

This report is required by law (42 USC 1395g; 42 CFR 413.20(b)). Failure to report can result in all interim FORM APPROVED payments made since the beginning of the cost reporting period being deemed overpayments (42 USC 1395g).

OMB NO. 0938-0050
EXPIRES 03-31-2022

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY	Provider CCN: 15-0002	Period: From 01/01/2020 To 12/31/2020	Worksheet S Parts I-III Date/Time Prepared: 7/23/2021 10:58 am
--	-----------------------	---	---

PART I - COST REPORT STATUS

Provider use only	1. ☒ Electronically prepared cost report	Date: 7/23/2021	Time: 10:58 am
	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 METHODIST HOSPITALS, INC (15-0002) for the cost reporting period beginning 01/01/2020 and ending 12/31/2020 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

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

(Signed) MATT DOYLE

Officer or Administrator of Provider(s)

CEO

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	1,945,959	-27,960	0	-931,180	1.00
2.00	Subprovider - IPF	0	378	-2		-362,105	2.00
3.00	Subprovider - IRF	0	70,804	0		-39,637	3.00
5.00	Swing Bed - SNF	0	0	0		0	5.00
6.00	Swing Bed - NF	0				0	6.00
9.00	HOME HEALTH AGENCY I	0	0	0		0	9.00
200.00	Total	0	2,017,141	-27,962	0	-1,332,922	200.00

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA				Provider CCN: 15-0002		Period: From 01/01/2020 To 12/31/2020		Worksheet S-2 Part I Date/Time Prepared: 7/23/2021 10:58 am				
1.00		2.00		3.00		4.00						
Hospital and Hospital Health Care Complex Address:												
1.00	Street: 600 GRANT STREET			PO Box:				1.00				
2.00	City: GARY			State: IN		Zip Code: 46402		County: LAKE				
		Component Name		CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N)				
								V	XVIII			
								XIX				
Hospital and Hospital-Based Component Identification:												
3.00	Hospital			METHODIST HOSPITALS, INC	150002	23844	1	01/01/1966	N	P	O	3.00
4.00	Subprovider - IPF			GERIATRIC PSYCH	15S002	23844	4	01/01/2012	N	P	O	4.00
5.00	Subprovider - IRF			REHABILITATION	15T002	23844	5	01/01/1984	N	P	O	5.00
6.00	Subprovider - (Other)											6.00
7.00	Swing Beds - SNF											7.00
8.00	Swing Beds - NF											8.00
9.00	Hospital-Based SNF											9.00
10.00	Hospital-Based NF											10.00
11.00	Hospital-Based OLTC											11.00
12.00	Hospital-Based HHA			METHODIST HOME CARE SERVICES	157536	23844		02/12/2002	N	P	O	12.00
13.00	Separately Certified ASC											13.00
14.00	Hospital-Based Hospice											14.00
15.00	Hospital-Based Health Clinic - RHC											15.00
16.00	Hospital-Based Health Clinic - FQHC											16.00
17.00	Hospital-Based (CMHC) I											17.00
18.00	Renal Dialysis											18.00
19.00	Other											19.00
							From:	To:				
							1.00	2.00				
20.00	Cost Reporting Period (mm/dd/yyyy)						01/01/2020	12/31/2020		20.00		
21.00	Type of Control (see instructions)						2			21.00		
							1.00	2.00		3.00		
Inpatient PPS Information												
22.00	Does this facility qualify and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.106(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no.					Y	N		22.00			
22.01	Did this hospital receive interim uncompensated care payments for this cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)					Y	Y		22.01			
22.02	Is this a newly merged hospital that requires final uncompensated care payments to be determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1.					N	N		22.02			
22.03	Did this hospital receive a geographic reclassification from urban to rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)					N	N		22.03			
23.00	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.											
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.					3	N		23.00			
				In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of State Medicaid paid days	Out-of State Medicaid eligible unpaid	Medicaid HMO days	Other Medicaid days			
				1.00	2.00	3.00	4.00	5.00	6.00			
24.00	If this provider is an IPPS hospital, enter the in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.			4,112	6,865	0	983	14,026	0	24.00		

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA				Provider CCN: 15-0002		Period: From 01/01/2020 To 12/31/2020		Worksheet S-2 Part I Date/Time Prepared: 7/23/2021 10:58 am	
		In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of State Medicaid paid days	Out-of State Medicaid eligible unpaid	Medicaid HMO days	Other Medicaid days		
		1.00	2.00	3.00	4.00	5.00	6.00		
25.00	If this provider is an IRF, enter the in-state Medicaid paid days in column 1, the in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5.	195	327	0	0	478			25.00
						Urban/Rural S	Date of Geogr		
						1.00	2.00		
26.00	Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter "1" for urban or "2" for rural.					1			26.00
27.00	Enter your standard geographic classification (not wage) status at the end of the cost reporting period. Enter in column 1, "1" for urban or "2" for rural. If applicable, enter the effective date of the geographic reclassification in column 2.					1			27.00
35.00	If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period.					0			35.00
						Beginning:	Ending:		
						1.00	2.00		
36.00	Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.								36.00
37.00	If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status is in effect in the cost reporting period.					0			37.00
37.01	Is this hospital a former MDH that is eligible for the MDH transitional payment in accordance with FY 2016 OPPS final rule? Enter "Y" for yes or "N" for no. (see instructions)								37.01
38.00	If line 37 is 1, enter the beginning and ending dates of MDH status. If line 37 is greater than 1, subscript this line for the number of periods in excess of one and enter subsequent dates.								38.00
						Y/N	Y/N		
						1.00	2.00		
39.00	Does this facility qualify for the inpatient hospital payment adjustment for low volume hospitals in accordance with 42 CFR §412.101(b)(2)(i), (ii), or (iii)? Enter in column 1 "Y" for yes or "N" for no. Does the facility meet the mileage requirements in accordance with 42 CFR §412.101(b)(2)(i), (ii), or (iii)? Enter in column 2 "Y" for yes or "N" for no. (see instructions)					N	N		39.00
40.00	Is this hospital subject to the HAC program reduction adjustment? Enter "Y" for yes or "N" for no in column 1, for discharges prior to October 1. Enter "Y" for yes or "N" for no in column 2, for discharges on or after October 1. (see instructions)					N	N		40.00
						V	XVIII	XIX	
						1.00	2.00	3.00	
Prospective Payment System (PPS)-Capital									
45.00	Does this facility qualify and receive Capital payment for disproportionate share in accordance with 42 CFR Section §412.320? (see instructions)					N	Y	N	45.00
46.00	Is this facility eligible for additional payment exception for extraordinary circumstances pursuant to 42 CFR §412.348(f)? If yes, complete Wkst. L, Pt. III and Wkst. L-1, Pt. I through Pt. III.					N	N	N	46.00
47.00	Is this a new hospital under 42 CFR §412.300(b) PPS capital? Enter "Y" for yes or "N" for no.					N	N	N	47.00
48.00	Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.					N	N	N	48.00
Teaching Hospitals									
56.00	Is this a hospital involved in training residents in approved GME programs? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", are you impacted by CR 11642 (or subsequent CR), MA GME payment reduction? Enter "Y" for yes or "N" for no in column 2.					Y	Y		56.00
57.00	If line 56 is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y" did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If column 2 is "N", complete Wkst. D, Parts III & IV and D-2, Pt. II, if applicable.					N			57.00
58.00	If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, chapter 21, §2148? If yes, complete Wkst. D-5.					N			58.00
59.00	Are costs claimed on line 100 of Worksheet A? If yes, complete Wkst. D-2, Pt. I.					N			59.00
				NAHE 413.85 Y/N	Worksheet A Line #	Pass-Through Qualification Criterion Code			
				1.00	2.00	3.00			
60.00	Are you claiming nursing and allied health education (NAHE) costs for any programs that meet the criteria under 42 CFR 413.85? (see instructions) Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", are you impacted by CR 11642 (or subsequent CR) NAHE MA payment adjustment? Enter "Y" for yes or "N" for no in column 2.			Y	N				60.00
60.01	If line 60 is yes, complete columns 2 and 3 for each program. (see instructions)					23.00	2		60.01

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

Provider CCN: 15-0002

Period:
From 01/01/2020
To 12/31/2020Worksheet S-2
Part I
Date/Time Prepared:
7/23/2021 10:58 am

	Y/N	IME	Direct GME	IME	Direct GME	
	1.00	2.00	3.00	4.00	5.00	
61.00 Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions)	N			0.00	0.00	61.00
61.01 Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions)						61.01
61.02 Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions)						61.02
61.03 Enter the base line FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions)						61.03
61.04 Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period.(see instructions).						61.04
61.05 Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions)						61.05
61.06 Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)						61.06
	Program Name		Program Code	Unweighted IME FTE Count	Unweighted Direct GME FTE Count	
	1.00	2.00	3.00	4.00		
61.10 Of the FTEs in line 61.05, specify each new program specialty, if any, and the number of FTE residents for each new program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count.				0.00	0.00	61.10
61.20 Of the FTEs in line 61.05, specify each expanded program specialty, if any, and the number of FTE residents for each expanded program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count.				0.00	0.00	61.20
					1.00	
ACA Provisions Affecting the Health Resources and Services Administration (HRSA)						
62.00 Enter the number of FTE residents that your hospital trained in this cost reporting period for which your hospital received HRSA PCRE funding (see instructions)					0.00	62.00
62.01 Enter the number of FTE residents that rotated from a Teaching Health Center (THC) into your hospital during in this cost reporting period of HRSA THC program. (see instructions)					0.00	62.01
Teaching Hospitals that Claim Residents in Nonprovider Settings						
63.00 Has your facility trained residents in nonprovider settings during this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If yes, complete lines 64 through 67. (see instructions)					N	63.00
		Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))		
		1.00	2.00	3.00		
Section 5504 of the ACA Base Year FTE Residents in Nonprovider Settings--This base year is your cost reporting period that begins on or after July 1, 2009 and before June 30, 2010.						
64.00 Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)			0.00	0.00	0.000000	64.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

Provider CCN: 15-0002

Period:
From 01/01/2020
To 12/31/2020Worksheet S-2
Part I
Date/Time Prepared:
7/23/2021 10:58 am

	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					
66.00	Enter in column 1 the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)		0.00	0.00	0.000000	66.00
	Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))	
	1.00	2.00	3.00	4.00	5.00	
67.00	Enter in column 1, the program name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)		0.00	0.00	0.000000	67.00
			1.00	2.00	3.00	
70.00	Inpatient Psychiatric Facility PPS					
70.00	Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? Enter "Y" for yes or "N" for no.				Y	70.00
71.00	If line 70 is yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost report filed on or before November 15, 2004? Enter "Y" for yes or "N" for no. (see 42 CFR 412.424(d)(1)(iii)(c)) Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)				N N 0	71.00
	Inpatient Rehabilitation Facility PPS					
75.00	Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF subprovider? Enter "Y" for yes and "N" for no.				Y	75.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 15-0002	Period: From 01/01/2020 To 12/31/2020	Worksheet S-2 Part I Date/Time Prepared: 7/23/2021 10:58 am	
			1.00	2.00	3.00
76.00	If line 75 is yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)	N	N	0	76.00
			1.00		
Long Term Care Hospital PPS					
80.00	Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for no.	N			80.00
81.00	Is this a LTCH co-located within another hospital for part or all of the cost reporting period? Enter "Y" for yes and "N" for no.	N			81.00
TEFRA Providers					
85.00	Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no.	N			85.00
86.00	Did this facility establish a new Other subprovider (excluded unit) under 42 CFR Section §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.	N			86.00
87.00	Is this hospital an extended neoplastic disease care hospital classified under section 1886(d)(1)(B)(vi)? Enter "Y" for yes or "N" for no.	N			87.00
			V	XIX	
			1.00	2.00	
Title V and XIX Services					
90.00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.	N	Y		90.00
91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.	N	Y		91.00
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.		N		92.00
93.00	Does this facility operate an ICF/IID facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.	N	N		93.00
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.	N	N		94.00
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00		95.00
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.	N	N		96.00
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00		97.00
98.00	Does title V or XIX follow Medicare (title XVIII) for the interns and residents post stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y		98.00
98.01	Does title V or XIX follow Medicare (title XVIII) for the reporting of charges on Wkst. C, Pt. I? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y		98.01
98.02	Does title V or XIX follow Medicare (title XVIII) for the calculation of observation bed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y		98.02
98.03	Does title V or XIX follow Medicare (title XVIII) for a critical access hospital (CAH) reimbursed 101% of inpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N		98.03
98.04	Does title V or XIX follow Medicare (title XVIII) for a CAH reimbursed 101% of outpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N		98.04
98.05	Does title V or XIX follow Medicare (title XVIII) and add back the RCE disallowance on Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y		98.05
98.06	Does title V or XIX follow Medicare (title XVIII) when cost reimbursed for Wkst. D, Pts. I through IV? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y		98.06
Rural Providers					
105.00	Does this hospital qualify as a CAH?	N			105.00
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)	N			106.00
107.00	Column 1: If line 105 is Y, is this facility eligible for cost reimbursement for I&R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) Column 2: If column 1 is Y and line 70 or line 75 is Y, do you train I&Rs in an approved medical education program in the CAH's excluded IPF and/or IRF unit(s)? Enter "Y" for yes or "N" for no in column 2. (see instructions)	N			107.00
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	N			108.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 15-0002		Period: From 01/01/2020 To 12/31/2020		Worksheet S-2 Part I Date/Time Prepared: 7/23/2021 10:58 am	
		Physical 1.00	Occupational 2.00	Speech 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.	N	N	N	N		109.00
						1.00	
110.00	Did this hospital participate in the Rural Community Hospital Demonstration project (\$410A Demonstration) for the current cost reporting period? Enter "Y" for yes or "N" for no. If yes, complete Worksheet E, Part A, lines 200 through 218, and Worksheet E-2, lines 200 through 215, as applicable.	N					110.00
						1.00	
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	
112.00	Did this hospital participate in the Pennsylvania Rural Health Model demonstration for any portion of the current cost reporting period? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2, the date the hospital began participating in the demonstration. In column 3, enter the date the hospital ceased participation in the demonstration, if applicable.	N					112.00
Miscellaneous Cost Reporting Information							
115.00	Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in column 1. If column 1 is yes, enter the method used (A, B, or E only) in column 2. If column 2 is "E", enter in column 3 either "93" percent for short term hospital or "98" percent for long term care (includes psychiatric, rehabilitation and long term hospitals providers) based on the definition in CMS Pub.15-1, chapter 22, §2208.1.	N					115.00
116.00	Is this facility classified as a referral center? Enter "Y" for yes or "N" for no.	N					116.00
117.00	Is this facility legally-required to carry malpractice insurance? Enter "Y" for yes or "N" for no.	Y					117.00
118.00	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.	1					118.00
		Premiums	Losses	Insurance			
		1.00	2.00	3.00			
118.01	List amounts of malpractice premiums and paid losses:	1,095,852		0			118.01
						1.00	
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein.	N					118.02
119.00	DO NOT USE THIS LINE						119.00
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 1, "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2, "Y" for yes or "N" for no.	N				N	120.00
121.00	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter "Y" for yes or "N" for no.	Y					121.00
122.00	Does the cost report contain healthcare related taxes as defined in §1903(w)(3) of the Act? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2 the Worksheet A line number where these taxes are included.	N					122.00
Transplant Center Information							
125.00	Does this facility operate a transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.	N					125.00
126.00	If this is a Medicare certified kidney transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.						126.00
127.00	If this is a Medicare certified heart transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.						127.00
128.00	If this is a Medicare certified liver transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.						128.00
129.00	If this is a Medicare certified lung transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.						129.00
130.00	If this is a Medicare certified pancreas transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.						130.00
131.00	If this is a Medicare certified intestinal transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.						131.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 15-0002		Period: From 01/01/2020 To 12/31/2020		Worksheet S-2 Part I Date/Time Prepared: 7/23/2021 10:58 am	
		1.00		2.00			
132.00	If this is a Medicare certified islet transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					132.00	
133.00	Removed and reserved					133.00	
134.00	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.					134.00	
All Providers							
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)	N				140.00	
1.00		2.00		3.00			
If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number.							
141.00	Name:	Contractor's Name:		Contractor's Number:		141.00	
142.00	Street:	PO Box:				142.00	
143.00	City:	State:		Zip Code:		143.00	
				1.00			
144.00	Are provider based physicians' costs included in Worksheet A?			Y		144.00	
		1.00		2.00			
145.00	If costs for renal services are claimed on Wkst. A, line 74, are the costs for inpatient services only? Enter "Y" for yes or "N" for no in column 1. If column 1 is no, does the dialysis facility include Medicare utilization for this cost reporting period? Enter "Y" for yes or "N" for no in column 2.	Y				145.00	
146.00	Has the cost allocation methodology changed from the previously filed cost report? Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, chapter 40, §4020) If yes, enter the approval date (mm/dd/yyyy) in column 2.	N				146.00	
				1.00			
147.00	Was there a change in the statistical basis? Enter "Y" for yes or "N" for no.			N		147.00	
148.00	Was there a change in the order of allocation? Enter "Y" for yes or "N" for no.			N		148.00	
149.00	Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no.			N		149.00	
		Part A		Part B		Title V	
		1.00		2.00		3.00	
						Title XIX	
						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	
156.00	Subprovider - IPF	N		N		N	
157.00	Subprovider - IRF	N		N		N	
158.00	SUBPROVIDER						
159.00	SNF	N		N		N	
160.00	HOME HEALTH AGENCY	N		N		N	
161.00	CMHC			N		N	
						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	
		0		1.00		2.00	
						3.00	
						4.00	
						5.00	
166.00	If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions)					0.00	
						1.00	
Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act							
167.00	Is this provider a meaningful user under §1886(n)? Enter "Y" for yes or "N" for no.			Y		167.00	
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)					168.00	
168.01	If this provider is a CAH and is not a meaningful user, does this provider qualify for a hardship exception under §413.70(a)(6)(ii)? Enter "Y" for yes or "N" for no. (see instructions)					168.01	
169.00	If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)			9.99		169.00	

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 15-0002	Period: From 01/01/2020 To 12/31/2020	Worksheet S-2 Part I Date/Time Prepared: 7/23/2021 10:58 am
			Beginning 1.00	Ending 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		0171.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 15-0002		Period: From 01/01/2020 To 12/31/2020		Worksheet S-2 Part II Date/Time Prepared: 7/23/2021 10:58 am	
		Y/N	Date				
		1.00	2.00				
General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format.							
COMPLETED BY ALL HOSPITALS							
Provider Organization and Operation							
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)	N					1.00
		Y/N	Date	V/I			
		1.00	2.00	3.00			
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.	N					2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)	N					3.00
		Y/N	Type	Date			
		1.00	2.00	3.00			
Financial Data and Reports							
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	Y	A				4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.	N					5.00
		Y/N	Legal Oper.				
		1.00	2.00				
Approved Educational Activities							
6.00	Column 1: Are costs claimed for nursing school? Column 2: If yes, is the provider is the legal operator of the program?	N					6.00
7.00	Are costs claimed for Allied Health Programs? If "Y" see instructions.	Y					7.00
8.00	Were nursing school and/or allied health programs approved and/or renewed during the cost reporting period? If yes, see instructions.	Y					8.00
9.00	Are costs claimed for Interns and Residents in an approved graduate medical education program in the current cost report? If yes, see instructions.	Y					9.00
10.00	Was an approved Intern and Resident GME program initiated or renewed in the current cost reporting period? If yes, see instructions.	N					10.00
11.00	Are GME cost directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions.	N					11.00
		Y/N					
		1.00					
Bad Debts							
12.00	Is the provider seeking reimbursement for bad debts? If yes, see instructions.	Y					12.00
13.00	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.	N					13.00
14.00	If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.	N					14.00
Bed Complement							
15.00	Did total beds available change from the prior cost reporting period? If yes, see instructions.	N					15.00
		Part A		Part B			
		Y/N	Date	Y/N	Date		
		1.00	2.00	3.00	4.00		
PS&R Data							
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)	N		N			16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	Y	03/19/2021	Y	03/19/2021		17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N		N			18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		N			19.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE

Provider CCN: 15-0002

Period:
From 01/01/2020
To 12/31/2020Worksheet S-2
Part II
Date/Time Prepared:
7/23/2021 10:58 am

		Description	Y/N	Y/N	
		0	1.00	3.00	
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:		N	N	20.00
		Y/N	Date	Y/N	Date
		1.00	2.00	3.00	4.00
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		N	21.00
				1.00	
COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)					
Capital Related Cost					
22.00	Have assets been relifed for Medicare purposes? If yes, see instructions		N		22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.				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.		N		32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.		N		33.00
Provider-Based Physicians					
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.		Y		34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.		N		35.00
		Y/N	Date		
		1.00	2.00		
Home Office Costs					
36.00	Were home office costs claimed on the cost report?		N		36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.		N		37.00
38.00	If line 36 is yes, was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.		N		38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.		N		39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.		N		40.00
		1.00	2.00		
Cost Report Preparer Contact Information					
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	MICHAEL	ALESSANDRINI		41.00
42.00	Enter the employer/company name of the cost report preparer.	BLUE & CO., LLC			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	317-713-7959	MALESSANDRINI@BLUEANDCO.COM		43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 15-0002	Period: From 01/01/2020 To 12/31/2020	Worksheet S-2 Part II Date/Time Prepared: 7/23/2021 10:58 am
		3.00		
Cost Report Preparer Contact Information				
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	DIRECTOR		41.00
42.00	Enter the employer/company name of the cost report preparer.			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.			43.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 15-0002

Period:
From 01/01/2020
To 12/31/2020Worksheet S-3
Part I
Date/Time Prepared:
7/23/2021 10:58 am

Component	Worksheet A Line Number	No. of Beds	Bed Days Available	CAH Hours	I/P Days / O/P Visits / Trips	
					Title V	
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	376	137,616	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)		376	137,616	0.00	0	7.00
8.00 INTENSIVE CARE UNIT	31.00	33	12,078	0.00	0	8.00
8.01 NEONATAL ICU	31.01	36	13,176	0.00	0	8.01
9.00 CORONARY CARE UNIT						9.00
10.00 BURN INTENSIVE CARE UNIT						10.00
11.00 SURGICAL INTENSIVE CARE UNIT						11.00
12.00 OTHER SPECIAL CARE (SPECIFY)						12.00
13.00 NURSERY	43.00				0	13.00
14.00 Total (see instructions)		445	162,870	0.00	0	14.00
15.00 CAH visits					0	15.00
16.00 SUBPROVIDER - IPF	40.00	12	4,392		0	16.00
17.00 SUBPROVIDER - IRF	41.00	39	14,274		0	17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY	101.00				0	22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
24.10 HOSPICE (non-distinct part)	30.00					24.10
25.00 CMHC - CMHC						25.00
26.00 RURAL HEALTH CLINIC						26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	26.25
27.00 Total (sum of lines 14-26)		496			0	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)		0	0			32.00
32.01 Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00 LTCH non-covered days						33.00
33.01 LTCH site neutral days and discharges						33.01

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 15-0002

Period:
From 01/01/2020
To 12/31/2020Worksheet S-3
Part I
Date/Time Prepared:
7/23/2021 10:58 am

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)	19,768	4,106	63,491		1.00
2.00	HMO and other (see instructions)	18,379	21,784			2.00
3.00	HMO IPF Subprovider	0	447			3.00
4.00	HMO IRF Subprovider	0	805			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)	19,768	4,106	63,491		7.00
8.00	INTENSIVE CARE UNIT	3,100	0	9,403		8.00
8.01	NEONATAL ICU	0	0	3,047		8.01
9.00	CORONARY CARE UNIT					9.00
10.00	BURN INTENSIVE CARE UNIT					10.00
11.00	SURGICAL INTENSIVE CARE UNIT					11.00
12.00	OTHER SPECIAL CARE (SPECIFY)					12.00
13.00	NURSERY		0	2,545		13.00
14.00	Total (see instructions)	22,868	4,106	78,486	3.00	1,832.61
15.00	CAH visits	0	0	0		15.00
16.00	SUBPROVIDER - IPF	949	70	2,515	0.00	14.00
17.00	SUBPROVIDER - IRF	2,666	195	5,409	0.00	30.22
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	7,805	1,182	23,979	0.00	28.16
23.00	AMBULATORY SURGICAL CENTER (D.P.)					23.00
24.00	HOSPICE					24.00
24.10	HOSPICE (non-distinct part)			182		24.10
25.00	CMHC - CMHC					25.00
26.00	RURAL HEALTH CLINIC					26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0.00	0.00
27.00	Total (sum of lines 14-26)				3.00	1,904.99
28.00	Observation Bed Days		4,045	14,773		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	96	102		32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)			0		32.01
33.00	LTCH non-covered days	0				33.00
33.01	LTCH site neutral days and discharges	0				33.01

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 15-0002

Period:
From 01/01/2020
To 12/31/2020Worksheet S-3
Part I
Date/Time Prepared:
7/23/2021 10:58 am

Component	Full Time Equivalents	Discharges			Total All Patients	
	Nonpaid Workers	Title V	Title XVIII	Title XIX		
	11.00	12.00	13.00	14.00	15.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)		0	3,383	514	11,565	1.00
2.00 HMO and other (see instructions)			2,160	3,461		2.00
3.00 HMO IPF Subprovider				25		3.00
4.00 HMO IRF Subprovider				54		4.00
5.00 Hospital Adults & Peds. Swing Bed SNF						5.00
6.00 Hospital Adults & Peds. Swing Bed NF						6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)						7.00
8.00 INTENSIVE CARE UNIT						8.00
8.01 NEONATAL ICU						8.01
9.00 CORONARY CARE UNIT						9.00
10.00 BURN INTENSIVE CARE UNIT						10.00
11.00 SURGICAL INTENSIVE CARE UNIT						11.00
12.00 OTHER SPECIAL CARE (SPECIFY)						12.00
13.00 NURSERY						13.00
14.00 Total (see instructions)	0.00	0	3,383	514	11,565	14.00
15.00 CAH visits						15.00
16.00 SUBPROVIDER - IPF	0.00	0	42	3	173	16.00
17.00 SUBPROVIDER - IRF	0.00	0	183	14	372	17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY	0.00					22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
24.10 HOSPICE (non-distinct part)						24.10
25.00 CMHC - CMHC						25.00
26.00 RURAL HEALTH CLINIC						26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER	0.00					26.25
27.00 Total (sum of lines 14-26)	0.00					27.00
28.00 Observation Bed Days						28.00
29.00 Ambulance Trips						29.00
30.00 Employee discount days (see instruction)						30.00
31.00 Employee discount days - IRF						31.00
32.00 Labor & delivery days (see instructions)						32.00
32.01 Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00 LTCH non-covered days			0			33.00
33.01 LTCH site neutral days and discharges			0			33.01

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 15-0002

Period:
From 01/01/2020
To 12/31/2020Worksheet S-3
Part II
Date/Time Prepared:
7/23/2021 10:58 am

	Wkst. A Line Number	Amount Reported	Reclassificat ion 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	148,683,146	-388,650	148,294,496	3,967,910.00	37.37 1.00
2.00	Non-physician anesthetist Part A		0	0	0	0.00	0.00 2.00
3.00	Non-physician anesthetist Part B		0	0	0	0.00	0.00 3.00
4.00	Physician-Part A - Administrative		26,000	0	26,000	145.00	179.31 4.00
4.01	Physicians - Part A - Teaching		0	0	0	0.00	0.00 4.01
5.00	Physician and Non Physician-Part B		2,217,675	0	2,217,675	21,191.00	104.65 5.00
6.00	Non-physician-Part B for hospital-based RHC and FQHC services		0	0	0	0.00	0.00 6.00
7.00	Interns & residents (in an approved program)	21.00	0	0	0	0.00	0.00 7.00
7.01	Contracted interns and residents (in an approved programs)		252,816	0	252,816	6,240.00	40.52 7.01
8.00	Home office and/or related organization personnel		0	0	0	0.00	0.00 8.00
9.00	SNF	44.00	0	0	0	0.00	0.00 9.00
10.00	Excluded area salaries (see instructions)		27,760,199	552,708	28,312,907	547,724.00	51.69 10.00
OTHER WAGES & RELATED COSTS							
11.00	Contract labor: Direct Patient Care		11,161,434	0	11,161,434	172,765.00	64.60 11.00
12.00	Contract labor: Top level management and other management and administrative services		0	0	0	0.00	0.00 12.00
13.00	Contract labor: Physician-Part A - Administrative		744,375	0	744,375	4,518.00	164.76 13.00
14.00	Home office and/or related organization salaries and wage-related costs		0	0	0	0.00	0.00 14.00
14.01	Home office salaries		0	0	0	0.00	0.00 14.01
14.02	Related organization salaries		0	0	0	0.00	0.00 14.02
15.00	Home office: Physician Part A - Administrative		0	0	0	0.00	0.00 15.00
16.00	Home office and Contract Physicians Part A - Teaching		0	0	0	0.00	0.00 16.00
16.01	Home office Physicians Part A - Teaching		0	0	0	0.00	0.00 16.01
16.02	Home office contract Physicians Part A - Teaching		0	0	0	0.00	0.00 16.02
WAGE-RELATED COSTS							
17.00	Wage-related costs (core) (see instructions)		33,113,497	0	33,113,497		
18.00	Wage-related costs (other) (see instructions)						
19.00	Excluded areas		5,885,021	0	5,885,021		
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		2,617	0	2,617		
22.01	Physician Part A - Teaching		0	0	0		
23.00	Physician Part B		316,583	0	316,583		
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: 15-0002

Period:
From 01/01/2020
To 12/31/2020Worksheet S-3
Part II
Date/Time Prepared:
7/23/2021 10:58 am

		Wkst. A Line Number	Amount Reported	Reclassificat ion 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	1,916,032	-71,319	1,844,713	31,807.00	58.00	26.00
27.00	Administrative & General	5.00	22,275,602	-917,625	21,357,977	615,083.00	34.72	27.00
28.00	Administrative & General under contract (see inst.)		1,787,185	0	1,787,185	8,890.00	201.03	28.00
29.00	Maintenance & Repairs	6.00	0	0	0	0.00	0.00	29.00
30.00	Operation of Plant	7.00	3,889,109	-21,236	3,867,873	152,946.00	25.29	30.00
31.00	Laundry & Linen Service	8.00	0	0	0	0.00	0.00	31.00
32.00	Housekeeping	9.00	4,147,379	-15,377	4,132,002	253,158.00	16.32	32.00
33.00	Housekeeping under contract (see instructions)		0	0	0	0.00	0.00	33.00
34.00	Dietary	10.00	3,081,985	-1,078,470	2,003,515	92,140.00	21.74	34.00
35.00	Dietary under contract (see instructions)		0	0	0	0.00	0.00	35.00
36.00	Cafeteria	11.00	346,372	1,077,725	1,424,097	65,395.00	21.78	36.00
37.00	Maintenance of Personnel	12.00	0	0	0	0.00	0.00	37.00
38.00	Nursing Administration	13.00	3,636,319	-5,421	3,630,898	60,257.00	60.26	38.00
39.00	Central Services and Supply	14.00	616,865	-9,779	607,086	28,730.00	21.13	39.00
40.00	Pharmacy	15.00	0	0	0	0.00	0.00	40.00
41.00	Medical Records & Medical Records Library	16.00	2,030,401	-4,893	2,025,508	81,604.00	24.82	41.00
42.00	Social Service	17.00	699	441,467	442,166	14,487.00	30.52	42.00
43.00	Other General Service	18.00	0	0	0	0.00	0.00	43.00

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 15-0002

Period:
From 01/01/2020
To 12/31/2020Worksheet S-3
Part III
Date/Time Prepared:
7/23/2021 10:58 am

	Worksheet A Line Number	Amount Reported	Reclassificat ion 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)	147,999,840	-388,650	147,611,190	3,949,369.00	37.38	1.00
2.00	Excluded area salaries (see instructions)	27,760,199	552,708	28,312,907	547,724.00	51.69	2.00
3.00	Subtotal salaries (line 1 minus line 2)	120,239,641	-941,358	119,298,283	3,401,645.00	35.07	3.00
4.00	Subtotal other wages & related costs (see inst.)	11,905,809	0	11,905,809	177,283.00	67.16	4.00
5.00	Subtotal wage-related costs (see inst.)	33,116,114	0	33,116,114	0.00	27.76	5.00
6.00	Total (sum of lines 3 thru 5)	165,261,564	-941,358	164,320,206	3,578,928.00	45.91	6.00
7.00	Total overhead cost (see instructions)	43,727,948	-604,928	43,123,020	1,404,497.00	30.70	7.00

HOSPITAL WAGE RELATED COSTS		Provider CCN: 15-0002	Period: From 01/01/2020 To 12/31/2020	Worksheet S-3 Part IV Date/Time Prepared: 7/23/2021 10:58 am
				Amount Reported
				1.00
PART IV - WAGE RELATED COSTS				
Part A - Core List				
RETIREMENT COST				
1.00	401K Employer Contributions		2,140,624	1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution		0	2.00
3.00	Nonqualified Defined Benefit Plan Cost (see instructions)		3,200,000	3.00
4.00	Qualified Defined Benefit Plan Cost (see instructions)		0	4.00
PLAN ADMINISTRATIVE COSTS (Paid to External Organization)				
5.00	401K/TSA Plan Administration fees		0	5.00
6.00	Legal/Accounting/Management Fees-Pension Plan		0	6.00
7.00	Employee Managed Care Program Administration Fees		0	7.00
HEALTH AND INSURANCE COST				
8.00	Health Insurance (Purchased or Self Funded)		0	8.00
8.01	Health Insurance (Self Funded without a Third Party Administrator)		0	8.01
8.02	Health Insurance (Self Funded with a Third Party Administrator)		15,831,309	8.02
8.03	Health Insurance (Purchased)		0	8.03
9.00	Prescription Drug Plan		3,893,759	9.00
10.00	Dental, Hearing and Vision Plan		825,918	10.00
11.00	Life Insurance (If employee is owner or beneficiary)		451,764	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)		388,650	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)		0	14.00
15.00	'Workers' Compensation Insurance		1,500,804	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		10,132,435	17.00
18.00	Medicare Taxes - Employers Portion Only		0	18.00
19.00	Unemployment Insurance		746,374	19.00
20.00	State or Federal Unemployment Taxes		0	20.00
OTHER				
21.00	Executive Deferred Compensation (Other Than Retirement Cost Reported on lines 1 through 4 above. (see instructions))		0	21.00
22.00	Day Care Cost and Allowances		0	22.00
23.00	Tuition Reimbursement		206,080	23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)		39,317,717	24.00
Part B - Other than Core Related Cost				
25.00	OTHER WAGE RELATED COSTS (SPECIFY)			25.00

HOSPITAL CONTRACT LABOR AND BENEFIT COST

Provider CCN: 15-0002

Period:
From 01/01/2020
To 12/31/2020Worksheet S-3
Part V
Date/Time Prepared:
7/23/2021 10:58 am

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	11,161,434	39,317,717	1.00
2.00	Hospital	11,161,434	39,317,717	2.00
3.00	Subprovider - IPF	0	0	3.00
4.00	Subprovider - IRF	0	0	4.00
5.00	Subprovider - (Other)	0	0	5.00
6.00	Swing Beds - SNF	0	0	6.00
7.00	Swing Beds - NF	0	0	7.00
8.00	Hospital-Based SNF			8.00
9.00	Hospital-Based NF			9.00
10.00	Hospital-Based OLTC			10.00
11.00	Hospital-Based HHA	0	0	11.00
12.00	Separately Certified ASC			12.00
13.00	Hospital-Based Hospice			13.00
14.00	Hospital-Based Health Clinic RHC			14.00
15.00	Hospital-Based Health Clinic FQHC			15.00
16.00	Hospital-Based-CMHC			16.00
17.00	Renal Dialysis	0	0	17.00
18.00	Other	0	0	18.00

HOME HEALTH AGENCY STATISTICAL DATA		Provider CCN: 15-0002 Component CCN: 15-7536		Period: From 01/01/2020 To 12/31/2020		Worksheet S-4 Date/Time Prepared: 7/23/2021 10:58 am	
				Home Health Agency I		PPS	
				1.00			
0.00	County					0.00	
		Title V	Title XVIII	Title XIX	Other	Total	
		1.00	2.00	3.00	4.00	5.00	
HOME HEALTH AGENCY STATISTICAL DATA							
1.00	Home Health Aide Hours	0	0	0	0	0	1.00
2.00	Unduplicated Census Count (see instructions)	0.00	320.00	0.00	0.00	0.00	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	0.00	0.00	3.00
4.00	Director(s) and Assistant Director(s)			0.00	0.00	0.00	4.00
5.00	Other Administrative Personnel			0.00	0.00	0.00	5.00
6.00	Direct Nursing Service			0.00	0.00	0.00	6.00
7.00	Nursing Supervisor			0.00	0.00	0.00	7.00
8.00	Physical Therapy Service			0.00	0.00	0.00	8.00
9.00	Physical Therapy Supervisor			0.00	0.00	0.00	9.00
10.00	Occupational Therapy Service			0.00	0.00	0.00	10.00
11.00	Occupational Therapy Supervisor			0.00	0.00	0.00	11.00
12.00	Speech Pathology Service			0.00	0.00	0.00	12.00
13.00	Speech Pathology Supervisor			0.00	0.00	0.00	13.00
14.00	Medical Social Service			0.00	0.00	0.00	14.00
15.00	Medical Social Service Supervisor			0.00	0.00	0.00	15.00
16.00	Home Health Aide			0.00	0.00	0.00	16.00
17.00	Home Health Aide Supervisor			0.00	0.00	0.00	17.00
18.00	Other (specify)			0.00	0.00	0.00	18.00
HOME HEALTH AGENCY CBSA CODES							
19.00	Enter in column 1 the number of CBSAs where you provided services during the cost reporting period.			1			19.00
20.00	List those CBSA code(s) in column 1 serviced during this cost reporting period (line 20 contains the first code).			23844			20.00
		Full Episodes		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	3,376	731	82	29	4,218	21.00
22.00	Skilled Nursing Visit Charges	670,009	145,260	16,285	5,606	837,160	22.00
23.00	Physical Therapy Visits	1,670	355	20	22	2,067	23.00
24.00	Physical Therapy Visit Charges	361,178	76,927	4,340	4,690	447,135	24.00
25.00	Occupational Therapy Visits	437	212	1	4	654	25.00
26.00	Occupational Therapy Visit Charges	95,475	46,368	219	876	142,938	26.00
27.00	Speech Pathology Visits	35	16	0	1	52	27.00
28.00	Speech Pathology Visit Charges	8,147	3,760	0	235	12,142	28.00
29.00	Medical Social Service Visits	16	2	0	0	18	29.00
30.00	Medical Social Service Visit Charges	5,072	634	0	0	5,706	30.00
31.00	Home Health Aide Visits	627	149	1	19	796	31.00
32.00	Home Health Aide Visit Charges	55,703	13,211	89	1,656	70,659	32.00
33.00	Total visits (sum of lines 21, 23, 25, 27, 29, and 31)	6,161	1,465	104	75	7,805	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)	1,195,584	286,160	20,933	13,063	1,515,740	35.00
36.00	Total Number of Episodes (standard/non outlier)	507		60	6	573	36.00
37.00	Total Number of Outlier Episodes		59		0	59	37.00
38.00	Total Non-Routine Medical Supply Charges	191,266	51,442	2,911	0	245,619	38.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA		Provider CCN: 15-0002	Period: From 01/01/2020 To 12/31/2020	Worksheet S-10 Date/Time Prepared: 7/23/2021 10:58 am
				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)			0.239014 1.00
Medicaid (see instructions for each line)				
2.00	Net revenue from Medicaid	66,695,202		2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?	Y		3.00
4.00	If line 3 is yes, does line 2 include all DSH and/or supplemental payments from Medicaid?	N		4.00
5.00	If line 4 is no, then enter DSH and/or supplemental payments from Medicaid	47,216,205		5.00
6.00	Medicaid charges	399,692,071		6.00
7.00	Medicaid cost (line 1 times line 6)	95,532,001		7.00
8.00	Difference between net revenue and costs for Medicaid program (line 7 minus sum of lines 2 and 5; if < zero then enter zero)	0		8.00
Children's Health Insurance Program (CHIP) (see instructions for each line)				
9.00	Net revenue from stand-alone CHIP	0		9.00
10.00	Stand-alone CHIP charges	0		10.00
11.00	Stand-alone CHIP cost (line 1 times line 10)	0		11.00
12.00	Difference between net revenue and costs for stand-alone CHIP (line 11 minus line 9; if < zero then enter zero)	0		12.00
Other state or local government indigent care program (see instructions for each line)				
13.00	Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9)	0		13.00
14.00	Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)	0		14.00
15.00	State or local indigent care program cost (line 1 times line 14)	0		15.00
16.00	Difference between net revenue and costs for state or local indigent care program (line 15 minus line 13; if < zero then enter zero)	0		16.00
Grants, donations and total unreimbursed cost for Medicaid, CHIP and state/local indigent care programs (see instructions for each line)				
17.00	Private grants, donations, or endowment income restricted to funding charity care	0		17.00
18.00	Government grants, appropriations or transfers for support of hospital operations	0		18.00
19.00	Total unreimbursed cost for Medicaid, CHIP and state and local indigent care programs (sum of lines 8, 12 and 16)	0		19.00
		Uninsured patients	Insured patients	Total (col. 1 + col. 2)
		1.00	2.00	3.00
Uncompensated Care (see instructions for each line)				
20.00	Charity care charges and uninsured discounts for the entire facility (see instructions)	22,447,981	1,471,028	23,919,009 20.00
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	5,365,382	1,471,028	6,836,410 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)	5,365,382	1,471,028	6,836,410 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)	22,074,259		26.00
27.00	Medicare reimbursable bad debts for the entire hospital complex (see instructions)	1,325,239		27.00
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)	2,038,829		27.01
28.00	Non-Medicare bad debt expense (see instructions)	20,035,430		28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)	5,502,338		29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)	12,338,748		30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	12,338,748		31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 15-0002

