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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY	Provider CCN: 15-0057	Period: From 01/01/2020 To 12/31/2020	Worksheet S Parts I-III Date/Time Prepared: 7/28/2021 12:22 pm

PART I - COST REPORT STATUS

Provider use only

1. [X] Electronically prepared cost report — Date: 7/28/2021 Time: 12:22 pm
2. [ ] Manually prepared cost report
3. [0] If this is an amended report enter the number of times the provider resubmitted this cost report
4. [F] Medicare Utilization. Enter "F" for full or "L" for low.

Contractor use only

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

PART II - CERTIFICATION

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

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

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by FRANCISCAN HEALTH MOORESVILLE (15-0057) 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 Part A	Title XVIII Part B	HIT	Title XIX	
		1.00	2.00	3.00	4.00	5.00	
	PART III - SETTLEMENT SUMMARY						
1.00	Hospital	0	1,167,670	-6,201	0	0	1.00
2.00	Subprovider - IPF	0	0	0		0	2.00
3.00	Subprovider - IRF	0	0	0		0	3.00
5.00	Swing Bed - SNF	0	0	0		0	5.00
6.00	Swing Bed - NF	0				0	6.00
200.00	Total	0	1,167,670	-6,201	0	0	200.00

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-0057 | Period: From 01/01/2020 To 12/31/2020 | Worksheet S-2 Part I Date/Time Prepared: 7/28/2021 12:22 pm

	1.00	2.00	3.00	4.00	
	Hospital and Hospital Health Care Complex Address:				
1.00	Street: 1201 HADLEY ROAD	PO Box:			1.00
2.00	City: MOORESVILLE	State: IN	Zip Code: 46158	County:	2.00

		Component Name	CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N) V	XVIII	XIX	
		1.00	2.00	3.00	4.00	5.00	6.00	7.00	8.00	
	Hospital and Hospital-Based Component Identification:									
3.00	Hospital	FRANCISCAN HEALTH MOORESVILLE	150057	26900	1	07/01/1996	N	P	P	3.00
4.00	Subprovider - IPF									4.00
5.00	Subprovider - IRF									5.00
6.00	Subprovider - (Other)									6.00
7.00	Swing Beds - SNF									7.00
8.00	Swing Beds - NF									8.00
9.00	Hospital-Based SNF									9.00
10.00	Hospital-Based NF									10.00
11.00	Hospital-Based OLTC									11.00
12.00	Hospital-Based HHA									12.00
13.00	Separately Certified ASC									13.00
14.00	Hospital-Based Hospice									14.00
15.00	Hospital-Based Health Clinic - RHC									15.00
16.00	Hospital-Based Health Clinic - FQHC									16.00
17.00	Hospital-Based (CMHC) I									17.00
18.00	Renal Dialysis									18.00
19.00	Other									19.00

		From:	To:	
		1.00	2.00	
20.00	Cost Reporting Period (mm/dd/yyyy)	01/01/2020	12/31/2020	20.00
21.00	Type of Control (see instructions)	2		21.00

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

		In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of State Medicaid paid days	Out-of State Medicaid eligible unpaid	Medicaid HMO days	Other Medicaid days	
		1.00	2.00	3.00	4.00	5.00	6.00	
24.00	If this provider is an IPPS hospital, enter the in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.	46	1	0	0	1,291	72	24.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-0057 | Period: From 01/01/2020 To 12/31/2020 | Worksheet S-2 Part I Date/Time Prepared: 7/28/2021 12:22 pm

		In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of State Medicaid paid days	Out-of State Medicaid eligible unpaid	Medicaid HMO days	Other Medicaid days	
		1.00	2.00	3.00	4.00	5.00	6.00	
25.00	If this provider is an IRF, enter the in-state Medicaid paid days in column 1, the in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5.	0	0	0	0	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)	Y	Y	39.00
40.00	Is this hospital subject to the HAC program reduction adjustment? Enter "Y" for yes or "N" for no in column 1, for discharges prior to October 1. Enter "Y" for yes or "N" for no in column 2, for discharges on or after October 1. (see instructions)	N	N	40.00

		V	XVIII	XIX	
		1.00	2.00	3.00	
	Prospective Payment System (PPS)-Capital				
45.00	Does this facility qualify and receive Capital payment for disproportionate share in accordance with 42 CFR Section §412.320? (see instructions)	N	N	N	45.00
46.00	Is this facility eligible for additional payment exception for extraordinary circumstances pursuant to 42 CFR §412.348(f)? If yes, complete Wkst. L, Pt. III and Wkst. L-1, Pt. I through Pt. III.	N	N	N	46.00
47.00	Is this a new hospital under 42 CFR §412.300(b) PPS capital? Enter "Y for yes or "N" for no.	N	N	N	47.00
48.00	Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.	N	N	N	48.00
	Teaching Hospitals				
56.00	Is this a hospital involved in training residents in approved GME programs? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", are you impacted by CR 11642 (or subsequent CR), MA GME payment reduction? Enter "Y" for yes or "N" for no in column 2.	N	N		56.00
57.00	If line 56 is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y" did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If column 2 is "N", complete Wkst. D, Parts III & IV and D-2, Pt. II, if applicable.	N			57.00
58.00	If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, chapter 21, §2148? If yes, complete Wkst. D-5.	N			58.00
59.00	Are costs claimed on line 100 of Worksheet A? If yes, complete Wkst. D-2, Pt. I.	N			59.00

		NAHE 413.85 Y/N	Worksheet A Line #	Pass-Through Qualification Criterion Code	
		1.00	2.00	3.00	
60.00	Are you claiming nursing and allied health education (NAHE) costs for any programs that meet the criteria under 42 CFR 413.85? (see instructions) Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", are you impacted by CR 11642 (or subsequent CR) NAHE MA payment adjustement? Enter "Y" for yes or "N" for no in column 2.	N			60.00

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		Y/N	IME	Direct GME	IME	Direct GME	
		1.00	2.00	3.00	4.00	5.00	
61.00	Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions)	N			0.00	0.00	61.00
61.01	Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions)						61.01
61.02	Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions)						61.02
61.03	Enter the base line FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions)						61.03
61.04	Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period.(see instructions).						61.04
61.05	Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions)						61.05
61.06	Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)						61.06

		Program Name	Program Code	Unweighted IME FTE Count	Unweighted Direct GME FTE Count	
		1.00	2.00	3.00	4.00	
61.10	Of the FTEs in line 61.05, specify each new program specialty, if any, and the number of FTE residents for each new program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count.			0.00	0.00	61.10
61.20	Of the FTEs in line 61.05, specify each expanded program specialty, if any, and the number of FTE residents for each expanded program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count.			0.00	0.00	61.20

		1.00	
	ACA Provisions Affecting the Health Resources and Services Administration (HRSA)		
62.00	Enter the number of FTE residents that your hospital trained in this cost reporting period for which your hospital received HRSA PCRE funding (see instructions)	0.00	62.00
62.01	Enter the number of FTE residents that rotated from a Teaching Health Center (THC) into your hospital during in this cost reporting period of HRSA THC program. (see instructions)	0.00	62.01
	Teaching Hospitals that Claim Residents in Nonprovider Settings		
63.00	Has your facility trained residents in nonprovider settings during this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If yes, complete lines 64 through 67. (see instructions)	N	63.00

		Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))	
		1.00	2.00	3.00	
	Section 5504 of the ACA Base Year FTE Residents in Nonprovider Settings--This base year is your cost reporting period that begins on or after July 1, 2009 and before June 30, 2010.				
64.00	Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)	0.00	0.00	0.000000	64.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-0057 | Period: From 01/01/2020 To 12/31/2020 | Worksheet S-2 Part I | Date/Time Prepared: 7/28/2021 12:22 pm

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

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

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

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

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		1.00	
	Long Term Care Hospital PPS		
80.00	Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for no.	N	80.00
81.00	Is this a LTCH co-located within another hospital for part or all of the cost reporting period? Enter "Y" for yes and "N" for no.	N	81.00
	TEFRA Providers		
85.00	Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no.	N	85.00
86.00	Did this facility establish a new Other subprovider (excluded unit) under 42 CFR Section §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.		86.00
87.00	Is this hospital an extended neoplastic disease care hospital classified under section 1886(d)(1)(B)(vi)? Enter "Y" for yes or "N" for no.	N	87.00

		V	XIX	
		1.00	2.00	
	Title V and XIX Services			
90.00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.	N	Y	90.00
91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.	N	Y	91.00
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.		N	92.00
93.00	Does this facility operate an ICF/IID facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.	N	N	93.00
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.	N	N	94.00
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	95.00
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.	N	N	96.00
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	97.00
98.00	Does title V or XIX follow Medicare (title XVIII) for the interns and residents post stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	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.	N	Y	98.01
98.02	Does title V or XIX follow Medicare (title XVIII) for the calculation of observation bed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	Y	98.02
98.03	Does title V or XIX follow Medicare (title XVIII) for a critical access hospital (CAH) reimbursed 101% of inpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.03
98.04	Does title V or XIX follow Medicare (title XVIII) for a CAH reimbursed 101% of outpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.04
98.05	Does title V or XIX follow Medicare (title XVIII) and add back the RCE disallowance on Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	Y	98.05
98.06	Does title V or XIX follow Medicare (title XVIII) when cost reimbursed for Wkst. D, Pts. I through IV? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	Y	98.06
	Rural Providers			
105.00	Does this hospital qualify as a CAH?	N		105.00
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)	N		106.00
107.00	Column 1: If line 105 is Y, is this facility eligible for cost reimbursement for I&R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) Column 2: If column 1 is Y and line 70 or line 75 is Y, do you train I&Rs in an approved medical education program in the CAH's excluded IPF and/or IRF unit(s)? Enter "Y" for yes or "N" for no in column 2. (see instructions)	N		107.00
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	N		108.00

		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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-0057 | Period: From 01/01/2020 To 12/31/2020 | Worksheet S-2 Part I | Date/Time Prepared: 7/28/2021 12:22 pm

		1.00	2.00	
111.00	If this facility qualifies as a CAH, did it participate in the Frontier Community Health Integration Project (FCHIP) demonstration for this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If the response to column 1 is Y, enter the integration prong of the FCHIP demo in which this CAH is participating in column 2. Enter all that apply: "A" for Ambulance services; "B" for additional beds; and/or "C" for tele-health services.	N		111.00

		1.00	2.00	3.00	
112.00	Did this hospital participate in the Pennsylvania Rural Health Model demonstration for any portion of the current cost reporting period? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2, the date the hospital began participating in the demonstration. In column 3, enter the date the hospital ceased participation in the demonstration, if applicable.	N			112.00
	Miscellaneous Cost Reporting Information				
115.00	Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in column 1. If column 1 is yes, enter the method used (A, B, or E only) in column 2. If column 2 is "E", enter in column 3 either "93" percent for short term hospital or "98" percent for long term care (includes psychiatric, rehabilitation and long term hospitals providers) based on the definition in CMS Pub.15-1, chapter 22, §2208.1.	N		0	115.00
116.00	Is this facility classified as a referral center? Enter "Y" for yes or "N" for no.	N			116.00
117.00	Is this facility legally-required to carry malpractice insurance? Enter "Y" for yes or "N" for no.	N			117.00
118.00	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.	2			118.00

		Premiums	Losses	Insurance	
		1.00	2.00	3.00	
118.01	List amounts of malpractice premiums and paid losses:	265,898	0	150,344	118.01

		1.00	2.00	
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein.	N		118.02
119.00	DO NOT USE THIS LINE			119.00
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 1, "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2, "Y" for yes or "N" for no.	N	N	120.00
121.00	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter "Y" for yes or "N" for no.	Y		121.00
122.00	Does the cost report contain healthcare related taxes as defined in §1903(w)(3) of the Act?Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2 the Worksheet A line number where these taxes are included.	Y	5.03	122.00
	Transplant Center Information			
125.00	Does this facility operate a transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.	N		125.00
126.00	If this is a Medicare certified kidney transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			126.00
127.00	If this is a Medicare certified heart transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			127.00
128.00	If this is a Medicare certified liver transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			128.00
129.00	If this is a Medicare certified lung transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			129.00
130.00	If this is a Medicare certified pancreas transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			130.00
131.00	If this is a Medicare certified intestinal transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			131.00
132.00	If this is a Medicare certified islet transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			132.00
133.00	Removed and reserved			133.00
134.00	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.			134.00
	All Providers			
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)	Y	158014	140.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-0057 | Period: From 01/01/2020 To 12/31/2020 | Worksheet S-2 Part I | Date/Time Prepared: 7/28/2021 12:22 pm

	1.00	2.00	3.00	
	If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number.			
141.00	Name: FRANCISCAN ALLIANCE, INC. AND AFFILI	Contractor's Name: WISCONSIN PHYSICIANS SERVICE	Contractor's Number: 08101	141.00
142.00	Street: 1515 W DRAGOON TRL	PO Box: 1290		142.00
143.00	City: MISHAWAKA	State: IN	Zip Code: 46544	143.00

		1.00	
144.00	Are provider based physicians' costs included in Worksheet A?	Y	144.00

		1.00	2.00	
145.00	If costs for renal services are claimed on Wkst. A, line 74, are the costs for inpatient services only? Enter "Y" for yes or "N" for no in column 1. If column 1 is no, does the dialysis facility include Medicare utilization for this cost reporting period? Enter "Y" for yes or "N" for no in column 2.			145.00
146.00	Has the cost allocation methodology changed from the previously filed cost report? Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, chapter 40, §4020) If yes, enter the approval date (mm/dd/yyyy) in column 2.	N		146.00

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

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

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

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

		1.00	
	Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act		
167.00	Is this provider a meaningful user under §1886(n)? Enter "Y" for yes or "N" for no.	Y	167.00
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)		168.00
168.01	If this provider is a CAH and is not a meaningful user, does this provider qualify for a hardship exception under §413.70(a)(6)(ii)? Enter "Y" for yes or "N" for no. (see instructions)		168.01
169.00	If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)	9.99	169.00

		Beginning	Ending	
		1.00	2.00	
170.00	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)			170.00

		1.00	2.00	
171.00	If line 167 is "Y", does this provider have any days for individuals enrolled in section 1876 Medicare cost plans reported on Wkst. S-3, Pt. I, line 2, col. 6? Enter "Y" for yes and "N" for no in column 1. If column 1 is yes, enter the number of section 1876 Medicare days in column 2. (see instructions)	N	0	171.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 15-0057 | Period: From 01/01/2020 To 12/31/2020 | Worksheet S-2 Part II | Date/Time Prepared: 7/28/2021 12:22 pm

		Y/N	Date	
		1.00	2.00	
	General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format.			
	COMPLETED BY ALL HOSPITALS			
	Provider Organization and Operation			
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)	N		1.00

		Y/N	Date	V/I	
		1.00	2.00	3.00	
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.	N			2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)	Y			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	04/20/2021	4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.	N			5.00

		Y/N	Legal Oper.	
		1.00	2.00	
	Approved Educational Activities			
6.00	Column 1: Are costs claimed for nursing school? Column 2: If yes, is the provider is the legal operator of the program?	N		6.00
7.00	Are costs claimed for Allied Health Programs? If "Y" see instructions.	N		7.00
8.00	Were nursing school and/or allied health programs approved and/or renewed during the cost reporting period? If yes, see instructions.	N		8.00
9.00	Are costs claimed for Interns and Residents in an approved graduate medical education program in the current cost report? If yes, see instructions.	N		9.00
10.00	Was an approved Intern and Resident GME program initiated or renewed in the current cost reporting period? If yes, see instructions.	N		10.00
11.00	Are GME cost directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions.	N		11.00

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

		Part A		Part B		
		Y/N	Date	Y/N	Date	
		1.00	2.00	3.00	4.00	
	PS&R Data					
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see instructions)	N		N		16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	Y	05/12/2021	Y	05/12/2021	17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N		N		18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		N		19.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 15-0057 | Period: From 01/01/2020 To 12/31/2020 | Worksheet S-2 Part II Date/Time Prepared: 7/28/2021 12:22 pm

		Description		Y/N	Y/N	
		0		1.00	3.00	
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:			N	N	20.00
		Y/N	Date	Y/N	Date	
		1.00	2.00	3.00	4.00	
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		N		21.00
					1.00	
	COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)					
	Capital Related Cost					
22.00	Have assets been relifed for Medicare purposes? If yes, see instructions				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.				Y	34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.				N	35.00
				Y/N	Date	
				1.00	2.00	
	Home Office Costs					
36.00	Were home office costs claimed on the cost report?			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.			Y		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.	STEVE		HOWELL		41.00
42.00	Enter the employer/company name of the cost report preparer.	FRANCISCAN ALLIANCE				42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	(765) 428-5927		STEVEN.HOWELL@FRANCISCANALLIANCE.ORG		43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider CCN: 15-0057	Period: From 01/01/2020 To 12/31/2020	Worksheet S-2 Part II Date/Time Prepared: 7/28/2021 12:22 pm

		3.00		
	Cost Report Preparer Contact Information			
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	MANAGER COST REPORTING		41.00
42.00	Enter the employer/company name of the cost report preparer.			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.			43.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 15-0057 | Period: From 01/01/2020 To 12/31/2020 | Worksheet S-3 Part I | Date/Time Prepared: 7/28/2021 12:22 pm

	Component	Worksheet A Line Number	No. of Beds	Bed Days Available	CAH Hours	I/P Days / O/P Visits / Trips Title V	
		1.00	2.00	3.00	4.00	5.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30.00	89	32,610	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)		89	32,610	0.00	0	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	34.00	10	3,660	0.00	0	11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY	43.00				0	13.00
14.00	Total (see instructions)		99	36,270	0.00	0	14.00
15.00	CAH visits					0	15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)	30.00					24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	26.25
27.00	Total (sum of lines 14-26)		99				27.00
28.00	Observation Bed Days					0	28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)		0	0			32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00	LTCH non-covered days						33.00
33.01	LTCH site neutral days and discharges						33.01

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 15-0057 | Period: From 01/01/2020 To 12/31/2020 | Worksheet S-3 Part I | Date/Time Prepared: 7/28/2021 12:22 pm

	Component	I/P Days / O/P Visits / Trips			Full Time Equivalents		
		Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
		6.00	7.00	8.00	9.00	10.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	2,101	39	5,145			1.00
2.00	HMO and other (see instructions)	1,658	848				2.00
3.00	HMO IPF Subprovider	0	0				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)	2,101	39	5,145			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	462	7	1,150			11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY		444	649			13.00
14.00	Total (see instructions)	2,563	490	6,944	0.00	311.75	14.00
15.00	CAH visits	0	0	0			15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)			0			24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0.00	0.00	26.25
27.00	Total (sum of lines 14-26)				0.00	311.75	27.00
28.00	Observation Bed Days		199	1,267			28.00
29.00	Ambulance Trips	0					29.00
30.00	Employee discount days (see instruction)			0			30.00
31.00	Employee discount days - IRF			0			31.00
32.00	Labor & delivery days (see instructions)	0	72	121			32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)			0			32.01
33.00	LTCH non-covered days	0					33.00
33.01	LTCH site neutral days and discharges	0					33.01

