

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: 14-0252	Period: From 10/01/2019 To 09/30/2020	Worksheet S Parts I-III Date/Time Prepared: 4/29/2021 1:24 pm
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PART I - COST REPORT STATUS			
Provider use only	1. ☒ Electronically prepared cost report 2. ☐ Manually prepared cost report 3. ☐ If this is an amended report enter the number of times the provider resubmitted this cost report 4. ☒ Medicare Utilization. Enter "F" for full or "L" for low.		
Contractor use only	5. ☒ Cost Report Status (1) As Submitted (2) Settled without Audit (3) Settled with Audit (4) Reopened (5) Amended 6. Date Received: 7. Contractor No. 8. ☒ Initial Report for this Provider CCN 9. ☒ Final Report for this Provider CCN 10. NPR Date: 11. Contractor's Vendor Code: 4 12. ☐ If line 5, column 1 is 4: Enter number of times reopened = 0-9.		

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 NORTHWEST COMMUNITY HOSPITAL (14-0252) for the cost reporting period beginning 10/01/2019 and ending 09/30/2020 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.

☒ 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) JOHN SKEANS
 Officer or Administrator of Provider(s)

EXECUTIVE VP/CFO
 Title

(Dated when report is electronically signed.)
 Date

Cost Center Description		Title V	Title XVIII		HIT	Title XIX	
			Part A	Part B			
		1.00	2.00	3.00	4.00	5.00	
	PART III - SETTLEMENT SUMMARY						
1.00	Hospital	0	-236,532	-459,189	0	0	1.00
2.00	Subprovider - IPF	0	-49,387	12		0	2.00
3.00	Subprovider - IRF	0	-2,389	54		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	-1		0	9.00
200.00	Total	0	-288,308	-459,124	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: 14-0252		Period: From 10/01/2019 To 09/30/2020		Worksheet S-2 Part I Date/Time Prepared: 4/29/2021 1:24 pm	
1.00		2.00		3.00		4.00			
Hospital and Hospital Health Care Complex Address:									
1.00	Street: 800 WEST CENTRAL ROAD			PO Box:				1.00	
2.00	City: ARLINGTON HEIGHTS			State: IL		Zip Code: 60005		County: COOK	
		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
Hospital and Hospital-Based Component Identification:									
3.00	Hospital			NORTHWEST COMMUNITY HOSPITAL	140252	16974	1	07/01/1966	N
4.00	Subprovider - IPF			NWCH PSYCHIATRIC UNIT	14S252	16974	4	11/01/1985	N
5.00	Subprovider - IRF			NWC REHAB	14T252	16974	5	10/01/2015	N
6.00	Subprovider - (Other)								
7.00	Swing Beds - SNF								
8.00	Swing Beds - NF								
9.00	Hospital-Based SNF								
10.00	Hospital-Based NF								
11.00	Hospital-Based OLTC								
12.00	Hospital-Based HHA			NORTHWEST COMMUNITY HOME CARE SERVIC	147094	16974		07/01/1966	N
13.00	Separately Certified ASC								
14.00	Hospital-Based Hospice								
15.00	Hospital-Based Health Clinic - RHC								
16.00	Hospital-Based Health Clinic - FQHC								
17.00	Hospital-Based (CMHC) I								
17.10	Hospital-Based (CORF) I								
17.20	Hospital-Based (OPT) I								
17.30	Hospital-Based (OOT) I								
17.40	Hospital-Based (OSP) I								
18.00	Renal Dialysis								
19.00	Other								
							From:	To:	
							1.00	2.00	
20.00	Cost Reporting Period (mm/dd/yyyy)						10/01/2019	09/30/2020	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	N		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.					1	N		23.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

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	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.	3,824	289	0	0	6,288	1,030	24.00
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.	238	0	0	0	159		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 OPSS 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
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
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
48.00 Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.					N	N	N
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		
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.							
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		
59.00 Are costs claimed on line 100 of Worksheet A? If yes, complete Wkst. D-2, Pt. I.					N		

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-0252		Period: From 10/01/2019 To 09/30/2020		Worksheet S-2 Part I Date/Time Prepared: 4/29/2021 1:24 pm	
		NAHE 413.85 Y/N	Worksheet A Line #	Pass-Through Qualification Criterion Code			
		1.00	2.00	3.00			
60.00	Are you claiming nursing and allied health education (NAHE) costs for any programs that meet the criteria under 42 CFR 413.85? (see instructions) Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", are you impacted by CR 11642 (or subsequent CR) NAHE MA payment adjustment? Enter "Y" for yes or "N" for no in column 2.	N	N			60.00	
		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			
64.00	Section 5504 of the ACA Base Year FTE Residents in Nonprovider Settings--This base year is your cost reporting period that begins on or after July 1, 2009 and before June 30, 2010. Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)	0.00		0.00	0.000000		64.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

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	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	
66.00	Section 5504 of the ACA Current Year FTE Residents in Nonprovider Settings--Effective for cost reporting periods beginning on or after July 1, 2010					
	Enter in column 1 the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)		0.00	0.00	0.000000	66.00
			Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))	
			1.00	2.00	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	
70.00	Inpatient Psychiatric Facility PPS Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? Enter "Y" for yes or "N" for no.				Y	70.00
71.00	If line 70 is yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost report filed on or before November 15, 2004? Enter "Y" for yes or "N" for no. (see 42 CFR 412.424(d)(1)(iii)(c)) Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)				N N 0	71.00
75.00	Inpatient Rehabilitation Facility PPS 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

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			1.00	
Long Term Care Hospital PPS				
80.00	Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for no.	N		80.00
81.00	Is this a LTCH co-located within another hospital for part or all of the cost reporting period? Enter "Y" for yes and "N" for no.	N		81.00
TEFRA Providers				
85.00	Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no.	N		85.00
86.00	Did this facility establish a new Other subprovider (excluded unit) under 42 CFR Section §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.			86.00
87.00	Is this hospital an extended neoplastic disease care hospital classified under section 1886(d)(1)(B)(vi)? Enter "Y" for yes or "N" for no.	N		87.00
		V	XIX	
		1.00	2.00	
Title V and XIX Services				
90.00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.	N	Y	90.00
91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.	N	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	N	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	N	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	N	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
		1.00	2.00	3.00
				Respiratory
				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.			
				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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-0252	Period: From 10/01/2019 To 09/30/2020	Worksheet S-2 Part I Date/Time Prepared: 4/29/2021 1:24 pm
		1.00	2.00	
111.00	If this facility qualifies as a CAH, did it participate in the Frontier Community Health Integration Project (FCHIP) demonstration for this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If the response to column 1 is Y, enter the integration prong of the FCHIP demo in which this CAH is participating in column 2. Enter all that apply: "A" for Ambulance services; "B" for additional beds; and/or "C" for tele-health services.	N		111.00
		1.00	2.00	3.00
112.00	Did this hospital participate in the Pennsylvania Rural Health Model demonstration for any portion of the current cost reporting period? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2, the date the hospital began participating in the demonstration. In column 3, enter the date the hospital ceased participation in the demonstration, if applicable.	N		112.00
Miscellaneous Cost Reporting Information				
115.00	Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in column 1. If column 1 is yes, enter the method used (A, B, or E only) in column 2. If column 2 is "E", enter in column 3 either "93" percent for short term hospital or "98" percent for long term care (includes psychiatric, rehabilitation and long term hospitals providers) based on the definition in CMS Pub.15-1, chapter 22, §2208.1.	N		0 115.00
116.00	Is this facility classified as a referral center? Enter "Y" for yes or "N" for no.	N		116.00
117.00	Is this facility legally required to carry malpractice insurance? Enter "Y" for yes or "N" for no.	N		117.00
118.00	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.	1		118.00
		Premiums	Losses	Insurance
		1.00	2.00	3.00
118.01	List amounts of malpractice premiums and paid losses:	10,662,252	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)	N		140.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-0252		Period: From 10/01/2019 To 09/30/2020		Worksheet S-2 Part I Date/Time Prepared: 4/29/2021 1:24 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:	Contractor's Name:		Contractor's Number:		141.00	
142.00	Street:	PO Box:				142.00	
143.00	City:	State:		Zip Code:		143.00	
						1.00	
144.00	Are provider based physicians' costs included in Worksheet A?					Y	144.00
						1.00	2.00
145.00	If costs for renal services are claimed on Wkst. A, line 74, are the costs for inpatient services only? Enter "Y" for yes or "N" for no in column 1. If column 1 is no, does the dialysis facility include Medicare utilization for this cost reporting period? Enter "Y" for yes or "N" for no in column 2.			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	
161.10	CORF		N	N	N	161.10	
161.20	OUTPATIENT PHYSICAL THERAPY		N	N	N	161.20	
161.30	OUTPATIENT OCCUPATIONAL THERAPY		N	N	N	161.30	
161.40	OUTPATIENT SPEECH PATHOLOGY		N	N	N	161.40	
						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
						1.00	
Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act							
167.00	Is this provider a meaningful user under §1886(n)? Enter "Y" for yes or "N" for no.					Y	167.00
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)						168.00
168.01	If this provider is a CAH and is not a meaningful user, does this provider qualify for a hardship exception under §413.70(a)(6)(ii)? Enter "Y" for yes or "N" for no. (see instructions)						168.01
169.00	If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)					9.99	169.00
		Beginning		Ending			
		1.00		2.00			
170.00	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)						170.00
		1.00		2.00			
171.00	If line 167 is "Y", does this provider have any days for individuals enrolled in section 1876 Medicare cost plans reported on Wkst. S-3, Pt. I, line 2, col. 6? Enter "Y" for yes and "N" for no in column 1. If column 1 is yes, enter the number of section 1876 Medicare days in column 2. (see instructions)					N	0

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 14-0252	Period: From 10/01/2019 To 09/30/2020	Worksheet S-2 Part II Date/Time Prepared: 4/29/2021 1:24 pm
			Y/N 1.00	Date 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 1.00	Date 2.00	V/I 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 1.00	Type 2.00	Date 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 1.00	Legal Oper. 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.	Y		15.00
		Part A		Part B
		Y/N 1.00	Date 2.00	Y/N 3.00
				Date 4.00
PS&R Data				
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)	Y	02/19/2021	Y
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	N		N
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
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

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 14-0252	Period: From 10/01/2019 To 09/30/2020	Worksheet S-2 Part II Date/Time Prepared: 4/29/2021 1:24 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
		Y/N	Date	Y/N
		1.00	2.00	3.00
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N	N	
				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.	TONY	LEONE	41.00
42.00	Enter the employer/company name of the cost report preparer.	TONY LEONE, CPA		42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	847/275-1023	TONY@LEONE-CONSULTING.COM	43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE

Provider CCN: 14-0252

Period:
From 10/01/2019
To 09/30/2020Worksheet S-2
Part II
Date/Time Prepared:
4/29/2021 1:24 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.	CONSULTANT	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: 14-0252

Period:
From 10/01/2019
To 09/30/2020Worksheet S-3
Part I
Date/Time Prepared:
4/29/2021 1:24 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	356	130,296	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)		356	130,296	0.00	0	7.00
8.00 INTENSIVE CARE UNIT	31.00	60	21,960	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 NEONATAL INTENSIVE CARE UNIT	35.00	8	2,928	0.00	0	12.00
13.00 NURSERY	43.00				0	13.00
14.00 Total (see instructions)		424	155,184	0.00	0	14.00
15.00 CAH visits					0	15.00
16.00 SUBPROVIDER - IPF	40.00	52	19,032		0	16.00
17.00 SUBPROVIDER - IRF	41.00	33	12,078		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
25.10 CMHC - CORF	99.10				0	25.10
25.20 CMHC - OUTPATIENT PHYSICAL THERAPY	99.20				0	25.20
25.30 CMHC - OUTPATIENT OCCUPATIONAL THERAPY	99.30				0	25.30
25.40 CMHC - OUTPATIENT SPEECH PATHOLOGY	99.40				0	25.40
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)		509				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: 14-0252

Period:
From 10/01/2019
To 09/30/2020Worksheet S-3
Part I
Date/Time Prepared:
4/29/2021 1:24 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)	31,045	3,061	67,401			1.00
2.00	HMO and other (see instructions)	18,166	7,324				2.00
3.00	HMO IPF Subprovider	662	3,091				3.00
4.00	HMO IRF Subprovider	1,133	159				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)	31,045	3,061	67,401			7.00
8.00	INTENSIVE CARE UNIT	3,928	127	7,461			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	NEONATAL INTENSIVE CARE UNIT	0	253	3,651			12.00
13.00	NURSERY		511	4,264			13.00
14.00	Total (see instructions)	34,973	3,952	82,777	0.00	2,530.34	14.00
15.00	CAH visits	0	0	0			15.00
16.00	SUBPROVIDER - IPF	2,361	1,263	13,755	0.00	81.70	16.00
17.00	SUBPROVIDER - IRF	5,614	229	9,047	0.00	40.45	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	31,062	0	46,348	0.00	60.61	22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)			2,263			24.10
25.00	CMHC - CMHC						25.00
25.10	CMHC - CORF	0	0	0	0.00	0.00	25.10
25.20	CMHC - OUTPATIENT PHYSICAL THERAPY	0	0	0	0.00	0.00	25.20
25.30	CMHC - OUTPATIENT OCCUPATIONAL THERAPY	0	0	0	0.00	0.00	25.30
25.40	CMHC - OUTPATIENT SPEECH PATHOLOGY	0	0	0	0.00	0.00	25.40
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	2,713.10	27.00
28.00	Observation Bed Days		0	1,511			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	155	921			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: 14-0252

Period:
From 10/01/2019
To 09/30/2020Worksheet S-3
Part I
Date/Time Prepared:
4/29/2021 1:24 pm

Component	Full Time Equivalents	Discharges			Total All Patients	
	Nonpaid Workers	Title V	Title XVIII	Title XIX		
	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	7,633	641	18,962	1.00
2.00 HMO and other (see instructions)			1,963	1,459		2.00
3.00 HMO IPF Subprovider				647		3.00
4.00 HMO IRF Subprovider				12		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 NEONATAL INTENSIVE CARE UNIT						12.00
13.00 NURSERY						13.00
14.00 Total (see instructions)	0.00	0	7,633	641	18,962	14.00
15.00 CAH visits						15.00
16.00 SUBPROVIDER - IPF	0.00	0	254	170	1,918	16.00
17.00 SUBPROVIDER - IRF	0.00	0	437	14	649	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
25.10 CMHC - CORF	0.00					25.10
25.20 CMHC - OUTPATIENT PHYSICAL THERAPY	0.00					25.20
25.30 CMHC - OUTPATIENT OCCUPATIONAL THERAPY	0.00					25.30
25.40 CMHC - OUTPATIENT SPEECH PATHOLOGY	0.00					25.40
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: 14-0252

Period:
From 10/01/2019
To 09/30/2020Worksheet S-3
Part II
Date/Time Prepared:
4/29/2021 1:24 pm

	Wkst. A Line Number	Amount Reported	Reclassificati on 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	205,448,259	0	205,448,259	5,643,246.00	36.41
2.00	Non-physician anesthetist Part A		0	0	0	0.00	0.00
3.00	Non-physician anesthetist Part B		0	0	0	0.00	0.00
4.00	Physician-Part A - Administrative		873,888	0	873,888	6,991.00	125.00
4.01	Physicians - Part A - Teaching		0	0	0	0.00	0.00
5.00	Physician and Non Physician-Part B		1,989	0	1,989	16.00	124.31
6.00	Non-physician-Part B for hospital-based RHC and FQHC services		0	0	0	0.00	0.00
7.00	Interns & residents (in an approved program)	21.00	0	0	0	0.00	0.00
7.01	Contracted interns and residents (in an approved programs)		0	0	0	0.00	0.00
8.00	Home office and/or related organization personnel		0	0	0	0.00	0.00
9.00	SNF	44.00	0	0	0	0.00	0.00
10.00	Excluded area salaries (see instructions)		16,228,967	24,991	16,253,958	438,444.00	37.07
OTHER WAGES & RELATED COSTS							
11.00	Contract labor: Direct Patient Care		10,712,509	0	10,712,509	125,634.00	85.27
12.00	Contract labor: Top level management and other management and administrative services		0	0	0	0.00	0.00
13.00	Contract labor: Physician-Part A - Administrative		3,571,510	0	3,571,510	32,277.00	110.65
14.00	Home office and/or related organization salaries and wage-related costs		0	0	0	0.00	0.00
14.01	Home office salaries		0	0	0	0.00	0.00
14.02	Related organization salaries		0	0	0	0.00	0.00
15.00	Home office: Physician Part A - Administrative		0	0	0	0.00	0.00
16.00	Home office and Contract Physicians Part A - Teaching		0	0	0	0.00	0.00
16.01	Home office Physicians Part A - Teaching		0	0	0	0.00	0.00
16.02	Home office contract Physicians Part A - Teaching		0	0	0	0.00	0.00
WAGE-RELATED COSTS							
17.00	Wage-related costs (core) (see instructions)		41,302,600	0	41,302,600		
18.00	Wage-related costs (other) (see instructions)						
19.00	Excluded areas		3,509,516	0	3,509,516		
20.00	Non-physician anesthetist Part A		0	0	0		
21.00	Non-physician anesthetist Part B		0	0	0		
22.00	Physician Part A - Administrative		98,551	0	98,551		
22.01	Physician Part A - Teaching		0	0	0		
23.00	Physician Part B		225	0	225		
24.00	Wage-related costs (RHC/FQHC)		0	0	0		
25.00	Interns & residents (in an approved program)		0	0	0		
25.50	Home office wage-related (core)		0	0	0		
25.51	Related organization wage-related (core)		0	0	0		
25.52	Home office: Physician Part A - Administrative - wage-related (core)		0	0	0		

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 14-0252

Period:
From 10/01/2019
To 09/30/2020Worksheet S-3
Part II
Date/Time Prepared:
4/29/2021 1:24 pm

		Wkst. A Line Number	Amount Reported	Reclassificati on 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	1,624,258	0	1,624,258	36,754.00	44.19	26.00
27.00	Administrative & General	5.00	40,000,787	-10,332	39,990,455	954,665.00	41.89	27.00
28.00	Administrative & General under contract (see inst.)		5,833,427	0	5,833,427	52,684.00	110.72	28.00
29.00	Maintenance & Repairs	6.00	0	0	0	0.00	0.00	29.00
30.00	Operation of Plant	7.00	7,228,874	0	7,228,874	174,354.00	41.46	30.00
31.00	Laundry & Linen Service	8.00	0	0	0	0.00	0.00	31.00
32.00	Housekeeping	9.00	3,629,428	0	3,629,428	232,271.00	15.63	32.00
33.00	Housekeeping under contract (see instructions)		830,323	0	830,323	10,400.00	79.84	33.00
34.00	Dietary	10.00	3,231,820	-1,116,930	2,114,890	115,333.00	18.34	34.00
35.00	Dietary under contract (see instructions)		917,873	0	917,873	16,374.00	56.06	35.00
36.00	Cafeteria	11.00	0	1,116,930	1,116,930	60,909.00	18.34	36.00
37.00	Maintenance of Personnel	12.00	0	0	0	0.00	0.00	37.00
38.00	Nursing Administration	13.00	8,019,575	0	8,019,575	168,919.00	47.48	38.00
39.00	Central Services and Supply	14.00	3,065,574	0	3,065,574	116,548.00	26.30	39.00
40.00	Pharmacy	15.00	4,817,682	-15,912	4,801,770	105,750.00	45.41	40.00
41.00	Medical Records & Medical Records Library	16.00	1,661,089	0	1,661,089	48,243.00	34.43	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: 14-0252

Period:
From 10/01/2019
To 09/30/2020Worksheet S-3
Part III
Date/Time Prepared:
4/29/2021 1:24 pm

	Worksheet A Line Number	Amount Reported	Reclassificati on 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)	213,027,893	0	213,027,893	5,722,688.00	37.23	1.00
2.00	Excluded area salaries (see instructions)	16,228,967	24,991	16,253,958	438,444.00	37.07	2.00
3.00	Subtotal salaries (line 1 minus line 2)	196,798,926	-24,991	196,773,935	5,284,244.00	37.24	3.00
4.00	Subtotal other wages & related costs (see inst.)	14,284,019	0	14,284,019	157,911.00	90.46	4.00
5.00	Subtotal wage-related costs (see inst.)	41,401,151	0	41,401,151	0.00	21.04	5.00
6.00	Total (sum of lines 3 thru 5)	252,484,096	-24,991	252,459,105	5,442,155.00	46.39	6.00
7.00	Total overhead cost (see instructions)	80,860,710	-26,244	80,834,466	2,093,204.00	38.62	7.00

HOSPITAL WAGE RELATED COSTS		Provider CCN: 14-0252	Period: From 10/01/2019 To 09/30/2020	Worksheet S-3 Part IV Date/Time Prepared: 4/29/2021 1:24 pm
				Amount Reported
				1.00
PART IV - WAGE RELATED COSTS				
Part A - Core List				
RETIREMENT COST				
1.00	401K Employer Contributions		4,654,189	1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution		0	2.00
3.00	Nonqualified Defined Benefit Plan Cost (see instructions)		0	3.00
4.00	Qualified Defined Benefit Plan Cost (see instructions)		13,345	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)		21,552,703	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		771,615	10.00
11.00	Life Insurance (If employee is owner or beneficiary)		315,803	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)		663,988	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)		0	14.00
15.00	'Workers' Compensation Insurance		2,007,580	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		14,234,648	17.00
18.00	Medicare Taxes - Employers Portion Only		0	18.00
19.00	Unemployment Insurance		247,224	19.00
20.00	State or Federal Unemployment Taxes		2,832	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		446,964	23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)		44,910,891	24.00
Part B - Other than Core Related Cost				
25.00	OTHER WAGE RELATED COST			25.00

HOSPITAL CONTRACT LABOR AND BENEFIT COST

Provider CCN: 14-0252

 Period:
 From 10/01/2019
 To 09/30/2020

 Worksheet S-3
 Part V
 Date/Time Prepared:
 4/29/2021 1:24 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	10,712,509	44,910,891	1.00
2.00	Hospital	10,712,509	41,401,376	2.00
3.00	Subprovider - IPF	0	1,330,560	3.00
4.00	Subprovider - IRF	0	633,558	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
16.10	Hospital-Based-CMHC 10	0	0	16.10
16.20	Hospital-Based-CMHC 20	0	0	16.20
16.30	Hospital-Based-CMHC 30	0	0	16.30
16.40	Hospital-Based-CMHC 40	0	0	16.40
17.00	Renal Dialysis	0	0	17.00
18.00	Other	0	1,545,397	18.00

Health Financial Systems		NORTHWEST COMMUNITY HOSPITAL		In Lieu of Form CMS-2552-10		
HOME HEALTH AGENCY STATISTICAL DATA		Provider CCN: 14-0252 Component CCN: 14-7094		Period: From 10/01/2019 To 09/30/2020 Worksheet S-4 Date/Time Prepared: 4/29/2021 1:24 pm		
				Home Health Agency I PPS		
				1.00		
0.00 County				COOK 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	1,863	0	918	2,781 1.00
2.00	Unduplicated Census Count (see instructions)	0.00	1,568.00	0.00	1,183.00	2,751.00 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)	0.00		0.00	3.00	3.00 3.00
4.00	Director(s) and Assistant Director(s)			0.13	0.00	0.13 4.00
5.00	Other Administrative Personnel			11.85	0.00	11.85 5.00
6.00	Direct Nursing Service			22.50	0.00	22.50 6.00
7.00	Nursing Supervisor			0.00	0.00	0.00 7.00
8.00	Physical Therapy Service			18.09	0.00	18.09 8.00
9.00	Physical Therapy Supervisor			0.00	0.00	0.00 9.00
10.00	Occupational Therapy Service			4.86	0.00	4.86 10.00
11.00	Occupational Therapy Supervisor			0.00	0.00	0.00 11.00
12.00	Speech Pathology Service			0.53	0.00	0.53 12.00
13.00	Speech Pathology Supervisor			0.00	0.00	0.00 13.00
14.00	Medical Social Service			0.81	0.00	0.81 14.00
15.00	Medical Social Service Supervisor			0.00	0.00	0.00 15.00
16.00	Home Health Aide			1.84	0.00	1.84 16.00
17.00	Home Health Aide Supervisor			0.00	0.00	0.00 17.00
18.00	CONTINUUM PERSONNEL			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.			14		19.00
20.00	List those CBSA code(s) in column 1 serviced during this cost reporting period (line 20 contains the first code).			11180		20.00
20.01				16580		20.01
20.02				16974		20.02
20.03				20994		20.03
20.04				27500		20.04
20.05				28100		20.05
20.06				29404		20.06
20.07				33124		20.07
20.08				34940		20.08
20.09				35614		20.09
20.10				40420		20.10
20.11				48300		20.11
20.12				99914		20.12
20.13				99939		20.13

HOME HEALTH AGENCY STATISTICAL DATA

Provider CCN: 14-0252

Period:

Worksheet S-4

Component CCN: 14-7094

From 10/01/2019

Date/Time Prepared:

To 09/30/2020

4/29/2021 1:24 pm

Home Health
Agency I

PPS

		Full Episodes		LUPA Episodes	PEP Only Episodes	Total (cols. 1-4)	
		Without Outliers	With Outliers				
		1.00	2.00	3.00	4.00	5.00	
	PPS ACTIVITY DATA						
21.00	Skilled Nursing Visits	12,886	640	387	71	13,984	21.00
22.00	Skilled Nursing Visit Charges	2,396,796	119,040	71,982	13,206	2,601,024	22.00
23.00	Physical Therapy Visits	11,177	502	181	59	11,919	23.00
24.00	Physical Therapy Visit Charges	2,995,436	134,536	48,508	15,812	3,194,292	24.00
25.00	Occupational Therapy Visits	3,130	271	18	31	3,450	25.00
26.00	Occupational Therapy Visit Charges	838,304	72,628	4,824	8,308	924,064	26.00
27.00	Speech Pathology Visits	321	52	2	0	375	27.00
28.00	Speech Pathology Visit Charges	86,028	13,936	536	0	100,500	28.00
29.00	Medical Social Service Visits	121	10	1	1	133	29.00
30.00	Medical Social Service Visit Charges	29,403	2,430	243	243	32,319	30.00
31.00	Home Health Aide Visits	1,136	91	6	9	1,242	31.00
32.00	Home Health Aide Visit Charges	153,360	12,285	810	1,215	167,670	32.00
33.00	Total visits (sum of lines 21, 23, 25, 27, 29, and 31)	28,771	1,566	595	171	31,103	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)	6,499,327	354,855	126,903	38,784	7,019,869	35.00
36.00	Total Number of Episodes (standard/non outlier)	2,631		303	22	2,956	36.00
37.00	Total Number of Outlier Episodes		72		0	72	37.00
38.00	Total Non-Routine Medical Supply Charges	386,464	40,006	20,574	4,021	451,065	38.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA		Provider CCN: 14-0252	Period: From 10/01/2019 To 09/30/2020	Worksheet S-10 Date/Time Prepared: 4/29/2021 1:24 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)			0.277699 1.00
Medicaid (see instructions for each line)				
2.00	Net revenue from Medicaid	21,658,394		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	132,392,446		6.00
7.00	Medicaid cost (line 1 times line 6)	36,765,250		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)	15,106,856		8.00
Children's Health Insurance Program (CHIP) (see instructions for each line)				
9.00	Net revenue from stand-alone CHIP	0		9.00
10.00	Stand-alone CHIP charges	0		10.00
11.00	Stand-alone CHIP cost (line 1 times line 10)	0		11.00
12.00	Difference between net revenue and costs for stand-alone CHIP (line 11 minus line 9; if < zero then enter zero)	0		12.00
Other state or local government indigent care program (see instructions for each line)				
13.00	Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9)	0		13.00
14.00	Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)	0		14.00
15.00	State or local indigent care program cost (line 1 times line 14)	0		15.00
16.00	Difference between net revenue and costs for state or local indigent care program (line 15 minus line 13; if < zero then enter zero)	0		16.00
Grants, donations and total unreimbursed cost for Medicaid, CHIP and state/local indigent care programs (see instructions for each line)				
17.00	Private grants, donations, or endowment income restricted to funding charity care	0		17.00
18.00	Government grants, appropriations or transfers for support of hospital operations	0		18.00
19.00	Total unreimbursed cost for Medicaid, CHIP and state and local indigent care programs (sum of lines 8, 12 and 16)	15,106,856		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)	31,924,680	3,697,347	35,622,027 20.00
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	8,865,452	3,697,347	12,562,799 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)	8,865,452	3,697,347	12,562,799 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)	20,906,199		26.00
27.00	Medicare reimbursable bad debts for the entire hospital complex (see instructions)	1,270,490		27.00
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)	1,954,600		27.01
28.00	Non-Medicare bad debt expense (see instructions)	18,951,599		28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)	5,946,950		29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)	18,509,749		30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	33,616,605		31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-0252

Period:
From 10/01/2019
To 09/30/2020

Worksheet A

Date/Time Prepared:
4/29/2021 1:24 pm

Cost Center Description			Salaries	Other	Total (col. 1 + col. 2)	Reclassification ons (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		14,248,920	14,248,920	8,097,546	22,346,466	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		23,628,824	23,628,824	0	23,628,824	2.00
3.00	00300	OTHER CAP REL COSTS		0	0	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	1,624,258	27,688,189	29,312,447	0	29,312,447	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	40,000,787	73,779,168	113,779,955	-3,324,490	110,455,465	5.00
6.00	00600	MAINTENANCE & REPAIRS	0	0	0	0	0	6.00
7.00	00700	OPERATION OF PLANT	7,228,874	18,904,085	26,132,959	25,970	26,158,929	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0	0	0	8.00
9.00	00900	HOUSEKEEPING	3,629,428	3,862,034	7,491,462	30,476	7,521,938	9.00
10.00	01000	DIETARY	3,231,820	3,428,778	6,660,598	-2,301,929	4,358,669	10.00
11.00	01100	CAFETERIA	0	0	0	2,301,929	2,301,929	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	8,019,575	1,155,442	9,175,017	0	9,175,017	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	3,065,574	1,239,420	4,304,994	3,905,711	8,210,705	14.00
15.00	01500	PHARMACY	4,817,682	9,169,498	13,987,180	-8,762,355	5,224,825	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,661,089	2,357,030	4,018,119	0	4,018,119	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
20.00	02000	NURSING SCHOOL	0	0	0	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0	22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	31,218,043	5,584,424	36,802,467	-3,839,120	32,963,347	30.00
31.00	03100	INTENSIVE CARE UNIT	7,946,306	2,795,709	10,742,015	-1,033,587	9,708,428	31.00
35.00	02060	NEONATAL INTENSIVE CARE UNIT	2,119,742	952,609	3,072,351	-906,685	2,165,666	35.00
40.00	04000	SUBPROVIDER - IPF	5,871,277	1,245,186	7,116,463	-35,705	7,080,758	40.00
41.00	04100	SUBPROVIDER - IRF	2,543,506	4,398,694	6,942,200	-4,184,064	2,758,136	41.00
43.00	04300	NURSERY	0	0	0	2,143,021	2,143,021	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	12,305,091	27,062,361	39,367,452	-22,280,959	17,086,493	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	3,532,667	1,515,638	5,048,305	-705,918	4,342,387	52.00
53.00	05300	ANESTHESIOLOGY	10,541	508,508	519,049	-479,050	39,999	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	14,164,699	7,747,408	21,912,107	-2,684,529	19,227,578	54.00
54.01	05401	OFFSITE-DIAGNOSTIC SERVICES	1,616,310	502,176	2,118,486	-136,135	1,982,351	54.01
56.01	03480	ONCOLOGY	1,818,043	8,924,007	10,742,050	-92,662	10,649,388	56.01
60.00	06000	LABORATORY	7,737,751	12,458,721	20,196,472	-1,082,742	19,113,730	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	442,042	2,450,824	2,892,866	-30,412	2,862,454	62.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	2,308,852	652,143	2,960,995	-366,832	2,594,163	65.00
66.00	06600	PHYSICAL THERAPY	7,764,505	1,454,562	9,219,067	-234,262	8,984,805	66.00
66.01	06601	IP REHAB THERAPIES	0	0	0	4,032,686	4,032,686	66.01
69.00	06900	ELECTROCARDIOLOGY	4,597,125	2,592,991	7,190,116	-261,179	6,928,937	69.00
69.01	03630	CARDIAC CATH LAB	2,181,784	10,714,531	12,896,315	-10,412,169	2,484,146	69.01
69.02	03160	CARDIAC REHABILITATION	0	0	0	0	0	69.02
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	25,635,520	25,635,520	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	18,051,503	18,051,503	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	8,507,178	8,507,178	73.00
73.01	07301	FLU VACCINE DRUGS CHG TO PATIENTS	0	0	0	185,880	185,880	73.01
74.00	07400	RENAL DIALYSIS	0	1,889,744	1,889,744	-14,559	1,875,185	74.00
76.97	07697	CARDIAC REHABILITATION	560,772	74,664	635,436	-11,967	623,469	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								
90.01	09001	OUTPATIENT TREATMENT CENTERS	2,586,707	1,655,408	4,242,115	-194,791	4,047,324	90.01
90.02	09002	PARTIAL HOSPITALIZATION PROGRAM	1,406,720	120,040	1,526,760	-1,041	1,525,719	90.02
91.00	09100	EMERGENCY	8,970,911	4,737,134	13,708,045	-1,906,849	11,801,196	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	2,651,594	356,522	3,008,116	-141,165	2,866,951	92.01
OTHER REIMBURSABLE COST CENTERS								
99.10	09910	CORF	0	0	0	0	0	99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY	0	0	0	0	0	99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY	0	0	0	0	0	99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY	0	0	0	0	0	99.40
101.00	10100	HOME HEALTH AGENCY	5,133,398	2,086,117	7,219,515	956	7,220,471	101.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE		7,546,272	7,546,272	-7,546,272	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	202,767,473	289,487,781	492,255,254	-53,052	492,202,202	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	139,456	155,580	295,036	0	295,036	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-0252

Period:
From 10/01/2019
To 09/30/2020

Worksheet A

Date/Time Prepared:
4/29/2021 1:24 pm

Cost Center Description			Salaries	Other	Total (col. 1 + col. 2)	Reclassificati ons (See A-6)	Reclassified Trial Balance (col. 3 +- col. 4)	
			1.00	2.00	3.00	4.00	5.00	
192.01	19201	DAY SURGERY CENTER	0	0	0	0	0	192.01
192.02	19202	RESIDENTIAL TREATMENT CENTER	854,579	90,336	944,915	0	944,915	192.02
192.03	19203	MOBILE DENTAL CLINIC	185,312	75,343	260,655	0	260,655	192.03
192.04	19204	EMS CONTINUING EDUCATION	0	0	0	0	0	192.04
194.00	07950	CORPORATE HEALTH	185,358	54,087	239,445	0	239,445	194.00
194.01	07951	MARKETING/COMMUNICATION	0	0	0	53,052	53,052	194.01
194.02	07952	FOUNDATION	0	0	0	0	0	194.02
194.03	07953	OTHER NRCC	869,508	2,373,159	3,242,667	0	3,242,667	194.03
194.04	07954	OP PHARMACY	446,573	3,624,626	4,071,199	0	4,071,199	194.04
200.00		TOTAL (SUM OF LINES 118 through 199)	205,448,259	295,860,912	501,309,171	0	501,309,171	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-0252

Period:
From 10/01/2019
To 09/30/2020

Worksheet A

Date/Time Prepared:
4/29/2021 1:24 pm

Cost Center Description			Adjustments (See A-8) 6.00	Net Expenses For Allocation 7.00	
GENERAL SERVICE COST CENTERS					
1.00	00100	CAP REL COSTS-BLDG & FIXT	3,894,271	26,240,737	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	-580,902	23,047,922	2.00
3.00	00300	OTHER CAP REL COSTS	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	4,075,182	33,387,629	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-24,606,363	85,849,102	5.00
6.00	00600	MAINTENANCE & REPAIRS	0	0	6.00
7.00	00700	OPERATION OF PLANT	-4,707	26,154,222	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	8.00
9.00	00900	HOUSEKEEPING	0	7,521,938	9.00
10.00	01000	DIETARY	0	4,358,669	10.00
11.00	01100	CAFETERIA	-1,218,152	1,083,777	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	-234,609	8,940,408	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	-10,515	8,200,190	14.00
15.00	01500	PHARMACY	-1,219	5,223,606	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-1,501	4,016,618	16.00
17.00	01700	SOCIAL SERVICE	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	19.00
20.00	02000	NURSING SCHOOL	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	-455,740	32,507,607	30.00
31.00	03100	INTENSIVE CARE UNIT	-129,399	9,579,029	31.00
35.00	02060	NEONATAL INTENSIVE CARE UNIT	0	2,165,666	35.00
40.00	04000	SUBPROVIDER - IPF	-106	7,080,652	40.00
41.00	04100	SUBPROVIDER - IRF	0	2,758,136	41.00
43.00	04300	NURSERY	0	2,143,021	43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	-120,470	16,966,023	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	-519,327	3,823,060	52.00
53.00	05300	ANESTHESIOLOGY	0	39,999	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-66,497	19,161,081	54.00
54.01	05401	OFFSITE-DIAGNOSTIC SERVICES	0	1,982,351	54.01
56.01	03480	ONCOLOGY	-21,605	10,627,783	56.01
60.00	06000	LABORATORY	-482,295	18,631,435	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	2,862,454	62.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0	2,594,163	65.00
66.00	06600	PHYSICAL THERAPY	-950	8,983,855	66.00
66.01	06601	IP REHAB THERAPIES	0	4,032,686	66.01
69.00	06900	ELECTROCARDIOLOGY	-1,221,121	5,707,816	69.00
69.01	03630	CARDIAC CATH LAB	0	2,484,146	69.01
69.02	03160	CARDIAC REHABILITATION	0	0	69.02
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	25,635,520	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	18,051,503	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	8,507,178	73.00
73.01	07301	FLU VACCINE DRUGS CHG TO PATIENTS	0	185,880	73.01
74.00	07400	RENAL DIALYSIS	0	1,875,185	74.00
76.97	07697	CARDIAC REHABILITATION	-2,680	620,789	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	76.99
OUTPATIENT SERVICE COST CENTERS					
90.01	09001	OUTPATIENT TREATMENT CENTERS	-1,399	4,045,925	90.01
90.02	09002	PARTIAL HOSPITALIZATION PROGRAM	0	1,525,719	90.02
91.00	09100	EMERGENCY	-766,173	11,035,023	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART			92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	0	2,866,951	92.01
OTHER REIMBURSABLE COST CENTERS					
99.10	09910	CORF	0	0	99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY	0	0	99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY	0	0	99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY	0	0	99.40
101.00	10100	HOME HEALTH AGENCY	0	7,220,471	101.00
SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE	0	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-22,476,277	469,725,925	118.00
NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	295,036	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	192.00
192.01	19201	DAY SURGERY CENTER	0	0	192.01
192.02	19202	RESIDENTIAL TREATMENT CENTER	-104,072	840,843	192.02

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-0252

Period:
From 10/01/2019
To 09/30/2020

Worksheet A

Date/Time Prepared:
4/29/2021 1:24 pm

Cost Center Description			Adjustments (See A-8)	Net Expenses For Allocation	
			6.00	7.00	
192.03	19203	MOBILE DENTAL CLINIC	-74,449	186,206	192.03
192.04	19204	EMS CONTINUING EDUCATION	0	0	192.04
194.00	07950	CORPORATE HEALTH	0	239,445	194.00
194.01	07951	MARKETING/COMMUNICATION	0	53,052	194.01
194.02	07952	FOUNDATION	0	0	194.02
194.03	07953	OTHER NRCC	-949,967	2,292,700	194.03
194.04	07954	OP PHARMACY	0	4,071,199	194.04
200.00		TOTAL (SUM OF LINES 118 through 199)	-23,604,765	477,704,406	200.00

RECLASSIFICATIONS

Provider CCN: 14-0252

Period:
From 10/01/2019
To 09/30/2020

Worksheet A-6

Date/Time Prepared:
4/29/2021 1:24 pm

	Increases					
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
	A - SHARED EXPENSES					
1.00	CAFETERIA	11.00	1,116,930	1,184,999	1.00	
	TOTALS		1,116,930	1,184,999		
	B - FLOAT POOL					
1.00	INTENSIVE CARE UNIT	31.00	42,289	5,238	1.00	
2.00	SUBPROVIDER - IPF	40.00	13,907	1,723	2.00	
3.00	NEONATAL INTENSIVE CARE UNIT	35.00	3,690	457	3.00	
4.00	OPERATING ROOM	50.00	851	105	4.00	
5.00	EMERGENCY	91.00	4,257	527	5.00	
6.00	HOME HEALTH AGENCY	101.00	851	105	6.00	
	TOTALS		65,845	8,155		
	D - COST OF MEDICAL SUPPLIES SOLD					
1.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	25,635,520	1.00	
2.00	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	18,051,503	2.00	
3.00	CENTRAL SERVICES & SUPPLY	14.00	0	1,241,993	3.00	
4.00	CENTRAL SERVICES & SUPPLY	14.00	0	2,663,718	4.00	
5.00		0.00	0	0	5.00	
6.00		0.00	0	0	6.00	
7.00		0.00	0	0	7.00	
8.00		0.00	0	0	8.00	
9.00		0.00	0	0	9.00	
10.00		0.00	0	0	10.00	
11.00		0.00	0	0	11.00	
12.00		0.00	0	0	12.00	
13.00		0.00	0	0	13.00	
14.00		0.00	0	0	14.00	
15.00		0.00	0	0	15.00	
16.00		0.00	0	0	16.00	
17.00		0.00	0	0	17.00	
18.00		0.00	0	0	18.00	
19.00		0.00	0	0	19.00	
20.00		0.00	0	0	20.00	
21.00		0.00	0	0	21.00	
22.00		0.00	0	0	22.00	
23.00		0.00	0	0	23.00	
24.00		0.00	0	0	24.00	
25.00		0.00	0	0	25.00	
26.00		0.00	0	0	26.00	
27.00		0.00	0	0	27.00	
	TOTALS		0	47,592,734		
	E - COST OF DRUGS SOLD					
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	8,507,178	1.00	
	TOTALS		0	8,507,178		
	F - PARAMEDICAL EDUCATION					
1.00		0.00	0	0	1.00	
	TOTALS		0	0		
	H - SALT CREEK OCCUPANCY COSTS					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	102,405	1.00	
2.00	OPERATION OF PLANT	7.00	0	25,970	2.00	
3.00	HOUSEKEEPING	9.00	0	30,476	3.00	
	TOTALS		0	158,851		
	I - FLU VACCINES					
1.00	FLU VACCINE DRUGS CHG TO PATIENTS	73.01	34,070	151,810	1.00	
2.00		0.00	0	0	2.00	
3.00		0.00	0	0	3.00	
4.00		0.00	0	0	4.00	
5.00		0.00	0	0	5.00	
6.00		0.00	0	0	6.00	
7.00		0.00	0	0	7.00	
8.00		0.00	0	0	8.00	
9.00		0.00	0	0	9.00	
10.00		0.00	0	0	10.00	
11.00		0.00	0	0	11.00	
	TOTALS		34,070	151,810		
	J - PROPERTY INSURANCE					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	448,869	1.00	
	TOTALS		0	448,869		
	K - LDR COST ALLOCATION					
1.00	NURSERY	43.00	1,802,560	340,461	1.00	
2.00		0.00	0	0	2.00	
	TOTALS		1,802,560	340,461		

