

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION
AND SETTLEMENT SUMMARY

Provider CCN: 26-0104

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

Worksheet S
Parts I-III
Date/Time Prepared:
7/30/2021 8:44 am

PART I - COST REPORT STATUS

Provider use only	1. ☒ Electronically prepared cost report	Date: 7/30/2021	Time: 8:44 am
	2. ☐ Manually prepared cost report		
	3. ☐ If this is an amended report enter the number of times the provider resubmitted this cost report		
	4. ☒ Medicare Utilization. Enter "F" for full or "L" for low.		
Contractor use only	5. ☒ Cost Report Status (1) As Submitted (2) Settled without Audit (3) Settled with Audit (4) Reopened (5) Amended	6. Date Received: 7. Contractor No. 8. ☒ Initial Report for this Provider CCN 9. ☒ Final Report for this Provider CCN	10. NPR Date: 11. Contractor's Vendor Code: 4 12. ☐ If line 5, column 1 is 4: Enter number of times reopened = 0-9.

PART II - CERTIFICATION

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

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

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by SSM HEALTH DEPAUL HOSPITAL (26-0104) for the cost reporting period beginning 01/01/2020 and ending 12/31/2020 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

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

(Signed)

Officer or Administrator of Provider(s)

Title

Date

Cost Center Description		Title V	Title XVIII		HIT	Title XIX	
			Part A	Part B			
		1.00	2.00	3.00	4.00	5.00	
	PART III - SETTLEMENT SUMMARY						
1.00	Hospital	0	1,802,562	-73,049	0	0	1.00
2.00	Subprovider - IPF	0	39,551	59		0	2.00
3.00	Subprovider - IRF	0	0	0		0	3.00
5.00	Swing Bed - SNF	0	0	0		0	5.00
6.00	Swing Bed - NF	0				0	6.00
7.00	SKILLED NURSING FACILITY	0	71,735	0		0	7.00
200.00	Total	0	1,913,848	-72,990	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: 26-0104		Period: From 01/01/2020 To 12/31/2020		Worksheet S-2 Part I Date/Time Prepared: 7/30/2021 8:44 am		
1.00		2.00		3.00		4.00				
Hospital and Hospital Health Care Complex Address:										
1.00	Street: 12303 DEPAUL DRIVE			PO Box:				1.00		
2.00	City: BRIDGETON			State: MO		Zip Code: 63044		County: ST. LOUIS		
		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 DEPAUL HOSPITAL	260104	41180	1	01/01/1966	N	P	O
4.00	Subprovider - IPF		SSM HEALTH DEPAUL HOSPITAL	26S104	41180	4	07/01/1985	N	P	O
5.00	Subprovider - IRF									
6.00	Subprovider - (Other)									
7.00	Swing Beds - SNF									
8.00	Swing Beds - NF									
9.00	Hospital-Based SNF		SSM HEALTH DEPAUL HOSPITAL-ANN HOUSE	265842	41180		09/11/2012	N	P	P
10.00	Hospital-Based NF									
11.00	Hospital-Based OLTC									
12.00	Hospital-Based HHA									
13.00	Separately Certified ASC									
14.00	Hospital-Based Hospice									
15.00	Hospital-Based Health Clinic - RHC									
16.00	Hospital-Based Health Clinic - FQHC									
17.00	Hospital-Based (CMHC) I									
18.00	Renal Dialysis									
19.00	Other									
							From:	To:		
							1.00	2.00		
20.00	Cost Reporting Period (mm/dd/yyyy)						01/01/2020		12/31/2020	
21.00	Type of Control (see instructions)						1			
							1.00	2.00	3.00	
Inpatient PPS Information										
22.00	Does this facility qualify and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.106(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no.					Y	N			
22.01	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			
22.02	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			
22.03	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	
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			

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

Provider CCN: 26-0104

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From 01/01/2020
To 12/31/2020Worksheet S-2
Part I
Date/Time Prepared:
7/30/2021 8:44 am

		In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of State Medicaid paid days	Out-of State Medicaid eligible unpaid	Medicaid HMO days	Other Medicaid days	
		1.00	2.00	3.00	4.00	5.00	6.00	
24.00	If this provider is an IPPS hospital, enter the in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.	15,473	3,421	640	834	7,363	329	24.00
25.00	If this provider is an IRF, enter the in-state Medicaid paid days in column 1, the in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5.	0	0	0	0	0		25.00
						Urban/Rural S	Date of Geogr	
						1.00	2.00	
26.00	Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter "1" for urban or "2" for rural.					1		26.00
27.00	Enter your standard geographic classification (not wage) status at the end of the cost reporting period. Enter in column 1, "1" for urban or "2" for rural. If applicable, enter the effective date of the geographic reclassification in column 2.					1		27.00
35.00	If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period.					0		35.00
						Beginning:	Ending:	
						1.00	2.00	
36.00	Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.							36.00
37.00	If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status is in effect in the cost reporting period.					0		37.00
37.01	Is this hospital a former MDH that is eligible for the MDH transitional payment in accordance with FY 2016 OPPS final rule? Enter "Y" for yes or "N" for no. (see instructions)							37.01
38.00	If line 37 is 1, enter the beginning and ending dates of MDH status. If line 37 is greater than 1, subscript this line for the number of periods in excess of one and enter subsequent dates.							38.00
						Y/N	Y/N	
						1.00	2.00	
39.00	Does this facility qualify for the inpatient hospital payment adjustment for low volume hospitals in accordance with 42 CFR §412.101(b)(2)(i), (ii), or (iii)? Enter in column 1 "Y" for yes or "N" for no. Does the facility meet the mileage requirements in accordance with 42 CFR 412.101(b)(2)(i), (ii), or (iii)? Enter in column 2 "Y" for yes or "N" for no. (see instructions)					N	N	39.00
40.00	Is this hospital subject to the HAC program reduction adjustment? Enter "Y" for yes or "N" for no in column 1, for discharges prior to October 1. Enter "Y" for yes or "N" for no in column 2, for discharges on or after October 1. (see instructions)					N	Y	40.00
						V	XVIII	XIX
						1.00	2.00	3.00
Prospective Payment System (PPS)-Capital								
45.00	Does this facility qualify and receive Capital payment for disproportionate share in accordance with 42 CFR Section §412.320? (see instructions)					N	Y	N
46.00	Is this facility eligible for additional payment exception for extraordinary circumstances pursuant to 42 CFR §412.348(f)? If yes, complete Wkst. L, Pt. III and Wkst. L-1, Pt. I through Pt. III.					N	N	N
47.00	Is this a new hospital under 42 CFR §412.300(b) PPS capital? Enter "Y" for yes or "N" for no.					N	N	N
48.00	Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.					N	N	N
Teaching Hospitals								
56.00	Is this a hospital involved in training residents in approved GME programs? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", are you impacted by CR 11642 (or subsequent CR), MA GME payment reduction? Enter "Y" for yes or "N" for no in column 2.					Y	Y	
57.00	If line 56 is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y" did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If column 2 is "N", complete Wkst. D, Parts III & IV and D-2, Pt. II, if applicable.					N		
58.00	If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, chapter 21, §2148? If yes, complete Wkst. D-5.					N		
59.00	Are costs claimed on line 100 of Worksheet A? If yes, complete Wkst. D-2, Pt. I.					N		

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		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	
		Y/N	IME	Direct GME	IME	Direct GME	
		1.00	2.00	3.00	4.00	5.00	
61.00	Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions)	N			0.00	0.00	61.00
61.01	Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions)						61.01
61.02	Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions)						61.02
61.03	Enter the base line FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions)						61.03
61.04	Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period.(see instructions).						61.04
61.05	Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions)						61.05
61.06	Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)						61.06
		Program Name		Program Code	Unweighted IME FTE Count	Unweighted Direct GME FTE Count	
		1.00		2.00	3.00	4.00	
61.10	Of the FTEs in line 61.05, specify each new program specialty, if any, and the number of FTE residents for each new program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count.				0.00	0.00	61.10
61.20	Of the FTEs in line 61.05, specify each expanded program specialty, if any, and the number of FTE residents for each expanded program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count.				0.00	0.00	61.20
							1.00
ACA Provisions Affecting the Health Resources and Services Administration (HRSA)							
62.00	Enter the number of FTE residents that your hospital trained in this cost reporting period for which your hospital received HRSA PCRE funding (see instructions)						0.00
62.01	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

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			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	14.53	0.000000	66.00	
		Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))	
		1.00	2.00	3.00	4.00	5.00	
67.00	Enter in column 1, the program name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)			0.00	0.00	0.000000	67.00

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

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				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			
110.00	Did this hospital participate in the Rural Community Hospital Demonstration project (§410A Demonstration) for the current cost reporting period? Enter "Y" for yes or "N" for no. If yes, complete Worksheet E, Part A, lines 200 through 218, and Worksheet E-2, lines 200 through 215, as applicable.	N				110.00	
				1.00			
111.00	If this facility qualifies as a CAH, did it participate in the Frontier Community Health Integration Project (FCHIP) demonstration for this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If the response to column 1 is Y, enter the integration prong of the FCHIP demo in which this CAH is participating in column 2. Enter all that apply: "A" for Ambulance services; "B" for additional beds; and/or "C" for tele-health services.	N				111.00	
				1.00			
112.00	Did this hospital participate in the Pennsylvania Rural Health Model demonstration for any portion of the current cost reporting period? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2, the date the hospital began participating in the demonstration. In column 3, enter the date the hospital ceased participation in the demonstration, if applicable.	N				112.00	
<u>Miscellaneous Cost Reporting Information</u>							
115.00	Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in column 1. If column 1 is yes, enter the method used (A, B, or E only) in column 2. If column 2 is "E", enter in column 3 either "93" percent for short term hospital or "98" percent for long term care (includes psychiatric, rehabilitation and long term hospitals providers) based on the definition in CMS Pub.15-1, chapter 22, §2208.1.	N				115.00	
116.00	Is this facility classified as a referral center? Enter "Y" for yes or "N" for no.	N				116.00	
117.00	Is this facility legally-required to carry malpractice insurance? Enter "Y" for yes or "N" for no.	Y				117.00	
118.00	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.	1				118.00	
		Premiums	Losses	Insurance			
		1.00	2.00	3.00			
118.01	List amounts of malpractice premiums and paid losses:	446,293		10,000		118.01	
				1.00			
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein.	N				118.02	
119.00	DO NOT USE THIS LINE					119.00	
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 1, "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2, "Y" for yes or "N" for no.	N		N		120.00	
121.00	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter "Y" for yes or "N" for no.	Y				121.00	
122.00	Does the cost report contain healthcare related taxes as defined in §1903(w)(3) of the Act? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2 the Worksheet A line number where these taxes are included.	Y		5.00		122.00	
<u>Transplant Center Information</u>							
125.00	Does this facility operate a transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.	N				125.00	
126.00	If this is a Medicare certified kidney transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					126.00	
127.00	If this is a Medicare certified heart transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					127.00	
128.00	If this is a Medicare certified liver transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					128.00	
129.00	If this is a Medicare certified lung transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					129.00	

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 26-0104		Period: From 01/01/2020 To 12/31/2020		Worksheet S-2 Part I Date/Time Prepared: 7/30/2021 8:44 am	
		1.00		2.00			
130.00	If this is a Medicare certified pancreas transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					130.00	
131.00	If this is a Medicare certified intestinal transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					131.00	
132.00	If this is a Medicare certified islet transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					132.00	
133.00	Removed and reserved					133.00	
134.00	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.					134.00	
All Providers							
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)	Y		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 CORP	Contractor's Name: WPS		Contractor's Number: 05301		141.00	
142.00	Street: 10101 WOODFIELD LANE	PO Box: PO BOX 86		Zip Code: 63132		142.00	
143.00	City: ST. LOUIS	State: MO				143.00	
						1.00	
144.00	Are provider based physicians' costs included in Worksheet A?			Y		144.00	
						1.00	
145.00	If costs for renal services are claimed on Wkst. A, line 74, are the costs for inpatient services only? Enter "Y" for yes or "N" for no in column 1. If column 1 is no, does the dialysis facility include Medicare utilization for this cost reporting period? Enter "Y" for yes or "N" for no in column 2.	Y				145.00	
146.00	Has the cost allocation methodology changed from the previously filed cost report? Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, chapter 40, §4020) If yes, enter the approval date (mm/dd/yyyy) in column 2.	N				146.00	
						1.00	
147.00	Was there a change in the statistical basis? Enter "Y" for yes or "N" for no.			N		147.00	
148.00	Was there a change in the order of allocation? Enter "Y" for yes or "N" for no.			N		148.00	
149.00	Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no.			N		149.00	
		Part A		Part B		Title V	
		1.00		2.00		3.00	
						Title XIX	
						4.00	
Does this facility contain a provider that qualifies for an exemption from the application of the lower of costs or charges? Enter "Y" for yes or "N" for no for each component for Part A and Part B. (See 42 CFR §413.13)							
155.00	Hospital	N		N		N	
156.00	Subprovider - IPF	N		N		N	
157.00	Subprovider - IRF	N		N		N	
158.00	SUBPROVIDER						
159.00	SNF	N		N		N	
160.00	HOME HEALTH AGENCY	N		N		N	
161.00	CMHC	N		N		N	
						1.00	
Multicampus							
165.00	Is this hospital part of a Multicampus hospital that has one or more campuses in different CBSAs? Enter "Y" for yes or "N" for no.			N		165.00	
		Name		County		State	
		0		1.00		2.00	
						Zip Code	
						3.00	
						CBSA	
						4.00	
						FTE/Campus	
						5.00	
166.00	If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions)					0.00	
						1.00	
Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act							
167.00	Is this provider a meaningful user under §1886(n)? Enter "Y" for yes or "N" for no.			Y		167.00	
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)					168.00	
168.01	If this provider is a CAH and is not a meaningful user, does this provider qualify for a hardship exception under §413.70(a)(6)(ii)? Enter "Y" for yes or "N" for no. (see instructions)					168.01	
169.00	If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)			9.99		169.00	

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 26-0104	Period: From 01/01/2020 To 12/31/2020	Worksheet S-2 Part I Date/Time Prepared: 7/30/2021 8:44 am
			Beginning 1.00	Ending 2.00
170.00	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)			170.00
			1.00	2.00
171.00	If line 167 is "Y", does this provider have any days for individuals enrolled in section 1876 Medicare cost plans reported on Wkst. S-3, Pt. I, line 2, col. 6? Enter "Y" for yes and "N" for no in column 1. If column 1 is yes, enter the number of section 1876 Medicare days in column 2. (see instructions)		N	0171.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 26-0104		Period: From 01/01/2020 To 12/31/2020		Worksheet S-2 Part II Date/Time Prepared: 7/30/2021 8:44 am	
		Y/N	Date				
		1.00	2.00				
General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format.							
COMPLETED BY ALL HOSPITALS							
Provider Organization and Operation							
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)	N					1.00
		Y/N	Date	V/I			
		1.00	2.00	3.00			
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.	N					2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)	N					3.00
		Y/N	Type	Date			
		1.00	2.00	3.00			
Financial Data and Reports							
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	Y	A				4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.	N					5.00
		Y/N	Legal Oper.				
		1.00	2.00				
Approved Educational Activities							
6.00	Column 1: Are costs claimed for nursing school? Column 2: If yes, is the provider is the legal operator of the program?	Y	Y				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.	Y					10.00
11.00	Are GME cost directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions.	N					11.00
		Y/N					
		1.00					
Bad Debts							
12.00	Is the provider seeking reimbursement for bad debts? If yes, see instructions.	Y					12.00
13.00	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.	N					13.00
14.00	If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.	N					14.00
Bed Complement							
15.00	Did total beds available change from the prior cost reporting period? If yes, see instructions.	N					15.00
		Part A		Part B			
		Y/N	Date	Y/N	Date		
		1.00	2.00	3.00	4.00		
PS&R Data							
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)	Y	05/18/2021	Y	05/18/2021		16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	N		N			17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N		N			18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		N			19.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE

Provider CCN: 26-0104

Period:
From 01/01/2020
To 12/31/2020Worksheet S-2
Part II
Date/Time Prepared:
7/30/2021 8:44 am

		Description	Y/N	Y/N	
		0	1.00	3.00	
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:		N	N	20.00
		Y/N	Date	Y/N	Date
		1.00	2.00	3.00	4.00
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N	N		21.00
				1.00	
COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)					
Capital Related Cost					
22.00	Have assets been relifed for Medicare purposes? If yes, see instructions		N		22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.		N		23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions		N		24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.		N		25.00
26.00	Were assets subject to Sec.2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.		N		26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.		N		27.00
Interest Expense					
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.		N		28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions		N		29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.		N		30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.		N		31.00
Purchased Services					
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.		N		32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.		N		33.00
Provider-Based Physicians					
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.		N		34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.		N		35.00
		Y/N	Date		
		1.00	2.00		
Home Office Costs					
36.00	Were home office costs claimed on the cost report?		Y		36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.		Y		37.00
38.00	If line 36 is yes, was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.		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.	PATRICIA	RACHELL		41.00
42.00	Enter the employer/company name of the cost report preparer.	BKD, LLP			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	314.231.5544	PRACHELL@BKD.COM		43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE

Provider CCN: 26-0104

Period:
From 01/01/2020
To 12/31/2020Worksheet S-2
Part II
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		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.	MANAGING DIRECTOR	41.00
42.00	Enter the employer/company name of the cost report preparer.		42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.		43.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 26-0104

Period:
From 01/01/2020
To 12/31/2020Worksheet S-3
Part I
Date/Time Prepared:
7/30/2021 8:44 am

Component	Worksheet A Line Number	No. of Beds	Bed Days Available	CAH Hours	I/P Days / O/P Visits / Trips	
					Title V	
					5.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30.00	350	128,100	0.00	0	1.00
2.00 HMO and other (see instructions)						2.00
3.00 HMO IPF Subprovider						3.00
4.00 HMO IRF Subprovider						4.00
5.00 Hospital Adults & Peds. Swing Bed SNF					0	5.00
6.00 Hospital Adults & Peds. Swing Bed NF					0	6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)		350	128,100	0.00	0	7.00
8.00 INTENSIVE CARE UNIT	31.00	70	25,620	0.00	0	8.00
9.00 CORONARY CARE UNIT						9.00
10.00 BURN INTENSIVE CARE UNIT						10.00
11.00 SURGICAL INTENSIVE CARE UNIT						11.00
12.00 OTHER SPECIAL CARE (SPECIFY)						12.00
13.00 NURSERY	43.00				0	13.00
14.00 Total (see instructions)		420	153,720	0.00	0	14.00
15.00 CAH visits					0	15.00
16.00 SUBPROVIDER - IPF	40.00	25	9,150		0	16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY	44.00	52	19,032		0	19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY						22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
24.10 HOSPICE (non-distinct part)	30.00					24.10
25.00 CMHC - CMHC						25.00
26.00 RURAL HEALTH CLINIC						26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	26.25
27.00 Total (sum of lines 14-26)		497				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: 26-0104

Period:
From 01/01/2020
To 12/31/2020Worksheet S-3
Part I
Date/Time Prepared:
7/30/2021 8:44 am

Component		I/P Days / O/P Visits / Trips			Full Time Equivalents	
		Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll
		6.00	7.00	8.00	9.00	10.00
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	18,233	12,995	77,645		1.00
2.00	HMO and other (see instructions)	22,724	12,258			2.00
3.00	HMO IPF Subprovider	465	169			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)	18,233	12,995	77,645		7.00
8.00	INTENSIVE CARE UNIT	5,446	2,344	16,643		8.00
9.00	CORONARY CARE UNIT					9.00
10.00	BURN INTENSIVE CARE UNIT					10.00
11.00	SURGICAL INTENSIVE CARE UNIT					11.00
12.00	OTHER SPECIAL CARE (SPECIFY)					12.00
13.00	NURSERY		134	1,965		13.00
14.00	Total (see instructions)	23,679	15,473	96,253	14.53	1,606.24
15.00	CAH visits	0	0	0		15.00
16.00	SUBPROVIDER - IPF	1,449	1,487	4,544	0.00	32.30
17.00	SUBPROVIDER - IRF					17.00
18.00	SUBPROVIDER					18.00
19.00	SKILLED NURSING FACILITY	3,824	11,241	16,044	0.00	74.28
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
27.00	Total (sum of lines 14-26)				14.53	1,712.82
28.00	Observation Bed Days		722	8,536		28.00
29.00	Ambulance Trips	0				29.00
30.00	Employee discount days (see instruction)			1,237		30.00
31.00	Employee discount days - IRF			0		31.00
32.00	Labor & delivery days (see instructions)	0	329	436		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: 26-0104

Period:
From 01/01/2020
To 12/31/2020Worksheet S-3
Part I
Date/Time Prepared:
7/30/2021 8:44 am

Component	Full Time Equivalents	Discharges			Total All Patients	
	Nonpaid Workers	Title V	Title XVIII	Title XIX		
	11.00	12.00	13.00	14.00	15.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)		0	4,171	2,869	20,229	1.00
2.00 HMO and other (see instructions)			3,649	2,428		2.00
3.00 HMO IPF Subprovider				42		3.00
4.00 HMO IRF Subprovider				0		4.00
5.00 Hospital Adults & Peds. Swing Bed SNF						5.00
6.00 Hospital Adults & Peds. Swing Bed NF						6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)						7.00
8.00 INTENSIVE CARE UNIT						8.00
9.00 CORONARY CARE UNIT						9.00
10.00 BURN INTENSIVE CARE UNIT						10.00
11.00 SURGICAL INTENSIVE CARE UNIT						11.00
12.00 OTHER SPECIAL CARE (SPECIFY)						12.00
13.00 NURSERY						13.00
14.00 Total (see instructions)	0.00	0	4,171	2,869	20,229	14.00
15.00 CAH visits						15.00
16.00 SUBPROVIDER - IPF	0.00	0	199	258	856	16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY	0.00					19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY						22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
24.10 HOSPICE (non-distinct part)						24.10
25.00 CMHC - CMHC						25.00
26.00 RURAL HEALTH CLINIC						26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER	0.00					26.25
27.00 Total (sum of lines 14-26)	0.00					27.00
28.00 Observation Bed Days						28.00
29.00 Ambulance Trips						29.00
30.00 Employee discount days (see instruction)						30.00
31.00 Employee discount days - IRF						31.00
32.00 Labor & delivery days (see instructions)						32.00
32.01 Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00 LTCH non-covered days			0			33.00
33.01 LTCH site neutral days and discharges			0			33.01

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 26-0104

Period:
From 01/01/2020
To 12/31/2020Worksheet S-3
Part II
Date/Time Prepared:
7/30/2021 8:44 am

		Wkst. A Line Number	Amount Reported	Reclassificat ion of Salaries (from Wkst. A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
	PART II - WAGE DATA							
	SALARIES							
1.00	Total salaries (see instructions)	200.00	128,216,458	0	128,216,458	3,562,667.11	35.99	1.00
2.00	Non-physician anesthetist Part A		0	0	0	0.00	0.00	2.00
3.00	Non-physician anesthetist Part B		0	0	0	0.00	0.00	3.00
4.00	Physician-Part A - Administrative		322,214	0	322,214	2,664.00	120.95	4.00
4.01	Physicians - Part A - Teaching		0	0	0	0.00	0.00	4.01
5.00	Physician and Non Physician-Part B		4,205,411	0	4,205,411	31,703.51	132.65	5.00
6.00	Non-physician-Part B for hospital-based RHC and FQHC services		0	0	0	0.00	0.00	6.00
7.00	Interns & residents (in an approved program)	21.00	1,117,273	0	1,117,273	33,986.32	32.87	7.00
7.01	Contracted interns and residents (in an approved programs)		0	0	0	0.00	0.00	7.01
8.00	Home office and/or related organization personnel		0	0	0	0.00	0.00	8.00
9.00	SNF	44.00	2,464,093	0	2,464,093	154,498.97	15.95	9.00
10.00	Excluded area salaries (see instructions)		5,603,647	-2,833,164	2,770,483	81,157.40	34.14	10.00
	OTHER WAGES & RELATED COSTS							
11.00	Contract labor: Direct Patient Care		19,042,679	0	19,042,679	313,116.79	60.82	11.00
12.00	Contract labor: Top level management and other management and administrative services		0	0	0	0.00	0.00	12.00
13.00	Contract labor: Physician-Part A - Administrative		628,093	0	628,093	4,006.00	156.79	13.00
14.00	Home office and/or related organization salaries and wage-related costs		0	0	0	0.00	0.00	14.00
14.01	Home office salaries		25,897,432	0	25,897,432	651,264.36	39.76	14.01
14.02	Related organization salaries		0	0	0	0.00	0.00	14.02
15.00	Home office: Physician Part A - Administrative		0	0	0	0.00	0.00	15.00
16.00	Home office and Contract Physicians Part A - Teaching		0	0	0	0.00	0.00	16.00
16.01	Home office Physicians Part A - Teaching		0	0	0	0.00	0.00	16.01
16.02	Home office contract Physicians Part A - Teaching		0	0	0	0.00	0.00	16.02
	WAGE-RELATED COSTS							
17.00	Wage-related costs (core) (see instructions)		49,725,379	0	49,725,379			17.00
18.00	Wage-related costs (other) (see instructions)							18.00
19.00	Excluded areas		3,032,738	0	3,032,738			19.00
20.00	Non-physician anesthetist Part A		0	0	0			20.00
21.00	Non-physician anesthetist Part B		0	0	0			21.00
22.00	Physician Part A - Administrative		126,952	0	126,952			22.00
22.01	Physician Part A - Teaching		0	0	0			22.01
23.00	Physician Part B		1,656,932	0	1,656,932			23.00
24.00	Wage-related costs (RHC/FQHC)		0	0	0			24.00
25.00	Interns & residents (in an approved program)		397,749	0	397,749			25.00
25.50	Home office wage-related (core)		9,897,368	0	9,897,368			25.50
25.51	Related organization wage-related (core)		0	0	0			25.51
25.52	Home office: Physician Part A - Administrative - wage-related (core)		0	0	0			25.52

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 26-0104

Period:
From 01/01/2020
To 12/31/2020Worksheet S-3
Part II
Date/Time Prepared:
7/30/2021 8:44 am

		Wkst. A Line Number	Amount Reported	Reclassificat ion of Salaries (from Wkst. A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
25.53	Home office: Physicians Part A - Teaching - wage-related (core)		0	0	0			25.53
OVERHEAD COSTS - DIRECT SALARIES								
26.00	Employee Benefits Department	4.00	1,501,825	0	1,501,825	9,489.94	158.25	26.00
27.00	Administrative & General	5.00	13,900,042	-355,002	13,545,040	355,965.77	38.05	27.00
28.00	Administrative & General under contract (see inst.)		1,206,153	0	1,206,153	12,666.89	95.22	28.00
29.00	Maintenance & Repairs	6.00	0	0	0	0.00	0.00	29.00
30.00	Operation of Plant	7.00	1,672,546	0	1,672,546	55,440.57	30.17	30.00
31.00	Laundry & Linen Service	8.00	125,714	0	125,714	8,000.76	15.71	31.00
32.00	Housekeeping	9.00	2,483,707	0	2,483,707	159,425.61	15.58	32.00
33.00	Housekeeping under contract (see instructions)		258,210	0	258,210	8,762.00	29.47	33.00
34.00	Dietary	10.00	2,491,789	-1,496,422	995,367	61,258.18	16.25	34.00
35.00	Dietary under contract (see instructions)		563,471	0	563,471	18,934.00	29.76	35.00
36.00	Cafeteria	11.00	0	1,496,422	1,496,422	92,201.58	16.23	36.00
37.00	Maintenance of Personnel	12.00	0	0	0	0.00	0.00	37.00
38.00	Nursing Administration	13.00	2,862,263	0	2,862,263	66,310.50	43.16	38.00
39.00	Central Services and Supply	14.00	330,237	355,002	685,239	36,070.91	19.00	39.00
40.00	Pharmacy	15.00	5,227,792	61,574	5,289,366	123,810.41	42.72	40.00
41.00	Medical Records & Medical Records Library	16.00	311,702	0	311,702	16,674.26	18.69	41.00
42.00	Social Service	17.00	417,607	0	417,607	12,734.01	32.79	42.00
43.00	Other General Service	18.00	0	0	0	0.00	0.00	43.00

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 26-0104

Period:
From 01/01/2020
To 12/31/2020Worksheet S-3
Part III
Date/Time Prepared:
7/30/2021 8:44 am

	Worksheet A Line Number	Amount Reported	Reclassificat ion of Salaries (from Worksheet A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
	1.00	2.00	3.00	4.00	5.00	6.00	
PART III - HOSPITAL WAGE INDEX SUMMARY							
1.00	Net salaries (see instructions)	124,921,608	0	124,921,608	3,537,340.17	35.32	1.00
2.00	Excluded area salaries (see instructions)	8,067,740	-2,833,164	5,234,576	235,656.37	22.21	2.00
3.00	Subtotal salaries (line 1 minus line 2)	116,853,868	2,833,164	119,687,032	3,301,683.80	36.25	3.00
4.00	Subtotal other wages & related costs (see inst.)	45,568,204	0	45,568,204	968,387.15	47.06	4.00
5.00	Subtotal wage-related costs (see inst.)	59,749,699	0	59,749,699	0.00	49.92	5.00
6.00	Total (sum of lines 3 thru 5)	222,171,771	2,833,164	225,004,935	4,270,070.95	52.69	6.00
7.00	Total overhead cost (see instructions)	33,353,058	61,574	33,414,632	1,037,745.39	32.20	7.00

HOSPITAL WAGE RELATED COSTS

Provider CCN: 26-0104

Period:
From 01/01/2020
To 12/31/2020Worksheet S-3
Part IV
Date/Time Prepared:
7/30/2021 8:44 am

		Amount Reported	
		1.00	
PART IV - WAGE RELATED COSTS			
Part A - Core List			
RETIREMENT COST			
1.00	401K Employer Contributions	2,292,580	1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution	0	2.00
3.00	Nonqualified Defined Benefit Plan Cost (see instructions)	8,044,737	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)	21,992,999	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	8,758,323	9.00
10.00	Dental, Hearing and Vision Plan	638,880	10.00
11.00	Life Insurance (If employee is owner or beneficiary)	399,113	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)	415,126	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)	0	14.00
15.00	'Workers' Compensation Insurance	2,331,197	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	9,090,640	17.00
18.00	Medicare Taxes - Employers Portion Only	0	18.00
19.00	Unemployment Insurance	0	19.00
20.00	State or Federal Unemployment Taxes	245,639	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	472,949	22.00
23.00	Tuition Reimbursement	257,567	23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)	54,939,750	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: 26-0104

Period:
From 01/01/2020
To 12/31/2020Worksheet S-3
Part V
Date/Time Prepared:
7/30/2021 8:44 am

Cost Center Description		Contract Labor	Benefit Cost	
		1.00	2.00	
PART V - Contract Labor and Benefit Cost				
Hospital and Hospital-Based Component Identification:				
1.00	Total facility's contract labor and benefit cost	19,752,365	54,939,750	1.00
2.00	Hospital	19,042,679	52,892,041	2.00
3.00	Subprovider - IPF	79,048	991,864	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	630,638	1,055,845	8.00
9.00	Hospital-Based NF			9.00
10.00	Hospital-Based OLTC			10.00
11.00	Hospital-Based HHA			11.00
12.00	Separately Certified ASC			12.00
13.00	Hospital-Based Hospice			13.00
14.00	Hospital-Based Health Clinic RHC			14.00
15.00	Hospital-Based Health Clinic FQHC			15.00
16.00	Hospital-Based-CMHC			16.00
17.00	Renal Dialysis	0	0	17.00
18.00	Other	0	0	18.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA		Provider CCN: 26-0104	Period: From 01/01/2020 To 12/31/2020	Worksheet S-10 Date/Time Prepared: 7/30/2021 8:44 am	
				1.00	
Uncompensated and indigent care cost computation					
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided by line 202 column 8)			0.265879	1.00
Medicaid (see instructions for each line)					
2.00	Net revenue from Medicaid			37,535,397	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			2,691,697	5.00
6.00	Medicaid charges			188,671,888	6.00
7.00	Medicaid cost (line 1 times line 6)			50,163,893	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)			9,936,799	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)			9,936,799	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)	54,469,460	3,957,545	58,427,005	20.00
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	14,482,286	3,957,545	18,439,831	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)	14,482,286	3,957,545	18,439,831	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)			29,912,711	26.00
27.00	Medicare reimbursable bad debts for the entire hospital complex (see instructions)			1,721,163	27.00
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)			2,647,943	27.01
28.00	Non-Medicare bad debt expense (see instructions)			27,264,768	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)			8,175,909	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)			26,615,740	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)			36,552,539	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 26-0104