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 15-0057 | Period: From 01/01/2020 To 12/31/2020 | Worksheet S-3 Part I | Date/Time Prepared: 7/28/2021 12:22 pm

	Component	Full Time Equivalents	Discharges				
		Nonpaid Workers	Title V	Title XVIII	Title XIX	Total All Patients	
		11.00	12.00	13.00	14.00	15.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)		0	781	34	2,406	1.00
2.00	HMO and other (see instructions)			398	605		2.00
3.00	HMO IPF Subprovider				0		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	781	34	2,406	14.00
15.00	CAH visits						15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)						24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0.00					26.25
27.00	Total (sum of lines 14-26)	0.00					27.00
28.00	Observation Bed Days						28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)						32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00	LTCH non-covered days			0			33.00
33.01	LTCH site neutral days and discharges			0			33.01

HOSPITAL WAGE INDEX INFORMATION | Provider CCN: 15-0057 | Period: From 01/01/2020 To 12/31/2020 | Worksheet S-3 Part II Date/Time Prepared: 7/28/2021 12:22 pm

		Wkst. A Line Number	Amount Reported	Reclassification of Salaries (from Wkst. A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
	PART II - WAGE DATA							
	SALARIES							
1.00	Total salaries (see instructions)	200.00	22,092,442	0	22,092,442	649,201.69	34.03	1.00
2.00	Non-physician anesthetist Part A		0	0	0	0.00	0.00	2.00
3.00	Non-physician anesthetist Part B		0	0	0	0.00	0.00	3.00
4.00	Physician-Part A - Administrative		0	0	0	0.00	0.00	4.00
4.01	Physicians - Part A - Teaching		0	0	0	0.00	0.00	4.01
5.00	Physician and Non Physician-Part B		0	0	0	0.00	0.00	5.00
6.00	Non-physician-Part B for hospital-based RHC and FQHC services		0	0	0	0.00	0.00	6.00
7.00	Interns & residents (in an approved program)	21.00	0	0	0	0.00	0.00	7.00
7.01	Contracted interns and residents (in an approved programs)		0	0	0	0.00	0.00	7.01
8.00	Home office and/or related organization personnel		0	0	0	0.00	0.00	8.00
9.00	SNF	44.00	0	0	0	0.00	0.00	9.00
10.00	Excluded area salaries (see instructions)		498,579	0	498,579	14,345.32	34.76	10.00
	OTHER WAGES & RELATED COSTS							
11.00	Contract labor: Direct Patient Care		234,986	0	234,986	3,423.25	68.64	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		123,578	0	123,578	802.34	154.02	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		6,273,831	0	6,273,831	162,385.00	38.64	14.01
14.02	Related organization salaries		4,868,576	0	4,868,576	121,972.18	39.92	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)		7,421,425	0	7,421,425			17.00
18.00	Wage-related costs (other) (see instructions)							18.00
19.00	Excluded areas		166,126	0	166,126			19.00
20.00	Non-physician anesthetist Part A		0	0	0			20.00
21.00	Non-physician anesthetist Part B		0	0	0			21.00
22.00	Physician Part A - Administrative		0	0	0			22.00
22.01	Physician Part A - Teaching		0	0	0			22.01
23.00	Physician Part B		0	0	0			23.00
24.00	Wage-related costs (RHC/FQHC)		0	0	0			24.00
25.00	Interns & residents (in an approved program)		0	0	0			25.00
25.50	Home office wage-related (core)		1,851,673	0	1,851,673			25.50
25.51	Related organization wage-related (core)		1,318,909	0	1,318,909			25.51
25.52	Home office: Physician Part A - Administrative - wage-related (core)		0	0	0			25.52

HOSPITAL WAGE INDEX INFORMATION | Provider CCN: 15-0057 | Period: From 01/01/2020 To 12/31/2020 | Worksheet S-3 Part II | Date/Time Prepared: 7/28/2021 12:22 pm

		Wkst. A Line Number	Amount Reported	Reclassification of Salaries (from Wkst. A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
25.53	Home office: Physicians Part A - Teaching - wage-related (core)		0	0	0			25.53
	OVERHEAD COSTS - DIRECT SALARIES							
26.00	Employee Benefits Department	4.00	0	0	0	0.00	0.00	26.00
27.00	Administrative & General	5.00	806,609	0	806,609	18,937.81	42.59	27.00
28.00	Administrative & General under contract (see inst.)		365,094	0	365,094	3,192.00	114.38	28.00
29.00	Maintenance & Repairs	6.00	0	0	0	0.00	0.00	29.00
30.00	Operation of Plant	7.00	1,287,928	0	1,287,928	46,779.22	27.53	30.00
31.00	Laundry & Linen Service	8.00	12,888	0	12,888	987.91	13.05	31.00
32.00	Housekeeping	9.00	1,139,397	0	1,139,397	70,462.72	16.17	32.00
33.00	Housekeeping under contract (see instructions)		6,617	0	6,617	196.81	33.62	33.00
34.00	Dietary	10.00	329,514	-213,278	116,236	6,184.72	18.79	34.00
35.00	Dietary under contract (see instructions)		0	0	0	0.00	0.00	35.00
36.00	Cafeteria	11.00	75,605	213,278	288,883	14,956.33	19.32	36.00
37.00	Maintenance of Personnel	12.00	0	0	0	0.00	0.00	37.00
38.00	Nursing Administration	13.00	15,169	0	15,169	388.50	39.05	38.00
39.00	Central Services and Supply	14.00	97,159	0	97,159	5,233.81	18.56	39.00
40.00	Pharmacy	15.00	960,956	0	960,956	22,013.63	43.65	40.00
41.00	Medical Records & Medical Records Library	16.00	0	0	0	0.00	0.00	41.00
42.00	Social Service	17.00	0	0	0	0.00	0.00	42.00
43.00	Other General Service	18.00	0	0	0	0.00	0.00	43.00

HOSPITAL WAGE INDEX INFORMATION | Provider CCN: 15-0057 | Period: From 01/01/2020 To 12/31/2020 | Worksheet S-3 Part III Date/Time Prepared: 7/28/2021 12:22 pm

		Worksheet A Line Number	Amount Reported	Reclassification of Salaries (from Worksheet A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
	PART III - HOSPITAL WAGE INDEX SUMMARY							
1.00	Net salaries (see instructions)		22,464,153	0	22,464,153	652,590.50	34.42	1.00
2.00	Excluded area salaries (see instructions)		498,579	0	498,579	14,345.32	34.76	2.00
3.00	Subtotal salaries (line 1 minus line 2)		21,965,574	0	21,965,574	638,245.18	34.42	3.00
4.00	Subtotal other wages & related costs (see inst.)		11,500,971	0	11,500,971	288,582.77	39.85	4.00
5.00	Subtotal wage-related costs (see inst.)		10,592,007	0	10,592,007	0.00	48.22	5.00
6.00	Total (sum of lines 3 thru 5)		44,058,552	0	44,058,552	926,827.95	47.54	6.00
7.00	Total overhead cost (see instructions)		5,096,936	0	5,096,936	189,333.46	26.92	7.00

HOSPITAL WAGE RELATED COSTS | Provider CCN: 15-0057 | Period: From 01/01/2020 To 12/31/2020 | Worksheet S-3 Part IV Date/Time Prepared: 7/28/2021 12:22 pm

		Amount Reported	
		1.00	
	PART IV - WAGE RELATED COSTS		
	Part A - Core List		
	RETIREMENT COST		
1.00	401K Employer Contributions	497,572	1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution	0	2.00
3.00	Nonqualified Defined Benefit Plan Cost (see instructions)	0	3.00
4.00	Qualified Defined Benefit Plan Cost (see instructions)	2,061,857	4.00
	PLAN ADMINISTRATIVE COSTS (Paid to External Organization)		
5.00	401K/TSA Plan Administration fees	0	5.00
6.00	Legal/Accounting/Management Fees-Pension Plan	0	6.00
7.00	Employee Managed Care Program Administration Fees	0	7.00
	HEALTH AND INSURANCE COST		
8.00	Health Insurance (Purchased or Self Funded)	0	8.00
8.01	Health Insurance (Self Funded without a Third Party Administrator)	0	8.01
8.02	Health Insurance (Self Funded with a Third Party Administrator)	2,781,764	8.02
8.03	Health Insurance (Purchased)	0	8.03
9.00	Prescription Drug Plan	0	9.00
10.00	Dental, Hearing and Vision Plan	169,300	10.00
11.00	Life Insurance (If employee is owner or beneficiary)	8,206	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)	75,048	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)	0	14.00
15.00	'Workers' Compensation Insurance	248,385	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	1,715,822	17.00
18.00	Medicare Taxes - Employers Portion Only	0	18.00
19.00	Unemployment Insurance	29,597	19.00
20.00	State or Federal Unemployment Taxes	0	20.00
	OTHER		
21.00	Executive Deferred Compensation (Other Than Retirement Cost Reported on lines 1 through 4 above. (see instructions))	0	21.00
22.00	Day Care Cost and Allowances	0	22.00
23.00	Tuition Reimbursement	0	23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)	7,587,551	24.00
	Part B - Other than Core Related Cost		
25.00	OTHER WAGE RELATED COSTS (SPECIFY)		25.00

HOSPITAL CONTRACT LABOR AND BENEFIT COST | Provider CCN: 15-0057 | Period: From 01/01/2020 To 12/31/2020 | Worksheet S-3 Part V | Date/Time Prepared: 7/28/2021 12:22 pm

	Cost Center Description	Contract Labor	Benefit Cost	
		1.00	2.00	
	PART V - Contract Labor and Benefit Cost			
	Hospital and Hospital-Based Component Identification:			
1.00	Total facility's contract labor and benefit cost	234,986	7,587,551	1.00
2.00	Hospital	234,986	7,587,551	2.00
3.00	Subprovider - IPF			3.00
4.00	Subprovider - IRF			4.00
5.00	Subprovider - (Other)	0	0	5.00
6.00	Swing Beds - SNF	0	0	6.00
7.00	Swing Beds - NF	0	0	7.00
8.00	Hospital-Based SNF			8.00
9.00	Hospital-Based NF			9.00
10.00	Hospital-Based OLTC			10.00
11.00	Hospital-Based HHA			11.00
12.00	Separately Certified ASC			12.00
13.00	Hospital-Based Hospice			13.00
14.00	Hospital-Based Health Clinic RHC			14.00
15.00	Hospital-Based Health Clinic FQHC			15.00
16.00	Hospital-Based-CMHC			16.00
17.00	Renal Dialysis	0	0	17.00
18.00	Other	0	0	18.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA | Provider CCN: 15-0057 | Period: From 01/01/2020 To 12/31/2020 | Worksheet S-10 | Date/Time Prepared: 7/28/2021 12:22 pm

		1.00	
	Uncompensated and indigent care cost computation		
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided by line 202 column 8)	0.175797	1.00
	Medicaid (see instructions for each line)		
2.00	Net revenue from Medicaid	11,643,156	2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?	N	3.00
4.00	If line 3 is yes, does line 2 include all DSH and/or supplemental payments from Medicaid?	N	4.00
5.00	If line 4 is no, then enter DSH and/or supplemental payments from Medicaid	0	5.00
6.00	Medicaid charges	70,657,191	6.00
7.00	Medicaid cost (line 1 times line 6)	12,421,322	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)	778,166	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)	778,166	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)	13,691,482	3,316,213	17,007,695	20.00
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	2,406,921	3,316,213	5,723,134	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)	2,406,921	3,316,213	5,723,134	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)	10,271,678	26.00
27.00	Medicare reimbursable bad debts for the entire hospital complex (see instructions)	221,772	27.00
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)	341,188	27.01
28.00	Non-Medicare bad debt expense (see instructions)	9,930,490	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)	1,865,166	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)	7,588,300	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	8,366,466	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 15-0057 | Period: From 01/01/2020 To 12/31/2020 | Worksheet A | Date/Time Prepared: 7/28/2021 12:22 pm

		Cost Center Description	Salaries	Other	Total (col. 1 + col. 2)	Reclassifications (See A-6)	Reclassified Trial Balance (col. 3 +- col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT		0	0	4,076,623	4,076,623	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		6,225,217	6,225,217	-3,914,807	2,310,410	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	0	0	6,553,487	6,553,487	4.00
5.01	00570	ADMITTING	0	2,008	2,008	-1,366	642	5.01
5.02	00580	CASHIERING/ACCOUNTS RECEIVABLE	0	0	0	0	0	5.02
5.03	00590	OTHER ADMIN & GENERAL	806,609	4,534,394	5,341,003	-245,472	5,095,531	5.03
7.00	00700	OPERATION OF PLANT	1,287,928	2,239,693	3,527,621	-414,290	3,113,331	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	12,888	286,048	298,936	-7,199	291,737	8.00
9.00	00900	HOUSEKEEPING	1,139,397	588,519	1,727,916	-351,698	1,376,218	9.00
10.00	01000	DIETARY	329,514	227,247	556,761	-490,315	66,446	10.00
11.00	01100	CAFETERIA	75,605	120,771	196,376	355,990	552,366	11.00
13.00	01300	NURSING ADMINISTRATION	15,169	1,820	16,989	-1,268	15,721	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	97,159	33,173	130,332	-27,316	103,016	14.00
15.00	01500	PHARMACY	960,956	2,462,212	3,423,168	-2,376,178	1,046,990	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	0	16.00
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
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	4,366,499	3,156,427	7,522,926	-3,251,145	4,271,781	30.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	1,716,770	623,541	2,340,311	-584,711	1,755,600	34.00
43.00	04300	NURSERY	0	0	0	392,748	392,748	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,793,587	15,282,356	17,075,943	-13,528,959	3,546,984	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	10,008	3,734	13,742	1,386,830	1,400,572	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,869,855	806,582	2,676,437	-755,736	1,920,701	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	457,051	3,348,255	3,805,306	-134,679	3,670,627	55.00
60.00	06000	LABORATORY	0	3,675,218	3,675,218	-103,096	3,572,122	60.00
64.00	06400	INTRAVENOUS THERAPY	784,532	12,385,060	13,169,592	-11,924,127	1,245,465	64.00
65.00	06500	RESPIRATORY THERAPY	879,940	506,470	1,386,410	-480,111	906,299	65.00
66.00	06600	PHYSICAL THERAPY	1,439,811	476,881	1,916,692	-456,001	1,460,691	66.00
67.00	06700	OCCUPATIONAL THERAPY	160,323	57,363	217,686	-55,812	161,874	67.00
68.00	06800	SPEECH PATHOLOGY	25,736	7,793	33,529	-7,247	26,282	68.00
69.00	06900	ELECTROCARDIOLOGY	208,816	148,809	357,625	-115,677	241,948	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	12,901	23,926	36,827	-22,521	14,306	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	3,616,246	3,616,246	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	10,658,759	10,658,759	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	13,518,282	13,518,282	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	133,342	100,110	233,452	-41,449	192,003	90.00
90.01	09001	WOUND CARE INSTITUTE	4,106	2,386	6,492	-2,339	4,153	90.01
90.02	09002	OP NUTRITIONAL COUNSELING	31,849	10,054	41,903	-10,054	31,849	90.02
91.00	09100	EMERGENCY	2,973,512	1,286,865	4,260,377	-1,102,517	3,157,860	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)	21,593,863	58,622,932	80,216,795	152,875	80,369,670	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	31,865	66,200	98,065	-9,243	88,822	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	218,064	159,039	377,103	-74,380	302,723	192.00
194.00	07950	COMMUNITY RELATIONS & MARKETING	0	0	0	0	0	194.00
194.01	07951	PLAINFIELD RADIOLOGY & PHYSICAL THE	248,650	256,393	505,043	-69,252	435,791	194.01
194.02	07952	JV MV ENDOSCOPY	0	0	0	0	0	194.02
194.03	07953	SOUTHWEST CENTER FOR WOMENS HEALTH	0	0	0	0	0	194.03
194.04	07954	OTHER NRCC	0	10,240,554	10,240,554	0	10,240,554	194.04
200.00		TOTAL (SUM OF LINES 118 through 199)	22,092,442	69,345,118	91,437,560	0	91,437,560	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 15-0057 | Period: From 01/01/2020 To 12/31/2020 | Worksheet A | Date/Time Prepared: 7/28/2021 12:22 pm

		Cost Center Description	Adjustments (See A-8)	Net Expenses For Allocation		
			6.00	7.00		
		GENERAL SERVICE COST CENTERS				
1.00	00100	CAP REL COSTS-BLDG & FIXT	932,192	5,008,815		1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	0	2,310,410		2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	3,898,205	10,451,692		4.00
5.01	00570	ADMITTING	0	642		5.01
5.02	00580	CASHIERING/ACCOUNTS RECEIVABLE	0	0		5.02
5.03	00590	OTHER ADMIN & GENERAL	15,742,053	20,837,584		5.03
7.00	00700	OPERATION OF PLANT	930,540	4,043,871		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	-18,643	273,094		8.00
9.00	00900	HOUSEKEEPING	-21,000	1,355,218		9.00
10.00	01000	DIETARY	-26,831	39,615		10.00
11.00	01100	CAFETERIA	-194,481	357,885		11.00
13.00	01300	NURSING ADMINISTRATION	148,286	164,007		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	-2	103,014		14.00
15.00	01500	PHARMACY	89,344	1,136,334		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	28,445	28,445		16.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0		21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0		22.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	-1,520,457	2,751,324		30.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	0	1,755,600		34.00
43.00	04300	NURSERY	0	392,748		43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	-1,594,818	1,952,166		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	1,400,572		52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	162,227	2,082,928		54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	-922,038	2,748,589		55.00
60.00	06000	LABORATORY	-37,215	3,534,907		60.00
64.00	06400	INTRAVENOUS THERAPY	-453,297	792,168		64.00
65.00	06500	RESPIRATORY THERAPY	-3,730	902,569		65.00
66.00	06600	PHYSICAL THERAPY	-1,711	1,458,980		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	161,874		67.00
68.00	06800	SPEECH PATHOLOGY	0	26,282		68.00
69.00	06900	ELECTROCARDIOLOGY	0	241,948		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	768	15,074		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	3,616,246		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	10,658,759		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	13,518,282		73.00
74.00	07400	RENAL DIALYSIS	0	0		74.00
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0	192,003		90.00
90.01	09001	WOUND CARE INSTITUTE	0	4,153		90.01
90.02	09002	OP NUTRITIONAL COUNSELING	0	31,849		90.02
91.00	09100	EMERGENCY	0	3,157,860		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)	17,137,837	97,507,507		118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	88,822		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	302,723		192.00
194.00	07950	COMMUNITY RELATIONS & MARKETING	6,158	6,158		194.00
194.01	07951	PLAINFIELD RADIOLOGY & PHYSICAL THE	0	435,791		194.01
194.02	07952	JV MV ENDOSCOPY	0	0		194.02
194.03	07953	SOUTHWEST CENTER FOR WOMENS HEALTH	0	0		194.03
194.04	07954	OTHER NRCC	4,650,722	14,891,276		194.04
200.00		TOTAL (SUM OF LINES 118 through 199)	21,794,717	113,232,277		200.00

