

This report is required by law (42 USC 1395g; 42 CFR 413.20(b)). Failure to report can result in all interim payments made since the beginning of the cost reporting period being deemed overpayments (42 USC 1395g). FORM APPROVED OMB NO. 0938-0050 EXPIRES 03-31-2022

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY	Provider CCN: 26-0091	Period: From 01/01/2020 To 12/31/2020	Worksheet S Parts I-III Date/Time Prepared: 9/24/2021 7:02 pm
--	-----------------------	---	--

PART I - COST REPORT STATUS			
Provider use only	1. ☒ Electronically prepared cost report 2. ☐ Manually prepared cost report 3. ☐ If this is an amended report enter the number of times the provider resubmitted this cost report 4. ☐ Medicare Utilization. Enter "F" for full or "L" for low.		
Contractor use only	5. ☐ Cost Report Status (1) As Submitted (2) Settled without Audit (3) Settled with Audit (4) Reopened (5) Amended 6. Date Received: 7. Contractor No. 8. ☐ Initial Report for this Provider CCN 9. ☐ Final Report for this Provider CCN 10. NPR Date: 11. Contractor's Vendor Code: 4 12. ☐ If line 5, column 1 is 4: Enter number of times reopened = 0-9.		

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

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

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by SSM HEALTH ST. MARY'S HOSPITAL - STL (26-0091) 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) EILEEN LAMM
 Officer or Administrator of Provider(s)

REG VP-FINANCE
 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	34,265	22,809	0	0	1.00
2.00	Subprovider - IPF	0	0	0		0	2.00
3.00	Subprovider - IRF	0	0	0		0	3.00
5.00	Swing Bed - SNF	0	0	0		0	5.00
6.00	Swing Bed - NF	0				0	6.00
200.00	Total	0	34,265	22,809	0	0	200.00

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA				Provider CCN: 26-0091		Period: From 01/01/2020 To 12/31/2020		Worksheet S-2 Part I Date/Time Prepared: 9/24/2021 7:02 pm		
1.00		2.00		3.00		4.00				
Hospital and Hospital Health Care Complex Address:										
1.00	Street: 6420 CLAYTON ROAD			PO Box:				1.00		
2.00	City: ST. LOUIS			State: MO		Zip Code: 63117-		County: ST. LOUIS 2.00		
		Component Name	CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N)			
							V	XVIII	XIX	
		1.00	2.00	3.00	4.00	5.00	6.00	7.00	8.00	
Hospital and Hospital-Based Component Identification:										
3.00	Hospital		SSM HEALTH ST. MARY'S HOSPITAL - STL	260091	41180	1	07/01/1966	N	P O	3.00
4.00	Subprovider - IPF		SSM HEALTH ST. MARY'S HOSPITAL - PSY	26S091	41180	4	01/01/1984	N	P O	4.00
5.00	Subprovider - IRF									5.00
6.00	Subprovider - (Other)									6.00
7.00	Swing Beds - SNF									7.00
8.00	Swing Beds - NF									8.00
9.00	Hospital-Based SNF									9.00
10.00	Hospital-Based NF									10.00
11.00	Hospital-Based OLTC									11.00
12.00	Hospital-Based HHA									12.00
13.00	Separately Certified ASC									13.00
14.00	Hospital-Based Hospice									14.00
15.00	Hospital-Based Health Clinic - RHC									15.00
16.00	Hospital-Based Health Clinic - FQHC									16.00
17.00	Hospital-Based (CMHC) I									17.00
18.00	Renal Dialysis		SSM HEALTH ST. MARY'S HOSPITAL ESRD	262320	41180		03/01/1998			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)					1				21.00
						1.00		2.00		
						2.00		3.00		
Inpatient PPS Information										
22.00	Does this facility qualify and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.106(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no.				Y	N				22.00
22.01	Did this hospital receive interim uncompensated care payments for this cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)				Y	Y				22.01
22.02	Is this a newly merged hospital that requires final uncompensated care payments to be determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1.				N	N				22.02
22.03	Did this hospital receive a geographic reclassification from urban to rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no.				N	N	N			22.03
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.				3	N				23.00

Worksheet S-2
Part I
Date/Time Prepared:
9/24/2021 7:02 pm

MCRIF32 - 16.12.172.0

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

Provider CCN: 26-0091

Period:
From 01/01/2020
To 12/31/2020Worksheet S-2
Part I
Date/Time Prepared:
9/24/2021 7:02 pm

		NAHE 413.85 Y/N	Worksheet A Line #	Pass-Through Qualification Criterion Code		
		1.00	2.00	3.00		
60.00	Are you claiming nursing and allied health education (NAHE) costs for any programs that meet the criteria under 42 CFR 413.85? (see instructions) Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", are you impacted by CR 11642 (or subsequent CR) NAHE MA payment adjustment? Enter "Y" for yes or "N" for no in column 2.	Y	Y		60.00	
60.01	If line 60 is yes, complete columns 2 and 3 for each program. (see instructions)		23.00	1	60.01	
60.02	If line 60 is yes, complete columns 2 and 3 for each program. (see instructions)		23.01	1	60.02	
		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
61.01	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)					
61.02	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)					
61.03	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)					
61.04	Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period.(see instructions).					
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)					
61.06	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)					
		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
62.01	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
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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

Provider CCN: 26-0091

Period:
From 01/01/2020
To 12/31/2020Worksheet S-2
Part I
Date/Time Prepared:
9/24/2021 7:02 pm

			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	
		Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))	
		1.00	2.00	3.00	4.00	5.00	
65.00	Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the program name associated with primary care FTEs for each primary care program in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)			0.00	0.00	0.000000	65.00
			Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))		
			1.00	2.00	3.00		
Section 5504 of the ACA Current Year FTE Residents in Nonprovider Settings--Effective for cost reporting periods beginning on or after July 1, 2010							
66.00	Enter in column 1 the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)		0.00	96.34	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)	FAMILY MEDICINE	1350	0.00	16.57	0.000000	67.00
67.01		INTERNAL MEDICINE	1400	0.00	29.54	0.000000	67.01
67.02		PEDIATRICS	2000	0.00	50.71	0.000000	67.02
67.03		FAMILY MEDICINE	3600	0.00	0.41	0.000000	67.03
67.04		PEDIATRICS	5250	0.00	0.41	0.000000	67.04

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 26-0091	Period: From 01/01/2020 To 12/31/2020	Worksheet S-2 Part I Date/Time Prepared: 9/24/2021 7:02 pm	
			1.00	2.00	3.00
Inpatient Psychiatric Facility PPS					
70.00	Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? Enter "Y" for yes or "N" for no.	Y			70.00
71.00	If line 70 is yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost report filed on or before November 15, 2004? Enter "Y" for yes or "N" for no. (see 42 CFR 412.424(d)(1)(iii)(c)) Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)	Y	N	0	71.00
Inpatient Rehabilitation Facility PPS					
75.00	Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF subprovider? Enter "Y" for yes and "N" for no.	N			75.00
76.00	If line 75 is yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)			0	76.00
			1.00		
Long Term Care Hospital PPS					
80.00	Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for no.		N		80.00
81.00	Is this a LTCH co-located within another hospital for part or all of the cost reporting period? Enter "Y" for yes and "N" for no.		N		81.00
TEFRA Providers					
85.00	Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no.		N		85.00
86.00	Did this facility establish a new Other subprovider (excluded unit) under 42 CFR Section §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.				86.00
87.00	Is this hospital an extended neoplastic disease care hospital classified under section 1886(d)(1)(B)(vi)? Enter "Y" for yes or "N" for no.		N		87.00
			V	XIX	
			1.00	2.00	
Title V and XIX Services					
90.00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.	N	Y		90.00
91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.	N	Y		91.00
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.		N		92.00
93.00	Does this facility operate an ICF/IID facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.	N	N		93.00
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.	N	N		94.00
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00		95.00
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.	N	N		96.00
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00		97.00
98.00	Does title V or XIX follow Medicare (title XVIII) for the interns and residents post stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y		98.00
98.01	Does title V or XIX follow Medicare (title XVIII) for the reporting of charges on Wkst. C, Pt. I? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y		98.01
98.02	Does title V or XIX follow Medicare (title XVIII) for the calculation of observation bed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y		98.02
98.03	Does title V or XIX follow Medicare (title XVIII) for a critical access hospital (CAH) reimbursed 101% of inpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N		98.03
98.04	Does title V or XIX follow Medicare (title XVIII) for a CAH reimbursed 101% of outpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N		98.04
98.05	Does title V or XIX follow Medicare (title XVIII) and add back the RCE disallowance on Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y		98.05
98.06	Does title V or XIX follow Medicare (title XVIII) when cost reimbursed for Wkst. D, Pts. I through IV? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y		98.06
Rural Providers					
105.00	Does this hospital qualify as a CAH?	N			105.00
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)	N			106.00
107.00	Column 1: If line 105 is Y, is this facility eligible for cost reimbursement for I&R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) Column 2: If column 1 is Y and line 70 or line 75 is Y, do you train I&Rs in an approved medical education program in the CAH's excluded IPF and/or IRF unit(s)? Enter "Y" for yes or "N" for no in column 2. (see instructions)	N			107.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 26-0091		Period: From 01/01/2020 To 12/31/2020		Worksheet S-2 Part I Date/Time Prepared: 9/24/2021 7:02 pm	
				V	XIX		
				1.00	2.00		
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	N				108.00	
		Physical	Occupational	Speech	Respiratory		
		1.00	2.00	3.00	4.00		
109.00	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.	N	N	N	N	109.00	
				1.00	2.00		
110.00	Did this hospital participate in the Rural Community Hospital Demonstration project (§410A Demonstration) for the current cost reporting period? Enter "Y" for yes or "N" for no. If yes, complete Worksheet E, Part A, lines 200 through 218, and Worksheet E-2, lines 200 through 215, as applicable.	N				110.00	
				1.00	2.00		
111.00	If this facility qualifies as a CAH, did it participate in the Frontier Community Health Integration Project (FCHIP) demonstration for this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If the response to column 1 is Y, enter the integration prong of the FCHIP demo in which this CAH is participating in column 2. Enter all that apply: "A" for Ambulance services; "B" for additional beds; and/or "C" for tele-health services.	N				111.00	
				1.00	2.00		
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.	2				118.00	
		Premiums	Losses	Insurance			
		1.00	2.00	3.00			
118.01	List amounts of malpractice premiums and paid losses:	10,873,336		42,325		118.01	
				1.00	2.00		
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein.	N				118.02	
119.00	DO NOT USE THIS LINE					119.00	
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 1, "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2, "Y" for yes or "N" for no.	N		N		120.00	
121.00	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter "Y" for yes or "N" for no.	Y				121.00	
122.00	Does the cost report contain healthcare related taxes as defined in §1903(w)(3) of the Act? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2 the Worksheet A line number where these taxes are included.	Y		5.00		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.	Y				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.	03/01/1985				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.	09/01/2000				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.	09/01/2000				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	

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 26-0091		Period: From 01/01/2020 To 12/31/2020		Worksheet S-2 Part I Date/Time Prepared: 9/24/2021 7:02 pm	
		1.00		2.00			
131.00	If this is a Medicare certified intestinal transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					131.00	
132.00	If this is a Medicare certified islet transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					132.00	
133.00	Removed and reserved					133.00	
134.00	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.					134.00	
All Providers							
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)	Y		269020		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: SSM HEALTH CARE CORPORATION	Contractor's Name: WPS		Contractor's Number: 05301		141.00	
142.00	Street: 10101 WOODFIELD LANE	PO Box:				142.00	
143.00	City: ST. LOUIS	State: MO		Zip Code: 63132		143.00	
		1.00		2.00			
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.	N		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		2.00			
147.00	Was there a change in the statistical basis? Enter "Y" for yes or "N" for no.	Y				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	N	155.00	
156.00	Subprovider - IPF	N	N	N	N	156.00	
157.00	Subprovider - IRF	N	N	N	N	157.00	
158.00	SUBPROVIDER					158.00	
159.00	SNF	N	N	N	N	159.00	
160.00	HOME HEALTH AGENCY	N	N	N	N	160.00	
161.00	CMHC		N	N	N	161.00	
		1.00		2.00			
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	
		Zip Code		CBSA		FTE/Campus	
		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		2.00			
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: 26-0091	Period: From 01/01/2020 To 12/31/2020	Worksheet S-2 Part I Date/Time Prepared: 9/24/2021 7:02 pm
			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: 26-0091	Period: From 01/01/2020 To 12/31/2020	Worksheet S-2 Part II Date/Time Prepared: 9/24/2021 7:02 pm
			Y/N 1.00	Date 2.00
General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format.				
COMPLETED BY ALL HOSPITALS				
Provider Organization and Operation				
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)	N		1.00
		Y/N 1.00	Date 2.00	V/I 3.00
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.	N		2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)	N		3.00
		Y/N 1.00	Type 2.00	Date 3.00
Financial Data and Reports				
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	Y	A	4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.	Y		5.00
			Y/N 1.00	Legal Oper. 2.00
Approved Educational Activities				
6.00	Column 1: Are costs claimed for nursing school? Column 2: If yes, is the provider is the legal operator of the program?	N		6.00
7.00	Are costs claimed for Allied Health Programs? If "Y" see instructions.	Y		7.00
8.00	Were nursing school and/or allied health programs approved and/or renewed during the cost reporting period? If yes, see instructions.	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.		Y	15.00
		Part A		Part B
		Y/N 1.00	Date 2.00	Y/N 3.00
				Date 4.00
PS&R Data				
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)	Y	05/18/2021	Y
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	N		N
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N		N
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		N

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 26-0091	Period: From 01/01/2020 To 12/31/2020	Worksheet S-2 Part II Date/Time Prepared: 9/24/2021 7:02 pm
		Description	Y/N	Y/N
		0	1.00	3.00
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:		N	N
		Y/N	Date	Y/N
		1.00	2.00	3.00
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N	N	
				1.00
COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)				
Capital Related Cost				
22.00	Have assets been relifed for Medicare purposes? If yes, see instructions			22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.			23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions			24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.			25.00
26.00	Were assets subject to Sec.2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.			26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.			27.00
Interest Expense				
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.			28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions			29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.			30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.			31.00
Purchased Services				
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.			32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.			33.00
Provider-Based Physicians				
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.			34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.			35.00
		Y/N	Date	
		1.00	2.00	
Home Office Costs				
36.00	Were home office costs claimed on the cost report?	Y		36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.	Y		37.00
38.00	If line 36 is yes, was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.	N		38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.	Y		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.	FRANCISCO	JUDILLA	41.00
42.00	Enter the employer/company name of the cost report preparer.	SSM HEALTH		42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	314-989-6835	FRANCISCO.JUDILLA@SSMHEALTH.COM	43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 26-0091	Period: From 01/01/2020 To 12/31/2020	Worksheet S-2 Part II Date/Time Prepared: 9/24/2021 7:02 pm
		3.00		
Cost Report Preparer Contact Information				
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	MANAGER, GOVERNMENT REIMBURSEMENT		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: 26-0091

Period:
From 01/01/2020
To 12/31/2020Worksheet S-3
Part I
Date/Time Prepared:
9/24/2021 7:02 pm

Component		Worksheet A Line Number	No. of Beds	Bed Days Available	CAH Hours	I/P Days / O/P Visits / Trips	
						Title V	
1.00		30.00	261	95,526	0.00	0	1.00
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)						
2.00	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)		261	95,526	0.00	0	7.00
8.00	INTENSIVE CARE UNIT	31.00	57	20,862	0.00	0	8.00
8.01	PEDIATRIC INTENSIVE CARE UNIT	31.01	43	15,738	0.00	0	8.01
8.02	NEONATAL INTENSIVE CARE UNIT	31.02	112	40,992	0.00	0	8.02
8.03	INTERMEDIATE CARE UNIT	31.03	168	61,488	0.00	0	8.03
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)		641	234,606	0.00	0	14.00
15.00	CAH visits					0	15.00
16.00	SUBPROVIDER - IPF	40.00	42	15,372		0	16.00
17.00	SUBPROVIDER - IRF						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						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)		683				27.00
28.00	Observation Bed Days					0	28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)		0	0			32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00	LTCH non-covered days						33.00
33.01	LTCH site neutral days and discharges						33.01

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 26-0091

Period:
From 01/01/2020
To 12/31/2020Worksheet S-3
Part I
Date/Time Prepared:
9/24/2021 7:02 pm

Component		I/P Days / O/P Visits / Trips			Full Time Equivalents		
		Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
		6.00	7.00	8.00	9.00	10.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	6,982	3,290	39,250			1.00
2.00	HMO and other (see instructions)	14,521	50,436				2.00
3.00	HMO IPF Subprovider	1,497	92				3.00
4.00	HMO IRF Subprovider	0	0				4.00
5.00	Hospital Adults & Peds. Swing Bed SNF	0	0	0			5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	0			6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	6,982	3,290	39,250			7.00
8.00	INTENSIVE CARE UNIT	3,868	1,522	11,632			8.00
8.01	PEDIATRIC INTENSIVE CARE UNIT	55	668	8,814			8.01
8.02	NEONATAL INTENSIVE CARE UNIT	0	2,453	28,327			8.02
8.03	INTERMEDIATE CARE UNIT	6,370	2,929	22,137			8.03
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		333	5,340			13.00
14.00	Total (see instructions)	17,275	11,195	115,500	197.12	2,819.19	14.00
15.00	CAH visits	0	0	0			15.00
16.00	SUBPROVIDER - IPF	5,422	3,045	12,611	1.04	60.31	16.00
17.00	SUBPROVIDER - IRF						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						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)			0			24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0.00	0.00	26.25
27.00	Total (sum of lines 14-26)				198.16	2,879.50	27.00
28.00	Observation Bed Days		531	8,621			28.00
29.00	Ambulance Trips	0					29.00
30.00	Employee discount days (see instruction)			1,620			30.00
31.00	Employee discount days - IRF			0			31.00
32.00	Labor & delivery days (see instructions)	0	1,049	1,350			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: 26-0091

Period:
From 01/01/2020
To 12/31/2020Worksheet S-3
Part I
Date/Time Prepared:
9/24/2021 7:02 pm

Component	Full Time Equivalents	Discharges			Total All Patients	
	Nonpaid Workers	Title V	Title XVIII	Title XIX		
	11.00	12.00	13.00	14.00	15.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)		0	2,793	1,948	22,254	1.00
2.00 HMO and other (see instructions)			2,376	8,574		2.00
3.00 HMO IPF Subprovider				40		3.00
4.00 HMO IRF Subprovider				0		4.00
5.00 Hospital Adults & Peds. Swing Bed SNF						5.00
6.00 Hospital Adults & Peds. Swing Bed NF						6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)						7.00
8.00 INTENSIVE CARE UNIT						8.00
8.01 PEDIATRIC INTENSIVE CARE UNIT						8.01
8.02 NEONATAL INTENSIVE CARE UNIT						8.02
8.03 INTERMEDIATE CARE UNIT						8.03
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	2,793	1,948	22,254	14.00
15.00 CAH visits						15.00
16.00 SUBPROVIDER - IPF	0.00	0	348	356	1,331	16.00
17.00 SUBPROVIDER - IRF						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						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: 26-0091

Period:
From 01/01/2020
To 12/31/2020Worksheet S-3
Part II
Date/Time Prepared:
9/24/2021 7:02 pm

	Wkst. A Line Number	Amount Reported	Reclassificati on of Salaries (from Wkst. A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
	1.00	2.00	3.00	4.00	5.00	6.00	
PART II - WAGE DATA							
SALARIES							
1.00	Total salaries (see instructions)	200.00	225,204,717	0	225,204,717	5,989,361.00	37.60
2.00	Non-physician anesthetist Part A		0	0	0	0.00	0.00
3.00	Non-physician anesthetist Part B		0	0	0	0.00	0.00
4.00	Physician-Part A - Administrative		546,248	0	546,248	3,798.00	143.83
4.01	Physicians - Part A - Teaching		739,301	0	739,301	7,043.00	104.97
5.00	Physician and Non Physician-Part B		19,690,251	0	19,690,251	217,638.00	90.47
6.00	Non-physician-Part B for hospital-based RHC and FQHC services		8,410	0	8,410	144.00	58.40
7.00	Interns & residents (in an approved program)	21.00	0	1,830,615	1,830,615	65,960.00	27.75
7.01	Contracted interns and residents (in an approved programs)		13,627,032	0	13,627,032	363,460.00	37.49
8.00	Home office and/or related organization personnel		0	0	0	0.00	0.00
9.00	SNF	44.00	0	0	0	0.00	0.00
10.00	Excluded area salaries (see instructions)		14,030,612	479,506	14,510,118	347,228.00	41.79
OTHER WAGES & RELATED COSTS							
11.00	Contract labor: Direct Patient Care		21,508,467	0	21,508,467	460,893.00	46.67
12.00	Contract labor: Top level management and other management and administrative services		0	0	0	0.00	0.00
13.00	Contract labor: Physician-Part A - Administrative		7,190,295	0	7,190,295	47,258.00	152.15
14.00	Home office and/or related organization salaries and wage-related costs		0	0	0	0.00	0.00
14.01	Home office salaries		10,371,042	0	10,371,042	244,565.00	42.41
14.02	Related organization salaries		0	0	0	0.00	0.00
15.00	Home office: Physician Part A - Administrative		0	0	0	0.00	0.00
16.00	Home office and Contract Physicians Part A - Teaching		0	0	0	0.00	0.00
16.01	Home office Physicians Part A - Teaching		0	0	0	0.00	0.00
16.02	Home office contract Physicians Part A - Teaching		25,427,539	0	25,427,539	165,137.00	153.98
WAGE-RELATED COSTS							
17.00	Wage-related costs (core) (see instructions)		69,600,144	0	69,600,144		
18.00	Wage-related costs (other) (see instructions)						
19.00	Excluded areas		5,669,896	0	5,669,896		
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		50,745	0	50,745		
22.01	Physician Part A - Teaching		94,535	0	94,535		
23.00	Physician Part B		2,832,599	0	2,832,599		
24.00	Wage-related costs (RHC/FQHC)		1,870	0	1,870		
25.00	Interns & residents (in an approved program)		885,353	0	885,353		
25.50	Home office wage-related (core)		3,917,492	0	3,917,492		
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: 26-0091

Period:
From 01/01/2020
To 12/31/2020Worksheet S-3
Part II
Date/Time Prepared:
9/24/2021 7:02 pm

		Wkst. A Line Number	Amount Reported	Reclassificati on of Salaries (from Wkst. A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
25.53	Home office: Physicians Part A - Teaching - wage-related (core)		0	0	0			25.53
OVERHEAD COSTS - DIRECT SALARIES								
26.00	Employee Benefits Department	4.00	1,862,956	0	1,862,956	3,196.00	582.90	26.00
27.00	Administrative & General	5.00	21,999,919	-810,829	21,189,090	234,494.00	90.36	27.00
28.00	Administrative & General under contract (see inst.)		448,082	0	448,082	6,800.00	65.89	28.00
29.00	Maintenance & Repairs	6.00	0	0	0	0.00	0.00	29.00
30.00	Operation of Plant	7.00	3,043,971	0	3,043,971	107,756.00	28.25	30.00
31.00	Laundry & Linen Service	8.00	226,687	0	226,687	18,330.00	12.37	31.00
32.00	Housekeeping	9.00	4,396,490	0	4,396,490	358,236.00	12.27	32.00
33.00	Housekeeping under contract (see instructions)		687,354	0	687,354	23,324.00	29.47	33.00
34.00	Dietary	10.00	3,809,888	-2,727,154	1,082,734	88,238.00	12.27	34.00
35.00	Dietary under contract (see instructions)		1,188,869	0	1,188,869	39,949.00	29.76	35.00
36.00	Cafeteria	11.00	0	2,727,154	2,727,154	179,992.00	15.15	36.00
37.00	Maintenance of Personnel	12.00	0	0	0	0.00	0.00	37.00
38.00	Nursing Administration	13.00	5,285,378	0	5,285,378	122,954.00	42.99	38.00
39.00	Central Services and Supply	14.00	531,454	568,326	1,099,780	62,290.00	17.66	39.00
40.00	Pharmacy	15.00	7,626,463	-479,506	7,146,957	161,218.00	44.33	40.00
41.00	Medical Records & Medical Records Library	16.00	681,142	0	681,142	34,486.00	19.75	41.00
42.00	Social Service	17.00	1,320,307	207,804	1,528,111	28,820.00	53.02	42.00
43.00	Other General Service	18.00	0	0	0	0.00	0.00	43.00

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 26-0091

Period:
From 01/01/2020
To 12/31/2020Worksheet S-3
Part III
Date/Time Prepared:
9/24/2021 7:02 pm

	Worksheet A Line Number	Amount Reported	Reclassificati on of Salaries (from Worksheet A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
	1.00	2.00	3.00	4.00	5.00	6.00	
PART III - HOSPITAL WAGE INDEX SUMMARY							
1.00	Net salaries (see instructions)	193,464,028	-1,830,615	191,633,413	5,405,189.00	35.45	1.00
2.00	Excluded area salaries (see instructions)	14,030,612	479,506	14,510,118	347,228.00	41.79	2.00
3.00	Subtotal salaries (line 1 minus line 2)	179,433,416	-2,310,121	177,123,295	5,057,961.00	35.02	3.00
4.00	Subtotal other wages & related costs (see inst.)	39,069,804	0	39,069,804	752,716.00	51.91	4.00
5.00	Subtotal wage-related costs (see inst.)	73,568,381	0	73,568,381	0.00	41.54	5.00
6.00	Total (sum of lines 3 thru 5)	292,071,601	-2,310,121	289,761,480	5,810,677.00	49.87	6.00
7.00	Total overhead cost (see instructions)	53,108,960	-514,205	52,594,755	1,470,083.00	35.78	7.00

HOSPITAL WAGE RELATED COSTS		Provider CCN: 26-0091	Period: From 01/01/2020 To 12/31/2020	Worksheet S-3 Part IV Date/Time Prepared: 9/24/2021 7:02 pm
				Amount Reported
				1.00
PART IV - WAGE RELATED COSTS				
Part A - Core List				
RETIREMENT COST				
1.00	401K Employer Contributions			0 1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution			0 2.00
3.00	Nonqualified Defined Benefit Plan Cost (see instructions)		9,917,834	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)		34,643,268	8.01
8.02	Health Insurance (Self Funded with a Third Party Administrator)		0	8.02
8.03	Health Insurance (Purchased)		0	8.03
9.00	Prescription Drug Plan		13,993,186	9.00
10.00	Dental, Hearing and Vision Plan		1,020,740	10.00
11.00	Life Insurance (If employee is owner or beneficiary)		0	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)		234,858	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)		0	14.00
15.00	'Workers' Compensation Insurance		2,150,181	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		16,392,086	17.00
18.00	Medicare Taxes - Employers Portion Only		0	18.00
19.00	Unemployment Insurance		308,495	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		474,494	23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)		79,135,142	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: 26-0091

Period:
From 01/01/2020
To 12/31/2020Worksheet S-3
Part V
Date/Time Prepared:
9/24/2021 7:02 pm

Cost Center Description		Contract Labor	Benefit Cost	
		1.00	2.00	
PART V - Contract Labor and Benefit Cost				
Hospital and Hospital-Based Component Identification:				
1.00	Total facility's contract labor and benefit cost	21,508,467	79,135,142	1.00
2.00	Hospital	21,508,467	69,600,144	2.00
3.00	Subprovider - IPF	0	1,885,352	3.00
4.00	Subprovider - IRF			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			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	7,649,646	18.00

HOSPITAL RENAL DIALYSIS DEPARTMENT STATISTICAL DATA

Provider CCN: 26-0091

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

Worksheet S-5

Date/Time Prepared:
9/24/2021 7:02 pm

		Outpatient		Training		Home			
		Regular	High Flux	Hemodialysis	CAPD / CCPD	Hemodialysis	CAPD / CCPD		
		1.00	2.00	3.00	4.00	5.00	6.00		
1.00	Number of patients in program at end of cost reporting period	13	7	0	3	0	6	1.00	
2.00	Number of times per week patient receives dialysis	3.50	3.50	0.00	0.00	0.00	7.00	2.00	
3.00	Average patient dialysis time including setup	6.00	6.00	0.00	13.00			3.00	
4.00	CAPD exchanges per day				12.00		12.00	4.00	
5.00	Number of days in year dialysis furnished	365	365					5.00	
6.00	Number of stations	4	4	0	0			6.00	
7.00	Treatment capacity per day per station	2	2					7.00	
8.00	Utilization (see instructions)	0.02	0.07					8.00	
9.00	Average times dialyzers re-used	0.00	0.00					9.00	
10.00	Percentage of patients re-using dialyzers	0.00	0.00					10.00	
							Y/N		
							1.00		
ESRD PPS									
10.01	Is the dialysis facility approved as a low-volume facility for this cost reporting period? Enter "Y" for yes or "N" for no. (see instructions)						Y	10.01	
10.02	Did your facility elect 100% PPS effective January 1, 2011? Enter "Y" for yes or "N" for no. (See instructions for "new" providers.)						Y	10.02	
						Prior to 1/1	After 12/31		
						1.00	2.00		
10.03	If you responded "N" to line 10.02, enter in column 1 the year of transition for periods prior to January 1 and enter in column 2 the year of transition for periods after December 31. (see instructions)						0	0	10.03
TRANSPLANT INFORMATION									
11.00	Number of patients on transplant list						4		11.00
12.00	Number of patients transplanted during the cost reporting period						4		12.00
EPOETIN									
13.00	Net costs of Epoetin furnished to all maintenance dialysis patients by the provider.								13.00
14.00	Epoetin amount from Worksheet A for Home Dialysis program								14.00
15.00	Number of EPO units furnished relating to the renal dialysis department								15.00
16.00	Number of EPO units furnished relating to the home dialysis department								16.00
ARANESP									
17.00	Net costs of ARANESP furnished to all maintenance dialysis patients by the provider.								17.00
18.00	ARANESP amount from Worksheet A for Home Dialysis program								18.00
19.00	Number of ARANESP units furnished relating to the renal dialysis department								19.00
20.00	Number of ARANESP units furnished relating to the home dialysis department								20.00
						MCP	INITIAL METHOD		
						1.00	2.00		
PHYSICIAN PAYMENT METHOD									
21.00	Enter "X" if method(s) is applicable						X		21.00
		ESA Description	Net Cost of ESAs for Renal Patients	Net Cost of ESAs for Home Patients	Number of ESA Units - Renal Dialysis Dept.	Number of ESA Units - Home Dialysis Dept.			
		1.00	2.00	3.00	4.00	5.00			
ESAs									
22.00	Enter in column 1 the ESA description. Enter in column 2 the net costs of ESAs furnished to all renal dialysis patients. Enter in column 3 the net cost of ESAs furnished to all home dialysis program patients. Enter in column 4 the number of ESA units furnished to patients in the renal dialysis department. Enter in column 5 the number of units furnished to patients in the home dialysis program. (see instructions)	PROCRIT 2,000	2,233	0	470	0		22.00	
22.01		PROCRIT 4,000	606	0	254	0		22.01	
22.02		PROCRIT 10,000	136	0	184	0		22.02	
22.03		PROCRIT 20,000	608	0	1,271	0		22.03	
22.04		PROCRIT 40,000	30,229	0	126,960	0		22.04	

HOSPITAL RENAL DIALYSIS DEPARTMENT STATISTICAL DATA

Provider CCN: 26-0091

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

Worksheet S-5

Date/Time Prepared:
9/24/2021 7:02 pm

		CCN	Treatments	
		1.00	2.00	
23.00	If line 10.01 is yes, enter in column 1 the CCN for each renal dialysis facility listed on Worksheet S-2, Part I, line 18, and its subscripts. Enter in column 2, the total treatments for each CCN. (see instructions)	26320	3,103	23.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA		Provider CCN: 26-0091	Period: From 01/01/2020 To 12/31/2020	Worksheet S-10 Date/Time Prepared: 9/24/2021 7:02 pm	
				1.00	
Uncompensated and indigent care cost computation					
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided by line 202 column 8)		0.248330		1.00
Medicaid (see instructions for each line)					
2.00	Net revenue from Medicaid		151,972,540		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		122,871,244		5.00
6.00	Medicaid charges		727,612,620		6.00
7.00	Medicaid cost (line 1 times line 6)		180,688,042		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)	56,876,778	5,629,970	62,506,748	20.00
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	14,124,210	5,629,970	19,754,180	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)	14,124,210	5,629,970	19,754,180	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)		26,282,860		26.00
27.00	Medicare reimbursable bad debts for the entire hospital complex (see instructions)		1,623,670		27.00
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)		2,497,953		27.01
28.00	Non-Medicare bad debt expense (see instructions)		23,784,907		28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)		6,780,789		29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)		26,534,969		30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)		26,534,969		31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 26-0091

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

Worksheet A

Date/Time Prepared:
9/24/2021 7:02 pm

Cost Center Description		Salaries	Other	Total (col. 1 + col. 2)	Reclassification ons (See A-6)	Reclassified Trial Balance (col. 3 + col. 4)	
		1.00	2.00	3.00	4.00	5.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT		17,479,943	17,479,943	0	17,479,943 1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP		13,671,592	13,671,592	0	13,671,592 2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	1,862,956	48,164,159	50,027,115	0	50,027,115 4.00
5.00	00500	ADMINISTRATIVE & GENERAL	21,999,919	153,487,204	175,487,123	-3,765,882	171,721,241 5.00
7.00	00700	OPERATION OF PLANT	3,043,971	16,030,140	19,073,111	-654	19,073,457 7.00
8.00	00800	LAUNDRY & LINEN SERVICE	226,687	1,871,828	2,098,515	-41,868	2,056,647 8.00
9.00	00900	HOUSEKEEPING	4,396,490	3,260,953	7,657,443	-208,050	7,449,393 9.00
10.00	01000	DIETARY	3,809,888	6,796,314	10,606,202	-7,902,209	2,703,993 10.00
11.00	01100	CAFETERIA	0	0	0	7,897,232	7,897,232 11.00
13.00	01300	NURSING ADMINISTRATION	5,285,378	1,564,122	6,849,500	-1,137	6,848,363 13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	531,454	2,107,920	2,639,374	2,071,094	4,710,468 14.00
15.00	01500	PHARMACY	7,626,463	50,942,442	58,568,905	-49,934,710	8,634,195 15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	681,142	304,371	985,513	-272	985,241 16.00
17.00	01700	SOCIAL SERVICE	1,320,307	367,619	1,687,926	315,619	2,003,545 17.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	0	0	1,830,615	1,830,615 21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	2,574,556	63,790,765	66,365,321	-1,830,634	64,534,687 22.00
23.00	02300	PARAMED ED - PHARMACY RESIDENCY	367,950	39,304	407,254	52,771	460,025 23.00
23.01	02301	PARAMED ED - PHARMACY RESIDENCY - CG	373,091	32,882	405,973	441,324	847,297 23.01
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	22,227,955	6,871,650	29,099,605	-4,246,291	24,853,314 30.00
31.00	03100	INTENSIVE CARE UNIT	8,780,717	4,073,862	12,854,579	-4,988,829	7,865,750 31.00
31.01	02080	PEDIATRIC INTENSIVE CARE UNIT	7,118,391	2,043,786	9,162,177	-1,606,625	7,555,552 31.01
31.02	02060	NEONATAL INTENSIVE CARE UNIT	18,637,588	4,718,559	23,356,147	-1,681,757	21,674,390 31.02
31.03	02400	INTERMEDIATE CARE UNIT	11,679,135	2,507,904	14,187,039	3,402,125	17,589,164 31.03
40.00	04000	SUBPROVIDER - IPF	5,279,661	1,572,525	6,852,186	-66,948	6,785,238 40.00
43.00	04300	NURSERY	0	0	0	2,255,635	2,255,635 43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	10,092,588	21,743,621	31,836,209	-17,436,889	14,399,320 50.00
51.00	05100	RECOVERY ROOM	1,703,225	267,650	1,970,875	-85,275	1,885,600 51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	9,088,897	2,651,983	11,740,880	-1,474,046	10,266,834 52.00
53.00	05300	ANESTHESIOLOGY	719,021	6,193,076	6,912,097	-1,210,311	5,701,786 53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	6,129,939	5,686,307	11,816,246	-3,055,053	8,761,193 54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	1,306,572	4,391,321	5,697,893	-21,903	5,675,990 55.00
56.00	05600	RADIOISOTOPE	237,201	521,185	758,386	-5,916	752,470 56.00
57.00	05700	CT SCAN	1,112,562	870,547	1,983,109	-274,065	1,709,044 57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	716,044	369,194	1,085,238	-143,384	941,854 58.00
59.00	05900	CARDIAC CATHETERIZATION	1,254,833	6,263,590	7,518,423	-4,916,164	2,602,259 59.00
60.00	06000	LABORATORY	5,355,782	10,371,039	15,726,821	-868,867	14,857,954 60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	1,038,915	2,610,887	3,649,802	4,741,162	8,390,964 62.00
64.00	06400	INTRAVENOUS THERAPY	2,831,004	1,821,409	4,652,413	-534,851	4,117,562 64.00
65.00	06500	RESPIRATORY THERAPY	5,985,452	3,467,151	9,452,603	-893,892	8,558,711 65.00
66.00	06600	PHYSICAL THERAPY	735,794	1,523,561	2,259,355	-5,372	2,253,983 66.00
66.01	06601	CLINICAL NUTRITION	1,075,390	89,337	1,164,727	0	1,164,727 66.01
67.00	06700	OCCUPATIONAL THERAPY	532,435	688,544	1,220,979	-10,026	1,210,953 67.00
68.00	06800	SPEECH PATHOLOGY	770,853	608,410	1,379,263	-241,351	1,137,912 68.00
69.00	06900	ELECTROCARDIOLOGY	2,386,873	663,043	3,049,916	-53,039	2,996,877 69.00
69.01	06901	CARDIAC REHAB	200,258	24,903	225,161	-2,122	223,039 69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	1,042,192	508,019	1,550,211	-98,830	1,451,381 70.00
70.01	03320	ELECTROSHOCK THERAPY	105,020	13,622	118,642	-4,244	114,398 70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	29,358,930	29,358,930 71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	13,360,542	13,360,542 72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	45,030,896	45,030,896 73.00
74.00	07400	RENAL DIALYSIS	645,218	1,762,340	2,407,558	-355,539	2,052,019 74.00
76.00	03330	ENDOSCOPY	1,612,891	1,690,789	3,303,680	-833,695	2,469,985 76.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	20,783,182	8,227,652	29,010,834	-495,138	28,515,696 90.00
91.00	09100	EMERGENCY	11,908,967	4,029,586	15,938,553	-1,462,107	14,476,446 91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					92.00
SPECIAL PURPOSE COST CENTERS							
105.00	10500	KIDNEY ACQUISITION	260,878	899,662	1,160,540	-177,396	983,144 105.00
106.00	10600	HEART ACQUISITION	0	0	0	88,698	88,698 106.00
107.00	10700	LIVER ACQUISITION	0	0	0	88,698	88,698 107.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	217,455,685	489,658,272	707,113,957	0	707,113,957 118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	50,581	103,884	154,465	0	154,465 190.00
191.00	19100	RESEARCH	0	0	0	0	0 191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	159,357	375,490	534,847	0	534,847 192.00
194.00	07950	NONREIMBURSABLE COST CENTERS	1,896,711	790,506	2,687,217	0	2,687,217 194.00
194.02	07952	POISON CONTROL	2,341,371	952,078	3,293,449	0	3,293,449 194.02
194.03	07953	RETAIL PHARMACY	1,463,920	35,269,956	36,733,876	0	36,733,876 194.03
194.04	07954	RURAL HEALTH CLINIC - 5295	1,068,222	617,400	1,685,622	0	1,685,622 194.04