RECLASSIFICATIONS

Provider CCN: 14-0252

Period:
From 10/01/2019
To 09/30/2020

Worksheet A-6

Date/Time Prepared:
4/29/2021 1:24 pm

	Increases					
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
1.00	M - INTEREST EXPENSE					1.00
	CAP REL COSTS-BLDG & FIXT	1.00	0	7,546,272		
	TOTALS		0	7,546,272		
1.00	O - MARKETING RECLASS					1.00
	MARKETING/COMMUNICATION	194.01	10,332	42,720		
	TOTALS		10,332	42,720		
1.00	P - IP REHAB THERAPY					1.00
	IP REHAB THERAPIES	66.01	0	4,032,686		
	TOTALS		0	4,032,686		
500.00	Grand Total: Increases		3,029,737	70,014,735		500.00

RECLASSIFICATIONS

Provider CCN: 14-0252

Period:
From 10/01/2019
To 09/30/2020

Worksheet A-6

Date/Time Prepared:
4/29/2021 1:24 pm

	Decreases						
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	A - SHARED EXPENSES						
1.00	DIETARY	10.00	1,116,930	1,184,999	0		1.00
	TOTALS		1,116,930	1,184,999			
	B - FLOAT POOL						
1.00	ADULTS & PEDIATRICS	30.00	65,845	8,155	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
	TOTALS		65,845	8,155			
	D - COST OF MEDICAL SUPPLIES SOLD						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	2,663,718	0		1.00
2.00	PHARMACY	15.00	0	87,455	0		2.00
3.00		0.00	0	0	0		3.00
4.00	EMERGENCY	91.00	0	281,004	0		4.00
5.00	ADULTS & PEDIATRICS	30.00	0	2,305,667	0		5.00
6.00	INTENSIVE CARE UNIT	31.00	0	1,079,791	0		6.00
7.00	NEONATAL INTENSIVE CARE UNIT	35.00	0	226,845	0		7.00
8.00	SUBPROVIDER - IPF	40.00	0	51,305	0		8.00
9.00	SUBPROVIDER - IRF	41.00	0	151,309	0		9.00
10.00	OPERATING ROOM	50.00	0	22,281,550	0		10.00
11.00	DELIVERY ROOM & LABOR ROOM	52.00	0	698,425	0		11.00
12.00	ANESTHESIOLOGY	53.00	0	479,050	0		12.00
13.00	RADIOLOGY-DIAGNOSTIC	54.00	0	2,684,529	0		13.00
14.00	OFFSITE-DIAGNOSTIC SERVICES	54.01	0	136,135	0		14.00
15.00	ONCOLOGY	56.01	0	84,486	0		15.00
16.00	LABORATORY	60.00	0	1,082,742	0		16.00
17.00	WHOLE BLOOD & PACKED RED BLOOD CELL	62.00	0	30,412	0		17.00
18.00	RESPIRATORY THERAPY	65.00	0	366,832	0		18.00
19.00	PHYSICAL THERAPY	66.00	0	234,262	0		19.00
20.00	ELECTROCARDIOLOGY	69.00	0	261,179	0		20.00
21.00	CARDIAC CATH LAB	69.01	0	10,412,169	0		21.00
22.00	RENAL DIALYSIS	74.00	0	14,559	0		22.00
23.00	CARDIAC REHABILITATION	76.97	0	11,967	0		23.00
24.00	OUTPATIENT TREATMENT CENTERS	90.01	0	194,508	0		24.00
25.00	PARTIAL HOSPITALIZATION PROGRAM	90.02	0	1,041	0		25.00
26.00	EMERGENCY	91.00	0	1,630,629	0		26.00
27.00	OBSERVATION BEDS (DISTINCT PART)	92.01	0	141,165	0		27.00
	TOTALS		0	47,592,734			
	E - COST OF DRUGS SOLD						
1.00	PHARMACY	15.00	0	8,507,178	0		1.00
	TOTALS		0	8,507,178			
	F - PARAMEDICAL EDUCATION						
1.00		0.00	0	0	0		1.00
	TOTALS		0	0			
	H - SALT CREEK OCCUPANCY COSTS						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	102,405	10		1.00
2.00	ADMINISTRATIVE & GENERAL	5.00	0	25,970	0		2.00
3.00	ADMINISTRATIVE & GENERAL	5.00	0	30,476	0		3.00
	TOTALS		0	158,851			
	I - FLU VACCINES						
1.00	PHARMACY	15.00	0	151,810	0		1.00
2.00	PHARMACY	15.00	15,912	0	0		2.00
3.00	ADULTS & PEDIATRICS	30.00	140	0	0		3.00
4.00	INTENSIVE CARE UNIT	31.00	1,323	0	0		4.00
5.00	NEONATAL INTENSIVE CARE UNIT	35.00	279	0	0		5.00
6.00	SUBPROVIDER - IPF	40.00	30	0	0		6.00
7.00	SUBPROVIDER - IRF	41.00	69	0	0		7.00
8.00	OPERATING ROOM	50.00	365	0	0		8.00
9.00	DELIVERY ROOM & LABOR ROOM	52.00	7,493	0	0		9.00
10.00	ONCOLOGY	56.01	8,176	0	0		10.00
11.00	OUTPATIENT TREATMENT CENTERS	90.01	283	0	0		11.00
	TOTALS		34,070	151,810			
	J - PROPERTY INSURANCE						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	448,869	12		1.00
	TOTALS		0	448,869			
	K - LDR COST ALLOCATION						
1.00	NEONATAL INTENSIVE CARE UNIT	35.00	509,324	174,384	0		1.00
2.00	ADULTS & PEDIATRICS	30.00	1,293,236	166,077	0		2.00
	TOTALS		1,802,560	340,461			

RECLASSIFICATIONS

Provider CCN: 14-0252

Period:
From 10/01/2019
To 09/30/2020

Worksheet A-6

Date/Time Prepared:
4/29/2021 1:24 pm

Decreases						
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.	
	6.00	7.00	8.00	9.00	10.00	
	M - INTEREST EXPENSE					
1.00	INTEREST EXPENSE	113.00	0	7,546,272	11	1.00
	TOTALS		0	7,546,272		
	O - MARKETING RECLASS					
1.00	ADMINISTRATIVE & GENERAL	5.00	10,332	42,720	0	1.00
	TOTALS		10,332	42,720		
	P - IP REHAB THERAPY					
1.00	SUBPROVIDER - IRF	41.00	0	4,032,686	0	1.00
	TOTALS		0	4,032,686		
500.00	Grand Total: Decreases		3,029,737	70,014,735		500.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-0252

Period:
From 10/01/2019
To 09/30/2020Worksheet A-7
Part I
Date/Time Prepared:
4/29/2021 1:24 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	89,072	0	0	0	0	1.00
2.00	Land Improvements	15,182,110	406,669	0	406,669	17,924	2.00
3.00	Buildings and Fixtures	318,705,276	5,567,530	0	5,567,530	4,107,243	3.00
4.00	Building Improvements	3,480,507	0	0	0	192,625	4.00
5.00	Fixed Equipment	216,463,568	1,917,022	0	1,917,022	380,338	5.00
6.00	Movable Equipment	253,345,647	36,876,297	0	36,876,297	7,212,110	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	807,266,180	44,767,518	0	44,767,518	11,910,240	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	807,266,180	44,767,518	0	44,767,518	11,910,240	10.00
		Ending Balance	Fully Depreciated Assets				
		6.00	7.00				
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	89,072	0				1.00
2.00	Land Improvements	15,570,855	0				2.00
3.00	Buildings and Fixtures	320,165,563	0				3.00
4.00	Building Improvements	3,287,882	0				4.00
5.00	Fixed Equipment	218,000,252	0				5.00
6.00	Movable Equipment	283,009,834	0				6.00
7.00	HIT designated Assets	0	0				7.00
8.00	Subtotal (sum of lines 1-7)	840,123,458	0				8.00
9.00	Reconciling Items	0	0				9.00
10.00	Total (line 8 minus line 9)	840,123,458	0				10.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-0252

Period:
From 10/01/2019
To 09/30/2020Worksheet A-7
Part II
Date/Time Prepared:
4/29/2021 1:24 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	14,248,920	0	0	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	23,628,824	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	37,877,744	0	0	0	0	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Other	Total (1) (sum				
		Capital-Related Costs (see instructions)	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	14,248,920				1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	23,628,824				2.00
3.00	Total (sum of lines 1-2)	0	37,877,744				3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-0252

Period:
From 10/01/2019
To 09/30/2020Worksheet A-7
Part III
Date/Time Prepared:
4/29/2021 1:24 pm

Cost Center Description		COMPUTATION OF RATIOS			ALLOCATION OF OTHER CAPITAL		
		Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	
		1.00	2.00	3.00	4.00	5.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	557,113,625	0	557,113,625	0.663133	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	283,009,833	0	283,009,833	0.336867	0	2.00
3.00	Total (sum of lines 1-2)	840,123,458	0	840,123,458	1.000000	0	3.00
Cost Center Description		ALLOCATION OF OTHER CAPITAL			SUMMARY OF CAPITAL		
		Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	Depreciation	Lease	
		6.00	7.00	8.00	9.00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	18,143,190	102,405	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	23,047,922	0	2.00
3.00	Total (sum of lines 1-2)	0	0	0	41,191,112	102,405	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	7,546,273	448,869	0	0	26,240,737	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	0	23,047,922	2.00
3.00	Total (sum of lines 1-2)	7,546,273	448,869	0	0	49,288,659	3.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 14-0252

Period:
From 10/01/2019
To 09/30/2020

Worksheet A-8

Date/Time Prepared:
4/29/2021 1:24 pm

Cost Center Description		Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted		Wkst. A-7 Ref.	
				Cost Center	Line #		
		1.00	2.00	3.00	4.00	5.00	
1.00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)			0CAP REL COSTS-BLDG & FIXT	1.00	0	1.00
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)			0CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
3.00	Investment income - other (chapter 2)		0		0.00	0	3.00
4.00	Trade, quantity, and time discounts (chapter 8)		0		0.00	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)		0		0.00	0	5.00
6.00	Rental of provider space by suppliers (chapter 8)		0		0.00	0	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)	A	-47,414	ADMINISTRATIVE & GENERAL	5.00	0	7.00
8.00	Television and radio service (chapter 21)	A	-4,707	OPERATION OF PLANT	7.00	0	8.00
9.00	Parking lot (chapter 21)		0		0.00	0	9.00
10.00	Provider-based physician adjustment	A-8-2	-3,076,194			0	10.00
11.00	Sale of scrap, waste, etc. (chapter 23)		0		0.00	0	11.00
12.00	Related organization transactions (chapter 10)	A-8-1	0			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests	B	-1,218,152	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		0		0.00	0	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	0	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	RESPIRATORY THERAPY	65.00		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	PHYSICAL THERAPY	66.00		24.00
25.00	Utilization review - physicians' compensation (chapter 21)		0	*** Cost Center Deleted ***	114.00		25.00
26.00	Depreciation - CAP REL COSTS-BLDG & FIXT		0	CAP REL COSTS-BLDG & FIXT	1.00	0	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	*** Cost Center Deleted ***	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	*** Cost Center Deleted ***	68.00		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest		0		0.00	0	32.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 14-0252

Period:
From 10/01/2019
To 09/30/2020

Worksheet A-8

Date/Time Prepared:
4/29/2021 1:24 pm

Cost Center Description		Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted		Line #	Wkst. A-7 Ref.	
				Cost Center				
		1.00	2.00	3.00		4.00	5.00	
33.00	OTHER ADJUSTMENTS (SPECIFY) (3)		0			0.00	0	33.00
35.00	PHO EXPENSE	A	0	ADMINISTRATIVE & GENERAL		5.00	0	35.00
38.00	LOBBYING PORTION OF DUES	A	-52,935	ADMINISTRATIVE & GENERAL		5.00	0	38.00
39.00	PROVIDER ASSESSMENT REBATE	A	-22,984,494	ADMINISTRATIVE & GENERAL		5.00	0	39.00
41.14	PARAMED EDUCATION TUITION INCOM	B	-418,543	EMERGENCY		91.00	0	41.14
41.88	PIANO DEPRECIATION	A	-1,371	CAP REL COSTS-MVBLE EQUIP		2.00	9	41.88
42.00	OTHER ADJUSTMENTS (SPECIFY) (3)		0			0.00	0	42.00
42.01	OTHER ADJUSTMENTS (SPECIFY) (3)		0			0.00	0	42.01
45.01	MISC OPERATING INCOME	B	406,388	ADMINISTRATIVE & GENERAL		5.00	0	45.01
45.02	MISC OPERATING INCOME	B	-38,426	NURSING ADMINISTRATION		13.00	0	45.02
45.03	MISC OPERATING INCOME	B	-1,501	MEDICAL RECORDS & LIBRARY		16.00	0	45.03
45.04	MISC OPERATING INCOME	B	-50,613	ADULTS & PEDIATRICS		30.00	0	45.04
45.05	MISC OPERATING INCOME	B	0	SUBPROVIDER - IPF		40.00	0	45.05
45.06	MISC OPERATING INCOME	B	-87,470	OPERATING ROOM		50.00	0	45.06
45.07	MISC OPERATING INCOME	B	-5,627	RADIOLOGY-DIAGNOSTIC		54.00	0	45.07
45.08	MISC OPERATING INCOME	B	-210	ONCOLOGY		56.01	0	45.08
45.09	MISC OPERATING INCOME	B	-193,488	LABORATORY		60.00	0	45.09
45.10	MISC OPERATING INCOME	B	-360	PHYSICAL THERAPY		66.00	0	45.10
45.11	MISC OPERATING INCOME	B	-63,594	ELECTROCARDIOLOGY		69.00	0	45.11
45.14	MISC OPERATING INCOME	B	-10,515	CENTRAL SERVICES & SUPPLY		14.00	0	45.14
45.16	PENSION COSTS ADD BACK	A	4,095,301	EMPLOYEE BENEFITS DEPARTMENT		4.00	0	45.16
45.17	OTHER ADJUSTMENTS (SPECIFY) (3)		0			0.00	0	45.17
45.18	OFFSET RESEARCH COSTS	A	-194,473	NURSING ADMINISTRATION		13.00	0	45.18
45.26	NON ALLOWABLE TRAVEL	A	-18,049	ADMINISTRATIVE & GENERAL		5.00	0	45.26
45.32	CSM AND 901 DEPRECIATION	A	-444,725	CAP REL COSTS-BLDG & FIXT		1.00	9	45.32
45.33	AMORT OF DEPR EXP OF DEMOLISHED		0			0.00	0	45.33
45.35	MED VS BOOK DEP DIFF	A	4,338,995	CAP REL COSTS-BLDG & FIXT		1.00	9	45.35
45.36	MED VS BOOK DEPR DIFF	A	-579,531	CAP REL COSTS-MVBLE EQUIP		2.00	9	45.36
46.00	PT B NON PHY COST	A	-1,500,000	ADMINISTRATIVE & GENERAL		5.00	0	46.00
47.00	PROFESSIONAL COMPONENT	A	-104,072	RESIDENTIAL TREATMENT CENTER		192.02	0	47.00
47.01	PROFESSIONAL COMPONENT	A	-74,449	MOBILE DENTAL CLINIC		192.03	0	47.01
47.02	PROFESSIONAL COMPONENT	A	-34,854	OTHER NRCC		194.03	0	47.02
47.03	PROFESSIONAL COMPONENT	A	-816,313	OTHER NRCC		194.03	0	47.03
47.04	NON HOSP EXPENSES	A	-256,045	ADMINISTRATIVE & GENERAL		5.00	0	47.04
47.05	OFFSET DONATIONS	A	-20,109	EMPLOYEE BENEFITS DEPARTMENT		4.00	0	47.05
47.06	OFFSET DONATIONS	A	-48,000	ADMINISTRATIVE & GENERAL		5.00	0	47.06
47.07	OFFSET COMMUNITY SUPPORT	A	-417	ADMINISTRATIVE & GENERAL		5.00	0	47.07
47.08	OFFSET COMMUNITY SUPPORT		0			0.00	0	47.08
47.09	OFFSET COMMUNITY SUPPORT	A	-98,800	OTHER NRCC		194.03	0	47.09
47.10	OTHER ADJUSTMENTS (SPECIFY) (3)		0			0.00	0	47.10
47.11	OFFSET INTERCOMPANY RENT	A	1	ADMINISTRATIVE & GENERAL		5.00	0	47.11
47.12	LOSS ON EARLY ESTINGUISHMENT OF DEBT	A	1	CAP REL COSTS-BLDG & FIXT		1.00	11	47.12
47.13	OTHER ADJUSTMENTS (SPECIFY) (3)		0			0.00	0	47.13
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-23,604,765					50.00

(1) Description - all chapter references in this column pertain to CMS Pub. 15-1.

(2) Basis for adjustment (see instructions).

A. Costs - if cost, including applicable overhead, can be determined.

B. Amount Received - if cost cannot be determined.

(3) Additional adjustments may be made on lines 33 thru 49 and subscripts thereof.

Note: See instructions for column 5 referencing to Worksheet A-7.

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 14-0252

Period:
From 10/01/2019
To 09/30/2020

Worksheet A-8-2

Date/Time Prepared:
4/29/2021 1:24 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	4.00	EMPLOYEE BENEFITS DEPARTMENT	213	0	213	211,500	2	1.00
2.00	5.00	ADMINISTRATIVE & GENERAL	564,902	0	564,902	211,500	4,519	2.00
3.00	13.00	NURSING ADMINISTRATION	9,235	0	9,235	211,500	74	3.00
4.00	15.00	PHARMACY	6,303	0	6,303	211,500	50	4.00
5.00	30.00	ADULTS & PEDIATRICS	405,127	405,127	0	0	0	5.00
6.00	31.00	INTENSIVE CARE UNIT	1,022,580	0	1,022,580	211,500	8,784	6.00
7.00	35.00	NEONATAL INTENSIVE CARE UNIT	523,374	0	523,374	211,500	8,784	7.00
8.00	40.00	SUBPROVIDER - IPF	818	0	818	211,500	7	8.00
9.00	50.00	OPERATING ROOM	33,000	33,000	0	0	0	9.00
10.00	52.00	DELIVERY ROOM & LABOR ROOM	519,327	519,327	0	0	0	10.00
11.00	54.00	RADIOLOGY-DIAGNOSTIC	60,870	60,870	0	0	0	11.00
12.00	56.01	ONCOLOGY	47,426	0	47,426	211,500	256	12.00
13.00	60.00	LABORATORY	462,286	211,650	250,636	266,300	1,355	13.00
14.00	66.00	PHYSICAL THERAPY	590	590	0	0	0	14.00
15.00	69.00	ELECTROCARDIOLOGY	1,157,527	1,157,527	0	0	0	15.00
16.00	76.97	CARDIAC REHABILITATION	2,680	2,680	0	0	0	16.00
17.00	90.01	OUTPATIENT TREATMENT CENTERS	1,399	1,399	0	0	0	17.00
18.00	91.00	EMERGENCY	1,469,800	0	1,469,800	211,500	11,036	18.00
200.00			6,287,457	2,392,170	3,895,287		34,867	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	4.00	EMPLOYEE BENEFITS DEPARTMENT	203	10	0	0	0	1.00
2.00	5.00	ADMINISTRATIVE & GENERAL	459,504	22,975	0	0	0	2.00
3.00	13.00	NURSING ADMINISTRATION	7,525	376	0	0	0	3.00
4.00	15.00	PHARMACY	5,084	254	0	0	0	4.00
5.00	30.00	ADULTS & PEDIATRICS	0	0	0	0	0	5.00
6.00	31.00	INTENSIVE CARE UNIT	893,181	44,659	0	0	0	6.00
7.00	35.00	NEONATAL INTENSIVE CARE UNIT	893,181	44,659	0	0	0	7.00
8.00	40.00	SUBPROVIDER - IPF	712	36	0	0	0	8.00
9.00	50.00	OPERATING ROOM	0	0	0	0	0	9.00
10.00	52.00	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	10.00
11.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	11.00
12.00	56.01	ONCOLOGY	26,031	1,302	0	0	0	12.00
13.00	60.00	LABORATORY	173,479	8,674	0	0	0	13.00
14.00	66.00	PHYSICAL THERAPY	0	0	0	0	0	14.00
15.00	69.00	ELECTROCARDIOLOGY	0	0	0	0	0	15.00
16.00	76.97	CARDIAC REHABILITATION	0	0	0	0	0	16.00
17.00	90.01	OUTPATIENT TREATMENT CENTERS	0	0	0	0	0	17.00
18.00	91.00	EMERGENCY	1,122,170	56,109	0	0	0	18.00
200.00			3,581,070	179,054	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	4.00	EMPLOYEE BENEFITS DEPARTMENT	0	203	10	10		1.00
2.00	5.00	ADMINISTRATIVE & GENERAL	0	459,504	105,398	105,398		2.00
3.00	13.00	NURSING ADMINISTRATION	0	7,525	1,710	1,710		3.00
4.00	15.00	PHARMACY	0	5,084	1,219	1,219		4.00
5.00	30.00	ADULTS & PEDIATRICS	0	0	0	405,127		5.00
6.00	31.00	INTENSIVE CARE UNIT	0	893,181	129,399	129,399		6.00
7.00	35.00	NEONATAL INTENSIVE CARE UNIT	0	893,181	0	0		7.00
8.00	40.00	SUBPROVIDER - IPF	0	712	106	106		8.00
9.00	50.00	OPERATING ROOM	0	0	0	33,000		9.00
10.00	52.00	DELIVERY ROOM & LABOR ROOM	0	0	0	519,327		10.00
11.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	60,870		11.00
12.00	56.01	ONCOLOGY	0	26,031	21,395	21,395		12.00
13.00	60.00	LABORATORY	0	173,479	77,157	288,807		13.00
14.00	66.00	PHYSICAL THERAPY	0	0	0	590		14.00
15.00	69.00	ELECTROCARDIOLOGY	0	0	0	1,157,527		15.00
16.00	76.97	CARDIAC REHABILITATION	0	0	0	2,680		16.00
17.00	90.01	OUTPATIENT TREATMENT CENTERS	0	0	0	1,399		17.00
18.00	91.00	EMERGENCY	0	1,122,170	347,630	347,630		18.00
200.00			0	3,581,070	684,024	3,076,194		200.00

COST ALLOCATION - GENERAL SERVICE COSTS

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Cost Center Description		Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
			BLDG & FIXT	MVBLE EQUIP			
		0	1.00	2.00	4.00	4A	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT	26,240,737	26,240,737			1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	23,047,922	23,047,922			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	33,387,629	386,585	4,324	33,778,538	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	85,849,102	6,072,926	13,954,012	6,627,390	5.00
6.00	00600	MAINTENANCE & REPAIRS	0	0	0	0	6.00
7.00	00700	OPERATION OF PLANT	26,154,222	3,562,862	219,864	1,197,998	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0	0	8.00
9.00	00900	HOUSEKEEPING	7,521,938	0	7,799	601,483	9.00
10.00	01000	DIETARY	4,358,669	314,826	70,177	350,488	10.00
11.00	01100	CAFETERIA	1,083,777	207,036	0	185,102	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	8,940,408	257,018	134,316	1,329,036	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	8,200,190	469,233	374,904	508,039	14.00
15.00	01500	PHARMACY	5,223,606	187,111	146,967	795,769	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	4,016,618	159,247	4,936	275,282	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	19.00
20.00	02000	NURSING SCHOOL	0	0	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	22.00
23.00	02300	PARAMED ED PRGM- (SPECIFY)	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	32,507,607	3,445,090	691,057	4,948,323	30.00
31.00	03100	INTENSIVE CARE UNIT	9,579,029	971,397	183,888	1,323,683	31.00
35.00	02060	NEONATAL INTENSIVE CARE UNIT	2,165,666	75,313	92,382	267,450	35.00
40.00	04000	SUBPROVIDER - IPF	7,080,652	642,847	91,482	975,311	40.00
41.00	04100	SUBPROVIDER - IRF	2,758,136	453,430	44,381	421,509	41.00
43.00	04300	NURSERY	2,143,021	152,706	0	298,727	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	16,966,023	2,368,776	2,309,170	2,039,329	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	3,823,060	354,222	103,556	584,206	52.00
53.00	05300	ANESTHESIOLOGY	39,999	19,736	94,855	1,747	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	19,161,081	1,293,407	1,821,389	2,347,431	54.00
54.01	05401	OFFSITE-DIAGNOSTIC SERVICES	1,982,351	0	323,247	267,861	54.01
56.01	03480	ONCOLOGY	10,627,783	641,373	68,935	299,938	56.01
60.00	06000	LABORATORY	18,631,435	510,028	259,494	1,282,331	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	2,862,454	35,161	30,967	73,257	62.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	2,594,163	119,586	75,270	382,632	65.00
66.00	06600	PHYSICAL THERAPY	8,983,855	371,198	111,968	1,286,765	66.00
66.01	06601	IP REHAB THERAPIES	4,032,686	0	0	0	66.01
69.00	06900	ELECTROCARDIOLOGY	5,707,816	203,104	522,500	761,854	69.00
69.01	03630	CARDIAC CATH LAB	2,484,146	90,247	705,841	361,574	69.01
69.02	03160	CARDIAC REHABILITATION	0	0	0	0	69.02
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	25,635,520	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	18,051,503	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	8,507,178	0	0	0	73.00
73.01	07301	FLU VACCINE DRUGS CHG TO PATIENTS	185,880	0	0	5,646	73.01
74.00	07400	RENAL DIALYSIS	1,875,185	0	79,432	0	74.00
76.97	07697	CARDIAC REHABILITATION	620,789	333,163	20,003	92,933	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							
90.01	09001	OUTPATIENT TREATMENT CENTERS	4,045,925	816,688	202,212	428,633	90.01
90.02	09002	PARTIAL HOSPITALIZATION PROGRAM	1,525,719	183,519	0	233,127	90.02
91.00	09100	EMERGENCY	11,035,023	611,429	152,003	1,487,401	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	2,866,951	0	28,954	439,433	92.01
OTHER REIMBURSABLE COST CENTERS							
99.10	09910	CORF	0	0	0	0	99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY	0	0	0	0	99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY	0	0	0	0	99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY	0	0	0	0	99.40
101.00	10100	HOME HEALTH AGENCY	7,220,471	195,694	24,570	850,868	101.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	469,725,925	25,504,958	22,954,855	33,332,556	468,451,097

COST ALLOCATION - GENERAL SERVICE COSTS

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Cost Center Description			CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
			Net Expenses for Cost Allocation (from Wkst A col. 7)	BLDG & FIXT	MVBLE EQUIP		
			0	1.00	2.00	4.00	4A
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	295,036	214,182	0	23,111	532,329 190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0 192.00
192.01	19201	DAY SURGERY CENTER	0	0	0	0	0 192.01
192.02	19202	RESIDENTIAL TREATMENT CENTER	840,843	0	10,613	141,624	993,080 192.02
192.03	19203	MOBILE DENTAL CLINIC	186,206	0	51,774	30,711	268,691 192.03
192.04	19204	EMS CONTINUING EDUCATION	0	0	0	0	0 192.04
194.00	07950	CORPORATE HEALTH	239,445	102,875	9,074	30,718	382,112 194.00
194.01	07951	MARKETING/COMMUNICATION	53,052	76,221	0	1,712	130,985 194.01
194.02	07952	FOUNDATION	0	33,989	0	0	33,989 194.02
194.03	07953	OTHER NRCC	2,292,700	308,512	21,606	144,098	2,766,916 194.03
194.04	07954	OP PHARMACY	4,071,199	0	0	74,008	4,145,207 194.04
200.00		Cross Foot Adjustments					0 200.00
201.00		Negative Cost Centers		0	0	0	0 201.00
202.00		TOTAL (sum lines 118 through 201)	477,704,406	26,240,737	23,047,922	33,778,538	477,704,406 202.00

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Cost Center Description			ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
			5.00	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
5.00	00500	ADMINISTRATIVE & GENERAL	112,503,430					5.00
6.00	00600	MAINTENANCE & REPAIRS	0	0				6.00
7.00	00700	OPERATION OF PLANT	9,591,400		40,726,346			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0	0		8.00
9.00	00900	HOUSEKEEPING	2,504,896	0	0	0	10,636,116	9.00
10.00	01000	DIETARY	1,569,302	0	790,568	0	206,465	10.00
11.00	01100	CAFETERIA	454,669	0	519,893	0	135,776	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	3,284,149	0	645,404	0	168,554	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	2,942,692	0	1,178,304	0	307,727	14.00
15.00	01500	PHARMACY	1,957,238	0	469,859	0	122,709	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,372,736	0	399,888	0	104,435	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
20.00	02000	NURSING SCHOOL	0	0	0	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0	22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	12,812,795	0	8,651,055	0	2,259,314	30.00
31.00	03100	INTENSIVE CARE UNIT	3,714,574	0	2,439,301	0	637,049	31.00
35.00	02060	NEONATAL INTENSIVE CARE UNIT	801,203	0	189,121	0	49,391	35.00
40.00	04000	SUBPROVIDER - IPF	2,707,929	0	1,614,270	0	421,584	40.00
41.00	04100	SUBPROVIDER - IRF	1,132,873	0	1,138,619	0	297,362	41.00
43.00	04300	NURSERY	799,245	0	383,464	0	100,146	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	7,295,853	0	5,948,294	0	1,553,460	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,498,721	0	889,496	0	232,301	52.00
53.00	05300	ANESTHESIOLOGY	48,161	0	49,559	0	12,943	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	7,585,432	0	3,247,907	0	848,225	54.00
54.01	05401	OFFSITE-DIAGNOSTIC SERVICES	792,777	0	0	0	0	54.01
56.01	03480	ONCOLOGY	3,585,200	0	1,610,567	0	420,617	56.01
60.00	06000	LABORATORY	6,371,673	0	1,280,744	0	334,480	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	924,744	0	88,294	0	23,059	62.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	977,056	0	300,296	0	78,426	65.00
66.00	06600	PHYSICAL THERAPY	3,312,801	0	932,124	0	243,434	66.00
66.01	06601	IP REHAB THERAPIES	1,242,305	0	0	0	0	66.01
69.00	06900	ELECTROCARDIOLOGY	2,216,569	0	510,019	0	133,197	69.00
69.01	03630	CARDIAC CATH LAB	1,121,892	0	226,622	0	59,185	69.01
69.02	03160	CARDIAC REHABILITATION	0	0	0	0	0	69.02
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	7,897,253	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	5,560,928	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,620,713	0	0	0	0	73.00
73.01	07301	FLU VACCINE DRUGS CHG TO PATIENTS	59,001	0	0	0	0	73.01
74.00	07400	RENAL DIALYSIS	602,137	0	0	0	0	74.00
76.97	07697	CARDIAC REHABILITATION	328,664	0	836,614	0	218,491	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								
90.01	09001	OUTPATIENT TREATMENT CENTERS	1,692,309	0	2,050,805	0	535,589	90.01
90.02	09002	PARTIAL HOSPITALIZATION PROGRAM	598,363	0	460,840	0	120,353	90.02
91.00	09100	EMERGENCY	4,092,828	0	1,535,374	0	400,979	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	1,027,481	0	0	0	0	92.01
OTHER REIMBURSABLE COST CENTERS								
99.10	09910	CORF	0	0	0	0	0	99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY	0	0	0	0	0	99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY	0	0	0	0	0	99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY	0	0	0	0	0	99.40
101.00	10100	HOME HEALTH AGENCY	2,554,303	0	491,411	0	128,337	101.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	109,652,865	0	38,878,712	0	10,153,588	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	163,989	0	537,837	0	140,462	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
192.01	19201	DAY SURGERY CENTER	0	0	0	0	0	192.01
192.02	19202	RESIDENTIAL TREATMENT CENTER	305,927	0	0	0	0	192.02
192.03	19203	MOBILE DENTAL CLINIC	82,773	0	0	0	0	192.03

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Cost Center Description			ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
			5.00	6.00	7.00	8.00	9.00	
192.04	19204	EMS CONTINUING EDUCATION	0	0	0	0	0	192.04
194.00	07950	CORPORATE HEALTH	117,713	0	258,333	0	67,466	194.00
194.01	07951	MARKETING/COMMUNICATION	40,351	0	191,400	0	49,986	194.01
194.02	07952	FOUNDATION	10,471	0	85,351	0	22,290	194.02
194.03	07953	OTHER NRCC	852,373	0	774,713	0	202,324	194.03
194.04	07954	OP PHARMACY	1,276,968	0	0	0	0	194.04
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)	112,503,430	0	40,726,346	0	10,636,116	202.00

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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
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
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	7,660,495					10.00
11.00	01100	CAFETERIA	0	2,586,253				11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0			12.00
13.00	01300	NURSING ADMINISTRATION	0	110,991	0	14,869,876		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	76,580	0	0	14,057,669	14.00
15.00	01500	PHARMACY	0	69,485	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	31,699	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
20.00	02000	NURSING SCHOOL	0	0	0	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0	22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	5,413,284	607,298	0	5,727,861	0	30.00
31.00	03100	INTENSIVE CARE UNIT	273,223	102,012	0	962,154	0	31.00
35.00	02060	NEONATAL INTENSIVE CARE UNIT	0	33,816	0	318,944	0	35.00
40.00	04000	SUBPROVIDER - IPF	1,093,121	103,821	0	979,215	0	40.00
41.00	04100	SUBPROVIDER - IRF	645,711	55,583	0	524,247	0	41.00
43.00	04300	NURSERY	0	29,824	0	281,289	0	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	211,958	0	1,999,140	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	58,438	0	551,175	0	52.00
53.00	05300	ANESTHESIOLOGY	0	208	0	1,965	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	236,299	0	0	0	54.00
54.01	05401	OFFSITE-DIAGNOSTIC SERVICES	0	26,520	0	0	0	54.01
56.01	03480	ONCOLOGY	0	27,159	0	256,153	0	56.01
60.00	06000	LABORATORY	0	184,441	0	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	8,851	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	43,565	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	135,607	0	0	0	66.00
66.01	06601	IP REHAB THERAPIES	0	0	0	0	0	66.01
69.00	06900	ELECTROCARDIOLOGY	0	70,046	0	660,656	0	69.00
69.01	03630	CARDIAC CATH LAB	0	30,006	0	283,012	0	69.01
69.02	03160	CARDIAC REHABILITATION	0	0	0	0	0	69.02
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	8,570,003	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	5,466,652	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
73.01	07301	FLU VACCINE DRUGS CHG TO PATIENTS	0	633	0	0	0	73.01
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.97	07697	CARDIAC REHABILITATION	0	10,483	0	98,878	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								
90.01	09001	OUTPATIENT TREATMENT CENTERS	0	50,168	0	0	0	90.01
90.02	09002	PARTIAL HOSPITALIZATION PROGRAM	0	26,101	0	246,175	0	90.02
91.00	09100	EMERGENCY	0	160,670	0	1,515,405	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0		0			92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	0	49,154	0	463,607	0	92.01
OTHER REIMBURSABLE COST CENTERS								
99.10	09910	CORF	0	0	0	0	0	99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY	0	0	0	0	0	99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY	0	0	0	0	0	99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY	0	0	0	0	0	99.40
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	7,425,339	2,551,416	0	14,869,876	14,036,655	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	4,627	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
192.01	19201	DAY SURGERY CENTER	0	0	0	0	0	192.01
192.02	19202	RESIDENTIAL TREATMENT CENTER	235,156	14,120	0	0	627	192.02

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Cost Center Description			DIETARY	CAFETERIA	MAINTENANCE OF PERSONNEL	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	
			10.00	11.00	12.00	13.00	14.00	
192.03	19203	MOBILE DENTAL CLINIC	0	0	0	0	4,973	192.03
192.04	19204	EMS CONTINUING EDUCATION	0	0	0	0	188	192.04
194.00	07950	CORPORATE HEALTH	0	2,772	0	0	188	194.00
194.01	07951	MARKETING/COMMUNICATION	0	158	0	0	0	194.01
194.02	07952	FOUNDATION	0	0	0	0	0	194.02
194.03	07953	OTHER NRCC	0	5,140	0	0	14,238	194.03
194.04	07954	OP PHARMACY	0	8,020	0	0	800	194.04
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)	7,660,495	2,586,253	0	14,869,876	14,057,669	202.00

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Cost Center Description			PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	NONPHYSICIAN ANESTHETISTS	NURSING SCHOOL	
			15.00	16.00	17.00	19.00	20.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
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	8,972,744					15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	6,364,841				16.00
17.00	01700	SOCIAL SERVICE	0	0	0			17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0		19.00
20.00	02000	NURSING SCHOOL	0	0	0		0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0			21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0			22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	0			23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	9,320	473,321	0	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	951	151,435	0	0	0	31.00
35.00	02060	NEONATAL INTENSIVE CARE UNIT	4,648	30,105	0	0	0	35.00
40.00	04000	SUBPROVIDER - IPF	163	126,384	0	0	0	40.00
41.00	04100	SUBPROVIDER - IRF	280	60,735	0	0	0	41.00
43.00	04300	NURSERY	0	36,000	0	0	0	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	81,432	487,816	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	688	53,111	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	49,916	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,806	1,395,622	0	0	0	54.00
54.01	05401	OFFSITE-DIAGNOSTIC SERVICES	708	178,384	0	0	0	54.01
56.01	03480	ONCOLOGY	3,628,030	109,214	0	0	0	56.01
60.00	06000	LABORATORY	285	760,719	0	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	61,228	0	0	0	62.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	346	107,488	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	3,502	165,631	0	0	0	66.00
66.01	06601	IP REHAB THERAPIES	0	48,611	0	0	0	66.01
69.00	06900	ELECTROCARDIOLOGY	61,350	182,430	0	0	0	69.00
69.01	03630	CARDIAC CATH LAB	15	202,344	0	0	0	69.01
69.02	03160	CARDIAC REHABILITATION	0	0	0	0	0	69.02
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	527,208	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	287,898	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	3,525,539	221,735	0	0	0	73.00
73.01	07301	FLU VACCINE DRUGS CHG TO PATIENTS	64,056	2,447	0	0	0	73.01
74.00	07400	RENAL DIALYSIS	0	28,135	0	0	0	74.00
76.97	07697	CARDIAC REHABILITATION	0	8,540	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								
90.01	09001	OUTPATIENT TREATMENT CENTERS	99,459	88,762	0	0	0	90.01
90.02	09002	PARTIAL HOSPITALIZATION PROGRAM	98	9,980	0	0	0	90.02
91.00	09100	EMERGENCY	1,954	470,252	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	358	39,390	0	0	0	92.01
OTHER REIMBURSABLE COST CENTERS								
99.10	09910	CORF	0	0	0	0	0	99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY	0	0	0	0	0	99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY	0	0	0	0	0	99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY	0	0	0	0	0	99.40
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	7,486,988	6,364,841	0	0	0	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
192.01	19201	DAY SURGERY CENTER	0	0	0	0	0	192.01
192.02	19202	RESIDENTIAL TREATMENT CENTER	43	0	0	0	0	192.02

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Cost Center Description			PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	NONPHYSICIAN ANESTHETISTS	NURSING SCHOOL	
			15.00	16.00	17.00	19.00	20.00	
192.03	19203	MOBILE DENTAL CLINIC	169	0	0	0	0	192.03
192.04	19204	EMS CONTINUING EDUCATION	0	0	0	0	0	192.04
194.00	07950	CORPORATE HEALTH	0	0	0	0	0	194.00
194.01	07951	MARKETING/COMMUNICATION	0	0	0	0	0	194.01
194.02	07952	FOUNDATION	0	0	0	0	0	194.02
194.03	07953	OTHER NRCC	7,855	0	0	0	0	194.03
194.04	07954	OP PHARMACY	1,477,689	0	0	0	0	194.04
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)	8,972,744	6,364,841	0	0	0	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

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Cost Center Description			INTERNS & RESIDENTS		PARAMED ED PRGM	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	
			SERVICES-SALARY & FRINGES APPRV	SERVICES-OTHER PRGM COSTS APPRV				
			21.00	22.00	23.00	24.00	25.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
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
20.00	02000	NURSING SCHOOL						20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0					21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV		0				22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)			0			23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	0	0	0	77,546,325	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	20,338,696	0	31.00
35.00	02060	NEONATAL INTENSIVE CARE UNIT	0	0	0	4,028,039	0	35.00
40.00	04000	SUBPROVIDER - IPF	0	0	0	15,836,779	0	40.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	7,532,866	0	41.00
43.00	04300	NURSERY	0	0	0	4,224,422	0	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	0	41,261,251	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	8,148,974	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	319,089	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	37,940,599	0	54.00
54.01	05401	OFFSITE-DIAGNOSTIC SERVICES	0	0	0	3,571,848	0	54.01
56.01	03480	ONCOLOGY	0	0	0	21,274,969	0	56.01
60.00	06000	LABORATORY	0	0	0	29,615,630	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0	4,108,015	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	4,678,828	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	15,546,885	0	66.00
66.01	06601	IP REHAB THERAPIES	0	0	0	5,323,602	0	66.01
69.00	06900	ELECTROCARDIOLOGY	0	0	0	11,029,541	0	69.00
69.01	03630	CARDIAC CATH LAB	0	0	0	5,564,884	0	69.01
69.02	03160	CARDIAC REHABILITATION	0	0	0	0	0	69.02
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	42,629,984	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	29,366,981	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	14,875,165	0	73.00
73.01	07301	FLU VACCINE DRUGS CHG TO PATIENTS	0	0	0	317,663	0	73.01
74.00	07400	RENAL DIALYSIS	0	0	0	2,584,889	0	74.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	2,568,558	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								
90.01	09001	OUTPATIENT TREATMENT CENTERS	0	0	0	10,010,550	0	90.01
90.02	09002	PARTIAL HOSPITALIZATION PROGRAM	0	0	0	3,404,275	0	90.02
91.00	09100	EMERGENCY	0	0	0	21,463,318	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	0	0	0	4,915,328	0	92.01
OTHER REIMBURSABLE COST CENTERS								
99.10	09910	CORF	0	0	0	0	0	99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY	0	0	0	0	0	99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY	0	0	0	0	0	99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY	0	0	0	0	0	99.40
101.00	10100	HOME HEALTH AGENCY	0	0	0	11,465,654	0	101.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	0	0	461,493,607	0	118.00