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

Worksheet A

Date/Time Prepared:

7/23/2021 10:58 am

Cost Center Description		Salaries	Other	Total (col. 1 + col. 2)	Reclassificat ions (See A-6)	Reclassified Trial Balance (col. 3 + col. 4)	
		1.00	2.00	3.00	4.00	5.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT	0	0	20,004,108	20,004,108	1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	1,916,032	29,778,429	31,694,461	309,544	4.00
5.01	00550	DATA PROCESSING	4,421,091	8,992,508	13,413,599	-1,685,113	5.01
5.02	00560	PURCHASING RECEIVING AND STORES	934,029	2,812,395	3,746,424	-164,694	5.02
5.03	00570	ADMITTING	2,187,720	514,081	2,701,801	-1,641	5.03
5.04	00580	CASHIERING/ACCOUNTS RECEIVABLE	2,588,237	4,299,083	6,887,320	-490,957	5.04
5.05	00590	OTHER A&G	11,626,002	24,891,726	36,517,728	-13,440,309	5.05
5.06	00592	PATIENT TRANSPORTATION	518,523	55,754	574,277	-25,125	5.06
7.00	00700	OPERATION OF PLANT	3,889,109	8,368,050	12,257,159	5,144,128	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	1,265,392	1,265,392	0	8.00
9.00	00900	HOUSEKEEPING	4,147,379	1,275,491	5,422,870	-227,441	9.00
10.00	01000	DIETARY	3,081,985	2,697,123	5,779,108	-2,249,756	10.00
11.00	01100	CAFETERIA	346,372	37,498	383,870	2,176,384	11.00
13.00	01300	NURSING ADMINISTRATION	3,636,319	1,175,906	4,812,225	-99,091	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	616,865	1,616,223	2,233,088	-486,722	14.00
15.00	01500	PHARMACY	0	15,625,959	15,625,959	-9,622,542	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	2,030,401	908,120	2,938,521	-9,214	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	441,467	17.00
17.01	01701	STAFF EDUCATION	0	0	0	0	17.01
17.02	01702	MEDICAL EDUCATION	699	18,617	19,316	-121	17.02
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	0	0	252,816	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	0	0	0	31,168	22.00
23.00	02300	PARAMED ED PROGRAM	392,097	63,757	455,854	198,802	23.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	28,804,106	15,050,480	43,854,586	-754,846	30.00
31.00	03100	INTENSIVE CARE UNIT	8,115,908	3,138,791	11,254,699	-721,846	31.00
31.01	03101	NEONATAL ICU	1,717,684	1,506,107	3,223,791	-40,549	31.01
40.00	04000	SUBPROVIDER - IPF	1,120,792	103,002	1,223,794	-10,350	40.00
41.00	04100	SUBPROVIDER - IRF	2,209,465	414,910	2,624,375	-40,441	41.00
43.00	04300	NURSERY	1,481,686	416,880	1,898,566	-129,748	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	3,717,487	16,707,498	20,424,985	-11,981,005	50.00
50.01	05001	ENDOSCOPY	864,851	1,088,451	1,953,302	-354,606	50.01
51.00	05100	RECOVERY ROOM	954,520	110,464	1,064,984	13,357	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	2,884,565	1,240,328	4,124,893	-231,100	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,335,542	2,298,903	4,634,445	-872,226	54.00
54.01	05401	RADIOLOGY - ULTRASOUND	1,135,713	872,273	2,007,986	-438,649	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	490,377	2,408,391	2,898,768	-745,136	55.00
55.01	05501	INFUSION CENTER	10,712	28,647	39,359	-9,409	55.01
56.00	05600	RADIOISOTOPE	515,023	1,484,734	1,999,757	-242,747	56.00
57.00	05700	CT SCAN	1,143,733	1,207,073	2,350,806	-373,579	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	398,968	1,070,650	1,469,618	-701,489	58.00
59.00	05900	CARDIAC CATHETERIZATION	2,346,104	6,326,033	8,672,137	-4,510,045	59.00
60.00	06000	LABORATORY	3,570,772	10,947,780	14,518,552	-62,076	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	60.01
61.00	06100	PBP CLINICAL LAB SERVICES-PRGM ONLY	0	0	0	0	61.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	1,165,554	348,436	1,513,990	-12,390	62.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	2,538,307	1,288,847	3,827,154	-316,521	65.00
66.00	06600	PHYSICAL THERAPY	1,370,351	131,731	1,502,082	-8,051	66.00
67.00	06700	OCCUPATIONAL THERAPY	1,119,504	92,396	1,211,900	-500	67.00
68.00	06800	SPEECH PATHOLOGY	436,319	43,755	480,074	-7	68.00
69.00	06900	ELECTROCARDIOLOGY	728,670	324,994	1,053,664	-181,124	69.00
69.01	06901	CARDIAC REHAB	386,936	366,110	753,046	-219,905	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	1,004,508	9,777,162	10,781,670	-9,554,083	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	10,389,568	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	10,149,884	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	403,891	2,724,440	3,128,331	15,880,811	73.00
74.00	07400	RENAL DIALYSIS	0	2,426,281	2,426,281	-1,263	74.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	2,448,215	2,474,574	4,922,789	-232,084	90.00
91.00	09100	EMERGENCY	6,892,178	5,936,070	12,828,248	-1,183,321	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					92.00
OTHER REIMBURSABLE COST CENTERS							
101.00	10100	HOME HEALTH AGENCY	2,377,380	442,674	2,820,054	-25,140	101.00
SPECIAL PURPOSE COST CENTERS							
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	127,022,681	197,194,977	324,217,658	2,535,075	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	1,269	1,269	-1,153	190.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 15-0002

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

Worksheet A

Date/Time Prepared:
7/23/2021 10:58 am

Cost Center Description			Salaries	Other	Total (col. 1 + col. 2)	Reclassificat ions (See A-6)	Reclassified Trial Balance (col. 3 + col. 4)	
			1.00	2.00	3.00	4.00	5.00	
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	21,587,240	12,673,531	34,260,771	-797,284	33,463,487	192.00
192.01	19201	OTHER NON-REIMBURSABLE	0	2,081,251	2,081,251	-1,736,638	344,613	192.01
192.02	19202	FAMILY HEALTH/GARY COMM HEALTH	73,225	26,922	100,147	0	100,147	192.02
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
200.00		TOTAL (SUM OF LINES 118 through 199)	148,683,146	211,977,950	360,661,096	0	360,661,096	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 15-0002

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

Worksheet A

Date/Time Prepared:
7/23/2021 10:58 am

Cost Center Description			Adjustments (See A-8)	Net Expenses For Allocation	
			6.00	7.00	
GENERAL SERVICE COST CENTERS					
1.00	00100	CAP REL COSTS-BLDG & FIXT	-2,214,438	17,789,670	1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	791,862	32,795,867	4.00
5.01	00550	DATA PROCESSING	-207,657	11,520,829	5.01
5.02	00560	PURCHASING RECEIVING AND STORES	0	3,581,730	5.02
5.03	00570	ADMITTING	0	2,700,160	5.03
5.04	00580	CASHIERING/ACCOUNTS RECEIVABLE	-27,608	6,368,755	5.04
5.05	00590	OTHER A&G	-384,159	22,693,260	5.05
5.06	00592	PATIENT TRANSPORTATION	0	549,152	5.06
7.00	00700	OPERATION OF PLANT	0	17,401,287	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	1,265,392	8.00
9.00	00900	HOUSEKEEPING	-790	5,194,639	9.00
10.00	01000	DIETARY	-540	3,528,812	10.00
11.00	01100	CAFETERIA	-606,218	1,954,036	11.00
13.00	01300	NURSING ADMINISTRATION	-620	4,712,514	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	1,746,366	14.00
15.00	01500	PHARMACY	0	6,003,417	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-93,419	2,835,888	16.00
17.00	01700	SOCIAL SERVICE	0	441,467	17.00
17.01	01701	STAFF EDUCATION	0	0	17.01
17.02	01702	MEDICAL EDUCATION	0	19,195	17.02
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	252,816	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	0	31,168	22.00
23.00	02300	PARAMED ED PROGRAM	-202,966	451,690	23.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	-7,812,201	35,287,539	30.00
31.00	03100	INTENSIVE CARE UNIT	0	10,532,853	31.00
31.01	03101	NEONATAL ICU	-1,007,871	2,175,371	31.01
40.00	04000	SUBPROVIDER - IPF	0	1,213,444	40.00
41.00	04100	SUBPROVIDER - IRF	0	2,583,934	41.00
43.00	04300	NURSERY	0	1,768,818	43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	-1,236,001	7,207,979	50.00
50.01	05001	ENDOSCOPY	0	1,598,696	50.01
51.00	05100	RECOVERY ROOM	0	1,078,341	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	3,893,793	52.00
53.00	05300	ANESTHESIOLOGY	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	3,762,219	54.00
54.01	05401	RADIOLOGY - ULTRASOUND	-3,342	1,565,995	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	0	2,153,632	55.00
55.01	05501	INFUSION CENTER	0	29,950	55.01
56.00	05600	RADIOISOTOPE	0	1,757,010	56.00
57.00	05700	CT SCAN	-6,369	1,970,858	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	768,129	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	4,162,092	59.00
60.00	06000	LABORATORY	-62,767	14,393,709	60.00
60.01	06001	BLOOD LABORATORY	0	0	60.01
61.00	06100	PBP CLINICAL LAB SERVICES-PRGM ONLY	0	0	61.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	-69,123	1,432,477	62.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	3,510,633	65.00
66.00	06600	PHYSICAL THERAPY	0	1,494,031	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	1,211,400	67.00
68.00	06800	SPEECH PATHOLOGY	0	480,067	68.00
69.00	06900	ELECTROCARDIOLOGY	0	872,540	69.00
69.01	06901	CARDIAC REHAB	-99,190	433,951	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	-200	1,227,387	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	10,389,568	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	10,149,884	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	-241,465	18,767,677	73.00
74.00	07400	RENAL DIALYSIS	0	2,425,018	74.00
OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	-316	4,690,389	90.00
91.00	09100	EMERGENCY	-2,290,590	9,354,337	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)			92.00
OTHER REIMBURSABLE COST CENTERS					
101.00	10100	HOME HEALTH AGENCY	0	2,794,914	101.00
SPECIAL PURPOSE COST CENTERS					
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-15,775,988	310,976,745	118.00
NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	116	190.00
191.00	19100	RESEARCH	0	0	191.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 15-0002

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

Worksheet A

Date/Time Prepared:
7/23/2021 10:58 am

Cost Center Description			Adjustments (See A-8)	Net Expenses For Allocation	
			6.00	7.00	
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	33,463,487	192.00
192.01	19201	OTHER NON-REIMBURSABLE	0	344,613	192.01
192.02	19202	FAMILY HEALTH/GARY COMM HEALTH	0	100,147	192.02
193.00	19300	NONPAID WORKERS	0	0	193.00
200.00		TOTAL (SUM OF LINES 118 through 199)	-15,775,988	344,885,108	200.00

RECLASSIFICATIONS

Provider CCN: 15-0002

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

Worksheet A-6

Date/Time Prepared:
7/23/2021 10:58 am

	Increases					
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
	A - CAFETERIA					
1.00	CAFETERIA	11.00	1,078,703	1,099,210		1.00
	0		1,078,703	1,099,210		
	B - CLINICAL TRAINING COST					
1.00	PARAMED ED PROGRAM	23.00	202,791	0		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
	0		202,791	0		
	C - SOCIAL WORKERS					
1.00	SOCIAL SERVICE	17.00	441,467	0		1.00
	0		441,467	0		
	E - RESIDENTS					
1.00	I&R SERVICES-SALARY & FRINGES APPRVD	21.00	0	252,816		1.00
2.00	I&R SERVICES-OTHER PRGM COSTS APPRVD	22.00	0	31,168		2.00
	0		0	283,984		
	F - MED SUPPLY					
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	10,389,568		1.00
2.00	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	10,149,884		2.00
3.00		0.00	0	0		3.00
4.00		0.00	0	0		4.00
5.00		0.00	0	0		5.00
6.00		0.00	0	0		6.00
7.00		0.00	0	0		7.00
8.00		0.00	0	0		8.00
9.00		0.00	0	0		9.00
10.00		0.00	0	0		10.00
11.00		0.00	0	0		11.00
12.00		0.00	0	0		12.00
13.00		0.00	0	0		13.00
14.00		0.00	0	0		14.00
15.00		0.00	0	0		15.00
16.00		0.00	0	0		16.00
17.00		0.00	0	0		17.00
18.00		0.00	0	0		18.00
19.00		0.00	0	0		19.00
20.00		0.00	0	0		20.00
21.00		0.00	0	0		21.00
22.00		0.00	0	0		22.00
23.00		0.00	0	0		23.00
24.00		0.00	0	0		24.00
25.00		0.00	0	0		25.00
26.00		0.00	0	0		26.00
27.00		0.00	0	0		27.00
28.00		0.00	0	0		28.00
29.00		0.00	0	0		29.00
30.00		0.00	0	0		30.00
31.00		0.00	0	0		31.00
32.00		0.00	0	0		32.00
33.00		0.00	0	0		33.00
34.00		0.00	0	0		34.00
35.00		0.00	0	0		35.00
36.00		0.00	0	0		36.00
37.00		0.00	0	0		37.00
38.00		0.00	0	0		38.00
39.00		0.00	0	0		39.00
40.00		0.00	0	0		40.00
41.00		0.00	0	0		41.00
42.00		0.00	0	0		42.00
43.00		0.00	0	0		43.00
44.00		0.00	0	0		44.00
45.00		0.00	0	0		45.00
46.00		0.00	0	0		46.00
47.00		0.00	0	0		47.00
	0		0	20,539,452		

RECLASSIFICATIONS

Provider CCN: 15-0002

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

Worksheet A-6

Date/Time Prepared:
7/23/2021 10:58 am

Increases					
	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
G - LIGHT DUTY					
1.00	HOUSEKEEPING	9.00	3,808	0	1.00
2.00	DIETARY	10.00	3,063	0	2.00
3.00	CENTRAL SERVICES & SUPPLY	14.00	797	0	3.00
4.00	ADULTS & PEDIATRICS	30.00	9,235	0	4.00
5.00	INTENSIVE CARE UNIT	31.00	2,704	0	5.00
6.00	SUBPROVIDER - IRF	41.00	10,453	0	6.00
7.00	OPERATING ROOM	50.00	12,837	0	7.00
8.00	RECOVERY ROOM	51.00	26,225	0	8.00
9.00	EMERGENCY	91.00	2,197	0	9.00
0			71,319	0	
H - INTEREST EXPENSE					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	2,320,975	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
0			0	2,320,975	
I - CORPORATE EXPENSE					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	6,079,640	1.00
2.00	OPERATION OF PLANT	7.00	0	4,485,594	2.00
0			0	10,565,234	
J - DRUG EXPENSE					
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	16,155,759	1.00
2.00		0.00	0	0	2.00
3.00		0.00	0	0	3.00
0			0	16,155,759	
K - PHYSICIAN RECLASS					
1.00	OTHER A&G	5.05	0	37,200	1.00
2.00	CLINIC	90.00	0	20,210	2.00
0			0	57,410	
L - PSTD RECLASS					
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	388,650	1.00
2.00		0.00	0	0	2.00
3.00		0.00	0	0	3.00
4.00		0.00	0	0	4.00
5.00		0.00	0	0	5.00
6.00		0.00	0	0	6.00
7.00		0.00	0	0	7.00
8.00		0.00	0	0	8.00
9.00		0.00	0	0	9.00
10.00		0.00	0	0	10.00
11.00		0.00	0	0	11.00
12.00		0.00	0	0	12.00
13.00		0.00	0	0	13.00
14.00		0.00	0	0	14.00
15.00		0.00	0	0	15.00
16.00		0.00	0	0	16.00
17.00		0.00	0	0	17.00
18.00		0.00	0	0	18.00
19.00		0.00	0	0	19.00
20.00		0.00	0	0	20.00
21.00		0.00	0	0	21.00
22.00		0.00	0	0	22.00
23.00		0.00	0	0	23.00
24.00		0.00	0	0	24.00
25.00		0.00	0	0	25.00
26.00		0.00	0	0	26.00
27.00		0.00	0	0	27.00
28.00		0.00	0	0	28.00
29.00		0.00	0	0	29.00
0			0	388,650	
M - DEPRECIATION RECLASS					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	11,603,493	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

	Increases					
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
10.00		0.00	0	0		10.00
11.00		0.00	0	0		11.00
12.00		0.00	0	0		12.00
13.00		0.00	0	0		13.00
14.00		0.00	0	0		14.00
15.00		0.00	0	0		15.00
16.00		0.00	0	0		16.00
17.00		0.00	0	0		17.00
18.00		0.00	0	0		18.00
19.00		0.00	0	0		19.00
20.00		0.00	0	0		20.00
21.00		0.00	0	0		21.00
22.00		0.00	0	0		22.00
23.00		0.00	0	0		23.00
24.00		0.00	0	0		24.00
25.00		0.00	0	0		25.00
26.00		0.00	0	0		26.00
27.00		0.00	0	0		27.00
28.00		0.00	0	0		28.00
29.00		0.00	0	0		29.00
30.00		0.00	0	0		30.00
31.00		0.00	0	0		31.00
32.00		0.00	0	0		32.00
33.00		0.00	0	0		33.00
34.00		0.00	0	0		34.00
35.00		0.00	0	0		35.00
36.00		0.00	0	0		36.00
37.00		0.00	0	0		37.00
38.00		0.00	0	0		38.00
39.00		0.00	0	0		39.00
40.00		0.00	0	0		40.00
41.00		0.00	0	0		41.00
42.00		0.00	0	0		42.00
43.00		0.00	0	0		43.00
44.00		0.00	0	0		44.00
45.00		0.00	0	0		45.00
46.00		0.00	0	0		46.00
47.00		0.00	0	0		47.00
48.00		0.00	0	0		48.00
49.00		0.00	0	0		49.00
			0	11,603,493		
	N - DEPT 9101 RECLASS					
1.00	PHYSICIANS' PRIVATE OFFICES	192.00	420,367	30,631		1.00
			420,367	30,631		
	O - UTILITIES RECLASS					
1.00	OPERATION OF PLANT	7.00	0	1,042,519		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
			0	1,042,519		
	P - C SECTION RECLASS					
1.00	OPERATING ROOM	50.00	42,510	0		1.00
			42,510	0		
500.00	Grand Total: Increases		2,257,157	64,087,317		500.00

RECLASSIFICATIONS

Provider CCN: 15-0002

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

Worksheet A-6

Date/Time Prepared:
7/23/2021 10:58 am

	Decreases						11/23/2021 10:58 am
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	A - CAFETERIA						
1.00	DIETARY	10.00	1,078,703	1,099,210	0		1.00
	0		1,078,703	1,099,210			
	B - CLINICAL TRAINING COST						
1.00	ADULTS & PEDIATRICS	30.00	8,593	0	0		1.00
2.00	OPERATING ROOM	50.00	7,986	0	0		2.00
3.00	CARDIAC CATHETERIZATION	59.00	5,755	0	0		3.00
4.00	DELIVERY ROOM & LABOR ROOM	52.00	8,662	0	0		4.00
5.00	RESPIRATORY THERAPY	65.00	12,855	0	0		5.00
6.00	EMERGENCY	91.00	158,940	0	0		6.00
	0		202,791	0			
	C - SOCIAL WORKERS						
1.00	OTHER A&G	5.05	441,467	0	0		1.00
	0		441,467	0			
	E - RESIDENTS						
1.00	EMERGENCY	91.00	0	283,984	0		1.00
2.00		0.00	0	0	0		2.00
	0		0	283,984			
	F - MED SUPPLY						
1.00	PURCHASING RECEIVING AND STORES	5.02	0	115,962	0		1.00
2.00	ADMITTING	5.03	0	2	0		2.00
3.00	CASHIERING/ACCOUNTS RECEIVABLE	5.04	0	2	0		3.00
4.00	OTHER A&G	5.05	0	576	0		4.00
5.00	PATIENT TRANSPORTATION	5.06	0	12	0		5.00
6.00	OPERATION OF PLANT	7.00	0	250	0		6.00
7.00	HOUSEKEEPING	9.00	0	859	0		7.00
8.00	DIETARY	10.00	0	28	0		8.00
9.00	NURSING ADMINISTRATION	13.00	0	1,179	0		9.00
10.00	CENTRAL SERVICES & SUPPLY	14.00	0	111,261	0		10.00
11.00	PHARMACY	15.00	0	49,441	0		11.00
12.00	MEDICAL RECORDS & LIBRARY	16.00	0	53	0		12.00
13.00	MEDICAL EDUCATION	17.02	0	121	0		13.00
14.00	PARAMED ED PROGRAM	23.00	0	363	0		14.00
15.00	ADULTS & PEDIATRICS	30.00	0	486,221	0		15.00
16.00	INTENSIVE CARE UNIT	31.00	0	189,050	0		16.00
17.00	NEONATAL ICU	31.01	0	816	0		17.00
18.00	SUBPROVIDER - IRF	41.00	0	35,075	0		18.00
19.00	NURSERY	43.00	0	53,437	0		19.00
20.00	OPERATING ROOM	50.00	0	11,376,735	0		20.00
21.00	ENDOSCOPY	50.01	0	261,477	0		21.00
22.00	RECOVERY ROOM	51.00	0	11,865	0		22.00
23.00	DELIVERY ROOM & LABOR ROOM	52.00	0	52,810	0		23.00
24.00	RADIOLOGY-DIAGNOSTIC	54.00	0	3,893	0		24.00
25.00	RADIOLOGY - ULTRASOUND	54.01	0	56,193	0		25.00
26.00	RADIOLOGY-THERAPEUTIC	55.00	0	5,168	0		26.00
27.00	INFUSION CENTER	55.01	0	5,809	0		27.00
28.00	RADIOISOTOPE	56.00	0	273	0		28.00
29.00	CT SCAN	57.00	0	43,040	0		29.00
30.00	MAGNETIC RESONANCE IMAGING (MRI)	58.00	0	242	0		30.00
31.00	CARDIAC CATHETERIZATION	59.00	0	4,147,983	0		31.00
32.00	LABORATORY	60.00	0	2,389	0		32.00
33.00	WHOLE BLOOD & PACKED RED BLOOD CELLS	62.00	0	350	0		33.00
34.00	RESPIRATORY THERAPY	65.00	0	208,572	0		34.00
35.00	PHYSICAL THERAPY	66.00	0	6,318	0		35.00
36.00	OCCUPATIONAL THERAPY	67.00	0	58	0		36.00
37.00	SPEECH PATHOLOGY	68.00	0	7	0		37.00
38.00	ELECTROCARDIOLOGY	69.00	0	3,070	0		38.00
39.00	CARDIAC REHAB	69.01	0	1,170	0		39.00
40.00	ELECTROENCEPHALOGRAPHY	70.00	0	2,535,578	0		40.00
41.00	DRUGS CHARGED TO PATIENTS	73.00	0	234,895	0		41.00
42.00	RENAL DIALYSIS	74.00	0	1,263	0		42.00
43.00	CLINIC	90.00	0	79,529	0		43.00
44.00	EMERGENCY	91.00	0	392,979	0		44.00
45.00	HOME HEALTH AGENCY	101.00	0	23,337	0		45.00
46.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	39,608	0		46.00
47.00	OTHER NON-REIMBURSABLE	192.01	0	133	0		47.00
	0		0	20,539,452			

RECLASSIFICATIONS

Provider CCN: 15-0002

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

Worksheet A-6

Date/Time Prepared:
7/23/2021 10:58 am

		Decreases					11/23/2021 10:58 am	
Cost Center		Line #	Salary	Other	wkst. A-7 Ref.			
6.00		7.00	8.00	9.00	10.00			
G - LIGHT DUTY								
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	71,319	0	0	1.00		
2.00		0.00	0	0	0	2.00		
3.00		0.00	0	0	0	3.00		
4.00		0.00	0	0	0	4.00		
5.00		0.00	0	0	0	5.00		
6.00		0.00	0	0	0	6.00		
7.00		0.00	0	0	0	7.00		
8.00		0.00	0	0	0	8.00		
9.00		0.00	0	0	0	9.00		
0			71,319	0				
H - INTEREST EXPENSE								
1.00	OTHER A&G	5.05	0	2,143,869	11	1.00		
2.00	RADIOLOGY-DIAGNOSTIC	54.00	0	13,220	0	2.00		
3.00	RADIOLOGY - ULTRASOUND	54.01	0	6,610	0	3.00		
4.00	RADIOLOGY-THERAPEUTIC	55.00	0	2,240	0	4.00		
5.00	CT SCAN	57.00	0	6,610	0	5.00		
6.00	MAGNETIC RESONANCE IMAGING (MRI)	58.00	0	6,610	0	6.00		
7.00	OTHER NON-REIMBURSABLE	192.01	0	141,816	0	7.00		
0			0	2,320,975				
I - CORPORATE EXPENSE								
1.00	OTHER A&G	5.05	0	10,565,234	9	1.00		
2.00		0.00	0	0	0	2.00		
0			0	10,565,234				
J - DRUG EXPENSE								
1.00	PHARMACY	15.00	0	9,338,634	0	1.00		
2.00	INFUSION CENTER	55.01	0	2,572	0	2.00		
3.00	ELECTROENCEPHALOGRAPHY	70.00	0	6,814,553	0	3.00		
0			0	16,155,759				
K - PHYSICIAN RECLASS								
1.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	57,410	0	1.00		
2.00		0.00	0	0	0	2.00		
0			0	57,410				
L - PSTD RECLASS								
1.00	PURCHASING RECEIVING AND STORES	5.02	790	0	0	1.00		
2.00	CASHIERING/ACCOUNTS RECEIVABLE	5.04	8,853	0	0	2.00		
3.00	OTHER A&G	5.05	36,600	0	0	3.00		
4.00	PATIENT TRANSPORTATION	5.06	9,548	0	0	4.00		
5.00	OPERATION OF PLANT	7.00	21,236	0	0	5.00		
6.00	HOUSEKEEPING	9.00	19,185	0	0	6.00		
7.00	DIETARY	10.00	2,830	0	0	7.00		
8.00	CAFETERIA	11.00	978	0	0	8.00		
9.00	NURSING ADMINISTRATION	13.00	5,421	0	0	9.00		
10.00	CENTRAL SERVICES & SUPPLY	14.00	10,576	0	0	10.00		
11.00	MEDICAL RECORDS & LIBRARY	16.00	4,893	0	0	11.00		
12.00	ADULTS & PEDIATRICS	30.00	77,405	0	0	12.00		
13.00	INTENSIVE CARE UNIT	31.00	3,350	0	0	13.00		
14.00	SUBPROVIDER - IRF	41.00	5,891	0	0	14.00		
15.00	NURSERY	43.00	6,324	0	0	15.00		
16.00	OPERATING ROOM	50.00	14,048	0	0	16.00		
17.00	ENDOSCOPY	50.01	662	0	0	17.00		
18.00	DELIVERY ROOM & LABOR ROOM	52.00	675	0	0	18.00		
19.00	RADIOLOGY-DIAGNOSTIC	54.00	17,755	0	0	19.00		
20.00	RADIOLOGY - ULTRASOUND	54.01	4,951	0	0	20.00		
21.00	RADIOLOGY-THERAPEUTIC	55.00	2,990	0	0	21.00		
22.00	CARDIAC CATHETERIZATION	59.00	9,597	0	0	22.00		
23.00	LABORATORY	60.00	14,410	0	0	23.00		
24.00	WHOLE BLOOD & PACKED RED BLOOD CELLS	62.00	3,259	0	0	24.00		
25.00	RESPIRATORY THERAPY	65.00	3,753	0	0	25.00		
26.00	CLINIC	90.00	5,626	0	0	26.00		
27.00	EMERGENCY	91.00	22,032	0	0	27.00		
28.00	HOME HEALTH AGENCY	101.00	1,236	0	0	28.00		
29.00	PHYSICIANS' PRIVATE OFFICES	192.00	73,776	0	0	29.00		
0			388,650	0				
M - DEPRECIATION RECLASS								
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	7,787	9	1.00		
2.00	DATA PROCESSING	5.01	0	1,531,195	0	2.00		
3.00	PURCHASING RECEIVING AND STORES	5.02	0	47,942	0	3.00		
4.00	ADMITTING	5.03	0	1,639	0	4.00		

RECLASSIFICATIONS

Provider CCN: 15-0002

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

Worksheet A-6

Date/Time Prepared:
7/23/2021 10:58 am

	Decreases						7/23/2021 10:58 am
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
5.00	CASHIERING/ACCOUNTS RECEIVABLE	5.04	0	4,374	0		5.00
6.00	OTHER A&G	5.05	0	289,763	0		6.00
7.00	PATIENT TRANSPORTATION	5.06	0	15,565	0		7.00
8.00	OPERATION OF PLANT	7.00	0	362,499	0		8.00
9.00	HOUSEKEEPING	9.00	0	58,984	0		9.00
10.00	DIETARY	10.00	0	72,048	0		10.00
11.00	CAFETERIA	11.00	0	551	0		11.00
12.00	NURSING ADMINISTRATION	13.00	0	92,491	0		12.00
13.00	CENTRAL SERVICES & SUPPLY	14.00	0	365,682	0		13.00
14.00	PHARMACY	15.00	0	234,467	0		14.00
15.00	MEDICAL RECORDS & LIBRARY	16.00	0	4,268	0		15.00
16.00	PARAMED ED PROGRAM	23.00	0	3,626	0		16.00
17.00	ADULTS & PEDIATRICS	30.00	0	191,862	0		17.00
18.00	INTENSIVE CARE UNIT	31.00	0	532,150	0		18.00
19.00	NEONATAL ICU	31.01	0	39,733	0		19.00
20.00	SUBPROVIDER - IPF	40.00	0	10,350	0		20.00
21.00	SUBPROVIDER - IRF	41.00	0	9,928	0		21.00
22.00	NURSERY	43.00	0	69,987	0		22.00
23.00	OPERATING ROOM	50.00	0	637,583	0		23.00
24.00	ENDOSCOPY	50.01	0	92,467	0		24.00
25.00	RECOVERY ROOM	51.00	0	1,003	0		25.00
26.00	DELIVERY ROOM & LABOR ROOM	52.00	0	126,443	0		26.00
27.00	RADIOLOGY-DIAGNOSTIC	54.00	0	837,358	0		27.00
28.00	RADIOLOGY - ULTRASOUND	54.01	0	370,895	0		28.00
29.00	RADIOLOGY-THERAPEUTIC	55.00	0	734,738	0		29.00
30.00	INFUSION CENTER	55.01	0	1,028	0		30.00
31.00	RADIOISOTOPE	56.00	0	242,474	0		31.00
32.00	CT SCAN	57.00	0	323,929	0		32.00
33.00	MAGNETIC RESONANCE IMAGING (MRI)	58.00	0	694,637	0		33.00
34.00	CARDIAC CATHETERIZATION	59.00	0	346,710	0		34.00
35.00	LABORATORY	60.00	0	45,277	0		35.00
36.00	WHOLE BLOOD & PACKED RED BLOOD CELLS	62.00	0	8,781	0		36.00
37.00	RESPIRATORY THERAPY	65.00	0	91,341	0		37.00
38.00	PHYSICAL THERAPY	66.00	0	1,733	0		38.00
39.00	OCCUPATIONAL THERAPY	67.00	0	442	0		39.00
40.00	ELECTROCARDIOLOGY	69.00	0	178,054	0		40.00
41.00	CARDIAC REHAB	69.01	0	173,055	0		41.00
42.00	ELECTROENCEPHALOGRAPHY	70.00	0	203,952	0		42.00
43.00	DRUGS CHARGED TO PATIENTS	73.00	0	40,053	0		43.00
44.00	CLINIC	90.00	0	167,139	0		44.00
45.00	EMERGENCY	91.00	0	327,583	0		45.00
46.00	HOME HEALTH AGENCY	101.00	0	567	0		46.00
47.00	GIFT, FLOWER, COFFEE SHOP & CANTEEN	190.00	0	1,153	0		47.00
48.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	737,946	0		48.00
49.00	OTHER NON-REIMBURSABLE	192.01	0	1,270,261	0		49.00
	0		0	11,603,493			
N - DEPT 9101 RECLASS							
1.00	CASHIERING/ACCOUNTS RECEIVABLE	5.04	420,367	30,631	0		1.00
	0		420,367	30,631			
O - UTILITIES RECLASS							
1.00	DATA PROCESSING	5.01	0	153,918	0		1.00
2.00	CASHIERING/ACCOUNTS RECEIVABLE	5.04	0	26,730	0		2.00
3.00	HOUSEKEEPING	9.00	0	152,221	0		3.00
4.00	CARDIAC REHAB	69.01	0	45,680	0		4.00
5.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	339,542	0		5.00
6.00	OTHER NON-REIMBURSABLE	192.01	0	324,428	0		6.00
	0		0	1,042,519			
P - C SECTION RECLASS							
1.00	DELIVERY ROOM & LABOR ROOM	52.00	42,510	0	0		1.00
	0		42,510	0			
500.00	Grand Total: Decreases		2,645,807	63,698,667			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 15-0002

Period:
From 01/01/2020
To 12/31/2020Worksheet A-7
Part I
Date/Time Prepared:
7/23/2021 10:58 am

		Beginning Balances	Acquisitions			Disposals and Retirements	
			Purchases	Donation	Total		
		1.00	2.00	3.00	4.00	5.00	
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES							
1.00	Land	5,373,674	0	0	0	0	1.00
2.00	Land Improvements	6,844,912	51,545	0	51,545	0	2.00
3.00	Buildings and Fixtures	270,428,699	37,857,258	0	37,857,258	0	3.00
4.00	Building Improvements	0	1,230,154	0	1,230,154	0	4.00
5.00	Fixed Equipment	0	0	0	0	0	5.00
6.00	Movable Equipment	211,854,063	0	0	0	12,785,137	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	494,501,348	39,138,957	0	39,138,957	12,785,137	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	494,501,348	39,138,957	0	39,138,957	12,785,137	10.00
		Ending Balance	Fully Depreciated Assets				
		6.00	7.00				
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES							
1.00	Land	5,373,674	0				1.00
2.00	Land Improvements	6,896,457	0				2.00
3.00	Buildings and Fixtures	308,285,957	0				3.00
4.00	Building Improvements	1,230,154	0				4.00
5.00	Fixed Equipment	0	0				5.00
6.00	Movable Equipment	199,068,926	0				6.00
7.00	HIT designated Assets	0	0				7.00
8.00	Subtotal (sum of lines 1-7)	520,855,168	0				8.00
9.00	Reconciling Items	0	0				9.00
10.00	Total (line 8 minus line 9)	520,855,168	0				10.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 15-0002

Period:
From 01/01/2020
To 12/31/2020Worksheet A-7
Part II
Date/Time Prepared:
7/23/2021 10:58 am

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

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 15-0002

Period:
From 01/01/2020
To 12/31/2020Worksheet A-7
Part III
Date/Time Prepared:
7/23/2021 10:58 am

Cost Center Description		COMPUTATION OF RATIOS			ALLOCATION OF OTHER CAPITAL		
		Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	
		1.00	2.00	3.00	4.00	5.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	520,855,168	0	520,855,168	1.000000	0	1.00
3.00	Total (sum of lines 1-2)	520,855,168	0	520,855,168	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	17,647,854	0	1.00
3.00	Total (sum of lines 1-2)	0	0	0	17,647,854	0	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	141,816	0	0	0	17,789,670	1.00
3.00	Total (sum of lines 1-2)	141,816	0	0	0	17,789,670	3.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 15-0002

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

Worksheet A-8

Date/Time Prepared:
7/23/2021 10:58 am

Cost Center Description		Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted		Wkst. A-7 Ref.	
				Cost Center	Line #		
				3.00	4.00	5.00	
1.00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)	B	-2,179,159	CAP REL COSTS-BLDG & FIXT	1.00	11	1.00
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)		0	*** Cost Center Deleted ***	2.00	0	2.00
3.00	Investment income - other (chapter 2)		0		0.00	0	3.00
4.00	Trade, quantity, and time discounts (chapter 8)		0		0.00	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)		0		0.00	0	5.00
6.00	Rental of provider space by suppliers (chapter 8)		0		0.00	0	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)		0		0.00	0	7.00
8.00	Television and radio service (chapter 21)		0		0.00	0	8.00
9.00	Parking lot (chapter 21)		0		0.00	0	9.00
10.00	Provider-based physician adjustment	A-8-2	-12,345,948			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	-606,218	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	B	-93,419	MEDICAL RECORDS & LIBRARY	16.00	0	18.00
19.00	Nursing and allied health education (tuition, fees, books, etc.)		0		0.00	0	19.00
20.00	Vending machines	B	-540	DIETARY	10.00	0	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	0	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	RESPIRATORY THERAPY	65.00		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	PHYSICAL THERAPY	66.00		24.00
25.00	Utilization review - physicians' compensation (chapter 21)		0	*** Cost Center Deleted ***	114.00		25.00
26.00	Depreciation - CAP REL COSTS-BLDG & FIXT	A	-35,279	CAP REL COSTS-BLDG & FIXT	1.00	9	26.00
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP		0	*** Cost Center Deleted ***	2.00	0	27.00
28.00	Non-physician Anesthetist		0	*** Cost Center Deleted ***	19.00		28.00
29.00	Physicians' assistant		0		0.00	0	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	OCCUPATIONAL THERAPY	67.00		30.00
30.99	Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS	30.00		30.99

ADJUSTMENTS TO EXPENSES

Provider CCN: 15-0002

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

Worksheet A-8

Date/Time Prepared:
7/23/2021 10:58 am

Cost Center Description		Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted		Wkst. A-7 Ref.	
				Cost Center	Line #		
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	SPEECH PATHOLOGY	68.00		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest		0		0.00	0	32.00
33.00	DATA PROCESSING OTHER INCOME	B	-207,657	DATA PROCESSING	5.01	0	33.00
33.01	CASH, A/R, COLLECTIONS OTHER INCOME	B	-27,608	CASHIERING/ACCOUNTS RECEIVABLE	5.04	0	33.01
33.02	A&G OTHER INCOME	B	-367,358	OTHER A&G	5.05	0	33.02
33.03	ENVIRONMENTAL SERVICES OTHER INCOME	B	-790	HOUSEKEEPING	9.00	0	33.03
33.04	NURSING ADMIN OTHER INCOME	B	-620	NURSING ADMINISTRATION	13.00	0	33.04
33.05	PARAMED ED PROGRAM OTHER INCOME	B	-67,266	PARAMED ED PROGRAM	23.00	0	33.05
33.06	ADULTS & PEDS OTHER INCOME	B	-10,626	ADULTS & PEDIATRICS	30.00	0	33.06
33.07	LAB OTHER INCOME	B	-62,767	LABORATORY	60.00	0	33.07
33.08	BLOOD OTHER INCOME	B	-69,123	WHOLE BLOOD & PACKED RED BLOOD CELLS	62.00	0	33.08
33.09	CARDIAC REHAB OTHER INCOME	B	-99,190	CARDIAC REHAB	69.01	0	33.09
33.10	CLINIC OTHER INCOME	B	-316	CLINIC	90.00	0	33.10
33.11	EMT OFFSET	B	-29,188	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.11
33.12	EMT OFFSET	B	-135,700	PARAMED ED PROGRAM	23.00	0	33.12
33.13	DUES/LOBBYING	A	-16,801	OTHER A&G	5.05	0	33.13
33.14	RX PROGRAM	A	-241,465	DRUGS CHARGED TO PATIENTS	73.00	0	33.14
33.15	PENSION ADJUSTMENT	A	821,050	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.15
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-15,775,988				50.00

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

(2) Basis for adjustment (see instructions).