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 26-0091

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

Worksheet A

Date/Time Prepared:
9/24/2021 7:02 pm

Cost Center Description			Salaries	Other	Total (col. 1 + col. 2)	Reclassificati ons (See A-6)	Reclassified Trial Balance (col. 3 +- col. 4)	
			1.00	2.00	3.00	4.00	5.00	
194.05	07955	RURAL HEALTH CLINIC - 5296	768,870	354,603	1,123,473	0	1,123,473	194.05
200.00		TOTAL (SUM OF LINES 118 through 199)	225,204,717	528,122,189	753,326,906	0	753,326,906	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 26-0091

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

Worksheet A

Date/Time Prepared:
9/24/2021 7:02 pm

Cost Center Description			Adjustments (See A-8)	Net Expenses For Allocation	
			6.00	7.00	
GENERAL SERVICE COST CENTERS					
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT	-2,397,062	15,082,881	1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP	3,535,655	17,207,247	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-16,066,062	33,961,053	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-74,692,029	97,029,212	5.00
7.00	00700	OPERATION OF PLANT	-852,925	18,220,532	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	-66,087	1,990,560	8.00
9.00	00900	HOUSEKEEPING	-22,499	7,426,894	9.00
10.00	01000	DIETARY	-353	2,703,640	10.00
11.00	01100	CAFETERIA	-2,628,522	5,268,710	11.00
13.00	01300	NURSING ADMINISTRATION	-122,593	6,725,770	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	-1,651	4,708,817	14.00
15.00	01500	PHARMACY	-212,824	8,421,371	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-2,799	982,442	16.00
17.00	01700	SOCIAL SERVICE	-75,273	1,928,272	17.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	-1,830,615	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	-31,404,449	33,130,238	22.00
23.00	02300	PARAMED ED - PHARMACY RESIDENCY	-107	459,918	23.00
23.01	02301	PARAMED ED - PHARMACY RESIDENCY - CG	0	847,297	23.01
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	-3,260,325	21,592,989	30.00
31.00	03100	INTENSIVE CARE UNIT	-1,620,011	6,245,739	31.00
31.01	02080	PEDIATRIC INTENSIVE CARE UNIT	-34,518	7,521,034	31.01
31.02	02060	NEONATAL INTENSIVE CARE UNIT	-2,989,271	18,685,119	31.02
31.03	02400	INTERMEDIATE CARE UNIT	-3,748	17,585,416	31.03
40.00	04000	SUBPROVIDER - IPF	-456,817	6,328,421	40.00
43.00	04300	NURSERY	0	2,255,635	43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	-806,316	13,593,004	50.00
51.00	05100	RECOVERY ROOM	-874	1,884,726	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	-647,002	9,619,832	52.00
53.00	05300	ANESTHESIOLOGY	-4,657,389	1,044,397	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-338,339	8,422,854	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	-247,752	5,428,238	55.00
56.00	05600	RADIOISOTOPE	-180	752,290	56.00
57.00	05700	CT SCAN	-23,585	1,685,459	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	-7,485	934,369	58.00
59.00	05900	CARDIAC CATHETERIZATION	-33,196	2,569,063	59.00
60.00	06000	LABORATORY	-1,005,067	13,852,887	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	-547,276	7,843,688	62.00
64.00	06400	INTRAVENOUS THERAPY	-117,924	3,999,638	64.00
65.00	06500	RESPIRATORY THERAPY	-151,000	8,407,711	65.00
66.00	06600	PHYSICAL THERAPY	-111	2,253,872	66.00
66.01	06601	CLINICAL NUTRITION	-50,727	1,114,000	66.01
67.00	06700	OCCUPATIONAL THERAPY	-11,492	1,199,461	67.00
68.00	06800	SPEECH PATHOLOGY	-53,968	1,083,944	68.00
69.00	06900	ELECTROCARDIOLOGY	-195,149	2,801,728	69.00
69.01	06901	CARDIAC REHAB	0	223,039	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	-470,771	980,610	70.00
70.01	03320	ELECTROSHOCK THERAPY	-73	114,325	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	-1,283,909	28,075,021	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	13,360,542	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	45,030,896	73.00
74.00	07400	RENAL DIALYSIS	-3,434	2,048,585	74.00
76.00	03330	ENDOSCOPY	-542	2,469,443	76.00
OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	-8,610,636	19,905,060	90.00
91.00	09100	EMERGENCY	-443,724	14,032,722	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)			92.00
SPECIAL PURPOSE COST CENTERS					
105.00	10500	KIDNEY ACQUISITION	0	983,144	105.00
106.00	10600	HEART ACQUISITION	0	88,698	106.00
107.00	10700	LIVER ACQUISITION	0	88,698	107.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-154,912,806	552,201,151	118.00
NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	154,465	190.00
191.00	19100	RESEARCH	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	534,847	192.00
194.00	07950	NONREIMBURSABLE COST CENTERS	0	2,687,217	194.00
194.02	07952	POISON CONTROL	0	3,293,449	194.02
194.03	07953	RETAIL PHARMACY	0	36,733,876	194.03
194.04	07954	RURAL HEALTH CLINIC - 5295	0	1,685,622	194.04
194.05	07955	RURAL HEALTH CLINIC - 5296	0	1,123,473	194.05
200.00		TOTAL (SUM OF LINES 118 through 199)	-154,912,806	598,414,100	200.00

RECLASSIFICATIONS

Provider CCN: 26-0091

Period:
From 01/01/2020
To 12/31/2020Worksheet A-6
Date/Time Prepared:
9/24/2021 7:02 pm

	Increases					
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
	A - DRUG, SUPPLY, IMPLANT, IV, & BLOOD					
1.00	WHOLE BLOOD & PACKED RED BLOOD CELLS	62.00	0	4,741,162		1.00
2.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	29,358,930		2.00
3.00	IMPL. DEV. CHARGED TO PATIENT	72.00	0	13,360,542		3.00
4.00	DRUGS CHARGED TO PATIENTS	73.00	0	45,030,896		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
	TOTALS		0	92,491,530		
	B - DIETARY					
1.00	CAFETERIA	11.00	2,727,154	5,170,078		1.00
	TOTALS		2,727,154	5,170,078		
	C - BEHAVIORIAL HEALTH ADMINISTRATION					
1.00	SOCIAL SERVICE	17.00	207,804	107,815		1.00
2.00	EMERGENCY	91.00	181,877	138,018		2.00
	TOTALS		389,681	245,833		
	D - INPATIENT, L&D					
1.00	NEONATAL INTENSIVE CARE UNIT	31.02	103,961	21,427		1.00
2.00	INTERMEDIATE CARE UNIT	31.03	3,346,007	1,186,589		2.00
3.00	NURSERY	43.00	1,536,084	719,551		3.00
4.00		0.00	0	0		4.00
	TOTALS		4,986,052	1,927,567		
	E - INTERN & RESIDENT					
1.00	I&R SERVICES-SALARY & FRINGES APPRVD	21.00	1,830,615	0		1.00
	TOTALS		1,830,615	0		
	F - PHARMACY RESIDENT					
1.00	PARAMED ED - PHARMACY RESIDENCY	23.00	42,688	10,083		1.00
2.00	PARAMED ED - PHARMACY RESIDENCY - CG	23.01	436,818	4,506		2.00
	TOTALS		479,506	14,589		
	H - ORGAN TRANSPLANT					
1.00	HEART ACQUISITION	106.00	44,349	44,349		1.00
2.00	LIVER ACQUISITION	107.00	44,349	44,349		2.00
	TOTALS		88,698	88,698		

RECLASSIFICATIONS

Provider CCN: 26-0091

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

Worksheet A-6

Date/Time Prepared:
9/24/2021 7:02 pm

Increases					
Cost Center	Line #	Salary	Other		
2.00	3.00	4.00	5.00		
I - CENTRAL DISTRIBUTION					
1.00	CENTRAL SERVICES & SUPPLY	14.00	568,326	1,510,616	1.00
	TOTALS		568,326	1,510,616	
500.00	Grand Total: Increases		11,070,032	101,448,911	500.00

RECLASSIFICATIONS

Provider CCN: 26-0091

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

Worksheet A-6

Date/Time Prepared:
9/24/2021 7:02 pm

	Decreases							
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.			
	6.00	7.00	8.00	9.00	10.00			
	A - DRUG, SUPPLY, IMPLANT, IV, & BLOOD							
1.00	ADMINISTRATIVE & GENERAL	5.00	0	1,260,413	0			1.00
2.00	OPERATION OF PLANT	7.00	0	654	0			2.00
3.00	LAUNDRY & LINEN SERVICE	8.00	0	41,868	0			3.00
4.00	HOUSEKEEPING	9.00	0	208,050	0			4.00
5.00	DIETARY	10.00	0	4,977	0			5.00
6.00	NURSING ADMINISTRATION	13.00	0	1,137	0			6.00
7.00	CENTRAL SERVICES & SUPPLY	14.00	0	7,848	0			7.00
8.00	PHARMACY	15.00	0	49,440,615	0			8.00
9.00	MEDICAL RECORDS & LIBRARY	16.00	0	272	0			9.00
10.00	I&R SERVICES-OTHER PRGM	22.00	0	19	0			10.00
	COSTS APPRVD							
11.00	ADULTS & PEDIATRICS	30.00	0	1,862,365	0			11.00
12.00	INTENSIVE CARE UNIT	31.00	0	1,632,255	0			12.00
13.00	PEDIATRIC INTENSIVE CARE UNIT	31.01	0	1,143,905	0			13.00
	UNIT							
14.00	NEONATAL INTENSIVE CARE UNIT	31.02	0	1,807,145	0			14.00
15.00	INTERMEDIATE CARE UNIT	31.03	0	1,130,471	0			15.00
16.00	SUBPROVIDER - IPF	40.00	0	66,948	0			16.00
17.00	OPERATING ROOM	50.00	0	17,436,889	0			17.00
18.00	RECOVERY ROOM	51.00	0	85,275	0			18.00
19.00	DELIVERY ROOM & LABOR ROOM	52.00	0	763,647	0			19.00
20.00	ANESTHESIOLOGY	53.00	0	1,210,311	0			20.00
21.00	RADIOLOGY-DIAGNOSTIC	54.00	0	3,055,053	0			21.00
22.00	RADIOLOGY-THERAPEUTIC	55.00	0	21,903	0			22.00
23.00	RADIOISOTOPE	56.00	0	5,916	0			23.00
24.00	CT SCAN	57.00	0	274,065	0			24.00
25.00	MAGNETIC RESONANCE IMAGING (MRI)	58.00	0	143,384	0			25.00
26.00	CARDIAC CATHETERIZATION	59.00	0	4,916,164	0			26.00
27.00	LABORATORY	60.00	0	868,867	0			27.00
28.00	INTRAVENOUS THERAPY	64.00	0	534,851	0			28.00
29.00	RESPIRATORY THERAPY	65.00	0	893,892	0			29.00
30.00	PHYSICAL THERAPY	66.00	0	5,372	0			30.00
31.00	OCCUPATIONAL THERAPY	67.00	0	10,026	0			31.00
32.00	SPEECH PATHOLOGY	68.00	0	241,351	0			32.00
33.00	ELECTROCARDIOLOGY	69.00	0	53,039	0			33.00
34.00	CARDIAC REHAB	69.01	0	2,122	0			34.00
35.00	ELECTROENCEPHALOGRAPHY	70.00	0	98,830	0			35.00
36.00	ELECTROSHOCK THERAPY	70.01	0	4,244	0			36.00
37.00	RENAL DIALYSIS	74.00	0	355,539	0			37.00
38.00	ENDOSCOPY	76.00	0	833,695	0			38.00
39.00	CLINIC	90.00	0	495,138	0			39.00
40.00	EMERGENCY	91.00	0	1,573,015	0			40.00
	TOTALS		0	92,491,530				
	B - DIETARY							
1.00	DIETARY	10.00	2,727,154	5,170,078	0			1.00
	TOTALS		2,727,154	5,170,078				
	C - BEHAVIORIAL HEALTH ADMINISTRATION							
1.00	EMERGENCY	91.00	147,178	61,809	0			1.00
2.00	ADMINISTRATIVE & GENERAL	5.00	242,503	184,024	0			2.00
	TOTALS		389,681	245,833				
	D - INPATIENT, L&D							
1.00	ADULTS & PEDIATRICS	30.00	1,645,430	738,496	0			1.00
2.00	INTENSIVE CARE UNIT	31.00	2,446,886	909,688	0			2.00
3.00	PEDIATRIC INTENSIVE CARE UNIT	31.01	347,909	114,811	0			3.00
4.00	DELIVERY ROOM & LABOR ROOM	52.00	545,827	164,572	0			4.00
	TOTALS		4,986,052	1,927,567				
	E - INTERN & RESIDENT							
1.00	I&R SERVICES-OTHER PRGM	22.00	1,830,615	0	0			1.00
	COSTS APPRVD							
	TOTALS		1,830,615	0				
	F - PHARMACY RESIDENT							
1.00	PHARMACY	15.00	479,506	14,589	0			1.00
2.00		0.00	0	0	0			2.00
	TOTALS		479,506	14,589				
	H - ORGAN TRANSPLANT							
1.00	KIDNEY ACQUISITION	105.00	88,698	88,698	0			1.00
2.00		0.00	0	0	0			2.00
	TOTALS		88,698	88,698				

RECLASSIFICATIONS

Provider CCN: 26-0091

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

Worksheet A-6

Date/Time Prepared:
9/24/2021 7:02 pm

	Decreases				Wkst. A-7 Ref.	
	Cost Center	Line #	Salary	Other		
	6.00	7.00	8.00	9.00		
	I - CENTRAL DISTRIBUTION					
1.00	ADMINISTRATIVE & GENERAL	5.00	568,326	1,510,616		
	TOTALS		568,326	1,510,616		
500.00	Grand Total: Decreases		11,070,032	101,448,911		500.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 26-0091

Period:
From 01/01/2020
To 12/31/2020Worksheet A-7
Part I
Date/Time Prepared:
9/24/2021 7:02 pm

		Beginning Balances	Acquisitions			Disposals and Retirements	
			Purchases	Donation	Total		
		1.00	2.00	3.00	4.00	5.00	
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES							
1.00	Land	22,484,768	0	0	0	901,542	1.00
2.00	Land Improvements	10,418,858	0	11,199	11,199	0	2.00
3.00	Buildings and Fixtures	708,866,049	22,046,279	-2,715,629	19,330,650	27,001,588	3.00
4.00	Building Improvements	5,471,779	376,191	326,401	702,592	392,099	4.00
5.00	Fixed Equipment	0	0	0	0	0	5.00
6.00	Movable Equipment	1,398,984	0	0	0	0	6.00
7.00	HIT designated Assets	207,811	91,624	45,411	137,035	0	7.00
8.00	Subtotal (sum of lines 1-7)	748,848,249	22,514,094	-2,332,618	20,181,476	28,295,229	8.00
9.00	Reconciling Items	18,300,535	9,424,830	-14,770,548	-5,345,718	847,947	9.00
10.00	Total (line 8 minus line 9)	730,547,714	13,089,264	12,437,930	25,527,194	27,447,282	10.00
		Ending Balance	Fully Depreciated Assets				
		6.00	7.00				
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES							
1.00	Land	21,583,226	0				1.00
2.00	Land Improvements	10,430,057	0				2.00
3.00	Buildings and Fixtures	701,195,111	0				3.00
4.00	Building Improvements	5,782,272	0				4.00
5.00	Fixed Equipment	0	0				5.00
6.00	Movable Equipment	1,398,984	0				6.00
7.00	HIT designated Assets	344,846	0				7.00
8.00	Subtotal (sum of lines 1-7)	740,734,496	0				8.00
9.00	Reconciling Items	12,106,870	0				9.00
10.00	Total (line 8 minus line 9)	728,627,626	0				10.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 26-0091

Period:
From 01/01/2020
To 12/31/2020Worksheet A-7
Part II
Date/Time Prepared:
9/24/2021 7:02 pm

Cost Center Description		SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	NEW CAP REL COSTS-BLDG & FIXT	14,132,226	0	3,347,717	0	0	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	13,671,592	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	27,803,818	0	3,347,717	0	0	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Other	Total (1) (sum				
		Capital-Related Costs (see instructions)	of cols. 9 through 14)				
		14.00	15.00				
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	17,479,943				1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	13,671,592				2.00
3.00	Total (sum of lines 1-2)	0	31,151,535				3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 26-0091

Period:
From 01/01/2020
To 12/31/2020Worksheet A-7
Part III
Date/Time Prepared:
9/24/2021 7:02 pm

Cost Center Description		COMPUTATION OF RATIOS			ALLOCATION OF OTHER CAPITAL		
		Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	
		1.00	2.00	3.00	4.00	5.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	NEW CAP REL COSTS-BLDG & FIXT	726,883,795	0	726,883,795	0.997607	0	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	1,743,830	0	1,743,830	0.002393	0	2.00
3.00	Total (sum of lines 1-2)	728,627,625	0	728,627,625	1.000000	0	3.00
Cost Center Description		ALLOCATION OF OTHER CAPITAL			SUMMARY OF CAPITAL		
		Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	Depreciation	Lease	
		6.00	7.00	8.00	9.00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	0	0	15,084,384	0	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0	0	17,207,247	0	2.00
3.00	Total (sum of lines 1-2)	0	0	0	32,291,631	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	NEW CAP REL COSTS-BLDG & FIXT	-1,503	0	0	0	15,082,881	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0	0	0	17,207,247	2.00
3.00	Total (sum of lines 1-2)	-1,503	0	0	0	32,290,128	3.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 26-0091

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

Worksheet A-8

Date/Time Prepared:
9/24/2021 7:02 pm

Cost Center Description		Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted		Wkst. A-7 Ref.	
				Cost Center	Line #		
		1.00	2.00	3.00	4.00	5.00	
1.00	Investment income - NEW CAP REL COSTS-BLDG & FIXT (chapter 2)			0 NEW CAP REL COSTS-BLDG & FIXT	1.00	0	1.00
2.00	Investment income - NEW CAP REL COSTS-MVBLE EQUIP (chapter 2)			0 NEW CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
3.00	Investment income - other (chapter 2)		0		0.00	0	3.00
4.00	Trade, quantity, and time discounts (chapter 8)		0		0.00	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)		0		0.00	0	5.00
6.00	Rental of provider space by suppliers (chapter 8)		0		0.00	0	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)		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	-53,457,737			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	-31,606,631			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests		0		0.00	0	14.00
15.00	Rental of quarters to employee and others		0		0.00	0	15.00
16.00	Sale of medical and surgical supplies to other than patients		0		0.00	0	16.00
17.00	Sale of drugs to other than patients		0		0.00	0	17.00
18.00	Sale of medical records and abstracts		0		0.00	0	18.00
19.00	Nursing and allied health education (tuition, fees, books, etc.)		0		0.00	0	19.00
20.00	Vending machines		0		0.00	0	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	0	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3		0 RESPIRATORY THERAPY	65.00		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3		0 PHYSICAL THERAPY	66.00		24.00
25.00	Utilization review - physicians' compensation (chapter 21)			0 *** Cost Center Deleted ***	114.00		25.00
26.00	Depreciation - NEW CAP REL COSTS-BLDG & FIXT			0 NEW CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
27.00	Depreciation - NEW CAP REL COSTS-MVBLE EQUIP			0 NEW CAP REL COSTS-MVBLE EQUIP	2.00	0	27.00
28.00	Non-physician Anesthetist			0 *** Cost Center Deleted ***	19.00		28.00
29.00	Physicians' assistant			0	0.00	0	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3		0 OCCUPATIONAL THERAPY	67.00		30.00
30.99	Hospice (non-distinct) (see instructions)			0 ADULTS & PEDIATRICS	30.00		30.99
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3		0 SPEECH PATHOLOGY	68.00		31.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 26-0091

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

Worksheet A-8

Date/Time Prepared:
9/24/2021 7:02 pm

Cost Center Description		Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted		Line #	Wkst. A-7 Ref.	
				Cost Center				
		1.00	2.00	3.00		4.00	5.00	
32.00	CAH HIT Adjustment for Depreciation and Interest		0			0.00	0	32.00
33.00	FRA	A	0	ADMINISTRATIVE & GENERAL		5.00	0	33.00
34.00	BAD DEBT	A	0	ADMINISTRATIVE & GENERAL		5.00	0	34.00
35.00	MID-LEVEL	A	-1,989,241	EMPLOYEE BENEFITS DEPARTMENT		4.00	0	35.00
35.01	MID-LEVEL	A	-40,787	ADMINISTRATIVE & GENERAL		5.00	0	35.01
35.02	MID-LEVEL	A	-73,982	NURSING ADMINISTRATION		13.00	0	35.02
35.03	MID-LEVEL	A	-57,317	ADULTS & PEDIATRICS		30.00	0	35.03
35.04	MID-LEVEL	A	-7,026	PEDIATRIC INTENSIVE CARE UNIT		31.01	0	35.04
35.05	MID-LEVEL	A	-2,036,220	NEONATAL INTENSIVE CARE UNIT		31.02	0	35.05
35.06	MID-LEVEL	A	-698,847	OPERATING ROOM		50.00	0	35.06
35.07	MID-LEVEL	A	-33,849	DELIVERY ROOM & LABOR ROOM		52.00	0	35.07
35.08	MID-LEVEL	A	-229,959	RADIOLOGY-DIAGNOSTIC		54.00	0	35.08
35.09	MID-LEVEL	A	-138,765	RESPIRATORY THERAPY		65.00	0	35.09
35.10	MID-LEVEL	A	-266,232	ELECTROENCEPHALOGRAPHY		70.00	0	35.10
35.11	MID-LEVEL	A	-919,389	CLINIC		90.00	0	35.11
35.12	MID-LEVEL	A	-168,687	EMERGENCY		91.00	0	35.12
36.00	NON-MEDICAL TRANSPORT	A	-58,607	ADMINISTRATIVE & GENERAL		5.00	0	36.00
36.01	NON-MEDICAL TRANSPORT	A	-150	OPERATION OF PLANT		7.00	0	36.01
36.02	NON-MEDICAL TRANSPORT	A	-75,038	SOCIAL SERVICE		17.00	0	36.02
36.03	NON-MEDICAL TRANSPORT	A	-31,063	SUBPROVIDER - IPF		40.00	0	36.03
36.04	NON-MEDICAL TRANSPORT	A	-1,695	DELIVERY ROOM & LABOR ROOM		52.00	0	36.04
36.05	NON-MEDICAL TRANSPORT	A	-80,963	CLINIC		90.00	0	36.05
36.06	NON-MEDICAL TRANSPORT	A	-1,337	EMERGENCY		91.00	0	36.06
37.00	LOBBYING	A	-101,033	ADMINISTRATIVE & GENERAL		5.00	0	37.00
38.00	MARKETING	A	-32,180	ADMINISTRATIVE & GENERAL		5.00	0	38.00
38.01	MARKETING	A	-145	DIETARY		10.00	0	38.01
38.02	MARKETING	A	-6,119	NURSING ADMINISTRATION		13.00	0	38.02
38.03	MARKETING	A	-625	I&R SERVICES-OTHER PRGM COSTS APPRVD		22.00	0	38.03
38.04	MARKETING	A	-20,607	ADULTS & PEDIATRICS		30.00	0	38.04
38.05	MARKETING	A	-400	INTRAVENOUS THERAPY		64.00	0	38.05
38.06	MARKETING	A	-2,500	ELECTROCARDIOLOGY		69.00	0	38.06
38.07	MARKETING	A	-25,175	CLINIC		90.00	0	38.07
38.08	MARKETING	A	-8,080	EMERGENCY		91.00	0	38.08
39.00	GIFT	A	-209,146	EMPLOYEE BENEFITS DEPARTMENT		4.00	0	39.00
39.01	GIFT	A	-822,465	ADMINISTRATIVE & GENERAL		5.00	0	39.01
39.02	GIFT	A	-24,588	NURSING ADMINISTRATION		13.00	0	39.02
39.03	GIFT	A	-96	PHARMACY		15.00	0	39.03
39.04	GIFT	A	-235	SOCIAL SERVICE		17.00	0	39.04
39.05	GIFT	A	-60	I&R SERVICES-OTHER PRGM COSTS APPRVD		22.00	0	39.05
39.06	GIFT	A	-107	PARAMED ED - PHARMACY RESIDENCY		23.00	0	39.06
39.07	GIFT	A	-27,973	ADULTS & PEDIATRICS		30.00	0	39.07
39.08	GIFT	A	-1,967	INTENSIVE CARE UNIT		31.00	0	39.08
39.09	GIFT	A	-9,256	NEONATAL INTENSIVE CARE UNIT		31.02	0	39.09
39.10	GIFT	A	-3,748	INTERMEDIATE CARE UNIT		31.03	0	39.10
39.11	GIFT	A	-139	DELIVERY ROOM & LABOR ROOM		52.00	0	39.11
39.12	GIFT	A	-362	CARDIAC CATHETERIZATION		59.00	0	39.12
39.13	GIFT	A	-78	LABORATORY		60.00	0	39.13
39.14	GIFT	A	-533	RESPIRATORY THERAPY		65.00	0	39.14
39.15	GIFT	A	-74	RENAL DIALYSIS		74.00	0	39.15
39.16	GIFT	A	-15,178	CLINIC		90.00	0	39.16
39.17	GIFT	A	-12,030	EMERGENCY		91.00	0	39.17
40.00	ENTERTAINMENT	A	-894	ADMINISTRATIVE & GENERAL		5.00	0	40.00
40.01	ENTERTAINMENT	A	0	NURSING ADMINISTRATION		13.00	0	40.01
40.02	ENTERTAINMENT	A	-605	I&R SERVICES-OTHER PRGM COSTS APPRVD		22.00	0	40.02
40.03	ENTERTAINMENT	A	-3,399	RADIOLOGY-DIAGNOSTIC		54.00	0	40.03
41.00	TELEPHONE	A	-20,572	ADMINISTRATIVE & GENERAL		5.00	0	41.00
41.01	TELEPHONE	A	-156	OPERATION OF PLANT		7.00	0	41.01
41.02	TELEPHONE	A	-208	DIETARY		10.00	0	41.02
41.03	TELEPHONE	A	-3	NURSING ADMINISTRATION		13.00	0	41.03
41.04	TELEPHONE	A	-1	PEDIATRIC INTENSIVE CARE UNIT		31.01	0	41.04
41.05	TELEPHONE	A	-80	NEONATAL INTENSIVE CARE UNIT		31.02	0	41.05
41.06	TELEPHONE	A	0	OPERATING ROOM		50.00	0	41.06

ADJUSTMENTS TO EXPENSES

Provider CCN: 26-0091

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

Worksheet A-8

Date/Time Prepared:
9/24/2021 7:02 pm

Cost Center Description		Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted		Line #	Wkst. A-7 Ref.
				Cost Center			
		1.00	2.00	3.00		4.00	5.00
41.07	TELEPHONE	A	-2,151	DELIVERY ROOM & LABOR ROOM		52.00	0 41.07
41.08	TELEPHONE	A	-64	WHOLE BLOOD & PACKED RED BLOOD CELLS		62.00	0 41.08
41.09	TELEPHONE	A	-143	RESPIRATORY THERAPY		65.00	0 41.09
41.10	TELEPHONE	A	-68	PHYSICAL THERAPY		66.00	0 41.10
41.11	TELEPHONE	A	-171	SPEECH PATHOLOGY		68.00	0 41.11
41.12	TELEPHONE	A	0	ELECTROENCEPHALOGRAPHY		70.00	0 41.12
41.13	TELEPHONE	A	-50	ENDOSCOPY		76.00	9 41.13
41.14	TELEPHONE	A	-7,565	CLINIC		90.00	0 41.14
41.15	TELEPHONE	A	-167	EMERGENCY		91.00	0 41.15
42.00	TELEVISION	A	-11,905	NEW CAP REL COSTS-MVBLE EQUIP		2.00	9 42.00
43.00	MISCELLANEOUS REVENUE	B	0	EMPLOYEE BENEFITS DEPARTMENT		4.00	0 43.00
43.01	MISCELLANEOUS REVENUE	B	-51,567,497	ADMINISTRATIVE & GENERAL		5.00	0 43.01
43.02	MISCELLANEOUS REVENUE	B	-853,484	OPERATION OF PLANT		7.00	0 43.02
43.03	MISCELLANEOUS REVENUE	B	-66,087	LAUNDRY & LINEN SERVICE		8.00	0 43.03
43.04	MISCELLANEOUS REVENUE	B	-22,499	HOUSEKEEPING		9.00	0 43.04
43.05	MISCELLANEOUS REVENUE	B	-2,628,522	CAFETERIA		11.00	0 43.05
43.06	MISCELLANEOUS REVENUE	B	-17,901	NURSING ADMINISTRATION		13.00	0 43.06
43.07	MISCELLANEOUS REVENUE	B	-1,651	CENTRAL SERVICES & SUPPLY		14.00	0 43.07
43.08	MISCELLANEOUS REVENUE	B	-50,557	PHARMACY		15.00	0 43.08
43.09	MISCELLANEOUS REVENUE	B	-2,799	MEDICAL RECORDS & LIBRARY		16.00	0 43.09
43.10	MISCELLANEOUS REVENUE	B	-360,325	I&R SERVICES-OTHER PRGM COSTS APPRVD		22.00	0 43.10
43.11	MISCELLANEOUS REVENUE	B	-584,047	ADULTS & PEDIATRICS		30.00	0 43.11
43.12	MISCELLANEOUS REVENUE	B	0	INTENSIVE CARE UNIT		31.00	0 43.12
43.13	MISCELLANEOUS REVENUE	B	-27,491	PEDIATRIC INTENSIVE CARE UNIT		31.01	0 43.13
43.14	MISCELLANEOUS REVENUE	B	-115	NEONATAL INTENSIVE CARE UNIT		31.02	0 43.14
43.15	MISCELLANEOUS REVENUE	B	0	INTERMEDIATE CARE UNIT		31.03	0 43.15
43.16	MISCELLANEOUS REVENUE	B	-107,469	OPERATING ROOM		50.00	0 43.16
43.17	MISCELLANEOUS REVENUE	B	-874	RECOVERY ROOM		51.00	0 43.17
43.18	MISCELLANEOUS REVENUE	B	0	DELIVERY ROOM & LABOR ROOM		52.00	0 43.18
43.19	MISCELLANEOUS REVENUE	B	-8,616	ANESTHESIOLOGY		53.00	0 43.19
43.20	MISCELLANEOUS REVENUE	B	-104,981	RADIOLOGY-DIAGNOSTIC		54.00	0 43.20
43.21	MISCELLANEOUS REVENUE	B	-274,997	RADIOLOGY-THERAPEUTIC		55.00	0 43.21
43.22	MISCELLANEOUS REVENUE	B	-180	RADIOISOTOPE		56.00	0 43.22
43.23	MISCELLANEOUS REVENUE	B	-23,585	CT SCAN		57.00	0 43.23
43.24	MISCELLANEOUS REVENUE	B	-7,485	MAGNETIC RESONANCE IMAGING (MRI)		58.00	0 43.24
43.25	MISCELLANEOUS REVENUE	B	-32,834	CARDIAC CATHETERIZATION		59.00	0 43.25
43.26	MISCELLANEOUS REVENUE	B	-653,861	LABORATORY		60.00	0 43.26
43.27	MISCELLANEOUS REVENUE	B	-547,212	WHOLE BLOOD & PACKED RED BLOOD CELLS		62.00	0 43.27
43.28	MISCELLANEOUS REVENUE	B	-117,524	INTRAVENOUS THERAPY		64.00	0 43.28
43.29	MISCELLANEOUS REVENUE	B	-11,559	RESPIRATORY THERAPY		65.00	0 43.29
43.30	MISCELLANEOUS REVENUE	B	-43	PHYSICAL THERAPY		66.00	0 43.30
43.31	MISCELLANEOUS REVENUE	B	-50,727	CLINICAL NUTRITION		66.01	0 43.31
43.32	MISCELLANEOUS REVENUE	B	-11,492	OCCUPATIONAL THERAPY		67.00	0 43.32
43.33	MISCELLANEOUS REVENUE	B	-53,797	SPEECH PATHOLOGY		68.00	0 43.33
43.34	MISCELLANEOUS REVENUE	B	-39,968	ELECTROCARDIOLOGY		69.00	0 43.34
43.35	MISCELLANEOUS REVENUE	B	-2,312	ELECTROENCEPHALOGRAPHY		70.00	0 43.35
43.36	MISCELLANEOUS REVENUE	B	0	RENAL DIALYSIS		74.00	0 43.36
43.37	MISCELLANEOUS REVENUE	B	-492	ENDOSCOPY		76.00	0 43.37
43.38	MISCELLANEOUS REVENUE	B	-1,573,270	CLINIC		90.00	0 43.38
43.39	MISCELLANEOUS REVENUE	B	-71,472	EMERGENCY		91.00	0 43.39
44.00	INTEREST INCOME	A	-1,688,458	ADMINISTRATIVE & GENERAL		5.00	0 44.00
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-154,912,806				50.00

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

(2) Basis for adjustment (see instructions).

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

B. Amount Received - if cost cannot be determined.

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

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

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS

Provider CCN: 26-0091

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

Worksheet A-8-1

Date/Time Prepared:
9/24/2021 7:02 pm

	Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in wks. A, column 5	
	1.00	2.00	3.00	4.00	5.00	
A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:						
1.00	1.00	NEW CAP REL COSTS-BLDG & FIX	HOME OFFICE	952,158	0	1.00
2.00	2.00	NEW CAP REL COSTS-MVBLE EQUI	HOME OFFICE	3,547,560	0	2.00
3.00	1.00	NEW CAP REL COSTS-BLDG & FIX	HOME OFFICE - INTEREST	0	3,347,669	3.00
4.00	4.00	EMPLOYEE BENEFITS DEPARTMENT	HOME OFFICE	16,186,244	30,053,919	4.00
4.01	5.00	ADMINISTRATIVE & GENERAL	HOME OFFICE	57,635,398	77,072,232	4.01
4.02	7.00	OPERATION OF PLANT	HOME OFFICE	0	-865	4.02
4.03	71.00	MEDICAL SUPPLIES CHARGED TO	HOME OFFICE	-1,283,909	0	4.03
4.04	1.00	NEW CAP REL COSTS-BLDG & FIX	NETWORK--CORP 130 - INTEREST	-1,551	0	4.04
4.05	5.00	ADMINISTRATIVE & GENERAL	NETWORK--CORP 130	16,749,938	15,125,893	4.05
4.06	30.00	ADULTS & PEDIATRICS	NETWORK--CORP 130	556,836	502,846	4.06
4.07	40.00	SUBPROVIDER - IPF	NETWORK--CORP 130	1,290,795	1,165,642	4.07
4.08	55.00	RADIOLOGY-THERAPEUTIC	NETWORK--CORP 130	281,005	253,760	4.08
4.09	70.00	ELECTROENCEPHALOGRAPHY	NETWORK--CORP 130	-101	-92	4.09
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.			95,914,373	127,521,004	5.00

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

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

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

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

6.00	G	SSM HEALTH CARE	100.00	FRAN SISTERS OF MARY	100.00	6.00
7.00	G	SSM HEALTH CARE	100.00	FRAN SISTERS OF MARY	100.00	7.00
8.00	G	SSM INFO CENTER	100.00	FRAN SISTERS OF MARY	100.00	8.00
9.00			0.00		0.00	9.00
10.00			0.00		0.00	10.00
100.00	G. Other (financial or non-financial) specify:	CHURCH				100.00

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

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

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS

Provider CCN: 26-0091

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

Worksheet A-8-1

Date/Time Prepared:
9/24/2021 7:02 pm

	Net Adjustments (col. 4 minus col. 5)*	Wkst. A-7 Ref.		
	6.00	7.00		
A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:				
1.00	952,158	9		1.00
2.00	3,547,560	9		2.00
3.00	-3,347,669	11		3.00
4.00	-13,867,675	0		4.00
4.01	-19,436,834	0		4.01
4.02	865	0		4.02
4.03	-1,283,909	0		4.03
4.04	-1,551	11		4.04
4.05	1,624,045	0		4.05
4.06	53,990	0		4.06
4.07	125,153	0		4.07
4.08	27,245	0		4.08
4.09	-9	0		4.09
5.00	-31,606,631			5.00

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

	Related Organization(s) and/or Home Office		
	Type of Business		
	6.00		

B. INTERRELATIONSHIP TO RELATED ORGANIZATION(S) AND/OR HOME OFFICE:

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

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

6.00	HOME OFFICE		6.00
7.00	ST LOUIS NETWORK		7.00
8.00	DATA PROCESSING SERVICES		8.00
9.00			9.00
10.00			10.00
100.00			100.00

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

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

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 26-0091

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

Worksheet A-8-2

Date/Time Prepared:
9/24/2021 7:02 pm

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	5.00	ADMINISTRATIVE & GENERAL	7,742,021	0	7,742,021	211,500	51,093	1.00
2.00	15.00	PHARMACY	162,171	162,171	0	0	0	2.00
3.00	21.00	I&R SERVICES-SALARY & FRINGES APPRVD	1,830,615	1,830,615	0	0	0	3.00
4.00	22.00	I&R SERVICES-OTHER PRGM COSTS APPRVD	48,550,560	22,383,720	26,166,840	211,500	172,180	4.00
5.00	30.00	ADULTS & PEDIATRICS	2,624,371	2,624,371	0	0	0	5.00
6.00	31.00	INTENSIVE CARE UNIT	1,618,044	1,618,044	0	0	0	6.00
7.00	31.02	NEONATAL INTENSIVE CARE UNIT	943,600	943,600	0	0	0	7.00
8.00	40.00	SUBPROVIDER - IPF	550,907	550,907	0	0	0	8.00
9.00	52.00	DELIVERY ROOM & LABOR ROOM	609,168	609,168	0	0	0	9.00
10.00	53.00	ANESTHESIOLOGY	4,648,773	4,648,773	0	0	0	10.00
11.00	60.00	LABORATORY	351,128	351,128	0	0	0	11.00
12.00	69.00	ELECTROCARDIOLOGY	152,681	152,681	0	0	0	12.00
13.00	70.00	ELECTROENCEPHALOGRAPHY	202,218	202,218	0	0	0	13.00
14.00	70.01	ELECTROSHOCK THERAPY	73	73	0	0	0	14.00
15.00	74.00	RENAL DIALYSIS	3,360	3,360	0	0	0	15.00
16.00	90.00	CLINIC	5,989,096	5,989,096	0	0	0	16.00
17.00	91.00	EMERGENCY	181,951	181,951	0	0	0	17.00
200.00			76,160,737	42,251,876	33,908,861		223,273	200.00
	Wkst. A Line #	Cost Center/Physician Identifier	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	5.00	ADMINISTRATIVE & GENERAL	5,195,274	259,764	0	0	0	1.00
2.00	15.00	PHARMACY	0	0	0	0	0	2.00
3.00	21.00	I&R SERVICES-SALARY & FRINGES APPRVD	0	0	0	0	0	3.00
4.00	22.00	I&R SERVICES-OTHER PRGM COSTS APPRVD	17,507,726	875,386	0	0	0	4.00
5.00	30.00	ADULTS & PEDIATRICS	0	0	0	0	0	5.00
6.00	31.00	INTENSIVE CARE UNIT	0	0	0	0	0	6.00
7.00	31.02	NEONATAL INTENSIVE CARE UNIT	0	0	0	0	0	7.00
8.00	40.00	SUBPROVIDER - IPF	0	0	0	0	0	8.00
9.00	52.00	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	9.00
10.00	53.00	ANESTHESIOLOGY	0	0	0	0	0	10.00
11.00	60.00	LABORATORY	0	0	0	0	0	11.00
12.00	69.00	ELECTROCARDIOLOGY	0	0	0	0	0	12.00
13.00	70.00	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	13.00
14.00	70.01	ELECTROSHOCK THERAPY	0	0	0	0	0	14.00
15.00	74.00	RENAL DIALYSIS	0	0	0	0	0	15.00
16.00	90.00	CLINIC	0	0	0	0	0	16.00
17.00	91.00	EMERGENCY	0	0	0	0	0	17.00
200.00			22,703,000	1,135,150	0	0	0	200.00
	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment		
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00	5.00	ADMINISTRATIVE & GENERAL	0	5,195,274	2,546,747	2,546,747		1.00
2.00	15.00	PHARMACY	0	0	0	162,171		2.00
3.00	21.00	I&R SERVICES-SALARY & FRINGES APPRVD	0	0	0	1,830,615		3.00
4.00	22.00	I&R SERVICES-OTHER PRGM COSTS APPRVD	0	17,507,726	8,659,114	31,042,834		4.00
5.00	30.00	ADULTS & PEDIATRICS	0	0	0	2,624,371		5.00
6.00	31.00	INTENSIVE CARE UNIT	0	0	0	1,618,044		6.00
7.00	31.02	NEONATAL INTENSIVE CARE UNIT	0	0	0	943,600		7.00
8.00	40.00	SUBPROVIDER - IPF	0	0	0	550,907		8.00
9.00	52.00	DELIVERY ROOM & LABOR ROOM	0	0	0	609,168		9.00
10.00	53.00	ANESTHESIOLOGY	0	0	0	4,648,773		10.00
11.00	60.00	LABORATORY	0	0	0	351,128		11.00
12.00	69.00	ELECTROCARDIOLOGY	0	0	0	152,681		12.00
13.00	70.00	ELECTROENCEPHALOGRAPHY	0	0	0	202,218		13.00
14.00	70.01	ELECTROSHOCK THERAPY	0	0	0	73		14.00
15.00	74.00	RENAL DIALYSIS	0	0	0	3,360		15.00
16.00	90.00	CLINIC	0	0	0	5,989,096		16.00
17.00	91.00	EMERGENCY	0	0	0	181,951		17.00
200.00			0	22,703,000	11,205,861	53,457,737		200.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 26-0091