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

Worksheet A

Date/Time Prepared:
7/30/2021 8:44 am

Cost Center Description			Salaries	Other	Total (col. 1 + col. 2)	Reclassificat ions (See A-6)	Reclassified Trial Balance (col. 3 + col. 4)	
			1.00	2.00	3.00	4.00	5.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT		9,214,171	9,214,171	-53,420	9,160,751	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		8,820,037	8,820,037	0	8,820,037	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	1,501,825	25,689,906	27,191,731	53,420	27,245,151	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	13,900,042	88,443,915	102,343,957	-1,762,020	100,581,937	5.00
7.00	00700	OPERATION OF PLANT	1,672,546	8,667,767	10,340,313	0	10,340,313	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	125,714	1,194,292	1,320,006	0	1,320,006	8.00
9.00	00900	HOUSEKEEPING	2,483,707	1,908,640	4,392,347	0	4,392,347	9.00
10.00	01000	DIETARY	2,491,789	5,148,839	7,640,628	-4,596,547	3,044,081	10.00
11.00	01100	CAFETERIA	0	0	0	4,588,513	4,588,513	11.00
13.00	01300	NURSING ADMINISTRATION	2,862,263	2,544,940	5,407,203	0	5,407,203	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	330,237	1,399,946	1,730,183	1,233,892	2,964,075	14.00
15.00	01500	PHARMACY	5,227,792	43,492,075	48,719,867	-42,159,281	6,560,586	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	311,702	180,949	492,651	0	492,651	16.00
17.00	01700	SOCIAL SERVICE	417,607	290,862	708,469	-5,320	703,149	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	1,117,273	173,554	1,290,827	-173,554	1,117,273	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	173,554	173,554	22.00
23.00	02300	PHARMACY RESIDENCY PRGM	309,446	33,851	343,297	-41,917	301,380	23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	34,815,976	11,947,320	46,763,296	-3,028,589	43,734,707	30.00
31.00	03100	INTENSIVE CARE UNIT	6,635,601	5,091,364	11,726,965	3,679,085	15,406,050	31.00
40.00	04000	SUBPROVIDER - IPF	5,106,025	1,902,878	7,008,903	-3,897,215	3,111,688	40.00
43.00	04300	NURSERY	256,531	19,646	276,177	462,273	738,450	43.00
44.00	04400	SKILLED NURSING FACILITY	2,464,093	2,170,117	4,634,210	-197,001	4,437,209	44.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	7,752,303	23,819,309	31,571,612	-18,554,934	13,016,678	50.00
51.00	05100	RECOVERY ROOM	853,829	134,713	988,542	-24,787	963,755	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	2,808,611	1,396,763	4,205,374	-2,046,020	2,159,354	52.00
52.01	05201	PERINATAL CLINIC	686,205	687,659	1,373,864	-12,106	1,361,758	52.01
53.00	05300	ANESTHESIOLOGY	83,170	4,660,894	4,744,064	-443,209	4,300,855	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,811,813	8,074,696	10,886,509	-3,651,107	7,235,402	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	2,127,418	1,130,404	3,257,822	-22,951	3,234,871	55.00
56.00	05600	RADIOISOTOPE	186,613	632,519	819,132	-3,657	815,475	56.00
57.00	05700	CT SCAN	866,705	689,547	1,556,252	-195,381	1,360,871	57.00
58.00	05800	MRI	321,804	105,402	427,206	-24,546	402,660	58.00
59.00	05900	CARDIAC CATHETERIZATION	1,307,721	8,549,801	9,857,522	-8,043,776	1,813,746	59.00
60.00	06000	LABORATORY	1,875,010	4,336,393	6,211,403	-44,032	6,167,371	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	446,658	1,354,770	1,801,428	1,021,311	2,822,739	62.00
64.00	06400	INTRAVENOUS THERAPY	1,836,194	1,152,954	2,989,148	-357,255	2,631,893	64.00
65.00	06500	RESPIRATORY THERAPY	2,545,221	1,662,850	4,208,071	-410,382	3,797,689	65.00
66.00	06600	PHYSICAL THERAPY	0	2,221,460	2,221,460	-11,154	2,210,306	66.00
66.01	06601	CLINICAL NUTRITION	536,744	44,519	581,263	-269	580,994	66.01
67.00	06700	OCCUPATIONAL THERAPY	0	1,169,240	1,169,240	-19,190	1,150,050	67.00
68.00	06800	SPEECH PATHOLOGY	0	560,439	560,439	-1,060	559,379	68.00
69.00	06900	ELECTROCARDIOLOGY	2,808,247	1,885,568	4,693,815	-472,940	4,220,875	69.00
69.01	06901	CARDIAC REHABILITATION	222,317	24,895	247,212	-1,763	245,449	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	250,342	132,281	382,623	-41,996	340,627	70.00
70.01	07001	ELECTROSHOCK THERAPY	65,854	17,043	82,897	-8,178	74,719	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	23,925,137	23,925,137	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	14,856,038	14,856,038	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	42,767,289	42,767,289	73.00
74.00	07400	RENAL DIALYSIS	1,814	2,056,452	2,058,266	-50,284	2,007,982	74.00
76.00	03330	ENDOSCOPY	818,931	900,449	1,719,380	-649,261	1,070,119	76.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	4,798,053	4,080,680	8,878,733	-701,193	8,177,540	90.00
91.00	09100	EMERGENCY	9,986,536	6,722,607	16,709,143	-1,054,189	15,654,954	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	128,028,282	296,539,376	424,567,658	28	424,567,686	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	40,375	35,486	75,861	0	75,861	190.00
191.00	19100	RESEARCH	101,611	10,303	111,914	0	111,914	191.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	0	0	0	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07951	NONREIMBURSABLE	46,190	9,388	55,578	-28	55,550	194.00
194.01	07952	NONREIMBURSABLE	0	0	0	0	0	194.01
194.02	07953	NONREIMBURSABLE	0	0	0	0	0	194.02
194.03	07950	RETAIL PHARMACY	0	20,707,736	20,707,736	0	20,707,736	194.03
200.00		TOTAL (SUM OF LINES 118 through 199)	128,216,458	317,302,289	445,518,747	0	445,518,747	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 26-0104

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

Worksheet A

Date/Time Prepared:
7/30/2021 8:44 am

Cost Center Description			Adjustments (See A-8)	Net Expenses For Allocation	
			6.00	7.00	
GENERAL SERVICE COST CENTERS					
1.00	00100	CAP REL COSTS-BLDG & FIXT	-1,034,673	8,126,078	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	2,071,873	10,891,910	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	6,684,665	33,929,816	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-15,275,334	85,306,603	5.00
7.00	00700	OPERATION OF PLANT	-284,924	10,055,389	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	1,320,006	8.00
9.00	00900	HOUSEKEEPING	0	4,392,347	9.00
10.00	01000	DIETARY	-1,155,997	1,888,084	10.00
11.00	01100	CAFETERIA	0	4,588,513	11.00
13.00	01300	NURSING ADMINISTRATION	-89,852	5,317,351	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	2,964,075	14.00
15.00	01500	PHARMACY	-90,451	6,470,135	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-504	492,147	16.00
17.00	01700	SOCIAL SERVICE	-62,801	640,348	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	19.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	1,117,273	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	173,554	22.00
23.00	02300	PHARMACY RESIDENCY PRGM	-91	301,289	23.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	-8,212,843	35,521,864	30.00
31.00	03100	INTENSIVE CARE UNIT	-1,797,597	13,608,453	31.00
40.00	04000	SUBPROVIDER - IPF	-714,503	2,397,185	40.00
43.00	04300	NURSERY	0	738,450	43.00
44.00	04400	SKILLED NURSING FACILITY	-180,611	4,256,598	44.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	-59,769	12,956,909	50.00
51.00	05100	RECOVERY ROOM	0	963,755	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	-12,021	2,147,333	52.00
52.01	05201	PERINATAL CLINIC	-709,659	652,099	52.01
53.00	05300	ANESTHESIOLOGY	-3,600,885	699,970	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-98,446	7,136,956	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	-37,313	3,197,558	55.00
56.00	05600	RADIOISOTOPE	-798	814,677	56.00
57.00	05700	CT SCAN	-91,663	1,269,208	57.00
58.00	05800	MRI	-24,998	377,662	58.00
59.00	05900	CARDIAC CATHETERIZATION	-7,875	1,805,871	59.00
60.00	06000	LABORATORY	-1,917,338	4,250,033	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	-27,142	2,795,597	62.00
64.00	06400	INTRAVENOUS THERAPY	-106,212	2,525,681	64.00
65.00	06500	RESPIRATORY THERAPY	-13,636	3,784,053	65.00
66.00	06600	PHYSICAL THERAPY	0	2,210,306	66.00
66.01	06601	CLINICAL NUTRITION	-73,097	507,897	66.01
67.00	06700	OCCUPATIONAL THERAPY	0	1,150,050	67.00
68.00	06800	SPEECH PATHOLOGY	74	559,453	68.00
69.00	06900	ELECTROCARDIOLOGY	-366,504	3,854,371	69.00
69.01	06901	CARDIAC REHABILITATION	-5,392	240,057	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	-133,388	207,239	70.00
70.01	07001	ELECTROSHOCK THERAPY	0	74,719	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	-1,446,146	22,478,991	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	14,856,038	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	42,767,289	73.00
74.00	07400	RENAL DIALYSIS	-1,814	2,006,168	74.00
76.00	03330	ENDOSCOPY	-3,273	1,066,846	76.00
OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	-1,535,570	6,641,970	90.00
91.00	09100	EMERGENCY	-4,102,013	11,552,941	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART			92.00
SPECIAL PURPOSE COST CENTERS					
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-34,518,521	390,049,165	118.00
NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	0	75,861	190.00
191.00	19100	RESEARCH	0	111,914	191.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	0	192.00
193.00	19300	NONPAID WORKERS	0	0	193.00
194.00	07951	NONREIMBURSABLE	0	55,550	194.00
194.01	07952	NONREIMBURSABLE	0	0	194.01
194.02	07953	NONREIMBURSABLE	0	0	194.02
194.03	07950	RETAIL PHARMACY	0	20,707,736	194.03
200.00		TOTAL (SUM OF LINES 118 through 199)	-34,518,521	411,000,226	200.00

RECLASSIFICATIONS

Provider CCN: 26-0104

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

Worksheet A-6

Date/Time Prepared:
7/30/2021 8:44 am

Increases					
	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
A - PHARMACY					
1.00	WHOLE BLOOD & PACKED RED BLOOD CELL	62.00	0	2,154,882	1.00
2.00	DRUGS CHARGED TO PATIENTS	73.00	0	42,767,289	2.00
3.00		0.00	0	0	3.00
4.00		0.00	0	0	4.00
5.00		0.00	0	0	5.00
6.00		0.00	0	0	6.00
7.00		0.00	0	0	7.00
8.00		0.00	0	0	8.00
9.00		0.00	0	0	9.00
10.00		0.00	0	0	10.00
11.00		0.00	0	0	11.00
12.00		0.00	0	0	12.00
13.00		0.00	0	0	13.00
14.00		0.00	0	0	14.00
15.00		0.00	0	0	15.00
16.00		0.00	0	0	16.00
17.00		0.00	0	0	17.00
18.00		0.00	0	0	18.00
19.00		0.00	0	0	19.00
20.00		0.00	0	0	20.00
21.00		0.00	0	0	21.00
22.00		0.00	0	0	22.00
23.00		0.00	0	0	23.00
24.00		0.00	0	0	24.00
0			0	44,922,171	
B - NURSERY & L&D					
1.00	ADULTS & PEDIATRICS	30.00	1,002,159	537,643	1.00
2.00	INTENSIVE CARE UNIT	31.00	3,697,218	1,575,353	2.00
3.00	NURSERY	43.00	449,642	288,833	3.00
4.00		0.00	0	0	4.00
0			5,149,019	2,401,829	
C - CENTRAL SUPPLY					
1.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	23,925,137	1.00
2.00	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	14,856,038	2.00
3.00		0.00	0	0	3.00
4.00		0.00	0	0	4.00
5.00		0.00	0	0	5.00
6.00		0.00	0	0	6.00
7.00		0.00	0	0	7.00
8.00		0.00	0	0	8.00
9.00		0.00	0	0	9.00
10.00		0.00	0	0	10.00
11.00		0.00	0	0	11.00
12.00		0.00	0	0	12.00
13.00		0.00	0	0	13.00
14.00		0.00	0	0	14.00
15.00		0.00	0	0	15.00
16.00		0.00	0	0	16.00
17.00		0.00	0	0	17.00
18.00		0.00	0	0	18.00
19.00		0.00	0	0	19.00
20.00		0.00	0	0	20.00
21.00		0.00	0	0	21.00
22.00		0.00	0	0	22.00
23.00		0.00	0	0	23.00
24.00		0.00	0	0	24.00
25.00		0.00	0	0	25.00
26.00		0.00	0	0	26.00
27.00		0.00	0	0	27.00
28.00		0.00	0	0	28.00
29.00		0.00	0	0	29.00
30.00		0.00	0	0	30.00
31.00		0.00	0	0	31.00
32.00		0.00	0	0	32.00
33.00		0.00	0	0	33.00
0			0	38,781,175	
E - BHM - ADMIN					
1.00	PHARMACY	15.00	19,657	7,492	1.00
2.00	ADULTS & PEDIATRICS	30.00	2,547,493	970,899	2.00
3.00	CLINIC	90.00	181,998	69,363	3.00

Provider CCN: 26-0104

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

Worksheet A-6

Date/Time Prepared:
7/30/2021 8:44 am

	Increases					
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
4.00	EMERGENCY	91.00	42,099	16,045		4.00
			2,791,247	1,063,799		
	F - PARKING GARAGE					
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	53,420		1.00
2.00		0.00	0	0		2.00
			0	53,420		
	G - CENTRAL DISTRIBUTION					
1.00	CENTRAL SERVICES & SUPPLY	14.00	355,002	943,598		1.00
			355,002	943,598		
	H - RESIDENCY ANCILLARY					
1.00	I&R SERVICES-OTHER PRGM	22.00	0	173,554		1.00
	COSTS APPRV					
2.00		0.00	0	0		2.00
			0	173,554		
	I - PHARMACY RESIDENCY					
1.00	PHARMACY	15.00	41,917	0		1.00
2.00		0.00	0	0		2.00
			41,917	0		
	J - DIETARY					
1.00	CAFETERIA	11.00	1,496,422	3,092,091		1.00
			1,496,422	3,092,091		
500.00	Grand Total: Increases		9,833,607	91,431,637		500.00

RECLASSIFICATIONS

Provider CCN: 26-0104

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

Worksheet A-6

Date/Time Prepared:
7/30/2021 8:44 am

	Decreases						7/30/2021 8:44 am
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	A - PHARMACY						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	463,420	0		1.00
2.00	DIETARY	10.00	0	8,034	0		2.00
3.00	CENTRAL SERVICES & SUPPLY	14.00	0	64,708	0		3.00
4.00	PHARMACY	15.00	0	42,228,347	0		4.00
5.00	SOCIAL SERVICE	17.00	0	5,320	0		5.00
6.00	ADULTS & PEDIATRICS	30.00	0	1,818	0		6.00
7.00	INTENSIVE CARE UNIT	31.00	0	929	0		7.00
8.00	SUBPROVIDER - IPF	40.00	0	23,126	0		8.00
9.00	SKILLED NURSING FACILITY	44.00	0	139,653	0		9.00
10.00	OPERATING ROOM	50.00	0	79	0		10.00
11.00	RECOVERY ROOM	51.00	0	167	0		11.00
12.00	DELIVERY ROOM & LABOR ROOM	52.00	0	12	0		12.00
13.00	PERINATAL CLINIC	52.01	0	43	0		13.00
14.00	RADIOLOGY-DIAGNOSTIC	54.00	0	736	0		14.00
15.00	RADIOLOGY-THERAPEUTIC	55.00	0	1,330	0		15.00
16.00	RADIOISOTOPE	56.00	0	82	0		16.00
17.00	CARDIAC CATHETERIZATION	59.00	0	4,109	0		17.00
18.00	WHOLE BLOOD & PACKED RED BLOOD CELL	62.00	0	1,131,270	0		18.00
19.00	RESPIRATORY THERAPY	65.00	0	367	0		19.00
20.00	ELECTROCARDIOLOGY	69.00	0	335	0		20.00
21.00	CARDIAC REHABILITATION	69.01	0	114	0		21.00
22.00	ENDOSCOPY	76.00	0	6	0		22.00
23.00	CLINIC	90.00	0	847,703	0		23.00
24.00	EMERGENCY	91.00	0	463	0		24.00
	0		0	44,922,171			
	B - NURSERY & L&D						
1.00	ADULTS & PEDIATRICS	30.00	3,704,582	1,578,810	0		1.00
2.00	INTENSIVE CARE UNIT	31.00	129,316	120,331	0		2.00
3.00	NURSERY	43.00	256,531	19,646	0		3.00
4.00	DELIVERY ROOM & LABOR ROOM	52.00	1,058,590	683,042	0		4.00
	0		5,149,019	2,401,829			
	C - CENTRAL SUPPLY						
1.00	ADULTS & PEDIATRICS	30.00	0	2,801,573	0		1.00
2.00	INTENSIVE CARE UNIT	31.00	0	1,342,910	0		2.00
3.00	SUBPROVIDER - IPF	40.00	0	19,043	0		3.00
4.00	NURSERY	43.00	0	25	0		4.00
5.00	SKILLED NURSING FACILITY	44.00	0	57,348	0		5.00
6.00	OPERATING ROOM	50.00	0	18,554,855	0		6.00
7.00	RECOVERY ROOM	51.00	0	24,620	0		7.00
8.00	DELIVERY ROOM & LABOR ROOM	52.00	0	304,376	0		8.00
9.00	PERINATAL CLINIC	52.01	0	12,063	0		9.00
10.00	ANESTHESIOLOGY	53.00	0	443,209	0		10.00
11.00	RADIOLOGY-DIAGNOSTIC	54.00	0	3,650,371	0		11.00
12.00	RADIOLOGY-THERAPEUTIC	55.00	0	21,621	0		12.00
13.00	RADIOISOTOPE	56.00	0	3,575	0		13.00
14.00	CT SCAN	57.00	0	195,381	0		14.00
15.00	MRI	58.00	0	24,546	0		15.00
16.00	CARDIAC CATHETERIZATION	59.00	0	8,039,667	0		16.00
17.00	LABORATORY	60.00	0	44,032	0		17.00
18.00	WHOLE BLOOD & PACKED RED BLOOD CELL	62.00	0	2,301	0		18.00
19.00	INTRAVENOUS THERAPY	64.00	0	357,255	0		19.00
20.00	RESPIRATORY THERAPY	65.00	0	410,015	0		20.00
21.00	PHYSICAL THERAPY	66.00	0	11,154	0		21.00
22.00	CLINICAL NUTRITION	66.01	0	269	0		22.00
23.00	OCCUPATIONAL THERAPY	67.00	0	19,190	0		23.00
24.00	SPEECH PATHOLOGY	68.00	0	1,060	0		24.00
25.00	ELECTROCARDIOLOGY	69.00	0	472,605	0		25.00
26.00	CARDIAC REHABILITATION	69.01	0	1,649	0		26.00
27.00	ELECTROENCEPHALOGRAPHY	70.00	0	41,996	0		27.00
28.00	ELECTROSHOCK THERAPY	70.01	0	8,178	0		28.00
29.00	RENAL DIALYSIS	74.00	0	50,284	0		29.00
30.00	ENDOSCOPY	76.00	0	649,255	0		30.00
31.00	CLINIC	90.00	0	104,851	0		31.00
32.00	EMERGENCY	91.00	0	1,111,870	0		32.00
33.00	NONREIMBURSABLE	194.00	0	28	0		33.00
	0		0	38,781,175			
	E - BHM - ADMIN						
1.00	SUBPROVIDER - IPF	40.00	2,791,247	1,063,799	0		1.00
2.00		0.00	0	0	0		2.00
3.00		0.00	0	0	0		3.00
4.00		0.00	0	0	0		4.00

RECLASSIFICATIONS

Provider CCN: 26-0104

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

Worksheet A-6

Date/Time Prepared:
7/30/2021 8:44 am

	Decreases						
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	0		2,791,247	1,063,799			
	F - PARKING GARAGE						
1.00		0.00	0	0	0		1.00
2.00	CAP REL COSTS-BLDG & FIXT	1.00	0	53,420	9		2.00
	0		0	53,420			
	G - CENTRAL DISTRIBUTION						
1.00	ADMINISTRATIVE & GENERAL	5.00	355,002	943,598	0		1.00
	0		355,002	943,598			
	H - RESIDENCY ANCILLARY						
1.00		0.00	0	0	0		1.00
2.00	I&R SERVICES-SALARY & FRINGES APPRV	21.00	0	173,554	0		2.00
	0		0	173,554			
	I - PHARMACY RESIDENCY						
1.00		0.00	0	0	0		1.00
2.00	PHARMACY RESIDENCY PRGM	23.00	41,917	0	0		2.00
	0		41,917	0			
	J - DIETARY						
1.00	DIETARY	10.00	1,496,422	3,092,091	0		1.00
	0		1,496,422	3,092,091			
500.00	Grand Total: Decreases		9,833,607	91,431,637			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 26-0104

Period:
From 01/01/2020
To 12/31/2020Worksheet A-7
Part I
Date/Time Prepared:
7/30/2021 8:44 am

		Beginning Balances	Acquisitions			Disposals and Retirements	
			Purchases	Donation	Total		
			1.00	2.00	3.00		
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	9,615,392	0	0	0	0	1.00
2.00	Land Improvements	2,991,433	98,033	0	98,033	0	2.00
3.00	Buildings and Fixtures	131,428,607	0	-1,004,006	-1,004,006	385,132	3.00
4.00	Building Improvements	0	0	0	0	0	4.00
5.00	Fixed Equipment	4,126,760	494,439	0	494,439	0	5.00
6.00	Movable Equipment	93,249,326	15,215,356	123,151	15,338,507	3,946,192	6.00
7.00	HIT designated Assets	1,173,264	57,012	0	57,012	2,207	7.00
8.00	Subtotal (sum of lines 1-7)	242,584,782	15,864,840	-880,855	14,983,985	4,333,531	8.00
9.00	Reconciling Items	21,086,339	0	-18,141,760	-18,141,760	1,278	9.00
10.00	Total (line 8 minus line 9)	221,498,443	15,864,840	17,260,905	33,125,745	4,332,253	10.00
		Ending Balance	Fully Depreciated Assets				
		6.00	7.00				
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	9,615,392	0				1.00
2.00	Land Improvements	3,089,466	0				2.00
3.00	Buildings and Fixtures	130,039,469	0				3.00
4.00	Building Improvements	0	0				4.00
5.00	Fixed Equipment	4,621,199	0				5.00
6.00	Movable Equipment	104,641,641	0				6.00
7.00	HIT designated Assets	1,228,069	0				7.00
8.00	Subtotal (sum of lines 1-7)	253,235,236	0				8.00
9.00	Reconciling Items	2,943,301	0				9.00
10.00	Total (line 8 minus line 9)	250,291,935	0				10.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 26-0104

Period:
From 01/01/2020
To 12/31/2020Worksheet A-7
Part II
Date/Time Prepared:
7/30/2021 8:44 am

Cost Center Description		SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	CAP REL COSTS-BLDG & FIXT	7,623,640	0	1,590,531	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	8,820,037	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	16,443,677	0	1,590,531	0	0	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Other Capital-Relat ed Costs (see instructions)	Total (1) (sum of cols. 9 through 14)				
		14.00	15.00				
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	CAP REL COSTS-BLDG & FIXT	0	9,214,171				1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	8,820,037				2.00
3.00	Total (sum of lines 1-2)	0	18,034,208				3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 26-0104

Period:
From 01/01/2020
To 12/31/2020Worksheet A-7
Part III
Date/Time Prepared:
7/30/2021 8:44 am

Cost Center Description		COMPUTATION OF RATIOS			ALLOCATION OF OTHER CAPITAL		
		Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	
		1.00	2.00	3.00	4.00	5.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	142,744,326	0	142,744,326	0.563683	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	110,490,909	0	110,490,909	0.436317	0	2.00
3.00	Total (sum of lines 1-2)	253,235,235	0	253,235,235	1.000000	0	3.00
Cost Center Description		ALLOCATION OF OTHER CAPITAL			SUMMARY OF CAPITAL		
		Taxes	Other Capital-Relat ed Costs	Total (sum of cols. 5 through 7)	Depreciation	Lease	
		6.00	7.00	8.00	9.00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	8,127,444	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	10,891,910	0	2.00
3.00	Total (sum of lines 1-2)	0	0	0	19,019,354	0	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Relat ed Costs (see instructions)	Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	-1,366	0	0	0	8,126,078	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	0	10,891,910	2.00
3.00	Total (sum of lines 1-2)	-1,366	0	0	0	19,017,988	3.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 26-0104

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

Worksheet A-8

Date/Time Prepared:
7/30/2021 8:44 am

Cost Center Description		Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted		Wkst. A-7 Ref.	
				Cost Center	Line #		
				3.00	4.00		
1.00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)			0CAP REL COSTS-BLDG & FIXT	1.00	0	1.00
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)			0CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
3.00	Investment income - other (chapter 2)			0	0.00	0	3.00
4.00	Trade, quantity, and time discounts (chapter 8)			0	0.00	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)			0	0.00	0	5.00
6.00	Rental of provider space by suppliers (chapter 8)			0	0.00	0	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)			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	-20,163,702			0	10.00
11.00	Sale of scrap, waste, etc. (chapter 23)			0	0.00	0	11.00
12.00	Related organization transactions (chapter 10)	A-8-1	-3,542,594			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		0RESPIRATORY THERAPY	65.00		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3		0PHYSICAL THERAPY	66.00		24.00
25.00	Utilization review - physicians' compensation (chapter 21)			0*** Cost Center Deleted ***	114.00		25.00
26.00	Depreciation - CAP REL COSTS-BLDG & FIXT			0CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP			0CAP REL COSTS-MVBLE EQUIP	2.00	0	27.00
28.00	Non-physician Anesthetist			0NONPHYSICIAN ANESTHETISTS	19.00		28.00
29.00	Physicians' assistant			0	0.00	0	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3		0OCCUPATIONAL THERAPY	67.00		30.00
30.99	Hospice (non-distinct) (see instructions)			0ADULTS & PEDIATRICS	30.00		30.99

ADJUSTMENTS TO EXPENSES

Provider CCN: 26-0104

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

Worksheet A-8

Date/Time Prepared:
7/30/2021 8:44 am

Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted			
			Cost Center	Line #	Wkst. A-7 Ref.	
1.00	2.00	3.00	4.00	5.00		
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	SPEECH PATHOLOGY	68.00	31.00
32.00	CAH HIT Adjustment for Depreciation and Interest		0		0.00	0 32.00
33.00	BAD DEBT	A	42,447	ADMINISTRATIVE & GENERAL	5.00	0 33.00
33.01	BAD DEBT	A	-106,485	SKILLED NURSING FACILITY	44.00	0 33.01
33.02	GIFT	A	-653,032	ADMINISTRATIVE & GENERAL	5.00	0 33.02
33.03	GIFT	A	-4,597	NURSING ADMINISTRATION	13.00	0 33.03
33.04	GIFT	A	-465	PHARMACY	15.00	0 33.04
33.05	GIFT	A	-91	PHARMACY RESIDENCY PRGM	23.00	0 33.05
33.06	GIFT	A	-6,052	ADULTS & PEDIATRICS	30.00	0 33.06
33.07	GIFT	A	-100	SUBPROVIDER - IPF	40.00	0 33.07
33.08	GIFT	A	-24,626	SKILLED NURSING FACILITY	44.00	0 33.08
33.09	GIFT	A	-55	OPERATING ROOM	50.00	0 33.09
33.10	GIFT	A	-8,178	DELIVERY ROOM & LABOR ROOM	52.00	0 33.10
33.11	GIFT	A	-52	PERINATAL CLINIC	52.01	0 33.11
33.12	GIFT	A	-145	RADIOLOGY-DIAGNOSTIC	54.00	0 33.12
33.13	GIFT	A	-29	RADIOISOTOPE	56.00	0 33.13
33.14	GIFT	A	-83	CT SCAN	57.00	0 33.14
33.15	GIFT	A	-29	MRI	58.00	0 33.15
33.16	GIFT	A	-190	RESPIRATORY THERAPY	65.00	0 33.16
33.17	GIFT	A	-439	CLINIC	90.00	0 33.17
33.18	GIFT	A	-489	EMERGENCY	91.00	0 33.18
33.19	PHONE	A	-6,855	SKILLED NURSING FACILITY	44.00	0 33.19
33.20	ENTERTAINMENT	A	-33,482	ADMINISTRATIVE & GENERAL	5.00	0 33.20
33.21	ENTERTAINMENT	A	-60	SUBPROVIDER - IPF	40.00	0 33.21
33.22	ENTERTAINMENT	A	-438	SKILLED NURSING FACILITY	44.00	0 33.22
33.23	ENTERTAINMENT	A	-3,660	RADIOLOGY-DIAGNOSTIC	54.00	0 33.23
33.24	ENTERTAINMENT	A	-29	EMERGENCY	91.00	0 33.24
33.27	NURSE PRACTITIONER	A	-227,729	ADULTS & PEDIATRICS	30.00	0 33.27
33.31	NURSE PRACTITIONER	A	-116,781	SUBPROVIDER - IPF	40.00	0 33.31
33.32	NURSE PRACTITIONER	A	-130,654	PERINATAL CLINIC	52.01	0 33.32
33.33	NURSE PRACTITIONER	A	-22,665	CLINIC	90.00	0 33.33
33.34	NURSE PRACTITIONER	A	-196,145	EMPLOYEE BENEFITS DEPARTMENT	4.00	0 33.34
33.35	NON-MEDICAL TRANSPORT	A	-62,801	SOCIAL SERVICE	17.00	0 33.35
33.36	NON-MEDICAL TRANSPORT	A	-122,879	SUBPROVIDER - IPF	40.00	0 33.36
33.37	NON-MEDICAL TRANSPORT	A	-6,707	SKILLED NURSING FACILITY	44.00	0 33.37
33.38	NON-MEDICAL TRANSPORT	A	-120,709	CLINIC	90.00	0 33.38
33.39	NON-MEDICAL TRANSPORT	A	820	EMERGENCY	91.00	0 33.39
33.40	MARKETING	A	-6,400	ADMINISTRATIVE & GENERAL	5.00	0 33.40
33.42	MARKETING	A	-33,942	SKILLED NURSING FACILITY	44.00	0 33.42
33.43	MARKETING	A	-224	CLINIC	90.00	0 33.43
33.44	MARKETING	A	-1,766	EMERGENCY	91.00	0 33.44
33.45	FRA	A	-13,012	ADMINISTRATIVE & GENERAL	5.00	0 33.45
33.46	MISCELLANEOUS REVENUE	B	-2,968,735	ADMINISTRATIVE & GENERAL	5.00	0 33.46
33.47	MISCELLANEOUS REVENUE	B	-267,985	OPERATION OF PLANT	7.00	0 33.47
33.48	MISCELLANEOUS REVENUE	B	-1,155,997	DIETARY	10.00	0 33.48
33.49	MISCELLANEOUS REVENUE	B	-85,255	NURSING ADMINISTRATION	13.00	0 33.49
33.51	MISCELLANEOUS REVENUE	B	-86,303	PHARMACY	15.00	0 33.51
33.52	MISCELLANEOUS REVENUE	B	-504	MEDICAL RECORDS & LIBRARY	16.00	0 33.52
33.53	MISCELLANEOUS REVENUE	B	-11,185	ADULTS & PEDIATRICS	30.00	0 33.53
33.54	MISCELLANEOUS REVENUE	B	-6,789	INTENSIVE CARE UNIT	31.00	0 33.54
33.55	MISCELLANEOUS REVENUE	B	-811	SUBPROVIDER - IPF	40.00	0 33.55
33.56	MISCELLANEOUS REVENUE	B	-1,558	SKILLED NURSING FACILITY	44.00	0 33.56
33.57	MISCELLANEOUS REVENUE	B	-31,071	OPERATING ROOM	50.00	0 33.57
33.58	MISCELLANEOUS REVENUE	B	-2,371	DELIVERY ROOM & LABOR ROOM	52.00	0 33.58
33.59	MISCELLANEOUS REVENUE	B	-136,301	PERINATAL CLINIC	52.01	0 33.59
33.60	MISCELLANEOUS REVENUE	B	-17,078	ANESTHESIOLOGY	53.00	0 33.60
33.61	MISCELLANEOUS REVENUE	B	-94,641	RADIOLOGY-DIAGNOSTIC	54.00	0 33.61
33.62	MISCELLANEOUS REVENUE	B	-29,564	RADIOLOGY-THERAPEUTIC	55.00	0 33.62
33.63	MISCELLANEOUS REVENUE	B	-769	RADIOISOTOPE	56.00	0 33.63
33.64	MISCELLANEOUS REVENUE	B	-91,580	CT SCAN	57.00	0 33.64
33.65	MISCELLANEOUS REVENUE	B	-24,969	MRI	58.00	0 33.65
33.66	MISCELLANEOUS REVENUE	B	-7,875	CARDIAC CATHETERIZATION	59.00	0 33.66
33.67	MISCELLANEOUS REVENUE	B	-1,613,815	LABORATORY	60.00	0 33.67