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Cost Center Description			INTERNS & RESIDENTS		PARAMED ED PRGM	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	
			SERVICES-SALAR Y & FRINGES APPRV	SERVICES-OTHER PRGM COSTS APPRV				
			21.00	22.00	23.00	24.00	25.00	
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	1,379,244	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
192.01	19201	DAY SURGERY CENTER	0	0	0	0	0	192.01
192.02	19202	RESIDENTIAL TREATMENT CENTER	0	0	0	1,548,953	0	192.02
192.03	19203	MOBILE DENTAL CLINIC	0	0	0	356,606	0	192.03
192.04	19204	EMS CONTINUING EDUCATION	0	0	0	188	0	192.04
194.00	07950	CORPORATE HEALTH	0	0	0	828,584	0	194.00
194.01	07951	MARKETING/COMMUNICATION	0	0	0	412,880	0	194.01
194.02	07952	FOUNDATION	0	0	0	152,101	0	194.02
194.03	07953	OTHER NRCC	0	0	0	4,623,559	0	194.03
194.04	07954	OP PHARMACY	0	0	0	6,908,684	0	194.04
200.00		Cross Foot Adjustments	0	0	0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	0	0	0	477,704,406	0	202.00

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Cost Center Description			Total	
			26.00	
GENERAL SERVICE COST CENTERS				
1.00	00100	CAP REL COSTS-BLDG & FIXT		1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT		4.00
5.00	00500	ADMINISTRATIVE & GENERAL		5.00
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
20.00	02000	NURSING SCHOOL		20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV		21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV		22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)		23.00
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	77,546,325	30.00
31.00	03100	INTENSIVE CARE UNIT	20,338,696	31.00
35.00	02060	NEONATAL INTENSIVE CARE UNIT	4,028,039	35.00
40.00	04000	SUBPROVIDER - IPF	15,836,779	40.00
41.00	04100	SUBPROVIDER - IRF	7,532,866	41.00
43.00	04300	NURSERY	4,224,422	43.00
ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	41,261,251	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	8,148,974	52.00
53.00	05300	ANESTHESIOLOGY	319,089	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	37,940,599	54.00
54.01	05401	OFFSITE-DIAGNOSTIC SERVICES	3,571,848	54.01
56.01	03480	ONCOLOGY	21,274,969	56.01
60.00	06000	LABORATORY	29,615,630	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	4,108,015	62.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	62.30
65.00	06500	RESPIRATORY THERAPY	4,678,828	65.00
66.00	06600	PHYSICAL THERAPY	15,546,885	66.00
66.01	06601	IP REHAB THERAPIES	5,323,602	66.01
69.00	06900	ELECTROCARDIOLOGY	11,029,541	69.00
69.01	03630	CARDIAC CATH LAB	5,564,884	69.01
69.02	03160	CARDIAC REHABILITATION	0	69.02
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	42,629,984	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	29,366,981	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	14,875,165	73.00
73.01	07301	FLU VACCINE DRUGS CHG TO PATIENTS	317,663	73.01
74.00	07400	RENAL DIALYSIS	2,584,889	74.00
76.97	07697	CARDIAC REHABILITATION	2,568,558	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	76.98
76.99	07699	LITHOTRIPSY	0	76.99
OUTPATIENT SERVICE COST CENTERS				
90.01	09001	OUTPATIENT TREATMENT CENTERS	10,010,550	90.01
90.02	09002	PARTIAL HOSPITALIZATION PROGRAM	3,404,275	90.02
91.00	09100	EMERGENCY	21,463,318	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART		92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	4,915,328	92.01
OTHER REIMBURSABLE COST CENTERS				
99.10	09910	CORF	0	99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY	0	99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY	0	99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY	0	99.40
101.00	10100	HOME HEALTH AGENCY	11,465,654	101.00
SPECIAL PURPOSE COST CENTERS				
113.00	11300	INTEREST EXPENSE		113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	461,493,607	118.00
NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	1,379,244	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	192.00
192.01	19201	DAY SURGERY CENTER	0	192.01
192.02	19202	RESIDENTIAL TREATMENT CENTER	1,548,953	192.02
192.03	19203	MOBILE DENTAL CLINIC	356,606	192.03
192.04	19204	EMS CONTINUING EDUCATION	188	192.04

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0252

Period:
From 10/01/2019
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Cost Center Description			Total	
			26.00	
194.00	07950	CORPORATE HEALTH	828,584	194.00
194.01	07951	MARKETING/COMMUNICATION	412,880	194.01
194.02	07952	FOUNDATION	152,101	194.02
194.03	07953	OTHER NRCC	4,623,559	194.03
194.04	07954	OP PHARMACY	6,908,684	194.04
200.00		Cross Foot Adjustments	0	200.00
201.00		Negative Cost Centers	0	201.00
202.00		TOTAL (sum lines 118 through 201)	477,704,406	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0252

Period:
From 10/01/2019
To 09/30/2020Worksheet B
Part II
Date/Time Prepared:
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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	
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	386,585	4,324	390,909	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	9,811,944	6,072,926	13,954,012	76,678	5.00
6.00	00600	MAINTENANCE & REPAIRS	0	0	0	0	6.00
7.00	00700	OPERATION OF PLANT	225,274	3,562,862	219,864	4,008,000	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0	0	8.00
9.00	00900	HOUSEKEEPING	924	0	7,799	8,723	9.00
10.00	01000	DIETARY	2,249	314,826	70,177	387,252	10.00
11.00	01100	CAFETERIA	0	207,036	0	207,036	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	5,679	257,018	134,316	397,013	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	757,011	469,233	374,904	1,601,148	14.00
15.00	01500	PHARMACY	115,520	187,111	146,967	449,598	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	56,838	159,247	4,936	221,021	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	19.00
20.00	02000	NURSING SCHOOL	0	0	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	38,235	3,445,090	691,057	4,174,382	30.00
31.00	03100	INTENSIVE CARE UNIT	19,137	971,397	183,888	1,174,422	31.00
35.00	02060	NEONATAL INTENSIVE CARE UNIT	685	75,313	92,382	168,380	35.00
40.00	04000	SUBPROVIDER - IPF	100,919	642,847	91,482	835,248	40.00
41.00	04100	SUBPROVIDER - IRF	268	453,430	44,381	498,079	41.00
43.00	04300	NURSERY	0	152,706	0	152,706	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	268,405	2,368,776	2,309,170	4,946,351	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	4,546	354,222	103,556	462,324	52.00
53.00	05300	ANESTHESIOLOGY	9,009	19,736	94,855	123,600	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,103,051	1,293,407	1,821,389	4,217,847	54.00
54.01	05401	OFFSITE-DIAGNOSTIC SERVICES	112,160	0	323,247	435,407	54.01
56.01	03480	ONCOLOGY	4,961	641,373	68,935	715,269	56.01
60.00	06000	LABORATORY	91,898	510,028	259,494	861,420	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	2,615	35,161	30,967	68,743	62.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	30,360	119,586	75,270	225,216	65.00
66.00	06600	PHYSICAL THERAPY	386,029	371,198	111,968	869,195	66.00
66.01	06601	IP REHAB THERAPIES	0	0	0	0	66.01
69.00	06900	ELECTROCARDIOLOGY	256,142	203,104	522,500	981,746	69.00
69.01	03630	CARDIAC CATH LAB	73,710	90,247	705,841	869,798	69.01
69.02	03160	CARDIAC REHABILITATION	0	0	0	0	69.02
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
73.01	07301	FLU VACCINE DRUGS CHG TO PATIENTS	0	0	0	0	73.01
74.00	07400	RENAL DIALYSIS	0	0	79,432	79,432	74.00
76.97	07697	CARDIAC REHABILITATION	12,382	333,163	20,003	365,548	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							
90.01	09001	OUTPATIENT TREATMENT CENTERS	108,053	816,688	202,212	1,126,953	90.01
90.02	09002	PARTIAL HOSPITALIZATION PROGRAM	6,046	183,519	0	189,565	90.02
91.00	09100	EMERGENCY	358,535	611,429	152,003	1,121,967	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				0	92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	0	0	28,954	28,954	92.01
OTHER REIMBURSABLE COST CENTERS							
99.10	09910	CORF	0	0	0	0	99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY	0	0	0	0	99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY	0	0	0	0	99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY	0	0	0	0	99.40
101.00	10100	HOME HEALTH AGENCY	20,354	195,694	24,570	240,618	101.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	13,982,939	25,504,958	22,954,855	62,442,752	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	214,182	0	214,182	190.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0252

Period:
From 10/01/2019
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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	
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
192.01	19201	DAY SURGERY CENTER	0	0	0	0	0	192.01
192.02	19202	RESIDENTIAL TREATMENT CENTER	10,492	0	10,613	21,105	1,639	192.02
192.03	19203	MOBILE DENTAL CLINIC	13,880	0	51,774	65,654	355	192.03
192.04	19204	EMS CONTINUING EDUCATION	0	0	0	0	0	192.04
194.00	07950	CORPORATE HEALTH	3,945	102,875	9,074	115,894	356	194.00
194.01	07951	MARKETING/COMMUNICATION	0	76,221	0	76,221	20	194.01
194.02	07952	FOUNDATION	0	33,989	0	33,989	0	194.02
194.03	07953	OTHER NRCC	470	308,512	21,606	330,588	1,668	194.03
194.04	07954	OP PHARMACY	3,204	0	0	3,204	857	194.04
200.00		Cross Foot Adjustments				0		200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	14,014,930	26,240,737	23,047,922	63,303,589	390,909	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0252

Period:
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Cost Center Description			ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
			5.00	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
5.00	00500	ADMINISTRATIVE & GENERAL	29,915,560					5.00
6.00	00600	MAINTENANCE & REPAIRS	0	0				6.00
7.00	00700	OPERATION OF PLANT	2,550,419	0	6,572,284			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0	0		8.00
9.00	00900	HOUSEKEEPING	666,069	0	0	0	681,753	9.00
10.00	01000	DIETARY	417,288	0	127,579	0	13,234	10.00
11.00	01100	CAFETERIA	120,900	0	83,899	0	8,703	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	873,278	0	104,153	0	10,804	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	782,482	0	190,151	0	19,725	14.00
15.00	01500	PHARMACY	520,443	0	75,824	0	7,865	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	365,020	0	64,533	0	6,694	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
20.00	02000	NURSING SCHOOL	0	0	0	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0	22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	3,407,135	0	1,396,077	0	144,816	30.00
31.00	03100	INTENSIVE CARE UNIT	987,731	0	393,646	0	40,834	31.00
35.00	02060	NEONATAL INTENSIVE CARE UNIT	213,045	0	30,520	0	3,166	35.00
40.00	04000	SUBPROVIDER - IPF	720,057	0	260,506	0	27,023	40.00
41.00	04100	SUBPROVIDER - IRF	301,239	0	183,747	0	19,060	41.00
43.00	04300	NURSERY	212,525	0	61,882	0	6,419	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	1,940,017	0	959,916	0	99,574	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	398,520	0	143,544	0	14,890	52.00
53.00	05300	ANESTHESIOLOGY	12,806	0	7,998	0	830	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,017,018	0	524,137	0	54,369	54.00
54.01	05401	OFFSITE-DIAGNOSTIC SERVICES	210,805	0	0	0	0	54.01
56.01	03480	ONCOLOGY	953,329	0	259,908	0	26,961	56.01
60.00	06000	LABORATORY	1,694,272	0	206,682	0	21,439	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	245,896	0	14,249	0	1,478	62.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	259,806	0	48,461	0	5,027	65.00
66.00	06600	PHYSICAL THERAPY	880,896	0	150,423	0	15,604	66.00
66.01	06601	IP REHAB THERAPIES	330,337	0	0	0	0	66.01
69.00	06900	ELECTROCARDIOLOGY	589,401	0	82,305	0	8,538	69.00
69.01	03630	CARDIAC CATH LAB	298,319	0	36,572	0	3,794	69.01
69.02	03160	CARDIAC REHABILITATION	0	0	0	0	0	69.02
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	2,099,934	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1,478,689	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	696,865	0	0	0	0	73.00
73.01	07301	FLU VACCINE DRUGS CHG TO PATIENTS	15,689	0	0	0	0	73.01
74.00	07400	RENAL DIALYSIS	160,112	0	0	0	0	74.00
76.97	07697	CARDIAC REHABILITATION	87,394	0	135,010	0	14,005	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								
90.01	09001	OUTPATIENT TREATMENT CENTERS	449,997	0	330,952	0	34,330	90.01
90.02	09002	PARTIAL HOSPITALIZATION PROGRAM	159,109	0	74,369	0	7,714	90.02
91.00	09100	EMERGENCY	1,088,311	0	247,774	0	25,702	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	273,214	0	0	0	0	92.01
OTHER REIMBURSABLE COST CENTERS								
99.10	09910	CORF	0	0	0	0	0	99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY	0	0	0	0	0	99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY	0	0	0	0	0	99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY	0	0	0	0	0	99.40
101.00	10100	HOME HEALTH AGENCY	679,207	0	79,302	0	8,226	101.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	29,157,574	0	6,274,119	0	650,824	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	43,606	0	86,794	0	9,003	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
192.01	19201	DAY SURGERY CENTER	0	0	0	0	0	192.01
192.02	19202	RESIDENTIAL TREATMENT CENTER	81,348	0	0	0	0	192.02
192.03	19203	MOBILE DENTAL CLINIC	22,010	0	0	0	0	192.03

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0252

Period:
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Cost Center Description			ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
			5.00	6.00	7.00	8.00	9.00	
192.04	19204	EMS CONTINUING EDUCATION	0	0	0	0	0	192.04
194.00	07950	CORPORATE HEALTH	31,301	0	41,689	0	4,324	194.00
194.01	07951	MARKETING/COMMUNICATION	10,730	0	30,887	0	3,204	194.01
194.02	07952	FOUNDATION	2,784	0	13,774	0	1,429	194.02
194.03	07953	OTHER NRCC	226,652	0	125,021	0	12,969	194.03
194.04	07954	OP PHARMACY	339,555	0	0	0	0	194.04
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)	29,915,560	0	6,572,284	0	681,753	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0252

Period:
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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
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
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	949,409					10.00
11.00	01100	CAFETERIA	0	422,680				11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0			12.00
13.00	01300	NURSING ADMINISTRATION	0	18,140	0	1,418,770		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	12,516	0	0	2,611,902	14.00
15.00	01500	PHARMACY	0	11,356	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	5,181	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
20.00	02000	NURSING SCHOOL	0	0	0	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0	22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	670,899	99,251	0	546,510	0	30.00
31.00	03100	INTENSIVE CARE UNIT	33,862	16,672	0	91,801	0	31.00
35.00	02060	NEONATAL INTENSIVE CARE UNIT	0	5,527	0	30,431	0	35.00
40.00	04000	SUBPROVIDER - IPF	135,477	16,968	0	93,429	0	40.00
41.00	04100	SUBPROVIDER - IRF	80,027	9,084	0	50,020	0	41.00
43.00	04300	NURSERY	0	4,874	0	26,838	0	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	34,641	0	190,743	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	9,551	0	52,589	0	52.00
53.00	05300	ANESTHESIOLOGY	0	34	0	187	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	38,619	0	0	0	54.00
54.01	05401	OFFSITE-DIAGNOSTIC SERVICES	0	4,334	0	0	0	54.01
56.01	03480	ONCOLOGY	0	4,439	0	24,440	0	56.01
60.00	06000	LABORATORY	0	30,144	0	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	1,447	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	7,120	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	22,163	0	0	0	66.00
66.01	06601	IP REHAB THERAPIES	0	0	0	0	0	66.01
69.00	06900	ELECTROCARDIOLOGY	0	11,448	0	63,035	0	69.00
69.01	03630	CARDIAC CATH LAB	0	4,904	0	27,003	0	69.01
69.02	03160	CARDIAC REHABILITATION	0	0	0	0	0	69.02
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	1,592,306	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	1,015,691	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
73.01	07301	FLU VACCINE DRUGS CHG TO PATIENTS	0	103	0	0	0	73.01
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.97	07697	CARDIAC REHABILITATION	0	1,713	0	9,434	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								
90.01	09001	OUTPATIENT TREATMENT CENTERS	0	8,199	0	0	0	90.01
90.02	09002	PARTIAL HOSPITALIZATION PROGRAM	0	4,266	0	23,488	0	90.02
91.00	09100	EMERGENCY	0	26,259	0	144,588	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	0	92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	0	8,033	0	44,234	0	92.01
OTHER REIMBURSABLE COST CENTERS								
99.10	09910	CORF	0	0	0	0	0	99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY	0	0	0	0	0	99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY	0	0	0	0	0	99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY	0	0	0	0	0	99.40
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE	0	0	0	0	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	920,265	416,986	0	1,418,770	2,607,997	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	756	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
192.01	19201	DAY SURGERY CENTER	0	0	0	0	0	192.01
192.02	19202	RESIDENTIAL TREATMENT CENTER	29,144	2,308	0	0	117	192.02

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0252

Period:
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Cost Center Description			DIETARY	CAFETERIA	MAINTENANCE OF PERSONNEL	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	
			10.00	11.00	12.00	13.00	14.00	
192.03	19203	MOBILE DENTAL CLINIC	0	0	0	0	924	192.03
192.04	19204	EMS CONTINUING EDUCATION	0	0	0	0	35	192.04
194.00	07950	CORPORATE HEALTH	0	453	0	0	35	194.00
194.01	07951	MARKETING/COMMUNICATION	0	26	0	0	0	194.01
194.02	07952	FOUNDATION	0	0	0	0	0	194.02
194.03	07953	OTHER NRCC	0	840	0	0	2,645	194.03
194.04	07954	OP PHARMACY	0	1,311	0	0	149	194.04
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)	949,409	422,680	0	1,418,770	2,611,902	202.00

ALLOCATION OF CAPITAL RELATED COSTS

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Cost Center Description			PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	NONPHYSICIAN ANESTHETISTS	NURSING SCHOOL	
			15.00	16.00	17.00	19.00	20.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
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	1,074,296					15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	665,635				16.00
17.00	01700	SOCIAL SERVICE	0	0	0			17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0		19.00
20.00	02000	NURSING SCHOOL	0	0	0		0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0			21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0			22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	0			23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	1,116	49,494	0			30.00
31.00	03100	INTENSIVE CARE UNIT	114	15,835	0			31.00
35.00	02060	NEONATAL INTENSIVE CARE UNIT	557	3,148	0			35.00
40.00	04000	SUBPROVIDER - IPF	20	13,216	0			40.00
41.00	04100	SUBPROVIDER - IRF	33	6,351	0			41.00
43.00	04300	NURSERY	0	3,764	0			43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	9,750	51,009	0			50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	82	5,554	0			52.00
53.00	05300	ANESTHESIOLOGY	0	5,220	0			53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	456	146,018	0			54.00
54.01	05401	OFFSITE-DIAGNOSTIC SERVICES	85	18,653	0			54.01
56.01	03480	ONCOLOGY	434,386	11,420	0			56.01
60.00	06000	LABORATORY	34	79,546	0			60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	6,402	0			62.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0			62.30
65.00	06500	RESPIRATORY THERAPY	41	11,240	0			65.00
66.00	06600	PHYSICAL THERAPY	419	17,320	0			66.00
66.01	06601	IP REHAB THERAPIES	0	5,083	0			66.01
69.00	06900	ELECTROCARDIOLOGY	7,345	19,076	0			69.00
69.01	03630	CARDIAC CATH LAB	2	21,158	0			69.01
69.02	03160	CARDIAC REHABILITATION	0	0	0			69.02
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	55,128	0			71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	30,105	0			72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	422,105	23,186	0			73.00
73.01	07301	FLU VACCINE DRUGS CHG TO PATIENTS	7,669	256	0			73.01
74.00	07400	RENAL DIALYSIS	0	2,942	0			74.00
76.97	07697	CARDIAC REHABILITATION	0	893	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								
90.01	09001	OUTPATIENT TREATMENT CENTERS	11,908	9,282	0			90.01
90.02	09002	PARTIAL HOSPITALIZATION PROGRAM	12	1,044	0			90.02
91.00	09100	EMERGENCY	234	49,173	0			91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	43	4,119	0			92.01
OTHER REIMBURSABLE COST CENTERS								
99.10	09910	CORF	0	0	0			99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY	0	0	0			99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY	0	0	0			99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY	0	0	0			99.40
101.00	10100	HOME HEALTH AGENCY	0	0	0			101.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	896,411	665,635	0	0	0	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0			190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0			192.00
192.01	19201	DAY SURGERY CENTER	0	0	0			192.01
192.02	19202	RESIDENTIAL TREATMENT CENTER	5	0	0			192.02

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0252

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Cost Center Description			PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	NONPHYSICIAN ANESTHETISTS	NURSING SCHOOL	
			15.00	16.00	17.00	19.00	20.00	
192.03	19203	MOBILE DENTAL CLINIC	20	0	0			192.03
192.04	19204	EMS CONTINUING EDUCATION	0	0	0			192.04
194.00	07950	CORPORATE HEALTH	0	0	0			194.00
194.01	07951	MARKETING/COMMUNICATION	0	0	0			194.01
194.02	07952	FOUNDATION	0	0	0			194.02
194.03	07953	OTHER NRCC	940	0	0			194.03
194.04	07954	OP PHARMACY	176,920	0	0			194.04
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)	1,074,296	665,635	0	0	0	202.00

ALLOCATION OF CAPITAL RELATED COSTS

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Cost Center Description			INTERNS & RESIDENTS		PARAMED ED PRGM	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	
			SERVICES-SALARY & FRINGES APPRV	SERVICES-OTHER PRGM COSTS APPRV				
			21.00	22.00	23.00	24.00	25.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
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
20.00	02000	NURSING SCHOOL						20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0					21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV		0				22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)			0			23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS				10,546,949	0	30.00
31.00	03100	INTENSIVE CARE UNIT				2,770,237	0	31.00
35.00	02060	NEONATAL INTENSIVE CARE UNIT				457,869	0	35.00
40.00	04000	SUBPROVIDER - IPF				2,113,232	0	40.00
41.00	04100	SUBPROVIDER - IRF				1,152,518	0	41.00
43.00	04300	NURSERY				472,465	0	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM				8,255,603	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM				1,093,815	0	52.00
53.00	05300	ANESTHESIOLOGY				150,695	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC				7,025,632	0	54.00
54.01	05401	OFFSITE-DIAGNOSTIC SERVICES				672,384	0	54.01
56.01	03480	ONCOLOGY				2,433,623	0	56.01
60.00	06000	LABORATORY				2,908,378	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL				339,063	0	62.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS				0	0	62.30
65.00	06500	RESPIRATORY THERAPY				561,339	0	65.00
66.00	06600	PHYSICAL THERAPY				1,970,912	0	66.00
66.01	06601	IP REHAB THERAPIES				335,420	0	66.01
69.00	06900	ELECTROCARDIOLOGY				1,771,711	0	69.00
69.01	03630	CARDIAC CATH LAB				1,265,735	0	69.01
69.02	03160	CARDIAC REHABILITATION				0	0	69.02
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT				3,747,368	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS				2,524,485	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS				1,142,156	0	73.00
73.01	07301	FLU VACCINE DRUGS CHG TO PATIENTS				23,782	0	73.01
74.00	07400	RENAL DIALYSIS				242,486	0	74.00
76.97	07697	CARDIAC REHABILITATION				615,073	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								
90.01	09001	OUTPATIENT TREATMENT CENTERS				1,976,582	0	90.01
90.02	09002	PARTIAL HOSPITALIZATION PROGRAM				462,265	0	90.02
91.00	09100	EMERGENCY				2,721,222	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					0	92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)				363,683	0	92.01
OTHER REIMBURSABLE COST CENTERS								
99.10	09910	CORF				0	0	99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY				0	0	99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY				0	0	99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY				0	0	99.40
101.00	10100	HOME HEALTH AGENCY				1,017,200	0	101.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	0	0	61,133,882	0	118.00

ALLOCATION OF CAPITAL RELATED COSTS

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Cost Center Description			INTERNS & RESIDENTS		PARAMED ED PRGM	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	
			SERVICES-SALAR Y & FRINGES APPRV	SERVICES-OTHER PRGM COSTS APPRV				
			21.00	22.00	23.00	24.00	25.00	
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN				354,608	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES				0	0	192.00
192.01	19201	DAY SURGERY CENTER				0	0	192.01
192.02	19202	RESIDENTIAL TREATMENT CENTER				135,666	0	192.02
192.03	19203	MOBILE DENTAL CLINIC				88,963	0	192.03
192.04	19204	EMS CONTINUING EDUCATION				35	0	192.04
194.00	07950	CORPORATE HEALTH				194,052	0	194.00
194.01	07951	MARKETING/COMMUNICATION				121,088	0	194.01
194.02	07952	FOUNDATION				51,976	0	194.02
194.03	07953	OTHER NRCC				701,323	0	194.03
194.04	07954	OP PHARMACY				521,996	0	194.04
200.00		Cross Foot Adjustments	0	0	0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	0	0	0	63,303,589	0	202.00

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Cost Center Description			Total	
			26.00	
GENERAL SERVICE COST CENTERS				
1.00	00100	CAP REL COSTS-BLDG & FIXT		1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT		4.00
5.00	00500	ADMINISTRATIVE & GENERAL		5.00
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
20.00	02000	NURSING SCHOOL		20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV		21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV		22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)		23.00
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	10,546,949	30.00
31.00	03100	INTENSIVE CARE UNIT	2,770,237	31.00
35.00	02060	NEONATAL INTENSIVE CARE UNIT	457,869	35.00
40.00	04000	SUBPROVIDER - IPF	2,113,232	40.00
41.00	04100	SUBPROVIDER - IRF	1,152,518	41.00
43.00	04300	NURSERY	472,465	43.00
ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	8,255,603	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,093,815	52.00
53.00	05300	ANESTHESIOLOGY	150,695	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	7,025,632	54.00
54.01	05401	OFFSITE-DIAGNOSTIC SERVICES	672,384	54.01
56.01	03480	ONCOLOGY	2,433,623	56.01
60.00	06000	LABORATORY	2,908,378	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	339,063	62.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	62.30
65.00	06500	RESPIRATORY THERAPY	561,339	65.00
66.00	06600	PHYSICAL THERAPY	1,970,912	66.00
66.01	06601	IP REHAB THERAPIES	335,420	66.01
69.00	06900	ELECTROCARDIOLOGY	1,771,711	69.00
69.01	03630	CARDIAC CATH LAB	1,265,735	69.01
69.02	03160	CARDIAC REHABILITATION	0	69.02
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	3,747,368	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	2,524,485	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,142,156	73.00
73.01	07301	FLU VACCINE DRUGS CHG TO PATIENTS	23,782	73.01
74.00	07400	RENAL DIALYSIS	242,486	74.00
76.97	07697	CARDIAC REHABILITATION	615,073	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	76.98
76.99	07699	LITHOTRIPSY	0	76.99
OUTPATIENT SERVICE COST CENTERS				
90.01	09001	OUTPATIENT TREATMENT CENTERS	1,976,582	90.01
90.02	09002	PARTIAL HOSPITALIZATION PROGRAM	462,265	90.02
91.00	09100	EMERGENCY	2,721,222	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART		92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	363,683	92.01
OTHER REIMBURSABLE COST CENTERS				
99.10	09910	CORF	0	99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY	0	99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY	0	99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY	0	99.40
101.00	10100	HOME HEALTH AGENCY	1,017,200	101.00
SPECIAL PURPOSE COST CENTERS				
113.00	11300	INTEREST EXPENSE		113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	61,133,882	118.00
NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	354,608	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	192.00
192.01	19201	DAY SURGERY CENTER	0	192.01
192.02	19202	RESIDENTIAL TREATMENT CENTER	135,666	192.02
192.03	19203	MOBILE DENTAL CLINIC	88,963	192.03
192.04	19204	EMS CONTINUING EDUCATION	35	192.04

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0252

 Period:
 From 10/01/2019
 To 09/30/2020

 Worksheet B
 Part II
 Date/Time Prepared:
 4/29/2021 1:24 pm

Cost Center Description			Total	
			26.00	
194.00	07950	CORPORATE HEALTH	194,052	194.00
194.01	07951	MARKETING/COMMUNICATION	121,088	194.01
194.02	07952	FOUNDATION	51,976	194.02
194.03	07953	OTHER NRCC	701,323	194.03
194.04	07954	OP PHARMACY	521,996	194.04
200.00		Cross Foot Adjustments	0	200.00
201.00		Negative Cost Centers	0	201.00
202.00		TOTAL (sum lines 118 through 201)	63,303,589	202.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0252

Period:
From 10/01/2019
To 09/30/2020

Worksheet B-1

Date/Time Prepared:
4/29/2021 1:24 pm

Cost Center Description			CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM COST)	
			BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (DOLLAR VALUE)				
			1.00	2.00	4.00	5A	5.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT	694,055					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		20,160,426				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	10,225	3,782	203,824,001			4.00
5.00	00500	ADMINISTRATIVE & GENERAL	160,626	12,205,821	39,990,455	-112,503,430	365,200,976	5.00
6.00	00600	MAINTENANCE & REPAIRS	0	0	0	0	0	6.00
7.00	00700	OPERATION OF PLANT	94,236	192,319	7,228,874	0	31,134,946	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0	0	0	8.00
9.00	00900	HOUSEKEEPING	0	6,822	3,629,428	0	8,131,220	9.00
10.00	01000	DIETARY	8,327	61,385	2,114,890	0	5,094,160	10.00
11.00	01100	CAFETERIA	5,476	0	1,116,930	0	1,475,915	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	6,798	117,489	8,019,575	0	10,660,778	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	12,411	327,935	3,065,574	0	9,552,366	14.00
15.00	01500	PHARMACY	4,949	128,555	4,801,770	0	6,353,453	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	4,212	4,318	1,661,089	0	4,456,083	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
20.00	02000	NURSING SCHOOL	0	0	0	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0	22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	91,121	604,480	29,858,822	0	41,592,077	30.00
31.00	03100	INTENSIVE CARE UNIT	25,693	160,850	7,987,272	0	12,057,997	31.00
35.00	02060	NEONATAL INTENSIVE CARE UNIT	1,992	80,808	1,613,829	0	2,600,811	35.00
40.00	04000	SUBPROVIDER - IPF	17,003	80,021	5,885,154	0	8,790,292	40.00
41.00	04100	SUBPROVIDER - IRF	11,993	38,821	2,543,437	0	3,677,456	41.00
43.00	04300	NURSERY	4,039	0	1,802,560	0	2,594,454	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	62,653	2,019,872	12,305,577	0	23,683,298	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	9,369	90,582	3,525,174	0	4,865,044	52.00
53.00	05300	ANESTHESIOLOGY	522	82,971	10,541	0	156,337	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	34,210	1,593,201	14,164,699	0	24,623,308	54.00
54.01	05401	OFFSITE-DIAGNOSTIC SERVICES	0	282,750	1,616,310	0	2,573,459	54.01
56.01	03480	ONCOLOGY	16,964	60,299	1,809,867	0	11,638,029	56.01
60.00	06000	LABORATORY	13,490	226,984	7,737,751	0	20,683,288	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	930	27,087	442,042	0	3,001,839	62.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	3,163	65,840	2,308,852	0	3,171,651	65.00
66.00	06600	PHYSICAL THERAPY	9,818	97,940	7,764,505	0	10,753,786	66.00
66.01	06601	IP REHAB THERAPIES	0	0	0	0	4,032,686	66.01
69.00	06900	ELECTROCARDIOLOGY	5,372	457,040	4,597,125	0	7,195,274	69.00
69.01	03630	CARDIAC CATH LAB	2,387	617,412	2,181,784	0	3,641,808	69.01
69.02	03160	CARDIAC REHABILITATION	0	0	0	0	0	69.02
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	25,635,520	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	18,051,503	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	8,507,178	73.00
73.01	07301	FLU VACCINE DRUGS CHG TO PATIENTS	0	0	34,070	0	191,526	73.01
74.00	07400	RENAL DIALYSIS	0	69,481	0	0	1,954,617	74.00
76.97	07697	CARDIAC REHABILITATION	8,812	17,497	560,772	0	1,066,888	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								
90.01	09001	OUTPATIENT TREATMENT CENTERS	21,601	176,878	2,586,424	0	5,493,458	90.01
90.02	09002	PARTIAL HOSPITALIZATION PROGRAM	4,854	0	1,406,720	0	1,942,365	90.02
91.00	09100	EMERGENCY	16,172	132,960	8,975,168	0	13,285,856	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	0	25,327	2,651,594	0	3,335,338	92.01
OTHER REIMBURSABLE COST CENTERS								
99.10	09910	CORF	0	0	0	0	0	99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY	0	0	0	0	0	99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY	0	0	0	0	0	99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY	0	0	0	0	0	99.40
101.00	10100	HOME HEALTH AGENCY	5,176	21,492	5,134,249	0	8,291,603	101.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	674,594	20,079,019	201,132,883	-112,503,430	355,947,667	118.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0252

Period:
From 10/01/2019
To 09/30/2020

Worksheet B-1

Date/Time Prepared:
4/29/2021 1:24 pm

Cost Center Description			CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM COST)	
			BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (DOLLAR VALUE)				
			1.00	2.00	4.00	5A	5.00	
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	5,665	0	139,456	0	532,329	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
192.01	19201	DAY SURGERY CENTER	0	0	0	0	0	192.01
192.02	19202	RESIDENTIAL TREATMENT CENTER	0	9,283	854,579	0	993,080	192.02
192.03	19203	MOBILE DENTAL CLINIC	0	45,288	185,312	0	268,691	192.03
192.04	19204	EMS CONTINUING EDUCATION	0	0	0	0	0	192.04
194.00	07950	CORPORATE HEALTH	2,721	7,937	185,358	0	382,112	194.00
194.01	07951	MARKETING/COMMUNICATION	2,016	0	10,332	0	130,985	194.01
194.02	07952	FOUNDATION	899	0	0	0	33,989	194.02
194.03	07953	OTHER NRCC	8,160	18,899	869,508	0	2,766,916	194.03
194.04	07954	OP PHARMACY	0	0	446,573	0	4,145,207	194.04
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)	26,240,737	23,047,922	33,778,538		112,503,430	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	37.807864	1.143226	0.165724		0.308059	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)			390,909		29,915,560	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)			0.001918		0.081915	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: 14-0252

Period:
From 10/01/2019
To 09/30/2020

Worksheet B-1

Date/Time Prepared:
4/29/2021 1:24 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
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS	0					6.00
7.00	00700	OPERATION OF PLANT	0	428,968				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0			8.00
9.00	00900	HOUSEKEEPING	0	0	0	428,968		9.00
10.00	01000	DIETARY	0	8,327	0	8,327	303,057	10.00
11.00	01100	CAFETERIA	0	5,476	0	5,476	0	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	0	6,798	0	6,798	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	12,411	0	12,411	0	14.00
15.00	01500	PHARMACY	0	4,949	0	4,949	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	4,212	0	4,212	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
20.00	02000	NURSING SCHOOL	0	0	0	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0	22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	0	91,121	0	91,121	214,155	30.00
31.00	03100	INTENSIVE CARE UNIT	0	25,693	0	25,693	10,809	31.00
35.00	02060	NEONATAL INTENSIVE CARE UNIT	0	1,992	0	1,992	0	35.00
40.00	04000	SUBPROVIDER - IPF	0	17,003	0	17,003	43,245	40.00
41.00	04100	SUBPROVIDER - IRF	0	11,993	0	11,993	25,545	41.00
43.00	04300	NURSERY	0	4,039	0	4,039	0	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	62,653	0	62,653	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	9,369	0	9,369	0	52.00
53.00	05300	ANESTHESIOLOGY	0	522	0	522	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	34,210	0	34,210	0	54.00
54.01	05401	OFFSITE-DIAGNOSTIC SERVICES	0	0	0	0	0	54.01
56.01	03480	ONCOLOGY	0	16,964	0	16,964	0	56.01
60.00	06000	LABORATORY	0	13,490	0	13,490	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	930	0	930	0	62.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0	3,163	0	3,163	0	65.00
66.00	06600	PHYSICAL THERAPY	0	9,818	0	9,818	0	66.00
66.01	06601	IP REHAB THERAPIES	0	0	0	0	0	66.01
69.00	06900	ELECTROCARDIOLOGY	0	5,372	0	5,372	0	69.00
69.01	03630	CARDIAC CATH LAB	0	2,387	0	2,387	0	69.01
69.02	03160	CARDIAC REHABILITATION	0	0	0	0	0	69.02
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
73.01	07301	FLU VACCINE DRUGS CHG TO PATIENTS	0	0	0	0	0	73.01
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.97	07697	CARDIAC REHABILITATION	0	8,812	0	8,812	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								
90.01	09001	OUTPATIENT TREATMENT CENTERS	0	21,601	0	21,601	0	90.01
90.02	09002	PARTIAL HOSPITALIZATION PROGRAM	0	4,854	0	4,854	0	90.02
91.00	09100	EMERGENCY	0	16,172	0	16,172	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	0	92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	0	0	0	0	0	92.01
OTHER REIMBURSABLE COST CENTERS								
99.10	09910	CORF	0	0	0	0	0	99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY	0	0	0	0	0	99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY	0	0	0	0	0	99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY	0	0	0	0	0	99.40
101.00	10100	HOME HEALTH AGENCY	0	5,176	0	5,176	0	101.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE	0	0	0	0	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	409,507	0	409,507	293,754	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	5,665	0	5,665	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
192.01	19201	DAY SURGERY CENTER	0	0	0	0	0	192.01

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0252

Period:
From 10/01/2019
To 09/30/2020

Worksheet B-1

Date/Time Prepared:
4/29/2021 1:24 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	
192.02	19202	RESIDENTIAL TREATMENT CENTER	0	0	0	0	9,303	192.02
192.03	19203	MOBILE DENTAL CLINIC	0	0	0	0	0	192.03
192.04	19204	EMS CONTINUING EDUCATION	0	0	0	0	0	192.04
194.00	07950	CORPORATE HEALTH	0	2,721	0	2,721	0	194.00
194.01	07951	MARKETING/COMMUNICATION	0	2,016	0	2,016	0	194.01
194.02	07952	FOUNDATION	0	899	0	899	0	194.02
194.03	07953	OTHER NRCC	0	8,160	0	8,160	0	194.03
194.04	07954	OP PHARMACY	0	0	0	0	0	194.04
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)	0	40,726,346	0	10,636,116	7,660,495	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.000000	94.940289	0.000000	24.794661	25.277407	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	0	6,572,284	0	681,753	949,409	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.000000	15.321152	0.000000	1.589286	3.132774	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: 14-0252

Period:
From 10/01/2019
To 09/30/2020

Worksheet B-1

Date/Time Prepared:
4/29/2021 1:24 pm

Cost Center Description			CAFETERIA (FTE'S SERVED)	MAINTENANCE OF PERSONNEL (NUMBER HOUSED)	NURSING ADMINISTRATION (FTE'S NRSNG HRS)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUISITION)	
			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
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
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	3,936,060					11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0				12.00
13.00	01300	NURSING ADMINISTRATION	168,919	0	2,399,416			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	116,548	0	0	46,420,220		14.00
15.00	01500	PHARMACY	105,750	0	0	0	21,265,006	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	48,243	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
20.00	02000	NURSING SCHOOL	0	0	0	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0	22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	924,253	0	924,253	0	22,089	30.00
31.00	03100	INTENSIVE CARE UNIT	155,254	0	155,254	0	2,253	31.00
35.00	02060	NEONATAL INTENSIVE CARE UNIT	51,465	0	51,465	0	11,016	35.00
40.00	04000	SUBPROVIDER - IPF	158,007	0	158,007	0	386	40.00
41.00	04100	SUBPROVIDER - IRF	84,593	0	84,593	0	663	41.00
43.00	04300	NURSERY	45,389	0	45,389	0	0	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	322,583	0	322,583	0	192,991	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	88,938	0	88,938	0	1,630	52.00
53.00	05300	ANESTHESIOLOGY	317	0	317	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	359,627	0	0	0	9,019	54.00
54.01	05401	OFFSITE-DIAGNOSTIC SERVICES	40,362	0	0	0	1,678	54.01
56.01	03480	ONCOLOGY	41,333	0	41,333	0	8,598,275	56.01
60.00	06000	LABORATORY	280,704	0	0	0	676	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	13,470	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	66,303	0	0	0	819	65.00
66.00	06600	PHYSICAL THERAPY	206,383	0	0	0	8,299	66.00
66.01	06601	IP REHAB THERAPIES	0	0	0	0	0	66.01
69.00	06900	ELECTROCARDIOLOGY	106,604	0	106,604	0	145,397	69.00
69.01	03630	CARDIAC CATH LAB	45,667	0	45,667	0	36	69.01
69.02	03160	CARDIAC REHABILITATION	0	0	0	0	0	69.02
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	28,299,238	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	18,051,586	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	8,355,368	73.00
73.01	07301	FLU VACCINE DRUGS CHG TO PATIENTS	963	0	0	0	151,810	73.01
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.97	07697	CARDIAC REHABILITATION	15,955	0	15,955	0	1	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								
90.01	09001	OUTPATIENT TREATMENT CENTERS	76,352	0	0	0	235,714	90.01
90.02	09002	PARTIAL HOSPITALIZATION PROGRAM	39,723	0	39,723	0	232	90.02
91.00	09100	EMERGENCY	244,527	0	244,527	0	4,630	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	74,808	0	74,808	0	849	92.01
OTHER REIMBURSABLE COST CENTERS								
99.10	09910	CORF	0	0	0	0	0	99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY	0	0	0	0	0	99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY	0	0	0	0	0	99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY	0	0	0	0	0	99.40
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	3,883,040	0	2,399,416	46,350,824	17,743,831	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	7,042	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0252