Period:
From 01/01/2020
To 12/31/2020Worksheet B
Part I
Date/Time Prepared:
9/24/2021 7:02 pm

Cost Center Description		Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
			NEW BLDG & FIXT	NEW MVBLE EQUIP			
		0	1.00	2.00	4.00	4A	
GENERAL SERVICE COST CENTERS							
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT	15,082,881	15,082,881			1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP	17,207,247	17,207,247			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	33,961,053	49,813	34,010,866		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	97,029,212	2,918,302	3,226,650	104,591,592	5.00
7.00	00700	OPERATION OF PLANT	18,220,532	1,949,600	463,542	22,373,996	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	1,990,560	40,040	34,520	2,065,120	8.00
9.00	00900	HOUSEKEEPING	7,426,894	108,914	669,506	8,231,508	9.00
10.00	01000	DIETARY	2,703,640	309,449	185,267	3,363,237	10.00
11.00	01100	CAFETERIA	5,268,710	169,833	415,296	5,853,839	11.00
13.00	01300	NURSING ADMINISTRATION	6,725,770	37,292	804,868	8,803,715	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	4,708,817	283,759	167,477	5,638,698	14.00
15.00	01500	PHARMACY	8,421,371	104,335	1,088,353	9,634,618	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	982,442	137,999	103,726	1,225,223	16.00
17.00	01700	SOCIAL SERVICE	1,928,272	5,104	232,704	2,166,080	17.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	0	278,770	278,770	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	33,130,238	412,511	113,289	33,657,771	22.00
23.00	02300	PARAMED ED - PHARMACY RESIDENCY	459,918	2,678	62,533	525,129	23.00
23.01	02301	PARAMED ED - PHARMACY RESIDENCY - CG	847,297	2,537	123,335	973,169	23.01
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	21,592,989	1,636,169	3,134,348	27,030,846	30.00
31.00	03100	INTENSIVE CARE UNIT	6,245,739	176,847	964,528	7,662,720	31.00
31.01	02080	PEDIATRIC INTENSIVE CARE UNIT	7,521,034	290,318	1,031,023	9,186,615	31.01
31.02	02060	NEONATAL INTENSIVE CARE UNIT	18,685,119	534,906	2,854,001	23,241,392	31.02
31.03	02400	INTERMEDIATE CARE UNIT	17,585,416	801,374	2,288,059	20,757,690	31.03
40.00	04000	SUBPROVIDER - IPF	6,328,421	196,422	803,997	7,347,102	40.00
43.00	04300	NURSERY	2,255,635	17,160	233,918	2,506,713	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	13,593,004	770,520	1,536,919	17,595,028	50.00
51.00	05100	RECOVERY ROOM	1,884,726	183,739	259,371	2,332,740	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	9,619,832	207,923	1,300,956	11,653,625	52.00
53.00	05300	ANESTHESIOLOGY	1,044,397	26,387	109,494	1,414,053	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	8,422,854	363,092	933,479	11,581,120	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	5,428,238	45,740	198,967	5,724,865	55.00
56.00	05600	RADIOISOTOPE	752,290	48,641	36,121	942,024	56.00
57.00	05700	CT SCAN	1,685,459	14,078	169,423	2,064,075	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	934,369	36,412	109,041	1,659,867	58.00
59.00	05900	CARDIAC CATHETERIZATION	2,569,063	136,210	191,088	3,559,658	59.00
60.00	06000	LABORATORY	13,852,887	339,232	815,589	15,407,312	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	7,843,688	14,310	158,208	8,047,950	62.00
64.00	06400	INTRAVENOUS THERAPY	3,999,638	107,772	431,111	4,650,958	64.00
65.00	06500	RESPIRATORY THERAPY	8,407,711	106,710	911,477	9,804,931	65.00
66.00	06600	PHYSICAL THERAPY	2,253,872	69,914	112,048	2,444,411	66.00
66.01	06601	CLINICAL NUTRITION	1,114,000	13,178	163,763	1,290,941	66.01
67.00	06700	OCCUPATIONAL THERAPY	1,199,461	15,745	81,080	1,296,899	67.00
68.00	06800	SPEECH PATHOLOGY	1,083,944	34,128	117,387	1,276,972	68.00
69.00	06900	ELECTROCARDIOLOGY	2,801,728	111,470	363,478	3,831,510	69.00
69.01	06901	CARDIAC REHAB	223,039	50,844	30,496	326,230	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	980,610	6,195	158,707	1,369,120	70.00
70.01	03320	ELECTROSHOCK THERAPY	114,325	0	15,993	130,318	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	28,075,021	0	0	28,075,021	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	13,360,542	0	0	13,360,542	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	45,030,896	0	0	45,030,896	73.00
74.00	07400	RENAL DIALYSIS	2,048,585	28,610	98,255	2,226,858	74.00
76.00	03330	ENDOSCOPY	2,469,443	156,089	245,614	3,363,726	76.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	19,905,060	856,856	3,164,905	24,724,052	90.00
91.00	09100	EMERGENCY	14,032,722	489,075	1,818,805	16,707,143	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				0	92.00
SPECIAL PURPOSE COST CENTERS							
105.00	10500	KIDNEY ACQUISITION	983,144	768	26,220	1,010,309	105.00
106.00	10600	HEART ACQUISITION	88,698	778	6,754	96,230	106.00
107.00	10700	LIVER ACQUISITION	88,698	778	6,754	96,230	107.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	552,201,151	14,420,556	32,830,827	550,211,167	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	154,465	31,925	7,703	194,742	190.00
191.00	19100	RESEARCH	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	534,847	577,433	24,267	1,138,945	192.00
194.00	07950	NONREIMBURSABLE COST CENTERS	2,687,217	43,770	288,835	3,128,943	194.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 26-0091

Period:
From 01/01/2020
To 12/31/2020Worksheet B
Part I
Date/Time Prepared:
9/24/2021 7:02 pm

Cost Center Description			Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
				NEW BLDG & FIXT	NEW MVBLE EQUIP			
			0	1.00	2.00	4.00	4A	
194.02	07952	POISON CONTROL	3,293,449	0	13,645	356,549	3,663,643	194.02
194.03	07953	RETAIL PHARMACY	36,733,876	9,197	13,010	222,929	36,979,012	194.03
194.04	07954	RURAL HEALTH CLINIC - 5295	1,685,622	0	5,347	162,671	1,853,640	194.04
194.05	07955	RURAL HEALTH CLINIC - 5296	1,123,473	0	3,450	117,085	1,244,008	194.05
200.00		Cross Foot Adjustments					0	200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	598,414,100	15,082,881	17,207,247	34,010,866	598,414,100	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 26-0091

Period:
From 01/01/2020
To 12/31/2020Worksheet B
Part I
Date/Time Prepared:
9/24/2021 7:02 pm

Cost Center Description			ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
			5.00	7.00	8.00	9.00	10.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	104,591,592					5.00
7.00	00700	OPERATION OF PLANT	5,071,916	27,445,912				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	468,138	108,109	2,641,367			8.00
9.00	00900	HOUSEKEEPING	1,865,984	294,066	0	10,391,558		9.00
10.00	01000	DIETARY	762,405	835,511	0	321,045	5,282,198	10.00
11.00	01100	CAFETERIA	1,326,995	458,549	0	176,197	0	11.00
13.00	01300	NURSING ADMINISTRATION	1,995,697	100,687	0	38,689	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	1,278,225	766,149	0	294,393	0	14.00
15.00	01500	PHARMACY	2,184,052	281,705	0	108,245	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	277,743	372,596	0	143,170	0	16.00
17.00	01700	SOCIAL SERVICE	491,024	13,780	0	5,295	0	17.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	63,194	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	277,587	1,113,778	0	427,969	0	22.00
23.00	02300	PARAMED ED - PHARMACY RESIDENCY	119,040	7,231	0	2,778	0	23.00
23.01	02301	PARAMED ED - PHARMACY RESIDENCY - CG	220,606	6,849	0	2,632	0	23.01
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	6,127,568	4,417,647	809,250	1,697,485	1,618,333	30.00
31.00	03100	INTENSIVE CARE UNIT	1,737,047	477,486	239,826	183,474	479,604	31.00
31.01	02080	PEDIATRIC INTENSIVE CARE UNIT	2,082,495	783,858	181,725	301,197	363,414	31.01
31.02	02060	NEONATAL INTENSIVE CARE UNIT	5,268,545	1,444,245	584,040	554,951	1,167,962	31.02
31.03	02400	INTERMEDIATE CARE UNIT	4,705,519	2,163,706	456,416	831,404	912,740	31.03
40.00	04000	SUBPROVIDER - IPF	1,665,500	530,339	260,011	203,783	519,969	40.00
43.00	04300	NURSERY	568,242	46,332	110,099	17,803	220,176	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	3,988,582	2,080,401	0	799,394	0	50.00
51.00	05100	RECOVERY ROOM	528,804	496,095	0	190,625	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	2,641,737	561,391	0	215,715	0	52.00
53.00	05300	ANESTHESIOLOGY	320,549	71,245	0	27,376	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,625,301	980,348	0	376,699	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	1,297,758	123,498	0	47,454	0	55.00
56.00	05600	RADIOISOTOPE	213,546	131,330	0	50,463	0	56.00
57.00	05700	CT SCAN	467,901	38,010	0	14,605	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	376,272	98,313	0	37,777	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	806,932	367,767	0	141,314	0	59.00
60.00	06000	LABORATORY	3,492,653	915,924	0	351,944	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	1,824,374	38,638	0	14,847	0	62.00
64.00	06400	INTRAVENOUS THERAPY	1,054,316	290,983	0	111,810	0	64.00
65.00	06500	RESPIRATORY THERAPY	2,222,660	288,118	0	110,709	0	65.00
66.00	06600	PHYSICAL THERAPY	554,119	188,768	0	72,534	0	66.00
66.01	06601	CLINICAL NUTRITION	292,641	35,582	0	13,672	0	66.01
67.00	06700	OCCUPATIONAL THERAPY	293,991	42,512	0	16,335	0	67.00
68.00	06800	SPEECH PATHOLOGY	289,474	92,146	0	35,407	0	68.00
69.00	06900	ELECTROCARDIOLOGY	868,557	300,970	0	115,648	0	69.00
69.01	06901	CARDIAC REHAB	73,952	137,278	0	52,749	0	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	310,363	16,727	0	6,427	0	70.00
70.01	03320	ELECTROSHOCK THERAPY	29,542	0	0	0	0	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	6,364,270	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	3,028,675	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	10,208,148	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	504,802	77,248	0	29,683	0	74.00
76.00	03330	ENDOSCOPY	762,516	421,439	0	161,938	0	76.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	5,604,646	2,313,509	0	888,966	0	90.00
91.00	09100	EMERGENCY	3,787,309	1,320,500	0	507,402	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
SPECIAL PURPOSE COST CENTERS								
105.00	10500	KIDNEY ACQUISITION	229,025	2,074	0	797	0	105.00
106.00	10600	HEART ACQUISITION	21,814	2,101	0	807	0	106.00
107.00	10700	LIVER ACQUISITION	21,814	2,101	0	807	0	107.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	93,664,565	25,657,639	2,641,367	9,704,414	5,282,198	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	44,146	86,198	0	33,122	0	190.00
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	258,185	1,559,066	0	599,071	0	192.00
194.00	07950	NONREIMBURSABLE COST CENTERS	709,294	118,178	0	45,410	0	194.00
194.02	07952	POISON CONTROL	830,504	0	0	0	0	194.02
194.03	07953	RETAIL PHARMACY	8,382,698	24,831	0	9,541	0	194.03
194.04	07954	RURAL HEALTH CLINIC - 5295	420,198	0	0	0	0	194.04
194.05	07955	RURAL HEALTH CLINIC - 5296	282,002	0	0	0	0	194.05
200.00		Cross Foot Adjustments						200.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 26-0091

Period:
From 01/01/2020
To 12/31/2020Worksheet B
Part I
Date/Time Prepared:
9/24/2021 7:02 pm

Cost Center Description			ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
			5.00	7.00	8.00	9.00	10.00	
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	104,591,592	27,445,912	2,641,367	10,391,558	5,282,198	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 26-0091

Period:
From 01/01/2020
To 12/31/2020Worksheet B
Part I
Date/Time Prepared:
9/24/2021 7:02 pm

Cost Center Description			CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
			11.00	13.00	14.00	15.00	16.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA	7,815,580					11.00
13.00	01300	NURSING ADMINISTRATION	216,642	11,155,430				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	45,079	0	8,022,544			14.00
15.00	01500	PHARMACY	292,947	0	178,457	12,680,024		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	27,919	0	0	0	2,046,651	16.00
17.00	01700	SOCIAL SERVICE	62,636	0	0	0	0	17.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	75,035	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	30,493	0	3	0	0	22.00
23.00	02300	PARAMED ED - PHARMACY RESIDENCY	16,832	0	0	0	0	23.00
23.01	02301	PARAMED ED - PHARMACY RESIDENCY - CG	33,197	0	0	0	0	23.01
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	843,657	517,615	539,847	3,576	143,722	30.00
31.00	03100	INTENSIVE CARE UNIT	259,617	0	333,350	710	43,469	31.00
31.01	02080	PEDIATRIC INTENSIVE CARE UNIT	277,515	257,438	334,314	4,085	55,678	31.01
31.02	02060	NEONATAL INTENSIVE CARE UNIT	768,197	413,123	522,647	3,444	160,685	31.02
31.03	02400	INTERMEDIATE CARE UNIT	615,866	5,087,935	327,616	1,015	75,391	31.03
40.00	04000	SUBPROVIDER - IPF	216,408	277,452	19,307	257	22,176	40.00
43.00	04300	NURSERY	62,963	2,056,451	0	0	6,108	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	413,685	574,075	2,037,581	19,633	146,950	50.00
51.00	05100	RECOVERY ROOM	69,813	45,083	4,666	155	19,862	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	350,172	0	212,494	2,475	63,069	52.00
53.00	05300	ANESTHESIOLOGY	29,472	0	340,213	19,757	51,712	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	251,260	88,481	878,494	1,185	84,130	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	53,555	0	6,424	1	45,328	55.00
56.00	05600	RADIOISOTOPE	9,723	0	1,711	167	5,092	56.00
57.00	05700	CT SCAN	45,603	0	80,330	2,461	67,995	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	29,350	0	42,079	683	33,400	58.00
59.00	05900	CARDIAC CATHETERIZATION	51,434	51,403	803,244	576	45,192	59.00
60.00	06000	LABORATORY	219,528	0	57,451	145	184,772	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	42,584	0	16,864	61	22,415	62.00
64.00	06400	INTRAVENOUS THERAPY	116,040	190,551	155,821	268	19,061	64.00
65.00	06500	RESPIRATORY THERAPY	245,338	0	310,639	6,432	83,369	65.00
66.00	06600	PHYSICAL THERAPY	30,159	0	1,239	0	8,405	66.00
66.01	06601	CLINICAL NUTRITION	44,079	0	0	0	687	66.01
67.00	06700	OCCUPATIONAL THERAPY	21,824	0	2,944	0	6,066	67.00
68.00	06800	SPEECH PATHOLOGY	31,596	0	1,409	0	6,552	68.00
69.00	06900	ELECTROCARDIOLOGY	97,836	0	15,588	10,723	66,148	69.00
69.01	06901	CARDIAC REHAB	8,208	0	622	0	760	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	42,718	0	27,981	1	6,868	70.00
70.01	03320	ELECTROSHOCK THERAPY	4,305	0	1,245	0	737	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	22,229	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	23,034	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	12,513,199	293,344	73.00
74.00	07400	RENAL DIALYSIS	26,447	79,844	103,292	1,693	9,908	74.00
76.00	03330	ENDOSCOPY	66,111	95,223	252,370	1,057	25,505	76.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	851,861	553,324	106,604	84,808	50,681	90.00
91.00	09100	EMERGENCY	489,559	665,189	297,508	1,457	145,927	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
SPECIAL PURPOSE COST CENTERS								
105.00	10500	KIDNEY ACQUISITION	7,057	0	0	0	148	105.00
106.00	10600	HEART ACQUISITION	1,818	0	0	0	38	106.00
107.00	10700	LIVER ACQUISITION	1,818	0	0	0	38	107.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	7,497,956	10,953,187	8,014,354	12,680,024	2,046,651	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	2,073	0	6	0	0	190.00
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	6,532	0	0	0	0	192.00
194.00	07950	NONREIMBURSABLE COST CENTERS	77,744	202,243	111	0	0	194.00
194.02	07952	POISON CONTROL	95,970	0	0	0	0	194.02
194.03	07953	RETAIL PHARMACY	60,005	0	498	0	0	194.03
194.04	07954	RURAL HEALTH CLINIC - 5295	43,785	0	3,874	0	0	194.04
194.05	07955	RURAL HEALTH CLINIC - 5296	31,515	0	3,701	0	0	194.05

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 26-0091

Period:
From 01/01/2020
To 12/31/2020Worksheet B
Part I
Date/Time Prepared:
9/24/2021 7:02 pm

Cost Center Description		CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
		11.00	13.00	14.00	15.00	16.00	
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)	7,815,580	11,155,430	8,022,544	12,680,024	2,046,651	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 26-0091

Period:
From 01/01/2020
To 12/31/2020Worksheet B
Part I
Date/Time Prepared:
9/24/2021 7:02 pm

Cost Center Description			SOCIAL SERVICE	INTERNS & RESIDENTS		PARAMED ED - PHARMACY RESIDENCY	PARAMED ED - PHARMACY RESIDENCY - CG	
				SERVICES-SALAR Y & FRINGES	SERVICES-OTHER PRGM COSTS			
				17.00	21.00			
	GENERAL SERVICE COST CENTERS							
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION						13.00
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	2,738,815					17.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	416,999				21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	0		35,507,611			22.00
23.00	02300	PARAMED ED - PHARMACY RESIDENCY	0			671,010		23.00
23.01	02301	PARAMED ED - PHARMACY RESIDENCY - CG	0				1,236,453	23.01
	INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	839,104	255,442	21,750,735	378,518	612,897	30.00
31.00	03100	INTENSIVE CARE UNIT	248,674	0	0	120,438	0	31.00
31.01	02080	PEDIATRIC INTENSIVE CARE UNIT	188,430	0	0	0	303,784	31.01
31.02	02060	NEONATAL INTENSIVE CARE UNIT	605,587	0	0	0	106,591	31.02
31.03	02400	INTERMEDIATE CARE UNIT	473,255	4,366	371,807	0	0	31.03
40.00	04000	SUBPROVIDER - IPF	269,604	0	0	0	0	40.00
43.00	04300	NURSERY	114,161	0	0	0	0	43.00
	ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	39,298	3,346,267	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	56,764	4,833,497	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	10,916	929,519	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	10,916	929,519	0	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	0	55.00
56.00	05600	RADIOISOTOPE	0	2,183	185,904	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	4,366	371,807	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	0	62.00
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
66.01	06601	CLINICAL NUTRITION	0	0	0	0	0	66.01
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	4,366	371,807	0	0	69.00
69.01	06901	CARDIAC REHAB	0	0	0	0	0	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0	19,649	1,673,134	0	0	70.00
70.01	03320	ELECTROSHOCK THERAPY	0	0	0	0	0	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	86,027	149,227	74.00
76.00	03330	ENDOSCOPY	0	0	0	0	0	76.00
	OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0	0	0	86,027	0	90.00
91.00	09100	EMERGENCY	0	8,733	743,615	0	63,954	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
	SPECIAL PURPOSE COST CENTERS							
105.00	10500	KIDNEY ACQUISITION	0	0	0	0	0	105.00
106.00	10600	HEART ACQUISITION	0	0	0	0	0	106.00
107.00	10700	LIVER ACQUISITION	0	0	0	0	0	107.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	2,738,815	416,999	35,507,611	671,010	1,236,453	118.00
	NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07950	NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.00
194.02	07952	POISON CONTROL	0	0	0	0	0	194.02
194.03	07953	RETAIL PHARMACY	0	0	0	0	0	194.03

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 26-0091

Period:
From 01/01/2020
To 12/31/2020Worksheet B
Part I
Date/Time Prepared:
9/24/2021 7:02 pm

Cost Center Description			INTERNS & RESIDENTS			PARAMED ED - PHARMACY RESIDENCY	PARAMED ED - PHARMACY RESIDENCY - CG	
			SOCIAL SERVICE	SERVICES-SALAR	SERVICES-OTHER			
				Y & FRINGES	PRGM COSTS			
			17.00	21.00	22.00	23.00	23.01	
194.04	07954	RURAL HEALTH CLINIC - 5295	0	0	0	0	0	194.04
194.05	07955	RURAL HEALTH CLINIC - 5296	0	0	0	0	0	194.05
200.00		Cross Foot Adjustments		0	0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	2,738,815	416,999	35,507,611	671,010	1,236,453	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 26-0091

Period:
From 01/01/2020
To 12/31/2020Worksheet B
Part I
Date/Time Prepared:
9/24/2021 7:02 pm

Cost Center Description			Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			24.00	25.00	26.00	
GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT				1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT				4.00
5.00	00500	ADMINISTRATIVE & GENERAL				5.00
7.00	00700	OPERATION OF PLANT				7.00
8.00	00800	LAUNDRY & LINEN SERVICE				8.00
9.00	00900	HOUSEKEEPING				9.00
10.00	01000	DIETARY				10.00
11.00	01100	CAFETERIA				11.00
13.00	01300	NURSING ADMINISTRATION				13.00
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
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 - PHARMACY RESIDENCY				23.00
23.01	02301	PARAMED ED - PHARMACY RESIDENCY - CG				23.01
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	67,586,242	-22,006,177	45,580,065	30.00
31.00	03100	INTENSIVE CARE UNIT	11,786,415	0	11,786,415	31.00
31.01	02080	PEDIATRIC INTENSIVE CARE UNIT	14,320,548	0	14,320,548	31.01
31.02	02060	NEONATAL INTENSIVE CARE UNIT	34,841,409	0	34,841,409	31.02
31.03	02400	INTERMEDIATE CARE UNIT	36,784,726	-376,173	36,408,553	31.03
40.00	04000	SUBPROVIDER - IPF	11,331,908	0	11,331,908	40.00
43.00	04300	NURSERY	5,709,048	0	5,709,048	43.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	31,040,894	-3,385,565	27,655,329	50.00
51.00	05100	RECOVERY ROOM	3,687,843	0	3,687,843	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	20,590,939	-4,890,261	15,700,678	52.00
53.00	05300	ANESTHESIOLOGY	3,214,812	-940,435	2,274,377	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	17,807,453	-940,435	16,867,018	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	7,298,883	0	7,298,883	55.00
56.00	05600	RADIOISOTOPE	1,542,143	-188,087	1,354,056	56.00
57.00	05700	CT SCAN	2,780,980	0	2,780,980	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	2,277,741	0	2,277,741	58.00
59.00	05900	CARDIAC CATHETERIZATION	5,827,520	0	5,827,520	59.00
60.00	06000	LABORATORY	21,005,902	-376,173	20,629,729	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	10,007,733	0	10,007,733	62.00
64.00	06400	INTRAVENOUS THERAPY	6,589,808	0	6,589,808	64.00
65.00	06500	RESPIRATORY THERAPY	13,072,196	0	13,072,196	65.00
66.00	06600	PHYSICAL THERAPY	3,299,635	0	3,299,635	66.00
66.01	06601	CLINICAL NUTRITION	1,677,602	0	1,677,602	66.01
67.00	06700	OCCUPATIONAL THERAPY	1,680,571	0	1,680,571	67.00
68.00	06800	SPEECH PATHOLOGY	1,733,556	0	1,733,556	68.00
69.00	06900	ELECTROCARDIOLOGY	5,683,153	-376,173	5,306,980	69.00
69.01	06901	CARDIAC REHAB	599,799	0	599,799	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	3,472,988	-1,692,783	1,780,205	70.00
70.01	03320	ELECTROSHOCK THERAPY	166,147	0	166,147	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	34,461,520	0	34,461,520	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	16,412,251	0	16,412,251	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	68,045,587	0	68,045,587	73.00
74.00	07400	RENAL DIALYSIS	3,295,029	-33,812	3,261,217	74.00
76.00	03330	ENDOSCOPY	5,149,885	0	5,149,885	76.00
OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	35,264,478	0	35,264,478	90.00
91.00	09100	EMERGENCY	24,738,296	-752,348	23,985,948	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)		0		92.00
SPECIAL PURPOSE COST CENTERS						
105.00	10500	KIDNEY ACQUISITION	1,249,410	0	1,249,410	105.00
106.00	10600	HEART ACQUISITION	122,808	0	122,808	106.00
107.00	10700	LIVER ACQUISITION	122,808	0	122,808	107.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	536,280,666	-35,958,422	500,322,244	118.00
NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	360,287	0	360,287	190.00
191.00	19100	RESEARCH	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	3,561,799	0	3,561,799	192.00
194.00	07950	NONREIMBURSABLE COST CENTERS	4,281,923	0	4,281,923	194.00
194.02	07952	POISON CONTROL	4,590,117	0	4,590,117	194.02
194.03	07953	RETAIL PHARMACY	45,456,585	0	45,456,585	194.03

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 26-0091

Period:
From 01/01/2020
To 12/31/2020Worksheet B
Part I
Date/Time Prepared:
9/24/2021 7:02 pm

Cost Center Description			Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			24.00	25.00	26.00		
194.04	07954	RURAL HEALTH CLINIC - 5295	2,321,497	0	2,321,497		194.04
194.05	07955	RURAL HEALTH CLINIC - 5296	1,561,226	0	1,561,226		194.05
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)	598,414,100	-35,958,422	562,455,678		202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 26-0091

Period:
From 01/01/2020
To 12/31/2020Worksheet B
Part II
Date/Time Prepared:
9/24/2021 7:02 pm

Cost Center Description			CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
			Directly Assigned New Capital Related Costs	NEW BLDG & FIXT	NEW MVBLE EQUIP		
			0	1.00	2.00	2A	4.00
GENERAL SERVICE COST CENTERS							
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	49,813	0	49,813	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	875,548	2,918,302	1,417,428	5,211,278	5.00
7.00	00700	OPERATION OF PLANT	7,849	1,949,600	1,740,322	3,697,771	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	40,040	0	40,040	8.00
9.00	00900	HOUSEKEEPING	135,736	108,914	26,194	270,844	9.00
10.00	01000	DIETARY	4,959	309,449	185,267	499,675	10.00
11.00	01100	CAFETERIA	0	169,833	0	169,833	11.00
13.00	01300	NURSING ADMINISTRATION	0	37,292	1,235,785	1,273,077	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	165,050	283,759	478,645	927,454	14.00
15.00	01500	PHARMACY	860,208	104,335	20,559	985,102	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	137,999	1,056	139,055	16.00
17.00	01700	SOCIAL SERVICE	0	5,104	0	5,104	17.00
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	412,511	1,743	414,254	22.00
23.00	02300	PARAMED ED - PHARMACY RESIDENCY	0	2,678	0	2,678	23.00
23.01	02301	PARAMED ED - PHARMACY RESIDENCY - CG	0	2,537	0	2,537	23.01
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	189,869	1,636,169	667,340	2,493,378	30.00
31.00	03100	INTENSIVE CARE UNIT	20	176,847	275,606	452,473	31.00
31.01	02080	PEDIATRIC INTENSIVE CARE UNIT	0	290,318	344,240	634,558	31.01
31.02	02060	NEONATAL INTENSIVE CARE UNIT	0	534,906	1,167,366	1,702,272	31.02
31.03	02400	INTERMEDIATE CARE UNIT	0	801,374	82,841	884,215	31.03
40.00	04000	SUBPROVIDER - IPF	0	196,422	18,262	214,684	40.00
43.00	04300	NURSERY	0	17,160	0	17,160	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	771,044	770,520	1,694,585	3,236,149	50.00
51.00	05100	RECOVERY ROOM	0	183,739	4,904	188,643	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	247,943	207,923	524,914	980,780	52.00
53.00	05300	ANESTHESIOLOGY	78,144	26,387	233,775	338,306	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	288,357	363,092	1,861,695	2,513,144	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	152,629	45,740	51,920	250,289	55.00
56.00	05600	RADIOISOTOPE	0	48,641	104,972	153,613	56.00
57.00	05700	CT SCAN	34,569	14,078	195,115	243,762	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	106,165	36,412	580,045	722,622	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	136,210	663,297	799,507	59.00
60.00	06000	LABORATORY	157,742	339,232	399,604	896,578	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	9,702	14,310	31,744	55,756	62.00
64.00	06400	INTRAVENOUS THERAPY	319,230	107,772	112,437	539,439	64.00
65.00	06500	RESPIRATORY THERAPY	21,575	106,710	379,033	507,318	65.00
66.00	06600	PHYSICAL THERAPY	0	69,914	8,577	78,491	66.00
66.01	06601	CLINICAL NUTRITION	0	13,178	0	13,178	66.01
67.00	06700	OCCUPATIONAL THERAPY	0	15,745	613	16,358	67.00
68.00	06800	SPEECH PATHOLOGY	0	34,128	41,513	75,641	68.00
69.00	06900	ELECTROCARDIOLOGY	74,338	111,470	554,834	740,642	69.00
69.01	06901	CARDIAC REHAB	0	50,844	21,851	72,695	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0	6,195	223,608	229,803	70.00
70.01	03320	ELECTROSHOCK THERAPY	0	0	0	0	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	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	28,610	51,408	80,018	74.00
76.00	03330	ENDOSCOPY	613,123	156,089	492,580	1,261,792	76.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	1,945,734	856,856	797,231	3,599,821	90.00
91.00	09100	EMERGENCY	155,184	489,075	366,541	1,010,800	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				0	92.00
SPECIAL PURPOSE COST CENTERS							
105.00	10500	KIDNEY ACQUISITION	0	768	177	945	105.00
106.00	10600	HEART ACQUISITION	0	778	0	778	106.00
107.00	10700	LIVER ACQUISITION	0	778	0	778	107.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	7,214,718	14,420,556	17,059,627	38,694,901	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	31,925	649	32,574	190.00
191.00	19100	RESEARCH	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	121,917	577,433	2,398	701,748	192.00
194.00	07950	NONREIMBURSABLE COST CENTERS	990	43,770	109,121	153,881	194.00
194.02	07952	POISON CONTROL	68,594	0	13,645	82,239	194.02

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 26-0091

Period:
From 01/01/2020
To 12/31/2020Worksheet B
Part II
Date/Time Prepared:
9/24/2021 7:02 pm

Cost Center Description			Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
				NEW BLDG & FIXT	NEW MVBLE EQUIP			
			0	1.00	2.00	2A	4.00	
194.03	07953	RETAIL PHARMACY	37,407	9,197	13,010	59,614	326	194.03
194.04	07954	RURAL HEALTH CLINIC - 5295	123,418	0	5,347	128,765	238	194.04
194.05	07955	RURAL HEALTH CLINIC - 5296	61,622	0	3,450	65,072	171	194.05
200.00		Cross Foot Adjustments				0		200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	7,628,666	15,082,881	17,207,247	39,918,794	49,813	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 26-0091

Period:
From 01/01/2020
To 12/31/2020Worksheet B
Part II
Date/Time Prepared:
9/24/2021 7:02 pm

Cost Center Description			ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
			5.00	7.00	8.00	9.00	10.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	5,216,011					5.00
7.00	00700	OPERATION OF PLANT	252,938	3,951,388				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	23,346	15,564	79,001			8.00
9.00	00900	HOUSEKEEPING	93,057	42,337	0	407,218		9.00
10.00	01000	DIETARY	38,021	120,289	0	12,581	670,807	10.00
11.00	01100	CAFETERIA	66,178	66,017	0	6,905	0	11.00
13.00	01300	NURSING ADMINISTRATION	99,526	14,496	0	1,516	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	63,745	110,302	0	11,536	0	14.00
15.00	01500	PHARMACY	108,919	40,557	0	4,242	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	13,851	53,643	0	5,610	0	16.00
17.00	01700	SOCIAL SERVICE	24,488	1,984	0	207	0	17.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	3,151	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	13,843	160,351	0	16,771	0	22.00
23.00	02300	PARAMED ED - PHARMACY RESIDENCY	5,937	1,041	0	109	0	23.00
23.01	02301	PARAMED ED - PHARMACY RESIDENCY - CG	11,002	986	0	103	0	23.01
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	305,584	636,008	24,204	66,519	205,519	30.00
31.00	03100	INTENSIVE CARE UNIT	86,627	68,744	7,173	7,190	60,907	31.00
31.01	02080	PEDIATRIC INTENSIVE CARE UNIT	103,855	112,852	5,435	11,803	46,151	31.01
31.02	02060	NEONATAL INTENSIVE CARE UNIT	262,744	207,928	17,468	21,747	148,324	31.02
31.03	02400	INTERMEDIATE CARE UNIT	234,666	311,509	13,651	32,581	115,912	31.03
40.00	04000	SUBPROVIDER - IPF	83,059	76,353	7,777	7,986	66,033	40.00
43.00	04300	NURSERY	28,338	6,670	3,293	698	27,961	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	198,912	299,515	0	31,326	0	50.00
51.00	05100	RECOVERY ROOM	26,372	71,423	0	7,470	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	131,744	80,824	0	8,453	0	52.00
53.00	05300	ANESTHESIOLOGY	15,986	10,257	0	1,073	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	130,925	141,141	0	14,762	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	64,720	17,780	0	1,860	0	55.00
56.00	05600	RADIOISOTOPE	10,650	18,908	0	1,978	0	56.00
57.00	05700	CT SCAN	23,334	5,472	0	572	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	18,765	14,154	0	1,480	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	40,242	52,947	0	5,538	0	59.00
60.00	06000	LABORATORY	174,180	131,866	0	13,792	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	90,982	5,563	0	582	0	62.00
64.00	06400	INTRAVENOUS THERAPY	52,579	41,893	0	4,382	0	64.00
65.00	06500	RESPIRATORY THERAPY	110,845	41,480	0	4,338	0	65.00
66.00	06600	PHYSICAL THERAPY	27,634	27,177	0	2,842	0	66.00
66.01	06601	CLINICAL NUTRITION	14,594	5,123	0	536	0	66.01
67.00	06700	OCCUPATIONAL THERAPY	14,661	6,120	0	640	0	67.00
68.00	06800	SPEECH PATHOLOGY	14,436	13,266	0	1,388	0	68.00
69.00	06900	ELECTROCARDIOLOGY	43,315	43,331	0	4,532	0	69.00
69.01	06901	CARDIAC REHAB	3,688	19,764	0	2,067	0	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	15,478	2,408	0	252	0	70.00
70.01	03320	ELECTROSHOCK THERAPY	1,473	0	0	0	0	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	317,388	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	151,041	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	509,078	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	25,175	11,121	0	1,163	0	74.00
76.00	03330	ENDOSCOPY	38,027	60,675	0	6,346	0	76.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	279,505	333,076	0	34,836	0	90.00
91.00	09100	EMERGENCY	188,874	190,112	0	19,884	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
SPECIAL PURPOSE COST CENTERS								
105.00	10500	KIDNEY ACQUISITION	11,422	299	0	31	0	105.00
106.00	10600	HEART ACQUISITION	1,088	302	0	32	0	106.00
107.00	10700	LIVER ACQUISITION	1,088	302	0	32	0	107.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	4,671,076	3,693,930	79,001	380,291	670,807	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	2,202	12,410	0	1,298	0	190.00
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	12,876	224,459	0	23,476	0	192.00
194.00	07950	NONREIMBURSABLE COST CENTERS	35,373	17,014	0	1,779	0	194.00
194.02	07952	POISON CONTROL	41,417	0	0	0	0	194.02
194.03	07953	RETAIL PHARMACY	418,048	3,575	0	374	0	194.03
194.04	07954	RURAL HEALTH CLINIC - 5295	20,955	0	0	0	0	194.04
194.05	07955	RURAL HEALTH CLINIC - 5296	14,064	0	0	0	0	194.05
200.00		Cross Foot Adjustments						200.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 26-0091

Period:
From 01/01/2020
To 12/31/2020Worksheet B
Part II
Date/Time Prepared:
9/24/2021 7:02 pm

Cost Center Description			ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
			5.00	7.00	8.00	9.00	10.00	
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	5,216,011	3,951,388	79,001	407,218	670,807	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 26-0091

Period:
From 01/01/2020
To 12/31/2020Worksheet B
Part II
Date/Time Prepared:
9/24/2021 7:02 pm