ADJUSTMENTS TO EXPENSES

Provider CCN: 26-0104

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

Worksheet A-8

Date/Time Prepared:
7/30/2021 8:44 am

Cost Center Description		Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted		Wkst. A-7 Ref.	
				Cost Center	Line #		
33.68	MISCELLANEOUS REVENUE	B	-27,142	WHOLE BLOOD & PACKED RED BLOOD CELL	62.00	0	33.68
33.69	MISCELLANEOUS REVENUE	B	-87,207	INTRAVENOUS THERAPY	64.00	0	33.69
33.70	MISCELLANEOUS REVENUE	B	-2,032	RESPIRATORY THERAPY	65.00	0	33.70
33.71	MISCELLANEOUS REVENUE	B	-73,097	CLINICAL NUTRITION	66.01	0	33.71
33.72	MISCELLANEOUS REVENUE	B	74	SPEECH PATHOLOGY	68.00	0	33.72
33.73	MISCELLANEOUS REVENUE	B	-6,645	ELECTROCARDIOLOGY	69.00	0	33.73
33.74	MISCELLANEOUS REVENUE	B	-3,273	ENDOSCOPY	76.00	0	33.74
33.75	MISCELLANEOUS REVENUE	B	-540,346	CLINIC	90.00	0	33.75
33.76	MISCELLANEOUS REVENUE	B	-13,214	EMERGENCY	91.00	0	33.76
33.77	LOBBYING	A	-52,929	ADMINISTRATIVE & GENERAL	5.00	0	33.77
33.78	MISC MD COMPENSATION	A	-41,559	CLINIC	90.00	0	33.78
33.79	PHYSICIAN BENEFITS	A	-1,460,891	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.79
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-34,518,521				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: 26-0104

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

Worksheet A-8-1

Date/Time Prepared:
7/30/2021 8:44 am

	Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in wks. A, column 5	
	1.00	2.00	3.00	4.00	5.00	
A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:						
1.00		1.00	CAP REL COSTS-BLDG & FIXT	HOME OFFICE	557,224	0
2.00		2.00	CAP REL COSTS-MVBLE EQUIP	HOME OFFICE	2,071,873	0
3.00		1.00	CAP REL COSTS-BLDG & FIXT	HOME OFFICE - INTEREST	0	1,590,991
4.00		4.00	EMPLOYEE BENEFITS DEPARTMENT	HOME OFFICE	8,341,701	0
4.01		5.00	ADMINISTRATIVE & GENERAL	HOME OFFICE	33,646,445	44,911,568
4.02		7.00	OPERATION OF PLANT	HOME OFFICE	0	16,939
4.03		71.00	MEDICAL SUPPLIES CHARGED TO	HOME OFFICE	-1,446,146	0
4.04		1.00	CAP REL COSTS-BLDG & FIXT	NETWORK--CORP 130 - INTEREST	-906	0
4.05		5.00	ADMINISTRATIVE & GENERAL	NETWORK--CORP 130	8,894,296	9,039,633
4.06		30.00	ADULTS & PEDIATRICS	NETWORK--CORP 130	595,686	605,420
4.07		40.00	SUBPROVIDER - IPF	NETWORK--CORP 130	2,089,037	2,123,173
4.08		55.00	RADIOLOGY-THERAPEUTIC	NETWORK--CORP 130	249,680	253,760
4.09		70.00	ELECTROENCEPHALOGRAPHY	NETWORK--CORP 130	-92	-92
4.10		0.00			0	0
5.00			TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.		54,998,798	58,541,392

* 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	100.00	FRAN SISTERS SM	100.00	6.00
7.00	G	SSM HEALTH	100.00	FRAN SISTERS SM	100.00	7.00
8.00	G	SSM HEALTH	100.00	FRAN SISTERS SM	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:					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: 26-0104

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

Worksheet A-8-1

Date/Time Prepared:
7/30/2021 8:44 am

	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	557,224	9		1.00
2.00	2,071,873	9		2.00
3.00	-1,590,991	11		3.00
4.00	8,341,701	0		4.00
4.01	-11,265,123	0		4.01
4.02	-16,939	0		4.02
4.03	-1,446,146	0		4.03
4.04	-906	11		4.04
4.05	-145,337	0		4.05
4.06	-9,734	0		4.06
4.07	-34,136	0		4.07
4.08	-4,080	0		4.08
4.09	0	0		4.09
4.10	0	0		4.10
5.00	-3,542,594			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	STL NETWORK	7.00
8.00	SSM HOSPITALS	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: 26-0104

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

Worksheet A-8-2

Date/Time Prepared:
7/30/2021 8:44 am

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	5.00	ADMINISTRATIVE & GENERAL	444,309	124,557	319,752	211,500	2,602	1.00
2.00	15.00	PHARMACY	3,683	3,683	0	211,500	0	2.00
3.00	30.00	ADULTS & PEDIATRICS	8,084,049	7,939,052	144,997	197,500	1,326	3.00
4.00	31.00	INTENSIVE CARE UNIT	1,790,808	1,790,808	0	211,500	0	4.00
5.00	40.00	SUBPROVIDER - IPF	476,780	421,660	55,120	181,300	425	5.00
6.00	50.00	OPERATING ROOM	36,743	28,643	8,100	246,400	81	6.00
7.00	52.00	DELIVERY ROOM & LABOR ROOM	1,472	1,472	0	237,100	0	7.00
8.00	52.01	PERINATAL CLINIC	442,652	442,652	0	237,100	0	8.00
9.00	53.00	ANESTHESIOLOGY	3,623,515	3,552,965	70,550	239,400	345	9.00
10.00	55.00	RADIOLOGY-THERAPEUTIC	41,970	0	41,970	271,900	293	10.00
11.00	59.00	CARDIAC CATHETERIZATION	-5,213	0	-5,213	211,500	-23	11.00
12.00	60.00	LABORATORY	305,877	303,523	2,354	260,300	24	12.00
13.00	64.00	INTRAVENOUS THERAPY	19,005	19,005	0	211,500	0	13.00
14.00	65.00	RESPIRATORY THERAPY	35,411	0	35,411	211,500	236	14.00
15.00	69.00	ELECTROCARDIOLOGY	359,859	359,859	0	211,500	0	15.00
16.00	69.01	CARDIAC REHABILITATION	9,663	0	9,663	211,500	42	16.00
17.00	70.00	ELECTROENCEPHALOGRAPHY	267,304	0	267,304	211,500	1,317	17.00
18.00	74.00	RENAL DIALYSIS	1,814	1,814	0	211,500	0	18.00
19.00	90.00	CLINIC	809,913	809,613	300	197,500	3	19.00
20.00	91.00	EMERGENCY	4,087,335	4,087,335	0	197,500	0	20.00
200.00			20,836,949	19,886,641	950,308		6,671	200.00

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 26-0104

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

Worksheet A-8-2

Date/Time Prepared:
7/30/2021 8:44 am

	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	264,578	13,229	0	0	0	1.00
2.00	15.00	PHARMACY	0	0	0	0	0	2.00
3.00	30.00	ADULTS & PEDIATRICS	125,906	6,295	0	0	0	3.00
4.00	31.00	INTENSIVE CARE UNIT	0	0	0	0	0	4.00
5.00	40.00	SUBPROVIDER - IPF	37,044	1,852	0	0	0	5.00
6.00	50.00	OPERATING ROOM	9,595	480	0	0	0	6.00
7.00	52.00	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	7.00
8.00	52.01	PERINATAL CLINIC	0	0	0	0	0	8.00
9.00	53.00	ANESTHESIOLOGY	39,708	1,985	0	0	0	9.00
10.00	55.00	RADIOLOGY-THERAPEUTIC	38,301	1,915	0	0	0	10.00
11.00	59.00	CARDIAC CATHETERIZATION	-2,339	-117	0	0	0	11.00
12.00	60.00	LABORATORY	3,003	150	0	0	0	12.00
13.00	64.00	INTRAVENOUS THERAPY	0	0	0	0	0	13.00
14.00	65.00	RESPIRATORY THERAPY	23,997	1,200	0	0	0	14.00
15.00	69.00	ELECTROCARDIOLOGY	0	0	0	0	0	15.00
16.00	69.01	CARDIAC REHABILITATION	4,271	214	0	0	0	16.00
17.00	70.00	ELECTROENCEPHALOGRAPHY	133,916	6,696	0	0	0	17.00
18.00	74.00	RENAL DIALYSIS	0	0	0	0	0	18.00
19.00	90.00	CLINIC	285	14	0	0	0	19.00
20.00	91.00	EMERGENCY	0	0	0	0	0	20.00
200.00			678,265	33,913	0	0	0	200.00

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 26-0104

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

Worksheet A-8-2

Date/Time Prepared:
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	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	264,578	55,174	179,731		1.00
2.00	15.00	PHARMACY	0	0	0	3,683		2.00
3.00	30.00	ADULTS & PEDIATRICS	0	125,906	19,091	7,958,143		3.00
4.00	31.00	INTENSIVE CARE UNIT	0	0	0	1,790,808		4.00
5.00	40.00	SUBPROVIDER - IPF	0	37,044	18,076	439,736		5.00
6.00	50.00	OPERATING ROOM	0	9,595	0	28,643		6.00
7.00	52.00	DELIVERY ROOM & LABOR ROOM	0	0	0	1,472		7.00
8.00	52.01	PERINATAL CLINIC	0	0	0	442,652		8.00
9.00	53.00	ANESTHESIOLOGY	0	39,708	30,842	3,583,807		9.00
10.00	55.00	RADIOLOGY-THERAPEUTIC	0	38,301	3,669	3,669		10.00
11.00	59.00	CARDIAC CATHETERIZATION	0	-2,456	0	0		11.00
12.00	60.00	LABORATORY	0	3,003	0	303,523		12.00
13.00	64.00	INTRAVENOUS THERAPY	0	0	0	19,005		13.00
14.00	65.00	RESPIRATORY THERAPY	0	23,997	11,414	11,414		14.00
15.00	69.00	ELECTROCARDIOLOGY	0	0	0	359,859		15.00
16.00	69.01	CARDIAC REHABILITATION	0	4,271	5,392	5,392		16.00
17.00	70.00	ELECTROENCEPHALOGRAPHY	0	133,916	133,388	133,388		17.00
18.00	74.00	RENAL DIALYSIS	0	0	0	1,814		18.00
19.00	90.00	CLINIC	0	285	15	809,628		19.00
20.00	91.00	EMERGENCY	0	0	0	4,087,335		20.00
200.00			0	678,148	277,061	20,163,702		200.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 26-0104

Period:
From 01/01/2020
To 12/31/2020Worksheet B
Part I
Date/Time Prepared:
7/30/2021 8:44 am

Cost Center Description			Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
				BLDG & FIXT	MVBLE EQUIP			
			0	1.00	2.00	4.00	4A	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT	8,126,078	8,126,078				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	10,891,910		10,891,910			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	33,929,816	32,482	43,538	34,005,836		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	85,306,603	1,309,745	1,755,537	3,834,169		5.00
7.00	00700	OPERATION OF PLANT	10,055,389	711,548	953,733	473,790	92,206,054	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	1,320,006	24,470	32,799	35,612	1,412,887	8.00
9.00	00900	HOUSEKEEPING	4,392,347	19,014	25,486	703,572	5,140,419	9.00
10.00	01000	DIETARY	1,888,084	193,439	259,279	281,963	2,622,765	10.00
11.00	01100	CAFETERIA	4,588,513	0	0	423,899	5,012,412	11.00
13.00	01300	NURSING ADMINISTRATION	5,317,351	73,566	98,606	810,808	6,300,331	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	2,964,075	214,542	287,565	194,111	3,660,293	14.00
15.00	01500	PHARMACY	6,470,135	31,716	42,511	1,498,260	8,042,622	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	492,147	48,985	65,658	88,297	695,087	16.00
17.00	01700	SOCIAL SERVICE	640,348	13,335	17,874	118,298	789,855	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	1,117,273	0	0	316,496	1,433,769	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	173,554	13,380	17,934	0	204,868	22.00
23.00	02300	PHARMACY RESIDENCY PRGM	301,289	5,979	8,014	75,784	391,066	23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	35,521,864	1,644,638	2,204,415	9,242,803	48,613,720	30.00
31.00	03100	INTENSIVE CARE UNIT	13,608,453	236,912	317,549	2,890,397	17,053,311	31.00
40.00	04000	SUBPROVIDER - IPF	2,397,185	357,430	479,086	622,638	3,856,339	40.00
43.00	04300	NURSERY	738,450	78,789	105,606	127,372	1,050,217	43.00
44.00	04400	SKILLED NURSING FACILITY	4,256,598	0	0	0	4,256,598	44.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	12,956,909	673,942	903,328	2,196,034	16,730,213	50.00
51.00	05100	RECOVERY ROOM	963,755	0	0	241,868	1,205,623	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	2,147,333	375,343	503,097	495,320	3,521,093	52.00
52.01	05201	PERINATAL CLINIC	652,099	169,791	227,582	157,374	1,206,846	52.01
53.00	05300	ANESTHESIOLOGY	699,970	9,946	13,331	23,560	746,807	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	7,136,956	135,975	182,256	796,516	8,251,703	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	3,197,558	127,374	170,728	602,644	4,098,304	55.00
56.00	05600	RADIOISOTOPE	814,677	16,914	22,670	52,863	907,124	56.00
57.00	05700	CT SCAN	1,269,208	133,753	179,277	245,516	1,827,754	57.00
58.00	05800	MRI	377,662	30,927	41,453	91,159	541,201	58.00
59.00	05900	CARDIAC CATHETERIZATION	1,805,871	86,257	115,616	370,445	2,378,189	59.00
60.00	06000	LABORATORY	4,250,033	251,203	336,704	531,143	5,369,083	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	2,795,597	9,235	12,378	126,527	2,943,737	62.00
64.00	06400	INTRAVENOUS THERAPY	2,525,681	43,473	58,270	520,148	3,147,572	64.00
65.00	06500	RESPIRATORY THERAPY	3,784,053	90,102	120,769	720,997	4,715,921	65.00
66.00	06600	PHYSICAL THERAPY	2,210,306	88,768	118,982	0	2,418,056	66.00
66.01	06601	CLINICAL NUTRITION	507,897	0	0	152,046	659,943	66.01
67.00	06700	OCCUPATIONAL THERAPY	1,150,050	47,396	63,528	0	1,260,974	67.00
68.00	06800	SPEECH PATHOLOGY	559,453	1,100	1,475	0	562,028	68.00
69.00	06900	ELECTROCARDIOLOGY	3,854,371	10,846	14,538	795,506	4,675,261	69.00
69.01	06901	CARDIAC REHABILITATION	240,057	105,904	141,950	62,977	550,888	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	207,239	7,646	10,248	70,916	296,049	70.00
70.01	07001	ELECTROSHOCK THERAPY	74,719	17,225	23,087	18,655	133,686	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	22,478,991	0	0	0	22,478,991	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	14,856,038	0	0	0	14,856,038	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	42,767,289	0	0	0	42,767,289	73.00
74.00	07400	RENAL DIALYSIS	2,006,168	16,469	22,075	0	2,044,712	74.00
76.00	03330	ENDOSCOPY	1,066,846	45,851	61,457	231,983	1,406,137	76.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	6,641,970	289,809	388,449	1,197,599	8,517,827	90.00
91.00	09100	EMERGENCY	11,552,941	308,378	413,339	2,512,466	14,787,124	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					0	92.00
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	390,049,165	8,103,597	10,861,777	33,952,531	389,943,246	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	75,861	18,725	25,098	0	119,684	190.00
191.00	19100	RESEARCH	111,914	0	0	11,437	123,351	191.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	0	0	28,784	28,784	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07951	NONREIMBURSABLE	55,550	3,756	5,035	13,084	77,425	194.00
194.01	07952	NONREIMBURSABLE	0	0	0	0	0	194.01
194.02	07953	NONREIMBURSABLE	0	0	0	0	0	194.02
194.03	07950	RETAIL PHARMACY	20,707,736	0	0	0	20,707,736	194.03

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 26-0104

Period:
From 01/01/2020
To 12/31/2020Worksheet B
Part I
Date/Time Prepared:
7/30/2021 8:44 am

Cost Center Description			Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
				BLDG & FIXT	MVBLE EQUIP			
			0	1.00	2.00	4.00	4A	
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)	411,000,226	8,126,078	10,891,910	34,005,836	411,000,226	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 26-0104

Period:
From 01/01/2020
To 12/31/2020Worksheet B
Part I
Date/Time Prepared:
7/30/2021 8:44 am

Cost Center Description			ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
			5.00	7.00	8.00	9.00	10.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	92,206,054					5.00
7.00	00700	OPERATION OF PLANT	3,527,052	15,721,512				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	408,655	63,355	1,884,897			8.00
9.00	00900	HOUSEKEEPING	1,486,784	49,228	0	6,676,431		9.00
10.00	01000	DIETARY	758,593	500,824	0	214,218	4,096,400	10.00
11.00	01100	CAFETERIA	1,449,760	0	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	1,822,270	190,467	0	81,469	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	1,058,681	555,461	0	237,588	0	14.00
15.00	01500	PHARMACY	2,326,200	82,114	0	35,123	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	201,043	126,824	0	54,247	0	16.00
17.00	01700	SOCIAL SERVICE	228,453	34,526	0	14,768	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	414,695	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	59,255	34,641	0	14,817	0	22.00
23.00	02300	PHARMACY RESIDENCY PRGM	113,110	15,479	0	6,621	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	14,060,681	4,258,054	1,480,824	1,821,305	3,218,239	30.00
31.00	03100	INTENSIVE CARE UNIT	4,932,397	613,378	317,411	262,361	689,821	31.00
40.00	04000	SUBPROVIDER - IPF	1,115,384	925,404	86,662	395,824	188,340	40.00
43.00	04300	NURSERY	303,758	203,989	0	87,253	0	43.00
44.00	04400	SKILLED NURSING FACILITY	1,231,153	0	0	0	0	44.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	4,838,946	1,744,872	0	746,337	0	50.00
51.00	05100	RECOVERY ROOM	348,707	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,018,420	971,784	0	415,662	0	52.00
52.01	05201	PERINATAL CLINIC	349,061	439,599	0	188,030	0	52.01
53.00	05300	ANESTHESIOLOGY	216,002	25,750	0	11,014	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,386,673	352,047	0	150,582	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	1,185,369	329,778	0	141,056	0	55.00
56.00	05600	RADIOISOTOPE	262,371	43,790	0	18,730	0	56.00
57.00	05700	CT SCAN	528,649	346,293	0	148,120	0	57.00
58.00	05800	MRI	156,534	80,071	0	34,249	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	687,853	223,324	0	95,523	0	59.00
60.00	06000	LABORATORY	1,552,921	650,378	0	278,187	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	851,429	23,909	0	10,227	0	62.00
64.00	06400	INTRAVENOUS THERAPY	910,385	112,554	0	48,143	0	64.00
65.00	06500	RESPIRATORY THERAPY	1,364,005	233,279	0	99,781	0	65.00
66.00	06600	PHYSICAL THERAPY	699,384	229,826	0	98,304	0	66.00
66.01	06601	CLINICAL NUTRITION	190,878	0	0	0	0	66.01
67.00	06700	OCCUPATIONAL THERAPY	364,717	122,710	0	52,487	0	67.00
68.00	06800	SPEECH PATHOLOGY	162,558	2,848	0	1,218	0	68.00
69.00	06900	ELECTROCARDIOLOGY	1,352,244	28,081	0	12,011	0	69.00
69.01	06901	CARDIAC REHABILITATION	159,336	274,192	0	117,230	0	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	85,627	19,795	0	8,467	0	70.00
70.01	07001	ELECTROSHOCK THERAPY	38,667	44,596	0	19,075	0	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	6,501,688	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	4,296,871	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	12,369,754	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	591,400	42,639	0	18,238	0	74.00
76.00	03330	ENDOSCOPY	406,703	118,711	0	50,776	0	76.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	2,463,645	750,330	0	320,940	0	90.00
91.00	09100	EMERGENCY	4,276,939	798,407	0	341,504	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	86,115,660	15,663,307	1,884,897	6,651,535	4,096,400	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	34,617	48,480	0	20,736	0	190.00
191.00	19100	RESEARCH	35,677	0	0	0	0	191.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	8,325	0	0	0	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07951	NONREIMBURSABLE	22,394	9,725	0	4,160	0	194.00
194.01	07952	NONREIMBURSABLE	0	0	0	0	0	194.01
194.02	07953	NONREIMBURSABLE	0	0	0	0	0	194.02
194.03	07950	RETAIL PHARMACY	5,989,381	0	0	0	0	194.03
200.00		Cross Foot Adjustments	0	0	0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	92,206,054	15,721,512	1,884,897	6,676,431	4,096,400	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 26-0104

Period:
From 01/01/2020
To 12/31/2020Worksheet B
Part I
Date/Time Prepared:
7/30/2021 8:44 am

Cost Center Description			CAFETERIA	NURSING ADMINISTRATIO N	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
			11.00	13.00	14.00	15.00	16.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA	6,462,172					11.00
13.00	01300	NURSING ADMINISTRATION	185,455	8,579,992				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	44,399	0	5,556,422			14.00
15.00	01500	PHARMACY	342,694	0	0	10,828,753		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	20,196	0	0	0	1,097,397	16.00
17.00	01700	SOCIAL SERVICE	27,058	0	0	1,302	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	72,391	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0	22.00
23.00	02300	PHARMACY RESIDENCY PRGM	17,334	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	2,114,038	3,705,574	0	445	118,445	30.00
31.00	03100	INTENSIVE CARE UNIT	661,116	1,496,506	0	227	37,378	31.00
40.00	04000	SUBPROVIDER - IPF	142,415	299,691	0	5,660	20,724	40.00
43.00	04300	NURSERY	29,134	69,182	0	0	1,943	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	502,295	792,382	0	19	89,350	50.00
51.00	05100	RECOVERY ROOM	55,322	103,613	0	41	7,391	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	113,294	263,550	0	3	8,476	52.00
52.01	05201	PERINATAL CLINIC	35,996	35,764	0	11	4,534	52.01
53.00	05300	ANESTHESIOLOGY	5,389	0	0	0	22,980	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	182,186	74,942	0	180	51,015	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	137,842	116,635	0	326	34,823	55.00
56.00	05600	RADIOISOTOPE	12,091	0	0	20	4,834	56.00
57.00	05700	CT SCAN	56,156	0	0	0	50,145	57.00
58.00	05800	MRI	20,851	28	0	0	12,256	58.00
59.00	05900	CARDIAC CATHETERIZATION	84,731	130,321	0	1,006	33,000	59.00
60.00	06000	LABORATORY	121,488	0	0	0	71,457	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	28,940	0	0	276,865	7,067	62.00
64.00	06400	INTRAVENOUS THERAPY	118,973	213,380	0	0	16,624	64.00
65.00	06500	RESPIRATORY THERAPY	164,913	0	0	90	25,806	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	5,982	66.00
66.01	06601	CLINICAL NUTRITION	34,777	0	0	0	40	66.01
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	3,466	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	2,281	68.00
69.00	06900	ELECTROCARDIOLOGY	181,955	96,638	0	82	51,644	69.00
69.01	06901	CARDIAC REHABILITATION	14,405	29,441	0	28	599	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	16,220	3,128	0	0	5,149	70.00
70.01	07001	ELECTROSHOCK THERAPY	4,267	8,539	0	0	323	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	3,424,759	0	18,477	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	2,131,663	0	22,313	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	10,334,869	248,754	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	5,128	74.00
76.00	03330	ENDOSCOPY	53,061	101,909	0	1	10,774	76.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	273,925	119,999	0	207,465	18,142	90.00
91.00	09100	EMERGENCY	574,672	918,579	0	113	86,077	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	6,449,979	8,579,801	5,556,422	10,828,753	1,097,397	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
191.00	19100	RESEARCH	2,616	0	0	0	0	191.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	6,584	0	0	0	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07951	NONREIMBURSABLE	2,993	191	0	0	0	194.00
194.01	07952	NONREIMBURSABLE	0	0	0	0	0	194.01
194.02	07953	NONREIMBURSABLE	0	0	0	0	0	194.02
194.03	07950	RETAIL PHARMACY	0	0	0	0	0	194.03
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	6,462,172	8,579,992	5,556,422	10,828,753	1,097,397	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 26-0104

Period:
From 01/01/2020
To 12/31/2020Worksheet B
Part I
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Cost Center Description			SOCIAL SERVICE	NONPHYSICIAN ANESTHETISTS	INTERNS & RESIDENTS		PHARMACY RESIDENCY PRGM	
					SERVICES-SALA RY & FRINGES APPRV	SERVICES-OTHE R PRGM COSTS APPRV		
			17.00	19.00	21.00	22.00	23.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
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	1,095,962					17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS		0				19.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV			1,920,855			21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV				313,581		22.00
23.00	02300	PHARMACY RESIDENCY PRGM					543,610	23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	861,016	0	775,106	126,537	171,667	30.00
31.00	03100	INTENSIVE CARE UNIT	184,557	0	0	0	114,444	31.00
40.00	04000	SUBPROVIDER - IPF	50,389	0	0	0	85,833	40.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	1,041,590	170,041	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
52.01	05201	PERINATAL CLINIC	0	0	0	0	0	52.01
53.00	05300	ANESTHESIOLOGY	0	0	8,116	1,325	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	12,174	1,987	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	MRI	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	6,764	1,104	0	59.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0	0	0	62.00
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	85,833	69.00
69.01	06901	CARDIAC REHABILITATION	0	0	0	0	0	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
70.01	07001	ELECTROSHOCK THERAPY	0	0	0	0	0	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.00	03330	ENDOSCOPY	0	0	0	0	0	76.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	77,105	12,587	85,833	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	1,095,962	0	1,920,855	313,581	543,610	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEN	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
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07951	NONREIMBURSABLE	0	0	0	0	0	194.00
194.01	07952	NONREIMBURSABLE	0	0	0	0	0	194.01
194.02	07953	NONREIMBURSABLE	0	0	0	0	0	194.02
194.03	07950	RETAIL PHARMACY	0	0	0	0	0	194.03
200.00		Cross Foot Adjustments		0	0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 26-0104

Period:
From 01/01/2020
To 12/31/2020Worksheet B
Part I
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Cost Center Description		SOCIAL SERVICE	NONPHYSICIAN ANESTHETISTS	INTERNS & RESIDENTS		PHARMACY RESIDENCY PRGM	
				SERVICES-SALA RY & FRINGES APPRV	SERVICES-OTHE R PRGM COSTS APPRV		
				21.00	22.00		
202.00	TOTAL (sum lines 118 through 201)	1,095,962	0	1,920,855	313,581	543,610	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 26-0104

Period:
From 01/01/2020
To 12/31/2020Worksheet B
Part I
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Cost Center Description			Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			24.00	25.00	26.00	
GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT				4.00
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
19.00	01900	NONPHYSICIAN ANESTHETISTS				19.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV				21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV				22.00
23.00	02300	PHARMACY RESIDENCY PRGM				23.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	81,325,651	-901,643	80,424,008	30.00
31.00	03100	INTENSIVE CARE UNIT	26,362,907	0	26,362,907	31.00
40.00	04000	SUBPROVIDER - IPF	7,172,665	0	7,172,665	40.00
43.00	04300	NURSERY	1,745,476	0	1,745,476	43.00
44.00	04400	SKILLED NURSING FACILITY	5,487,751	0	5,487,751	44.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	26,656,045	-1,211,631	25,444,414	50.00
51.00	05100	RECOVERY ROOM	1,720,697	0	1,720,697	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	6,312,282	0	6,312,282	52.00
52.01	05201	PERINATAL CLINIC	2,259,841	0	2,259,841	52.01
53.00	05300	ANESTHESIOLOGY	1,037,383	-9,441	1,027,942	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	11,463,489	-14,161	11,449,328	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	6,044,133	0	6,044,133	55.00
56.00	05600	RADIOISOTOPE	1,248,960	0	1,248,960	56.00
57.00	05700	CT SCAN	2,957,117	0	2,957,117	57.00
58.00	05800	MRI	845,190	0	845,190	58.00
59.00	05900	CARDIAC CATHETERIZATION	3,641,815	-7,868	3,633,947	59.00
60.00	06000	LABORATORY	8,043,514	0	8,043,514	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	4,142,174	0	4,142,174	62.00
64.00	06400	INTRAVENOUS THERAPY	4,567,631	0	4,567,631	64.00
65.00	06500	RESPIRATORY THERAPY	6,603,795	0	6,603,795	65.00
66.00	06600	PHYSICAL THERAPY	3,451,552	0	3,451,552	66.00
66.01	06601	CLINICAL NUTRITION	885,638	0	885,638	66.01
67.00	06700	OCCUPATIONAL THERAPY	1,804,354	0	1,804,354	67.00
68.00	06800	SPEECH PATHOLOGY	730,933	0	730,933	68.00
69.00	06900	ELECTROCARDIOLOGY	6,483,749	0	6,483,749	69.00
69.01	06901	CARDIAC REHABILITATION	1,146,169	0	1,146,169	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	434,435	0	434,435	70.00
70.01	07001	ELECTROSHOCK THERAPY	249,153	0	249,153	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	32,423,915	0	32,423,915	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	21,306,885	0	21,306,885	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	65,720,666	0	65,720,666	73.00
74.00	07400	RENAL DIALYSIS	2,702,117	0	2,702,117	74.00
76.00	03330	ENDOSCOPY	2,148,072	0	2,148,072	76.00
OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	12,672,273	0	12,672,273	90.00
91.00	09100	EMERGENCY	21,958,940	-89,692	21,869,248	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART		0		92.00
SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	383,757,367	-2,234,436	381,522,931	118.00
NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	223,517	0	223,517	190.00
191.00	19100	RESEARCH	161,644	0	161,644	191.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	43,693	0	43,693	192.00
193.00	19300	NONPAID WORKERS	0	0	0	193.00
194.00	07951	NONREIMBURSABLE	116,888	0	116,888	194.00
194.01	07952	NONREIMBURSABLE	0	0	0	194.01
194.02	07953	NONREIMBURSABLE	0	0	0	194.02
194.03	07950	RETAIL PHARMACY	26,697,117	0	26,697,117	194.03
200.00		Cross Foot Adjustments	0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	201.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 26-0104

Period:
From 01/01/2020
To 12/31/2020Worksheet B
Part I
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Cost Center Description		Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
		24.00	25.00	26.00		
202.00	TOTAL (sum lines 118 through 201)	411,000,226	-2,234,436	408,765,790		202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 26-0104