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		Increases			
	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
	A - MEDICAL SUPPLIES				
1.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	3,616,246	1.00
2.00	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	10,658,759	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
	TOTALS		0	14,275,005	
	B - DRUGS				
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	13,518,282	1.00
2.00		0.00	0	0	2.00
3.00		0.00	0	0	3.00
4.00		0.00	0	0	4.00
5.00		0.00	0	0	5.00
6.00		0.00	0	0	6.00
7.00		0.00	0	0	7.00
8.00		0.00	0	0	8.00
9.00		0.00	0	0	9.00
10.00		0.00	0	0	10.00
11.00		0.00	0	0	11.00
12.00		0.00	0	0	12.00
13.00		0.00	0	0	13.00
14.00		0.00	0	0	14.00
15.00		0.00	0	0	15.00
	TOTALS		0	13,518,282	
	C - EQUIPMENT LEASE				
1.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	70,973	1.00
2.00		0.00	0	0	2.00
3.00		0.00	0	0	3.00
4.00		0.00	0	0	4.00
5.00		0.00	0	0	5.00
	TOTALS		0	70,973	
	D - DEPRECIATION				
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	4,076,623	1.00
2.00		0.00	0	0	2.00
	TOTALS		0	4,076,623	
	E - EMPLOYEE BENEFITS				
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	6,553,487	1.00
2.00		0.00	0	0	2.00
3.00		0.00	0	0	3.00
4.00		0.00	0	0	4.00
5.00		0.00	0	0	5.00
6.00		0.00	0	0	6.00
7.00		0.00	0	0	7.00
8.00		0.00	0	0	8.00
9.00		0.00	0	0	9.00
10.00		0.00	0	0	10.00
11.00		0.00	0	0	11.00
12.00		0.00	0	0	12.00
13.00		0.00	0	0	13.00
14.00		0.00	0	0	14.00
15.00		0.00	0	0	15.00
16.00		0.00	0	0	16.00
17.00		0.00	0	0	17.00

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	Increases					
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
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
	TOTALS		0	6,553,487		
	F - CAFETERIA					
1.00	CAFETERIA	11.00	213,278	164,061		1.00
	TOTALS		213,278	164,061		
	G - NURSERY					
1.00	NURSERY	43.00	362,465	30,283		1.00
2.00	DELIVERY ROOM & LABOR ROOM	52.00	1,283,175	107,207		2.00
	TOTALS		1,645,640	137,490		
500.00	Grand Total: Increases		1,858,918	38,795,921		500.00

RECLASSIFICATIONS | Provider CCN: 15-0057 | Period: From 01/01/2020 To 12/31/2020 | Worksheet A-6 | Date/Time Prepared: 7/28/2021 12:22 pm

		Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	A - MEDICAL SUPPLIES						
1.00	ADMITTING	5.01	0	1,366	0		1.00
2.00	OTHER ADMIN & GENERAL	5.03	0	64	0		2.00
3.00	OPERATION OF PLANT	7.00	0	1,550	0		3.00
4.00	LAUNDRY & LINEN SERVICE	8.00	0	754	0		4.00
5.00	HOUSEKEEPING	9.00	0	7,114	0		5.00
6.00	DIETARY	10.00	0	9,543	0		6.00
7.00	NURSING ADMINISTRATION	13.00	0	1,268	0		7.00
8.00	PHARMACY	15.00	0	135,859	0		8.00
9.00	ADULTS & PEDIATRICS	30.00	0	181,312	0		9.00
10.00	SURGICAL INTENSIVE CARE UNIT	34.00	0	68,789	0		10.00
11.00	OPERATING ROOM	50.00	0	12,968,877	0		11.00
12.00	DELIVERY ROOM & LABOR ROOM	52.00	0	21	0		12.00
13.00	RADIOLOGY-DIAGNOSTIC	54.00	0	186,148	0		13.00
14.00	RADIOLOGY-THERAPEUTIC	55.00	0	3,881	0		14.00
15.00	LABORATORY	60.00	0	12,253	0		15.00
16.00	INTRAVENOUS THERAPY	64.00	0	199,385	0		16.00
17.00	RESPIRATORY THERAPY	65.00	0	199,979	0		17.00
18.00	PHYSICAL THERAPY	66.00	0	10,462	0		18.00
19.00	OCCUPATIONAL THERAPY	67.00	0	9,384	0		19.00
20.00	ELECTROCARDIOLOGY	69.00	0	52,935	0		20.00
21.00	ELECTROENCEPHALOGRAPHY	70.00	0	19,163	0		21.00
22.00	CLINIC	90.00	0	546	0		22.00
23.00	WOUND CARE INSTITUTE	90.01	0	985	0		23.00
24.00	EMERGENCY	91.00	0	203,367	0		24.00
	TOTALS		0	14,275,005			
	B - DRUGS						
1.00	CENTRAL SERVICES & SUPPLY	14.00	0	1,195	0		1.00
2.00	PHARMACY	15.00	0	1,949,976	0		2.00
3.00	ADULTS & PEDIATRICS	30.00	0	580	0		3.00
4.00	SURGICAL INTENSIVE CARE UNIT	34.00	0	3	0		4.00
5.00	OPERATING ROOM	50.00	0	18,643	0		5.00
6.00	RADIOLOGY-DIAGNOSTIC	54.00	0	4,234	0		6.00
7.00	RADIOLOGY-THERAPEUTIC	55.00	0	89	0		7.00
8.00	INTRAVENOUS THERAPY	64.00	0	11,540,016	0		8.00
9.00	RESPIRATORY THERAPY	65.00	0	1,658	0		9.00
10.00	PHYSICAL THERAPY	66.00	0	967	0		10.00
11.00	OCCUPATIONAL THERAPY	67.00	0	146	0		11.00
12.00	ELECTROCARDIOLOGY	69.00	0	89	0		12.00
13.00	CLINIC	90.00	0	18	0		13.00
14.00	WOUND CARE INSTITUTE	90.01	0	1	0		14.00
15.00	EMERGENCY	91.00	0	667	0		15.00
	TOTALS		0	13,518,282			
	C - EQUIPMENT LEASE						
1.00	OPERATION OF PLANT	7.00	0	11,050	10		1.00
2.00	PHARMACY	15.00	0	33	0		2.00
3.00	SURGICAL INTENSIVE CARE UNIT	34.00	0	31,920	0		3.00
4.00	OPERATING ROOM	50.00	0	1,993	0		4.00
5.00	RESPIRATORY THERAPY	65.00	0	25,977	0		5.00
	TOTALS		0	70,973			
	D - DEPRECIATION						
1.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	3,985,780	9		1.00
2.00	LABORATORY	60.00	0	90,843	0		2.00
	TOTALS		0	4,076,623			
	E - EMPLOYEE BENEFITS						
1.00	OTHER ADMIN & GENERAL	5.03	0	245,408	0		1.00
2.00	OPERATION OF PLANT	7.00	0	401,690	0		2.00
3.00	LAUNDRY & LINEN SERVICE	8.00	0	6,445	0		3.00
4.00	HOUSEKEEPING	9.00	0	344,584	0		4.00
5.00	DIETARY	10.00	0	103,433	0		5.00
6.00	CAFETERIA	11.00	0	21,349	0		6.00
7.00	CENTRAL SERVICES & SUPPLY	14.00	0	26,121	0		7.00
8.00	PHARMACY	15.00	0	290,310	0		8.00
9.00	ADULTS & PEDIATRICS	30.00	0	1,286,123	0		9.00
10.00	SURGICAL INTENSIVE CARE UNIT	34.00	0	483,999	0		10.00
11.00	OPERATING ROOM	50.00	0	539,446	0		11.00
12.00	DELIVERY ROOM & LABOR ROOM	52.00	0	3,531	0		12.00
13.00	RADIOLOGY-DIAGNOSTIC	54.00	0	565,354	0		13.00
14.00	RADIOLOGY-THERAPEUTIC	55.00	0	130,709	0		14.00
15.00	INTRAVENOUS THERAPY	64.00	0	184,726	0		15.00
16.00	RESPIRATORY THERAPY	65.00	0	252,497	0		16.00
17.00	PHYSICAL THERAPY	66.00	0	444,572	0		17.00
18.00	OCCUPATIONAL THERAPY	67.00	0	46,282	0		18.00
19.00	SPEECH PATHOLOGY	68.00	0	7,247	0		19.00

RECLASSIFICATIONS | Provider CCN: 15-0057 | Period: From 01/01/2020 To 12/31/2020 | Worksheet A-6 | Date/Time Prepared: 7/28/2021 12:22 pm

		Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
20.00	ELECTROCARDIOLOGY	69.00	0	62,653	0		20.00
21.00	ELECTROENCEPHALOGRAPHY	70.00	0	3,358	0		21.00
22.00	CLINIC	90.00	0	40,885	0		22.00
23.00	WOUND CARE INSTITUTE	90.01	0	1,353	0		23.00
24.00	OP NUTRITIONAL COUNSELING	90.02	0	10,054	0		24.00
25.00	EMERGENCY	91.00	0	898,483	0		25.00
26.00	GIFT, FLOWER, COFFEE SHOP & CANTEEN	190.00	0	9,243	0		26.00
27.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	74,380	0		27.00
28.00	PLAINFIELD RADIOLOGY & PHYSICAL THE	194.01	0	69,252	0		28.00
	TOTALS		0	6,553,487			
	F - CAFETERIA						
1.00	DIETARY	10.00	213,278	164,061	0		1.00
	TOTALS		213,278	164,061			
	G - NURSERY						
1.00	ADULTS & PEDIATRICS	30.00	1,645,640	137,490	0		1.00
2.00		0.00	0	0	0		2.00
	TOTALS		1,645,640	137,490			
500.00	Grand Total: Decreases		1,858,918	38,795,921			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-0057 | Period: From 01/01/2020 To 12/31/2020 | Worksheet A-7 Part I | Date/Time Prepared: 7/28/2021 12:22 pm

		Beginning Balances	Acquisitions			Disposals and Retirements	
			Purchases	Donation	Total		
		1.00	2.00	3.00	4.00	5.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	0	0	0	0	0	1.00
2.00	Land Improvements	2,073,733	565,557	0	565,557	0	2.00
3.00	Buildings and Fixtures	62,464,763	820,872	0	820,872	0	3.00
4.00	Building Improvements	2,782,508	8,746	0	8,746	71,504	4.00
5.00	Fixed Equipment	39,526,725	6,837,334	0	6,837,334	0	5.00
6.00	Movable Equipment	31,063,717	1,192,870	0	1,192,870	2,795,408	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	137,911,446	9,425,379	0	9,425,379	2,866,912	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	137,911,446	9,425,379	0	9,425,379	2,866,912	10.00

		Ending Balance	Fully Depreciated Assets	
		6.00	7.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES			
1.00	Land	0	0	1.00
2.00	Land Improvements	2,639,290	1,282,035	2.00
3.00	Buildings and Fixtures	63,285,635	1,675,978	3.00
4.00	Building Improvements	2,719,750	1,352,390	4.00
5.00	Fixed Equipment	46,364,059	447,168	5.00
6.00	Movable Equipment	29,461,179	14,904,929	6.00
7.00	HIT designated Assets	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	144,469,913	19,662,500	8.00
9.00	Reconciling Items	0	0	9.00
10.00	Total (line 8 minus line 9)	144,469,913	19,662,500	10.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-0057 | Period: From 01/01/2020 To 12/31/2020 | Worksheet A-7 Part II | Date/Time Prepared: 7/28/2021 12:22 pm

	Cost Center Description	SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	6,040,029	185,188	0	0	0	2.00
3.00	Total (sum of lines 1-2)	6,040,029	185,188	0	0	0	3.00

	Cost Center Description	SUMMARY OF CAPITAL			
		Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)		
		14.00	15.00		
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2				
1.00	CAP REL COSTS-BLDG & FIXT	0	0		1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	6,225,217		2.00
3.00	Total (sum of lines 1-2)	0	6,225,217		3.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-0057 | Period: From 01/01/2020 To 12/31/2020 | Worksheet A-7 Part III Date/Time Prepared: 7/28/2021 12:22 pm

	Cost Center Description	COMPUTATION OF RATIOS: Gross Assets	COMPUTATION OF RATIOS: Capitalized Leases	COMPUTATION OF RATIOS: Gross Assets for Ratio (col. 1 - col. 2)	ALLOCATION OF OTHER CAPITAL: Ratio (see instructions)	ALLOCATION OF OTHER CAPITAL: Insurance	
		1.00	2.00	3.00	4.00	5.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	115,008,734	0	115,008,734	0.817020	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	27,609,301	1,851,878	25,757,423	0.182980	0	2.00
3.00	Total (sum of lines 1-2)	142,618,035	1,851,878	140,766,157	1.000000	0	3.00

	Cost Center Description	ALLOCATION OF OTHER CAPITAL: Taxes	ALLOCATION OF OTHER CAPITAL: Other Capital-Related Costs	ALLOCATION OF OTHER CAPITAL: Total (sum of cols. 5 through 7)	SUMMARY OF CAPITAL: Depreciation	SUMMARY OF CAPITAL: Lease	
		6.00	7.00	8.00	9.00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	4,076,623	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	2,054,249	256,161	2.00
3.00	Total (sum of lines 1-2)	0	0	0	6,130,872	256,161	3.00

	Cost Center Description	SUMMARY OF CAPITAL: Interest	SUMMARY OF CAPITAL: Insurance (see instructions)	SUMMARY OF CAPITAL: Taxes (see instructions)	SUMMARY OF CAPITAL: Other Capital-Related Costs (see instructions)	SUMMARY OF CAPITAL: Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	932,192	0	0	0	5,008,815	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	0	2,310,410	2.00
3.00	Total (sum of lines 1-2)	932,192	0	0	0	7,319,225	3.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 15-0057 | Period: From 01/01/2020 To 12/31/2020 | Worksheet A-8 | Date/Time Prepared: 7/28/2021 12:22 pm

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
1.00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)		0	CAP REL COSTS-BLDG & FIXT	1.00	0	1.00
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
3.00	Investment income - other (chapter 2)		0		0.00	0	3.00
4.00	Trade, quantity, and time discounts (chapter 8)		0		0.00	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)		0		0.00	0	5.00
6.00	Rental of provider space by suppliers (chapter 8)		0		0.00	0	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)		0		0.00	0	7.00
8.00	Television and radio service (chapter 21)	A	-9,302	OPERATION OF PLANT	7.00	0	8.00
9.00	Parking lot (chapter 21)		0		0.00	0	9.00
10.00	Provider-based physician adjustment	A-8-2	-3,341,853			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	29,612,523			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests	B	-192,575	CAFETERIA	11.00	0	14.00
15.00	Rental of quarters to employee and others		0		0.00	0	15.00
16.00	Sale of medical and surgical supplies to other than patients		0		0.00	0	16.00
17.00	Sale of drugs to other than patients		0		0.00	0	17.00
18.00	Sale of medical records and abstracts		0		0.00	0	18.00
19.00	Nursing and allied health education (tuition, fees, books, etc.)		0		0.00	0	19.00
20.00	Vending machines	B	-916	CAFETERIA	11.00	0	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	0	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	RESPIRATORY THERAPY	65.00		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	PHYSICAL THERAPY	66.00		24.00
25.00	Utilization review - physicians' compensation (chapter 21)		0	*** Cost Center Deleted ***	114.00		25.00
26.00	Depreciation - CAP REL COSTS-BLDG & FIXT		0	CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	27.00
28.00	Non-physician Anesthetist		0	*** Cost Center Deleted ***	19.00		28.00
29.00	Physicians' assistant		0		0.00	0	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	OCCUPATIONAL THERAPY	67.00		30.00
30.99	Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS	30.00		30.99
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	SPEECH PATHOLOGY	68.00		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest		0		0.00	0	32.00
33.00	MISC INCOME	B	-17,198	OTHER ADMIN & GENERAL	5.03	0	33.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 15-0057 | Period: From 01/01/2020 To 12/31/2020 | Worksheet A-8 | Date/Time Prepared: 7/28/2021 12:22 pm

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
33.01	MISC INCOME	B	-3,600	OPERATION OF PLANT	7.00	0	33.01
33.02	MISC INCOME	B	-18,643	LAUNDRY & LINEN SERVICE	8.00	0	33.02
33.03	MISC INCOME	B	-21,000	HOUSEKEEPING	9.00	0	33.03
33.04	MISC INCOME	B	-990	CAFETERIA	11.00	0	33.04
33.05	MISC INCOME	B	-36,365	PHARMACY	15.00	0	33.05
33.06	MISC INCOME	B	-2,243	ADULTS & PEDIATRICS	30.00	0	33.06
33.07	MISC INCOME	B	-637	OPERATING ROOM	50.00	0	33.07
33.08	MISC INCOME	B	-51,363	RADIOLOGY-DIAGNOSTIC	54.00	0	33.08
33.09	MISC INCOME	B	-918,076	RADIOLOGY-THERAPEUTIC	55.00	0	33.09
33.10	MISC INCOME	B	-3,447	RESPIRATORY THERAPY	65.00	0	33.10
33.11	MISC INCOME	B	-1,711	PHYSICAL THERAPY	66.00	0	33.11
33.12	REBATES	B	-26,831	DIETARY	10.00	0	33.12
33.13	REBATES	B	-2	CENTRAL SERVICES & SUPPLY	14.00	0	33.13
33.14	REBATES	B	-38,305	PHARMACY	15.00	0	33.14
33.15	REBATES	B	-64,681	OPERATING ROOM	50.00	0	33.15
33.16	REBATES	B	-3,962	RADIOLOGY-THERAPEUTIC	55.00	0	33.16
33.17	REBATES	B	-453,297	INTRAVENOUS THERAPY	64.00	0	33.17
33.18	REBATES	B	-6	RESPIRATORY THERAPY	65.00	0	33.18
33.19	NEUROLOGY TESTING EXPENSES	A	768	ELECTROENCEPHALOGRAPHY	70.00	0	33.19
33.20	ON CALL COVERAGE	A	-175,930	OTHER ADMIN & GENERAL	5.03	0	33.20
33.21	ON CALL COVERAGE	A	-63,688	ADULTS & PEDIATRICS	30.00	0	33.21
33.22	NON ALLOWABLE INTEREST	A	-510,170	CAP REL COSTS-BLDG & FIXT	1.00	11	33.22
33.23	HAF OFFSET	A	-3,838,242	OTHER ADMIN & GENERAL	5.03	0	33.23
33.24	PENSION ADJ PER REGS 2142.5	A	1,976,736	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.24
33.25	ADVERTISING	A	-277	RESPIRATORY THERAPY	65.00	0	33.25
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		21,794,717				50.00

(1) Description - all chapter references in this column pertain to CMS Pub. 15-1.
(2) Basis for adjustment (see instructions).
A. Costs - if cost, including applicable overhead, can be determined.
B. Amount Received - if cost cannot be determined.
(3) Additional adjustments may be made on lines 33 thru 49 and subscripts thereof.
Note: See instructions for column 5 referencing to Worksheet A-7.