Cost Center Description			CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
			11.00	13.00	14.00	15.00	16.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA	309,541					11.00
13.00	01300	NURSING ADMINISTRATION	8,578	1,398,372				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	1,785	0	1,115,067			14.00
15.00	01500	PHARMACY	11,600	0	24,804	1,176,818		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,105	0	0	0	213,416	16.00
17.00	01700	SOCIAL SERVICE	2,480	0	0	0	0	17.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	2,971	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	1,207	0	0	0	0	22.00
23.00	02300	PARAMED ED - PHARMACY RESIDENCY	666	0	0	0	0	23.00
23.01	02301	PARAMED ED - PHARMACY RESIDENCY - CG	1,314	0	0	0	0	23.01
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	33,405	64,885	75,034	332	14,995	30.00
31.00	03100	INTENSIVE CARE UNIT	10,280	0	46,333	66	4,535	31.00
31.01	02080	PEDIATRIC INTENSIVE CARE UNIT	10,988	32,271	46,467	379	5,809	31.01
31.02	02060	NEONATAL INTENSIVE CARE UNIT	30,418	51,786	72,643	320	16,764	31.02
31.03	02400	INTERMEDIATE CARE UNIT	24,386	637,791	45,536	94	7,866	31.03
40.00	04000	SUBPROVIDER - IPF	8,569	34,780	2,683	24	2,314	40.00
43.00	04300	NURSERY	2,493	257,783	0	0	637	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	16,380	71,962	283,209	1,822	15,331	50.00
51.00	05100	RECOVERY ROOM	2,764	5,651	649	14	2,072	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	13,865	0	29,535	230	6,580	52.00
53.00	05300	ANESTHESIOLOGY	1,167	0	47,287	1,834	5,395	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	9,949	11,091	122,103	110	8,777	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	2,121	0	893	0	4,729	55.00
56.00	05600	RADIOISOTOPE	385	0	238	15	531	56.00
57.00	05700	CT SCAN	1,806	0	11,165	228	7,094	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	1,162	0	5,849	63	3,485	58.00
59.00	05900	CARDIAC CATHETERIZATION	2,037	6,444	111,644	53	4,715	59.00
60.00	06000	LABORATORY	8,692	0	7,985	13	19,277	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	1,686	0	2,344	6	2,339	62.00
64.00	06400	INTRAVENOUS THERAPY	4,595	23,886	21,658	25	1,989	64.00
65.00	06500	RESPIRATORY THERAPY	9,714	0	43,176	597	8,698	65.00
66.00	06600	PHYSICAL THERAPY	1,194	0	172	0	877	66.00
66.01	06601	CLINICAL NUTRITION	1,745	0	0	0	72	66.01
67.00	06700	OCCUPATIONAL THERAPY	864	0	409	0	633	67.00
68.00	06800	SPEECH PATHOLOGY	1,251	0	196	0	684	68.00
69.00	06900	ELECTROCARDIOLOGY	3,874	0	2,167	995	6,901	69.00
69.01	06901	CARDIAC REHAB	325	0	87	0	79	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	1,691	0	3,889	0	717	70.00
70.01	03320	ELECTROSHOCK THERAPY	170	0	173	0	77	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	2,319	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	2,403	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	1,161,337	30,491	73.00
74.00	07400	RENAL DIALYSIS	1,047	10,009	14,357	157	1,034	74.00
76.00	03330	ENDOSCOPY	2,618	11,936	35,077	98	2,661	76.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	33,809	69,361	14,817	7,871	5,288	90.00
91.00	09100	EMERGENCY	19,385	83,384	41,351	135	15,225	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
SPECIAL PURPOSE COST CENTERS								
105.00	10500	KIDNEY ACQUISITION	279	0	0	0	15	105.00
106.00	10600	HEART ACQUISITION	72	0	0	0	4	106.00
107.00	10700	LIVER ACQUISITION	72	0	0	0	4	107.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	296,964	1,373,020	1,113,930	1,176,818	213,416	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	82	0	1	0	0	190.00
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	259	0	0	0	0	192.00
194.00	07950	NONREIMBURSABLE COST CENTERS	3,078	25,352	15	0	0	194.00
194.02	07952	POISON CONTROL	3,800	0	0	0	0	194.02
194.03	07953	RETAIL PHARMACY	2,376	0	69	0	0	194.03
194.04	07954	RURAL HEALTH CLINIC - 5295	1,734	0	538	0	0	194.04
194.05	07955	RURAL HEALTH CLINIC - 5296	1,248	0	514	0	0	194.05

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 26-0091

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

 Worksheet B
 Part II
 Date/Time Prepared:
 9/24/2021 7:02 pm

Cost Center Description		CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
		11.00	13.00	14.00	15.00	16.00	
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)	309,541	1,398,372	1,115,067	1,176,818	213,416	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 26-0091

Period:
From 01/01/2020
To 12/31/2020Worksheet B
Part II
Date/Time Prepared:
9/24/2021 7:02 pm

Cost Center Description			INTERNS & RESIDENTS			PARAMED ED - PHARMACY RESIDENCY	PARAMED ED - PHARMACY RESIDENCY - CG	
			SOCIAL SERVICE	SERVICES-SALAR Y & FRINGES	SERVICES-OTHER PRGM COSTS			
			17.00	21.00	22.00	23.00	23.01	
GENERAL SERVICE COST CENTERS								
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION						13.00
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	34,604					17.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	6,530				21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	0		606,592			22.00
23.00	02300	PARAMED ED - PHARMACY RESIDENCY	0			10,523		23.00
23.01	02301	PARAMED ED - PHARMACY RESIDENCY - CG	0				16,123	23.01
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	10,603					30.00
31.00	03100	INTENSIVE CARE UNIT	3,142					31.00
31.01	02080	PEDIATRIC INTENSIVE CARE UNIT	2,381					31.01
31.02	02060	NEONATAL INTENSIVE CARE UNIT	7,651					31.02
31.03	02400	INTERMEDIATE CARE UNIT	5,979					31.03
40.00	04000	SUBPROVIDER - IPF	3,406					40.00
43.00	04300	NURSERY	1,442					43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0					50.00
51.00	05100	RECOVERY ROOM	0					51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0					52.00
53.00	05300	ANESTHESIOLOGY	0					53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0					54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0					55.00
56.00	05600	RADIOISOTOPE	0					56.00
57.00	05700	CT SCAN	0					57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0					58.00
59.00	05900	CARDIAC CATHETERIZATION	0					59.00
60.00	06000	LABORATORY	0					60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0					62.00
64.00	06400	INTRAVENOUS THERAPY	0					64.00
65.00	06500	RESPIRATORY THERAPY	0					65.00
66.00	06600	PHYSICAL THERAPY	0					66.00
66.01	06601	CLINICAL NUTRITION	0					66.01
67.00	06700	OCCUPATIONAL THERAPY	0					67.00
68.00	06800	SPEECH PATHOLOGY	0					68.00
69.00	06900	ELECTROCARDIOLOGY	0					69.00
69.01	06901	CARDIAC REHAB	0					69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0					70.00
70.01	03320	ELECTROSHOCK THERAPY	0					70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0					71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0					72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0					73.00
74.00	07400	RENAL DIALYSIS	0					74.00
76.00	03330	ENDOSCOPY	0					76.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0					90.00
91.00	09100	EMERGENCY	0					91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
SPECIAL PURPOSE COST CENTERS								
105.00	10500	KIDNEY ACQUISITION	0					105.00
106.00	10600	HEART ACQUISITION	0					106.00
107.00	10700	LIVER ACQUISITION	0					107.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	34,604	0	0	0	0	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0					190.00
191.00	19100	RESEARCH	0					191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0					192.00
194.00	07950	NONREIMBURSABLE COST CENTERS	0					194.00
194.02	07952	POISON CONTROL	0					194.02
194.03	07953	RETAIL PHARMACY	0					194.03

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 26-0091

Period:
From 01/01/2020
To 12/31/2020Worksheet B
Part II
Date/Time Prepared:
9/24/2021 7:02 pm

Cost Center Description			SOCIAL SERVICE	INTERNS & RESIDENTS		PARAMED ED - PHARMACY RESIDENCY	PARAMED ED - PHARMACY RESIDENCY - CG	
				SERVICES-SALAR Y & FRINGES	SERVICES-OTHER PRGM COSTS			
			17.00	21.00	22.00	23.00	23.01	
194.04	07954	RURAL HEALTH CLINIC - 5295	0					194.04
194.05	07955	RURAL HEALTH CLINIC - 5296	0					194.05
200.00		Cross Foot Adjustments		6,530	606,592	10,523	16,123	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	34,604	6,530	606,592	10,523	16,123	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 26-0091

Period:
From 01/01/2020
To 12/31/2020Worksheet B
Part II
Date/Time Prepared:
9/24/2021 7:02 pm

Cost Center Description			Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			24.00	25.00	26.00	
GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT				1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT				4.00
5.00	00500	ADMINISTRATIVE & GENERAL				5.00
7.00	00700	OPERATION OF PLANT				7.00
8.00	00800	LAUNDRY & LINEN SERVICE				8.00
9.00	00900	HOUSEKEEPING				9.00
10.00	01000	DIETARY				10.00
11.00	01100	CAFETERIA				11.00
13.00	01300	NURSING ADMINISTRATION				13.00
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
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 - PHARMACY RESIDENCY				23.00
23.01	02301	PARAMED ED - PHARMACY RESIDENCY - CG				23.01
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	3,935,056	0	3,935,056	30.00
31.00	03100	INTENSIVE CARE UNIT	748,882	0	748,882	31.00
31.01	02080	PEDIATRIC INTENSIVE CARE UNIT	1,014,459	0	1,014,459	31.01
31.02	02060	NEONATAL INTENSIVE CARE UNIT	2,544,244	0	2,544,244	31.02
31.03	02400	INTERMEDIATE CARE UNIT	2,317,537	0	2,317,537	31.03
40.00	04000	SUBPROVIDER - IPF	508,845	0	508,845	40.00
43.00	04300	NURSERY	346,818	0	346,818	43.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	4,156,857	0	4,156,857	50.00
51.00	05100	RECOVERY ROOM	305,438	0	305,438	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,253,916	0	1,253,916	52.00
53.00	05300	ANESTHESIOLOGY	421,465	0	421,465	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,953,369	0	2,953,369	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	342,683	0	342,683	55.00
56.00	05600	RADIOISOTOPE	186,371	0	186,371	56.00
57.00	05700	CT SCAN	293,681	0	293,681	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	767,740	0	767,740	58.00
59.00	05900	CARDIAC CATHETERIZATION	1,023,407	0	1,023,407	59.00
60.00	06000	LABORATORY	1,253,577	0	1,253,577	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	159,490	0	159,490	62.00
64.00	06400	INTRAVENOUS THERAPY	691,077	0	691,077	64.00
65.00	06500	RESPIRATORY THERAPY	727,501	0	727,501	65.00
66.00	06600	PHYSICAL THERAPY	138,551	0	138,551	66.00
66.01	06601	CLINICAL NUTRITION	35,488	0	35,488	66.01
67.00	06700	OCCUPATIONAL THERAPY	39,804	0	39,804	67.00
68.00	06800	SPEECH PATHOLOGY	107,034	0	107,034	68.00
69.00	06900	ELECTROCARDIOLOGY	846,289	0	846,289	69.00
69.01	06901	CARDIAC REHAB	98,750	0	98,750	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	254,470	0	254,470	70.00
70.01	03320	ELECTROSHOCK THERAPY	1,916	0	1,916	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	319,707	0	319,707	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	153,444	0	153,444	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,700,906	0	1,700,906	73.00
74.00	07400	RENAL DIALYSIS	144,225	0	144,225	74.00
76.00	03330	ENDOSCOPY	1,419,590	0	1,419,590	76.00
OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	4,383,019	0	4,383,019	90.00
91.00	09100	EMERGENCY	1,571,813	0	1,571,813	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)		0		92.00
SPECIAL PURPOSE COST CENTERS						
105.00	10500	KIDNEY ACQUISITION	13,029	0	13,029	105.00
106.00	10600	HEART ACQUISITION	2,286	0	2,286	106.00
107.00	10700	LIVER ACQUISITION	2,286	0	2,286	107.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	37,185,020	0	37,185,020	118.00
NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	48,578	0	48,578	190.00
191.00	19100	RESEARCH	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	962,854	0	962,854	192.00
194.00	07950	NONREIMBURSABLE COST CENTERS	236,915	0	236,915	194.00
194.02	07952	POISON CONTROL	127,978	0	127,978	194.02
194.03	07953	RETAIL PHARMACY	484,382	0	484,382	194.03

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 26-0091

Period:
From 01/01/2020
To 12/31/2020Worksheet B
Part II
Date/Time Prepared:
9/24/2021 7:02 pm

Cost Center Description			Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			24.00	25.00	26.00		
194.04	07954	RURAL HEALTH CLINIC - 5295	152,230	0	152,230		194.04
194.05	07955	RURAL HEALTH CLINIC - 5296	81,069	0	81,069		194.05
200.00		Cross Foot Adjustments	639,768	0	639,768		200.00
201.00		Negative Cost Centers	0	0	0		201.00
202.00		TOTAL (sum lines 118 through 201)	39,918,794	0	39,918,794		202.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 26-0091

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

Worksheet B-1

Date/Time Prepared:
9/24/2021 7:02 pm

Cost Center Description			CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
			NEW BLDG & FIXT (SQUARE FEET)	NEW MVBLE EQUIP (DOLLAR VALUE)				
			1.00	2.00	4.00	5A	5.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT	1,492,452					1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP		13,671,588				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	4,929	0	223,341,761			4.00
5.00	00500	ADMINISTRATIVE & GENERAL	288,766	1,126,182	21,189,090	-104,591,592	461,389,260	5.00
7.00	00700	OPERATION OF PLANT	192,913	1,382,729	3,043,971	0	22,373,996	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	3,962	0	226,687	0	2,065,120	8.00
9.00	00900	HOUSEKEEPING	10,777	20,812	4,396,490	0	8,231,508	9.00
10.00	01000	DIETARY	30,620	147,199	1,082,734	0	3,363,237	10.00
11.00	01100	CAFETERIA	16,805	0	2,727,154	0	5,853,839	11.00
13.00	01300	NURSING ADMINISTRATION	3,690	981,862	5,285,378	0	8,803,715	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	28,078	380,295	1,099,780	0	5,638,698	14.00
15.00	01500	PHARMACY	10,324	16,335	7,146,957	0	9,634,618	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	13,655	839	681,142	0	1,225,223	16.00
17.00	01700	SOCIAL SERVICE	505	0	1,528,111	0	2,166,080	17.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	0	1,830,615	0	278,770	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	40,818	1,385	743,941	-32,433,248	1,224,533	22.00
23.00	02300	PARAMED ED - PHARMACY RESIDENCY	265	0	410,638	0	525,129	23.00
23.01	02301	PARAMED ED - PHARMACY RESIDENCY - CG	251	0	809,909	0	973,169	23.01
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	161,899	530,218	20,582,525	0	27,030,846	30.00
31.00	03100	INTENSIVE CARE UNIT	17,499	218,976	6,333,831	0	7,662,720	31.00
31.01	02080	PEDIATRIC INTENSIVE CARE UNIT	28,727	273,507	6,770,482	0	9,186,615	31.01
31.02	02060	NEONATAL INTENSIVE CARE UNIT	52,929	927,501	18,741,549	0	23,241,392	31.02
31.03	02400	INTERMEDIATE CARE UNIT	79,296	65,819	15,025,142	0	20,757,690	31.03
40.00	04000	SUBPROVIDER - IPF	19,436	14,510	5,279,661	0	7,347,102	40.00
43.00	04300	NURSERY	1,698	0	1,536,084	0	2,506,713	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	76,243	1,346,390	10,092,588	0	17,595,028	50.00
51.00	05100	RECOVERY ROOM	18,181	3,896	1,703,225	0	2,332,740	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	20,574	417,057	8,543,070	0	11,653,625	52.00
53.00	05300	ANESTHESIOLOGY	2,611	185,740	719,021	0	1,414,053	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	35,928	1,479,167	6,129,939	0	11,581,120	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	4,526	41,252	1,306,572	0	5,724,865	55.00
56.00	05600	RADIOISOTOPE	4,813	83,403	237,201	0	942,024	56.00
57.00	05700	CT SCAN	1,393	155,024	1,112,562	0	2,064,075	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	3,603	460,860	716,044	0	1,659,867	58.00
59.00	05900	CARDIAC CATHETERIZATION	13,478	527,006	1,254,833	0	3,559,658	59.00
60.00	06000	LABORATORY	33,567	317,495	5,355,782	0	15,407,312	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	1,416	25,221	1,038,915	0	8,047,950	62.00
64.00	06400	INTRAVENOUS THERAPY	10,664	89,334	2,831,004	0	4,650,958	64.00
65.00	06500	RESPIRATORY THERAPY	10,559	301,151	5,985,452	0	9,804,931	65.00
66.00	06600	PHYSICAL THERAPY	6,918	6,815	735,794	0	2,444,411	66.00
66.01	06601	CLINICAL NUTRITION	1,304	0	1,075,390	0	1,290,941	66.01
67.00	06700	OCCUPATIONAL THERAPY	1,558	487	532,435	0	1,296,899	67.00
68.00	06800	SPEECH PATHOLOGY	3,377	32,983	770,853	0	1,276,972	68.00
69.00	06900	ELECTROCARDIOLOGY	11,030	440,829	2,386,873	0	3,831,510	69.00
69.01	06901	CARDIAC REHAB	5,031	17,361	200,258	0	326,230	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	613	177,662	1,042,192	0	1,369,120	70.00
70.01	03320	ELECTROSHOCK THERAPY	0	0	105,020	0	130,318	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	28,075,021	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	13,360,542	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	45,030,896	73.00
74.00	07400	RENAL DIALYSIS	2,831	40,845	645,218	0	2,226,858	74.00
76.00	03330	ENDOSCOPY	15,445	391,367	1,612,891	0	3,363,726	76.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	84,786	633,420	20,783,182	0	24,724,052	90.00
91.00	09100	EMERGENCY	48,394	291,226	11,943,666	0	16,707,143	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
SPECIAL PURPOSE COST CENTERS								
105.00	10500	KIDNEY ACQUISITION	76	141	172,180	0	1,010,309	105.00
106.00	10600	HEART ACQUISITION	77	0	44,349	0	96,230	106.00
107.00	10700	LIVER ACQUISITION	77	0	44,349	0	96,230	107.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	1,426,915	13,554,301	215,592,729	-137,024,840	413,186,327	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	3,159	516	50,581	0	194,742	190.00
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	57,137	1,905	159,357	0	1,138,945	192.00
194.00	07950	NONREIMBURSABLE COST CENTERS	4,331	86,699	1,896,711	0	3,128,943	194.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 26-0091

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

Worksheet B-1

Date/Time Prepared:
9/24/2021 7:02 pm

Cost Center Description			CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
			NEW BLDG & FIXT (SQUARE FEET)	NEW MVBLE EQUIP (DOLLAR VALUE)				
			1.00	2.00	4.00	5A	5.00	
194.02	07952	POISON CONTROL	0	10,841	2,341,371	0	3,663,643	194.02
194.03	07953	RETAIL PHARMACY	910	10,337	1,463,920	0	36,979,012	194.03
194.04	07954	RURAL HEALTH CLINIC - 5295	0	4,248	1,068,222	0	1,853,640	194.04
194.05	07955	RURAL HEALTH CLINIC - 5296	0	2,741	768,870	0	1,244,008	194.05
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)	15,082,881	17,207,247	34,010,866		104,591,592	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	10.106108	1.258614	0.152282		0.226688	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)			49,813		5,216,011	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)			0.000223		0.011305	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: 26-0091

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

Worksheet B-1

Date/Time Prepared:
9/24/2021 7:02 pm

Cost Center Description		OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (TOTAL PATIENT DAYS)	HOUSEKEEPING (SQUARE FEET)	DIETARY (TOTAL PATIENT DAYS)	CAFETERIA (GROSS SALARIES)	
		7.00	8.00	9.00	10.00	11.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500	ADMINISTRATIVE & GENERAL					5.00
7.00	00700	OPERATION OF PLANT	1,005,844				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	3,962	128,111			8.00
9.00	00900	HOUSEKEEPING	10,777	0	991,105		9.00
10.00	01000	DIETARY	30,620	0	30,620	128,111	10.00
11.00	01100	CAFETERIA	16,805	0	16,805	0	11.00
13.00	01300	NURSING ADMINISTRATION	3,690	0	3,690	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	28,078	0	28,078	0	14.00
15.00	01500	PHARMACY	10,324	0	10,324	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	13,655	0	13,655	0	16.00
17.00	01700	SOCIAL SERVICE	505	0	505	0	17.00
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	40,818	0	40,818	0	22.00
23.00	02300	PARAMED ED - PHARMACY RESIDENCY	265	0	265	0	23.00
23.01	02301	PARAMED ED - PHARMACY RESIDENCY - CG	251	0	251	0	23.01
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	161,899	39,250	161,899	39,250	30.00
31.00	03100	INTENSIVE CARE UNIT	17,499	11,632	17,499	11,632	31.00
31.01	02080	PEDIATRIC INTENSIVE CARE UNIT	28,727	8,814	28,727	8,814	31.01
31.02	02060	NEONATAL INTENSIVE CARE UNIT	52,929	28,327	52,929	28,327	31.02
31.03	02400	INTERMEDIATE CARE UNIT	79,296	22,137	79,296	22,137	31.03
40.00	04000	SUBPROVIDER - IPF	19,436	12,611	19,436	12,611	40.00
43.00	04300	NURSERY	1,698	5,340	1,698	5,340	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	76,243	0	76,243	0	50.00
51.00	05100	RECOVERY ROOM	18,181	0	18,181	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	20,574	0	20,574	0	52.00
53.00	05300	ANESTHESIOLOGY	2,611	0	2,611	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	35,928	0	35,928	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	4,526	0	4,526	0	55.00
56.00	05600	RADIOISOTOPE	4,813	0	4,813	0	56.00
57.00	05700	CT SCAN	1,393	0	1,393	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	3,603	0	3,603	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	13,478	0	13,478	0	59.00
60.00	06000	LABORATORY	33,567	0	33,567	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	1,416	0	1,416	0	62.00
64.00	06400	INTRAVENOUS THERAPY	10,664	0	10,664	0	64.00
65.00	06500	RESPIRATORY THERAPY	10,559	0	10,559	0	65.00
66.00	06600	PHYSICAL THERAPY	6,918	0	6,918	0	66.00
66.01	06601	CLINICAL NUTRITION	1,304	0	1,304	0	66.01
67.00	06700	OCCUPATIONAL THERAPY	1,558	0	1,558	0	67.00
68.00	06800	SPEECH PATHOLOGY	3,377	0	3,377	0	68.00
69.00	06900	ELECTROCARDIOLOGY	11,030	0	11,030	0	69.00
69.01	06901	CARDIAC REHAB	5,031	0	5,031	0	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	613	0	613	0	70.00
70.01	03320	ELECTROSHOCK THERAPY	0	0	0	0	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	2,831	0	2,831	0	74.00
76.00	03330	ENDOSCOPY	15,445	0	15,445	0	76.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	84,786	0	84,786	0	90.00
91.00	09100	EMERGENCY	48,394	0	48,394	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					92.00
SPECIAL PURPOSE COST CENTERS							
105.00	10500	KIDNEY ACQUISITION	76	0	76	0	105.00
106.00	10600	HEART ACQUISITION	77	0	77	0	106.00
107.00	10700	LIVER ACQUISITION	77	0	77	0	107.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	940,307	128,111	925,568	128,111	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	3,159	0	3,159	0	190.00
191.00	19100	RESEARCH	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	57,137	0	57,137	0	192.00
194.00	07950	NONREIMBURSABLE COST CENTERS	4,331	0	4,331	0	194.00
194.02	07952	POISON CONTROL	0	0	0	0	194.02
194.03	07953	RETAIL PHARMACY	910	0	910	0	194.03
194.04	07954	RURAL HEALTH CLINIC - 5295	0	0	0	0	194.04

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 26-0091

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

Worksheet B-1

Date/Time Prepared:
9/24/2021 7:02 pm

Cost Center Description			OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (TOTAL PATIENT DAYS)	HOUSEKEEPING (SQUARE FEET)	DIETARY (TOTAL PATIENT DAYS)	CAFETERIA (GROSS SALARIES)	
			7.00	8.00	9.00	10.00	11.00	
194.05	07955	RURAL HEALTH CLINIC - 5296	0	0	0	0	768,870	194.05
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)	27,445,912	2,641,367	10,391,558	5,282,198	7,815,580	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	27.286450	20.617800	10.484820	41.231417	0.040989	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	3,951,388	79,001	407,218	670,807	309,541	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	3.928430	0.616661	0.410873	5.236139	0.001623	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: 26-0091

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

Worksheet B-1

Date/Time Prepared:
9/24/2021 7:02 pm

Cost Center Description			NURSING ADMINISTRATION (DIRECT NRSNG HRS)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)	SOCIAL SERVICE (TOTAL PATIENT DAYS)	
			13.00	14.00	15.00	16.00	17.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION	211,809					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	27,235,205				14.00
15.00	01500	PHARMACY	0	605,831	45,631,235			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	2,014,744,244		16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	128,111	17.00
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	11	0	0	0	22.00
23.00	02300	PARAMED ED - PHARMACY RESIDENCY	0	0	0	0	0	23.00
23.01	02301	PARAMED ED - PHARMACY RESIDENCY - CG	0	0	0	0	0	23.01
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	9,828	1,832,693	12,869	141,459,040	39,250	30.00
31.00	03100	INTENSIVE CARE UNIT	0	1,131,669	2,554	42,784,402	11,632	31.00
31.01	02080	PEDIATRIC INTENSIVE CARE UNIT	4,888	1,134,942	14,701	54,800,937	8,814	31.01
31.02	02060	NEONATAL INTENSIVE CARE UNIT	7,844	1,774,301	12,393	158,154,964	28,327	31.02
31.03	02400	INTERMEDIATE CARE UNIT	96,605	1,112,203	3,652	74,203,817	22,137	31.03
40.00	04000	SUBPROVIDER - IPF	5,268	65,543	924	21,826,836	12,611	40.00
43.00	04300	NURSERY	39,046	0	0	6,012,014	5,340	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	10,900	6,917,227	70,652	144,635,594	0	50.00
51.00	05100	RECOVERY ROOM	856	15,840	556	19,549,025	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	721,384	8,906	62,075,993	0	52.00
53.00	05300	ANESTHESIOLOGY	0	1,154,968	71,098	50,897,607	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,680	2,982,343	4,263	82,804,832	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	21,808	3	44,613,765	0	55.00
56.00	05600	RADIOISOTOPE	0	5,810	600	5,011,379	0	56.00
57.00	05700	CT SCAN	0	272,708	8,858	66,923,946	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	142,850	2,458	32,873,790	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	976	2,726,882	2,074	44,480,134	0	59.00
60.00	06000	LABORATORY	0	195,038	522	181,862,087	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	57,250	219	22,061,914	0	62.00
64.00	06400	INTRAVENOUS THERAPY	3,618	528,988	965	18,761,097	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	1,054,567	23,146	82,056,197	0	65.00
66.00	06600	PHYSICAL THERAPY	0	4,206	0	8,272,943	0	66.00
66.01	06601	CLINICAL NUTRITION	0	0	0	676,260	0	66.01
67.00	06700	OCCUPATIONAL THERAPY	0	9,995	0	5,970,911	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	4,784	0	6,448,841	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	52,920	38,588	65,106,446	0	69.00
69.01	06901	CARDIAC REHAB	0	2,113	0	748,095	0	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0	94,991	3	6,760,038	0	70.00
70.01	03320	ELECTROSHOCK THERAPY	0	4,226	0	724,977	0	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	21,879,343	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	22,671,618	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	45,030,896	289,047,514	0	73.00
74.00	07400	RENAL DIALYSIS	1,516	350,660	6,094	9,751,994	0	74.00
76.00	03330	ENDOSCOPY	1,808	856,756	3,803	25,103,047	0	76.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	10,506	361,904	305,196	49,883,013	0	90.00
91.00	09100	EMERGENCY	12,630	1,009,992	5,242	143,629,334	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
SPECIAL PURPOSE COST CENTERS								
105.00	10500	KIDNEY ACQUISITION	0	0	0	145,530	0	105.00
106.00	10600	HEART ACQUISITION	0	0	0	37,485	0	106.00
107.00	10700	LIVER ACQUISITION	0	0	0	37,485	0	107.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	207,969	27,207,403	45,631,235	2,014,744,244	128,111	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	21	0	0	0	190.00
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07950	NONREIMBURSABLE COST CENTERS	3,840	377	0	0	0	194.00
194.02	07952	POISON CONTROL	0	0	0	0	0	194.02
194.03	07953	RETAIL PHARMACY	0	1,691	0	0	0	194.03

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 26-0091

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

Worksheet B-1

Date/Time Prepared:
9/24/2021 7:02 pm

Cost Center Description			NURSING ADMINISTRATION (DIRECT NRSING HRS)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)	SOCIAL SERVICE (TOTAL PATIENT DAYS)	
			13.00	14.00	15.00	16.00	17.00	
194.04	07954	RURAL HEALTH CLINIC - 5295	0	13,150	0	0	0	194.04
194.05	07955	RURAL HEALTH CLINIC - 5296	0	12,563	0	0	0	194.05
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)	11,155,430	8,022,544	12,680,024	2,046,651	2,738,815	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	52.667403	0.294565	0.277880	0.001016	21.378453	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	1,398,372	1,115,067	1,176,818	213,416	34,604	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	6.602042	0.040942	0.025790	0.000106	0.270110	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: 26-0091

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

Worksheet B-1

Date/Time Prepared:
9/24/2021 7:02 pm

Cost Center Description		INTERNS & RESIDENTS		PARAMED ED - PHARMACY RESIDENCY (ASSIGNED TIME)	PARAMED ED - PHARMACY RESIDENCY - CG (ASSIGNED TIME)		
		SERVICES-SALAR Y & FRINGES (ASSIGNED TIME)	SERVICES-OTHER PRGM COSTS (ASSIGNED TIME)				
		21.00	22.00				
GENERAL SERVICE COST CENTERS							
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500	ADMINISTRATIVE & GENERAL					5.00
7.00	00700	OPERATION OF PLANT					7.00
8.00	00800	LAUNDRY & LINEN SERVICE					8.00
9.00	00900	HOUSEKEEPING					9.00
10.00	01000	DIETARY					10.00
11.00	01100	CAFETERIA					11.00
13.00	01300	NURSING ADMINISTRATION					13.00
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
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	191				21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD		191			22.00
23.00	02300	PARAMED ED - PHARMACY RESIDENCY			78		23.00
23.01	02301	PARAMED ED - PHARMACY RESIDENCY - CG				232	23.01
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	117	117	44	115	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	14	0	31.00
31.01	02080	PEDIATRIC INTENSIVE CARE UNIT	0	0	0	57	31.01
31.02	02060	NEONATAL INTENSIVE CARE UNIT	0	0	0	20	31.02
31.03	02400	INTERMEDIATE CARE UNIT	2	2	0	0	31.03
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	40.00
43.00	04300	NURSERY	0	0	0	0	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	18	18	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	26	26	0	0	52.00
53.00	05300	ANESTHESIOLOGY	5	5	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	5	5	0	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	55.00
56.00	05600	RADIOISOTOPE	1	1	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	2	2	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	62.00
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
66.01	06601	CLINICAL NUTRITION	0	0	0	0	66.01
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	2	2	0	0	69.00
69.01	06901	CARDIAC REHAB	0	0	0	0	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	9	9	0	0	70.00
70.01	03320	ELECTROSHOCK THERAPY	0	0	0	0	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	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	10	28	74.00
76.00	03330	ENDOSCOPY	0	0	0	0	76.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0	0	10	0	90.00
91.00	09100	EMERGENCY	4	4	0	12	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					92.00
SPECIAL PURPOSE COST CENTERS							
105.00	10500	KIDNEY ACQUISITION	0	0	0	0	105.00
106.00	10600	HEART ACQUISITION	0	0	0	0	106.00
107.00	10700	LIVER ACQUISITION	0	0	0	0	107.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	191	191	78	232	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	190.00
191.00	19100	RESEARCH	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	192.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 26-0091

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

Worksheet B-1

Date/Time Prepared:
9/24/2021 7:02 pm

Cost Center Description			INTERNS & RESIDENTS		PARAMED ED - PHARMACY RESIDENCY (ASSIGNED TIME)	PARAMED ED - PHARMACY RESIDENCY - CG (ASSIGNED TIME)		
			SERVICES-SALAR Y & FRINGES (ASSIGNED TIME)	SERVICES-OTHER PRGM COSTS (ASSIGNED TIME)				
			21.00	22.00	23.00	23.01		
194.00	07950	NONREIMBURSABLE COST CENTERS	0	0	0	0		194.00
194.02	07952	POISON CONTROL	0	0	0	0		194.02
194.03	07953	RETAIL PHARMACY	0	0	0	0		194.03
194.04	07954	RURAL HEALTH CLINIC - 5295	0	0	0	0		194.04
194.05	07955	RURAL HEALTH CLINIC - 5296	0	0	0	0		194.05
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)	416,999	35,507,611	671,010	1,236,453		202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	2,183.240838	185,903.722513	8,602.692308	5,329.538793		203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	6,530	606,592	10,523	16,123		204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	34.188482	3,175.874346	134.910256	69.495690		205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)			0	0		206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)			0.000000	0.000000		207.00

Provider CCN: 26-0091

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

Worksheet B-2

Date/Time Prepared:
9/24/2021 7:02 pm

		Description	Worksheet		Amount	
			CODE	Line No.		
			1.00	2.00	3.00	4.00
1.00		ADJ FOR EPO COSTS IN RENAL DIALYSIS		1	74.00	0 1.00
2.00		ADJ FOR EPO COSTS IN HOME PROGRAM		1	94.00	0 2.00
3.00		ADJ FOR ARANESP COSTS IN RENAL DIALYSIS		1	74.00	0 3.00
4.00		ADJ FOR ARANESP COSTS IN HOME PROGRAM		1	94.00	0 4.00
5.00		ADJ FOR ESA COSTS IN RENAL DIALYSIS		1	74.00	-33,812 5.00
6.00		ADJ FOR ESA COSTS IN HOME PROGRAM		1	94.00	0 6.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 26-0091

Period:
From 01/01/2020
To 12/31/2020Worksheet C
Part I
Date/Time Prepared:
9/24/2021 7:02 pm

			Title XVIII	Hospital	PPS	
Cost Center Description		Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs		
				Total Costs	RCE Disallowance	
		1.00	2.00	3.00	4.00	5.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS		45,580,065	0	45,580,065 30.00
31.00	03100	INTENSIVE CARE UNIT		11,786,415	0	11,786,415 31.00
31.01	02080	PEDIATRIC INTENSIVE CARE UNIT		14,320,548	0	14,320,548 31.01
31.02	02060	NEONATAL INTENSIVE CARE UNIT		34,841,409	0	34,841,409 31.02
31.03	02400	INTERMEDIATE CARE UNIT		36,408,553	0	36,408,553 31.03
40.00	04000	SUBPROVIDER - IPF		11,331,908	0	11,331,908 40.00
43.00	04300	NURSERY		5,709,048	0	5,709,048 43.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM		27,655,329	0	27,655,329 50.00
51.00	05100	RECOVERY ROOM		3,687,843	0	3,687,843 51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM		15,700,678	0	15,700,678 52.00
53.00	05300	ANESTHESIOLOGY		2,274,377	0	2,274,377 53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC		16,867,018	0	16,867,018 54.00
55.00	05500	RADIOLOGY-THERAPEUTIC		7,298,883	0	7,298,883 55.00
56.00	05600	RADIOISOTOPE		1,354,056	0	1,354,056 56.00
57.00	05700	CT SCAN		2,780,980	0	2,780,980 57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)		2,277,741	0	2,277,741 58.00
59.00	05900	CARDIAC CATHETERIZATION		5,827,520	0	5,827,520 59.00
60.00	06000	LABORATORY		20,629,729	0	20,629,729 60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS		10,007,733	0	10,007,733 62.00
64.00	06400	INTRAVENOUS THERAPY		6,589,808	0	6,589,808 64.00
65.00	06500	RESPIRATORY THERAPY	0	13,072,196	0	13,072,196 65.00
66.00	06600	PHYSICAL THERAPY	0	3,299,635	0	3,299,635 66.00
66.01	06601	CLINICAL NUTRITION	0	1,677,602	0	1,677,602 66.01
67.00	06700	OCCUPATIONAL THERAPY	0	1,680,571	0	1,680,571 67.00
68.00	06800	SPEECH PATHOLOGY	0	1,733,556	0	1,733,556 68.00
69.00	06900	ELECTROCARDIOLOGY		5,306,980	0	5,306,980 69.00
69.01	06901	CARDIAC REHAB		599,799	0	599,799 69.01
70.00	07000	ELECTROENCEPHALOGRAPHY		1,780,205	0	1,780,205 70.00
70.01	03320	ELECTROSHOCK THERAPY		166,147	0	166,147 70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS		34,461,520	0	34,461,520 71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT		16,412,251	0	16,412,251 72.00
73.00	07300	DRUGS CHARGED TO PATIENTS		68,045,587	0	68,045,587 73.00
74.00	07400	RENAL DIALYSIS		3,261,217	0	3,261,217 74.00
76.00	03330	ENDOSCOPY		5,149,885	0	5,149,885 76.00
OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC		35,264,478	0	35,264,478 90.00
91.00	09100	EMERGENCY		23,985,948	0	23,985,948 91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)		8,208,399	0	8,208,399 92.00
SPECIAL PURPOSE COST CENTERS						
105.00	10500	KIDNEY ACQUISITION		1,249,410		1,249,410 105.00
106.00	10600	HEART ACQUISITION		122,808		122,808 106.00
107.00	10700	LIVER ACQUISITION		122,808		122,808 107.00
200.00		Subtotal (see instructions)	0	508,530,643	0	508,530,643 200.00
201.00		Less Observation Beds		8,208,399		8,208,399 201.00
202.00		Total (see instructions)	0	500,322,244	0	500,322,244 202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 26-0091

Period:
From 01/01/2020
To 12/31/2020Worksheet C
Part I
Date/Time Prepared:
9/24/2021 7:02 pm

			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	114,311,151		114,311,151			30.00
31.00	03100	INTENSIVE CARE UNIT	42,784,402		42,784,402			31.00
31.01	02080	PEDIATRIC INTENSIVE CARE UNIT	54,800,937		54,800,937			31.01
31.02	02060	NEONATAL INTENSIVE CARE UNIT	158,154,964		158,154,964			31.02
31.03	02400	INTERMEDIATE CARE UNIT	74,203,817		74,203,817			31.03
40.00	04000	SUBPROVIDER - IPF	21,826,836		21,826,836			40.00
43.00	04300	NURSERY	6,012,014		6,012,014			43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	60,839,685	83,795,909	144,635,594	0.191207	0.000000	50.00
51.00	05100	RECOVERY ROOM	4,315,802	15,233,223	19,549,025	0.188646	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	31,282,415	30,793,578	62,075,993	0.252927	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	22,442,995	28,454,612	50,897,607	0.044685	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	18,370,248	64,434,584	82,804,832	0.203696	0.000000	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	531,080	44,082,685	44,613,765	0.163602	0.000000	55.00
56.00	05600	RADIOISOTOPE	1,347,917	3,663,462	5,011,379	0.270196	0.000000	56.00
57.00	05700	CT SCAN	23,620,931	43,303,015	66,923,946	0.041554	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	8,826,925	24,046,865	32,873,790	0.069287	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	19,070,572	25,409,562	44,480,134	0.131014	0.000000	59.00
60.00	06000	LABORATORY	98,130,848	83,731,239	181,862,087	0.113436	0.000000	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	16,554,722	5,507,192	22,061,914	0.453620	0.000000	62.00
64.00	06400	INTRAVENOUS THERAPY	964,101	17,796,996	18,761,097	0.351249	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	62,188,300	19,867,897	82,056,197	0.159308	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	6,197,625	2,075,318	8,272,943	0.398847	0.000000	66.00
66.01	06601	CLINICAL NUTRITION	1,874	674,386	676,260	2.480706	0.000000	66.01
67.00	06700	OCCUPATIONAL THERAPY	4,446,234	1,524,677	5,970,911	0.281460	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	2,452,641	3,996,200	6,448,841	0.268817	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	24,232,210	40,874,236	65,106,446	0.081512	0.000000	69.00
69.01	06901	CARDIAC REHAB	173	747,922	748,095	0.801768	0.000000	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	2,394,994	4,365,044	6,760,038	0.263342	0.000000	70.00
70.01	03320	ELECTROSHOCK THERAPY	320,667	404,310	724,977	0.229176	0.000000	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	8,550,902	13,328,441	21,879,343	1.575071	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	9,588,797	13,082,821	22,671,618	0.723912	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	90,042,778	199,004,736	289,047,514	0.235413	0.000000	73.00
74.00	07400	RENAL DIALYSIS	4,575,326	5,176,668	9,751,994	0.334415	0.000000	74.00
76.00	03330	ENDOSCOPY	3,170,420	21,932,627	25,103,047	0.205150	0.000000	76.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	198,018	49,684,995	49,883,013	0.706944	0.000000	90.00
91.00	09100	EMERGENCY	38,325,648	105,303,686	143,629,334	0.166999	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	3,998,451	23,149,438	27,147,889	0.302359	0.000000	92.00
SPECIAL PURPOSE COST CENTERS								
105.00	10500	KIDNEY ACQUISITION	145,530	0	145,530			105.00
106.00	10600	HEART ACQUISITION	37,485	0	37,485			106.00
107.00	10700	LIVER ACQUISITION	37,485	0	37,485			107.00
200.00		Subtotal (see instructions)	1,039,297,920	975,446,324	2,014,744,244			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	1,039,297,920	975,446,324	2,014,744,244			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 26-0091

