATORY	12,881,314	127,698,865	0.100873		60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	1,730,080	5,603,104	0.308772		62.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0.000000		62.30
65.00	06500	RESPIRATORY THERAPY	4,029,897	20,514,071	0.196446		65.00
66.00	06600	PHYSICAL THERAPY	4,904,830	16,409,705	0.298898		66.00
67.00	06700	OCCUPATIONAL THERAPY	1,293,953	7,134,946	0.181354		67.00
68.00	06800	SPEECH PATHOLOGY	545,551	1,344,715	0.405700		68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	2,227,801	22,095,722	0.100825		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	10,759,275	26,545,380	0.405316		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	17,690,717	35,695,354	0.495603		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	20,304,662	110,242,958	0.184181		73.00
74.00	07400	RENAL DIALYSIS	1,029,037	3,988,736	0.257986		74.00
76.97	07697	CARDIAC REHABILITATION	1,580,414	2,059,117	0.767520		76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0.000000		76.98
76.99	07699	LITHOTRIPSY	0	0	0.000000		76.99
		OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	7,455,688	16,543,866	0.450662		90.00
91.00	09100	EMERGENCY	10,852,690	95,539,169	0.113594		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	4,746,563	14,223,813	0.333705		92.00
		OTHER REIMBURSABLE COST CENTERS					
101.00	10100	HOME HEALTH AGENCY	3,960,319	4,777,469	0.828958		101.00
200.00		Subtotal (sum of lines 50 thru 199)	162,391,284	968,201,061			200.00
201.00		Less Observation Beds	4,746,563	0			201.00
202.00		Total (line 200 minus line 201)	157,644,721	968,201,061			202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

Provider CCN: 15-0034 | Period: From 07/01/2019 To 06/30/2020 | Worksheet D Part I Date/Time Prepared: 11/25/2020 2:58 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	4,242,411	0	4,242,411	43,827	96.80	30.00
31.00	INTENSIVE CARE UNIT	618,798		618,798	5,137	120.46	31.00
41.00	SUBPROVIDER - IRF	513,250	0	513,250	5,991	85.67	41.00
43.00	NURSERY	214,876		214,876	1,417	151.64	43.00
200.00	Total (lines 30 through 199)	5,589,335		5,589,335	56,372		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	16,879	1,633,887				30.00
31.00	INTENSIVE CARE UNIT	1,707	205,625				31.00
41.00	SUBPROVIDER - IRF	3,787	324,432				41.00
43.00	NURSERY	0	0				43.00
200.00	Total (lines 30 through 199)	22,373	2,163,944				200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 15-0034 | Period: From 07/01/2019 To 06/30/2020 | Worksheet D Part II Date/Time Prepared: 11/25/2020 2:58 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	1,544,584	121,072,178	0.012758	15,784,356	201,377	50.00
51.00	05100	RECOVERY ROOM	289,847	14,895,166	0.019459	1,948,288	37,912	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	200,781	3,782,209	0.053086	8,938	474	52.00
53.00	05300	ANESTHESIOLOGY	24,221	24,243,755	0.000999	3,368,739	3,365	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	790,332	87,269,983	0.009056	4,932,467	44,668	54.00
54.01	03630	ULTRA SOUND	132,356	20,956,930	0.006316	1,419,535	8,966	54.01
56.00	05600	RADIOISOTOPE	250,051	18,018,157	0.013878	1,262,339	17,519	56.00
57.00	05700	CT SCAN	167,076	75,928,829	0.002200	9,051,739	19,914	57.00
59.00	05900	CARDIAC CATHETERIZATION	483,851	91,616,864	0.005281	13,577,621	71,703	59.00
60.00	06000	LABORATORY	576,026	127,698,865	0.004511	16,165,533	72,923	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	46,763	5,603,104	0.008346	1,369,753	11,432	62.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0.000000	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	179,485	20,514,071	0.008749	8,139,093	71,209	65.00
66.00	06600	PHYSICAL THERAPY	710,568	16,409,705	0.043302	1,672,665	72,430	66.00
67.00	06700	OCCUPATIONAL THERAPY	39,266	7,134,946	0.005503	944,775	5,199	67.00
68.00	06800	SPEECH PATHOLOGY	12,227	1,344,715	0.009093	256,980	2,337	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	155,900	22,095,722	0.007056	2,195,919	15,494	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	113,949	26,545,380	0.004293	4,956,486	21,278	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	186,192	35,695,354	0.005216	9,339,590	48,715	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	298,602	110,242,958	0.002709	19,859,912	53,801	73.00
74.00	07400	RENAL DIALYSIS	5,294	3,988,736	0.001327	1,637,620	2,173	74.00
76.97	07697	CARDIAC REHABILITATION	323,731	2,059,117	0.157218	162,777	25,591	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0.000000	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0.000000	0	0	76.99
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	1,111,163	16,543,866	0.067165	232,069	15,587	90.00
91.00	09100	EMERGENCY	868,449	95,539,169	0.009090	12,666,373	115,137	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	526,584	14,223,813	0.037021	1,385,122	51,279	92.00
200.00		Total (lines 50 through 199)	9,037,298	963,423,592		132,338,689	990,483	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 15-0034 | Period: From 07/01/2019 To 06/30/2020 | Worksheet D Part III Date/Time Prepared: 11/25/2020 2:58 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	44,031	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	21,421	0	31.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
200.00		Total (lines 30 through 199)	0	0	0	65,452	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	44,031	43,827	1.00	16,879	30.00
31.00	03100	INTENSIVE CARE UNIT		21,421	5,137	4.17	1,707	31.00
41.00	04100	SUBPROVIDER - IRF	0	0	5,991	0.00	3,787	41.00
43.00	04300	NURSERY		0	1,417	0.00	0	43.00
200.00		Total (lines 30 through 199)		65,452	56,372		22,373	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	16,879	30.00
31.00	03100	INTENSIVE CARE UNIT	7,118	31.00
41.00	04100	SUBPROVIDER - IRF	0	41.00
43.00	04300	NURSERY	0	43.00
200.00		Total (lines 30 through 199)	23,997	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-0034 | Period: From 07/01/2019 To 06/30/2020 | Worksheet D Part IV | Date/Time Prepared: 11/25/2020 2:58 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	42,841	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	03630	ULTRA SOUND	0	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0	0	0	62.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	23,801	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
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	0	0	270,136	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0		0		5,463	92.00
200.00		Total (lines 50 through 199)	0	0	0	0	342,241	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-0034 | Period: From 07/01/2019 To 06/30/2020 | Worksheet D Part IV Date/Time Prepared: 11/25/2020 2:58 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	42,841	42,841	121,072,178	0.000354	50.00
51.00	05100	RECOVERY ROOM	0	0	0	14,895,166	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	3,782,209	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	24,243,755	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	87,269,983	0.000000	54.00
54.01	03630	ULTRA SOUND	0	0	0	20,956,930	0.000000	54.01
56.00	05600	RADIOISOTOPE	0	0	0	18,018,157	0.000000	56.00
57.00	05700	CT SCAN	0	0	0	75,928,829	0.000000	57.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	91,616,864	0.000000	59.00
60.00	06000	LABORATORY	0	0	0	127,698,865	0.000000	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0	5,603,104	0.000000	62.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0.000000	62.30
65.00	06500	RESPIRATORY THERAPY	0	23,801	23,801	20,514,071	0.001160	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	16,409,705	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	7,134,946	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	1,344,715	0.000000	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	22,095,722	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	26,545,380	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	35,695,354	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	110,242,958	0.000000	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	3,988,736	0.000000	74.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	2,059,117	0.000000	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0.000000	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0.000000	76.99
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	16,543,866	0.000000	90.00
91.00	09100	EMERGENCY	0	270,136	270,136	95,539,169	0.002827	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	5,463	5,463	14,223,813	0.000384	92.00
200.00		Total (lines 50 through 199)	0	342,241	342,241	963,423,592		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-0034 | Period: From 07/01/2019 To 06/30/2020 | Worksheet D Part IV | Date/Time Prepared: 11/25/2020 2:58 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	0.000354	15,784,356	5,588	20,310,387	7,190	50.00
51.00	05100	RECOVERY ROOM	0.000000	1,948,288	0	2,405,036	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	8,938	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	3,368,739	0	4,297,055	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	4,932,467	0	20,077,010	0	54.00
54.01	03630	ULTRA SOUND	0.000000	1,419,535	0	4,278,434	0	54.01
56.00	05600	RADIOISOTOPE	0.000000	1,262,339	0	5,396,703	0	56.00
57.00	05700	CT SCAN	0.000000	9,051,739	0	15,205,316	0	57.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	13,577,621	0	23,718,177	0	59.00
60.00	06000	LABORATORY	0.000000	16,165,533	0	8,838,359	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0.000000	1,369,753	0	605,827	0	62.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0.000000	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0.001160	8,139,093	9,441	506,910	588	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	1,672,665	0	13,029	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	944,775	0	2,574	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	256,980	0	4,475	0	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	2,195,919	0	5,822,496	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	4,956,486	0	4,705,487	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	9,339,590	0	5,364,106	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	19,859,912	0	22,406,127	0	73.00
74.00	07400	RENAL DIALYSIS	0.000000	1,637,620	0	177,974	0	74.00
76.97	07697	CARDIAC REHABILITATION	0.000000	162,777	0	733,602	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0.000000	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0.000000	0	0	0	0	76.99
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.000000	232,069	0	6,032,802	0	90.00
91.00	09100	EMERGENCY	0.002827	12,666,373	35,808	11,351,398	32,090	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000384	1,385,122	532	2,669,646	1,025	92.00
200.00		Total (lines 50 through 199)		132,338,689	51,369	164,922,930	40,893	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-0034 | Period: From 07/01/2019 To 06/30/2020 | Worksheet D Part V Date/Time Prepared: 11/25/2020 2:58 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	0.203486	20,310,387	0	267,368	4,132,879	50.00
51.00	05100	RECOVERY ROOM	0.257588	2,405,036	0	0	619,508	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.568210	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.030744	4,297,055	0	0	132,109	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.114960	20,077,010	0	0	2,308,053	54.00
54.01	03630	ULTRA SOUND	0.101424	4,278,434	0	0	433,936	54.01
56.00	05600	RADIOISOTOPE	0.142555	5,396,703	0	0	769,327	56.00
57.00	05700	CT SCAN	0.045364	15,205,316	0	0	689,774	57.00
59.00	05900	CARDIAC CATHETERIZATION	0.074874	23,718,177	0	0	1,775,875	59.00
60.00	06000	LABORATORY	0.100873	8,838,359	0	0	891,552	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0.308772	605,827	0	0	187,062	62.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0.000000	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0.196446	506,910	0	0	99,580	65.00
66.00	06600	PHYSICAL THERAPY	0.298898	13,029	0	0	3,894	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.181354	2,574	0	0	467	67.00
68.00	06800	SPEECH PATHOLOGY	0.405700	4,475	0	0	1,816	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.100825	5,822,496	0	0	587,053	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.405316	4,705,487	0	0	1,907,209	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.495603	5,364,106	0	0	2,658,467	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.184181	22,406,127	0	123,222	4,126,783	73.00
74.00	07400	RENAL DIALYSIS	0.257986	177,974	0	0	45,915	74.00
76.97	07697	CARDIAC REHABILITATION	0.767520	733,602	0	0	563,054	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0.000000	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0.000000	0	0	0	0	76.99
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.450662	6,032,802	0	0	2,718,755	90.00
91.00	09100	EMERGENCY	0.113594	11,351,398	0	0	1,289,451	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.333705	2,669,646	0	0	890,874	92.00
200.00		Subtotal (see instructions)		164,922,930	0	390,590	26,833,393	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 - line 201)		164,922,930	0	390,590	26,833,393	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-0034 | Period: From 07/01/2019 To 06/30/2020 | Worksheet D Part V Date/Time Prepared: 11/25/2020 2:58 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Costs: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	54,406		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	03630	ULTRA SOUND	0	0		54.01
56.00	05600	RADIOISOTOPE	0	0		56.00
57.00	05700	CT SCAN	0	0		57.00
59.00	05900	CARDIAC CATHETERIZATION	0	0		59.00
60.00	06000	LABORATORY	0	0		60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0		62.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0		62.30
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
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	22,695		73.00
74.00	07400	RENAL DIALYSIS	0	0		74.00
76.97	07697	CARDIAC REHABILITATION	0	0		76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0		76.98
76.99	07699	LITHOTRIPSY	0	0		76.99
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0	0		90.00
91.00	09100	EMERGENCY	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0		92.00
200.00		Subtotal (see instructions)	0	77,101		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	0	77,101		202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 15-0034 | Component CCN: 15-T034 | Period: From 07/01/2019 To 06/30/2020 | Worksheet D Part II Date/Time Prepared: 11/25/2020 2:58 pm