Period:
From 01/01/2020
To 12/31/2020Worksheet B
Part II
Date/Time Prepared:
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Cost Center Description			CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
			Directly Assigned New Capital Related Costs	BLDG & FIXT	MVBLE EQUIP		
			0	1.00	2.00	2A	4.00
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	32,482	43,538	76,020	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	1,297,900	1,309,745	1,755,537	4,363,182	5.00
7.00	00700	OPERATION OF PLANT	0	711,548	953,733	1,665,281	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	24,470	32,799	57,269	8.00
9.00	00900	HOUSEKEEPING	0	19,014	25,486	44,500	9.00
10.00	01000	DIETARY	4,251	193,439	259,279	456,969	10.00
11.00	01100	CAFETERIA	0	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	73,566	98,606	172,172	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	103,082	214,542	287,565	605,189	14.00
15.00	01500	PHARMACY	542,633	31,716	42,511	616,860	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	48,985	65,658	114,643	16.00
17.00	01700	SOCIAL SERVICE	0	13,335	17,874	31,209	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	19.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	17,727	0	0	17,727	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	13,380	17,934	31,314	22.00
23.00	02300	PHARMACY RESIDENCY PRGM	0	5,979	8,014	13,993	23.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	347	1,644,638	2,204,415	3,849,400	30.00
31.00	03100	INTENSIVE CARE UNIT	85,736	236,912	317,549	640,197	31.00
40.00	04000	SUBPROVIDER - IPF	0	357,430	479,086	836,516	40.00
43.00	04300	NURSERY	0	78,789	105,606	184,395	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	44.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	1,325,311	673,942	903,328	2,902,581	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	375,343	503,097	878,440	52.00
52.01	05201	PERINATAL CLINIC	146,482	169,791	227,582	543,855	52.01
53.00	05300	ANESTHESIOLOGY	112,046	9,946	13,331	135,323	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	280,095	135,975	182,256	598,326	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	695,835	127,374	170,728	993,937	55.00
56.00	05600	RADIOISOTOPE	0	16,914	22,670	39,584	56.00
57.00	05700	CT SCAN	0	133,753	179,277	313,030	57.00
58.00	05800	MRI	0	30,927	41,453	72,380	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	86,257	115,616	201,873	59.00
60.00	06000	LABORATORY	124,466	251,203	336,704	712,373	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	9,235	12,378	21,613	62.00
64.00	06400	INTRAVENOUS THERAPY	283,738	43,473	58,270	385,481	64.00
65.00	06500	RESPIRATORY THERAPY	164,352	90,102	120,769	375,223	65.00
66.00	06600	PHYSICAL THERAPY	0	88,768	118,982	207,750	66.00
66.01	06601	CLINICAL NUTRITION	0	0	0	0	66.01
67.00	06700	OCCUPATIONAL THERAPY	0	47,396	63,528	110,924	67.00
68.00	06800	SPEECH PATHOLOGY	0	1,100	1,475	2,575	68.00
69.00	06900	ELECTROCARDIOLOGY	377,954	10,846	14,538	403,338	69.00
69.01	06901	CARDIAC REHABILITATION	0	105,904	141,950	247,854	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0	7,646	10,248	17,894	70.00
70.01	07001	ELECTROSHOCK THERAPY	0	17,225	23,087	40,312	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	16,469	22,075	38,544	74.00
76.00	03330	ENDOSCOPY	56,461	45,851	61,457	163,769	76.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	798,730	289,809	388,449	1,476,988	90.00
91.00	09100	EMERGENCY	163,913	308,378	413,339	885,630	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				0	92.00
SPECIAL PURPOSE COST CENTERS							
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	6,581,059	8,103,597	10,861,777	25,546,433	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	0	18,725	25,098	43,823	190.00
191.00	19100	RESEARCH	0	0	0	0	191.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	0	0	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	193.00
194.00	07951	NONREIMBURSABLE	0	3,756	5,035	8,791	194.00
194.01	07952	NONREIMBURSABLE	0	0	0	0	194.01
194.02	07953	NONREIMBURSABLE	0	0	0	0	194.02
194.03	07950	RETAIL PHARMACY	0	0	0	0	194.03
200.00		Cross Foot Adjustments				0	200.00

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ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 26-0104

Period:
From 01/01/2020
To 12/31/2020Worksheet B
Part II
Date/Time Prepared:
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Cost Center Description			ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
			5.00	7.00	8.00	9.00	10.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	4,371,750					5.00
7.00	00700	OPERATION OF PLANT	167,223	1,833,563				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	19,375	7,389	84,113			8.00
9.00	00900	HOUSEKEEPING	70,491	5,741	0	122,304		9.00
10.00	01000	DIETARY	35,966	58,410	0	3,924	555,899	10.00
11.00	01100	CAFETERIA	68,735	0	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	86,396	22,214	0	1,492	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	50,194	64,782	0	4,352	0	14.00
15.00	01500	PHARMACY	110,288	9,577	0	643	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	9,532	14,791	0	994	0	16.00
17.00	01700	SOCIAL SERVICE	10,831	4,027	0	271	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	19,661	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	2,809	4,040	0	271	0	22.00
23.00	02300	PHARMACY RESIDENCY PRGM	5,363	1,805	0	121	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	666,766	496,610	66,082	33,370	436,728	30.00
31.00	03100	INTENSIVE CARE UNIT	233,852	71,537	14,164	4,806	93,612	31.00
40.00	04000	SUBPROVIDER - IPF	52,882	107,928	3,867	7,251	25,559	40.00
43.00	04300	NURSERY	14,402	23,791	0	1,598	0	43.00
44.00	04400	SKILLED NURSING FACILITY	58,371	0	0	0	0	44.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	229,421	203,500	0	13,672	0	50.00
51.00	05100	RECOVERY ROOM	16,533	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	48,285	113,337	0	7,614	0	52.00
52.01	05201	PERINATAL CLINIC	16,549	51,269	0	3,444	0	52.01
53.00	05300	ANESTHESIOLOGY	10,241	3,003	0	202	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	113,156	41,058	0	2,758	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	56,200	38,461	0	2,584	0	55.00
56.00	05600	RADIOISOTOPE	12,439	5,107	0	343	0	56.00
57.00	05700	CT SCAN	25,064	40,387	0	2,713	0	57.00
58.00	05800	MRI	7,421	9,338	0	627	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	32,612	26,046	0	1,750	0	59.00
60.00	06000	LABORATORY	73,626	75,852	0	5,096	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	40,367	2,788	0	187	0	62.00
64.00	06400	INTRAVENOUS THERAPY	43,163	13,127	0	882	0	64.00
65.00	06500	RESPIRATORY THERAPY	64,669	27,207	0	1,828	0	65.00
66.00	06600	PHYSICAL THERAPY	33,159	26,804	0	1,801	0	66.00
66.01	06601	CLINICAL NUTRITION	9,050	0	0	0	0	66.01
67.00	06700	OCCUPATIONAL THERAPY	17,292	14,311	0	961	0	67.00
68.00	06800	SPEECH PATHOLOGY	7,707	332	0	22	0	68.00
69.00	06900	ELECTROCARDIOLOGY	64,112	3,275	0	220	0	69.00
69.01	06901	CARDIAC REHABILITATION	7,554	31,978	0	2,148	0	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	4,060	2,309	0	155	0	70.00
70.01	07001	ELECTROSHOCK THERAPY	1,833	5,201	0	349	0	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	308,254	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	203,721	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	586,468	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	28,039	4,973	0	334	0	74.00
76.00	03330	ENDOSCOPY	19,282	13,845	0	930	0	76.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	116,805	87,509	0	5,879	0	90.00
91.00	09100	EMERGENCY	202,776	93,116	0	6,256	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	4,082,995	1,826,775	84,113	121,848	555,899	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	1,641	5,654	0	380	0	190.00
191.00	19100	RESEARCH	1,692	0	0	0	0	191.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	395	0	0	0	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07951	NONREIMBURSABLE	1,062	1,134	0	76	0	194.00
194.01	07952	NONREIMBURSABLE	0	0	0	0	0	194.01
194.02	07953	NONREIMBURSABLE	0	0	0	0	0	194.02
194.03	07950	RETAIL PHARMACY	283,965	0	0	0	0	194.03
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)	4,371,750	1,833,563	84,113	122,304	555,899	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 26-0104

Period:
From 01/01/2020
To 12/31/2020Worksheet B
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Cost Center Description			CAFETERIA	NURSING ADMINISTRATIO N	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
			11.00	13.00	14.00	15.00	16.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA	69,682					11.00
13.00	01300	NURSING ADMINISTRATION	2,001	286,087				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	479	0	725,430			14.00
15.00	01500	PHARMACY	3,697	0	0	744,413		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	218	0	0	0	140,375	16.00
17.00	01700	SOCIAL SERVICE	292	0	0	90	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	781	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0	22.00
23.00	02300	PHARMACY RESIDENCY PRGM	187	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	22,777	123,556	0	31	15,121	30.00
31.00	03100	INTENSIVE CARE UNIT	7,132	49,899	0	16	4,772	31.00
40.00	04000	SUBPROVIDER - IPF	1,536	9,993	0	389	2,646	40.00
43.00	04300	NURSERY	314	2,307	0	0	248	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	5,419	26,421	0	1	11,406	50.00
51.00	05100	RECOVERY ROOM	597	3,455	0	3	943	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,222	8,788	0	0	1,082	52.00
52.01	05201	PERINATAL CLINIC	388	1,192	0	1	579	52.01
53.00	05300	ANESTHESIOLOGY	58	0	0	0	2,934	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,965	2,499	0	12	6,513	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	1,487	3,889	0	22	4,446	55.00
56.00	05600	RADIOISOTOPE	130	0	0	1	617	56.00
57.00	05700	CT SCAN	606	0	0	0	6,401	57.00
58.00	05800	MRI	225	1	0	0	1,565	58.00
59.00	05900	CARDIAC CATHETERIZATION	914	4,345	0	69	4,213	59.00
60.00	06000	LABORATORY	1,311	0	0	0	9,122	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	312	0	0	19,032	902	62.00
64.00	06400	INTRAVENOUS THERAPY	1,283	7,115	0	0	2,122	64.00
65.00	06500	RESPIRATORY THERAPY	1,779	0	0	6	3,294	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	764	66.00
66.01	06601	CLINICAL NUTRITION	375	0	0	0	5	66.01
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	442	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	291	68.00
69.00	06900	ELECTROCARDIOLOGY	1,963	3,222	0	6	6,593	69.00
69.01	06901	CARDIAC REHABILITATION	155	982	0	2	76	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	175	104	0	0	657	70.00
70.01	07001	ELECTROSHOCK THERAPY	46	285	0	0	41	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	447,132	0	2,359	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	278,298	0	2,848	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	710,462	32,038	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	655	74.00
76.00	03330	ENDOSCOPY	572	3,398	0	0	1,375	76.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	2,955	4,001	0	14,262	2,316	90.00
91.00	09100	EMERGENCY	6,200	30,629	0	8	10,989	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
SPECIAL PURPOSE COST CENTERS								
118.00	SUBTOTALS (SUM OF LINES 1 through 117)		69,551	286,081	725,430	744,413	140,375	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
191.00	19100	RESEARCH	28	0	0	0	0	191.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	71	0	0	0	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07951	NONREIMBURSABLE	32	6	0	0	0	194.00
194.01	07952	NONREIMBURSABLE	0	0	0	0	0	194.01
194.02	07953	NONREIMBURSABLE	0	0	0	0	0	194.02
194.03	07950	RETAIL PHARMACY	0	0	0	0	0	194.03
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)	69,682	286,087	725,430	744,413	140,375	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 26-0104

Period:
From 01/01/2020
To 12/31/2020Worksheet B
Part II
Date/Time Prepared:
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Cost Center Description			SOCIAL SERVICE	NONPHYSICIAN ANESTHETISTS	INTERNS & RESIDENTS		PHARMACY RESIDENCY PRGM	
					SERVICES-SALA RY & FRINGES APPRV	SERVICES-OTHE R PRGM COSTS APPRV		
			17.00	19.00	21.00	22.00	23.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
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	46,984					17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0				19.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0		38,876			21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0			38,434		22.00
23.00	02300	PHARMACY RESIDENCY PRGM	0				21,638	23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	36,912					30.00
31.00	03100	INTENSIVE CARE UNIT	7,912					31.00
40.00	04000	SUBPROVIDER - IPF	2,160					40.00
43.00	04300	NURSERY	0					43.00
44.00	04400	SKILLED NURSING FACILITY	0					44.00
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
52.01	05201	PERINATAL CLINIC	0					52.01
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	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 CELL	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 REHABILITATION	0					69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0					70.00
70.01	07001	ELECTROSHOCK THERAPY	0					70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0					71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	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								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	46,984	0	0	0	0	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEN	0					190.00
191.00	19100	RESEARCH	0					191.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	0					192.00
193.00	19300	NONPAID WORKERS	0					193.00
194.00	07951	NONREIMBURSABLE	0					194.00
194.01	07952	NONREIMBURSABLE	0					194.01
194.02	07953	NONREIMBURSABLE	0					194.02
194.03	07950	RETAIL PHARMACY	0					194.03
200.00		Cross Foot Adjustments		0	38,876	38,434	21,638	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 26-0104

Period:
From 01/01/2020
To 12/31/2020Worksheet B
Part II
Date/Time Prepared:
7/30/2021 8:44 am

Cost Center Description			SOCIAL SERVICE	NONPHYSICIAN ANESTHETISTS	INTERNS & RESIDENTS		PHARMACY RESIDENCY PRGM	
					SERVICES-SALARY & FRINGES APPRV	SERVICES-OTHER PRGM COSTS APPRV		
					17.00	19.00		
202.00		TOTAL (sum lines 118 through 201)	46,984	0	38,876	38,434	21,638	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 26-0104

Period:
From 01/01/2020
To 12/31/2020Worksheet B
Part II
Date/Time Prepared:
7/30/2021 8:44 am

Cost Center Description			Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			24.00	25.00	26.00	
GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT				4.00
5.00	00500	ADMINISTRATIVE & GENERAL				5.00
7.00	00700	OPERATION OF PLANT				7.00
8.00	00800	LAUNDRY & LINEN SERVICE				8.00
9.00	00900	HOUSEKEEPING				9.00
10.00	01000	DIETARY				10.00
11.00	01100	CAFETERIA				11.00
13.00	01300	NURSING ADMINISTRATION				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY				14.00
15.00	01500	PHARMACY				15.00
16.00	01600	MEDICAL RECORDS & LIBRARY				16.00
17.00	01700	SOCIAL SERVICE				17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS				19.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV				21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV				22.00
23.00	02300	PHARMACY RESIDENCY PRGM				23.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	5,768,037	0	5,768,037	30.00
31.00	03100	INTENSIVE CARE UNIT	1,134,358	0	1,134,358	31.00
40.00	04000	SUBPROVIDER - IPF	1,052,118	0	1,052,118	40.00
43.00	04300	NURSERY	227,340	0	227,340	43.00
44.00	04400	SKILLED NURSING FACILITY	58,371	0	58,371	44.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	3,397,328	0	3,397,328	50.00
51.00	05100	RECOVERY ROOM	22,071	0	22,071	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,059,875	0	1,059,875	52.00
52.01	05201	PERINATAL CLINIC	617,629	0	617,629	52.01
53.00	05300	ANESTHESIOLOGY	151,814	0	151,814	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	768,067	0	768,067	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	1,102,373	0	1,102,373	55.00
56.00	05600	RADIOISOTOPE	58,339	0	58,339	56.00
57.00	05700	CT SCAN	388,750	0	388,750	57.00
58.00	05800	MRI	91,761	0	91,761	58.00
59.00	05900	CARDIAC CATHETERIZATION	272,650	0	272,650	59.00
60.00	06000	LABORATORY	878,567	0	878,567	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	85,484	0	85,484	62.00
64.00	06400	INTRAVENOUS THERAPY	454,335	0	454,335	64.00
65.00	06500	RESPIRATORY THERAPY	475,617	0	475,617	65.00
66.00	06600	PHYSICAL THERAPY	270,278	0	270,278	66.00
66.01	06601	CLINICAL NUTRITION	9,770	0	9,770	66.01
67.00	06700	OCCUPATIONAL THERAPY	143,930	0	143,930	67.00
68.00	06800	SPEECH PATHOLOGY	10,927	0	10,927	68.00
69.00	06900	ELECTROCARDIOLOGY	484,507	0	484,507	69.00
69.01	06901	CARDIAC REHABILITATION	290,890	0	290,890	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	25,512	0	25,512	70.00
70.01	07001	ELECTROSHOCK THERAPY	48,109	0	48,109	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	757,745	0	757,745	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	484,867	0	484,867	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,328,968	0	1,328,968	73.00
74.00	07400	RENAL DIALYSIS	72,545	0	72,545	74.00
76.00	03330	ENDOSCOPY	203,689	0	203,689	76.00
OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	1,713,391	0	1,713,391	90.00
91.00	09100	EMERGENCY	1,241,218	0	1,241,218	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART		0		92.00
SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	25,151,230	0	25,151,230	118.00
NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	51,498	0	51,498	190.00
191.00	19100	RESEARCH	1,746	0	1,746	191.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	530	0	530	192.00
193.00	19300	NONPAID WORKERS	0	0	0	193.00
194.00	07951	NONREIMBURSABLE	11,130	0	11,130	194.00
194.01	07952	NONREIMBURSABLE	0	0	0	194.01
194.02	07953	NONREIMBURSABLE	0	0	0	194.02
194.03	07950	RETAIL PHARMACY	283,965	0	283,965	194.03
200.00		Cross Foot Adjustments	98,948	0	98,948	200.00
201.00		Negative Cost Centers	0	0	0	201.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 26-0104

Period:
From 01/01/2020
To 12/31/2020Worksheet B
Part II
Date/Time Prepared:
7/30/2021 8:44 am

Cost Center Description		Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
		24.00	25.00	26.00		
202.00	TOTAL (sum lines 118 through 201)	25,599,047	0	25,599,047		202.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 26-0104

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

Worksheet B-1

Date/Time Prepared:
7/30/2021 8:44 am

Cost Center Description			CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
			BLDG & FIXT (SQUARE FEET)	MOVABLE EQUIP (SQUARE FEET)				
			1.00	2.00	4.00	5A	5.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT	731,241					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		731,241				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	2,923	2,923	120,045,127			4.00
5.00	00500	ADMINISTRATIVE & GENERAL	117,860	117,860	13,535,148	-92,206,054	318,794,172	5.00
7.00	00700	OPERATION OF PLANT	64,030	64,030	1,672,546	0	12,194,460	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	2,202	2,202	125,714	0	1,412,887	8.00
9.00	00900	HOUSEKEEPING	1,711	1,711	2,483,707	0	5,140,419	9.00
10.00	01000	DIETARY	17,407	17,407	995,367	0	2,622,765	10.00
11.00	01100	CAFETERIA	0	0	1,496,422	0	5,012,412	11.00
13.00	01300	NURSING ADMINISTRATION	6,620	6,620	2,862,263	0	6,300,331	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	19,306	19,306	685,239	0	3,660,293	14.00
15.00	01500	PHARMACY	2,854	2,854	5,289,066	0	8,042,622	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	4,408	4,408	311,702	0	695,087	16.00
17.00	01700	SOCIAL SERVICE	1,200	1,200	417,607	0	789,855	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	1,117,273	0	1,433,769	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	1,204	1,204	0	0	204,868	22.00
23.00	02300	PHARMACY RESIDENCY PRGM	538	538	267,529	0	391,066	23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	147,996	147,996	32,628,187	0	48,613,720	30.00
31.00	03100	INTENSIVE CARE UNIT	21,319	21,319	10,203,503	0	17,053,311	31.00
40.00	04000	SUBPROVIDER - IPF	32,164	32,164	2,197,997	0	3,856,339	40.00
43.00	04300	NURSERY	7,090	7,090	449,642	0	1,050,217	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	4,256,598	44.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	60,646	60,646	7,752,303	0	16,730,213	50.00
51.00	05100	RECOVERY ROOM	0	0	853,829	0	1,205,623	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	33,776	33,776	1,748,549	0	3,521,093	52.00
52.01	05201	PERINATAL CLINIC	15,279	15,279	555,551	0	1,206,846	52.01
53.00	05300	ANESTHESIOLOGY	895	895	83,170	0	746,807	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	12,236	12,236	2,811,813	0	8,251,703	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	11,462	11,462	2,127,418	0	4,098,304	55.00
56.00	05600	RADIOISOTOPE	1,522	1,522	186,613	0	907,124	56.00
57.00	05700	CT SCAN	12,036	12,036	866,705	0	1,827,754	57.00
58.00	05800	MRI	2,783	2,783	321,804	0	541,201	58.00
59.00	05900	CARDIAC CATHETERIZATION	7,762	7,762	1,307,721	0	2,378,189	59.00
60.00	06000	LABORATORY	22,605	22,605	1,875,010	0	5,369,083	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	831	831	446,658	0	2,943,737	62.00
64.00	06400	INTRAVENOUS THERAPY	3,912	3,912	1,836,194	0	3,147,572	64.00
65.00	06500	RESPIRATORY THERAPY	8,108	8,108	2,545,221	0	4,715,921	65.00
66.00	06600	PHYSICAL THERAPY	7,988	7,988	0	0	2,418,056	66.00
66.01	06601	CLINICAL NUTRITION	0	0	536,744	0	659,943	66.01
67.00	06700	OCCUPATIONAL THERAPY	4,265	4,265	0	0	1,260,974	67.00
68.00	06800	SPEECH PATHOLOGY	99	99	0	0	562,028	68.00
69.00	06900	ELECTROCARDIOLOGY	976	976	2,808,247	0	4,675,261	69.00
69.01	06901	CARDIAC REHABILITATION	9,530	9,530	222,317	0	550,888	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	688	688	250,342	0	296,049	70.00
70.01	07001	ELECTROSHOCK THERAPY	1,550	1,550	65,854	0	133,686	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	22,478,991	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	14,856,038	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	42,767,289	73.00
74.00	07400	RENAL DIALYSIS	1,482	1,482	0	0	2,044,712	74.00
76.00	03330	ENDOSCOPY	4,126	4,126	818,931	0	1,406,137	76.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	26,079	26,079	4,227,691	0	8,517,827	90.00
91.00	09100	EMERGENCY	27,750	27,750	8,869,354	0	14,787,124	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	729,218	729,218	119,856,951	-92,206,054	297,737,192	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	1,685	1,685	0	0	119,684	190.00
191.00	19100	RESEARCH	0	0	40,375	0	123,351	191.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	0	101,611	0	28,784	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07951	NONREIMBURSABLE	338	338	46,190	0	77,425	194.00
194.01	07952	NONREIMBURSABLE	0	0	0	0	0	194.01
194.02	07953	NONREIMBURSABLE	0	0	0	0	0	194.02
194.03	07950	RETAIL PHARMACY	0	0	0	0	20,707,736	194.03

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 26-0104

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

Worksheet B-1

Date/Time Prepared:
7/30/2021 8:44 am

Cost Center Description			CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliatio n	ADMINISTRATIV E & GENERAL (ACCUM. COST)	
			BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (SQUARE FEET)				
			1.00	2.00	4.00	5A	5.00	
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	8,126,078	10,891,910	34,005,836		92,206,054	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	11.112722	14.895103	0.283275		0.289234	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)			76,020		4,371,750	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)			0.000633		0.013713	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: 26-0104

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

Worksheet B-1

Date/Time Prepared:
7/30/2021 8:44 am

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	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT	546,428					7.00
8.00	00800	LAUNDRY & LINEN SERVICE	2,202	98,832				8.00
9.00	00900	HOUSEKEEPING	1,711	0	542,515			9.00
10.00	01000	DIETARY	17,407	0	17,407	98,832		10.00
11.00	01100	CAFETERIA	0	0	0	0	99,736,223	11.00
13.00	01300	NURSING ADMINISTRATION	6,620	0	6,620	0	2,862,263	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	19,306	0	19,306	0	685,239	14.00
15.00	01500	PHARMACY	2,854	0	2,854	0	5,289,066	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	4,408	0	4,408	0	311,702	16.00
17.00	01700	SOCIAL SERVICE	1,200	0	1,200	0	417,607	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	1,117,273	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	1,204	0	1,204	0	0	22.00
23.00	02300	PHARMACY RESIDENCY PRGM	538	0	538	0	267,529	23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	147,996	77,645	147,996	77,645	32,628,187	30.00
31.00	03100	INTENSIVE CARE UNIT	21,319	16,643	21,319	16,643	10,203,503	31.00
40.00	04000	SUBPROVIDER - IPF	32,164	4,544	32,164	4,544	2,197,997	40.00
43.00	04300	NURSERY	7,090	0	7,090	0	449,642	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	60,646	0	60,646	0	7,752,303	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	853,829	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	33,776	0	33,776	0	1,748,549	52.00
52.01	05201	PERINATAL CLINIC	15,279	0	15,279	0	555,551	52.01
53.00	05300	ANESTHESIOLOGY	895	0	895	0	83,170	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	12,236	0	12,236	0	2,811,813	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	11,462	0	11,462	0	2,127,418	55.00
56.00	05600	RADIOISOTOPE	1,522	0	1,522	0	186,613	56.00
57.00	05700	CT SCAN	12,036	0	12,036	0	866,705	57.00
58.00	05800	MRI	2,783	0	2,783	0	321,804	58.00
59.00	05900	CARDIAC CATHETERIZATION	7,762	0	7,762	0	1,307,721	59.00
60.00	06000	LABORATORY	22,605	0	22,605	0	1,875,010	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	831	0	831	0	446,658	62.00
64.00	06400	INTRAVENOUS THERAPY	3,912	0	3,912	0	1,836,194	64.00
65.00	06500	RESPIRATORY THERAPY	8,108	0	8,108	0	2,545,221	65.00
66.00	06600	PHYSICAL THERAPY	7,988	0	7,988	0	0	66.00
66.01	06601	CLINICAL NUTRITION	0	0	0	0	536,744	66.01
67.00	06700	OCCUPATIONAL THERAPY	4,265	0	4,265	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	99	0	99	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	976	0	976	0	2,808,247	69.00
69.01	06901	CARDIAC REHABILITATION	9,530	0	9,530	0	222,317	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	688	0	688	0	250,342	70.00
70.01	07001	ELECTROSHOCK THERAPY	1,550	0	1,550	0	65,854	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	1,482	0	1,482	0	0	74.00
76.00	03300	ENDOSCOPY	4,126	0	4,126	0	818,931	76.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	26,079	0	26,079	0	4,227,691	90.00
91.00	09100	EMERGENCY	27,750	0	27,750	0	8,869,354	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	544,405	98,832	540,492	98,832	99,548,047	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	1,685	0	1,685	0	0	190.00
191.00	19100	RESEARCH	0	0	0	0	40,375	191.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	0	0	0	101,611	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07951	NONREIMBURSABLE	338	0	338	0	46,190	194.00
194.01	07952	NONREIMBURSABLE	0	0	0	0	0	194.01
194.02	07953	NONREIMBURSABLE	0	0	0	0	0	194.02
194.03	07950	RETAIL PHARMACY	0	0	0	0	0	194.03
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 26-0104

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

Worksheet B-1

Date/Time Prepared:
7/30/2021 8:44 am

Cost Center Description			OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (TOTAL PATI ENT DAYS)	HOUSEKEEPING (SQUARE FEET)	DIETARY (TOTAL PATI ENT DAYS)	CAFETERIA (GROSS SALARIES)	
			7.00	8.00	9.00	10.00	11.00	
202.00		Cost to be allocated (per Wkst. B, Part I)	15,721,512	1,884,897	6,676,431	4,096,400	6,462,172	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	28.771425	19.071728	12.306445	41.448114	0.064793	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	1,833,563	84,113	122,304	555,899	69,682	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	3.355544	0.851071	0.225439	5.624686	0.000699	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: 26-0104

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

Worksheet B-1

Date/Time Prepared:
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Cost Center Description			NURSING ADMINISTRATIO N (DIRECT NRSING HRS)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS CHAR GES)	SOCIAL SERVICE (TOTAL PATI ENT DAYS)	
			13.00	14.00	15.00	16.00	17.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION	1,525,323					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	38,723,821				14.00
15.00	01500	PHARMACY	0	0	44,246,356			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	1,458,403,881		16.00
17.00	01700	SOCIAL SERVICE	0	0	5,320	0	98,832	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0	22.00
23.00	02300	PHARMACY RESIDENCY PRGM	0	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	658,765	0	1,818	157,506,579	77,645	30.00
31.00	03100	INTENSIVE CARE UNIT	266,044	0	929	49,705,404	16,643	31.00
40.00	04000	SUBPROVIDER - IPF	53,278	0	23,126	27,557,895	4,544	40.00
43.00	04300	NURSERY	12,299	0	0	2,583,211	0	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	140,867	0	79	118,816,753	0	50.00
51.00	05100	RECOVERY ROOM	18,420	0	167	9,828,096	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	46,853	0	12	11,271,427	0	52.00
52.01	05201	PERINATAL CLINIC	6,358	0	43	6,029,682	0	52.01
53.00	05300	ANESTHESIOLOGY	0	0	0	30,558,944	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	13,323	0	736	67,838,661	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	20,735	0	1,330	46,307,767	0	55.00
56.00	05600	RADIOISOTOPE	0	0	82	6,428,816	0	56.00
57.00	05700	CT SCAN	0	0	0	66,681,812	0	57.00
58.00	05800	MRI	5	0	0	16,297,791	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	23,168	0	4,109	43,882,715	0	59.00
60.00	06000	LABORATORY	0	0	0	95,022,662	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	1,131,270	9,397,147	0	62.00
64.00	06400	INTRAVENOUS THERAPY	37,934	0	0	22,106,387	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	367	34,316,120	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	7,954,151	0	66.00
66.01	06601	CLINICAL NUTRITION	0	0	0	53,263	0	66.01
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	4,609,249	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	3,033,374	0	68.00
69.00	06900	ELECTROCARDIOLOGY	17,180	0	335	68,675,806	0	69.00
69.01	06901	CARDIAC REHABILITATION	5,234	0	114	796,289	0	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	556	0	0	6,846,842	0	70.00
70.01	07001	ELECTROSHOCK THERAPY	1,518	0	0	428,895	0	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	23,867,784	0	24,569,849	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	14,856,037	0	29,671,199	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	42,228,347	329,891,873	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	6,819,224	0	74.00
76.00	03330	ENDOSCOPY	18,117	0	6	14,326,643	0	76.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	21,333	0	847,703	24,125,183	0	90.00
91.00	09100	EMERGENCY	163,302	0	463	114,464,172	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	1,525,289	38,723,821	44,246,356	1,458,403,881	98,832	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEN	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
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07951	NONREIMBURSABLE	34	0	0	0	0	194.00
194.01	07952	NONREIMBURSABLE	0	0	0	0	0	194.01
194.02	07953	NONREIMBURSABLE	0	0	0	0	0	194.02
194.03	07950	RETAIL PHARMACY	0	0	0	0	0	194.03
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 26-0104

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

Worksheet B-1

Date/Time Prepared:
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Cost Center Description		NURSING ADMINISTRATIO N (DIRECT NRSING HRS)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS CHAR GES)	SOCIAL SERVICE (TOTAL PATI ENT DAYS)	
		13.00	14.00	15.00	16.00	17.00	
202.00	Cost to be allocated (per Wkst. B, Part I)	8,579,992	5,556,422	10,828,753	1,097,397	1,095,962	202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	5.625033	0.143488	0.244738	0.000752	11.089141	203.00
204.00	Cost to be allocated (per Wkst. B, Part II)	286,087	725,430	744,413	140,375	46,984	204.00
205.00	Unit cost multiplier (Wkst. B, Part II)	0.187558	0.018733	0.016824	0.000096	0.475393	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: 26-0104

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

Worksheet B-1

Date/Time Prepared:
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Cost Center Description			INTERNS & RESIDENTS		PHARMACY RESIDENCY PRGM (ASSIGNED TIME)		
			NONPHYSICIAN ANESTHETISTS (ASSIGNED TIME)	SERVICES-SALA RY & FRINGES APPRV (ASSIGNED TIME)	SERVICES-OTHE R PRGM COSTS APPRV (ASSIGNED TIME)		
			19.00	21.00	22.00	23.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
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
19.00	01900	NONPHYSICIAN ANESTHETISTS	0				19.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV		2,840			21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV			2,840		22.00
23.00	02300	PHARMACY RESIDENCY PRGM				1,368	23.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	0	1,146	1,146	432	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	288	31.00
40.00	04000	SUBPROVIDER - IPF	0	0	0	216	40.00
43.00	04300	NURSERY	0	0	0	0	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	44.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	1,540	1,540	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	52.00
52.01	05201	PERINATAL CLINIC	0	0	0	0	52.01
53.00	05300	ANESTHESIOLOGY	0	12	12	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	18	18	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	55.00
56.00	05600	RADIOISOTOPE	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	10	10	0	59.00
60.00	06000	LABORATORY	0	0	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0	0	62.00
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	0	0	0	216	69.00
69.01	06901	CARDIAC REHABILITATION	0	0	0	0	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	70.00
70.01	07001	ELECTROSHOCK THERAPY	0	0	0	0	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	74.00
76.00	03330	ENDOSCOPY	0	0	0	0	76.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	114	114	216	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					92.00
SPECIAL PURPOSE COST CENTERS							
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	2,840	2,840	1,368	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
193.00	19300	NONPAID WORKERS	0	0	0	0	193.00
194.00	07951	NONREIMBURSABLE	0	0	0	0	194.00
194.01	07952	NONREIMBURSABLE	0	0	0	0	194.01
194.02	07953	NONREIMBURSABLE	0	0	0	0	194.02
194.03	07950	RETAIL PHARMACY	0	0	0	0	194.03