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

B. Amount Received - if cost cannot be determined.

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

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

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 15-0002

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

Worksheet A-8-2

Date/Time Prepared:
7/23/2021 10:58 am

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	30.00	ADULTS & PEDIATRICS	7,816,319	7,785,538	30,781	211,500	145	1.00
2.00	31.01	NEONATAL ICU	1,007,871	1,007,871	0	211,500	0	2.00
3.00	50.00	OPERATING ROOM	1,236,001	1,236,001	0	246,400	0	3.00
4.00	54.01	RADIOLOGY - ULTRASOUND	3,342	3,342	0	211,500	0	4.00
5.00	57.00	CT SCAN	6,369	6,369	0	211,500	0	5.00
6.00	70.00	ELECTROENCEPHALOGRAPHY	200	200	0	211,500	0	6.00
7.00	91.00	EMERGENCY	2,290,590	2,290,590	0	211,500	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			12,360,692	12,329,911	30,781		145	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	30.00	ADULTS & PEDIATRICS	14,744	737	0	0	0	1.00
2.00	31.01	NEONATAL ICU	0	0	0	0	0	2.00
3.00	50.00	OPERATING ROOM	0	0	0	0	0	3.00
4.00	54.01	RADIOLOGY - ULTRASOUND	0	0	0	0	0	4.00
5.00	57.00	CT SCAN	0	0	0	0	0	5.00
6.00	70.00	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	6.00
7.00	91.00	EMERGENCY	0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			14,744	737	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	30.00	ADULTS & PEDIATRICS	0	14,744	16,037	7,801,575		1.00
2.00	31.01	NEONATAL ICU	0	0	0	1,007,871		2.00
3.00	50.00	OPERATING ROOM	0	0	0	1,236,001		3.00
4.00	54.01	RADIOLOGY - ULTRASOUND	0	0	0	3,342		4.00
5.00	57.00	CT SCAN	0	0	0	6,369		5.00
6.00	70.00	ELECTROENCEPHALOGRAPHY	0	0	0	200		6.00
7.00	91.00	EMERGENCY	0	0	0	2,290,590		7.00
8.00	0.00		0	0	0	0		8.00
9.00	0.00		0	0	0	0		9.00
10.00	0.00		0	0	0	0		10.00
200.00			0	14,744	16,037	12,345,948		200.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 15-0002

Period:
From 01/01/2020
To 12/31/2020Worksheet B
Part I
Date/Time Prepared:
7/23/2021 10:58 am

Cost Center Description		Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS	EMPLOYEE BENEFITS DEPARTMENT	DATA PROCESSING	PURCHASING RECEIVING AND STORES	
			BLDG & FIXT				
		0	1.00	4.00	5.01	5.02	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT	17,789,670	17,789,670			1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	32,795,867	74,508	32,870,375		4.00
5.01	00550	DATA PROCESSING	11,520,829	115,937	992,305	12,629,071	5.01
5.02	00560	PURCHASING RECEIVING AND STORES	3,581,730	92,498	209,464	0	5.02
5.03	00570	ADMITTING	2,700,160	122,586	491,029	0	5.03
5.04	00580	CASHIERING/ACCOUNTS RECEIVABLE	6,368,755	386,618	484,587	0	5.04
5.05	00590	OTHER A&G	22,693,260	1,256,249	2,502,132	12,629,071	5.05
5.06	00592	PATIENT TRANSPORTATION	549,152	0	114,238	0	5.06
7.00	00700	OPERATION OF PLANT	17,401,287	3,776,214	868,136	0	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	1,265,392	224,873	0	0	8.00
9.00	00900	HOUSEKEEPING	5,194,639	260,323	927,420	0	9.00
10.00	01000	DIETARY	3,528,812	237,779	449,685	0	10.00
11.00	01100	CAFETERIA	1,954,036	166,236	319,636	0	11.00
13.00	01300	NURSING ADMINISTRATION	4,712,514	80,109	814,948	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	1,746,366	452,181	136,259	0	14.00
15.00	01500	PHARMACY	6,003,417	239,154	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	2,835,888	142,645	454,621	0	16.00
17.00	01700	SOCIAL SERVICE	441,467	20,551	99,086	0	17.00
17.01	01701	STAFF EDUCATION	0	140,626	0	0	17.01
17.02	01702	MEDICAL EDUCATION	19,195	4,718	157	0	17.02
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	252,816	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	31,168	56,354	0	0	22.00
23.00	02300	PARAMED ED PROGRAM	451,690	42,439	133,521	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	35,287,539	3,951,417	6,447,807	0	30.00
31.00	03100	INTENSIVE CARE UNIT	10,532,853	250,596	1,821,454	0	31.00
31.01	03101	NEONATAL ICU	2,175,371	28,486	385,531	0	31.01
40.00	04000	SUBPROVIDER - IPF	1,213,444	50,109	251,560	0	40.00
41.00	04100	SUBPROVIDER - IRF	2,583,934	394,149	496,934	0	41.00
43.00	04300	NURSERY	1,768,818	308,123	331,142	0	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	7,207,979	752,483	841,860	0	50.00
50.01	05001	ENDOSCOPY	1,598,696	0	193,965	0	50.01
51.00	05100	RECOVERY ROOM	1,078,341	183,506	220,126	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	3,893,793	88,347	635,798	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,762,219	669,371	520,223	0	54.00
54.01	05401	RADIOLOGY - ULTRASOUND	1,565,995	63,759	253,797	0	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	2,153,632	170,121	109,393	0	55.00
55.01	05501	INFUSION CENTER	29,950	4,542	2,404	0	55.01
56.00	05600	RADIOISOTOPE	1,757,010	114,083	115,596	0	56.00
57.00	05700	CT SCAN	1,970,858	108,027	256,709	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	768,129	53,049	89,548	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	4,162,092	101,341	523,133	0	59.00
60.00	06000	LABORATORY	14,393,709	296,694	798,218	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	60.01
61.00	06100	PBP CLINICAL LAB SERVICES-PRGM ONLY	0	0	0	0	61.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	1,432,477	4,857	260,875	0	62.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	3,510,633	97,973	565,990	0	65.00
66.00	06600	PHYSICAL THERAPY	1,494,031	154,793	307,573	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	1,211,400	133,031	251,270	0	67.00
68.00	06800	SPEECH PATHOLOGY	480,067	22,658	97,931	0	68.00
69.00	06900	ELECTROCARDIOLOGY	872,540	0	163,549	0	69.00
69.01	06901	CARDIAC REHAB	433,951	0	86,847	0	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	1,227,387	0	225,460	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	10,389,568	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	10,149,884	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	18,767,677	20,967	90,653	0	73.00
74.00	07400	RENAL DIALYSIS	2,425,018	55,294	0	0	74.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	4,690,389	961,069	548,234	0	90.00
91.00	09100	EMERGENCY	9,354,337	341,416	1,506,810	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					92.00
OTHER REIMBURSABLE COST CENTERS							
101.00	10100	HOME HEALTH AGENCY	2,794,914	0	533,321	0	101.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 15-0002

Period:
From 01/01/2020
To 12/31/2020Worksheet B
Part I
Date/Time Prepared:
7/23/2021 10:58 am

Cost Center Description			Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS	EMPLOYEE BENEFITS DEPARTMENT	DATA PROCESSING	PURCHASING RECEIVING AND STORES	
				BLDG & FIXT				
			0	1.00	4.00	5.01	5.02	
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	310,976,745	17,272,859	27,930,935	12,629,071	3,856,636	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	116	22,721	0	0	9	190.00
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	33,463,487	336,975	4,923,005	0	27,013	192.00
192.01	19201	OTHER NON-REIMBURSABLE	344,613	43,612	0	0	8	192.01
192.02	19202	FAMILY HEALTH/GARY COMM HEALTH	100,147	113,503	16,435	0	26	192.02
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	344,885,108	17,789,670	32,870,375	12,629,071	3,883,692	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 15-0002

Period:
From 01/01/2020
To 12/31/2020Worksheet B
Part I
Date/Time Prepared:
7/23/2021 10:58 am

Cost Center Description			ADMITTING	CASHIERING/AC COUNTS RECEIVABLE	Subtotal	OTHER A&G	PATIENT TRANSPORTATIO N	
			5.03	5.04	5A.04	5.05	5.06	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00550	DATA PROCESSING						5.01
5.02	00560	PURCHASING RECEIVING AND STORES						5.02
5.03	00570	ADMITTING	3,318,877					5.03
5.04	00580	CASHIERING/ACCOUNTS RECEIVABLE	0	7,241,012				5.04
5.05	00590	OTHER A&G	0	0	39,081,079	39,081,079		5.05
5.06	00592	PATIENT TRANSPORTATION	0	0	663,642	84,812	748,454	5.06
7.00	00700	OPERATION OF PLANT	0	0	22,087,164	2,822,695	0	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	1,490,314	190,459	0	8.00
9.00	00900	HOUSEKEEPING	0	0	6,424,463	821,034	0	9.00
10.00	01000	DIETARY	0	0	4,277,893	546,706	23	10.00
11.00	01100	CAFETERIA	0	0	2,439,998	311,827	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	0	5,625,525	718,931	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	2,364,420	302,168	0	14.00
15.00	01500	PHARMACY	0	0	6,258,838	799,867	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	3,433,837	438,838	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	561,104	71,708	0	17.00
17.01	01701	STAFF EDUCATION	0	0	140,626	17,972	0	17.01
17.02	01702	MEDICAL EDUCATION	0	0	24,223	3,096	0	17.02
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	0	252,816	32,309	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	0	0	87,522	11,185	0	22.00
23.00	02300	PARAMED ED PROGRAM	0	0	628,317	80,298	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	259,653	566,587	46,833,800	5,985,199	275,308	30.00
31.00	03100	INTENSIVE CARE UNIT	60,552	132,130	12,902,819	1,648,954	4,511	31.00
31.01	03101	NEONATAL ICU	19,751	43,098	2,654,444	339,233	0	31.01
40.00	04000	SUBPROVIDER - IPF	11,670	25,465	1,552,260	198,376	0	40.00
41.00	04100	SUBPROVIDER - IRF	14,086	30,736	3,529,284	451,035	6,847	41.00
43.00	04300	NURSERY	6,309	13,766	2,443,763	312,308	23	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	347,227	757,682	10,072,791	1,287,283	0	50.00
50.01	05001	ENDOSCOPY	32,172	70,203	1,925,021	246,014	19,453	50.01
51.00	05100	RECOVERY ROOM	24,190	52,785	1,561,417	199,540	23	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	12,195	26,611	4,671,510	597,010	8,489	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	99,941	218,079	5,287,675	675,754	52,785	54.00
54.01	05401	RADIOLOGY - ULTRASOUND	53,382	116,484	2,067,151	264,178	90,003	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	52,019	113,511	2,600,283	332,311	4,811	55.00
55.01	05501	INFUSION CENTER	67	146	38,950	4,978	0	55.01
56.00	05600	RADIOISOTOPE	34,241	74,716	2,196,843	280,752	44,643	56.00
57.00	05700	CT SCAN	319,278	696,694	3,380,399	432,008	167,978	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	71,972	157,050	1,146,529	146,524	49,223	58.00
59.00	05900	CARDIAC CATHETERIZATION	172,235	375,833	5,401,554	690,308	3,562	59.00
60.00	06000	LABORATORY	502,563	1,095,553	17,417,099	2,225,870	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
61.00	06100	PBP CLINICAL LAB SERVICES-PRGM ONLY	0	0	0	0	0	61.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	27,540	60,095	1,809,323	231,228	0	62.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	101,217	220,865	4,558,717	582,595	162	65.00
66.00	06600	PHYSICAL THERAPY	20,031	43,710	2,021,699	258,369	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	14,989	32,707	1,644,251	210,132	0	67.00
68.00	06800	SPEECH PATHOLOGY	6,707	14,635	622,751	79,586	0	68.00
69.00	06900	ELECTROCARDIOLOGY	59,741	130,361	1,227,348	156,853	2,383	69.00
69.01	06901	CARDIAC REHAB	2,566	5,598	529,176	67,628	0	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	66,161	144,369	1,674,240	213,965	5,135	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	128,047	279,411	11,835,196	1,512,514	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	73,754	160,938	11,398,813	1,456,746	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	425,371	928,200	20,270,720	2,590,557	0	73.00
74.00	07400	RENAL DIALYSIS	26,975	58,862	2,570,014	328,443	0	74.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	61,299	133,761	6,400,684	817,995	162	90.00
91.00	09100	EMERGENCY	199,918	436,240	12,031,097	1,537,550	12,953	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS								
101.00	10100	HOME HEALTH AGENCY	11,058	24,131	3,374,036	431,195	0	101.00
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	3,318,877	7,241,012	305,493,438	34,046,902	748,454	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	22,846	2,920	0	190.00
191.00	19100	RESEARCH	0	0	0	0	0	191.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 15-0002

Period:
From 01/01/2020
To 12/31/2020Worksheet B
Part I
Date/Time Prepared:
7/23/2021 10:58 am

Cost Center Description			ADMITTING	CASHIERING/AC COUNTS RECEIVABLE	Subtotal	OTHER A&G	PATIENT TRANSPORTATIO N	
			5.03	5.04	5A.04	5.05	5.06	
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	38,750,480	4,952,234	0	192.00
192.01	19201	OTHER NON-REIMBURSABLE	0	0	388,233	49,615	0	192.01
192.02	19202	FAMILY HEALTH/GARY COMM HEALTH	0	0	230,111	29,408	0	192.02
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
200.00		Cross Foot Adjustments			0			200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	3,318,877	7,241,012	344,885,108	39,081,079	748,454	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 15-0002

Period:
From 01/01/2020
To 12/31/2020Worksheet B
Part I
Date/Time Prepared:
7/23/2021 10:58 am

Cost Center Description		OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	
		7.00	8.00	9.00	10.00	11.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.01	00550	DATA PROCESSING					5.01
5.02	00560	PURCHASING RECEIVING AND STORES					5.02
5.03	00570	ADMITTING					5.03
5.04	00580	CASHIERING/ACCOUNTS RECEIVABLE					5.04
5.05	00590	OTHER A&G					5.05
5.06	00592	PATIENT TRANSPORTATION					5.06
7.00	00700	OPERATION OF PLANT	24,909,859				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	468,159	2,148,932			8.00
9.00	00900	HOUSEKEEPING	541,962	0	7,787,459		9.00
10.00	01000	DIETARY	495,028	0	161,299	5,480,926	10.00
11.00	01100	CAFETERIA	346,083	0	112,767	0	11.00
13.00	01300	NURSING ADMINISTRATION	166,778	77,467	54,343	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	941,388	1,621	306,741	0	14.00
15.00	01500	PHARMACY	497,890	0	162,232	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	296,969	0	96,764	0	16.00
17.00	01700	SOCIAL SERVICE	42,784	0	13,941	0	17.00
17.01	01701	STAFF EDUCATION	292,767	0	95,395	0	17.01
17.02	01702	MEDICAL EDUCATION	9,823	0	3,201	0	17.02
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	117,322	0	38,228	0	22.00
23.00	02300	PARAMED ED PROGRAM	88,353	0	28,789	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	8,226,394	884,760	2,680,474	4,382,649	30.00
31.00	03100	INTENSIVE CARE UNIT	521,712	141,681	169,994	203,336	31.00
31.01	03101	NEONATAL ICU	59,305	0	19,324	0	31.01
40.00	04000	SUBPROVIDER - IPF	104,321	0	33,992	155,782	40.00
41.00	04100	SUBPROVIDER - IRF	820,572	93,145	267,374	330,639	41.00
43.00	04300	NURSERY	641,477	40,945	209,018	0	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	1,566,581	259,360	510,453	0	50.00
50.01	05001	ENDOSCOPY	0	31,009	0	0	50.01
51.00	05100	RECOVERY ROOM	382,039	15,716	124,483	1,747	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	183,928	54,505	59,931	146,723	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,393,552	50,685	454,073	0	54.00
54.01	05401	RADIOLOGY - ULTRASOUND	132,739	18,433	43,252	0	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	354,173	12,822	115,403	0	55.00
55.01	05501	INFUSION CENTER	9,455	0	3,081	0	55.01
56.00	05600	RADIOISOTOPE	237,507	12,073	77,389	0	56.00
57.00	05700	CT SCAN	224,900	25,837	73,281	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	110,441	11,463	35,986	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	210,980	51,265	68,746	0	59.00
60.00	06000	LABORATORY	617,681	0	201,265	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	60.01
61.00	06100	PBP CLINICAL LAB SERVICES-PRGM ONLY					61.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	10,112	0	3,295	0	62.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	203,968	0	66,461	0	65.00
66.00	06600	PHYSICAL THERAPY	322,262	0	105,005	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	276,956	0	90,243	0	67.00
68.00	06800	SPEECH PATHOLOGY	47,171	0	15,370	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	3,319	0	0	69.00
69.01	06901	CARDIAC REHAB	0	272	0	0	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0	14,358	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	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	43,651	0	14,223	0	73.00
74.00	07400	RENAL DIALYSIS	115,116	23,734	37,509	0	74.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	2,000,833	53,462	651,949	0	90.00
91.00	09100	EMERGENCY	710,788	271,000	231,602	260,050	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					92.00
OTHER REIMBURSABLE COST CENTERS							
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS							
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	23,833,920	2,148,932	7,436,876	5,480,926	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	47,302	0	15,413	0	190.00
191.00	19100	RESEARCH	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	701,543	0	228,590	0	192.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 15-0002

Period:
From 01/01/2020
To 12/31/2020Worksheet B
Part I
Date/Time Prepared:
7/23/2021 10:58 am

Cost Center Description			OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	
			7.00	8.00	9.00	10.00	11.00	
192.01	19201	OTHER NON-REIMBURSABLE	90,795	0	29,585	0	0	192.01
192.02	19202	FAMILY HEALTH/GARY COMM HEALTH	236,299	0	76,995	0	0	192.02
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
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)	24,909,859	2,148,932	7,787,459	5,480,926	3,210,675	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 15-0002

Period:
From 01/01/2020
To 12/31/2020Worksheet B
Part I
Date/Time Prepared:
7/23/2021 10:58 am

Cost Center Description			NURSING ADMINISTRATIO N	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	
			13.00	14.00	15.00	16.00	17.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00550	DATA PROCESSING						5.01
5.02	00560	PURCHASING RECEIVING AND STORES						5.02
5.03	00570	ADMITTING						5.03
5.04	00580	CASHIERING/ACCOUNTS RECEIVABLE						5.04
5.05	00590	OTHER A&G						5.05
5.06	00592	PATIENT TRANSPORTATION						5.06
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION	6,726,326					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	3,956,046				14.00
15.00	01500	PHARMACY	0	0	7,718,827			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	4,379,194		16.00
17.00	01700	SOCIAL SERVICE	64,464	0	0	0	773,980	17.00
17.01	01701	STAFF EDUCATION	0	0	0	0	0	17.01
17.02	01702	MEDICAL EDUCATION	0	0	0	0	0	17.02
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	0	0	0	0	0	22.00
23.00	02300	PARAMED ED PROGRAM	111,300	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	3,391,317	0	0	342,687	618,078	30.00
31.00	03100	INTENSIVE CARE UNIT	695,850	0	0	79,916	0	31.00
31.01	03101	NEONATAL ICU	163,581	0	0	26,067	0	31.01
40.00	04000	SUBPROVIDER - IPF	129,839	0	0	15,402	0	40.00
41.00	04100	SUBPROVIDER - IRF	280,299	0	0	18,590	123,837	41.00
43.00	04300	NURSERY	136,849	0	0	8,326	0	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	468,528	0	0	458,267	0	50.00
50.01	05001	ENDOSCOPY	95,829	0	0	42,461	0	50.01
51.00	05100	RECOVERY ROOM	87,423	0	0	31,926	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	326,550	0	0	16,095	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	131,900	0	54.00
54.01	05401	RADIOLOGY - ULTRASOUND	0	0	0	70,453	0	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	68,654	0	55.00
55.01	05501	INFUSION CENTER	0	0	0	88	0	55.01
56.00	05600	RADIOISOTOPE	0	0	0	45,190	0	56.00
57.00	05700	CT SCAN	0	0	0	421,380	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	94,988	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	227,314	0	59.00
60.00	06000	LABORATORY	0	0	505,827	662,254	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
61.00	06100	PBP CLINICAL LAB SERVICES-PRGM ONLY	0	0	0	36,347	0	61.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	0	62.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	133,585	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	26,437	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	19,782	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	8,852	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	78,846	0	69.00
69.01	06901	CARDIAC REHAB	0	0	0	3,386	0	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	87,318	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	2,001,107	0	168,995	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	1,954,939	0	97,339	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	7,133,408	561,401	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	35,601	0	74.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0	80,902	0	90.00
91.00	09100	EMERGENCY	774,497	0	0	263,850	32,065	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
OTHER REIMBURSABLE COST CENTERS								
101.00	10100	HOME HEALTH AGENCY	0	0	112	14,595	0	101.00
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	6,726,326	3,956,046	7,639,347	4,379,194	773,980	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
191.00	19100	RESEARCH	0	0	0	0	0	191.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 15-0002

Period:
From 01/01/2020
To 12/31/2020Worksheet B
Part I
Date/Time Prepared:
7/23/2021 10:58 am

Cost Center Description			NURSING ADMINISTRATIO N	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	
			13.00	14.00	15.00	16.00	17.00	
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	79,480	0	0	192.00
192.01	19201	OTHER NON-REIMBURSABLE	0	0	0	0	0	192.01
192.02	19202	FAMILY HEALTH/GARY COMM HEALTH	0	0	0	0	0	192.02
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
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)	6,726,326	3,956,046	7,718,827	4,379,194	773,980	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 15-0002

Period:
From 01/01/2020
To 12/31/2020Worksheet B
Part I
Date/Time Prepared:
7/23/2021 10:58 am

Cost Center Description		STAFF EDUCATION	MEDICAL EDUCATION	INTERNS & RESIDENTS		PARAMED ED PROGRAM	
				SERVICES-SALA RY & FRINGES	SERVICES-OTHE R PRGM COSTS		
		17.01	17.02	21.00	22.00	23.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.01	00550	DATA PROCESSING					5.01
5.02	00560	PURCHASING RECEIVING AND STORES					5.02
5.03	00570	ADMITTING					5.03
5.04	00580	CASHIERING/ACCOUNTS RECEIVABLE					5.04
5.05	00590	OTHER A&G					5.05
5.06	00592	PATIENT TRANSPORTATION					5.06
7.00	00700	OPERATION OF PLANT					7.00
8.00	00800	LAUNDRY & LINEN SERVICE					8.00
9.00	00900	HOUSEKEEPING					9.00
10.00	01000	DIETARY					10.00
11.00	01100	CAFETERIA					11.00
13.00	01300	NURSING ADMINISTRATION					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY					14.00
15.00	01500	PHARMACY					15.00
16.00	01600	MEDICAL RECORDS & LIBRARY					16.00
17.00	01700	SOCIAL SERVICE					17.00
17.01	01701	STAFF EDUCATION	546,760				17.01
17.02	01702	MEDICAL EDUCATION	72	40,415			17.02
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	0	285,125		21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	0	0		254,257	22.00
23.00	02300	PARAMED ED PROGRAM	567	0			23.00
						972,117	
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	233,322	0	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	49,085	0	0	0	31.00
31.01	03101	NEONATAL ICU	488	0	0	0	31.01
40.00	04000	SUBPROVIDER - IPF	2,446	0	0	0	40.00
41.00	04100	SUBPROVIDER - IRF	32,140	0	0	0	41.00
43.00	04300	NURSERY	25,073	0	0	0	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	41,739	0	0	0	50.00
50.01	05001	ENDOSCOPY	9,585	0	0	0	50.01
51.00	05100	RECOVERY ROOM	1,349	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	35,949	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	11,636	0	0	0	54.00
54.01	05401	RADIOLOGY - ULTRASOUND	3,472	0	0	0	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	2,224	0	0	0	55.00
55.01	05501	INFUSION CENTER	387	0	0	0	55.01
56.00	05600	RADIOISOTOPE	22	0	0	0	56.00
57.00	05700	CT SCAN	6,342	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	30,031	0	0	0	59.00
60.00	06000	LABORATORY	1,492	0	0	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	60.01
61.00	06100	PBP CLINICAL LAB SERVICES-PRGM ONLY					61.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	1,134	0	0	0	62.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	5,890	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	1,134	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	1,198	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	495	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	847	0	0	0	69.00
69.01	06901	CARDIAC REHAB	43	0	0	0	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	2,145	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	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	65	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	74.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	2,210	0	0	0	90.00
91.00	09100	EMERGENCY	34,357	40,415	285,125	254,257	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					92.00
OTHER REIMBURSABLE COST CENTERS							
101.00	10100	HOME HEALTH AGENCY	2,697	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS							
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	539,636	40,415	285,125	254,257	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	190.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 15-0002

Period:
From 01/01/2020
To 12/31/2020Worksheet B
Part I
Date/Time Prepared:
7/23/2021 10:58 am

Cost Center Description			STAFF EDUCATION	MEDICAL EDUCATION	INTERNS & RESIDENTS		PARAMED ED PROGRAM	
					SERVICES-SALA RY & FRINGES	SERVICES-OTHE R PRGM COSTS		
			17.01	17.02	21.00	22.00	23.00	
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	7,124	0	0	0	0	192.00
192.01	19201	OTHER NON-REIMBURSABLE	0	0	0	0	0	192.01
192.02	19202	FAMILY HEALTH/GARY COMM HEALTH	0	0	0	0	0	192.02
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
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)	546,760	40,415	285,125	254,257	972,117	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 15-0002

Period:
From 01/01/2020
To 12/31/2020Worksheet B
Part I
Date/Time Prepared:
7/23/2021 10:58 am

Cost Center Description			Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			24.00	25.00	26.00	
GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT				1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT				4.00
5.01	00550	DATA PROCESSING				5.01
5.02	00560	PURCHASING RECEIVING AND STORES				5.02
5.03	00570	ADMITTING				5.03
5.04	00580	CASHIERING/ACCOUNTS RECEIVABLE				5.04
5.05	00590	OTHER A&G				5.05
5.06	00592	PATIENT TRANSPORTATION				5.06
7.00	00700	OPERATION OF PLANT				7.00
8.00	00800	LAUNDRY & LINEN SERVICE				8.00
9.00	00900	HOUSEKEEPING				9.00
10.00	01000	DIETARY				10.00
11.00	01100	CAFETERIA				11.00
13.00	01300	NURSING ADMINISTRATION				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY				14.00
15.00	01500	PHARMACY				15.00
16.00	01600	MEDICAL RECORDS & LIBRARY				16.00
17.00	01700	SOCIAL SERVICE				17.00
17.01	01701	STAFF EDUCATION				17.01
17.02	01702	MEDICAL EDUCATION				17.02
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD				21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD				22.00
23.00	02300	PARAMED ED PROGRAM				23.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	74,905,006	0	74,905,006	30.00
31.00	03100	INTENSIVE CARE UNIT	16,633,512	0	16,633,512	31.00
31.01	03101	NEONATAL ICU	3,313,138	0	3,313,138	31.01
40.00	04000	SUBPROVIDER - IPF	2,232,657	0	2,232,657	40.00
41.00	04100	SUBPROVIDER - IRF	6,040,631	0	6,040,631	41.00
43.00	04300	NURSERY	3,860,194	0	3,860,194	43.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	14,810,206	0	14,810,206	50.00
50.01	05001	ENDOSCOPY	2,399,071	0	2,399,071	50.01
51.00	05100	RECOVERY ROOM	2,432,763	0	2,432,763	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	6,201,893	0	6,201,893	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	8,164,273	0	8,164,273	54.00
54.01	05401	RADIOLOGY - ULTRASOUND	2,729,221	0	2,729,221	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	3,508,119	0	3,508,119	55.00
55.01	05501	INFUSION CENTER	57,280	0	57,280	55.01
56.00	05600	RADIOISOTOPE	2,910,016	0	2,910,016	56.00
57.00	05700	CT SCAN	4,774,252	0	4,774,252	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	1,611,915	0	1,611,915	58.00
59.00	05900	CARDIAC CATHETERIZATION	6,746,020	0	6,746,020	59.00
60.00	06000	LABORATORY	21,783,629	0	21,783,629	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	60.01
61.00	06100	PBP CLINICAL LAB SERVICES-PRGM ONLY	0	0	0	61.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	2,173,300	0	2,173,300	62.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	5,642,388	0	5,642,388	65.00
66.00	06600	PHYSICAL THERAPY	2,779,988	0	2,779,988	66.00
67.00	06700	OCCUPATIONAL THERAPY	2,278,966	0	2,278,966	67.00
68.00	06800	SPEECH PATHOLOGY	786,657	0	786,657	68.00
69.00	06900	ELECTROCARDIOLOGY	1,497,330	0	1,497,330	69.00
69.01	06901	CARDIAC REHAB	615,283	0	615,283	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	2,030,901	0	2,030,901	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	15,517,812	0	15,517,812	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	14,907,837	0	14,907,837	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	30,627,682	0	30,627,682	73.00
74.00	07400	RENAL DIALYSIS	3,110,417	0	3,110,417	74.00
OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	10,089,392	0	10,089,392	90.00
91.00	09100	EMERGENCY	17,951,751	-539,382	17,412,369	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)		0		92.00
OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	3,822,635	0	3,822,635	101.00
SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	298,946,135	-539,382	298,406,753	118.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 15-0002

Period:
From 01/01/2020
To 12/31/2020Worksheet B
Part I
Date/Time Prepared:
7/23/2021 10:58 am

Cost Center Description			Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			24.00	25.00	26.00	
NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	88,481	0	88,481	190.00
191.00	19100	RESEARCH	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	44,719,451	0	44,719,451	192.00
192.01	19201	OTHER NON-REIMBURSABLE	558,228	0	558,228	192.01
192.02	19202	FAMILY HEALTH/GARY COMM HEALTH	572,813	0	572,813	192.02
193.00	19300	NONPAID WORKERS	0	0	0	193.00
200.00		Cross Foot Adjustments	0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	344,885,108	-539,382	344,345,726	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 15-0002

Period:
From 01/01/2020
To 12/31/2020Worksheet B
Part II
Date/Time Prepared:
7/23/2021 10:58 am

Cost Center Description		Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS	Subtotal	EMPLOYEE BENEFITS DEPARTMENT	DATA PROCESSING	
			BLDG & FIXT				
		0	1.00	2A	4.00	5.01	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	74,508	74,508	74,508	4.00
5.01	00550	DATA PROCESSING	0	115,937	115,937	2,250	5.01
5.02	00560	PURCHASING RECEIVING AND STORES	0	92,498	92,498	475	5.02
5.03	00570	ADMITTING	0	122,586	122,586	1,114	5.03
5.04	00580	CASHIERING/ACCOUNTS RECEIVABLE	0	386,618	386,618	1,099	5.04
5.05	00590	OTHER A&G	0	1,256,249	1,256,249	5,674	5.05
5.06	00592	PATIENT TRANSPORTATION	0	0	0	259	5.06
7.00	00700	OPERATION OF PLANT	0	3,776,214	3,776,214	1,969	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	224,873	224,873	0	8.00
9.00	00900	HOUSEKEEPING	0	260,323	260,323	2,103	9.00
10.00	01000	DIETARY	0	237,779	237,779	1,020	10.00
11.00	01100	CAFETERIA	0	166,236	166,236	725	11.00
13.00	01300	NURSING ADMINISTRATION	0	80,109	80,109	1,848	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	452,181	452,181	309	14.00
15.00	01500	PHARMACY	0	239,154	239,154	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	142,645	142,645	1,031	16.00
17.00	01700	SOCIAL SERVICE	0	20,551	20,551	225	17.00
17.01	01701	STAFF EDUCATION	0	140,626	140,626	0	17.01
17.02	01702	MEDICAL EDUCATION	0	4,718	4,718	0	17.02
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	0	56,354	56,354	0	22.00
23.00	02300	PARAMED ED PROGRAM	0	42,439	42,439	303	23.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	0	3,951,417	3,951,417	14,588	30.00
31.00	03100	INTENSIVE CARE UNIT	0	250,596	250,596	4,131	31.00
31.01	03101	NEONATAL ICU	0	28,486	28,486	874	31.01
40.00	04000	SUBPROVIDER - IPF	0	50,109	50,109	570	40.00
41.00	04100	SUBPROVIDER - IRF	0	394,149	394,149	1,127	41.00
43.00	04300	NURSERY	0	308,123	308,123	751	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	752,483	752,483	1,909	50.00
50.01	05001	ENDOSCOPY	0	0	0	440	50.01
51.00	05100	RECOVERY ROOM	0	183,506	183,506	499	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	88,347	88,347	1,442	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	669,371	669,371	1,180	54.00
54.01	05401	RADIOLOGY - ULTRASOUND	0	63,759	63,759	576	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	0	170,121	170,121	248	55.00
55.01	05501	INFUSION CENTER	0	4,542	4,542	5	55.01
56.00	05600	RADIOISOTOPE	0	114,083	114,083	262	56.00
57.00	05700	CT SCAN	0	108,027	108,027	582	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	53,049	53,049	203	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	101,341	101,341	1,186	59.00
60.00	06000	LABORATORY	0	296,694	296,694	1,810	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	60.01
61.00	06100	PBP CLINICAL LAB SERVICES-PRGM ONLY	0	0	0	0	61.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	4,857	4,857	592	62.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	97,973	97,973	1,284	65.00
66.00	06600	PHYSICAL THERAPY	0	154,793	154,793	698	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	133,031	133,031	570	67.00
68.00	06800	SPEECH PATHOLOGY	0	22,658	22,658	222	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	371	69.00
69.01	06901	CARDIAC REHAB	0	0	0	197	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	511	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	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	20,967	20,967	206	73.00
74.00	07400	RENAL DIALYSIS	0	55,294	55,294	0	74.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0	961,069	961,069	1,243	90.00
91.00	09100	EMERGENCY	0	341,416	341,416	3,417	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS							
101.00	10100	HOME HEALTH AGENCY	0	0	0	1,209	101.00
SPECIAL PURPOSE COST CENTERS							
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	17,272,859	17,272,859	63,307	118.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 15-0002

Period:
From 01/01/2020
To 12/31/2020Worksheet B
Part II
Date/Time Prepared:
7/23/2021 10:58 am

Cost Center Description			CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS DEPARTMENT	DATA PROCESSING	
			Directly Assigned New Capital Related Costs	BLDG & FIXT				
			0	1.00	2A	4.00	5.01	
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	22,721	22,721	0	0	190.00
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	336,975	336,975	11,164	0	192.00
192.01	19201	OTHER NON-REIMBURSABLE	0	43,612	43,612	0	0	192.01
192.02	19202	FAMILY HEALTH/GARY COMM HEALTH	0	113,503	113,503	37	0	192.02
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
200.00		Cross Foot Adjustments		0	0			200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	0	17,789,670	17,789,670	74,508	118,187	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 15-0002

Period:
From 01/01/2020
To 12/31/2020Worksheet B
Part II
Date/Time Prepared:
7/23/2021 10:58 am

Cost Center Description			PURCHASING RECEIVING AND STORES	ADMITTING	CASHIERING/AC COUNTS RECEIVABLE	OTHER A&G	PATIENT TRANSPORTATIO N	
			5.02	5.03	5.04	5.05	5.06	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00550	DATA PROCESSING						5.01
5.02	00560	PURCHASING RECEIVING AND STORES	92,973					5.02
5.03	00570	ADMITTING	122	123,822				5.03
5.04	00580	CASHIERING/ACCOUNTS RECEIVABLE	25	0	387,742			5.04
5.05	00590	OTHER A&G	9	0	0	1,380,119		5.05
5.06	00592	PATIENT TRANSPORTATION	6	0	0	2,995	3,260	5.06
7.00	00700	OPERATION OF PLANT	994	0	0	99,679	0	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	1	0	0	6,726	0	8.00
9.00	00900	HOUSEKEEPING	1,007	0	0	28,994	0	9.00
10.00	01000	DIETARY	1,475	0	0	19,306	0	10.00
11.00	01100	CAFETERIA	2	0	0	11,012	0	11.00
13.00	01300	NURSING ADMINISTRATION	430	0	0	25,388	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	709	0	0	10,671	0	14.00
15.00	01500	PHARMACY	389	0	0	28,246	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	16	0	0	15,497	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	2,532	0	17.00
17.01	01701	STAFF EDUCATION	0	0	0	635	0	17.01
17.02	01702	MEDICAL EDUCATION	4	0	0	109	0	17.02
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	0	0	1,141	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	0	0	0	395	0	22.00
23.00	02300	PARAMED ED PROGRAM	16	0	0	2,836	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	7,679	9,671	30,381	211,387	1,199	30.00
31.00	03100	INTENSIVE CARE UNIT	2,519	2,255	7,085	58,230	20	31.00
31.01	03101	NEONATAL ICU	53	736	2,311	11,980	0	31.01
40.00	04000	SUBPROVIDER - IPF	0	435	1,365	7,005	0	40.00
41.00	04100	SUBPROVIDER - IRF	226	525	1,648	15,928	30	41.00
43.00	04300	NURSERY	374	235	738	11,029	0	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	3,963	12,933	40,627	45,459	0	50.00
50.01	05001	ENDOSCOPY	718	1,198	3,764	8,688	85	50.01
51.00	05100	RECOVERY ROOM	59	901	2,830	7,047	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	353	454	1,427	21,083	37	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	427	3,722	11,694	23,863	230	54.00
54.01	05401	RADIOLOGY - ULTRASOUND	329	1,988	6,246	9,329	392	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	38	1,938	6,087	11,735	21	55.00
55.01	05501	INFUSION CENTER	44	2	8	176	0	55.01
56.00	05600	RADIOISOTOPE	2,422	1,275	4,006	9,914	194	56.00
57.00	05700	CT SCAN	690	11,892	37,357	15,256	732	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	162	2,681	8,421	5,174	214	58.00
59.00	05900	CARDIAC CATHETERIZATION	1,602	6,415	20,152	24,377	16	59.00
60.00	06000	LABORATORY	7,908	18,926	58,219	78,603	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
61.00	06100	PBP CLINICAL LAB SERVICES-PRGM ONLY						61.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	562	1,026	3,222	8,165	0	62.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	1,485	3,770	11,843	20,573	1	65.00
66.00	06600	PHYSICAL THERAPY	37	746	2,344	9,124	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	20	558	1,754	7,421	0	67.00
68.00	06800	SPEECH PATHOLOGY	18	250	785	2,810	0	68.00
69.00	06900	ELECTROCARDIOLOGY	28	2,225	6,990	5,539	10	69.00
69.01	06901	CARDIAC REHAB	5	96	300	2,388	0	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	260	2,464	7,741	7,556	22	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	24,860	4,769	14,982	53,412	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	24,279	2,747	8,630	51,443	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	906	15,843	49,771	91,482	0	73.00
74.00	07400	RENAL DIALYSIS	93	1,005	3,156	11,598	0	74.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	142	2,283	7,172	28,886	1	90.00
91.00	09100	EMERGENCY	4,605	7,446	23,392	54,296	56	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
OTHER REIMBURSABLE COST CENTERS								
101.00	10100	HOME HEALTH AGENCY	254	412	1,294	15,227	0	101.00
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	92,325	123,822	387,742	1,202,345	3,260	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	103	0	190.00
191.00	19100	RESEARCH	0	0	0	0	0	191.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 15-0002