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS | Provider CCN: 15-0057 | Period: From 01/01/2020 To 12/31/2020 | Worksheet A-8-1 | Date/Time Prepared: 7/28/2021 12:22 pm

	Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in Wks. A, column 5	
	1.00	2.00	3.00	4.00	5.00	
	A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:					
1.00	4.00	EMPLOYEE BENEFITS DEPARTMENT	SHARED SERVICE ALLOCATION	1,921,469	0	1.00
2.00	5.03	OTHER ADMIN & GENERAL	SHARED SERVICE ALLOCATION	6,139,927	0	2.00
3.00	7.00	OPERATION OF PLANT	SHARED SERVICE ALLOCAITON	943,442	0	3.00
4.00	13.00	NURSING ADMINISTRATION	SHARED SERVICE ALLOCATION	148,286	0	4.00
4.01	16.00	MEDICAL RECORDS & LIBRARY	SHARED SERVICE ALLOCATION	28,445	0	4.01
4.02	54.00	RADIOLOGY-DIAGNOSTIC	SHARED SERVICE ALLOCATION	213,590	0	4.02
4.03	1.00	CAP REL COSTS-BLDG & FIXT	SHARED SERVICE ALLOCATION	34,037	0	4.03
4.04	194.00	COMMUNITY RELATIONS & MARKET	SHARED SERVICE ALLOCATION	6,158	0	4.04
4.05	194.04	OTHER NRCC	SHARED SERVICE ALLOCATION	4,650,722	0	4.05
4.06	60.00	LABORATORY	SHARED SERVICE ALLOCATION	3,350,400	3,387,615	4.06
4.07	5.03	OTHER ADMIN & GENERAL	FRANCISCAN HOME OFFICE	12,358,296	0	4.07
4.08	1.00	CAP REL COSTS-BLDG & FIXT	FRANCISCAN HOME OFFICE	1,408,325	0	4.08
4.09	5.03	OTHER ADMIN & GENERAL	FRANCISCAN HOME OFFICE	574,306	0	4.09
4.10	5.03	OTHER ADMIN & GENERAL	FRANCISCAN HOME OFFICE	1,058,721	0	4.10
4.11	15.00	PHARMACY	FRANCISCAN HOME OFFICE	164,014	0	4.11
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.			33,000,138	3,387,615	5.00

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

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

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

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

6.00	B	HOME OFFICE	100.00	FRANC. ALLIANCE	100.00	6.00
7.00	B	APHL	100.00	APHL	100.00	7.00
8.00	G	FH CENTRAL INDY	100.00	FRANC. HEALTH	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:	REGION HOME OFF				100.00

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

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

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS | Provider CCN: 15-0057 | Period: From 01/01/2020 To 12/31/2020 | Worksheet A-8-1 | Date/Time Prepared: 7/28/2021 12:22 pm

	Net Adjustments (col. 4 minus col. 5)*	Wkst. A-7 Ref.		
	6.00	7.00		
	A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:			
1.00	1,921,469	0		1.00
2.00	6,139,927	0		2.00
3.00	943,442	0		3.00
4.00	148,286	0		4.00
4.01	28,445	0		4.01
4.02	213,590	0		4.02
4.03	34,037	11		4.03
4.04	6,158	0		4.04
4.05	4,650,722	0		4.05
4.06	-37,215	0		4.06
4.07	12,358,296	0		4.07
4.08	1,408,325	11		4.08
4.09	574,306	0		4.09
4.10	1,058,721	0		4.10
4.11	164,014	0		4.11
5.00	29,612,523			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	HEALTH SYSTEM		6.00
7.00	SHARED LAB		7.00
8.00	HOSPITAL		8.00
9.00			9.00
10.00			10.00
100.00			100.00

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

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

PROVIDER BASED PHYSICIAN ADJUSTMENT | Provider CCN: 15-0057 | Period: From 01/01/2020 To 12/31/2020 | Worksheet A-8-2 | Date/Time Prepared: 7/28/2021 12:22 pm

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	5.03	OTHER ADMIN & GENERAL	357,827	357,827	0	179,000	0	1.00
2.00	30.00	ADULTS & PEDIATRICS	1,454,526	1,454,526	0	179,000	0	2.00
3.00	50.00	OPERATING ROOM	1,529,500	1,529,500	0	246,400	0	3.00
4.00	60.00	LABORATORY	0	0	0	0	0	4.00
5.00	65.00	RESPIRATORY THERAPY	0	0	0	0	0	5.00
6.00	91.00	EMERGENCY	0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			3,341,853	3,341,853	0		0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	5.03	OTHER ADMIN & GENERAL	0	0	0	0	0	1.00
2.00	30.00	ADULTS & PEDIATRICS	0	0	0	0	0	2.00
3.00	50.00	OPERATING ROOM	0	0	0	0	0	3.00
4.00	60.00	LABORATORY	0	0	0	0	0	4.00
5.00	65.00	RESPIRATORY THERAPY	0	0	0	0	0	5.00
6.00	91.00	EMERGENCY	0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			0	0	0	0	0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment		
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00	5.03	OTHER ADMIN & GENERAL	0	0	0	357,827		1.00
2.00	30.00	ADULTS & PEDIATRICS	0	0	0	1,454,526		2.00
3.00	50.00	OPERATING ROOM	0	0	0	1,529,500		3.00
4.00	60.00	LABORATORY	0	0	0	0		4.00
5.00	65.00	RESPIRATORY THERAPY	0	0	0	0		5.00
6.00	91.00	EMERGENCY	0	0	0	0		6.00
7.00	0.00		0	0	0	0		7.00
8.00	0.00		0	0	0	0		8.00
9.00	0.00		0	0	0	0		9.00
10.00	0.00		0	0	0	0		10.00
200.00			0	0	0	3,341,853		200.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-0057 | Period: From 01/01/2020 To 12/31/2020 | Worksheet B Part I Date/Time Prepared: 7/28/2021 12:22 pm

		Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS BLDG & FIXT	CAPITAL RELATED COSTS MVBLE EQUIP	EMPLOYEE BENEFITS DEPARTMENT	ADMITTING	
			0	1.00	2.00	4.00	5.01	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	5,008,815	5,008,815				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	2,310,410		2,310,410			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	10,451,692	0	0	10,451,692		4.00
5.01	00570	ADMITTING	642	43,796	20,202	0	64,640	5.01
5.02	00580	CASHIERING/ACCOUNTS RECEIVABLE	0	0	0	0	0	5.02
5.03	00590	OTHER ADMIN & GENERAL	20,837,584	123,477	56,956	381,598	0	5.03
7.00	00700	OPERATION OF PLANT	4,043,871	1,048,977	483,860	609,305	0	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	273,094	16,178	7,462	6,097	0	8.00
9.00	00900	HOUSEKEEPING	1,355,218	79,773	36,797	539,036	0	9.00
10.00	01000	DIETARY	39,615	61,646	28,435	54,990	0	10.00
11.00	01100	CAFETERIA	357,885	52,935	24,417	136,667	0	11.00
13.00	01300	NURSING ADMINISTRATION	164,007	1,969	908	7,176	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	103,014	35,048	16,167	45,965	0	14.00
15.00	01500	PHARMACY	1,136,334	37,017	17,075	454,618	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	28,445	0	0	0	0	16.00
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
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,751,324	664,041	306,301	1,287,208	6,418	30.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	1,755,600	147,028	67,819	812,185	2,152	34.00
43.00	04300	NURSERY	392,748	0	0	171,478	799	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,952,166	409,416	188,851	848,526	12,225	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,400,572	0	0	611,791	2,929	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,082,928	153,120	70,630	884,608	2,803	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	2,748,589	128,102	59,089	216,226	31	55.00
60.00	06000	LABORATORY	3,534,907	72,121	33,267	0	4,151	60.00
64.00	06400	INTRAVENOUS THERAPY	792,168	0	0	371,153	225	64.00
65.00	06500	RESPIRATORY THERAPY	902,569	41,586	19,182	416,290	1,757	65.00
66.00	06600	PHYSICAL THERAPY	1,458,980	128,937	59,475	681,159	1,343	66.00
67.00	06700	OCCUPATIONAL THERAPY	161,874	75,761	34,946	75,847	127	67.00
68.00	06800	SPEECH PATHOLOGY	26,282	0	0	12,175	135	68.00
69.00	06900	ELECTROCARDIOLOGY	241,948	17,738	8,182	98,789	343	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	15,074	58,005	26,756	6,103	20	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	3,616,246	0	0	0	7,053	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	10,658,759	0	0	0	11,530	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	13,518,282	0	0	0	5,113	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	192,003	50,204	23,158	63,083	19	90.00
90.01	09001	WOUND CARE INSTITUTE	4,153	0	0	1,943	1	90.01
90.02	09002	OP NUTRITIONAL COUNSELING	31,849	0	0	15,067	0	90.02
91.00	09100	EMERGENCY	3,157,860	239,004	110,245	1,406,736	5,466	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)	97,507,507	3,685,879	1,700,180	10,215,819	64,640	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	88,822	20,468	9,441	15,075	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	302,723	0	0	103,164	0	192.00
194.00	07950	COMMUNITY RELATIONS & MARKETING	6,158	0	0	0	0	194.00
194.01	07951	PLAINFIELD RADIOLOGY & PHYSICAL THE	435,791	0	0	117,634	0	194.01
194.02	07952	JV MV ENDOSCOPY	0	0	0	0	0	194.02
194.03	07953	SOUTHWEST CENTER FOR WOMENS HEALTH	0	0	0	0	0	194.03
194.04	07954	OTHER NRCC	14,891,276	1,302,468	600,789	0	0	194.04
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	113,232,277	5,008,815	2,310,410	10,451,692	64,640	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-0057 | Period: From 01/01/2020 To 12/31/2020 | Worksheet B Part I | Date/Time Prepared: 7/28/2021 12:22 pm

		Cost Center Description	CASHIERING/ACCOUNTS RECEIVABLE	Subtotal	OTHER ADMIN & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	
			5.02	5A.02	5.03	7.00	8.00	
		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
5.01	00570	ADMITTING						5.01
5.02	00580	CASHIERING/ACCOUNTS RECEIVABLE	0					5.02
5.03	00590	OTHER ADMIN & GENERAL	0	21,399,615	21,399,615			5.03
7.00	00700	OPERATION OF PLANT	0	6,186,013	1,441,514	7,627,527		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	302,831	70,568	32,536	405,935	8.00
9.00	00900	HOUSEKEEPING	0	2,010,824	468,578	160,438	0	9.00
10.00	01000	DIETARY	0	184,686	43,037	123,980	0	10.00
11.00	01100	CAFETERIA	0	571,904	133,270	106,461	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	174,060	40,561	3,960	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	200,194	46,651	70,488	0	14.00
15.00	01500	PHARMACY	0	1,645,044	383,341	74,448	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	28,445	6,628	0	0	16.00
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
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	5,015,292	1,168,703	1,335,505	118,577	30.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	0	2,784,784	648,933	295,700	25,539	34.00
43.00	04300	NURSERY	0	565,025	131,667	0	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	3,411,184	794,901	823,409	89,222	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	2,015,292	469,619	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	3,194,089	744,312	307,952	43,852	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	3,152,037	734,513	257,635	0	55.00
60.00	06000	LABORATORY	0	3,644,446	849,258	145,048	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0	1,163,546	271,139	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	1,381,384	321,901	83,637	0	65.00
66.00	06600	PHYSICAL THERAPY	0	2,329,894	542,931	259,316	7,180	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	348,555	81,223	152,370	3,128	67.00
68.00	06800	SPEECH PATHOLOGY	0	38,592	8,993	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	367,000	85,521	35,674	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	105,958	24,691	116,659	442	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	3,623,299	844,330	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	10,670,289	2,486,476	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	13,523,395	3,151,330	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	328,467	76,542	100,970	4,797	90.00
90.01	09001	WOUND CARE INSTITUTE	0	6,097	1,421	0	0	90.01
90.02	09002	OP NUTRITIONAL COUNSELING	0	46,916	10,933	0	0	90.02
91.00	09100	EMERGENCY	0	4,919,311	1,146,337	480,680	92,350	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)	0	95,338,468	17,229,822	4,966,866	385,087	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	133,806	31,181	41,165	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	405,887	94,583	0	1,203	192.00
194.00	07950	COMMUNITY RELATIONS & MARKETING	0	6,158	1,435	0	0	194.00
194.01	07951	PLAINFIELD RADIOLOGY & PHYSICAL THE	0	553,425	128,964	0	0	194.01
194.02	07952	JV MV ENDOSCOPY	0	0	0	0	0	194.02
194.03	07953	SOUTHWEST CENTER FOR WOMENS HEALTH	0	0	0	0	0	194.03
194.04	07954	OTHER NRCC	0	16,794,533	3,913,630	2,619,496	19,645	194.04
200.00		Cross Foot Adjustments		0				200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	0	113,232,277	21,399,615	7,627,527	405,935	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-0057 | Period: From 01/01/2020 To 12/31/2020 | Worksheet B Part I | Date/Time Prepared: 7/28/2021 12:22 pm

		Cost Center Description	HOUSEKEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	
			9.00	10.00	11.00	13.00	14.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00570	ADMITTING						5.01
5.02	00580	CASHIERING/ACCOUNTS RECEIVABLE						5.02
5.03	00590	OTHER ADMIN & GENERAL						5.03
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING	2,639,840					9.00
10.00	01000	DIETARY	44,023	395,726				10.00
11.00	01100	CAFETERIA	37,802	0	849,437			11.00
13.00	01300	NURSING ADMINISTRATION	1,406	0	742	220,729		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	25,029	0	0	0	342,362	14.00
15.00	01500	PHARMACY	26,435	0	42,007	0	407	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	0	16.00
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
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	474,207	293,205	154,092	65,283	493	30.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	104,996	65,536	69,023	29,243	204	34.00
43.00	04300	NURSERY	0	36,985	16,336	0	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	292,374	0	97,034	41,109	3,407	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	57,929	24,542	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	109,347	0	98,533	0	600	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	91,480	0	23,707	0	711	55.00
60.00	06000	LABORATORY	51,503	0	0	0	1	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	356	64.00
65.00	06500	RESPIRATORY THERAPY	29,698	0	47,779	0	100	65.00
66.00	06600	PHYSICAL THERAPY	92,077	0	71,080	0	127	66.00
67.00	06700	OCCUPATIONAL THERAPY	54,103	0	8,596	0	24	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	12,667	0	8,303	0	624	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	41,423	0	0	0	12	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	84,309	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	248,498	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	35,852	0	12,657	0	22	90.00
90.01	09001	WOUND CARE INSTITUTE	0	0	0	0	0	90.01
90.02	09002	OP NUTRITIONAL COUNSELING	0	0	0	0	0	90.02
91.00	09100	EMERGENCY	170,679	0	137,640	60,552	525	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)	1,695,101	395,726	845,458	220,729	340,420	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	14,617	0	3,979	0	1,328	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	309	192.00
194.00	07950	COMMUNITY RELATIONS & MARKETING	0	0	0	0	0	194.00
194.01	07951	PLAINFIELD RADIOLOGY & PHYSICAL THE	0	0	0	0	273	194.01
194.02	07952	JV MV ENDOSCOPY	0	0	0	0	0	194.02
194.03	07953	SOUTHWEST CENTER FOR WOMENS HEALTH	0	0	0	0	0	194.03
194.04	07954	OTHER NRCC	930,122	0	0	0	32	194.04
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	2,639,840	395,726	849,437	220,729	342,362	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-0057 | Period: From 01/01/2020 To 12/31/2020 | Worksheet B Part I | Date/Time Prepared: 7/28/2021 12:22 pm

		Cost Center Description	PHARMACY	MEDICAL RECORDS & LIBRARY	INTERNS & RESIDENTS SERVICES-SALARY & FRINGES APPRV	INTERNS & RESIDENTS SERVICES-OTHER PRGM COSTS APPRV	Subtotal	
			15.00	16.00	21.00	22.00	24.00	
		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
5.01	00570	ADMITTING						5.01
5.02	00580	CASHIERING/ACCOUNTS RECEIVABLE						5.02
5.03	00590	OTHER ADMIN & GENERAL						5.03
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	2,171,682					15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	35,073				16.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0			21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0		0		22.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	1,244	0	0	8,626,601	30.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	0	279	0	0	4,024,237	34.00
43.00	04300	NURSERY	0	104	0	0	750,117	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	3,160	0	0	5,555,800	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	380	0	0	2,567,762	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	4,127	0	0	4,502,812	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	2,206	0	0	4,262,289	55.00
60.00	06000	LABORATORY	0	2,835	0	0	4,693,091	60.00
64.00	06400	INTRAVENOUS THERAPY	0	557	0	0	1,435,598	64.00
65.00	06500	RESPIRATORY THERAPY	0	458	0	0	1,864,957	65.00
66.00	06600	PHYSICAL THERAPY	0	807	0	0	3,303,412	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	111	0	0	648,110	67.00
68.00	06800	SPEECH PATHOLOGY	0	32	0	0	47,617	68.00
69.00	06900	ELECTROCARDIOLOGY	0	636	0	0	510,425	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	144	0	0	289,329	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	1,777	0	0	4,553,715	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	2,874	0	0	13,408,137	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,171,682	6,973	0	0	18,853,380	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	36	0	0	559,343	90.00
90.01	09001	WOUND CARE INSTITUTE	0	0	0	0	7,518	90.01
90.02	09002	OP NUTRITIONAL COUNSELING	0	2	0	0	57,851	90.02
91.00	09100	EMERGENCY	0	6,331	0	0	7,014,405	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)	2,171,682	35,073	0	0	87,536,506	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	226,076	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	501,982	192.00
194.00	07950	COMMUNITY RELATIONS & MARKETING	0	0	0	0	7,593	194.00
194.01	07951	PLAINFIELD RADIOLOGY & PHYSICAL THE	0	0	0	0	682,662	194.01
194.02	07952	JV MV ENDOSCOPY	0	0	0	0	0	194.02
194.03	07953	SOUTHWEST CENTER FOR WOMENS HEALTH	0	0	0	0	0	194.03
194.04	07954	OTHER NRCC	0	0	0	0	24,277,458	194.04
200.00		Cross Foot Adjustments			0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	2,171,682	35,073	0	0	113,232,277	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-0057 | Period: From 01/01/2020 To 12/31/2020 | Worksheet B Part I | Date/Time Prepared: 7/28/2021 12:22 pm