Period:
From 01/01/2020
To 12/31/2020Worksheet C
Part I
Date/Time Prepared:
9/24/2021 7:02 pm

Cost Center Description		PPS Inpatient Ratio	Title XVIII	Hospital	PPS
		11.00			
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS			30.00
31.00	03100	INTENSIVE CARE UNIT			31.00
31.01	02080	PEDIATRIC INTENSIVE CARE UNIT			31.01
31.02	02060	NEONATAL INTENSIVE CARE UNIT			31.02
31.03	02400	INTERMEDIATE CARE UNIT			31.03
40.00	04000	SUBPROVIDER - IPF			40.00
43.00	04300	NURSERY			43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0.191207		50.00
51.00	05100	RECOVERY ROOM	0.188646		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.252927		52.00
53.00	05300	ANESTHESIOLOGY	0.044685		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.203696		54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.163602		55.00
56.00	05600	RADIOISOTOPE	0.270196		56.00
57.00	05700	CT SCAN	0.041554		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.069287		58.00
59.00	05900	CARDIAC CATHETERIZATION	0.131014		59.00
60.00	06000	LABORATORY	0.113436		60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.453620		62.00
64.00	06400	INTRAVENOUS THERAPY	0.351249		64.00
65.00	06500	RESPIRATORY THERAPY	0.159308		65.00
66.00	06600	PHYSICAL THERAPY	0.398847		66.00
66.01	06601	CLINICAL NUTRITION	2.480706		66.01
67.00	06700	OCCUPATIONAL THERAPY	0.281460		67.00
68.00	06800	SPEECH PATHOLOGY	0.268817		68.00
69.00	06900	ELECTROCARDIOLOGY	0.081512		69.00
69.01	06901	CARDIAC REHAB	0.801768		69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0.263342		70.00
70.01	03320	ELECTROSHOCK THERAPY	0.229176		70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1.575071		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.723912		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.235413		73.00
74.00	07400	RENAL DIALYSIS	0.334415		74.00
76.00	03330	ENDOSCOPY	0.205150		76.00
OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	0.706944		90.00
91.00	09100	EMERGENCY	0.166999		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.302359		92.00
SPECIAL PURPOSE COST CENTERS					
105.00	10500	KIDNEY ACQUISITION			105.00
106.00	10600	HEART ACQUISITION			106.00
107.00	10700	LIVER ACQUISITION			107.00
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: 26-0091

Period:
From 01/01/2020
To 12/31/2020Worksheet C
Part I
Date/Time Prepared:
9/24/2021 7:02 pm

			Title XIX	Hospital	Cost	
Cost Center Description			Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs	
					Total 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	45,580,065		45,580,065	30.00
31.00	03100	INTENSIVE CARE UNIT	11,786,415		11,786,415	31.00
31.01	02080	PEDIATRIC INTENSIVE CARE UNIT	14,320,548		14,320,548	31.01
31.02	02060	NEONATAL INTENSIVE CARE UNIT	34,841,409		34,841,409	31.02
31.03	02400	INTERMEDIATE CARE UNIT	36,408,553		36,408,553	31.03
40.00	04000	SUBPROVIDER - IPF	11,331,908		11,331,908	40.00
43.00	04300	NURSERY	5,709,048		5,709,048	43.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	27,655,329		27,655,329	50.00
51.00	05100	RECOVERY ROOM	3,687,843		3,687,843	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	15,700,678		15,700,678	52.00
53.00	05300	ANESTHESIOLOGY	2,274,377		2,274,377	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	16,867,018		16,867,018	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	7,298,883		7,298,883	55.00
56.00	05600	RADIOISOTOPE	1,354,056		1,354,056	56.00
57.00	05700	CT SCAN	2,780,980		2,780,980	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	2,277,741		2,277,741	58.00
59.00	05900	CARDIAC CATHETERIZATION	5,827,520		5,827,520	59.00
60.00	06000	LABORATORY	20,629,729		20,629,729	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	10,007,733		10,007,733	62.00
64.00	06400	INTRAVENOUS THERAPY	6,589,808		6,589,808	64.00
65.00	06500	RESPIRATORY THERAPY	13,072,196	0	13,072,196	65.00
66.00	06600	PHYSICAL THERAPY	3,299,635	0	3,299,635	66.00
66.01	06601	CLINICAL NUTRITION	1,677,602	0	1,677,602	66.01
67.00	06700	OCCUPATIONAL THERAPY	1,680,571	0	1,680,571	67.00
68.00	06800	SPEECH PATHOLOGY	1,733,556	0	1,733,556	68.00
69.00	06900	ELECTROCARDIOLOGY	5,306,980		5,306,980	69.00
69.01	06901	CARDIAC REHAB	599,799		599,799	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	1,780,205		1,780,205	70.00
70.01	03320	ELECTROSHOCK THERAPY	166,147		166,147	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	34,461,520		34,461,520	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	16,412,251		16,412,251	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	68,045,587		68,045,587	73.00
74.00	07400	RENAL DIALYSIS	3,261,217		3,261,217	74.00
76.00	03330	ENDOSCOPY	5,149,885		5,149,885	76.00
OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	35,264,478		35,264,478	90.00
91.00	09100	EMERGENCY	23,985,948		23,985,948	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	8,208,399		8,208,399	92.00
SPECIAL PURPOSE COST CENTERS						
105.00	10500	KIDNEY ACQUISITION	1,249,410		1,249,410	105.00
106.00	10600	HEART ACQUISITION	122,808		122,808	106.00
107.00	10700	LIVER ACQUISITION	122,808		122,808	107.00
200.00		Subtotal (see instructions)	508,530,643	0	508,530,643	200.00
201.00		Less Observation Beds	8,208,399		8,208,399	201.00
202.00		Total (see instructions)	500,322,244	0	500,322,244	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 26-0091

Period:
From 01/01/2020
To 12/31/2020Worksheet C
Part I
Date/Time Prepared:
9/24/2021 7:02 pm

			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	114,311,151		114,311,151			30.00	
31.00	03100	INTENSIVE CARE UNIT	42,784,402		42,784,402			31.00	
31.01	02080	PEDIATRIC INTENSIVE CARE UNIT	54,800,937		54,800,937			31.01	
31.02	02060	NEONATAL INTENSIVE CARE UNIT	158,154,964		158,154,964			31.02	
31.03	02400	INTERMEDIATE CARE UNIT	74,203,817		74,203,817			31.03	
40.00	04000	SUBPROVIDER - IPF	21,826,836		21,826,836			40.00	
43.00	04300	NURSERY	6,012,014		6,012,014			43.00	
	ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	60,839,685	83,795,909	144,635,594	0.191207	0.000000	50.00	
51.00	05100	RECOVERY ROOM	4,315,802	15,233,223	19,549,025	0.188646	0.000000	51.00	
52.00	05200	DELIVERY ROOM & LABOR ROOM	31,282,415	30,793,578	62,075,993	0.252927	0.000000	52.00	
53.00	05300	ANESTHESIOLOGY	22,442,995	28,454,612	50,897,607	0.044685	0.000000	53.00	
54.00	05400	RADIOLOGY-DIAGNOSTIC	18,370,248	64,434,584	82,804,832	0.203696	0.000000	54.00	
55.00	05500	RADIOLOGY-THERAPEUTIC	531,080	44,082,685	44,613,765	0.163602	0.000000	55.00	
56.00	05600	RADIOISOTOPE	1,347,917	3,663,462	5,011,379	0.270196	0.000000	56.00	
57.00	05700	CT SCAN	23,620,931	43,303,015	66,923,946	0.041554	0.000000	57.00	
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	8,826,925	24,046,865	32,873,790	0.069287	0.000000	58.00	
59.00	05900	CARDIAC CATHETERIZATION	19,070,572	25,409,562	44,480,134	0.131014	0.000000	59.00	
60.00	06000	LABORATORY	98,130,848	83,731,239	181,862,087	0.113436	0.000000	60.00	
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	16,554,722	5,507,192	22,061,914	0.453620	0.000000	62.00	
64.00	06400	INTRAVENOUS THERAPY	964,101	17,796,996	18,761,097	0.351249	0.000000	64.00	
65.00	06500	RESPIRATORY THERAPY	62,188,300	19,867,897	82,056,197	0.159308	0.000000	65.00	
66.00	06600	PHYSICAL THERAPY	6,197,625	2,075,318	8,272,943	0.398847	0.000000	66.00	
66.01	06601	CLINICAL NUTRITION	1,874	674,386	676,260	2.480706	0.000000	66.01	
67.00	06700	OCCUPATIONAL THERAPY	4,446,234	1,524,677	5,970,911	0.281460	0.000000	67.00	
68.00	06800	SPEECH PATHOLOGY	2,452,641	3,996,200	6,448,841	0.268817	0.000000	68.00	
69.00	06900	ELECTROCARDIOLOGY	24,232,210	40,874,236	65,106,446	0.081512	0.000000	69.00	
69.01	06901	CARDIAC REHAB	173	747,922	748,095	0.801768	0.000000	69.01	
70.00	07000	ELECTROENCEPHALOGRAPHY	2,394,994	4,365,044	6,760,038	0.263342	0.000000	70.00	
70.01	03320	ELECTROSHOCK THERAPY	320,667	404,310	724,977	0.229176	0.000000	70.01	
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	8,550,902	13,328,441	21,879,343	1.575071	0.000000	71.00	
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	9,588,797	13,082,821	22,671,618	0.723912	0.000000	72.00	
73.00	07300	DRUGS CHARGED TO PATIENTS	90,042,778	199,004,736	289,047,514	0.235413	0.000000	73.00	
74.00	07400	RENAL DIALYSIS	4,575,326	5,176,668	9,751,994	0.334415	0.000000	74.00	
76.00	03330	ENDOSCOPY	3,170,420	21,932,627	25,103,047	0.205150	0.000000	76.00	
	OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	198,018	49,684,995	49,883,013	0.706944	0.000000	90.00	
91.00	09100	EMERGENCY	38,325,648	105,303,686	143,629,334	0.166999	0.000000	91.00	
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	3,998,451	23,149,438	27,147,889	0.302359	0.000000	92.00	
	SPECIAL PURPOSE COST CENTERS								
105.00	10500	KIDNEY ACQUISITION	145,530	0	145,530			105.00	
106.00	10600	HEART ACQUISITION	37,485	0	37,485			106.00	
107.00	10700	LIVER ACQUISITION	37,485	0	37,485			107.00	
200.00		Subtotal (see instructions)	1,039,297,920	975,446,324	2,014,744,244			200.00	
201.00		Less Observation Beds						201.00	
202.00		Total (see instructions)	1,039,297,920	975,446,324	2,014,744,244			202.00	

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 26-0091

Period:
From 01/01/2020
To 12/31/2020Worksheet C
Part I
Date/Time Prepared:
9/24/2021 7:02 pm

Cost Center Description			PPS Inpatient Ratio	Title XIX	Hospital	Cost
			11.00			
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS				30.00
31.00	03100	INTENSIVE CARE UNIT				31.00
31.01	02080	PEDIATRIC INTENSIVE CARE UNIT				31.01
31.02	02060	NEONATAL INTENSIVE CARE UNIT				31.02
31.03	02400	INTERMEDIATE CARE UNIT				31.03
40.00	04000	SUBPROVIDER - IPF				40.00
43.00	04300	NURSERY				43.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.000000			50.00
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
55.00	05500	RADIOLOGY-THERAPEUTIC	0.000000			55.00
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
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.000000			62.00
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
66.01	06601	CLINICAL NUTRITION	0.000000			66.01
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
70.01	03320	ELECTROSHOCK THERAPY	0.000000			70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000			71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.000000			72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000			73.00
74.00	07400	RENAL DIALYSIS	0.000000			74.00
76.00	03330	ENDOSCOPY	0.000000			76.00
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
SPECIAL PURPOSE COST CENTERS						
105.00	10500	KIDNEY ACQUISITION				105.00
106.00	10600	HEART ACQUISITION				106.00
107.00	10700	LIVER ACQUISITION				107.00
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: 26-0091

Period:
From 01/01/2020
To 12/31/2020Worksheet D
Part I
Date/Time Prepared:
9/24/2021 7:02 pm

			Title XVIII		Hospital	PPS	
Cost Center Description		Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)	
		1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	ADULTS & PEDIATRICS	3,935,056	0	3,935,056	47,871	82.20	30.00
31.00	INTENSIVE CARE UNIT	748,882		748,882	11,632	64.38	31.00
31.01	PEDIATRIC INTENSIVE CARE UNIT	1,014,459		1,014,459	8,814	115.10	31.01
31.02	NEONATAL INTENSIVE CARE UNIT	2,544,244		2,544,244	28,327	89.82	31.02
31.03	INTERMEDIATE CARE UNIT	2,317,537		2,317,537	22,137	104.69	31.03
40.00	SUBPROVIDER - IPF	508,845	0	508,845	12,611	40.35	40.00
43.00	NURSERY	346,818		346,818	5,340	64.95	43.00
200.00	Total (lines 30 through 199)	11,415,841		11,415,841	136,732		200.00
Cost Center Description		Inpatient Program days	Inpatient Program Capital Cost (col. 5 x col. 6)				
		6.00	7.00				
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	ADULTS & PEDIATRICS	6,982	573,920				
31.00	INTENSIVE CARE UNIT	3,868	249,022				
31.01	PEDIATRIC INTENSIVE CARE UNIT	55	6,331				
31.02	NEONATAL INTENSIVE CARE UNIT	0	0				
31.03	INTERMEDIATE CARE UNIT	6,370	666,875				
40.00	SUBPROVIDER - IPF	5,422	218,778				
43.00	NURSERY	0	0				
200.00	Total (lines 30 through 199)	22,697	1,714,926				

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS				Provider CCN: 26-0091	Period: From 01/01/2020 To 12/31/2020	Worksheet D Part II Date/Time Prepared: 9/24/2021 7:02 pm		
				Title XVIII		Hospital		PPS
Cost Center Description			Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	4,156,857	144,635,594	0.028740	10,229,051	293,983	50.00
51.00	05100	RECOVERY ROOM	305,438	19,549,025	0.015624	646,413	10,100	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,253,916	62,075,993	0.020200	140,122	2,830	52.00
53.00	05300	ANESTHESIOLOGY	421,465	50,897,607	0.008281	2,076,760	17,198	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,953,369	82,804,832	0.035667	3,110,985	110,960	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	342,683	44,613,765	0.007681	113,198	869	55.00
56.00	05600	RADIOISOTOPE	186,371	5,011,379	0.037190	219,146	8,150	56.00
57.00	05700	CT SCAN	293,681	66,923,946	0.004388	4,428,456	19,432	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	767,740	32,873,790	0.023354	1,238,093	28,914	58.00
59.00	05900	CARDIAC CATHETERIZATION	1,023,407	44,480,134	0.023008	2,038,154	46,894	59.00
60.00	06000	LABORATORY	1,253,577	181,862,087	0.006893	14,588,655	100,560	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	159,490	22,061,914	0.007229	1,055,691	7,632	62.00
64.00	06400	INTRAVENOUS THERAPY	691,077	18,761,097	0.036836	5,950	219	64.00
65.00	06500	RESPIRATORY THERAPY	727,501	82,056,197	0.008866	5,508,321	48,837	65.00
66.00	06600	PHYSICAL THERAPY	138,551	8,272,943	0.016747	1,540,144	25,793	66.00
66.01	06601	CLINICAL NUTRITION	35,488	676,260	0.052477	0	0	66.01
67.00	06700	OCCUPATIONAL THERAPY	39,804	5,970,911	0.006666	851,895	5,679	67.00
68.00	06800	SPEECH PATHOLOGY	107,034	6,448,841	0.016597	555,199	9,215	68.00
69.00	06900	ELECTROCARDIOLOGY	846,289	65,106,446	0.012999	4,066,641	52,862	69.00
69.01	06901	CARDIAC REHAB	98,750	748,095	0.132002	0	0	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	254,470	6,760,038	0.037643	564,419	21,246	70.00
70.01	03320	ELECTROSHOCK THERAPY	1,916	724,977	0.002643	32,752	87	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	319,707	21,879,343	0.014612	1,378,922	20,149	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	153,444	22,671,618	0.006768	1,742,474	11,793	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,700,906	289,047,514	0.005885	13,693,836	80,588	73.00
74.00	07400	RENAL DIALYSIS	144,225	9,751,994	0.014789	2,470,775	36,540	74.00
76.00	03330	ENDOSCOPY	1,419,590	25,103,047	0.056551	588,090	33,257	76.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	4,383,019	49,883,013	0.087866	64,547	5,671	90.00
91.00	09100	EMERGENCY	1,571,813	143,629,334	0.010944	7,062,169	77,288	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	708,656	27,147,889	0.026104	2,349,383	61,328	92.00
200.00		Total (lines 50 through 199)	26,460,234	1,542,429,623		82,360,241	1,138,074	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS					Provider CCN: 26-0091		Period: From 01/01/2020 To 12/31/2020		Worksheet D Part III Date/Time Prepared: 9/24/2021 7:02 pm	
					Title XVIII		Hospital		PPS	
Cost Center Description					Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health Cost	All Other Medical Education Cost	
					1A	1.00	2A	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS										
30.00	03000	ADULTS & PEDIATRICS	0	0	0	991,415	0	30.00		
31.00	03100	INTENSIVE CARE UNIT	0	0	0	120,438	0	31.00		
31.01	02080	PEDIATRIC INTENSIVE CARE UNIT	0	0	0	303,784	0	31.01		
31.02	02060	NEONATAL INTENSIVE CARE UNIT	0	0	0	106,591	0	31.02		
31.03	02400	INTERMEDIATE CARE UNIT	0	0	0	0	0	31.03		
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	0	40.00		
43.00	04300	NURSERY	0	0	0	0	0	43.00		
200.00		Total (lines 30 through 199)	0	0	0	1,522,228	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	991,415	47,871	20.71	6,982	30.00		
31.00	03100	INTENSIVE CARE UNIT		120,438	11,632	10.35	3,868	31.00		
31.01	02080	PEDIATRIC INTENSIVE CARE UNIT		303,784	8,814	34.47	55	31.01		
31.02	02060	NEONATAL INTENSIVE CARE UNIT		106,591	28,327	3.76	0	31.02		
31.03	02400	INTERMEDIATE CARE UNIT		0	22,137	0.00	6,370	31.03		
40.00	04000	SUBPROVIDER - IPF	0	0	12,611	0.00	5,422	40.00		
43.00	04300	NURSERY		0	5,340	0.00	0	43.00		
200.00		Total (lines 30 through 199)		1,522,228	136,732		22,697	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	144,597					30.00		
31.00	03100	INTENSIVE CARE UNIT	40,034					31.00		
31.01	02080	PEDIATRIC INTENSIVE CARE UNIT	1,896					31.01		
31.02	02060	NEONATAL INTENSIVE CARE UNIT	0					31.02		
31.03	02400	INTERMEDIATE CARE UNIT	0					31.03		
40.00	04000	SUBPROVIDER - IPF	0					40.00		
43.00	04300	NURSERY	0					43.00		
200.00		Total (lines 30 through 199)	186,527					200.00		

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS				Provider CCN: 26-0091		Period: From 01/01/2020 To 12/31/2020		Worksheet D Part IV Date/Time Prepared: 9/24/2021 7:02 pm	
				Title XVIII		Hospital		PPS	
Cost Center Description				Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health	
				1.00	2A	2.00	3A	3.00	
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM		0	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM		0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM		0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY		0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC		0	0	0	0	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC		0	0	0	0	0	55.00
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
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS		0	0	0	0	0	62.00
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
66.01	06601	CLINICAL NUTRITION		0	0	0	0	0	66.01
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
70.01	03320	ELECTROSHOCK THERAPY		0	0	0	0	0	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS		0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT		0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS		0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS		0	0	0	0	235,254	74.00
76.00	03330	ENDOSCOPY		0	0	0	0	0	76.00
OUTPATIENT SERVICE COST CENTERS									
90.00	09000	CLINIC		0	0	0	0	86,027	90.00
91.00	09100	EMERGENCY		0	0	0	0	63,954	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)		0	0	0	0	178,541	92.00
200.00		Total (lines 50 through 199)		0	0	0	0	563,776	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

Provider CCN: 26-0091

Period:
From 01/01/2020
To 12/31/2020Worksheet D
Part IV
Date/Time Prepared:
9/24/2021 7:02 pm

			Title XVIII		Hospital	PPS		
	Cost Center Description	All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7) (see instructions)		
		4.00	5.00	6.00	7.00	8.00		
	ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	0	0	144,635,594	0.000000	50.00
51.00	05100	RECOVERY ROOM	0	0	0	19,549,025	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	62,075,993	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	50,897,607	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	82,804,832	0.000000	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	44,613,765	0.000000	55.00
56.00	05600	RADIOISOTOPE	0	0	0	5,011,379	0.000000	56.00
57.00	05700	CT SCAN	0	0	0	66,923,946	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	32,873,790	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	44,480,134	0.000000	59.00
60.00	06000	LABORATORY	0	0	0	181,862,087	0.000000	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	22,061,914	0.000000	62.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	18,761,097	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	82,056,197	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	8,272,943	0.000000	66.00
66.01	06601	CLINICAL NUTRITION	0	0	0	676,260	0.000000	66.01
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	5,970,911	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	6,448,841	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	65,106,446	0.000000	69.00
69.01	06901	CARDIAC REHAB	0	0	0	748,095	0.000000	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	6,760,038	0.000000	70.00
70.01	03320	ELECTROSHOCK THERAPY	0	0	0	724,977	0.000000	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	21,879,343	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	22,671,618	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	289,047,514	0.000000	73.00
74.00	07400	RENAL DIALYSIS	0	235,254	235,254	9,751,994	0.024124	74.00
76.00	03330	ENDOSCOPY	0	0	0	25,103,047	0.000000	76.00
	OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0	86,027	86,027	49,883,013	0.001725	90.00
91.00	09100	EMERGENCY	0	63,954	63,954	143,629,334	0.000445	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	178,541	178,541	27,147,889	0.006577	92.00
200.00		Total (lines 50 through 199)	0	563,776	563,776	1,542,429,623		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 26-0091

Period:
From 01/01/2020
To 12/31/2020Worksheet D
Part IV
Date/Time Prepared:
9/24/2021 7:02 pm

Cost Center Description			Title XVIII			Hospital		PPS	
			Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)		
									9.00
	ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0.000000	10,229,051	0	21,775,432	0	50.00	
51.00	05100	RECOVERY ROOM	0.000000	646,413	0	1,960,795	0	51.00	
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	140,122	0	31,372	0	52.00	
53.00	05300	ANESTHESIOLOGY	0.000000	2,076,760	0	2,073,648	0	53.00	
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	3,110,985	0	5,313,905	0	54.00	
55.00	05500	RADIOLOGY-THERAPEUTIC	0.000000	113,198	0	16,870,447	0	55.00	
56.00	05600	RADIOISOTOPE	0.000000	219,146	0	787,369	0	56.00	
57.00	05700	CT SCAN	0.000000	4,428,456	0	4,820,758	0	57.00	
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000	1,238,093	0	1,497,046	0	58.00	
59.00	05900	CARDIAC CATHETERIZATION	0.000000	2,038,154	0	1,729,291	0	59.00	
60.00	06000	LABORATORY	0.000000	14,588,655	0	5,110,941	0	60.00	
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.000000	1,055,691	0	126,572	0	62.00	
64.00	06400	INTRAVENOUS THERAPY	0.000000	5,950	0	1,718,101	0	64.00	
65.00	06500	RESPIRATORY THERAPY	0.000000	5,508,321	0	394,380	0	65.00	
66.00	06600	PHYSICAL THERAPY	0.000000	1,540,144	0	73,290	0	66.00	
66.01	06601	CLINICAL NUTRITION	0.000000	0	0	0	0	66.01	
67.00	06700	OCCUPATIONAL THERAPY	0.000000	851,895	0	19,326	0	67.00	
68.00	06800	SPEECH PATHOLOGY	0.000000	555,199	0	24,079	0	68.00	
69.00	06900	ELECTROCARDIOLOGY	0.000000	4,066,641	0	3,710,701	0	69.00	
69.01	06901	CARDIAC REHAB	0.000000	0	0	0	0	69.01	
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	564,419	0	360,388	0	70.00	
70.01	03320	ELECTROSHOCK THERAPY	0.000000	32,752	0	27,056	0	70.01	
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	1,378,922	0	2,968,143	0	71.00	
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.000000	1,742,474	0	2,130,596	0	72.00	
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	13,693,836	0	54,277,414	0	73.00	
74.00	07400	RENAL DIALYSIS	0.024124	2,470,775	59,605	8,012	193	74.00	
76.00	03330	ENDOSCOPY	0.000000	588,090	0	1,526,544	0	76.00	
	OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0.001725	64,547	111	4,132,361	7,128	90.00	
91.00	09100	EMERGENCY	0.000445	7,062,169	3,143	6,548,286	2,914	91.00	
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.006577	2,349,383	15,452	4,663,768	30,674	92.00	
200.00		Total (lines 50 through 199)		82,360,241	78,311	144,680,021	40,909	200.00	

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST			Provider CCN: 26-0091		Period: From 01/01/2020 To 12/31/2020		Worksheet D Part V Date/Time Prepared: 9/24/2021 7:02 pm	
			Title XVIII		Hospital		PPS	
Cost Center Description			Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges		Costs		
				PPS Reimbursed Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0.191207	21,775,432	35,836	0	4,163,615	50.00
51.00	05100	RECOVERY ROOM	0.188646	1,960,795	0	0	369,896	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.252927	31,372	0	0	7,935	52.00
53.00	05300	ANESTHESIOLOGY	0.044685	2,073,648	0	0	92,661	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.203696	5,313,905	0	0	1,082,421	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.163602	16,870,447	0	0	2,760,039	55.00
56.00	05600	RADIOISOTOPE	0.270196	787,369	0	0	212,744	56.00
57.00	05700	CT SCAN	0.041554	4,820,758	0	0	200,322	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.069287	1,497,046	0	0	103,726	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.131014	1,729,291	0	0	226,561	59.00
60.00	06000	LABORATORY	0.113436	5,110,941	0	0	579,765	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.453620	126,572	0	0	57,416	62.00
64.00	06400	INTRAVENOUS THERAPY	0.351249	1,718,101	0	0	603,481	64.00
65.00	06500	RESPIRATORY THERAPY	0.159308	394,380	0	0	62,828	65.00
66.00	06600	PHYSICAL THERAPY	0.398847	73,290	0	0	29,231	66.00
66.01	06601	CLINICAL NUTRITION	2.480706	0	0	0	0	66.01
67.00	06700	OCCUPATIONAL THERAPY	0.281460	19,326	0	0	5,439	67.00
68.00	06800	SPEECH PATHOLOGY	0.268817	24,079	0	0	6,473	68.00
69.00	06900	ELECTROCARDIOLOGY	0.081512	3,710,701	0	0	302,467	69.00
69.01	06901	CARDIAC REHAB	0.801768	0	0	0	0	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0.263342	360,388	0	0	94,905	70.00
70.01	03320	ELECTROSHOCK THERAPY	0.229176	27,056	0	0	6,201	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1.575071	2,968,143	0	0	4,675,036	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.723912	2,130,596	0	0	1,542,364	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.235413	54,277,414	5,540	270,597	12,777,609	73.00
74.00	07400	RENAL DIALYSIS	0.334415	8,012	0	0	2,679	74.00
76.00	03330	ENDOSCOPY	0.205150	1,526,544	0	0	313,171	76.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0.706944	4,132,361	0	392	2,921,348	90.00
91.00	09100	EMERGENCY	0.166999	6,548,286	0	0	1,093,557	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.302359	4,663,768	0	0	1,410,132	92.00
200.00		Subtotal (see instructions)		144,680,021	41,376	270,989	35,704,022	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 - line 201)		144,680,021	41,376	270,989	35,704,022	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 26-0091

Period:
From 01/01/2020
To 12/31/2020Worksheet D
Part V
Date/Time Prepared:
9/24/2021 7:02 pm

			Title XVIII		Hospital	PPS
	Cost Center Description		Costs			
			Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
	ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	6,852	0		50.00
51.00	05100	RECOVERY ROOM	0	0		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0		52.00
53.00	05300	ANESTHESIOLOGY	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0		54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0		55.00
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
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0		62.00
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
66.01	06601	CLINICAL NUTRITION	0	0		66.01
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
70.01	03320	ELECTROSHOCK THERAPY	0	0		70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,304	63,702		73.00
74.00	07400	RENAL DIALYSIS	0	0		74.00
76.00	03330	ENDOSCOPY	0	0		76.00
	OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	0	277		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)	8,156	63,979		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	8,156	63,979		202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS				Provider CCN: 26-0091	Period: From 01/01/2020 To 12/31/2020	Worksheet D Part II Date/Time Prepared: 9/24/2021 7:02 pm		
				Component CCN: 26-S091				
				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	4,156,857	144,635,594	0.028740	175,599	5,047	50.00
51.00	05100	RECOVERY ROOM	305,438	19,549,025	0.015624	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,253,916	62,075,993	0.020200	0	0	52.00
53.00	05300	ANESTHESIOLOGY	421,465	50,897,607	0.008281	16,459	136	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,953,369	82,804,832	0.035667	556,401	19,845	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	342,683	44,613,765	0.007681	12,464	96	55.00
56.00	05600	RADIOISOTOPE	186,371	5,011,379	0.037190	1,064	40	56.00
57.00	05700	CT SCAN	293,681	66,923,946	0.004388	157,857	693	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	767,740	32,873,790	0.023354	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	1,023,407	44,480,134	0.023008	0	0	59.00
60.00	06000	LABORATORY	1,253,577	181,862,087	0.006893	288,890	1,991	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	159,490	22,061,914	0.007229	300,158	2,170	62.00
64.00	06400	INTRAVENOUS THERAPY	691,077	18,761,097	0.036836	16,100	593	64.00
65.00	06500	RESPIRATORY THERAPY	727,501	82,056,197	0.008866	0	0	65.00
66.00	06600	PHYSICAL THERAPY	138,551	8,272,943	0.016747	0	0	66.00
66.01	06601	CLINICAL NUTRITION	35,488	676,260	0.052477	0	0	66.01
67.00	06700	OCCUPATIONAL THERAPY	39,804	5,970,911	0.006666	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	107,034	6,448,841	0.016597	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	846,289	65,106,446	0.012999	0	0	69.00
69.01	06901	CARDIAC REHAB	98,750	748,095	0.132002	0	0	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	254,470	6,760,038	0.037643	0	0	70.00
70.01	03320	ELECTROSHOCK THERAPY	1,916	724,977	0.002643	0	0	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	319,707	21,879,343	0.014612	29,409	430	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	153,444	22,671,618	0.006768	90,000	609	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,700,906	289,047,514	0.005885	486,980	2,866	73.00
74.00	07400	RENAL DIALYSIS	144,225	9,751,994	0.014789	0	0	74.00
76.00	03330	ENDOSCOPY	1,419,590	25,103,047	0.056551	0	0	76.00
	OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	4,383,019	49,883,013	0.087866	0	0	90.00
91.00	09100	EMERGENCY	1,571,813	143,629,334	0.010944	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	27,147,889	0.000000	0	0	92.00
200.00		Total (lines 50 through 199)	25,751,578	1,542,429,623		2,131,381	34,516	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS			Provider CCN: 26-0091 Component CCN: 26-S091		Period: From 01/01/2020 To 12/31/2020		Worksheet D Part IV Date/Time Prepared: 9/24/2021 7:02 pm	
			Title XVIII		Subprovider - IPF		PPS	
Cost Center Description			Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health	
			1.00	2A	2.00	3A	3.00	
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
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
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	0	55.00
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
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	0	62.00
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
66.01	06601	CLINICAL NUTRITION	0	0	0	0	0	66.01
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
70.01	03320	ELECTROSHOCK THERAPY	0	0	0	0	0	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	235,254	74.00
76.00	03330	ENDOSCOPY	0	0	0	0	0	76.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0	0	86,027	90.00
91.00	09100	EMERGENCY	0	0	0	0	63,954	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	385,235	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS			Provider CCN: 26-0091 Component CCN: 26-S091		Period: From 01/01/2020 To 12/31/2020		Worksheet D Part IV Date/Time Prepared: 9/24/2021 7:02 pm	
			Title XVIII		Subprovider - IPF		PPS	
Cost Center Description			All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7) (see instructions)	
			4.00	5.00	6.00	7.00	8.00	
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	0	144,635,594	0.000000	50.00
51.00	05100	RECOVERY ROOM	0	0	0	19,549,025	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	62,075,993	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	50,897,607	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	82,804,832	0.000000	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	44,613,765	0.000000	55.00
56.00	05600	RADIOISOTOPE	0	0	0	5,011,379	0.000000	56.00
57.00	05700	CT SCAN	0	0	0	66,923,946	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	32,873,790	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	44,480,134	0.000000	59.00
60.00	06000	LABORATORY	0	0	0	181,862,087	0.000000	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	22,061,914	0.000000	62.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	18,761,097	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	82,056,197	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	8,272,943	0.000000	66.00
66.01	06601	CLINICAL NUTRITION	0	0	0	676,260	0.000000	66.01
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	5,970,911	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	6,448,841	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	65,106,446	0.000000	69.00
69.01	06901	CARDIAC REHAB	0	0	0	748,095	0.000000	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	6,760,038	0.000000	70.00
70.01	03320	ELECTROSHOCK THERAPY	0	0	0	724,977	0.000000	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	21,879,343	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	22,671,618	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	289,047,514	0.000000	73.00
74.00	07400	RENAL DIALYSIS	0	235,254	235,254	9,751,994	0.024124	74.00
76.00	03330	ENDOSCOPY	0	0	0	25,103,047	0.000000	76.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	86,027	86,027	49,883,013	0.001725	90.00
91.00	09100	EMERGENCY	0	63,954	63,954	143,629,334	0.000445	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	27,147,889	0.000000	92.00
200.00		Total (lines 50 through 199)	0	385,235	385,235	1,542,429,623		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS				Provider CCN: 26-0091 Component CCN: 26-S091		Period: From 01/01/2020 To 12/31/2020		Worksheet D Part IV Date/Time Prepared: 9/24/2021 7:02 pm	
				Title XVIII		Subprovider - IPF		PPS	
Cost Center Description				Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
				9.00	10.00	11.00	12.00	13.00	
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM		0.000000	175,599	0	51,901	0	50.00
51.00	05100	RECOVERY ROOM		0.000000	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM		0.000000	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY		0.000000	16,459	0	128,235	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC		0.000000	556,401	0	401	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC		0.000000	12,464	0	0	0	55.00
56.00	05600	RADIOISOTOPE		0.000000	1,064	0	5,473	0	56.00
57.00	05700	CT SCAN		0.000000	157,857	0	5,036	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	0	0	0	0	59.00
60.00	06000	LABORATORY		0.000000	288,890	0	11,492	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS		0.000000	300,158	0	948,392	0	62.00
64.00	06400	INTRAVENOUS THERAPY		0.000000	16,100	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY		0.000000	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY		0.000000	0	0	0	0	66.00
66.01	06601	CLINICAL NUTRITION		0.000000	0	0	0	0	66.01
67.00	06700	OCCUPATIONAL THERAPY		0.000000	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY		0.000000	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY		0.000000	0	0	0	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
70.01	03320	ELECTROSHOCK THERAPY		0.000000	0	0	0	0	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS		0.000000	29,409	0	150	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT		0.000000	90,000	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS		0.000000	486,980	0	392	0	73.00
74.00	07400	RENAL DIALYSIS		0.024124	0	0	0	0	74.00
76.00	03330	ENDOSCOPY		0.000000	0	0	0	0	76.00
OUTPATIENT SERVICE COST CENTERS									
90.00	09000	CLINIC		0.001725	0	0	0	0	90.00
91.00	09100	EMERGENCY		0.000445	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)		0.000000	0	0	0	0	92.00
200.00		Total (lines 50 through 199)			2,131,381	0	1,151,472	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST				Provider CCN: 26-0091	Period: From 01/01/2020 To 12/31/2020	Worksheet D Part V Date/Time Prepared: 9/24/2021 7:02 pm		
				Component CCN: 26-S091				
				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	0.191207	51,901	0	0	9,924	50.00
51.00	05100	RECOVERY ROOM	0.188646	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.252927	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.044685	128,235	0	0	5,730	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.203696	401	0	0	82	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.163602	0	0	0	0	55.00
56.00	05600	RADIOISOTOPE	0.270196	5,473	0	0	1,479	56.00
57.00	05700	CT SCAN	0.041554	5,036	0	0	209	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.069287	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.131014	0	0	0	0	59.00
60.00	06000	LABORATORY	0.113436	11,492	0	0	1,304	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.453620	948,392	0	0	430,210	62.00
64.00	06400	INTRAVENOUS THERAPY	0.351249	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.159308	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.398847	0	0	0	0	66.00
66.01	06601	CLINICAL NUTRITION	2.480706	0	0	0	0	66.01
67.00	06700	OCCUPATIONAL THERAPY	0.281460	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.268817	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.081512	0	0	0	0	69.00
69.01	06901	CARDIAC REHAB	0.801768	0	0	0	0	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0.263342	0	0	0	0	70.00
70.01	03320	ELECTROSHOCK THERAPY	0.229176	0	0	0	0	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1.575071	150	0	0	236	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.723912	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.235413	392	0	0	92	73.00
74.00	07400	RENAL DIALYSIS	0.334415	0	0	0	0	74.00
76.00	03330	ENDOSCOPY	0.205150	0	0	0	0	76.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0.706944	0	0	0	0	90.00
91.00	09100	EMERGENCY	0.166999	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.302359	0	0	0	0	92.00
200.00		Subtotal (see instructions)		1,151,472	0	0	449,266	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 - line 201)		1,151,472	0	0	449,266	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 26-0091

Period:

Worksheet D

Component CCN: 26-S091

From 01/01/2020
To 12/31/2020Part V
Date/Time Prepared:
9/24/2021 7:02 pm

Title XVIII

Subprovider -
IPF

PPS

	Cost Center Description	Costs			
		Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
		6.00	7.00		
	ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	0	50.00
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
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	55.00
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
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	62.00
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
66.01	06601	CLINICAL NUTRITION	0	0	66.01
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
70.01	03320	ELECTROSHOCK THERAPY	0	0	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	74.00
76.00	03330	ENDOSCOPY	0	0	76.00
	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 MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 26-0091

Period:
From 01/01/2020
To 12/31/2020Worksheet D
Part V
Date/Time Prepared:
9/24/2021 7:02 pm

			Title XIX		Hospital	Cost	
	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	0.191207	0	100,685	0	0
51.00	05100	RECOVERY ROOM	0.188646	0	0	0	0
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.252927	0	0	0	0
53.00	05300	ANESTHESIOLOGY	0.044685	0	0	0	0
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.203696	0	5,687,185	0	0
55.00	05500	RADIOLOGY-THERAPEUTIC	0.163602	0	4,015,445	0	0
56.00	05600	RADIOISOTOPE	0.270196	0	509,399	0	0
57.00	05700	CT SCAN	0.041554	0	3,631,805	0	0
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.069287	0	1,576,489	0	0
59.00	05900	CARDIAC CATHETERIZATION	0.131014	0	1,345,993	0	0
60.00	06000	LABORATORY	0.113436	0	9,903,518	0	0
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.453620	0	191,774	0	0
64.00	06400	INTRAVENOUS THERAPY	0.351249	0	0	0	0
65.00	06500	RESPIRATORY THERAPY	0.159308	0	328,527	0	0
66.00	06600	PHYSICAL THERAPY	0.398847	0	135,143	0	0
66.01	06601	CLINICAL NUTRITION	2.480706	0	0	0	0
67.00	06700	OCCUPATIONAL THERAPY	0.281460	0	91,030	0	0
68.00	06800	SPEECH PATHOLOGY	0.268817	0	98,379	0	0
69.00	06900	ELECTROCARDIOLOGY	0.081512	0	2,155,329	0	0
69.01	06901	CARDIAC REHAB	0.801768	0	0	0	0
70.00	07000	ELECTROENCEPHALOGRAPHY	0.263342	0	457,833	0	0
70.01	03320	ELECTROSHOCK THERAPY	0.229176	0	45,568	0	0
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1.575071	0	2,358,644	0	0
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.723912	0	0	0	0
73.00	07300	DRUGS CHARGED TO PATIENTS	0.235413	0	0	0	0
74.00	07400	RENAL DIALYSIS	0.334415	0	2,895,091	0	0
76.00	03330	ENDOSCOPY	0.205150	0	23,829	0	0
	OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.706944	0	19,082,793	0	0
91.00	09100	EMERGENCY	0.166999	0	11,033,517	0	0
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.302359	0	2,204,757	0	0
200.00		Subtotal (see instructions)		0	67,872,733	0	0
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0	0
202.00		Net Charges (line 200 - line 201)		0	67,872,733	0	0