Period:
From 01/01/2020
To 12/31/2020Worksheet B
Part II
Date/Time Prepared:
7/23/2021 10:58 am

Cost Center Description			PURCHASING RECEIVING AND STORES	ADMITTING	CASHIERING/AC COUNTS RECEIVABLE	OTHER A&G	PATIENT TRANSPORTATIO N	
			5.02	5.03	5.04	5.05	5.06	
192.00	19200	PHYSICIANS' PRIVATE OFFICES	647	0	0	174,881	0	192.00
192.01	19201	OTHER NON-REIMBURSABLE	0	0	0	1,752	0	192.01
192.02	19202	FAMILY HEALTH/GARY COMM HEALTH	1	0	0	1,038	0	192.02
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
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)	92,973	123,822	387,742	1,380,119	3,260	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 15-0002

Period:
From 01/01/2020
To 12/31/2020Worksheet B
Part II
Date/Time Prepared:
7/23/2021 10:58 am

Cost Center Description		OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	
		7.00	8.00	9.00	10.00	11.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.01	00550	DATA PROCESSING					5.01
5.02	00560	PURCHASING RECEIVING AND STORES					5.02
5.03	00570	ADMITTING					5.03
5.04	00580	CASHIERING/ACCOUNTS RECEIVABLE					5.04
5.05	00590	OTHER A&G					5.05
5.06	00592	PATIENT TRANSPORTATION					5.06
7.00	00700	OPERATION OF PLANT	3,878,856				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	72,900	304,500			8.00
9.00	00900	HOUSEKEEPING	84,392	0	376,819		9.00
10.00	01000	DIETARY	77,084	0	7,805	344,469	10.00
11.00	01100	CAFETERIA	53,891	0	5,457	0	11.00
13.00	01300	NURSING ADMINISTRATION	25,970	10,977	2,630	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	146,589	230	14,843	0	14.00
15.00	01500	PHARMACY	77,529	0	7,850	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	46,243	0	4,682	0	16.00
17.00	01700	SOCIAL SERVICE	6,662	0	675	0	17.00
17.01	01701	STAFF EDUCATION	45,588	0	4,616	0	17.01
17.02	01702	MEDICAL EDUCATION	1,530	0	155	0	17.02
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	18,269	0	1,850	0	22.00
23.00	02300	PARAMED ED PROGRAM	13,758	0	1,393	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	1,280,978	125,369	129,699	275,444	30.00
31.00	03100	INTENSIVE CARE UNIT	81,239	20,076	8,226	12,779	31.00
31.01	03101	NEONATAL ICU	9,235	0	935	0	31.01
40.00	04000	SUBPROVIDER - IPF	16,244	0	1,645	9,791	40.00
41.00	04100	SUBPROVIDER - IRF	127,776	13,199	12,938	20,780	41.00
43.00	04300	NURSERY	99,888	5,802	10,114	0	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	243,941	36,751	24,700	0	50.00
50.01	05001	ENDOSCOPY	0	4,394	0	0	50.01
51.00	05100	RECOVERY ROOM	59,489	2,227	6,023	110	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	28,641	7,723	2,900	9,221	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	216,998	7,182	21,972	0	54.00
54.01	05401	RADIOLOGY - ULTRASOUND	20,670	2,612	2,093	0	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	55,150	1,817	5,584	0	55.00
55.01	05501	INFUSION CENTER	1,472	0	149	0	55.01
56.00	05600	RADIOISOTOPE	36,984	1,711	3,745	0	56.00
57.00	05700	CT SCAN	35,021	3,661	3,546	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	17,197	1,624	1,741	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	32,853	7,264	3,326	0	59.00
60.00	06000	LABORATORY	96,183	0	9,739	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	60.01
61.00	06100	PBP CLINICAL LAB SERVICES-PRGM ONLY					61.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	1,575	0	159	0	62.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	31,761	0	3,216	0	65.00
66.00	06600	PHYSICAL THERAPY	50,181	0	5,081	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	43,126	0	4,367	0	67.00
68.00	06800	SPEECH PATHOLOGY	7,345	0	744	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	470	0	0	69.00
69.01	06901	CARDIAC REHAB	0	39	0	0	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0	2,034	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	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	6,797	0	688	0	73.00
74.00	07400	RENAL DIALYSIS	17,925	3,363	1,815	0	74.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	311,561	7,575	31,546	0	90.00
91.00	09100	EMERGENCY	110,681	38,400	11,207	16,344	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					92.00
OTHER REIMBURSABLE COST CENTERS							
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS							
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	3,711,316	304,500	359,854	344,469	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	7,366	0	746	0	190.00
191.00	19100	RESEARCH	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	109,241	0	11,061	0	192.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 15-0002

Period:
From 01/01/2020
To 12/31/2020Worksheet B
Part II
Date/Time Prepared:
7/23/2021 10:58 am

Cost Center Description			OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	
			7.00	8.00	9.00	10.00	11.00	
192.01	19201	OTHER NON-REIMBURSABLE	14,138	0	1,432	0	0	192.01
192.02	19202	FAMILY HEALTH/GARY COMM HEALTH	36,795	0	3,726	0	0	192.02
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	3,878,856	304,500	376,819	344,469	237,323	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 15-0002

Period:
From 01/01/2020
To 12/31/2020Worksheet B
Part II
Date/Time Prepared:
7/23/2021 10:58 am

Cost Center Description			NURSING ADMINISTRATIO N	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	
			13.00	14.00	15.00	16.00	17.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00550	DATA PROCESSING						5.01
5.02	00560	PURCHASING RECEIVING AND STORES						5.02
5.03	00570	ADMITTING						5.03
5.04	00580	CASHIERING/ACCOUNTS RECEIVABLE						5.04
5.05	00590	OTHER A&G						5.05
5.06	00592	PATIENT TRANSPORTATION						5.06
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION	153,508					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	628,467				14.00
15.00	01500	PHARMACY	0	0	353,168			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	218,451		16.00
17.00	01700	SOCIAL SERVICE	1,471	0	0	0	33,593	17.00
17.01	01701	STAFF EDUCATION	0	0	0	0	0	17.01
17.02	01702	MEDICAL EDUCATION	0	0	0	0	0	17.02
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	0	0	0	0	0	22.00
23.00	02300	PARAMED ED PROGRAM	2,540	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	77,398	0	0	17,095	26,826	30.00
31.00	03100	INTENSIVE CARE UNIT	15,881	0	0	3,987	0	31.00
31.01	03101	NEONATAL ICU	3,733	0	0	1,300	0	31.01
40.00	04000	SUBPROVIDER - IPF	2,963	0	0	768	0	40.00
41.00	04100	SUBPROVIDER - IRF	6,397	0	0	927	5,375	41.00
43.00	04300	NURSERY	3,123	0	0	415	0	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	10,693	0	0	22,861	0	50.00
50.01	05001	ENDOSCOPY	2,187	0	0	2,118	0	50.01
51.00	05100	RECOVERY ROOM	1,995	0	0	1,593	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	7,452	0	0	803	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	6,580	0	54.00
54.01	05401	RADIOLOGY - ULTRASOUND	0	0	0	3,515	0	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	3,425	0	55.00
55.01	05501	INFUSION CENTER	0	0	0	4	0	55.01
56.00	05600	RADIOISOTOPE	0	0	0	2,254	0	56.00
57.00	05700	CT SCAN	0	0	0	21,021	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	4,739	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	11,340	0	59.00
60.00	06000	LABORATORY	0	0	23,144	33,029	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
61.00	06100	PBP CLINICAL LAB SERVICES-PRGM ONLY	0	0	0	1,813	0	61.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	0	62.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	6,664	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	1,319	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	987	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	442	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	3,933	0	69.00
69.01	06901	CARDIAC REHAB	0	0	0	169	0	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	4,356	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	317,901	0	8,430	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	310,566	0	4,856	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	326,382	28,006	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	1,776	0	74.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0	4,036	0	90.00
91.00	09100	EMERGENCY	17,675	0	0	13,162	1,392	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
OTHER REIMBURSABLE COST CENTERS								
101.00	10100	HOME HEALTH AGENCY	0	0	5	728	0	101.00
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	153,508	628,467	349,531	218,451	33,593	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
191.00	19100	RESEARCH	0	0	0	0	0	191.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 15-0002

Period:
From 01/01/2020
To 12/31/2020Worksheet B
Part II
Date/Time Prepared:
7/23/2021 10:58 am

Cost Center Description			NURSING ADMINISTRATIO N	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	
			13.00	14.00	15.00	16.00	17.00	
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	3,637	0	0	192.00
192.01	19201	OTHER NON-REIMBURSABLE	0	0	0	0	0	192.01
192.02	19202	FAMILY HEALTH/GARY COMM HEALTH	0	0	0	0	0	192.02
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
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)	153,508	628,467	353,168	218,451	33,593	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 15-0002

Period:
From 01/01/2020
To 12/31/2020Worksheet B
Part II
Date/Time Prepared:
7/23/2021 10:58 am

Cost Center Description		STAFF EDUCATION	MEDICAL EDUCATION	INTERNS & RESIDENTS		PARAMED ED PROGRAM	
				SERVICES-SALA RY & FRINGES	SERVICES-OTHE R PRGM COSTS		
		17.01	17.02	21.00	22.00	23.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.01	00550	DATA PROCESSING					5.01
5.02	00560	PURCHASING RECEIVING AND STORES					5.02
5.03	00570	ADMITTING					5.03
5.04	00580	CASHIERING/ACCOUNTS RECEIVABLE					5.04
5.05	00590	OTHER A&G					5.05
5.06	00592	PATIENT TRANSPORTATION					5.06
7.00	00700	OPERATION OF PLANT					7.00
8.00	00800	LAUNDRY & LINEN SERVICE					8.00
9.00	00900	HOUSEKEEPING					9.00
10.00	01000	DIETARY					10.00
11.00	01100	CAFETERIA					11.00
13.00	01300	NURSING ADMINISTRATION					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY					14.00
15.00	01500	PHARMACY					15.00
16.00	01600	MEDICAL RECORDS & LIBRARY					16.00
17.00	01700	SOCIAL SERVICE					17.00
17.01	01701	STAFF EDUCATION	191,465				17.01
17.02	01702	MEDICAL EDUCATION	25	6,541			17.02
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	0	1,141		21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	0	0		76,868	22.00
23.00	02300	PARAMED ED PROGRAM	198	0			23.00
						66,033	
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	81,703	0			30.00
31.00	03100	INTENSIVE CARE UNIT	17,189	0			31.00
31.01	03101	NEONATAL ICU	171	0			31.01
40.00	04000	SUBPROVIDER - IPF	857	0			40.00
41.00	04100	SUBPROVIDER - IRF	11,255	0			41.00
43.00	04300	NURSERY	8,780	0			43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	14,616	0			50.00
50.01	05001	ENDOSCOPY	3,356	0			50.01
51.00	05100	RECOVERY ROOM	472	0			51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	12,589	0			52.00
53.00	05300	ANESTHESIOLOGY	0	0			53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,075	0			54.00
54.01	05401	RADIOLOGY - ULTRASOUND	1,216	0			54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	779	0			55.00
55.01	05501	INFUSION CENTER	136	0			55.01
56.00	05600	RADIOISOTOPE	8	0			56.00
57.00	05700	CT SCAN	2,221	0			57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0			58.00
59.00	05900	CARDIAC CATHETERIZATION	10,516	0			59.00
60.00	06000	LABORATORY	523	0			60.00
60.01	06001	BLOOD LABORATORY	0	0			60.01
61.00	06100	PBP CLINICAL LAB SERVICES-PRGM ONLY		0			61.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	397	0			62.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0			63.00
64.00	06400	INTRAVENOUS THERAPY	0	0			64.00
65.00	06500	RESPIRATORY THERAPY	2,063	0			65.00
66.00	06600	PHYSICAL THERAPY	397	0			66.00
67.00	06700	OCCUPATIONAL THERAPY	420	0			67.00
68.00	06800	SPEECH PATHOLOGY	173	0			68.00
69.00	06900	ELECTROCARDIOLOGY	296	0			69.00
69.01	06901	CARDIAC REHAB	15	0			69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	751	0			70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0			71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0			72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	23	0			73.00
74.00	07400	RENAL DIALYSIS	0	0			74.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	774	0			90.00
91.00	09100	EMERGENCY	12,031	6,541			91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					92.00
OTHER REIMBURSABLE COST CENTERS							
101.00	10100	HOME HEALTH AGENCY	945	0			101.00
SPECIAL PURPOSE COST CENTERS							
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	188,970	6,541	0	0	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEN	0	0			190.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 15-0002

Period:
From 01/01/2020
To 12/31/2020Worksheet B
Part II
Date/Time Prepared:
7/23/2021 10:58 am

Cost Center Description			STAFF EDUCATION	MEDICAL EDUCATION	INTERNS & RESIDENTS		PARAMED ED PROGRAM	
					SERVICES-SALA RY & FRINGES	SERVICES-OTHE R PRGM COSTS		
			17.01	17.02	21.00	22.00	23.00	
191.00	19100	RESEARCH	0	0				191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	2,495	0				192.00
192.01	19201	OTHER NON-REIMBURSABLE	0	0				192.01
192.02	19202	FAMILY HEALTH/GARY COMM HEALTH	0	0				192.02
193.00	19300	NONPAID WORKERS	0	0				193.00
200.00		Cross Foot Adjustments			1,141	76,868	66,033	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	191,465	6,541	1,141	76,868	66,033	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 15-0002

Period:
From 01/01/2020
To 12/31/2020Worksheet B
Part II
Date/Time Prepared:
7/23/2021 10:58 am

Cost Center Description			Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			24.00	25.00	26.00	
GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT				1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT				4.00
5.01	00550	DATA PROCESSING				5.01
5.02	00560	PURCHASING RECEIVING AND STORES				5.02
5.03	00570	ADMITTING				5.03
5.04	00580	CASHIERING/ACCOUNTS RECEIVABLE				5.04
5.05	00590	OTHER A&G				5.05
5.06	00592	PATIENT TRANSPORTATION				5.06
7.00	00700	OPERATION OF PLANT				7.00
8.00	00800	LAUNDRY & LINEN SERVICE				8.00
9.00	00900	HOUSEKEEPING				9.00
10.00	01000	DIETARY				10.00
11.00	01100	CAFETERIA				11.00
13.00	01300	NURSING ADMINISTRATION				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY				14.00
15.00	01500	PHARMACY				15.00
16.00	01600	MEDICAL RECORDS & LIBRARY				16.00
17.00	01700	SOCIAL SERVICE				17.00
17.01	01701	STAFF EDUCATION				17.01
17.02	01702	MEDICAL EDUCATION				17.02
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD				21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD				22.00
23.00	02300	PARAMED ED PROGRAM				23.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	6,318,521	0	6,318,521	30.00
31.00	03100	INTENSIVE CARE UNIT	500,154	0	500,154	31.00
31.01	03101	NEONATAL ICU	63,561	0	63,561	31.01
40.00	04000	SUBPROVIDER - IPF	94,726	0	94,726	40.00
41.00	04100	SUBPROVIDER - IRF	618,701	0	618,701	41.00
43.00	04300	NURSERY	452,507	0	452,507	43.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,221,669	0	1,221,669	50.00
50.01	05001	ENDOSCOPY	29,143	0	29,143	50.01
51.00	05100	RECOVERY ROOM	268,754	0	268,754	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	189,953	0	189,953	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	975,145	0	975,145	54.00
54.01	05401	RADIOLOGY - ULTRASOUND	115,648	0	115,648	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	258,232	0	258,232	55.00
55.01	05501	INFUSION CENTER	6,563	0	6,563	55.01
56.00	05600	RADIOISOTOPE	178,011	0	178,011	56.00
57.00	05700	CT SCAN	243,120	0	243,120	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	96,444	0	96,444	58.00
59.00	05900	CARDIAC CATHETERIZATION	224,990	0	224,990	59.00
60.00	06000	LABORATORY	636,024	0	636,024	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	60.01
61.00	06100	PBP CLINICAL LAB SERVICES-PRGM ONLY				61.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	28,419	0	28,419	62.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	187,360	0	187,360	65.00
66.00	06600	PHYSICAL THERAPY	228,052	0	228,052	66.00
67.00	06700	OCCUPATIONAL THERAPY	194,945	0	194,945	67.00
68.00	06800	SPEECH PATHOLOGY	36,366	0	36,366	68.00
69.00	06900	ELECTROCARDIOLOGY	21,912	0	21,912	69.00
69.01	06901	CARDIAC REHAB	4,301	0	4,301	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	28,189	0	28,189	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	424,354	0	424,354	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	402,521	0	402,521	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	542,080	0	542,080	73.00
74.00	07400	RENAL DIALYSIS	96,025	0	96,025	74.00
OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	1,362,290	0	1,362,290	90.00
91.00	09100	EMERGENCY	679,803	0	679,803	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)		0		92.00
OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	20,074	0	20,074	101.00
SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	16,748,557	0	16,748,557	118.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 15-0002

Period:
From 01/01/2020
To 12/31/2020Worksheet B
Part II
Date/Time Prepared:
7/23/2021 10:58 am

Cost Center Description			Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			24.00	25.00	26.00		
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	30,936	0	30,936		190.00
191.00	19100	RESEARCH	0	0	0		191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	650,101	0	650,101		192.00
192.01	19201	OTHER NON-REIMBURSABLE	60,934	0	60,934		192.01
192.02	19202	FAMILY HEALTH/GARY COMM HEALTH	155,100	0	155,100		192.02
193.00	19300	NONPAID WORKERS	0	0	0		193.00
200.00		Cross Foot Adjustments	144,042	0	144,042		200.00
201.00		Negative Cost Centers	0	0	0		201.00
202.00		TOTAL (sum lines 118 through 201)	17,789,670	0	17,789,670		202.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 15-0002

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

Worksheet B-1

Date/Time Prepared:
7/23/2021 10:58 am

Cost Center Description		CAPITAL RELATED COSTS BLDG & FIXT (SQUARE FEET)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	DATA PROCESSING (MACHINE TIME)	PURCHASING RECEIVING AND STORES (PURCHASE REQUISITIONS)	ADMITTING (GROSS CHARGES)	
		1.00	4.00	5.01	5.02	5.03	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT	1,410,133				1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	5,906	146,449,783			4.00
5.01	00550	DATA PROCESSING	9,190	4,421,091	100		5.01
5.02	00560	PURCHASING RECEIVING AND STORES	7,332	933,239	0	38,865,863	5.02
5.03	00570	ADMITTING	9,717	2,187,720	0	51,059	1,248,490,741
5.04	00580	CASHIERING/ACCOUNTS RECEIVABLE	30,646	2,159,017	0	10,528	0
5.05	00590	OTHER A&G	99,579	11,147,935	100	3,670	0
5.06	00592	PATIENT TRANSPORTATION	0	508,975	0	2,521	0
7.00	00700	OPERATION OF PLANT	299,329	3,867,873	0	415,580	0
8.00	00800	LAUNDRY & LINEN SERVICE	17,825	0	0	488	0
9.00	00900	HOUSEKEEPING	20,635	4,132,002	0	421,123	0
10.00	01000	DIETARY	18,848	2,003,515	0	616,623	0
11.00	01100	CAFETERIA	13,177	1,424,097	0	901	0
13.00	01300	NURSING ADMINISTRATION	6,350	3,630,898	0	179,671	0
14.00	01400	CENTRAL SERVICES & SUPPLY	35,843	607,086	0	296,364	0
15.00	01500	PHARMACY	18,957	0	0	162,790	0
16.00	01600	MEDICAL RECORDS & LIBRARY	11,307	2,025,508	0	6,839	0
17.00	01700	SOCIAL SERVICE	1,629	441,467	0	0	0
17.01	01701	STAFF EDUCATION	11,147	0	0	0	0
17.02	01702	MEDICAL EDUCATION	374	699	0	1,528	0
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	0	0	0	0
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	4,467	0	0	0	0
23.00	02300	PARAMED ED PROGRAM	3,364	594,888	0	6,676	0
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	313,217	28,727,343	0	3,210,345	97,687,339
31.00	03100	INTENSIVE CARE UNIT	19,864	8,115,262	0	1,053,117	22,781,049
31.01	03101	NEONATAL ICU	2,258	1,717,684	0	22,086	7,430,733
40.00	04000	SUBPROVIDER - IPF	3,972	1,120,792	0	118	4,390,602
41.00	04100	SUBPROVIDER - IRF	31,243	2,214,027	0	94,515	5,299,296
43.00	04300	NURSERY	24,424	1,475,362	0	156,165	2,373,522
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	59,647	3,750,800	0	1,656,827	130,634,836
50.01	05001	ENDOSCOPY	0	864,189	0	300,076	12,103,945
51.00	05100	RECOVERY ROOM	14,546	980,745	0	24,706	9,100,944
52.00	05200	DELIVERY ROOM & LABOR ROOM	7,003	2,832,718	0	147,770	4,588,061
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0
54.00	05400	RADIOLOGY-DIAGNOSTIC	53,059	2,317,787	0	178,549	37,599,891
54.01	05401	RADIOLOGY - ULTRASOUND	5,054	1,130,762	0	137,438	20,083,443
55.00	05500	RADIOLOGY-THERAPEUTIC	13,485	487,387	0	16,081	19,570,831
55.01	05501	INFUSION CENTER	360	10,712	0	18,424	25,146
56.00	05600	RADIOISOTOPE	9,043	515,023	0	1,012,723	12,882,091
57.00	05700	CT SCAN	8,563	1,143,733	0	288,542	120,119,715
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	4,205	398,968	0	67,862	27,077,576
59.00	05900	CARDIAC CATHETERIZATION	8,033	2,330,752	0	669,698	64,798,733
60.00	06000	LABORATORY	23,518	3,556,362	0	3,306,064	188,928,767
60.01	06001	BLOOD LABORATORY	0	0	0	0	0
61.00	06100	PBP CLINICAL LAB SERVICES-PRGM ONLY					
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	385	1,162,295	0	234,962	10,361,291
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0
65.00	06500	RESPIRATORY THERAPY	7,766	2,521,699	0	620,853	38,080,245
66.00	06600	PHYSICAL THERAPY	12,270	1,370,351	0	15,623	7,536,136
67.00	06700	OCCUPATIONAL THERAPY	10,545	1,119,504	0	8,549	5,639,108
68.00	06800	SPEECH PATHOLOGY	1,796	436,319	0	7,539	2,523,295
69.00	06900	ELECTROCARDIOLOGY	0	728,670	0	11,581	22,476,024
69.01	06901	CARDIAC REHAB	0	386,936	0	2,141	965,245
70.00	07000	ELECTROENCEPHALOGRAPHY	0	1,004,508	0	108,715	24,891,183
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	10,389,568	48,174,273
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	10,149,884	27,747,861
73.00	07300	DRUGS CHARGED TO PATIENTS	1,662	403,891	0	378,799	160,034,418
74.00	07400	RENAL DIALYSIS	4,383	0	0	38,677	10,148,623
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	76,181	2,442,589	0	59,368	23,062,202
91.00	09100	EMERGENCY	27,063	6,713,403	0	1,925,189	75,213,874
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					
OTHER REIMBURSABLE COST CENTERS							
101.00	10100	HOME HEALTH AGENCY	0	2,376,144	0	106,194	4,160,443

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 15-0002

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

Worksheet B-1

Date/Time Prepared:
7/23/2021 10:58 am

Cost Center Description			CAPITAL RELATED COSTS	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	DATA PROCESSING (MACHINE TIME)	PURCHASING RECEIVING AND STORES (PURCHASE REQUISITIONS)	ADMITTING (GROSS CHARGES)	
			BLDG & FIXT (SQUARE FEET)					
			1.00	4.00	5.01	5.02	5.03	
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	1,369,167	124,442,727	100	38,595,109	1,248,490,741	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	1,801	0	0	87	0	190.00
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	26,711	21,933,831	0	270,326	0	192.00
192.01	19201	OTHER NON-REIMBURSABLE	3,457	0	0	83	0	192.01
192.02	19202	FAMILY HEALTH/GARY COMM HEALTH	8,997	73,225	0	258	0	192.02
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
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)	17,789,670	32,870,375	12,629,071	3,883,692	3,318,877	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	12.615597	0.224448	126,290.71000	0.099926	0.002658	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)		74,508	118,187	92,973	123,822	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)		0.000509	1,181.870000	0.002392	0.000099	205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)						206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 15-0002

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

Worksheet B-1

Date/Time Prepared:
7/23/2021 10:58 am

Cost Center Description			CASHIERING/AC COUNTS RECEIVABLE (GROSS CHARGES)	Reconciliatio n	OTHER A&G (ACCUM. COST)	PATIENT TRANSPORTATIO N (NUMBER OF TRIPS)	OPERATION OF PLANT (SQUARE FEET)	
			5.04	5A.05	5.05	5.06	7.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00550	DATA PROCESSING						5.01
5.02	00560	PURCHASING RECEIVING AND STORES						5.02
5.03	00570	ADMITTING						5.03
5.04	00580	CASHIERING/ACCOUNTS RECEIVABLE	1,248,490,741					5.04
5.05	00590	OTHER A&G	0	-39,081,079	305,804,029			5.05
5.06	00592	PATIENT TRANSPORTATION	0	0	663,642	32,357		5.06
7.00	00700	OPERATION OF PLANT	0	0	22,087,164	0	948,434	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	1,490,314	0	17,825	8.00
9.00	00900	HOUSEKEEPING	0	0	6,424,463	0	20,635	9.00
10.00	01000	DIETARY	0	0	4,277,893	0	18,848	10.00
11.00	01100	CAFETERIA	0	0	2,439,998	0	13,177	11.00
13.00	01300	NURSING ADMINISTRATION	0	0	5,625,525	0	6,350	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	2,364,420	0	35,843	14.00
15.00	01500	PHARMACY	0	0	6,258,838	0	18,957	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	3,433,837	0	11,307	16.00
17.00	01700	SOCIAL SERVICE	0	0	561,104	0	1,629	17.00
17.01	01701	STAFF EDUCATION	0	0	140,626	0	11,147	17.01
17.02	01702	MEDICAL EDUCATION	0	0	24,223	0	374	17.02
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	0	252,816	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	0	0	87,522	0	4,467	22.00
23.00	02300	PARAMED ED PROGRAM	0	0	628,317	0	3,364	23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	97,687,339	0	46,833,800	11,902	313,217	30.00
31.00	03100	INTENSIVE CARE UNIT	22,781,049	0	12,902,819	195	19,864	31.00
31.01	03101	NEONATAL ICU	7,430,733	0	2,654,444	0	2,258	31.01
40.00	04000	SUBPROVIDER - IPF	4,390,602	0	1,552,260	0	3,972	40.00
41.00	04100	SUBPROVIDER - IRF	5,299,296	0	3,529,284	296	31,243	41.00
43.00	04300	NURSERY	2,373,522	0	2,443,763	1	24,424	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	130,634,836	0	10,072,791	0	59,647	50.00
50.01	05001	ENDOSCOPY	12,103,945	0	1,925,021	841	0	50.01
51.00	05100	RECOVERY ROOM	9,100,944	0	1,561,417	1	14,546	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	4,588,061	0	4,671,510	367	7,003	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	37,599,891	0	5,287,675	2,282	53,059	54.00
54.01	05401	RADIOLOGY - ULTRASOUND	20,083,443	0	2,067,151	3,891	5,054	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	19,570,831	0	2,600,283	208	13,485	55.00
55.01	05501	INFUSION CENTER	25,146	0	38,950	0	360	55.01
56.00	05600	RADIOISOTOPE	12,882,091	0	2,196,843	1,930	9,043	56.00
57.00	05700	CT SCAN	120,119,715	0	3,380,399	7,262	8,563	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	27,077,576	0	1,146,529	2,128	4,205	58.00
59.00	05900	CARDIAC CATHETERIZATION	64,798,733	0	5,401,554	154	8,033	59.00
60.00	06000	LABORATORY	188,928,767	0	17,417,099	0	23,518	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
61.00	06100	PBP CLINICAL LAB SERVICES-PRGM ONLY	0	0	0	0	0	61.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	10,361,291	0	1,809,323	0	385	62.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	38,080,245	0	4,558,717	7	7,766	65.00
66.00	06600	PHYSICAL THERAPY	7,536,136	0	2,021,699	0	12,270	66.00
67.00	06700	OCCUPATIONAL THERAPY	5,639,108	0	1,644,251	0	10,545	67.00
68.00	06800	SPEECH PATHOLOGY	2,523,295	0	622,751	0	1,796	68.00
69.00	06900	ELECTROCARDIOLOGY	22,476,024	0	1,227,348	103	0	69.00
69.01	06901	CARDIAC REHAB	965,245	0	529,176	0	0	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	24,891,183	0	1,674,240	222	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	48,174,273	0	11,835,196	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	27,747,861	0	11,398,813	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	160,034,418	0	20,270,720	0	1,662	73.00
74.00	07400	RENAL DIALYSIS	10,148,623	0	2,570,014	0	4,383	74.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	23,062,202	0	6,400,684	7	76,181	90.00
91.00	09100	EMERGENCY	75,213,874	0	12,031,097	560	27,063	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
OTHER REIMBURSABLE COST CENTERS								
101.00	10100	HOME HEALTH AGENCY	4,160,443	0	3,374,036	0	0	101.00
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	1,248,490,741	-39,081,079	266,412,359	32,357	907,468	118.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 15-0002

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

Worksheet B-1

Date/Time Prepared:
7/23/2021 10:58 am

Cost Center Description			CASHIERING/AC COUNTS RECEIVABLE (GROSS CHARGES)	Reconciliatio n	OTHER A&G (ACCUM. COST)	PATIENT TRANSPORTATIO N (NUMBER OF TRIPS)	OPERATION OF PLANT (SQUARE FEET)	
			5.04	5A.05	5.05	5.06	7.00	
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	22,846	0	1,801	190.00
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	38,750,480	0	26,711	192.00
192.01	19201	OTHER NON-REIMBURSABLE	0	0	388,233	0	3,457	192.01
192.02	19202	FAMILY HEALTH/GARY COMM HEALTH	0	0	230,111	0	8,997	192.02
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
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)	7,241,012		39,081,079	748,454	24,909,859	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.005800		0.127798	23.131131	26.264199	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	387,742		1,380,119	3,260	3,878,856	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.000311		0.004513	0.100751	4.089748	205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)						206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 15-0002

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

Worksheet B-1

Date/Time Prepared:
7/23/2021 10:58 am

Cost Center Description		LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	CAFETERIA (PRODUCTIVE HOURS)	NURSING ADMINISTRATIO N (DIRECT NURS. HRS.)	
		8.00	9.00	10.00	11.00	13.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.01	00550	DATA PROCESSING					5.01
5.02	00560	PURCHASING RECEIVING AND STORES					5.02
5.03	00570	ADMITTING					5.03
5.04	00580	CASHIERING/ACCOUNTS RECEIVABLE					5.04
5.05	00590	OTHER A&G					5.05
5.06	00592	PATIENT TRANSPORTATION					5.06
7.00	00700	OPERATION OF PLANT					7.00
8.00	00800	LAUNDRY & LINEN SERVICE	1,454,194				8.00
9.00	00900	HOUSEKEEPING	0	909,974			9.00
10.00	01000	DIETARY	0	18,848	269,820		10.00
11.00	01100	CAFETERIA	0	13,177	0	2,323,013	11.00
13.00	01300	NURSING ADMINISTRATION	52,422	6,350	0	60,257	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	1,097	35,843	0	28,730	14.00
15.00	01500	PHARMACY	0	18,957	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	11,307	0	81,604	16.00
17.00	01700	SOCIAL SERVICE	0	1,629	0	14,455	17.00
17.01	01701	STAFF EDUCATION	0	11,147	0	0	17.01
17.02	01702	MEDICAL EDUCATION	0	374	0	0	17.02
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	0	4,467	0	0	22.00
23.00	02300	PARAMED ED PROGRAM	0	3,364	0	24,957	23.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	598,722	313,217	215,753	760,442	30.00
31.00	03100	INTENSIVE CARE UNIT	95,876	19,864	10,010	156,032	31.00
31.01	03101	NEONATAL ICU	0	2,258	0	36,680	31.01
40.00	04000	SUBPROVIDER - IPF	0	3,972	7,669	29,114	40.00
41.00	04100	SUBPROVIDER - IRF	63,032	31,243	16,277	62,852	41.00
43.00	04300	NURSERY	27,708	24,424	0	30,686	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	175,510	59,647	0	105,059	50.00
50.01	05001	ENDOSCOPY	20,984	0	0	21,488	50.01
51.00	05100	RECOVERY ROOM	10,635	14,546	86	19,603	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	36,884	7,003	7,223	73,223	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	34,299	53,059	0	76,848	54.00
54.01	05401	RADIOLOGY - ULTRASOUND	12,474	5,054	0	28,608	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	8,677	13,485	0	12,617	55.00
55.01	05501	INFUSION CENTER	0	360	0	247	55.01
56.00	05600	RADIOISOTOPE	8,170	9,043	0	11,285	56.00
57.00	05700	CT SCAN	17,484	8,563	0	30,480	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	7,757	4,205	0	12,127	58.00
59.00	05900	CARDIAC CATHETERIZATION	34,691	8,033	0	45,047	59.00
60.00	06000	LABORATORY	0	23,518	0	110,078	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	60.01
61.00	06100	PBP CLINICAL LAB SERVICES-PRGM ONLY	0	0	0	0	61.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	385	0	59,229	62.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	7,766	0	65,848	65.00
66.00	06600	PHYSICAL THERAPY	0	12,270	0	32,618	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	10,545	0	26,339	67.00
68.00	06800	SPEECH PATHOLOGY	0	1,796	0	8,995	68.00
69.00	06900	ELECTROCARDIOLOGY	2,246	0	0	20,066	69.00
69.01	06901	CARDIAC REHAB	184	0	0	10,692	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	9,716	0	0	24,412	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	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	1,662	0	9,881	73.00
74.00	07400	RENAL DIALYSIS	16,061	4,383	0	0	74.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	36,178	76,181	0	58,747	90.00
91.00	09100	EMERGENCY	183,387	27,063	12,802	173,667	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS							
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS							
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	1,454,194	869,008	269,820	2,323,013	1,508,258

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 15-0002

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

Worksheet B-1

Date/Time Prepared:
7/23/2021 10:58 am

Cost Center Description			LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	CAFETERIA (PRODUCTIVE HOURS)	NURSING ADMINISTRATIO N (DIRECT NURS. HRS.)	
			8.00	9.00	10.00	11.00	13.00	
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	1,801	0	0	0	190.00
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	26,711	0	0	0	192.00
192.01	19201	OTHER NON-REIMBURSABLE	0	3,457	0	0	0	192.01
192.02	19202	FAMILY HEALTH/GARY COMM HEALTH	0	8,997	0	0	0	192.02
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
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)	2,148,932	7,787,459	5,480,926	3,210,675	6,726,326	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	1.477748	8.557892	20.313268	1.382117	4.459665	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	304,500	376,819	344,469	237,323	153,508	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.209394	0.414099	1.276662	0.102162	0.101778	205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)						206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 15-0002

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

Worksheet B-1

Date/Time Prepared:
7/23/2021 10:58 am

Cost Center Description		CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)	SOCIAL SERVICE (TIME SPENT)	STAFF EDUCATION (TIME SPENT)	
		14.00	15.00	16.00	17.00	17.01	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.01	00550	DATA PROCESSING					5.01
5.02	00560	PURCHASING RECEIVING AND STORES					5.02
5.03	00570	ADMITTING					5.03
5.04	00580	CASHIERING/ACCOUNTS RECEIVABLE					5.04
5.05	00590	OTHER A&G					5.05
5.06	00592	PATIENT TRANSPORTATION					5.06
7.00	00700	OPERATION OF PLANT					7.00
8.00	00800	LAUNDRY & LINEN SERVICE					8.00
9.00	00900	HOUSEKEEPING					9.00
10.00	01000	DIETARY					10.00
11.00	01100	CAFETERIA					11.00
13.00	01300	NURSING ADMINISTRATION					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	20,539,452				14.00
15.00	01500	PHARMACY	0	19,260,879			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	1,248,490,741		16.00
17.00	01700	SOCIAL SERVICE	0	0	0	700	17.00
17.01	01701	STAFF EDUCATION	0	0	0	0	76,213
17.02	01702	MEDICAL EDUCATION	0	0	0	0	10
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	0	0	0	0
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	0	0	0	0	0
23.00	02300	PARAMED ED PROGRAM	0	0	0	0	79
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	0	0	97,687,339	559	32,523
31.00	03100	INTENSIVE CARE UNIT	0	0	22,781,049	0	6,842
31.01	03101	NEONATAL ICU	0	0	7,430,733	0	68
40.00	04000	SUBPROVIDER - IPF	0	0	4,390,602	0	341
41.00	04100	SUBPROVIDER - IRF	0	0	5,299,296	112	4,480
43.00	04300	NURSERY	0	0	2,373,522	0	3,495
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	0	130,634,836	0	5,818
50.01	05001	ENDOSCOPY	0	0	12,103,945	0	1,336
51.00	05100	RECOVERY ROOM	0	0	9,100,944	0	188
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	4,588,061	0	5,011
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	37,599,891	0	1,622
54.01	05401	RADIOLOGY - ULTRASOUND	0	0	20,083,443	0	484
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	19,570,831	0	310
55.01	05501	INFUSION CENTER	0	0	25,146	0	54
56.00	05600	RADIOISOTOPE	0	0	12,882,091	0	3
57.00	05700	CT SCAN	0	0	120,119,715	0	884
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	27,077,576	0	0
59.00	05900	CARDIAC CATHETERIZATION	0	0	64,798,733	0	4,186
60.00	06000	LABORATORY	0	1,262,195	188,928,767	0	208
60.01	06001	BLOOD LABORATORY	0	0	0	0	0
61.00	06100	PBP CLINICAL LAB SERVICES-PRGM ONLY	0	0	0	0	0
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	10,361,291	0	158
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0
65.00	06500	RESPIRATORY THERAPY	0	0	38,080,245	0	821
66.00	06600	PHYSICAL THERAPY	0	0	7,536,136	0	158
67.00	06700	OCCUPATIONAL THERAPY	0	0	5,639,108	0	167
68.00	06800	SPEECH PATHOLOGY	0	0	2,523,295	0	69
69.00	06900	ELECTROCARDIOLOGY	0	0	22,476,024	0	118
69.01	06901	CARDIAC REHAB	0	0	965,245	0	6
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	24,891,183	0	299
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	10,389,568	0	48,174,273	0	0
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	10,149,884	0	27,747,861	0	0
73.00	07300	DRUGS CHARGED TO PATIENTS	0	17,800,078	160,034,418	0	9
74.00	07400	RENAL DIALYSIS	0	0	10,148,623	0	0
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0	0	23,062,202	0	308
91.00	09100	EMERGENCY	0	0	75,213,874	29	4,789
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0
OTHER REIMBURSABLE COST CENTERS							
101.00	10100	HOME HEALTH AGENCY	0	280	4,160,443	0	376
SPECIAL PURPOSE COST CENTERS							
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	20,539,452	19,062,553	1,248,490,741	700	75,220