		Cost Center Description	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			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
5.01	00570	ADMITTING				5.01
5.02	00580	CASHIERING/ACCOUNTS RECEIVABLE				5.02
5.03	00590	OTHER ADMIN & GENERAL				5.03
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
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV				21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV				22.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	0	8,626,601		30.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	0	4,024,237		34.00
43.00	04300	NURSERY	0	750,117		43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	5,555,800		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	2,567,762		52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	4,502,812		54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	4,262,289		55.00
60.00	06000	LABORATORY	0	4,693,091		60.00
64.00	06400	INTRAVENOUS THERAPY	0	1,435,598		64.00
65.00	06500	RESPIRATORY THERAPY	0	1,864,957		65.00
66.00	06600	PHYSICAL THERAPY	0	3,303,412		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	648,110		67.00
68.00	06800	SPEECH PATHOLOGY	0	47,617		68.00
69.00	06900	ELECTROCARDIOLOGY	0	510,425		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	289,329		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	4,553,715		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	13,408,137		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	18,853,380		73.00
74.00	07400	RENAL DIALYSIS	0	0		74.00
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0	559,343		90.00
90.01	09001	WOUND CARE INSTITUTE	0	7,518		90.01
90.02	09002	OP NUTRITIONAL COUNSELING	0	57,851		90.02
91.00	09100	EMERGENCY	0	7,014,405		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)	0	87,536,506		118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	226,076		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	501,982		192.00
194.00	07950	COMMUNITY RELATIONS & MARKETING	0	7,593		194.00
194.01	07951	PLAINFIELD RADIOLOGY & PHYSICAL THE	0	682,662		194.01
194.02	07952	JV MV ENDOSCOPY	0	0		194.02
194.03	07953	SOUTHWEST CENTER FOR WOMENS HEALTH	0	0		194.03
194.04	07954	OTHER NRCC	0	24,277,458		194.04
200.00		Cross Foot Adjustments	0	0		200.00
201.00		Negative Cost Centers	0	0		201.00
202.00		TOTAL (sum lines 118 through 201)	0	113,232,277		202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-0057 | Period: From 01/01/2020 To 12/31/2020 | Worksheet B Part II Date/Time Prepared: 7/28/2021 12:22 pm

		Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS BLDG & FIXT	CAPITAL RELATED COSTS MVBLE EQUIP	Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
			0	1.00	2.00	2A	4.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	0	0	0	0	4.00
5.01	00570	ADMITTING	0	43,796	20,202	63,998	0	5.01
5.02	00580	CASHIERING/ACCOUNTS RECEIVABLE	0	0	0	0	0	5.02
5.03	00590	OTHER ADMIN & GENERAL	0	123,477	56,956	180,433	0	5.03
7.00	00700	OPERATION OF PLANT	0	1,048,977	483,860	1,532,837	0	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	16,178	7,462	23,640	0	8.00
9.00	00900	HOUSEKEEPING	0	79,773	36,797	116,570	0	9.00
10.00	01000	DIETARY	0	61,646	28,435	90,081	0	10.00
11.00	01100	CAFETERIA	0	52,935	24,417	77,352	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	1,969	908	2,877	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	35,048	16,167	51,215	0	14.00
15.00	01500	PHARMACY	0	37,017	17,075	54,092	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	0	16.00
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
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	664,041	306,301	970,342	0	30.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	0	147,028	67,819	214,847	0	34.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	409,416	188,851	598,267	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	153,120	70,630	223,750	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	128,102	59,089	187,191	0	55.00
60.00	06000	LABORATORY	0	72,121	33,267	105,388	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	41,586	19,182	60,768	0	65.00
66.00	06600	PHYSICAL THERAPY	0	128,937	59,475	188,412	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	75,761	34,946	110,707	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	17,738	8,182	25,920	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	58,005	26,756	84,761	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	50,204	23,158	73,362	0	90.00
90.01	09001	WOUND CARE INSTITUTE	0	0	0	0	0	90.01
90.02	09002	OP NUTRITIONAL COUNSELING	0	0	0	0	0	90.02
91.00	09100	EMERGENCY	0	239,004	110,245	349,249	0	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)	0	3,685,879	1,700,180	5,386,059	0	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	20,468	9,441	29,909	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07950	COMMUNITY RELATIONS & MARKETING	0	0	0	0	0	194.00
194.01	07951	PLAINFIELD RADIOLOGY & PHYSICAL THE	0	0	0	0	0	194.01
194.02	07952	JV MV ENDOSCOPY	0	0	0	0	0	194.02
194.03	07953	SOUTHWEST CENTER FOR WOMENS HEALTH	0	0	0	0	0	194.03
194.04	07954	OTHER NRCC	0	1,302,468	600,789	1,903,257	0	194.04
200.00		Cross Foot Adjustments				0		200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	0	5,008,815	2,310,410	7,319,225	0	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-0057 | Period: From 01/01/2020 To 12/31/2020 | Worksheet B Part II | Date/Time Prepared: 7/28/2021 12:22 pm

		Cost Center Description	ADMITTING	CASHIERING/ACCOUNTS RECEIVABLE	OTHER ADMIN & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	
			5.01	5.02	5.03	7.00	8.00	
		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
5.01	00570	ADMITTING	63,998					5.01
5.02	00580	CASHIERING/ACCOUNTS RECEIVABLE	0	0				5.02
5.03	00590	OTHER ADMIN & GENERAL	0	0	180,433			5.03
7.00	00700	OPERATION OF PLANT	0	0	12,156	1,544,993		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	595	6,590	30,825	8.00
9.00	00900	HOUSEKEEPING	0	0	3,951	32,498	0	9.00
10.00	01000	DIETARY	0	0	363	25,113	0	10.00
11.00	01100	CAFETERIA	0	0	1,124	21,564	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	0	342	802	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	393	14,278	0	14.00
15.00	01500	PHARMACY	0	0	3,233	15,080	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	56	0	0	16.00
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
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	6,358	0	9,855	270,513	9,004	30.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	2,132	0	5,472	59,895	1,939	34.00
43.00	04300	NURSERY	792	0	1,110	0	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	12,065	0	6,703	166,786	6,775	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	2,902	0	3,960	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,778	0	6,276	62,377	3,330	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	30	0	6,194	52,185	0	55.00
60.00	06000	LABORATORY	4,113	0	7,161	29,380	0	60.00
64.00	06400	INTRAVENOUS THERAPY	223	0	2,286	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	1,741	0	2,714	16,941	0	65.00
66.00	06600	PHYSICAL THERAPY	1,331	0	4,578	52,526	545	66.00
67.00	06700	OCCUPATIONAL THERAPY	126	0	685	30,863	238	67.00
68.00	06800	SPEECH PATHOLOGY	134	0	76	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	340	0	721	7,226	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	19	0	208	23,630	34	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	6,988	0	7,120	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	11,424	0	20,967	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	5,066	0	26,573	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	19	0	645	20,452	364	90.00
90.01	09001	WOUND CARE INSTITUTE	1	0	12	0	0	90.01
90.02	09002	OP NUTRITIONAL COUNSELING	0	0	92	0	0	90.02
91.00	09100	EMERGENCY	5,416	0	9,666	97,364	7,013	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)	63,998	0	145,287	1,006,063	29,242	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	263	8,338	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	798	0	91	192.00
194.00	07950	COMMUNITY RELATIONS & MARKETING	0	0	12	0	0	194.00
194.01	07951	PLAINFIELD RADIOLOGY & PHYSICAL THE	0	0	1,087	0	0	194.01
194.02	07952	JV MV ENDOSCOPY	0	0	0	0	0	194.02
194.03	07953	SOUTHWEST CENTER FOR WOMENS HEALTH	0	0	0	0	0	194.03
194.04	07954	OTHER NRCC	0	0	32,986	530,592	1,492	194.04
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	63,998	0	180,433	1,544,993	30,825	202.00

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		Cost Center Description	HOUSEKEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	
			9.00	10.00	11.00	13.00	14.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00570	ADMITTING						5.01
5.02	00580	CASHIERING/ACCOUNTS RECEIVABLE						5.02
5.03	00590	OTHER ADMIN & GENERAL						5.03
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING	153,019					9.00
10.00	01000	DIETARY	2,552	118,109				10.00
11.00	01100	CAFETERIA	2,191	0	102,231			11.00
13.00	01300	NURSING ADMINISTRATION	81	0	89	4,191		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	1,451	0	0	0	67,337	14.00
15.00	01500	PHARMACY	1,532	0	5,056	0	80	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	0	16.00
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
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	27,488	87,510	18,545	1,239	97	30.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	6,086	19,560	8,307	555	40	34.00
43.00	04300	NURSERY	0	11,039	1,966	0	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	16,948	0	11,678	781	670	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	6,972	466	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	6,338	0	11,859	0	118	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	5,303	0	2,853	0	140	55.00
60.00	06000	LABORATORY	2,985	0	0	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	70	64.00
65.00	06500	RESPIRATORY THERAPY	1,721	0	5,750	0	20	65.00
66.00	06600	PHYSICAL THERAPY	5,337	0	8,555	0	25	66.00
67.00	06700	OCCUPATIONAL THERAPY	3,136	0	1,035	0	5	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	734	0	999	0	123	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	2,401	0	0	0	2	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	16,580	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	48,878	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	2,078	0	1,523	0	4	90.00
90.01	09001	WOUND CARE INSTITUTE	0	0	0	0	0	90.01
90.02	09002	OP NUTRITIONAL COUNSELING	0	0	0	0	0	90.02
91.00	09100	EMERGENCY	9,893	0	16,565	1,150	103	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)	98,255	118,109	101,752	4,191	66,955	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	847	0	479	0	261	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	61	192.00
194.00	07950	COMMUNITY RELATIONS & MARKETING	0	0	0	0	0	194.00
194.01	07951	PLAINFIELD RADIOLOGY & PHYSICAL THE	0	0	0	0	54	194.01
194.02	07952	JV MV ENDOSCOPY	0	0	0	0	0	194.02
194.03	07953	SOUTHWEST CENTER FOR WOMENS HEALTH	0	0	0	0	0	194.03
194.04	07954	OTHER NRCC	53,917	0	0	0	6	194.04
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	153,019	118,109	102,231	4,191	67,337	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-0057 | Period: From 01/01/2020 To 12/31/2020 | Worksheet B Part II | Date/Time Prepared: 7/28/2021 12:22 pm

		Cost Center Description	PHARMACY	MEDICAL RECORDS & LIBRARY	INTERNS & RESIDENTS SERVICES-SALARY & FRINGES APPRV	INTERNS & RESIDENTS SERVICES-OTHER PRGM COSTS APPRV	Subtotal	
			15.00	16.00	21.00	22.00	24.00	
		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
5.01	00570	ADMITTING						5.01
5.02	00580	CASHIERING/ACCOUNTS RECEIVABLE						5.02
5.03	00590	OTHER ADMIN & GENERAL						5.03
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	79,073					15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	56				16.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0			21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0		0		22.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	0			1,400,951	30.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	0	0			318,833	34.00
43.00	04300	NURSERY	0	0			14,907	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0			820,673	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0			14,300	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0			316,826	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0			253,896	55.00
60.00	06000	LABORATORY	0	0			149,027	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0			2,579	64.00
65.00	06500	RESPIRATORY THERAPY	0	0			89,655	65.00
66.00	06600	PHYSICAL THERAPY	0	0			261,309	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0			146,795	67.00
68.00	06800	SPEECH PATHOLOGY	0	0			210	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0			36,063	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0			111,055	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0			30,688	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0			81,269	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	79,073	56			110,768	73.00
74.00	07400	RENAL DIALYSIS	0	0			0	74.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0			98,447	90.00
90.01	09001	WOUND CARE INSTITUTE	0	0			13	90.01
90.02	09002	OP NUTRITIONAL COUNSELING	0	0			92	90.02
91.00	09100	EMERGENCY	0	0			496,419	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)	79,073	56	0	0	4,754,775	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0			40,097	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0			950	192.00
194.00	07950	COMMUNITY RELATIONS & MARKETING	0	0			12	194.00
194.01	07951	PLAINFIELD RADIOLOGY & PHYSICAL THE	0	0			1,141	194.01
194.02	07952	JV MV ENDOSCOPY	0	0			0	194.02
194.03	07953	SOUTHWEST CENTER FOR WOMENS HEALTH	0	0			0	194.03
194.04	07954	OTHER NRCC	0	0			2,522,250	194.04
200.00		Cross Foot Adjustments			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)	79,073	56	0	0	7,319,225	202.00

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		Cost Center Description	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			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
5.01	00570	ADMITTING				5.01
5.02	00580	CASHIERING/ACCOUNTS RECEIVABLE				5.02
5.03	00590	OTHER ADMIN & GENERAL				5.03
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
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV				21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV				22.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	0	1,400,951		30.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	0	318,833		34.00
43.00	04300	NURSERY	0	14,907		43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	820,673		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	14,300		52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	316,826		54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	253,896		55.00
60.00	06000	LABORATORY	0	149,027		60.00
64.00	06400	INTRAVENOUS THERAPY	0	2,579		64.00
65.00	06500	RESPIRATORY THERAPY	0	89,655		65.00
66.00	06600	PHYSICAL THERAPY	0	261,309		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	146,795		67.00
68.00	06800	SPEECH PATHOLOGY	0	210		68.00
69.00	06900	ELECTROCARDIOLOGY	0	36,063		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	111,055		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	30,688		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	81,269		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	110,768		73.00
74.00	07400	RENAL DIALYSIS	0	0		74.00
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0	98,447		90.00
90.01	09001	WOUND CARE INSTITUTE	0	13		90.01
90.02	09002	OP NUTRITIONAL COUNSELING	0	92		90.02
91.00	09100	EMERGENCY	0	496,419		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)	0	4,754,775		118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	40,097		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	950		192.00
194.00	07950	COMMUNITY RELATIONS & MARKETING	0	12		194.00
194.01	07951	PLAINFIELD RADIOLOGY & PHYSICAL THE	0	1,141		194.01
194.02	07952	JV MV ENDOSCOPY	0	0		194.02
194.03	07953	SOUTHWEST CENTER FOR WOMENS HEALTH	0	0		194.03
194.04	07954	OTHER NRCC	0	2,522,250		194.04
200.00		Cross Foot Adjustments	0	0		200.00
201.00		Negative Cost Centers	0	0		201.00
202.00		TOTAL (sum lines 118 through 201)	0	7,319,225		202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-0057 | Period: From 01/01/2020 To 12/31/2020 | Worksheet B-1 | Date/Time Prepared: 7/28/2021 12:22 pm

		Cost Center Description	CAPITAL RELATED COSTS					
			BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (SQUARE FEET)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	ADMITTING (INPATIENT CHARGES)	CASHIERING/ACCOUNTS RECEIVABLE (GROSS CHARGES)	
			1.00	2.00	4.00	5.01	5.02	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	269,675					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		269,675				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	0	22,092,442			4.00
5.01	00570	ADMITTING	2,358	2,358	0	119,661,368		5.01
5.02	00580	CASHIERING/ACCOUNTS RECEIVABLE	0	0	0	0	497,939,431	5.02
5.03	00590	OTHER ADMIN & GENERAL	6,648	6,648	806,609	0	0	5.03
7.00	00700	OPERATION OF PLANT	56,477	56,477	1,287,928	0	0	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	871	871	12,888	0	0	8.00
9.00	00900	HOUSEKEEPING	4,295	4,295	1,139,397	0	0	9.00
10.00	01000	DIETARY	3,319	3,319	116,236	0	0	10.00
11.00	01100	CAFETERIA	2,850	2,850	288,883	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	106	106	15,169	0	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	1,887	1,887	97,159	0	0	14.00
15.00	01500	PHARMACY	1,993	1,993	960,956	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	0	16.00
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
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	35,752	35,752	2,720,859	11,884,774	17,764,543	30.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	7,916	7,916	1,716,770	3,984,892	3,984,892	34.00
43.00	04300	NURSERY	0	0	362,465	1,480,007	1,480,007	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	22,043	22,043	1,793,587	22,594,505	45,148,625	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	1,293,183	5,424,536	5,424,536	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	8,244	8,244	1,869,855	5,191,624	58,954,524	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	6,897	6,897	457,051	56,734	31,507,945	55.00
60.00	06000	LABORATORY	3,883	3,883	0	7,687,581	40,494,865	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	784,532	415,948	7,958,312	64.00
65.00	06500	RESPIRATORY THERAPY	2,239	2,239	879,940	3,254,238	6,538,912	65.00
66.00	06600	PHYSICAL THERAPY	6,942	6,942	1,439,811	2,487,251	11,532,219	66.00
67.00	06700	OCCUPATIONAL THERAPY	4,079	4,079	160,323	235,420	1,590,779	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	25,736	250,125	452,300	68.00
69.00	06900	ELECTROCARDIOLOGY	955	955	208,816	635,856	9,086,236	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	3,123	3,123	12,901	36,147	2,064,065	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	13,061,041	25,389,029	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	21,352,557	41,057,675	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	9,468,946	96,516,056	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	2,703	2,703	133,342	35,098	520,105	90.00
90.01	09001	WOUND CARE INSTITUTE	0	0	4,106	1,390	3,282	90.01
90.02	09002	OP NUTRITIONAL COUNSELING	0	0	31,849	0	32,132	90.02
91.00	09100	EMERGENCY	12,868	12,868	2,973,512	10,122,698	90,438,392	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)	198,448	198,448	21,593,863	119,661,368	497,939,431	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	1,102	1,102	31,865	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	218,064	0	0	192.00
194.00	07950	COMMUNITY RELATIONS & MARKETING	0	0	0	0	0	194.00
194.01	07951	PLAINFIELD RADIOLOGY & PHYSICAL THE	0	0	248,650	0	0	194.01
194.02	07952	JV MV ENDOSCOPY	0	0	0	0	0	194.02
194.03	07953	SOUTHWEST CENTER FOR WOMENS HEALTH	0	0	0	0	0	194.03
194.04	07954	OTHER NRCC	70,125	70,125	0	0	0	194.04
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	5,008,815	2,310,410	10,451,692	64,640	0	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	18.573524	8.567387	0.473089	0.000540	0.000000	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)			0	63,998	0	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)			0.000000	0.000535	0.000000	205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)						206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-0057 | Period: From 01/01/2020 To 12/31/2020 | Worksheet B-1 | Date/Time Prepared: 7/28/2021 12:22 pm