Title XVIII | Subprovider - IRF | PPS

		Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,544,584	121,072,178	0.012758	136,308	1,739	50.00
51.00	05100	RECOVERY ROOM	289,847	14,895,166	0.019459	11,954	233	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	200,781	3,782,209	0.053086	0	0	52.00
53.00	05300	ANESTHESIOLOGY	24,221	24,243,755	0.000999	20,614	21	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	790,332	87,269,983	0.009056	194,300	1,760	54.00
54.01	03630	ULTRA SOUND	132,356	20,956,930	0.006316	43,623	276	54.01
56.00	05600	RADIOISOTOPE	250,051	18,018,157	0.013878	19,774	274	56.00
57.00	05700	CT SCAN	167,076	75,928,829	0.002200	169,246	372	57.00
59.00	05900	CARDIAC CATHETERIZATION	483,851	91,616,864	0.005281	66,311	350	59.00
60.00	06000	LABORATORY	576,026	127,698,865	0.004511	748,676	3,377	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	46,763	5,603,104	0.008346	50,794	424	62.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0.000000	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	179,485	20,514,071	0.008749	597,600	5,228	65.00
66.00	06600	PHYSICAL THERAPY	710,568	16,409,705	0.043302	1,801,318	78,001	66.00
67.00	06700	OCCUPATIONAL THERAPY	39,266	7,134,946	0.005503	1,843,481	10,145	67.00
68.00	06800	SPEECH PATHOLOGY	12,227	1,344,715	0.009093	252,328	2,294	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	155,900	22,095,722	0.007056	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	113,949	26,545,380	0.004293	409,641	1,759	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	186,192	35,695,354	0.005216	7,447	39	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	298,602	110,242,958	0.002709	1,975,250	5,351	73.00
74.00	07400	RENAL DIALYSIS	5,294	3,988,736	0.001327	353,335	469	74.00
76.97	07697	CARDIAC REHABILITATION	323,731	2,059,117	0.157218	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0.000000	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0.000000	0	0	76.99
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	1,111,163	16,543,866	0.067165	19,042	1,279	90.00
91.00	09100	EMERGENCY	868,449	95,539,169	0.009090	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	14,223,813	0.000000	0	0	92.00
200.00		Total (lines 50 through 199)	8,510,714	963,423,592		8,721,042	113,391	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-0034 | Component CCN: 15-T034 | Period: From 07/01/2019 To 06/30/2020 | Worksheet D Part IV Date/Time Prepared: 11/25/2020 2:58 pm

Title XVIII | Subprovider - IRF | PPS

		Cost Center Description	Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health	
			1.00	2A	2.00	3A	3.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	42,841	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	03630	ULTRA SOUND	0	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0	0	0	62.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	23,801	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
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	0	0	270,136	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0		0		0	92.00
200.00		Total (lines 50 through 199)	0	0	0	0	336,778	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-0034 | Component CCN: 15-T034 | Period: From 07/01/2019 To 06/30/2020 | Worksheet D Part IV | Date/Time Prepared: 11/25/2020 2:58 pm

Title XVIII | Subprovider - IRF | PPS

		Cost Center Description	All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7) (see instructions)	
			4.00	5.00	6.00	7.00	8.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	42,841	42,841	121,072,178	0.000354	50.00
51.00	05100	RECOVERY ROOM	0	0	0	14,895,166	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	3,782,209	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	24,243,755	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	87,269,983	0.000000	54.00
54.01	03630	ULTRA SOUND	0	0	0	20,956,930	0.000000	54.01
56.00	05600	RADIOISOTOPE	0	0	0	18,018,157	0.000000	56.00
57.00	05700	CT SCAN	0	0	0	75,928,829	0.000000	57.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	91,616,864	0.000000	59.00
60.00	06000	LABORATORY	0	0	0	127,698,865	0.000000	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0	5,603,104	0.000000	62.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0.000000	62.30
65.00	06500	RESPIRATORY THERAPY	0	23,801	23,801	20,514,071	0.001160	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	16,409,705	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	7,134,946	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	1,344,715	0.000000	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	22,095,722	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	26,545,380	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	35,695,354	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	110,242,958	0.000000	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	3,988,736	0.000000	74.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	2,059,117	0.000000	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0.000000	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0.000000	76.99
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	16,543,866	0.000000	90.00
91.00	09100	EMERGENCY	0	270,136	270,136	95,539,169	0.002827	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	14,223,813	0.000000	92.00
200.00		Total (lines 50 through 199)	0	336,778	336,778	963,423,592		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-0034 | Component CCN: 15-T034 | Period: From 07/01/2019 To 06/30/2020 | Worksheet D Part IV | Date/Time Prepared: 11/25/2020 2:58 pm

Title XVIII | Subprovider - IRF | PPS

		Cost Center Description	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
			9.00	10.00	11.00	12.00	13.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.000354	136,308	48	0	0	50.00
51.00	05100	RECOVERY ROOM	0.000000	11,954	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	20,614	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	194,300	0	0	0	54.00
54.01	03630	ULTRA SOUND	0.000000	43,623	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0.000000	19,774	0	0	0	56.00
57.00	05700	CT SCAN	0.000000	169,246	0	0	0	57.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	66,311	0	0	0	59.00
60.00	06000	LABORATORY	0.000000	748,676	0	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0.000000	50,794	0	0	0	62.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0.000000	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0.001160	597,600	693	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	1,801,318	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	1,843,481	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	252,328	0	0	0	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	409,641	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	7,447	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	1,975,250	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0.000000	353,335	0	0	0	74.00
76.97	07697	CARDIAC REHABILITATION	0.000000	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0.000000	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0.000000	0	0	0	0	76.99
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.000000	19,042	0	0	0	90.00
91.00	09100	EMERGENCY	0.002827	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	0	0	0	0	92.00
200.00		Total (lines 50 through 199)		8,721,042	741	0	0	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

Provider CCN: 15-0034 | Period: From 07/01/2019 To 06/30/2020 | Worksheet D Part I Date/Time Prepared: 11/25/2020 2:58 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	4,242,411	0	4,242,411	43,827	96.80	30.00
31.00	INTENSIVE CARE UNIT	618,798		618,798	5,137	120.46	31.00
41.00	SUBPROVIDER - IRF	513,250	0	513,250	5,991	85.67	41.00
43.00	NURSERY	214,876		214,876	1,417	151.64	43.00
200.00	Total (lines 30 through 199)	5,589,335		5,589,335	56,372		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	1,331	128,841		30.00
31.00	INTENSIVE CARE UNIT	38	4,577		31.00
41.00	SUBPROVIDER - IRF	0	0		41.00
43.00	NURSERY	227	34,422		43.00
200.00	Total (lines 30 through 199)	1,596	167,840		200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 15-0034 | Period: From 07/01/2019 To 06/30/2020 | Worksheet D Part II Date/Time Prepared: 11/25/2020 2:58 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	1,544,584	121,072,178	0.012758	288,828	3,685	50.00
51.00	05100	RECOVERY ROOM	289,847	14,895,166	0.019459	32,486	632	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	200,781	3,782,209	0.053086	91,396	4,852	52.00
53.00	05300	ANESTHESIOLOGY	24,221	24,243,755	0.000999	60,446	60	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	790,332	87,269,983	0.009056	80,630	730	54.00
54.01	03630	ULTRA SOUND	132,356	20,956,930	0.006316	40,782	258	54.01
56.00	05600	RADIOISOTOPE	250,051	18,018,157	0.013878	24,937	346	56.00
57.00	05700	CT SCAN	167,076	75,928,829	0.002200	187,928	413	57.00
59.00	05900	CARDIAC CATHETERIZATION	483,851	91,616,864	0.005281	119,072	629	59.00
60.00	06000	LABORATORY	576,026	127,698,865	0.004511	563,637	2,543	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	46,763	5,603,104	0.008346	13,995	117	62.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0.000000	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	179,485	20,514,071	0.008749	193,187	1,690	65.00
66.00	06600	PHYSICAL THERAPY	710,568	16,409,705	0.043302	39,451	1,708	66.00
67.00	06700	OCCUPATIONAL THERAPY	39,266	7,134,946	0.005503	14,639	81	67.00
68.00	06800	SPEECH PATHOLOGY	12,227	1,344,715	0.009093	29,341	267	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	155,900	22,095,722	0.007056	7,717	54	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	113,949	26,545,380	0.004293	157,431	676	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	186,192	35,695,354	0.005216	52,574	274	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	298,602	110,242,958	0.002709	1,130,139	3,062	73.00
74.00	07400	RENAL DIALYSIS	5,294	3,988,736	0.001327	31,639	42	74.00
76.97	07697	CARDIAC REHABILITATION	323,731	2,059,117	0.157218	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0.000000	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0.000000	0	0	76.99
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	1,111,163	16,543,866	0.067165	1,204	81	90.00
91.00	09100	EMERGENCY	868,449	95,539,169	0.009090	277,662	2,524	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	526,584	14,223,813	0.037021	30,501	1,129	92.00
200.00		Total (lines 50 through 199)	9,037,298	963,423,592		3,469,622	25,853	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 15-0034 | Period: From 07/01/2019 To 06/30/2020 | Worksheet D Part III Date/Time Prepared: 11/25/2020 2:58 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	44,031	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	21,421	0	31.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
200.00		Total (lines 30 through 199)	0	0	0	65,452	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	44,031	43,827	1.00	1,331	30.00
31.00	03100	INTENSIVE CARE UNIT		21,421	5,137	4.17	38	31.00
41.00	04100	SUBPROVIDER - IRF	0	0	5,991	0.00	0	41.00
43.00	04300	NURSERY		0	1,417	0.00	227	43.00
200.00		Total (lines 30 through 199)		65,452	56,372		1,596	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	1,331	30.00
31.00	03100	INTENSIVE CARE UNIT	158	31.00
41.00	04100	SUBPROVIDER - IRF	0	41.00
43.00	04300	NURSERY	0	43.00
200.00		Total (lines 30 through 199)	1,489	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-0034 | Period: From 07/01/2019 To 06/30/2020 | Worksheet D Part IV | Date/Time Prepared: 11/25/2020 2:58 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	42,841	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	03630	ULTRA SOUND	0	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0	0	0	62.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	23,801	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
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	0	0	270,136	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0		0		5,463	92.00
200.00		Total (lines 50 through 199)	0	0	0	0	342,241	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-0034 | Period: From 07/01/2019 To 06/30/2020 | Worksheet D Part IV Date/Time Prepared: 11/25/2020 2:58 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	42,841	42,841	121,072,178	0.000354	50.00
51.00	05100	RECOVERY ROOM	0	0	0	14,895,166	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	3,782,209	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	24,243,755	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	87,269,983	0.000000	54.00
54.01	03630	ULTRA SOUND	0	0	0	20,956,930	0.000000	54.01
56.00	05600	RADIOISOTOPE	0	0	0	18,018,157	0.000000	56.00
57.00	05700	CT SCAN	0	0	0	75,928,829	0.000000	57.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	91,616,864	0.000000	59.00
60.00	06000	LABORATORY	0	0	0	127,698,865	0.000000	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0	5,603,104	0.000000	62.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0.000000	62.30
65.00	06500	RESPIRATORY THERAPY	0	23,801	23,801	20,514,071	0.001160	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	16,409,705	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	7,134,946	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	1,344,715	0.000000	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	22,095,722	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	26,545,380	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	35,695,354	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	110,242,958	0.000000	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	3,988,736	0.000000	74.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	2,059,117	0.000000	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0.000000	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0.000000	76.99
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	16,543,866	0.000000	90.00
91.00	09100	EMERGENCY	0	270,136	270,136	95,539,169	0.002827	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	5,463	5,463	14,223,813	0.000384	92.00
200.00		Total (lines 50 through 199)	0	342,241	342,241	963,423,592		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-0034 | Period: From 07/01/2019 To 06/30/2020 | Worksheet D Part IV | Date/Time Prepared: 11/25/2020 2:58 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	0.000354	288,828	102	0	0	50.00
51.00	05100	RECOVERY ROOM	0.000000	32,486	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	91,396	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	60,446	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	80,630	0	0	0	54.00
54.01	03630	ULTRA SOUND	0.000000	40,782	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0.000000	24,937	0	0	0	56.00
57.00	05700	CT SCAN	0.000000	187,928	0	0	0	57.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	119,072	0	0	0	59.00
60.00	06000	LABORATORY	0.000000	563,637	0	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0.000000	13,995	0	0	0	62.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0.000000	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0.001160	193,187	224	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	39,451	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	14,639	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	29,341	0	0	0	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	7,717	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	157,431	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	52,574	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	1,130,139	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0.000000	31,639	0	0	0	74.00
76.97	07697	CARDIAC REHABILITATION	0.000000	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0.000000	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0.000000	0	0	0	0	76.99
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.000000	1,204	0	0	0	90.00
91.00	09100	EMERGENCY	0.002827	277,662	785	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000384	30,501	12	0	0	92.00
200.00		Total (lines 50 through 199)		3,469,622	1,123	0	0	200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 15-0034 | Component CCN: 15-T034 | Period: From 07/01/2019 To 06/30/2020 | Worksheet D Part II Date/Time Prepared: 11/25/2020 2:58 pm

Title XIX | Subprovider - IRF | PPS

		Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,544,584	121,072,178	0.012758	0	0	50.00
51.00	05100	RECOVERY ROOM	289,847	14,895,166	0.019459	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	200,781	3,782,209	0.053086	0	0	52.00
53.00	05300	ANESTHESIOLOGY	24,221	24,243,755	0.000999	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	790,332	87,269,983	0.009056	0	0	54.00
54.01	03630	ULTRA SOUND	132,356	20,956,930	0.006316	0	0	54.01
56.00	05600	RADIOISOTOPE	250,051	18,018,157	0.013878	0	0	56.00
57.00	05700	CT SCAN	167,076	75,928,829	0.002200	0	0	57.00
59.00	05900	CARDIAC CATHETERIZATION	483,851	91,616,864	0.005281	0	0	59.00
60.00	06000	LABORATORY	576,026	127,698,865	0.004511	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	46,763	5,603,104	0.008346	0	0	62.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0.000000	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	179,485	20,514,071	0.008749	0	0	65.00
66.00	06600	PHYSICAL THERAPY	710,568	16,409,705	0.043302	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	39,266	7,134,946	0.005503	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	12,227	1,344,715	0.009093	0	0	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	155,900	22,095,722	0.007056	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	113,949	26,545,380	0.004293	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	186,192	35,695,354	0.005216	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	298,602	110,242,958	0.002709	0	0	73.00
74.00	07400	RENAL DIALYSIS	5,294	3,988,736	0.001327	0	0	74.00
76.97	07697	CARDIAC REHABILITATION	323,731	2,059,117	0.157218	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0.000000	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0.000000	0	0	76.99
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	1,111,163	16,543,866	0.067165	0	0	90.00
91.00	09100	EMERGENCY	868,449	95,539,169	0.009090	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	14,223,813	0.000000	0	0	92.00
200.00		Total (lines 50 through 199)	8,510,714	963,423,592		0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-0034
Component CCN: 15-T034