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 15-0002

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

Worksheet B-1

Date/Time Prepared:
7/23/2021 10:58 am

Cost Center Description			CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)	SOCIAL SERVICE (TIME SPENT)	STAFF EDUCATION (TIME SPENT)	
			14.00	15.00	16.00	17.00	17.01	
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	198,326	0	0	993	192.00
192.01	19201	OTHER NON-REIMBURSABLE	0	0	0	0	0	192.01
192.02	19202	FAMILY HEALTH/GARY COMM HEALTH	0	0	0	0	0	192.02
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	3,956,046	7,718,827	4,379,194	773,980	546,760	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.192607	0.400752	0.003508	1,105.685714	7.174104	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	628,467	353,168	218,451	33,593	191,465	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.030598	0.018336	0.000175	47.990000	2.512235	205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)						206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 15-0002

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

Worksheet B-1

Date/Time Prepared:
7/23/2021 10:58 am

Cost Center Description		INTERNS & RESIDENTS			PARAMED ED PROGRAM (ASSIGNED TIME)		
		MEDICAL EDUCATION (ASSIGNED TIME)	SERVICES-SALARY & FRINGES (ASSIGNED TIME)	SERVICES-OTHER PRGM COSTS (ASSIGNED TIME)			
		17.02	21.00	22.00	23.00		
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.01	00550	DATA PROCESSING					5.01
5.02	00560	PURCHASING RECEIVING AND STORES					5.02
5.03	00570	ADMITTING					5.03
5.04	00580	CASHIERING/ACCOUNTS RECEIVABLE					5.04
5.05	00590	OTHER A&G					5.05
5.06	00592	PATIENT TRANSPORTATION					5.06
7.00	00700	OPERATION OF PLANT					7.00
8.00	00800	LAUNDRY & LINEN SERVICE					8.00
9.00	00900	HOUSEKEEPING					9.00
10.00	01000	DIETARY					10.00
11.00	01100	CAFETERIA					11.00
13.00	01300	NURSING ADMINISTRATION					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY					14.00
15.00	01500	PHARMACY					15.00
16.00	01600	MEDICAL RECORDS & LIBRARY					16.00
17.00	01700	SOCIAL SERVICE					17.00
17.01	01701	STAFF EDUCATION					17.01
17.02	01702	MEDICAL EDUCATION	100				17.02
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	100			21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	0		100		22.00
23.00	02300	PARAMED ED PROGRAM	0			100	23.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	31.00
31.01	03101	NEONATAL ICU	0	0	0	0	31.01
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	40.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	41.00
43.00	04300	NURSERY	0	0	0	0	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	0	0	0	50.00
50.01	05001	ENDOSCOPY	0	0	0	0	50.01
51.00	05100	RECOVERY ROOM	0	0	0	0	51.00
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	RADIOLOGY - ULTRASOUND	0	0	0	0	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	55.00
55.01	05501	INFUSION CENTER	0	0	0	0	55.01
56.00	05600	RADIOISOTOPE	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	59.00
60.00	06000	LABORATORY	0	0	0	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	60.01
61.00	06100	PBP CLINICAL LAB SERVICES-PRGM ONLY	0	0	0	0	61.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	62.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	69.00
69.01	06901	CARDIAC REHAB	0	0	0	0	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	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
74.00	07400	RENAL DIALYSIS	0	0	0	0	74.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0	0	0	0	90.00
91.00	09100	EMERGENCY	100	100	100	100	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					92.00
OTHER REIMBURSABLE COST CENTERS							
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS							
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	100	100	100	100	118.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 15-0002

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

Worksheet B-1

Date/Time Prepared:
7/23/2021 10:58 am

Cost Center Description			INTERNS & RESIDENTS			PARAM ED PROGRAM (ASSIGNED TIME)	
			MEDICAL EDUCATION (ASSIGNED TIME)	SERVICES-SALA RY & FRINGES (ASSIGNED TIME)	SERVICES-OTHE R PRGM COSTS (ASSIGNED TIME)		
				21.00	22.00		
		17.02				23.00	
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	190.00
191.00	19100	RESEARCH	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	192.00
192.01	19201	OTHER NON-REIMBURSABLE	0	0	0	0	192.01
192.02	19202	FAMILY HEALTH/GARY COMM HEALTH	0	0	0	0	192.02
193.00	19300	NONPAID WORKERS	0	0	0	0	193.00
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)	40,415	285,125	254,257	972,117	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	404.150000	2,851.250000	2,542.570000	9,721.170000	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	6,541	1,141	76,868	66,033	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	65.410000	11.410000	768.680000	660.330000	205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)				0	206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)				0.000000	207.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 15-0002

Period:
From 01/01/2020
To 12/31/2020Worksheet C
Part I
Date/Time Prepared:
7/23/2021 10:58 am

			Title XVIII	Hospital	PPS	
Cost Center Description		Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs		
				Total Costs	RCE Disallowance	
		1.00	2.00	3.00	4.00	5.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	74,905,006	74,905,006	16,037	74,921,043 30.00
31.00	03100	INTENSIVE CARE UNIT	16,633,512	16,633,512	0	16,633,512 31.00
31.01	03101	NEONATAL ICU	3,313,138	3,313,138	0	3,313,138 31.01
40.00	04000	SUBPROVIDER - IPF	2,232,657	2,232,657	0	2,232,657 40.00
41.00	04100	SUBPROVIDER - IRF	6,040,631	6,040,631	0	6,040,631 41.00
43.00	04300	NURSERY	3,860,194	3,860,194	0	3,860,194 43.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	14,810,206	14,810,206	0	14,810,206 50.00
50.01	05001	ENDOSCOPY	2,399,071	2,399,071	0	2,399,071 50.01
51.00	05100	RECOVERY ROOM	2,432,763	2,432,763	0	2,432,763 51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	6,201,893	6,201,893	0	6,201,893 52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0 53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	8,164,273	8,164,273	0	8,164,273 54.00
54.01	05401	RADIOLOGY - ULTRASOUND	2,729,221	2,729,221	0	2,729,221 54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	3,508,119	3,508,119	0	3,508,119 55.00
55.01	05501	INFUSION CENTER	57,280	57,280	0	57,280 55.01
56.00	05600	RADIOISOTOPE	2,910,016	2,910,016	0	2,910,016 56.00
57.00	05700	CT SCAN	4,774,252	4,774,252	0	4,774,252 57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	1,611,915	1,611,915	0	1,611,915 58.00
59.00	05900	CARDIAC CATHETERIZATION	6,746,020	6,746,020	0	6,746,020 59.00
60.00	06000	LABORATORY	21,783,629	21,783,629	0	21,783,629 60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0 60.01
61.00	06100	PBP CLINICAL LAB SERVICES-PRGM ONLY	0	0	0	0 61.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	2,173,300	2,173,300	0	2,173,300 62.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0 63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0 64.00
65.00	06500	RESPIRATORY THERAPY	5,642,388	5,642,388	0	5,642,388 65.00
66.00	06600	PHYSICAL THERAPY	2,779,988	2,779,988	0	2,779,988 66.00
67.00	06700	OCCUPATIONAL THERAPY	2,278,966	2,278,966	0	2,278,966 67.00
68.00	06800	SPEECH PATHOLOGY	786,657	786,657	0	786,657 68.00
69.00	06900	ELECTROCARDIOLOGY	1,497,330	1,497,330	0	1,497,330 69.00
69.01	06901	CARDIAC REHAB	615,283	615,283	0	615,283 69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	2,030,901	2,030,901	0	2,030,901 70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	15,517,812	15,517,812	0	15,517,812 71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	14,907,837	14,907,837	0	14,907,837 72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	30,627,682	30,627,682	0	30,627,682 73.00
74.00	07400	RENAL DIALYSIS	3,110,417	3,110,417	0	3,110,417 74.00
OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	10,089,392	10,089,392	0	10,089,392 90.00
91.00	09100	EMERGENCY	17,412,369	17,412,369	0	17,412,369 91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	14,142,045	14,142,045	0	14,142,045 92.00
OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	3,822,635	3,822,635	0	3,822,635 101.00
200.00		Subtotal (see instructions)	312,548,798	312,548,798	16,037	312,564,835 200.00
201.00		Less Observation Beds	14,142,045	14,142,045	0	14,142,045 201.00
202.00		Total (see instructions)	298,406,753	298,406,753	16,037	298,422,790 202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 15-0002

Period:
From 01/01/2020
To 12/31/2020Worksheet C
Part I
Date/Time Prepared:
7/23/2021 10:58 am

			Title XVIII			Hospital	PPS
Cost Center Description			Charges			Cost or Other Ratio	TEFRA Inpatient Ratio
			Inpatient	Outpatient	Total (col. 6 + col. 7)		
			6.00	7.00	8.00		
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	71,846,210		71,846,210		30.00
31.00	03100	INTENSIVE CARE UNIT	22,781,049		22,781,049		31.00
31.01	03101	NEONATAL ICU	7,430,733		7,430,733		31.01
40.00	04000	SUBPROVIDER - IPF	4,390,602		4,390,602		40.00
41.00	04100	SUBPROVIDER - IRF	5,299,296		5,299,296		41.00
43.00	04300	NURSERY	2,373,522		2,373,522		43.00
	ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	57,185,055	73,449,781	130,634,836	0.113371	0.000000
50.01	05001	ENDOSCOPY	3,237,175	8,866,770	12,103,945	0.198206	0.000000
51.00	05100	RECOVERY ROOM	3,340,823	5,760,121	9,100,944	0.267309	0.000000
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,972,099	2,615,962	4,588,061	1.351746	0.000000
53.00	05300	ANESTHESIOLOGY	0	0	0	0.000000	0.000000
54.00	05400	RADIOLOGY-DIAGNOSTIC	10,346,278	27,253,613	37,599,891	0.217136	0.000000
54.01	05401	RADIOLOGY - ULTRASOUND	4,872,619	15,210,824	20,083,443	0.135894	0.000000
55.00	05500	RADIOLOGY-THERAPEUTIC	1,257,688	18,313,143	19,570,831	0.179252	0.000000
55.01	05501	INFUSION CENTER	1,249	23,897	25,146	2.277897	0.000000
56.00	05600	RADIOISOTOPE	4,412,286	8,469,805	12,882,091	0.225896	0.000000
57.00	05700	CT SCAN	45,909,764	74,209,951	120,119,715	0.039746	0.000000
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	10,162,357	16,915,219	27,077,576	0.059530	0.000000
59.00	05900	CARDIAC CATHETERIZATION	31,140,170	33,658,563	64,798,733	0.104107	0.000000
60.00	06000	LABORATORY	85,685,178	103,243,589	188,928,767	0.115301	0.000000
60.01	06001	BLOOD LABORATORY	0	0	0	0.000000	0.000000
61.00	06100	PBP CLINICAL LAB SERVICES-PRGM ONLY	0	0	0	0.000000	0.000000
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	7,555,301	2,805,990	10,361,291	0.209752	0.000000
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0.000000	0.000000
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0.000000	0.000000
65.00	06500	RESPIRATORY THERAPY	34,817,142	3,263,103	38,080,245	0.148171	0.000000
66.00	06600	PHYSICAL THERAPY	6,795,719	740,417	7,536,136	0.368888	0.000000
67.00	06700	OCCUPATIONAL THERAPY	5,181,357	457,751	5,639,108	0.404136	0.000000
68.00	06800	SPEECH PATHOLOGY	2,301,780	221,515	2,523,295	0.311758	0.000000
69.00	06900	ELECTROCARDIOLOGY	12,250,033	10,225,991	22,476,024	0.066619	0.000000
69.01	06901	CARDIAC REHAB	188,463	776,782	965,245	0.637437	0.000000
70.00	07000	ELECTROENCEPHALOGRAPHY	6,769,637	18,121,546	24,891,183	0.081591	0.000000
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	22,615,962	25,558,311	48,174,273	0.322118	0.000000
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	13,105,136	14,642,725	27,747,861	0.537261	0.000000
73.00	07300	DRUGS CHARGED TO PATIENTS	104,879,767	55,154,651	160,034,418	0.191382	0.000000
74.00	07400	RENAL DIALYSIS	9,263,118	885,505	10,148,623	0.306487	0.000000
	OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	300,480	22,761,722	23,062,202	0.437486	0.000000
91.00	09100	EMERGENCY	18,613,397	56,600,477	75,213,874	0.231505	0.000000
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	5,468,994	20,372,135	25,841,129	0.547269	0.000000
	OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	4,160,443	4,160,443		101.00
200.00		Subtotal (see instructions)	623,750,439	624,740,302	1,248,490,741		200.00
201.00		Less Observation Beds					201.00
202.00		Total (see instructions)	623,750,439	624,740,302	1,248,490,741		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES				Provider CCN:15-0002	Period: From 01/01/2020 To 12/31/2020	Worksheet C Part I Date/Time Prepared: 7/23/2021 10:58 am
				Title XVIII	Hospital	PPS
Cost Center Description			PPS Inpatient Ratio			
			11.00			
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS				30.00
31.00	03100	INTENSIVE CARE UNIT				31.00
31.01	03101	NEONATAL ICU				31.01
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	0.113371			50.00
50.01	05001	ENDOSCOPY	0.198206			50.01
51.00	05100	RECOVERY ROOM	0.267309			51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1.351746			52.00
53.00	05300	ANESTHESIOLOGY	0.000000			53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.217136			54.00
54.01	05401	RADIOLOGY - ULTRASOUND	0.135894			54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	0.179252			55.00
55.01	05501	INFUSION CENTER	2.277897			55.01
56.00	05600	RADIOISOTOPE	0.225896			56.00
57.00	05700	CT SCAN	0.039746			57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.059530			58.00
59.00	05900	CARDIAC CATHETERIZATION	0.104107			59.00
60.00	06000	LABORATORY	0.115301			60.00
60.01	06001	BLOOD LABORATORY	0.000000			60.01
61.00	06100	PBP CLINICAL LAB SERVICES-PRGM ONLY	0.000000			61.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.209752			62.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.000000			63.00
64.00	06400	INTRAVENOUS THERAPY	0.000000			64.00
65.00	06500	RESPIRATORY THERAPY	0.148171			65.00
66.00	06600	PHYSICAL THERAPY	0.368888			66.00
67.00	06700	OCCUPATIONAL THERAPY	0.404136			67.00
68.00	06800	SPEECH PATHOLOGY	0.311758			68.00
69.00	06900	ELECTROCARDIOLOGY	0.066619			69.00
69.01	06901	CARDIAC REHAB	0.637437			69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0.081591			70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.322118			71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.537261			72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.191382			73.00
74.00	07400	RENAL DIALYSIS	0.306487			74.00
OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.437486			90.00
91.00	09100	EMERGENCY	0.231505			91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.547269			92.00
OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY				101.00
200.00		Subtotal (see instructions)				200.00
201.00		Less Observation Beds				201.00
202.00		Total (see instructions)				202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 15-0002

Period:
From 01/01/2020
To 12/31/2020Worksheet C
Part I
Date/Time Prepared:
7/23/2021 10:58 am

			Title XIX		Hospital		Cost	
Cost Center Description			Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs			
					Total Costs	RCE Disallowance	Total Costs	
			1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	74,905,006		74,905,006	16,037	74,921,043	30.00
31.00	03100	INTENSIVE CARE UNIT	16,633,512		16,633,512	0	16,633,512	31.00
31.01	03101	NEONATAL ICU	3,313,138		3,313,138	0	3,313,138	31.01
40.00	04000	SUBPROVIDER - IPF	2,232,657		2,232,657	0	2,232,657	40.00
41.00	04100	SUBPROVIDER - IRF	6,040,631		6,040,631	0	6,040,631	41.00
43.00	04300	NURSERY	3,860,194		3,860,194	0	3,860,194	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	14,810,206		14,810,206	0	14,810,206	50.00
50.01	05001	ENDOSCOPY	2,399,071		2,399,071	0	2,399,071	50.01
51.00	05100	RECOVERY ROOM	2,432,763		2,432,763	0	2,432,763	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	6,201,893		6,201,893	0	6,201,893	52.00
53.00	05300	ANESTHESIOLOGY	0		0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	8,164,273		8,164,273	0	8,164,273	54.00
54.01	05401	RADIOLOGY - ULTRASOUND	2,729,221		2,729,221	0	2,729,221	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	3,508,119		3,508,119	0	3,508,119	55.00
55.01	05501	INFUSION CENTER	57,280		57,280	0	57,280	55.01
56.00	05600	RADIOISOTOPE	2,910,016		2,910,016	0	2,910,016	56.00
57.00	05700	CT SCAN	4,774,252		4,774,252	0	4,774,252	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	1,611,915		1,611,915	0	1,611,915	58.00
59.00	05900	CARDIAC CATHETERIZATION	6,746,020		6,746,020	0	6,746,020	59.00
60.00	06000	LABORATORY	21,783,629		21,783,629	0	21,783,629	60.00
60.01	06001	BLOOD LABORATORY	0		0	0	0	60.01
61.00	06100	PBP CLINICAL LAB SERVICES-PRGM ONLY	0		0	0	0	61.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	2,173,300		2,173,300	0	2,173,300	62.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0		0	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0		0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	5,642,388	0	5,642,388	0	5,642,388	65.00
66.00	06600	PHYSICAL THERAPY	2,779,988	0	2,779,988	0	2,779,988	66.00
67.00	06700	OCCUPATIONAL THERAPY	2,278,966	0	2,278,966	0	2,278,966	67.00
68.00	06800	SPEECH PATHOLOGY	786,657	0	786,657	0	786,657	68.00
69.00	06900	ELECTROCARDIOLOGY	1,497,330		1,497,330	0	1,497,330	69.00
69.01	06901	CARDIAC REHAB	615,283		615,283	0	615,283	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	2,030,901		2,030,901	0	2,030,901	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	15,517,812		15,517,812	0	15,517,812	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	14,907,837		14,907,837	0	14,907,837	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	30,627,682		30,627,682	0	30,627,682	73.00
74.00	07400	RENAL DIALYSIS	3,110,417		3,110,417	0	3,110,417	74.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	10,089,392		10,089,392	0	10,089,392	90.00
91.00	09100	EMERGENCY	17,412,369		17,412,369	0	17,412,369	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	14,142,045		14,142,045		14,142,045	92.00
OTHER REIMBURSABLE COST CENTERS								
101.00	10100	HOME HEALTH AGENCY	3,822,635		3,822,635		3,822,635	101.00
200.00		Subtotal (see instructions)	312,548,798	0	312,548,798	16,037	312,564,835	200.00
201.00		Less Observation Beds	14,142,045		14,142,045		14,142,045	201.00
202.00		Total (see instructions)	298,406,753	0	298,406,753	16,037	298,422,790	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 15-0002

Period:
From 01/01/2020
To 12/31/2020Worksheet C
Part I
Date/Time Prepared:
7/23/2021 10:58 am

			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	71,846,210		71,846,210		30.00
31.00	03100	INTENSIVE CARE UNIT	22,781,049		22,781,049		31.00
31.01	03101	NEONATAL ICU	7,430,733		7,430,733		31.01
40.00	04000	SUBPROVIDER - IPF	4,390,602		4,390,602		40.00
41.00	04100	SUBPROVIDER - IRF	5,299,296		5,299,296		41.00
43.00	04300	NURSERY	2,373,522		2,373,522		43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	57,185,055	73,449,781	130,634,836	0.113371	0.000000
50.01	05001	ENDOSCOPY	3,237,175	8,866,770	12,103,945	0.198206	0.000000
51.00	05100	RECOVERY ROOM	3,340,823	5,760,121	9,100,944	0.267309	0.000000
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,972,099	2,615,962	4,588,061	1.351746	0.000000
53.00	05300	ANESTHESIOLOGY	0	0	0	0.000000	0.000000
54.00	05400	RADIOLOGY-DIAGNOSTIC	10,346,278	27,253,613	37,599,891	0.217136	0.000000
54.01	05401	RADIOLOGY - ULTRASOUND	4,872,619	15,210,824	20,083,443	0.135894	0.000000
55.00	05500	RADIOLOGY-THERAPEUTIC	1,257,688	18,313,143	19,570,831	0.179252	0.000000
55.01	05501	INFUSION CENTER	1,249	23,897	25,146	2.277897	0.000000
56.00	05600	RADIOISOTOPE	4,412,286	8,469,805	12,882,091	0.225896	0.000000
57.00	05700	CT SCAN	45,909,764	74,209,951	120,119,715	0.039746	0.000000
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	10,162,357	16,915,219	27,077,576	0.059530	0.000000
59.00	05900	CARDIAC CATHETERIZATION	31,140,170	33,658,563	64,798,733	0.104107	0.000000
60.00	06000	LABORATORY	85,685,178	103,243,589	188,928,767	0.115301	0.000000
60.01	06001	BLOOD LABORATORY	0	0	0	0.000000	0.000000
61.00	06100	PBP CLINICAL LAB SERVICES-PRGM ONLY	0	0	0	0.000000	0.000000
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	7,555,301	2,805,990	10,361,291	0.209752	0.000000
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0.000000	0.000000
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0.000000	0.000000
65.00	06500	RESPIRATORY THERAPY	34,817,142	3,263,103	38,080,245	0.148171	0.000000
66.00	06600	PHYSICAL THERAPY	6,795,719	740,417	7,536,136	0.368888	0.000000
67.00	06700	OCCUPATIONAL THERAPY	5,181,357	457,751	5,639,108	0.404136	0.000000
68.00	06800	SPEECH PATHOLOGY	2,301,780	221,515	2,523,295	0.311758	0.000000
69.00	06900	ELECTROCARDIOLOGY	12,250,033	10,225,991	22,476,024	0.066619	0.000000
69.01	06901	CARDIAC REHAB	188,463	776,782	965,245	0.637437	0.000000
70.00	07000	ELECTROENCEPHALOGRAPHY	6,769,637	18,121,546	24,891,183	0.081591	0.000000
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	22,615,962	25,558,311	48,174,273	0.322118	0.000000
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	13,105,136	14,642,725	27,747,861	0.537261	0.000000
73.00	07300	DRUGS CHARGED TO PATIENTS	104,879,767	55,154,651	160,034,418	0.191382	0.000000
74.00	07400	RENAL DIALYSIS	9,263,118	885,505	10,148,623	0.306487	0.000000
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	300,480	22,761,722	23,062,202	0.437486	0.000000
91.00	09100	EMERGENCY	18,613,397	56,600,477	75,213,874	0.231505	0.000000
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	5,468,994	20,372,135	25,841,129	0.547269	0.000000
OTHER REIMBURSABLE COST CENTERS							
101.00	10100	HOME HEALTH AGENCY	0	4,160,443	4,160,443		101.00
200.00		Subtotal (see instructions)	623,750,439	624,740,302	1,248,490,741		200.00
201.00		Less Observation Beds					201.00
202.00		Total (see instructions)	623,750,439	624,740,302	1,248,490,741		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 15-0002

Period:
From 01/01/2020
To 12/31/2020Worksheet C
Part I
Date/Time Prepared:
7/23/2021 10:58 am

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
31.01	03101	NEONATAL ICU			31.01
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
50.01	05001	ENDOSCOPY	0.000000		50.01
51.00	05100	RECOVERY ROOM	0.000000		51.00
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	RADIOLOGY - ULTRASOUND	0.000000		54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	0.000000		55.00
55.01	05501	INFUSION CENTER	0.000000		55.01
56.00	05600	RADIOISOTOPE	0.000000		56.00
57.00	05700	CT SCAN	0.000000		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000		58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000		59.00
60.00	06000	LABORATORY	0.000000		60.00
60.01	06001	BLOOD LABORATORY	0.000000		60.01
61.00	06100	PBP CLINICAL LAB SERVICES-PRGM ONLY	0.000000		61.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.000000		62.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.000000		63.00
64.00	06400	INTRAVENOUS THERAPY	0.000000		64.00
65.00	06500	RESPIRATORY THERAPY	0.000000		65.00
66.00	06600	PHYSICAL THERAPY	0.000000		66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000		67.00
68.00	06800	SPEECH PATHOLOGY	0.000000		68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000		69.00
69.01	06901	CARDIAC REHAB	0.000000		69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	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
74.00	07400	RENAL DIALYSIS	0.000000		74.00
OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	0.000000		90.00
91.00	09100	EMERGENCY	0.000000		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000		92.00
OTHER REIMBURSABLE COST CENTERS					
101.00	10100	HOME HEALTH AGENCY			101.00
200.00		Subtotal (see instructions)			200.00
201.00		Less Observation Beds			201.00
202.00		Total (see instructions)			202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

Provider CCN: 15-0002

Period:
From 01/01/2020
To 12/31/2020Worksheet D
Part I
Date/Time Prepared:
7/23/2021 10:58 am

			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	6,318,521	0	6,318,521	78,264	80.73	30.00
31.00	INTENSIVE CARE UNIT	500,154		500,154	9,403	53.19	31.00
31.01	NEONATAL ICU	63,561		63,561	3,047	20.86	31.01
40.00	SUBPROVIDER - IPF	94,726	0	94,726	2,515	37.66	40.00
41.00	SUBPROVIDER - IRF	618,701	0	618,701	5,409	114.38	41.00
43.00	NURSERY	452,507		452,507	2,545	177.80	43.00
200.00	Total (lines 30 through 199)	8,048,170		8,048,170	101,183		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	19,768	1,595,871				
31.00	INTENSIVE CARE UNIT	3,100	164,889				
31.01	NEONATAL ICU	0	0				
40.00	SUBPROVIDER - IPF	949	35,739				
41.00	SUBPROVIDER - IRF	2,666	304,937				
43.00	NURSERY	0	0				
200.00	Total (lines 30 through 199)	26,483	2,101,436				

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS					Provider CCN: 15-0002	Period: From 01/01/2020 To 12/31/2020	Worksheet D Part II Date/Time Prepared: 7/23/2021 10:58 am	
					Title XVIII	Hospital	PPS	
Cost Center Description			Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
	ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	1,221,669	130,634,836	0.009352	13,096,883	122,482	50.00
50.01	05001	ENDOSCOPY	29,143	12,103,945	0.002408	1,158,308	2,789	50.01
51.00	05100	RECOVERY ROOM	268,754	9,100,944	0.029530	836,111	24,690	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	189,953	4,588,061	0.041402	19,187	794	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0.000000	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	975,145	37,599,891	0.025935	3,698,801	95,928	54.00
54.01	05401	RADIOLOGY - ULTRASOUND	115,648	20,083,443	0.005758	1,333,623	7,679	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	258,232	19,570,831	0.013195	645,346	8,515	55.00
55.01	05501	INFUSION CENTER	6,563	25,146	0.260996	0	0	55.01
56.00	05600	RADIOISOTOPE	178,011	12,882,091	0.013818	1,468,832	20,296	56.00
57.00	05700	CT SCAN	243,120	120,119,715	0.002024	15,344,738	31,058	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	96,444	27,077,576	0.003562	3,355,029	11,951	58.00
59.00	05900	CARDIAC CATHETERIZATION	224,990	64,798,733	0.003472	9,316,436	32,347	59.00
60.00	06000	LABORATORY	636,024	188,928,767	0.003366	26,181,211	88,126	60.00
60.01	06001	BLOOD LABORATORY	0	0	0.000000	0	0	60.01
61.00	06100	PBP CLINICAL LAB SERVICES-PRGM ONLY						61.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	28,419	10,361,291	0.002743	2,231,931	6,122	62.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0.000000	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0.000000	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	187,360	38,080,245	0.004920	10,300,539	50,679	65.00
66.00	06600	PHYSICAL THERAPY	228,052	7,536,136	0.030261	1,552,017	46,966	66.00
67.00	06700	OCCUPATIONAL THERAPY	194,945	5,639,108	0.034570	1,040,871	35,983	67.00
68.00	06800	SPEECH PATHOLOGY	36,366	2,523,295	0.014412	786,589	11,336	68.00
69.00	06900	ELECTROCARDIOLOGY	21,912	22,476,024	0.000975	4,134,769	4,031	69.00
69.01	06901	CARDIAC REHAB	4,301	965,245	0.004456	0	0	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	28,189	24,891,183	0.001132	2,740,132	3,102	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	424,354	48,174,273	0.008809	7,540,121	66,421	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	402,521	27,747,861	0.014506	3,314,597	48,082	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	542,080	160,034,418	0.003387	30,990,253	104,964	73.00
74.00	07400	RENAL DIALYSIS	96,025	10,148,623	0.009462	3,485,511	32,980	74.00
	OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	1,362,290	23,062,202	0.059070	63,606	3,757	90.00
91.00	09100	EMERGENCY	679,803	75,213,874	0.009038	6,374,326	57,611	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1,192,684	25,841,129	0.046154	1,922,184	88,716	92.00
200.00		Total (lines 50 through 199)	9,872,997	1,130,208,886		152,931,951	1,007,405	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS					Provider CCN:15-0002		Period: From 01/01/2020 To 12/31/2020		Worksheet D Part III Date/Time Prepared: 7/23/2021 10:58 am	
					Title XVIII		Hospital		PPS	
Cost Center Description			Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health Cost	All Other Medical Education Cost			
			1A	1.00	2A	2.00	3.00			
INPATIENT ROUTINE SERVICE COST CENTERS										
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	0	0	30.00	
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	0	31.00	
31.01	03101	NEONATAL ICU	0	0	0	0	0	0	31.01	
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	78,264	0.00	19,768	30.00		
31.00	03100	INTENSIVE CARE UNIT		0	9,403	0.00	3,100	31.00		
31.01	03101	NEONATAL ICU		0	3,047	0.00	0	31.01		
40.00	04000	SUBPROVIDER - IPF	0	0	2,515	0.00	949	40.00		
41.00	04100	SUBPROVIDER - IRF	0	0	5,409	0.00	2,666	41.00		
43.00	04300	NURSERY		0	2,545	0.00	0	43.00		
200.00		Total (lines 30 through 199)		0	101,183		26,483	200.00		
Cost Center Description			Inpatient Program Pass-Through Cost (col. 7 x col. 8)							
			9.00							
INPATIENT ROUTINE SERVICE COST CENTERS										
30.00	03000	ADULTS & PEDIATRICS	0						30.00	
31.00	03100	INTENSIVE CARE UNIT	0						31.00	
31.01	03101	NEONATAL ICU	0						31.01	
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: 15-0002

Period:
From 01/01/2020
To 12/31/2020Worksheet D
Part IV
Date/Time Prepared:
7/23/2021 10:58 am

			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
50.01	05001	ENDOSCOPY	0	0	0	0	0
51.00	05100	RECOVERY ROOM	0	0	0	0	0
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0
54.01	05401	RADIOLOGY - ULTRASOUND	0	0	0	0	0
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	0
55.01	05501	INFUSION CENTER	0	0	0	0	0
56.00	05600	RADIOISOTOPE	0	0	0	0	0
57.00	05700	CT SCAN	0	0	0	0	0
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0
60.00	06000	LABORATORY	0	0	0	0	0
60.01	06001	BLOOD LABORATORY	0	0	0	0	0
61.00	06100	PBP CLINICAL LAB SERVICES-PRGM ONLY	0	0	0	0	0
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	0
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0
69.01	06901	CARDIAC REHAB	0	0	0	0	0
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0
74.00	07400	RENAL DIALYSIS	0	0	0	0	0
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0	0	0	0	0
91.00	09100	EMERGENCY	0	0	0	0	972,117
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0
200.00		Total (lines 50 through 199)	0	0	0	0	972,117

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS			Provider CCN: 15-0002		Period: From 01/01/2020 To 12/31/2020		Worksheet D Part IV Date/Time Prepared: 7/23/2021 10:58 am	
			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	130,634,836	0.000000	50.00
50.01	05001	ENDOSCOPY	0	0	0	12,103,945	0.000000	50.01
51.00	05100	RECOVERY ROOM	0	0	0	9,100,944	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	4,588,061	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	37,599,891	0.000000	54.00
54.01	05401	RADIOLOGY - ULTRASOUND	0	0	0	20,083,443	0.000000	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	19,570,831	0.000000	55.00
55.01	05501	INFUSION CENTER	0	0	0	25,146	0.000000	55.01
56.00	05600	RADIOISOTOPE	0	0	0	12,882,091	0.000000	56.00
57.00	05700	CT SCAN	0	0	0	120,119,715	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	27,077,576	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	64,798,733	0.000000	59.00
60.00	06000	LABORATORY	0	0	0	188,928,767	0.000000	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0.000000	60.01
61.00	06100	PBP CLINICAL LAB SERVICES-PRGM ONLY	0	0	0	0	0.000000	61.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	10,361,291	0.000000	62.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0.000000	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	38,080,245	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	7,536,136	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	5,639,108	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	2,523,295	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	22,476,024	0.000000	69.00
69.01	06901	CARDIAC REHAB	0	0	0	965,245	0.000000	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	24,891,183	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	48,174,273	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	27,747,861	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	160,034,418	0.000000	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	10,148,623	0.000000	74.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0	23,062,202	0.000000	90.00
91.00	09100	EMERGENCY	0	972,117	972,117	75,213,874	0.012925	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	25,841,129	0.000000	92.00
200.00		Total (lines 50 through 199)	0	972,117	972,117	1,130,208,886		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS				Provider CCN: 15-0002		Period: From 01/01/2020 To 12/31/2020		Worksheet D Part IV Date/Time Prepared: 7/23/2021 10:58 am	
				Title XVIII		Hospital		PPS	
Cost Center Description				Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
				9.00	10.00	11.00	12.00	13.00	
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM		0.000000	13,096,883	0	15,035,359	0	50.00
50.01	05001	ENDOSCOPY		0.000000	1,158,308	0	2,465,906	0	50.01
51.00	05100	RECOVERY ROOM		0.000000	836,111	0	1,055,071	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM		0.000000	19,187	0	106,254	0	52.00
53.00	05300	ANESTHESIOLOGY		0.000000	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC		0.000000	3,698,801	0	3,857,690	0	54.00
54.01	05401	RADIOLOGY - ULTRASOUND		0.000000	1,333,623	0	1,480,270	0	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC		0.000000	645,346	0	4,857,574	0	55.00
55.01	05501	INFUSION CENTER		0.000000	0	0	649	0	55.01
56.00	05600	RADIOISOTOPE		0.000000	1,468,832	0	2,143,998	0	56.00
57.00	05700	CT SCAN		0.000000	15,344,738	0	13,221,246	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)		0.000000	3,355,029	0	3,084,740	0	58.00
59.00	05900	CARDIAC CATHETERIZATION		0.000000	9,316,436	0	9,534,478	0	59.00
60.00	06000	LABORATORY		0.000000	26,181,211	0	6,506,477	0	60.00
60.01	06001	BLOOD LABORATORY		0.000000	0	0	0	0	60.01
61.00	06100	PBP CLINICAL LAB SERVICES-PRGM ONLY							61.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS		0.000000	2,231,931	0	199,695	0	62.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.		0.000000	0	0	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY		0.000000	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY		0.000000	10,300,539	0	577,518	0	65.00
66.00	06600	PHYSICAL THERAPY		0.000000	1,552,017	0	59	0	66.00
67.00	06700	OCCUPATIONAL THERAPY		0.000000	1,040,871	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY		0.000000	786,589	0	23,537	0	68.00
69.00	06900	ELECTROCARDIOLOGY		0.000000	4,134,769	0	1,903,885	0	69.00
69.01	06901	CARDIAC REHAB		0.000000	0	0	184,792	0	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY		0.000000	2,740,132	0	4,679,897	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS		0.000000	7,540,121	0	5,823,112	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS		0.000000	3,314,597	0	3,499,005	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS		0.000000	30,990,253	0	17,210,817	0	73.00
74.00	07400	RENAL DIALYSIS		0.000000	3,485,511	0	393,735	0	74.00
OUTPATIENT SERVICE COST CENTERS									
90.00	09000	CLINIC		0.000000	63,606	0	4,276,800	0	90.00
91.00	09100	EMERGENCY		0.012925	6,374,326	82,388	6,222,288	80,423	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)		0.000000	1,922,184	0	2,178,737	0	92.00
200.00		Total (lines 50 through 199)			152,931,951	82,388	110,523,589	80,423	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 15-0002

Period:
From 01/01/2020
To 12/31/2020Worksheet D
Part V
Date/Time Prepared:
7/23/2021 10:58 am

			Title XVIII		Hospital		PPS	
Cost Center Description			Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges		Costs		
				PPS Reimbursed Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0.113371	15,035,359	32	0	1,704,574	50.00
50.01	05001	ENDOSCOPY	0.198206	2,465,906	0	0	488,757	50.01
51.00	05100	RECOVERY ROOM	0.267309	1,055,071	0	0	282,030	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1.351746	106,254	0	0	143,628	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.217136	3,857,690	0	0	837,643	54.00
54.01	05401	RADIOLOGY - ULTRASOUND	0.135894	1,480,270	0	0	201,160	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	0.179252	4,857,574	0	0	870,730	55.00
55.01	05501	INFUSION CENTER	2.277897	649	2	0	1,478	55.01
56.00	05600	RADIOISOTOPE	0.225896	2,143,998	0	0	484,321	56.00
57.00	05700	CT SCAN	0.039746	13,221,246	0	0	525,492	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.059530	3,084,740	0	0	183,635	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.104107	9,534,478	0	0	992,606	59.00
60.00	06000	LABORATORY	0.115301	6,506,477	28,879	0	750,203	60.00
60.01	06001	BLOOD LABORATORY	0.000000	0	0	0	0	60.01
61.00	06100	PBP CLINICAL LAB SERVICES-PRGM ONLY	0.000000	0	0	0	0	61.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.209752	199,695	2,194	0	41,886	62.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.000000	0	0	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0.000000	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.148171	577,518	0	0	85,571	65.00
66.00	06600	PHYSICAL THERAPY	0.368888	59	0	0	22	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.404136	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.311758	23,537	0	0	7,338	68.00
69.00	06900	ELECTROCARDIOLOGY	0.066619	1,903,885	0	0	126,835	69.00
69.01	06901	CARDIAC REHAB	0.637437	184,792	0	0	117,793	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0.081591	4,679,897	15	0	381,837	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.322118	5,823,112	0	0	1,875,729	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.537261	3,499,005	0	0	1,879,879	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.191382	17,210,817	0	40,085	3,293,841	73.00
74.00	07400	RENAL DIALYSIS	0.306487	393,735	0	0	120,675	74.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0.437486	4,276,800	0	0	1,871,040	90.00
91.00	09100	EMERGENCY	0.231505	6,222,288	1,591	131	1,440,491	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.547269	2,178,737	0	0	1,192,355	92.00
200.00		Subtotal (see instructions)		110,523,589	32,713	40,216	19,901,549	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 - line 201)		110,523,589	32,713	40,216	19,901,549	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 15-0002

Period:
From 01/01/2020
To 12/31/2020Worksheet D
Part V
Date/Time Prepared:
7/23/2021 10:58 am

			Title XVIII		Hospital	PPS
	Cost Center Description		Costs			
			Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
	ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	4	0		50.00
50.01	05001	ENDOSCOPY	0	0		50.01
51.00	05100	RECOVERY ROOM	0	0		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0		52.00
53.00	05300	ANESTHESIOLOGY	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0		54.00
54.01	05401	RADIOLOGY - ULTRASOUND	0	0		54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0		55.00
55.01	05501	INFUSION CENTER	5	0		55.01
56.00	05600	RADIOISOTOPE	0	0		56.00
57.00	05700	CT SCAN	0	0		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0		58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0		59.00
60.00	06000	LABORATORY	3,330	0		60.00
60.01	06001	BLOOD LABORATORY	0	0		60.01
61.00	06100	PBP CLINICAL LAB SERVICES-PRGM ONLY	0	0		61.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	460	0		62.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0		63.00
64.00	06400	INTRAVENOUS THERAPY	0	0		64.00
65.00	06500	RESPIRATORY THERAPY	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0		69.00
69.01	06901	CARDIAC REHAB	0	0		69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	1	0		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	7,672		73.00
74.00	07400	RENAL DIALYSIS	0	0		74.00
	OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	0	0		90.00
91.00	09100	EMERGENCY	368	30		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0		92.00
200.00		Subtotal (see instructions)	4,168	7,702		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	4,168	7,702		202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN:15-0002