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 26-0091

Period:
From 01/01/2020
To 12/31/2020Worksheet D
Part V
Date/Time Prepared:
9/24/2021 7:02 pm

			Title XIX		Hospital	Cost
	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	19,252	0		50.00
51.00	05100	RECOVERY ROOM	0	0		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0		52.00
53.00	05300	ANESTHESIOLOGY	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,158,457	0		54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	656,935	0		55.00
56.00	05600	RADIOISOTOPE	137,638	0		56.00
57.00	05700	CT SCAN	150,916	0		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	109,230	0		58.00
59.00	05900	CARDIAC CATHETERIZATION	176,344	0		59.00
60.00	06000	LABORATORY	1,123,415	0		60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	86,993	0		62.00
64.00	06400	INTRAVENOUS THERAPY	0	0		64.00
65.00	06500	RESPIRATORY THERAPY	52,337	0		65.00
66.00	06600	PHYSICAL THERAPY	53,901	0		66.00
66.01	06601	CLINICAL NUTRITION	0	0		66.01
67.00	06700	OCCUPATIONAL THERAPY	25,621	0		67.00
68.00	06800	SPEECH PATHOLOGY	26,446	0		68.00
69.00	06900	ELECTROCARDIOLOGY	175,685	0		69.00
69.01	06901	CARDIAC REHAB	0	0		69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	120,567	0		70.00
70.01	03320	ELECTROSHOCK THERAPY	10,443	0		70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	3,715,032	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0		73.00
74.00	07400	RENAL DIALYSIS	968,162	0		74.00
76.00	03330	ENDOSCOPY	4,889	0		76.00
	OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	13,490,466	0		90.00
91.00	09100	EMERGENCY	1,842,586	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	666,628	0		92.00
200.00		Subtotal (see instructions)	24,771,943	0		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	24,771,943	0		202.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 26-0091	Period: From 01/01/2020 To 12/31/2020	Worksheet D-1 Date/Time Prepared: 9/24/2021 7:02 pm	
		Title XVIII	Hospital	PPS	
Cost Center Description				1.00	
PART I - ALL PROVIDER COMPONENTS					
INPATIENT DAYS					
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		47,871	1.00	
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		47,871	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.		20,550	3.00	
4.00	Semi-private room days (excluding swing-bed and observation bed days)		18,700	4.00	
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		0	5.00	
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	6.00	
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		0	7.00	
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	8.00	
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions)		6,982	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)		45,580,065	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)		45,580,065	27.00	
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT					
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)		120,323,165	28.00	
29.00	Private room charges (excluding swing-bed charges)		46,813,808	29.00	
30.00	Semi-private room charges (excluding swing-bed charges)		73,509,357	30.00	
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		0.378814	31.00	
32.00	Average private room per diem charge (line 29 ÷ line 3)		2,278.04	32.00	
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)		3,930.98	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)		45,580,065	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)		952.14	38.00	
39.00	Program general inpatient routine service cost (line 9 x line 38)		6,647,841	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)		6,647,841	41.00	

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 26-0091

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

Worksheet D-1

Date/Time Prepared:
9/24/2021 7:02 pm

Cost Center Description		Title XVIII		Hospital		PPS
		Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)
		1.00	2.00	3.00	4.00	5.00
42.00	NURSERY (title V & XIX only)	0	0	0.00	0	0
Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	11,786,415	11,632	1,013.28	3,868	3,919,367
43.01	PEDIATRIC INTENSIVE CARE UNIT	14,320,548	8,814	1,624.75	55	89,361
43.02	NEONATAL INTENSIVE CARE UNIT	34,841,409	28,327	1,229.97	0	0
43.03	INTERMEDIATE CARE UNIT	36,408,553	22,137	1,644.69	6,370	10,476,675
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)					17,497,882
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					38,631,126
PASS THROUGH COST ADJUSTMENTS						
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)					1,682,675
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					1,216,385
52.00	Total Program excludable cost (sum of lines 50 and 51)					2,899,060
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					35,732,066
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)					
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)					
72.00	Program routine service cost (line 9 x line 71)					
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)					
74.00	Total Program general inpatient routine service costs (line 72 + line 73)					
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)					
76.00	Per diem capital-related costs (line 75 ÷ line 2)					
77.00	Program capital-related costs (line 9 x line 76)					
78.00	Inpatient routine service cost (line 74 minus line 77)					
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)					
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)					
81.00	Inpatient routine service cost per diem limitation					
82.00	Inpatient routine service cost limitation (line 9 x line 81)					
83.00	Reasonable inpatient routine service costs (see instructions)					
84.00	Program inpatient ancillary services (see instructions)					
85.00	Utilization review - physician compensation (see instructions)					
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)					
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
87.00	Total observation bed days (see instructions)					8,621
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					952.14
89.00	Observation bed cost (line 87 x line 88) (see instructions)					8,208,399

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 26-0091

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

Worksheet D-1

Date/Time Prepared:
9/24/2021 7:02 pm

		Title XVIII		Hospital	PPS	
Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
	1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00 Capital-related cost	3,935,056	45,580,065	0.086333	8,208,399	708,656	90.00
91.00 Nursing School cost	0	45,580,065	0.000000	8,208,399	0	91.00
92.00 Allied health cost	991,415	45,580,065	0.021751	8,208,399	178,541	92.00
93.00 All other Medical Education	0	45,580,065	0.000000	8,208,399	0	93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 26-0091 Component CCN: 26-S091	Period: From 01/01/2020 To 12/31/2020	Worksheet D-1 Date/Time Prepared: 9/24/2021 7:02 pm
		Title XVIII	Subprovider - IPF	PPS
Cost Center Description			1.00	
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		12,611	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		12,611	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.		870	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)		11,741	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions)		5,422	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)		11,331,908	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)		11,331,908	27.00
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)		21,826,836	28.00
29.00	Private room charges (excluding swing-bed charges)		1,506,052	29.00
30.00	Semi-private room charges (excluding swing-bed charges)		20,320,784	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		0.519173	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)		1,731.09	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)		1,730.75	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)		0.34	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)		0.18	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)		157	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)		11,331,751	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)		898.57	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		4,872,047	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)		0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)		4,872,047	41.00

COMPUTATION OF INPATIENT OPERATING COST				Provider CCN: 26-0091 Component CCN: 26-S091	Period: From 01/01/2020 To 12/31/2020	Worksheet D-1 Date/Time Prepared: 9/24/2021 7:02 pm	
				Title XVIII		Subprovider - IPF	PPS
	Cost Center Description	Total	Total	Average Per	Program Days	Program Cost (col. 3 x col. 4)	
		Inpatient Cost	Inpatient Days	Diem (col. 1 ÷ col. 2)			
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)	0	0	0.00	0		42.00
Intensive Care Type Inpatient Hospital Units							
43.00	INTENSIVE CARE UNIT	0	0	0.00	0	0	43.00
43.01	PEDIATRIC INTENSIVE CARE UNIT	0	0	0.00	0	0	43.01
43.02	NEONATAL INTENSIVE CARE UNIT	0	0	0.00	0	0	43.02
43.03	INTERMEDIATE CARE UNIT	0	0	0.00	0	0	43.03
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)					557,232	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					5,429,279	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)					218,778	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					34,516	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)					253,294	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					5,175,985	53.00
TARGET AMOUNT AND LIMIT COMPUTATION							
54.00	Program discharges					0	54.00
55.00	Target amount per discharge					0.00	55.00
56.00	Target amount (line 54 x line 55)					0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)					0	57.00
58.00	Bonus payment (see instructions)					0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket					0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket					0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)					0	61.00
62.00	Relief payment (see instructions)					0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)					0	63.00
PROGRAM INPATIENT ROUTINE SWING BED COST							
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)					0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)					0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)					0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)					0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)					0	69.00
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY							
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)						70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)						71.00
72.00	Program routine service cost (line 9 x line 71)						72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)						73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)						74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)						75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)						76.00
77.00	Program capital-related costs (line 9 x line 76)						77.00
78.00	Inpatient routine service cost (line 74 minus line 77)						78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)						79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)						80.00
81.00	Inpatient routine service cost per diem limitation						81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)						82.00
83.00	Reasonable inpatient routine service costs (see instructions)						83.00
84.00	Program inpatient ancillary services (see instructions)						84.00
85.00	Utilization review - physician compensation (see instructions)						85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)						86.00
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
87.00	Total observation bed days (see instructions)					0	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					0.00	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)					0	89.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 26-0091 Component CCN: 26-S091		Period: From 01/01/2020 To 12/31/2020		Worksheet D-1 Date/Time Prepared: 9/24/2021 7:02 pm	
		Title XVIII		Subprovider - IPF		PPS	
Cost Center Description		Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00	Capital-related cost	508,845	11,331,908	0.044904	0	0	90.00
91.00	Nursing School cost	0	11,331,908	0.000000	0	0	91.00
92.00	Allied health cost	0	11,331,908	0.000000	0	0	92.00
93.00	All other Medical Education	0	11,331,908	0.000000	0	0	93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 26-0091	Period: From 01/01/2020 To 12/31/2020	Worksheet D-1 Date/Time Prepared: 9/24/2021 7:02 pm
Cost Center Description		Title XIX	Hospital	Cost
				1.00
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)			47,871 1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)			47,871 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.			20,550 3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)			18,700 4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period			0 5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)			0 6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period			0 7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)			0 8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions)			3,290 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)			5,340 15.00
16.00	Nursery days (title V or XIX only)			333 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)			45,580,065 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)			45,580,065 27.00
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)			114,311,151 28.00
29.00	Private room charges (excluding swing-bed charges)			46,813,808 29.00
30.00	Semi-private room charges (excluding swing-bed charges)			67,497,343 30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)			0.398737 31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)			2,278.04 32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)			3,609.48 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)			45,580,065 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)			952.14 38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)			3,132,541 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)			3,132,541 41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 26-0091

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

Worksheet D-1

Date/Time Prepared:
9/24/2021 7:02 pm

		Title XIX		Hospital		Cost	
	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)	5,709,048	5,340	1,069.11	333	356,014	42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	11,786,415	11,632	1,013.28	1,522	1,542,212	43.00
43.01	PEDIATRIC INTENSIVE CARE UNIT	14,320,548	8,814	1,624.75	668	1,085,333	43.01
43.02	NEONATAL INTENSIVE CARE UNIT	34,841,409	28,327	1,229.97	2,453	3,017,116	43.02
43.03	INTERMEDIATE CARE UNIT	36,408,553	22,137	1,644.69	2,929	4,817,297	43.03
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)					9,592,610	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					23,543,123	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)					8,621	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					952.14	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)					8,208,399	89.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 26-0091

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

Worksheet D-1

Date/Time Prepared:
9/24/2021 7:02 pm

		Title XIX		Hospital		Cost	
Cost Center Description		Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00	Capital-related cost	3,935,056	45,580,065	0.086333	8,208,399	708,656	90.00
91.00	Nursing School cost	0	45,580,065	0.000000	8,208,399	0	91.00
92.00	Allied health cost	0	45,580,065	0.000000	8,208,399	0	92.00
93.00	All other Medical Education	0	45,580,065	0.000000	8,208,399	0	93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 26-0091 Component CCN: 26-S091	Period: From 01/01/2020 To 12/31/2020	Worksheet D-1 Date/Time Prepared: 9/24/2021 7:02 pm
		Title XIX	Subprovider - IPF	Cost
Cost Center Description				1.00
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)			12,611 1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)			12,611 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.			870 3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)			11,741 4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period			0 5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)			0 6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period			0 7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)			0 8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions)			3,045 9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)			0 10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)			0 11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period			0 12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)			0 13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)			0 14.00
15.00	Total nursery days (title V or XIX only)			5,340 15.00
16.00	Nursery days (title V or XIX only)			333 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)			11,331,908 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)			11,331,908 27.00
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)			21,826,836 28.00
29.00	Private room charges (excluding swing-bed charges)			1,506,052 29.00
30.00	Semi-private room charges (excluding swing-bed charges)			20,320,784 30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)			0.519173 31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)			1,731.09 32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)			1,730.75 33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)			0.34 34.00
35.00	Average per diem private room cost differential (line 34 x line 31)			0.18 35.00
36.00	Private room cost differential adjustment (line 3 x line 35)			157 36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)			11,331,751 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)			898.56 38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)			2,736,115 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)			2,736,115 41.00

COMPUTATION OF INPATIENT OPERATING COST				Provider CCN: 26-0091 Component CCN: 26-S091	Period: From 01/01/2020 To 12/31/2020	Worksheet D-1 Date/Time Prepared: 9/24/2021 7:02 pm		
				Title XIX		Subprovider - IPF	Cost	
	Cost Center Description	Total	Total	Average Per	Program Days	Program Cost (col. 3 x col. 4)		
		Inpatient Cost	Inpatient Days	Diem (col. 1 ÷ col. 2)				
		1.00	2.00	3.00	4.00	5.00		
42.00	NURSERY (title V & XIX only)	0	0	0.00	0		42.00	
Intensive Care Type Inpatient Hospital Units								
43.00	INTENSIVE CARE UNIT	0	0	0.00	0	0	43.00	
43.01	PEDIATRIC INTENSIVE CARE UNIT	0	0	0.00	0	0	43.01	
43.02	NEONATAL INTENSIVE CARE UNIT	0	0	0.00	0	0	43.02	
43.03	INTERMEDIATE CARE UNIT	0	0	0.00	0	0	43.03	
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)						217,050	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)						2,953,165	49.00
PASS THROUGH COST ADJUSTMENTS								
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)						0	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)						0	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)						0	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)						0	53.00
TARGET AMOUNT AND LIMIT COMPUTATION								
54.00	Program discharges						0	54.00
55.00	Target amount per discharge						0.00	55.00
56.00	Target amount (line 54 x line 55)						0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)						0	57.00
58.00	Bonus payment (see instructions)						0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket						0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket						0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)						0	61.00
62.00	Relief payment (see instructions)						0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)						0	63.00
PROGRAM INPATIENT ROUTINE SWING BED COST								
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)						0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)						0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)						0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)						0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)						0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)						0	69.00
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY								
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)							70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)							71.00
72.00	Program routine service cost (line 9 x line 71)							72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)							73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)							74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)							75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)							76.00
77.00	Program capital-related costs (line 9 x line 76)							77.00
78.00	Inpatient routine service cost (line 74 minus line 77)							78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)							79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)							80.00
81.00	Inpatient routine service cost per diem limitation							81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)							82.00
83.00	Reasonable inpatient routine service costs (see instructions)							83.00
84.00	Program inpatient ancillary services (see instructions)							84.00
85.00	Utilization review - physician compensation (see instructions)							85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)							86.00
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST								
87.00	Total observation bed days (see instructions)						0	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)						0.00	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)						0	89.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 26-0091 Component CCN: 26-S091		Period: From 01/01/2020 To 12/31/2020		Worksheet D-1 Date/Time Prepared: 9/24/2021 7:02 pm	
		Title XIX		Subprovider - IPF		Cost	
Cost Center Description		Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00	Capital-related cost	508,845	11,331,908	0.044904	0	0	90.00
91.00	Nursing School cost	0	11,331,908	0.000000	0	0	91.00
92.00	Allied health cost	0	11,331,908	0.000000	0	0	92.00
93.00	All other Medical Education	0	11,331,908	0.000000	0	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 26-0091	Period: From 01/01/2020 To 12/31/2020	Worksheet D-3 Date/Time Prepared: 9/24/2021 7:02 pm	
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	7,919,147		30.00
31.00	03100	INTENSIVE CARE UNIT	10,481,549		31.00
31.01	02080	PEDIATRIC INTENSIVE CARE UNIT	382,635		31.01
31.02	02060	NEONATAL INTENSIVE CARE UNIT	0		31.02
31.03	02400	INTERMEDIATE CARE UNIT	14,198,187		31.03
40.00	04000	SUBPROVIDER - IPF	1,582,200		40.00
43.00	04300	NURSERY			43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	10,229,051	1,955,866	50.00
51.00	05100	RECOVERY ROOM	646,413	121,943	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	140,122	35,441	52.00
53.00	05300	ANESTHESIOLOGY	2,076,760	92,800	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,110,985	633,695	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	113,198	18,519	55.00
56.00	05600	RADIOISOTOPE	219,146	59,212	56.00
57.00	05700	CT SCAN	4,428,456	184,020	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	1,238,093	85,784	58.00
59.00	05900	CARDIAC CATHETERIZATION	2,038,154	267,027	59.00
60.00	06000	LABORATORY	14,588,655	1,654,879	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	1,055,691	478,883	62.00
64.00	06400	INTRAVENOUS THERAPY	5,950	2,090	64.00
65.00	06500	RESPIRATORY THERAPY	5,508,321	877,520	65.00
66.00	06600	PHYSICAL THERAPY	1,540,144	614,282	66.00
66.01	06601	CLINICAL NUTRITION	0	0	66.01
67.00	06700	OCCUPATIONAL THERAPY	851,895	239,774	67.00
68.00	06800	SPEECH PATHOLOGY	555,199	149,247	68.00
69.00	06900	ELECTROCARDIOLOGY	4,066,641	331,480	69.00
69.01	06901	CARDIAC REHAB	0	0	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	564,419	148,635	70.00
70.01	03320	ELECTROSHOCK THERAPY	32,752	7,506	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,378,922	2,171,900	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	1,742,474	1,261,398	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	13,693,836	3,223,707	73.00
74.00	07400	RENAL DIALYSIS	2,470,775	826,264	74.00
76.00	03330	ENDOSCOPY	588,090	120,647	76.00
OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	64,547	45,631	90.00
91.00	09100	EMERGENCY	7,062,169	1,179,375	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	2,349,383	710,357	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)	82,360,241	17,497,882	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)	82,360,241		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 26-0091 Component CCN: 26-S091	Period: From 01/01/2020 To 12/31/2020	Worksheet D-3 Date/Time Prepared: 9/24/2021 7:02 pm	
		Title XVIII	Subprovider - IPF	PPS	
Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDIATRICS		0		30.00
31.00	03100 INTENSIVE CARE UNIT		0		31.00
31.01	02080 PEDIATRIC INTENSIVE CARE UNIT		0		31.01
31.02	02060 NEONATAL INTENSIVE CARE UNIT		0		31.02
31.03	02400 INTERMEDIATE CARE UNIT		0		31.03
40.00	04000 SUBPROVIDER - IPF		8,502,855		40.00
43.00	04300 NURSERY				43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.191207	175,599	33,576	50.00
51.00	05100 RECOVERY ROOM	0.188646	0	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.252927	0	0	52.00
53.00	05300 ANESTHESIOLOGY	0.044685	16,459	735	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.203696	556,401	113,337	54.00
55.00	05500 RADIOLOGY-THERAPEUTIC	0.163602	12,464	2,039	55.00
56.00	05600 RADIOISOTOPE	0.270196	1,064	287	56.00
57.00	05700 CT SCAN	0.041554	157,857	6,560	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0.069287	0	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	0.131014	0	0	59.00
60.00	06000 LABORATORY	0.113436	288,890	32,771	60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0.453620	300,158	136,158	62.00
64.00	06400 INTRAVENOUS THERAPY	0.351249	16,100	5,655	64.00
65.00	06500 RESPIRATORY THERAPY	0.159308	0	0	65.00
66.00	06600 PHYSICAL THERAPY	0.398847	0	0	66.00
66.01	06601 CLINICAL NUTRITION	2.480706	0	0	66.01
67.00	06700 OCCUPATIONAL THERAPY	0.281460	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0.268817	0	0	68.00
69.00	06900 ELECTROCARDIOLOGY	0.081512	0	0	69.00
69.01	06901 CARDIAC REHAB	0.801768	0	0	69.01
70.00	07000 ELECTROENCEPHALOGRAPHY	0.263342	0	0	70.00
70.01	03320 ELECTROSHOCK THERAPY	0.229176	0	0	70.01
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	1.575071	29,409	46,321	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	0.723912	90,000	65,152	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.235413	486,980	114,641	73.00
74.00	07400 RENAL DIALYSIS	0.334415	0	0	74.00
76.00	03330 ENDOSCOPY	0.205150	0	0	76.00
OUTPATIENT SERVICE COST CENTERS					
90.00	09000 CLINIC	0.706944	0	0	90.00
91.00	09100 EMERGENCY	0.166999	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.302359	0	0	92.00
200.00	Total (sum of lines 50 through 94 and 96 through 98)		2,131,381	557,232	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)		2,131,381		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT			Provider CCN: 26-0091	Period: From 01/01/2020 To 12/31/2020	Worksheet D-3 Date/Time Prepared: 9/24/2021 7:02 pm	
			Title XIX	Hospital	Cost	
Cost Center Description			Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
	INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS		7,461,012		30.00
31.00	03100	INTENSIVE CARE UNIT		4,128,641		31.00
31.01	02080	PEDIATRIC INTENSIVE CARE UNIT		3,727,803		31.01
31.02	02060	NEONATAL INTENSIVE CARE UNIT		12,581,617		31.02
31.03	02400	INTERMEDIATE CARE UNIT		6,500,450		31.03
40.00	04000	SUBPROVIDER - IPF		416,700		40.00
43.00	04300	NURSERY		374,545		43.00
	ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0.191207	5,332,437	1,019,599	50.00
51.00	05100	RECOVERY ROOM	0.188646	327,644	61,809	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.252927	605,003	153,022	52.00
53.00	05300	ANESTHESIOLOGY	0.044685	1,168,473	52,213	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.203696	1,907,838	388,619	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.163602	169,653	27,756	55.00
56.00	05600	RADIOISOTOPE	0.270196	75,653	20,441	56.00
57.00	05700	CT SCAN	0.041554	2,322,650	96,515	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.069287	831,060	57,582	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.131014	789,086	103,381	59.00
60.00	06000	LABORATORY	0.113436	10,604,258	1,202,905	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.453620	1,144,540	519,186	62.00
64.00	06400	INTRAVENOUS THERAPY	0.351249	3,512	1,234	64.00
65.00	06500	RESPIRATORY THERAPY	0.159308	4,937,998	786,663	65.00
66.00	06600	PHYSICAL THERAPY	0.398847	774,707	308,990	66.00
66.01	06601	CLINICAL NUTRITION	2.480706	0	0	66.01
67.00	06700	OCCUPATIONAL THERAPY	0.281460	525,313	147,855	67.00
68.00	06800	SPEECH PATHOLOGY	0.268817	236,143	63,479	68.00
69.00	06900	ELECTROCARDIOLOGY	0.081512	2,061,560	168,042	69.00
69.01	06901	CARDIAC REHAB	0.801768	0	0	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0.263342	347,716	91,568	70.00
70.01	03320	ELECTROSHOCK THERAPY	0.229176	0	0	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1.575071	818,878	1,289,791	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.723912	638,956	462,548	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.235413	10,036,504	2,362,724	73.00
74.00	07400	RENAL DIALYSIS	0.334415	436,357	145,924	74.00
76.00	03330	ENDOSCOPY	0.205150	296,192	60,764	76.00
	OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	0.706944	0	0	90.00
91.00	09100	EMERGENCY	0.166999	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.302359	0	0	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		46,392,131	9,592,610	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)		46,392,131		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 26-0091 Component CCN: 26-S091	Period: From 01/01/2020 To 12/31/2020	Worksheet D-3 Date/Time Prepared: 9/24/2021 7:02 pm	
		Title XIX	Subprovider - IPF	Cost	
Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDIATRICS		0		30.00
31.00	03100 INTENSIVE CARE UNIT		0		31.00
31.01	02080 PEDIATRIC INTENSIVE CARE UNIT		0		31.01
31.02	02060 NEONATAL INTENSIVE CARE UNIT		0		31.02
31.03	02400 INTERMEDIATE CARE UNIT		0		31.03
40.00	04000 SUBPROVIDER - IPF		3,707,035		40.00
43.00	04300 NURSERY		0		43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.191207	6,822	1,304	50.00
51.00	05100 RECOVERY ROOM	0.188646	84	16	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.252927	0	0	52.00
53.00	05300 ANESTHESIOLOGY	0.044685	19,331	864	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.203696	31,245	6,364	54.00
55.00	05500 RADIOLOGY-THERAPEUTIC	0.163602	0	0	55.00
56.00	05600 RADIOISOTOPE	0.270196	0	0	56.00
57.00	05700 CT SCAN	0.041554	57,600	2,394	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0.069287	5,400	374	58.00
59.00	05900 CARDIAC CATHETERIZATION	0.131014	0	0	59.00
60.00	06000 LABORATORY	0.113436	460,273	52,212	60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0.453620	0	0	62.00
64.00	06400 INTRAVENOUS THERAPY	0.351249	0	0	64.00
65.00	06500 RESPIRATORY THERAPY	0.159308	10,889	1,735	65.00
66.00	06600 PHYSICAL THERAPY	0.398847	28,855	11,509	66.00
66.01	06601 CLINICAL NUTRITION	2.480706	0	0	66.01
67.00	06700 OCCUPATIONAL THERAPY	0.281460	1,066	300	67.00
68.00	06800 SPEECH PATHOLOGY	0.268817	8,174	2,197	68.00
69.00	06900 ELECTROCARDIOLOGY	0.081512	12,750	1,039	69.00
69.01	06901 CARDIAC REHAB	0.801768	0	0	69.01
70.00	07000 ELECTROENCEPHALOGRAPHY	0.263342	1,519	400	70.00
70.01	03320 ELECTROSHOCK THERAPY	0.229176	69,776	15,991	70.01
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	1.575071	735	1,158	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	0.723912	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.235413	504,178	118,690	73.00
74.00	07400 RENAL DIALYSIS	0.334415	0	0	74.00
76.00	03330 ENDOSCOPY	0.205150	2,451	503	76.00
OUTPATIENT SERVICE COST CENTERS					
90.00	09000 CLINIC	0.706944	0	0	90.00
91.00	09100 EMERGENCY	0.166999	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.302359	0	0	92.00
200.00	Total (sum of lines 50 through 94 and 96 through 98)		1,221,148	217,050	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)		1,221,148		202.00

COMPUTATION OF ORGAN ACQUISITION COSTS AND CHARGES FOR A TRANSPLANT HOSPITAL WITH A MEDICARE-CERTIFIED TRANSPLANT PROGRAM				Provider CCN: 26-0091	Period: From 01/01/2020 To 12/31/2020	Worksheet D-4	
				Component CCN:		Date/Time Prepared: 9/24/2021 7:02 pm	
				Kidney		Hospital	PPS
Cost Center Description		Worksheet D-1 Line Numbers	Inpatient Routine Organ Charges	Per Diem Costs (from Wkst. D-1, Part II)	Organ Acquisition	Cost (col. 2 x col. 3)	
		0	1.00	2.00	3.00	4.00	
PART I - COMPUTATION OF ORGAN ACQUISITION COSTS (INPATIENT ROUTINE AND ANCILLARY SERVICES)							
Computation of Inpatient Routine Service Costs Applicable to Organ Acquisition							
1.00	ADULTS & PEDIATRICS	38.00	0	952.14	0		1.00
2.00	INTENSIVE CARE UNIT	43.00	10,960	1,013.28	5	5,066	2.00
2.01	PEDIATRIC INTENSIVE CARE UNIT	43.01	0	1,624.75	0	0	2.01
2.02	NEONATAL INTENSIVE CARE UNIT	43.02	0	1,229.97	0	0	2.02
2.03	INTERMEDIATE CARE UNIT	43.03	0	1,644.69	0	0	2.03
3.00	CORONARY CARE UNIT	44.00	0	0.00	0	0	3.00
4.00	BURN INTENSIVE CARE UNIT	45.00	0	0.00	0	0	4.00
5.00	SURGICAL INTENSIVE CARE UNIT	46.00	0	0.00	0	0	5.00
6.00	OTHER SPECIAL CARE (SPECIFY)	47.00	0	0.00	0	0	6.00
7.00	TOTAL (sum of lines 1 through 6)		10,960		5	5,066	7.00
Cost Center Description			Worksheet C Line Numbers	Ratio of Cost/Charges (from Wkst. C)	Organ Acquisition Ancillary Charges	Organ Acquisition Ancillary Costs	
			0	1.00	2.00	3.00	
Computation of Ancillary Service Cost Applicable to Organ Acquisition							
8.00	OPERATING ROOM		50.00	0.191207	24,860	4,753	8.00
9.00	RECOVERY ROOM		51.00	0.188646	0	0	9.00
10.00	DELIVERY ROOM & LABOR ROOM		52.00	0.252927	0	0	10.00
11.00	ANESTHESIOLOGY		53.00	0.044685	0	0	11.00
12.00	RADIOLOGY-DIAGNOSTIC		54.00	0.203696	10,356	2,109	12.00
13.00	RADIOLOGY-THERAPEUTIC		55.00	0.163602	0	0	13.00
14.00	RADIOISOTOPE		56.00	0.270196	0	0	14.00
15.00	CT SCAN		57.00	0.041554	0	0	15.00
16.00	MAGNETIC RESONANCE IMAGING (MRI)		58.00	0.069287	0	0	16.00
17.00	CARDIAC CATHETERIZATION		59.00	0.131014	0	0	17.00
18.00	LABORATORY		60.00	0.113436	80,648	9,148	18.00
19.00	PBP CLINICAL LAB SERVICES-PRGM ONLY		61.00	0.000000	0	0	19.00
20.00	WHOLE BLOOD & PACKED RED BLOOD CELLS		62.00	0.453620	118	54	20.00
21.00	BLOOD STORING, PROCESSING & TRANS.		63.00	0.000000	0	0	21.00
22.00	INTRAVENOUS THERAPY		64.00	0.351249	51	18	22.00
23.00	RESPIRATORY THERAPY		65.00	0.159308	3,142	501	23.00
24.00	PHYSICAL THERAPY		66.00	0.398847	0	0	24.00
24.01	CLINICAL NUTRITION		66.01	2.480706	0	0	24.01
25.00	OCCUPATIONAL THERAPY		67.00	0.281460	0	0	25.00
26.00	SPEECH PATHOLOGY		68.00	0.268817	0	0	26.00
27.00	ELECTROCARDIOLOGY		69.00	0.081512	7,190	586	27.00
27.01	CARDIAC REHAB		69.01	0.801768	0	0	27.01
28.00	ELECTROENCEPHALOGRAPHY		70.00	0.263342	0	0	28.00
28.01	ELECTROSHOCK THERAPY		70.01	0.229176	0	0	28.01
29.00	MEDICAL SUPPLIES CHARGED TO PATIENTS		71.00	1.575071	0	0	29.00
30.00	IMPL. DEV. CHARGED TO PATIENT		72.00	0.723912	0	0	30.00
31.00	DRUGS CHARGED TO PATIENTS		73.00	0.235413	0	0	31.00
32.00	RENAL DIALYSIS		74.00	0.334415	0	0	32.00
33.00	ASC (NON-DISTINCT PART)		75.00	0.000000	0	0	33.00
34.00	ENDOSCOPY		76.00	0.205150	0	0	34.00
35.00	RURAL HEALTH CLINIC		88.00	0.000000	0	0	35.00
36.00	FEDERALLY QUALIFIED HEALTH CENTER		89.00	0.000000	0	0	36.00
37.00	CLINIC		90.00	0.706944	886	626	37.00
38.00	EMERGENCY		91.00	0.166999	0	0	38.00
39.00	OBSERVATION BEDS (NON-DISTINCT PART)		92.00	0.302359	0	0	39.00
40.00	OTHER OUTPATIENT SERVICE COST CENTER						40.00
41.00	TOTAL (sum of lines 8 through 40)				127,251	17,795	41.00

(1) Organs procured outside your center by a procurement team from your center are not to be included in the count.
 (2) Organs procured outside your center by a procurement team from your center are included in the count.

COMPUTATION OF ORGAN ACQUISITION COSTS AND CHARGES FOR A TRANSPLANT HOSPITAL WITH A MEDICARE-CERTIFIED TRANSPLANT PROGRAM					Provider CCN: 26-0091	Period: From 01/01/2020 To 12/31/2020	Worksheet D-4
					Component CCN:		Date/Time Prepared: 9/24/2021 7:02 pm
					Kidney	Hospital	PPS
Cost Center Description					Worksheet D-2, Part I Line Numbers	Average Cost Per Day (from Wkst. D-2, Part I, col. 4)	Organ Acquisition Costs (col. 1 x col. 2)
					0	1.00	2.00
							3.00
PART II - COMPUTATION OF ORGAN ACQUISITION COSTS (OTHER THAN INPATIENT ROUTINE AND ANCILLARY SERVICES COSTS)							
Computation of the Cost of Inpatient Services of Interns and Residents Not In Approved Teaching Program							
42.00	ADULTS & PEDIATRICS	2.00	0.00	0	0	42.00	
43.00	INTENSIVE CARE UNIT	3.00	0.00	5	0	43.00	
43.01	PEDIATRIC INTENSIVE CARE UNIT	3.01	0.00	0	0	43.01	
43.02	NEONATAL INTENSIVE CARE UNIT	3.02	0.00	0	0	43.02	
43.03	INTERMEDIATE CARE UNIT	3.03	0.00	0	0	43.03	
44.00	CORONARY CARE UNIT	4.00	0.00	0	0	44.00	
45.00	BURN INTENSIVE CARE UNIT	5.00	0.00	0	0	45.00	
46.00	SURGICAL INTENSIVE CARE UNIT	6.00	0.00	0	0	46.00	
47.00	OTHER SPECIAL CARE (SPECIFY)	7.00	0.00	0	0	47.00	
48.00	TOTAL (sum of lines 42 through 47)			5	0	48.00	
Cost Center Description					Worksheet D-2, Part I Line Numbers	Organ Charges (see instructions)	Ratio of Cost To Charges from Wkst. D-2, Part I, col. 4
					0	1.00	2.00
							3.00
Computation of the Cost of Outpatient Services of Interns and Residents Not In Approved Teaching Program							
49.00	RURAL HEALTH CLINIC	21.00	0	0.000000	0	49.00	
50.00	FEDERALLY QUALIFIED HEALTH CENTER	22.00	0	0.000000	0	50.00	
51.00	CLINIC	23.00	886	0.000000	0	51.00	
52.00	EMERGENCY	24.00	0	0.000000	0	52.00	
53.00	OBSERVATION BEDS (NON-DISTINCT PART)	25.00	0	0.000000	0	53.00	
54.00	OTHER OUTPATIENT SERVICE COST CENTER	26.00	0	0.000000	0	54.00	
55.00	TOTAL (sum of lines 49 through 52)		886		0	55.00	
Cost Center Description					Cost		Charges
					Part A	Part B	Part A
					1.00	2.00	3.00
							4.00
PART III - SUMMARY OF COSTS AND CHARGES							
56.00	Routine and Ancillary from Part I	22,861		138,211		56.00	
57.00	Interns and Residents (inpatient)	0		0		57.00	
58.00	Interns and Residents (outpatient)	0		0		58.00	
59.00	Direct Organ Acquisition (see instructions)	1,249,410		1,334,800		59.00	
60.00	Cost of physicians' services in a teaching hospital (see instructions)	0		0		60.00	
61.00	Total (sum of lines 56 thru 60)	1,272,271		1,473,011		61.00	
62.00	Total Usable Organs (see instructions)		13			62.00	
63.00	Medicare Usable Organs (see instructions)		10			63.00	
64.00	Ratio of Medicare Usable Organs to Total Usable Organs (line 63 ÷ line 62)		0.769231			64.00	
65.00	Medicare Cost/Charges (see instructions)	978,670		1,133,086		65.00	
66.00	Revenue for Organs Sold	30,997		0		66.00	
67.00	Subtotal (line 65 minus line 66)	947,673		1,133,086		67.00	
68.00	Organs Furnished Part B	0	0	0	0	68.00	
69.00	Net Organ Acquisition Cost and Charges (see instructions)	947,673	0	1,133,086	0	69.00	
Cost Center Description					Living Related	Cadaveric	Revenue
					1.00	2.00	3.00
PART IV - STATISTICS							
70.00	Organs Excised in Provider (1)		1	9		70.00	
71.00	Organs Purchased from Other Transplant Hospitals (2)		0	0		71.00	
72.00	Organs Purchased from Non-Transplant Hospitals		0	0		72.00	
73.00	Organs Purchased from OPOs		0	3		73.00	
74.00	Total (sum of lines 70 through 73)		1	12		74.00	
75.00	Organs Transplanted		1	3	1,055,527	75.00	
76.00	Organs Sold to Other Hospitals		0	0	0	76.00	
77.00	Organs Sold to OPOs		0	9	30,997	77.00	
78.00	Organs Sold to Transplant Hospitals		0	0	0	78.00	
79.00	Organs Sold to Military or VA Hospitals		0	0	0	79.00	
80.00	Organs Sold Outside the U.S.		0	0	0	80.00	
81.00	Organs Sent Outside the U.S. (no revenue received)		0	0	0	81.00	
82.00	Organs Used for Research		0	0	0	82.00	
83.00	Unusable/Discarded Organs		0	0	0	83.00	
84.00	Total (sum of lines 75 through 83 should equal line 74)		1	12		84.00	

(1) Organs procured outside your center by a procurement team from your center are not to be included in the count.
(2) Organs procured outside your center by a procurement team from your center are included in the count.