Period:
From 07/01/2019
To 06/30/2020

Worksheet D
Part IV
Date/Time Prepared:
11/25/2020 2:58 pm

Title XIX

Subprovider - IRF

PPS

		Cost Center Description	Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health	
			1.00	2A	2.00	3A	3.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	42,841	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	03630	ULTRA SOUND	0	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0	0	0	62.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	23,801	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
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	0	0	270,136	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0		0		0	92.00
200.00		Total (lines 50 through 199)	0	0	0	0	336,778	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-0034 | Component CCN: 15-T034 | Period: From 07/01/2019 To 06/30/2020 | Worksheet D Part IV | Date/Time Prepared: 11/25/2020 2:58 pm

Title XIX | Subprovider - IRF | PPS

		Cost Center Description	All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7) (see instructions)	
			4.00	5.00	6.00	7.00	8.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	42,841	42,841	121,072,178	0.000354	50.00
51.00	05100	RECOVERY ROOM	0	0	0	14,895,166	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	3,782,209	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	24,243,755	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	87,269,983	0.000000	54.00
54.01	03630	ULTRA SOUND	0	0	0	20,956,930	0.000000	54.01
56.00	05600	RADIOISOTOPE	0	0	0	18,018,157	0.000000	56.00
57.00	05700	CT SCAN	0	0	0	75,928,829	0.000000	57.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	91,616,864	0.000000	59.00
60.00	06000	LABORATORY	0	0	0	127,698,865	0.000000	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0	5,603,104	0.000000	62.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0.000000	62.30
65.00	06500	RESPIRATORY THERAPY	0	23,801	23,801	20,514,071	0.001160	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	16,409,705	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	7,134,946	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	1,344,715	0.000000	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	22,095,722	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	26,545,380	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	35,695,354	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	110,242,958	0.000000	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	3,988,736	0.000000	74.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	2,059,117	0.000000	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0.000000	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0.000000	76.99
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	16,543,866	0.000000	90.00
91.00	09100	EMERGENCY	0	270,136	270,136	95,539,169	0.002827	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	14,223,813	0.000000	92.00
200.00		Total (lines 50 through 199)	0	336,778	336,778	963,423,592		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-0034 | Component CCN: 15-T034 | Period: From 07/01/2019 To 06/30/2020 | Worksheet D Part IV | Date/Time Prepared: 11/25/2020 2:58 pm

Title XIX | Subprovider - IRF | PPS

		Cost Center Description	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	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	0.000354	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0.000000	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	0	0	0	0	54.00
54.01	03630	ULTRA SOUND	0.000000	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0.000000	0	0	0	0	56.00
57.00	05700	CT SCAN	0.000000	0	0	0	0	57.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	0	0	0	0	59.00
60.00	06000	LABORATORY	0.000000	0	0	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0.000000	0	0	0	0	62.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0.000000	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0.001160	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	0	0	0	0	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0.000000	0	0	0	0	74.00
76.97	07697	CARDIAC REHABILITATION	0.000000	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0.000000	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0.000000	0	0	0	0	76.99
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.000000	0	0	0	0	90.00
91.00	09100	EMERGENCY	0.002827	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	0	0	0	0	92.00
200.00		Total (lines 50 through 199)		0	0	0	0	200.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-0034 | Period: From 07/01/2019 To 06/30/2020 | Worksheet D-1 | Date/Time Prepared: 11/25/2020 2:58 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)	43,827	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	43,827	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)	38,387	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)	16,879	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)	38,240,494	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)	38,240,494	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)	38,240,494	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)	872.53	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	14,727,434	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)	14,727,434	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-0034 | Period: From 07/01/2019 To 06/30/2020 | Worksheet D-1 | Date/Time Prepared: 11/25/2020 2:58 pm

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	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	8,313,591	5,137	1,618.37	1,707	2,762,558	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)	23,646,110	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	41,136,102	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)	1,863,509	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	1,041,852	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	2,905,361	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	38,230,741	53.00
	TARGET AMOUNT AND LIMIT COMPUTATION		
54.00	Program discharges	0	54.00
55.00	Target amount per discharge	0.00	55.00
56.00	Target amount (line 54 x line 55)	0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)	0	57.00
58.00	Bonus payment (see instructions)	0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket	0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket	0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)	0	61.00
62.00	Relief payment (see instructions)	0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)	0	63.00
	PROGRAM INPATIENT ROUTINE SWING BED COST		
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)	0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)	0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)	0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)	0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)	0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)	0	69.00
	PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY		
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)		70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)		71.00
72.00	Program routine service cost (line 9 x line 71)		72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)		73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)		74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)		75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)		76.00
77.00	Program capital-related costs (line 9 x line 76)		77.00
78.00	Inpatient routine service cost (line 74 minus line 77)		78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)		79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)		80.00
81.00	Inpatient routine service cost per diem limitation		81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)		82.00
83.00	Reasonable inpatient routine service costs (see instructions)		83.00
84.00	Program inpatient ancillary services (see instructions)		84.00
85.00	Utilization review - physician compensation (see instructions)		85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)		86.00
	PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST		
87.00	Total observation bed days (see instructions)	5,440	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	872.53	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	4,746,563	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-0034 | Period: From 07/01/2019 To 06/30/2020 | Worksheet D-1 | Date/Time Prepared: 11/25/2020 2:58 pm

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	Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	4,242,411	38,240,494	0.110940	4,746,563	526,584	90.00
91.00	Nursing School cost	0	38,240,494	0.000000	4,746,563	0	91.00
92.00	Allied health cost	44,031	38,240,494	0.001151	4,746,563	5,463	92.00
93.00	All other Medical Education	0	38,240,494	0.000000	4,746,563	0	93.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 15-0034 Component CCN: 15-T034	Period: From 07/01/2019 To 06/30/2020	Worksheet D-1 Date/Time Prepared: 11/25/2020 2:58 pm
	Title XVIII	Subprovider - IRF	PPS

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	5,991	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	5,991	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.	0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)	5,991	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)	3,787	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)	5,151,834	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)	5,151,834	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)	5,151,834	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)	859.93	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	3,256,555	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)	0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)	3,256,555	41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 15-0034 | Component CCN: 15-T034 | Period: From 07/01/2019 To 06/30/2020 | Worksheet D-1 | Date/Time Prepared: 11/25/2020 2:58 pm

Title XVIII | Subprovider - IRF | PPS

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

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	1,890,937	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	5,147,492	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)	324,432	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	114,132	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	438,564	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	4,708,928	53.00
	TARGET AMOUNT AND LIMIT COMPUTATION		
54.00	Program discharges	0	54.00
55.00	Target amount per discharge	0.00	55.00
56.00	Target amount (line 54 x line 55)	0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)	0	57.00
58.00	Bonus payment (see instructions)	0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket	0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket	0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)	0	61.00
62.00	Relief payment (see instructions)	0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)	0	63.00
	PROGRAM INPATIENT ROUTINE SWING BED COST		
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)	0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)	0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)	0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)	0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)	0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)	0	69.00
	PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY		
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)		70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)		71.00
72.00	Program routine service cost (line 9 x line 71)		72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)		73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)		74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)		75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)		76.00
77.00	Program capital-related costs (line 9 x line 76)		77.00
78.00	Inpatient routine service cost (line 74 minus line 77)		78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)		79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)		80.00
81.00	Inpatient routine service cost per diem limitation		81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)		82.00
83.00	Reasonable inpatient routine service costs (see instructions)		83.00
84.00	Program inpatient ancillary services (see instructions)		84.00
85.00	Utilization review - physician compensation (see instructions)		85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)		86.00
	PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST		
87.00	Total observation bed days (see instructions)	0	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	0.00	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	0	89.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 15-0034 Component CCN: 15-T034	Period: From 07/01/2019 To 06/30/2020	Worksheet D-1 Date/Time Prepared: 11/25/2020 2:58 pm
	Title XVIII	Subprovider - IRF	PPS

	Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	513,250	5,151,834	0.099625	0	0	90.00
91.00	Nursing School cost	0	5,151,834	0.000000	0	0	91.00
92.00	Allied health cost	0	5,151,834	0.000000	0	0	92.00
93.00	All other Medical Education	0	5,151,834	0.000000	0	0	93.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-0034 | Period: From 07/01/2019 To 06/30/2020 | Worksheet D-1 | Date/Time Prepared: 11/25/2020 2:58 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)	43,827	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	43,827	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)	38,387	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions)	1,331	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)	1,417	15.00
16.00	Nursery days (title V or XIX only)	227	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)	38,240,494	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)	38,240,494	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)	38,240,494	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)	872.53	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	1,161,337	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)	0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)	1,161,337	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-0034 | Period: From 07/01/2019 To 06/30/2020 | Worksheet D-1 | Date/Time Prepared: 11/25/2020 2:58 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)	2,298,802	1,417	1,622.30	227	368,262	42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	8,313,591	5,137	1,618.37	38	61,498	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)	630,216	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	2,221,313	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)	169,329	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	26,976	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	196,305	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	2,025,008	53.00
	TARGET AMOUNT AND LIMIT COMPUTATION		
54.00	Program discharges	0	54.00
55.00	Target amount per discharge	0.00	55.00
56.00	Target amount (line 54 x line 55)	0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)	0	57.00
58.00	Bonus payment (see instructions)	0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket	0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket	0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)	0	61.00
62.00	Relief payment (see instructions)	0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)	0	63.00
	PROGRAM INPATIENT ROUTINE SWING BED COST		
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)	0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)	0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)	0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)	0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)	0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)	0	69.00
	PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY		
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)		70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)		71.00
72.00	Program routine service cost (line 9 x line 71)		72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)		73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)		74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)		75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)		76.00
77.00	Program capital-related costs (line 9 x line 76)		77.00
78.00	Inpatient routine service cost (line 74 minus line 77)		78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)		79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)		80.00
81.00	Inpatient routine service cost per diem limitation		81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)		82.00
83.00	Reasonable inpatient routine service costs (see instructions)		83.00
84.00	Program inpatient ancillary services (see instructions)		84.00
85.00	Utilization review - physician compensation (see instructions)		85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)		86.00
	PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST		
87.00	Total observation bed days (see instructions)	5,440	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	872.53	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	4,746,563	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-0034 | Period: From 07/01/2019 To 06/30/2020 | Worksheet D-1 | Date/Time Prepared: 11/25/2020 2:58 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	4,242,411	38,240,494	0.110940	4,746,563	526,584	90.00
91.00	Nursing School cost	0	38,240,494	0.000000	4,746,563	0	91.00
92.00	Allied health cost	44,031	38,240,494	0.001151	4,746,563	5,463	92.00
93.00	All other Medical Education	0	38,240,494	0.000000	4,746,563	0	93.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 15-0034 Component CCN: 15-T034	Period: From 07/01/2019 To 06/30/2020	Worksheet D-1 Date/Time Prepared: 11/25/2020 2:58 pm
	Title XIX	Subprovider - IRF	PPS

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	5,991	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	5,991	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.	0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)	5,991	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions)	0	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)	0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period	0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15.00	Total nursery days (title V or XIX only)	1,417	15.00
16.00	Nursery days (title V or XIX only)	227	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)	5,151,834	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)	5,151,834	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)	5,151,834	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)	859.93	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	0	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)	0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)	0	41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 15-0034 | Component CCN: 15-T034 | Period: From 07/01/2019 To 06/30/2020 | Worksheet D-1 | Date/Time Prepared: 11/25/2020 2:58 pm

Title XIX | Subprovider - IRF | PPS

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

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

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 15-0034 Component CCN: 15-T034	Period: From 07/01/2019 To 06/30/2020	Worksheet D-1 Date/Time Prepared: 11/25/2020 2:58 pm
	Title XIX	Subprovider - IRF	PPS

	Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	513,250	5,151,834	0.099625	0	0	90.00
91.00	Nursing School cost	0	5,151,834	0.000000	0	0	91.00
92.00	Allied health cost	0	5,151,834	0.000000	0	0	92.00
93.00	All other Medical Education	0	5,151,834	0.000000	0	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 15-0034 | Period: From 07/01/2019 To 06/30/2020 | Worksheet D-3 | Date/Time Prepared: 11/25/2020 2:58 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		26,400,986		30.00
31.00	03100	INTENSIVE CARE UNIT		5,032,595		31.00
41.00	04100	SUBPROVIDER - IRF		0		41.00
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.203520	15,784,356	3,212,432	50.00
51.00	05100	RECOVERY ROOM	0.257588	1,948,288	501,856	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.568210	8,938	5,079	52.00
53.00	05300	ANESTHESIOLOGY	0.030744	3,368,739	103,569	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.115089	4,932,467	567,673	54.00
54.01	03630	ULTRA SOUND	0.101424	1,419,535	143,975	54.01
56.00	05600	RADIOISOTOPE	0.142555	1,262,339	179,953	56.00
57.00	05700	CT SCAN	0.045364	9,051,739	410,623	57.00
59.00	05900	CARDIAC CATHETERIZATION	0.074944	13,577,621	1,017,561	59.00
60.00	06000	LABORATORY	0.101145	16,165,533	1,635,063	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0.308772	1,369,753	422,941	62.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0.000000	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0.196469	8,139,093	1,599,079	65.00
66.00	06600	PHYSICAL THERAPY	0.298898	1,672,665	499,956	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.181354	944,775	171,339	67.00
68.00	06800	SPEECH PATHOLOGY	0.405700	256,980	104,257	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.100952	2,195,919	221,682	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.405316	4,956,486	2,008,943	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.495603	9,339,590	4,628,729	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.184181	19,859,912	3,657,818	73.00
74.00	07400	RENAL DIALYSIS	0.257986	1,637,620	422,483	74.00
76.97	07697	CARDIAC REHABILITATION	0.767520	162,777	124,935	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0.000000	0	0	76.98
76.99	07699	LITHOTRIPSY	0.000000	0	0	76.99
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0.452958	232,069	105,118	90.00
91.00	09100	EMERGENCY	0.113594	12,666,373	1,438,824	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.333705	1,385,122	462,222	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		132,338,689	23,646,110	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)		132,338,689		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