Period:
From 10/01/2019
To 09/30/2020

Worksheet B-1

Date/Time Prepared:
4/29/2021 1:24 pm

Cost Center Description			CAFETERIA (FTE'S SERVED)	MAINTENANCE OF PERSONNEL (NUMBER HOUSED)	NURSING ADMINISTRATION (FTE'S NRSING HRS)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUISTION)	
			11.00	12.00	13.00	14.00	15.00	
192.01	19201	DAY SURGERY CENTER	0	0	0	0	0	192.01
192.02	19202	RESIDENTIAL TREATMENT CENTER	21,489	0	0	2,072	102	192.02
192.03	19203	MOBILE DENTAL CLINIC	0	0	0	16,422	400	192.03
192.04	19204	EMS CONTINUING EDUCATION	0	0	0	622	0	192.04
194.00	07950	CORPORATE HEALTH	4,219	0	0	622	0	194.00
194.01	07951	MARKETING/COMMUNICATION	241	0	0	0	0	194.01
194.02	07952	FOUNDATION	0	0	0	0	0	194.02
194.03	07953	OTHER NRCC	7,823	0	0	47,015	18,616	194.03
194.04	07954	OP PHARMACY	12,206	0	0	2,643	3,502,057	194.04
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)	2,586,253	0	14,869,876	14,057,669	8,972,744	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.657066	0.000000	6.197290	0.302835	0.421949	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	422,680	0	1,418,770	2,611,902	1,074,296	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.107387	0.000000	0.591298	0.056266	0.050519	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: 14-0252

Period:
From 10/01/2019
To 09/30/2020

Worksheet B-1

Date/Time Prepared:
4/29/2021 1:24 pm

Cost Center Description			MEDICAL RECORDS & LIBRARY (GROSS REVENUE)	SOCIAL SERVICE (TIME SPENT)	NONPHYSICIAN ANESTHETISTS (ASSIGNED TIME)	NURSING SCHOOL (ASSIGNED TIME)	INTERNS & RESIDENTS SERVICES-SALAR Y & FRINGES APPRV (ASSIGNED TIME)	
			16.00	17.00	19.00	20.00	21.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
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	1,651,376,601					16.00
17.00	01700	SOCIAL SERVICE	0	0				17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0			19.00
20.00	02000	NURSING SCHOOL	0	0		0		20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0			0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0				22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0				23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	122,812,930	0	0	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	39,292,831	0	0	0	0	31.00
35.00	02060	NEONATAL INTENSIVE CARE UNIT	7,811,250	0	0	0	0	35.00
40.00	04000	SUBPROVIDER - IPF	32,792,984	0	0	0	0	40.00
41.00	04100	SUBPROVIDER - IRF	15,758,892	0	0	0	0	41.00
43.00	04300	NURSERY	9,340,867	0	0	0	0	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	126,573,829	0	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	13,780,626	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	12,951,830	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	362,010,769	0	0	0	0	54.00
54.01	05401	OFFSITE-DIAGNOSTIC SERVICES	46,285,295	0	0	0	0	54.01
56.01	03480	ONCOLOGY	28,337,755	0	0	0	0	56.01
60.00	06000	LABORATORY	197,384,306	0	0	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	15,886,763	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	27,889,968	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	42,976,435	0	0	0	0	66.00
66.01	06601	IP REHAB THERAPIES	12,613,064	0	0	0	0	66.01
69.00	06900	ELECTROCARDIOLOGY	47,335,227	0	0	0	0	69.00
69.01	03630	CARDIAC CATH LAB	52,502,430	0	0	0	0	69.01
69.02	03160	CARDIAC REHABILITATION	0	0	0	0	0	69.02
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	136,795,042	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	74,701,057	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	57,533,757	0	0	0	0	73.00
73.01	07301	FLU VACCINE DRUGS CHG TO PATIENTS	634,849	0	0	0	0	73.01
74.00	07400	RENAL DIALYSIS	7,300,123	0	0	0	0	74.00
76.97	07697	CARDIAC REHABILITATION	2,215,923	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								
90.01	09001	OUTPATIENT TREATMENT CENTERS	23,031,256	0	0	0	0	90.01
90.02	09002	PARTIAL HOSPITALIZATION PROGRAM	2,589,470	0	0	0	0	90.02
91.00	09100	EMERGENCY	122,016,486	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	10,220,587	0	0	0	0	92.01
OTHER REIMBURSABLE COST CENTERS								
99.10	09910	CORF	0	0	0	0	0	99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY	0	0	0	0	0	99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY	0	0	0	0	0	99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY	0	0	0	0	0	99.40
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	1,651,376,601	0	0	0	0	118.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0252

Period:
From 10/01/2019
To 09/30/2020

Worksheet B-1

Date/Time Prepared:
4/29/2021 1:24 pm

Cost Center Description		MEDICAL RECORDS & LIBRARY (GROSS REVENUE)	SOCIAL SERVICE (TIME SPENT)	NONPHYSICIAN ANESTHETISTS (ASSIGNED TIME)	NURSING SCHOOL (ASSIGNED TIME)	INTERNS & RESIDENTS SERVICES-SALAR Y & FRINGES APPRV (ASSIGNED TIME)	
		16.00	17.00	19.00	20.00	21.00	
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	192.00
192.01	19201	DAY SURGERY CENTER	0	0	0	0	192.01
192.02	19202	RESIDENTIAL TREATMENT CENTER	0	0	0	0	192.02
192.03	19203	MOBILE DENTAL CLINIC	0	0	0	0	192.03
192.04	19204	EMS CONTINUING EDUCATION	0	0	0	0	192.04
194.00	07950	CORPORATE HEALTH	0	0	0	0	194.00
194.01	07951	MARKETING/COMMUNICATION	0	0	0	0	194.01
194.02	07952	FOUNDATION	0	0	0	0	194.02
194.03	07953	OTHER NRCC	0	0	0	0	194.03
194.04	07954	OP PHARMACY	0	0	0	0	194.04
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)	6,364,841	0	0	0	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.003854	0.000000	0.000000	0.000000	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	665,635	0	0	0	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.000403	0.000000	0.000000	0.000000	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

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0252

Period:
From 10/01/2019
To 09/30/2020

Worksheet B-1

Date/Time Prepared:
4/29/2021 1:24 pm

Cost Center Description			INTERNS & RESIDENTS	PARAMED ED PRGM (ASSIGNED TIME)	
			SERVICES-OTHER PRGM COSTS APPRV (ASSIGNED TIME)		
			22.00		
GENERAL SERVICE COST CENTERS					
1.00	00100	CAP REL COSTS-BLDG & FIXT			1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT			4.00
5.00	00500	ADMINISTRATIVE & GENERAL			5.00
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
20.00	02000	NURSING SCHOOL			20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV			21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0		22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)		0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	31.00
35.00	02060	NEONATAL INTENSIVE CARE UNIT	0	0	35.00
40.00	04000	SUBPROVIDER - IPF	0	0	40.00
41.00	04100	SUBPROVIDER - IRF	0	0	41.00
43.00	04300	NURSERY	0	0	43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	54.00
54.01	05401	OFFSITE-DIAGNOSTIC SERVICES	0	0	54.01
56.01	03480	ONCOLOGY	0	0	56.01
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
66.01	06601	IP REHAB THERAPIES	0	0	66.01
69.00	06900	ELECTROCARDIOLOGY	0	0	69.00
69.01	03630	CARDIAC CATH LAB	0	0	69.01
69.02	03160	CARDIAC REHABILITATION	0	0	69.02
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	73.00
73.01	07301	FLU VACCINE DRUGS CHG TO PATIENTS	0	0	73.01
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					
90.01	09001	OUTPATIENT TREATMENT CENTERS	0	0	90.01
90.02	09002	PARTIAL HOSPITALIZATION PROGRAM	0	0	90.02
91.00	09100	EMERGENCY	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART			92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	0	0	92.01
OTHER REIMBURSABLE COST CENTERS					
99.10	09910	CORF	0	0	99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY	0	0	99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY	0	0	99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY	0	0	99.40
101.00	10100	HOME HEALTH AGENCY	0	0	101.00
SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE			113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	0	118.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0252

Period:
From 10/01/2019
To 09/30/2020Worksheet B-1
Date/Time Prepared:
4/29/2021 1:24 pm

Cost Center Description			INTERNS & RESIDENTS	PARAMED ED PRGM (ASSIGNED TIME)	
			SERVICES-OTHER PRGM COSTS		
			APPRV (ASSIGNED TIME)		
			22.00		
NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	192.00
192.01	19201	DAY SURGERY CENTER	0	0	192.01
192.02	19202	RESIDENTIAL TREATMENT CENTER	0	0	192.02
192.03	19203	MOBILE DENTAL CLINIC	0	0	192.03
192.04	19204	EMS CONTINUING EDUCATION	0	0	192.04
194.00	07950	CORPORATE HEALTH	0	0	194.00
194.01	07951	MARKETING/COMMUNICATION	0	0	194.01
194.02	07952	FOUNDATION	0	0	194.02
194.03	07953	OTHER NRCC	0	0	194.03
194.04	07954	OP PHARMACY	0	0	194.04
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)	0	0	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.000000	0.000000	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	0	0	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.000000	0.000000	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: 14-0252		Period: From 10/01/2019 To 09/30/2020		Worksheet C Part I Date/Time Prepared: 4/29/2021 1:24 pm	
			Title XVIII		Hospital		PPS	
Cost Center Description			Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs			
					Total Costs	RCE Disallowance	Total Costs	
			1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	77,546,325		77,546,325	0	77,546,325	30.00
31.00	03100	INTENSIVE CARE UNIT	20,338,696		20,338,696	129,399	20,468,095	31.00
35.00	02060	NEONATAL INTENSIVE CARE UNIT	4,028,039		4,028,039	0	4,028,039	35.00
40.00	04000	SUBPROVIDER - IPF	15,836,779		15,836,779	106	15,836,885	40.00
41.00	04100	SUBPROVIDER - IRF	7,532,866		7,532,866	0	7,532,866	41.00
43.00	04300	NURSERY	4,224,422		4,224,422	0	4,224,422	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	41,261,251		41,261,251	0	41,261,251	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	8,148,974		8,148,974	0	8,148,974	52.00
53.00	05300	ANESTHESIOLOGY	319,089		319,089	0	319,089	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	37,940,599		37,940,599	0	37,940,599	54.00
54.01	05401	OFFSITE-DIAGNOSTIC SERVICES	3,571,848		3,571,848	0	3,571,848	54.01
56.01	03480	ONCOLOGY	21,274,969		21,274,969	21,395	21,296,364	56.01
60.00	06000	LABORATORY	29,615,630		29,615,630	77,157	29,692,787	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	4,108,015		4,108,015	0	4,108,015	62.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0		0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	4,678,828	0	4,678,828	0	4,678,828	65.00
66.00	06600	PHYSICAL THERAPY	15,546,885	0	15,546,885	0	15,546,885	66.00
66.01	06601	IP REHAB THERAPIES	5,323,602	0	5,323,602	0	5,323,602	66.01
69.00	06900	ELECTROCARDIOLOGY	11,029,541		11,029,541	0	11,029,541	69.00
69.01	03630	CARDIAC CATH LAB	5,564,884		5,564,884	0	5,564,884	69.01
69.02	03160	CARDIAC REHABILITATION	0		0	0	0	69.02
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	42,629,984		42,629,984	0	42,629,984	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	29,366,981		29,366,981	0	29,366,981	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	14,875,165		14,875,165	0	14,875,165	73.00
73.01	07301	FLU VACCINE DRUGS CHG TO PATIENTS	317,663		317,663	0	317,663	73.01
74.00	07400	RENAL DIALYSIS	2,584,889		2,584,889	0	2,584,889	74.00
76.97	07697	CARDIAC REHABILITATION	2,568,558		2,568,558	0	2,568,558	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								
90.01	09001	OUTPATIENT TREATMENT CENTERS	10,010,550		10,010,550	0	10,010,550	90.01
90.02	09002	PARTIAL HOSPITALIZATION PROGRAM	3,404,275		3,404,275	0	3,404,275	90.02
91.00	09100	EMERGENCY	21,463,318		21,463,318	347,630	21,810,948	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1,700,313		1,700,313		1,700,313	92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	4,915,328		4,915,328	0	4,915,328	92.01
OTHER REIMBURSABLE COST CENTERS								
99.10	09910	CORF	0		0		0	99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY	0		0		0	99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY	0		0		0	99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY	0		0		0	99.40
101.00	10100	HOME HEALTH AGENCY	11,465,654		11,465,654		11,465,654	101.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	463,193,920	0	463,193,920	575,687	463,769,607	200.00
201.00		Less Observation Beds	1,700,313		1,700,313		1,700,313	201.00
202.00		Total (see instructions)	461,493,607	0	461,493,607	575,687	462,069,294	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0252

Period:
From 10/01/2019
To 09/30/2020Worksheet C
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			Title XVIII		Hospital	PPS		
Cost Center Description			Charges		Cost or Other Ratio	TEFRA Inpatient Ratio		
			Inpatient	Outpatient				Total (col. 6 + col. 7)
			6.00	7.00				8.00
	INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	122,812,930		122,812,930		30.00	
31.00	03100	INTENSIVE CARE UNIT	39,292,831		39,292,831		31.00	
35.00	02060	NEONATAL INTENSIVE CARE UNIT	7,811,250		7,811,250		35.00	
40.00	04000	SUBPROVIDER - IPF	32,792,984		32,792,984		40.00	
41.00	04100	SUBPROVIDER - IRF	15,758,892		15,758,892		41.00	
43.00	04300	NURSERY	9,340,867		9,340,867		43.00	
	ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	43,848,354	82,725,475	126,573,829	0.325986	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	13,010,188	770,438	13,780,626	0.591336	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	6,024,016	6,927,814	12,951,830	0.024637	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	97,885,049	264,125,720	362,010,769	0.104805	0.000000	54.00
54.01	05401	OFFSITE-DIAGNOSTIC SERVICES	333,360	45,951,935	46,285,295	0.077170	0.000000	54.01
56.01	03480	ONCOLOGY	71,787	28,265,968	28,337,755	0.750764	0.000000	56.01
60.00	06000	LABORATORY	84,974,216	112,410,090	197,384,306	0.150040	0.000000	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	10,910,756	4,976,007	15,886,763	0.258581	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	25,923,969	1,965,999	27,889,968	0.167760	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	8,900,246	34,076,189	42,976,435	0.361754	0.000000	66.00
66.01	06601	IP REHAB THERAPIES	12,613,064	0	12,613,064	0.422070	0.000000	66.01
69.00	06900	ELECTROCARDIOLOGY	12,621,193	34,714,034	47,335,227	0.233009	0.000000	69.00
69.01	03630	CARDIAC CATH LAB	26,309,698	26,192,732	52,502,430	0.105993	0.000000	69.01
69.02	03160	CARDIAC REHABILITATION	0	0	0	0.000000	0.000000	69.02
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	70,576,097	66,218,945	136,795,042	0.311634	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	42,944,563	31,756,494	74,701,057	0.393127	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	47,527,213	10,006,544	57,533,757	0.258547	0.000000	73.00
73.01	07301	FLU VACCINE DRUGS CHG TO PATIENTS	268,877	365,972	634,849	0.500376	0.000000	73.01
74.00	07400	RENAL DIALYSIS	6,921,521	378,602	7,300,123	0.354088	0.000000	74.00
76.97	07697	CARDIAC REHABILITATION	2,293	2,213,630	2,215,923	1.159137	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							
90.01	09001	OUTPATIENT TREATMENT CENTERS	172,868	22,858,388	23,031,256	0.434651	0.000000	90.01
90.02	09002	PARTIAL HOSPITALIZATION PROGRAM	227,070	2,362,400	2,589,470	1.314661	0.000000	90.02
91.00	09100	EMERGENCY	44,218,292	77,798,194	122,016,486	0.175905	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	599,766	1,218,848	1,818,614	0.934950	0.000000	92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	3,267,607	6,952,980	10,220,587	0.480924	0.000000	92.01
	OTHER REIMBURSABLE COST CENTERS							
99.10	09910	CORF	0	0	0			99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY	0	0	0			99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY	0	0	0			99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY	0	0	0			99.40
101.00	10100	HOME HEALTH AGENCY	0	8,655,411	8,655,411			101.00
	SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	787,961,817	873,888,809	1,661,850,626			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	787,961,817	873,888,809	1,661,850,626			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0252

Period:
From 10/01/2019
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Cost Center Description		PPS Inpatient Ratio	Title XVIII	Hospital	PPS
		11.00			
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS			30.00
31.00	03100	INTENSIVE CARE UNIT			31.00
35.00	02060	NEONATAL INTENSIVE CARE UNIT			35.00
40.00	04000	SUBPROVIDER - IPF			40.00
41.00	04100	SUBPROVIDER - IRF			41.00
43.00	04300	NURSERY			43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0.325986		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.591336		52.00
53.00	05300	ANESTHESIOLOGY	0.024637		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.104805		54.00
54.01	05401	OFFSITE-DIAGNOSTIC SERVICES	0.077170		54.01
56.01	03480	ONCOLOGY	0.751519		56.01
60.00	06000	LABORATORY	0.150431		60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0.258581		62.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0.000000		62.30
65.00	06500	RESPIRATORY THERAPY	0.167760		65.00
66.00	06600	PHYSICAL THERAPY	0.361754		66.00
66.01	06601	IP REHAB THERAPIES	0.422070		66.01
69.00	06900	ELECTROCARDIOLOGY	0.233009		69.00
69.01	03630	CARDIAC CATH LAB	0.105993		69.01
69.02	03160	CARDIAC REHABILITATION	0.000000		69.02
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.311634		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.393127		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.258547		73.00
73.01	07301	FLU VACCINE DRUGS CHG TO PATIENTS	0.500376		73.01
74.00	07400	RENAL DIALYSIS	0.354088		74.00
76.97	07697	CARDIAC REHABILITATION	1.159137		76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0.000000		76.98
76.99	07699	LITHOTRIPSY	0.000000		76.99
OUTPATIENT SERVICE COST CENTERS					
90.01	09001	OUTPATIENT TREATMENT CENTERS	0.434651		90.01
90.02	09002	PARTIAL HOSPITALIZATION PROGRAM	1.314661		90.02
91.00	09100	EMERGENCY	0.178754		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.934950		92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	0.480924		92.01
OTHER REIMBURSABLE COST CENTERS					
99.10	09910	CORF			99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY			99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY			99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY			99.40
101.00	10100	HOME HEALTH AGENCY			101.00
SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE			113.00
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: 14-0252

Period:
From 10/01/2019
To 09/30/2020Worksheet C
Part I
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			Title XIX	Hospital	Cost	
Cost Center Description			Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Total Costs	Total Costs
			1.00	2.00	3.00	4.00
						5.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	77,546,325		77,546,325	0
31.00	03100	INTENSIVE CARE UNIT	20,338,696		20,338,696	0
35.00	02060	NEONATAL INTENSIVE CARE UNIT	4,028,039		4,028,039	0
40.00	04000	SUBPROVIDER - IPF	15,836,779		15,836,779	0
41.00	04100	SUBPROVIDER - IRF	7,532,866		7,532,866	0
43.00	04300	NURSERY	4,224,422		4,224,422	0
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	41,261,251		41,261,251	0
52.00	05200	DELIVERY ROOM & LABOR ROOM	8,148,974		8,148,974	0
53.00	05300	ANESTHESIOLOGY	319,089		319,089	0
54.00	05400	RADIOLOGY-DIAGNOSTIC	37,940,599		37,940,599	0
54.01	05401	OFFSITE-DIAGNOSTIC SERVICES	3,571,848		3,571,848	0
56.01	03480	ONCOLOGY	21,274,969		21,274,969	0
60.00	06000	LABORATORY	29,615,630		29,615,630	0
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	4,108,015		4,108,015	0
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0		0	0
65.00	06500	RESPIRATORY THERAPY	4,678,828	0	4,678,828	0
66.00	06600	PHYSICAL THERAPY	15,546,885	0	15,546,885	0
66.01	06601	IP REHAB THERAPIES	5,323,602	0	5,323,602	0
69.00	06900	ELECTROCARDIOLOGY	11,029,541		11,029,541	0
69.01	03630	CARDIAC CATH LAB	5,564,884		5,564,884	0
69.02	03160	CARDIAC REHABILITATION	0		0	0
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	42,629,984		42,629,984	0
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	29,366,981		29,366,981	0
73.00	07300	DRUGS CHARGED TO PATIENTS	14,875,165		14,875,165	0
73.01	07301	FLU VACCINE DRUGS CHG TO PATIENTS	317,663		317,663	0
74.00	07400	RENAL DIALYSIS	2,584,889		2,584,889	0
76.97	07697	CARDIAC REHABILITATION	2,568,558		2,568,558	0
76.98	07698	HYPERBARIC OXYGEN THERAPY	0		0	0
76.99	07699	LITHOTRIPSY	0		0	0
OUTPATIENT SERVICE COST CENTERS						
90.01	09001	OUTPATIENT TREATMENT CENTERS	10,010,550		10,010,550	0
90.02	09002	PARTIAL HOSPITALIZATION PROGRAM	3,404,275		3,404,275	0
91.00	09100	EMERGENCY	21,463,318		21,463,318	0
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1,700,313		1,700,313	0
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	4,915,328		4,915,328	0
OTHER REIMBURSABLE COST CENTERS						
99.10	09910	CORF	0		0	0
99.20	09920	OUTPATIENT PHYSICAL THERAPY	0		0	0
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY	0		0	0
99.40	09940	OUTPATIENT SPEECH PATHOLOGY	0		0	0
101.00	10100	HOME HEALTH AGENCY	11,465,654		11,465,654	0
SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE				113.00
200.00		Subtotal (see instructions)	463,193,920	0	463,193,920	0
201.00		Less Observation Beds	1,700,313		1,700,313	0
202.00		Total (see instructions)	461,493,607	0	461,493,607	0

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0252

Period:
From 10/01/2019
To 09/30/2020Worksheet C
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					Title XIX		Hospital	Cost	
Cost Center Description			Charges			Cost or Other Ratio	TEFRA Inpatient Ratio		
			Inpatient	Outpatient	Total (col. 6 + col. 7)				
			6.00	7.00	8.00				
INPATIENT ROUTINE SERVICE COST CENTERS									
30.00	03000	ADULTS & PEDIATRICS	0		0			30.00	
31.00	03100	INTENSIVE CARE UNIT	0		0			31.00	
35.00	02060	NEONATAL INTENSIVE CARE UNIT	0		0			35.00	
40.00	04000	SUBPROVIDER - IPF	0		0			40.00	
41.00	04100	SUBPROVIDER - IRF	0		0			41.00	
43.00	04300	NURSERY	0		0			43.00	
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM	0	0	0	0.000000	0.000000	50.00	
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0.000000	0.000000	52.00	
53.00	05300	ANESTHESIOLOGY	0	0	0	0.000000	0.000000	53.00	
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0.000000	0.000000	54.00	
54.01	05401	OFFSITE-DIAGNOSTIC SERVICES	0	0	0	0.000000	0.000000	54.01	
56.01	03480	ONCOLOGY	0	0	0	0.000000	0.000000	56.01	
60.00	06000	LABORATORY	0	0	0	0.000000	0.000000	60.00	
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0	0.000000	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	0	0	0	0.000000	0.000000	65.00	
66.00	06600	PHYSICAL THERAPY	0	0	0	0.000000	0.000000	66.00	
66.01	06601	IP REHAB THERAPIES	0	0	0	0.000000	0.000000	66.01	
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0.000000	0.000000	69.00	
69.01	03630	CARDIAC CATH LAB	0	0	0	0.000000	0.000000	69.01	
69.02	03160	CARDIAC REHABILITATION	0	0	0	0.000000	0.000000	69.02	
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0.000000	0.000000	71.00	
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0.000000	0.000000	72.00	
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0.000000	0.000000	73.00	
73.01	07301	FLU VACCINE DRUGS CHG TO PATIENTS	0	0	0	0.000000	0.000000	73.01	
74.00	07400	RENAL DIALYSIS	0	0	0	0.000000	0.000000	74.00	
76.97	07697	CARDIAC REHABILITATION	0	0	0	0.000000	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									
90.01	09001	OUTPATIENT TREATMENT CENTERS	0	0	0	0.000000	0.000000	90.01	
90.02	09002	PARTIAL HOSPITALIZATION PROGRAM	0	0	0	0.000000	0.000000	90.02	
91.00	09100	EMERGENCY	0	0	0	0.000000	0.000000	91.00	
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0.000000	0.000000	92.00	
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	0	0	0	0.000000	0.000000	92.01	
OTHER REIMBURSABLE COST CENTERS									
99.10	09910	CORF	0	0	0			99.10	
99.20	09920	OUTPATIENT PHYSICAL THERAPY	0	0	0			99.20	
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY	0	0	0			99.30	
99.40	09940	OUTPATIENT SPEECH PATHOLOGY	0	0	0			99.40	
101.00	10100	HOME HEALTH AGENCY	0	0	0			101.00	
SPECIAL PURPOSE COST CENTERS									
113.00	11300	INTEREST EXPENSE						113.00	
200.00		Subtotal (see instructions)	0	0	0			200.00	
201.00		Less Observation Beds						201.00	
202.00		Total (see instructions)	0	0	0			202.00	

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0252

Period:
From 10/01/2019
To 09/30/2020Worksheet C
Part I
Date/Time Prepared:
4/29/2021 1:24 pm

Cost Center Description			PPS Inpatient Ratio	Title XIX	Hospital	Cost
			11.00			
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS				30.00
31.00	03100	INTENSIVE CARE UNIT				31.00
35.00	02060	NEONATAL INTENSIVE CARE UNIT				35.00
40.00	04000	SUBPROVIDER - IPF				40.00
41.00	04100	SUBPROVIDER - IRF				41.00
43.00	04300	NURSERY				43.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.000000			50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000			52.00
53.00	05300	ANESTHESIOLOGY	0.000000			53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000			54.00
54.01	05401	OFFSITE-DIAGNOSTIC SERVICES	0.000000			54.01
56.01	03480	ONCOLOGY	0.000000			56.01
60.00	06000	LABORATORY	0.000000			60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0.000000			62.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0.000000			62.30
65.00	06500	RESPIRATORY THERAPY	0.000000			65.00
66.00	06600	PHYSICAL THERAPY	0.000000			66.00
66.01	06601	IP REHAB THERAPIES	0.000000			66.01
69.00	06900	ELECTROCARDIOLOGY	0.000000			69.00
69.01	03630	CARDIAC CATH LAB	0.000000			69.01
69.02	03160	CARDIAC REHABILITATION	0.000000			69.02
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000			71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000			72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000			73.00
73.01	07301	FLU VACCINE DRUGS CHG TO PATIENTS	0.000000			73.01
74.00	07400	RENAL DIALYSIS	0.000000			74.00
76.97	07697	CARDIAC REHABILITATION	0.000000			76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0.000000			76.98
76.99	07699	LITHOTRIPSY	0.000000			76.99
OUTPATIENT SERVICE COST CENTERS						
90.01	09001	OUTPATIENT TREATMENT CENTERS	0.000000			90.01
90.02	09002	PARTIAL HOSPITALIZATION PROGRAM	0.000000			90.02
91.00	09100	EMERGENCY	0.000000			91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000			92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	0.000000			92.01
OTHER REIMBURSABLE COST CENTERS						
99.10	09910	CORF				99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY				99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY				99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY				99.40
101.00	10100	HOME HEALTH AGENCY				101.00
SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE				113.00
200.00		Subtotal (see instructions)				200.00
201.00		Less Observation Beds				201.00
202.00		Total (see instructions)				202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

Provider CCN: 14-0252

Period:
From 10/01/2019
To 09/30/2020Worksheet D
Part I
Date/Time Prepared:
4/29/2021 1:24 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	10,546,949	0	10,546,949	68,912	153.05	30.00
31.00	INTENSIVE CARE UNIT	2,770,237		2,770,237	7,461	371.30	31.00
35.00	NEONATAL INTENSIVE CARE UNIT	457,869		457,869	3,651	125.41	35.00
40.00	SUBPROVIDER - IPF	2,113,232	0	2,113,232	13,755	153.63	40.00
41.00	SUBPROVIDER - IRF	1,152,518	0	1,152,518	9,047	127.39	41.00
43.00	NURSERY	472,465		472,465	4,264	110.80	43.00
200.00	Total (lines 30 through 199)	17,513,270		17,513,270	107,090		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	31,045	4,751,437				30.00
31.00	INTENSIVE CARE UNIT	3,928	1,458,466				31.00
35.00	NEONATAL INTENSIVE CARE UNIT	0	0				35.00
40.00	SUBPROVIDER - IPF	2,361	362,720				40.00
41.00	SUBPROVIDER - IRF	5,614	715,167				41.00
43.00	NURSERY	0	0				43.00
200.00	Total (lines 30 through 199)	42,948	7,287,790				200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS				Provider CCN: 14-0252	Period: From 10/01/2019 To 09/30/2020	Worksheet D Part II Date/Time Prepared: 4/29/2021 1:24 pm		
				Title XVIII		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	8,255,603	126,573,829	0.065224	20,240,644	1,320,176	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,093,815	13,780,626	0.079373	9,818	779	52.00
53.00	05300	ANESTHESIOLOGY	150,695	12,951,830	0.011635	2,767,402	32,199	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	7,025,632	362,010,769	0.019407	44,582,015	865,203	54.00
54.01	05401	OFFSITE-DIAGNOSTIC SERVICES	672,384	46,285,295	0.014527	157,115	2,282	54.01
56.01	03480	ONCOLOGY	2,433,623	28,337,755	0.085879	54,253	4,659	56.01
60.00	06000	LABORATORY	2,908,378	197,384,306	0.014735	36,490,547	537,688	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	339,063	15,886,763	0.021342	4,612,340	98,437	62.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0.000000	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	561,339	27,889,968	0.020127	12,177,159	245,090	65.00
66.00	06600	PHYSICAL THERAPY	1,970,912	42,976,435	0.045860	4,927,587	225,979	66.00
66.01	06601	IP REHAB THERAPIES	335,420	12,613,064	0.026593	0	0	66.01
69.00	06900	ELECTROCARDIOLOGY	1,771,711	47,335,227	0.037429	6,386,453	239,039	69.00
69.01	03630	CARDIAC CATH LAB	1,265,735	52,502,430	0.024108	13,190,037	317,985	69.01
69.02	03160	CARDIAC REHABILITATION	0	0	0.000000	0	0	69.02
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	3,747,368	136,795,042	0.027394	30,354,031	831,518	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	2,524,485	74,701,057	0.033795	22,545,685	761,931	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,142,156	57,533,757	0.019852	20,993,628	416,766	73.00
73.01	07301	FLU VACCINE DRUGS CHG TO PATIENTS	23,782	634,849	0.037461	0	0	73.01
74.00	07400	RENAL DIALYSIS	242,486	7,300,123	0.033217	3,610,010	119,914	74.00
76.97	07697	CARDIAC REHABILITATION	615,073	2,215,923	0.277570	1,612	447	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							
90.01	09001	OUTPATIENT TREATMENT CENTERS	1,976,582	23,031,256	0.085822	72,082	6,186	90.01
90.02	09002	PARTIAL HOSPITALIZATION PROGRAM	462,265	2,589,470	0.178517	12,750	2,276	90.02
91.00	09100	EMERGENCY	2,721,222	122,016,486	0.022302	20,890,277	465,895	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	231,256	1,818,614	0.127161	258,302	32,846	92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	363,683	10,220,587	0.035583	1,623,786	57,779	92.01
200.00		Total (lines 50 through 199)	42,834,668	1,425,385,461		245,957,533	6,585,074	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS					Provider CCN: 14-0252		Period: From 10/01/2019 To 09/30/2020		Worksheet D Part III Date/Time Prepared: 4/29/2021 1:24 pm	
					Title XVIII		Hospital		PPS	
Cost Center Description			Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health Cost	All Other Medical Education Cost			
			1A	1.00	2A	2.00	3.00			
INPATIENT ROUTINE SERVICE COST CENTERS										
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	0	0	30.00	
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	0	31.00	
35.00	02060	NEONATAL INTENSIVE CARE UNIT	0	0	0	0	0	0	35.00	
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	0	0	40.00	
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	0	41.00	
43.00	04300	NURSERY	0	0	0	0	0	0	43.00	
200.00		Total (lines 30 through 199)	0	0	0	0	0	0	200.00	
Cost Center Description			Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days			
			4.00	5.00	6.00	7.00	8.00			
INPATIENT ROUTINE SERVICE COST CENTERS										
30.00	03000	ADULTS & PEDIATRICS	0	0	68,912	0.00	31,045	30.00		
31.00	03100	INTENSIVE CARE UNIT	0	0	7,461	0.00	3,928	31.00		
35.00	02060	NEONATAL INTENSIVE CARE UNIT	0	0	3,651	0.00	0	35.00		
40.00	04000	SUBPROVIDER - IPF	0	0	13,755	0.00	2,361	40.00		
41.00	04100	SUBPROVIDER - IRF	0	0	9,047	0.00	5,614	41.00		
43.00	04300	NURSERY	0	0	4,264	0.00	0	43.00		
200.00		Total (lines 30 through 199)	0	0	107,090		42,948	200.00		
Cost Center Description			Inpatient Program Pass-Through Cost (col. 7 x col. 8)							
			9.00							
INPATIENT ROUTINE SERVICE COST CENTERS										
30.00	03000	ADULTS & PEDIATRICS	0							30.00
31.00	03100	INTENSIVE CARE UNIT	0							31.00
35.00	02060	NEONATAL INTENSIVE CARE UNIT	0							35.00
40.00	04000	SUBPROVIDER - IPF	0							40.00
41.00	04100	SUBPROVIDER - IRF	0							41.00
43.00	04300	NURSERY	0							43.00
200.00		Total (lines 30 through 199)	0							200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS			Provider CCN: 14-0252		Period: From 10/01/2019 To 09/30/2020		Worksheet D Part IV Date/Time Prepared: 4/29/2021 1:24 pm	
			Title XVIII		Hospital		PPS	
Cost Center Description			Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health	
			1.00	2A	2.00	3A	3.00	
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
54.01	05401	OFFSITE-DIAGNOSTIC SERVICES	0	0	0	0	0	54.01
56.01	03480	ONCOLOGY	0	0	0	0	0	56.01
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	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
66.01	06601	IP REHAB THERAPIES	0	0	0	0	0	66.01
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
69.01	03630	CARDIAC CATH LAB	0	0	0	0	0	69.01
69.02	03160	CARDIAC REHABILITATION	0	0	0	0	0	69.02
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
73.01	07301	FLU VACCINE DRUGS CHG TO PATIENTS	0	0	0	0	0	73.01
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								
90.01	09001	OUTPATIENT TREATMENT CENTERS	0	0	0	0	0	90.01
90.02	09002	PARTIAL HOSPITALIZATION PROGRAM	0	0	0	0	0	90.02
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	0	92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	0	0	0	0	0	92.01
200.00		Total (lines 50 through 199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS			Provider CCN: 14-0252		Period: From 10/01/2019 To 09/30/2020		Worksheet D Part IV Date/Time Prepared: 4/29/2021 1:24 pm	
			Title XVIII		Hospital		PPS	
Cost Center Description			All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7) (see instructions)	
			4.00	5.00	6.00	7.00	8.00	
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	0	126,573,829	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	13,780,626	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	12,951,830	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	362,010,769	0.000000	54.00
54.01	05401	OFFSITE-DIAGNOSTIC SERVICES	0	0	0	46,285,295	0.000000	54.01
56.01	03480	ONCOLOGY	0	0	0	28,337,755	0.000000	56.01
60.00	06000	LABORATORY	0	0	0	197,384,306	0.000000	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0	15,886,763	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	0	0	27,889,968	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	42,976,435	0.000000	66.00
66.01	06601	IP REHAB THERAPIES	0	0	0	12,613,064	0.000000	66.01
69.00	06900	ELECTROCARDIOLOGY	0	0	0	47,335,227	0.000000	69.00
69.01	03630	CARDIAC CATH LAB	0	0	0	52,502,430	0.000000	69.01
69.02	03160	CARDIAC REHABILITATION	0	0	0	0	0.000000	69.02
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	136,795,042	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	74,701,057	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	57,533,757	0.000000	73.00
73.01	07301	FLU VACCINE DRUGS CHG TO PATIENTS	0	0	0	634,849	0.000000	73.01
74.00	07400	RENAL DIALYSIS	0	0	0	7,300,123	0.000000	74.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	2,215,923	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								
90.01	09001	OUTPATIENT TREATMENT CENTERS	0	0	0	23,031,256	0.000000	90.01
90.02	09002	PARTIAL HOSPITALIZATION PROGRAM	0	0	0	2,589,470	0.000000	90.02
91.00	09100	EMERGENCY	0	0	0	122,016,486	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	1,818,614	0.000000	92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	0	0	0	10,220,587	0.000000	92.01
200.00		Total (lines 50 through 199)	0	0	0	1,425,385,461		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-0252

Period:
From 10/01/2019
To 09/30/2020Worksheet D
Part IV
Date/Time Prepared:
4/29/2021 1:24 pm

Cost Center Description		Title XVIII			Hospital		PPS	
		Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)		
		9.00	10.00	11.00	12.00	13.00		
ANCILLARY SERVICE COST CENTERS								
50.00	05000 OPERATING ROOM	0.000000	20,240,644	0	24,446,752	0	50.00	
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.000000	9,818	0	122	0	52.00	
53.00	05300 ANESTHESIOLOGY	0.000000	2,767,402	0	2,058,142	0	53.00	
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.000000	44,582,015	0	86,939,794	0	54.00	
54.01	05401 OFFSITE-DIAGNOSTIC SERVICES	0.000000	157,115	0	14,494,817	0	54.01	
56.01	03480 ONCOLOGY	0.000000	54,253	0	16,952,902	0	56.01	
60.00	06000 LABORATORY	0.000000	36,490,547	0	14,061,350	0	60.00	
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0.000000	4,612,340	0	2,269,703	0	62.00	
62.30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0.000000	0	0	0	0	62.30	
65.00	06500 RESPIRATORY THERAPY	0.000000	12,177,159	0	669,834	0	65.00	
66.00	06600 PHYSICAL THERAPY	0.000000	4,927,587	0	1,039,179	0	66.00	
66.01	06601 IP REHAB THERAPIES	0.000000	0	0	0	0	66.01	
69.00	06900 ELECTROCARDIOLOGY	0.000000	6,386,453	0	12,621,484	0	69.00	
69.01	03630 CARDIAC CATH LAB	0.000000	13,190,037	0	12,533,873	0	69.01	
69.02	03160 CARDIAC REHABILITATION	0.000000	0	0	0	0	69.02	
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	30,354,031	0	21,001,266	0	71.00	
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.000000	22,545,685	0	17,157,920	0	72.00	
73.00	07300 DRUGS CHARGED TO PATIENTS	0.000000	20,993,628	0	3,029,884	0	73.00	
73.01	07301 FLU VACCINE DRUGS CHG TO PATIENTS	0.000000	0	0	0	0	73.01	
74.00	07400 RENAL DIALYSIS	0.000000	3,610,010	0	358,184	0	74.00	
76.97	07697 CARDIAC REHABILITATION	0.000000	1,612	0	936,377	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								
90.01	09001 OUTPATIENT TREATMENT CENTERS	0.000000	72,082	0	4,040,218	0	90.01	
90.02	09002 PARTIAL HOSPITALIZATION PROGRAM	0.000000	12,750	0	46,325	0	90.02	
91.00	09100 EMERGENCY	0.000000	20,890,277	0	16,805,596	0	91.00	
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0.000000	258,302	0	768,596	0	92.00	
92.01	09201 OBSERVATION BEDS (DISTINCT PART)	0.000000	1,623,786	0	2,412,067	0	92.01	
200.00	Total (lines 50 through 199)		245,957,533	0	254,644,385	0	200.00	

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-0252

Period:
From 10/01/2019
To 09/30/2020Worksheet D
Part V
Date/Time Prepared:
4/29/2021 1:24 pm

			Title XVIII		Hospital		PPS		
Cost Center Description			Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges		Costs			
				PPS Reimbursed Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	PPS Services (see inst.)		
			1.00	2.00	3.00	4.00	5.00		
	ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0.325986	24,446,752	1	79	7,969,299	50.00	
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.591336	122	0	0	72	52.00	
53.00	05300	ANESTHESIOLOGY	0.024637	2,058,142	0	0	50,706	53.00	
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.104805	86,939,794	415	10,709	9,111,725	54.00	
54.01	05401	OFFSITE-DIAGNOSTIC SERVICES	0.077170	14,494,817	12	2,727	1,118,565	54.01	
56.01	03480	ONCOLOGY	0.750764	16,952,902	193	44,295	12,727,629	56.01	
60.00	06000	LABORATORY	0.150040	14,061,350	273	0	2,109,765	60.00	
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0.258581	2,269,703	31	0	586,902	62.00	
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0.000000	0	0	0	0	62.30	
65.00	06500	RESPIRATORY THERAPY	0.167760	669,834	1	0	112,371	65.00	
66.00	06600	PHYSICAL THERAPY	0.361754	1,039,179	0	75	375,927	66.00	
66.01	06601	IP REHAB THERAPIES	0.422070	0	0	0	0	66.01	
69.00	06900	ELECTROCARDIOLOGY	0.233009	12,621,484	1	168	2,940,919	69.00	
69.01	03630	CARDIAC CATH LAB	0.105993	12,533,873	7	895	1,328,503	69.01	
69.02	03160	CARDIAC REHABILITATION	0.000000	0	0	0	0	69.02	
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.311634	21,001,266	0	21	6,544,709	71.00	
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.393127	17,157,920	0	0	6,745,242	72.00	
73.00	07300	DRUGS CHARGED TO PATIENTS	0.258547	3,029,884	33	7,707	783,367	73.00	
73.01	07301	FLU VACCINE DRUGS CHG TO PATIENTS	0.500376	0	0	0	0	73.01	
74.00	07400	RENAL DIALYSIS	0.354088	358,184	0	0	126,829	74.00	
76.97	07697	CARDIAC REHABILITATION	1.159137	936,377	0	0	1,085,389	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								
90.01	09001	OUTPATIENT TREATMENT CENTERS	0.434651	4,040,218	2	607	1,756,085	90.01	
90.02	09002	PARTIAL HOSPITALIZATION PROGRAM	1.314661	46,325	0	0	60,902	90.02	
91.00	09100	EMERGENCY	0.175905	16,805,596	11	84	2,956,188	91.00	
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.934950	768,596	0	3	718,599	92.00	
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	0.480924	2,412,067	0	4	1,160,021	92.01	
200.00		Subtotal (see instructions)		254,644,385	980	67,374	60,369,714	200.00	
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00	
202.00		Net Charges (line 200 - line 201)		254,644,385	980	67,374	60,369,714	202.00	