Period:

Worksheet D

Component CCN:15-S002

From 01/01/2020

Part II

To 12/31/2020

Date/Time Prepared:
7/23/2021 10:58 am

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	1,221,669	130,634,836	0.009352	0	0	50.00
50.01	05001 ENDOSCOPY	29,143	12,103,945	0.002408	0	0	50.01
51.00	05100 RECOVERY ROOM	268,754	9,100,944	0.029530	0	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	189,953	4,588,061	0.041402	0	0	52.00
53.00	05300 ANESTHESIOLOGY	0	0	0.000000	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	975,145	37,599,891	0.025935	6,748	175	54.00
54.01	05401 RADIOLOGY - ULTRASOUND	115,648	20,083,443	0.005758	5,513	32	54.01
55.00	05500 RADIOLOGY-THERAPEUTIC	258,232	19,570,831	0.013195	0	0	55.00
55.01	05501 INFUSION CENTER	6,563	25,146	0.260996	0	0	55.01
56.00	05600 RADIOISOTOPE	178,011	12,882,091	0.013818	5,843	81	56.00
57.00	05700 CT SCAN	243,120	120,119,715	0.002024	36,118	73	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	96,444	27,077,576	0.003562	0	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	224,990	64,798,733	0.003472	12,745	44	59.00
60.00	06000 LABORATORY	636,024	188,928,767	0.003366	175,235	590	60.00
60.01	06001 BLOOD LABORATORY	0	0	0.000000	0	0	60.01
61.00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY	0	0	0.000000	0	0	61.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	28,419	10,361,291	0.002743	10,682	29	62.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0	0	0.000000	0	0	63.00
64.00	06400 INTRAVENOUS THERAPY	0	0	0.000000	0	0	64.00
65.00	06500 RESPIRATORY THERAPY	187,360	38,080,245	0.004920	4,315	21	65.00
66.00	06600 PHYSICAL THERAPY	228,052	7,536,136	0.030261	3,442	104	66.00
67.00	06700 OCCUPATIONAL THERAPY	194,945	5,639,108	0.034570	660	23	67.00
68.00	06800 SPEECH PATHOLOGY	36,366	2,523,295	0.014412	0	0	68.00
69.00	06900 ELECTROCARDIOLOGY	21,912	22,476,024	0.000975	21,916	21	69.00
69.01	06901 CARDIAC REHAB	4,301	965,245	0.004456	0	0	69.01
70.00	07000 ELECTROENCEPHALOGRAPHY	28,189	24,891,183	0.001132	0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	424,354	48,174,273	0.008809	2,379	21	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	402,521	27,747,861	0.014506	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	542,080	160,034,418	0.003387	464,965	1,575	73.00
74.00	07400 RENAL DIALYSIS	96,025	10,148,623	0.009462	124,434	1,177	74.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000 CLINIC	1,362,290	23,062,202	0.059070	0	0	90.00
91.00	09100 EMERGENCY	679,803	75,213,874	0.009038	27,650	250	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	25,841,129	0.000000	0	0	92.00
200.00	Total (lines 50 through 199)	8,680,313	1,130,208,886		902,645	4,216	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS				Provider CCN:15-0002 Component CCN:15-S002		Period: From 01/01/2020 To 12/31/2020		Worksheet D Part IV Date/Time Prepared: 7/23/2021 10:58 am	
				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
50.01	05001	ENDOSCOPY		0	0	0	0	0	50.01
51.00	05100	RECOVERY ROOM		0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM		0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY		0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC		0	0	0	0	0	54.00
54.01	05401	RADIOLOGY - ULTRASOUND		0	0	0	0	0	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC		0	0	0	0	0	55.00
55.01	05501	INFUSION CENTER		0	0	0	0	0	55.01
56.00	05600	RADIOISOTOPE		0	0	0	0	0	56.00
57.00	05700	CT SCAN		0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)		0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION		0	0	0	0	0	59.00
60.00	06000	LABORATORY		0	0	0	0	0	60.00
60.01	06001	BLOOD LABORATORY		0	0	0	0	0	60.01
61.00	06100	PBP CLINICAL LAB SERVICES-PRGM ONLY		0	0	0	0	0	61.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS		0	0	0	0	0	62.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.		0	0	0	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY		0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY		0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY		0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY		0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY		0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY		0	0	0	0	0	69.00
69.01	06901	CARDIAC REHAB		0	0	0	0	0	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY		0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS		0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS		0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS		0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS		0	0	0	0	0	74.00
OUTPATIENT SERVICE COST CENTERS									
90.00	09000	CLINIC		0	0	0	0	0	90.00
91.00	09100	EMERGENCY		0	0	0	0	972,117	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)		0	0	0	0	0	92.00
200.00		Total (lines 50 through 199)		0	0	0	0	972,117	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS				Provider CCN:15-0002 Component CCN:15-S002		Period: From 01/01/2020 To 12/31/2020		Worksheet D Part IV Date/Time Prepared: 7/23/2021 10:58 am	
				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	130,634,836	0.000000	50.00
50.01	05001	ENDOSCOPY		0	0	0	12,103,945	0.000000	50.01
51.00	05100	RECOVERY ROOM		0	0	0	9,100,944	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM		0	0	0	4,588,061	0.000000	52.00
53.00	05300	ANESTHESIOLOGY		0	0	0	0	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC		0	0	0	37,599,891	0.000000	54.00
54.01	05401	RADIOLOGY - ULTRASOUND		0	0	0	20,083,443	0.000000	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC		0	0	0	19,570,831	0.000000	55.00
55.01	05501	INFUSION CENTER		0	0	0	25,146	0.000000	55.01
56.00	05600	RADIOISOTOPE		0	0	0	12,882,091	0.000000	56.00
57.00	05700	CT SCAN		0	0	0	120,119,715	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)		0	0	0	27,077,576	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION		0	0	0	64,798,733	0.000000	59.00
60.00	06000	LABORATORY		0	0	0	188,928,767	0.000000	60.00
60.01	06001	BLOOD LABORATORY		0	0	0	0	0.000000	60.01
61.00	06100	PBP CLINICAL LAB SERVICES-PRGM ONLY		0	0	0	10,361,291	0.000000	61.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS		0	0	0	0	0.000000	62.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.		0	0	0	0	0.000000	63.00
64.00	06400	INTRAVENOUS THERAPY		0	0	0	0	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY		0	0	0	38,080,245	0.000000	65.00
66.00	06600	PHYSICAL THERAPY		0	0	0	7,536,136	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY		0	0	0	5,639,108	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY		0	0	0	2,523,295	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY		0	0	0	22,476,024	0.000000	69.00
69.01	06901	CARDIAC REHAB		0	0	0	965,245	0.000000	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY		0	0	0	24,891,183	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS		0	0	0	48,174,273	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS		0	0	0	27,747,861	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS		0	0	0	160,034,418	0.000000	73.00
74.00	07400	RENAL DIALYSIS		0	0	0	10,148,623	0.000000	74.00
OUTPATIENT SERVICE COST CENTERS									
90.00	09000	CLINIC		0	0	0	23,062,202	0.000000	90.00
91.00	09100	EMERGENCY		0	972,117	972,117	75,213,874	0.012925	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)		0	0	0	25,841,129	0.000000	92.00
200.00		Total (lines 50 through 199)		0	972,117	972,117	1,130,208,886		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS				Provider CCN: 15-0002 Component CCN: 15-S002		Period: From 01/01/2020 To 12/31/2020		Worksheet D Part IV Date/Time Prepared: 7/23/2021 10:58 am	
				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	50.00
50.01	05001	ENDOSCOPY		0.000000	0	0	0	0	50.01
51.00	05100	RECOVERY ROOM		0.000000	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM		0.000000	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY		0.000000	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC		0.000000	6,748	0	1,105	0	54.00
54.01	05401	RADIOLOGY - ULTRASOUND		0.000000	5,513	0	444	0	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC		0.000000	0	0	0	0	55.00
55.01	05501	INFUSION CENTER		0.000000	0	0	0	0	55.01
56.00	05600	RADIOISOTOPE		0.000000	5,843	0	0	0	56.00
57.00	05700	CT SCAN		0.000000	36,118	0	2,527	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)		0.000000	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION		0.000000	12,745	0	0	0	59.00
60.00	06000	LABORATORY		0.000000	175,235	0	0	0	60.00
60.01	06001	BLOOD LABORATORY		0.000000	0	0	0	0	60.01
61.00	06100	PBP CLINICAL LAB SERVICES-PRGM ONLY		0.000000	0	0	0	0	61.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS		0.000000	10,682	0	0	0	62.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.		0.000000	0	0	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY		0.000000	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY		0.000000	4,315	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY		0.000000	3,442	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY		0.000000	660	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY		0.000000	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY		0.000000	21,916	0	536	0	69.00
69.01	06901	CARDIAC REHAB		0.000000	0	0	0	0	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY		0.000000	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS		0.000000	2,379	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	464,965	0	0	0	73.00
74.00	07400	RENAL DIALYSIS		0.000000	124,434	0	0	0	74.00
OUTPATIENT SERVICE COST CENTERS									
90.00	09000	CLINIC		0.000000	0	0	0	0	90.00
91.00	09100	EMERGENCY		0.012925	27,650	357	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)		0.000000	0	0	0	0	92.00
200.00		Total (lines 50 through 199)			902,645	357	4,612	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST				Provider CCN:15-0002	Period: From 01/01/2020 To 12/31/2020	Worksheet D Part V Date/Time Prepared: 7/23/2021 10:58 am		
				Component CCN:15-S002				
				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	0.113371	0	0	0	0	50.00
50.01	05001	ENDOSCOPY	0.198206	0	0	0	0	50.01
51.00	05100	RECOVERY ROOM	0.267309	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1.351746	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.217136	1,105	0	0	240	54.00
54.01	05401	RADIOLOGY - ULTRASOUND	0.135894	444	0	0	60	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	0.179252	0	0	0	0	55.00
55.01	05501	INFUSION CENTER	2.277897	0	0	0	0	55.01
56.00	05600	RADIOISOTOPE	0.225896	0	0	0	0	56.00
57.00	05700	CT SCAN	0.039746	2,527	0	0	100	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.059530	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.104107	0	0	0	0	59.00
60.00	06000	LABORATORY	0.115301	0	0	0	0	60.00
60.01	06001	BLOOD LABORATORY	0.000000	0	0	0	0	60.01
61.00	06100	PBP CLINICAL LAB SERVICES-PRGM ONLY	0.000000	0	0	0	0	61.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.209752	0	0	0	0	62.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.000000	0	0	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0.000000	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.148171	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.368888	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.404136	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.311758	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.066619	536	0	0	36	69.00
69.01	06901	CARDIAC REHAB	0.637437	0	0	0	0	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0.081591	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.322118	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.537261	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.191382	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0.306487	0	0	0	0	74.00
	OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0.437486	0	0	0	0	90.00
91.00	09100	EMERGENCY	0.231505	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.547269	0	0	0	0	92.00
200.00		Subtotal (see instructions)		4,612	0	0	436	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 - line 201)		4,612	0	0	436	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST			Provider CCN:15-0002		Period: From 01/01/2020 To 12/31/2020	Worksheet D Part V Date/Time Prepared: 7/23/2021 10:58 am
			Component CCN:15-S002			
			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
50.01	05001	ENDOSCOPY	0	0		50.01
51.00	05100	RECOVERY ROOM	0	0		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0		52.00
53.00	05300	ANESTHESIOLOGY	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0		54.00
54.01	05401	RADIOLOGY - ULTRASOUND	0	0		54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0		55.00
55.01	05501	INFUSION CENTER	0	0		55.01
56.00	05600	RADIOISOTOPE	0	0		56.00
57.00	05700	CT SCAN	0	0		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0		58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0		59.00
60.00	06000	LABORATORY	0	0		60.00
60.01	06001	BLOOD LABORATORY	0	0		60.01
61.00	06100	PBP CLINICAL LAB SERVICES-PRGM ONLY	0			61.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0		62.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0		63.00
64.00	06400	INTRAVENOUS THERAPY	0	0		64.00
65.00	06500	RESPIRATORY THERAPY	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0		69.00
69.01	06901	CARDIAC REHAB	0	0		69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0		73.00
74.00	07400	RENAL DIALYSIS	0	0		74.00
OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0		90.00
91.00	09100	EMERGENCY	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0		92.00
200.00		Subtotal (see instructions)	0	0		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	0	0		202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS				Provider CCN: 15-0002	Period: From 01/01/2020 To 12/31/2020	Worksheet D Part II Date/Time Prepared: 7/23/2021 10:58 am		
				Component CCN: 15-T002				
				Title XVIII	Subprovider - IRF	PPS		
Cost Center Description		Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)		
		1.00	2.00	3.00	4.00	5.00		
	ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	1,221,669	130,634,836	0.009352	217,418	2,033	50.00
50.01	05001	ENDOSCOPY	29,143	12,103,945	0.002408	18,194	44	50.01
51.00	05100	RECOVERY ROOM	268,754	9,100,944	0.029530	9,930	293	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	189,953	4,588,061	0.041402	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0.000000	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	975,145	37,599,891	0.025935	77,511	2,010	54.00
54.01	05401	RADIOLOGY - ULTRASOUND	115,648	20,083,443	0.005758	11,010	63	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	258,232	19,570,831	0.013195	131,892	1,740	55.00
55.01	05501	INFUSION CENTER	6,563	25,146	0.260996	0	0	55.01
56.00	05600	RADIOISOTOPE	178,011	12,882,091	0.013818	11,983	166	56.00
57.00	05700	CT SCAN	243,120	120,119,715	0.002024	128,397	260	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	96,444	27,077,576	0.003562	69,661	248	58.00
59.00	05900	CARDIAC CATHETERIZATION	224,990	64,798,733	0.003472	35,044	122	59.00
60.00	06000	LABORATORY	636,024	188,928,767	0.003366	739,931	2,491	60.00
60.01	06001	BLOOD LABORATORY	0	0	0.000000	0	0	60.01
61.00	06100	PBP CLINICAL LAB SERVICES-PRGM ONLY						61.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	28,419	10,361,291	0.002743	27,409	75	62.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0.000000	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0.000000	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	187,360	38,080,245	0.004920	262,024	1,289	65.00
66.00	06600	PHYSICAL THERAPY	228,052	7,536,136	0.030261	1,325,831	40,121	66.00
67.00	06700	OCCUPATIONAL THERAPY	194,945	5,639,108	0.034570	1,143,885	39,544	67.00
68.00	06800	SPEECH PATHOLOGY	36,366	2,523,295	0.014412	120,199	1,732	68.00
69.00	06900	ELECTROCARDIOLOGY	21,912	22,476,024	0.000975	27,243	27	69.00
69.01	06901	CARDIAC REHAB	4,301	965,245	0.004456	0	0	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	28,189	24,891,183	0.001132	10,415	12	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	424,354	48,174,273	0.008809	96,241	848	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	402,521	27,747,861	0.014506	26,030	378	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	542,080	160,034,418	0.003387	1,786,137	6,050	73.00
74.00	07400	RENAL DIALYSIS	96,025	10,148,623	0.009462	206,721	1,956	74.00
	OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	1,362,290	23,062,202	0.059070	0	0	90.00
91.00	09100	EMERGENCY	679,803	75,213,874	0.009038	1,816	16	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	25,841,129	0.000000	0	0	92.00
200.00		Total (lines 50 through 199)	8,680,313	1,130,208,886		6,484,922	101,518	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS				Provider CCN: 15-0002 Component CCN: 15-T002		Period: From 01/01/2020 To 12/31/2020		Worksheet D Part IV Date/Time Prepared: 7/23/2021 10:58 am	
				Title XVIII		Subprovider - IRF		PPS	
Cost Center Description				Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health	
				1.00	2A	2.00	3A	3.00	
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM		0	0	0	0	0	50.00
50.01	05001	ENDOSCOPY		0	0	0	0	0	50.01
51.00	05100	RECOVERY ROOM		0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM		0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY		0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC		0	0	0	0	0	54.00
54.01	05401	RADIOLOGY - ULTRASOUND		0	0	0	0	0	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC		0	0	0	0	0	55.00
55.01	05501	INFUSION CENTER		0	0	0	0	0	55.01
56.00	05600	RADIOISOTOPE		0	0	0	0	0	56.00
57.00	05700	CT SCAN		0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)		0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION		0	0	0	0	0	59.00
60.00	06000	LABORATORY		0	0	0	0	0	60.00
60.01	06001	BLOOD LABORATORY		0	0	0	0	0	60.01
61.00	06100	PBP CLINICAL LAB SERVICES-PRGM ONLY		0	0	0	0	0	61.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS		0	0	0	0	0	62.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.		0	0	0	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY		0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY		0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY		0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY		0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY		0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY		0	0	0	0	0	69.00
69.01	06901	CARDIAC REHAB		0	0	0	0	0	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY		0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS		0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS		0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS		0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS		0	0	0	0	0	74.00
OUTPATIENT SERVICE COST CENTERS									
90.00	09000	CLINIC		0	0	0	0	0	90.00
91.00	09100	EMERGENCY		0	0	0	0	972,117	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)		0	0	0	0	0	92.00
200.00		Total (lines 50 through 199)		0	0	0	0	972,117	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS				Provider CCN:15-0002 Component CCN:15-T002		Period: From 01/01/2020 To 12/31/2020		Worksheet D Part IV Date/Time Prepared: 7/23/2021 10:58 am	
				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	130,634,836	0.000000	50.00
50.01	05001	ENDOSCOPY		0	0	0	12,103,945	0.000000	50.01
51.00	05100	RECOVERY ROOM		0	0	0	9,100,944	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM		0	0	0	4,588,061	0.000000	52.00
53.00	05300	ANESTHESIOLOGY		0	0	0	0	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC		0	0	0	37,599,891	0.000000	54.00
54.01	05401	RADIOLOGY - ULTRASOUND		0	0	0	20,083,443	0.000000	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC		0	0	0	19,570,831	0.000000	55.00
55.01	05501	INFUSION CENTER		0	0	0	25,146	0.000000	55.01
56.00	05600	RADIOISOTOPE		0	0	0	12,882,091	0.000000	56.00
57.00	05700	CT SCAN		0	0	0	120,119,715	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)		0	0	0	27,077,576	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION		0	0	0	64,798,733	0.000000	59.00
60.00	06000	LABORATORY		0	0	0	188,928,767	0.000000	60.00
60.01	06001	BLOOD LABORATORY		0	0	0	0	0.000000	60.01
61.00	06100	PBP CLINICAL LAB SERVICES-PRGM ONLY		0	0	0	10,361,291	0.000000	61.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS		0	0	0	0	0.000000	62.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.		0	0	0	0	0.000000	63.00
64.00	06400	INTRAVENOUS THERAPY		0	0	0	0	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY		0	0	0	38,080,245	0.000000	65.00
66.00	06600	PHYSICAL THERAPY		0	0	0	7,536,136	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY		0	0	0	5,639,108	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY		0	0	0	2,523,295	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY		0	0	0	22,476,024	0.000000	69.00
69.01	06901	CARDIAC REHAB		0	0	0	965,245	0.000000	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY		0	0	0	24,891,183	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS		0	0	0	48,174,273	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS		0	0	0	27,747,861	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS		0	0	0	160,034,418	0.000000	73.00
74.00	07400	RENAL DIALYSIS		0	0	0	10,148,623	0.000000	74.00
OUTPATIENT SERVICE COST CENTERS									
90.00	09000	CLINIC		0	0	0	23,062,202	0.000000	90.00
91.00	09100	EMERGENCY		0	972,117	972,117	75,213,874	0.012925	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)		0	0	0	25,841,129	0.000000	92.00
200.00		Total (lines 50 through 199)		0	972,117	972,117	1,130,208,886		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS				Provider CCN: 15-0002 Component CCN: 15-T002		Period: From 01/01/2020 To 12/31/2020		Worksheet D Part IV Date/Time Prepared: 7/23/2021 10:58 am	
				Title XVIII		Subprovider - IRF		PPS	
Cost Center Description				Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	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	217,418	0	0	0	50.00
50.01	05001	ENDOSCOPY		0.000000	18,194	0	0	0	50.01
51.00	05100	RECOVERY ROOM		0.000000	9,930	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM		0.000000	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY		0.000000	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC		0.000000	77,511	0	0	0	54.00
54.01	05401	RADIOLOGY - ULTRASOUND		0.000000	11,010	0	0	0	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC		0.000000	131,892	0	0	0	55.00
55.01	05501	INFUSION CENTER		0.000000	0	0	0	0	55.01
56.00	05600	RADIOISOTOPE		0.000000	11,983	0	0	0	56.00
57.00	05700	CT SCAN		0.000000	128,397	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)		0.000000	69,661	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION		0.000000	35,044	0	0	0	59.00
60.00	06000	LABORATORY		0.000000	739,931	0	0	0	60.00
60.01	06001	BLOOD LABORATORY		0.000000	0	0	0	0	60.01
61.00	06100	PBP CLINICAL LAB SERVICES-PRGM ONLY		0.000000					61.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS		0.000000	27,409	0	0	0	62.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.		0.000000	0	0	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY		0.000000	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY		0.000000	262,024	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY		0.000000	1,325,831	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY		0.000000	1,143,885	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY		0.000000	120,199	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY		0.000000	27,243	0	0	0	69.00
69.01	06901	CARDIAC REHAB		0.000000	0	0	0	0	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY		0.000000	10,415	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS		0.000000	96,241	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS		0.000000	26,030	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS		0.000000	1,786,137	0	0	0	73.00
74.00	07400	RENAL DIALYSIS		0.000000	206,721	0	0	0	74.00
OUTPATIENT SERVICE COST CENTERS									
90.00	09000	CLINIC		0.000000	0	0	0	0	90.00
91.00	09100	EMERGENCY		0.012925	1,816	23	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)		0.000000	0	0	0	0	92.00
200.00		Total (lines 50 through 199)			6,484,922	23	0	0	200.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 15-0002	Period: From 01/01/2020 To 12/31/2020	Worksheet D-1 Date/Time Prepared: 7/23/2021 10:58 am	
Cost Center Description		Title XVIII	Hospital	PPS	
				1.00	
PART I - ALL PROVIDER COMPONENTS					
INPATIENT DAYS					
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)			78,264	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)			78,264	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)			63,491	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)			19,768	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)			74,921,043	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)			74,921,043	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)			74,921,043	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)			957.29	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)			18,923,709	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)			18,923,709	41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 15-0002

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

Worksheet D-1

Date/Time Prepared:
7/23/2021 10:58 am

		Title XVIII		Hospital	PPS	
Cost Center Description		Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)
		1.00	2.00	3.00	4.00	5.00
42.00	NURSERY (title V & XIX only)	0	0	0.00	0	0
	Intensive Care Type Inpatient Hospital Units					
43.00	INTENSIVE CARE UNIT	16,633,512	9,403	1,768.96	3,100	5,483,776
43.01	NEONATAL ICU	3,313,138	3,047	1,087.34	0	0
44.00	CORONARY CARE UNIT					
45.00	BURN INTENSIVE CARE UNIT					
46.00	SURGICAL INTENSIVE CARE UNIT					
47.00	OTHER SPECIAL CARE (SPECIFY)					
	Cost Center Description					
						1.00
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					25,690,063
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					50,097,548
	PASS THROUGH COST ADJUSTMENTS					
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)					1,760,760
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					1,089,793
52.00	Total Program excludable cost (sum of lines 50 and 51)					2,850,553
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					47,246,995
	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)					14,773
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					957.29
89.00	Observation bed cost (line 87 x line 88) (see instructions)					14,142,045

COMPUTATION OF INPATIENT OPERATING COST				Provider CCN: 15-0002		Period: From 01/01/2020 To 12/31/2020		Worksheet D-1 Date/Time Prepared: 7/23/2021 10:58 am	
				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	6,318,521	74,921,043	0.084336	14,142,045	1,192,684		90.00	
91.00	Nursing School cost	0	74,921,043	0.000000	14,142,045	0		91.00	
92.00	Allied health cost	0	74,921,043	0.000000	14,142,045	0		92.00	
93.00	All other Medical Education	0	74,921,043	0.000000	14,142,045	0		93.00	

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 15-0002	Period: From 01/01/2020 To 12/31/2020	Worksheet D-1
		Component CCN: 15-S002		Date/Time Prepared: 7/23/2021 10:58 am
		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)		2,515	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		2,515	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)		2,515	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)		949	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)		0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period		0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)		0	14.00
15.00	Total nursery days (title V or XIX only)		0	15.00
16.00	Nursery days (title V or XIX only)		0	16.00
SWING BED ADJUSTMENT				
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period		0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)		2,232,657	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)		0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)		0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)		0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)		0	25.00
26.00	Total swing-bed cost (see instructions)		0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)		2,232,657	27.00
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)		0	28.00
29.00	Private room charges (excluding swing-bed charges)		0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)		0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)		0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)		0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)		0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)		0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)		0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)		2,232,657	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)		887.74	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		842,465	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)		842,465	41.00

COMPUTATION OF INPATIENT OPERATING COST				Provider CCN: 15-0002	Period: From 01/01/2020 To 12/31/2020	Worksheet D-1
				Component CCN: 15-S002		Date/Time Prepared: 7/23/2021 10:58 am
				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
43.01	NEONATAL ICU	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	OTHER SPECIAL CARE (SPECIFY)					
Cost Center Description						
						1.00
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					166,669
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					1,009,134
PASS THROUGH COST ADJUSTMENTS						
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)					35,739
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					4,573
52.00	Total Program excludable cost (sum of lines 50 and 51)					40,312
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					968,822
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: 15-0002 Component CCN: 15-S002		Period: From 01/01/2020 To 12/31/2020		Worksheet D-1 Date/Time Prepared: 7/23/2021 10:58 am	
		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	94,726	2,232,657	0.042427	0	0	90.00
91.00	Nursing School cost	0	2,232,657	0.000000	0	0	91.00
92.00	Allied health cost	0	2,232,657	0.000000	0	0	92.00
93.00	All other Medical Education	0	2,232,657	0.000000	0	0	93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 15-0002	Period: From 01/01/2020 To 12/31/2020	Worksheet D-1
		Component CCN: 15-T002		Date/Time Prepared: 7/23/2021 10:58 am
		Title XVIII	Subprovider - IRF	PPS
Cost Center Description				1.00
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		5,409	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		5,409	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.		0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)		5,409	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)		2,666	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)		6,040,631	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)		6,040,631	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)		6,040,631	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)		1,116.77	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		2,977,309	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)		2,977,309	41.00

COMPUTATION OF INPATIENT OPERATING COST				Provider CCN: 15-0002	Period: From 01/01/2020 To 12/31/2020	Worksheet D-1
				Component CCN: 15-T002		Date/Time Prepared: 7/23/2021 10:58 am
				Title XVIII	Subprovider - IRF	PPS
Cost Center Description		Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)
		1.00	2.00	3.00	4.00	5.00
42.00	NURSERY (title V & XIX only)	0	0	0.00	0	0
Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	0	0	0.00	0	0
43.01	NEONATAL ICU	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	OTHER SPECIAL CARE (SPECIFY)					
Cost Center Description						
						1.00
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					1,660,473
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					4,637,782
PASS THROUGH COST ADJUSTMENTS						
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)					304,937
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					101,541
52.00	Total Program excludable cost (sum of lines 50 and 51)					406,478
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					4,231,304
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: 15-0002 Component CCN: 15-T002		Period: From 01/01/2020 To 12/31/2020	Worksheet D-1 Date/Time Prepared: 7/23/2021 10:58 am	
		Title XVIII		Subprovider - IRF	PPS	
Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
	1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00 Capital-related cost	618,701	6,040,631	0.102423	0	0	90.00
91.00 Nursing School cost	0	6,040,631	0.000000	0	0	91.00
92.00 Allied health cost	0	6,040,631	0.000000	0	0	92.00
93.00 All other Medical Education	0	6,040,631	0.000000	0	0	93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 15-0002	Period: From 01/01/2020 To 12/31/2020	Worksheet D-1 Date/Time Prepared: 7/23/2021 10:58 am		
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)			78,264	1.00	
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)			78,264	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)			63,491	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)			4,106	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)			2,545	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)			74,905,006	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)			74,905,006	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)			74,905,006	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)			957.08	38.00	
39.00	Program general inpatient routine service cost (line 9 x line 38)			3,929,770	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)			3,929,770	41.00	

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 15-0002

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

Worksheet D-1

Date/Time Prepared:
7/23/2021 10:58 am

Cost Center Description		Title XIX		Hospital		Cost	
		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)	3,860,194	2,545	1,516.78	0	0	42.00
Intensive Care Type Inpatient Hospital Units							
43.00	INTENSIVE CARE UNIT	16,633,512	9,403	1,768.96	0	0	43.00
43.01	NEONATAL ICU	3,313,138	3,047	1,087.34	0	0	43.01
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00
Cost Center Description						1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					3,210,282	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					7,140,052	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)					14,773	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					957.08	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)					14,138,943	89.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 15-0002

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

Worksheet D-1

Date/Time Prepared:
7/23/2021 10:58 am

		Title XIX		Hospital	Cost	
Cost Center Description		Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)
		1.00	2.00	3.00	4.00	5.00
COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	6,318,521	74,905,006	0.084354	14,138,943	1,192,676
91.00	Nursing School cost	0	74,905,006	0.000000	14,138,943	0
92.00	Allied health cost	0	74,905,006	0.000000	14,138,943	0
93.00	All other Medical Education	0	74,905,006	0.000000	14,138,943	0

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 15-0002	Period: From 01/01/2020 To 12/31/2020	Worksheet D-1
		Component CCN: 15-S002		Date/Time Prepared: 7/23/2021 10:58 am
		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)		2,515	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		2,515	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)		2,515	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)		70	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)		2,545	15.00
16.00	Nursery days (title V or XIX only)		0	16.00
SWING BED ADJUSTMENT				
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period		0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)		2,232,657	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)		0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)		0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)		0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)		0	25.00
26.00	Total swing-bed cost (see instructions)		0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)		2,232,657	27.00
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)		0	28.00
29.00	Private room charges (excluding swing-bed charges)		0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)		0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)		0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)		0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)		0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)		0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)		0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)		2,232,657	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)		887.74	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		62,142	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)		62,142	41.00

COMPUTATION OF INPATIENT OPERATING COST				Provider CCN: 15-0002	Period: From 01/01/2020 To 12/31/2020	Worksheet D-1
				Component CCN: 15-S002		Date/Time Prepared: 7/23/2021 10:58 am
				Title XIX	Subprovider - IPF	Cost
Cost Center Description		Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)
		1.00	2.00	3.00	4.00	5.00
42.00	NURSERY (title V & XIX only)	0	0	0.00	0	0
Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	0	0	0.00	0	0
43.01	NEONATAL ICU	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	OTHER SPECIAL CARE (SPECIFY)					
Cost Center Description						
						1.00
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					68,995
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					131,137
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
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					0
52.00	Total Program excludable cost (sum of lines 50 and 51)					0
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					0
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: 15-0002 Component CCN: 15-S002		Period: From 01/01/2020 To 12/31/2020		Worksheet D-1 Date/Time Prepared: 7/23/2021 10:58 am	
		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	94,726	2,232,657	0.042427	0	0	90.00
91.00	Nursing School cost	0	2,232,657	0.000000	0	0	91.00
92.00	Allied health cost	0	2,232,657	0.000000	0	0	92.00
93.00	All other Medical Education	0	2,232,657	0.000000	0	0	93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 15-0002 Component CCN: 15-T002	Period: From 01/01/2020 To 12/31/2020	Worksheet D-1 Date/Time Prepared: 7/23/2021 10:58 am
		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)		5,409	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		5,409	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.		0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)		5,409	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)		195	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)		2,545	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)		6,040,631	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)		6,040,631	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)		6,040,631	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)		1,116.77	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		217,770	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)		217,770	41.00