Provider CCN: 15-0034 | Component CCN: 15-T034 | Period: From 07/01/2019 To 06/30/2020 | Worksheet D-3 | Date/Time Prepared: 11/25/2020 2:58 pm

Title XVIII | Subprovider - IRF | PPS

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		0		30.00
31.00	03100	INTENSIVE CARE UNIT		0		31.00
41.00	04100	SUBPROVIDER - IRF		4,709,754		41.00
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.203520	136,308	27,741	50.00
51.00	05100	RECOVERY ROOM	0.257588	11,954	3,079	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.568210	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.030744	20,614	634	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.115089	194,300	22,362	54.00
54.01	03630	ULTRA SOUND	0.101424	43,623	4,424	54.01
56.00	05600	RADIOISOTOPE	0.142555	19,774	2,819	56.00
57.00	05700	CT SCAN	0.045364	169,246	7,678	57.00
59.00	05900	CARDIAC CATHETERIZATION	0.074944	66,311	4,970	59.00
60.00	06000	LABORATORY	0.101145	748,676	75,725	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0.308772	50,794	15,684	62.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0.000000	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0.196469	597,600	117,410	65.00
66.00	06600	PHYSICAL THERAPY	0.298898	1,801,318	538,410	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.181354	1,843,481	334,323	67.00
68.00	06800	SPEECH PATHOLOGY	0.405700	252,328	102,369	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.100952	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.405316	409,641	166,034	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.495603	7,447	3,691	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.184181	1,975,250	363,804	73.00
74.00	07400	RENAL DIALYSIS	0.257986	353,335	91,155	74.00
76.97	07697	CARDIAC REHABILITATION	0.767520	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0.000000	0	0	76.98
76.99	07699	LITHOTRIPSY	0.000000	0	0	76.99
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0.452958	19,042	8,625	90.00
91.00	09100	EMERGENCY	0.113594	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.333705	0	0	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		8,721,042	1,890,937	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)		8,721,042		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 15-0034 | Period: From 07/01/2019 To 06/30/2020 | Worksheet D-3 | Date/Time Prepared: 11/25/2020 2:58 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		786,978		30.00
31.00	03100	INTENSIVE CARE UNIT		289,093		31.00
41.00	04100	SUBPROVIDER - IRF		0		41.00
43.00	04300	NURSERY		217,430		43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.203520	288,828	58,782	50.00
51.00	05100	RECOVERY ROOM	0.257588	32,486	8,368	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.568210	91,396	51,932	52.00
53.00	05300	ANESTHESIOLOGY	0.030744	60,446	1,858	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.115089	80,630	9,280	54.00
54.01	03630	ULTRA SOUND	0.101424	40,782	4,136	54.01
56.00	05600	RADIOISOTOPE	0.142555	24,937	3,555	56.00
57.00	05700	CT SCAN	0.045364	187,928	8,525	57.00
59.00	05900	CARDIAC CATHETERIZATION	0.074944	119,072	8,924	59.00
60.00	06000	LABORATORY	0.101145	563,637	57,009	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0.308772	13,995	4,321	62.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0.000000	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0.196469	193,187	37,955	65.00
66.00	06600	PHYSICAL THERAPY	0.298898	39,451	11,792	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.181354	14,639	2,655	67.00
68.00	06800	SPEECH PATHOLOGY	0.405700	29,341	11,904	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.100952	7,717	779	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.405316	157,431	63,809	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.495603	52,574	26,056	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.184181	1,130,139	208,150	73.00
74.00	07400	RENAL DIALYSIS	0.257986	31,639	8,162	74.00
76.97	07697	CARDIAC REHABILITATION	0.767520	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0.000000	0	0	76.98
76.99	07699	LITHOTRIPSY	0.000000	0	0	76.99
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0.452958	1,204	545	90.00
91.00	09100	EMERGENCY	0.113594	277,662	31,541	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.333705	30,501	10,178	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		3,469,622	630,216	200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0		201.00
202.00		Net charges (line 200 minus line 201)		3,469,622		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0034	Period: From 07/01/2019 To 06/30/2020	Worksheet E Part A Date/Time Prepared: 11/25/2020 2:58 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)	10,230,693	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1 (see instructions)	26,983,884	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)	24,710	2.03
2.04	Outlier payments for discharges occurring on or after October 1 (see instructions)	253,924	2.04
3.00	Managed Care Simulated Payments	0	3.00
4.00	Bed days available divided by number of days in the cost reporting period (see instructions)	165.00	4.00
	Indirect Medical Education Adjustment		
5.00	FTE count for allopathic and osteopathic programs for the most recent cost reporting period ending on or before 12/31/1996.(see instructions)	0.00	5.00
6.00	FTE count for allopathic and osteopathic programs that meet the criteria for an add-on to the cap for new programs in accordance with 42 CFR 413.79(e)	0.00	6.00
7.00	MMA Section 422 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(1)	0.00	7.00
7.01	ACA § 5503 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(2) If the cost report straddles July 1, 2011 then see instructions.	0.00	7.01
8.00	Adjustment (increase or decrease) to the FTE count for allopathic and osteopathic programs for affiliated programs in accordance with 42 CFR 413.75(b), 413.79(c)(2)(iv), 64 FR 26340 (May 12, 1998), and 67 FR 50069 (August 1, 2002).	0.00	8.00
8.01	The amount of increase if the hospital was awarded FTE cap slots under § 5503 of the ACA. If the cost report straddles July 1, 2011, see instructions.	0.00	8.01
8.02	The amount of increase if the hospital was awarded FTE cap slots from a closed teaching hospital under § 5506 of ACA. (see instructions)	0.00	8.02
9.00	Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus lines (8, 8,01 and 8,02) (see instructions)	0.00	9.00
10.00	FTE count for allopathic and osteopathic programs in the current year from your records	0.00	10.00
11.00	FTE count for residents in dental and podiatric programs.	0.00	11.00
12.00	Current year allowable FTE (see instructions)	0.00	12.00
13.00	Total allowable FTE count for the prior year.	0.00	13.00
14.00	Total allowable FTE count for the penultimate year if that year ended on or after September 30, 1997, otherwise enter zero.	0.00	14.00
15.00	Sum of lines 12 through 14 divided by 3.	0.00	15.00
16.00	Adjustment for residents in initial years of the program	0.00	16.00
17.00	Adjustment for residents displaced by program or hospital closure	0.00	17.00
18.00	Adjusted rolling average FTE count	0.00	18.00
19.00	Current year resident to bed ratio (line 18 divided by line 4).	0.000000	19.00
20.00	Prior year resident to bed ratio (see instructions)	0.000000	20.00
21.00	Enter the lesser of lines 19 or 20 (see instructions)	0.000000	21.00
22.00	IME payment adjustment (see instructions)	0	22.00
22.01	IME payment adjustment - Managed Care (see instructions)	0	22.01
	Indirect Medical Education Adjustment for the Add-on for § 422 of the MMA		
23.00	Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 CFR 412.105 (f)(1)(iv)(C).	0.00	23.00
24.00	IME FTE Resident Count Over Cap (see instructions)	0.00	24.00
25.00	If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see instructions)	0.00	25.00
26.00	Resident to bed ratio (divide line 25 by line 4)	0.000000	26.00
27.00	IME payments adjustment factor. (see instructions)	0.000000	27.00
28.00	IME add-on adjustment amount (see instructions)	0	28.00
28.01	IME add-on adjustment amount - Managed Care (see instructions)	0	28.01
29.00	Total IME payment (sum of lines 22 and 28)	0	29.00
29.01	Total IME payment - Managed Care (sum of lines 22.01 and 28.01)	0	29.01
	Disproportionate Share Adjustment		
30.00	Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)	3.43	30.00
31.00	Percentage of Medicaid patient days (see instructions)	15.10	31.00
32.00	Sum of lines 30 and 31	18.53	32.00
33.00	Allowable disproportionate share percentage (see instructions)	4.79	33.00
34.00	Disproportionate share adjustment (see instructions)	445,645	34.00

CALCULATION OF REIMBURSEMENT SETTLEMENT | Provider CCN: 15-0034 | Period: From 07/01/2019 To 06/30/2020 | Worksheet E Part A Date/Time Prepared: 11/25/2020 2:58 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)	8,272,872,447	8,350,599,096	35.00
35.01	Factor 3 (see instructions)	0.000222432	0.000167267	35.01
35.02	Hospital uncompensated care payment (If line 34 is zero, enter zero on this line) (see instructions)	1,840,149	1,396,784	35.02
35.03	Pro rata share of the hospital uncompensated care payment amount (see instructions)	463,819	1,045,680	35.03
36.00	Total uncompensated care (sum of columns 1 and 2 on line 35.03)	1,509,499		36.00
	Additional payment for high percentage of ESRD beneficiary discharges (lines 40 through 46)			
40.00	Total Medicare discharges on Worksheet S-3, Part I excluding discharges for MS-DRGs 652, 682, 683, 684 and 685 (see instructions)	0		40.00
		Before 1/1	On/After 1/1	
		1.00	1.01	
41.00	Total ESRD Medicare discharges excluding MS-DRGs 652, 682, 683, 684 an 685. (see instructions)	0	0	41.00
41.01	Total ESRD Medicare covered and paid discharges excluding MS-DRGs 652, 682, 683, 684 an 685. (see instructions)	0	0	41.01
42.00	Divide line 41 by line 40 (if less than 10%, you do not qualify for adjustment)	0.00		42.00
43.00	Total Medicare ESRD inpatient days excluding MS-DRGs 652, 682, 683, 684 an 685. (see instructions)	0		43.00
44.00	Ratio of average length of stay to one week (line 43 divided by line 41 divided by 7 days)	0.000000		44.00
45.00	Average weekly cost for dialysis treatments (see instructions)	0.00	0.00	45.00
46.00	Total additional payment (line 45 times line 44 times line 41.01)	0		46.00
47.00	Subtotal (see instructions)	39,448,355		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)		39,448,355	49.00
50.00	Payment for inpatient program capital (from Wkst. L, Pt. I and Pt. II, as applicable)		3,111,954	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		18,441	53.00
54.00	Special add-on payments for new technologies		8,316	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).		23,997	57.00
58.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 11 line 200)		51,369	58.00
59.00	Total (sum of amounts on lines 49 through 58)		42,662,432	59.00
60.00	Primary payer payments		5,990	60.00
61.00	Total amount payable for program beneficiaries (line 59 minus line 60)		42,656,442	61.00
62.00	Deductibles billed to program beneficiaries		3,714,612	62.00
63.00	Coinsurance billed to program beneficiaries		249,370	63.00
64.00	Allowable bad debts (see instructions)		450,112	64.00
65.00	Adjusted reimbursable bad debts (see instructions)		292,573	65.00
66.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		59,274	66.00
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)		38,985,033	67.00
68.00	Credits received from manufacturers for replaced devices for applicable to MS-DRGs (see instructions)		5,157	68.00
69.00	Outlier payments reconciliation (sum of lines 93, 95 and 96).(For SCH see instructions)		0	69.00
70.00	ADD BACK GME REIMBURSEMENT		0	70.00
70.01	OTHER ADJ (NO DESC ENTERED)		0	70.01
70.02	OTHER ADJUSTMENTS PER PSR		0	70.02
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)		-50,764	70.93
70.94	HRR adjustment amount (see instructions)		-837,451	70.94
70.95	Recovery of accelerated depreciation		0	70.95

CALCULATION OF REIMBURSEMENT SETTLEMENT | Provider CCN: 15-0034 | Period: From 07/01/2019 To 06/30/2020 | Worksheet E Part A | Date/Time Prepared: 11/25/2020 2:58 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)		0	70.99
71.00	Amount due provider (line 67 minus lines 68 plus/minus lines 69 & 70)		38,091,661	71.00
71.01	Sequestration adjustment (see instructions)		636,131	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		37,292,695	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)		162,835	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		529,174	75.00
	TO BE COMPLETED BY CONTRACTOR (lines 90 through 96)			
90.00	Operating outlier amount from Wkst. E, Pt. A, line 2, or sum of 2.03 plus 2.04 (see instructions)		0	90.00
91.00	Capital outlier from Wkst. L, Pt. I, line 2		0	91.00
92.00	Operating outlier reconciliation adjustment amount (see instructions)		0	92.00
93.00	Capital outlier reconciliation adjustment amount (see instructions)		0	93.00
94.00	The rate used to calculate the time value of money (see instructions)		0.00	94.00
95.00	Time value of money for operating expenses (see instructions)		0	95.00
96.00	Time value of money for capital related expenses (see instructions)		0	96.00

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

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0034	Period: From 07/01/2019 To 06/30/2020	Worksheet E Part B Date/Time Prepared: 11/25/2020 2:58 pm
	Title XVIII	Hospital	PPS