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST			Provider CCN: 14-0252		Period: From 10/01/2019 To 09/30/2020	Worksheet D Part V Date/Time Prepared: 4/29/2021 1:24 pm
			Title XVIII		Hospital	PPS
Cost Center Description			Costs			
			Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	26		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0		52.00
53.00	05300	ANESTHESIOLOGY	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	43	1,122		54.00
54.01	05401	OFFSITE-DIAGNOSTIC SERVICES	1	210		54.01
56.01	03480	ONCOLOGY	145	33,255		56.01
60.00	06000	LABORATORY	41	0		60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	8	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	27		66.00
66.01	06601	IP REHAB THERAPIES	0	0		66.01
69.00	06900	ELECTROCARDIOLOGY	0	39		69.00
69.01	03630	CARDIAC CATH LAB	1	95		69.01
69.02	03160	CARDIAC REHABILITATION	0	0		69.02
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	7		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	9	1,993		73.00
73.01	07301	FLU VACCINE DRUGS CHG TO PATIENTS	0	0		73.01
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						
90.01	09001	OUTPATIENT TREATMENT CENTERS	1	264		90.01
90.02	09002	PARTIAL HOSPITALIZATION PROGRAM	0	0		90.02
91.00	09100	EMERGENCY	2	15		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	3		92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	0	2		92.01
200.00		Subtotal (see instructions)	251	37,058		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	251	37,058		202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 14-0252

Period:

Worksheet D

Component CCN: 14-S252

From 10/01/2019
To 09/30/2020Part II
Date/Time Prepared:
4/29/2021 1:24 pm

				Title XVIII		Subprovider - IPF	PPS	
Cost Center Description			Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	8,255,603	126,573,829	0.065224	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,093,815	13,780,626	0.079373	0	0	52.00
53.00	05300	ANESTHESIOLOGY	150,695	12,951,830	0.011635	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	7,025,632	362,010,769	0.019407	101,529	1,970	54.00
54.01	05401	OFFSITE-DIAGNOSTIC SERVICES	672,384	46,285,295	0.014527	0	0	54.01
56.01	03480	ONCOLOGY	2,433,623	28,337,755	0.085879	0	0	56.01
60.00	06000	LABORATORY	2,908,378	197,384,306	0.014735	378,403	5,576	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	339,063	15,886,763	0.021342	178	4	62.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0.000000	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	561,339	27,889,968	0.020127	2,242	45	65.00
66.00	06600	PHYSICAL THERAPY	1,970,912	42,976,435	0.045860	49,547	2,272	66.00
66.01	06601	IP REHAB THERAPIES	335,420	12,613,064	0.026593	0	0	66.01
69.00	06900	ELECTROCARDIOLOGY	1,771,711	47,335,227	0.037429	66,268	2,480	69.00
69.01	03630	CARDIAC CATH LAB	1,265,735	52,502,430	0.024108	0	0	69.01
69.02	03160	CARDIAC REHABILITATION	0	0	0.000000	0	0	69.02
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	3,747,368	136,795,042	0.027394	27,516	754	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	2,524,485	74,701,057	0.033795	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,142,156	57,533,757	0.019852	181,840	3,610	73.00
73.01	07301	FLU VACCINE DRUGS CHG TO PATIENTS	23,782	634,849	0.037461	0	0	73.01
74.00	07400	RENAL DIALYSIS	242,486	7,300,123	0.033217	0	0	74.00
76.97	07697	CARDIAC REHABILITATION	615,073	2,215,923	0.277570	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								
90.01	09001	OUTPATIENT TREATMENT CENTERS	1,976,582	23,031,256	0.085822	0	0	90.01
90.02	09002	PARTIAL HOSPITALIZATION PROGRAM	462,265	2,589,470	0.178517	71,909	12,837	90.02
91.00	09100	EMERGENCY	2,721,222	122,016,486	0.022302	442,959	9,879	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	1,818,614	0.000000	0	0	92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	363,683	10,220,587	0.035583	0	0	92.01
200.00		Total (lines 50 through 199)	42,603,412	1,425,385,461		1,322,391	39,427	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS				Provider CCN: 14-0252 Component CCN: 14-S252		Period: From 10/01/2019 To 09/30/2020		Worksheet D Part IV Date/Time Prepared: 4/29/2021 1:24 pm	
				Title XVIII		Subprovider - IPF		PPS	
Cost Center Description				Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health	
				1.00	2A	2.00	3A	3.00	
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM		0	0	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM		0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY		0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC		0	0	0	0	0	54.00
54.01	05401	OFFSITE-DIAGNOSTIC SERVICES		0	0	0	0	0	54.01
56.01	03480	ONCOLOGY		0	0	0	0	0	56.01
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	0	65.00
66.00	06600	PHYSICAL THERAPY		0	0	0	0	0	66.00
66.01	06601	IP REHAB THERAPIES		0	0	0	0	0	66.01
69.00	06900	ELECTROCARDIOLOGY		0	0	0	0	0	69.00
69.01	03630	CARDIAC CATH LAB		0	0	0	0	0	69.01
69.02	03160	CARDIAC REHABILITATION		0	0	0	0	0	69.02
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
73.01	07301	FLU VACCINE DRUGS CHG TO PATIENTS		0	0	0	0	0	73.01
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									
90.01	09001	OUTPATIENT TREATMENT CENTERS		0	0	0	0	0	90.01
90.02	09002	PARTIAL HOSPITALIZATION PROGRAM		0	0	0	0	0	90.02
91.00	09100	EMERGENCY		0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART		0	0	0	0	0	92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)		0	0	0	0	0	92.01
200.00		Total (lines 50 through 199)		0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS				Provider CCN: 14-0252 Component CCN: 14-S252		Period: From 10/01/2019 To 09/30/2020		Worksheet D Part IV Date/Time Prepared: 4/29/2021 1:24 pm	
				Title XVIII		Subprovider - IPF		PPS	
Cost Center Description				All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7) (see instructions)	
				4.00	5.00	6.00	7.00	8.00	
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM		0	0	0	126,573,829	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM		0	0	0	13,780,626	0.000000	52.00
53.00	05300	ANESTHESIOLOGY		0	0	0	12,951,830	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC		0	0	0	362,010,769	0.000000	54.00
54.01	05401	OFFSITE-DIAGNOSTIC SERVICES		0	0	0	46,285,295	0.000000	54.01
56.01	03480	ONCOLOGY		0	0	0	28,337,755	0.000000	56.01
60.00	06000	LABORATORY		0	0	0	197,384,306	0.000000	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL		0	0	0	15,886,763	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	0	0	27,889,968	0.000000	65.00
66.00	06600	PHYSICAL THERAPY		0	0	0	42,976,435	0.000000	66.00
66.01	06601	IP REHAB THERAPIES		0	0	0	12,613,064	0.000000	66.01
69.00	06900	ELECTROCARDIOLOGY		0	0	0	47,335,227	0.000000	69.00
69.01	03630	CARDIAC CATH LAB		0	0	0	52,502,430	0.000000	69.01
69.02	03160	CARDIAC REHABILITATION		0	0	0	0	0.000000	69.02
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT		0	0	0	136,795,042	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS		0	0	0	74,701,057	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS		0	0	0	57,533,757	0.000000	73.00
73.01	07301	FLU VACCINE DRUGS CHG TO PATIENTS		0	0	0	634,849	0.000000	73.01
74.00	07400	RENAL DIALYSIS		0	0	0	7,300,123	0.000000	74.00
76.97	07697	CARDIAC REHABILITATION		0	0	0	2,215,923	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									
90.01	09001	OUTPATIENT TREATMENT CENTERS		0	0	0	23,031,256	0.000000	90.01
90.02	09002	PARTIAL HOSPITALIZATION PROGRAM		0	0	0	2,589,470	0.000000	90.02
91.00	09100	EMERGENCY		0	0	0	122,016,486	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART		0	0	0	1,818,614	0.000000	92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)		0	0	0	10,220,587	0.000000	92.01
200.00		Total (lines 50 through 199)		0	0	0	1,425,385,461		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS				Provider CCN: 14-0252 Component CCN: 14-S252		Period: From 10/01/2019 To 09/30/2020		Worksheet D Part IV Date/Time Prepared: 4/29/2021 1:24 pm	
				Title XVIII		Subprovider - IPF		PPS	
Cost Center Description				Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
				9.00	10.00	11.00	12.00	13.00	
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM	0.000000	0	0	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	101,529	0	0	1,934	0	54.00
54.01	05401	OFFSITE-DIAGNOSTIC SERVICES	0.000000	0	0	0	0	0	54.01
56.01	03480	ONCOLOGY	0.000000	0	0	0	0	0	56.01
60.00	06000	LABORATORY	0.000000	378,403	0	0	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0.000000	178	0	0	0	0	62.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0.000000	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0.000000	2,242	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	49,547	0	0	0	0	66.00
66.01	06601	IP REHAB THERAPIES	0.000000	0	0	0	0	0	66.01
69.00	06900	ELECTROCARDIOLOGY	0.000000	66,268	0	0	658	0	69.00
69.01	03630	CARDIAC CATH LAB	0.000000	0	0	0	0	0	69.01
69.02	03160	CARDIAC REHABILITATION	0.000000	0	0	0	0	0	69.02
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	27,516	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	181,840	0	0	601	0	73.00
73.01	07301	FLU VACCINE DRUGS CHG TO PATIENTS	0.000000	0	0	0	0	0	73.01
74.00	07400	RENAL DIALYSIS	0.000000	0	0	0	0	0	74.00
76.97	07697	CARDIAC REHABILITATION	0.000000	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0.000000	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0.000000	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS									
90.01	09001	OUTPATIENT TREATMENT CENTERS	0.000000	0	0	0	0	0	90.01
90.02	09002	PARTIAL HOSPITALIZATION PROGRAM	0.000000	71,909	0	0	2,610	0	90.02
91.00	09100	EMERGENCY	0.000000	442,959	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	0	0	0	0	0	92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	0.000000	0	0	0	0	0	92.01
200.00		Total (lines 50 through 199)			1,322,391	0	5,803	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-0252

Period:

Worksheet D

Component CCN: 14-S252

From 10/01/2019
To 09/30/2020Part V
Date/Time Prepared:
4/29/2021 1:24 pm

Title XVIII

Subprovider -
IPF

PPS

Cost Center Description		Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges		Costs	
			PPS Reimbursed Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	PPS Services (see inst.)
		1.00	2.00	3.00	4.00	5.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	0.325986	0	0	0	0 50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.591336	0	0	0	0 52.00
53.00	05300 ANESTHESIOLOGY	0.024637	0	0	0	0 53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.104805	1,934	0	0	203 54.00
54.01	05401 OFFSITE-DIAGNOSTIC SERVICES	0.077170	0	0	0	0 54.01
56.01	03480 ONCOLOGY	0.750764	0	0	0	0 56.01
60.00	06000 LABORATORY	0.150040	0	0	0	0 60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0.258581	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	0.167760	0	0	0	0 65.00
66.00	06600 PHYSICAL THERAPY	0.361754	0	0	0	0 66.00
66.01	06601 IP REHAB THERAPIES	0.422070	0	0	0	0 66.01
69.00	06900 ELECTROCARDIOLOGY	0.233009	658	0	0	153 69.00
69.01	03630 CARDIAC CATH LAB	0.105993	0	0	0	0 69.01
69.02	03160 CARDIAC REHABILITATION	0.000000	0	0	0	0 69.02
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.311634	0	0	0	0 71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.393127	0	0	0	0 72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.258547	601	0	77	155 73.00
73.01	07301 FLU VACCINE DRUGS CHG TO PATIENTS	0.500376	0	0	0	0 73.01
74.00	07400 RENAL DIALYSIS	0.354088	0	0	0	0 74.00
76.97	07697 CARDIAC REHABILITATION	1.159137	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						
90.01	09001 OUTPATIENT TREATMENT CENTERS	0.434651	0	0	0	0 90.01
90.02	09002 PARTIAL HOSPITALIZATION PROGRAM	1.314661	2,610	0	0	3,431 90.02
91.00	09100 EMERGENCY	0.175905	0	0	0	0 91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0.934950	0	0	0	0 92.00
92.01	09201 OBSERVATION BEDS (DISTINCT PART)	0.480924	0	0	0	0 92.01
200.00	Subtotal (see instructions)		5,803	0	77	3,942 200.00
201.00	Less PBP Clinic Lab. Services-Program Only Charges			0	0	201.00
202.00	Net Charges (line 200 - line 201)		5,803	0	77	3,942 202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-0252

Period:

Worksheet D

Component CCN: 14-S252

From 10/01/2019
To 09/30/2020Part V
Date/Time Prepared:
4/29/2021 1:24 pm

Title XVIII

Subprovider -
IPF

PPS

	Cost Center Description	Costs			
		Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
		6.00	7.00		
	ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	54.00
54.01	05401	OFFSITE-DIAGNOSTIC SERVICES	0	0	54.01
56.01	03480	ONCOLOGY	0	0	56.01
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
66.01	06601	IP REHAB THERAPIES	0	0	66.01
69.00	06900	ELECTROCARDIOLOGY	0	0	69.00
69.01	03630	CARDIAC CATH LAB	0	0	69.01
69.02	03160	CARDIAC REHABILITATION	0	0	69.02
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	20	73.00
73.01	07301	FLU VACCINE DRUGS CHG TO PATIENTS	0	0	73.01
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				
90.01	09001	OUTPATIENT TREATMENT CENTERS	0	0	90.01
90.02	09002	PARTIAL HOSPITALIZATION PROGRAM	0	0	90.02
91.00	09100	EMERGENCY	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	0	0	92.01
200.00		Subtotal (see instructions)	0	20	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0		201.00
202.00		Net Charges (line 200 - line 201)	0	20	202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 14-0252

Period:

Worksheet D

Component CCN: 14-T252

From 10/01/2019

Part II

To 09/30/2020

Date/Time Prepared:
4/29/2021 1:24 pm

				Title XVIII	Subprovider - IRF	4/29/2021 1:24 pm 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	8,255,603	126,573,829	0.065224	20,688	1,349	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,093,815	13,780,626	0.079373	0	0	52.00
53.00	05300	ANESTHESIOLOGY	150,695	12,951,830	0.011635	1,414	16	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	7,025,632	362,010,769	0.019407	548,108	10,637	54.00
54.01	05401	OFFSITE-DIAGNOSTIC SERVICES	672,384	46,285,295	0.014527	827	12	54.01
56.01	03480	ONCOLOGY	2,433,623	28,337,755	0.085879	0	0	56.01
60.00	06000	LABORATORY	2,908,378	197,384,306	0.014735	1,178,898	17,371	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	339,063	15,886,763	0.021342	23,681	505	62.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0.000000	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	561,339	27,889,968	0.020127	752,902	15,154	65.00
66.00	06600	PHYSICAL THERAPY	1,970,912	42,976,435	0.045860	22,287	1,022	66.00
66.01	06601	IP REHAB THERAPIES	335,420	12,613,064	0.026593	7,827,931	208,168	66.01
69.00	06900	ELECTROCARDIOLOGY	1,771,711	47,335,227	0.037429	39,055	1,462	69.00
69.01	03630	CARDIAC CATH LAB	1,265,735	52,502,430	0.024108	0	0	69.01
69.02	03160	CARDIAC REHABILITATION	0	0	0.000000	0	0	69.02
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	3,747,368	136,795,042	0.027394	221,716	6,074	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	2,524,485	74,701,057	0.033795	16,361	553	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,142,156	57,533,757	0.019852	876,553	17,401	73.00
73.01	07301	FLU VACCINE DRUGS CHG TO PATIENTS	23,782	634,849	0.037461	0	0	73.01
74.00	07400	RENAL DIALYSIS	242,486	7,300,123	0.033217	484,304	16,087	74.00
76.97	07697	CARDIAC REHABILITATION	615,073	2,215,923	0.277570	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								
90.01	09001	OUTPATIENT TREATMENT CENTERS	1,976,582	23,031,256	0.085822	1,401	120	90.01
90.02	09002	PARTIAL HOSPITALIZATION PROGRAM	462,265	2,589,470	0.178517	0	0	90.02
91.00	09100	EMERGENCY	2,721,222	122,016,486	0.022302	14,328	320	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	1,818,614	0.000000	0	0	92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	363,683	10,220,587	0.035583	43	2	92.01
200.00		Total (lines 50 through 199)	42,603,412	1,425,385,461		12,030,497	296,253	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS				Provider CCN: 14-0252 Component CCN: 14-T252		Period: From 10/01/2019 To 09/30/2020		Worksheet D Part IV Date/Time Prepared: 4/29/2021 1:24 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	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM		0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY		0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC		0	0	0	0	0	54.00
54.01	05401	OFFSITE-DIAGNOSTIC SERVICES		0	0	0	0	0	54.01
56.01	03480	ONCOLOGY		0	0	0	0	0	56.01
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	0	65.00
66.00	06600	PHYSICAL THERAPY		0	0	0	0	0	66.00
66.01	06601	IP REHAB THERAPIES		0	0	0	0	0	66.01
69.00	06900	ELECTROCARDIOLOGY		0	0	0	0	0	69.00
69.01	03630	CARDIAC CATH LAB		0	0	0	0	0	69.01
69.02	03160	CARDIAC REHABILITATION		0	0	0	0	0	69.02
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
73.01	07301	FLU VACCINE DRUGS CHG TO PATIENTS		0	0	0	0	0	73.01
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									
90.01	09001	OUTPATIENT TREATMENT CENTERS		0	0	0	0	0	90.01
90.02	09002	PARTIAL HOSPITALIZATION PROGRAM		0	0	0	0	0	90.02
91.00	09100	EMERGENCY		0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART		0	0	0	0	0	92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)		0	0	0	0	0	92.01
200.00		Total (lines 50 through 199)		0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS			Provider CCN: 14-0252 Component CCN: 14-T252		Period: From 10/01/2019 To 09/30/2020		Worksheet D Part IV Date/Time Prepared: 4/29/2021 1:24 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	0	0	126,573,829	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	13,780,626	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	12,951,830	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	362,010,769	0.000000	54.00
54.01	05401	OFFSITE-DIAGNOSTIC SERVICES	0	0	0	46,285,295	0.000000	54.01
56.01	03480	ONCOLOGY	0	0	0	28,337,755	0.000000	56.01
60.00	06000	LABORATORY	0	0	0	197,384,306	0.000000	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0	15,886,763	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	0	0	27,889,968	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	42,976,435	0.000000	66.00
66.01	06601	IP REHAB THERAPIES	0	0	0	12,613,064	0.000000	66.01
69.00	06900	ELECTROCARDIOLOGY	0	0	0	47,335,227	0.000000	69.00
69.01	03630	CARDIAC CATH LAB	0	0	0	52,502,430	0.000000	69.01
69.02	03160	CARDIAC REHABILITATION	0	0	0	0	0.000000	69.02
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	136,795,042	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	74,701,057	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	57,533,757	0.000000	73.00
73.01	07301	FLU VACCINE DRUGS CHG TO PATIENTS	0	0	0	634,849	0.000000	73.01
74.00	07400	RENAL DIALYSIS	0	0	0	7,300,123	0.000000	74.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	2,215,923	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								
90.01	09001	OUTPATIENT TREATMENT CENTERS	0	0	0	23,031,256	0.000000	90.01
90.02	09002	PARTIAL HOSPITALIZATION PROGRAM	0	0	0	2,589,470	0.000000	90.02
91.00	09100	EMERGENCY	0	0	0	122,016,486	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	1,818,614	0.000000	92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	0	0	0	10,220,587	0.000000	92.01
200.00		Total (lines 50 through 199)	0	0	0	1,425,385,461		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS				Provider CCN: 14-0252 Component CCN: 14-T252		Period: From 10/01/2019 To 09/30/2020		Worksheet D Part IV Date/Time Prepared: 4/29/2021 1:24 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	0.000000		20,688	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000		0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.000000		1,414	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000		548,108	0	7,144	0	54.00
54.01	05401	OFFSITE-DIAGNOSTIC SERVICES	0.000000		827	0	0	0	54.01
56.01	03480	ONCOLOGY	0.000000		0	0	0	0	56.01
60.00	06000	LABORATORY	0.000000		1,178,898	0	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0.000000		23,681	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	0.000000		752,902	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000		22,287	0	0	0	66.00
66.01	06601	IP REHAB THERAPIES	0.000000		7,827,931	0	0	0	66.01
69.00	06900	ELECTROCARDIOLOGY	0.000000		39,055	0	987	0	69.00
69.01	03630	CARDIAC CATH LAB	0.000000		0	0	0	0	69.01
69.02	03160	CARDIAC REHABILITATION	0.000000		0	0	0	0	69.02
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000		221,716	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000		16,361	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000		876,553	0	224	0	73.00
73.01	07301	FLU VACCINE DRUGS CHG TO PATIENTS	0.000000		0	0	0	0	73.01
74.00	07400	RENAL DIALYSIS	0.000000		484,304	0	2,489	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									
90.01	09001	OUTPATIENT TREATMENT CENTERS	0.000000		1,401	0	0	0	90.01
90.02	09002	PARTIAL HOSPITALIZATION PROGRAM	0.000000		0	0	0	0	90.02
91.00	09100	EMERGENCY	0.000000		14,328	0	1,608	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000		0	0	0	0	92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	0.000000		43	0	0	0	92.01
200.00		Total (lines 50 through 199)			12,030,497	0	12,452	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-0252

Period:

Worksheet D

Component CCN: 14-T252

From 10/01/2019
To 09/30/2020Part V
Date/Time Prepared:
4/29/2021 1:24 pm

Title XVIII

Subprovider -
IRF

PPS

Cost Center Description		Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges		Costs	
			PPS Reimbursed Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	PPS Services (see inst.)
		1.00	2.00	3.00	4.00	5.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	0.325986	0	0	0	0 50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.591336	0	0	0	0 52.00
53.00	05300 ANESTHESIOLOGY	0.024637	0	0	0	0 53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.104805	7,144	0	0	749 54.00
54.01	05401 OFFSITE-DIAGNOSTIC SERVICES	0.077170	0	0	0	0 54.01
56.01	03480 ONCOLOGY	0.750764	0	0	0	0 56.01
60.00	06000 LABORATORY	0.150040	0	0	0	0 60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0.258581	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	0.167760	0	0	0	0 65.00
66.00	06600 PHYSICAL THERAPY	0.361754	0	0	0	0 66.00
66.01	06601 IP REHAB THERAPIES	0.422070	0	0	0	0 66.01
69.00	06900 ELECTROCARDIOLOGY	0.233009	987	0	0	230 69.00
69.01	03630 CARDIAC CATH LAB	0.105993	0	0	0	0 69.01
69.02	03160 CARDIAC REHABILITATION	0.000000	0	0	0	0 69.02
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.311634	0	0	0	0 71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.393127	0	0	0	0 72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.258547	224	0	672	58 73.00
73.01	07301 FLU VACCINE DRUGS CHG TO PATIENTS	0.500376	0	0	0	0 73.01
74.00	07400 RENAL DIALYSIS	0.354088	2,489	0	0	881 74.00
76.97	07697 CARDIAC REHABILITATION	1.159137	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						
90.01	09001 OUTPATIENT TREATMENT CENTERS	0.434651	0	0	0	0 90.01
90.02	09002 PARTIAL HOSPITALIZATION PROGRAM	1.314661	0	0	0	0 90.02
91.00	09100 EMERGENCY	0.175905	1,608	0	0	283 91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0.934950	0	0	0	0 92.00
92.01	09201 OBSERVATION BEDS (DISTINCT PART)	0.480924	0	0	0	0 92.01
200.00	Subtotal (see instructions)		12,452	0	672	2,201 200.00
201.00	Less PBP Clinic Lab. Services-Program Only Charges			0	0	201.00
202.00	Net Charges (line 200 - line 201)		12,452	0	672	2,201 202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST			Provider CCN: 14-0252 Component CCN: 14-T252		Period: From 10/01/2019 To 09/30/2020		Worksheet D Part V Date/Time Prepared: 4/29/2021 1:24 pm	
			Title XVIII		Subprovider - IRF		PPS	
	Cost Center Description	Costs						
		Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)					
		6.00	7.00					
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0				50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0				52.00
53.00	05300	ANESTHESIOLOGY	0	0				53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0				54.00
54.01	05401	OFFSITE-DIAGNOSTIC SERVICES	0	0				54.01
56.01	03480	ONCOLOGY	0	0				56.01
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
66.01	06601	IP REHAB THERAPIES	0	0				66.01
69.00	06900	ELECTROCARDIOLOGY	0	0				69.00
69.01	03630	CARDIAC CATH LAB	0	0				69.01
69.02	03160	CARDIAC REHABILITATION	0	0				69.02
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	174				73.00
73.01	07301	FLU VACCINE DRUGS CHG TO PATIENTS	0	0				73.01
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								
90.01	09001	OUTPATIENT TREATMENT CENTERS	0	0				90.01
90.02	09002	PARTIAL HOSPITALIZATION PROGRAM	0	0				90.02
91.00	09100	EMERGENCY	0	0				91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0				92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	0	0				92.01
200.00		Subtotal (see instructions)	0	174				200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0					201.00
202.00		Net Charges (line 200 - line 201)	0	174				202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

Provider CCN: 14-0252

Period:
From 10/01/2019
To 09/30/2020Worksheet D
Part I
Date/Time Prepared:
4/29/2021 1:24 pm

			Title XIX		Hospital	Cost	
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	10,546,949	0	10,546,949	68,912	153.05	30.00
31.00	INTENSIVE CARE UNIT	2,770,237		2,770,237	7,461	371.30	31.00
35.00	NEONATAL INTENSIVE CARE UNIT	457,869		457,869	3,651	125.41	35.00
40.00	SUBPROVIDER - IPF	2,113,232	0	2,113,232	13,755	153.63	40.00
41.00	SUBPROVIDER - IRF	1,152,518	0	1,152,518	9,047	127.39	41.00
43.00	NURSERY	472,465		472,465	4,264	110.80	43.00
200.00	Total (lines 30 through 199)	17,513,270		17,513,270	107,090		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	3,061	468,486				30.00
31.00	INTENSIVE CARE UNIT	127	47,155				31.00
35.00	NEONATAL INTENSIVE CARE UNIT	253	31,729				35.00
40.00	SUBPROVIDER - IPF	1,263	194,035				40.00
41.00	SUBPROVIDER - IRF	229	29,172				41.00
43.00	NURSERY	511	56,619				43.00
200.00	Total (lines 30 through 199)	5,444	827,196				200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 14-0252

Period:
From 10/01/2019
To 09/30/2020Worksheet D
Part II
Date/Time Prepared:
4/29/2021 1:24 pm

Cost Center Description		Title XIX		Hospital		Cost	
		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	8,255,603	0	0.000000	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,093,815	0	0.000000	0	52.00
53.00	05300	ANESTHESIOLOGY	150,695	0	0.000000	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	7,025,632	0	0.000000	0	54.00
54.01	05401	OFFSITE-DIAGNOSTIC SERVICES	672,384	0	0.000000	0	54.01
56.01	03480	ONCOLOGY	2,433,623	0	0.000000	0	56.01
60.00	06000	LABORATORY	2,908,378	0	0.000000	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	339,063	0	0.000000	0	62.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0.000000	0	62.30
65.00	06500	RESPIRATORY THERAPY	561,339	0	0.000000	0	65.00
66.00	06600	PHYSICAL THERAPY	1,970,912	0	0.000000	0	66.00
66.01	06601	IP REHAB THERAPIES	335,420	0	0.000000	0	66.01
69.00	06900	ELECTROCARDIOLOGY	1,771,711	0	0.000000	0	69.00
69.01	03630	CARDIAC CATH LAB	1,265,735	0	0.000000	0	69.01
69.02	03160	CARDIAC REHABILITATION	0	0	0.000000	0	69.02
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	3,747,368	0	0.000000	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	2,524,485	0	0.000000	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,142,156	0	0.000000	0	73.00
73.01	07301	FLU VACCINE DRUGS CHG TO PATIENTS	23,782	0	0.000000	0	73.01
74.00	07400	RENAL DIALYSIS	242,486	0	0.000000	0	74.00
76.97	07697	CARDIAC REHABILITATION	615,073	0	0.000000	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0.000000	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0.000000	0	76.99
OUTPATIENT SERVICE COST CENTERS							
90.01	09001	OUTPATIENT TREATMENT CENTERS	1,976,582	0	0.000000	0	90.01
90.02	09002	PARTIAL HOSPITALIZATION PROGRAM	462,265	0	0.000000	0	90.02
91.00	09100	EMERGENCY	2,721,222	0	0.000000	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	231,256	0	0.000000	0	92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	363,683	0	0.000000	0	92.01
200.00		Total (lines 50 through 199)	42,834,668	0		0	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS					Provider CCN: 14-0252		Period: From 10/01/2019 To 09/30/2020		Worksheet D Part III Date/Time Prepared: 4/29/2021 1:24 pm		
					Title XIX		Hospital		Cost		
Cost Center Description			Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health Cost	All Other Medical Education Cost				
			1A	1.00	2A	2.00	3.00				
INPATIENT ROUTINE SERVICE COST CENTERS											
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	0	0	30.00		
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	0	31.00		
35.00	02060	NEONATAL INTENSIVE CARE UNIT	0	0	0	0	0	0	35.00		
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	0	0	40.00		
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	0	41.00		
43.00	04300	NURSERY	0	0	0	0	0	0	43.00		
200.00		Total (lines 30 through 199)	0	0	0	0	0	0	200.00		
Cost Center Description			Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	Total Patient Days	Per Diem (col. 5 ÷ col. 6)		Inpatient Program Days			
			4.00	5.00	6.00	7.00		8.00			
INPATIENT ROUTINE SERVICE COST CENTERS											
30.00	03000	ADULTS & PEDIATRICS	0	0	68,912	0.00	3,061		30.00		
31.00	03100	INTENSIVE CARE UNIT	0	0	7,461	0.00	127		31.00		
35.00	02060	NEONATAL INTENSIVE CARE UNIT	0	0	3,651	0.00	253		35.00		
40.00	04000	SUBPROVIDER - IPF	0	0	13,755	0.00	1,263		40.00		
41.00	04100	SUBPROVIDER - IRF	0	0	9,047	0.00	229		41.00		
43.00	04300	NURSERY	0	0	4,264	0.00	511		43.00		
200.00		Total (lines 30 through 199)	0	0	107,090		5,444		200.00		
Cost Center Description			Inpatient Program Pass-Through Cost (col. 7 x col. 8)								
			9.00								
INPATIENT ROUTINE SERVICE COST CENTERS											
30.00	03000	ADULTS & PEDIATRICS	0								30.00
31.00	03100	INTENSIVE CARE UNIT	0								31.00
35.00	02060	NEONATAL INTENSIVE CARE UNIT	0								35.00
40.00	04000	SUBPROVIDER - IPF	0								40.00
41.00	04100	SUBPROVIDER - IRF	0								41.00
43.00	04300	NURSERY	0								43.00
200.00		Total (lines 30 through 199)	0								200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

Provider CCN: 14-0252

Period:
From 10/01/2019
To 09/30/2020Worksheet D
Part IV
Date/Time Prepared:
4/29/2021 1:24 pm

Cost Center Description		Title XIX		Hospital		Cost	
		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	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	54.00
54.01	05401	OFFSITE-DIAGNOSTIC SERVICES	0	0	0	0	54.01
56.01	03480	ONCOLOGY	0	0	0	0	56.01
60.00	06000	LABORATORY	0	0	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0	0	62.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	66.00
66.01	06601	IP REHAB THERAPIES	0	0	0	0	66.01
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	69.00
69.01	03630	CARDIAC CATH LAB	0	0	0	0	69.01
69.02	03160	CARDIAC REHABILITATION	0	0	0	0	69.02
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
73.01	07301	FLU VACCINE DRUGS CHG TO PATIENTS	0	0	0	0	73.01
74.00	07400	RENAL DIALYSIS	0	0	0	0	74.00
76.97	07697	CARDIAC REHABILITATION	0	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							
90.01	09001	OUTPATIENT TREATMENT CENTERS	0	0	0	0	90.01
90.02	09002	PARTIAL HOSPITALIZATION PROGRAM	0	0	0	0	90.02
91.00	09100	EMERGENCY	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	0	0	0	0	92.01
200.00		Total (lines 50 through 199)	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

Provider CCN: 14-0252

Period:
From 10/01/2019
To 09/30/2020

Worksheet D
Part IV
Date/Time Prepared:
4/29/2021 1:24 pm

Cost Center Description			Title XIX		Hospital		Cost	
			All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7) (see instructions)	
			4.00	5.00	6.00	7.00	8.00	
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	0	0	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0.000000	54.00
54.01	05401	OFFSITE-DIAGNOSTIC SERVICES	0	0	0	0	0.000000	54.01
56.01	03480	ONCOLOGY	0	0	0	0	0.000000	56.01
60.00	06000	LABORATORY	0	0	0	0	0.000000	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0	0	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	0	0	0	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0.000000	66.00
66.01	06601	IP REHAB THERAPIES	0	0	0	0	0.000000	66.01
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0.000000	69.00
69.01	03630	CARDIAC CATH LAB	0	0	0	0	0.000000	69.01
69.02	03160	CARDIAC REHABILITATION	0	0	0	0	0.000000	69.02
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0.000000	73.00
73.01	07301	FLU VACCINE DRUGS CHG TO PATIENTS	0	0	0	0	0.000000	73.01
74.00	07400	RENAL DIALYSIS	0	0	0	0	0.000000	74.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	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								
90.01	09001	OUTPATIENT TREATMENT CENTERS	0	0	0	0	0.000000	90.01
90.02	09002	PARTIAL HOSPITALIZATION PROGRAM	0	0	0	0	0.000000	90.02
91.00	09100	EMERGENCY	0	0	0	0	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	0.000000	92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	0	0	0	0	0.000000	92.01
200.00		Total (lines 50 through 199)	0	0	0	0		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

Provider CCN: 14-0252

Period:
From 10/01/2019
To 09/30/2020

Worksheet D
Part IV
Date/Time Prepared:
4/29/2021 1:24 pm

Cost Center Description		Title XIX			Hospital		Cost	
		Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)		
		9.00	10.00	11.00	12.00	13.00		
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0.000000	0	0	0	0	50.00
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	05401	OFFSITE-DIAGNOSTIC SERVICES	0.000000	0	0	0	0	54.01
56.01	03480	ONCOLOGY	0.000000	0	0	0	0	56.01
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	0.000000	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	0	0	0	0	66.00
66.01	06601	IP REHAB THERAPIES	0.000000	0	0	0	0	66.01
69.00	06900	ELECTROCARDIOLOGY	0.000000	0	0	0	0	69.00
69.01	03630	CARDIAC CATH LAB	0.000000	0	0	0	0	69.01
69.02	03160	CARDIAC REHABILITATION	0.000000	0	0	0	0	69.02
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
73.01	07301	FLU VACCINE DRUGS CHG TO PATIENTS	0.000000	0	0	0	0	73.01
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								
90.01	09001	OUTPATIENT TREATMENT CENTERS	0.000000	0	0	0	0	90.01
90.02	09002	PARTIAL HOSPITALIZATION PROGRAM	0.000000	0	0	0	0	90.02
91.00	09100	EMERGENCY	0.000000	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	0	0	0	0	92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	0.000000	0	0	0	0	92.01
200.00		Total (lines 50 through 199)		0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

Provider CCN: 14-0252

Component CCN: 14-S252

Period:
From 10/01/2019
To 09/30/2020

Worksheet D
Part IV
Date/Time Prepared:
4/29/2021 1:24 pm

			Title XIX		Subprovider - IPF		Cost	
Cost Center Description			Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health	
			1.00	2A	2.00	3A	3.00	
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
54.01	05401	OFFSITE-DIAGNOSTIC SERVICES	0	0	0	0	0	54.01
56.01	03480	ONCOLOGY	0	0	0	0	0	56.01
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	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
66.01	06601	IP REHAB THERAPIES	0	0	0	0	0	66.01
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
69.01	03630	CARDIAC CATH LAB	0	0	0	0	0	69.01
69.02	03160	CARDIAC REHABILITATION	0	0	0	0	0	69.02
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
73.01	07301	FLU VACCINE DRUGS CHG TO PATIENTS	0	0	0	0	0	73.01
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								
90.01	09001	OUTPATIENT TREATMENT CENTERS	0	0	0	0	0	90.01
90.02	09002	PARTIAL HOSPITALIZATION PROGRAM	0	0	0	0	0	90.02
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	0	92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	0	0	0	0	0	92.01
200.00		Total (lines 50 through 199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS				Provider CCN: 14-0252 Component CCN: 14-S252		Period: From 10/01/2019 To 09/30/2020		Worksheet D Part IV Date/Time Prepared: 4/29/2021 1:24 pm	
				Title XIX		Subprovider - IPF		Cost	
Cost Center Description				All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7) (see instructions)	
				4.00	5.00	6.00	7.00	8.00	
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM		0	0	0	0	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM		0	0	0	0	0.000000	52.00
53.00	05300	ANESTHESIOLOGY		0	0	0	0	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC		0	0	0	0	0.000000	54.00
54.01	05401	OFFSITE-DIAGNOSTIC SERVICES		0	0	0	0	0.000000	54.01
56.01	03480	ONCOLOGY		0	0	0	0	0.000000	56.01
60.00	06000	LABORATORY		0	0	0	0	0.000000	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL		0	0	0	0	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	0	0	0	0.000000	65.00
66.00	06600	PHYSICAL THERAPY		0	0	0	0	0.000000	66.00
66.01	06601	IP REHAB THERAPIES		0	0	0	0	0.000000	66.01
69.00	06900	ELECTROCARDIOLOGY		0	0	0	0	0.000000	69.00
69.01	03630	CARDIAC CATH LAB		0	0	0	0	0.000000	69.01
69.02	03160	CARDIAC REHABILITATION		0	0	0	0	0.000000	69.02
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT		0	0	0	0	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS		0	0	0	0	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS		0	0	0	0	0.000000	73.00
73.01	07301	FLU VACCINE DRUGS CHG TO PATIENTS		0	0	0	0	0.000000	73.01
74.00	07400	RENAL DIALYSIS		0	0	0	0	0.000000	74.00
76.97	07697	CARDIAC REHABILITATION		0	0	0	0	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									
90.01	09001	OUTPATIENT TREATMENT CENTERS		0	0	0	0	0.000000	90.01
90.02	09002	PARTIAL HOSPITALIZATION PROGRAM		0	0	0	0	0.000000	90.02
91.00	09100	EMERGENCY		0	0	0	0	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART		0	0	0	0	0.000000	92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)		0	0	0	0	0.000000	92.01
200.00		Total (lines 50 through 199)		0	0	0	0		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS				Provider CCN: 14-0252 Component CCN: 14-S252		Period: From 10/01/2019 To 09/30/2020		Worksheet D Part IV Date/Time Prepared: 4/29/2021 1:24 pm	
				Title XIX		Subprovider - IPF		Cost	
Cost Center Description				Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
				9.00	10.00	11.00	12.00	13.00	
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM	0.000000	0	0	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	0	0	0	0	0	54.00
54.01	05401	OFFSITE-DIAGNOSTIC SERVICES	0.000000	0	0	0	0	0	54.01
56.01	03480	ONCOLOGY	0.000000	0	0	0	0	0	56.01
60.00	06000	LABORATORY	0.000000	0	0	0	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0.000000	0	0	0	0	0	62.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0.000000	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0.000000	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	0	0	0	0	0	66.00
66.01	06601	IP REHAB THERAPIES	0.000000	0	0	0	0	0	66.01
69.00	06900	ELECTROCARDIOLOGY	0.000000	0	0	0	0	0	69.00
69.01	03630	CARDIAC CATH LAB	0.000000	0	0	0	0	0	69.01
69.02	03160	CARDIAC REHABILITATION	0.000000	0	0	0	0	0	69.02
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	0	0	0	0	0	73.00
73.01	07301	FLU VACCINE DRUGS CHG TO PATIENTS	0.000000	0	0	0	0	0	73.01
74.00	07400	RENAL DIALYSIS	0.000000	0	0	0	0	0	74.00
76.97	07697	CARDIAC REHABILITATION	0.000000	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0.000000	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0.000000	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS									
90.01	09001	OUTPATIENT TREATMENT CENTERS	0.000000	0	0	0	0	0	90.01
90.02	09002	PARTIAL HOSPITALIZATION PROGRAM	0.000000	0	0	0	0	0	90.02
91.00	09100	EMERGENCY	0.000000	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	0	0	0	0	0	92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	0.000000	0	0	0	0	0	92.01
200.00		Total (lines 50 through 199)		0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS				Provider CCN: 14-0252 Component CCN: 14-T252		Period: From 10/01/2019 To 09/30/2020		Worksheet D Part IV Date/Time Prepared: 4/29/2021 1:24 pm	
				Title XIX		Subprovider - IRF		Cost	
Cost Center Description				Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health	
				1.00	2A	2.00	3A	3.00	
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM		0	0	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM		0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY		0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC		0	0	0	0	0	54.00
54.01	05401	OFFSITE-DIAGNOSTIC SERVICES		0	0	0	0	0	54.01
56.01	03480	ONCOLOGY		0	0	0	0	0	56.01
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	0	65.00
66.00	06600	PHYSICAL THERAPY		0	0	0	0	0	66.00
66.01	06601	IP REHAB THERAPIES		0	0	0	0	0	66.01
69.00	06900	ELECTROCARDIOLOGY		0	0	0	0	0	69.00
69.01	03630	CARDIAC CATH LAB		0	0	0	0	0	69.01
69.02	03160	CARDIAC REHABILITATION		0	0	0	0	0	69.02
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
73.01	07301	FLU VACCINE DRUGS CHG TO PATIENTS		0	0	0	0	0	73.01
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									
90.01	09001	OUTPATIENT TREATMENT CENTERS		0	0	0	0	0	90.01
90.02	09002	PARTIAL HOSPITALIZATION PROGRAM		0	0	0	0	0	90.02
91.00	09100	EMERGENCY		0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART		0	0	0	0	0	92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)		0	0	0	0	0	92.01
200.00		Total (lines 50 through 199)		0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS				Provider CCN: 14-0252 Component CCN: 14-T252		Period: From 10/01/2019 To 09/30/2020		Worksheet D Part IV Date/Time Prepared: 4/29/2021 1:24 pm	
				Title XIX		Subprovider - IRF		Cost	
Cost Center Description				All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7) (see instructions)	
				4.00	5.00	6.00	7.00	8.00	
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM		0	0	0	0	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM		0	0	0	0	0.000000	52.00
53.00	05300	ANESTHESIOLOGY		0	0	0	0	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC		0	0	0	0	0.000000	54.00
54.01	05401	OFFSITE-DIAGNOSTIC SERVICES		0	0	0	0	0.000000	54.01
56.01	03480	ONCOLOGY		0	0	0	0	0.000000	56.01
60.00	06000	LABORATORY		0	0	0	0	0.000000	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL		0	0	0	0	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	0	0	0	0.000000	65.00
66.00	06600	PHYSICAL THERAPY		0	0	0	0	0.000000	66.00
66.01	06601	IP REHAB THERAPIES		0	0	0	0	0.000000	66.01
69.00	06900	ELECTROCARDIOLOGY		0	0	0	0	0.000000	69.00
69.01	03630	CARDIAC CATH LAB		0	0	0	0	0.000000	69.01
69.02	03160	CARDIAC REHABILITATION		0	0	0	0	0.000000	69.02
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT		0	0	0	0	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS		0	0	0	0	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS		0	0	0	0	0.000000	73.00
73.01	07301	FLU VACCINE DRUGS CHG TO PATIENTS		0	0	0	0	0.000000	73.01
74.00	07400	RENAL DIALYSIS		0	0	0	0	0.000000	74.00
76.97	07697	CARDIAC REHABILITATION		0	0	0	0	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									
90.01	09001	OUTPATIENT TREATMENT CENTERS		0	0	0	0	0.000000	90.01
90.02	09002	PARTIAL HOSPITALIZATION PROGRAM		0	0	0	0	0.000000	90.02
91.00	09100	EMERGENCY		0	0	0	0	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART		0	0	0	0	0.000000	92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)		0	0	0	0	0.000000	92.01
200.00		Total (lines 50 through 199)		0	0	0	0		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS				Provider CCN: 14-0252 Component CCN: 14-T252		Period: From 10/01/2019 To 09/30/2020		Worksheet D Part IV Date/Time Prepared: 4/29/2021 1:24 pm	
				Title XIX		Subprovider - IRF		Cost	
Cost Center Description				Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
				9.00	10.00	11.00	12.00	13.00	
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM	0.000000	0	0	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	0	0	0	0	0	54.00
54.01	05401	OFFSITE-DIAGNOSTIC SERVICES	0.000000	0	0	0	0	0	54.01
56.01	03480	ONCOLOGY	0.000000	0	0	0	0	0	56.01
60.00	06000	LABORATORY	0.000000	0	0	0	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0.000000	0	0	0	0	0	62.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0.000000	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0.000000	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	0	0	0	0	0	66.00
66.01	06601	IP REHAB THERAPIES	0.000000	0	0	0	0	0	66.01
69.00	06900	ELECTROCARDIOLOGY	0.000000	0	0	0	0	0	69.00
69.01	03630	CARDIAC CATH LAB	0.000000	0	0	0	0	0	69.01
69.02	03160	CARDIAC REHABILITATION	0.000000	0	0	0	0	0	69.02
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	0	0	0	0	0	73.00
73.01	07301	FLU VACCINE DRUGS CHG TO PATIENTS	0.000000	0	0	0	0	0	73.01
74.00	07400	RENAL DIALYSIS	0.000000	0	0	0	0	0	74.00
76.97	07697	CARDIAC REHABILITATION	0.000000	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0.000000	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0.000000	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS									
90.01	09001	OUTPATIENT TREATMENT CENTERS	0.000000	0	0	0	0	0	90.01
90.02	09002	PARTIAL HOSPITALIZATION PROGRAM	0.000000	0	0	0	0	0	90.02
91.00	09100	EMERGENCY	0.000000	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	0	0	0	0	0	92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	0.000000	0	0	0	0	0	92.01
200.00		Total (lines 50 through 199)		0	0	0	0	0	200.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-0252	Period: From 10/01/2019 To 09/30/2020	Worksheet D-1 Date/Time Prepared: 4/29/2021 1:24 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)		68,912	1.00	
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		68,912	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)		67,401	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)		31,045	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)		77,546,325	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)		77,546,325	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)		77,546,325	37.00	
PART II - HOSPITAL AND SUBPROVIDERS ONLY					
PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS					
38.00	Adjusted general inpatient routine service cost per diem (see instructions)		1,125.29	38.00	
39.00	Program general inpatient routine service cost (line 9 x line 38)		34,934,628	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)		34,934,628	41.00	