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 26-0104

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

Worksheet B-1

Date/Time Prepared:
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Cost Center Description			INTERNS & RESIDENTS					
			NONPHYSICIAN ANESTHETISTS (ASSIGNED TIME)	SERVICES-SALA RY & FRINGES APPRV (ASSIGNED TIME)	SERVICES-OTHE R PRGM COSTS APPRV (ASSIGNED TIME)	PHARMACY RESIDENCY PRGM (ASSIGNED TIME)		
			19.00	21.00	22.00	23.00		
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	0	1,920,855	313,581	543,610		202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.000000	676.357394	110.415845	397.375731		203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	0	38,876	38,434	21,638		204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.000000	13.688732	13.533099	15.817251		205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)				0		206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)				0.000000		207.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 26-0104

Period:
From 01/01/2020
To 12/31/2020Worksheet C
Part I
Date/Time Prepared:
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			Title XVIII		Hospital		PPS
Cost Center Description			Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs		
					Total Costs	RCE Disallowance	Total Costs
			1.00	2.00	3.00	4.00	5.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	80,424,008		80,424,008	19,091	80,443,099
31.00	03100	INTENSIVE CARE UNIT	26,362,907		26,362,907	0	26,362,907
40.00	04000	SUBPROVIDER - IPF	7,172,665		7,172,665	18,076	7,190,741
43.00	04300	NURSERY	1,745,476		1,745,476	0	1,745,476
44.00	04400	SKILLED NURSING FACILITY	5,487,751		5,487,751	0	5,487,751
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	25,444,414		25,444,414	0	25,444,414
51.00	05100	RECOVERY ROOM	1,720,697		1,720,697	0	1,720,697
52.00	05200	DELIVERY ROOM & LABOR ROOM	6,312,282		6,312,282	0	6,312,282
52.01	05201	PERINATAL CLINIC	2,259,841		2,259,841	0	2,259,841
53.00	05300	ANESTHESIOLOGY	1,027,942		1,027,942	30,842	1,058,784
54.00	05400	RADIOLOGY-DIAGNOSTIC	11,449,328		11,449,328	0	11,449,328
55.00	05500	RADIOLOGY-THERAPEUTIC	6,044,133		6,044,133	3,669	6,047,802
56.00	05600	RADIOISOTOPE	1,248,960		1,248,960	0	1,248,960
57.00	05700	CT SCAN	2,957,117		2,957,117	0	2,957,117
58.00	05800	MRI	845,190		845,190	0	845,190
59.00	05900	CARDIAC CATHETERIZATION	3,633,947		3,633,947	0	3,633,947
60.00	06000	LABORATORY	8,043,514		8,043,514	0	8,043,514
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	4,142,174		4,142,174	0	4,142,174
64.00	06400	INTRAVENOUS THERAPY	4,567,631		4,567,631	0	4,567,631
65.00	06500	RESPIRATORY THERAPY	6,603,795	0	6,603,795	11,414	6,615,209
66.00	06600	PHYSICAL THERAPY	3,451,552	0	3,451,552	0	3,451,552
66.01	06601	CLINICAL NUTRITION	885,638	0	885,638	0	885,638
67.00	06700	OCCUPATIONAL THERAPY	1,804,354	0	1,804,354	0	1,804,354
68.00	06800	SPEECH PATHOLOGY	730,933	0	730,933	0	730,933
69.00	06900	ELECTROCARDIOLOGY	6,483,749		6,483,749	0	6,483,749
69.01	06901	CARDIAC REHABILITATION	1,146,169		1,146,169	5,392	1,151,561
70.00	07000	ELECTROENCEPHALOGRAPHY	434,435		434,435	133,388	567,823
70.01	07001	ELECTROSHOCK THERAPY	249,153		249,153	0	249,153
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	32,423,915		32,423,915	0	32,423,915
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	21,306,885		21,306,885	0	21,306,885
73.00	07300	DRUGS CHARGED TO PATIENTS	65,720,666		65,720,666	0	65,720,666
74.00	07400	RENAL DIALYSIS	2,702,117		2,702,117	0	2,702,117
76.00	03330	ENDOSCOPY	2,148,072		2,148,072	0	2,148,072
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	12,672,273		12,672,273	15	12,672,288
91.00	09100	EMERGENCY	21,869,248		21,869,248	0	21,869,248
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	7,967,673		7,967,673		7,967,673
200.00		Subtotal (see instructions)	389,490,604	0	389,490,604	221,887	389,712,491
201.00		Less Observation Beds	7,967,673		7,967,673		7,967,673
202.00		Total (see instructions)	381,522,931	0	381,522,931	221,887	381,744,818

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 26-0104

Period:
From 01/01/2020
To 12/31/2020Worksheet C
Part I
Date/Time Prepared:
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			Title XVIII		Hospital	PPS	
Cost Center Description			Charges			Cost or Other Ratio	TEFRA Inpatient Ratio
			Inpatient	Outpatient	Total (col. 6 + col. 7)		
			6.00	7.00	8.00		
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	128,981,583		128,981,583		30.00
31.00	03100	INTENSIVE CARE UNIT	49,473,158		49,473,158		31.00
40.00	04000	SUBPROVIDER - IPF	27,513,837		27,513,837		40.00
43.00	04300	NURSERY	2,545,145		2,545,145		43.00
44.00	04400	SKILLED NURSING FACILITY	4,226,875		4,226,875		44.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	48,653,706	63,839,299	112,493,005	0.226187	0.000000
51.00	05100	RECOVERY ROOM	5,149,147	4,259,091	9,408,238	0.182893	0.000000
52.00	05200	DELIVERY ROOM & LABOR ROOM	8,397,304	2,032,122	10,429,426	0.605238	0.000000
52.01	05201	PERINATAL CLINIC	131,659	5,555,673	5,687,332	0.397346	0.000000
53.00	05300	ANESTHESIOLOGY	13,320,735	15,892,521	29,213,256	0.035188	0.000000
54.00	05400	RADIOLOGY-DIAGNOSTIC	22,232,092	42,815,583	65,047,675	0.176014	0.000000
55.00	05500	RADIOLOGY-THERAPEUTIC	1,009,662	44,244,780	45,254,442	0.133559	0.000000
56.00	05600	RADIOISOTOPE	3,044,909	3,226,920	6,271,829	0.199138	0.000000
57.00	05700	CT SCAN	27,720,474	37,641,217	65,361,691	0.045242	0.000000
58.00	05800	MRI	5,698,826	9,821,055	15,519,881	0.054459	0.000000
59.00	05900	CARDIAC CATHETERIZATION	26,612,608	15,950,060	42,562,668	0.085379	0.000000
60.00	06000	LABORATORY	62,149,729	31,036,330	93,186,059	0.086317	0.000000
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	7,316,746	1,925,342	9,242,088	0.448186	0.000000
64.00	06400	INTRAVENOUS THERAPY	1,540,033	19,927,328	21,467,361	0.212771	0.000000
65.00	06500	RESPIRATORY THERAPY	28,197,590	5,586,392	33,783,982	0.195471	0.000000
66.00	06600	PHYSICAL THERAPY	6,423,383	1,437,698	7,861,081	0.439068	0.000000
66.01	06601	CLINICAL NUTRITION	0	49,117	49,117	18.031191	0.000000
67.00	06700	OCCUPATIONAL THERAPY	3,849,414	725,481	4,574,895	0.394403	0.000000
68.00	06800	SPEECH PATHOLOGY	2,716,540	303,448	3,019,988	0.242032	0.000000
69.00	06900	ELECTROCARDIOLOGY	24,549,785	42,688,512	67,238,297	0.096429	0.000000
69.01	06901	CARDIAC REHABILITATION	44,604	729,231	773,835	1.481154	0.000000
70.00	07000	ELECTROENCEPHALOGRAPHY	3,614,278	3,067,731	6,682,009	0.065016	0.000000
70.01	07001	ELECTROSHOCK THERAPY	133,856	292,191	426,047	0.584802	0.000000
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	12,114,491	12,455,358	24,569,849	1.319663	0.000000
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	17,937,159	11,734,040	29,671,199	0.718100	0.000000
73.00	07300	DRUGS CHARGED TO PATIENTS	69,993,737	259,898,136	329,891,873	0.199219	0.000000
74.00	07400	RENAL DIALYSIS	6,235,041	574,481	6,809,522	0.396814	0.000000
76.00	03330	ENDOSCOPY	3,196,260	10,185,263	13,381,523	0.160525	0.000000
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	59,540	23,876,034	23,935,574	0.529433	0.000000
91.00	09100	EMERGENCY	42,429,511	69,630,561	112,060,072	0.195156	0.000000
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	4,678,142	21,655,935	26,334,077	0.302561	0.000000
200.00		Subtotal (see instructions)	671,891,559	763,056,930	1,434,948,489		200.00
201.00		Less Observation Beds					201.00
202.00		Total (see instructions)	671,891,559	763,056,930	1,434,948,489		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES			Provider CCN: 26-0104	Period: From 01/01/2020 To 12/31/2020	Worksheet C Part I Date/Time Prepared: 7/30/2021 8:44 am
			Title XVIII	Hospital	PPS
Cost Center Description			PPS Inpatient Ratio		
			11.00		
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS			30.00
31.00	03100	INTENSIVE CARE UNIT			31.00
40.00	04000	SUBPROVIDER - IPF			40.00
43.00	04300	NURSERY			43.00
44.00	04400	SKILLED NURSING FACILITY			44.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0.226187		50.00
51.00	05100	RECOVERY ROOM	0.182893		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.605238		52.00
52.01	05201	PERINATAL CLINIC	0.397346		52.01
53.00	05300	ANESTHESIOLOGY	0.036243		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.176014		54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.133640		55.00
56.00	05600	RADIOISOTOPE	0.199138		56.00
57.00	05700	CT SCAN	0.045242		57.00
58.00	05800	MRI	0.054459		58.00
59.00	05900	CARDIAC CATHETERIZATION	0.085379		59.00
60.00	06000	LABORATORY	0.086317		60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0.448186		62.00
64.00	06400	INTRAVENOUS THERAPY	0.212771		64.00
65.00	06500	RESPIRATORY THERAPY	0.195809		65.00
66.00	06600	PHYSICAL THERAPY	0.439068		66.00
66.01	06601	CLINICAL NUTRITION	18.031191		66.01
67.00	06700	OCCUPATIONAL THERAPY	0.394403		67.00
68.00	06800	SPEECH PATHOLOGY	0.242032		68.00
69.00	06900	ELECTROCARDIOLOGY	0.096429		69.00
69.01	06901	CARDIAC REHABILITATION	1.488122		69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0.084978		70.00
70.01	07001	ELECTROSHOCK THERAPY	0.584802		70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1.319663		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.718100		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.199219		73.00
74.00	07400	RENAL DIALYSIS	0.396814		74.00
76.00	03330	ENDOSCOPY	0.160525		76.00
OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	0.529433		90.00
91.00	09100	EMERGENCY	0.195156		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.302561		92.00
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: 26-0104

Period:
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			Title XIX		Hospital	Cost		
Cost Center Description			Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs			
					Total Costs	RCE Disallowance		Total Costs
			1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	80,424,008		80,424,008	19,091	80,443,099	30.00
31.00	03100	INTENSIVE CARE UNIT	26,362,907		26,362,907	0	26,362,907	31.00
40.00	04000	SUBPROVIDER - IPF	7,172,665		7,172,665	18,076	7,190,741	40.00
43.00	04300	NURSERY	1,745,476		1,745,476	0	1,745,476	43.00
44.00	04400	SKILLED NURSING FACILITY	5,487,751		5,487,751	0	5,487,751	44.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	25,444,414		25,444,414	0	25,444,414	50.00
51.00	05100	RECOVERY ROOM	1,720,697		1,720,697	0	1,720,697	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	6,312,282		6,312,282	0	6,312,282	52.00
52.01	05201	PERINATAL CLINIC	2,259,841		2,259,841	0	2,259,841	52.01
53.00	05300	ANESTHESIOLOGY	1,027,942		1,027,942	30,842	1,058,784	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	11,449,328		11,449,328	0	11,449,328	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	6,044,133		6,044,133	3,669	6,047,802	55.00
56.00	05600	RADIOISOTOPE	1,248,960		1,248,960	0	1,248,960	56.00
57.00	05700	CT SCAN	2,957,117		2,957,117	0	2,957,117	57.00
58.00	05800	MRI	845,190		845,190	0	845,190	58.00
59.00	05900	CARDIAC CATHETERIZATION	3,633,947		3,633,947	0	3,633,947	59.00
60.00	06000	LABORATORY	8,043,514		8,043,514	0	8,043,514	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	4,142,174		4,142,174	0	4,142,174	62.00
64.00	06400	INTRAVENOUS THERAPY	4,567,631		4,567,631	0	4,567,631	64.00
65.00	06500	RESPIRATORY THERAPY	6,603,795	0	6,603,795	11,414	6,615,209	65.00
66.00	06600	PHYSICAL THERAPY	3,451,552	0	3,451,552	0	3,451,552	66.00
66.01	06601	CLINICAL NUTRITION	885,638	0	885,638	0	885,638	66.01
67.00	06700	OCCUPATIONAL THERAPY	1,804,354	0	1,804,354	0	1,804,354	67.00
68.00	06800	SPEECH PATHOLOGY	730,933	0	730,933	0	730,933	68.00
69.00	06900	ELECTROCARDIOLOGY	6,483,749		6,483,749	0	6,483,749	69.00
69.01	06901	CARDIAC REHABILITATION	1,146,169		1,146,169	5,392	1,151,561	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	434,435		434,435	133,388	567,823	70.00
70.01	07001	ELECTROSHOCK THERAPY	249,153		249,153	0	249,153	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	32,423,915		32,423,915	0	32,423,915	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	21,306,885		21,306,885	0	21,306,885	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	65,720,666		65,720,666	0	65,720,666	73.00
74.00	07400	RENAL DIALYSIS	2,702,117		2,702,117	0	2,702,117	74.00
76.00	03330	ENDOSCOPY	2,148,072		2,148,072	0	2,148,072	76.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	12,672,273		12,672,273	15	12,672,288	90.00
91.00	09100	EMERGENCY	21,869,248		21,869,248	0	21,869,248	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	7,967,673		7,967,673		7,967,673	92.00
200.00		Subtotal (see instructions)	389,490,604	0	389,490,604	221,887	389,712,491	200.00
201.00		Less Observation Beds	7,967,673		7,967,673		7,967,673	201.00
202.00		Total (see instructions)	381,522,931	0	381,522,931	221,887	381,744,818	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 26-0104

Period:
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To 12/31/2020Worksheet C
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			Title XIX		Hospital	Cost	
Cost Center Description			Charges			Cost or Other Ratio	TEFRA Inpatient Ratio
			Inpatient	Outpatient	Total (col. 6 + col. 7)		
			6.00	7.00	8.00	9.00	10.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	128,981,583		128,981,583		30.00
31.00	03100	INTENSIVE CARE UNIT	49,473,158		49,473,158		31.00
40.00	04000	SUBPROVIDER - IPF	27,513,837		27,513,837		40.00
43.00	04300	NURSERY	2,545,145		2,545,145		43.00
44.00	04400	SKILLED NURSING FACILITY	4,226,875		4,226,875		44.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	48,653,706	63,839,299	112,493,005	0.226187	0.000000
51.00	05100	RECOVERY ROOM	5,149,147	4,259,091	9,408,238	0.182893	0.000000
52.00	05200	DELIVERY ROOM & LABOR ROOM	8,397,304	2,032,122	10,429,426	0.605238	0.000000
52.01	05201	PERINATAL CLINIC	131,659	5,555,673	5,687,332	0.397346	0.000000
53.00	05300	ANESTHESIOLOGY	13,320,735	15,892,521	29,213,256	0.035188	0.000000
54.00	05400	RADIOLOGY-DIAGNOSTIC	22,232,092	42,815,583	65,047,675	0.176014	0.000000
55.00	05500	RADIOLOGY-THERAPEUTIC	1,009,662	44,244,780	45,254,442	0.133559	0.000000
56.00	05600	RADIOISOTOPE	3,044,909	3,226,920	6,271,829	0.199138	0.000000
57.00	05700	CT SCAN	27,720,474	37,641,217	65,361,691	0.045242	0.000000
58.00	05800	MRI	5,698,826	9,821,055	15,519,881	0.054459	0.000000
59.00	05900	CARDIAC CATHETERIZATION	26,612,608	15,950,060	42,562,668	0.085379	0.000000
60.00	06000	LABORATORY	62,149,729	31,036,330	93,186,059	0.086317	0.000000
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	7,316,746	1,925,342	9,242,088	0.448186	0.000000
64.00	06400	INTRAVENOUS THERAPY	1,540,033	19,927,328	21,467,361	0.212771	0.000000
65.00	06500	RESPIRATORY THERAPY	28,197,590	5,586,392	33,783,982	0.195471	0.000000
66.00	06600	PHYSICAL THERAPY	6,423,383	1,437,698	7,861,081	0.439068	0.000000
66.01	06601	CLINICAL NUTRITION	0	49,117	49,117	18.031191	0.000000
67.00	06700	OCCUPATIONAL THERAPY	3,849,414	725,481	4,574,895	0.394403	0.000000
68.00	06800	SPEECH PATHOLOGY	2,716,540	303,448	3,019,988	0.242032	0.000000
69.00	06900	ELECTROCARDIOLOGY	24,549,785	42,688,512	67,238,297	0.096429	0.000000
69.01	06901	CARDIAC REHABILITATION	44,604	729,231	773,835	1.481154	0.000000
70.00	07000	ELECTROENCEPHALOGRAPHY	3,614,278	3,067,731	6,682,009	0.065016	0.000000
70.01	07001	ELECTROSHOCK THERAPY	133,856	292,191	426,047	0.584802	0.000000
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	12,114,491	12,455,358	24,569,849	1.319663	0.000000
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	17,937,159	11,734,040	29,671,199	0.718100	0.000000
73.00	07300	DRUGS CHARGED TO PATIENTS	69,993,737	259,898,136	329,891,873	0.199219	0.000000
74.00	07400	RENAL DIALYSIS	6,235,041	574,481	6,809,522	0.396814	0.000000
76.00	03330	ENDOSCOPY	3,196,260	10,185,263	13,381,523	0.160525	0.000000
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	59,540	23,876,034	23,935,574	0.529433	0.000000
91.00	09100	EMERGENCY	42,429,511	69,630,561	112,060,072	0.195156	0.000000
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	4,678,142	21,655,935	26,334,077	0.302561	0.000000
200.00		Subtotal (see instructions)	671,891,559	763,056,930	1,434,948,489		200.00
201.00		Less Observation Beds					201.00
202.00		Total (see instructions)	671,891,559	763,056,930	1,434,948,489		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 26-0104

Period:
From 01/01/2020
To 12/31/2020Worksheet C
Part I
Date/Time Prepared:
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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
40.00	04000	SUBPROVIDER - IPF				40.00
43.00	04300	NURSERY				43.00
44.00	04400	SKILLED NURSING FACILITY				44.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.000000			50.00
51.00	05100	RECOVERY ROOM	0.000000			51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000			52.00
52.01	05201	PERINATAL CLINIC	0.000000			52.01
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	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 CELL	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 REHABILITATION	0.000000			69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000			70.00
70.01	07001	ELECTROSHOCK THERAPY	0.000000			70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000			71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000			72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000			73.00
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
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: 26-0104

Period:
From 01/01/2020
To 12/31/2020Worksheet D
Part I
Date/Time Prepared:
7/30/2021 8:44 am

			Title XVIII		Hospital	PPS	
Cost Center Description		Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	5,768,037	0	5,768,037	86,181	66.93	30.00
31.00	INTENSIVE CARE UNIT	1,134,358		1,134,358	16,643	68.16	31.00
40.00	SUBPROVIDER - IPF	1,052,118	0	1,052,118	4,544	231.54	40.00
43.00	NURSERY	227,340		227,340	1,965	115.69	43.00
44.00	SKILLED NURSING FACILITY	58,371		58,371	16,044	3.64	44.00
200.00	Total (lines 30 through 199)	8,240,224		8,240,224	125,377		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	18,233	1,220,335				
31.00	INTENSIVE CARE UNIT	5,446	371,199				
40.00	SUBPROVIDER - IPF	1,449	335,501				
43.00	NURSERY	0	0				
44.00	SKILLED NURSING FACILITY	3,824	13,919				
200.00	Total (lines 30 through 199)	28,952	1,940,954				

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS				Provider CCN: 26-0104	Period: From 01/01/2020 To 12/31/2020	Worksheet D Part II Date/Time Prepared: 7/30/2021 8:44 am		
				Title XVIII		Hospital	PPS	
	Cost Center Description		Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
	ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	3,397,328	112,493,005	0.030200	20,897,360	631,100	50.00
51.00	05100	RECOVERY ROOM	22,071	9,408,238	0.002346	1,772,397	4,158	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,059,875	10,429,426	0.101624	12,388	1,259	52.00
52.01	05201	PERINATAL CLINIC	617,629	5,687,332	0.108597	0	0	52.01
53.00	05300	ANESTHESIOLOGY	151,814	29,213,256	0.005197	3,144,450	16,342	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	768,067	65,047,675	0.011808	5,018,997	59,264	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	1,102,373	45,254,442	0.024359	335,933	8,183	55.00
56.00	05600	RADIOISOTOPE	58,339	6,271,829	0.009302	1,075,748	10,007	56.00
57.00	05700	CT SCAN	388,750	65,361,691	0.005948	8,410,430	50,025	57.00
58.00	05800	MRI	91,761	15,519,881	0.005912	1,720,906	10,174	58.00
59.00	05900	CARDIAC CATHETERIZATION	272,650	42,562,668	0.006406	6,343,628	40,637	59.00
60.00	06000	LABORATORY	878,567	93,186,059	0.009428	20,053,635	189,066	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	85,484	9,242,088	0.009249	1,716,944	15,880	62.00
64.00	06400	INTRAVENOUS THERAPY	454,335	21,467,361	0.021164	67,555	1,430	64.00
65.00	06500	RESPIRATORY THERAPY	475,617	33,783,982	0.014078	6,712,806	94,503	65.00
66.00	06600	PHYSICAL THERAPY	270,278	7,861,081	0.034382	1,915,816	65,870	66.00
66.01	06601	CLINICAL NUTRITION	9,770	49,117	0.198913	0	0	66.01
67.00	06700	OCCUPATIONAL THERAPY	143,930	4,574,895	0.031461	1,111,172	34,959	67.00
68.00	06800	SPEECH PATHOLOGY	10,927	3,019,988	0.003618	886,452	3,207	68.00
69.00	06900	ELECTROCARDIOLOGY	484,507	67,238,297	0.007206	7,366,149	53,080	69.00
69.01	06901	CARDIAC REHABILITATION	290,890	773,835	0.375907	7,098	2,668	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	25,512	6,682,009	0.003818	1,085,839	4,146	70.00
70.01	07001	ELECTROSHOCK THERAPY	48,109	426,047	0.112919	4,272	482	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	757,745	24,569,849	0.030840	3,593,552	110,825	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	484,867	29,671,199	0.016341	5,466,353	89,326	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,328,968	329,891,873	0.004028	19,219,454	77,416	73.00
74.00	07400	RENAL DIALYSIS	72,545	6,809,522	0.010653	3,204,831	34,141	74.00
76.00	03330	ENDOSCOPY	203,689	13,381,523	0.015222	836,212	12,729	76.00
	OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	1,713,391	23,935,574	0.071583	2,055	147	90.00
91.00	09100	EMERGENCY	1,241,218	112,060,072	0.011076	10,730,721	118,853	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	571,306	26,334,077	0.021695	2,974,955	64,542	92.00
200.00		Total (lines 50 through 199)	17,482,312	1,222,207,891		135,688,108	1,804,419	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 26-0104

Period:
From 01/01/2020
To 12/31/2020Worksheet D
Part III
Date/Time Prepared:
7/30/2021 8:44 am

				Title XVIII		Hospital		PPS	
Cost Center Description			Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health Cost	All Other Medical Education Cost		
			1A	1.00	2A	2.00	3.00		
	INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	0	0	0	171,667	0	30.00	
31.00	03100	INTENSIVE CARE UNIT	0	0	0	114,444	0	31.00	
40.00	04000	SUBPROVIDER - IPF	0	0	0	85,833	0	40.00	
43.00	04300	NURSERY	0	0	0	0	0	43.00	
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00	
200.00		Total (lines 30 through 199)	0	0	0	371,944	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	171,667	86,181	1.99	18,233	30.00	
31.00	03100	INTENSIVE CARE UNIT		114,444	16,643	6.88	5,446	31.00	
40.00	04000	SUBPROVIDER - IPF	0	85,833	4,544	18.89	1,449	40.00	
43.00	04300	NURSERY		0	1,965	0.00	0	43.00	
44.00	04400	SKILLED NURSING FACILITY		0	16,044	0.00	3,824	44.00	
200.00		Total (lines 30 through 199)		371,944	125,377		28,952	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	36,284						30.00
31.00	03100	INTENSIVE CARE UNIT	37,468						31.00
40.00	04000	SUBPROVIDER - IPF	27,372						40.00
43.00	04300	NURSERY	0						43.00
44.00	04400	SKILLED NURSING FACILITY	0						44.00
200.00		Total (lines 30 through 199)	101,124						200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

Provider CCN: 26-0104

Period:
From 01/01/2020
To 12/31/2020Worksheet D
Part IV
Date/Time Prepared:
7/30/2021 8:44 am

Cost Center Description			Title XVIII		Hospital		PPS
			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
52.01	05201	PERINATAL CLINIC	0	0	0	0	0 52.01
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	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 CELL	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	85,833 69.00
69.01	06901	CARDIAC REHABILITATION	0	0	0	0	0 69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0 70.00
70.01	07001	ELECTROSHOCK THERAPY	0	0	0	0	0 70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0 71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0 72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0 73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0 74.00
76.00	03330	ENDOSCOPY	0	0	0	0	0 76.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0	0	0	0	0 90.00
91.00	09100	EMERGENCY	0	0	0	0	85,833 91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	17,003 92.00
200.00		Total (lines 50 through 199)	0	0	0	0	188,669 200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

Provider CCN: 26-0104

Period:
From 01/01/2020
To 12/31/2020Worksheet D
Part IV
Date/Time Prepared:
7/30/2021 8:44 am

			Title XVIII		Hospital	PPS		
Cost Center Description			All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7) (see instructions)	
			4.00	5.00	6.00	7.00	8.00	
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	0	112,493,005	0.000000	50.00
51.00	05100	RECOVERY ROOM	0	0	0	9,408,238	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	10,429,426	0.000000	52.00
52.01	05201	PERINATAL CLINIC	0	0	0	5,687,332	0.000000	52.01
53.00	05300	ANESTHESIOLOGY	0	0	0	29,213,256	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	65,047,675	0.000000	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	45,254,442	0.000000	55.00
56.00	05600	RADIOISOTOPE	0	0	0	6,271,829	0.000000	56.00
57.00	05700	CT SCAN	0	0	0	65,361,691	0.000000	57.00
58.00	05800	MRI	0	0	0	15,519,881	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	42,562,668	0.000000	59.00
60.00	06000	LABORATORY	0	0	0	93,186,059	0.000000	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0	9,242,088	0.000000	62.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	21,467,361	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	33,783,982	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	7,861,081	0.000000	66.00
66.01	06601	CLINICAL NUTRITION	0	0	0	49,117	0.000000	66.01
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	4,574,895	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	3,019,988	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	85,833	85,833	67,238,297	0.001277	69.00
69.01	06901	CARDIAC REHABILITATION	0	0	0	773,835	0.000000	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	6,682,009	0.000000	70.00
70.01	07001	ELECTROSHOCK THERAPY	0	0	0	426,047	0.000000	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	24,569,849	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	29,671,199	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	329,891,873	0.000000	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	6,809,522	0.000000	74.00
76.00	03330	ENDOSCOPY	0	0	0	13,381,523	0.000000	76.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0	23,935,574	0.000000	90.00
91.00	09100	EMERGENCY	0	85,833	85,833	112,060,072	0.000766	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	17,003	17,003	26,334,077	0.000646	92.00
200.00		Total (lines 50 through 199)	0	188,669	188,669	1,222,207,891		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 26-0104

Period:
From 01/01/2020
To 12/31/2020Worksheet D
Part IV
Date/Time Prepared:
7/30/2021 8:44 am

				Title XVIII		Hospital	PPS			
	Cost Center Description			Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)		
				9.00	10.00	11.00	12.00	13.00		
	ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM		0.000000	20,897,360	0	31,131,891	0	50.00	
51.00	05100	RECOVERY ROOM		0.000000	1,772,397	0	3,536,520	0	51.00	
52.00	05200	DELIVERY ROOM & LABOR ROOM		0.000000	12,388	0	12,709	0	52.00	
52.01	05201	PERINATAL CLINIC		0.000000	0	0	0	0	52.01	
53.00	05300	ANESTHESIOLOGY		0.000000	3,144,450	0	2,603,288	0	53.00	
54.00	05400	RADIOLOGY-DIAGNOSTIC		0.000000	5,018,997	0	6,140,434	0	54.00	
55.00	05500	RADIOLOGY-THERAPEUTIC		0.000000	335,933	0	12,280,501	0	55.00	
56.00	05600	RADIOISOTOPE		0.000000	1,075,748	0	1,201,199	0	56.00	
57.00	05700	CT SCAN		0.000000	8,410,430	0	6,242,712	0	57.00	
58.00	05800	MRI		0.000000	1,720,906	0	2,473,900	0	58.00	
59.00	05900	CARDIAC CATHETERIZATION		0.000000	6,343,628	0	2,167,131	0	59.00	
60.00	06000	LABORATORY		0.000000	20,053,635	0	5,665,803	0	60.00	
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL		0.000000	1,716,944	0	180,467	0	62.00	
64.00	06400	INTRAVENOUS THERAPY		0.000000	67,555	0	1,542,398	0	64.00	
65.00	06500	RESPIRATORY THERAPY		0.000000	6,712,806	0	719,516	0	65.00	
66.00	06600	PHYSICAL THERAPY		0.000000	1,915,816	0	165,387	0	66.00	
66.01	06601	CLINICAL NUTRITION		0.000000	0	0	0	0	66.01	
67.00	06700	OCCUPATIONAL THERAPY		0.000000	1,111,172	0	16,414	0	67.00	
68.00	06800	SPEECH PATHOLOGY		0.000000	886,452	0	32,575	0	68.00	
69.00	06900	ELECTROCARDIOLOGY		0.001277	7,366,149	9,407	4,293,157	5,482	69.00	
69.01	06901	CARDIAC REHABILITATION		0.000000	7,098	0	270,065	0	69.01	
70.00	07000	ELECTROENCEPHALOGRAPHY		0.000000	1,085,839	0	612,186	0	70.00	
70.01	07001	ELECTROSHOCK THERAPY		0.000000	4,272	0	4,272	0	70.01	
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT		0.000000	3,593,552	0	3,234,719	0	71.00	
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS		0.000000	5,466,353	0	2,979,843	0	72.00	
73.00	07300	DRUGS CHARGED TO PATIENTS		0.000000	19,219,454	0	79,192,503	0	73.00	
74.00	07400	RENAL DIALYSIS		0.000000	3,204,831	0	236,292	0	74.00	
76.00	03330	ENDOSCOPY		0.000000	836,212	0	1,193,047	0	76.00	
	OUTPATIENT SERVICE COST CENTERS									
90.00	09000	CLINIC		0.000000	2,055	0	5,230,199	0	90.00	
91.00	09100	EMERGENCY		0.000766	10,730,721	8,220	6,650,469	5,094	91.00	
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART		0.000646	2,974,955	1,922	4,768,073	3,080	92.00	
200.00		Total (lines 50 through 199)			135,688,108	19,549	184,777,670	13,656	200.00	

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 26-0104

Period:
From 01/01/2020
To 12/31/2020Worksheet D
Part V
Date/Time Prepared:
7/30/2021 8:44 am