		Cost Center Description	Reconciliation	OTHER ADMIN & GENERAL (ACCUM. COST)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	
			5A.03	5.03	7.00	8.00	9.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00570	ADMITTING						5.01
5.02	00580	CASHIERING/ACCOUNTS RECEIVABLE						5.02
5.03	00590	OTHER ADMIN & GENERAL	-21,399,615	91,832,662				5.03
7.00	00700	OPERATION OF PLANT	0	6,186,013	204,192			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	302,831	871	337,037		8.00
9.00	00900	HOUSEKEEPING	0	2,010,824	4,295	0	199,026	9.00
10.00	01000	DIETARY	0	184,686	3,319	0	3,319	10.00
11.00	01100	CAFETERIA	0	571,904	2,850	0	2,850	11.00
13.00	01300	NURSING ADMINISTRATION	0	174,060	106	0	106	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	200,194	1,887	0	1,887	14.00
15.00	01500	PHARMACY	0	1,645,044	1,993	0	1,993	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	28,445	0	0	0	16.00
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
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	5,015,292	35,752	98,451	35,752	30.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	0	2,784,784	7,916	21,204	7,916	34.00
43.00	04300	NURSERY	0	565,025	0	0	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	3,411,184	22,043	74,079	22,043	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	2,015,292	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	3,194,089	8,244	36,409	8,244	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	3,152,037	6,897	0	6,897	55.00
60.00	06000	LABORATORY	0	3,644,446	3,883	0	3,883	60.00
64.00	06400	INTRAVENOUS THERAPY	0	1,163,546	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	1,381,384	2,239	0	2,239	65.00
66.00	06600	PHYSICAL THERAPY	0	2,329,894	6,942	5,961	6,942	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	348,555	4,079	2,597	4,079	67.00
68.00	06800	SPEECH PATHOLOGY	0	38,592	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	367,000	955	0	955	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	105,958	3,123	367	3,123	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	3,623,299	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	10,670,289	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	13,523,395	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	328,467	2,703	3,983	2,703	90.00
90.01	09001	WOUND CARE INSTITUTE	0	6,097	0	0	0	90.01
90.02	09002	OP NUTRITIONAL COUNSELING	0	46,916	0	0	0	90.02
91.00	09100	EMERGENCY	0	4,919,311	12,868	76,676	12,868	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)	-21,399,615	73,938,853	132,965	319,727	127,799	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	133,806	1,102	0	1,102	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	405,887	0	999	0	192.00
194.00	07950	COMMUNITY RELATIONS & MARKETING	0	6,158	0	0	0	194.00
194.01	07951	PLAINFIELD RADIOLOGY & PHYSICAL THE	0	553,425	0	0	0	194.01
194.02	07952	JV MV ENDOSCOPY	0	0	0	0	0	194.02
194.03	07953	SOUTHWEST CENTER FOR WOMENS HEALTH	0	0	0	0	0	194.03
194.04	07954	OTHER NRCC	0	16,794,533	70,125	16,311	70,125	194.04
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)		21,399,615	7,627,527	405,935	2,639,840	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)		0.233028	37.354681	1.204423	13.263795	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)		180,433	1,544,993	30,825	153,019	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)		0.001965	7.566374	0.091459	0.768839	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

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		Cost Center Description	DIETARY (TOTAL PATIENT DAYS)	CAFETERIA (FTE'S)	NURSING ADMINISTRATION (DIRECT NURSING)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	
			10.00	11.00	13.00	14.00	15.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00570	ADMITTING						5.01
5.02	00580	CASHIERING/ACCOUNTS RECEIVABLE						5.02
5.03	00590	OTHER ADMIN & GENERAL						5.03
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	6,944					10.00
11.00	01100	CAFETERIA	0	445,152				11.00
13.00	01300	NURSING ADMINISTRATION	0	389	273,034			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	14,684,842		14.00
15.00	01500	PHARMACY	0	22,014	0	17,460	100	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	0	16.00
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
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	5,145	80,752	80,752	21,165	0	30.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	1,150	36,172	36,172	8,761	0	34.00
43.00	04300	NURSERY	649	8,561	0	0	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	50,851	50,851	146,122	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	30,358	30,358	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	51,637	0	25,745	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	12,424	0	30,513	0	55.00
60.00	06000	LABORATORY	0	0	0	23	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	15,291	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	25,039	0	4,282	0	65.00
66.00	06600	PHYSICAL THERAPY	0	37,250	0	5,439	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	4,505	0	1,010	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	4,351	0	26,766	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	506	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	3,616,246	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	10,658,759	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	100	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	6,633	0	960	0	90.00
90.01	09001	WOUND CARE INSTITUTE	0	0	0	2	0	90.01
90.02	09002	OP NUTRITIONAL COUNSELING	0	0	0	0	0	90.02
91.00	09100	EMERGENCY	0	72,131	74,901	22,505	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)	6,944	443,067	273,034	14,601,555	100	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	2,085	0	56,957	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	13,266	0	192.00
194.00	07950	COMMUNITY RELATIONS & MARKETING	0	0	0	0	0	194.00
194.01	07951	PLAINFIELD RADIOLOGY & PHYSICAL THE	0	0	0	11,704	0	194.01
194.02	07952	JV MV ENDOSCOPY	0	0	0	0	0	194.02
194.03	07953	SOUTHWEST CENTER FOR WOMENS HEALTH	0	0	0	0	0	194.03
194.04	07954	OTHER NRCC	0	0	0	1,360	0	194.04
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	395,726	849,437	220,729	342,362	2,171,682	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	56.988191	1.908195	0.808430	0.023314	21,716.820000	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	118,109	102,231	4,191	67,337	79,073	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	17.008785	0.229654	0.015350	0.004585	790.730000	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

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		Cost Center Description	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)	INTERNS & RESIDENTS SERVICES-SALARY & FRINGES APPRV (ASSIGNED TIME)	INTERNS & RESIDENTS SERVICES-OTHER PRGM COSTS APPRV (ASSIGNED TIME)		
			16.00	21.00	22.00		
		GENERAL SERVICE COST CENTERS					
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.01	00570	ADMITTING					5.01
5.02	00580	CASHIERING/ACCOUNTS RECEIVABLE					5.02
5.03	00590	OTHER ADMIN & GENERAL					5.03
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	497,939,431				16.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0			21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0		0		22.00
		INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	17,764,543	0	0		30.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	3,984,892	0	0		34.00
43.00	04300	NURSERY	1,480,007	0	0		43.00
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	45,148,625	0	0		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	5,424,536	0	0		52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	58,954,524	0	0		54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	31,507,945	0	0		55.00
60.00	06000	LABORATORY	40,494,865	0	0		60.00
64.00	06400	INTRAVENOUS THERAPY	7,958,312	0	0		64.00
65.00	06500	RESPIRATORY THERAPY	6,538,912	0	0		65.00
66.00	06600	PHYSICAL THERAPY	11,532,219	0	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	1,590,779	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	452,300	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	9,086,236	0	0		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	2,064,065	0	0		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	25,389,029	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	41,057,675	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	96,516,056	0	0		73.00
74.00	07400	RENAL DIALYSIS	0	0	0		74.00
		OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	520,105	0	0		90.00
90.01	09001	WOUND CARE INSTITUTE	3,282	0	0		90.01
90.02	09002	OP NUTRITIONAL COUNSELING	32,132	0	0		90.02
91.00	09100	EMERGENCY	90,438,392	0	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)	497,939,431	0	0		118.00
		NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0		192.00
194.00	07950	COMMUNITY RELATIONS & MARKETING	0	0	0		194.00
194.01	07951	PLAINFIELD RADIOLOGY & PHYSICAL THE	0	0	0		194.01
194.02	07952	JV MV ENDOSCOPY	0	0	0		194.02
194.03	07953	SOUTHWEST CENTER FOR WOMENS HEALTH	0	0	0		194.03
194.04	07954	OTHER NRCC	0	0	0		194.04
200.00		Cross Foot Adjustments					200.00
201.00		Negative Cost Centers					201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	35,073	0	0		202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.000070	0.000000	0.000000		203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	56	0	0		204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.000000	0.000000	0.000000		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

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-0057 | Period: From 01/01/2020 To 12/31/2020 | Worksheet C Part I Date/Time Prepared: 7/28/2021 12:22 pm

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		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	Costs RCE Disallowance	Costs Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	8,626,601		8,626,601	0	8,626,601	30.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	4,024,237		4,024,237	0	4,024,237	34.00
43.00	04300	NURSERY	750,117		750,117	0	750,117	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	5,555,800		5,555,800	0	5,555,800	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	2,567,762		2,567,762	0	2,567,762	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,502,812		4,502,812	0	4,502,812	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	4,262,289		4,262,289	0	4,262,289	55.00
60.00	06000	LABORATORY	4,693,091		4,693,091	0	4,693,091	60.00
64.00	06400	INTRAVENOUS THERAPY	1,435,598		1,435,598	0	1,435,598	64.00
65.00	06500	RESPIRATORY THERAPY	1,864,957	0	1,864,957	0	1,864,957	65.00
66.00	06600	PHYSICAL THERAPY	3,303,412	0	3,303,412	0	3,303,412	66.00
67.00	06700	OCCUPATIONAL THERAPY	648,110	0	648,110	0	648,110	67.00
68.00	06800	SPEECH PATHOLOGY	47,617	0	47,617	0	47,617	68.00
69.00	06900	ELECTROCARDIOLOGY	510,425		510,425	0	510,425	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	289,329		289,329	0	289,329	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	4,553,715		4,553,715	0	4,553,715	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	13,408,137		13,408,137	0	13,408,137	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	18,853,380		18,853,380	0	18,853,380	73.00
74.00	07400	RENAL DIALYSIS	0		0	0	0	74.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	559,343		559,343	0	559,343	90.00
90.01	09001	WOUND CARE INSTITUTE	7,518		7,518	0	7,518	90.01
90.02	09002	OP NUTRITIONAL COUNSELING	57,851		57,851	0	57,851	90.02
91.00	09100	EMERGENCY	7,014,405		7,014,405	0	7,014,405	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1,704,596		1,704,596		1,704,596	92.00
200.00		Subtotal (see instructions)	89,241,102	0	89,241,102	0	89,241,102	200.00
201.00		Less Observation Beds	1,704,596		1,704,596		1,704,596	201.00
202.00		Total (see instructions)	87,536,506	0	87,536,506	0	87,536,506	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-0057 | Period: From 01/01/2020 To 12/31/2020 | Worksheet C Part I Date/Time Prepared: 7/28/2021 12:22 pm

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		Cost Center Description	Charges Inpatient	Charges Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	11,108,543		11,108,543			30.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	3,984,892		3,984,892			34.00
43.00	04300	NURSERY	1,480,007		1,480,007			43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	22,594,505	22,554,120	45,148,625	0.123056	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	5,424,536	0	5,424,536	0.473361	0.000000	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	5,191,624	53,762,900	58,954,524	0.076378	0.000000	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	56,734	31,451,211	31,507,945	0.135277	0.000000	55.00
60.00	06000	LABORATORY	7,687,581	32,807,284	40,494,865	0.115893	0.000000	60.00
64.00	06400	INTRAVENOUS THERAPY	415,948	7,542,364	7,958,312	0.180390	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	3,254,238	3,284,674	6,538,912	0.285209	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	2,487,251	9,044,968	11,532,219	0.286451	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	235,420	1,355,359	1,590,779	0.407417	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	250,125	202,175	452,300	0.105277	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	635,856	8,450,380	9,086,236	0.056176	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	36,147	2,027,918	2,064,065	0.140174	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	13,061,041	12,327,988	25,389,029	0.179358	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	21,352,557	19,705,118	41,057,675	0.326568	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	9,468,946	87,047,110	96,516,056	0.195339	0.000000	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0.000000	0.000000	74.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	35,098	485,007	520,105	1.075442	0.000000	90.00
90.01	09001	WOUND CARE INSTITUTE	1,390	1,892	3,282	2.290676	0.000000	90.01
90.02	09002	OP NUTRITIONAL COUNSELING	0	32,132	32,132	1.800417	0.000000	90.02
91.00	09100	EMERGENCY	10,122,698	80,315,694	90,438,392	0.077560	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	776,231	5,879,769	6,656,000	0.256099	0.000000	92.00
200.00		Subtotal (see instructions)	119,661,368	378,278,063	497,939,431			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	119,661,368	378,278,063	497,939,431			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-0057 | Period: From 01/01/2020 To 12/31/2020 | Worksheet C Part I Date/Time Prepared: 7/28/2021 12:22 pm

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		Cost Center Description	PPS Inpatient Ratio	
			11.00	
		INPATIENT ROUTINE SERVICE COST CENTERS		
30.00	03000	ADULTS & PEDIATRICS		30.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT		34.00
43.00	04300	NURSERY		43.00
		ANCILLARY SERVICE COST CENTERS		
50.00	05000	OPERATING ROOM	0.123056	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.473361	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.076378	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.135277	55.00
60.00	06000	LABORATORY	0.115893	60.00
64.00	06400	INTRAVENOUS THERAPY	0.180390	64.00
65.00	06500	RESPIRATORY THERAPY	0.285209	65.00
66.00	06600	PHYSICAL THERAPY	0.286451	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.407417	67.00
68.00	06800	SPEECH PATHOLOGY	0.105277	68.00
69.00	06900	ELECTROCARDIOLOGY	0.056176	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.140174	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.179358	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.326568	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.195339	73.00
74.00	07400	RENAL DIALYSIS	0.000000	74.00
		OUTPATIENT SERVICE COST CENTERS		
90.00	09000	CLINIC	1.075442	90.00
90.01	09001	WOUND CARE INSTITUTE	2.290676	90.01
90.02	09002	OP NUTRITIONAL COUNSELING	1.800417	90.02
91.00	09100	EMERGENCY	0.077560	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.256099	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: 15-0057 | Period: From 01/01/2020 To 12/31/2020 | Worksheet C Part I Date/Time Prepared: 7/28/2021 12:22 pm

Title XIX | 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	8,626,601		8,626,601	0	8,626,601	30.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	4,024,237		4,024,237	0	4,024,237	34.00
43.00	04300	NURSERY	750,117		750,117	0	750,117	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	5,555,800		5,555,800	0	5,555,800	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	2,567,762		2,567,762	0	2,567,762	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,502,812		4,502,812	0	4,502,812	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	4,262,289		4,262,289	0	4,262,289	55.00
60.00	06000	LABORATORY	4,693,091		4,693,091	0	4,693,091	60.00
64.00	06400	INTRAVENOUS THERAPY	1,435,598		1,435,598	0	1,435,598	64.00
65.00	06500	RESPIRATORY THERAPY	1,864,957	0	1,864,957	0	1,864,957	65.00
66.00	06600	PHYSICAL THERAPY	3,303,412	0	3,303,412	0	3,303,412	66.00
67.00	06700	OCCUPATIONAL THERAPY	648,110	0	648,110	0	648,110	67.00
68.00	06800	SPEECH PATHOLOGY	47,617	0	47,617	0	47,617	68.00
69.00	06900	ELECTROCARDIOLOGY	510,425		510,425	0	510,425	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	289,329		289,329	0	289,329	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	4,553,715		4,553,715	0	4,553,715	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	13,408,137		13,408,137	0	13,408,137	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	18,853,380		18,853,380	0	18,853,380	73.00
74.00	07400	RENAL DIALYSIS	0		0	0	0	74.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	559,343		559,343	0	559,343	90.00
90.01	09001	WOUND CARE INSTITUTE	7,518		7,518	0	7,518	90.01
90.02	09002	OP NUTRITIONAL COUNSELING	57,851		57,851	0	57,851	90.02
91.00	09100	EMERGENCY	7,014,405		7,014,405	0	7,014,405	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1,704,596		1,704,596		1,704,596	92.00
200.00		Subtotal (see instructions)	89,241,102	0	89,241,102	0	89,241,102	200.00
201.00		Less Observation Beds	1,704,596		1,704,596		1,704,596	201.00
202.00		Total (see instructions)	87,536,506	0	87,536,506	0	87,536,506	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-0057 | Period: From 01/01/2020 To 12/31/2020 | Worksheet C Part I Date/Time Prepared: 7/28/2021 12:22 pm

Title XIX | Hospital | PPS

		Cost Center Description	Charges Inpatient	Charges Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	11,108,543		11,108,543			30.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	3,984,892		3,984,892			34.00
43.00	04300	NURSERY	1,480,007		1,480,007			43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	22,594,505	22,554,120	45,148,625	0.123056	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	5,424,536	0	5,424,536	0.473361	0.000000	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	5,191,624	53,762,900	58,954,524	0.076378	0.000000	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	56,734	31,451,211	31,507,945	0.135277	0.000000	55.00
60.00	06000	LABORATORY	7,687,581	32,807,284	40,494,865	0.115893	0.000000	60.00
64.00	06400	INTRAVENOUS THERAPY	415,948	7,542,364	7,958,312	0.180390	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	3,254,238	3,284,674	6,538,912	0.285209	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	2,487,251	9,044,968	11,532,219	0.286451	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	235,420	1,355,359	1,590,779	0.407417	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	250,125	202,175	452,300	0.105277	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	635,856	8,450,380	9,086,236	0.056176	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	36,147	2,027,918	2,064,065	0.140174	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	13,061,041	12,327,988	25,389,029	0.179358	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	21,352,557	19,705,118	41,057,675	0.326568	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	9,468,946	87,047,110	96,516,056	0.195339	0.000000	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0.000000	0.000000	74.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	35,098	485,007	520,105	1.075442	0.000000	90.00
90.01	09001	WOUND CARE INSTITUTE	1,390	1,892	3,282	2.290676	0.000000	90.01
90.02	09002	OP NUTRITIONAL COUNSELING	0	32,132	32,132	1.800417	0.000000	90.02
91.00	09100	EMERGENCY	10,122,698	80,315,694	90,438,392	0.077560	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	776,231	5,879,769	6,656,000	0.256099	0.000000	92.00
200.00		Subtotal (see instructions)	119,661,368	378,278,063	497,939,431			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	119,661,368	378,278,063	497,939,431			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-0057 | Period: From 01/01/2020 To 12/31/2020 | Worksheet C Part I Date/Time Prepared: 7/28/2021 12:22 pm