COMPUTATION OF INPATIENT OPERATING COST				Provider CCN: 15-0002	Period: From 01/01/2020 To 12/31/2020	Worksheet D-1
				Component CCN: 15-T002		Date/Time Prepared: 7/23/2021 10:58 am
				Title XIX	Subprovider - IRF	Cost
Cost Center Description		Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)
		1.00	2.00	3.00	4.00	5.00
42.00	NURSERY (title V & XIX only)	0	0	0.00	0	0
Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	0	0	0.00	0	0
43.01	NEONATAL ICU	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	OTHER SPECIAL CARE (SPECIFY)					
Cost Center Description						
						1.00
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					337,918
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					555,688
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
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					0
52.00	Total Program excludable cost (sum of lines 50 and 51)					0
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					0
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: 15-0002 Component CCN: 15-T002		Period: From 01/01/2020 To 12/31/2020		Worksheet D-1 Date/Time Prepared: 7/23/2021 10:58 am	
		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	618,701	6,040,631	0.102423	0	0	90.00
91.00	Nursing School cost	0	6,040,631	0.000000	0	0	91.00
92.00	Allied health cost	0	6,040,631	0.000000	0	0	92.00
93.00	All other Medical Education	0	6,040,631	0.000000	0	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT			Provider CCN: 15-0002	Period: From 01/01/2020 To 12/31/2020	Worksheet D-3 Date/Time Prepared: 7/23/2021 10:58 am	
Cost Center Description			Title XVIII	Hospital	PPS	
			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		22,069,681		30.00
31.00	03100	INTENSIVE CARE UNIT		7,465,016		31.00
31.01	03101	NEONATAL ICU		0		31.01
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	0.113371	13,096,883	1,484,807	50.00
50.01	05001	ENDOSCOPY	0.198206	1,158,308	229,584	50.01
51.00	05100	RECOVERY ROOM	0.267309	836,111	223,500	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1.351746	19,187	25,936	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.217136	3,698,801	803,143	54.00
54.01	05401	RADIOLOGY - ULTRASOUND	0.135894	1,333,623	181,231	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	0.179252	645,346	115,680	55.00
55.01	05501	INFUSION CENTER	2.277897	0	0	55.01
56.00	05600	RADIOISOTOPE	0.225896	1,468,832	331,803	56.00
57.00	05700	CT SCAN	0.039746	15,344,738	609,892	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.059530	3,355,029	199,725	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.104107	9,316,436	969,906	59.00
60.00	06000	LABORATORY	0.115301	26,181,211	3,018,720	60.00
60.01	06001	BLOOD LABORATORY	0.000000	0	0	60.01
61.00	06100	PBP CLINICAL LAB SERVICES-PRGM ONLY	0.000000	0	0	61.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.209752	2,231,931	468,152	62.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.000000	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0.000000	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.148171	10,300,539	1,526,241	65.00
66.00	06600	PHYSICAL THERAPY	0.368888	1,552,017	572,520	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.404136	1,040,871	420,653	67.00
68.00	06800	SPEECH PATHOLOGY	0.311758	786,589	245,225	68.00
69.00	06900	ELECTROCARDIOLOGY	0.066619	4,134,769	275,454	69.00
69.01	06901	CARDIAC REHAB	0.637437	0	0	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0.081591	2,740,132	223,570	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.322118	7,540,121	2,428,809	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.537261	3,314,597	1,780,804	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.191382	30,990,253	5,930,977	73.00
74.00	07400	RENAL DIALYSIS	0.306487	3,485,511	1,068,264	74.00
OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.437486	63,606	27,827	90.00
91.00	09100	EMERGENCY	0.231505	6,374,326	1,475,688	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.547269	1,922,184	1,051,952	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		152,931,951	25,690,063	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)		152,931,951		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN:15-0002	Period: From 01/01/2020 To 12/31/2020	Worksheet D-3 Date/Time Prepared: 7/23/2021 10:58 am	
		Component CCN:15-S002			
		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
31.01	03101 NEONATAL ICU		0		31.01
40.00	04000 SUBPROVIDER - IPF		1,652,382		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	0.113371	0	0	50.00
50.01	05001 ENDOSCOPY	0.198206	0	0	50.01
51.00	05100 RECOVERY ROOM	0.267309	0	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	1.351746	0	0	52.00
53.00	05300 ANESTHESIOLOGY	0.000000	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.217136	6,748	1,465	54.00
54.01	05401 RADIOLOGY - ULTRASOUND	0.135894	5,513	749	54.01
55.00	05500 RADIOLOGY-THERAPEUTIC	0.179252	0	0	55.00
55.01	05501 INFUSION CENTER	2.277897	0	0	55.01
56.00	05600 RADIOISOTOPE	0.225896	5,843	1,320	56.00
57.00	05700 CT SCAN	0.039746	36,118	1,436	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0.059530	0	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	0.104107	12,745	1,327	59.00
60.00	06000 LABORATORY	0.115301	175,235	20,205	60.00
60.01	06001 BLOOD LABORATORY	0.000000	0	0	60.01
61.00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY	0.000000	0	0	61.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0.209752	10,682	2,241	62.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0.000000	0	0	63.00
64.00	06400 INTRAVENOUS THERAPY	0.000000	0	0	64.00
65.00	06500 RESPIRATORY THERAPY	0.148171	4,315	639	65.00
66.00	06600 PHYSICAL THERAPY	0.368888	3,442	1,270	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.404136	660	267	67.00
68.00	06800 SPEECH PATHOLOGY	0.311758	0	0	68.00
69.00	06900 ELECTROCARDIOLOGY	0.066619	21,916	1,460	69.00
69.01	06901 CARDIAC REHAB	0.637437	0	0	69.01
70.00	07000 ELECTROENCEPHALOGRAPHY	0.081591	0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.322118	2,379	766	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.537261	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.191382	464,965	88,986	73.00
74.00	07400 RENAL DIALYSIS	0.306487	124,434	38,137	74.00
OUTPATIENT SERVICE COST CENTERS					
90.00	09000 CLINIC	0.437486	0	0	90.00
91.00	09100 EMERGENCY	0.231505	27,650	6,401	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.547269	0	0	92.00
200.00	Total (sum of lines 50 through 94 and 96 through 98)		902,645	166,669	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)		902,645		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 15-0002	Period: From 01/01/2020 To 12/31/2020	Worksheet D-3 Date/Time Prepared: 7/23/2021 10:58 am	
		Component CCN: 15-T002			
		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
31.01	03101 NEONATAL ICU		0		31.01
40.00	04000 SUBPROVIDER - IPF		0		40.00
41.00	04100 SUBPROVIDER - IRF		2,634,763		41.00
43.00	04300 NURSERY				43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.113371	217,418	24,649	50.00
50.01	05001 ENDOSCOPY	0.198206	18,194	3,606	50.01
51.00	05100 RECOVERY ROOM	0.267309	9,930	2,654	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	1.351746	0	0	52.00
53.00	05300 ANESTHESIOLOGY	0.000000	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.217136	77,511	16,830	54.00
54.01	05401 RADIOLOGY - ULTRASOUND	0.135894	11,010	1,496	54.01
55.00	05500 RADIOLOGY-THERAPEUTIC	0.179252	131,892	23,642	55.00
55.01	05501 INFUSION CENTER	2.277897	0	0	55.01
56.00	05600 RADIOISOTOPE	0.225896	11,983	2,707	56.00
57.00	05700 CT SCAN	0.039746	128,397	5,103	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0.059530	69,661	4,147	58.00
59.00	05900 CARDIAC CATHETERIZATION	0.104107	35,044	3,648	59.00
60.00	06000 LABORATORY	0.115301	739,931	85,315	60.00
60.01	06001 BLOOD LABORATORY	0.000000	0	0	60.01
61.00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY	0.000000	0	0	61.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0.209752	27,409	5,749	62.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0.000000	0	0	63.00
64.00	06400 INTRAVENOUS THERAPY	0.000000	0	0	64.00
65.00	06500 RESPIRATORY THERAPY	0.148171	262,024	38,824	65.00
66.00	06600 PHYSICAL THERAPY	0.368888	1,325,831	489,083	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.404136	1,143,885	462,285	67.00
68.00	06800 SPEECH PATHOLOGY	0.311758	120,199	37,473	68.00
69.00	06900 ELECTROCARDIOLOGY	0.066619	27,243	1,815	69.00
69.01	06901 CARDIAC REHAB	0.637437	0	0	69.01
70.00	07000 ELECTROENCEPHALOGRAPHY	0.081591	10,415	850	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.322118	96,241	31,001	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.537261	26,030	13,985	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.191382	1,786,137	341,834	73.00
74.00	07400 RENAL DIALYSIS	0.306487	206,721	63,357	74.00
OUTPATIENT SERVICE COST CENTERS					
90.00	09000 CLINIC	0.437486	0	0	90.00
91.00	09100 EMERGENCY	0.231505	1,816	420	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.547269	0	0	92.00
200.00	Total (sum of lines 50 through 94 and 96 through 98)		6,484,922	1,660,473	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)		6,484,922		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT			Provider CCN: 15-0002	Period: From 01/01/2020 To 12/31/2020	Worksheet D-3 Date/Time Prepared: 7/23/2021 10:58 am
Cost Center Description			Title XIX	Hospital	Cost
			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		2,829,950	30.00
31.00	03100	INTENSIVE CARE UNIT		785,317	31.00
31.01	03101	NEONATAL ICU		990,981	31.01
40.00	04000	SUBPROVIDER - IPF		120,404	40.00
41.00	04100	SUBPROVIDER - IRF		132,526	41.00
43.00	04300	NURSERY		305,415	43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0.113371	3,106,300	352,164 50.00
50.01	05001	ENDOSCOPY	0.198206	103,508	20,516 50.01
51.00	05100	RECOVERY ROOM	0.267309	141,746	37,890 51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1.351746	370,920	501,390 52.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0 53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.217136	360,923	78,369 54.00
54.01	05401	RADIOLOGY - ULTRASOUND	0.135894	198,690	27,001 54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	0.179252	28,165	5,049 55.00
55.01	05501	INFUSION CENTER	2.277897	0	0 55.01
56.00	05600	RADIOISOTOPE	0.225896	155,535	35,135 56.00
57.00	05700	CT SCAN	0.039746	1,727,354	68,655 57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.059530	399,146	23,761 58.00
59.00	05900	CARDIAC CATHETERIZATION	0.104107	1,596,720	166,230 59.00
60.00	06000	LABORATORY	0.115301	3,709,607	427,721 60.00
60.01	06001	BLOOD LABORATORY	0.000000	0	0 60.01
61.00	06100	PBP CLINICAL LAB SERVICES-PRGM ONLY	0.000000	0	0 61.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.209752	56,293	11,808 62.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.000000	0	0 63.00
64.00	06400	INTRAVENOUS THERAPY	0.000000	0	0 64.00
65.00	06500	RESPIRATORY THERAPY	0.148171	1,413,985	209,512 65.00
66.00	06600	PHYSICAL THERAPY	0.368888	178,286	65,768 66.00
67.00	06700	OCCUPATIONAL THERAPY	0.404136	137,995	55,769 67.00
68.00	06800	SPEECH PATHOLOGY	0.311758	59,729	18,621 68.00
69.00	06900	ELECTROCARDIOLOGY	0.066619	429,181	28,592 69.00
69.01	06901	CARDIAC REHAB	0.637437	5,498	3,505 69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0.081591	192,635	15,717 70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.322118	0	0 71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.537261	0	0 72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.191382	3,935,154	753,118 73.00
74.00	07400	RENAL DIALYSIS	0.306487	269,971	82,743 74.00
OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	0.437486	15,265	6,678 90.00
91.00	09100	EMERGENCY	0.231505	926,847	214,570 91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.547269	0	0 92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		19,519,453	3,210,282 200.00
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)		19,519,453	202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN:15-0002	Period: From 01/01/2020 To 12/31/2020	Worksheet D-3 Date/Time Prepared: 7/23/2021 10:58 am	
		Component CCN:15-S002			
		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
31.01	03101 NEONATAL ICU		0		31.01
40.00	04000 SUBPROVIDER - IPF		1,083,510		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	0.113371	0	0	50.00
50.01	05001 ENDOSCOPY	0.198206	0	0	50.01
51.00	05100 RECOVERY ROOM	0.267309	0	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	1.351746	0	0	52.00
53.00	05300 ANESTHESIOLOGY	0.000000	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.217136	5,077	1,102	54.00
54.01	05401 RADIOLOGY - ULTRASOUND	0.135894	5,992	814	54.01
55.00	05500 RADIOLOGY-THERAPEUTIC	0.179252	0	0	55.00
55.01	05501 INFUSION CENTER	2.277897	0	0	55.01
56.00	05600 RADIOISOTOPE	0.225896	0	0	56.00
57.00	05700 CT SCAN	0.039746	11,412	454	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0.059530	10,184	606	58.00
59.00	05900 CARDIAC CATHETERIZATION	0.104107	0	0	59.00
60.00	06000 LABORATORY	0.115301	119,343	13,760	60.00
60.01	06001 BLOOD LABORATORY	0.000000	0	0	60.01
61.00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY	0.000000	0	0	61.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0.209752	14,245	2,988	62.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0.000000	0	0	63.00
64.00	06400 INTRAVENOUS THERAPY	0.000000	0	0	64.00
65.00	06500 RESPIRATORY THERAPY	0.148171	0	0	65.00
66.00	06600 PHYSICAL THERAPY	0.368888	2,014	743	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.404136	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0.311758	0	0	68.00
69.00	06900 ELECTROCARDIOLOGY	0.066619	12,082	805	69.00
69.01	06901 CARDIAC REHAB	0.637437	0	0	69.01
70.00	07000 ELECTROENCEPHALOGRAPHY	0.081591	0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.322118	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.537261	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.191382	223,471	42,768	73.00
74.00	07400 RENAL DIALYSIS	0.306487	0	0	74.00
OUTPATIENT SERVICE COST CENTERS					
90.00	09000 CLINIC	0.437486	0	0	90.00
91.00	09100 EMERGENCY	0.231505	20,942	4,848	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.547269	196	107	92.00
200.00	Total (sum of lines 50 through 94 and 96 through 98)		424,958	68,995	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)		424,958		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 15-0002	Period: From 01/01/2020 To 12/31/2020	Worksheet D-3 Date/Time Prepared: 7/23/2021 10:58 am	
		Component CCN: 15-T002			
		Title XIX	Subprovider - IRF	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
31.01	03101 NEONATAL ICU		0		31.01
40.00	04000 SUBPROVIDER - IPF		0		40.00
41.00	04100 SUBPROVIDER - IRF		558,502		41.00
43.00	04300 NURSERY		0		43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.113371	0	0	50.00
50.01	05001 ENDOSCOPY	0.198206	1,647	326	50.01
51.00	05100 RECOVERY ROOM	0.267309	0	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	1.351746	0	0	52.00
53.00	05300 ANESTHESIOLOGY	0.000000	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.217136	10,725	2,329	54.00
54.01	05401 RADIOLOGY - ULTRASOUND	0.135894	3,633	494	54.01
55.00	05500 RADIOLOGY-THERAPEUTIC	0.179252	0	0	55.00
55.01	05501 INFUSION CENTER	2.277897	0	0	55.01
56.00	05600 RADIOISOTOPE	0.225896	1,995	451	56.00
57.00	05700 CT SCAN	0.039746	36,781	1,462	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0.059530	19,122	1,138	58.00
59.00	05900 CARDIAC CATHETERIZATION	0.104107	0	0	59.00
60.00	06000 LABORATORY	0.115301	125,351	14,453	60.00
60.01	06001 BLOOD LABORATORY	0.000000	0	0	60.01
61.00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY	0.000000	0	0	61.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0.209752	5,327	1,117	62.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0.000000	0	0	63.00
64.00	06400 INTRAVENOUS THERAPY	0.000000	0	0	64.00
65.00	06500 RESPIRATORY THERAPY	0.148171	38,507	5,706	65.00
66.00	06600 PHYSICAL THERAPY	0.368888	287,353	106,001	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.404136	239,282	96,702	67.00
68.00	06800 SPEECH PATHOLOGY	0.311758	48,225	15,035	68.00
69.00	06900 ELECTROCARDIOLOGY	0.066619	6,639	442	69.00
69.01	06901 CARDIAC REHAB	0.637437	0	0	69.01
70.00	07000 ELECTROENCEPHALOGRAPHY	0.081591	4,161	340	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.322118	9,838	3,169	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.537261	1,791	962	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.191382	377,138	72,177	73.00
74.00	07400 RENAL DIALYSIS	0.306487	36,620	11,224	74.00
OUTPATIENT SERVICE COST CENTERS					
90.00	09000 CLINIC	0.437486	52	23	90.00
91.00	09100 EMERGENCY	0.231505	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.547269	7,979	4,367	92.00
200.00	Total (sum of lines 50 through 94 and 96 through 98)		1,262,166	337,918	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)		1,262,166		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 15-0002	Period: From 01/01/2020 To 12/31/2020	Worksheet E Part A Date/Time Prepared: 7/23/2021 10:58 am
		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)		24,501,826	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1 (see instructions)		9,999,138	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)		714,298	2.03
2.04	Outlier payments for discharges occurring on or after October 1 (see instructions)		292,537	2.04
3.00	Managed Care Simulated Payments		24,468,631	3.00
4.00	Bed days available divided by number of days in the cost reporting period (see instructions)		404.14	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)		8.53	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)		8.53	9.00
10.00	FTE count for allopathic and osteopathic programs in the current year from your records		3.00	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)		3.00	12.00
13.00	Total allowable FTE count for the prior year.		3.00	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.		3.00	14.00
15.00	Sum of lines 12 through 14 divided by 3.		3.00	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		3.00	18.00
19.00	Current year resident to bed ratio (line 18 divided by line 4).		0.007423	19.00
20.00	Prior year resident to bed ratio (see instructions)		0.007026	20.00
21.00	Enter the lesser of lines 19 or 20 (see instructions)		0.007026	21.00
22.00	IME payment adjustment (see instructions)		132,277	22.00
22.01	IME payment adjustment - Managed Care (see instructions)		93,813	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)		-5.53	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)		132,277	29.00
29.01	Total IME payment - Managed Care (sum of lines 22.01 and 28.01)		93,813	29.01
Disproportionate Share Adjustment				
30.00	Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)		8.39	30.00
31.00	Percentage of Medicaid patient days (see instructions)		33.07	31.00
32.00	Sum of lines 30 and 31		41.46	32.00
33.00	Allowable disproportionate share percentage (see instructions)		23.42	33.00
34.00	Disproportionate share adjustment (see instructions)		2,020,032	34.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 15-0002	Period: From 01/01/2020 To 12/31/2020	Worksheet E Part A Date/Time Prepared: 7/23/2021 10:58 am
		Title XVIII	Hospital	PPS
			Prior to 10/1	On/After 10/1
			1.00	2.00
Uncompensated Care Adjustment				
35.00	Total uncompensated care amount (see instructions)		0	0
35.01	Factor 3 (see instructions)	0.000000000	0.000000000	
35.02	Hospital uncompensated care payment (If line 34 is zero, enter zero on this line) (see instructions)	4,631,104	3,595,654	
35.03	Pro rata share of the hospital uncompensated care payment amount (see instructions)	3,467,002	906,303	
36.00	Total uncompensated care (sum of columns 1 and 2 on line 35.03)	4,373,305		
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	
41.00	Total ESRD Medicare discharges excluding MS-DRGs 652, 682, 683, 684 and 685. (see instructions)		0	
41.01	Total ESRD Medicare covered and paid discharges excluding MS-DRGs 652, 682, 683, 684 and 685. (see instructions)		0	
42.00	Divide line 41 by line 40 (if less than 10%, you do not qualify for adjustment)	0.00		
43.00	Total Medicare ESRD inpatient days excluding MS-DRGs 652, 682, 683, 684 and 685. (see instructions)		0	
44.00	Ratio of average length of stay to one week (line 43 divided by line 41 divided by 7 days)	0.000000		
45.00	Average weekly cost for dialysis treatments (see instructions)	0.00		
46.00	Total additional payment (line 45 times line 44 times line 41.01)		0	
47.00	Subtotal (see instructions)	42,033,413		
48.00	Hospital specific payments (to be completed by SCH and MDH, small rural hospitals only. (see instructions)		0	
			Amount	
			1.00	
49.00	Total payment for inpatient operating costs (see instructions)		42,127,226	
50.00	Payment for inpatient program capital (from Wkst. L, Pt. I and Pt. II, as applicable)		2,957,254	
51.00	Exception payment for inpatient program capital (Wkst. L, Pt. III, see instructions)		0	
52.00	Direct graduate medical education payment (from Wkst. E-4, line 49 see instructions).		84,173	
53.00	Nursing and Allied Health Managed Care payment		58,596	
54.00	Special add-on payments for new technologies		120,148	
54.01	Islet isolation add-on payment		0	
55.00	Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line 69)		0	
56.00	Cost of physicians' services in a teaching hospital (see instructions)		0	
57.00	Routine service other pass through costs (from Wkst. D, Pt. III, column 9, lines 30 through 35).		0	
58.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 11 line 200)		82,388	
59.00	Total (sum of amounts on lines 49 through 58)		45,429,785	
60.00	Primary payer payments		14,216	
61.00	Total amount payable for program beneficiaries (line 59 minus line 60)		45,415,569	
62.00	Deductibles billed to program beneficiaries		3,028,432	
63.00	Coinurance billed to program beneficiaries		350,867	
64.00	Allowable bad debts (see instructions)		1,159,574	
65.00	Adjusted reimbursable bad debts (see instructions)		753,723	
66.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		153,233	
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)		42,789,993	
68.00	Credits received from manufacturers for replaced devices for applicable to MS-DRGs (see instructions)		0	
69.00	Outlier payments reconciliation (sum of lines 93, 95 and 96). (For SCH see instructions)		0	
70.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	
70.50	Rural Community Hospital Demonstration Project (§410A Demonstration) adjustment (see instructions)		0	
70.87	Demonstration payment adjustment amount before sequestration		0	
70.88	SCH or MDH volume decrease adjustment (contractor use only)		0	
70.89	Pioneer ACO demonstration payment adjustment amount (see instructions)		0	
70.90	HSP bonus payment HVBP adjustment amount (see instructions)		0	
70.91	HSP bonus payment HRR adjustment amount (see instructions)		0	
70.92	Bundled Model 1 discount amount (see instructions)		0	
70.93	HVBP payment adjustment amount (see instructions)		-116,882	
70.94	HRR adjustment amount (see instructions)		-471,273	
70.95	Recovery of accelerated depreciation		0	

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 15-0002	Period: From 01/01/2020 To 12/31/2020	Worksheet E Part A Date/Time Prepared: 7/23/2021 10:58 am	
		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)		42,201,838	71.00	
71.01	Sequestration adjustment (see instructions)		278,532	71.01	
71.02	Demonstration payment adjustment amount after sequestration		0	71.02	
71.03	Sequestration adjustment-PARHM pass-throughs			71.03	
72.00	Interim payments		39,977,347	72.00	
72.01	Interim payments-PARHM			72.01	
73.00	Tentative settlement (for contractor use only)		0	73.00	
73.01	Tentative settlement-PARHM (for contractor use only)			73.01	
74.00	Balance due provider/program (line 71 minus lines 71.01, 71.02, 72, and 73)		1,945,959	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		1,209,886	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: 15-0002

Period:
From 01/01/2020
To 12/31/2020Worksheet E
Part A Exhibit 4
Date/Time Prepared:
7/23/2021 10:58 am

		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	24,501,826	0	24,501,826		24,501,826
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	9,999,138	0		9,999,138	9,999,138
1.03	DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October 1	1.03	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
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	714,298	0	714,298		714,298
2.03	Outlier payments for discharges occurring on or after October 1 (see instructions)	2.04	292,537	0		292,537	292,537
3.00	Operating outlier reconciliation	2.01	0	0	0	0	0
4.00	Managed care simulated payments	3.00	24,468,631	0	17,676,495	6,792,136	24,468,631
Indirect Medical Education Adjustment							
5.00	Amount from Worksheet E, Part A, line 21 (see instructions)	21.00	0.007026	0.007026	0.007026	0.007026	
6.00	IME payment adjustment (see instructions)	22.00	132,277	0	93,940	38,337	132,277
6.01	IME payment adjustment for managed care (see instructions)	22.01	93,813	0	67,772	26,041	93,813
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	
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	132,277	0	93,940	38,337	132,277
9.01	Total IME payment for managed care (sum of lines 6.01 and 8.01)	29.01	93,813	0	67,772	26,041	93,813
Disproportionate Share Adjustment							
10.00	Allowable disproportionate share percentage (see instructions)	33.00	0.2342	0.2342	0.2342	0.2342	
11.00	Disproportionate share adjustment (see instructions)	34.00	2,020,032	0	1,434,582	585,450	2,020,032
11.01	Uncompensated care payments	36.00	4,373,305	0	3,467,002	906,303	4,373,305
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	42,033,413	0	30,211,648	11,821,765	42,033,413
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	42,127,226	0	30,279,420	11,847,806	42,127,226

LOW VOLUME CALCULATION EXHIBIT 4

Provider CCN: 15-0002

Period:
From 01/01/2020
To 12/31/2020Worksheet E
Part A Exhibit 4
Date/Time Prepared:
7/23/2021 10:58 am

		Title XVIII		Hospital		PPS	
		W/S E, Part A line	Amounts (from E, Part A)	Pre/Post Entitlement	Period Prior to 10/01	Period On/After 10/01	Total (Col 2 through 4)
		0	1.00	2.00	3.00	4.00	5.00
16.00	Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable)	50.00	2,957,254	0	2,127,632	829,622	2,957,254
17.00	Special add-on payments for new technologies	54.00	120,148	0	0	120,148	120,148
17.01	Net organ aquisition cost						
17.02	Credits received from manufacturers for replaced devices for applicable MS-DRGs	68.00	0	0	0	0	0
18.00	Capital outlier reconciliation adjustment amount (see instructions)	93.00	0	0	0	0	0
19.00	SUBTOTAL			0	32,407,052	12,797,576	45,204,628
		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	2,660,433	0	1,914,575	745,858	2,660,433
20.01	Model 4 BPCI Capital DRG other than outlier	1.01	0	0	0	0	0
21.00	Capital DRG outlier payments	2.00	52,859	0	37,490	15,369	52,859
21.01	Model 4 BPCI Capital DRG outlier payments	2.01	0	0	0	0	0
22.00	Indirect medical education percentage (see instructions)	5.00	0.0041	0.0041	0.0041	0.0041	
23.00	Indirect medical education adjustment (see instructions)	6.00	10,908	0	7,850	3,058	10,908
24.00	Allowable disproportionate share percentage (see instructions)	10.00	0.0876	0.0876	0.0876	0.0876	
25.00	Disproportionate share adjustment (see instructions)	11.00	233,054	0	167,717	65,337	233,054
26.00	Total prospective capital payments (see instructions)	12.00	2,957,254	0	2,127,632	829,622	2,957,254
		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	
28.00	Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)	70.96			0		0
29.00	Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)	70.97				0	0
100.00	Transfer low volume adjustments to Wkst. E, Pt. A.		Y				

HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULATION EXHIBIT 5

Provider CCN: 15-0002

Period:
From 01/01/2020
To 12/31/2020Worksheet E
Part A Exhibit 5
Date/Time Prepared:
7/23/2021 10:58 am

		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	24,501,826	24,501,826		24,501,826	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	9,999,138		9,999,138	9,999,138	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	714,298	714,298		714,298	2.02
2.03	Outlier payments for discharges occurring on or after October 1 (see instructions)	2.04	292,537		292,537	292,537	2.03
3.00	Operating outlier reconciliation	2.01	0	0	0	0	3.00
4.00	Managed care simulated payments	3.00	24,468,631	17,676,495	6,792,136	24,468,631	4.00
Indirect Medical Education Adjustment							
5.00	Amount from Worksheet E, Part A, line 21 (see instructions)	21.00	0.007026	0.007026	0.007026		5.00
6.00	IME payment adjustment (see instructions)	22.00	132,277	93,940	38,337	132,277	6.00
6.01	IME payment adjustment for managed care (see instructions)	22.01	93,813	67,772	26,041	93,813	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	132,277	93,940	38,337	132,277	9.00
9.01	Total IME payment for managed care (sum of lines 6.01 and 8.01)	29.01	93,813	67,772	26,041	93,813	9.01
Disproportionate Share Adjustment							
10.00	Allowable disproportionate share percentage (see instructions)	33.00	0.2342	0.2342	0.2342		10.00
11.00	Disproportionate share adjustment (see instructions)	34.00	2,020,032	1,434,582	585,450	2,020,032	11.00
11.01	Uncompensated care payments	36.00	4,373,305	3,467,002	906,303	4,373,305	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	42,033,413	30,211,648	11,821,765	42,033,413	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	42,127,226	30,279,420	11,847,806	42,127,226	15.00
16.00	Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable)	50.00	2,957,254	2,127,632	829,622	2,957,254	16.00
17.00	Special add-on payments for new technologies	54.00	120,148	0	120,148	120,148	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			32,407,052	12,797,576	45,204,628	19.00

HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULATION EXHIBIT 5

Provider CCN: 15-0002

Period:
From 01/01/2020
To 12/31/2020Worksheet E
Part A Exhibit 5
Date/Time Prepared:
7/23/2021 10:58 am

		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	2,660,433	1,914,575	745,858	2,660,433	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	52,859	37,490	15,369	52,859	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	0.0041	0.0041	0.0041		22.00
23.00	Indirect medical education adjustment (see instructions)	6.00	10,908	7,850	3,058	10,908	23.00
24.00	Allowable disproportionate share percentage (see instructions)	10.00	0.0876	0.0876	0.0876		24.00
25.00	Disproportionate share adjustment (see instructions)	11.00	233,054	167,717	65,337	233,054	25.00
26.00	Total prospective capital payments (see instructions)	12.00	2,957,254	2,127,632	829,622	2,957,254	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	-116,882	-99,516	-17,366	-116,882	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	-471,273	-335,674	-135,599	-471,273	31.00
31.01	HRR adjustment for HSP bonus payment (see instructions)	70.91	0	0	0	0	31.01
						(Amt. to Wkst. E, Pt. A)	
		0	1.00	2.00	3.00	4.00	
32.00	HAC Reduction Program adjustment (see instructions)	70.99		0	0	0	32.00
100.00	Transfer HAC Reduction Program adjustment to Wkst. E, Pt. A.		N				100.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 15-0002	Period: From 01/01/2020 To 12/31/2020	Worksheet E Part B Date/Time Prepared: 7/23/2021 10:58 am
		Title XVIII	Hospital	PPS
				1.00
PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)		11,870	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)		19,821,126	2.00
3.00	OPPS payments		16,604,970	3.00
4.00	Outlier payment (see instructions)		212,327	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		80,423	9.00
10.00	Organ acquisitions		0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)		11,870	11.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
12.00	Ancillary service charges		72,929	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)		72,929	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)		72,929	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)		61,059	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)		11,870	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)		16,897,720	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)		2,531,379	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)		14,378,211	27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 50)		30,063	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)		14,408,274	30.00
31.00	Primary payer payments		9,136	31.00
32.00	Subtotal (line 30 minus line 31)		14,399,138	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)		879,255	34.00
35.00	Adjusted reimbursable bad debts (see instructions)		571,516	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		368,231	36.00
37.00	Subtotal (see instructions)		14,970,654	37.00
38.00	MSP-LCC reconciliation amount from PS&R		139	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)		14,970,515	40.00
40.01	Sequestration adjustment (see instructions)		98,805	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		14,899,670	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)		-27,960	43.00
43.01	Balance due provider/program-PARHM (see instructions)		0	43.01
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		0	44.00
TO BE COMPLETED BY CONTRACTOR				
90.00	Original outlier amount (see instructions)		0	90.00
91.00	Outlier reconciliation adjustment amount (see instructions)		0	91.00
92.00	The rate used to calculate the Time Value of Money		0.00	92.00
93.00	Time Value of Money (see instructions)		0	93.00
94.00	Total (sum of lines 91 and 93)		0	94.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 15-0002	Period: From 01/01/2020 To 12/31/2020	Worksheet E Part B Date/Time Prepared: 7/23/2021 10:58 am
		Component CCN: 15-S002		
		Title XVIII	Subprovider - IPF	PPS
				1.00
PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)		0	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)		436	2.00
3.00	OPPS payments		446	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)		0	11.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
12.00	Ancillary service charges		0	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)		0	14.00
Customary charges				
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis		0	15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)		0	16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)		0.000000	17.00
18.00	Total customary charges (see instructions)		0	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)		0	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)		0	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)		446	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)		89	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)		357	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)		357	30.00
31.00	Primary payer payments		0	31.00
32.00	Subtotal (line 30 minus line 31)		357	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)		357	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)		357	40.00
40.01	Sequestration adjustment (see instructions)		2	40.01
40.02	Demonstration payment adjustment amount after sequestration		0	40.02
40.03	Sequestration adjustment-PARHM pass-throughs		40.03	
41.00	Interim payments		357	41.00
41.01	Interim payments-PARHM		41.01	
42.00	Tentative settlement (for contractors use only)		0	42.00
42.01	Tentative settlement-PARHM (for contractor use only)		42.01	
43.00	Balance due provider/program (see instructions)		-2	43.00
43.01	Balance due provider/program-PARHM (see instructions)		43.01	
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		0	44.00
TO BE COMPLETED BY CONTRACTOR				
90.00	Original outlier amount (see instructions)		0	90.00
91.00	Outlier reconciliation adjustment amount (see instructions)		0	91.00
92.00	The rate used to calculate the Time Value of Money		0.00	92.00
93.00	Time Value of Money (see instructions)		0	93.00
94.00	Total (sum of lines 91 and 93)		0	94.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 15-0002

Period:
From 01/01/2020
To 12/31/2020Worksheet E-1
Part I
Date/Time Prepared:
7/23/2021 10:58 am

		Title XVIII		Hospital		PPS
		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		39,244,241		14,192,943	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
Program to Provider						
3.01	ADJUSTMENTS TO PROVIDER	12/31/2020	733,106	12/31/2020	706,727	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)		733,106		706,727	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)		39,977,347		14,899,670	4.00
TO BE COMPLETED BY CONTRACTOR						
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
Program to Provider						
5.01	TENTATIVE TO PROVIDER		0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
Provider to Program						
5.50	TENTATIVE TO PROGRAM		0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		1,945,959		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		27,960	6.02
7.00	Total Medicare program liability (see instructions)		41,923,306		14,871,710	7.00
				Contractor Number	NPR Date (Mo/Day/Yr)	
		0		1.00	2.00	
8.00	Name of Contractor					8.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 15-0002

Period:

Worksheet E-1

Component CCN: 15-S002

From 01/01/2020
To 12/31/2020Part I
Date/Time Prepared:
7/23/2021 10:58 am

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		673,897		357	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
Program to Provider						
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
Provider to Program						
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		673,897		357	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		378		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		2	6.02
7.00	Total Medicare program liability (see instructions)		674,275		355	7.00
				Contractor Number	NPR Date (Mo/Day/Yr)	
		0		1.00	2.00	
8.00	Name of Contractor					8.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED		Provider CCN: 15-0002 Component CCN: 15-T002		Period: From 01/01/2020 To 12/31/2020		Worksheet E-1 Part I Date/Time Prepared: 7/23/2021 10:58 am	
		Title XVIII		Subprovider - IRF		PPS	
		Inpatient Part A		Part B			
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount		
		1.00	2.00	3.00	4.00		
1.00	Total interim payments paid to provider					0	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		4,385,425			0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)						3.00
Program to Provider							
3.01	ADJUSTMENTS TO PROVIDER		0			0	3.01
3.02			0			0	3.02
3.03			0			0	3.03
3.04			0			0	3.04
3.05			0			0	3.05
Provider to Program							
3.50	ADJUSTMENTS TO PROGRAM		0			0	3.50
3.51			0			0	3.51
3.52			0			0	3.52
3.53			0			0	3.53
3.54			0			0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0			0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		4,385,425			0	4.00
TO BE COMPLETED BY CONTRACTOR							
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)						5.00
Program to Provider							
5.01	TENTATIVE TO PROVIDER		0			0	5.01
5.02			0			0	5.02
5.03			0			0	5.03
Provider to Program							
5.50	TENTATIVE TO PROGRAM		0			0	5.50
5.51			0			0	5.51
5.52			0			0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0			0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)						6.00
6.01	SETTLEMENT TO PROVIDER		70,804			0	6.01
6.02	SETTLEMENT TO PROGRAM		0			0	6.02
7.00	Total Medicare program liability (see instructions)		4,456,229			0	7.00
		0		Contractor Number	NPR Date (Mo/Day/Yr)		
				1.00	2.00		
8.00	Name of Contractor					8.00	

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT		Provider CCN: 15-0002	Period: From 01/01/2020 To 12/31/2020	Worksheet E-1 Part II Date/Time Prepared: 7/23/2021 10:58 am
		Title XVIII	Hospital	PPS
				1.00
TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS				
HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION				
1.00	Total hospital discharges as defined in AARA §4102 from Wkst. S-3, Pt. I col. 15 line 14			1.00
2.00	Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, 8-12			2.00
3.00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2			3.00
4.00	Total inpatient days from S-3, Pt. I col. 8 sum of lines 1, 8-12			4.00
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200			5.00
6.00	Total hospital charity care charges from Wkst. S-10, col. 3 line 20			6.00
7.00	CAH only - The reasonable cost incurred for the purchase of certified HIT technology Wkst. S-2, Pt. I line 168			7.00
8.00	Calculation of the HIT incentive payment (see instructions)			8.00
9.00	Sequestration adjustment amount (see instructions)			9.00
10.00	Calculation of the HIT incentive payment after sequestration (see instructions)			10.00
INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH				
30.00	Initial/interim HIT payment adjustment (see instructions)			30.00
31.00	Other Adjustment (specify)			31.00
32.00	Balance due provider (line 8 (or line 10) minus line 30 and line 31) (see instructions)			32.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 15-0002	Period: From 01/01/2020 To 12/31/2020	Worksheet E-3 Part II Date/Time Prepared: 7/23/2021 10:58 am
		Component CCN: 15-S002		
		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)		823,503	1.00
2.00	Net IPF PPS Outlier Payments		41,059	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)		6.871585	9.00
10.00	Teaching Adjustment Factor $\{(1 + (\text{line 8}/\text{line 9})) \text{ raised to the power of } .5150 - 1\}$.		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)		864,562	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)		864,562	16.00
17.00	Primary payer payments		0	17.00
18.00	Subtotal (line 16 less line 17).		864,562	18.00
19.00	Deductibles		32,340	19.00
20.00	Subtotal (line 18 minus line 19)		832,222	20.00
21.00	Coinsurance		153,824	21.00
22.00	Subtotal (line 20 minus line 21)		678,398	22.00
23.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)		0	23.00
24.00	Adjusted reimbursable bad debts (see instructions)		0	24.00
25.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		0	25.00
26.00	Subtotal (sum of lines 22 and 24)		678,398	26.00
27.00	Direct graduate medical education payments (see instructions)		0	27.00
28.00	Other pass through costs (see instructions)		357	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)		678,755	31.00
31.01	Sequestration adjustment (see instructions)		4,480	31.01
31.02	Demonstration payment adjustment amount after sequestration		0	31.02
32.00	Interim payments		673,897	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)		378	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		41,059	50.00
51.00	Outlier reconciliation adjustment amount (see instructions)		0	51.00
52.00	The rate used to calculate the Time Value of Money		0.00	52.00
53.00	Time Value of Money (see instructions)		0	53.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 15-0002	Period: From 01/01/2020 To 12/31/2020	Worksheet E-3 Part III Date/Time Prepared: 7/23/2021 10:58 am
		Component CCN: 15-T002		
		Title XVIII	Subprovider - IRF	PPS
				1.00
PART III - MEDICARE PART A SERVICES - IRF PPS				
1.00	Net Federal PPS Payment (see instructions)		3,988,740	1.00
2.00	Medicare SSI ratio (IRF PPS only) (see instructions)		0.0822	2.00
3.00	Inpatient Rehabilitation LIP Payments (see instructions)		311,521	3.00
4.00	Outlier Payments		221,808	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)		14.778689	10.00
11.00	Teaching Adjustment Factor (see instructions)		0.000000	11.00
12.00	Teaching Adjustment (see instructions)		0	12.00
13.00	Total PPS Payment (see instructions)		4,522,069	13.00
14.00	Nursing and Allied Health Managed Care payments (see instruction)		0	14.00
15.00	Organ acquisition (DO NOT USE THIS LINE)		0	15.00
16.00	Cost of physicians' services in a teaching hospital (see instructions)		0	16.00
17.00	Subtotal (see instructions)		4,522,069	17.00
18.00	Primary payer payments		0	18.00
19.00	Subtotal (line 17 less line 18).		4,522,069	19.00
20.00	Deductibles		14,080	20.00
21.00	Subtotal (line 19 minus line 20)		4,507,989	21.00
22.00	Coinsurance		22,176	22.00
23.00	Subtotal (line 21 minus line 22)		4,485,813	23.00
24.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)		0	24.00
25.00	Adjusted reimbursable bad debts (see instructions)		0	25.00
26.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		0	26.00
27.00	Subtotal (sum of lines 23 and 25)		4,485,813	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)		23	29.00
30.00	Outlier payments reconciliation		0	30.00
31.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	31.00
31.50	Pioneer ACO demonstration payment adjustment (see instructions)		0	31.50
31.99	Demonstration payment adjustment amount before sequestration		0	31.99
32.00	Total amount payable to the provider (see instructions)		4,485,836	32.00
32.01	Sequestration adjustment (see instructions)		29,607	32.01
32.02	Demonstration payment adjustment amount after sequestration		0	32.02
33.00	Interim payments		4,385,425	33.00
34.00	Tentative settlement (for contractor use only)		0	34.00
35.00	Balance due provider/program (line 32 minus lines 32.01, 32.02, 33, and 34)		70,804	35.00
36.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		0	36.00
TO BE COMPLETED BY CONTRACTOR				
50.00	Original outlier amount from Wkst. E-3, Pt. III, line 4		221,808	50.00
51.00	Outlier reconciliation adjustment amount (see instructions)		0	51.00
52.00	The rate used to calculate the Time Value of Money		0.00	52.00
53.00	Time Value of Money (see instructions)		0	53.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 15-0002	Period: From 01/01/2020 To 12/31/2020	Worksheet E-3 Part VII Date/Time Prepared: 7/23/2021 10:58 am	
		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	7,140,052		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)	7,140,052	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)	7,140,052	0	7.00	
COMPUTATION OF LESSER OF COST OR CHARGES					
Reasonable Charges					
8.00	Routine service charges	5,164,593		8.00	
9.00	Ancillary service charges	19,519,453	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)	24,684,046	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)	24,684,046	0	16.00	
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)	17,543,994	0	17.00	
18.00	Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 16) (see instructions)	0	0	18.00	
19.00	Interns and Residents (see instructions)	0	0	19.00	
20.00	Cost of physicians' services in a teaching hospital (see instructions)	0	0	20.00	
21.00	Cost of covered services (enter the lesser of line 4 or line 16)	7,140,052	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)	7,140,052	0	29.00	
COMPUTATION OF REIMBURSEMENT SETTLEMENT					
30.00	Excess of reasonable cost (from line 18)	0	0	30.00	
31.00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)	7,140,052	0	31.00	
32.00	Deductibles	0		32.00	
33.00	Coinurance	0		33.00	
34.00	Allowable bad debts (see instructions)	0		34.00	
35.00	Utilization review	0		35.00	
36.00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)	7,140,052	0	36.00	
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0		37.00	
38.00	Subtotal (line 36 ± line 37)	7,140,052	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)	7,140,052	0	40.00	
41.00	Interim payments	8,071,232	0	41.00	
42.00	Balance due provider/program (line 40 minus line 41)	-931,180		42.00	
43.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, chapter 1, §115.2	0	0	43.00	

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 15-0002 Component CCN: 15-S002	Period: From 01/01/2020 To 12/31/2020	Worksheet E-3 Part VII Date/Time Prepared: 7/23/2021 10:58 am
		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		131,137	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)		131,137	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)		131,137	7.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable Charges				
8.00	Routine service charges		424,960	8.00
9.00	Ancillary service charges		424,958	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)		849,918	12.00
CUSTOMARY CHARGES				
13.00	Amount actually collected from patients liable for payment for services on a charge basis		0	13.00
14.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)		0	14.00
15.00	Ratio of line 13 to line 14 (not to exceed 1.000000)		0.000000	15.00
16.00	Total customary charges (see instructions)		849,918	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)		718,781	17.00
18.00	Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 16) (see instructions)		0	18.00
19.00	Interns and Residents (see instructions)		0	19.00
20.00	Cost of physicians' services in a teaching hospital (see instructions)		0	20.00
21.00	Cost of covered services (enter the lesser of line 4 or line 16)		131,137	21.00
PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be completed for PPS providers.				
22.00	Other than outlier payments		0	22.00
23.00	Outlier payments		0	23.00
24.00	Program capital payments		0	24.00
25.00	Capital exception payments (see instructions)		0	25.00
26.00	Routine and Ancillary service other pass through costs		0	26.00
27.00	Subtotal (sum of lines 22 through 26)		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)		131,137	29.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT				
30.00	Excess of reasonable cost (from line 18)		0	30.00
31.00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)		131,137	31.00
32.00	Deductibles		0	32.00
33.00	Coinsurance		0	33.00
34.00	Allowable bad debts (see instructions)		0	34.00
35.00	Utilization review		0	35.00
36.00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)		131,137	36.00
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	37.00
38.00	Subtotal (line 36 ± line 37)		131,137	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)		131,137	40.00
41.00	Interim payments		493,242	41.00
42.00	Balance due provider/program (line 40 minus line 41)		-362,105	42.00
43.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, chapter 1, §115.2		0	43.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 15-0002 Component CCN: 15-T002	Period: From 01/01/2020 To 12/31/2020	Worksheet E-3 Part VII Date/Time Prepared: 7/23/2021 10:58 am	
		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		555,688		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)		555,688	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)		555,688	0	7.00
COMPUTATION OF LESSER OF COST OR CHARGES					
Reasonable Charges					
8.00	Routine service charges		558,502		8.00
9.00	Ancillary service charges		1,262,166	0	9.00
10.00	Organ acquisition charges, net of revenue		0		10.00
11.00	Incentive from target amount computation		0		11.00
12.00	Total reasonable charges (sum of lines 8 through 11)		1,820,668	0	12.00
CUSTOMARY CHARGES					
13.00	Amount actually collected from patients liable for payment for services on a charge basis		0	0	13.00
14.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)		0	0	14.00
15.00	Ratio of line 13 to line 14 (not to exceed 1.000000)		0.000000	0.000000	15.00
16.00	Total customary charges (see instructions)		1,820,668	0	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)		1,264,980	0	17.00
18.00	Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 16) (see instructions)		0	0	18.00
19.00	Interns and Residents (see instructions)		0	0	19.00
20.00	Cost of physicians' services in a teaching hospital (see instructions)		0	0	20.00
21.00	Cost of covered services (enter the lesser of line 4 or line 16)		555,688	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)		555,688	0	29.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT					
30.00	Excess of reasonable cost (from line 18)		0	0	30.00
31.00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)		555,688	0	31.00
32.00	Deductibles		0	0	32.00
33.00	Coinsurance		0	0	33.00
34.00	Allowable bad debts (see instructions)		0	0	34.00
35.00	Utilization review		0	0	35.00
36.00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)		555,688	0	36.00
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	0	37.00
38.00	Subtotal (line 36 ± line 37)		555,688	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)		555,688	0	40.00
41.00	Interim payments		595,325	0	41.00
42.00	Balance due provider/program (line 40 minus line 41)		-39,637	0	42.00
43.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, chapter 1, §115.2		0	0	43.00