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-0252

Period:
From 10/01/2019
To 09/30/2020

Worksheet D-1

Date/Time Prepared:
4/29/2021 1:24 pm

Cost Center Description		Title XVIII			Hospital	PPS
		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
	Intensive Care Type Inpatient Hospital Units					
43.00	INTENSIVE CARE UNIT	20,468,095	7,461	2,743.34	3,928	10,775,840
44.00	CORONARY CARE UNIT					
45.00	BURN INTENSIVE CARE UNIT					
46.00	SURGICAL INTENSIVE CARE UNIT					
47.00	NEONATAL INTENSIVE CARE UNIT	4,028,039	3,651	1,103.27	0	0
	Cost Center Description					1.00
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					54,626,374
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					100,336,842
	PASS THROUGH COST ADJUSTMENTS					
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)					6,209,903
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					6,585,074
52.00	Total Program excludable cost (sum of lines 50 and 51)					12,794,977
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					87,541,865
	TARGET AMOUNT AND LIMIT COMPUTATION					
54.00	Program discharges					0
55.00	Target amount per discharge					0.00
56.00	Target amount (line 54 x line 55)					0
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)					0
58.00	Bonus payment (see instructions)					0
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
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket					0.00
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
62.00	Relief payment (see instructions)					0
63.00	Allowable Inpatient cost plus incentive payment (see instructions)					0
	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
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					0
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)					0
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
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
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)					0
	PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY					
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)					70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)					71.00
72.00	Program routine service cost (line 9 x line 71)					72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)					73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)					74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)					75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)					76.00
77.00	Program capital-related costs (line 9 x line 76)					77.00
78.00	Inpatient routine service cost (line 74 minus line 77)					78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)					79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)					80.00
81.00	Inpatient routine service cost per diem limitation					81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)					82.00
83.00	Reasonable inpatient routine service costs (see instructions)					83.00
84.00	Program inpatient ancillary services (see instructions)					84.00
85.00	Utilization review - physician compensation (see instructions)					85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)					86.00
	PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST					
87.00	Total observation bed days (see instructions)					1,511
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					1,125.29
89.00	Observation bed cost (line 87 x line 88) (see instructions)					1,700,313

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-0252

Period:
From 10/01/2019
To 09/30/2020

Worksheet D-1

Date/Time Prepared:
4/29/2021 1:24 pm

		Title XVIII		Hospital	PPS	
Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
	1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00 Capital-related cost	10,546,949	77,546,325	0.136008	1,700,313	231,256	90.00
91.00 Nursing School cost	0	77,546,325	0.000000	1,700,313	0	91.00
92.00 Allied health cost	0	77,546,325	0.000000	1,700,313	0	92.00
93.00 All other Medical Education	0	77,546,325	0.000000	1,700,313	0	93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-0252 Component CCN: 14-S252	Period: From 10/01/2019 To 09/30/2020	Worksheet D-1 Date/Time Prepared: 4/29/2021 1:24 pm
		Title XVIII	Subprovider - IPF	PPS
Cost Center Description			1.00	
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		13,755	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		13,755	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)		13,755	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions)		2,361	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)		15,836,885	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)		15,836,885	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)		15,836,885	37.00
PART II - HOSPITAL AND SUBPROVIDERS ONLY				
PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS				
38.00	Adjusted general inpatient routine service cost per diem (see instructions)		1,151.35	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		2,718,337	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)		2,718,337	41.00

COMPUTATION OF INPATIENT OPERATING COST				Provider CCN: 14-0252 Component CCN: 14-S252	Period: From 10/01/2019 To 09/30/2020	Worksheet D-1 Date/Time Prepared: 4/29/2021 1:24 pm
				Title XVIII	Subprovider - IPF	PPS
Cost Center Description		Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)
		1.00	2.00	3.00	4.00	5.00
42.00	NURSERY (title V & XIX only)	0	0	0.00	0	0
Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	0	0	0.00	0	0
44.00	CORONARY CARE UNIT					
45.00	BURN INTENSIVE CARE UNIT					
46.00	SURGICAL INTENSIVE CARE UNIT					
47.00	NEONATAL INTENSIVE CARE UNIT	0	0	0.00	0	0
Cost Center Description						
						1.00
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					330,658
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					3,048,995
PASS THROUGH COST ADJUSTMENTS						
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)					362,720
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					39,427
52.00	Total Program excludable cost (sum of lines 50 and 51)					402,147
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					2,646,848
TARGET AMOUNT AND LIMIT COMPUTATION						
54.00	Program discharges					0
55.00	Target amount per discharge					0.00
56.00	Target amount (line 54 x line 55)					0
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)					0
58.00	Bonus payment (see instructions)					0
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
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket					0.00
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
62.00	Relief payment (see instructions)					0
63.00	Allowable Inpatient cost plus incentive payment (see instructions)					0
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
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					0
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)					0
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
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
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)					0
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
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					0.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)					0

COMPUTATION OF INPATIENT OPERATING COST			Provider CCN: 14-0252 Component CCN: 14-S252		Period: From 10/01/2019 To 09/30/2020		Worksheet D-1 Date/Time Prepared: 4/29/2021 1:24 pm
			Title XVIII		Subprovider - IPF		PPS
Cost Center Description		Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00	Capital-related cost	2,113,232	15,836,885	0.133437	0	0	90.00
91.00	Nursing School cost	0	15,836,885	0.000000	0	0	91.00
92.00	Allied health cost	0	15,836,885	0.000000	0	0	92.00
93.00	All other Medical Education	0	15,836,885	0.000000	0	0	93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-0252 Component CCN: 14-T252	Period: From 10/01/2019 To 09/30/2020	Worksheet D-1 Date/Time Prepared: 4/29/2021 1:24 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)		9,047	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		9,047	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)		9,047	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)		5,614	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)		7,532,866	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)		7,532,866	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)		7,532,866	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)		832.64	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		4,674,441	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)		4,674,441	41.00

COMPUTATION OF INPATIENT OPERATING COST			Provider CCN: 14-0252 Component CCN: 14-T252	Period: From 10/01/2019 To 09/30/2020	Worksheet D-1 Date/Time Prepared: 4/29/2021 1:24 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
Intensive Care Type Inpatient Hospital Units					
43.00 INTENSIVE CARE UNIT	0	0	0.00	0	0
44.00 CORONARY CARE UNIT					
45.00 BURN INTENSIVE CARE UNIT					
46.00 SURGICAL INTENSIVE CARE UNIT					
47.00 NEONATAL INTENSIVE CARE UNIT	0	0	0.00	0	0
Cost Center Description					
					1.00
48.00 Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					4,171,990
49.00 Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					8,846,431
PASS THROUGH COST ADJUSTMENTS					
50.00 Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)					715,167
51.00 Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					296,253
52.00 Total Program excludable cost (sum of lines 50 and 51)					1,011,420
53.00 Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					7,835,011
TARGET AMOUNT AND LIMIT COMPUTATION					
54.00 Program discharges					0
55.00 Target amount per discharge					0.00
56.00 Target amount (line 54 x line 55)					0
57.00 Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)					0
58.00 Bonus payment (see instructions)					0
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
60.00 Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket					0.00
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
62.00 Relief payment (see instructions)					0
63.00 Allowable Inpatient cost plus incentive payment (see instructions)					0
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
65.00 Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					0
66.00 Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)					0
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
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
69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)					0
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
88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					0.00
89.00 Observation bed cost (line 87 x line 88) (see instructions)					0

COMPUTATION OF INPATIENT OPERATING COST			Provider CCN: 14-0252 Component CCN: 14-T252		Period: From 10/01/2019 To 09/30/2020		Worksheet D-1 Date/Time Prepared: 4/29/2021 1:24 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		1,152,518	7,532,866	0.152999	0	0	90.00
91.00	Nursing School cost		0	7,532,866	0.000000	0	0	91.00
92.00	Allied health cost		0	7,532,866	0.000000	0	0	92.00
93.00	All other Medical Education		0	7,532,866	0.000000	0	0	93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-0252	Period: From 10/01/2019 To 09/30/2020	Worksheet D-1 Date/Time Prepared: 4/29/2021 1:24 pm
Cost Center Description		Title XIX	Hospital	Cost
				1.00
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)			68,912 1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)			68,912 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)			67,401 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)			3,061 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)			4,264 15.00
16.00	Nursery days (title V or XIX only)			511 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)			77,546,325 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)			77,546,325 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)			77,546,325 37.00
PART II - HOSPITAL AND SUBPROVIDERS ONLY				
PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS				
38.00	Adjusted general inpatient routine service cost per diem (see instructions)			1,125.29 38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)			3,444,513 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)			3,444,513 41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-0252

Period:
From 10/01/2019
To 09/30/2020

Worksheet D-1

Date/Time Prepared:
4/29/2021 1:24 pm

Cost Center Description		Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Hospital 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)	4,224,422	4,264	990.72	511	506,258	42.00	
Intensive Care Type Inpatient Hospital Units								
43.00	INTENSIVE CARE UNIT	20,338,696	7,461	2,726.00	127	346,202	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	NEONATAL INTENSIVE CARE UNIT	4,028,039	3,651	1,103.27	253	279,127	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)						4,576,100	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)						1,511	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)						1,125.29	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)						1,700.313	89.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-0252

Period:
From 10/01/2019
To 09/30/2020

Worksheet D-1

Date/Time Prepared:
4/29/2021 1:24 pm

Cost Center Description		Title XIX		Hospital		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	10,546,949	77,546,325	0.136008	1,700,313	231,256	90.00
91.00	Nursing School cost	0	77,546,325	0.000000	1,700,313	0	91.00
92.00	Allied health cost	0	77,546,325	0.000000	1,700,313	0	92.00
93.00	All other Medical Education	0	77,546,325	0.000000	1,700,313	0	93.00

Health Financial Systems		NORTHWEST COMMUNITY HOSPITAL		In Lieu of Form CMS-2552-10	
COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-0252	Period: From 10/01/2019	Worksheet D-1	
		Component CCN: 14-S252	To 09/30/2020	Date/Time Prepared: 4/29/2021 1:24 pm	
		Title XIX	Subprovider - IPF	Cost	
Cost Center Description				1.00	
PART I - ALL PROVIDER COMPONENTS					
INPATIENT DAYS					
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)			13,755	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)			13,755	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)			13,755	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)			1,263	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)			4,264	15.00
16.00	Nursery days (title V or XIX only)			511	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)			15,836,779	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)			15,836,779	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)			15,836,779	37.00
PART II - HOSPITAL AND SUBPROVIDERS ONLY					
PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS					
38.00	Adjusted general inpatient routine service cost per diem (see instructions)			1,151.35	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)			1,454,155	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)			1,454,155	41.00

COMPUTATION OF INPATIENT OPERATING COST				Provider CCN: 14-0252 Component CCN: 14-S252	Period: From 10/01/2019 To 09/30/2020	Worksheet D-1 Date/Time Prepared: 4/29/2021 1:24 pm	
				Title XIX		Subprovider - IPF	Cost
Cost Center Description		Total	Total	Average Per	Program Days	Program Cost (col. 3 x col. 4)	
		Inpatient Cost	Inpatient Days	Diem (col. 1 ÷ col. 2)			
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)	0	0	0.00	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	NEONATAL INTENSIVE CARE UNIT	0	0	0.00	0	0	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)					1,454,155	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: 14-0252 Component CCN: 14-S252		Period: From 10/01/2019 To 09/30/2020		Worksheet D-1 Date/Time Prepared: 4/29/2021 1:24 pm	
		Title XIX		Subprovider - IPF		Cost	
Cost Center Description		Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00	Capital-related cost	2,113,232	15,836,779	0.133438	0	0	90.00
91.00	Nursing School cost	0	15,836,779	0.000000	0	0	91.00
92.00	Allied health cost	0	15,836,779	0.000000	0	0	92.00
93.00	All other Medical Education	0	15,836,779	0.000000	0	0	93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-0252 Component CCN: 14-T252	Period: From 10/01/2019 To 09/30/2020	Worksheet D-1 Date/Time Prepared: 4/29/2021 1:24 pm
		Title XIX	Subprovider - IRF	Cost
Cost Center Description				1.00
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)			9,047 1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)			9,047 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)			9,047 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)			229 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)			4,264 15.00
16.00	Nursery days (title V or XIX only)			511 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)			7,532,866 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)			7,532,866 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)			7,532,866 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)			832.64 38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)			190,675 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)			190,675 41.00

COMPUTATION OF INPATIENT OPERATING COST				Provider CCN: 14-0252 Component CCN: 14-T252	Period: From 10/01/2019 To 09/30/2020	Worksheet D-1 Date/Time Prepared: 4/29/2021 1:24 pm	
				Title XIX		Subprovider - IRF	Cost
Cost Center Description		Total	Total	Average Per	Program Days	Program Cost (col. 3 x col. 4)	
		Inpatient Cost	Inpatient Days	Diem (col. 1 ÷ col. 2)			
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)	0	0	0.00	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	NEONATAL INTENSIVE CARE UNIT	0	0	0.00	0	0	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)					190,675	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: 14-0252 Component CCN: 14-T252		Period: From 10/01/2019 To 09/30/2020		Worksheet D-1 Date/Time Prepared: 4/29/2021 1:24 pm	
			Title XIX		Subprovider - IRF		Cost	
Cost Center Description			Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
			1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH COST								
90.00	Capital-related cost		1,152,518	7,532,866	0.152999	0	0	90.00
91.00	Nursing School cost		0	7,532,866	0.000000	0	0	91.00
92.00	Allied health cost		0	7,532,866	0.000000	0	0	92.00
93.00	All other Medical Education		0	7,532,866	0.000000	0	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT			Provider CCN: 14-0252	Period: From 10/01/2019 To 09/30/2020	Worksheet D-3 Date/Time Prepared: 4/29/2021 1:24 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		55,789,086	30.00
31.00	03100	INTENSIVE CARE UNIT		17,958,353	31.00
35.00	02060	NEONATAL INTENSIVE CARE UNIT		0	35.00
40.00	04000	SUBPROVIDER - IPF		0	40.00
41.00	04100	SUBPROVIDER - IRF		0	41.00
43.00	04300	NURSERY			43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0.325986	20,240,644	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.591336	9,818	52.00
53.00	05300	ANESTHESIOLOGY	0.024637	2,767,402	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.104805	44,582,015	54.00
54.01	05401	OFFSITE-DIAGNOSTIC SERVICES	0.077170	157,115	54.01
56.01	03480	ONCOLOGY	0.751519	54,253	56.01
60.00	06000	LABORATORY	0.150431	36,490,547	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0.258581	4,612,340	62.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0.000000	0	62.30
65.00	06500	RESPIRATORY THERAPY	0.167760	12,177,159	65.00
66.00	06600	PHYSICAL THERAPY	0.361754	4,927,587	66.00
66.01	06601	IP REHAB THERAPIES	0.422070	0	66.01
69.00	06900	ELECTROCARDIOLOGY	0.233009	6,386,453	69.00
69.01	03630	CARDIAC CATH LAB	0.105993	13,190,037	69.01
69.02	03160	CARDIAC REHABILITATION	0.000000	0	69.02
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.311634	30,354,031	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.393127	22,545,685	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.258547	20,993,628	73.00
73.01	07301	FLU VACCINE DRUGS CHG TO PATIENTS	0.500376	0	73.01
74.00	07400	RENAL DIALYSIS	0.354088	3,610,010	74.00
76.97	07697	CARDIAC REHABILITATION	1.159137	1,612	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0.000000	0	76.98
76.99	07699	LITHOTRIPSY	0.000000	0	76.99
OUTPATIENT SERVICE COST CENTERS					
90.01	09001	OUTPATIENT TREATMENT CENTERS	0.434651	72,082	90.01
90.02	09002	PARTIAL HOSPITALIZATION PROGRAM	1.314661	12,750	90.02
91.00	09100	EMERGENCY	0.178754	20,890,277	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.934950	258,302	92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	0.480924	1,623,786	92.01
200.00		Total (sum of lines 50 through 94 and 96 through 98)		245,957,533	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)		245,957,533	202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 14-0252	Period: From 10/01/2019 To 09/30/2020	Worksheet D-3 Date/Time Prepared: 4/29/2021 1:24 pm	
		Component CCN: 14-S252			
		Title XVIII	Subprovider - IPF	PPS	
Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDIATRICS		0		30.00
31.00	03100 INTENSIVE CARE UNIT		0		31.00
35.00	02060 NEONATAL INTENSIVE CARE UNIT		0		35.00
40.00	04000 SUBPROVIDER - IPF		5,645,564		40.00
41.00	04100 SUBPROVIDER - IRF		0		41.00
43.00	04300 NURSERY				43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.325986	0	0	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.591336	0	0	52.00
53.00	05300 ANESTHESIOLOGY	0.024637	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.104805	101,529	10,641	54.00
54.01	05401 OFFSITE-DIAGNOSTIC SERVICES	0.077170	0	0	54.01
56.01	03480 ONCOLOGY	0.751519	0	0	56.01
60.00	06000 LABORATORY	0.150431	378,403	56,924	60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0.258581	178	46	62.00
62.30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0.000000	0	0	62.30
65.00	06500 RESPIRATORY THERAPY	0.167760	2,242	376	65.00
66.00	06600 PHYSICAL THERAPY	0.361754	49,547	17,924	66.00
66.01	06601 IP REHAB THERAPIES	0.422070	0	0	66.01
69.00	06900 ELECTROCARDIOLOGY	0.233009	66,268	15,441	69.00
69.01	03630 CARDIAC CATH LAB	0.105993	0	0	69.01
69.02	03160 CARDIAC REHABILITATION	0.000000	0	0	69.02
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.311634	27,516	8,575	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.393127	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.258547	181,840	47,014	73.00
73.01	07301 FLU VACCINE DRUGS CHG TO PATIENTS	0.500376	0	0	73.01
74.00	07400 RENAL DIALYSIS	0.354088	0	0	74.00
76.97	07697 CARDIAC REHABILITATION	1.159137	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					
90.01	09001 OUTPATIENT TREATMENT CENTERS	0.434651	0	0	90.01
90.02	09002 PARTIAL HOSPITALIZATION PROGRAM	1.314661	71,909	94,536	90.02
91.00	09100 EMERGENCY	0.178754	442,959	79,181	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.934950	0	0	92.00
92.01	09201 OBSERVATION BEDS (DISTINCT PART)	0.480924	0	0	92.01
200.00	Total (sum of lines 50 through 94 and 96 through 98)		1,322,391	330,658	200.00
201.00	Less PBP Clinic Laboratory Services-Program only charges (line 61)		0		201.00
202.00	Net charges (line 200 minus line 201)		1,322,391		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 14-0252 Component CCN: 14-T252	Period: From 10/01/2019 To 09/30/2020	Worksheet D-3 Date/Time Prepared: 4/29/2021 1:24 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
35.00	02060 NEONATAL INTENSIVE CARE UNIT		0		35.00
40.00	04000 SUBPROVIDER - IPF		0		40.00
41.00	04100 SUBPROVIDER - IRF		9,778,676		41.00
43.00	04300 NURSERY				43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.325986	20,688	6,744	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.591336	0	0	52.00
53.00	05300 ANESTHESIOLOGY	0.024637	1,414	35	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.104805	548,108	57,444	54.00
54.01	05401 OFFSITE-DIAGNOSTIC SERVICES	0.077170	827	64	54.01
56.01	03480 ONCOLOGY	0.751519	0	0	56.01
60.00	06000 LABORATORY	0.150431	1,178,898	177,343	60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0.258581	23,681	6,123	62.00
62.30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0.000000	0	0	62.30
65.00	06500 RESPIRATORY THERAPY	0.167760	752,902	126,307	65.00
66.00	06600 PHYSICAL THERAPY	0.361754	22,287	8,062	66.00
66.01	06601 IP REHAB THERAPIES	0.422070	7,827,931	3,303,935	66.01
69.00	06900 ELECTROCARDIOLOGY	0.233009	39,055	9,100	69.00
69.01	03630 CARDIAC CATH LAB	0.105993	0	0	69.01
69.02	03160 CARDIAC REHABILITATION	0.000000	0	0	69.02
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.311634	221,716	69,094	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.393127	16,361	6,432	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.258547	876,553	226,630	73.00
73.01	07301 FLU VACCINE DRUGS CHG TO PATIENTS	0.500376	0	0	73.01
74.00	07400 RENAL DIALYSIS	0.354088	484,304	171,486	74.00
76.97	07697 CARDIAC REHABILITATION	1.159137	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					
90.01	09001 OUTPATIENT TREATMENT CENTERS	0.434651	1,401	609	90.01
90.02	09002 PARTIAL HOSPITALIZATION PROGRAM	1.314661	0	0	90.02
91.00	09100 EMERGENCY	0.178754	14,328	2,561	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.934950	0	0	92.00
92.01	09201 OBSERVATION BEDS (DISTINCT PART)	0.480924	43	21	92.01
200.00	Total (sum of lines 50 through 94 and 96 through 98)		12,030,497	4,171,990	200.00
201.00	Less PBP Clinic Laboratory Services-Program only charges (line 61)		0	0	201.00
202.00	Net charges (line 200 minus line 201)		12,030,497		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 14-0252	Period: From 10/01/2019 To 09/30/2020	Worksheet D-3 Date/Time Prepared: 4/29/2021 1:24 pm	
		Title XIX	Hospital	Cost	
Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS		0	30.00
31.00	03100	INTENSIVE CARE UNIT		0	31.00
35.00	02060	NEONATAL INTENSIVE CARE UNIT		0	35.00
40.00	04000	SUBPROVIDER - IPF		0	40.00
41.00	04100	SUBPROVIDER - IRF		0	41.00
43.00	04300	NURSERY		0	43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0.000000	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	0	54.00
54.01	05401	OFFSITE-DIAGNOSTIC SERVICES	0.000000	0	54.01
56.01	03480	ONCOLOGY	0.000000	0	56.01
60.00	06000	LABORATORY	0.000000	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0.000000	0	62.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0.000000	0	62.30
65.00	06500	RESPIRATORY THERAPY	0.000000	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	0	66.00
66.01	06601	IP REHAB THERAPIES	0.000000	0	66.01
69.00	06900	ELECTROCARDIOLOGY	0.000000	0	69.00
69.01	03630	CARDIAC CATH LAB	0.000000	0	69.01
69.02	03160	CARDIAC REHABILITATION	0.000000	0	69.02
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	0	73.00
73.01	07301	FLU VACCINE DRUGS CHG TO PATIENTS	0.000000	0	73.01
74.00	07400	RENAL DIALYSIS	0.000000	0	74.00
76.97	07697	CARDIAC REHABILITATION	0.000000	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0.000000	0	76.98
76.99	07699	LITHOTRIPSY	0.000000	0	76.99
OUTPATIENT SERVICE COST CENTERS					
90.01	09001	OUTPATIENT TREATMENT CENTERS	0.000000	0	90.01
90.02	09002	PARTIAL HOSPITALIZATION PROGRAM	0.000000	0	90.02
91.00	09100	EMERGENCY	0.000000	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	0	92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	0.000000	0	92.01
200.00		Total (sum of lines 50 through 94 and 96 through 98)		0	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)		0	202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 14-0252 Component CCN: 14-S252	Period: From 10/01/2019 To 09/30/2020	Worksheet D-3 Date/Time Prepared: 4/29/2021 1:24 pm	
		Title XIX	Subprovider - IPF	Cost	
Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDIATRICS		0		30.00
31.00	03100 INTENSIVE CARE UNIT		0		31.00
35.00	02060 NEONATAL INTENSIVE CARE UNIT		0		35.00
40.00	04000 SUBPROVIDER - IPF		0		40.00
41.00	04100 SUBPROVIDER - IRF		0		41.00
43.00	04300 NURSERY		0		43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.000000	0	0	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.000000	0	0	52.00
53.00	05300 ANESTHESIOLOGY	0.000000	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.000000	0	0	54.00
54.01	05401 OFFSITE-DIAGNOSTIC SERVICES	0.000000	0	0	54.01
56.01	03480 ONCOLOGY	0.000000	0	0	56.01
60.00	06000 LABORATORY	0.000000	0	0	60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0.000000	0	0	62.00
62.30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0.000000	0	0	62.30
65.00	06500 RESPIRATORY THERAPY	0.000000	0	0	65.00
66.00	06600 PHYSICAL THERAPY	0.000000	0	0	66.00
66.01	06601 IP REHAB THERAPIES	0.000000	0	0	66.01
69.00	06900 ELECTROCARDIOLOGY	0.000000	0	0	69.00
69.01	03630 CARDIAC CATH LAB	0.000000	0	0	69.01
69.02	03160 CARDIAC REHABILITATION	0.000000	0	0	69.02
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.000000	0	0	73.00
73.01	07301 FLU VACCINE DRUGS CHG TO PATIENTS	0.000000	0	0	73.01
74.00	07400 RENAL DIALYSIS	0.000000	0	0	74.00
76.97	07697 CARDIAC REHABILITATION	0.000000	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					
90.01	09001 OUTPATIENT TREATMENT CENTERS	0.000000	0	0	90.01
90.02	09002 PARTIAL HOSPITALIZATION PROGRAM	0.000000	0	0	90.02
91.00	09100 EMERGENCY	0.000000	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	0	0	92.00
92.01	09201 OBSERVATION BEDS (DISTINCT PART)	0.000000	0	0	92.01
200.00	Total (sum of lines 50 through 94 and 96 through 98)		0	0	200.00
201.00	Less PBP Clinic Laboratory Services-Program only charges (line 61)		0	0	201.00
202.00	Net charges (line 200 minus line 201)		0	0	202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0252	Period: From 10/01/2019 To 09/30/2020	Worksheet E Part A Date/Time Prepared: 4/29/2021 1:24 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)		0	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1 (see instructions)		76,933,564	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)		0	2.03
2.04	Outlier payments for discharges occurring on or after October 1 (see instructions)		605,429	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)		413.69	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)		2.47	30.00
31.00	Percentage of Medicaid patient days (see instructions)		13.66	31.00
32.00	Sum of lines 30 and 31		16.13	32.00
33.00	Allowable disproportionate share percentage (see instructions)		3.23	33.00
34.00	Disproportionate share adjustment (see instructions)		621,239	34.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0252	Period: From 10/01/2019 To 09/30/2020	Worksheet E Part A Date/Time Prepared: 4/29/2021 1:24 pm	
		Title XVIII	Hospital	PPS	
			Prior to 10/1	On/After 10/1	
			1.00	2.00	
Uncompensated Care Adjustment					
35.00	Total uncompensated care amount (see instructions)		0	8,350,599,096	35.00
35.01	Factor 3 (see instructions)	0.000000000	0.000577509		35.01
35.02	Hospital uncompensated care payment (If line 34 is zero, enter zero on this line) (see instructions)		0	4,822,546	35.02
35.03	Pro rata share of the hospital uncompensated care payment amount (see instructions)		0	4,822,546	35.03
36.00	Total uncompensated care (sum of columns 1 and 2 on line 35.03)		4,822,546		36.00
Additional payment for high percentage of ESRD beneficiary discharges (lines 40 through 46)					
40.00	Total Medicare discharges, excluding MS-DRGs 652, 682, 683, 684 and 685. (see instructions)		0		40.00
			Before 1/1	On/After 1/1	
			1.00	1.01	
41.00	Total ESRD Medicare discharges excluding MS-DRGs 652, 682, 683, 684 and 685. (see instructions)		0	0	41.00
41.01	Total ESRD Medicare covered and paid discharges excluding MS-DRGs 652, 682, 683, 684 and 685. (see instructions)		0	0	41.01
42.00	Divide line 41 by line 40 (if less than 10%, you do not qualify for adjustment)	0.00			42.00
43.00	Total Medicare ESRD inpatient days excluding MS-DRGs 652, 682, 683, 684 and 685. (see instructions)		0		43.00
44.00	Ratio of average length of stay to one week (line 43 divided by line 41 divided by 7 days)	0.000000			44.00
45.00	Average weekly cost for dialysis treatments (see instructions)	0.00	0.00		45.00
46.00	Total additional payment (line 45 times line 44 times line 41.01)		0		46.00
47.00	Subtotal (see instructions)		82,982,778		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)			82,982,778	49.00
50.00	Payment for inpatient program capital (from Wkst. L, Pt. I and Pt. II, as applicable)			6,469,666	50.00
51.00	Exception payment for inpatient program capital (Wkst. L, Pt. III, see instructions)			0	51.00
52.00	Direct graduate medical education payment (from Wkst. E-4, line 49 see instructions).			0	52.00
53.00	Nursing and Allied Health Managed Care payment			0	53.00
54.00	Special add-on payments for new technologies			0	54.00
54.01	Islet isolation add-on payment			0	54.01
55.00	Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line 69)			0	55.00
56.00	Cost of physicians' services in a teaching hospital (see instructions)			0	56.00
57.00	Routine service other pass through costs (from Wkst. D, Pt. III, column 9, lines 30 through 35).			0	57.00
58.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 11 line 200)			0	58.00
59.00	Total (sum of amounts on lines 49 through 58)			89,452,444	59.00
60.00	Primary payer payments			65,729	60.00
61.00	Total amount payable for program beneficiaries (line 59 minus line 60)			89,386,715	61.00
62.00	Deductibles billed to program beneficiaries			7,612,660	62.00
63.00	Coinsurance billed to program beneficiaries			273,812	63.00
64.00	Allowable bad debts (see instructions)			1,015,545	64.00
65.00	Adjusted reimbursable bad debts (see instructions)			660,104	65.00
66.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			542,040	66.00
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)			82,160,347	67.00
68.00	Credits received from manufacturers for replaced devices for applicable to MS-DRGs (see instructions)			0	68.00
69.00	Outlier payments reconciliation (sum of lines 93, 95 and 96). (For SCH see instructions)			0	69.00
70.00	OTHER ADJ-ALLIED HEALTH A&G			0	70.00
70.50	Rural Community Hospital Demonstration Project (\$410A Demonstration) adjustment (see instructions)			0	70.50
70.87	Demonstration payment adjustment amount before sequestration			0	70.87
70.88	SCH or MDH volume decrease adjustment (contractor use only)			0	70.88
70.89	Pioneer ACO demonstration payment adjustment amount (see instructions)			0	70.89
70.90	HSP bonus payment HVBP adjustment amount (see instructions)			0	70.90
70.91	HSP bonus payment HRR adjustment amount (see instructions)			0	70.91
70.92	Bundled Model 1 discount amount (see instructions)			0	70.92
70.93	HVBP payment adjustment amount (see instructions)			-465,519	70.93
70.94	HRR adjustment amount (see instructions)			-115,404	70.94
70.95	Recovery of accelerated depreciation			0	70.95

CALCULATION OF REIMBURSEMENT SETTLEMENT

Provider CCN: 14-0252

Period:
From 10/01/2019
To 09/30/2020Worksheet E
Part A
Date/Time Prepared:
4/29/2021 1:24 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)			81,579,424	71.00
71.01	Sequestration adjustment (see instructions)			946,321	71.01
71.02	Demonstration payment adjustment amount after sequestration			0	71.02
71.03	Sequestration adjustment-PARHM pass-throughs			0	71.03
72.00	Interim payments			80,869,635	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)			-236,532	74.00
74.01	Balance due provider/program-PARHM (see instructions)				74.01
75.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2			1,708,963	75.00
TO BE COMPLETED BY CONTRACTOR (lines 90 through 96)					
90.00	Operating outlier amount from Wkst. E, Pt. A, line 2, or sum of 2.03 plus 2.04 (see instructions)			0	90.00
91.00	Capital outlier from Wkst. L, Pt. I, line 2			0	91.00
92.00	Operating outlier reconciliation adjustment amount (see instructions)			0	92.00
93.00	Capital outlier reconciliation adjustment amount (see instructions)			0	93.00
94.00	The rate used to calculate the time value of money (see instructions)			0.00	94.00
95.00	Time value of money for operating expenses (see instructions)			0	95.00
96.00	Time value of money for capital related expenses (see instructions)			0	96.00
			Prior to 10/1	On/After 10/1	
			1.00	2.00	
	HSP Bonus Payment Amount				
100.00	HSP bonus amount (see instructions)			0	100.00
	HVBP Adjustment for HSP Bonus Payment				
101.00	HVBP adjustment factor (see instructions)			0.0000000000	101.00
102.00	HVBP adjustment amount for HSP bonus payment (see instructions)			0	102.00
	HRR Adjustment for HSP Bonus Payment				
103.00	HRR adjustment factor (see instructions)			0.0000	103.00
104.00	HRR adjustment amount for HSP bonus payment (see instructions)			0	104.00
	Rural Community Hospital Demonstration Project (§410A Demonstration) Adjustment				
200.00	Is this the first year of the current 5-year demonstration period under the 21st Century Cures Act? Enter "Y" for yes or "N" for no.				200.00
	Cost Reimbursement				
201.00	Medicare inpatient service costs (from Wkst. D-1, Pt. II, line 49)				201.00
202.00	Medicare discharges (see instructions)				202.00
203.00	Case-mix adjustment factor (see instructions)				203.00
	Computation of Demonstration Target Amount Limitation (N/A in first year of the current 5-year demonstration period)				
204.00	Medicare target amount				204.00
205.00	Case-mix adjusted target amount (line 203 times line 204)				205.00
206.00	Medicare inpatient routine cost cap (line 202 times line 205)				206.00
	Adjustment to Medicare Part A Inpatient Reimbursement				
207.00	Program reimbursement under the §410A Demonstration (see instructions)				207.00
208.00	Medicare Part A inpatient service costs (from Wkst. E, Pt. A, line 59)				208.00
209.00	Adjustment to Medicare IPPS payments (see instructions)				209.00
210.00	Reserved for future use				210.00
211.00	Total adjustment to Medicare IPPS payments (see instructions)				211.00
	Comparison of PPS versus Cost Reimbursement				
212.00	Total adjustment to Medicare Part A IPPS payments (from line 211)				212.00
213.00	Low-volume adjustment (see instructions)				213.00
218.00	Net Medicare Part A IPPS adjustment (difference between PPS and cost reimbursement) (line 212 minus line 213) (see instructions)				218.00

LOW VOLUME CALCULATION EXHIBIT 4

Provider CCN: 14-0252

Period:
From 10/01/2019
To 09/30/2020Worksheet E
Part A Exhibit 4
Date/Time Prepared:
4/29/2021 1:24 pm

		Title XVIII		Hospital		PPS	
		W/S E, Part A line	Amounts (from E, Part A)	Pre/Post Entitlement	Period Prior to 10/01	Period On/After 10/01	Total (Col 2 through 4)
		0	1.00	2.00	3.00	4.00	5.00
1.00	DRG amounts other than outlier payments	1.00	0	0	0	0	0
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1	1.01	0	0	0	0	0
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	76,933,564	0	0	76,933,564	76,933,564
1.03	DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October 1	1.03	0	0	0	0	0
1.04	DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1	1.04	0	0	0	0	0
2.00	Outlier payments for discharges (see instructions)	2.00					
2.01	Outlier payments for discharges for Model 4 BPCI	2.02	0	0	0	0	0
2.02	Outlier payments for discharges occurring prior to October 1 (see instructions)	2.03	0	0	1,036,771	0	1,036,771
2.03	Outlier payments for discharges occurring on or after October 1 (see instructions)	2.04	605,429	0	0	605,429	605,429
3.00	Operating outlier reconciliation	2.01	0	0	0	0	0
4.00	Managed care simulated payments	3.00	0	0	0	0	0
Indirect Medical Education Adjustment							
5.00	Amount from Worksheet E, Part A, line 21 (see instructions)	21.00	0.000000	0.000000	0.000000	0.000000	0
6.00	IME payment adjustment (see instructions)	22.00	0	0	0	0	0
6.01	IME payment adjustment for managed care (see instructions)	22.01	0	0	0	0	0
Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA							
7.00	IME payment adjustment factor (see instructions)	27.00	0.000000	0.000000	0.000000	0.000000	0
8.00	IME adjustment (see instructions)	28.00	0	0	0	0	0
8.01	IME payment adjustment add on for managed care (see instructions)	28.01	0	0	0	0	0
9.00	Total IME payment (sum of lines 6 and 8)	29.00	0	0	0	0	0
9.01	Total IME payment for managed care (sum of lines 6.01 and 8.01)	29.01	0	0	0	0	0
Disproportionate Share Adjustment							
10.00	Allowable disproportionate share percentage (see instructions)	33.00	0.0323	0.0323	0.0323	0.0323	0
11.00	Disproportionate share adjustment (see instructions)	34.00	621,239	0	0	621,239	621,239
11.01	Uncompensated care payments	36.00	4,822,546	0	0	1,639,612	1,639,612
Additional payment for high percentage of ESRD beneficiary discharges							
12.00	Total ESRD additional payment (see instructions)	46.00	0	0	0	0	0
13.00	Subtotal (see instructions)	47.00	82,982,778	0	1,036,771	81,946,007	82,982,778
14.00	Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see instructions)	48.00	0	0	0	0	0
15.00	Total payment for inpatient operating costs (see instructions)	49.00	82,982,778	0	1,036,771	81,946,007	82,982,778
16.00	Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable)	50.00	6,469,666	0	0	6,469,666	6,469,666

LOW VOLUME CALCULATION EXHIBIT 4

Provider CCN: 14-0252

Period:
From 10/01/2019
To 09/30/2020Worksheet E
Part A Exhibit 4
Date/Time Prepared:
4/29/2021 1:24 pm