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		Cost Center Description	PPS Inpatient Ratio		
			11.00		
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS			30.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT			34.00
43.00	04300	NURSERY			43.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0.123056		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.473361		52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.076378		54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.135277		55.00
60.00	06000	LABORATORY	0.115893		60.00
64.00	06400	INTRAVENOUS THERAPY	0.180390		64.00
65.00	06500	RESPIRATORY THERAPY	0.285209		65.00
66.00	06600	PHYSICAL THERAPY	0.286451		66.00
67.00	06700	OCCUPATIONAL THERAPY	0.407417		67.00
68.00	06800	SPEECH PATHOLOGY	0.105277		68.00
69.00	06900	ELECTROCARDIOLOGY	0.056176		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.140174		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.179358		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.326568		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.195339		73.00
74.00	07400	RENAL DIALYSIS	0.000000		74.00
		OUTPATIENT SERVICE COST CENTERS			
90.00	09000	CLINIC	1.075442		90.00
90.01	09001	WOUND CARE INSTITUTE	2.290676		90.01
90.02	09002	OP NUTRITIONAL COUNSELING	1.800417		90.02
91.00	09100	EMERGENCY	0.077560		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.256099		92.00
200.00		Subtotal (see instructions)			200.00
201.00		Less Observation Beds			201.00
202.00		Total (see instructions)			202.00

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

Provider CCN: 15-0057 | Period: From 01/01/2020 To 12/31/2020 | Worksheet C Part II Date/Time Prepared: 7/28/2021 12:22 pm

Title XIX | Hospital | PPS

		Cost Center Description	Total Cost (Wkst. B, Part I, col. 26)	Capital Cost (Wkst. B, Part II col. 26)	Operating Cost Net of Capital Cost (col. 1 - col. 2)	Capital Reduction	Operating Cost Reduction Amount	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	5,555,800	820,673	4,735,127	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	2,567,762	14,300	2,553,462	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,502,812	316,826	4,185,986	0	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	4,262,289	253,896	4,008,393	0	0	55.00
60.00	06000	LABORATORY	4,693,091	149,027	4,544,064	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY	1,435,598	2,579	1,433,019	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	1,864,957	89,655	1,775,302	0	0	65.00
66.00	06600	PHYSICAL THERAPY	3,303,412	261,309	3,042,103	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	648,110	146,795	501,315	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	47,617	210	47,407	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	510,425	36,063	474,362	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	289,329	111,055	178,274	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	4,553,715	30,688	4,523,027	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	13,408,137	81,269	13,326,868	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	18,853,380	110,768	18,742,612	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	559,343	98,447	460,896	0	0	90.00
90.01	09001	WOUND CARE INSTITUTE	7,518	13	7,505	0	0	90.01
90.02	09002	OP NUTRITIONAL COUNSELING	57,851	92	57,759	0	0	90.02
91.00	09100	EMERGENCY	7,014,405	496,419	6,517,986	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1,704,596	276,825	1,427,771	0	0	92.00
200.00		Subtotal (sum of lines 50 thru 199)	75,840,147	3,296,909	72,543,238	0	0	200.00
201.00		Less Observation Beds	1,704,596	276,825	1,427,771	0	0	201.00
202.00		Total (line 200 minus line 201)	74,135,551	3,020,084	71,115,467	0	0	202.00

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

Provider CCN: 15-0057 | Period: From 01/01/2020 To 12/31/2020 | Worksheet C Part II Date/Time Prepared: 7/28/2021 12:22 pm

Title XIX | Hospital | PPS

		Cost Center Description	Cost Net of Capital and Operating Cost Reduction	Total Charges (Worksheet C, Part I, column 8)	Outpatient Cost to Charge Ratio (col. 6 / col. 7)		
			6.00	7.00	8.00		
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	5,555,800	45,148,625	0.123056		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	2,567,762	5,424,536	0.473361		52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,502,812	58,954,524	0.076378		54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	4,262,289	31,507,945	0.135277		55.00
60.00	06000	LABORATORY	4,693,091	40,494,865	0.115893		60.00
64.00	06400	INTRAVENOUS THERAPY	1,435,598	7,958,312	0.180390		64.00
65.00	06500	RESPIRATORY THERAPY	1,864,957	6,538,912	0.285209		65.00
66.00	06600	PHYSICAL THERAPY	3,303,412	11,532,219	0.286451		66.00
67.00	06700	OCCUPATIONAL THERAPY	648,110	1,590,779	0.407417		67.00
68.00	06800	SPEECH PATHOLOGY	47,617	452,300	0.105277		68.00
69.00	06900	ELECTROCARDIOLOGY	510,425	9,086,236	0.056176		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	289,329	2,064,065	0.140174		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	4,553,715	25,389,029	0.179358		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	13,408,137	41,057,675	0.326568		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	18,853,380	96,516,056	0.195339		73.00
74.00	07400	RENAL DIALYSIS	0	0	0.000000		74.00
		OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	559,343	520,105	1.075442		90.00
90.01	09001	WOUND CARE INSTITUTE	7,518	3,282	2.290676		90.01
90.02	09002	OP NUTRITIONAL COUNSELING	57,851	32,132	1.800417		90.02
91.00	09100	EMERGENCY	7,014,405	90,438,392	0.077560		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1,704,596	6,656,000	0.256099		92.00
200.00		Subtotal (sum of lines 50 thru 199)	75,840,147	481,365,989			200.00
201.00		Less Observation Beds	1,704,596	0			201.00
202.00		Total (line 200 minus line 201)	74,135,551	481,365,989			202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS | Provider CCN: 15-0057 | Period: From 01/01/2020 To 12/31/2020 | Worksheet D Part I Date/Time Prepared: 7/28/2021 12:22 pm

Title XVIII | Hospital | PPS

	Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	1,400,951	0	1,400,951	6,412	218.49	30.00
34.00	SURGICAL INTENSIVE CARE UNIT	318,833		318,833	1,150	277.25	34.00
43.00	NURSERY	14,907		14,907	649	22.97	43.00
200.00	Total (lines 30 through 199)	1,734,691		1,734,691	8,211		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	2,101	459,047	30.00
34.00	SURGICAL INTENSIVE CARE UNIT	462	128,090	34.00
43.00	NURSERY	0	0	43.00
200.00	Total (lines 30 through 199)	2,563	587,137	200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS | Provider CCN: 15-0057 | Period: From 01/01/2020 To 12/31/2020 | Worksheet D Part II Date/Time Prepared: 7/28/2021 12:22 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	820,673	45,148,625	0.018177	9,262,896	168,372	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	14,300	5,424,536	0.002636	56,180	148	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	316,826	58,954,524	0.005374	1,707,242	9,175	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	253,896	31,507,945	0.008058	14,247	115	55.00
60.00	06000	LABORATORY	149,027	40,494,865	0.003680	2,574,416	9,474	60.00
64.00	06400	INTRAVENOUS THERAPY	2,579	7,958,312	0.000324	154,418	50	64.00
65.00	06500	RESPIRATORY THERAPY	89,655	6,538,912	0.013711	1,348,154	18,485	65.00
66.00	06600	PHYSICAL THERAPY	261,309	11,532,219	0.022659	1,188,949	26,940	66.00
67.00	06700	OCCUPATIONAL THERAPY	146,795	1,590,779	0.092279	99,062	9,141	67.00
68.00	06800	SPEECH PATHOLOGY	210	452,300	0.000464	33,552	16	68.00
69.00	06900	ELECTROCARDIOLOGY	36,063	9,086,236	0.003969	234,069	929	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	111,055	2,064,065	0.053804	14,628	787	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	30,688	25,389,029	0.001209	5,386,933	6,513	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	81,269	41,057,675	0.001979	9,924,968	19,642	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	110,768	96,516,056	0.001148	3,358,195	3,855	73.00
74.00	07400	RENAL DIALYSIS	0	0	0.000000	0	0	74.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	98,447	520,105	0.189283	0	0	90.00
90.01	09001	WOUND CARE INSTITUTE	13	3,282	0.003961	340	1	90.01
90.02	09002	OP NUTRITIONAL COUNSELING	92	32,132	0.002863	0	0	90.02
91.00	09100	EMERGENCY	496,419	90,438,392	0.005489	3,040,104	16,687	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	276,825	6,656,000	0.041590	333,614	13,875	92.00
200.00		Total (lines 50 through 199)	3,296,909	481,365,989		38,731,967	304,205	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 15-0057 | Period: From 01/01/2020 To 12/31/2020 | Worksheet D Part III Date/Time Prepared: 7/28/2021 12:22 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health Cost	All Other Medical Education Cost	
			1A	1.00	2A	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	0	30.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	0	0	0	0	0	34.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
200.00		Total (lines 30 through 199)	0	0	0	0	0	200.00

		Cost Center Description	Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days	
			4.00	5.00	6.00	7.00	8.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	0	6,412	0.00	2,101	30.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT		0	1,150	0.00	462	34.00
43.00	04300	NURSERY		0	649	0.00	0	43.00
200.00		Total (lines 30 through 199)		0	8,211		2,563	200.00

		Cost Center Description	Inpatient Program Pass-Through Cost (col. 7 x col. 8)	
			9.00	
		INPATIENT ROUTINE SERVICE COST CENTERS		
30.00	03000	ADULTS & PEDIATRICS	0	30.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	0	34.00
43.00	04300	NURSERY	0	43.00
200.00		Total (lines 30 through 199)	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 15-0057 | Period: From 01/01/2020 To 12/31/2020 | Worksheet D Part IV Date/Time Prepared: 7/28/2021 12:22 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health	
			1.00	2A	2.00	3A	3.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	0	55.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	WOUND CARE INSTITUTE	0	0	0	0	0	90.01
90.02	09002	OP NUTRITIONAL COUNSELING	0	0	0	0	0	90.02
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0		0		0	92.00
200.00		Total (lines 50 through 199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-0057 | Period: From 01/01/2020 To 12/31/2020 | Worksheet D Part IV Date/Time Prepared: 7/28/2021 12:22 pm

Title XVIII | Hospital | PPS

		Cost Center Description	All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7) (see instructions)	
			4.00	5.00	6.00	7.00	8.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	45,148,625	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	5,424,536	0.000000	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	58,954,524	0.000000	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	31,507,945	0.000000	55.00
60.00	06000	LABORATORY	0	0	0	40,494,865	0.000000	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	7,958,312	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	6,538,912	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	11,532,219	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	1,590,779	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	452,300	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	9,086,236	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	2,064,065	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	25,389,029	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	41,057,675	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	96,516,056	0.000000	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0.000000	74.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	520,105	0.000000	90.00
90.01	09001	WOUND CARE INSTITUTE	0	0	0	3,282	0.000000	90.01
90.02	09002	OP NUTRITIONAL COUNSELING	0	0	0	32,132	0.000000	90.02
91.00	09100	EMERGENCY	0	0	0	90,438,392	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	6,656,000	0.000000	92.00
200.00		Total (lines 50 through 199)	0	0	0	481,365,989		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-0057 | Period: From 01/01/2020 To 12/31/2020 | Worksheet D Part IV | Date/Time Prepared: 7/28/2021 12:22 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
			9.00	10.00	11.00	12.00	13.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.000000	9,262,896	0	8,038,541	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	56,180	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	1,707,242	0	13,483,387	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.000000	14,247	0	11,648,270	0	55.00
60.00	06000	LABORATORY	0.000000	2,574,416	0	703,141	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0.000000	154,418	0	2,949,259	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.000000	1,348,154	0	986,415	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	1,188,949	0	369,008	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	99,062	0	21,371	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	33,552	0	2,727	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	234,069	0	2,700,576	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	14,628	0	311,453	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	5,386,933	0	4,163,264	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	9,924,968	0	7,595,045	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	3,358,195	0	32,549,273	0	73.00
74.00	07400	RENAL DIALYSIS	0.000000	0	0	0	0	74.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.000000	0	0	324,691	0	90.00
90.01	09001	WOUND CARE INSTITUTE	0.000000	340	0	599	0	90.01
90.02	09002	OP NUTRITIONAL COUNSELING	0.000000	0	0	0	0	90.02
91.00	09100	EMERGENCY	0.000000	3,040,104	0	14,197,672	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	333,614	0	756,831	0	92.00
200.00		Total (lines 50 through 199)		38,731,967	0	100,801,523	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-0057 | Period: From 01/01/2020 To 12/31/2020 | Worksheet D Part V Date/Time Prepared: 7/28/2021 12:22 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.123056	8,038,541	0	0	989,191	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.473361	0	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.076378	13,483,387	0	0	1,029,834	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.135277	11,648,270	0	0	1,575,743	55.00
60.00	06000	LABORATORY	0.115893	703,141	0	0	81,489	60.00
64.00	06400	INTRAVENOUS THERAPY	0.180390	2,949,259	0	0	532,017	64.00
65.00	06500	RESPIRATORY THERAPY	0.285209	986,415	0	0	281,334	65.00
66.00	06600	PHYSICAL THERAPY	0.286451	369,008	0	0	105,703	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.407417	21,371	0	0	8,707	67.00
68.00	06800	SPEECH PATHOLOGY	0.105277	2,727	0	0	287	68.00
69.00	06900	ELECTROCARDIOLOGY	0.056176	2,700,576	0	0	151,708	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.140174	311,453	0	0	43,658	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.179358	4,163,264	1,727	0	746,715	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.326568	7,595,045	0	0	2,480,299	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.195339	32,549,273	0	31,182	6,358,142	73.00
74.00	07400	RENAL DIALYSIS	0.000000	0	0	0	0	74.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	1.075442	324,691	0	0	349,186	90.00
90.01	09001	WOUND CARE INSTITUTE	2.290676	599	0	0	1,372	90.01
90.02	09002	OP NUTRITIONAL COUNSELING	1.800417	0	0	0	0	90.02
91.00	09100	EMERGENCY	0.077560	14,197,672	0	0	1,101,171	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.256099	756,831	0	0	193,824	92.00
200.00		Subtotal (see instructions)		100,801,523	1,727	31,182	16,030,380	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 - line 201)		100,801,523	1,727	31,182	16,030,380	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-0057 | Period: From 01/01/2020 To 12/31/2020 | Worksheet D Part V Date/Time Prepared: 7/28/2021 12:22 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Costs: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	0		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0		52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0		54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0		55.00
60.00	06000	LABORATORY	0	0		60.00
64.00	06400	INTRAVENOUS THERAPY	0	0		64.00
65.00	06500	RESPIRATORY THERAPY	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	310	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	6,091		73.00
74.00	07400	RENAL DIALYSIS	0	0		74.00
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0	0		90.00
90.01	09001	WOUND CARE INSTITUTE	0	0		90.01
90.02	09002	OP NUTRITIONAL COUNSELING	0	0		90.02
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)	310	6,091		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	310	6,091		202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS | Provider CCN: 15-0057 | Period: From 01/01/2020 To 12/31/2020 | Worksheet D Part I Date/Time Prepared: 7/28/2021 12:22 pm

Title XIX | Hospital | PPS

	Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	1,400,951	0	1,400,951	6,412	218.49	30.00
34.00	SURGICAL INTENSIVE CARE UNIT	318,833		318,833	1,150	277.25	34.00
43.00	NURSERY	14,907		14,907	649	22.97	43.00
200.00	Total (lines 30 through 199)	1,734,691		1,734,691	8,211		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	39	8,521	30.00
34.00	SURGICAL INTENSIVE CARE UNIT	7	1,941	34.00
43.00	NURSERY	444	10,199	43.00
200.00	Total (lines 30 through 199)	490	20,661	200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS | Provider CCN: 15-0057 | Period: From 01/01/2020 To 12/31/2020 | Worksheet D Part II Date/Time Prepared: 7/28/2021 12:22 pm

Title XIX | Hospital | PPS

		Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	820,673	45,148,625	0.018177	190,646	3,465	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	14,300	5,424,536	0.002636	192,300	507	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	316,826	58,954,524	0.005374	51,784	278	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	253,896	31,507,945	0.008058	0	0	55.00
60.00	06000	LABORATORY	149,027	40,494,865	0.003680	136,105	501	60.00
64.00	06400	INTRAVENOUS THERAPY	2,579	7,958,312	0.000324	5,088	2	64.00
65.00	06500	RESPIRATORY THERAPY	89,655	6,538,912	0.013711	39,293	539	65.00
66.00	06600	PHYSICAL THERAPY	261,309	11,532,219	0.022659	18,636	422	66.00
67.00	06700	OCCUPATIONAL THERAPY	146,795	1,590,779	0.092279	4,203	388	67.00
68.00	06800	SPEECH PATHOLOGY	210	452,300	0.000464	15,730	7	68.00
69.00	06900	ELECTROCARDIOLOGY	36,063	9,086,236	0.003969	13,972	55	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	111,055	2,064,065	0.053804	1,696	91	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	30,688	25,389,029	0.001209	110,054	133	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	81,269	41,057,675	0.001979	77,568	154	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	110,768	96,516,056	0.001148	105,771	121	73.00
74.00	07400	RENAL DIALYSIS	0	0	0.000000	0	0	74.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	98,447	520,105	0.189283	1,656	313	90.00
90.01	09001	WOUND CARE INSTITUTE	13	3,282	0.003961	0	0	90.01
90.02	09002	OP NUTRITIONAL COUNSELING	92	32,132	0.002863	0	0	90.02
91.00	09100	EMERGENCY	496,419	90,438,392	0.005489	77,354	425	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	276,825	6,656,000	0.041590	8,083	336	92.00
200.00		Total (lines 50 through 199)	3,296,909	481,365,989		1,049,939	7,737	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 15-0057 | Period: From 01/01/2020 To 12/31/2020 | Worksheet D Part III Date/Time Prepared: 7/28/2021 12:22 pm

Title XIX | Hospital | PPS

		Cost Center Description	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health Cost	All Other Medical Education Cost	
			1A	1.00	2A	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	0	30.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	0	0	0	0	0	34.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
200.00		Total (lines 30 through 199)	0	0	0	0	0	200.00

		Cost Center Description	Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days	
			4.00	5.00	6.00	7.00	8.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	0	6,412	0.00	39	30.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT		0	1,150	0.00	7	34.00
43.00	04300	NURSERY		0	649	0.00	444	43.00
200.00		Total (lines 30 through 199)		0	8,211		490	200.00

		Cost Center Description	Inpatient Program Pass-Through Cost (col. 7 x col. 8)	
			9.00	
		INPATIENT ROUTINE SERVICE COST CENTERS		
30.00	03000	ADULTS & PEDIATRICS	0	30.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	0	34.00
43.00	04300	NURSERY	0	43.00
200.00		Total (lines 30 through 199)	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 15-0057 | Period: From 01/01/2020 To 12/31/2020 | Worksheet D Part IV | Date/Time Prepared: 7/28/2021 12:22 pm

Title XIX | Hospital | PPS

		Cost Center Description	Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health	
			1.00	2A	2.00	3A	3.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	0	55.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	WOUND CARE INSTITUTE	0	0	0	0	0	90.01
90.02	09002	OP NUTRITIONAL COUNSELING	0	0	0	0	0	90.02
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0		0		0	92.00
200.00		Total (lines 50 through 199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-0057 | Period: From 01/01/2020 To 12/31/2020 | Worksheet D Part IV Date/Time Prepared: 7/28/2021 12:22 pm