			Title XVIII		Hospital		PPS	
Cost Center Description			Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges		Costs		
				PPS Reimbursed Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0.226187	31,131,891	12,786	0	7,041,629	50.00
51.00	05100	RECOVERY ROOM	0.182893	3,536,520	0	0	646,805	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.605238	12,709	0	0	7,692	52.00
52.01	05201	PERINATAL CLINIC	0.397346	0	0	0	0	52.01
53.00	05300	ANESTHESIOLOGY	0.035188	2,603,288	0	0	91,604	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.176014	6,140,434	0	0	1,080,802	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.133559	12,280,501	0	0	1,640,171	55.00
56.00	05600	RADIOISOTOPE	0.199138	1,201,199	0	0	239,204	56.00
57.00	05700	CT SCAN	0.045242	6,242,712	0	0	282,433	57.00
58.00	05800	MRI	0.054459	2,473,900	0	0	134,726	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.085379	2,167,131	0	0	185,027	59.00
60.00	06000	LABORATORY	0.086317	5,665,803	0	0	489,055	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0.448186	180,467	0	0	80,883	62.00
64.00	06400	INTRAVENOUS THERAPY	0.212771	1,542,398	0	0	328,178	64.00
65.00	06500	RESPIRATORY THERAPY	0.195471	719,516	0	0	140,645	65.00
66.00	06600	PHYSICAL THERAPY	0.439068	165,387	0	0	72,616	66.00
66.01	06601	CLINICAL NUTRITION	18.031191	0	0	0	0	66.01
67.00	06700	OCCUPATIONAL THERAPY	0.394403	16,414	0	0	6,474	67.00
68.00	06800	SPEECH PATHOLOGY	0.242032	32,575	0	0	7,884	68.00
69.00	06900	ELECTROCARDIOLOGY	0.096429	4,293,157	0	0	413,985	69.00
69.01	06901	CARDIAC REHABILITATION	1.481154	270,065	0	0	400,008	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0.065016	612,186	0	0	39,802	70.00
70.01	07001	ELECTROSHOCK THERAPY	0.584802	4,272	0	0	2,498	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1.319663	3,234,719	0	0	4,268,739	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.718100	2,979,843	0	0	2,139,825	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.199219	79,192,503	1,452	247,531	15,776,651	73.00
74.00	07400	RENAL DIALYSIS	0.396814	236,292	0	0	93,764	74.00
76.00	03330	ENDOSCOPY	0.160525	1,193,047	0	0	191,514	76.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0.529433	5,230,199	0	656	2,769,040	90.00
91.00	09100	EMERGENCY	0.195156	6,650,469	0	0	1,297,879	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.302561	4,768,073	0	0	1,442,633	92.00
200.00		Subtotal (see instructions)		184,777,670	14,238	248,187	41,312,166	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 - line 201)		184,777,670	14,238	248,187	41,312,166	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 26-0104

Period:
From 01/01/2020
To 12/31/2020Worksheet D
Part V
Date/Time Prepared:
7/30/2021 8:44 am

			Title XVIII		Hospital	PPS
	Cost Center Description	Costs				
		Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)			
		6.00	7.00			
	ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	2,892	0		50.00
51.00	05100	RECOVERY ROOM	0	0		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0		52.00
52.01	05201	PERINATAL CLINIC	0	0		52.01
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	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 CELL	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 REHABILITATION	0	0		69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0		70.00
70.01	07001	ELECTROSHOCK THERAPY	0	0		70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	289	49,313		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	347		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)	3,181	49,660		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	3,181	49,660		202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS				Provider CCN: 26-0104	Period: From 01/01/2020 To 12/31/2020	Worksheet D Part II Date/Time Prepared: 7/30/2021 8:44 am		
				Component CCN: 26-S104				
				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	3,397,328	112,493,005	0.030200	660	20	50.00
51.00	05100	RECOVERY ROOM	22,071	9,408,238	0.002346	80	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,059,875	10,429,426	0.101624	0	0	52.00
52.01	05201	PERINATAL CLINIC	617,629	5,687,332	0.108597	0	0	52.01
53.00	05300	ANESTHESIOLOGY	151,814	29,213,256	0.005197	2,350	12	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	768,067	65,047,675	0.011808	12,057	142	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	1,102,373	45,254,442	0.024359	232	6	55.00
56.00	05600	RADIOISOTOPE	58,339	6,271,829	0.009302	0	0	56.00
57.00	05700	CT SCAN	388,750	65,361,691	0.005948	9,900	59	57.00
58.00	05800	MRI	91,761	15,519,881	0.005912	3,450	20	58.00
59.00	05900	CARDIAC CATHETERIZATION	272,650	42,562,668	0.006406	0	0	59.00
60.00	06000	LABORATORY	878,567	93,186,059	0.009428	315,709	2,977	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	85,484	9,242,088	0.009249	0	0	62.00
64.00	06400	INTRAVENOUS THERAPY	454,335	21,467,361	0.021164	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	475,617	33,783,982	0.014078	1,449	20	65.00
66.00	06600	PHYSICAL THERAPY	270,278	7,861,081	0.034382	0	0	66.00
66.01	06601	CLINICAL NUTRITION	9,770	49,117	0.198913	0	0	66.01
67.00	06700	OCCUPATIONAL THERAPY	143,930	4,574,895	0.031461	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	10,927	3,019,988	0.003618	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	484,507	67,238,297	0.007206	5,250	38	69.00
69.01	06901	CARDIAC REHABILITATION	290,890	773,835	0.375907	0	0	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	25,512	6,682,009	0.003818	0	0	70.00
70.01	07001	ELECTROSHOCK THERAPY	48,109	426,047	0.112919	7,120	804	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	757,745	24,569,849	0.030840	255	8	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	484,867	29,671,199	0.016341	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,328,968	329,891,873	0.004028	436,047	1,756	73.00
74.00	07400	RENAL DIALYSIS	72,545	6,809,522	0.010653	2,772	30	74.00
76.00	03330	ENDOSCOPY	203,689	13,381,523	0.015222	2,476	38	76.00
	OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	1,713,391	23,935,574	0.071583	0	0	90.00
91.00	09100	EMERGENCY	1,241,218	112,060,072	0.011076	204,560	2,266	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	26,334,077	0.000000	0	0	92.00
200.00		Total (lines 50 through 199)	16,911,006	1,222,207,891		1,004,367	8,196	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS				Provider CCN: 26-0104 Component CCN: 26-S104		Period: From 01/01/2020 To 12/31/2020		Worksheet D Part IV Date/Time Prepared: 7/30/2021 8:44 am	
				Title XVIII		Subprovider - IPF		PPS	
Cost Center Description				Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health	
				1.00	2A	2.00	3A	3.00	
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM		0	0	0	0	0	50.00
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
52.01	05201	PERINATAL CLINIC		0	0	0	0	0	52.01
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	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 CELL		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	85,833	69.00
69.01	06901	CARDIAC REHABILITATION		0	0	0	0	0	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY		0	0	0	0	0	70.00
70.01	07001	ELECTROSHOCK THERAPY		0	0	0	0	0	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT		0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS		0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS		0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS		0	0	0	0	0	74.00
76.00	03330	ENDOSCOPY		0	0	0	0	0	76.00
OUTPATIENT SERVICE COST CENTERS									
90.00	09000	CLINIC		0	0	0	0	0	90.00
91.00	09100	EMERGENCY		0	0	0	0	85,833	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	171,666	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS				Provider CCN: 26-0104 Component CCN: 26-S104		Period: From 01/01/2020 To 12/31/2020		Worksheet D Part IV Date/Time Prepared: 7/30/2021 8:44 am	
				Title XVIII		Subprovider - IPF		PPS	
Cost Center Description				All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7) (see instructions)	
				4.00	5.00	6.00	7.00	8.00	
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM		0	0	0	112,493,005	0.000000	50.00
51.00	05100	RECOVERY ROOM		0	0	0	9,408,238	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM		0	0	0	10,429,426	0.000000	52.00
52.01	05201	PERINATAL CLINIC		0	0	0	5,687,332	0.000000	52.01
53.00	05300	ANESTHESIOLOGY		0	0	0	29,213,256	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC		0	0	0	65,047,675	0.000000	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC		0	0	0	45,254,442	0.000000	55.00
56.00	05600	RADIOISOTOPE		0	0	0	6,271,829	0.000000	56.00
57.00	05700	CT SCAN		0	0	0	65,361,691	0.000000	57.00
58.00	05800	MRI		0	0	0	15,519,881	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION		0	0	0	42,562,668	0.000000	59.00
60.00	06000	LABORATORY		0	0	0	93,186,059	0.000000	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL		0	0	0	9,242,088	0.000000	62.00
64.00	06400	INTRAVENOUS THERAPY		0	0	0	21,467,361	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY		0	0	0	33,783,982	0.000000	65.00
66.00	06600	PHYSICAL THERAPY		0	0	0	7,861,081	0.000000	66.00
66.01	06601	CLINICAL NUTRITION		0	0	0	49,117	0.000000	66.01
67.00	06700	OCCUPATIONAL THERAPY		0	0	0	4,574,895	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY		0	0	0	3,019,988	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY		0	85,833	85,833	67,238,297	0.001277	69.00
69.01	06901	CARDIAC REHABILITATION		0	0	0	773,835	0.000000	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY		0	0	0	6,682,009	0.000000	70.00
70.01	07001	ELECTROSHOCK THERAPY		0	0	0	426,047	0.000000	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT		0	0	0	24,569,849	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS		0	0	0	29,671,199	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS		0	0	0	329,891,873	0.000000	73.00
74.00	07400	RENAL DIALYSIS		0	0	0	6,809,522	0.000000	74.00
76.00	03330	ENDOSCOPY		0	0	0	13,381,523	0.000000	76.00
OUTPATIENT SERVICE COST CENTERS									
90.00	09000	CLINIC		0	0	0	23,935,574	0.000000	90.00
91.00	09100	EMERGENCY		0	85,833	85,833	112,060,072	0.000766	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART		0	0	0	26,334,077	0.000000	92.00
200.00		Total (lines 50 through 199)		0	171,666	171,666	1,222,207,891		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS				Provider CCN: 26-0104 Component CCN: 26-S104		Period: From 01/01/2020 To 12/31/2020		Worksheet D Part IV Date/Time Prepared: 7/30/2021 8:44 am	
				Title XVIII		Subprovider - IPF		PPS	
Cost Center Description				Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
				9.00	10.00	11.00	12.00	13.00	
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM		0.000000	660	0	0		50.00
51.00	05100	RECOVERY ROOM		0.000000	80	0	2,346	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM		0.000000	0	0	0	0	52.00
52.01	05201	PERINATAL CLINIC		0.000000	0	0	0	0	52.01
53.00	05300	ANESTHESIOLOGY		0.000000	2,350	0	9,178	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC		0.000000	12,057	0	0	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC		0.000000	232	0	3,330	0	55.00
56.00	05600	RADIOISOTOPE		0.000000	0	0	0	0	56.00
57.00	05700	CT SCAN		0.000000	9,900	0	0	0	57.00
58.00	05800	MRI		0.000000	3,450	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION		0.000000	0	0	0	0	59.00
60.00	06000	LABORATORY		0.000000	315,709	0	17	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL		0.000000	0	0	0	0	62.00
64.00	06400	INTRAVENOUS THERAPY		0.000000	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY		0.000000	1,449	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		0.001277	5,250	7	0	0	69.00
69.01	06901	CARDIAC REHABILITATION		0.000000	0	0	0	0	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY		0.000000	0	0	0	0	70.00
70.01	07001	ELECTROSHOCK THERAPY		0.000000	7,120	0	35,600	0	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT		0.000000	255	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS		0.000000	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS		0.000000	436,047	0	11,719	0	73.00
74.00	07400	RENAL DIALYSIS		0.000000	2,772	0	0	0	74.00
76.00	03330	ENDOSCOPY		0.000000	2,476	0	0	0	76.00
OUTPATIENT SERVICE COST CENTERS									
90.00	09000	CLINIC		0.000000	0	0	0	0	90.00
91.00	09100	EMERGENCY		0.000766	204,560	157	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)			1,004,367	164	62,190	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST				Provider CCN: 26-0104		Period: From 01/01/2020 To 12/31/2020		Worksheet D Part V Date/Time Prepared: 7/30/2021 8:44 am	
				Component CCN: 26-S104					
				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	0.226187	0	0	0	0	50.00	
51.00	05100	RECOVERY ROOM	0.182893	2,346	0	0	429	51.00	
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.605238	0	0	0	0	52.00	
52.01	05201	PERINATAL CLINIC	0.397346	0	0	0	0	52.01	
53.00	05300	ANESTHESIOLOGY	0.035188	9,178	0	0	323	53.00	
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.176014	0	0	0	0	54.00	
55.00	05500	RADIOLOGY-THERAPEUTIC	0.133559	3,330	0	0	445	55.00	
56.00	05600	RADIOISOTOPE	0.199138	0	0	0	0	56.00	
57.00	05700	CT SCAN	0.045242	0	0	0	0	57.00	
58.00	05800	MRI	0.054459	0	0	0	0	58.00	
59.00	05900	CARDIAC CATHETERIZATION	0.085379	0	0	0	0	59.00	
60.00	06000	LABORATORY	0.086317	17	0	0	1	60.00	
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0.448186	0	0	0	0	62.00	
64.00	06400	INTRAVENOUS THERAPY	0.212771	0	0	0	0	64.00	
65.00	06500	RESPIRATORY THERAPY	0.195471	0	0	0	0	65.00	
66.00	06600	PHYSICAL THERAPY	0.439068	0	0	0	0	66.00	
66.01	06601	CLINICAL NUTRITION	18.031191	0	0	0	0	66.01	
67.00	06700	OCCUPATIONAL THERAPY	0.394403	0	0	0	0	67.00	
68.00	06800	SPEECH PATHOLOGY	0.242032	0	0	0	0	68.00	
69.00	06900	ELECTROCARDIOLOGY	0.096429	0	0	0	0	69.00	
69.01	06901	CARDIAC REHABILITATION	1.481154	0	0	0	0	69.01	
70.00	07000	ELECTROENCEPHALOGRAPHY	0.065016	0	0	0	0	70.00	
70.01	07001	ELECTROSHOCK THERAPY	0.584802	35,600	0	0	20,819	70.01	
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1.319663	0	0	0	0	71.00	
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.718100	0	0	0	0	72.00	
73.00	07300	DRUGS CHARGED TO PATIENTS	0.199219	11,719	0	0	2,335	73.00	
74.00	07400	RENAL DIALYSIS	0.396814	0	0	0	0	74.00	
76.00	03330	ENDOSCOPY	0.160525	0	0	0	0	76.00	
OUTPATIENT SERVICE COST CENTERS									
90.00	09000	CLINIC	0.529433	0	0	0	0	90.00	
91.00	09100	EMERGENCY	0.195156	0	0	0	0	91.00	
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.302561	0	0	0	0	92.00	
200.00		Subtotal (see instructions)		62,190	0	0	24,352	200.00	
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00	
202.00		Net Charges (line 200 - line 201)		62,190	0	0	24,352	202.00	

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST			Provider CCN: 26-0104		Period: From 01/01/2020 To 12/31/2020		Worksheet D Part V Date/Time Prepared: 7/30/2021 8:44 am	
			Component CCN: 26-S104					
			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
52.01	05201	PERINATAL CLINIC	0	0				52.01
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	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 CELL	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 REHABILITATION	0	0				69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0				70.00
70.01	07001	ELECTROSHOCK THERAPY	0	0				70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0				71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0				72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0				73.00
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 INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS				Provider CCN: 26-0104 Component CCN: 26-5842		Period: From 01/01/2020 To 12/31/2020		Worksheet D Part IV Date/Time Prepared: 7/30/2021 8:44 am	
				Title XVIII		Skilled Nursing Facility		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
52.01	05201	PERINATAL CLINIC		0	0	0	0	0	52.01
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	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 CELL		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	85,833	69.00
69.01	06901	CARDIAC REHABILITATION		0	0	0	0	0	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY		0	0	0	0	0	70.00
70.01	07001	ELECTROSHOCK THERAPY		0	0	0	0	0	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT		0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS		0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS		0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS		0	0	0	0	0	74.00
76.00	03330	ENDOSCOPY		0	0	0	0	0	76.00
OUTPATIENT SERVICE COST CENTERS									
90.00	09000	CLINIC		0	0	0	0	0	90.00
91.00	09100	EMERGENCY		0	0	0	0	85,833	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	171,666	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS				Provider CCN: 26-0104 Component CCN: 26-5842		Period: From 01/01/2020 To 12/31/2020		Worksheet D Part IV Date/Time Prepared: 7/30/2021 8:44 am	
				Title XVIII		Skilled Nursing Facility		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	112,493,005	0.000000	50.00
51.00	05100	RECOVERY ROOM		0	0	0	9,408,238	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM		0	0	0	10,429,426	0.000000	52.00
52.01	05201	PERINATAL CLINIC		0	0	0	5,687,332	0.000000	52.01
53.00	05300	ANESTHESIOLOGY		0	0	0	29,213,256	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC		0	0	0	65,047,675	0.000000	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC		0	0	0	45,254,442	0.000000	55.00
56.00	05600	RADIOISOTOPE		0	0	0	6,271,829	0.000000	56.00
57.00	05700	CT SCAN		0	0	0	65,361,691	0.000000	57.00
58.00	05800	MRI		0	0	0	15,519,881	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION		0	0	0	42,562,668	0.000000	59.00
60.00	06000	LABORATORY		0	0	0	93,186,059	0.000000	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL		0	0	0	9,242,088	0.000000	62.00
64.00	06400	INTRAVENOUS THERAPY		0	0	0	21,467,361	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY		0	0	0	33,783,982	0.000000	65.00
66.00	06600	PHYSICAL THERAPY		0	0	0	7,861,081	0.000000	66.00
66.01	06601	CLINICAL NUTRITION		0	0	0	49,117	0.000000	66.01
67.00	06700	OCCUPATIONAL THERAPY		0	0	0	4,574,895	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY		0	0	0	3,019,988	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY		0	85,833	85,833	67,238,297	0.001277	69.00
69.01	06901	CARDIAC REHABILITATION		0	0	0	773,835	0.000000	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY		0	0	0	6,682,009	0.000000	70.00
70.01	07001	ELECTROSHOCK THERAPY		0	0	0	426,047	0.000000	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT		0	0	0	24,569,849	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS		0	0	0	29,671,199	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS		0	0	0	329,891,873	0.000000	73.00
74.00	07400	RENAL DIALYSIS		0	0	0	6,809,522	0.000000	74.00
76.00	03330	ENDOSCOPY		0	0	0	13,381,523	0.000000	76.00
OUTPATIENT SERVICE COST CENTERS									
90.00	09000	CLINIC		0	0	0	23,935,574	0.000000	90.00
91.00	09100	EMERGENCY		0	85,833	85,833	112,060,072	0.000766	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART		0	0	0	26,334,077	0.000000	92.00
200.00		Total (lines 50 through 199)		0	171,666	171,666	1,222,207,891		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS				Provider CCN: 26-0104 Component CCN: 26-5842		Period: From 01/01/2020 To 12/31/2020		Worksheet D Part IV Date/Time Prepared: 7/30/2021 8:44 am	
				Title XVIII		Skilled Nursing Facility		PPS	
Cost Center Description				Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
				9.00	10.00	11.00	12.00	13.00	
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM	0.000000	0	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0.000000	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	0	0	0	0	52.00
52.01	05201	PERINATAL CLINIC	0.000000	0	0	0	0	0	52.01
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	7,348	0	0	0	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.000000	0	0	0	0	0	55.00
56.00	05600	RADIOISOTOPE	0.000000	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0.000000	0	0	0	0	0	57.00
58.00	05800	MRI	0.000000	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0.000000	10,546	0	0	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0.000000	0	0	0	0	0	62.00
64.00	06400	INTRAVENOUS THERAPY	0.000000	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.000000	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	420,547	0	0	0	0	66.00
66.01	06601	CLINICAL NUTRITION	0.000000	0	0	0	0	0	66.01
67.00	06700	OCCUPATIONAL THERAPY	0.000000	370,709	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	224,856	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.001277	0	0	0	0	0	69.00
69.01	06901	CARDIAC REHABILITATION	0.000000	0	0	0	0	0	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	0	0	0	0	0	70.00
70.01	07001	ELECTROSHOCK THERAPY	0.000000	0	0	0	0	0	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	4,745	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	109,652	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0.000000	0	0	0	0	0	74.00
76.00	03330	ENDOSCOPY	0.000000	0	0	0	0	0	76.00
OUTPATIENT SERVICE COST CENTERS									
90.00	09000	CLINIC	0.000000	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0.000766	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	0	0	0	0	0	92.00
200.00		Total (lines 50 through 199)			1,148,403	0	0	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 26-0104

Period:
From 01/01/2020
To 12/31/2020Worksheet D
Part V
Date/Time Prepared:
7/30/2021 8:44 am

			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	0.226187	0	3,294,282	0	0	50.00	
51.00	05100	RECOVERY ROOM	0.182893	0	476,458	0	0	51.00	
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.605238	0	105,248	0	0	52.00	
52.01	05201	PERINATAL CLINIC	0.397346	0	0	0	0	52.01	
53.00	05300	ANESTHESIOLOGY	0.035188	0	392,932	0	0	53.00	
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.176014	0	1,850,213	0	0	54.00	
55.00	05500	RADIOLOGY-THERAPEUTIC	0.133559	0	1,965,497	0	0	55.00	
56.00	05600	RADIOISOTOPE	0.199138	0	289,743	0	0	56.00	
57.00	05700	CT SCAN	0.045242	0	2,756,611	0	0	57.00	
58.00	05800	MRI	0.054459	0	501,342	0	0	58.00	
59.00	05900	CARDIAC CATHETERIZATION	0.085379	0	244,770	0	0	59.00	
60.00	06000	LABORATORY	0.086317	0	3,185,231	0	0	60.00	
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0.448186	0	39,293	0	0	62.00	
64.00	06400	INTRAVENOUS THERAPY	0.212771	0	1,154	0	0	64.00	
65.00	06500	RESPIRATORY THERAPY	0.195471	0	169,840	0	0	65.00	
66.00	06600	PHYSICAL THERAPY	0.439068	0	28,252	0	0	66.00	
66.01	06601	CLINICAL NUTRITION	18.031191	0	0	0	0	66.01	
67.00	06700	OCCUPATIONAL THERAPY	0.394403	0	16,801	0	0	67.00	
68.00	06800	SPEECH PATHOLOGY	0.242032	0	8,513	0	0	68.00	
69.00	06900	ELECTROCARDIOLOGY	0.096429	0	1,103,213	0	0	69.00	
69.01	06901	CARDIAC REHABILITATION	1.481154	0	14,534	0	0	69.01	
70.00	07000	ELECTROENCEPHALOGRAPHY	0.065016	0	191,026	0	0	70.00	
70.01	07001	ELECTROSHOCK THERAPY	0.584802	0	89,712	0	0	70.01	
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1.319663	0	474,211	0	0	71.00	
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.718100	0	283,976	0	0	72.00	
73.00	07300	DRUGS CHARGED TO PATIENTS	0.199219	0	14,823,633	0	0	73.00	
74.00	07400	RENAL DIALYSIS	0.396814	0	36,700	0	0	74.00	
76.00	03330	ENDOSCOPY	0.160525	0	198,959	0	0	76.00	
	OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0.529433	0	2,122,251	0	0	90.00	
91.00	09100	EMERGENCY	0.195156	0	6,256,014	0	0	91.00	
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.302561	0	1,702,335	0	0	92.00	
200.00		Subtotal (see instructions)		0	42,622,744	0	0	200.00	
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00	
202.00		Net Charges (line 200 - line 201)		0	42,622,744	0	0	202.00	

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 26-0104

Period:
From 01/01/2020
To 12/31/2020Worksheet D
Part V
Date/Time Prepared:
7/30/2021 8:44 am

			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	745,124	0		50.00
51.00	05100	RECOVERY ROOM	87,141	0		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	63,700	0		52.00
52.01	05201	PERINATAL CLINIC	0	0		52.01
53.00	05300	ANESTHESIOLOGY	13,826	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	325,663	0		54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	262,510	0		55.00
56.00	05600	RADIOISOTOPE	57,699	0		56.00
57.00	05700	CT SCAN	124,715	0		57.00
58.00	05800	MRI	27,303	0		58.00
59.00	05900	CARDIAC CATHETERIZATION	20,898	0		59.00
60.00	06000	LABORATORY	274,940	0		60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	17,611	0		62.00
64.00	06400	INTRAVENOUS THERAPY	246	0		64.00
65.00	06500	RESPIRATORY THERAPY	33,199	0		65.00
66.00	06600	PHYSICAL THERAPY	12,405	0		66.00
66.01	06601	CLINICAL NUTRITION	0	0		66.01
67.00	06700	OCCUPATIONAL THERAPY	6,626	0		67.00
68.00	06800	SPEECH PATHOLOGY	2,060	0		68.00
69.00	06900	ELECTROCARDIOLOGY	106,382	0		69.00
69.01	06901	CARDIAC REHABILITATION	21,527	0		69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	12,420	0		70.00
70.01	07001	ELECTROSHOCK THERAPY	52,464	0		70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	625,799	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	203,923	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,953,149	0		73.00
74.00	07400	RENAL DIALYSIS	14,563	0		74.00
76.00	03330	ENDOSCOPY	31,938	0		76.00
	OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	1,123,590	0		90.00
91.00	09100	EMERGENCY	1,220,899	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	515,060	0		92.00
200.00		Subtotal (see instructions)	8,957,380	0		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	8,957,380	0		202.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS				Provider CCN: 26-0104 Component CCN: 26-5842		Period: From 01/01/2020 To 12/31/2020		Worksheet D Part IV Date/Time Prepared: 7/30/2021 8:44 am	
				Title XIX		Skilled Nursing Facility		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
52.01	05201	PERINATAL CLINIC		0	0	0	0	0	52.01
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	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 CELL		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	85,833	69.00
69.01	06901	CARDIAC REHABILITATION		0	0	0	0	0	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY		0	0	0	0	0	70.00
70.01	07001	ELECTROSHOCK THERAPY		0	0	0	0	0	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT		0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS		0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS		0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS		0	0	0	0	0	74.00
76.00	03330	ENDOSCOPY		0	0	0	0	0	76.00
OUTPATIENT SERVICE COST CENTERS									
90.00	09000	CLINIC		0	0	0	0	0	90.00
91.00	09100	EMERGENCY		0	0	0	0	85,833	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	171,666	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS				Provider CCN: 26-0104 Component CCN: 26-5842		Period: From 01/01/2020 To 12/31/2020		Worksheet D Part IV Date/Time Prepared: 7/30/2021 8:44 am	
				Title XIX		Skilled Nursing Facility		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	112,493,005	0.000000	50.00
51.00	05100	RECOVERY ROOM		0	0	0	9,408,238	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM		0	0	0	10,429,426	0.000000	52.00
52.01	05201	PERINATAL CLINIC		0	0	0	5,687,332	0.000000	52.01
53.00	05300	ANESTHESIOLOGY		0	0	0	29,213,256	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC		0	0	0	65,047,675	0.000000	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC		0	0	0	45,254,442	0.000000	55.00
56.00	05600	RADIOISOTOPE		0	0	0	6,271,829	0.000000	56.00
57.00	05700	CT SCAN		0	0	0	65,361,691	0.000000	57.00
58.00	05800	MRI		0	0	0	15,519,881	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION		0	0	0	42,562,668	0.000000	59.00
60.00	06000	LABORATORY		0	0	0	93,186,059	0.000000	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL		0	0	0	9,242,088	0.000000	62.00
64.00	06400	INTRAVENOUS THERAPY		0	0	0	21,467,361	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY		0	0	0	33,783,982	0.000000	65.00
66.00	06600	PHYSICAL THERAPY		0	0	0	7,861,081	0.000000	66.00
66.01	06601	CLINICAL NUTRITION		0	0	0	49,117	0.000000	66.01
67.00	06700	OCCUPATIONAL THERAPY		0	0	0	4,574,895	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY		0	0	0	3,019,988	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY		0	85,833	85,833	67,238,297	0.001277	69.00
69.01	06901	CARDIAC REHABILITATION		0	0	0	773,835	0.000000	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY		0	0	0	6,682,009	0.000000	70.00
70.01	07001	ELECTROSHOCK THERAPY		0	0	0	426,047	0.000000	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT		0	0	0	24,569,849	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS		0	0	0	29,671,199	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS		0	0	0	329,891,873	0.000000	73.00
74.00	07400	RENAL DIALYSIS		0	0	0	6,809,522	0.000000	74.00
76.00	03330	ENDOSCOPY		0	0	0	13,381,523	0.000000	76.00
OUTPATIENT SERVICE COST CENTERS									
90.00	09000	CLINIC		0	0	0	23,935,574	0.000000	90.00
91.00	09100	EMERGENCY		0	85,833	85,833	112,060,072	0.000766	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART		0	0	0	26,334,077	0.000000	92.00
200.00		Total (lines 50 through 199)		0	171,666	171,666	1,222,207,891		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS				Provider CCN: 26-0104 Component CCN: 26-5842		Period: From 01/01/2020 To 12/31/2020		Worksheet D Part IV Date/Time Prepared: 7/30/2021 8:44 am	
				Title XIX		Skilled Nursing Facility		PPS	
Cost Center Description				Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
				9.00	10.00	11.00	12.00	13.00	
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM	0.000000	0	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0.000000	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	0	0	0	0	52.00
52.01	05201	PERINATAL CLINIC	0.000000	0	0	0	0	0	52.01
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	0	0	0	0	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.000000	0	0	0	0	0	55.00
56.00	05600	RADIOISOTOPE	0.000000	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0.000000	0	0	0	0	0	57.00
58.00	05800	MRI	0.000000	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0.000000	0	0	0	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0.000000	0	0	0	0	0	62.00
64.00	06400	INTRAVENOUS THERAPY	0.000000	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.000000	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	0	0	0	0	0	66.00
66.01	06601	CLINICAL NUTRITION	0.000000	0	0	0	0	0	66.01
67.00	06700	OCCUPATIONAL THERAPY	0.000000	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.001277	0	0	0	0	0	69.00
69.01	06901	CARDIAC REHABILITATION	0.000000	0	0	0	0	0	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	0	0	0	0	0	70.00
70.01	07001	ELECTROSHOCK THERAPY	0.000000	0	0	0	0	0	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0.000000	0	0	0	0	0	74.00
76.00	03330	ENDOSCOPY	0.000000	0	0	0	0	0	76.00
OUTPATIENT SERVICE COST CENTERS									
90.00	09000	CLINIC	0.000000	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0.000766	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	0	0	0	0	0	92.00
200.00		Total (lines 50 through 199)		0	0	0	0	0	200.00

Health Financial Systems		SSM HEALTH DEPAUL HOSPITAL		In Lieu of Form CMS-2552-10	
COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 26-0104	Period: From 01/01/2020 To 12/31/2020	Worksheet D-1 Date/Time Prepared: 7/30/2021 8:44 am	
		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)		86,181	1.00	
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		86,181	2.00	
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.		0	3.00	
4.00	Semi-private room days (excluding swing-bed and observation bed days)		77,645	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)		18,233	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)		80,443,099	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)		80,443,099	27.00	
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT					
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)		0	28.00	
29.00	Private room charges (excluding swing-bed charges)		0	29.00	
30.00	Semi-private room charges (excluding swing-bed charges)		0	30.00	
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		0.000000	31.00	
32.00	Average private room per diem charge (line 29 ÷ line 3)		0.00	32.00	
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)		0.00	33.00	
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)		0.00	34.00	
35.00	Average per diem private room cost differential (line 34 x line 31)		0.00	35.00	
36.00	Private room cost differential adjustment (line 3 x line 35)		0	36.00	
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)		80,443,099	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)		933.42	38.00	
39.00	Program general inpatient routine service cost (line 9 x line 38)		17,019,047	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)		17,019,047	41.00	

COMPUTATION OF INPATIENT OPERATING COST				Provider CCN: 26-0104	Period: From 01/01/2020 To 12/31/2020	Worksheet D-1 Date/Time Prepared: 7/30/2021 8:44 am	
				Title XVIII		Hospital	PPS
Cost Center Description		Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)	0	0	0.00	0	0	42.00
Intensive Care Type Inpatient Hospital Units							
43.00	INTENSIVE CARE UNIT	26,362,907	16,643	1,584.02	5,446	8,626,573	43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00
Cost Center Description							
							1.00
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					30,367,456	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					56,013,076	49.00
PASS THROUGH COST ADJUSTMENTS							
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)					1,665,286	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					1,823,968	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)					3,489,254	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					52,523,822	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)					8,536	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					933.42	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)					7,967,673	89.00

COMPUTATION OF INPATIENT OPERATING COST				Provider CCN: 26-0104		Period: From 01/01/2020 To 12/31/2020		Worksheet D-1 Date/Time Prepared: 7/30/2021 8:44 am	
				Title XVIII		Hospital		PPS	
Cost Center Description		Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)			
		1.00	2.00	3.00	4.00	5.00			
COMPUTATION OF OBSERVATION BED PASS THROUGH COST									
90.00	Capital-related cost	5,768,037	80,443,099	0.071703	7,967,673	571,306	90.00		
91.00	Nursing School cost	0	80,443,099	0.000000	7,967,673	0	91.00		
92.00	Allied health cost	171,667	80,443,099	0.002134	7,967,673	17,003	92.00		
93.00	All other Medical Education	0	80,443,099	0.000000	7,967,673	0	93.00		