				Title XVIII		Hospital	PPS	
		W/S E, Part A line	Amounts (from E, Part A)	Pre/Post Entitlement	Period Prior to 10/01	Period On/After 10/01	Total (Col 2 through 4)	
		0	1.00	2.00	3.00	4.00	5.00	
17.00	Special add-on payments for new technologies	54.00	0	0	0	0	0	17.00
17.01	Net organ aquisition cost							17.01
17.02	Credits received from manufacturers for replaced devices for applicable MS-DRGs	68.00	0	0	0	0	0	17.02
18.00	Capital outlier reconciliation adjustment amount (see instructions)	93.00	0	0	0	0	0	18.00
19.00	SUBTOTAL			0	1,036,771	88,415,673	89,452,444	19.00
		W/S L, line	(Amounts from L)					
		0	1.00	2.00	3.00	4.00	5.00	
20.00	Capital DRG other than outlier	1.00	6,078,728	0	0	6,078,728	6,078,728	20.00
20.01	Model 4 BPCI Capital DRG other than outlier	1.01	0	0	0	0	0	20.01
21.00	Capital DRG outlier payments	2.00	189,124	0	0	189,124	189,124	21.00
21.01	Model 4 BPCI Capital DRG outlier payments	2.01	0	0	0	0	0	21.01
22.00	Indirect medical education percentage (see instructions)	5.00	0.0000	0.0000	0.0000	0.0000		22.00
23.00	Indirect medical education adjustment (see instructions)	6.00	0	0	0	0	0	23.00
24.00	Allowable disproportionate share percentage (see instructions)	10.00	0.0332	0.0332	0.0332	0.0332		24.00
25.00	Disproportionate share adjustment (see instructions)	11.00	201,814	0	0	201,814	201,814	25.00
26.00	Total prospective capital payments (see instructions)	12.00	6,469,666	0	0	6,469,666	6,469,666	26.00
		W/S E, Part A line	(Amounts to E, Part A)					
		0	1.00	2.00	3.00	4.00	5.00	
27.00	Low volume adjustment factor				0.000000	0.000000		27.00
28.00	Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)	70.96			0		0	28.00
29.00	Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)	70.97				0	0	29.00
100.00	Transfer low volume adjustments to Wkst. E, Pt. A.		Y					100.00

HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULATION EXHIBIT 5

Provider CCN: 14-0252

Period:
From 10/01/2019
To 09/30/2020Worksheet E
Part A Exhibit 5
Date/Time Prepared:
4/29/2021 1:24 pm

		Title XVIII		Hospital		PPS	
		Wkst. E, Pt. A, line	Amt. from Wkst. E, Pt. A	Period to 10/01	Period on after 10/01	Total (cols. 2 and 3)	
		0	1.00	2.00	3.00	4.00	
1.00	DRG amounts other than outlier payments	1.00					1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1	1.01	0	0		0	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	76,933,564		76,933,564	76,933,564	1.02
1.03	DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October 1	1.03	0	0		0	1.03
1.04	DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1	1.04	0		0	0	1.04
2.00	Outlier payments for discharges (see instructions)	2.00					2.00
2.01	Outlier payments for discharges for Model 4 BPCI	2.02	0	0	0	0	2.01
2.02	Outlier payments for discharges occurring prior to October 1 (see instructions)	2.03	0	1,036,771		1,036,771	2.02
2.03	Outlier payments for discharges occurring on or after October 1 (see instructions)	2.04	605,429		605,429	605,429	2.03
3.00	Operating outlier reconciliation	2.01	0	0	0	0	3.00
4.00	Managed care simulated payments	3.00	0	0	0	0	4.00
Indirect Medical Education Adjustment							
5.00	Amount from Worksheet E, Part A, line 21 (see instructions)	21.00	0.000000	0.000000	0.000000		5.00
6.00	IME payment adjustment (see instructions)	22.00	0	0	0	0	6.00
6.01	IME payment adjustment for managed care (see instructions)	22.01	0	0	0	0	6.01
Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA							
7.00	IME payment adjustment factor (see instructions)	27.00	0.000000	0.000000	0.000000		7.00
8.00	IME adjustment (see instructions)	28.00	0	0	0	0	8.00
8.01	IME payment adjustment add on for managed care (see instructions)	28.01	0	0	0	0	8.01
9.00	Total IME payment (sum of lines 6 and 8)	29.00	0	0	0	0	9.00
9.01	Total IME payment for managed care (sum of lines 6.01 and 8.01)	29.01	0	0	0	0	9.01
Disproportionate Share Adjustment							
10.00	Allowable disproportionate share percentage (see instructions)	33.00	0.0323	0.0323	0.0323		10.00
11.00	Disproportionate share adjustment (see instructions)	34.00	621,239	0	621,239	621,239	11.00
11.01	Uncompensated care payments	36.00	4,822,546	0	3,370,161	3,370,161	11.01
Additional payment for high percentage of ESRD beneficiary discharges							
12.00	Total ESRD additional payment (see instructions)	46.00	0	0	0	0	12.00
13.00	Subtotal (see instructions)	47.00	82,982,778	1,036,771	81,946,007	82,982,778	13.00
14.00	Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see instructions)	48.00	0	0	0	0	14.00
15.00	Total payment for inpatient operating costs (see instructions)	49.00	82,982,778	1,036,771	81,946,007	82,982,778	15.00
16.00	Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable)	50.00	6,469,666	0	6,469,666	6,469,666	16.00
17.00	Special add-on payments for new technologies	54.00	0	0	0	0	17.00
17.01	Net organ acquisition cost						17.01
17.02	Credits received from manufacturers for replaced devices for applicable MS-DRGs	68.00	0	0	0	0	17.02
18.00	Capital outlier reconciliation adjustment amount (see instructions)	93.00	0	0	0	0	18.00
19.00	SUBTOTAL			1,036,771	88,415,673	89,452,444	19.00

HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULATION EXHIBIT 5

Provider CCN: 14-0252

Period:
From 10/01/2019
To 09/30/2020Worksheet E
Part A Exhibit 5
Date/Time Prepared:
4/29/2021 1:24 pm

		Title XVIII		Hospital		PPS	
		Wkst. L, line	(Amt. from Wkst. L)				
		0	1.00	2.00	3.00	4.00	
20.00	Capital DRG other than outlier	1.00	6,078,728	0	6,078,728	6,078,728	20.00
20.01	Model 4 BPCI Capital DRG other than outlier	1.01	0	0	0	0	20.01
21.00	Capital DRG outlier payments	2.00	189,124	0	189,124	189,124	21.00
21.01	Model 4 BPCI Capital DRG outlier payments	2.01	0	0	0	0	21.01
22.00	Indirect medical education percentage (see instructions)	5.00	0.0000	0.0000	0.0000		22.00
23.00	Indirect medical education adjustment (see instructions)	6.00	0	0	0	0	23.00
24.00	Allowable disproportionate share percentage (see instructions)	10.00	0.0332	0.0332	0.0332		24.00
25.00	Disproportionate share adjustment (see instructions)	11.00	201,814	0	201,814	201,814	25.00
26.00	Total prospective capital payments (see instructions)	12.00	6,469,666	0	6,469,666	6,469,666	26.00
		Wkst. E, Pt. A, line	(Amt. from Wkst. E, Pt. A)				
		0	1.00	2.00	3.00	4.00	
27.00							27.00
28.00	Low volume adjustment prior to October 1	70.96	0	0		0	28.00
29.00	Low volume adjustment on or after October 1	70.97	0		0	0	29.00
30.00	HVBP payment adjustment (see instructions)	70.93	-465,519	0	-465,519	-465,519	30.00
30.01	HVBP payment adjustment for HSP bonus payment (see instructions)	70.90	0	0	0	0	30.01
31.00	HRR adjustment (see instructions)	70.94	-115,404	0	-115,404	-115,404	31.00
31.01	HRR adjustment for HSP bonus payment (see instructions)	70.91	0	0	0	0	31.01
						(Amt. to Wkst. E, Pt. A)	
		0	1.00	2.00	3.00	4.00	
32.00	HAC Reduction Program adjustment (see instructions)	70.99		0	0	0	32.00
100.00	Transfer HAC Reduction Program adjustment to Wkst. E, Pt. A.		Y				100.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0252	Period: From 10/01/2019 To 09/30/2020	Worksheet E Part B Date/Time Prepared: 4/29/2021 1:24 pm
		Title XVIII	Hospital	PPS
				1.00
PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)		37,309	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)		60,369,714	2.00
3.00	OPPS payments		47,021,077	3.00
4.00	Outlier payment (see instructions)		24,366	4.00
4.01	Outlier reconciliation amount (see instructions)		0	4.01
5.00	Enter the hospital specific payment to cost ratio (see instructions)		0.899	5.00
6.00	Line 2 times line 5		54,272,373	6.00
7.00	Sum of lines 3, 4, and 4.01, divided by line 6		86.68	7.00
8.00	Transitional corridor payment (see instructions)		0	8.00
9.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200		0	9.00
10.00	Organ acquisitions		0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)		37,309	11.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
12.00	Ancillary service charges		68,354	12.00
13.00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, line 69)		0	13.00
14.00	Total reasonable charges (sum of lines 12 and 13)		68,354	14.00
Customary charges				
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis		0	15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a chargebasis had such payment been made in accordance with 42 CFR §413.13(e)		0	16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)		0.000000	17.00
18.00	Total customary charges (see instructions)		68,354	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)		31,045	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)		37,309	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)		47,045,443	24.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25.00	Deductibles and coinsurance amounts (for CAH, see instructions)		75	25.00
26.00	Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)		8,463,671	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)		38,619,006	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)		38,619,006	30.00
31.00	Primary payer payments		3,403	31.00
32.00	Subtotal (line 30 minus line 31)		38,615,603	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)		797,783	34.00
35.00	Adjusted reimbursable bad debts (see instructions)		518,559	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		432,028	36.00
37.00	Subtotal (see instructions)		39,134,162	37.00
38.00	MSP-LCC reconciliation amount from PS&R		-55	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	39.00
39.50	Pioneer ACO demonstration payment adjustment (see instructions)		0	39.50
39.97	Demonstration payment adjustment amount before sequestration		0	39.97
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)		0	39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION		0	39.99
40.00	Subtotal (see instructions)		39,134,217	40.00
40.01	Sequestration adjustment (see instructions)		453,957	40.01
40.02	Demonstration payment adjustment amount after sequestration		0	40.02
40.03	Sequestration adjustment-PARHM pass-throughs		0	40.03
41.00	Interim payments		39,139,449	41.00
41.01	Interim payments-PARHM		0	41.01
42.00	Tentative settlement (for contractors use only)		0	42.00
42.01	Tentative settlement-PARHM (for contractor use only)		0	42.01
43.00	Balance due provider/program (see instructions)		-459,189	43.00
43.01	Balance due provider/program-PARHM (see instructions)		0	43.01
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		0	44.00
TO BE COMPLETED BY CONTRACTOR				
90.00	Original outlier amount (see instructions)		0	90.00
91.00	Outlier reconciliation adjustment amount (see instructions)		0	91.00
92.00	The rate used to calculate the Time Value of Money		0.00	92.00
93.00	Time Value of Money (see instructions)		0	93.00
94.00	Total (sum of lines 91 and 93)		0	94.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0252 Component CCN: 14-S252	Period: From 10/01/2019 To 09/30/2020	Worksheet E Part B Date/Time Prepared: 4/29/2021 1:24 pm
		Title XVIII	Subprovider - IPF	PPS
			1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES			
1.00	Medical and other services (see instructions)		20	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)		3,942	2.00
3.00	OPPS payments		1,011	3.00
4.00	Outlier payment (see instructions)		0	4.00
4.01	Outlier reconciliation amount (see instructions)		0	4.01
5.00	Enter the hospital specific payment to cost ratio (see instructions)		0.000	5.00
6.00	Line 2 times line 5		0	6.00
7.00	Sum of lines 3, 4, and 4.01, divided by line 6		0.00	7.00
8.00	Transitional corridor payment (see instructions)		0	8.00
9.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200		0	9.00
10.00	Organ acquisitions		0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)		20	11.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
12.00	Ancillary service charges		77	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)		77	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)		77	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)		57	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)		20	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)		1,011	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)		194	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)		837	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)		837	30.00
31.00	Primary payer payments		0	31.00
32.00	Subtotal (line 30 minus line 31)		837	32.00
ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)				
33.00	Composite rate ESRD (from Wkst. I-5, line 11)		0	33.00
34.00	Allowable bad debts (see instructions)		0	34.00
35.00	Adjusted reimbursable bad debts (see instructions)		0	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		0	36.00
37.00	Subtotal (see instructions)		837	37.00
38.00	MSP-LCC reconciliation amount from PS&R		0	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	39.00
39.50	Pioneer ACO demonstration payment adjustment (see instructions)		39.50	
39.97	Demonstration payment adjustment amount before sequestration		0	39.97
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)		0	39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION		0	39.99
40.00	Subtotal (see instructions)		837	40.00
40.01	Sequestration adjustment (see instructions)		10	40.01
40.02	Demonstration payment adjustment amount after sequestration		0	40.02
40.03	Sequestration adjustment-PARHM pass-throughs		0	40.03
41.00	Interim payments		815	41.00
41.01	Interim payments-PARHM		0	41.01
42.00	Tentative settlement (for contractors use only)		0	42.00
42.01	Tentative settlement-PARHM (for contractor use only)		0	42.01
43.00	Balance due provider/program (see instructions)		12	43.00
43.01	Balance due provider/program-PARHM (see instructions)		0	43.01
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		0	44.00
TO BE COMPLETED BY CONTRACTOR				
90.00	Original outlier amount (see instructions)		0	90.00
91.00	Outlier reconciliation adjustment amount (see instructions)		0	91.00
92.00	The rate used to calculate the Time Value of Money		0.00	92.00
93.00	Time Value of Money (see instructions)		0	93.00
94.00	Total (sum of lines 91 and 93)		0	94.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0252 Component CCN: 14-T252	Period: From 10/01/2019 To 09/30/2020	Worksheet E Part B Date/Time Prepared: 4/29/2021 1:24 pm
		Title XVIII	Subprovider - IRF	PPS
			1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES			
1.00	Medical and other services (see instructions)		174	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)		2,201	2.00
3.00	OPPS payments		2,087	3.00
4.00	Outlier payment (see instructions)		0	4.00
4.01	Outlier reconciliation amount (see instructions)		0	4.01
5.00	Enter the hospital specific payment to cost ratio (see instructions)		0.000	5.00
6.00	Line 2 times line 5		0	6.00
7.00	Sum of lines 3, 4, and 4.01, divided by line 6		0.00	7.00
8.00	Transitional corridor payment (see instructions)		0	8.00
9.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200		0	9.00
10.00	Organ acquisitions		0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)		174	11.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
12.00	Ancillary service charges		672	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)		672	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)		672	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)		498	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)		174	21.00
22.00	Interns and residents (see instructions)		0	22.00
23.00	Cost of physicians' services in a teaching hospital (see instructions)		0	23.00
24.00	Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)		2,087	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)		386	26.00
27.00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions)		1,875	27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 50)		0	28.00
29.00	ESRD direct medical education costs (from Wkst. E-4, line 36)		0	29.00
30.00	Subtotal (sum of lines 27 through 29)		1,875	30.00
31.00	Primary payer payments		0	31.00
32.00	Subtotal (line 30 minus line 31)		1,875	32.00
ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)				
33.00	Composite rate ESRD (from Wkst. I-5, line 11)		0	33.00
34.00	Allowable bad debts (see instructions)		0	34.00
35.00	Adjusted reimbursable bad debts (see instructions)		0	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		0	36.00
37.00	Subtotal (see instructions)		1,875	37.00
38.00	MSP-LCC reconciliation amount from PS&R		0	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	39.00
39.50	Pioneer ACO demonstration payment adjustment (see instructions)		39.50	
39.97	Demonstration payment adjustment amount before sequestration		0	39.97
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)		0	39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION		0	39.99
40.00	Subtotal (see instructions)		1,875	40.00
40.01	Sequestration adjustment (see instructions)		22	40.01
40.02	Demonstration payment adjustment amount after sequestration		0	40.02
40.03	Sequestration adjustment-PARHM pass-throughs		0	40.03
41.00	Interim payments		1,799	41.00
41.01	Interim payments-PARHM		0	41.01
42.00	Tentative settlement (for contractors use only)		0	42.00
42.01	Tentative settlement-PARHM (for contractor use only)		0	42.01
43.00	Balance due provider/program (see instructions)		54	43.00
43.01	Balance due provider/program-PARHM (see instructions)		0	43.01
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		0	44.00
TO BE COMPLETED BY CONTRACTOR				
90.00	Original outlier amount (see instructions)		0	90.00
91.00	Outlier reconciliation adjustment amount (see instructions)		0	91.00
92.00	The rate used to calculate the Time Value of Money		0.00	92.00
93.00	Time Value of Money (see instructions)		0	93.00
94.00	Total (sum of lines 91 and 93)		0	94.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 14-0252

Period:
From 10/01/2019
To 09/30/2020Worksheet E-1
Part I
Date/Time Prepared:
4/29/2021 1:24 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		79,602,128		38,151,180	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		1,025,507		868,069	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	04/09/2020	242,000	04/09/2020	120,200	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
Provider to Program						
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		242,000		120,200	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		80,869,635		39,139,449	4.00
TO BE COMPLETED BY CONTRACTOR						
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
Program to Provider						
5.01	TENTATIVE TO PROVIDER		0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
Provider to Program						
5.50	TENTATIVE TO PROGRAM		0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		0		0	6.01
6.02	SETTLEMENT TO PROGRAM		236,532		459,189	6.02
7.00	Total Medicare program liability (see instructions)		80,633,103		38,680,260	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: 14-0252

Period:

Worksheet E-1

Component CCN: 14-S252

From 10/01/2019
To 09/30/2020Part I
Date/Time Prepared:
4/29/2021 1:24 pm

Title XVIII

Subprovider -
IPF

PPS

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider					1.00
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		1,997,743		815	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)		107,963		0	3.00
Program to Provider						
3.01	ADJUSTMENTS TO PROVIDER	04/09/2020	31,500		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)		31,500		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)		2,137,206		815	4.00
TO BE COMPLETED BY CONTRACTOR						
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
Program to Provider						
5.01	TENTATIVE TO PROVIDER		0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
Provider to Program						
5.50	TENTATIVE TO PROGRAM		0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		0		12	6.01
6.02	SETTLEMENT TO PROGRAM		49,387		0	6.02
7.00	Total Medicare program liability (see instructions)		2,087,819		827	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: 14-0252 Component CCN: 14-T252		Period: From 10/01/2019 To 09/30/2020		Worksheet E-1 Part I Date/Time Prepared: 4/29/2021 1:24 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						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		9,764,053		1,799		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)		9,764,053		1,799		4.00
TO BE COMPLETED BY CONTRACTOR							
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)						5.00
Program to Provider							
5.01	TENTATIVE TO PROVIDER		0		0		5.01
5.02			0		0		5.02
5.03			0		0		5.03
Provider to Program							
5.50	TENTATIVE TO PROGRAM		0		0		5.50
5.51			0		0		5.51
5.52			0		0		5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0		5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)						6.00
6.01	SETTLEMENT TO PROVIDER		0		54		6.01
6.02	SETTLEMENT TO PROGRAM		2,389		0		6.02
7.00	Total Medicare program liability (see instructions)		9,761,664		1,853		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: 14-0252	Period: From 10/01/2019 To 09/30/2020	Worksheet E-1 Part II Date/Time Prepared: 4/29/2021 1:24 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: 14-0252 Component CCN: 14-S252	Period: From 10/01/2019 To 09/30/2020	Worksheet E-3 Part II Date/Time Prepared: 4/29/2021 1:24 pm
		Title XVIII	Subprovider - IPF	PPS
				1.00
PART II - MEDICARE PART A SERVICES - IPF PPS				
1.00	Net Federal IPF PPS Payments (excluding outlier, ECT, and medical education payments)			2,312,533 1.00
2.00	Net IPF PPS Outlier Payments			0 2.00
3.00	Net IPF PPS ECT Payments			0 3.00
4.00	Unweighted intern and resident FTE count in the most recent cost report filed on or before November 15, 2004. (see instructions)			0.00 4.00
4.01	Cap increases for the unweighted intern and resident FTE count for residents that were displaced by program or hospital closure, that would not be counted without a temporary cap adjustment under 42 CFR §412.424(d)(1)(iii)(F)(1) or (2) (see instructions)			0.00 4.01
5.00	New Teaching program adjustment. (see instructions)			0.00 5.00
6.00	Current year's unweighted FTE count of I&R excluding FTEs in the new program growth period of a "new teaching program" (see instructions)			0.00 6.00
7.00	Current year's unweighted I&R FTE count for residents within the new program growth period of a "new teaching program" (see instructions)			0.00 7.00
8.00	Intern and resident count for IPF PPS medical education adjustment (see instructions)			0.00 8.00
9.00	Average Daily Census (see instructions)			37.581967 9.00
10.00	Teaching Adjustment Factor $\{((1 + (\text{line 8/line 9})) \text{ raised to the power of } .5150 - 1)\}$.			0.000000 10.00
11.00	Teaching Adjustment (line 1 multiplied by line 10).			0 11.00
12.00	Adjusted Net IPF PPS Payments (sum of lines 1, 2, 3 and 11)			2,312,533 12.00
13.00	Nursing and Allied Health Managed Care payment (see instruction)			0 13.00
14.00	Organ acquisition (DO NOT USE THIS LINE)			0 14.00
15.00	Cost of physicians' services in a teaching hospital (see instructions)			0 15.00
16.00	Subtotal (see instructions)			2,312,533 16.00
17.00	Primary payer payments			8,920 17.00
18.00	Subtotal (line 16 less line 17).			2,303,613 18.00
19.00	Deductibles			195,624 19.00
20.00	Subtotal (line 18 minus line 19)			2,107,989 20.00
21.00	Coinsurance			86,603 21.00
22.00	Subtotal (line 20 minus line 21)			2,021,386 22.00
23.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)			139,901 23.00
24.00	Adjusted reimbursable bad debts (see instructions)			90,936 24.00
25.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			82,860 25.00
26.00	Subtotal (sum of lines 22 and 24)			2,112,322 26.00
27.00	Direct graduate medical education payments (see instructions)			0 27.00
28.00	Other pass through costs (see instructions)			0 28.00
29.00	Outlier payments reconciliation			0 29.00
30.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0 30.00
30.50	Pioneer ACO demonstration payment adjustment (see instructions)			0 30.50
30.99	Demonstration payment adjustment amount before sequestration			0 30.99
31.00	Total amount payable to the provider (see instructions)			2,112,322 31.00
31.01	Sequestration adjustment (see instructions)			24,503 31.01
31.02	Demonstration payment adjustment amount after sequestration			0 31.02
32.00	Interim payments			2,137,206 32.00
33.00	Tentative settlement (for contractor use only)			0 33.00
34.00	Balance due provider/program (line 31 minus lines 31.01, 31.02, 32 and 33)			-49,387 34.00
35.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2			0 35.00
TO BE COMPLETED BY CONTRACTOR				
50.00	Original outlier amount from Worksheet E-3, Part II, line 2			0 50.00
51.00	Outlier reconciliation adjustment amount (see instructions)			0 51.00
52.00	The rate used to calculate the Time Value of Money			0.00 52.00
53.00	Time Value of Money (see instructions)			0 53.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0252 Component CCN: 14-T252	Period: From 10/01/2019 To 09/30/2020	Worksheet E-3 Part III Date/Time Prepared: 4/29/2021 1:24 pm
		Title XVIII	Subprovider - IRF	PPS
				1.00
	PART III - MEDICARE PART A SERVICES - IRF PPS			
1.00	Net Federal PPS Payment (see instructions)			9,687,348 1.00
2.00	Medicare SSI ratio (IRF PPS only) (see instructions)			0.0142 2.00
3.00	Inpatient Rehabilitation LIP Payments (see instructions)			175,341 3.00
4.00	Outlier Payments			112,704 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)			24.718579 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)			9,975,393 13.00
14.00	Nursing and Allied Health Managed Care payments (see instruction)			0 14.00
15.00	Organ acquisition (DO NOT USE THIS LINE)			0 15.00
16.00	Cost of physicians' services in a teaching hospital (see instructions)			0 16.00
17.00	Subtotal (see instructions)			9,975,393 17.00
18.00	Primary payer payments			0 18.00
19.00	Subtotal (line 17 less line 18).			9,975,393 19.00
20.00	Deductibles			27,808 20.00
21.00	Subtotal (line 19 minus line 20)			9,947,585 21.00
22.00	Coinsurance			72,248 22.00
23.00	Subtotal (line 21 minus line 22)			9,875,337 23.00
24.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)			1,371 24.00
25.00	Adjusted reimbursable bad debts (see instructions)			891 25.00
26.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			0 26.00
27.00	Subtotal (sum of lines 23 and 25)			9,876,228 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)			0 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)			9,876,228 32.00
32.01	Sequestration adjustment (see instructions)			114,564 32.01
32.02	Demonstration payment adjustment amount after sequestration			0 32.02
33.00	Interim payments			9,764,053 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)			-2,389 35.00
36.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2			8,610 36.00
TO BE COMPLETED BY CONTRACTOR				
50.00	Original outlier amount from Wkst. E-3, Pt. III, line 4			112,704 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: 14-0252	Period: From 10/01/2019 To 09/30/2020	Worksheet E-3 Part VII Date/Time Prepared: 4/29/2021 1:24 pm	
		Title XIX	Hospital	Cost	
			Inpatient	Outpatient	
			1.00	2.00	
PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR XIX SERVICES					
COMPUTATION OF NET COST OF COVERED SERVICES					
1.00	Inpatient hospital/SNF/NF services	4,576,100			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)	4,576,100		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)	4,576,100		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)	4,576,100		0	18.00
19.00	Interns and Residents (see instructions)	0		0	19.00
20.00	Cost of physicians' services in a teaching hospital (see instructions)	0		0	20.00
21.00	Cost of covered services (enter the lesser of line 4 or line 16)	0		0	21.00
PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be completed for PPS providers.					
22.00	Other than outlier payments	0		0	22.00
23.00	Outlier payments	0		0	23.00
24.00	Program capital payments	0			24.00
25.00	Capital exception payments (see instructions)	0			25.00
26.00	Routine and Ancillary service other pass through costs	0		0	26.00
27.00	Subtotal (sum of lines 22 through 26)	0		0	27.00
28.00	Customary charges (title V or XIX PPS covered services only)	0			28.00
29.00	Titles V or XIX (sum of lines 21 and 27)	0		0	29.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT					
30.00	Excess of reasonable cost (from line 18)	4,576,100		0	30.00
31.00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)	0		0	31.00
32.00	Deductibles	0		0	32.00
33.00	Coinurance	0		0	33.00
34.00	Allowable bad debts (see instructions)	0		0	34.00
35.00	Utilization review	0			35.00
36.00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)	0		0	36.00
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0		0	37.00
38.00	Subtotal (line 36 ± line 37)	0		0	38.00
39.00	Direct graduate medical education payments (from Wkst. E-4)	0			39.00
40.00	Total amount payable to the provider (sum of lines 38 and 39)	0		0	40.00
41.00	Interim payments	0		0	41.00
42.00	Balance due provider/program (line 40 minus line 41)	0		0	42.00
43.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, chapter 1, §115.2	0		0	43.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0252 Component CCN: 14-S252	Period: From 10/01/2019 To 09/30/2020	Worksheet E-3 Part VII Date/Time Prepared: 4/29/2021 1:24 pm	
		Title XIX	Subprovider - IPF	Cost	
			Inpatient 1.00	Outpatient 2.00	
PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR XIX SERVICES					
COMPUTATION OF NET COST OF COVERED SERVICES					
1.00	Inpatient hospital/SNF/NF services		1,454,155		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)		1,454,155	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)		1,454,155	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)		1,454,155	0	18.00
19.00	Interns and Residents (see instructions)		0	0	19.00
20.00	Cost of physicians' services in a teaching hospital (see instructions)		0	0	20.00
21.00	Cost of covered services (enter the lesser of line 4 or line 16)		0	0	21.00
PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be completed for PPS providers.					
22.00	Other than outlier payments		0	0	22.00
23.00	Outlier payments		0	0	23.00
24.00	Program capital payments		0		24.00
25.00	Capital exception payments (see instructions)		0		25.00
26.00	Routine and Ancillary service other pass through costs		0	0	26.00
27.00	Subtotal (sum of lines 22 through 26)		0	0	27.00
28.00	Customary charges (title V or XIX PPS covered services only)		0	0	28.00
29.00	Titles V or XIX (sum of lines 21 and 27)		0	0	29.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT					
30.00	Excess of reasonable cost (from line 18)		1,454,155	0	30.00
31.00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)		0	0	31.00
32.00	Deductibles		0	0	32.00
33.00	Coinurance		0	0	33.00
34.00	Allowable bad debts (see instructions)		0	0	34.00
35.00	Utilization review		0		35.00
36.00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)		0	0	36.00
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	0	37.00
38.00	Subtotal (line 36 ± line 37)		0	0	38.00
39.00	Direct graduate medical education payments (from Wkst. E-4)		0		39.00
40.00	Total amount payable to the provider (sum of lines 38 and 39)		0	0	40.00
41.00	Interim payments		0		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: 14-0252 Component CCN: 14-T252	Period: From 10/01/2019 To 09/30/2020	Worksheet E-3 Part VII Date/Time Prepared: 4/29/2021 1:24 pm
		Title XIX	Subprovider - IRF	Cost
		Inpatient 1.00	Outpatient 2.00	
PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR XIX SERVICES				
COMPUTATION OF NET COST OF COVERED SERVICES				
1.00	Inpatient hospital/SNF/NF services	190,675		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)	190,675	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)	190,675	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)	190,675	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	0	24.00
25.00	Capital exception payments (see instructions)	0	0	25.00
26.00	Routine and Ancillary service other pass through costs	0	0	26.00
27.00	Subtotal (sum of lines 22 through 26)	0	0	27.00
28.00	Customary charges (title V or XIX PPS covered services only)	0	0	28.00
29.00	Titles V or XIX (sum of lines 21 and 27)	0	0	29.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT				
30.00	Excess of reasonable cost (from line 18)	190,675	0	30.00
31.00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)	0	0	31.00
32.00	Deductibles	0	0	32.00
33.00	Coinurance	0	0	33.00
34.00	Allowable bad debts (see instructions)	0	0	34.00
35.00	Utilization review	0	0	35.00
36.00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)	0	0	36.00
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	37.00
38.00	Subtotal (line 36 ± line 37)	0	0	38.00
39.00	Direct graduate medical education payments (from Wkst. E-4)	0	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

DIRECT GRADUATE MEDICAL EDUCATION (GME) & ESRD OUTPATIENT DIRECT MEDICAL EDUCATION COSTS		Provider CCN: 14-0252	Period: From 10/01/2019 To 09/30/2020	Worksheet E-4 Date/Time Prepared: 4/29/2021 1:24 pm	
		Title XVIII	Hospital	PPS	
				1.00	
COMPUTATION OF TOTAL DIRECT GME AMOUNT					
1.00	Unweighted resident FTE count for allopathic and osteopathic programs for cost reporting periods ending on or before December 31, 1996.			0.00	1.00
2.00	Unweighted FTE resident cap add-on for new programs per 42 CFR 413.79(e)(1) (see instructions)			0.00	2.00
3.00	Amount of reduction to Direct GME cap under section 422 of MMA			0.00	3.00
3.01	Direct GME cap reduction amount under ACA §5503 in accordance with 42 CFR §413.79 (m). (see instructions for cost reporting periods straddling 7/1/2011)			0.00	3.01
4.00	Adjustment (plus or minus) to the FTE cap for allopathic and osteopathic programs due to a Medicare GME affiliation agreement (42 CFR §413.75(b) and § 413.79 (f))			0.00	4.00
4.01	ACA Section 5503 increase to the Direct GME FTE Cap (see instructions for cost reporting periods straddling 7/1/2011)			0.00	4.01
4.02	ACA Section 5506 number of additional direct GME FTE cap slots (see instructions for cost reporting periods straddling 7/1/2011)			0.00	4.02
5.00	FTE adjusted cap (line 1 plus line 2 minus line 3 and 3.01 plus or minus line 4 plus lines 4.01 and 4.02 plus applicable subscripts)			0.00	5.00
6.00	Unweighted resident FTE count for allopathic and osteopathic programs for the current year from your records (see instructions)			0.00	6.00
7.00	Enter the lesser of line 5 or line 6			0.00	7.00
		Primary Care	Other	Total	
		1.00	2.00	3.00	
8.00	Weighted FTE count for physicians in an allopathic and osteopathic program for the current year.	0.00	0.00	0.00	8.00
9.00	If line 6 is less than 5 enter the amount from line 8, otherwise multiply line 8 times the result of line 5 divided by the amount on line 6.	0.00	0.00	0.00	9.00
10.00	Weighted dental and podiatric resident FTE count for the current year		0.00		10.00
10.01	Unweighted dental and podiatric resident FTE count for the current year		0.00		10.01
11.00	Total weighted FTE count	0.00	0.00		11.00
12.00	Total weighted resident FTE count for the prior cost reporting year (see instructions)	0.00	0.00		12.00
13.00	Total weighted resident FTE count for the penultimate cost reporting year (see instructions)	0.00	0.00		13.00
14.00	Rolling average FTE count (sum of lines 11 through 13 divided by 3).	0.00	0.00		14.00
15.00	Adjustment for residents in initial years of new programs	0.00	0.00		15.00
15.01	Unweighted adjustment for residents in initial years of new programs	0.00	0.00		15.01
16.00	Adjustment for residents displaced by program or hospital closure	0.00	0.00		16.00
16.01	Unweighted adjustment for residents displaced by program or hospital closure	0.00	0.00		16.01
17.00	Adjusted rolling average FTE count	0.00	0.00		17.00
18.00	Per resident amount	0.00	0.00		18.00
19.00	Approved amount for resident costs	0	0	0	19.00
				1.00	
20.00	Additional unweighted allopathic and osteopathic direct GME FTE resident cap slots received under 42 Sec. 413.79(c)(4)			0.00	20.00
21.00	Direct GME FTE unweighted resident count over cap (see instructions)			0.00	21.00
22.00	Allowable additional direct GME FTE Resident Count (see instructions)			0.00	22.00
23.00	Enter the locality adjustment national average per resident amount (see instructions)			0.00	23.00
24.00	Multiply line 22 time line 23			0	24.00
25.00	Total direct GME amount (sum of lines 19 and 24)			0	25.00
		Inpatient Part A	Managed Care	Total	
		1.00	2.00	3.00	
COMPUTATION OF PROGRAM PATIENT LOAD					
26.00	Inpatient Days (see instructions) (Title XIX - see S-2 Part IX, line 3.02, column 2)	42,948	19,961		26.00
27.00	Total Inpatient Days (see instructions)	102,236	102,236		27.00
28.00	Ratio of inpatient days to total inpatient days	0.420087	0.195244		28.00
29.00	Program direct GME amount	0	0	0	29.00
29.01	Percent reduction for MA DGME				29.01
30.00	Reduction for direct GME payments for Medicare Advantage		0	0	30.00
31.00	Net Program direct GME amount			0	31.00

DIRECT GRADUATE MEDICAL EDUCATION (GME) & ESRD OUTPATIENT DIRECT MEDICAL EDUCATION COSTS		Provider CCN: 14-0252	Period: From 10/01/2019 To 09/30/2020	Worksheet E-4 Date/Time Prepared: 4/29/2021 1:24 pm	
		Title XVIII	Hospital	PPS	
			1.00		
	DIRECT MEDICAL EDUCATION COSTS FOR ESRD COMPOSITE RATE - TITLE XVIII ONLY (NURSING SCHOOL AND PARAMEDICAL EDUCATION COSTS)				
32.00	Renal dialysis direct medical education costs (from Wkst. B, Pt. I, sum of col. 20 and 23, lines 74 and 94)			0	32.00
33.00	Renal dialysis and home dialysis total charges (Wkst. C, Pt. I, col. 8, sum of lines 74 and 94)			7,300,123	33.00
34.00	Ratio of direct medical education costs to total charges (line 32 ÷ line 33)			0.000000	34.00
35.00	Medicare outpatient ESRD charges (see instructions)			0	35.00
36.00	Medicare outpatient ESRD direct medical education costs (line 34 x line 35)			0	36.00
APPORTIONMENT BASED ON MEDICARE REASONABLE COST - TITLE XVIII ONLY					
Part A Reasonable Cost					
37.00	Reasonable cost (see instructions)			112,232,268	37.00
38.00	Organ acquisition costs (Wkst. D-4, Pt. III, col. 1, line 69)			0	38.00
39.00	Cost of physicians' services in a teaching hospital (see instructions)			0	39.00
40.00	Primary payer payments (see instructions)			74,649	40.00
41.00	Total Part A reasonable cost (sum of lines 37 through 39 minus line 40)			112,157,619	41.00
Part B Reasonable Cost					
42.00	Reasonable cost (see instructions)			60,413,360	42.00
43.00	Primary payer payments (see instructions)			5,592	43.00
44.00	Total Part B reasonable cost (line 42 minus line 43)			60,407,768	44.00
45.00	Total reasonable cost (sum of lines 41 and 44)			172,565,387	45.00
46.00	Ratio of Part A reasonable cost to total reasonable cost (line 41 ÷ line 45)			0.649943	46.00
47.00	Ratio of Part B reasonable cost to total reasonable cost (line 44 ÷ line 45)			0.350057	47.00
ALLOCATION OF MEDICARE DIRECT GME COSTS BETWEEN PART A AND PART B					
48.00	Total program GME payment (line 31)			0	48.00
49.00	Part A Medicare GME payment (line 46 x 48) (title XVIII only) (see instructions)			0	49.00
50.00	Part B Medicare GME payment (line 47 x 48) (title XVIII only) (see instructions)			0	50.00

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

Provider CCN: 14-0252

Period:
From 10/01/2019
To 09/30/2020

Worksheet G

Date/Time Prepared:
4/29/2021 1:24 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	38,585,421	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	49,589,648	0	0	0	4.00
5.00 Other receivable	10,659,335	0	0	0	5.00
6.00 Allowances for uncollectible notes and accounts receivable	0	0	0	0	6.00
7.00 Inventory	9,021,423	0	0	0	7.00
8.00 Prepaid expenses	4,719,567	0	0	0	8.00
9.00 Other current assets	0	0	0	0	9.00
10.00 Due from other funds	-13,681,617	0	0	0	10.00
11.00 Total current assets (sum of lines 1-10)	98,893,777	0	0	0	11.00
FIXED ASSETS					
12.00 Land	89,072	0	0	0	12.00
13.00 Land improvements	15,570,855	0	0	0	13.00
14.00 Accumulated depreciation	-12,556,507	0	0	0	14.00
15.00 Buildings	320,165,563	0	0	0	15.00
16.00 Accumulated depreciation	-166,431,513	0	0	0	16.00
17.00 Leasehold improvements	3,287,882	0	0	0	17.00
18.00 Accumulated depreciation	-2,484,509	0	0	0	18.00
19.00 Fixed equipment	218,000,253	0	0	0	19.00
20.00 Accumulated depreciation	-137,188,483	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	283,009,833	0	0	0	23.00
24.00 Accumulated depreciation	-170,905,065	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)	350,557,381	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	30,894,865	0	0	0	34.00
35.00 Total other assets (sum of lines 31-34)	30,894,865	0	0	0	35.00
36.00 Total assets (sum of lines 11, 30, and 35)	480,346,023	0	0	0	36.00
CURRENT LIABILITIES					
37.00 Accounts payable	17,268,999	0	0	0	37.00
38.00 Salaries, wages, and fees payable	65,352,076	0	0	0	38.00
39.00 Payroll taxes payable	0	0	0	0	39.00
40.00 Notes and loans payable (short term)	8,270,000	0	0	0	40.00
41.00 Deferred income	0	0	0	0	41.00
42.00 Accelerated payments	0	0	0	0	42.00
43.00 Due to other funds	0	0	0	0	43.00
44.00 Other current liabilities	38,172,271	0	0	0	44.00
45.00 Total current liabilities (sum of lines 37 thru 44)	129,063,346	0	0	0	45.00
LONG TERM LIABILITIES					
46.00 Mortgage payable	0	0	0	0	46.00
47.00 Notes payable	225,669,494	0	0	0	47.00
48.00 Unsecured loans	0	0	0	0	48.00
49.00 Other long term liabilities	38,025,215	0	0	0	49.00
50.00 Total long term liabilities (sum of lines 46 thru 49)	263,694,709	0	0	0	50.00
51.00 Total liabilities (sum of lines 45 and 50)	392,758,055	0	0	0	51.00
CAPITAL ACCOUNTS					
52.00 General fund balance	87,587,968	0	0	0	52.00
53.00 Specific purpose fund	0	0	0	0	53.00
54.00 Donor created - endowment fund balance - restricted	0	0	0	0	54.00
55.00 Donor created - endowment fund balance - unrestricted	0	0	0	0	55.00
56.00 Governing body created - endowment fund balance	0	0	0	0	56.00
57.00 Plant fund balance - invested in plant	0	0	0	0	57.00
58.00 Plant fund balance - reserve for plant improvement, replacement, and expansion	0	0	0	0	58.00
59.00 Total fund balances (sum of lines 52 thru 58)	87,587,968	0	0	0	59.00
60.00 Total liabilities and fund balances (sum of lines 51 and 59)	480,346,023	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 14-0252

Period:
From 10/01/2019
To 09/30/2020

Worksheet G-1

Date/Time Prepared:
4/29/2021 1:24 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		128,399,417		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		9,511,236				2.00
3.00	Total (sum of line 1 and line 2)		137,910,653		0		3.00
4.00	Additions (credit adjustments) (specify)	0		0		0	4.00
5.00	RESTRICTED NET ASSETS TRANSFER	3,507,884		0		0	5.00
6.00		0		0		0	6.00
7.00	RECONCILING ITEM	1		0		0	7.00
8.00		0		0		0	8.00
9.00		0		0		0	9.00
10.00	Total additions (sum of line 4-9)		3,507,885		0		10.00
11.00	Subtotal (line 3 plus line 10)		141,418,538		0		11.00
12.00	Deductions (debit adjustments) (specify)	0		0		0	12.00
13.00		0		0		0	13.00
14.00		0		0		0	14.00
15.00	RESTRICTED NET ASSETS TRANSFER	53,830,569		0		0	15.00
16.00	ROUNDING	1		0		0	16.00
17.00		0		0		0	17.00
18.00	Total deductions (sum of lines 12-17)		53,830,570		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		87,587,968		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	RESTRICTED NET ASSETS TRANSFER		0				5.00
6.00			0				6.00
7.00	RECONCILING ITEM		0				7.00
8.00			0				8.00
9.00			0				9.00
10.00	Total additions (sum of line 4-9)	0		0			10.00
11.00	Subtotal (line 3 plus line 10)	0		0			11.00
12.00	Deductions (debit adjustments) (specify)		0				12.00
13.00			0				13.00
14.00			0				14.00
15.00	RESTRICTED NET ASSETS TRANSFER		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: 14-0252

Period:
From 10/01/2019
To 09/30/2020Worksheet G-2
Parts I & II
Date/Time Prepared:
4/29/2021 1:24 pm