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	77,101	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)	26,792,500	2.00
3.00	OPPS payments	27,058,115	3.00
4.00	Outlier payment (see instructions)	32,571	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	40,893	9.00
10.00	Organ acquisitions	0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)	77,101	11.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
12.00	Ancillary service charges	390,590	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)	390,590	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)	390,590	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)	313,489	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)	77,101	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)	27,131,579	24.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
25.00	Deductibles and coinsurance amounts (for CAH, see instructions)	0	25.00
26.00	Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)	5,103,869	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)	22,104,811	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)	22,104,811	30.00
31.00	Primary payer payments	14,208	31.00
32.00	Subtotal (line 30 minus line 31)	22,090,603	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)	599,125	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	389,431	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	325,416	36.00
37.00	Subtotal (see instructions)	22,480,034	37.00
38.00	MSP-LCC reconciliation amount from PS&R	-54	38.00
39.00	FDO LOSS	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)	22,480,088	40.00
40.01	Sequestration adjustment (see instructions)	375,417	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	22,306,325	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)	-201,654	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: 15-0034 | Period: From 07/01/2019 To 06/30/2020 | Worksheet E-1 Part I Date/Time Prepared: 11/25/2020 2:58 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		36,783,239		21,680,421	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		483,656		625,904	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	01/15/2020	25,800		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
	Provider to Program					
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		25,800		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		37,292,695		22,306,325	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		162,835		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		201,654	6.02
7.00	Total Medicare program liability (see instructions)		37,455,530		22,104,671	7.00

			Contractor Number	NPR Date (Mo/Day/Yr)	
		0	1.00	2.00	
8.00	Name of Contractor				8.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 15-0034 | Component CCN: 15-T034 | Period: From 07/01/2019 To 06/30/2020 | Worksheet E-1 Part I | Date/Time Prepared: 11/25/2020 2:58 pm

Title XVIII | Subprovider - IRF | PPS

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		7,158,220		0	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
	Program to Provider					
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
	Provider to Program					
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		7,158,220		0	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		79,241		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		7,237,461		0	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: 15-0034	Period: From 07/01/2019 To 06/30/2020	Worksheet E-1 Part II Date/Time Prepared: 11/25/2020 2:58 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: 15-0034 Component CCN: 15-T034	Period: From 07/01/2019 To 06/30/2020	Worksheet E-3 Part III Date/Time Prepared: 11/25/2020 2:58 pm
	Title XVIII	Subprovider - IRF	PPS

		1.00	
	PART III - MEDICARE PART A SERVICES - IRF PPS		
1.00	Net Federal PPS Payment (see instructions)	7,189,856	1.00
2.00	Medicare SSI ratio (IRF PPS only) (see instructions)	0.0284	2.00
3.00	Inpatient Rehabilitation LIP Payments (see instructions)	227,918	3.00
4.00	Outlier Payments	37,466	4.00
5.00	Unweighted intern and resident FTE count in the most recent cost reporting period ending on or prior to November 15, 2004 (see instructions)	0.00	5.00
5.01	Cap increases for the unweighted intern and resident FTE count for residents that were displaced by program or hospital closure, that would not be counted without a temporary cap adjustment under 42 CFR §412.424(d)(1)(iii)(F)(1) or (2) (see instructions)	0.00	5.01
6.00	New Teaching program adjustment. (see instructions)	0.00	6.00
7.00	Current year's unweighted FTE count of I&R excluding FTEs in the new program growth period of a "new teaching program" (see instructions)	0.00	7.00
8.00	Current year's unweighted I&R FTE count for residents within the new program growth period of a "new teaching program" (see instructions)	0.00	8.00
9.00	Intern and resident count for IRF PPS medical education adjustment (see instructions)	0.00	9.00
10.00	Average Daily Census (see instructions)	16.368852	10.00
11.00	Teaching Adjustment Factor (see instructions)	0.000000	11.00
12.00	Teaching Adjustment (see instructions)	0	12.00
13.00	Total PPS Payment (see instructions)	7,455,240	13.00
14.00	Nursing and Allied Health Managed Care payments (see instruction)	0	14.00
15.00	Organ acquisition (DO NOT USE THIS LINE)		15.00
16.00	Cost of physicians' services in a teaching hospital (see instructions)	0	16.00
17.00	Subtotal (see instructions)	7,455,240	17.00
18.00	Primary payer payments	0	18.00
19.00	Subtotal (line 17 less line 18).	7,455,240	19.00
20.00	Deductibles	35,904	20.00
21.00	Subtotal (line 19 minus line 20)	7,419,336	21.00
22.00	Coinsurance	65,527	22.00
23.00	Subtotal (line 21 minus line 22)	7,353,809	23.00
24.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)	8,967	24.00
25.00	Adjusted reimbursable bad debts (see instructions)	5,829	25.00
26.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	2,387	26.00
27.00	Subtotal (sum of lines 23 and 25)	7,359,638	27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 49)	0	28.00
29.00	Other pass through costs (see instructions)	741	29.00
30.00	Outlier payments reconciliation	0	30.00
31.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	31.00
31.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	31.50
31.99	Demonstration payment adjustment amount before sequestration	0	31.99
32.00	Total amount payable to the provider (see instructions)	7,360,379	32.00
32.01	Sequestration adjustment (see instructions)	122,918	32.01
32.02	Demonstration payment adjustment amount after sequestration	0	32.02
33.00	Interim payments	7,158,220	33.00
34.00	Tentative settlement (for contractor use only)	0	34.00
35.00	Balance due provider/program (line 32 minus lines 32.01, 32.02, 33, and 34)	79,241	35.00
36.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	36.00
	TO BE COMPLETED BY CONTRACTOR		
50.00	Original outlier amount from Wkst. E-3, Pt. III, line 4	37,466	50.00
51.00	Outlier reconciliation adjustment amount (see instructions)	0	51.00
52.00	The rate used to calculate the Time Value of Money	0.00	52.00
53.00	Time Value of Money (see instructions)	0	53.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0034	Period: From 07/01/2019 To 06/30/2020	Worksheet E-3 Part VII Date/Time Prepared: 11/25/2020 2:58 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		0	2.00
3.00	Organ acquisition (certified transplant centers only)	0		3.00
4.00	Subtotal (sum of lines 1, 2 and 3)	0	0	4.00
5.00	Inpatient primary payer payments	0		5.00
6.00	Outpatient primary payer payments		0	6.00
7.00	Subtotal (line 4 less sum of lines 5 and 6)	0	0	7.00
	COMPUTATION OF LESSER OF COST OR CHARGES			
	Reasonable Charges			
8.00	Routine service charges	786,978		8.00
9.00	Ancillary service charges	3,469,622	0	9.00
10.00	Organ acquisition charges, net of revenue	0		10.00
11.00	Incentive from target amount computation	0		11.00
12.00	Total reasonable charges (sum of lines 8 through 11)	4,256,600	0	12.00
	CUSTOMARY CHARGES			
13.00	Amount actually collected from patients liable for payment for services on a charge basis	0	0	13.00
14.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)	0	0	14.00
15.00	Ratio of line 13 to line 14 (not to exceed 1.000000)	0.000000	0.000000	15.00
16.00	Total customary charges (see instructions)	4,256,600	0	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)	4,256,600	0	17.00
18.00	Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 16) (see instructions)	0	0	18.00
19.00	Interns and Residents (see instructions)	0	0	19.00
20.00	Cost of physicians' services in a teaching hospital (see instructions)	0	0	20.00
21.00	Cost of covered services (enter the lesser of line 4 or line 16)	0	0	21.00
	PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be completed for PPS providers.			
22.00	Other than outlier payments	0	0	22.00
23.00	Outlier payments	0	0	23.00
24.00	Program capital payments	0		24.00
25.00	Capital exception payments (see instructions)	0		25.00
26.00	Routine and Ancillary service other pass through costs	2,612	0	26.00
27.00	Subtotal (sum of lines 22 through 26)	2,612	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)	2,612	0	29.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT			
30.00	Excess of reasonable cost (from line 18)	0	0	30.00
31.00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)	2,612	0	31.00
32.00	Deductibles	0	0	32.00
33.00	Coinsurance	0	0	33.00
34.00	Allowable bad debts (see instructions)	0	0	34.00
35.00	Utilization review	0		35.00
36.00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)	2,612	0	36.00
37.00	TO ZERO OUT SETTLEMENT, SINCE NO ADD	-2,612	0	37.00
38.00	Subtotal (line 36 ± line 37)	0	0	38.00
39.00	Direct graduate medical education payments (from Wkst. E-4)	0		39.00
40.00	Total amount payable to the provider (sum of lines 38 and 39)	0	0	40.00
41.00	Interim payments	0	0	41.00
42.00	Balance due provider/program (line 40 minus line 41)	0	0	42.00
43.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, chapter 1, §115.2	0	0	43.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0034 Component CCN: 15-T034	Period: From 07/01/2019 To 06/30/2020	Worksheet E-3 Part VII Date/Time Prepared: 11/25/2020 2:58 pm
	Title XIX	Subprovider - IRF	PPS

		Inpatient	Outpatient	
		1.00	2.00	
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR XIX SERVICES			
	COMPUTATION OF NET COST OF COVERED SERVICES			
1.00	Inpatient hospital/SNF/NF services	0		1.00
2.00	Medical and other services		0	2.00
3.00	Organ acquisition (certified transplant centers only)	0		3.00
4.00	Subtotal (sum of lines 1, 2 and 3)	0	0	4.00
5.00	Inpatient primary payer payments	0		5.00
6.00	Outpatient primary payer payments		0	6.00
7.00	Subtotal (line 4 less sum of lines 5 and 6)	0	0	7.00
	COMPUTATION OF LESSER OF COST OR CHARGES			
	Reasonable Charges			
8.00	Routine service charges	0		8.00
9.00	Ancillary service charges	0	0	9.00
10.00	Organ acquisition charges, net of revenue	0		10.00
11.00	Incentive from target amount computation	0		11.00
12.00	Total reasonable charges (sum of lines 8 through 11)	0	0	12.00
	CUSTOMARY CHARGES			
13.00	Amount actually collected from patients liable for payment for services on a charge basis	0	0	13.00
14.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)	0	0	14.00
15.00	Ratio of line 13 to line 14 (not to exceed 1.000000)	0.000000	0.000000	15.00
16.00	Total customary charges (see instructions)	0	0	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)	0	0	17.00
18.00	Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 16) (see instructions)	0	0	18.00
19.00	Interns and Residents (see instructions)	0	0	19.00
20.00	Cost of physicians' services in a teaching hospital (see instructions)	0	0	20.00
21.00	Cost of covered services (enter the lesser of line 4 or line 16)	0	0	21.00
	PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be completed for PPS providers.			
22.00	Other than outlier payments	0	0	22.00
23.00	Outlier payments	0	0	23.00
24.00	Program capital payments	0		24.00
25.00	Capital exception payments (see instructions)	0		25.00
26.00	Routine and Ancillary service other pass through costs	1,489	0	26.00
27.00	Subtotal (sum of lines 22 through 26)	1,489	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)	1,489	0	29.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT			
30.00	Excess of reasonable cost (from line 18)	0	0	30.00
31.00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)	1,489	0	31.00
32.00	Deductibles	0	0	32.00
33.00	Coinsurance	0	0	33.00
34.00	Allowable bad debts (see instructions)	0	0	34.00
35.00	Utilization review	0		35.00
36.00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)	1,489	0	36.00
37.00	TO ZERO OUT SETTLEMENT	-1,489	0	37.00
38.00	Subtotal (line 36 ± line 37)	0	0	38.00
39.00	Direct graduate medical education payments (from Wkst. E-4)	0		39.00
40.00	Total amount payable to the provider (sum of lines 38 and 39)	0	0	40.00
41.00	Interim payments	0	0	41.00
42.00	Balance due provider/program (line 40 minus line 41)	0	0	42.00
43.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, chapter 1, §115.2	0	0	43.00

BALANCE SHEET (If you are nonproprietary and do not maintain fund-type accounting records, complete the General Fund column only) | Provider CCN: 15-0034 | Period: From 07/01/2019 To 06/30/2020 | Worksheet G | Date/Time Prepared: 11/25/2020 2:58 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	2,898	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	32,204,618	0	0	0	4.00
5.00	Other receivable	0	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	0	0	0	0	6.00
7.00	Inventory	8,084,403	0	0	0	7.00
8.00	Prepaid expenses	29,333	0	0	0	8.00
9.00	Other current assets	0	0	0	0	9.00
10.00	Due from other funds	1,709,780	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	42,031,032	0	0	0	11.00
	FIXED ASSETS					
12.00	Land	0	0	0	0	12.00
13.00	Land improvements	0	0	0	0	13.00
14.00	Accumulated depreciation	0	0	0	0	14.00
15.00	Buildings	124,414,977	0	0	0	15.00
16.00	Accumulated depreciation	0	0	0	0	16.00
17.00	Leasehold improvements	0	0	0	0	17.00
18.00	Accumulated depreciation	0	0	0	0	18.00
19.00	Fixed equipment	0	0	0	0	19.00
20.00	Accumulated depreciation	0	0	0	0	20.00
21.00	Automobiles and trucks	0	0	0	0	21.00
22.00	Accumulated depreciation	0	0	0	0	22.00
23.00	Major movable equipment	0	0	0	0	23.00
24.00	Accumulated depreciation	0	0	0	0	24.00
25.00	Minor equipment depreciable	0	0	0	0	25.00
26.00	Accumulated depreciation	0	0	0	0	26.00
27.00	HIT designated Assets	0	0	0	0	27.00
28.00	Accumulated depreciation	0	0	0	0	28.00
29.00	Minor equipment-nondepreciable	0	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	124,414,977	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	11,001,637	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	11,001,637	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	177,447,646	0	0	0	36.00
	CURRENT LIABILITIES					
37.00	Accounts payable	1,769,940	0	0	0	37.00
38.00	Salaries, wages, and fees payable	8,661,974	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	0	0	0	0	40.00
41.00	Deferred income	0	0	0	0	41.00
42.00	Accelerated payments	0				42.00
43.00	Due to other funds	0	0	0	0	43.00
44.00	Other current liabilities	41,475,744	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	51,907,658	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	6,893,398	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	6,893,398	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	58,801,056	0	0	0	51.00
	CAPITAL ACCOUNTS					
52.00	General fund balance	118,646,590				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)	118,646,590	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	177,447,646	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES | Provider CCN: 15-0034 | Period: From 07/01/2019 To 06/30/2020 | Worksheet G-1 | Date/Time Prepared: 11/25/2020 2:58 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		160,392,766		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		28,499,912				2.00
3.00	Total (sum of line 1 and line 2)		188,892,678		0		3.00
4.00	Additions (credit adjustments) (specify)	0		0		0	4.00
5.00	TRANSFER OF FUNDS	0		0		0	5.00
6.00	CONTRIBUTIONS	147,000		0		0	6.00
7.00	RELEASE RESTRICTED ASSETS	186,000		0		0	7.00
8.00	OTHER	2,000		0		0	8.00
9.00		0		0		0	9.00
10.00	Total additions (sum of line 4-9)		335,000		0		10.00
11.00	Subtotal (line 3 plus line 10)		189,227,678		0		11.00
12.00	Deductions (debit adjustments) (specify)	0		0		0	12.00
13.00	TRANSFER FUNDS	69,793,000		0		0	13.00
14.00	ASSETS RELEASED	259,000		0		0	14.00
15.00	OTHER	529,000		0		0	15.00
16.00	ROUNDING	88		0		0	16.00
17.00		0		0		0	17.00
18.00	Total deductions (sum of lines 12-17)		70,581,088		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		118,646,590		0		19.00