DIRECT GRADUATE MEDICAL EDUCATION (GME) & ESRD OUTPATIENT DIRECT MEDICAL EDUCATION COSTS		Provider CCN: 15-0002	Period: From 01/01/2020 To 12/31/2020	Worksheet E-4 Date/Time Prepared: 7/23/2021 10:58 am	
		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.			10.83	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)			10.83	5.00
6.00	Unweighted resident FTE count for allopathic and osteopathic programs for the current year from your records (see instructions)			3.00	6.00
7.00	Enter the lesser of line 5 or line 6			3.00	7.00
		Primary Care 1.00	Other 2.00	Total 3.00	
8.00	Weighted FTE count for physicians in an allopathic and osteopathic program for the current year.	0.00	2.50	2.50	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	2.50	2.50	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	2.50		11.00
12.00	Total weighted resident FTE count for the prior cost reporting year (see instructions)	0.00	2.50		12.00
13.00	Total weighted resident FTE count for the penultimate cost reporting year (see instructions)	0.00	2.50		13.00
14.00	Rolling average FTE count (sum of lines 11 through 13 divided by 3).	0.00	2.50		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	2.50		17.00
18.00	Per resident amount	0.00	88,050.00		18.00
19.00	Approved amount for resident costs	0	220,125	220,125	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)			88,050.00	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)			220,125	25.00
		Inpatient Part A 1.00	Managed Care 2.00	Total 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)	26,483	18,379		26.00
27.00	Total Inpatient Days (see instructions)	83,967	83,967		27.00
28.00	Ratio of inpatient days to total inpatient days	0.315398	0.218884		28.00
29.00	Program direct GME amount	69,427	48,182	117,609	29.00
29.01	Percent reduction for MA DGME		7.00		29.01
30.00	Reduction for direct GME payments for Medicare Advantage		3,373	3,373	30.00
31.00	Net Program direct GME amount			114,236	31.00

DIRECT GRADUATE MEDICAL EDUCATION (GME) & ESRD OUTPATIENT DIRECT MEDICAL EDUCATION COSTS		Provider CCN:15-0002	Period: From 01/01/2020 To 12/31/2020	Worksheet E-4 Date/Time Prepared: 7/23/2021 10:58 am	
		Title XVIII	Hospital	PPS	
				1.00	
DIRECT MEDICAL EDUCATION COSTS FOR ESRD COMPOSITE RATE - TITLE XVIII ONLY (NURSING SCHOOL AND PARAMEDICAL EDUCATION COSTS)					
32.00	Renal dialysis direct medical education costs (from Wkst. B, Pt. I, sum of col. 20 and 23, lines 74 and 94)			0	32.00
33.00	Renal dialysis and home dialysis total charges (Wkst. C, Pt. I, col. 8, sum of lines 74 and 94)			10,148,623	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)			55,744,464	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)			14,216	40.00
41.00	Total Part A reasonable cost (sum of lines 37 through 39 minus line 40)			55,730,248	41.00
Part B Reasonable Cost					
42.00	Reasonable cost (see instructions)			19,913,855	42.00
43.00	Primary payer payments (see instructions)			9,272	43.00
44.00	Total Part B reasonable cost (line 42 minus line 43)			19,904,583	44.00
45.00	Total reasonable cost (sum of lines 41 and 44)			75,634,831	45.00
46.00	Ratio of Part A reasonable cost to total reasonable cost (line 41 ÷ line 45)			0.736833	46.00
47.00	Ratio of Part B reasonable cost to total reasonable cost (line 44 ÷ line 45)			0.263167	47.00
ALLOCATION OF MEDICARE DIRECT GME COSTS BETWEEN PART A AND PART B					
48.00	Total program GME payment (line 31)			114,236	48.00
49.00	Part A Medicare GME payment (line 46 x 48) (title XVIII only) (see instructions)			84,173	49.00
50.00	Part B Medicare GME payment (line 47 x 48) (title XVIII only) (see instructions)			30,063	50.00

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

Provider CCN: 15-0002

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

Worksheet G

Date/Time Prepared:
7/23/2021 10:58 am

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
CURRENT ASSETS						
1.00	Cash on hand in banks	112,222,084	0	0	0	1.00
2.00	Temporary investments	616,969	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	39,897,780	0	0	0	4.00
5.00	Other receivable	0	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	0	0	0	0	6.00
7.00	Inventory	12,736,109	0	0	0	7.00
8.00	Prepaid expenses	3,884,320	0	0	0	8.00
9.00	Other current assets	24,830,939	0	0	0	9.00
10.00	Due from other funds	0	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	194,188,201	0	0	0	11.00
FIXED ASSETS						
12.00	Land	5,373,674	0	0	0	12.00
13.00	Land improvements	6,896,457	0	0	0	13.00
14.00	Accumulated depreciation	-382,761,666	0	0	0	14.00
15.00	Buildings	308,285,957	0	0	0	15.00
16.00	Accumulated depreciation	0	0	0	0	16.00
17.00	Leasehold improvements	1,230,154	0	0	0	17.00
18.00	Accumulated depreciation	0	0	0	0	18.00
19.00	Fixed equipment	0	0	0	0	19.00
20.00	Accumulated depreciation	0	0	0	0	20.00
21.00	Automobiles and trucks	0	0	0	0	21.00
22.00	Accumulated depreciation	0	0	0	0	22.00
23.00	Major movable equipment	199,068,926	0	0	0	23.00
24.00	Accumulated depreciation	0	0	0	0	24.00
25.00	Minor equipment depreciable	0	0	0	0	25.00
26.00	Accumulated depreciation	0	0	0	0	26.00
27.00	HIT designated Assets	0	0	0	0	27.00
28.00	Accumulated depreciation	0	0	0	0	28.00
29.00	Minor equipment-nondepreciable	0	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	138,093,502	0	0	0	30.00
OTHER ASSETS						
31.00	Investments	117,777,851	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	688,643	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	118,466,494	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	450,748,197	0	0	0	36.00
CURRENT LIABILITIES						
37.00	Accounts payable	21,422,227	0	0	0	37.00
38.00	Salaries, wages, and fees payable	0	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	2,570,000	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	73,092,550	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	97,084,777	0	0	0	45.00
LONG TERM LIABILITIES						
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	70,619,022	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	24,563,340	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	95,182,362	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	192,267,139	0	0	0	51.00
CAPITAL ACCOUNTS						
52.00	General fund balance	258,481,058				52.00
53.00	Specific purpose fund		0			53.00
54.00	Donor created - endowment fund balance - restricted			0		54.00
55.00	Donor created - endowment fund balance - unrestricted			0		55.00
56.00	Governing body created - endowment fund balance			0		56.00
57.00	Plant fund balance - invested in plant				0	57.00
58.00	Plant fund balance - reserve for plant improvement, replacement, and expansion				0	58.00
59.00	Total fund balances (sum of lines 52 thru 58)	258,481,058	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	450,748,197	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 15-0002

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

Worksheet G-1

Date/Time Prepared:
7/23/2021 10:58 am

		General Fund		Special Purpose Fund		Endowment Fund	
		1.00	2.00	3.00	4.00	5.00	
1.00	Fund balances at beginning of period		242,801,511		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		15,679,547				2.00
3.00	Total (sum of line 1 and line 2)		258,481,058		0		3.00
4.00	Additions (credit adjustments) (specify)	0		0		0	4.00
5.00		0		0		0	5.00
6.00		0		0		0	6.00
7.00		0		0		0	7.00
8.00		0		0		0	8.00
9.00		0		0		0	9.00
10.00	Total additions (sum of line 4-9)		0		0		10.00
11.00	Subtotal (line 3 plus line 10)		258,481,058		0		11.00
12.00	Deductions (debit adjustments) (specify)	0		0		0	12.00
13.00		0		0		0	13.00
14.00		0		0		0	14.00
15.00		0		0		0	15.00
16.00		0		0		0	16.00
17.00		0		0		0	17.00
18.00	Total deductions (sum of lines 12-17)		0		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		258,481,058		0		19.00
		Endowment Fund	Plant Fund				
		6.00	7.00	8.00			
1.00	Fund balances at beginning of period	0		0			1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)						2.00
3.00	Total (sum of line 1 and line 2)	0		0			3.00
4.00	Additions (credit adjustments) (specify)		0				4.00
5.00			0				5.00
6.00			0				6.00
7.00			0				7.00
8.00			0				8.00
9.00			0				9.00
10.00	Total additions (sum of line 4-9)	0		0			10.00
11.00	Subtotal (line 3 plus line 10)	0		0			11.00
12.00	Deductions (debit adjustments) (specify)		0				12.00
13.00			0				13.00
14.00			0				14.00
15.00			0				15.00
16.00			0				16.00
17.00			0				17.00
18.00	Total deductions (sum of lines 12-17)	0		0			18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)	0		0			19.00

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES

Provider CCN: 15-0002

Period:
From 01/01/2020
To 12/31/2020Worksheet G-2
Parts I & II
Date/Time Prepared:
7/23/2021 10:58 am

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
PART I - PATIENT REVENUES					
General Inpatient Routine Services					
1.00	Hospital	71,895,042		71,895,042	1.00
2.00	SUBPROVIDER - IPF	4,390,602		4,390,602	2.00
3.00	SUBPROVIDER - IRF	5,299,851		5,299,851	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)	81,585,495		81,585,495	10.00
Intensive Care Type Inpatient Hospital Services					
11.00	INTENSIVE CARE UNIT	30,377,141		30,377,141	11.00
11.01	NEONATAL ICU	0		0	11.01
12.00	CORONARY CARE UNIT				12.00
13.00	BURN INTENSIVE CARE UNIT				13.00
14.00	SURGICAL INTENSIVE CARE UNIT				14.00
15.00	OTHER SPECIAL CARE (SPECIFY)				15.00
16.00	Total intensive care type inpatient hospital services (sum of lines 11-15)	30,377,141		30,377,141	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	111,962,636		111,962,636	17.00
18.00	Ancillary services	483,484,450	585,080,644	1,068,565,094	18.00
19.00	Outpatient services	24,021,470	88,875,970	112,897,440	19.00
20.00	RURAL HEALTH CLINIC	0	0	0	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY		4,239,040	4,239,040	22.00
23.00	AMBULANCE SERVICES				23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	OTHER (SPECIFY)	0	0	0	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	619,468,556	678,195,654	1,297,664,210	28.00
PART II - OPERATING EXPENSES					
29.00	Operating expenses (per Wkst. A, column 3, line 200)		360,661,096		29.00
30.00	ADD (SPECIFY)	0			30.00
31.00		0			31.00
32.00		0			32.00
33.00		0			33.00
34.00		0			34.00
35.00		0			35.00
36.00	Total additions (sum of lines 30-35)		0		36.00
37.00	DEDUCT (SPECIFY)	0			37.00
38.00		0			38.00
39.00		0			39.00
40.00		0			40.00
41.00		0			41.00
42.00	Total deductions (sum of lines 37-41)		0		42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer to Wkst. G-3, line 4)		360,661,096		43.00

STATEMENT OF REVENUES AND EXPENSES

Provider CCN: 15-0002

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

Worksheet G-3

Date/Time Prepared:
7/23/2021 10:58 am

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	1,297,664,210	1.00
2.00	Less contractual allowances and discounts on patients' accounts	968,790,134	2.00
3.00	Net patient revenues (line 1 minus line 2)	328,874,076	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	360,661,096	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-31,787,020	5.00
OTHER INCOME			
6.00	Contributions, donations, bequests, etc	0	6.00
7.00	Income from investments	3,107,936	7.00
8.00	Revenues from telephone and other miscellaneous communication services	0	8.00
9.00	Revenue from television and radio service	0	9.00
10.00	Purchase discounts	0	10.00
11.00	Rebates and refunds of expenses	0	11.00
12.00	Parking lot receipts	0	12.00
13.00	Revenue from laundry and linen service	0	13.00
14.00	Revenue from meals sold to employees and guests	0	14.00
15.00	Revenue from rental of living quarters	0	15.00
16.00	Revenue from sale of medical and surgical supplies to other than patients	0	16.00
17.00	Revenue from sale of drugs to other than patients	0	17.00
18.00	Revenue from sale of medical records and abstracts	0	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	0	20.00
21.00	Rental of vending machines	0	21.00
22.00	Rental of hospital space	0	22.00
23.00	Governmental appropriations	0	23.00
24.00	OTHER OPERATING INCOME	7,371,890	24.00
24.01	NON OPERATING INCOME	-641,333	24.01
24.02	CHANGE IN UNREALIZED GAIN/LOSS	3,017,551	24.02
24.03	REALIZED GAIN/LOSS INVESTMENT SALE	2,174,118	24.03
24.04	GAIN/LOSS ON ASSET DISPOSAL	-240,344	24.04
24.50	COVID-19 PHE Funding	32,881,752	24.50
25.00	Total other income (sum of lines 6-24)	47,671,570	25.00
26.00	Total (line 5 plus line 25)	15,884,550	26.00
27.00	FOUNDATION SALARIES	191,386	27.00
27.01	FOUNDATION OTHER	13,617	27.01
28.00	Total other expenses (sum of line 27 and subscripts)	205,003	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	15,679,547	29.00

ANALYSIS OF HOSPITAL-BASED HOME HEALTH AGENCY COSTS

Provider CCN: 15-0002

Period:

Worksheet H

HHA CCN: 15-7536

From 01/01/2020

Date/Time Prepared:

To 12/31/2020

7/23/2021 10:58 am

Home Health
Agency I

PPS

	Salaries	Employee Benefits	Transportation (see instructions)	Contracted/Purchased Services	Other Costs	Total (sum of cols. 1 thru 5)	
	1.00	2.00	3.00	4.00	5.00	6.00	
GENERAL SERVICE COST CENTERS							
1.00 Capital Related - Bldg. & Fixtures			0		0	0	1.00
2.00 Capital Related - Movable Equipment			0		0	0	2.00
3.00 Plant Operation & Maintenance	0	0	0	0	0	0	3.00
4.00 Transportation	0	0	0	0	0	0	4.00
5.00 Administrative and General	544,227	0	0	0	442,674	986,901	5.00
HHA REIMBURSABLE SERVICES							
6.00 Skilled Nursing Care	1,081,968	0	0	0	0	1,081,968	6.00
7.00 Physical Therapy	492,860	0	0	0	0	492,860	7.00
8.00 Occupational Therapy	155,042	0	0	0	0	155,042	8.00
9.00 Speech Pathology	37,059	0	0	0	0	37,059	9.00
10.00 Medical Social Services	4,585	0	0	0	0	4,585	10.00
11.00 Home Health Aide	61,640	0	0	0	0	61,640	11.00
12.00 Supplies (see instructions)	0	0	0	0	0	0	12.00
13.00 Drugs	0	0	0	0	0	0	13.00
14.00 DME	0	0	0	0	0	0	14.00
HHA NONREIMBURSABLE SERVICES							
15.00 Home Dialysis Aide Services	0	0	0	0	0	0	15.00
16.00 Respiratory Therapy	0	0	0	0	0	0	16.00
17.00 Private Duty Nursing	0	0	0	0	0	0	17.00
18.00 Clinic	0	0	0	0	0	0	18.00
19.00 Health Promotion Activities	0	0	0	0	0	0	19.00
20.00 Day Care Program	0	0	0	0	0	0	20.00
21.00 Home Delivered Meals Program	0	0	0	0	0	0	21.00
22.00 Homemaker Service	0	0	0	0	0	0	22.00
23.00 All Others (specify)	0	0	0	0	0	0	23.00
23.50 Telemedicine	0	0	0	0	0	0	23.50
24.00 Total (sum of lines 1-23)	2,377,381	0	0	0	442,674	2,820,055	24.00
	Reclassification	Reclassified Trial Balance (col. 6 + col.7)	Adjustments	Net Expenses for Allocation (col. 8 + col. 9)			
	7.00	8.00	9.00	10.00			
GENERAL SERVICE COST CENTERS							
1.00 Capital Related - Bldg. & Fixtures	0	0	0	0			1.00
2.00 Capital Related - Movable Equipment	0	0	0	0			2.00
3.00 Plant Operation & Maintenance	0	0	0	0			3.00
4.00 Transportation	0	0	0	0			4.00
5.00 Administrative and General	-25,141	961,760	0	961,760			5.00
HHA REIMBURSABLE SERVICES							
6.00 Skilled Nursing Care	0	1,081,968	0	1,081,968			6.00
7.00 Physical Therapy	0	492,860	0	492,860			7.00
8.00 Occupational Therapy	0	155,042	0	155,042			8.00
9.00 Speech Pathology	0	37,059	0	37,059			9.00
10.00 Medical Social Services	0	4,585	0	4,585			10.00
11.00 Home Health Aide	0	61,640	0	61,640			11.00
12.00 Supplies (see instructions)	0	0	0	0			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)	-25,141	2,794,914	0	2,794,914			24.00

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

COST ALLOCATION - HHA GENERAL SERVICE COST

Provider CCN: 15-0002

Period:

Worksheet H-1

HHA CCN: 15-7536

From 01/01/2020
To 12/31/2020Part I
Date/Time Prepared:
7/23/2021 10:58 amHome Health
Agency I

PPS

		Net Expenses for Cost Allocation (from Wkst. H, col. 10)	Capital Related Costs		Plant Operation & Maintenance	Transportatio n			
			Bldgs & Fixtures	Movable Equipment			Subtotal (cols. 0-4)		
									0
	GENERAL SERVICE COST CENTERS								
1.00	Capital Related - Bldg. & Fixtures	0	0				0	1.00	
2.00	Capital Related - Movable Equipment	0		0			0	2.00	
3.00	Plant Operation & Maintenance	0	0	0	0		0	3.00	
4.00	Transportation	0	0	0	0	0	0	4.00	
5.00	Administrative and General	961,760	0	0	0	0	961,760	5.00	
	HHA REIMBURSABLE SERVICES								
6.00	Skilled Nursing Care	1,081,968	0	0	0	0	1,081,968	6.00	
7.00	Physical Therapy	492,860	0	0	0	0	492,860	7.00	
8.00	Occupational Therapy	155,042	0	0	0	0	155,042	8.00	
9.00	Speech Pathology	37,059	0	0	0	0	37,059	9.00	
10.00	Medical Social Services	4,585	0	0	0	0	4,585	10.00	
11.00	Home Health Aide	61,640	0	0	0	0	61,640	11.00	
12.00	Supplies (see instructions)	0	0	0	0	0	0	12.00	
13.00	Drugs	0	0	0	0	0	0	13.00	
14.00	DME	0	0	0	0	0	0	14.00	
	HHA NONREIMBURSABLE SERVICES								
15.00	Home Dialysis Aide Services	0	0	0	0	0	0	15.00	
16.00	Respiratory Therapy	0	0	0	0	0	0	16.00	
17.00	Private Duty Nursing	0	0	0	0	0	0	17.00	
18.00	Clinic	0	0	0	0	0	0	18.00	
19.00	Health Promotion Activities	0	0	0	0	0	0	19.00	
20.00	Day Care Program	0	0	0	0	0	0	20.00	
21.00	Home Delivered Meals Program	0	0	0	0	0	0	21.00	
22.00	Homemaker Service	0	0	0	0	0	0	22.00	
23.00	All Others (specify)	0	0	0	0	0	0	23.00	
23.50	Telemedicine	0	0	0	0	0	0	23.50	
24.00	Total (sum of lines 1-23)	2,794,914	0	0	0	0	2,794,914	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	961,760						5.00	
	HHA REIMBURSABLE SERVICES								
6.00	Skilled Nursing Care	567,652	1,649,620					6.00	
7.00	Physical Therapy	258,578	751,438					7.00	
8.00	Occupational Therapy	81,342	236,384					8.00	
9.00	Speech Pathology	19,443	56,502					9.00	
10.00	Medical Social Services	2,406	6,991					10.00	
11.00	Home Health Aide	32,339	93,979					11.00	
12.00	Supplies (see instructions)	0	0					12.00	
13.00	Drugs	0	0					13.00	
14.00	DME	0	0					14.00	
	HHA NONREIMBURSABLE SERVICES								
15.00	Home Dialysis Aide Services	0	0					15.00	
16.00	Respiratory Therapy	0	0					16.00	
17.00	Private Duty Nursing	0	0					17.00	
18.00	Clinic	0	0					18.00	
19.00	Health Promotion Activities	0	0					19.00	
20.00	Day Care Program	0	0					20.00	
21.00	Home Delivered Meals Program	0	0					21.00	
22.00	Homemaker Service	0	0					22.00	
23.00	All Others (specify)	0	0					23.00	
23.50	Telemedicine	0	0					23.50	
24.00	Total (sum of lines 1-23)		2,794,914					24.00	

COST ALLOCATION - HHA STATISTICAL BASIS

Provider CCN: 15-0002

Period:

Worksheet H-1

HHA CCN: 15-7536

From 01/01/2020
To 12/31/2020Part II
Date/Time Prepared:
7/23/2021 10:58 amHome Health
Agency I

PPS

		Capital Related Costs		Plant Operation & Maintenance (SQUARE FEET)	Transportatio n (MILEAGE)	Reconciliatio n	Administrativ e & 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	0		0		3.00
4.00	Transportation (see instructions)	0	0	0	0			4.00
5.00	Administrative and General	0	0	0	0	-961,760	1,833,154	5.00
	HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	0	0	0	0	0	1,081,968	6.00
7.00	Physical Therapy	0	0	0	0	0	492,860	7.00
8.00	Occupational Therapy	0	0	0	0	0	155,042	8.00
9.00	Speech Pathology	0	0	0	0	0	37,059	9.00
10.00	Medical Social Services	0	0	0	0	0	4,585	10.00
11.00	Home Health Aide	0	0	0	0	0	61,640	11.00
12.00	Supplies (see instructions)	0	0	0	0	0	0	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)	0	0	0	0	-961,760	1,833,154	24.00
25.00	Cost To Be Allocated (per Worksheet H-1, Part I)	0	0	0	0		961,760	25.00
26.00	Unit Cost Multiplier	0.000000	0.000000	0.000000	0.000000		0.524648	26.00

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

Provider CCN: 15-0002

Period:

Worksheet H-2

HHA CCN: 15-7536

From 01/01/2020
To 12/31/2020Part I
Date/Time Prepared:
7/23/2021 10:58 amHome Health
Agency I

PPS

Cost Center Description		HHA Trial Balance (1)	CAPITAL RELATED COSTS	EMPLOYEE BENEFITS DEPARTMENT	DATA PROCESSING	PURCHASING RECEIVING AND STORES	ADMITTING	
			BLDG & FIXT					
		0	1.00	4.00	5.01	5.02	5.03	
1.00	Administrative and General	0	0	533,321	0	10,612	11,058	1.00
2.00	Skilled Nursing Care	1,649,620	0	0	0	0	0	2.00
3.00	Physical Therapy	751,438	0	0	0	0	0	3.00
4.00	Occupational Therapy	236,384	0	0	0	0	0	4.00
5.00	Speech Pathology	56,502	0	0	0	0	0	5.00
6.00	Medical Social Services	6,991	0	0	0	0	0	6.00
7.00	Home Health Aide	93,979	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)	2,794,914	0	533,321	0	10,612	11,058	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		CASHIERING/AC COUNTS RECEIVABLE	Subtotal	OTHER A&G	PATIENT TRANSPORTATIO N	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	
		5.04	5A.04	5.05	5.06	7.00	8.00	
1.00	Administrative and General	24,131	579,122	74,011	0	0	0	1.00
2.00	Skilled Nursing Care	0	1,649,620	210,819	0	0	0	2.00
3.00	Physical Therapy	0	751,438	96,032	0	0	0	3.00
4.00	Occupational Therapy	0	236,384	30,209	0	0	0	4.00
5.00	Speech Pathology	0	56,502	7,221	0	0	0	5.00
6.00	Medical Social Services	0	6,991	893	0	0	0	6.00
7.00	Home Health Aide	0	93,979	12,010	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)	24,131	3,374,036	431,195	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.		0.000000					21.00

(1) Column 0, line 20 must agree with Wkst. A, column 7, line 101.

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

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

Provider CCN: 15-0002

Period:

Worksheet H-2

HHA CCN: 15-7536

From 01/01/2020
To 12/31/2020Part I
Date/Time Prepared:
7/23/2021 10:58 am

Cost Center Description		HOUSEKEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATIO N	CENTRAL SERVICES & SUPPLY	PHARMACY	
		9.00	10.00	11.00	13.00	14.00	15.00	
1.00	Administrative and General	0	0	0	0	0	112	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	112	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		MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	STAFF EDUCATION	MEDICAL EDUCATION	INTERNS & RESIDENTS SERVICES-SALA RY & FRINGES	SERVICES-OTHE R PRGM COSTS	
		16.00	17.00	17.01	17.02	21.00	22.00	
1.00	Administrative and General	14,595	0	2,697	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)	14,595	0	2,697	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

(1) Column 0, line 20 must agree with Wkst. A, column 7, line 101.

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

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

Provider CCN: 15-0002

Period:

Worksheet H-2

HHA CCN: 15-7536

From 01/01/2020
To 12/31/2020Part I
Date/Time Prepared:
7/23/2021 10:58 am

						Home Health Agency I	PPS	
Cost Center Description		PARAMED ED PROGRAM	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Subtotal	Allocated HHA A&G (see Part II)	Total HHA Costs	
		23.00	24.00	25.00	26.00	27.00	28.00	
1.00	Administrative and General	0	670,537	0	670,537			1.00
2.00	Skilled Nursing Care	0	1,860,439	0	1,860,439	395,765	2,256,204	2.00
3.00	Physical Therapy	0	847,470	0	847,470	180,280	1,027,750	3.00
4.00	Occupational Therapy	0	266,593	0	266,593	56,712	323,305	4.00
5.00	Speech Pathology	0	63,723	0	63,723	13,556	77,279	5.00
6.00	Medical Social Services	0	7,884	0	7,884	1,677	9,561	6.00
7.00	Home Health Aide	0	105,989	0	105,989	22,547	128,536	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	3,822,635	0	3,822,635	670,537	3,822,635	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.					0.212727		21.00

(1) Column 0, line 20 must agree with Wkst. A, column 7, line 101.

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

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS

Provider CCN: 15-0002

Period:

Worksheet H-2

HHA CCN: 15-7536

From 01/01/2020
To 12/31/2020Part II
Date/Time Prepared:
7/23/2021 10:58 amHome Health
Agency I

PPS

Cost Center Description		CAPITAL RELATED COSTS	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	DATA PROCESSING (MACHINE TIME)	PURCHASING RECEIVING AND STORES (PURCHASE REQUISITIONS)	ADMITTING (GROSS CHARGES)	CASHIERING/AC COUNTS RECEIVABLE (GROSS CHARGES)	
		BLDG & FIXT (SQUARE FEET)						
		1.00	4.00	5.01	5.02	5.03	5.04	
1.00	Administrative and General	0	2,376,144	0	106,194	4,160,443	4,160,443	1.00
2.00	Skilled Nursing Care	0	0	0	0	0	0	2.00
3.00	Physical Therapy	0	0	0	0	0	0	3.00
4.00	Occupational Therapy	0	0	0	0	0	0	4.00
5.00	Speech Pathology	0	0	0	0	0	0	5.00
6.00	Medical Social Services	0	0	0	0	0	0	6.00
7.00	Home Health Aide	0	0	0	0	0	0	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
19.50	Telemedicine	0	0	0	0	0	0	19.50
20.00	Total (sum of lines 1-19)	0	2,376,144	0	106,194	4,160,443	4,160,443	20.00
21.00	Total cost to be allocated	0	533,321	0	10,612	11,058	24,131	21.00
22.00	Unit cost multiplier	0.000000	0.224448	0.000000	0.099930	0.002658	0.005800	22.00
Cost Center Description		Reconciliatio n	OTHER A&G (ACCUM. COST)	PATIENT TRANSPORTATIO N (NUMBER OF TRIPS)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	
		5A.05	5.05	5.06	7.00	8.00	9.00	
1.00	Administrative and General	0	579,122	0	0	0	0	1.00
2.00	Skilled Nursing Care	0	1,649,620	0	0	0	0	2.00
3.00	Physical Therapy	0	751,438	0	0	0	0	3.00
4.00	Occupational Therapy	0	236,384	0	0	0	0	4.00
5.00	Speech Pathology	0	56,502	0	0	0	0	5.00
6.00	Medical Social Services	0	6,991	0	0	0	0	6.00
7.00	Home Health Aide	0	93,979	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)		3,374,036	0	0	0	0	20.00
21.00	Total cost to be allocated		431,195	0	0	0	0	21.00
22.00	Unit cost multiplier		0.127798	0.000000	0.000000	0.000000	0.000000	22.00

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS

Provider CCN: 15-0002

Period:

Worksheet H-2

HHA CCN: 15-7536

From 01/01/2020
To 12/31/2020Part II
Date/Time Prepared:
7/23/2021 10:58 am

Cost Center Description		DIETARY (MEALS SERVED)	CAFETERIA (PRODUCTIVE HOURS)	NURSING ADMINISTRATIO N (DIRECT NURS. HRS.)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)	
		10.00	11.00	13.00	14.00	15.00	16.00	
1.00	Administrative and General	0	0	0	0	280	4,160,443	1.00
2.00	Skilled Nursing Care	0	0	0	0	0	0	2.00
3.00	Physical Therapy	0	0	0	0	0	0	3.00
4.00	Occupational Therapy	0	0	0	0	0	0	4.00
5.00	Speech Pathology	0	0	0	0	0	0	5.00
6.00	Medical Social Services	0	0	0	0	0	0	6.00
7.00	Home Health Aide	0	0	0	0	0	0	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
19.50	Telemedicine	0	0	0	0	0	0	19.50
20.00	Total (sum of lines 1-19)	0	0	0	0	280	4,160,443	20.00
21.00	Total cost to be allocated	0	0	0	0	112	14,595	21.00
22.00	Unit cost multiplier	0.000000	0.000000	0.000000	0.000000	0.400000	0.003508	22.00
Cost Center Description		SOCIAL SERVICE (TIME SPENT)	STAFF EDUCATION (TIME SPENT)	MEDICAL EDUCATION (ASSIGNED TIME)	INTERNS & RESIDENTS		PARAMED ED PROGRAM (ASSIGNED TIME)	
		17.00	17.01	17.02	SERVICES-SALA RY & FRINGES (ASSIGNED TIME)	SERVICES-OTHE R PRGM COSTS (ASSIGNED TIME)	23.00	
1.00	Administrative and General	0	376	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)	0	376	0	0	0	0	20.00
21.00	Total cost to be allocated	0	2,697	0	0	0	0	21.00
22.00	Unit cost multiplier	0.000000	7.172872	0.000000	0.000000	0.000000	0.000000	22.00

APPORTIONMENT OF PATIENT SERVICE COSTS

Provider CCN: 15-0002

Period:

Worksheet H-3

HHA CCN: 15-7536

From 01/01/2020
To 12/31/2020Part I
Date/Time Prepared:
7/23/2021 10:58 am

				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	2,256,204		2,256,204	13,720	164.45	1.00
2.00	Physical Therapy		3.00	1,027,750	0	1,027,750	5,898	174.25	2.00
3.00	Occupational Therapy		4.00	323,305	0	323,305	1,726	187.31	3.00
4.00	Speech Pathology		5.00	77,279	0	77,279	149	518.65	4.00
5.00	Medical Social Services		6.00	9,561		9,561	69	138.57	5.00
6.00	Home Health Aide		7.00	128,536		128,536	2,417	53.18	6.00
7.00	Total (sum of lines 1-6)			3,822,635	0	3,822,635	23,979		7.00
			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			23844	0	4,218			8.00
9.00	Physical Therapy			23844	0	2,067			9.00
10.00	Occupational Therapy			23844	0	654			10.00
11.00	Speech Pathology			23844	0	52			11.00
12.00	Medical Social Services			23844	0	18			12.00
13.00	Home Health Aide			23844	0	796			13.00
14.00	Total (sum of lines 8-13)				0	7,805			14.00
			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	0	0	0	0	0.000000	15.00
16.00	Cost of Drugs		9.00	0	0	0	0	0.000000	16.00
			Program Visits				Cost of Services		
					Part B				
					Not Subject to Deductibles & Coinsurance				
					Subject to Deductibles & Coinsurance				
			6.00	7.00	8.00	9.00	10.00	11.00	
PART I - COMPUTATION OF LESSER OF AGGREGATE PROGRAM COST, AGGREGATE OF THE PROGRAM LIMITATION COST, OR BENEFICIARY COST LIMITATION									
Cost Per Visit Computation									
1.00	Skilled Nursing Care		0	4,218		0	693,650		1.00
2.00	Physical Therapy		0	2,067		0	360,175		2.00
3.00	Occupational Therapy		0	654		0	122,501		3.00
4.00	Speech Pathology		0	52		0	26,970		4.00
5.00	Medical Social Services		0	18		0	2,494		5.00
6.00	Home Health Aide		0	796		0	42,331		6.00
7.00	Total (sum of lines 1-6)		0	7,805		0	1,248,121		7.00

APPORTIONMENT OF PATIENT SERVICE COSTS

Provider CCN: 15-0002

Period:

Worksheet H-3

HHA CCN: 15-7536

From 01/01/2020
To 12/31/2020Part I
Date/Time Prepared:
7/23/2021 10:58 am

Title XVIII

Home Health
Agency I

PPS

Cost Center Description						Agency 1			
		6.00	7.00	8.00	9.00	10.00	11.00		
	Limitation Cost Computation								
8.00	Skilled Nursing Care							8.00	
9.00	Physical Therapy							9.00	
10.00	Occupational Therapy							10.00	
11.00	Speech Pathology							11.00	
12.00	Medical Social Services							12.00	
13.00	Home Health Aide							13.00	
14.00	Total (sum of lines 8-13)							14.00	
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	245,619	0	0	0	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	693,650						1.00	
2.00	Physical Therapy	360,175						2.00	
3.00	Occupational Therapy	122,501						3.00	
4.00	Speech Pathology	26,970						4.00	
5.00	Medical Social Services	2,494						5.00	
6.00	Home Health Aide	42,331						6.00	
7.00	Total (sum of lines 1-6)	1,248,121						7.00	
Cost Center Description									
		12.00							
Limitation Cost Computation									
8.00	Skilled Nursing Care							8.00	
9.00	Physical Therapy							9.00	
10.00	Occupational Therapy							10.00	
11.00	Speech Pathology							11.00	
12.00	Medical Social Services							12.00	
13.00	Home Health Aide							13.00	
14.00	Total (sum of lines 8-13)							14.00	

APPORTIONMENT OF PATIENT SERVICE COSTS

Provider CCN: 15-0002

Period:

Worksheet H-3

HHA CCN: 15-7536

From 01/01/2020

Part II

To 12/31/2020

Date/Time Prepared:

7/23/2021 10:58 am

Title XVIII

Home Health

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	0.368888	0	0	col. 2, line 2.00		1.00
2.00 Occupational Therapy	67.00	0.404136	0	0	col. 2, line 3.00		2.00
3.00 Speech Pathology	68.00	0.311758	0	0	col. 2, line 4.00		3.00
4.00 Cost of Medical Supplies	71.00	0.322118	0	0	col. 2, line 15.00		4.00
5.00 Cost of Drugs	73.00	0.191382	0	0	col. 2, line 16.00		5.00

CALCULATION OF HHA REIMBURSEMENT SETTLEMENT		Provider CCN: 15-0002 HHA CCN: 15-7536	Period: From 01/01/2020 To 12/31/2020	Worksheet H-4 Part I-II Date/Time Prepared: 7/23/2021 10:58 am
		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	136	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	-136	10.00
11.00	Total PPS Reimbursement - Full Episodes without Outliers	0	1,035,085	11.00
12.00	Total PPS Reimbursement - Full Episodes with Outliers	0	117,317	12.00
13.00	Total PPS Reimbursement - LUPA Episodes	0	16,843	13.00
14.00	Total PPS Reimbursement - PEP Episodes	0	6,054	14.00
15.00	Total PPS Outlier Reimbursement - Full Episodes with Outliers	0	24,634	15.00
16.00	Total PPS Outlier Reimbursement - PEP Episodes	0	0	16.00
17.00	Total Other Payments	0	0	17.00
18.00	DME Payments	0	0	18.00
19.00	Oxygen Payments	0	0	19.00
20.00	Prosthetic and Orthotic Payments	0	0	20.00
21.00	Part B deductibles billed to Medicare patients (exclude coinsurance)	0	0	21.00
22.00	Subtotal (sum of lines 10 thru 20 minus line 21)	0	1,199,797	22.00
23.00	Excess reasonable cost (from line 8)	0	0	23.00
24.00	Subtotal (line 22 minus line 23)	0	1,199,797	24.00
25.00	Coinsurance billed to program patients (from your records)	0	0	25.00
26.00	Net cost (line 24 minus line 25)	0	1,199,797	26.00
27.00	Reimbursable bad debts (from your records)	0	0	27.00
28.00	Reimbursable bad debts for dual eligible beneficiaries (see instructions)	0	0	28.00
29.00	Total costs - current cost reporting period (line 26 plus line 27)	0	1,199,797	29.00
30.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	30.00
30.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	0	30.50
30.99	Demonstration payment adjustment amount before sequestration	0	0	30.99
31.00	Subtotal (see instructions)	0	1,199,797	31.00
31.01	Sequestration adjustment (see instructions)	0	8,870	31.01
31.02	Demonstration payment adjustment amount after sequestration	0	0	31.02
32.00	Interim payments (see instructions)	0	1,190,927	32.00
33.00	Tentative settlement (for contractor use only)	0	0	33.00
34.00	Balance due provider/program (line 31 minus lines 31.01, 32, and 33)	0	0	34.00
35.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	0	35.00

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED HHAS FOR SERVICES RENDERED
TO PROGRAM BENEFICIARIESProvider CCN: 15-0002
HHA CCN: 15-7536Period:
From 01/01/2020
To 12/31/2020

Worksheet H-5

Date/Time Prepared:
7/23/2021 10:58 am

		Home Health Agency I		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		0		1,190,927
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
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) Program to Provider				
3.01			0		0
3.02			0		0
3.03			0		0
3.04			0		0
3.05			0		0
Provider to Program					
3.50			0		0
3.51			0		0
3.52			0		0
3.53			0		0
3.54			0		0
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0
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		1,190,927
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) Program to Provider				
5.01			0		0
5.02			0		0
5.03			0		0
Provider to Program					
5.50			0		0
5.51			0		0
5.52			0		0
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0
6.00	Determined net settlement amount (balance due) based on the cost report. (1)				
6.01	SETTLEMENT TO PROVIDER		0		0
6.02	SETTLEMENT TO PROGRAM		0		0
7.00	Total Medicare program liability (see instructions)		0		1,190,927
		Contractor Number		NPR Date (Mo/Day/Yr)	
		0		1.00 2.00	
8.00	Name of Contractor				

CALCULATION OF CAPITAL PAYMENT		Provider CCN: 15-0002	Period: From 01/01/2020 To 12/31/2020	Worksheet L Parts I-III Date/Time Prepared: 7/23/2021 10:58 am
		Title XVIII	Hospital	PPS
		1.00		
PART I - FULLY PROSPECTIVE METHOD				
CAPITAL FEDERAL AMOUNT				
1.00	Capital DRG other than outlier		2,660,433	1.00
1.01	Model 4 BPCI Capital DRG other than outlier		0	1.01
2.00	Capital DRG outlier payments		52,859	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)		207.77	3.00
4.00	Number of interns & residents (see instructions)		3.00	4.00
5.00	Indirect medical education percentage (see instructions)		0.41	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)		10,908	6.00
7.00	Percentage of SSI recipient patient days to Medicare Part A patient days (Worksheet E, part A line 30) (see instructions)		8.39	7.00
8.00	Percentage of Medicaid patient days to total days (see instructions)		33.07	8.00
9.00	Sum of lines 7 and 8		41.46	9.00
10.00	Allowable disproportionate share percentage (see instructions)		8.76	10.00
11.00	Disproportionate share adjustment (see instructions)		233,054	11.00
12.00	Total prospective capital payments (see instructions)		2,957,254	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