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
PART I - PATIENT REVENUES					
General Inpatient Routine Services					
1.00	Hospital	132,153,797		132,153,797	1.00
2.00	SUBPROVIDER - IPF	32,792,984		32,792,984	2.00
3.00	SUBPROVIDER - IRF	15,758,892		15,758,892	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)	180,705,673		180,705,673	10.00
Intensive Care Type Inpatient Hospital Services					
11.00	INTENSIVE CARE UNIT	39,292,831		39,292,831	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	NEONATAL INTENSIVE CARE UNIT	7,811,250		7,811,250	15.00
16.00	Total intensive care type inpatient hospital services (sum of lines 11-15)	47,104,081		47,104,081	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	227,809,754		227,809,754	17.00
18.00	Ancillary services	560,152,064	865,233,398	1,425,385,462	18.00
19.00	Outpatient services	0	0	0	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		8,655,411	8,655,411	22.00
23.00	AMBULANCE SERVICES				23.00
24.00	CMHC				24.00
24.10	CORF	0	0	0	24.10
24.20	OUTPATIENT PHYSICAL THERAPY	0	0	0	24.20
24.30	OUTPATIENT OCCUPATIONAL THERAPY	0	0	0	24.30
24.40	OUTPATIENT SPEECH PATHOLOGY	0	0	0	24.40
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	RESIDENTIAL TREATMENT CENTER	2,506,063	204,203	2,710,266	27.00
27.01	OTHER NRCC CHARGES	3,883,744	102,428	3,986,172	27.01
27.02	MOBILE DENTAL CLINIC	0	501,894	501,894	27.02
27.03	OTHER (SPECIFY)	0	0	0	27.03
27.04	OTHER (SPECIFY)	0	0	0	27.04
27.05	OTHER (SPECIFY)	0	0	0	27.05
27.06	RECONCILING ITEM	0	-1	-1	27.06
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	794,351,625	874,697,333	1,669,048,958	28.00
PART II - OPERATING EXPENSES					
29.00	Operating expenses (per Wkst. A, column 3, line 200)		501,309,171		29.00
30.00	ADD (SPECIFY)	0			30.00
31.00		0			31.00
32.00		0			32.00
33.00		0			33.00
34.00		0			34.00
35.00	OTHER	0			35.00
36.00	Total additions (sum of lines 30-35)		0		36.00
37.00	RECONCILING ITEM	503			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)		503		42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer to Wkst. G-3, line 4)		501,308,668		43.00

STATEMENT OF REVENUES AND EXPENSES

Provider CCN: 14-0252

Period:
From 10/01/2019
To 09/30/2020

Worksheet G-3

Date/Time Prepared:
4/29/2021 1:24 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	1,669,048,958	1.00
2.00	Less contractual allowances and discounts on patients' accounts	1,204,165,821	2.00
3.00	Net patient revenues (line 1 minus line 2)	464,883,137	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	501,308,668	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-36,425,531	5.00
OTHER INCOME			
6.00	Contributions, donations, bequests, etc	1,031,291	6.00
7.00	Income from investments	0	7.00
8.00	Revenues from telephone and other miscellaneous communication services	0	8.00
9.00	Revenue from television and radio service	0	9.00
10.00	Purchase discounts	17,507	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	1,324,348	14.00
15.00	Revenue from rental of living quarters	0	15.00
16.00	Revenue from sale of medical and surgical supplies to other than patients	0	16.00
17.00	Revenue from sale of drugs to other than patients	0	17.00
18.00	Revenue from sale of medical records and abstracts	0	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	0	20.00
21.00	Rental of vending machines	0	21.00
22.00	Rental of hospital space	0	22.00
23.00	Governmental appropriations	0	23.00
24.00	PHYSICIANS OFFICES	1,675,571	24.00
24.01	OTHER REVENUE	0	24.01
24.02	MGT SERVICES	822,638	24.02
24.03	OTHER MISC	80,125	24.03
24.04	OP PHARMACY	4,243,731	24.04
24.05	RESEARCH	25,073	24.05
24.06	OTHER REVENUE	256,348	24.06
24.07	NON OPERATING REVENUE - PENSION	-4,095,301	24.07
24.08	INTERCOMPANY RENTAL	1,195,729	24.08
24.09	GAIN LOSS DISP FIXED ASSETS	-167,240	24.09
24.50	COVID-19 PHE Funding	39,526,948	24.50
25.00	Total other income (sum of lines 6-24)	45,936,768	25.00
26.00	Total (line 5 plus line 25)	9,511,237	26.00
27.00	RECONCILING ITEM	1	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	1	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	9,511,236	29.00

ANALYSIS OF HOSPITAL-BASED HOME HEALTH AGENCY COSTS

Provider CCN: 14-0252

Period:

Worksheet H

HHA CCN: 14-7094

From 10/01/2019

Date/Time Prepared:

To 09/30/2020

4/29/2021 1:24 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
2.00 Capital Related - Movable Equipment			0		0	0
3.00 Plant Operation & Maintenance	0	0	0	0	1,653	1,653
4.00 Transportation	0	0	0	0	0	0
5.00 Administrative and General	892,338	68,143	0	1,123,435	66,063	2,149,979
HHA REIMBURSABLE SERVICES						
6.00 Skilled Nursing Care	1,880,731	143,622	56,845	0	0	2,081,198
7.00 Physical Therapy	1,710,576	130,628	47,738	0	0	1,888,942
8.00 Occupational Therapy	449,149	34,299	13,158	0	0	496,606
9.00 Speech Pathology	51,042	3,898	1,499	0	0	56,439
10.00 Medical Social Services	72,988	5,574	533	0	0	79,095
11.00 Home Health Aide	76,574	5,848	4,992	0	0	87,414
12.00 Supplies (see instructions)	0	0	0	0	378,189	378,189
13.00 Drugs	0	0	0	0	0	0
14.00 DME	0	0	0	0	0	0
HHA NONREIMBURSABLE SERVICES						
15.00 Home Dialysis Aide Services	0	0	0	0	0	0
16.00 Respiratory Therapy	0	0	0	0	0	0
17.00 Private Duty Nursing	0	0	0	0	0	0
18.00 Clinic	0	0	0	0	0	0
19.00 Health Promotion Activities	0	0	0	0	0	0
20.00 Day Care Program	0	0	0	0	0	0
21.00 Home Delivered Meals Program	0	0	0	0	0	0
22.00 Homemaker Service	0	0	0	0	0	0
23.00 All Others (specify)	0	0	0	0	0	0
23.50 Telemedicine	0	0	0	0	0	0
24.00 Total (sum of lines 1-23)	5,133,398	392,012	124,765	1,123,435	445,905	7,219,515
	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	1,653	0	1,653		3.00
4.00 Transportation	0	0	0	0		4.00
5.00 Administrative and General	956	2,150,935	0	2,150,935		5.00
HHA REIMBURSABLE SERVICES						
6.00 Skilled Nursing Care	0	2,081,198	0	2,081,198		6.00
7.00 Physical Therapy	0	1,888,942	0	1,888,942		7.00
8.00 Occupational Therapy	0	496,606	0	496,606		8.00
9.00 Speech Pathology	0	56,439	0	56,439		9.00
10.00 Medical Social Services	0	79,095	0	79,095		10.00
11.00 Home Health Aide	0	87,414	0	87,414		11.00
12.00 Supplies (see instructions)	0	378,189	0	378,189		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)	956	7,220,471	0	7,220,471		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: 14-0252

Period:

Worksheet H-1

HHA CCN: 14-7094

From 10/01/2019
To 09/30/2020Part I
Date/Time Prepared:
4/29/2021 1:24 pmHome Health
Agency I

PPS

						Agency 1			
		Net Expenses for Cost Allocation (from Wkst. H, col. 10)	Capital Related Costs		Plant Operation & Maintenance	Transportation	Subtotal (cols. 0-4)		
			Bldgs & Fixtures	Movable Equipment					
			1.00	2.00					3.00
	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	1,653	0	0	1,653		0	3.00	
4.00	Transportation	0	0	0	0	0		4.00	
5.00	Administrative and General	2,150,935	0	0	1,653	0	2,152,588	5.00	
	HHA REIMBURSABLE SERVICES								
6.00	Skilled Nursing Care	2,081,198	0	0	0	0	2,081,198	6.00	
7.00	Physical Therapy	1,888,942	0	0	0	0	1,888,942	7.00	
8.00	Occupational Therapy	496,606	0	0	0	0	496,606	8.00	
9.00	Speech Pathology	56,439	0	0	0	0	56,439	9.00	
10.00	Medical Social Services	79,095	0	0	0	0	79,095	10.00	
11.00	Home Health Aide	87,414	0	0	0	0	87,414	11.00	
12.00	Supplies (see instructions)	378,189	0	0	0	0	378,189	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)	7,220,471	0	0	1,653	0	7,220,471	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	2,152,588						5.00	
	HHA REIMBURSABLE SERVICES								
6.00	Skilled Nursing Care	1,030,785	3,111,983					6.00	
7.00	Physical Therapy	776,947	2,665,889					7.00	
8.00	Occupational Therapy	102,701	599,307					8.00	
9.00	Speech Pathology	14,057	70,496					9.00	
10.00	Medical Social Services	73,491	152,586					10.00	
11.00	Home Health Aide	37,052	124,466					11.00	
12.00	Supplies (see instructions)	34,977	413,166					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)	82,578	82,578					23.00	
23.50	Telemedicine	0	0					23.50	
24.00	Total (sum of lines 1-23)		7,220,471					24.00	

COST ALLOCATION - HHA STATISTICAL BASIS

Provider CCN: 14-0252

Period:

Worksheet H-1

HHA CCN: 14-7094

From 10/01/2019
To 09/30/2020Part II
Date/Time Prepared:
4/29/2021 1:24 pmHome Health
Agency I

PPS

	Capital Related Costs		Plant Operation & Maintenance (SQUARE FEET)	Transportation (MILEAGE)	Reconciliation	Administrative & General (ACCUM. COST)	
	Bldgs & Fixtures (SQUARE FEET)	Movable Equipment (DOLLAR VALUE)					
	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	100	0		3.00
4.00	Transportation (see instructions)	0	0	0	0		4.00
5.00	Administrative and General	0	0	100	0	-2,152,588	18,518,099
HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	0	0	0	0	6,786,330	8,867,528
7.00	Physical Therapy	0	0	0	0	4,794,929	6,683,871
8.00	Occupational Therapy	0	0	0	0	386,902	883,508
9.00	Speech Pathology	0	0	0	0	64,489	120,928
10.00	Medical Social Services	0	0	0	0	553,131	632,226
11.00	Home Health Aide	0	0	0	0	231,331	318,745
12.00	Supplies (see instructions)	0	0	0	0	-77,290	300,899
13.00	Drugs	0	0	0	0	0	0
14.00	DME	0	0	0	0	0	0
HHA NONREIMBURSABLE SERVICES							
15.00	Home Dialysis Aide Services	0	0	0	0	0	0
16.00	Respiratory Therapy	0	0	0	0	0	0
17.00	Private Duty Nursing	0	0	0	0	0	0
18.00	Clinic	0	0	0	0	0	0
19.00	Health Promotion Activities	0	0	0	0	0	0
20.00	Day Care Program	0	0	0	0	0	0
21.00	Home Delivered Meals Program	0	0	0	0	0	0
22.00	Homemaker Service	0	0	0	0	0	0
23.00	All Others (specify)	0	0	0	0	710,394	710,394
23.50	Telemedicine	0	0	0	0	0	0
24.00	Total (sum of lines 1-23)	0	0	100	0	11,297,628	18,518,099
25.00	Cost To Be Allocated (per Worksheet H-1, Part I)	0	0	1,653	0		2,152,588
26.00	Unit Cost Multiplier	0.000000	0.000000	16.530000	0.000000		0.116242

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

Provider CCN: 14-0252

Period:

Worksheet H-2

HHA CCN: 14-7094

From 10/01/2019
To 09/30/2020Part I
Date/Time Prepared:
4/29/2021 1:24 pmHome Health
Agency I

PPS

Cost Center Description		HHA Trial Balance (1)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	Subtotal	ADMINISTRATIVE & GENERAL	
			BLDG & FIXT	MVBLE EQUIP				
		0	1.00	2.00	4.00	4A	5.00	
1.00	Administrative and General	0	195,694	24,570	148,023	368,287	177,147	1.00
2.00	Skilled Nursing Care	3,111,983	0	0	311,682	3,423,665	1,106,013	2.00
3.00	Physical Therapy	2,665,889	0	0	283,483	2,949,372	895,038	3.00
4.00	Occupational Therapy	599,307	0	0	74,435	673,742	139,062	4.00
5.00	Speech Pathology	70,496	0	0	8,459	78,955	15,613	5.00
6.00	Medical Social Services	152,586	0	0	12,096	164,682	60,470	6.00
7.00	Home Health Aide	124,466	0	0	12,690	137,156	52,596	7.00
8.00	Supplies (see instructions)	413,166	0	0	0	413,166	84,421	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)	82,578	0	0	0	82,578	23,943	19.00
19.50	Telemedicine	0	0	0	0	0	0	19.50
20.00	Total (sum of lines 1-19) (2)	7,220,471	195,694	24,570	850,868	8,291,603	2,554,303	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
Cost Center Description		MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	
		6.00	7.00	8.00	9.00	10.00	11.00	
1.00	Administrative and General	0	491,411	0	128,337	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	491,411	0	128,337	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: 14-0252

Period:

Worksheet H-2

HHA CCN: 14-7094

From 10/01/2019
To 09/30/2020Part I
Date/Time Prepared:
4/29/2021 1:24 pmHome Health
Agency I

PPS

Cost Center Description		MAINTENANCE OF PERSONNEL	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	
		12.00	13.00	14.00	15.00	16.00	17.00	
1.00	Administrative and General	0	0	0	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) (2)	0	0	0	0	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
Cost Center Description		NONPHYSICIAN ANESTHETISTS	NURSING SCHOOL	INTERNS & RESIDENTS		PARAMED ED PRGM	Subtotal	
		19.00	20.00	SERVICES-SALAR Y & FRINGES APPRV	SERVICES-OTHER PRGM COSTS APPRV	23.00	24.00	
1.00	Administrative and General	0	0	0	0	0	1,165,182	1.00
2.00	Skilled Nursing Care	0	0	0	0	0	4,529,678	2.00
3.00	Physical Therapy	0	0	0	0	0	3,844,410	3.00
4.00	Occupational Therapy	0	0	0	0	0	812,804	4.00
5.00	Speech Pathology	0	0	0	0	0	94,568	5.00
6.00	Medical Social Services	0	0	0	0	0	225,152	6.00
7.00	Home Health Aide	0	0	0	0	0	189,752	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	497,587	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	106,521	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	0	11,465,654	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: 14-0252

Period:

Worksheet H-2

HHA CCN: 14-7094

From 10/01/2019
To 09/30/2020Part I
Date/Time Prepared:
4/29/2021 1:24 pmHome Health
Agency I

PPS

Cost Center Description		Intern & Residents Cost & Post Stepdown Adjustments	Subtotal	Allocated HHA A&G (see Part II)	Total HHA Costs		
		25.00	26.00	27.00	28.00		
1.00	Administrative and General	0	1,165,182				1.00
2.00	Skilled Nursing Care	0	4,529,678	512,394	5,042,072		2.00
3.00	Physical Therapy	0	3,844,410	434,876	4,279,286		3.00
4.00	Occupational Therapy	0	812,804	91,944	904,748		4.00
5.00	Speech Pathology	0	94,568	10,697	105,265		5.00
6.00	Medical Social Services	0	225,152	25,469	250,621		6.00
7.00	Home Health Aide	0	189,752	21,465	211,217		7.00
8.00	Supplies (see instructions)	0	497,587	56,287	553,874		8.00
9.00	Drugs	0	0	0	0		9.00
10.00	DME	0	0	0	0		10.00
11.00	Home Dialysis Aide Services	0	0	0	0		11.00
12.00	Respiratory Therapy	0	0	0	0		12.00
13.00	Private Duty Nursing	0	0	0	0		13.00
14.00	Clinic	0	0	0	0		14.00
15.00	Health Promotion Activities	0	0	0	0		15.00
16.00	Day Care Program	0	0	0	0		16.00
17.00	Home Delivered Meals Program	0	0	0	0		17.00
18.00	Homemaker Service	0	0	0	0		18.00
19.00	All Others (specify)	0	106,521	12,050	118,571		19.00
19.50	Telemedicine	0	0	0	0		19.50
20.00	Total (sum of lines 1-19) (2)	0	11,465,654	1,165,182	11,465,654		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.			0.113119			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: 14-0252

Period:

Worksheet H-2

HHA CCN: 14-7094

From 10/01/2019
To 09/30/2020Part II
Date/Time Prepared:
4/29/2021 1:24 pmHome Health
Agency I

PPS

Cost Center Description		CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM COST)	MAINTENANCE & REPAIRS (SQUARE FEET)	
		BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (DOLLAR VALUE)					
		1.00	2.00	4.00	5A	5.00	6.00	
1.00	Administrative and General	5,176	21,492	893,189	106,082	474,369	0	1.00
2.00	Skilled Nursing Care	0	0	1,880,731	-461,953	2,961,712	0	2.00
3.00	Physical Therapy	0	0	1,710,576	-552,622	2,396,750	0	3.00
4.00	Occupational Therapy	0	0	449,149	-301,359	372,383	0	4.00
5.00	Speech Pathology	0	0	51,042	-37,146	41,809	0	5.00
6.00	Medical Social Services	0	0	72,988	-2,755	161,927	0	6.00
7.00	Home Health Aide	0	0	76,574	3,687	140,843	0	7.00
8.00	Supplies (see instructions)	0	0	0	-187,101	226,065	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	-18,462	64,116	0	19.00
19.50	Telemedicine	0	0	0	0	0	0	19.50
20.00	Total (sum of lines 1-19)	5,176	21,492	5,134,249		6,839,974	0	20.00
21.00	Total cost to be allocated	195,694	24,570	850,868		2,554,303	0	21.00
22.00	Unit cost multiplier	37.807960	1.143216	0.165724		0.373438	0.000000	22.00
Cost Center Description		OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	CAFETERIA (FTE'S SERVED)	MAINTENANCE OF PERSONNEL (NUMBER HOUSED)	
		7.00	8.00	9.00	10.00	11.00	12.00	
1.00	Administrative and General	5,176	0	5,176	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)	5,176	0	5,176	0	0	0	20.00
21.00	Total cost to be allocated	491,411	0	128,337	0	0	0	21.00
22.00	Unit cost multiplier	94.940301	0.000000	24.794629	0.000000	0.000000	0.000000	22.00

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS

Provider CCN: 14-0252

HHA CCN: 14-7094

Period:
From 10/01/2019
To 09/30/2020Worksheet H-2
Part II
Date/Time Prepared:
4/29/2021 1:24 pm

				Home Health Agency I		PPS	
Cost Center Description		NURSING ADMINISTRATION (FTE'S NRSING HRS)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUISITION)	MEDICAL RECORDS & LIBRARY (GROSS REVENUE)	SOCIAL SERVICE (TIME SPENT)	NONPHYSICIAN ANESTHETISTS (ASSIGNED TIME)
		13.00	14.00	15.00	16.00	17.00	19.00
1.00	Administrative and General	0	0	0	0	0	0
2.00	Skilled Nursing Care	0	0	0	0	0	0
3.00	Physical Therapy	0	0	0	0	0	0
4.00	Occupational Therapy	0	0	0	0	0	0
5.00	Speech Pathology	0	0	0	0	0	0
6.00	Medical Social Services	0	0	0	0	0	0
7.00	Home Health Aide	0	0	0	0	0	0
8.00	Supplies (see instructions)	0	0	0	0	0	0
9.00	Drugs	0	0	0	0	0	0
10.00	DME	0	0	0	0	0	0
11.00	Home Dialysis Aide Services	0	0	0	0	0	0
12.00	Respiratory Therapy	0	0	0	0	0	0
13.00	Private Duty Nursing	0	0	0	0	0	0
14.00	Clinic	0	0	0	0	0	0
15.00	Health Promotion Activities	0	0	0	0	0	0
16.00	Day Care Program	0	0	0	0	0	0
17.00	Home Delivered Meals Program	0	0	0	0	0	0
18.00	Homemaker Service	0	0	0	0	0	0
19.00	All Others (specify)	0	0	0	0	0	0
19.50	Telemedicine	0	0	0	0	0	0
20.00	Total (sum of lines 1-19)	0	0	0	0	0	0
21.00	Total cost to be allocated	0	0	0	0	0	0
22.00	Unit cost multiplier	0.000000	0.000000	0.000000	0.000000	0.000000	0.000000
Cost Center Description		NURSING SCHOOL (ASSIGNED TIME)	INTERNS & RESIDENTS SERVICES-SALARY & FRINGES APPRV (ASSIGNED TIME)	SERVICES-OTHER PRGM COSTS APPRV (ASSIGNED TIME)	PARAMED PRGM (ASSIGNED TIME)		
		20.00	21.00	22.00	23.00		
1.00	Administrative and General	0	0	0	0		
2.00	Skilled Nursing Care	0	0	0	0		
3.00	Physical Therapy	0	0	0	0		
4.00	Occupational Therapy	0	0	0	0		
5.00	Speech Pathology	0	0	0	0		
6.00	Medical Social Services	0	0	0	0		
7.00	Home Health Aide	0	0	0	0		
8.00	Supplies (see instructions)	0	0	0	0		
9.00	Drugs	0	0	0	0		
10.00	DME	0	0	0	0		
11.00	Home Dialysis Aide Services	0	0	0	0		
12.00	Respiratory Therapy	0	0	0	0		
13.00	Private Duty Nursing	0	0	0	0		
14.00	Clinic	0	0	0	0		
15.00	Health Promotion Activities	0	0	0	0		
16.00	Day Care Program	0	0	0	0		
17.00	Home Delivered Meals Program	0	0	0	0		
18.00	Homemaker Service	0	0	0	0		
19.00	All Others (specify)	0	0	0	0		
19.50	Telemedicine	0	0	0	0		
20.00	Total (sum of lines 1-19)	0	0	0	0		
21.00	Total cost to be allocated	0	0	0	0		
22.00	Unit cost multiplier	0.000000	0.000000	0.000000	0.000000		

APPORTIONMENT OF PATIENT SERVICE COSTS

Provider CCN: 14-0252

Period:

Worksheet H-3

HHA CCN: 14-7094

From 10/01/2019
To 09/30/2020Part I
Date/Time Prepared:
4/29/2021 1:24 pm

				Title XVIII		Home Health Agency I	PPS	
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	5,042,072		5,042,072	21,117	238.77	1.00
2.00	Physical Therapy	3.00	4,279,286	0	4,279,286	17,734	241.30	2.00
3.00	Occupational Therapy	4.00	904,748	0	904,748	4,888	185.10	3.00
4.00	Speech Pathology	5.00	105,265	0	105,265	557	188.99	4.00
5.00	Medical Social Services	6.00	250,621		250,621	198	1,265.76	5.00
6.00	Home Health Aide	7.00	211,217		211,217	1,854	113.93	6.00
7.00	Total (sum of lines 1-6)		10,793,209	0	10,793,209	46,348		7.00
Cost Center Description		Cost Limits	CBSA No. (1)	Part A	Program Visits			
					Part B			
					Not Subject to Deductibles & Coinsurance	Subject to Deductibles		
		0	1.00	2.00	3.00	4.00	5.00	
Limitation Cost Computation								
8.00	Skilled Nursing Care		11180	0	0			8.00
8.01	Skilled Nursing Care		16580	0	4			8.01
8.02	Skilled Nursing Care		16974	0	12,450			8.02
8.03	Skilled Nursing Care		20994	0	43			8.03
8.04	Skilled Nursing Care		27500	0	6			8.04
8.05	Skilled Nursing Care		28100	0	11			8.05
8.06	Skilled Nursing Care		29404	0	1,410			8.06
8.07	Skilled Nursing Care		33124	0	42			8.07
8.08	Skilled Nursing Care		34940	0	14			8.08
8.09	Skilled Nursing Care		35614	0	3			8.09
8.10	Skilled Nursing Care		40420	0	1			8.10
8.11	Skilled Nursing Care		48300	0	0			8.11
8.12	Skilled Nursing Care		99914	0	0			8.12
8.13	Skilled Nursing Care		99939	0	0			8.13
9.00	Physical Therapy		11180	0	21			9.00
9.01	Physical Therapy		16580	0	0			9.01
9.02	Physical Therapy		16974	0	10,478			9.02
9.03	Physical Therapy		20994	0	36			9.03
9.04	Physical Therapy		27500	0	0			9.04
9.05	Physical Therapy		28100	0	0			9.05
9.06	Physical Therapy		29404	0	1,357			9.06
9.07	Physical Therapy		33124	0	12			9.07
9.08	Physical Therapy		34940	0	7			9.08
9.09	Physical Therapy		35614	0	7			9.09
9.10	Physical Therapy		40420	0	1			9.10
9.11	Physical Therapy		48300	0	0			9.11
9.12	Physical Therapy		99914	0	0			9.12
9.13	Physical Therapy		99939	0	0			9.13
10.00	Occupational Therapy		11180	0	13			10.00
10.01	Occupational Therapy		16580	0	0			10.01
10.02	Occupational Therapy		16974	0	3,078			10.02
10.03	Occupational Therapy		20994	0	12			10.03
10.04	Occupational Therapy		27500	0	0			10.04
10.05	Occupational Therapy		28100	0	0			10.05
10.06	Occupational Therapy		29404	0	337			10.06
10.07	Occupational Therapy		33124	0	0			10.07
10.08	Occupational Therapy		34940	0	5			10.08
10.09	Occupational Therapy		35614	0	5			10.09
10.10	Occupational Therapy		40420	0	0			10.10
10.11	Occupational Therapy		48300	0	0			10.11
10.12	Occupational Therapy		99914	0	0			10.12
10.13	Occupational Therapy		99939	0	0			10.13
11.00	Speech Pathology		11180	0	0			11.00
11.01	Speech Pathology		16580	0	0			11.01
11.02	Speech Pathology		16974	0	325			11.02
11.03	Speech Pathology		20994	0	0			11.03
11.04	Speech Pathology		27500	0	0			11.04
11.05	Speech Pathology		28100	0	0			11.05
11.06	Speech Pathology		29404	0	49			11.06
11.07	Speech Pathology		33124	0	0			11.07
11.08	Speech Pathology		34940	0	0			11.08
11.09	Speech Pathology		35614	0	1			11.09
11.10	Speech Pathology		40420	0	0			11.10

APPORTIONMENT OF PATIENT SERVICE COSTS

Provider CCN: 14-0252

Period:

Worksheet H-3

HHA CCN: 14-7094

From 10/01/2019
To 09/30/2020Part I
Date/Time Prepared:
4/29/2021 1:24 pm

Title XVIII

Home Health
Agency I

PPS

Cost Center Description		Cost Limits	CBSA No. (1)	Part A	Program Visits			
					Part B			
					Not Subject to Deductibles & Coinsurance	Subject to Deductibles		
		0	1.00	2.00	3.00	4.00	5.00	
11.11	Speech Pathology		48300	0	0			11.11
11.12	Speech Pathology		99914	0	0			11.12
11.13	Speech Pathology		99939	0	0			11.13
12.00	Medical Social Services		11180	0	0			12.00
12.01	Medical Social Services		16580	0	0			12.01
12.02	Medical Social Services		16974	0	110			12.02
12.03	Medical Social Services		20994	0	0			12.03
12.04	Medical Social Services		27500	0	0			12.04
12.05	Medical Social Services		28100	0	1			12.05
12.06	Medical Social Services		29404	0	22			12.06
12.07	Medical Social Services		33124	0	0			12.07
12.08	Medical Social Services		34940	0	0			12.08
12.09	Medical Social Services		35614	0	0			12.09
12.10	Medical Social Services		40420	0	0			12.10
12.11	Medical Social Services		48300	0	0			12.11
12.12	Medical Social Services		99914	0	0			12.12
12.13	Medical Social Services		99939	0	0			12.13
13.00	Home Health Aide		11180	0	0			13.00
13.01	Home Health Aide		16580	0	0			13.01
13.02	Home Health Aide		16974	0	1,121			13.02
13.03	Home Health Aide		20994	0	11			13.03
13.04	Home Health Aide		27500	0	0			13.04
13.05	Home Health Aide		28100	0	0			13.05
13.06	Home Health Aide		29404	0	93			13.06
13.07	Home Health Aide		33124	0	17			13.07
13.08	Home Health Aide		34940	0	0			13.08
13.09	Home Health Aide		35614	0	0			13.09
13.10	Home Health Aide		40420	0	0			13.10
13.11	Home Health Aide		48300	0	0			13.11
13.12	Home Health Aide		99914	0	0			13.12
13.13	Home Health Aide		99939	0	0			13.13
14.00	Total (sum of lines 8-13)			0	31,103			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	553,874	80,820	634,694	673,040	0.943026	15.00
16.00	Cost of Drugs	9.00	0	0	0	0	0.000000	16.00
Cost Center Description		Program Visits			Cost of Services			
		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
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	13,984		0	3,338,960		1.00
2.00	Physical Therapy	0	11,919		0	2,876,055		2.00
3.00	Occupational Therapy	0	3,450		0	638,595		3.00
4.00	Speech Pathology	0	375		0	70,871		4.00
5.00	Medical Social Services	0	133		0	168,346		5.00
6.00	Home Health Aide	0	1,242		0	141,501		6.00
7.00	Total (sum of lines 1-6)	0	31,103		0	7,234,328		7.00

APPORTIONMENT OF PATIENT SERVICE COSTS

Provider CCN: 14-0252

Period:

Worksheet H-3

HHA CCN: 14-7094

From 10/01/2019
To 09/30/2020Part I
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Title XVIII

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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
8.01	Skilled Nursing Care							8.01
8.02	Skilled Nursing Care							8.02
8.03	Skilled Nursing Care							8.03
8.04	Skilled Nursing Care							8.04
8.05	Skilled Nursing Care							8.05
8.06	Skilled Nursing Care							8.06
8.07	Skilled Nursing Care							8.07
8.08	Skilled Nursing Care							8.08
8.09	Skilled Nursing Care							8.09
8.10	Skilled Nursing Care							8.10
8.11	Skilled Nursing Care							8.11
8.12	Skilled Nursing Care							8.12
8.13	Skilled Nursing Care							8.13
9.00	Physical Therapy							9.00
9.01	Physical Therapy							9.01
9.02	Physical Therapy							9.02
9.03	Physical Therapy							9.03
9.04	Physical Therapy							9.04
9.05	Physical Therapy							9.05
9.06	Physical Therapy							9.06
9.07	Physical Therapy							9.07
9.08	Physical Therapy							9.08
9.09	Physical Therapy							9.09
9.10	Physical Therapy							9.10
9.11	Physical Therapy							9.11
9.12	Physical Therapy							9.12
9.13	Physical Therapy							9.13
10.00	Occupational Therapy							10.00
10.01	Occupational Therapy							10.01
10.02	Occupational Therapy							10.02
10.03	Occupational Therapy							10.03
10.04	Occupational Therapy							10.04
10.05	Occupational Therapy							10.05
10.06	Occupational Therapy							10.06
10.07	Occupational Therapy							10.07
10.08	Occupational Therapy							10.08
10.09	Occupational Therapy							10.09
10.10	Occupational Therapy							10.10
10.11	Occupational Therapy							10.11
10.12	Occupational Therapy							10.12
10.13	Occupational Therapy							10.13
11.00	Speech Pathology							11.00
11.01	Speech Pathology							11.01
11.02	Speech Pathology							11.02
11.03	Speech Pathology							11.03
11.04	Speech Pathology							11.04
11.05	Speech Pathology							11.05
11.06	Speech Pathology							11.06
11.07	Speech Pathology							11.07
11.08	Speech Pathology							11.08
11.09	Speech Pathology							11.09
11.10	Speech Pathology							11.10
11.11	Speech Pathology							11.11
11.12	Speech Pathology							11.12
11.13	Speech Pathology							11.13
12.00	Medical Social Services							12.00
12.01	Medical Social Services							12.01
12.02	Medical Social Services							12.02
12.03	Medical Social Services							12.03
12.04	Medical Social Services							12.04
12.05	Medical Social Services							12.05
12.06	Medical Social Services							12.06
12.07	Medical Social Services							12.07
12.08	Medical Social Services							12.08
12.09	Medical Social Services							12.09
12.10	Medical Social Services							12.10
12.11	Medical Social Services							12.11
12.12	Medical Social Services							12.12
12.13	Medical Social Services							12.13
13.00	Home Health Aide							13.00
13.01	Home Health Aide							13.01

APPORTIONMENT OF PATIENT SERVICE COSTS

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				Title XVIII		Home Health Agency I		PPS	
Cost Center Description		6.00	7.00	8.00	9.00	10.00	11.00		
13.02	Home Health Aide							13.02	
13.03	Home Health Aide							13.03	
13.04	Home Health Aide							13.04	
13.05	Home Health Aide							13.05	
13.06	Home Health Aide							13.06	
13.07	Home Health Aide							13.07	
13.08	Home Health Aide							13.08	
13.09	Home Health Aide							13.09	
13.10	Home Health Aide							13.10	
13.11	Home Health Aide							13.11	
13.12	Home Health Aide							13.12	
13.13	Home Health Aide							13.13	
14.00	Total (sum of lines 8-13)							14.00	
Cost Center Description		Program Covered Charges			Cost of Services				
		Part A	Part B		Part A	Part B			
			Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance		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	451,064	0	0	425,365	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	3,338,960						1.00	
2.00	Physical Therapy	2,876,055						2.00	
3.00	Occupational Therapy	638,595						3.00	
4.00	Speech Pathology	70,871						4.00	
5.00	Medical Social Services	168,346						5.00	
6.00	Home Health Aide	141,501						6.00	
7.00	Total (sum of lines 1-6)	7,234,328						7.00	
Cost Center Description									
		12.00							
Limitation Cost Computation									
8.00	Skilled Nursing Care							8.00	
8.01	Skilled Nursing Care							8.01	
8.02	Skilled Nursing Care							8.02	
8.03	Skilled Nursing Care							8.03	
8.04	Skilled Nursing Care							8.04	
8.05	Skilled Nursing Care							8.05	
8.06	Skilled Nursing Care							8.06	
8.07	Skilled Nursing Care							8.07	
8.08	Skilled Nursing Care							8.08	
8.09	Skilled Nursing Care							8.09	
8.10	Skilled Nursing Care							8.10	
8.11	Skilled Nursing Care							8.11	
8.12	Skilled Nursing Care							8.12	
8.13	Skilled Nursing Care							8.13	
9.00	Physical Therapy							9.00	
9.01	Physical Therapy							9.01	
9.02	Physical Therapy							9.02	
9.03	Physical Therapy							9.03	
9.04	Physical Therapy							9.04	
9.05	Physical Therapy							9.05	
9.06	Physical Therapy							9.06	
9.07	Physical Therapy							9.07	
9.08	Physical Therapy							9.08	
9.09	Physical Therapy							9.09	
9.10	Physical Therapy							9.10	
9.11	Physical Therapy							9.11	
9.12	Physical Therapy							9.12	
9.13	Physical Therapy							9.13	
10.00	Occupational Therapy							10.00	
10.01	Occupational Therapy							10.01	
10.02	Occupational Therapy							10.02	
10.03	Occupational Therapy							10.03	

APPORTIONMENT OF PATIENT SERVICE COSTS

Provider CCN: 14-0252

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Title XVIII

Home Health
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PPS

Cost Center Description			
		12.00	
10.04	Occupational Therapy		10.04
10.05	Occupational Therapy		10.05
10.06	Occupational Therapy		10.06
10.07	Occupational Therapy		10.07
10.08	Occupational Therapy		10.08
10.09	Occupational Therapy		10.09
10.10	Occupational Therapy		10.10
10.11	Occupational Therapy		10.11
10.12	Occupational Therapy		10.12
10.13	Occupational Therapy		10.13
11.00	Speech Pathology		11.00
11.01	Speech Pathology		11.01
11.02	Speech Pathology		11.02
11.03	Speech Pathology		11.03
11.04	Speech Pathology		11.04
11.05	Speech Pathology		11.05
11.06	Speech Pathology		11.06
11.07	Speech Pathology		11.07
11.08	Speech Pathology		11.08
11.09	Speech Pathology		11.09
11.10	Speech Pathology		11.10
11.11	Speech Pathology		11.11
11.12	Speech Pathology		11.12
11.13	Speech Pathology		11.13
12.00	Medical Social Services		12.00
12.01	Medical Social Services		12.01
12.02	Medical Social Services		12.02
12.03	Medical Social Services		12.03
12.04	Medical Social Services		12.04
12.05	Medical Social Services		12.05
12.06	Medical Social Services		12.06
12.07	Medical Social Services		12.07
12.08	Medical Social Services		12.08
12.09	Medical Social Services		12.09
12.10	Medical Social Services		12.10
12.11	Medical Social Services		12.11
12.12	Medical Social Services		12.12
12.13	Medical Social Services		12.13
13.00	Home Health Aide		13.00
13.01	Home Health Aide		13.01
13.02	Home Health Aide		13.02
13.03	Home Health Aide		13.03
13.04	Home Health Aide		13.04
13.05	Home Health Aide		13.05
13.06	Home Health Aide		13.06
13.07	Home Health Aide		13.07
13.08	Home Health Aide		13.08
13.09	Home Health Aide		13.09
13.10	Home Health Aide		13.10
13.11	Home Health Aide		13.11
13.12	Home Health Aide		13.12
13.13	Home Health Aide		13.13
14.00	Total (sum of lines 8-13)		14.00

APPORTIONMENT OF PATIENT SERVICE COSTS

Provider CCN: 14-0252

Period:

Worksheet H-3

HHA CCN: 14-7094

From 10/01/2019

Part II

To 09/30/2020

Date/Time Prepared:

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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	0.361754	0	0	col. 2, line 2.00		1.00
1.01 Physical Therapy 1	66.01	0.422070	0	0	col. 2, line 2.01		1.01
2.00 Occupational Therapy							2.00
3.00 Speech Pathology							3.00
4.00 Cost of Medical Supplies	71.00	0.311634	259,344	80,820	col. 2, line 15.00		4.00
5.00 Cost of Drugs	73.00	0.258547	0	0	col. 2, line 16.00		5.00
5.01 Cost of Drugs 1	73.01	0.500376	0	0	col. 2, line 16.01		5.01

CALCULATION OF HHA REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0252 HHA CCN: 14-7094	Period: From 10/01/2019 To 09/30/2020	Worksheet H-4 Part I-II Date/Time Prepared: 4/29/2021 1:24 pm
		Title XVIII	Home Health Agency I	PPS
		Part A	Part B	
			Not Subject to Deductibles & Coinsurance	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
2.00	Total charges	0	0	0
Customary Charges				
3.00	Amount actually collected from patients liable for payment for services on a charge basis (from your records)	0	0	0
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
5.00	Ratio of line 3 to line 4 (not to exceed 1.000000)	0.000000	0.000000	0.000000
6.00	Total customary charges (see instructions)	0	0	0
7.00	Excess of total customary charges over total reasonable cost (complete only if line 6 exceeds line 1)	0	0	0
8.00	Excess of reasonable cost over customary charges (complete only if line 1 exceeds line 6)	0	0	0
9.00	Primary payer amounts	0	2,189	0
			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	-2,189
11.00	Total PPS Reimbursement - Full Episodes without Outliers		0	6,535,877
12.00	Total PPS Reimbursement - Full Episodes with Outliers		0	171,873
13.00	Total PPS Reimbursement - LUPA Episodes		0	109,455
14.00	Total PPS Reimbursement - PEP Episodes		0	20,792
15.00	Total PPS Outlier Reimbursement - Full Episodes with Outliers		0	29,087
16.00	Total PPS Outlier Reimbursement - PEP Episodes		0	0
17.00	Total Other Payments		0	0
18.00	DME Payments		0	0
19.00	Oxygen Payments		0	0
20.00	Prosthetic and Orthotic Payments		0	0
21.00	Part B deductibles billed to Medicare patients (exclude coinsurance)		0	0
22.00	Subtotal (sum of lines 10 thru 20 minus line 21)		0	6,864,895
23.00	Excess reasonable cost (from line 8)		0	0
24.00	Subtotal (line 22 minus line 23)		0	6,864,895
25.00	Coinsurance billed to program patients (from your records)		0	0
26.00	Net cost (line 24 minus line 25)		0	6,864,895
27.00	Reimbursable bad debts (from your records)			
28.00	Reimbursable bad debts for dual eligible beneficiaries (see instructions)			
29.00	Total costs - current cost reporting period (line 26 plus line 27)		0	6,864,895
30.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	0
30.50	Pioneer ACO demonstration payment adjustment (see instructions)		0	0
30.99	Demonstration payment adjustment amount before sequestration		0	0
31.00	Subtotal (see instructions)		0	6,864,895
31.01	Sequestration adjustment (see instructions)		0	84,445
31.02	Demonstration payment adjustment amount after sequestration		0	0
32.00	Interim payments (see instructions)		0	6,780,451
33.00	Tentative settlement (for contractor use only)		0	0
34.00	Balance due provider/program (line 31 minus lines 31.01, 32, and 33)		0	-1
35.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		0	0

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED HHAs FOR SERVICES RENDERED
TO PROGRAM BENEFICIARIESProvider CCN: 14-0252
HHA CCN: 14-7094Period:
From 10/01/2019
To 09/30/2020

Worksheet H-5

Date/Time Prepared:
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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		6,780,451	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		6,780,451	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		1	6.02
7.00	Total Medicare program liability (see instructions)		0		6,780,450	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: 14-0252	Period: From 10/01/2019 To 09/30/2020	Worksheet L Parts I-III Date/Time Prepared: 4/29/2021 1:24 pm
		Title XVIII	Hospital	PPS
		1.00		
PART I - FULLY PROSPECTIVE METHOD				
CAPITAL FEDERAL AMOUNT				
1.00	Capital DRG other than outlier	6,078,728		1.00
1.01	Model 4 BPCI Capital DRG other than outlier	0		1.01
2.00	Capital DRG outlier payments	189,124		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)	217.03		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)	2.47		7.00
8.00	Percentage of Medicaid patient days to total days (see instructions)	13.66		8.00
9.00	Sum of lines 7 and 8	16.13		9.00
10.00	Allowable disproportionate share percentage (see instructions)	3.32		10.00
11.00	Disproportionate share adjustment (see instructions)	201,814		11.00
12.00	Total prospective capital payments (see instructions)	6,469,666		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