		Endowment Fund	Plant Fund				
		6.00	7.00	8.00			
1.00	Fund balances at beginning of period	0		0			1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)						2.00
3.00	Total (sum of line 1 and line 2)	0		0			3.00
4.00	Additions (credit adjustments) (specify)		0				4.00
5.00	TRANSFER OF FUNDS		0				5.00
6.00	CONTRIBUTIONS		0				6.00
7.00	RELEASE RESTRICTED ASSETS		0				7.00
8.00	OTHER		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	TRANSFER FUNDS		0				13.00
14.00	ASSETS RELEASED		0				14.00
15.00	OTHER		0				15.00
16.00	ROUNDING		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: 15-0034 | Period: From 07/01/2019 To 06/30/2020 | Worksheet G-2 Parts I & II | Date/Time Prepared: 11/25/2020 2:58 pm

	Cost Center Description	Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospital	62,652,497		62,652,497	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF	7,455,388		7,455,388	3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	0		0	5.00
6.00	Swing bed - NF	0		0	6.00
7.00	SKILLED NURSING FACILITY				7.00
8.00	NURSING FACILITY				8.00
9.00	OTHER LONG TERM CARE				9.00
10.00	Total general inpatient care services (sum of lines 1-9)	70,107,885		70,107,885	10.00
	Intensive Care Type Inpatient Hospital Services				
11.00	INTENSIVE CARE UNIT	13,728,482		13,728,482	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)	13,728,482		13,728,482	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	83,836,367		83,836,367	17.00
18.00	Ancillary services	327,843,750	0	327,843,750	18.00
19.00	Outpatient services	0	637,568,368	637,568,368	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		4,778,403	4,778,403	22.00
23.00	AMBULANCE SERVICES				23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	PHYSICIAN OFFICES	1,903	1,066,502	1,068,405	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	411,682,020	643,413,273	1,055,095,293	28.00
	PART II - OPERATING EXPENSES				
29.00	Operating expenses (per Wkst. A, column 3, line 200)		248,807,382		29.00
30.00	ADD (SPECIFY)	0			30.00
31.00	BAD DEBTS	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)		248,807,382		43.00

STATEMENT OF REVENUES AND EXPENSES | Provider CCN: 15-0034 | Period: From 07/01/2019 To 06/30/2020 | Worksheet G-3 | Date/Time Prepared: 11/25/2020 2:58 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	1,055,095,293	1.00
2.00	Less contractual allowances and discounts on patients' accounts	786,409,850	2.00
3.00	Net patient revenues (line 1 minus line 2)	268,685,443	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	248,807,382	4.00
5.00	Net income from service to patients (line 3 minus line 4)	19,878,061	5.00
	OTHER INCOME		
6.00	Contributions, donations, bequests, etc	1,556	6.00
7.00	Income from investments	142,444	7.00
8.00	Revenues from telephone and other miscellaneous communication services	0	8.00
9.00	Revenue from television and radio service	0	9.00
10.00	Purchase discounts	0	10.00
11.00	Rebates and refunds of expenses	0	11.00
12.00	Parking lot receipts	0	12.00
13.00	Revenue from laundry and linen service	0	13.00
14.00	Revenue from meals sold to employees and guests	988,867	14.00
15.00	Revenue from rental of living quarters	0	15.00
16.00	Revenue from sale of medical and surgical supplies to other than patients	0	16.00
17.00	Revenue from sale of drugs to other than patients	0	17.00
18.00	Revenue from sale of medical records and abstracts	0	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	0	20.00
21.00	Rental of vending machines	3,127	21.00
22.00	Rental of hospital space	1,038,234	22.00
23.00	Governmental appropriations	0	23.00
24.00	OTHER OPERATING INCOME	407,711	24.00
24.01	CARDIO INCOME	46,590	24.01
24.02	RELEASED TEMP ASSETS	67,708	24.02
24.03	LAB INCOME	163,028	24.03
24.04	THERAPY INCOME	263	24.04
24.05	CLASSES	40,300	24.05
24.06	PHOTOGRAPHIC FEES	0	24.06
24.07	GAIN ON SALE OF ASSETS	0	24.07
24.08	ROUNDING	0	24.08
24.50	COVID-19 PHE Funding	5,722,023	24.50
25.00	Total other income (sum of lines 6-24)	8,621,851	25.00
26.00	Total (line 5 plus line 25)	28,499,912	26.00
27.00	ROUNDING	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)	28,499,912	29.00

ANALYSIS OF HOSPITAL-BASED HOME HEALTH AGENCY COSTS

Provider CCN: 15-0034 | HHA CCN: 15-7313 | Period: From 07/01/2019 To 06/30/2020 | Worksheet H | Date/Time Prepared: 11/25/2020 2:58 pm

Home Health Agency I | PPS

		Salaries	Employee Benefits	Transportation (see instructions)	Contracted/Purchased Services	Other Costs	Total (sum of cols. 1 thru 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
	GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. & Fixtures			0		0	0	1.00
2.00	Capital Related - Movable Equipment			0		0	0	2.00
3.00	Plant Operation & Maintenance	0	0	0	0	0	0	3.00
4.00	Transportation	0	0	0	0	0	0	4.00
5.00	Administrative and General	775,498	243,385	0	0	54,239	1,073,122	5.00
	HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	761,068	0	106,246	0	0	867,314	6.00
7.00	Physical Therapy	615,998	0	0	26,181	0	642,179	7.00
8.00	Occupational Therapy	93,961	0	0	27,963	0	121,924	8.00
9.00	Speech Pathology	38,942	0	0	0	0	38,942	9.00
10.00	Medical Social Services	12,814	0	0	0	0	12,814	10.00
11.00	Home Health Aide	79,804	0	15,456	0	0	95,260	11.00
12.00	Supplies (see instructions)	0	0	0	0	117,907	117,907	12.00
13.00	Drugs	0	0	0	0	0	0	13.00
14.00	DME	0	0	0	0	0	0	14.00
	HHA NONREIMBURSABLE SERVICES							
15.00	Home Dialysis Aide Services	0	0	0	0	0	0	15.00
16.00	Respiratory Therapy	0	0	0	0	0	0	16.00
17.00	Private Duty Nursing	0	0	0	0	0	0	17.00
18.00	Clinic	0	0	0	0	0	0	18.00
19.00	Health Promotion Activities	0	0	0	0	0	0	19.00
20.00	Day Care Program	0	0	0	0	0	0	20.00
21.00	Home Delivered Meals Program	0	0	0	0	0	0	21.00
22.00	Homemaker Service	0	0	0	0	0	0	22.00
23.00	All Others (specify)	0	0	0	0	0	0	23.00
23.50	Telemedicine	0	0	0	0	0	0	23.50
24.00	Total (sum of lines 1-23)	2,378,085	243,385	121,702	54,144	172,146	2,969,462	24.00

		Reclassification	Reclassified Trial Balance (col. 6 + col.7)	Adjustments	Net Expenses for Allocation (col. 8 + col. 9)			
		7.00	8.00	9.00	10.00			
	GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. & Fixtures	0	0	0	0			1.00
2.00	Capital Related - Movable Equipment	0	0	0	0			2.00
3.00	Plant Operation & Maintenance	0	0	0	0			3.00
4.00	Transportation	0	0	0	0			4.00
5.00	Administrative and General	0	1,073,122	-6,472	1,066,650			5.00
	HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	0	867,314	0	867,314			6.00
7.00	Physical Therapy	0	642,179	0	642,179			7.00
8.00	Occupational Therapy	0	121,924	0	121,924			8.00
9.00	Speech Pathology	0	38,942	0	38,942			9.00
10.00	Medical Social Services	0	12,814	0	12,814			10.00
11.00	Home Health Aide	0	95,260	0	95,260			11.00
12.00	Supplies (see instructions)	0	117,907	0	117,907			12.00
13.00	Drugs	0	0	0	0			13.00
14.00	DME	0	0	0	0			14.00
	HHA NONREIMBURSABLE SERVICES							
15.00	Home Dialysis Aide Services	0	0	0	0			15.00
16.00	Respiratory Therapy	0	0	0	0			16.00
17.00	Private Duty Nursing	0	0	0	0			17.00
18.00	Clinic	0	0	0	0			18.00
19.00	Health Promotion Activities	0	0	0	0			19.00
20.00	Day Care Program	0	0	0	0			20.00
21.00	Home Delivered Meals Program	0	0	0	0			21.00
22.00	Homemaker Service	0	0	0	0			22.00
23.00	All Others (specify)	0	0	0	0			23.00
23.50	Telemedicine	0	0	0	0			23.50
24.00	Total (sum of lines 1-23)	0	2,969,462	-6,472	2,962,990			24.00

Column, 6 line 24 should agree with the Worksheet A, column 3, line 101, or subscript as applicable.

COST ALLOCATION - HHA GENERAL SERVICE COST | Provider CCN: 15-0034 | HHA CCN: 15-7313 | Period: From 07/01/2019 To 06/30/2020 | Worksheet H-1 Part I | Date/Time Prepared: 11/25/2020 2:58 pm

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			Capital Related Costs					
		Net Expenses for Cost Allocation (from Wkst. H, col. 10)	Bldgs & Fixtures	Movable Equipment	Plant Operation & Maintenance	Transportation	Subtotal (cols. 0-4)	
		0	1.00	2.00	3.00	4.00	4A.00	
	GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. & Fixtures	0	0				0	1.00
2.00	Capital Related - Movable Equipment	0		0			0	2.00
3.00	Plant Operation & Maintenance	0	0	0	0		0	3.00
4.00	Transportation	0	0	0	0	0		4.00
5.00	Administrative and General	1,066,650	0	0	0	0	1,066,650	5.00
	HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	867,314	0	0	0	0	867,314	6.00
7.00	Physical Therapy	642,179	0	0	0	0	642,179	7.00
8.00	Occupational Therapy	121,924	0	0	0	0	121,924	8.00
9.00	Speech Pathology	38,942	0	0	0	0	38,942	9.00
10.00	Medical Social Services	12,814	0	0	0	0	12,814	10.00
11.00	Home Health Aide	95,260	0	0	0	0	95,260	11.00
12.00	Supplies (see instructions)	117,907	0	0	0	0	117,907	12.00
13.00	Drugs	0	0	0	0		0	13.00
14.00	DME	0	0	0	0	0	0	14.00
	HHA NONREIMBURSABLE SERVICES							
15.00	Home Dialysis Aide Services	0	0	0	0	0	0	15.00
16.00	Respiratory Therapy	0	0	0	0	0	0	16.00
17.00	Private Duty Nursing	0	0	0	0	0	0	17.00
18.00	Clinic	0	0	0	0	0	0	18.00
19.00	Health Promotion Activities	0	0	0	0	0	0	19.00
20.00	Day Care Program	0	0	0	0	0	0	20.00
21.00	Home Delivered Meals Program	0	0	0	0	0	0	21.00
22.00	Homemaker Service	0	0	0	0	0	0	22.00
23.00	All Others (specify)	0	0	0	0	0	0	23.00
23.50	Telemedicine	0	0	0	0	0	0	23.50
24.00	Total (sum of lines 1-23)	2,962,990	0	0	0	0	2,962,990	24.00

		Administrative & General	Total (cols. 4A + 5)		
		5.00	6.00		
	GENERAL SERVICE COST CENTERS				
1.00	Capital Related - Bldg. & Fixtures				1.00
2.00	Capital Related - Movable Equipment				2.00
3.00	Plant Operation & Maintenance				3.00
4.00	Transportation				4.00
5.00	Administrative and General	1,066,650			5.00
	HHA REIMBURSABLE SERVICES				
6.00	Skilled Nursing Care	463,265	1,330,579		6.00
7.00	Physical Therapy	329,513	971,692		7.00
8.00	Occupational Therapy	120,795	242,719		8.00
9.00	Speech Pathology	25,541	64,483		9.00
10.00	Medical Social Services	6,603	19,417		10.00
11.00	Home Health Aide	60,895	156,155		11.00
12.00	Supplies (see instructions)	60,038	177,945		12.00
13.00	Drugs	0	0		13.00
14.00	DME	0	0		14.00
	HHA NONREIMBURSABLE SERVICES				
15.00	Home Dialysis Aide Services	0	0		15.00
16.00	Respiratory Therapy	0	0		16.00
17.00	Private Duty Nursing	0	0		17.00
18.00	Clinic	0	0		18.00
19.00	Health Promotion Activities	0	0		19.00
20.00	Day Care Program	0	0		20.00
21.00	Home Delivered Meals Program	0	0		21.00
22.00	Homemaker Service	0	0		22.00
23.00	All Others (specify)	0	0		23.00
23.50	Telemedicine	0	0		23.50
24.00	Total (sum of lines 1-23)		2,962,990		24.00