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 26-0104 Component CCN: 26-S104	Period: From 01/01/2020 To 12/31/2020	Worksheet D-1 Date/Time Prepared: 7/30/2021 8:44 am
		Title XVIII	Subprovider - IPF	PPS
Cost Center Description			1.00	
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		4,544	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		4,544	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.		0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)		4,544	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions)		1,449	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)		0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period		0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)		0	14.00
15.00	Total nursery days (title V or XIX only)		0	15.00
16.00	Nursery days (title V or XIX only)		0	16.00
SWING BED ADJUSTMENT				
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period		0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)		7,190,741	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)		0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)		0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)		0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)		0	25.00
26.00	Total swing-bed cost (see instructions)		0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)		7,190,741	27.00
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)		0	28.00
29.00	Private room charges (excluding swing-bed charges)		0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)		0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)		0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)		0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)		0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)		0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)		0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)		7,190,741	37.00
PART II - HOSPITAL AND SUBPROVIDERS ONLY				
PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS				
38.00	Adjusted general inpatient routine service cost per diem (see instructions)		1,582.47	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		2,292,999	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)		2,292,999	41.00

COMPUTATION OF INPATIENT OPERATING COST				Provider CCN: 26-0104 Component CCN: 26-S104	Period: From 01/01/2020 To 12/31/2020	Worksheet D-1 Date/Time Prepared: 7/30/2021 8:44 am	
				Title XVIII	Subprovider - IPF	PPS	
	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)	0	0	0.00	0	0	42.00
Intensive Care Type Inpatient Hospital Units							
43.00	INTENSIVE CARE UNIT	0	0	0.00	0	0	43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00
Cost Center Description							
							1.00
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					163,867	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					2,456,866	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)					362,873	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					8,360	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)					371,233	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					2,085,633	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: 26-0104 Component CCN: 26-S104		Period: From 01/01/2020 To 12/31/2020	Worksheet D-1 Date/Time Prepared: 7/30/2021 8:44 am	
		Title XVIII		Subprovider - IPF	PPS	
Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
	1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00 Capital-related cost	1,052,118	7,190,741	0.146316	0	0	90.00
91.00 Nursing School cost	0	7,190,741	0.000000	0	0	91.00
92.00 Allied health cost	85,833	7,190,741	0.011937	0	0	92.00
93.00 All other Medical Education	0	7,190,741	0.000000	0	0	93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 26-0104 Component CCN: 26-5842	Period: From 01/01/2020 To 12/31/2020	Worksheet D-1 Date/Time Prepared: 7/30/2021 8:44 am
		Title XVIII	Skilled Nursing Facility	PPS
Cost Center Description			1.00	
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		16,044	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		16,044	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.		0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)		16,044	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)		3,824	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)		0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period		0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)		0	14.00
15.00	Total nursery days (title V or XIX only)		0	15.00
16.00	Nursery days (title V or XIX only)		0	16.00
SWING BED ADJUSTMENT				
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period		0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)		5,487,751	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)		0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)		0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)		0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)		0	25.00
26.00	Total swing-bed cost (see instructions)		0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)		5,487,751	27.00
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)		0	28.00
29.00	Private room charges (excluding swing-bed charges)		0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)		0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)		0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)		0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)		0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)		0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)		0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)		5,487,751	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)			38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)			39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)			40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)			41.00

COMPUTATION OF INPATIENT OPERATING COST			Provider CCN: 26-0104 Component CCN: 26-5842	Period: From 01/01/2020 To 12/31/2020	Worksheet D-1 Date/Time Prepared: 7/30/2021 8:44 am
			Title XVIII	Skilled Nursing Facility	PPS
Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)
42.00 NURSERY (title V & XIX only)	1.00	2.00	3.00	4.00	5.00
Intensive Care Type Inpatient Hospital Units					
43.00 INTENSIVE CARE UNIT					43.00
44.00 CORONARY CARE UNIT					44.00
45.00 BURN INTENSIVE CARE UNIT					45.00
46.00 SURGICAL INTENSIVE CARE UNIT					46.00
47.00 OTHER SPECIAL CARE (SPECIFY)					47.00
Cost Center Description					1.00
48.00 Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					48.00
49.00 Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					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)					50.00
51.00 Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					51.00
52.00 Total Program excludable cost (sum of lines 50 and 51)					52.00
53.00 Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					53.00
TARGET AMOUNT AND LIMIT COMPUTATION					
54.00 Program discharges					54.00
55.00 Target amount per discharge					55.00
56.00 Target amount (line 54 x line 55)					56.00
57.00 Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)					57.00
58.00 Bonus payment (see instructions)					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					59.00
60.00 Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket					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)					61.00
62.00 Relief payment (see instructions)					62.00
63.00 Allowable Inpatient cost plus incentive payment (see instructions)					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)					64.00
65.00 Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					65.00
66.00 Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)					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)					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)					68.00
69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)					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)					5,487,751 70.00
71.00 Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)					342.04 71.00
72.00 Program routine service cost (line 9 x line 71)					1,307,961 72.00
73.00 Medically necessary private room cost applicable to Program (line 14 x line 35)					0 73.00
74.00 Total Program general inpatient routine service costs (line 72 + line 73)					1,307,961 74.00
75.00 Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)					0 75.00
76.00 Per diem capital-related costs (line 75 ÷ line 2)					0.00 76.00
77.00 Program capital-related costs (line 9 x line 76)					0 77.00
78.00 Inpatient routine service cost (line 74 minus line 77)					0 78.00
79.00 Aggregate charges to beneficiaries for excess costs (from provider records)					0 79.00
80.00 Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)					0 80.00
81.00 Inpatient routine service cost per diem limitation					0.00 81.00
82.00 Inpatient routine service cost limitation (line 9 x line 81)					0 82.00
83.00 Reasonable inpatient routine service costs (see instructions)					1,307,961 83.00
84.00 Program inpatient ancillary services (see instructions)					415,590 84.00
85.00 Utilization review - physician compensation (see instructions)					0 85.00
86.00 Total Program inpatient operating costs (sum of lines 83 through 85)					1,723,551 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: 26-0104 Component CCN: 26-5842		Period: From 01/01/2020 To 12/31/2020		Worksheet D-1 Date/Time Prepared: 7/30/2021 8:44 am	
				Title XVIII		Skilled Nursing Facility		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			0	0	0.000000	0	0	90.00
91.00	Nursing School cost			0	0	0.000000	0	0	91.00
92.00	Allied health cost			0	0	0.000000	0	0	92.00
93.00	All other Medical Education			0	0	0.000000	0	0	93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 26-0104 Component CCN: 26-5842	Period: From 01/01/2020 To 12/31/2020	Worksheet D-1 Date/Time Prepared: 7/30/2021 8:44 am
		Title XIX	Skilled Nursing Facility	PPS
Cost Center Description			1.00	
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		16,044	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		16,044	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.		0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)		16,044	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)		11,241	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)		0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period		0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)		0	14.00
15.00	Total nursery days (title V or XIX only)		1,965	15.00
16.00	Nursery days (title V or XIX only)		134	16.00
SWING BED ADJUSTMENT				
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period		0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)		5,487,751	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)		0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)		0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)		0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)		0	25.00
26.00	Total swing-bed cost (see instructions)		0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)		5,487,751	27.00
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)		0	28.00
29.00	Private room charges (excluding swing-bed charges)		0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)		0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)		0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)		0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)		0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)		0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)		0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)		5,487,751	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)			38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)			39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)			40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)			41.00

COMPUTATION OF INPATIENT OPERATING COST				Provider CCN: 26-0104 Component CCN: 26-5842	Period: From 01/01/2020 To 12/31/2020	Worksheet D-1 Date/Time Prepared: 7/30/2021 8:44 am
				Title XIX	Skilled Nursing Facility	PPS
Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
42.00 NURSERY (title V & XIX only)	1.00	2.00	3.00	4.00	5.00	42.00
Intensive Care Type Inpatient Hospital Units						
43.00 INTENSIVE CARE UNIT						43.00
44.00 CORONARY CARE UNIT						44.00
45.00 BURN INTENSIVE CARE UNIT						45.00
46.00 SURGICAL INTENSIVE CARE UNIT						46.00
47.00 OTHER SPECIAL CARE (SPECIFY)						47.00
Cost Center Description					1.00	
48.00 Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)						48.00
49.00 Total Program inpatient costs (sum of lines 41 through 48)(see instructions)						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)						50.00
51.00 Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)						51.00
52.00 Total Program excludable cost (sum of lines 50 and 51)						52.00
53.00 Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)						53.00
TARGET AMOUNT AND LIMIT COMPUTATION						
54.00 Program discharges						54.00
55.00 Target amount per discharge						55.00
56.00 Target amount (line 54 x line 55)						56.00
57.00 Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)						57.00
58.00 Bonus payment (see instructions)						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						59.00
60.00 Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket						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)						61.00
62.00 Relief payment (see instructions)						62.00
63.00 Allowable Inpatient cost plus incentive payment (see instructions)						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)						64.00
65.00 Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)						65.00
66.00 Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)						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)						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)						68.00
69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)						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)					5,487,751	70.00
71.00 Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)					342.04	71.00
72.00 Program routine service cost (line 9 x line 71)					3,844,872	72.00
73.00 Medically necessary private room cost applicable to Program (line 14 x line 35)					0	73.00
74.00 Total Program general inpatient routine service costs (line 72 + line 73)					3,844,872	74.00
75.00 Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)					58,371	75.00
76.00 Per diem capital-related costs (line 75 ÷ line 2)					3.64	76.00
77.00 Program capital-related costs (line 9 x line 76)					40,917	77.00
78.00 Inpatient routine service cost (line 74 minus line 77)					3,803,955	78.00
79.00 Aggregate charges to beneficiaries for excess costs (from provider records)					0	79.00
80.00 Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)					3,803,955	80.00
81.00 Inpatient routine service cost per diem limitation					0.00	81.00
82.00 Inpatient routine service cost limitation (line 9 x line 81)					0	82.00
83.00 Reasonable inpatient routine service costs (see instructions)					40,917	83.00
84.00 Program inpatient ancillary services (see instructions)					0	84.00
85.00 Utilization review - physician compensation (see instructions)					0	85.00
86.00 Total Program inpatient operating costs (sum of lines 83 through 85)					40,917	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: 26-0104

Period:

Worksheet D-1

Component CCN: 26-5842

From 01/01/2020
To 12/31/2020Date/Time Prepared:
7/30/2021 8:44 am

Title XIX

Skilled Nursing
Facility

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	0	0	0.000000	0	0	90.00
91.00	Nursing School cost	0	0	0.000000	0	0	91.00
92.00	Allied health cost	0	0	0.000000	0	0	92.00
93.00	All other Medical Education	0	0	0.000000	0	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT			Provider CCN: 26-0104	Period: From 01/01/2020 To 12/31/2020	Worksheet D-3 Date/Time Prepared: 7/30/2021 8:44 am	
Cost Center Description			Title XVIII	Hospital	PPS	
			Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS		34,993,227		30.00
31.00	03100	INTENSIVE CARE UNIT		14,220,795		31.00
40.00	04000	SUBPROVIDER - IPF		1,818		40.00
43.00	04300	NURSERY				43.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.226187	20,897,360	4,726,711	50.00
51.00	05100	RECOVERY ROOM	0.182893	1,772,397	324,159	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.605238	12,388	7,498	52.00
52.01	05201	PERINATAL CLINIC	0.397346	0	0	52.01
53.00	05300	ANESTHESIOLOGY	0.036243	3,144,450	113,964	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.176014	5,018,997	883,414	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.133640	335,933	44,894	55.00
56.00	05600	RADIOISOTOPE	0.199138	1,075,748	214,222	56.00
57.00	05700	CT SCAN	0.045242	8,410,430	380,505	57.00
58.00	05800	MRI	0.054459	1,720,906	93,719	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.085379	6,343,628	541,613	59.00
60.00	06000	LABORATORY	0.086317	20,053,635	1,730,970	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0.448186	1,716,944	769,510	62.00
64.00	06400	INTRAVENOUS THERAPY	0.212771	67,555	14,374	64.00
65.00	06500	RESPIRATORY THERAPY	0.195809	6,712,806	1,314,428	65.00
66.00	06600	PHYSICAL THERAPY	0.439068	1,915,816	841,173	66.00
66.01	06601	CLINICAL NUTRITION	18.031191	0	0	66.01
67.00	06700	OCCUPATIONAL THERAPY	0.394403	1,111,172	438,250	67.00
68.00	06800	SPEECH PATHOLOGY	0.242032	886,452	214,550	68.00
69.00	06900	ELECTROCARDIOLOGY	0.096429	7,366,149	710,310	69.00
69.01	06901	CARDIAC REHABILITATION	1.488122	7,098	10,563	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0.084978	1,085,839	92,272	70.00
70.01	07001	ELECTROSHOCK THERAPY	0.584802	4,272	2,498	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1.319663	3,593,552	4,742,278	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.718100	5,466,353	3,925,388	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.199219	19,219,454	3,828,880	73.00
74.00	07400	RENAL DIALYSIS	0.396814	3,204,831	1,271,722	74.00
76.00	03330	ENDOSCOPY	0.160525	836,212	134,233	76.00
OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.529433	2,055	1,088	90.00
91.00	09100	EMERGENCY	0.195156	10,730,721	2,094,165	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.302561	2,974,955	900,105	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		135,688,108	30,367,456	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)		135,688,108		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 26-0104 Component CCN: 26-S104	Period: From 01/01/2020 To 12/31/2020	Worksheet D-3 Date/Time Prepared: 7/30/2021 8:44 am	
		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
40.00	04000 SUBPROVIDER - IPF		1,958,850		40.00
43.00	04300 NURSERY				43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.226187	660	149	50.00
51.00	05100 RECOVERY ROOM	0.182893	80	15	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.605238	0	0	52.00
52.01	05201 PERINATAL CLINIC	0.397346	0	0	52.01
53.00	05300 ANESTHESIOLOGY	0.036243	2,350	85	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.176014	12,057	2,122	54.00
55.00	05500 RADIOLOGY-THERAPEUTIC	0.133640	232	31	55.00
56.00	05600 RADIOISOTOPE	0.199138	0	0	56.00
57.00	05700 CT SCAN	0.045242	9,900	448	57.00
58.00	05800 MRI	0.054459	3,450	188	58.00
59.00	05900 CARDIAC CATHETERIZATION	0.085379	0	0	59.00
60.00	06000 LABORATORY	0.086317	315,709	27,251	60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0.448186	0	0	62.00
64.00	06400 INTRAVENOUS THERAPY	0.212771	0	0	64.00
65.00	06500 RESPIRATORY THERAPY	0.195809	1,449	284	65.00
66.00	06600 PHYSICAL THERAPY	0.439068	0	0	66.00
66.01	06601 CLINICAL NUTRITION	18.031191	0	0	66.01
67.00	06700 OCCUPATIONAL THERAPY	0.394403	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0.242032	0	0	68.00
69.00	06900 ELECTROCARDIOLOGY	0.096429	5,250	506	69.00
69.01	06901 CARDIAC REHABILITATION	1.488122	0	0	69.01
70.00	07000 ELECTROENCEPHALOGRAPHY	0.084978	0	0	70.00
70.01	07001 ELECTROSHOCK THERAPY	0.584802	7,120	4,164	70.01
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	1.319663	255	337	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.718100	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.199219	436,047	86,869	73.00
74.00	07400 RENAL DIALYSIS	0.396814	2,772	1,100	74.00
76.00	03330 ENDOSCOPY	0.160525	2,476	397	76.00
OUTPATIENT SERVICE COST CENTERS					
90.00	09000 CLINIC	0.529433	0	0	90.00
91.00	09100 EMERGENCY	0.195156	204,560	39,921	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0.302561	0	0	92.00
200.00	Total (sum of lines 50 through 94 and 96 through 98)		1,004,367	163,867	200.00
201.00	Less PBP Clinic Laboratory Services-Program only charges (line 61)		0	0	201.00
202.00	Net charges (line 200 minus line 201)		1,004,367		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 26-0104 Component CCN: 26-5842	Period: From 01/01/2020 To 12/31/2020	Worksheet D-3 Date/Time Prepared: 7/30/2021 8:44 am	
		Title XVIII	Skilled Nursing Facility	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
40.00	04000 SUBPROVIDER - IPF		0		40.00
43.00	04300 NURSERY				43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.226187	0	0	50.00
51.00	05100 RECOVERY ROOM	0.182893	0	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.605238	0	0	52.00
52.01	05201 PERINATAL CLINIC	0.397346	0	0	52.01
53.00	05300 ANESTHESIOLOGY	0.036243	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.176014	7,348	1,293	54.00
55.00	05500 RADIOLOGY-THERAPEUTIC	0.133640	0	0	55.00
56.00	05600 RADIOISOTOPE	0.199138	0	0	56.00
57.00	05700 CT SCAN	0.045242	0	0	57.00
58.00	05800 MRI	0.054459	0	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	0.085379	0	0	59.00
60.00	06000 LABORATORY	0.086317	10,546	910	60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0.448186	0	0	62.00
64.00	06400 INTRAVENOUS THERAPY	0.212771	0	0	64.00
65.00	06500 RESPIRATORY THERAPY	0.195809	0	0	65.00
66.00	06600 PHYSICAL THERAPY	0.439068	420,547	184,649	66.00
66.01	06601 CLINICAL NUTRITION	18.031191	0	0	66.01
67.00	06700 OCCUPATIONAL THERAPY	0.394403	370,709	146,209	67.00
68.00	06800 SPEECH PATHOLOGY	0.242032	224,856	54,422	68.00
69.00	06900 ELECTROCARDIOLOGY	0.096429	0	0	69.00
69.01	06901 CARDIAC REHABILITATION	1.488122	0	0	69.01
70.00	07000 ELECTROENCEPHALOGRAPHY	0.084978	0	0	70.00
70.01	07001 ELECTROSHOCK THERAPY	0.584802	0	0	70.01
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	1.319663	4,745	6,262	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.718100	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.199219	109,652	21,845	73.00
74.00	07400 RENAL DIALYSIS	0.396814	0	0	74.00
76.00	03330 ENDOSCOPY	0.160525	0	0	76.00
OUTPATIENT SERVICE COST CENTERS					
90.00	09000 CLINIC	0.529433	0	0	90.00
91.00	09100 EMERGENCY	0.195156	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0.302561	0	0	92.00
200.00	Total (sum of lines 50 through 94 and 96 through 98)		1,148,403	415,590	200.00
201.00	Less PBP Clinic Laboratory Services-Program only charges (line 61)		0	0	201.00
202.00	Net charges (line 200 minus line 201)		1,148,403		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT			Provider CCN: 26-0104	Period: From 01/01/2020 To 12/31/2020	Worksheet D-3 Date/Time Prepared: 7/30/2021 8:44 am	
			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		23,226,210		30.00
31.00	03100	INTENSIVE CARE UNIT		6,369,062		31.00
40.00	04000	SUBPROVIDER - IPF		0		40.00
43.00	04300	NURSERY		150,884		43.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.226187	5,353,787	1,210,957	50.00
51.00	05100	RECOVERY ROOM	0.182893	306,300	56,020	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.605238	205,746	124,525	52.00
52.01	05201	PERINATAL CLINIC	0.397346	0	0	52.01
53.00	05300	ANESTHESIOLOGY	0.035188	898,683	31,623	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.176014	1,764,493	310,575	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.133559	169,958	22,699	55.00
56.00	05600	RADIOISOTOPE	0.199138	365,284	72,742	56.00
57.00	05700	CT SCAN	0.045242	3,153,987	142,693	57.00
58.00	05800	MRI	0.054459	713,680	38,866	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.085379	1,431,716	122,238	59.00
60.00	06000	LABORATORY	0.086317	9,736,087	840,390	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0.448186	791,954	354,943	62.00
64.00	06400	INTRAVENOUS THERAPY	0.212771	2,158	459	64.00
65.00	06500	RESPIRATORY THERAPY	0.195471	3,002,955	586,991	65.00
66.00	06600	PHYSICAL THERAPY	0.439068	518,235	227,540	66.00
66.01	06601	CLINICAL NUTRITION	18.031191	0	0	66.01
67.00	06700	OCCUPATIONAL THERAPY	0.394403	321,064	126,629	67.00
68.00	06800	SPEECH PATHOLOGY	0.242032	293,656	71,074	68.00
69.00	06900	ELECTROCARDIOLOGY	0.096429	2,255,015	217,449	69.00
69.01	06901	CARDIAC REHABILITATION	1.481154	2,028	3,004	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0.065016	583,403	37,931	70.00
70.01	07001	ELECTROSHOCK THERAPY	0.584802	74,048	43,303	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1.319663	910,222	1,201,186	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.718100	754,026	541,466	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.199219	9,078,974	1,808,704	73.00
74.00	07400	RENAL DIALYSIS	0.396814	705,198	279,832	74.00
76.00	03330	ENDOSCOPY	0.160525	288,246	46,271	76.00
OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.529433	31,543	16,700	90.00
91.00	09100	EMERGENCY	0.195156	5,326,476	1,039,494	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.302561	969,625	293,371	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		50,008,547	9,869,675	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)		50,008,547		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 26-0104 Component CCN: 26-S104	Period: From 01/01/2020 To 12/31/2020	Worksheet D-3 Date/Time Prepared: 7/30/2021 8:44 am	
		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
40.00	04000 SUBPROVIDER - IPF		2,322,097		40.00
43.00	04300 NURSERY		0		43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.226187	0	0	50.00
51.00	05100 RECOVERY ROOM	0.182893	0	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.605238	0	0	52.00
52.01	05201 PERINATAL CLINIC	0.397346	0	0	52.01
53.00	05300 ANESTHESIOLOGY	0.035188	1,144	40	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.176014	12,432	2,188	54.00
55.00	05500 RADIOLOGY-THERAPEUTIC	0.133559	0	0	55.00
56.00	05600 RADIOISOTOPE	0.199138	0	0	56.00
57.00	05700 CT SCAN	0.045242	21,900	991	57.00
58.00	05800 MRI	0.054459	0	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	0.085379	0	0	59.00
60.00	06000 LABORATORY	0.086317	409,188	35,320	60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0.448186	0	0	62.00
64.00	06400 INTRAVENOUS THERAPY	0.212771	0	0	64.00
65.00	06500 RESPIRATORY THERAPY	0.195471	15,418	3,014	65.00
66.00	06600 PHYSICAL THERAPY	0.439068	0	0	66.00
66.01	06601 CLINICAL NUTRITION	18.031191	0	0	66.01
67.00	06700 OCCUPATIONAL THERAPY	0.394403	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0.242032	0	0	68.00
69.00	06900 ELECTROCARDIOLOGY	0.096429	12,750	1,229	69.00
69.01	06901 CARDIAC REHABILITATION	1.481154	0	0	69.01
70.00	07000 ELECTROENCEPHALOGRAPHY	0.065016	0	0	70.00
70.01	07001 ELECTROSHOCK THERAPY	0.584802	4,272	2,498	70.01
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	1.319663	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.718100	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.199219	383,279	76,356	73.00
74.00	07400 RENAL DIALYSIS	0.396814	0	0	74.00
76.00	03330 ENDOSCOPY	0.160525	0	0	76.00
OUTPATIENT SERVICE COST CENTERS					
90.00	09000 CLINIC	0.529433	2,925	1,549	90.00
91.00	09100 EMERGENCY	0.195156	295,821	57,731	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0.302561	0	0	92.00
200.00	Total (sum of lines 50 through 94 and 96 through 98)		1,159,129	180,916	200.00
201.00	Less PBP Clinic Laboratory Services-Program only charges (line 61)		0	0	201.00
202.00	Net charges (line 200 minus line 201)		1,159,129		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 26-0104	Period: From 01/01/2020 To 12/31/2020	Worksheet E Part A Date/Time Prepared: 7/30/2021 8:44 am
		Title XVIII	Hospital	PPS
				1.00
PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS				
1.00	DRG Amounts Other than Outlier Payments		0	1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1 (see instructions)		33,792,518	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1 (see instructions)		12,958,104	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)		335,710	2.03
2.04	Outlier payments for discharges occurring on or after October 1 (see instructions)		119,085	2.04
3.00	Managed Care Simulated Payments		42,997,133	3.00
4.00	Bed days available divided by number of days in the cost reporting period (see instructions)		396.68	4.00
Indirect Medical Education Adjustment				
5.00	FTE count for allopathic and osteopathic programs for the most recent cost reporting period ending on or before 12/31/1996.(see instructions)		0.00	5.00
6.00	FTE count for allopathic and osteopathic programs that meet the criteria for an add-on to the cap for new programs in accordance with 42 CFR 413.79(e)		0.00	6.00
7.00	MMA Section 422 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(1)		0.00	7.00
7.01	ACA § 5503 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(2) If the cost report straddles July 1, 2011 then see instructions.		0.00	7.01
8.00	Adjustment (increase or decrease) to the FTE count for allopathic and osteopathic programs for affiliated programs in accordance with 42 CFR 413.75(b), 413.79(c)(2)(iv), 64 FR 26340 (May 12, 1998), and 67 FR 50069 (August 1, 2002).		0.00	8.00
8.01	The amount of increase if the hospital was awarded FTE cap slots under § 5503 of the ACA. If the cost report straddles July 1, 2011, see instructions.		0.00	8.01
8.02	The amount of increase if the hospital was awarded FTE cap slots from a closed teaching hospital under § 5506 of ACA. (see instructions)		0.00	8.02
9.00	Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus lines (8, 8.01 and 8.02) (see instructions)		0.00	9.00
10.00	FTE count for allopathic and osteopathic programs in the current year from your records		0.00	10.00
11.00	FTE count for residents in dental and podiatric programs.		14.53	11.00
12.00	Current year allowable FTE (see instructions)		14.53	12.00
13.00	Total allowable FTE count for the prior year.		14.01	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.		13.17	14.00
15.00	Sum of lines 12 through 14 divided by 3.		13.90	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		13.90	18.00
19.00	Current year resident to bed ratio (line 18 divided by line 4).		0.035041	19.00
20.00	Prior year resident to bed ratio (see instructions)		0.036640	20.00
21.00	Enter the lesser of lines 19 or 20 (see instructions)		0.035041	21.00
22.00	IME payment adjustment (see instructions)		886,485	22.00
22.01	IME payment adjustment - Managed Care (see instructions)		815,312	22.01
Indirect Medical Education Adjustment for the Add-on for § 422 of the MMA				
23.00	Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 CFR 412.105 (f)(1)(iv)(C).		0.00	23.00
24.00	IME FTE Resident Count Over Cap (see instructions)		0.00	24.00
25.00	If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see instructions)		0.00	25.00
26.00	Resident to bed ratio (divide line 25 by line 4)		0.000000	26.00
27.00	IME payments adjustment factor. (see instructions)		0.000000	27.00
28.00	IME add-on adjustment amount (see instructions)		0	28.00
28.01	IME add-on adjustment amount - Managed Care (see instructions)		0	28.01
29.00	Total IME payment (sum of lines 22 and 28)		886,485	29.00
29.01	Total IME payment - Managed Care (sum of lines 22.01 and 28.01)		815,312	29.01
Disproportionate Share Adjustment				
30.00	Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)		5.72	30.00
31.00	Percentage of Medicaid patient days (see instructions)		28.65	31.00
32.00	Sum of lines 30 and 31		34.37	32.00
33.00	Allowable disproportionate share percentage (see instructions)		17.57	33.00
34.00	Disproportionate share adjustment (see instructions)		2,053,521	34.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 26-0104	Period: From 01/01/2020 To 12/31/2020	Worksheet E Part A Date/Time Prepared: 7/30/2021 8:44 am
		Title XVIII	Hospital	PPS
			Prior to 10/1	On/After 10/1
			1.00	2.00
Uncompensated Care Adjustment				
35.00	Total uncompensated care amount (see instructions)		8,350,599,096	8,290,014,521
35.01	Factor 3 (see instructions)		0.000773848	0.000812998
35.02	Hospital uncompensated care payment (If line 34 is zero, enter zero on this line) (see instructions)		6,462,091	6,739,761
35.03	Pro rata share of the hospital uncompensated care payment amount (see instructions)		4,837,741	1,698,790
36.00	Total uncompensated care (sum of columns 1 and 2 on line 35.03)		6,536,531	
Additional payment for high percentage of ESRD beneficiary discharges (lines 40 through 46)				
40.00	Total Medicare discharges, excluding MS-DRGs 652, 682, 683, 684 and 685. (see instructions)		0	
41.00	Total ESRD Medicare discharges excluding MS-DRGs 652, 682, 683, 684 and 685. (see instructions)		0	
41.01	Total ESRD Medicare covered and paid discharges excluding MS-DRGs 652, 682, 683, 684 and 685. (see instructions)		0	
42.00	Divide line 41 by line 40 (if less than 10%, you do not qualify for adjustment)		0.00	
43.00	Total Medicare ESRD inpatient days excluding MS-DRGs 652, 682, 683, 684 and 685. (see instructions)		0	
44.00	Ratio of average length of stay to one week (line 43 divided by line 41 divided by 7 days)		0.000000	
45.00	Average weekly cost for dialysis treatments (see instructions)		0.00	
46.00	Total additional payment (line 45 times line 44 times line 41.01)		0	
47.00	Subtotal (see instructions)		56,681,954	
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)		57,497,266	49.00
50.00	Payment for inpatient program capital (from Wkst. L, Pt. I and Pt. II, as applicable)		3,937,474	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).		481,507	52.00
53.00	Nursing and Allied Health Managed Care payment		65,631	53.00
54.00	Special add-on payments for new technologies		13,224	54.00
54.01	Islet isolation add-on payment		0	54.01
55.00	Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line 69)		0	55.00
56.00	Cost of physicians' services in a teaching hospital (see instructions)		0	56.00
57.00	Routine service other pass through costs (from Wkst. D, Pt. III, column 9, lines 30 through 35).		73,752	57.00
58.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 11 line 200)		19,549	58.00
59.00	Total (sum of amounts on lines 49 through 58)		62,088,403	59.00
60.00	Primary payer payments		64,886	60.00
61.00	Total amount payable for program beneficiaries (line 59 minus line 60)		62,023,517	61.00
62.00	Deductibles billed to program beneficiaries		4,014,880	62.00
63.00	Coinurance billed to program beneficiaries		221,034	63.00
64.00	Allowable bad debts (see instructions)		1,664,704	64.00
65.00	Adjusted reimbursable bad debts (see instructions)		1,082,058	65.00
66.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		1,181,256	66.00
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)		58,869,661	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		270	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)		-84,673	70.93
70.94	HRR adjustment amount (see instructions)		-116,604	70.94
70.95	Recovery of accelerated depreciation		0	70.95