COMPUTATION OF ORGAN ACQUISITION COSTS AND CHARGES FOR A TRANSPLANT HOSPITAL WITH A MEDICARE-CERTIFIED TRANSPLANT PROGRAM				Provider CCN: 26-0091	Period: From 01/01/2020 To 12/31/2020	Worksheet D-4 Date/Time Prepared: 9/24/2021 7:02 pm	
				Component CCN:			
				Liver	Hospital	PPS	
Cost Center Description		Worksheet D-1 Line Numbers	Inpatient Routine Organ Charges	Per Diem Costs (from Wkst. D-1, Part II)	Organ Acquisition	Cost (col. 2 x col. 3)	
		0	1.00	2.00	3.00	4.00	
PART I - COMPUTATION OF ORGAN ACQUISITION COSTS (INPATIENT ROUTINE AND ANCILLARY SERVICES)							
Computation of Inpatient Routine Service Costs Applicable to Organ Acquisition							
1.00	ADULTS & PEDIATRICS	38.00	0	952.14	0	0	1.00
2.00	INTENSIVE CARE UNIT	43.00	1,464	1,013.28	0	0	2.00
2.01	PEDIATRIC INTENSIVE CARE UNIT	43.01	0	1,624.75	0	0	2.01
2.02	NEONATAL INTENSIVE CARE UNIT	43.02	0	1,229.97	0	0	2.02
2.03	INTERMEDIATE CARE UNIT	43.03	0	1,644.69	0	0	2.03
3.00	CORONARY CARE UNIT	44.00	0	0.00	0	0	3.00
4.00	BURN INTENSIVE CARE UNIT	45.00	0	0.00	0	0	4.00
5.00	SURGICAL INTENSIVE CARE UNIT	46.00	0	0.00	0	0	5.00
6.00	OTHER SPECIAL CARE (SPECIFY)	47.00	0	0.00	0	0	6.00
7.00	TOTAL (sum of lines 1 through 6)		1,464		0	0	7.00
Cost Center Description		Worksheet C Line Numbers	Ratio of Cost/Charges (from Wkst. C)	Organ Acquisition Ancillary Charges	Organ Acquisition Ancillary Costs		
		0	1.00	2.00	3.00		
Computation of Ancillary Service Cost Applicable to Organ Acquisition							
8.00	OPERATING ROOM	50.00	0.191207	0	0	0	8.00
9.00	RECOVERY ROOM	51.00	0.188646	0	0	0	9.00
10.00	DELIVERY ROOM & LABOR ROOM	52.00	0.252927	0	0	0	10.00
11.00	ANESTHESIOLOGY	53.00	0.044685	0	0	0	11.00
12.00	RADIOLOGY-DIAGNOSTIC	54.00	0.203696	114	23	12.00	
13.00	RADIOLOGY-THERAPEUTIC	55.00	0.163602	0	0	13.00	
14.00	RADIOISOTOPE	56.00	0.270196	0	0	14.00	
15.00	CT SCAN	57.00	0.041554	0	0	15.00	
16.00	MAGNETIC RESONANCE IMAGING (MRI)	58.00	0.069287	0	0	16.00	
17.00	CARDIAC CATHETERIZATION	59.00	0.131014	0	0	17.00	
18.00	LABORATORY	60.00	0.113436	13,079	1,484	18.00	
19.00	PBP CLINICAL LAB SERVICES-PRGM ONLY	61.00	0.000000	0	0	19.00	
20.00	WHOLE BLOOD & PACKED RED BLOOD CELLS	62.00	0.453620	0	0	20.00	
21.00	BLOOD STORING, PROCESSING & TRANS.	63.00	0.000000	0	0	21.00	
22.00	INTRAVENOUS THERAPY	64.00	0.351249	0	0	22.00	
23.00	RESPIRATORY THERAPY	65.00	0.159308	255	41	23.00	
24.00	PHYSICAL THERAPY	66.00	0.398847	0	0	24.00	
24.01	CLINICAL NUTRITION	66.01	2.480706	0	0	24.01	
25.00	OCCUPATIONAL THERAPY	67.00	0.281460	0	0	25.00	
26.00	SPEECH PATHOLOGY	68.00	0.268817	0	0	26.00	
27.00	ELECTROCARDIOLOGY	69.00	0.081512	0	0	27.00	
27.01	CARDIAC REHAB	69.01	0.801768	0	0	27.01	
28.00	ELECTROENCEPHALOGRAPHY	70.00	0.263342	0	0	28.00	
28.01	ELECTROSHOCK THERAPY	70.01	0.229176	0	0	28.01	
29.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	1.575071	0	0	29.00	
30.00	IMPL. DEV. CHARGED TO PATIENT	72.00	0.723912	0	0	30.00	
31.00	DRUGS CHARGED TO PATIENTS	73.00	0.235413	0	0	31.00	
32.00	RENAL DIALYSIS	74.00	0.334415	0	0	32.00	
33.00	ASC (NON-DISTINCT PART)	75.00	0.000000	0	0	33.00	
34.00	ENDOSCOPY	76.00	0.205150	0	0	34.00	
35.00	RURAL HEALTH CLINIC	88.00	0.000000	0	0	35.00	
36.00	FEDERALLY QUALIFIED HEALTH CENTER	89.00	0.000000	0	0	36.00	
37.00	CLINIC	90.00	0.706944	0	0	37.00	
38.00	EMERGENCY	91.00	0.166999	0	0	38.00	
39.00	OBSERVATION BEDS (NON-DISTINCT PART)	92.00	0.302359	0	0	39.00	
40.00	OTHER OUTPATIENT SERVICE COST CENTER					40.00	
41.00	TOTAL (sum of lines 8 through 40)				13,448	1,548	41.00

(1) Organs procured outside your center by a procurement team from your center are not to be included in the count.
 (2) Organs procured outside your center by a procurement team from your center are included in the count.

COMPUTATION OF ORGAN ACQUISITION COSTS AND CHARGES FOR A TRANSPLANT HOSPITAL WITH A MEDICARE-CERTIFIED TRANSPLANT PROGRAM
Provider CCN: 26-0091
Period: From 01/01/2020 To 12/31/2020
Worksheet D-4
Date/Time Prepared: 9/24/2021 7:02 pm

		Component CCN:		To 12/31/2020		Date/Time Prepared: 9/24/2021 7:02 pm	
		Liver		Hospital		PPS	
Cost Center Description		Worksheet D-2, Part I Line Numbers	Average Cost Per Day (from Wkst. D-2, Part I, col. 4)	Organ Acquisition	Organ Acquisition Costs (col. 1 x col. 2)		
		0	1.00	2.00	3.00		
PART II - COMPUTATION OF ORGAN ACQUISITION COSTS (OTHER THAN INPATIENT ROUTINE AND ANCILLARY SERVICES COSTS)							
Computation of the Cost of Inpatient Services of Interns and Residents Not In Approved Teaching Program							
42.00	ADULTS & PEDIATRICS	2.00	0.00	0		0	42.00
43.00	INTENSIVE CARE UNIT	3.00	0.00	0		0	43.00
43.01	PEDIATRIC INTENSIVE CARE UNIT	3.01	0.00	0		0	43.01
43.02	NEONATAL INTENSIVE CARE UNIT	3.02	0.00	0		0	43.02
43.03	INTERMEDIATE CARE UNIT	3.03	0.00	0		0	43.03
44.00	CORONARY CARE UNIT	4.00	0.00	0		0	44.00
45.00	BURN INTENSIVE CARE UNIT	5.00	0.00	0		0	45.00
46.00	SURGICAL INTENSIVE CARE UNIT	6.00	0.00	0		0	46.00
47.00	OTHER SPECIAL CARE (SPECIFY)	7.00	0.00	0		0	47.00
48.00	TOTAL (sum of lines 42 through 47)			0		0	48.00
Cost Center Description		Worksheet D-2, Part I Line Numbers	Organ Charges (see instructions)	Ratio of Cost To Charges from Wkst. D-2, Part I, col. 4	Organ Acquisition Costs (col. 1 x col. 2)		
		0	1.00	2.00	3.00		
Computation of the Cost of Outpatient Services of Interns and Residents Not In Approved Teaching Program							
49.00	RURAL HEALTH CLINIC	21.00	0	0.000000		0	49.00
50.00	FEDERALLY QUALIFIED HEALTH CENTER	22.00	0	0.000000		0	50.00
51.00	CLINIC	23.00	0	0.000000		0	51.00
52.00	EMERGENCY	24.00	0	0.000000		0	52.00
53.00	OBSERVATION BEDS (NON-DISTINCT PART)	25.00	0	0.000000		0	53.00
54.00	OTHER OUTPATIENT SERVICE COST CENTER	26.00	0	0.000000		0	54.00
55.00	TOTAL (sum of lines 49 through 52)		0			0	55.00
Cost Center Description		Cost		Charges			
		Part A	Part B	Part A	Part B		
		1.00	2.00	3.00	4.00		
PART III - SUMMARY OF COSTS AND CHARGES							
56.00	Routine and Ancillary from Part I	1,548		14,912			56.00
57.00	Interns and Residents (inpatient)	0		0			57.00
58.00	Interns and Residents (outpatient)	0		0			58.00
59.00	Direct Organ Acquisition (see instructions)	122,808		132,887			59.00
60.00	Cost of physicians' services in a teaching hospital (see intructions)	0		0			60.00
61.00	Total (sum of lines 56 thru 60)	124,356		147,799			61.00
62.00	Total Usable Organs (see instructions)		2				62.00
63.00	Medicare Usable Organs (see instructions)		1				63.00
64.00	Ratio of Medicare Usable Organs to Total Usable Organs (line 63 ÷ line 62)		0.500000				64.00
65.00	Medicare Cost/Charges (see instructions)	62,178		73,900			65.00
66.00	Revenue for Organs Sold	2,228		0			66.00
67.00	Subtotal (line 65 minus line 66)	59,950		73,900			67.00
68.00	Organs Furnished Part B	0	0	0		0	68.00
69.00	Net Organ Acquisition Cost and Charges (see instructions)	59,950	0	73,900		0	69.00
Cost Center Description		Living Related		Cadaveric	Revenue		
		1.00	2.00	3.00			
PART IV - STATISTICS							
70.00	Organs Excised in Provider (1)		0	1			70.00
71.00	Organs Purchased from Other Transplant Hospitals (2)		0	0			71.00
72.00	Organs Purchased from Non-Transplant Hospitals		0	0			72.00
73.00	Organs Purchased from OPOs		0	1			73.00
74.00	Total (sum of lines 70 through 73)		0	2			74.00
75.00	Organs Transplanted		0	1		0	75.00
76.00	Organs Sold to Other Hospitals		0	0		0	76.00
77.00	Organs Sold to OPOs		0	1		2,228	77.00
78.00	Organs Sold to Transplant Hospitals		0	0		0	78.00
79.00	Organs Sold to Military or VA Hospitals		0	0		0	79.00
80.00	Organs Sold Outside the U.S.		0	0		0	80.00
81.00	Organs Sent Outside the U.S. (no revenue received)		0	0		0	81.00
82.00	Organs Used for Research		0	0		0	82.00
83.00	Unusable/Discarded Organs		0	0		0	83.00
84.00	Total (sum of lines 75 through 83 should equal line 74)		0	2		0	84.00

(1) Organs procured outside your center by a procurement team from your center are not to be included in the count.
(2) Organs procured outside your center by a procurement team from your center are included in the count.

COMPUTATION OF ORGAN ACQUISITION COSTS AND CHARGES FOR A TRANSPLANT HOSPITAL WITH A MEDICARE-CERTIFIED TRANSPLANT PROGRAM				Provider CCN: 26-0091	Period: From 01/01/2020 To 12/31/2020	Worksheet D-4 Date/Time Prepared: 9/24/2021 7:02 pm	
				Component CCN:			
				Heart	Hospital	PPS	
Cost Center Description		Worksheet D-1 Line Numbers	Inpatient Routine Organ Charges	Per Diem Costs (from Wkst. D-1, Part II)	Organ Acquisition	Cost (col. 2 x col. 3)	
		0	1.00	2.00	3.00	4.00	
PART I - COMPUTATION OF ORGAN ACQUISITION COSTS (INPATIENT ROUTINE AND ANCILLARY SERVICES)							
Computation of Inpatient Routine Service Costs Applicable to Organ Acquisition							
1.00	ADULTS & PEDIATRICS	38.00	0	952.14	0	0	1.00
2.00	INTENSIVE CARE UNIT	43.00	1,692	1,013.28	0	0	2.00
2.01	PEDIATRIC INTENSIVE CARE UNIT	43.01	0	1,624.75	0	0	2.01
2.02	NEONATAL INTENSIVE CARE UNIT	43.02	0	1,229.97	0	0	2.02
2.03	INTERMEDIATE CARE UNIT	43.03	0	1,644.69	0	0	2.03
3.00	CORONARY CARE UNIT	44.00	0	0.00	0	0	3.00
4.00	BURN INTENSIVE CARE UNIT	45.00	0	0.00	0	0	4.00
5.00	SURGICAL INTENSIVE CARE UNIT	46.00	0	0.00	0	0	5.00
6.00	OTHER SPECIAL CARE (SPECIFY)	47.00	0	0.00	0	0	6.00
7.00	TOTAL (sum of lines 1 through 6)		1,692		0	0	7.00
Cost Center Description			Worksheet C Line Numbers	Ratio of Cost/Charges (from Wkst. C)	Organ Acquisition Ancillary Charges	Organ Acquisition Ancillary Costs	
			0	1.00	2.00	3.00	
Computation of Ancillary Service Cost Applicable to Organ Acquisition							
8.00	OPERATING ROOM		50.00	0.191207	0	0	8.00
9.00	RECOVERY ROOM		51.00	0.188646	0	0	9.00
10.00	DELIVERY ROOM & LABOR ROOM		52.00	0.252927	0	0	10.00
11.00	ANESTHESIOLOGY		53.00	0.044685	102	5	11.00
12.00	RADIOLOGY-DIAGNOSTIC		54.00	0.203696	4,399	896	12.00
13.00	RADIOLOGY-THERAPEUTIC		55.00	0.163602	0	0	13.00
14.00	RADIOISOTOPE		56.00	0.270196	0	0	14.00
15.00	CT SCAN		57.00	0.041554	0	0	15.00
16.00	MAGNETIC RESONANCE IMAGING (MRI)		58.00	0.069287	0	0	16.00
17.00	CARDIAC CATHETERIZATION		59.00	0.131014	0	0	17.00
18.00	LABORATORY		60.00	0.113436	36,456	4,135	18.00
19.00	PBP CLINICAL LAB SERVICES-PRGM ONLY		61.00	0.000000	0	0	19.00
20.00	WHOLE BLOOD & PACKED RED BLOOD CELLS		62.00	0.453620	118	54	20.00
21.00	BLOOD STORING, PROCESSING & TRANS.		63.00	0.000000	0	0	21.00
22.00	INTRAVENOUS THERAPY		64.00	0.351249	0	0	22.00
23.00	RESPIRATORY THERAPY		65.00	0.159308	765	122	23.00
24.00	PHYSICAL THERAPY		66.00	0.398847	0	0	24.00
24.01	CLINICAL NUTRITION		66.01	2.480706	0	0	24.01
25.00	OCCUPATIONAL THERAPY		67.00	0.281460	0	0	25.00
26.00	SPEECH PATHOLOGY		68.00	0.268817	0	0	26.00
27.00	ELECTROCARDIOLOGY		69.00	0.081512	7,897	644	27.00
27.01	CARDIAC REHAB		69.01	0.801768	0	0	27.01
28.00	ELECTROENCEPHALOGRAPHY		70.00	0.263342	0	0	28.00
28.01	ELECTROSHOCK THERAPY		70.01	0.229176	0	0	28.01
29.00	MEDICAL SUPPLIES CHARGED TO PATIENTS		71.00	1.575071	0	0	29.00
30.00	IMPL. DEV. CHARGED TO PATIENT		72.00	0.723912	0	0	30.00
31.00	DRUGS CHARGED TO PATIENTS		73.00	0.235413	84	20	31.00
32.00	RENAL DIALYSIS		74.00	0.334415	0	0	32.00
33.00	ASC (NON-DISTINCT PART)		75.00	0.000000	0	0	33.00
34.00	ENDOSCOPY		76.00	0.205150	0	0	34.00
35.00	RURAL HEALTH CLINIC		88.00	0.000000	0	0	35.00
36.00	FEDERALLY QUALIFIED HEALTH CENTER		89.00	0.000000	0	0	36.00
37.00	CLINIC		90.00	0.706944	443	313	37.00
38.00	EMERGENCY		91.00	0.166999	0	0	38.00
39.00	OBSERVATION BEDS (NON-DISTINCT PART)		92.00	0.302359	0	0	39.00
40.00	OTHER OUTPATIENT SERVICE COST CENTER						40.00
41.00	TOTAL (sum of lines 8 through 40)				50,264	6,189	41.00

(1) Organs procured outside your center by a procurement team from your center are not to be included in the count.
 (2) Organs procured outside your center by a procurement team from your center are included in the count.

COMPUTATION OF ORGAN ACQUISITION COSTS AND CHARGES FOR A TRANSPLANT HOSPITAL WITH A MEDICARE-CERTIFIED TRANSPLANT PROGRAM					Provider CCN: 26-0091	Period: From 01/01/2020 To 12/31/2020	Worksheet D-4
					Component CCN:		Date/Time Prepared: 9/24/2021 7:02 pm
					Heart	Hospital	PPS
Cost Center Description					Worksheet D-2, Part I Line Numbers	Average Cost Per Day (from Wkst. D-2, Part I, col. 4)	Organ Acquisition Costs (col. 1 x col. 2)
					0	1.00	2.00
							3.00
PART II - COMPUTATION OF ORGAN ACQUISITION COSTS (OTHER THAN INPATIENT ROUTINE AND ANCILLARY SERVICES COSTS)							
Computation of the Cost of Inpatient Services of Interns and Residents Not In Approved Teaching Program							
42.00	ADULTS & PEDIATRICS	2.00	0.00	0	0	42.00	
43.00	INTENSIVE CARE UNIT	3.00	0.00	0	0	43.00	
43.01	PEDIATRIC INTENSIVE CARE UNIT	3.01	0.00	0	0	43.01	
43.02	NEONATAL INTENSIVE CARE UNIT	3.02	0.00	0	0	43.02	
43.03	INTERMEDIATE CARE UNIT	3.03	0.00	0	0	43.03	
44.00	CORONARY CARE UNIT	4.00	0.00	0	0	44.00	
45.00	BURN INTENSIVE CARE UNIT	5.00	0.00	0	0	45.00	
46.00	SURGICAL INTENSIVE CARE UNIT	6.00	0.00	0	0	46.00	
47.00	OTHER SPECIAL CARE (SPECIFY)	7.00	0.00	0	0	47.00	
48.00	TOTAL (sum of lines 42 through 47)			0	0	48.00	
Cost Center Description					Worksheet D-2, Part I Line Numbers	Organ Charges (see instructions)	Ratio of Cost To Charges from Wkst. D-2, Part I, col. 4
					0	1.00	2.00
							3.00
Computation of the Cost of Outpatient Services of Interns and Residents Not In Approved Teaching Program							
49.00	RURAL HEALTH CLINIC	21.00	0	0.000000	0	49.00	
50.00	FEDERALLY QUALIFIED HEALTH CENTER	22.00	0	0.000000	0	50.00	
51.00	CLINIC	23.00	443	0.000000	0	51.00	
52.00	EMERGENCY	24.00	0	0.000000	0	52.00	
53.00	OBSERVATION BEDS (NON-DISTINCT PART)	25.00	0	0.000000	0	53.00	
54.00	OTHER OUTPATIENT SERVICE COST CENTER	26.00	0	0.000000	0	54.00	
55.00	TOTAL (sum of lines 49 through 52)		443		0	55.00	
Cost Center Description					Cost		Charges
					Part A	Part B	Part A
					1.00	2.00	3.00
							4.00
PART III - SUMMARY OF COSTS AND CHARGES							
56.00	Routine and Ancillary from Part I	6,189		51,956		56.00	
57.00	Interns and Residents (inpatient)	0		0		57.00	
58.00	Interns and Residents (outpatient)	0		0		58.00	
59.00	Direct Organ Acquisition (see instructions)	122,808		132,887		59.00	
60.00	Cost of physicians' services in a teaching hospital (see instructions)	0		0		60.00	
61.00	Total (sum of lines 56 thru 60)	128,997		184,843		61.00	
62.00	Total Usable Organs (see instructions)		3			62.00	
63.00	Medicare Usable Organs (see instructions)		2			63.00	
64.00	Ratio of Medicare Usable Organs to Total Usable Organs (line 63 ÷ line 62)		0.666667			64.00	
65.00	Medicare Cost/Charges (see instructions)	85,998		123,229		65.00	
66.00	Revenue for Organs Sold	3,183		0		66.00	
67.00	Subtotal (line 65 minus line 66)	82,815		123,229		67.00	
68.00	Organs Furnished Part B	0	0	0	0	68.00	
69.00	Net Organ Acquisition Cost and Charges (see instructions)	82,815	0	123,229	0	69.00	
Cost Center Description					Living Related	Cadaveric	Revenue
					1.00	2.00	3.00
PART IV - STATISTICS							
70.00	Organs Excised in Provider (1)		0	2		70.00	
71.00	Organs Purchased from Other Transplant Hospitals (2)		0	0		71.00	
72.00	Organs Purchased from Non-Transplant Hospitals		0	0		72.00	
73.00	Organs Purchased from OPOs		0	1		73.00	
74.00	Total (sum of lines 70 through 73)		0	3		74.00	
75.00	Organs Transplanted		0	1	0	75.00	
76.00	Organs Sold to Other Hospitals		0	0	0	76.00	
77.00	Organs Sold to OPOs		0	2	3,183	77.00	
78.00	Organs Sold to Transplant Hospitals		0	0	0	78.00	
79.00	Organs Sold to Military or VA Hospitals		0	0	0	79.00	
80.00	Organs Sold Outside the U.S.		0	0	0	80.00	
81.00	Organs Sent Outside the U.S. (no revenue received)		0	0	0	81.00	
82.00	Organs Used for Research		0	0	0	82.00	
83.00	Unusable/Discarded Organs		0	0	0	83.00	
84.00	Total (sum of lines 75 through 83 should equal line 74)		0	3		84.00	

(1) Organs procured outside your center by a procurement team from your center are not to be included in the count.
(2) Organs procured outside your center by a procurement team from your center are included in the count.

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 26-0091	Period: From 01/01/2020 To 12/31/2020	Worksheet E Part A Date/Time Prepared: 9/24/2021 7:02 pm	
		Title XVIII	Hospital	PPS	
				1.00	
PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS					
1.00	DRG Amounts Other than Outlier Payments			0	1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1 (see instructions)			20,742,437	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1 (see instructions)			7,573,285	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)			462,073	2.03
2.04	Outlier payments for discharges occurring on or after October 1 (see instructions)			107,297	2.04
3.00	Managed Care Simulated Payments			23,868,917	3.00
4.00	Bed days available divided by number of days in the cost reporting period (see instructions)			617.45	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)			141.25	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).			39.90	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)			181.15	9.00
10.00	FTE count for allopathic and osteopathic programs in the current year from your records			188.56	10.00
11.00	FTE count for residents in dental and podiatric programs.			4.99	11.00
12.00	Current year allowable FTE (see instructions)			186.14	12.00
13.00	Total allowable FTE count for the prior year.			176.81	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.			168.75	14.00
15.00	Sum of lines 12 through 14 divided by 3.			177.23	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			177.23	18.00
19.00	Current year resident to bed ratio (line 18 divided by line 4).			0.287035	19.00
20.00	Prior year resident to bed ratio (see instructions)			0.341962	20.00
21.00	Enter the lesser of lines 19 or 20 (see instructions)			0.287035	21.00
22.00	IME payment adjustment (see instructions)			4,113,255	22.00
22.01	IME payment adjustment - Managed Care (see instructions)			3,467,294	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) .			1.00	23.00
24.00	IME FTE Resident Count Over Cap (see instructions)			7.41	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)			1.00	25.00
26.00	Resident to bed ratio (divide line 25 by line 4)			0.001620	26.00
27.00	IME payments adjustment factor. (see instructions)			0.000433	27.00
28.00	IME add-on adjustment amount (see instructions)			12,261	28.00
28.01	IME add-on adjustment amount - Managed Care (see instructions)			10,335	28.01
29.00	Total IME payment (sum of lines 22 and 28)			4,125,516	29.00
29.01	Total IME payment - Managed Care (sum of lines 22.01 and 28.01)			3,477,629	29.01
Disproportionate Share Adjustment					
30.00	Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)			9.06	30.00
31.00	Percentage of Medicaid patient days (see instructions)			52.91	31.00
32.00	Sum of lines 30 and 31			61.97	32.00
33.00	Allowable disproportionate share percentage (see instructions)			40.34	33.00
34.00	Disproportionate share adjustment (see instructions)			2,855,641	34.00

CALCULATION OF REIMBURSEMENT SETTLEMENT

Provider CCN: 26-0091

Period:
From 01/01/2020
To 12/31/2020Worksheet E
Part A
Date/Time Prepared:
9/24/2021 7:02 pm

		Title XVIII	Hospital	PPS
			Prior to 10/1	On/After 10/1
			1.00	2.00
	Uncompensated Care Adjustment			
35.00	Total uncompensated care amount (see instructions)		8,350,599,096	8,290,014,521
35.01	Factor 3 (see instructions)		0.000818178	0.000784984
35.02	Hospital uncompensated care payment (If line 34 is zero, enter zero on this line) (see instructions)		6,832,277	6,507,529
35.03	Pro rata share of the hospital uncompensated care payment amount (see instructions)		5,114,875	1,640,255
36.00	Total uncompensated care (sum of columns 1 and 2 on line 35.03)		6,755,130	
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 an 685. (see instructions)		0	
41.01	Total ESRD Medicare covered and paid discharges excluding MS-DRGs 652, 682, 683, 684 an 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 an 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)		42,621,379	
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)		46,099,008	49.00
50.00	Payment for inpatient program capital (from Wkst. L, Pt. I and Pt. II, as applicable)		2,907,602	50.00
51.00	Exception payment for inpatient program capital (Wkst. L, Pt. III, see instructions)		0	51.00
52.00	Direct graduate medical education payment (from Wkst. E-4, line 49 see instructions).		3,419,896	52.00
53.00	Nursing and Allied Health Managed Care payment		139,598	53.00
54.00	Special add-on payments for new technologies		10,750	54.00
54.01	Islet isolation add-on payment		0	54.01
55.00	Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line 69)		1,090,438	55.00
56.00	Cost of physicians' services in a teaching hospital (see intructions)		0	56.00
57.00	Routine service other pass through costs (from Wkst. D, Pt. III, column 9, lines 30 through 35).		186,527	57.00
58.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 11 line 200)		78,311	58.00
59.00	Total (sum of amounts on lines 49 through 58)		53,932,130	59.00
60.00	Primary payer payments		52,764	60.00
61.00	Total amount payable for program beneficiaries (line 59 minus line 60)		53,879,366	61.00
62.00	Deductibles billed to program beneficiaries		2,639,824	62.00
63.00	Coinurance billed to program beneficiaries		278,828	63.00
64.00	Allowable bad debts (see instructions)		1,443,123	64.00
65.00	Adjusted reimbursable bad debts (see instructions)		938,030	65.00
66.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		1,165,251	66.00
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)		51,898,744	67.00
68.00	Credits received from manufacturers for replaced devices for applicable to MS-DRGs (see instructions)		0	68.00
69.00	Outlier payments reconciliation (sum of lines 93, 95 and 96).(For SCH see instructions)		0	69.00
70.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	70.00
70.50	Rural Community Hospital Demonstration Project (\$410A Demonstration) adjustment (see instructions)		0	70.50
70.87	Demonstration payment adjustment amount before sequestration		0	70.87
70.88	SCH or MDH volume decrease adjustment (contractor use only)		0	70.88
70.89	Pioneer ACO demonstration payment adjustment amount (see instructions)		0	70.89
70.90	HSP bonus payment HVBP adjustment amount (see instructions)		0	70.90
70.91	HSP bonus payment HRR adjustment amount (see instructions)		0	70.91
70.92	Bundled Model 1 discount amount (see instructions)		0	70.92
70.93	HVBP payment adjustment amount (see instructions)		-71,837	70.93
70.94	HRR adjustment amount (see instructions)		0	70.94
70.95	Recovery of accelerated depreciation		0	70.95

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 26-0091	Period: From 01/01/2020 To 12/31/2020	Worksheet E Part A Date/Time Prepared: 9/24/2021 7:02 pm
		Title XVIII	Hospital	PPS
		FFY (yyyy)	Amount	
		0	1.00	
70.96	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period prior to 10/1)	0	0	70.96
70.97	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period ending on or after 10/1)	0	0	70.97
70.98	Low Volume Payment-3		0	70.98
70.99	HAC adjustment amount (see instructions)		129,132	70.99
71.00	Amount due provider (line 67 minus lines 68 plus/minus lines 69 & 70)		51,697,775	71.00
71.01	Sequestration adjustment (see instructions)		341,205	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		48,873,040	72.00
72.01	Interim payments-PARHM			72.01
73.00	Tentative settlement (for contractor use only)		2,449,265	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)		34,265	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		1,001,933	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	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	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: 26-0091

Period:
From 01/01/2020
To 12/31/2020Worksheet E
Part A Exhibit 4
Date/Time Prepared:
9/24/2021 7:02 pm

				Title XVIII		Hospital	PPS	
		W/S E, Part A line	Amounts (from E, Part A)	Pre/Post Entitlement	Period Prior to 10/01	Period On/After 10/01	Total (Col 2 through 4)	
		0	1.00	2.00	3.00	4.00	5.00	
1.00	DRG amounts other than outlier payments	1.00	0	0	0	0	0	1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1	1.01	20,742,437	0	20,742,437		20,742,437	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	7,573,285	0		7,573,285	7,573,285	1.02
1.03	DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October 1	1.03	0	0	0		0	1.03
1.04	DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1	1.04	0	0		0	0	1.04
2.00	Outlier payments for discharges (see instructions)	2.00						2.00
2.01	Outlier payments for discharges for Model 4 BPCI	2.02	0	0	0	0	0	2.01
2.02	Outlier payments for discharges occurring prior to October 1 (see instructions)	2.03	462,073	0	462,073		462,073	2.02
2.03	Outlier payments for discharges occurring on or after October 1 (see instructions)	2.04	107,297	0		107,297	107,297	2.03
3.00	Operating outlier reconciliation	2.01	0	0	0	0	0	3.00
4.00	Managed care simulated payments	3.00	23,868,917	0	17,003,150	6,865,767	23,868,917	4.00
Indirect Medical Education Adjustment								
5.00	Amount from Worksheet E, Part A, line 21 (see instructions)	21.00	0.287035	0.287035	0.287035	0.287035		5.00
6.00	IME payment adjustment (see instructions)	22.00	4,113,255	0	3,013,129	1,100,126	4,113,255	6.00
6.01	IME payment adjustment for managed care (see instructions)	22.01	3,467,294	0	2,469,945	997,349	3,467,294	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	0.000433	0.000433	0.000433	0.000433		7.00
8.00	IME adjustment (see instructions)	28.00	12,261	0	8,982	3,279	12,261	8.00
8.01	IME payment adjustment add on for managed care (see instructions)	28.01	10,335	0	7,362	2,973	10,335	8.01
9.00	Total IME payment (sum of lines 6 and 8)	29.00	4,125,516	0	3,022,111	1,103,405	4,125,516	9.00
9.01	Total IME payment for managed care (sum of lines 6.01 and 8.01)	29.01	3,477,629	0	2,477,307	1,000,322	3,477,629	9.01
Disproportionate Share Adjustment								
10.00	Allowable disproportionate share percentage (see instructions)	33.00	0.4034	0.4034	0.4034	0.4034		10.00
11.00	Disproportionate share adjustment (see instructions)	34.00	2,855,641	0	2,091,875	763,766	2,855,641	11.00
11.01	Uncompensated care payments	36.00	6,755,130	0	5,114,875	1,640,255	6,755,130	11.01
Additional payment for high percentage of ESRD beneficiary discharges								
12.00	Total ESRD additional payment (see instructions)	46.00	0	0	0	0	0	12.00
13.00	Subtotal (see instructions)	47.00	42,621,379	0	31,433,371	11,188,008	42,621,379	13.00
14.00	Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see instructions)	48.00	0	0	0	0	0	14.00
15.00	Total payment for inpatient operating costs (see instructions)	49.00	46,099,008	0	33,910,678	12,188,330	46,099,008	15.00
16.00	Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable)	50.00	2,907,602	0	2,152,519	755,083	2,907,602	16.00

LOW VOLUME CALCULATION EXHIBIT 4

Provider CCN: 26-0091

Period:
From 01/01/2020
To 12/31/2020Worksheet E
Part A Exhibit 4
Date/Time Prepared:
9/24/2021 7:02 pm

				Title XVIII		Hospital	PPS	
		W/S E, Part A line	Amounts (from E, Part A)	Pre/Post Entitlement	Period Prior to 10/01	Period On/After 10/01	Total (Col 2 through 4)	
		0	1.00	2.00	3.00	4.00	5.00	
17.00	Special add-on payments for new technologies	54.00	10,750	0	0	10,750	10,750	17.00
17.01	Net organ aquisition cost							17.01
17.02	Credits received from manufacturers for replaced devices for applicable MS-DRGs	68.00	0	0	0	0	0	17.02
18.00	Capital outlier reconciliation adjustment amount (see instructions)	93.00	0	0	0	0	0	18.00
19.00	SUBTOTAL			0	36,063,197	12,954,163	49,017,360	19.00
		W/S L, line	(Amounts from L)					
		0	1.00	2.00	3.00	4.00	5.00	
20.00	Capital DRG other than outlier	1.00	2,186,234	0	1,616,838	569,396	2,186,234	20.00
20.01	Model 4 BPCI Capital DRG other than outlier	1.01	0	0	0	0	0	20.01
21.00	Capital DRG outlier payments	2.00	42,761	0	33,814	8,947	42,761	21.00
21.01	Model 4 BPCI Capital DRG outlier payments	2.01	0	0	0	0	0	21.01
22.00	Indirect medical education percentage (see instructions)	5.00	0.1767	0.1767	0.1767	0.1767		22.00
23.00	Indirect medical education adjustment (see instructions)	6.00	386,308	0	285,696	100,612	386,308	23.00
24.00	Allowable disproportionate share percentage (see instructions)	10.00	0.1337	0.1337	0.1337	0.1337		24.00
25.00	Disproportionate share adjustment (see instructions)	11.00	292,299	0	216,171	76,128	292,299	25.00
26.00	Total prospective capital payments (see instructions)	12.00	2,907,602	0	2,152,519	755,083	2,907,602	26.00
		W/S E, Part A line	(Amounts to E, Part A)					
		0	1.00	2.00	3.00	4.00	5.00	
27.00	Low volume adjustment factor				0.000000	0.000000		27.00
28.00	Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)	70.96			0		0	28.00
29.00	Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)	70.97				0	0	29.00
100.00	Transfer low volume adjustments to Wkst. E, Pt. A.		N					100.00

HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULATION EXHIBIT 5

Provider CCN: 26-0091

Period:
From 01/01/2020
To 12/31/2020Worksheet E
Part A Exhibit 5
Date/Time Prepared:
9/24/2021 7:02 pm

		Title XVIII		Hospital		PPS	
		Wkst. E, Pt. A, line	Amt. from Wkst. E, Pt. A)	Period to 10/01	Period on after 10/01	Total (cols. 2 and 3)	
		0	1.00	2.00	3.00	4.00	
1.00	DRG amounts other than outlier payments	1.00					1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1	1.01	20,742,437	20,742,437		20,742,437	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	7,573,285		7,573,285	7,573,285	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	462,073	462,073		462,073	2.02
2.03	Outlier payments for discharges occurring on or after October 1 (see instructions)	2.04	107,297		107,297	107,297	2.03
3.00	Operating outlier reconciliation	2.01	0	0	0	0	3.00
4.00	Managed care simulated payments	3.00	23,868,917	17,003,150	6,865,767	23,868,917	4.00
Indirect Medical Education Adjustment							
5.00	Amount from Worksheet E, Part A, line 21 (see instructions)	21.00	0.287035	0.287035	0.287035		5.00
6.00	IME payment adjustment (see instructions)	22.00	4,113,255	3,013,129	1,100,126	4,113,255	6.00
6.01	IME payment adjustment for managed care (see instructions)	22.01	3,467,294	2,469,945	997,349	3,467,294	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	0.000433	0.000433	0.000433		7.00
8.00	IME adjustment (see instructions)	28.00	12,261	8,982	3,279	12,261	8.00
8.01	IME payment adjustment add on for managed care (see instructions)	28.01	10,335	7,362	2,973	10,335	8.01
9.00	Total IME payment (sum of lines 6 and 8)	29.00	4,125,516	3,022,111	1,103,405	4,125,516	9.00
9.01	Total IME payment for managed care (sum of lines 6.01 and 8.01)	29.01	3,477,629	2,477,307	1,000,322	3,477,629	9.01
Disproportionate Share Adjustment							
10.00	Allowable disproportionate share percentage (see instructions)	33.00	0.4034	0.4034	0.4034		10.00
11.00	Disproportionate share adjustment (see instructions)	34.00	2,855,641	2,091,875	763,766	2,855,641	11.00
11.01	Uncompensated care payments	36.00	6,755,130	5,114,875	1,640,255	6,755,130	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	42,621,379	31,433,371	11,188,008	42,621,379	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	46,099,008	33,910,678	12,188,330	46,099,008	15.00
16.00	Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable)	50.00	2,907,602	2,152,519	755,083	2,907,602	16.00
17.00	Special add-on payments for new technologies	54.00	10,750	0	10,750	10,750	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			36,063,197	12,954,163	49,017,360	19.00

HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULATION EXHIBIT 5

Provider CCN: 26-0091

Period:
From 01/01/2020
To 12/31/2020Worksheet E
Part A Exhibit 5
Date/Time Prepared:
9/24/2021 7:02 pm

		Title XVIII		Hospital		PPS	
		Wkst. L, line	(Amt. from Wkst. L)				
		0	1.00	2.00	3.00	4.00	
20.00	Capital DRG other than outlier	1.00	2,186,234	1,616,838	569,396	2,186,234	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	42,761	33,814	8,947	42,761	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	0.1767	0.1767	0.1767		22.00
23.00	Indirect medical education adjustment (see instructions)	6.00	386,308	285,696	100,612	386,308	23.00
24.00	Allowable disproportionate share percentage (see instructions)	10.00	0.1337	0.1337	0.1337		24.00
25.00	Disproportionate share adjustment (see instructions)	11.00	292,299	216,171	76,128	292,299	25.00
26.00	Total prospective capital payments (see instructions)	12.00	2,907,602	2,152,519	755,083	2,907,602	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	-71,837	-30,846	-40,991	-71,837	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	0	0	0	0	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	129,132	129,132	32.00
100.00	Transfer HAC Reduction Program adjustment to Wkst. E, Pt. A.		Y				100.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 26-0091	Period: From 01/01/2020 To 12/31/2020	Worksheet E Part B Date/Time Prepared: 9/24/2021 7:02 pm
		Title XVIII	Hospital	PPS
				1.00
PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)		72,135	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)		35,663,113	2.00
3.00	OPPS payments		26,642,878	3.00
4.00	Outlier payment (see instructions)		191,738	4.00
4.01	Outlier reconciliation amount (see instructions)		0	4.01
5.00	Enter the hospital specific payment to cost ratio (see instructions)		0.000	5.00
6.00	Line 2 times line 5		0	6.00
7.00	Sum of lines 3, 4, and 4.01, divided by line 6		0.00	7.00
8.00	Transitional corridor payment (see instructions)		0	8.00
9.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200		40,909	9.00
10.00	Organ acquisitions		0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)		72,135	11.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
12.00	Ancillary service charges		312,365	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)		312,365	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)		312,365	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)		240,230	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)		72,135	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)		26,875,525	24.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25.00	Deductibles and coinsurance amounts (for CAH, see instructions)		7,167	25.00
26.00	Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)		4,984,897	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)		21,955,596	27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 50)		2,746,189	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)		24,701,785	30.00
31.00	Primary payer payments		11,528	31.00
32.00	Subtotal (line 30 minus line 31)		24,690,257	32.00
ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)				
33.00	Composite rate ESRD (from Wkst. I-5, line 11)		3,340	33.00
34.00	Allowable bad debts (see instructions)		667,789	34.00
35.00	Adjusted reimbursable bad debts (see instructions)		434,063	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		358,616	36.00
37.00	Subtotal (see instructions)		25,127,660	37.00
38.00	MSP-LCC reconciliation amount from PS&R		-61	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)		25,127,721	40.00
40.01	Sequestration adjustment (see instructions)		165,843	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		24,127,636	41.00
41.01	Interim payments-PARHM		0	41.01
42.00	Tentative settlement (for contractors use only)		811,433	42.00
42.01	Tentative settlement-PARHM (for contractor use only)		0	42.01
43.00	Balance due provider/program (see instructions)		22,809	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: 26-0091 Component CCN: 26-S091	Period: From 01/01/2020 To 12/31/2020	Worksheet E Part B Date/Time Prepared: 9/24/2021 7:02 pm
		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)		449,266	2.00
3.00	OPPS payments		360,199	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 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)		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)		360,199	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)		72,042	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)		288,157	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)		288,157	30.00
31.00	Primary payer payments		0	31.00
32.00	Subtotal (line 30 minus line 31)		288,157	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)		288,157	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)		288,157	40.00
40.01	Sequestration adjustment (see instructions)		1,902	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		284,672	41.00
41.01	Interim payments-PARHM		0	41.01
42.00	Tentative settlement (for contractors use only)		1,583	42.00
42.01	Tentative settlement-PARHM (for contractor use only)		0	42.01
43.00	Balance due provider/program (see instructions)		0	43.00
43.01	Balance due provider/program-PARHM (see instructions)		0	43.01
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		0	44.00
TO BE COMPLETED BY CONTRACTOR				
90.00	Original outlier amount (see instructions)		0	90.00
91.00	Outlier reconciliation adjustment amount (see instructions)		0	91.00
92.00	The rate used to calculate the Time Value of Money		0.00	92.00
93.00	Time Value of Money (see instructions)		0	93.00
94.00	Total (sum of lines 91 and 93)		0	94.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 26-0091