COST ALLOCATION - HHA STATISTICAL BASIS | Provider CCN: 15-0034 | HHA CCN: 15-7313 | Period: From 07/01/2019 To 06/30/2020 | Worksheet H-1 Part II | Date/Time Prepared: 11/25/2020 2:58 pm

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		Capital Related Costs						
		Bldgs & Fixtures (SQUARE FEET)	Movable Equipment (DOLLAR VALUE)	Plant Operation & Maintenance (SQUARE FEET)	Transportation (MILEAGE)	Reconciliation	Administrative & General (ACCUM. COST)	
		1.00	2.00	3.00	4.00	5A.00	5.00	
	GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. & Fixtures	0				0		1.00
2.00	Capital Related - Movable Equipment		0			0		2.00
3.00	Plant Operation & Maintenance	0	0	0		0		3.00
4.00	Transportation (see instructions)	0	0	0	0			4.00
5.00	Administrative and General	0	0	0	0	-1,066,650	2,069,917	5.00
	HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	0	0	0	0	31,691	899,005	6.00
7.00	Physical Therapy	0	0	0	0	-2,735	639,444	7.00
8.00	Occupational Therapy	0	0	0	0	112,487	234,411	8.00
9.00	Speech Pathology	0	0	0	0	10,622	49,564	9.00
10.00	Medical Social Services	0	0	0	0	0	12,814	10.00
11.00	Home Health Aide	0	0	0	0	22,911	118,171	11.00
12.00	Supplies (see instructions)	0	0	0	0	-1,399	116,508	12.00
13.00	Drugs	0	0	0		0	0	13.00
14.00	DME	0	0	0	0	0	0	14.00
	HHA NONREIMBURSABLE SERVICES							
15.00	Home Dialysis Aide Services	0	0	0	0	0	0	15.00
16.00	Respiratory Therapy	0	0	0	0	0	0	16.00
17.00	Private Duty Nursing	0	0	0	0	0	0	17.00
18.00	Clinic	0	0	0	0	0	0	18.00
19.00	Health Promotion Activities	0	0	0	0	0	0	19.00
20.00	Day Care Program	0	0	0	0	0	0	20.00
21.00	Home Delivered Meals Program	0	0	0	0	0	0	21.00
22.00	Homemaker Service	0	0	0	0	0	0	22.00
23.00	All Others (specify)	0	0	0	0	0	0	23.00
23.50	Telemedicine	0	0	0	0	0	0	23.50
24.00	Total (sum of lines 1-23)	0	0	0	0	-893,073	2,069,917	24.00
25.00	Cost To Be Allocated (per Worksheet H-1, Part I)	0	0	0	0		1,066,650	25.00
26.00	Unit Cost Multiplier	0.000000	0.000000	0.000000	0.000000		0.515311	26.00

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

Provider CCN: 15-0034 HHA CCN: 15-7313

Period: From 07/01/2019 To 06/30/2020

Worksheet H-2 Part I Date/Time Prepared: 11/25/2020 2:58 pm

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	Cost Center Description	HHA Trial Balance (1)	CAPITAL RELATED COSTS BLDG & FIXT	CAPITAL RELATED COSTS MVBLE EQUIP	EMPLOYEE BENEFITS DEPARTMENT	MAINTENANCE OF PERSONNEL	NONPATIENT TELEPHONES	
		0	1.00	2.00	4.00	4.01	5.01	
1.00	Administrative and General	0	0	0	388,279	36,348	11,710	1.00
2.00	Skilled Nursing Care	1,330,579	0	0	0	0	0	2.00
3.00	Physical Therapy	971,692	0	0	0	0	0	3.00
4.00	Occupational Therapy	242,719	0	0	0	0	0	4.00
5.00	Speech Pathology	64,483	0	0	0	0	0	5.00
6.00	Medical Social Services	19,417	0	0	0	0	0	6.00
7.00	Home Health Aide	156,155	0	0	0	0	0	7.00
8.00	Supplies (see instructions)	177,945	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
19.50	Telemedicine	0	0	0	0	0	0	19.50
20.00	Total (sum of lines 1-19) (2)	2,962,990	0	0	388,279	36,348	11,710	20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.							21.00

	Cost Center Description	PURCHASING RECEIVING AND STORES	PATIENT REGISTRATION	PATIENT ACCOUNTING	Subtotal	ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS	
		5.02	5.03	5.04	5A.04	5.05	6.00	
1.00	Administrative and General	117	10,754	15,465	462,673	55,962	0	1.00
2.00	Skilled Nursing Care	0	0	0	1,330,579	177,430	0	2.00
3.00	Physical Therapy	0	0	0	971,692	126,201	0	3.00
4.00	Occupational Therapy	0	0	0	242,719	46,264	0	4.00
5.00	Speech Pathology	0	0	0	64,483	9,782	0	5.00
6.00	Medical Social Services	0	0	0	19,417	2,624	0	6.00
7.00	Home Health Aide	0	0	0	156,155	23,322	0	7.00
8.00	Supplies (see instructions)	0	0	0	177,945	21,373	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
19.50	Telemedicine	0	0	0	0	0	0	19.50
20.00	Total (sum of lines 1-19) (2)	117	10,754	15,465	3,425,663	462,958	0	20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.				0.000000			21.00

(1) Column 0, line 20 must agree with Wkst. A, column 7, line 101.
(2) Columns 0 through 26, line 20 must agree with the corresponding columns of Wkst. B, Part I, line 101.

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

Provider CCN: 15-0034 | HHA CCN: 15-7313 | Period: From 07/01/2019 To 06/30/2020 | Worksheet H-2 Part I | Date/Time Prepared: 11/25/2020 2:58 pm

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	Cost Center Description	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	MAINTENANCE OF PERSONNEL	
		7.00	8.00	9.00	10.00	11.00	12.00	
1.00	Administrative and General	0	0	0	0	57,299	0	1.00
2.00	Skilled Nursing Care	0	0	0	0	0	0	2.00
3.00	Physical Therapy	0	0	0	0	0	0	3.00
4.00	Occupational Therapy	0	0	0	0	0	0	4.00
5.00	Speech Pathology	0	0	0	0	0	0	5.00
6.00	Medical Social Services	0	0	0	0	0	0	6.00
7.00	Home Health Aide	0	0	0	0	0	0	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
19.50	Telemedicine	0	0	0	0	0	0	19.50
20.00	Total (sum of lines 1-19) (2)	0	0	0	0	57,299	0	20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.							21.00

	Cost Center Description	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	NONPHYSICIAN ANESTHETISTS	
		13.00	14.00	15.00	16.00	17.00	19.00	
1.00	Administrative and General	0	0	0	14,399	0	0	1.00
2.00	Skilled Nursing Care	0	0	0	0	0	0	2.00
3.00	Physical Therapy	0	0	0	0	0	0	3.00
4.00	Occupational Therapy	0	0	0	0	0	0	4.00
5.00	Speech Pathology	0	0	0	0	0	0	5.00
6.00	Medical Social Services	0	0	0	0	0	0	6.00
7.00	Home Health Aide	0	0	0	0	0	0	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
19.50	Telemedicine	0	0	0	0	0	0	19.50
20.00	Total (sum of lines 1-19) (2)	0	0	0	14,399	0	0	20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.							21.00

(1) Column 0, line 20 must agree with Wkst. A, column 7, line 101.
(2) Columns 0 through 26, line 20 must agree with the corresponding columns of Wkst. B, Part I, line 101.

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

Provider CCN: 15-0034 HHA CCN: 15-7313 | Period: From 07/01/2019 To 06/30/2020 | Worksheet H-2 Part I Date/Time Prepared: 11/25/2020 2:58 pm

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	Cost Center Description	PARAMEDICAL EDUCATION PROGRAM EMS	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Subtotal	Allocated HHA A&G (see Part II)	Total HHA Costs	
		23.00	24.00	25.00	26.00	27.00	28.00	
1.00	Administrative and General	0	590,333	0	590,333			1.00
2.00	Skilled Nursing Care	0	1,508,009	0	1,508,009	264,164	1,772,173	2.00
3.00	Physical Therapy	0	1,097,893	0	1,097,893	192,322	1,290,215	3.00
4.00	Occupational Therapy	0	288,983	0	288,983	50,622	339,605	4.00
5.00	Speech Pathology	0	74,265	0	74,265	13,009	87,274	5.00
6.00	Medical Social Services	0	22,041	0	22,041	3,861	25,902	6.00
7.00	Home Health Aide	0	179,477	0	179,477	31,440	210,917	7.00
8.00	Supplies (see instructions)	0	199,318	0	199,318	34,915	234,233	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
19.50	Telemedicine	0	0	0	0	0	0	19.50
20.00	Total (sum of lines 1-19) (2)	0	3,960,319	0	3,960,319	590,333	3,960,319	20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.					0.175174		21.00

(1) Column 0, line 20 must agree with Wkst. A, column 7, line 101.
(2) Columns 0 through 26, line 20 must agree with the corresponding columns of Wkst. B, Part I, line 101.

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS

Provider CCN: 15-0034 HHA CCN: 15-7313

Period: From 07/01/2019 To 06/30/2020

Worksheet H-2 Part II Date/Time Prepared: 11/25/2020 2:58 pm

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	Cost Center Description	CAPITAL RELATED COSTS BLDG & FIXT (SQUARE FEET)	CAPITAL RELATED COSTS MVBLE EQUIP (SQUARE FEET)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	MAINTENANCE OF PERSONNEL (NUMBER OF FTES)	NONPATIENT TELEPHONES (NUMBER OF PHONES)	PURCHASING RECEIVING AND STORES (SUPPLY EXP ENSE)	
		1.00	2.00	4.00	4.01	5.01	5.02	
1.00	Administrative and General	0	0	2,378,084	2,690	27	122	1.00
2.00	Skilled Nursing Care	0	0	0	0	0	0	2.00
3.00	Physical Therapy	0	0	0	0	0	0	3.00
4.00	Occupational Therapy	0	0	0	0	0	0	4.00
5.00	Speech Pathology	0	0	0	0	0	0	5.00
6.00	Medical Social Services	0	0	0	0	0	0	6.00
7.00	Home Health Aide	0	0	0	0	0	0	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
19.50	Telemedicine	0	0	0	0	0	0	19.50
20.00	Total (sum of lines 1-19)	0	0	2,378,084	2,690	27	122	20.00
21.00	Total cost to be allocated	0	0	388,279	36,348	11,710	117	21.00
22.00	Unit cost multiplier	0.000000	0.000000	0.163274	13.512268	433.703704	0.959016	22.00

	Cost Center Description	PATIENT REGISTRATION (GROSS REVE NUE)	PATIENT ACCOUNTING (GROSS REVE NUE)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	MAINTENANCE & REPAIRS (SQUARE FEET)	OPERATION OF PLANT (SQUARE FEET)	
		5.03	5.04	5A.05	5.05	6.00	7.00	
1.00	Administrative and General	4,777,469	4,777,469	-48,644	414,029	0	0	1.00
2.00	Skilled Nursing Care	0	0	-17,888	1,312,691	0	0	2.00
3.00	Physical Therapy	0	0	-38,002	933,690	0	0	3.00
4.00	Occupational Therapy	0	0	99,558	342,277	0	0	4.00
5.00	Speech Pathology	0	0	7,888	72,371	0	0	5.00
6.00	Medical Social Services	0	0	0	19,417	0	0	6.00
7.00	Home Health Aide	0	0	16,393	172,548	0	0	7.00
8.00	Supplies (see instructions)	0	0	-19,816	158,129	0	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
19.50	Telemedicine	0	0	0	0	0	0	19.50
20.00	Total (sum of lines 1-19)	4,777,469	4,777,469		3,425,152	0	0	20.00
21.00	Total cost to be allocated	10,754	15,465		462,958	0	0	21.00
22.00	Unit cost multiplier	0.002251	0.003237		0.135164	0.000000	0.000000	22.00

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS

Provider CCN: 15-0034 HHA CCN: 15-7313

Period: From 07/01/2019 To 06/30/2020

Worksheet H-2 Part II Date/Time Prepared: 11/25/2020 2:58 pm

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	Cost Center Description	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	CAFETERIA (NUMBER OF FTES)	MAINTENANCE OF PERSONNEL (NUMBER HOUSED)	NURSING ADMINISTRATION (NURSING HOURS)	
		8.00	9.00	10.00	11.00	12.00	13.00	
1.00	Administrative and General	0	0	0	2,690	0	0	1.00
2.00	Skilled Nursing Care	0	0	0	0	0	0	2.00
3.00	Physical Therapy	0	0	0	0	0	0	3.00
4.00	Occupational Therapy	0	0	0	0	0	0	4.00
5.00	Speech Pathology	0	0	0	0	0	0	5.00
6.00	Medical Social Services	0	0	0	0	0	0	6.00
7.00	Home Health Aide	0	0	0	0	0	0	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
19.50	Telemedicine	0	0	0	0	0	0	19.50
20.00	Total (sum of lines 1-19)	0	0	0	2,690	0	0	20.00
21.00	Total cost to be allocated	0	0	0	57,299	0	0	21.00
22.00	Unit cost multiplier	0.000000	0.000000	0.000000	21.300743	0.000000	0.000000	22.00

	Cost Center Description	CENTRAL SERVICES & SUPPLY (SUPPLY EXPENSE)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS REVENUE)	SOCIAL SERVICE (TIME SPENT)	NONPHYSICIAN ANESTHETISTS (ASSIGNED TIME)	PARAMEDICAL EDUCATION PROGRAM EMS (ASSIGNED TIME)	
		14.00	15.00	16.00	17.00	19.00	23.00	
1.00	Administrative and General	0	0	4,777,469	0	0	0	1.00
2.00	Skilled Nursing Care	0	0	0	0	0	0	2.00
3.00	Physical Therapy	0	0	0	0	0	0	3.00
4.00	Occupational Therapy	0	0	0	0	0	0	4.00
5.00	Speech Pathology	0	0	0	0	0	0	5.00
6.00	Medical Social Services	0	0	0	0	0	0	6.00
7.00	Home Health Aide	0	0	0	0	0	0	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
19.50	Telemedicine	0	0	0	0	0	0	19.50
20.00	Total (sum of lines 1-19)	0	0	4,777,469	0	0	0	20.00
21.00	Total cost to be allocated	0	0	14,399	0	0	0	21.00
22.00	Unit cost multiplier	0.000000	0.000000	0.003014	0.000000	0.000000	0.000000	22.00