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 26-0104	Period: From 01/01/2020 To 12/31/2020	Worksheet E Part A Date/Time Prepared: 7/30/2021 8:44 am	
		Title XVIII	Hospital	PPS	
		FFY (yyyy)	Amount		
		0	1.00		
70.96	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period prior to 10/1)	0	0	70.96	
70.97	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period ending on or after 10/1)	0	0	70.97	
70.98	Low Volume Payment-3		0	70.98	
70.99	HAC adjustment amount (see instructions)		167,479	70.99	
71.00	Amount due provider (line 67 minus lines 68 plus/minus lines 69 & 70)		58,501,175	71.00	
71.01	Sequestration adjustment (see instructions)		386,108	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		56,312,505	72.00	
72.01	Interim payments-PARHM			72.01	
73.00	Tentative settlement (for contractor use only)		0	73.00	
73.01	Tentative settlement-PARHM (for contractor use only)			73.01	
74.00	Balance due provider/program (line 71 minus lines 71.01, 71.02, 72, and 73)		1,802,562	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		1,110,304	75.00	
TO BE COMPLETED BY CONTRACTOR (lines 90 through 96)					
90.00	Operating outlier amount from Wkst. E, Pt. A, line 2, or sum of 2.03 plus 2.04 (see instructions)		0	90.00	
91.00	Capital outlier from Wkst. L, Pt. I, line 2		0	91.00	
92.00	Operating outlier reconciliation adjustment amount (see instructions)		0	92.00	
93.00	Capital outlier reconciliation adjustment amount (see instructions)		0	93.00	
94.00	The rate used to calculate the time value of money (see instructions)		0.00	94.00	
95.00	Time value of money for operating expenses (see instructions)		0	95.00	
96.00	Time value of money for capital related expenses (see instructions)		0	96.00	
			Prior to 10/1	On/After 10/1	
			1.00	2.00	
HSP Bonus Payment Amount					
100.00	HSP bonus amount (see instructions)		0	100.00	
HVBP Adjustment for HSP Bonus Payment					
101.00	HVBP adjustment factor (see instructions)		0.0000000000	101.00	
102.00	HVBP adjustment amount for HSP bonus payment (see instructions)		0	102.00	
HRR Adjustment for HSP Bonus Payment					
103.00	HRR adjustment factor (see instructions)		0.0000	103.00	
104.00	HRR adjustment amount for HSP bonus payment (see instructions)		0	104.00	
Rural Community Hospital Demonstration Project (§410A Demonstration) Adjustment					
200.00	Is this the first year of the current 5-year demonstration period under the 21st Century Cures Act? Enter "Y" for yes or "N" for no.			200.00	
Cost Reimbursement					
201.00	Medicare inpatient service costs (from Wkst. D-1, Pt. II, line 49)			201.00	
202.00	Medicare discharges (see instructions)			202.00	
203.00	Case-mix adjustment factor (see instructions)			203.00	
Computation of Demonstration Target Amount Limitation (N/A in first year of the current 5-year demonstration period)					
204.00	Medicare target amount			204.00	
205.00	Case-mix adjusted target amount (line 203 times line 204)			205.00	
206.00	Medicare inpatient routine cost cap (line 202 times line 205)			206.00	
Adjustment to Medicare Part A Inpatient Reimbursement					
207.00	Program reimbursement under the §410A Demonstration (see instructions)			207.00	
208.00	Medicare Part A inpatient service costs (from Wkst. E, Pt. A, line 59)			208.00	
209.00	Adjustment to Medicare IPPS payments (see instructions)			209.00	
210.00	Reserved for future use			210.00	
211.00	Total adjustment to Medicare IPPS payments (see instructions)			211.00	
Comparison of PPS versus Cost Reimbursement					
212.00	Total adjustment to Medicare Part A IPPS payments (from line 211)			212.00	
213.00	Low-volume adjustment (see instructions)			213.00	
218.00	Net Medicare Part A IPPS adjustment (difference between PPS and cost reimbursement) (line 212 minus line 213) (see instructions)			218.00	

HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULATION EXHIBIT 5

Provider CCN: 26-0104

Period:
From 01/01/2020
To 12/31/2020Worksheet E
Part A Exhibit 5
Date/Time Prepared:
7/30/2021 8:44 am

		Title XVIII		Hospital		PPS	
		Wkst. E, Pt. A, line	Amt. from Wkst. E, Pt. A)	Period to 10/01	Period on after 10/01	Total (cols. 2 and 3)	
		0	1.00	2.00	3.00	4.00	
1.00	DRG amounts other than outlier payments	1.00					1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1	1.01	33,792,518	33,792,518		33,792,518	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	12,958,104		12,958,104	12,958,104	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	335,710	335,710		335,710	2.02
2.03	Outlier payments for discharges occurring on or after October 1 (see instructions)	2.04	119,085		119,085	119,085	2.03
3.00	Operating outlier reconciliation	2.01	0	0	0	0	3.00
4.00	Managed care simulated payments	3.00	42,997,133	31,208,866	11,788,267	42,997,133	4.00
Indirect Medical Education Adjustment							
5.00	Amount from Worksheet E, Part A, line 21 (see instructions)	21.00	0.035041	0.035041	0.035041		5.00
6.00	IME payment adjustment (see instructions)	22.00	886,485	640,773	245,712	886,485	6.00
6.01	IME payment adjustment for managed care (see instructions)	22.01	815,312	591,783	223,529	815,312	6.01
Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA							
7.00	IME payment adjustment factor (see instructions)	27.00	0.000000	0.000000	0.000000		7.00
8.00	IME adjustment (see instructions)	28.00	0	0	0	0	8.00
8.01	IME payment adjustment add on for managed care (see instructions)	28.01	0	0	0	0	8.01
9.00	Total IME payment (sum of lines 6 and 8)	29.00	886,485	640,773	245,712	886,485	9.00
9.01	Total IME payment for managed care (sum of lines 6.01 and 8.01)	29.01	815,312	591,783	223,529	815,312	9.01
Disproportionate Share Adjustment							
10.00	Allowable disproportionate share percentage (see instructions)	33.00	0.1757	0.1757	0.1757		10.00
11.00	Disproportionate share adjustment (see instructions)	34.00	2,053,521	1,484,336	569,185	2,053,521	11.00
11.01	Uncompensated care payments	36.00	6,536,531	4,837,741	1,698,790	6,536,531	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	56,681,954	41,091,078	15,590,876	56,681,954	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	57,497,266	41,682,861	15,814,405	57,497,266	15.00
16.00	Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable)	50.00	3,937,474	2,876,735	1,060,739	3,937,474	16.00
17.00	Special add-on payments for new technologies	54.00	13,224	0	13,224	13,224	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			44,559,596	16,888,368	61,447,964	19.00

HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULATION EXHIBIT 5

Provider CCN: 26-0104

Period:
From 01/01/2020
To 12/31/2020Worksheet E
Part A Exhibit 5
Date/Time Prepared:
7/30/2021 8:44 am

		Title XVIII		Hospital		PPS	
		Wkst. L, line	(Amt. from Wkst. L)				
		0	1.00	2.00	3.00	4.00	
20.00	Capital DRG other than outlier	1.00	3,606,116	2,633,890	972,226	3,606,116	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	16,905	13,170	3,735	16,905	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	0.0151	0.0151	0.0151		22.00
23.00	Indirect medical education adjustment (see instructions)	6.00	54,452	39,771	14,681	54,452	23.00
24.00	Allowable disproportionate share percentage (see instructions)	10.00	0.0721	0.0721	0.0721		24.00
25.00	Disproportionate share adjustment (see instructions)	11.00	260,001	189,904	70,097	260,001	25.00
26.00	Total prospective capital payments (see instructions)	12.00	3,937,474	2,876,735	1,060,739	3,937,474	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	-84,673	0	-84,673	-84,673	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	-116,604	-60,827	-55,777	-116,604	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	167,479	167,479	32.00
100.00	Transfer HAC Reduction Program adjustment to Wkst. E, Pt. A.		Y				100.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 26-0104	Period: From 01/01/2020 To 12/31/2020	Worksheet E Part B Date/Time Prepared: 7/30/2021 8:44 am
		Title XVIII	Hospital	PPS
				1.00
PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)		52,841	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)		41,298,510	2.00
3.00	OPPS payments		35,243,828	3.00
4.00	Outlier payment (see instructions)		54,217	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		13,656	9.00
10.00	Organ acquisitions		0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)		52,841	11.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
12.00	Ancillary service charges		262,425	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)		262,425	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)		262,425	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)		209,584	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)		52,841	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)		35,311,701	24.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25.00	Deductibles and coinsurance amounts (for CAH, see instructions)		2,557	25.00
26.00	Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)		6,624,246	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)		28,737,739	27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 50)		321,936	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)		29,059,675	30.00
31.00	Primary payer payments		33,661	31.00
32.00	Subtotal (line 30 minus line 31)		29,026,014	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)		761,801	34.00
35.00	Adjusted reimbursable bad debts (see instructions)		495,171	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		345,916	36.00
37.00	Subtotal (see instructions)		29,521,185	37.00
38.00	MSP-LCC reconciliation amount from PS&R		23	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)		29,521,162	40.00
40.01	Sequestration adjustment (see instructions)		194,840	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		29,399,371	41.00
41.01	Interim payments-PARHM		0	41.01
42.00	Tentative settlement (for contractors use only)		0	42.00
42.01	Tentative settlement-PARHM (for contractor use only)		0	42.01
43.00	Balance due provider/program (see instructions)		-73,049	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: 26-0104 Component CCN: 26-S104	Period: From 01/01/2020 To 12/31/2020	Worksheet E Part B Date/Time Prepared: 7/30/2021 8:44 am
		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)		24,352	2.00
3.00	OPPS payments		14,592	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)		14,592	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)		3,241	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)		11,351	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)		11,351	30.00
31.00	Primary payer payments		0	31.00
32.00	Subtotal (line 30 minus line 31)		11,351	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)		11,351	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)		11,351	40.00
40.01	Sequestration adjustment (see instructions)		75	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		11,217	41.00
41.01	Interim payments-PARHM		0	41.01
42.00	Tentative settlement (for contractors use only)		0	42.00
42.01	Tentative settlement-PARHM (for contractor use only)		0	42.01
43.00	Balance due provider/program (see instructions)		59	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: 26-0104

Period:
From 01/01/2020
To 12/31/2020Worksheet E-1
Part I
Date/Time Prepared:
7/30/2021 8:44 am

		Title XVIII		Hospital		PPS
		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		56,312,505		29,399,371	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
Program to Provider						
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
Provider to Program						
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		56,312,505		29,399,371	4.00
TO BE COMPLETED BY CONTRACTOR						
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
Program to Provider						
5.01	TENTATIVE TO PROVIDER		0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
Provider to Program						
5.50	TENTATIVE TO PROGRAM		0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		1,802,562		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		73,049	6.02
7.00	Total Medicare program liability (see instructions)		58,115,067		29,326,322	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: 26-0104

Period:

Worksheet E-1

Component CCN: 26-S104

From 01/01/2020
To 12/31/2020Part I
Date/Time Prepared:
7/30/2021 8:44 am

Title XVIII

Subprovider -
IPF

PPS

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider					1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		1,060,082		11,217	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
Program to Provider						
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
Provider to Program						
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		1,060,082		11,217	4.00
TO BE COMPLETED BY CONTRACTOR						
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
Program to Provider						
5.01	TENTATIVE TO PROVIDER		0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
Provider to Program						
5.50	TENTATIVE TO PROGRAM		0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		39,551		59	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		1,099,633		11,276	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: 26-0104

Period:

Worksheet E-1

Component CCN: 26-5842

From 01/01/2020
To 12/31/2020Part I
Date/Time Prepared:
7/30/2021 8:44 am

Title XVIII

Skilled Nursing
Facility

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		1,891,818		0	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
Program to Provider						
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
Provider to Program						
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		1,891,818		0	4.00
TO BE COMPLETED BY CONTRACTOR						
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
Program to Provider						
5.01	TENTATIVE TO PROVIDER		0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
Provider to Program						
5.50	TENTATIVE TO PROGRAM		0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		72,212		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		1,964,030		0	7.00
				Contractor Number	NPR Date (Mo/Day/Yr)	
		0		1.00	2.00	
8.00	Name of Contractor					8.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT		Provider CCN: 26-0104	Period: From 01/01/2020 To 12/31/2020	Worksheet E-1 Part II Date/Time Prepared: 7/30/2021 8:44 am
		Title XVIII	Hospital	PPS
				1.00
TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS				
HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION				
1.00	Total hospital discharges as defined in AARA §4102 from Wkst. S-3, Pt. I col. 15 line 14			1.00
2.00	Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, 8-12			2.00
3.00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2			3.00
4.00	Total inpatient days from S-3, Pt. I col. 8 sum of lines 1, 8-12			4.00
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200			5.00
6.00	Total hospital charity care charges from Wkst. S-10, col. 3 line 20			6.00
7.00	CAH only - The reasonable cost incurred for the purchase of certified HIT technology Wkst. S-2, Pt. I line 168			7.00
8.00	Calculation of the HIT incentive payment (see instructions)			8.00
9.00	Sequestration adjustment amount (see instructions)			9.00
10.00	Calculation of the HIT incentive payment after sequestration (see instructions)			10.00
INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH				
30.00	Initial/interim HIT payment adjustment (see instructions)			30.00
31.00	Other Adjustment (specify)			31.00
32.00	Balance due provider (line 8 (or line 10) minus line 30 and line 31) (see instructions)			32.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 26-0104 Component CCN: 26-S104	Period: From 01/01/2020 To 12/31/2020	Worksheet E-3 Part II Date/Time Prepared: 7/30/2021 8:44 am
		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)	1,218,574	1.00	
2.00	Net IPF PPS Outlier Payments	0	2.00	
3.00	Net IPF PPS ECT Payments	1,638	3.00	
4.00	Unweighted intern and resident FTE count in the most recent cost report filed on or before November 15, 2004. (see instructions)	0.00	4.00	
4.01	Cap increases for the unweighted intern and resident FTE count for residents that were displaced by program or hospital closure, that would not be counted without a temporary cap adjustment under 42 CFR §412.424(d)(1)(iii)(F)(1) or (2) (see instructions)	0.00	4.01	
5.00	New Teaching program adjustment. (see instructions)	0.00	5.00	
6.00	Current year's unweighted FTE count of I&R excluding FTEs in the new program growth period of a "new teaching program" (see instructions)	0.00	6.00	
7.00	Current year's unweighted I&R FTE count for residents within the new program growth period of a "new teaching program" (see instructions)	0.00	7.00	
8.00	Intern and resident count for IPF PPS medical education adjustment (see instructions)	0.00	8.00	
9.00	Average Daily Census (see instructions)	12.415301	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)	1,220,212	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)		14.00	
15.00	Cost of physicians' services in a teaching hospital (see instructions)	0	15.00	
16.00	Subtotal (see instructions)	1,220,212	16.00	
17.00	Primary payer payments	462	17.00	
18.00	Subtotal (line 16 less line 17).	1,219,750	18.00	
19.00	Deductibles	168,773	19.00	
20.00	Subtotal (line 18 minus line 19)	1,050,977	20.00	
21.00	Coinsurance	43,296	21.00	
22.00	Subtotal (line 20 minus line 21)	1,007,681	22.00	
23.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)	110,342	23.00	
24.00	Adjusted reimbursable bad debts (see instructions)	71,722	24.00	
25.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	20,881	25.00	
26.00	Subtotal (sum of lines 22 and 24)	1,079,403	26.00	
27.00	Direct graduate medical education payments (see instructions)	0	27.00	
28.00	Other pass through costs (see instructions)	27,536	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)	1,106,939	31.00	
31.01	Sequestration adjustment (see instructions)	7,306	31.01	
31.02	Demonstration payment adjustment amount after sequestration	0	31.02	
32.00	Interim payments	1,060,082	32.00	
33.00	Tentative settlement (for contractor use only)	0	33.00	
34.00	Balance due provider/program (line 31 minus lines 31.01, 31.02, 32 and 33)	39,551	34.00	
35.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	35.00	
TO BE COMPLETED BY CONTRACTOR				
50.00	Original outlier amount from Worksheet E-3, Part II, line 2	0	50.00	
51.00	Outlier reconciliation adjustment amount (see instructions)	0	51.00	
52.00	The rate used to calculate the Time Value of Money	0.00	52.00	
53.00	Time Value of Money (see instructions)	0	53.00	

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 26-0104 Component CCN: 26-5842	Period: From 01/01/2020 To 12/31/2020	Worksheet E-3 Part VI Date/Time Prepared: 7/30/2021 8:44 am
		Title XVIII	Skilled Nursing Facility	PPS
				1.00
PART VI - CALCULATION OF REIMBURSEMENT SETTLEMENT - ALL OTHER HEALTH SERVICES FOR TITLE XVIII PART A PPS SNF SERVICES				
PROSPECTIVE PAYMENT AMOUNT (SEE INSTRUCTIONS)				
1.00	Resource Utilization Group Payment (RUGS)		2,141,378	1.00
2.00	Routine service other pass through costs		0	2.00
3.00	Ancillary service other pass through costs		0	3.00
4.00	Subtotal (sum of lines 1 through 3)		2,141,378	4.00
COMPUTATION OF NET COST OF COVERED SERVICES				
5.00	Medical and other services (Do not use this line as vaccine costs are included in line 1 of W/S E, Part B. This line is now shaded.)			5.00
6.00	Deductible		0	6.00
7.00	Coinsurance		237,248	7.00
8.00	Allowable bad debts (see instructions)		111,096	8.00
9.00	Reimbursable bad debts for dual eligible beneficiaries (see instructions)		61,308	9.00
10.00	Adjusted reimbursable bad debts (see instructions)		72,212	10.00
11.00	Utilization review		0	11.00
12.00	Subtotal (sum of lines 4, 5 minus lines 6 and 7, plus lines 10 and 11)(see instructions)		1,976,342	12.00
13.00	Inpatient primary payer payments		0	13.00
14.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	14.00
14.50	Pioneer ACO demonstration payment adjustment (see instructions)		0	14.50
14.99	Demonstration payment adjustment amount before sequestration		0	14.99
15.00	Subtotal (see instructions)		1,976,342	15.00
15.01	Sequestration adjustment (see instructions)		12,312	15.01
15.02	Demonstration payment adjustment amount after sequestration		0	15.02
15.75	Sequestration for non-claims based amounts (see instructions)		477	15.75
16.00	Interim payments		1,891,818	16.00
17.00	Tentative settlement (for contractor use only)		0	17.00
18.00	Balance due provider/program (line 15 minus lines 15.01, 15.02, 15.75, 16, and 17)		71,735	18.00
19.00	Protested amounts (nonallowable cost report items) in accordance with CMS 19 Pub. 15-2, chapter 1, §115.2		0	19.00

DIRECT GRADUATE MEDICAL EDUCATION (GME) & ESRD OUTPATIENT DIRECT MEDICAL EDUCATION COSTS		Provider CCN: 26-0104	Period: From 01/01/2020 To 12/31/2020	Worksheet E-4 Date/Time Prepared: 7/30/2021 8:44 am	
		Title XVIII	Hospital	PPS	
				1.00	
COMPUTATION OF TOTAL DIRECT GME AMOUNT					
1.00	Unweighted resident FTE count for allopathic and osteopathic programs for cost reporting periods ending on or before December 31, 1996.			0.00	1.00
2.00	Unweighted FTE resident cap add-on for new programs per 42 CFR 413.79(e)(1) (see instructions)			0.00	2.00
3.00	Amount of reduction to Direct GME cap under section 422 of MMA			0.00	3.00
3.01	Direct GME cap reduction amount under ACA §5503 in accordance with 42 CFR §413.79 (m). (see instructions for cost reporting periods straddling 7/1/2011)			0.00	3.01
4.00	Adjustment (plus or minus) to the FTE cap for allopathic and osteopathic programs due to a Medicare GME affiliation agreement (42 CFR §413.75(b) and § 413.79 (f))			0.00	4.00
4.01	ACA Section 5503 increase to the Direct GME FTE Cap (see instructions for cost reporting periods straddling 7/1/2011)			0.00	4.01
4.02	ACA Section 5506 number of additional direct GME FTE cap slots (see instructions for cost reporting periods straddling 7/1/2011)			0.00	4.02
5.00	FTE adjusted cap (line 1 plus line 2 minus line 3 and 3.01 plus or minus line 4 plus lines 4.01 and 4.02 plus applicable subscripts)			0.00	5.00
6.00	Unweighted resident FTE count for allopathic and osteopathic programs for the current year from your records (see instructions)			0.00	6.00
7.00	Enter the lesser of line 5 or line 6			0.00	7.00
		Primary Care 1.00	Other 2.00	Total 3.00	
8.00	Weighted FTE count for physicians in an allopathic and osteopathic program for the current year.	0.00	0.00	0.00	8.00
9.00	If line 6 is less than 5 enter the amount from line 8, otherwise multiply line 8 times the result of line 5 divided by the amount on line 6.	0.00	0.00	0.00	9.00
10.00	Weighted dental and podiatric resident FTE count for the current year		14.53		10.00
10.01	Unweighted dental and podiatric resident FTE count for the current year		0.00		10.01
11.00	Total weighted FTE count	0.00	14.53		11.00
12.00	Total weighted resident FTE count for the prior cost reporting year (see instructions)	0.00	14.01		12.00
13.00	Total weighted resident FTE count for the penultimate cost reporting year (see instructions)	0.00	13.17		13.00
14.00	Rolling average FTE count (sum of lines 11 through 13 divided by 3).	0.00	13.90		14.00
15.00	Adjustment for residents in initial years of new programs	0.00	0.00		15.00
15.01	Unweighted adjustment for residents in initial years of new programs	0.00	0.00		15.01
16.00	Adjustment for residents displaced by program or hospital closure	0.00	0.00		16.00
16.01	Unweighted adjustment for residents displaced by program or hospital closure	0.00	0.00		16.01
17.00	Adjusted rolling average FTE count	0.00	13.90		17.00
18.00	Per resident amount	122,882.58	122,882.58		18.00
19.00	Approved amount for resident costs	0	1,708,068	1,708,068	19.00
				1.00	
20.00	Additional unweighted allopathic and osteopathic direct GME FTE resident cap slots received under 42 Sec. 413.79(c)(4)			0.00	20.00
21.00	Direct GME FTE unweighted resident count over cap (see instructions)			0.00	21.00
22.00	Allowable additional direct GME FTE Resident Count (see instructions)			0.00	22.00
23.00	Enter the locality adjustment national average per resident amount (see instructions)			0.00	23.00
24.00	Multiply line 22 time line 23			0	24.00
25.00	Total direct GME amount (sum of lines 19 and 24)			1,708,068	25.00
		Inpatient Part A 1.00	Managed Care 2.00	Total 3.00	
COMPUTATION OF PROGRAM PATIENT LOAD					
26.00	Inpatient Days (see instructions) (Title XIX - see S-2 Part IX, line 3.02, column 2)	25,128	23,189		26.00
27.00	Total Inpatient Days (see instructions)	99,268	99,268		27.00
28.00	Ratio of inpatient days to total inpatient days	0.253133	0.233600		28.00
29.00	Program direct GME amount	432,368	399,005	831,373	29.00
29.01	Percent reduction for MA DGME		7.00		29.01
30.00	Reduction for direct GME payments for Medicare Advantage		27,930	27,930	30.00
31.00	Net Program direct GME amount			803,443	31.00

DIRECT GRADUATE MEDICAL EDUCATION (GME) & ESRD OUTPATIENT DIRECT MEDICAL EDUCATION COSTS		Provider CCN: 26-0104	Period: From 01/01/2020 To 12/31/2020	Worksheet E-4 Date/Time Prepared: 7/30/2021 8:44 am	
		Title XVIII	Hospital	PPS	
				1.00	
	DIRECT MEDICAL EDUCATION COSTS FOR ESRD COMPOSITE RATE - TITLE XVIII ONLY (NURSING SCHOOL AND PARAMEDICAL EDUCATION COSTS)				
32.00	Renal dialysis direct medical education costs (from Wkst. B, Pt. I, sum of col. 20 and 23, lines 74 and 94)			0	32.00
33.00	Renal dialysis and home dialysis total charges (Wkst. C, Pt. I, col. 8, sum of lines 74 and 94)			6,809,522	33.00
34.00	Ratio of direct medical education costs to total charges (line 32 ÷ line 33)			0.000000	34.00
35.00	Medicare outpatient ESRD charges (see instructions)			0	35.00
36.00	Medicare outpatient ESRD direct medical education costs (line 34 x line 35)			0	36.00
APPORTIONMENT BASED ON MEDICARE REASONABLE COST - TITLE XVIII ONLY					
Part A Reasonable Cost					
37.00	Reasonable cost (see instructions)			61,919,281	37.00
38.00	Organ acquisition costs (Wkst. D-4, Pt. III, col. 1, line 69)			0	38.00
39.00	Cost of physicians' services in a teaching hospital (see instructions)			0	39.00
40.00	Primary payer payments (see instructions)			65,348	40.00
41.00	Total Part A reasonable cost (sum of lines 37 through 39 minus line 40)			61,853,933	41.00
Part B Reasonable Cost					
42.00	Reasonable cost (see instructions)			41,389,359	42.00
43.00	Primary payer payments (see instructions)			33,661	43.00
44.00	Total Part B reasonable cost (line 42 minus line 43)			41,355,698	44.00
45.00	Total reasonable cost (sum of lines 41 and 44)			103,209,631	45.00
46.00	Ratio of Part A reasonable cost to total reasonable cost (line 41 ÷ line 45)			0.599304	46.00
47.00	Ratio of Part B reasonable cost to total reasonable cost (line 44 ÷ line 45)			0.400696	47.00
ALLOCATION OF MEDICARE DIRECT GME COSTS BETWEEN PART A AND PART B					
48.00	Total program GME payment (line 31)			803,443	48.00
49.00	Part A Medicare GME payment (line 46 x 48) (title XVIII only) (see instructions)			481,507	49.00
50.00	Part B Medicare GME payment (line 47 x 48) (title XVIII only) (see instructions)			321,936	50.00

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

Provider CCN: 26-0104

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

Worksheet G

Date/Time Prepared:
7/30/2021 8:44 am

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
CURRENT ASSETS						
1.00	Cash on hand in banks	332,298	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	62,964,099	0	0	0	4.00
5.00	Other receivable	6,107,495	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	0	0	0	0	6.00
7.00	Inventory	8,854,263	0	0	0	7.00
8.00	Prepaid expenses	1,040,300	0	0	0	8.00
9.00	Other current assets	0	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)	79,298,455	0	0	0	11.00
FIXED ASSETS						
12.00	Land	9,615,392	0	0	0	12.00
13.00	Land improvements	3,089,466	0	0	0	13.00
14.00	Accumulated depreciation	-2,458,889	0	0	0	14.00
15.00	Buildings	126,626,002	0	0	0	15.00
16.00	Accumulated depreciation	-59,372,966	0	0	0	16.00
17.00	Leasehold improvements	3,413,465	0	0	0	17.00
18.00	Accumulated depreciation	-2,577,554	0	0	0	18.00
19.00	Fixed equipment	20,828,252	0	0	0	19.00
20.00	Accumulated depreciation	-8,605,447	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	104,641,641	0	0	0	23.00
24.00	Accumulated depreciation	-67,608,857	0	0	0	24.00
25.00	Minor equipment depreciable	0	0	0	0	25.00
26.00	Accumulated depreciation	0	0	0	0	26.00
27.00	HIT designated Assets	0	0	0	0	27.00
28.00	Accumulated depreciation	0	0	0	0	28.00
29.00	Minor equipment-nondepreciable	0	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	127,590,505	0	0	0	30.00
OTHER ASSETS						
31.00	Investments	4,293,634	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	13,311,045	2,276,758	138,956	0	34.00
35.00	Total other assets (sum of lines 31-34)	17,604,679	2,276,758	138,956	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	224,493,639	2,276,758	138,956	0	36.00
CURRENT LIABILITIES						
37.00	Accounts payable	58,714,759	0	0	0	37.00
38.00	Salaries, wages, and fees payable	10,387,094	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	1,308,214	0	0	0	40.00
41.00	Deferred income	453,605	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	-142,648,482	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	-71,784,810	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	44,358,392	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	44,358,392	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	-27,426,418	0	0	0	51.00
CAPITAL ACCOUNTS						
52.00	General fund balance	251,920,057				52.00
53.00	Specific purpose fund		2,276,758			53.00
54.00	Donor created - endowment fund balance - restricted			138,956		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)	251,920,057	2,276,758	138,956	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	224,493,639	2,276,758	138,956	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 26-0104

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

Worksheet G-1

Date/Time Prepared:
7/30/2021 8:44 am

		General Fund		Special Purpose Fund		Endowment Fund	
		1.00	2.00	3.00	4.00	5.00	
1.00	Fund balances at beginning of period		234,747,030		2,286,869		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		51,673,339				2.00
3.00	Total (sum of line 1 and line 2)		286,420,369		2,286,869		3.00
4.00	Additions (credit adjustments) (specify)	0		0		0	4.00
5.00		0		0		0	5.00
6.00		0		0		0	6.00
7.00		0		0		0	7.00
8.00		0		0		0	8.00
9.00		0		0		0	9.00
10.00	Total additions (sum of line 4-9)		0		0		10.00
11.00	Subtotal (line 3 plus line 10)		286,420,369		2,286,869		11.00
12.00	DEDUCTIONS (DEBIT ADJUSTMENTS)	0		10,111		0	12.00
13.00	CORPORATE OFFICE	34,500,312		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)		34,500,312		10,111		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		251,920,057		2,276,758		19.00
		Endowment Fund	Plant Fund				
		6.00	7.00	8.00			
1.00	Fund balances at beginning of period	138,956		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)	138,956		0			3.00
4.00	Additions (credit adjustments) (specify)		0				4.00
5.00			0				5.00
6.00			0				6.00
7.00			0				7.00
8.00			0				8.00
9.00			0				9.00
10.00	Total additions (sum of line 4-9)	0		0			10.00
11.00	Subtotal (line 3 plus line 10)	138,956		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)	138,956		0			19.00

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES

Provider CCN: 26-0104

Period:
From 01/01/2020
To 12/31/2020Worksheet G-2
Parts I & II
Date/Time Prepared:
7/30/2021 8:44 am

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
PART I - PATIENT REVENUES					
General Inpatient Routine Services					
1.00	Hospital	131,526,730		131,526,730	1.00
2.00	SUBPROVIDER - IPF	27,513,837		27,513,837	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	4,226,875		4,226,875	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)	163,267,442		163,267,442	10.00
Intensive Care Type Inpatient Hospital Services					
11.00	INTENSIVE CARE UNIT	49,473,158		49,473,158	11.00
12.00	CORONARY CARE UNIT				12.00
13.00	BURN INTENSIVE CARE UNIT				13.00
14.00	SURGICAL INTENSIVE CARE UNIT				14.00
15.00	OTHER SPECIAL CARE (SPECIFY)				15.00
16.00	Total intensive care type inpatient hospital services (sum of lines 11-15)	49,473,158		49,473,158	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	212,740,600		212,740,600	17.00
18.00	Ancillary services	411,983,766	647,894,400	1,059,878,166	18.00
19.00	Outpatient services	47,167,193	115,162,531	162,329,724	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 PROFESSIONAL FEES	3,130,293	5,181,148	8,311,441	27.00
27.01	EMPLOYEE HEALTH INSURANCE	9,993,653	28,308,377	38,302,030	27.01
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	685,015,505	796,546,456	1,481,561,961	28.00
PART II - OPERATING EXPENSES					
29.00	Operating expenses (per Wkst. A, column 3, line 200)		445,518,747		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)		445,518,747		43.00

STATEMENT OF REVENUES AND EXPENSES

Provider CCN: 26-0104

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

Worksheet G-3

Date/Time Prepared:
7/30/2021 8:44 am

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	1,481,561,961	1.00
2.00	Less contractual allowances and discounts on patients' accounts	1,074,695,307	2.00
3.00	Net patient revenues (line 1 minus line 2)	406,866,654	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	445,518,747	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-38,652,093	5.00
OTHER INCOME			
6.00	Contributions, donations, bequests, etc	512,783	6.00
7.00	Income from investments	140,867	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	1,388	10.00
11.00	Rebates and refunds of expenses	0	11.00
12.00	Parking lot receipts	0	12.00
13.00	Revenue from laundry and linen service	0	13.00
14.00	Revenue from meals sold to employees and guests	1,155,997	14.00
15.00	Revenue from rental of living quarters	0	15.00
16.00	Revenue from sale of medical and surgical supplies to other than patients	0	16.00
17.00	Revenue from sale of drugs to other than patients	52,149,833	17.00
18.00	Revenue from sale of medical records and abstracts	474	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	0	20.00
21.00	Rental of vending machines	0	21.00
22.00	Rental of hospital space	460,119	22.00
23.00	Governmental appropriations	0	23.00
24.00	OTHER INCOME	5,673,465	24.00
24.50	COVID-19 PHE Funding	33,547,325	24.50
25.00	Total other income (sum of lines 6-24)	93,642,251	25.00
26.00	Total (line 5 plus line 25)	54,990,158	26.00
27.00	NON-OPERATING PENSION	3,316,819	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	3,316,819	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	51,673,339	29.00

CALCULATION OF CAPITAL PAYMENT		Provider CCN: 26-0104	Period: From 01/01/2020 To 12/31/2020	Worksheet L Parts I-III Date/Time Prepared: 7/30/2021 8:44 am
		Title XVIII	Hospital	PPS
		1.00		
PART I - FULLY PROSPECTIVE METHOD				
CAPITAL FEDERAL AMOUNT				
1.00	Capital DRG other than outlier		3,606,116	1.00
1.01	Model 4 BPCI Capital DRG other than outlier		0	1.01
2.00	Capital DRG outlier payments		16,905	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)		262.19	3.00
4.00	Number of interns & residents (see instructions)		13.90	4.00
5.00	Indirect medical education percentage (see instructions)		1.51	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)		54,452	6.00
7.00	Percentage of SSI recipient patient days to Medicare Part A patient days (Worksheet E, part A line 30) (see instructions)		5.72	7.00
8.00	Percentage of Medicaid patient days to total days (see instructions)		28.65	8.00
9.00	Sum of lines 7 and 8		34.37	9.00
10.00	Allowable disproportionate share percentage (see instructions)		7.21	10.00
11.00	Disproportionate share adjustment (see instructions)		260,001	11.00
12.00	Total prospective capital payments (see instructions)		3,937,474	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