Period:
From 01/01/2020
To 12/31/2020Worksheet E-1
Part I
Date/Time Prepared:
9/24/2021 7:02 pm

		Title XVIII		Hospital		PPS	
		Inpatient Part A		Part B			
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount		
		1.00	2.00	3.00	4.00		
1.00	Total interim payments paid to provider		43,815,404		21,761,479	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		3,924,836		2,366,157	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	11/25/2020	1,132,800		0	3.01	
3.02			0		0	3.02	
3.03			0		0	3.03	
3.04			0		0	3.04	
3.05			0		0	3.05	
Provider to Program							
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50	
3.51			0		0	3.51	
3.52			0		0	3.52	
3.53			0		0	3.53	
3.54			0		0	3.54	
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		1,132,800		0	3.99	
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		48,873,040		24,127,636	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	08/02/2021	2,449,265	08/02/2021	811,433	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)		2,449,265		811,433	5.99	
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00	
6.01	SETTLEMENT TO PROVIDER		34,265		22,809	6.01	
6.02	SETTLEMENT TO PROGRAM		0		0	6.02	
7.00	Total Medicare program liability (see instructions)		51,356,570		24,961,878	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: 26-0091

Period:

Worksheet E-1

Component CCN: 26-S091

From 01/01/2020
To 12/31/2020Part I
Date/Time Prepared:
9/24/2021 7:02 pm

Title XVIII

Subprovider -
IPF

PPS

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider					1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		4,515,238		284,672	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)		12,571		0	3.00
Program to Provider						
3.01	ADJUSTMENTS TO PROVIDER	11/25/2020	79,500		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
Provider to Program						
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		79,500		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		4,607,309		284,672	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	08/02/2021	108,598	08/02/2021	1,583	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)		108,598		1,583	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		0		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		4,715,907		286,255	7.00
				Contractor Number	NPR Date (Mo/Day/Yr)	
		0		1.00	2.00	
8.00	Name of Contractor					8.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT

Provider CCN: 26-0091

Period:
From 01/01/2020
To 12/31/2020Worksheet E-1
Part II
Date/Time Prepared:
9/24/2021 7:02 pm

Title XVIII

Hospital

PPS

1.00

TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS

HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION

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

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 26-0091 Component CCN: 26-S091	Period: From 01/01/2020 To 12/31/2020	Worksheet E-3 Part II Date/Time Prepared: 9/24/2021 7:02 pm
		Title XVIII	Subprovider - IPF	PPS
				1.00
PART II - MEDICARE PART A SERVICES - IPF PPS				
1.00	Net Federal IPF PPS Payments (excluding outlier, ECT, and medical education payments)			4,937,353 1.00
2.00	Net IPF PPS Outlier Payments			17,258 2.00
3.00	Net IPF PPS ECT Payments			39,875 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)			0.82 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)			34.456284 9.00
10.00	Teaching Adjustment Factor $\{((1 + (\text{line 8/line 9})) \text{ raised to the power of } .5150 - 1)\}$.			0.000000 10.00
11.00	Teaching Adjustment (line 1 multiplied by line 10).			0 11.00
12.00	Adjusted Net IPF PPS Payments (sum of lines 1, 2, 3 and 11)			4,994,486 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)			4,994,486 16.00
17.00	Primary payer payments			0 17.00
18.00	Subtotal (line 16 less line 17).			4,994,486 18.00
19.00	Deductibles			227,612 19.00
20.00	Subtotal (line 18 minus line 19)			4,766,874 20.00
21.00	Coinurance			267,872 21.00
22.00	Subtotal (line 20 minus line 21)			4,499,002 22.00
23.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)			381,903 23.00
24.00	Adjusted reimbursable bad debts (see instructions)			248,237 24.00
25.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			319,072 25.00
26.00	Subtotal (sum of lines 22 and 24)			4,747,239 26.00
27.00	Direct graduate medical education payments (see instructions)			0 27.00
28.00	Other pass through costs (see instructions)			0 28.00
29.00	Outlier payments reconciliation			0 29.00
30.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0 30.00
30.50	Pioneer ACO demonstration payment adjustment (see instructions)			0 30.50
30.99	Demonstration payment adjustment amount before sequestration			0 30.99
31.00	Total amount payable to the provider (see instructions)			4,747,239 31.00
31.01	Sequestration adjustment (see instructions)			31,332 31.01
31.02	Demonstration payment adjustment amount after sequestration			0 31.02
32.00	Interim payments			4,607,309 32.00
33.00	Tentative settlement (for contractor use only)			108,598 33.00
34.00	Balance due provider/program (line 31 minus lines 31.01, 31.02, 32 and 33)			0 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			17,258 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: 26-0091	Period: From 01/01/2020 To 12/31/2020	Worksheet E-3 Part VII Date/Time Prepared: 9/24/2021 7:02 pm	
		Title XIX	Hospital	Cost	
			Inpatient	Outpatient	
			1.00	2.00	
PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR XIX SERVICES					
COMPUTATION OF NET COST OF COVERED SERVICES					
1.00	Inpatient hospital/SNF/NF services	23,543,123			1.00
2.00	Medical and other services			24,771,943	2.00
3.00	Organ acquisition (certified transplant centers only)	0			3.00
4.00	Subtotal (sum of lines 1, 2 and 3)	23,543,123		24,771,943	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)	23,543,123		24,771,943	7.00
COMPUTATION OF LESSER OF COST OR CHARGES					
Reasonable Charges					
8.00	Routine service charges	0			8.00
9.00	Ancillary service charges	46,392,131		67,872,733	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)	46,392,131		67,872,733	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)	46,392,131		67,872,733	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)	22,849,008		43,100,790	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)	23,543,123		24,771,943	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)	23,543,123		24,771,943	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)	23,543,123		24,771,943	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)	23,543,123		24,771,943	36.00
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0			37.00
38.00	Subtotal (line 36 ± line 37)	23,543,123		24,771,943	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)	23,543,123		24,771,943	40.00
41.00	Interim payments	23,543,123		24,771,943	41.00
42.00	Balance due provider/program (line 40 minus line 41)	0		0	42.00
43.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, chapter 1, §115.2	0		0	43.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 26-0091 Component CCN: 26-S091	Period: From 01/01/2020 To 12/31/2020	Worksheet E-3 Part VII Date/Time Prepared: 9/24/2021 7:02 pm	
		Title XIX	Subprovider - IPF	Cost	
			Inpatient 1.00	Outpatient 2.00	
PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR XIX SERVICES					
COMPUTATION OF NET COST OF COVERED SERVICES					
1.00	Inpatient hospital/SNF/NF services		2,953,165		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)		2,953,165	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)		2,953,165	0	7.00
COMPUTATION OF LESSER OF COST OR CHARGES					
Reasonable Charges					
8.00	Routine service charges		0		8.00
9.00	Ancillary service charges		1,221,148	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)		1,221,148	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)		1,221,148	0	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)		0	0	17.00
18.00	Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 16) (see instructions)		1,732,017	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)		1,221,148	0	21.00
PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be completed for PPS providers.					
22.00	Other than outlier payments		0	0	22.00
23.00	Outlier payments		0	0	23.00
24.00	Program capital payments		0		24.00
25.00	Capital exception payments (see instructions)		0		25.00
26.00	Routine and Ancillary service other pass through costs		0	0	26.00
27.00	Subtotal (sum of lines 22 through 26)		0	0	27.00
28.00	Customary charges (title V or XIX PPS covered services only)		0	0	28.00
29.00	Titles V or XIX (sum of lines 21 and 27)		1,221,148	0	29.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT					
30.00	Excess of reasonable cost (from line 18)		1,732,017	0	30.00
31.00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)		1,221,148		31.00
32.00	Deductibles		0	0	32.00
33.00	Coinurance		0	0	33.00
34.00	Allowable bad debts (see instructions)		0	0	34.00
35.00	Utilization review		0		35.00
36.00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)		1,221,148	0	36.00
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0		37.00
38.00	Subtotal (line 36 ± line 37)		1,221,148	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)		1,221,148	0	40.00
41.00	Interim payments		1,221,148	0	41.00
42.00	Balance due provider/program (line 40 minus line 41)		0	0	42.00
43.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, chapter 1, §115.2		0	0	43.00

DIRECT GRADUATE MEDICAL EDUCATION (GME) & ESRD OUTPATIENT DIRECT MEDICAL EDUCATION COSTS
Provider CCN: 26-0091
Period: From 01/01/2020 To 12/31/2020
Worksheet E-4
Date/Time Prepared: 9/24/2021 7:02 pm

Title XVIII	Hospital	PPS
		1.00

COMPUTATION OF TOTAL DIRECT GME AMOUNT				
1.00	Unweighted resident FTE count for allopathic and osteopathic programs for cost reporting periods ending on or before December 31, 1996.		141.30	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))		46.10	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)		187.40	5.00
6.00	Unweighted resident FTE count for allopathic and osteopathic programs for the current year from your records (see instructions)		189.00	6.00
7.00	Enter the lesser of line 5 or line 6		187.40	7.00

		Primary Care	Other	Total	
		1.00	2.00	3.00	
8.00	Weighted FTE count for physicians in an allopathic and osteopathic program for the current year.	121.65	55.54	177.19	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.	120.62	55.07	175.69	9.00
10.00	Weighted dental and podiatric resident FTE count for the current year		4.99		10.00
10.01	Unweighted dental and podiatric resident FTE count for the current year		4.99		10.01
11.00	Total weighted FTE count	120.62	60.06		11.00
12.00	Total weighted resident FTE count for the prior cost reporting year (see instructions)	121.47	64.68		12.00
13.00	Total weighted resident FTE count for the penultimate cost reporting year (see instructions)	113.28	61.86		13.00
14.00	Rolling average FTE count (sum of lines 11 through 13 divided by 3).	118.46	62.20		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	118.46	62.20		17.00
18.00	Per resident amount	110,729.30	110,729.30		18.00
19.00	Approved amount for resident costs	13,116,993	6,887,362	20,004,355	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)		1.00	20.00
21.00	Direct GME FTE unweighted resident count over cap (see instructions)		1.60	21.00
22.00	Allowable additional direct GME FTE Resident Count (see instructions)		0.94	22.00
23.00	Enter the locality adjustment national average per resident amount (see instructions)		109,405.40	23.00
24.00	Multiply line 22 time line 23		102,841	24.00
25.00	Total direct GME amount (sum of lines 19 and 24)		20,107,196	25.00

	Inpatient Part A	Managed Care	Total	
	1.00	2.00	3.00	

COMPUTATION OF PROGRAM PATIENT LOAD				
26.00	Inpatient Days (see instructions) (Title XIX - see S-2 Part IX, line 3.02, column 2)	22,697	16,018	26.00
27.00	Total Inpatient Days (see instructions)	124,121	124,121	27.00
28.00	Ratio of inpatient days to total inpatient days	0.182862	0.129051	28.00
29.00	Program direct GME amount	3,676,842	2,594,854	29.00
29.01	Percent reduction for MA DGME		4.07	29.01
30.00	Reduction for direct GME payments for Medicare Advantage		105,611	30.00
31.00	Net Program direct GME amount		6,166,085	31.00

DIRECT GRADUATE MEDICAL EDUCATION (GME) & ESRD OUTPATIENT DIRECT MEDICAL EDUCATION COSTS		Provider CCN: 26-0091	Period: From 01/01/2020 To 12/31/2020	Worksheet E-4 Date/Time Prepared: 9/24/2021 7:02 pm	
		Title XVIII	Hospital	PPS	
			1.00		
	DIRECT MEDICAL EDUCATION COSTS FOR ESRD COMPOSITE RATE - TITLE XVIII ONLY (NURSING SCHOOL AND PARAMEDICAL EDUCATION COSTS)				
32.00	Renal dialysis direct medical education costs (from Wkst. B, Pt. I, sum of col. 20 and 23, lines 74 and 94)			235,254	32.00
33.00	Renal dialysis and home dialysis total charges (Wkst. C, Pt. I, col. 8, sum of lines 74 and 94)			9,751,994	33.00
34.00	Ratio of direct medical education costs to total charges (line 32 ÷ line 33)			0.024124	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)			44,060,405	37.00
38.00	Organ acquisition costs (Wkst. D-4, Pt. III, col. 1, line 69)			1,090,438	38.00
39.00	Cost of physicians' services in a teaching hospital (see instructions)			0	39.00
40.00	Primary payer payments (see instructions)			52,764	40.00
41.00	Total Part A reasonable cost (sum of lines 37 through 39 minus line 40)			45,098,079	41.00
Part B Reasonable Cost					
42.00	Reasonable cost (see instructions)			36,225,423	42.00
43.00	Primary payer payments (see instructions)			11,528	43.00
44.00	Total Part B reasonable cost (line 42 minus line 43)			36,213,895	44.00
45.00	Total reasonable cost (sum of lines 41 and 44)			81,311,974	45.00
46.00	Ratio of Part A reasonable cost to total reasonable cost (line 41 ÷ line 45)			0.554630	46.00
47.00	Ratio of Part B reasonable cost to total reasonable cost (line 44 ÷ line 45)			0.445370	47.00
ALLOCATION OF MEDICARE DIRECT GME COSTS BETWEEN PART A AND PART B					
48.00	Total program GME payment (line 31)			6,166,085	48.00
49.00	Part A Medicare GME payment (line 46 x 48) (title XVIII only) (see instructions)			3,419,896	49.00
50.00	Part B Medicare GME payment (line 47 x 48) (title XVIII only) (see instructions)			2,746,189	50.00

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

Provider CCN: 26-0091

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

Worksheet G

Date/Time Prepared:
9/24/2021 7:02 pm

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
CURRENT ASSETS						
1.00	Cash on hand in banks	612,745	0	0	0	1.00
2.00	Temporary investments	0	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	127,048,751	0	0	0	4.00
5.00	Other receivable	9,802,659	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	0	0	0	0	6.00
7.00	Inventory	12,418,482	0	0	0	7.00
8.00	Prepaid expenses	9,026,079	0	0	0	8.00
9.00	Other current assets	216,182,553	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)	375,091,269	0	0	0	11.00
FIXED ASSETS						
12.00	Land	21,583,226	0	0	0	12.00
13.00	Land improvements	10,430,057	0	0	0	13.00
14.00	Accumulated depreciation	-8,857,080	0	0	0	14.00
15.00	Buildings	478,873,774	0	0	0	15.00
16.00	Accumulated depreciation	-304,357,535	0	0	0	16.00
17.00	Leasehold improvements	5,782,271	0	0	0	17.00
18.00	Accumulated depreciation	-3,534,108	0	0	0	18.00
19.00	Fixed equipment	43,629,066	0	0	0	19.00
20.00	Accumulated depreciation	-39,023,556	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	180,282,250	0	0	0	23.00
24.00	Accumulated depreciation	-132,794,187	0	0	0	24.00
25.00	Minor equipment depreciable	1,398,984	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)	253,413,162	0	0	0	30.00
OTHER ASSETS						
31.00	Investments	140,978,171	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	121,913,953	24,714,076	24,661,969	0	34.00
35.00	Total other assets (sum of lines 31-34)	262,892,124	24,714,076	24,661,969	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	891,396,555	24,714,076	24,661,969	0	36.00
CURRENT LIABILITIES						
37.00	Accounts payable	90,022,564	0	0	0	37.00
38.00	Salaries, wages, and fees payable	19,657,135	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	1,131,434	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	0	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	110,811,133	0	0	0	45.00
LONG TERM LIABILITIES						
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	0	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	60,797,268	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	60,797,268	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	171,608,401	0	0	0	51.00
CAPITAL ACCOUNTS						
52.00	General fund balance	719,788,154				52.00
53.00	Specific purpose fund		24,714,076			53.00
54.00	Donor created - endowment fund balance - restricted			24,661,969		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)	719,788,154	24,714,076	24,661,969	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	891,396,555	24,714,076	24,661,969	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 26-0091

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

Worksheet G-1

Date/Time Prepared:
9/24/2021 7:02 pm

		General Fund		Special Purpose Fund		Endowment Fund	
		1.00	2.00	3.00	4.00	5.00	
1.00	Fund balances at beginning of period		521,414,509		19,284,246		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		220,406,021				2.00
3.00	Total (sum of line 1 and line 2)		741,820,530		19,284,246		3.00
4.00	ADDITIONS (CREDIT ADJUSTMENTS)	29,048		5,458,878		133,850	4.00
5.00	CORPORATE OFFICE	0		0		0	5.00
6.00	GAIN ON INVESTMENTS	0		0		1,789,550	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)		29,048		5,458,878		10.00
11.00	Subtotal (line 3 plus line 10)		741,849,578		24,743,124		11.00
12.00	DEDUCTIONS (DEBIT ADJUSTMENTS)	0		29,048		0	12.00
13.00	CORPORATE OFFICE	22,061,424		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)		22,061,424		29,048		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		719,788,154		24,714,076		19.00
		Endowment Fund		Plant Fund			
		6.00	7.00	8.00			
1.00	Fund balances at beginning of period	22,738,569		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)	22,738,569		0			3.00
4.00	ADDITIONS (CREDIT ADJUSTMENTS)		0				4.00
5.00	CORPORATE OFFICE		0				5.00
6.00	GAIN ON INVESTMENTS		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)	1,923,400		0			10.00
11.00	Subtotal (line 3 plus line 10)	24,661,969		0			11.00
12.00	DEDUCTIONS (DEBIT ADJUSTMENTS)		0				12.00
13.00	CORPORATE OFFICE		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)	24,661,969		0			19.00

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES

Provider CCN: 26-0091

Period:
From 01/01/2020
To 12/31/2020Worksheet G-2
Parts I & II
Date/Time Prepared:
9/24/2021 7:02 pm

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
PART I - PATIENT REVENUES					
General Inpatient Routine Services					
1.00	Hospital	120,323,165		120,323,165	1.00
2.00	SUBPROVIDER - IPF	21,826,836		21,826,836	2.00
3.00	SUBPROVIDER - IRF				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)	142,150,001		142,150,001	10.00
Intensive Care Type Inpatient Hospital Services					
11.00	INTENSIVE CARE UNIT	42,784,402		42,784,402	11.00
11.01	PEDIATRIC INTENSIVE CARE UNIT	54,800,937		54,800,937	11.01
11.02	NEONATAL INTENSIVE CARE UNIT	158,154,964		158,154,964	11.02
11.03	INTERMEDIATE CARE UNIT	74,203,817		74,203,817	11.03
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)	329,944,120		329,944,120	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	472,094,121		472,094,121	17.00
18.00	Ancillary services	524,459,188	797,298,049	1,321,757,237	18.00
19.00	Outpatient services	42,522,292	178,139,012	220,661,304	19.00
20.00	RURAL HEALTH CLINIC	0	0	0	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY				22.00
23.00	AMBULANCE SERVICES				23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	NON-REIMBURSABLE	414	5,262,807	5,263,221	27.00
27.01	ORGAN ACQUISITION CHARGES	248,158	9,257	257,415	27.01
27.02	PROFESSIONAL FEES	5,710,217	22,768,717	28,478,934	27.02
27.03	EMPLOYEE CHARGES	11,390,735	27,406,411	38,797,146	27.03
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	1,056,425,125	1,030,884,253	2,087,309,378	28.00
PART II - OPERATING EXPENSES					
29.00	Operating expenses (per Wkst. A, column 3, line 200)		753,326,906		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)		753,326,906		43.00

STATEMENT OF REVENUES AND EXPENSES

Provider CCN: 26-0091

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

Worksheet G-3

Date/Time Prepared:
9/24/2021 7:02 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	2,087,309,378	1.00
2.00	Less contractual allowances and discounts on patients' accounts	1,263,750,041	2.00
3.00	Net patient revenues (line 1 minus line 2)	823,559,337	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	753,326,906	4.00
5.00	Net income from service to patients (line 3 minus line 4)	70,232,431	5.00
OTHER INCOME			
6.00	Contributions, donations, bequests, etc	87,374,064	6.00
7.00	Income from investments	2,295,646	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	135,304	12.00
13.00	Revenue from laundry and linen service	0	13.00
14.00	Revenue from meals sold to employees and guests	2,699,893	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	423,867	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	4,360	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	8,162	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	163,010	20.00
21.00	Rental of vending machines	1,650	21.00
22.00	Rental of hospital space	1,494,526	22.00
23.00	Governmental appropriations	0	23.00
24.00	OTHER INCOME	62,955,584	24.00
24.50	COVID-19 PHE Funding	0	24.50
25.00	Total other income (sum of lines 6-24)	157,556,066	25.00
26.00	Total (line 5 plus line 25)	227,788,497	26.00
27.00	OTHER EXPENSES	7,382,476	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	7,382,476	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	220,406,021	29.00

ANALYSIS OF RENAL DIALYSIS DEPARTMENT COSTS

Provider CCN: 26-0091

Period:

Worksheet I-1

Component CCN: 26-2320

From 01/01/2020
To 12/31/2020Date/Time Prepared:
9/24/2021 7:02 pm

		Renal Dialysis			
		Total Costs	Basis	Statistics	FTEs per 2080 Hours
		1.00	2.00	3.00	4.00
1.00	REGISTERED NURSES	646,007	HOURS OF SERVICE	3,879.14	1.86
2.00	LICENSED PRACTICAL NURSES	0	HOURS OF SERVICE	0.00	0.00
3.00	NURSES AIDES	0	HOURS OF SERVICE	0.00	0.00
4.00	TECHNICIANS	0	HOURS OF SERVICE	0.00	0.00
5.00	SOCIAL WORKERS	0	HOURS OF SERVICE	0.00	0.00
6.00	DIETICIANS	0	HOURS OF SERVICE	0.00	0.00
7.00	PHYSICIANS	0	ACCUMULATED COST		
8.00	NON-PATIENT CARE SALARY	2,572	ACCUMULATED COST		
9.00	SUBTOTAL (SUM OF LINES 1-8)	648,579			
10.00	EMPLOYEE BENEFITS	50,789	SALARY		
11.00	CAPITAL RELATED COSTS-BLDGS. & FIXTURES	0	SQUARE FEET		
12.00	CAPITAL RELATED COSTS-MOV. EQUIP.	0	PERCENTAGE OF TIME		
13.00	MACHINE COSTS & REPAIRS	12,097	PERCENTAGE OF TIME		
14.00	SUPPLIES	4,340	REQUISITIONS		
15.00	DRUGS	0	REQUISITIONS		
16.00	OTHER	1,332,780	ACCUMULATED COST		
17.00	SUBTOTAL (SUM OF LINES 9-16)*	2,048,585			
18.00	CAPITAL RELATED COSTS-BLDGS. & FIXTURES	28,610	SQUARE FEET		
19.00	CAPITAL RELATED COSTS-MOV. EQUIP.	51,408	PERCENTAGE OF TIME		
20.00	EMPLOYEE BENEFITS DEPARTMENT	98,255	SALARY		
21.00	ADMINISTRATIVE & GENERAL	504,802	ACCUMULATED COST		
22.00	MAINT./REPAIRS-OPER-HOUSEKEEPING	106,931	SQUARE FEET		
23.00	MEDICAL EDUCATION PROGRAM COSTS	235,254			
24.00	CENTRAL SERVICE & SUPPLIES	103,292	REQUISITIONS		
25.00	PHARMACY	1,693	REQUISITIONS		
26.00	OTHER ALLOCATED COSTS	116,199	ACCUMULATED COST		
27.00	SUBTOTAL (SUM OF LINES 17-26)*	3,295,029			
28.00	LABORATORY (SEE INSTRUCTIONS)	0	CHARGES	0	
29.00	RESPIRATORY THERAPY (SEE INSTRUCTIONS)	0	CHARGES	0	
30.00	ENDOSCOPY	0	CHARGES	0	
31.00	TOTAL COSTS (SUM OF LINES 27-30)	3,295,029			

* Line 17, column 1 should agree with Worksheet A, column 7 for line 74 or line 94 as appropriate, and line 27, column 1 should agree with Worksheet B, Part I, column 24, less the sum of columns 21 and 22, for line 74 or line 94 as appropriate.

ALLOCATION OF RENAL DEPARTMENT COSTS TO TREATMENT MODALITIES

Provider CCN: 26-0091

Period:

Worksheet I-2

Component CCN: 26-2320

From 01/01/2020
To 12/31/2020Date/Time Prepared:
9/24/2021 7:02 pm

		Capital Related Costs		Direct Patient Care Salary		Renal Dialysis		
		Building	Equipment	RNs	Other	Employee Benefits Department	Drugs	
		1.00	2.00	3.00	4.00	5.00	6.00	
1.00	Total Renal Department Costs	135,541	63,505	646,007	0	149,044	-32,119	1.00
MAINTENANCE								
2.00	Hemodialysis	43,458	20,361	152,495	0	35,182	-7,582	2.00
2.01	AKI-Hemodialysis	0	0	0	0	0	1	2.01
3.00	Intermittent Peritoneal	0	0	0	0	0	0	3.00
3.01	AKI-Intermittent Peritoneal	0	0	0	0	0	0	3.01
TRAINING								
4.00	Hemodialysis	0	0	0	0	0	0	4.00
5.00	Intermittent Peritoneal	0	0	0	0	0	0	5.00
6.00	CAPD	0	0	0	0	0	0	6.00
7.00	CCPD	0	0	0	0	0	0	7.00
HOME								
8.00	Hemodialysis	0	0	18,738	0	4,323	-932	8.00
9.00	Intermittent Peritoneal	0	0	0	0	0	0	9.00
10.00	CAPD	0	0	3,351	0	774	-167	10.00
11.00	CCPD	0	0	148,305	0	34,216	-7,374	11.00
OTHER BILLABLE SERVICES								
12.00	Inpatient Dialysis	92,083	43,144	323,118	0	74,549	-16,065	12.00
13.00	Method II Home Patient	0	0	0	0	0	0	13.00
14.00	ESAs (included in Renal Department)						33,812	14.00
15.00								15.00
16.00	Other	0	0	0	0	0	0	16.00
17.00	Total (sum of lines 2 through 16)	135,541	63,505	646,007	0	149,044	-32,119	17.00
18.00	Medical Educational Program Costs							18.00
19.00	Total Renal Costs (line 17 + line 18)							19.00
		Medical Supplies	Routine Ancillary Services	Subtotal (sum of cols. 1-8)	Overhead	Total (col. 9 + col. 10)		
		7.00	8.00	9.00	10.00	11.00		
1.00	Total Renal Department Costs	107,632	0	1,069,610	1,956,353	3,025,963		1.00
MAINTENANCE								
2.00	Hemodialysis	25,407	0	269,321	492,597	761,918		2.00
2.01	AKI-Hemodialysis	0	0	1	2	3		2.01
3.00	Intermittent Peritoneal	0	0	0	0	0		3.00
3.01	AKI-Intermittent Peritoneal	0	0	0	0	0		3.01
TRAINING								
4.00	Hemodialysis	0	0	0	0	0		4.00
5.00	Intermittent Peritoneal	0	0	0	0	0		5.00
6.00	CAPD	0	0	0	0	0		6.00
7.00	CCPD	0	0	0	0	0		7.00
HOME								
8.00	Hemodialysis	3,122	0	25,251	46,185	71,436		8.00
9.00	Intermittent Peritoneal	0	0	0	0	0		9.00
10.00	CAPD	558	0	4,516	8,260	12,776		10.00
11.00	CCPD	24,709	0	199,856	365,543	565,399		11.00
OTHER BILLABLE SERVICES								
12.00	Inpatient Dialysis	53,836	0	570,665	1,043,766	1,614,431		12.00
13.00	Method II Home Patient	0	0	0	0	0		13.00
14.00	ESAs (included in Renal Department)							14.00
15.00								15.00
16.00	Other	0	0	0	0	0		16.00
17.00	Total (sum of lines 2 through 16)	107,632	0	1,069,610	1,956,353	3,025,963		17.00
18.00	Medical Educational Program Costs					235,254		18.00
19.00	Total Renal Costs (line 17 + line 18)					3,261,217		19.00

DIRECT AND INDIRECT RENAL DIALYSIS COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 26-0091
Component CCN: 26-2320Period:
From 01/01/2020
To 12/31/2020Worksheet I-3
Date/Time Prepared:
9/24/2021 7:02 pm

						Renal Dialysis			
			Capital Related Costs		Direct Patient Care Salary				
			Building (Square Feet)	Equipment (% of Time)	RNs (Hours)	Other (Hours)	Employee Benefits Department (Salary)		
		0	1.00	2.00	3.00	4.00	5.00		
1.00	Total Renal Department Costs		135,541	63,505	646,007	0	149,044	1.00	
MAINTENANCE									
2.00	Hemodialysis		59,260	16,453.00	152,441.00	0.00	36,515	2.00	
2.01	AKI-Hemodialysis		0	0.00	0.00	0.00	0	2.01	
3.00	Intermittent Peritoneal		0	0.00	0.00	0.00	0	3.00	
3.01	AKI-Intermittent Peritoneal		0	0.00	0.00	0.00	0	3.01	
TRAINING									
4.00	Hemodialysis		0	0.00	0.00	0.00	0	4.00	
5.00	Intermittent Peritoneal		0	0.00	0.00	0.00	0	5.00	
6.00	CAPD		0	0.00	0.00	0.00	0	6.00	
7.00	CCPD		0	0.00	0.00	0.00	0	7.00	
HOME									
8.00	Hemodialysis		0	0.00	18,731.00	0.00	4,487	8.00	
9.00	Intermittent Peritoneal		0	0.00	0.00	0.00	0	9.00	
10.00	CAPD		0	0.00	3,350.00	0.00	803	10.00	
11.00	CCPD		0	0.00	148,253.00	0.00	35,512	11.00	
OTHER BILLABLE SERVICES									
12.00	Inpatient Dialysis Treatments	3,103	125,565	34,863.00	323,004.00	0.00	77,372	12.00	
13.00	Method II Home Patient		0	0.00	0.00	0.00	0	13.00	
14.00	ESAs							14.00	
15.00								15.00	
16.00	Other		0	0.00	0.00	0.00	0	16.00	
17.00	Total Statistical Basis		184,825	51,316.00	645,779.00	0.00	154,689	17.00	
18.00	Unit Cost Multiplier (line 1 ÷ line 17)		0.733348	1.237528	1.000353	0.000000	0.963507	18.00	
		Drugs (Requist.)	Medical Supplies (Requist.)	Routine Ancillary Services (Charges)	Subtotal	Overhead (Accum. Cost)			
		6.00	7.00	8.00	9.00	10.00			
1.00	Total Renal Department Costs	-32,119	107,632	0	1,069,610	1,956,353		1.00	
MAINTENANCE									
2.00	Hemodialysis	-9,316	27,301	0				2.00	
2.01	AKI-Hemodialysis	0	0	0				2.01	
3.00	Intermittent Peritoneal	0	0	0				3.00	
3.01	AKI-Intermittent Peritoneal	0	0	0				3.01	
TRAINING									
4.00	Hemodialysis	0	0	0				4.00	
5.00	Intermittent Peritoneal	0	0	0				5.00	
6.00	CAPD	0	0	0				6.00	
7.00	CCPD	0	0	0				7.00	
HOME									
8.00	Hemodialysis	-1,145	3,355	0				8.00	
9.00	Intermittent Peritoneal	0	0	0				9.00	
10.00	CAPD	-205	600	0				10.00	
11.00	CCPD	-9,060	26,551	0				11.00	
OTHER BILLABLE SERVICES									
12.00	Inpatient Dialysis Treatments	-19,739	57,849	0				12.00	
13.00	Method II Home Patient	0	0	0				13.00	
14.00	ESAs							14.00	
15.00								15.00	
16.00	Other	0	0	0				16.00	
17.00	Total Statistical Basis	-39,465	115,656	0		1,069,610		17.00	
18.00	Unit Cost Multiplier (line 1 ÷ line 17)	0.813860	0.930622	0.000000		1.829034		18.00	

COMPUTATION OF AVERAGE COST PER TREATMENT FOR OUTPATIENT RENAL DIALYSIS

Provider CCN: 26-0091

Period:

Worksheet I-4

Component CCN: 26-2320

From 01/01/2020
To 12/31/2020Date/Time Prepared:
9/24/2021 7:02 pm

		Rate 0		Renal Dialysis		
		Number of Total Treatments	Total Cost (from Wkst. I-2, col. 11)	Average Cost of Treatments (col. 2 ÷ col. 1)	Number of Program Treatments	Total Program Expenses (see instructions)
		1.00	2.00	3.00	4.00	5.00
1.00	Maintenance - Hemodialysis	2,002	761,921	380.58	887	337,574
2.00	Maintenance - Peritoneal Dialysis	0	0	0.00	0	0
3.00	Training - Hemodialysis	0	0	0.00	0	0
4.00	Training - Peritoneal Dialysis	0	0	0.00	0	0
5.00	Training - CAPD	0	0	0.00	0	0
6.00	Training - CCPD	0	0	0.00	0	0
7.00	Home Program - Hemodialysis	246	71,436	290.39	0	0
8.00	Home Program - Peritoneal Dialysis	0	0	0.00	0	0
		Patient Weeks			Patient Weeks	
		1.00	2.00	3.00	4.00	5.00
9.00	Home Program - CAPD	6	12,776	2,129.33	0	0
10.00	Home Program - CCPD	279	565,399	2,026.52	94	190,493
11.00	Totals (sum of lines 1 through 8, cols. 1 and 4) (sum of lines 1 through 10, cols. 2, 5, and 6) (see instruction)	2,248	1,411,532		887	528,067
12.00	Total treatments (sum of lines 1 through 8 plus (sum of lines 9 and 10 times 3)) (see instruction)	3,103				
		Total Program Payment	Average Payment Rate (col. 6 ÷ col. 4)			
		6.00	7.00			
1.00	Maintenance - Hemodialysis	272,848	307.61			
2.00	Maintenance - Peritoneal Dialysis	0	0.00			
3.00	Training - Hemodialysis	0	0.00			
4.00	Training - Peritoneal Dialysis	0	0.00			
5.00	Training - CAPD	0	0.00			
6.00	Training - CCPD	0	0.00			
7.00	Home Program - Hemodialysis	0	0.00			
8.00	Home Program - Peritoneal Dialysis	0	0.00			
		6.00	7.00			
9.00	Home Program - CAPD	0	0.00			
10.00	Home Program - CCPD	69,874	743.34			
11.00	Totals (sum of lines 1 through 8, cols. 1 and 4) (sum of lines 1 through 10, cols. 2, 5, and 6) (see instruction)	342,722				
12.00	Total treatments (sum of lines 1 through 8 plus (sum of lines 9 and 10 times 3)) (see instruction)					

CALCULATION OF REIMBURSABLE BAD DEBTS - TITLE XVIII - PART B		Provider CCN: 26-0091	Period: From 01/01/2020 To 12/31/2020	Worksheet I-5 Date/Time Prepared: 9/24/2021 7:02 pm
		1.00	2.00	
PART I - CALCULATION OF REIMBURSABLE BAD DEBTS - TITLE XVIII - PART B				
1.00	Total expenses related to care of program beneficiaries (see instructions)	528,067		1.00
2.00	Total payment due (from Wkst. I-4, col. 6, line 11) (see instructions)	342,722	334,704	2.00
2.01	Total payment due (from Wkst. I-4, col. 6.01, line 11) (see instructions)			2.01
2.02	Total payment due (from Wkst. I-4, col. 6.02, line 11) (see instructions)			2.02
2.03	Total payment due (see instructions)	342,722	334,704	2.03
2.04	Outlier payments	960		2.04
3.00	Deductibles billed to Medicare (Part B) patients (see instructions)	8	8	3.00
3.01	Deductibles billed to Medicare (Part B) patients (see instructions)			3.01
3.02	Deductibles billed to Medicare (Part B) patients (see instructions)			3.02
3.03	Total deductibles billed to Medicare (Part B) patients (see instructions)	8	8	3.03
4.00	Coinsurance billed to Medicare (Part B) patients	68,541	66,938	4.00
4.01	Coinsurance billed to Medicare (Part B) patients (see instructions)			4.01
4.02	Coinsurance billed to Medicare (Part B) patients (see instructions)			4.02
4.03	Total coinsurance billed to Medicare (Part B) patients (see instructions)	68,541	66,938	4.03
5.00	Bad debts for deductibles and coinsurance, net of bad debt recoveries	5,138	5,138	5.00
5.01	Transition period 1 (75-25%) bad debts for deductibles and coinsurance net of bad debt recoveries for services rendered on or after 1/1/2011 but before 1/1/2012			5.01
5.02	Transition period 2 (50-50%) bad debts for deductibles and coinsurance net of bad debt recoveries for services rendered on or after 1/1/2012 but before 1/1/2013			5.02
5.03	Transition period 3 (25-75%) bad debts for deductibles and coinsurance net of bad debt recoveries for services rendered on or after 1/1/2013 but before 1/1/2014			5.03
5.04	100% PPS bad debts for deductibles and coinsurance net of bad debt recoveries for services rendered on or after 1/1/2014	0	0	5.04
5.05	Allowable bad debts (sum of lines 5 through line 5.04)	5,138	5,138	5.05
6.00	Adjusted reimbursable bad debts (see instructions)	3,340		6.00
7.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	0		7.00
8.00	Net deductibles and coinsurance billed to Medicare (Part B) patients (see instructions)	0	61,808	8.00
9.00	Program payment (see instructions)	0	267,757	9.00
10.00	Unrecovered from Medicare (Part B) patients (see instructions)			10.00
11.00	Reimbursable bad debts (see instructions) (transfer to Worksheet E, Part B, line 33)	3,340		11.00
PART II - CALCULATION OF FACILITY SPECIFIC COMPOSITE COST PERCENTAGE				
12.00	Total allowable expenses (see instructions)	1,445,344		12.00
13.00	Total composite costs (from Wkst. I-4, col. 2, line 11)	1,411,532		13.00
14.00	Facility specific composite cost percentage (line 13 divided by line 12)	0.976606		14.00

CALCULATION OF CAPITAL PAYMENT		Provider CCN: 26-0091	Period: From 01/01/2020 To 12/31/2020	Worksheet L Parts I-III Date/Time Prepared: 9/24/2021 7:02 pm
		Title XVIII	Hospital	PPS
		1.00		
PART I - FULLY PROSPECTIVE METHOD				
CAPITAL FEDERAL AMOUNT				
1.00	Capital DRG other than outlier		2,186,234	1.00
1.01	Model 4 BPCI Capital DRG other than outlier		0	1.01
2.00	Capital DRG outlier payments		42,761	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)		309.10	3.00
4.00	Number of interns & residents (see instructions)		178.23	4.00
5.00	Indirect medical education percentage (see instructions)		17.67	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)		386,308	6.00
7.00	Percentage of SSI recipient patient days to Medicare Part A patient days (Worksheet E, part A line 30) (see instructions)		9.06	7.00
8.00	Percentage of Medicaid patient days to total days (see instructions)		52.91	8.00
9.00	Sum of lines 7 and 8		61.97	9.00
10.00	Allowable disproportionate share percentage (see instructions)		13.37	10.00
11.00	Disproportionate share adjustment (see instructions)		292,299	11.00
12.00	Total prospective capital payments (see instructions)		2,907,602	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