APPORTIONMENT OF PATIENT SERVICE COSTS

Provider CCN: 15-0034 | HHA CCN: 15-7313 | Period: From 07/01/2019 To 06/30/2020 | Worksheet H-3 Part I | Date/Time Prepared: 11/25/2020 2:58 pm

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	Cost Center Description	From, Wkst. H-2, Part I, col. 28, line	Facility Costs (from Wkst. H-2, Part I)	Shared Ancillary Costs (from Part II)	Total HHA Costs (cols. 1 + 2)	Total Visits	Average Cost Per Visit (col. 3 ÷ col. 4)	
		0	1.00	2.00	3.00	4.00	5.00	
	PART I - COMPUTATION OF LESSER OF AGGREGATE PROGRAM COST, AGGREGATE OF THE PROGRAM LIMITATION COST, OR BENEFICIARY COST LIMITATION							
	Cost Per Visit Computation							
1.00	Skilled Nursing Care	2.00	1,772,173		1,772,173	11,977	147.96	1.00
2.00	Physical Therapy	3.00	1,290,215	0	1,290,215	8,058	160.12	2.00
3.00	Occupational Therapy	4.00	339,605	0	339,605	2,972	114.27	3.00
4.00	Speech Pathology	5.00	87,274	0	87,274	525	166.24	4.00
5.00	Medical Social Services	6.00	25,902		25,902	32	809.44	5.00
6.00	Home Health Aide	7.00	210,917		210,917	1,742	121.08	6.00
7.00	Total (sum of lines 1-6)		3,726,086	0	3,726,086	25,306		7.00

	Cost Center Description	Cost Limits	CBSA No. (1)	Part A	Program Visits Part B Not Subject to Deductibles & Coinsurance	Part B Subject to Deductibles		
		0	1.00	2.00	3.00	4.00	5.00	
	Limitation Cost Computation							
8.00	Skilled Nursing Care		23844	0	6,824			8.00
9.00	Physical Therapy		23844	0	4,677			9.00
10.00	Occupational Therapy		23844	0	1,854			10.00
11.00	Speech Pathology		23844	0	306			11.00
12.00	Medical Social Services		23844	0	23			12.00
13.00	Home Health Aide		23844	0	1,255			13.00
14.00	Total (sum of lines 8-13)			0	14,939			14.00

	Cost Center Description	From Wkst. H-2 Part I, col. 28, line	Facility Costs (from Wkst. H-2, Part I)	Shared Ancillary Costs (from Part II)	Total HHA Costs (cols. 1 + 2)	Total Charges (from HHA Records)	Ratio (col. 3 ÷ col. 4)	
		0	1.00	2.00	3.00	4.00	5.00	
	Supplies and Drugs Cost Computations							
15.00	Cost of Medical Supplies	8.00	234,233	0	234,233	234,417	0.999215	15.00
16.00	Cost of Drugs	9.00	0	0	0	0	0.000000	16.00

	Cost Center Description	Program Visits Part A	Program Visits Part B Not Subject to Deductibles & Coinsurance	Program Visits Part B Subject to Deductibles & Coinsurance	Cost of Services Part A	Part B Not Subject to Deductibles & Coinsurance	Part B Subject to Deductibles & Coinsurance	
		6.00	7.00	8.00	9.00	10.00	11.00	
	PART I - COMPUTATION OF LESSER OF AGGREGATE PROGRAM COST, AGGREGATE OF THE PROGRAM LIMITATION COST, OR BENEFICIARY COST LIMITATION							
	Cost Per Visit Computation							
1.00	Skilled Nursing Care	0	6,824		0	1,009,679		1.00
2.00	Physical Therapy	0	4,677		0	748,881		2.00
3.00	Occupational Therapy	0	1,854		0	211,857		3.00
4.00	Speech Pathology	0	306		0	50,869		4.00
5.00	Medical Social Services	0	23		0	18,617		5.00
6.00	Home Health Aide	0	1,255		0	151,955		6.00
7.00	Total (sum of lines 1-6)	0	14,939		0	2,191,858		7.00

	Cost Center Description							
		6.00	7.00	8.00	9.00	10.00	11.00	
	Limitation Cost Computation							
8.00	Skilled Nursing Care							8.00
9.00	Physical Therapy							9.00
10.00	Occupational Therapy							10.00
11.00	Speech Pathology							11.00
12.00	Medical Social Services							12.00
13.00	Home Health Aide							13.00
14.00	Total (sum of lines 8-13)							14.00

APPORTIONMENT OF PATIENT SERVICE COSTS

Provider CCN: 15-0034 | HHA CCN: 15-7313 | Period: From 07/01/2019 To 06/30/2020 | Worksheet H-3 Part I | Date/Time Prepared: 11/25/2020 2:58 pm

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	Cost Center Description	Program Covered Charges			Cost of Services			
			Part B			Part B		
		Part A	Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance	Part A	Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance	
		6.00	7.00	8.00	9.00	10.00	11.00	
	Supplies and Drugs Cost Computations							
15.00	Cost of Medical Supplies	0	224,519	0	0	224,343	0	15.00
16.00	Cost of Drugs		0	0		0	0	16.00

	Cost Center Description	Total Program Cost (sum of cols. 9-10)	
		12.00	
	PART I - COMPUTATION OF LESSER OF AGGREGATE PROGRAM COST, AGGREGATE OF THE PROGRAM LIMITATION COST, OR BENEFICIARY COST LIMITATION		
	Cost Per Visit Computation		
1.00	Skilled Nursing Care	1,009,679	1.00
2.00	Physical Therapy	748,881	2.00
3.00	Occupational Therapy	211,857	3.00
4.00	Speech Pathology	50,869	4.00
5.00	Medical Social Services	18,617	5.00
6.00	Home Health Aide	151,955	6.00
7.00	Total (sum of lines 1-6)	2,191,858	7.00

	Cost Center Description		
		12.00	
	Limitation Cost Computation		
8.00	Skilled Nursing Care		8.00
9.00	Physical Therapy		9.00
10.00	Occupational Therapy		10.00
11.00	Speech Pathology		11.00
12.00	Medical Social Services		12.00
13.00	Home Health Aide		13.00
14.00	Total (sum of lines 8-13)		14.00

APPORTIONMENT OF PATIENT SERVICE COSTS

Provider CCN: 15-0034 | HHA CCN: 15-7313 | Period: From 07/01/2019 To 06/30/2020 | Worksheet H-3 Part II | Date/Time Prepared: 11/25/2020 2:58 pm

Title XVIII | Home Health Agency I | PPS

	Cost Center Description	From Wkst. C, Part I, col. 9, line	Cost to Charge Ratio	Total HHA Charge (from provider records)	HHA Shared Ancillary Costs (col. 1 x col. 2)	Transfer to Part I as Indicated		
		0	1.00	2.00	3.00	4.00		
	PART II - APPORTIONMENT OF COST OF HHA SERVICES FURNISHED BY SHARED HOSPITAL DEPARTMENTS							
1.00	Physical Therapy	66.00	0.298898	0	0	col. 2, line 2.00		1.00
2.00	Occupational Therapy	67.00	0.181354	0	0	col. 2, line 3.00		2.00
3.00	Speech Pathology	68.00	0.405700	0	0	col. 2, line 4.00		3.00
4.00	Cost of Medical Supplies	71.00	0.405316	0	0	col. 2, line 15.00		4.00
5.00	Cost of Drugs	73.00	0.184181	0	0	col. 2, line 16.00		5.00

CALCULATION OF HHA REIMBURSEMENT SETTLEMENT

Provider CCN: 15-0034 | HHA CCN: 15-7313 | Period: From 07/01/2019 To 06/30/2020 | Worksheet H-4 Part I-II | Date/Time Prepared: 11/25/2020 2:58 pm

Title XVIII | Home Health Agency I | PPS

		Part A	Part B Not Subject to Deductibles & Coinsurance	Part B Subject to Deductibles & Coinsurance	
		1.00	2.00	3.00	
	PART I - COMPUTATION OF THE LESSER OF REASONABLE COST OR CUSTOMARY CHARGES				
	Reasonable Cost of Part A & Part B Services				
1.00	Reasonable cost of services (see instructions)	0	0	0	1.00
2.00	Total charges	0	0	0	2.00
	Customary Charges				
3.00	Amount actually collected from patients liable for payment for services on a charge basis (from your records)	0	0	0	3.00
4.00	Amount 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(b)	0	0	0	4.00
5.00	Ratio of line 3 to line 4 (not to exceed 1.000000)	0.000000	0.000000	0.000000	5.00
6.00	Total customary charges (see instructions)	0	0	0	6.00
7.00	Excess of total customary charges over total reasonable cost (complete only if line 6 exceeds line 1)	0	0	0	7.00
8.00	Excess of reasonable cost over customary charges (complete only if line 1 exceeds line 6)	0	0	0	8.00
9.00	Primary payer amounts	0	0	0	9.00

		Part A Services	Part B Services	
		1.00	2.00	
	PART II - COMPUTATION OF HHA REIMBURSEMENT SETTLEMENT			
10.00	Total reasonable cost (see instructions)	0	0	10.00
11.00	Total PPS Reimbursement - Full Episodes without Outliers	0	1,965,265	11.00
12.00	Total PPS Reimbursement - Full Episodes with Outliers	0	362,380	12.00
13.00	Total PPS Reimbursement - LUPA Episodes	0	32,622	13.00
14.00	Total PPS Reimbursement - PEP Episodes	0	23,307	14.00
15.00	Total PPS Outlier Reimbursement - Full Episodes with Outliers	0	106,597	15.00
16.00	Total PPS Outlier Reimbursement - PEP Episodes	0	9,984	16.00
17.00	Total Other Payments	0	0	17.00
18.00	DME Payments	0	0	18.00
19.00	Oxygen Payments	0	0	19.00
20.00	Prosthetic and Orthotic Payments	0	0	20.00
21.00	Part B deductibles billed to Medicare patients (exclude coinsurance)		0	21.00
22.00	Subtotal (sum of lines 10 thru 20 minus line 21)	0	2,500,155	22.00
23.00	Excess reasonable cost (from line 8)	0	0	23.00
24.00	Subtotal (line 22 minus line 23)	0	2,500,155	24.00
25.00	Coinsurance billed to program patients (from your records)		0	25.00
26.00	Net cost (line 24 minus line 25)	0	2,500,155	26.00
27.00	Reimbursable bad debts (from your records)			27.00
28.00	Reimbursable bad debts for dual eligible beneficiaries (see instructions)			28.00
29.00	Total costs - current cost reporting period (line 26 plus line 27)	0	2,500,155	29.00
30.00	OTHER ADJUSTMENT	0	882	30.00
30.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	0	30.50
30.99	Demonstration payment adjustment amount before sequestration	0	0	30.99
31.00	Subtotal (see instructions)	0	2,501,037	31.00
31.01	Sequestration adjustment (see instructions)	0	44,983	31.01
31.02	Demonstration payment adjustment amount after sequestration	0	0	31.02
32.00	Interim payments (see instructions)	0	2,456,054	32.00
33.00	Tentative settlement (for contractor use only)	0	0	33.00
34.00	Balance due provider/program (line 31 minus lines 31.01, 32, and 33)	0	0	34.00
35.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	0	35.00

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED HHAs FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES

Provider CCN: 15-0034 | HHA CCN: 15-7313 | Period: From 07/01/2019 To 06/30/2020 | Worksheet H-5 | Date/Time Prepared: 11/25/2020 2:58 pm

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		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		0		2,456,054	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			0		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
	Provider to Program					
3.50			0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. H-4, Part II, column as appropriate, line 32)		0		2,456,054	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			0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
	Provider to Program					
5.50			0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		0		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		0		2,456,054	7.00

			Contractor Number	NPR Date (Mo/Day/Yr)	
		0	1.00	2.00	
8.00	Name of Contractor				8.00

CALCULATION OF CAPITAL PAYMENT	Provider CCN: 15-0034	Period: From 07/01/2019 To 06/30/2020	Worksheet L Parts I-III Date/Time Prepared: 11/25/2020 2:58 pm
	Title XVIII	Hospital	PPS

		1.00	
	PART I - FULLY PROSPECTIVE METHOD		
	CAPITAL FEDERAL AMOUNT		
1.00	Capital DRG other than outlier	2,979,224	1.00
1.01	Model 4 BPCI Capital DRG other than outlier	0	1.01
2.00	Capital DRG outlier payments	18,924	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)	119.53	3.00
4.00	Number of interns & residents (see instructions)	0.00	4.00
5.00	Indirect medical education percentage (see instructions)	0.00	5.00
6.00	Indirect medical education adjustment (multiply line 5 by the sum of lines 1 and 1.01, columns 1 and 1.01)(see instructions)	0	6.00
7.00	Percentage of SSI recipient patient days to Medicare Part A patient days (Worksheet E, part A line 30) (see instructions)	3.43	7.00
8.00	Percentage of Medicaid patient days to total days (see instructions)	15.10	8.00
9.00	Sum of lines 7 and 8	18.53	9.00
10.00	Allowable disproportionate share percentage (see instructions)	3.82	10.00
11.00	Disproportionate share adjustment (see instructions)	113,806	11.00
12.00	Total prospective capital payments (see instructions)	3,111,954	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