Title XIX | Hospital | PPS

		Cost Center Description	All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7) (see instructions)	
			4.00	5.00	6.00	7.00	8.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	45,148,625	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	5,424,536	0.000000	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	58,954,524	0.000000	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	31,507,945	0.000000	55.00
60.00	06000	LABORATORY	0	0	0	40,494,865	0.000000	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	7,958,312	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	6,538,912	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	11,532,219	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	1,590,779	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	452,300	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	9,086,236	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	2,064,065	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	25,389,029	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	41,057,675	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	96,516,056	0.000000	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0.000000	74.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	520,105	0.000000	90.00
90.01	09001	WOUND CARE INSTITUTE	0	0	0	3,282	0.000000	90.01
90.02	09002	OP NUTRITIONAL COUNSELING	0	0	0	32,132	0.000000	90.02
91.00	09100	EMERGENCY	0	0	0	90,438,392	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	6,656,000	0.000000	92.00
200.00		Total (lines 50 through 199)	0	0	0	481,365,989		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-0057 | Period: From 01/01/2020 To 12/31/2020 | Worksheet D Part IV | Date/Time Prepared: 7/28/2021 12:22 pm

Title XIX | Hospital | PPS

		Cost Center Description	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
			9.00	10.00	11.00	12.00	13.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.000000	190,646	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	192,300	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	51,784	0	0	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.000000	0	0	0	0	55.00
60.00	06000	LABORATORY	0.000000	136,105	0	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0.000000	5,088	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.000000	39,293	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	18,636	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	4,203	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	15,730	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	13,972	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	1,696	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	110,054	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	77,568	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	105,771	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0.000000	0	0	0	0	74.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.000000	1,656	0	0	0	90.00
90.01	09001	WOUND CARE INSTITUTE	0.000000	0	0	0	0	90.01
90.02	09002	OP NUTRITIONAL COUNSELING	0.000000	0	0	0	0	90.02
91.00	09100	EMERGENCY	0.000000	77,354	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	8,083	0	0	0	92.00
200.00		Total (lines 50 through 199)		1,049,939	0	0	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-0057 | Period: From 01/01/2020 To 12/31/2020 | Worksheet D Part V Date/Time Prepared: 7/28/2021 12:22 pm

Title XIX | Hospital | PPS

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.123056	0	210,723	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.473361	0	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.076378	0	697,616	0	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.135277	0	10,792	0	0	55.00
60.00	06000	LABORATORY	0.115893	0	447,964	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0.180390	0	21,598	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.285209	0	31,567	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.286451	0	66,406	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.407417	0	9,933	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.105277	0	4,288	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.056176	0	20,163	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.140174	0	35,616	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.179358	0	158,435	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.326568	0	124,602	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.195339	0	442,516	0	0	73.00
74.00	07400	RENAL DIALYSIS	0.000000	0	0	0	0	74.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	1.075442	0	9,021	0	0	90.00
90.01	09001	WOUND CARE INSTITUTE	2.290676	0	0	0	0	90.01
90.02	09002	OP NUTRITIONAL COUNSELING	1.800417	0	1,146	0	0	90.02
91.00	09100	EMERGENCY	0.077560	0	2,331,407	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.256099	0	174,174	0	0	92.00
200.00		Subtotal (see instructions)		0	4,797,967	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	4,797,967	0	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-0057 | Period: From 01/01/2020 To 12/31/2020 | Worksheet D Part V Date/Time Prepared: 7/28/2021 12:22 pm

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		Cost Center Description	Costs: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	25,931	0		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0		52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	53,283	0		54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	1,460	0		55.00
60.00	06000	LABORATORY	51,916	0		60.00
64.00	06400	INTRAVENOUS THERAPY	3,896	0		64.00
65.00	06500	RESPIRATORY THERAPY	9,003	0		65.00
66.00	06600	PHYSICAL THERAPY	19,022	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	4,047	0		67.00
68.00	06800	SPEECH PATHOLOGY	451	0		68.00
69.00	06900	ELECTROCARDIOLOGY	1,133	0		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	4,992	0		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	28,417	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	40,691	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	86,441	0		73.00
74.00	07400	RENAL DIALYSIS	0	0		74.00
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	9,702	0		90.00
90.01	09001	WOUND CARE INSTITUTE	0	0		90.01
90.02	09002	OP NUTRITIONAL COUNSELING	2,063	0		90.02
91.00	09100	EMERGENCY	180,824	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	44,606	0		92.00
200.00		Subtotal (see instructions)	567,878	0		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	567,878	0		202.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-0057 | Period: From 01/01/2020 To 12/31/2020 | Worksheet D-1 | Date/Time Prepared: 7/28/2021 12:22 pm

Title XVIII | Hospital | PPS

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	6,412	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	6,412	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.	0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)	5,145	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions)	2,101	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)	8,626,601	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)	8,626,601	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)	8,626,601	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)	1,345.38	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	2,826,643	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)	2,826,643	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-0057 | Period: From 01/01/2020 To 12/31/2020 | Worksheet D-1 | Date/Time Prepared: 7/28/2021 12:22 pm

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	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)	0	0	0.00	0	0	42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT						43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT	4,024,237	1,150	3,499.34	462	1,616,695	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)	7,594,516	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	12,037,854	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)	587,137	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	304,205	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	891,342	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	11,146,512	53.00
	TARGET AMOUNT AND LIMIT COMPUTATION		
54.00	Program discharges	0	54.00
55.00	Target amount per discharge	0.00	55.00
56.00	Target amount (line 54 x line 55)	0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)	0	57.00
58.00	Bonus payment (see instructions)	0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket	0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket	0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)	0	61.00
62.00	Relief payment (see instructions)	0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)	0	63.00
	PROGRAM INPATIENT ROUTINE SWING BED COST		
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)	0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)	0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)	0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)	0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)	0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)	0	69.00
	PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY		
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)		70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)		71.00
72.00	Program routine service cost (line 9 x line 71)		72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)		73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)		74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)		75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)		76.00
77.00	Program capital-related costs (line 9 x line 76)		77.00
78.00	Inpatient routine service cost (line 74 minus line 77)		78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)		79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)		80.00
81.00	Inpatient routine service cost per diem limitation		81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)		82.00
83.00	Reasonable inpatient routine service costs (see instructions)		83.00
84.00	Program inpatient ancillary services (see instructions)		84.00
85.00	Utilization review - physician compensation (see instructions)		85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)		86.00
	PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST		
87.00	Total observation bed days (see instructions)	1,267	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	1,345.38	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	1,704,596	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-0057 | Period: From 01/01/2020 To 12/31/2020 | Worksheet D-1 | Date/Time Prepared: 7/28/2021 12:22 pm

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	Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	1,400,951	8,626,601	0.162399	1,704,596	276,825	90.00
91.00	Nursing School cost	0	8,626,601	0.000000	1,704,596	0	91.00
92.00	Allied health cost	0	8,626,601	0.000000	1,704,596	0	92.00
93.00	All other Medical Education	0	8,626,601	0.000000	1,704,596	0	93.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-0057 | Period: From 01/01/2020 To 12/31/2020 | Worksheet D-1 | Date/Time Prepared: 7/28/2021 12:22 pm

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	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)	6,412	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	6,412	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.	0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)	5,145	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)	39	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)	649	15.00
16.00	Nursery days (title V or XIX only)	444	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)	8,626,601	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)	8,626,601	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)	8,626,601	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)	1,345.38	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	52,470	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)	52,470	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-0057 | Period: From 01/01/2020 To 12/31/2020 | Worksheet D-1 | Date/Time Prepared: 7/28/2021 12:22 pm

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	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)	750,117	649	1,155.80	444	513,175	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	4,024,237	1,150	3,499.34	7	24,495	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)	231,652	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	821,792	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)	20,661	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	7,737	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	28,398	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	793,394	53.00
	TARGET AMOUNT AND LIMIT COMPUTATION		
54.00	Program discharges	0	54.00
55.00	Target amount per discharge	0.00	55.00
56.00	Target amount (line 54 x line 55)	0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)	0	57.00
58.00	Bonus payment (see instructions)	0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket	0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket	0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)	0	61.00
62.00	Relief payment (see instructions)	0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)	0	63.00
	PROGRAM INPATIENT ROUTINE SWING BED COST		
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)	0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)	0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)	0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)	0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)	0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)	0	69.00
	PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY		
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)		70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)		71.00
72.00	Program routine service cost (line 9 x line 71)		72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)		73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)		74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)		75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)		76.00
77.00	Program capital-related costs (line 9 x line 76)		77.00
78.00	Inpatient routine service cost (line 74 minus line 77)		78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)		79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)		80.00
81.00	Inpatient routine service cost per diem limitation		81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)		82.00
83.00	Reasonable inpatient routine service costs (see instructions)		83.00
84.00	Program inpatient ancillary services (see instructions)		84.00
85.00	Utilization review - physician compensation (see instructions)		85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)		86.00
	PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST		
87.00	Total observation bed days (see instructions)	1,267	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	1,345.38	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	1,704,596	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-0057 | Period: From 01/01/2020 To 12/31/2020 | Worksheet D-1 | Date/Time Prepared: 7/28/2021 12:22 pm

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	Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	1,400,951	8,626,601	0.162399	1,704,596	276,825	90.00
91.00	Nursing School cost	0	8,626,601	0.000000	1,704,596	0	91.00
92.00	Allied health cost	0	8,626,601	0.000000	1,704,596	0	92.00
93.00	All other Medical Education	0	8,626,601	0.000000	1,704,596	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 15-0057 | Period: From 01/01/2020 To 12/31/2020 | Worksheet D-3 | Date/Time Prepared: 7/28/2021 12:22 pm

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		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		4,657,269		30.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT		1,649,864		34.00
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.123056	9,262,896	1,139,855	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.473361	56,180	26,593	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.076378	1,707,242	130,396	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.135277	14,247	1,927	55.00
60.00	06000	LABORATORY	0.115893	2,574,416	298,357	60.00
64.00	06400	INTRAVENOUS THERAPY	0.180390	154,418	27,855	64.00
65.00	06500	RESPIRATORY THERAPY	0.285209	1,348,154	384,506	65.00
66.00	06600	PHYSICAL THERAPY	0.286451	1,188,949	340,576	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.407417	99,062	40,360	67.00
68.00	06800	SPEECH PATHOLOGY	0.105277	33,552	3,532	68.00
69.00	06900	ELECTROCARDIOLOGY	0.056176	234,069	13,149	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.140174	14,628	2,050	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.179358	5,386,933	966,190	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.326568	9,924,968	3,241,177	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.195339	3,358,195	655,986	73.00
74.00	07400	RENAL DIALYSIS	0.000000	0	0	74.00
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	1.075442	0	0	90.00
90.01	09001	WOUND CARE INSTITUTE	2.290676	340	779	90.01
90.02	09002	OP NUTRITIONAL COUNSELING	1.800417	0	0	90.02
91.00	09100	EMERGENCY	0.077560	3,040,104	235,790	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.256099	333,614	85,438	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		38,731,967	7,594,516	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)		38,731,967		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 15-0057 | Period: From 01/01/2020 To 12/31/2020 | Worksheet D-3 | Date/Time Prepared: 7/28/2021 12:22 pm

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		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		95,354		30.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT		49,448		34.00
43.00	04300	NURSERY		291,588		43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.123056	190,646	23,460	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.473361	192,300	91,027	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.076378	51,784	3,955	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.135277	0	0	55.00
60.00	06000	LABORATORY	0.115893	136,105	15,774	60.00
64.00	06400	INTRAVENOUS THERAPY	0.180390	5,088	918	64.00
65.00	06500	RESPIRATORY THERAPY	0.285209	39,293	11,207	65.00
66.00	06600	PHYSICAL THERAPY	0.286451	18,636	5,338	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.407417	4,203	1,712	67.00
68.00	06800	SPEECH PATHOLOGY	0.105277	15,730	1,656	68.00
69.00	06900	ELECTROCARDIOLOGY	0.056176	13,972	785	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.140174	1,696	238	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.179358	110,054	19,739	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.326568	77,568	25,331	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.195339	105,771	20,661	73.00
74.00	07400	RENAL DIALYSIS	0.000000	0	0	74.00
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	1.075442	1,656	1,781	90.00
90.01	09001	WOUND CARE INSTITUTE	2.290676	0	0	90.01
90.02	09002	OP NUTRITIONAL COUNSELING	1.800417	0	0	90.02
91.00	09100	EMERGENCY	0.077560	77,354	6,000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.256099	8,083	2,070	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		1,049,939	231,652	200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0		201.00
202.00		Net charges (line 200 minus line 201)		1,049,939		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0057	Period: From 01/01/2020 To 12/31/2020	Worksheet E Part A Date/Time Prepared: 7/28/2021 12:22 pm
	Title XVIII	Hospital	PPS

		1.00	
	PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS		
1.00	DRG Amounts Other than Outlier Payments	0	1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1 (see instructions)	5,814,942	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1 (see instructions)	2,630,317	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)	10,349	2.03
2.04	Outlier payments for discharges occurring on or after October 1 (see instructions)	9,585	2.04
3.00	Managed Care Simulated Payments	4,626,513	3.00
4.00	Bed days available divided by number of days in the cost reporting period (see instructions)	95.64	4.00
	Indirect Medical Education Adjustment		
5.00	FTE count for allopathic and osteopathic programs for the most recent cost reporting period ending on or before 12/31/1996.(see instructions)	0.00	5.00
6.00	FTE count for allopathic and osteopathic programs that meet the criteria for an add-on to the cap for new programs in accordance with 42 CFR 413.79(e)	0.00	6.00
7.00	MMA Section 422 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(1)	0.00	7.00
7.01	ACA § 5503 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(2) If the cost report straddles July 1, 2011 then see instructions.	0.00	7.01
8.00	Adjustment (increase or decrease) to the FTE count for allopathic and osteopathic programs for affiliated programs in accordance with 42 CFR 413.75(b), 413.79(c)(2)(iv), 64 FR 26340 (May 12, 1998), and 67 FR 50069 (August 1, 2002).	0.00	8.00
8.01	The amount of increase if the hospital was awarded FTE cap slots under § 5503 of the ACA. If the cost report straddles July 1, 2011, see instructions.	0.00	8.01
8.02	The amount of increase if the hospital was awarded FTE cap slots from a closed teaching hospital under § 5506 of ACA. (see instructions)	0.00	8.02
9.00	Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus lines (8, 8,01 and 8,02) (see instructions)	0.00	9.00
10.00	FTE count for allopathic and osteopathic programs in the current year from your records	0.00	10.00
11.00	FTE count for residents in dental and podiatric programs.	0.00	11.00
12.00	Current year allowable FTE (see instructions)	0.00	12.00
13.00	Total allowable FTE count for the prior year.	0.04	13.00
14.00	Total allowable FTE count for the penultimate year if that year ended on or after September 30, 1997, otherwise enter zero.	0.00	14.00
15.00	Sum of lines 12 through 14 divided by 3.	0.01	15.00
16.00	Adjustment for residents in initial years of the program	0.00	16.00
17.00	Adjustment for residents displaced by program or hospital closure	0.00	17.00
18.00	Adjusted rolling average FTE count	0.01	18.00
19.00	Current year resident to bed ratio (line 18 divided by line 4).	0.000105	19.00
20.00	Prior year resident to bed ratio (see instructions)	0.000501	20.00
21.00	Enter the lesser of lines 19 or 20 (see instructions)	0.000105	21.00
22.00	IME payment adjustment (see instructions)	490	22.00
22.01	IME payment adjustment - Managed Care (see instructions)	268	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)	490	29.00
29.01	Total IME payment - Managed Care (sum of lines 22.01 and 28.01)	268	29.01
	Disproportionate Share Adjustment		
30.00	Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)	2.20	30.00
31.00	Percentage of Medicaid patient days (see instructions)	19.96	31.00
32.00	Sum of lines 30 and 31	22.16	32.00
33.00	Allowable disproportionate share percentage (see instructions)	7.50	33.00
34.00	Disproportionate share adjustment (see instructions)	158,349	34.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0057	Period: From 01/01/2020 To 12/31/2020	Worksheet E Part A Date/Time Prepared: 7/28/2021 12:22 pm
	Title XVIII	Hospital	PPS

		Prior to 10/1	On/After 10/1	
		1.00	2.00	
	Uncompensated Care Adjustment			
35.00	Total uncompensated care amount (see instructions)	8,350,599,096	8,290,014,521	35.00
35.01	Factor 3 (see instructions)	0.000229299	0.000305200	35.01
35.02	Hospital uncompensated care payment (If line 34 is zero, enter zero on this line) (see instructions)	1,914,784	2,530,112	35.02
35.03	Pro rata share of the hospital uncompensated care payment amount (see instructions)	1,433,472	637,727	35.03
36.00	Total uncompensated care (sum of columns 1 and 2 on line 35.03)	2,071,199		36.00
	Additional payment for high percentage of ESRD beneficiary discharges (lines 40 through 46)			
40.00	Total Medicare discharges, excluding MS-DRGs 652, 682, 683, 684 and 685. (see instructions)	0		40.00
41.00	Total ESRD Medicare discharges excluding MS-DRGs 652, 682, 683, 684 an 685. (see instructions)	0		41.00
41.01	Total ESRD Medicare covered and paid discharges excluding MS-DRGs 652, 682, 683, 684 an 685. (see instructions)	0		41.01
42.00	Divide line 41 by line 40 (if less than 10%, you do not qualify for adjustment)	0.00		42.00
43.00	Total Medicare ESRD inpatient days excluding MS-DRGs 652, 682, 683, 684 an 685. (see instructions)	0		43.00
44.00	Ratio of average length of stay to one week (line 43 divided by line 41 divided by 7 days)	0.000000		44.00
45.00	Average weekly cost for dialysis treatments (see instructions)	0.00		45.00
46.00	Total additional payment (line 45 times line 44 times line 41.01)	0		46.00
47.00	Subtotal (see instructions)	10,695,231		47.00
48.00	Hospital specific payments (to be completed by SCH and MDH, small rural hospitals only.(see instructions)	0		48.00

		Amount	
		1.00	
49.00	Total payment for inpatient operating costs (see instructions)	10,695,499	49.00
50.00	Payment for inpatient program capital (from Wkst. L, Pt. I and Pt. II, as applicable)	658,708	50.00
51.00	Exception payment for inpatient program capital (Wkst. L, Pt. III, see instructions)	0	51.00
52.00	Direct graduate medical education payment (from Wkst. E-4, line 49 see instructions).	0	52.00
53.00	Nursing and Allied Health Managed Care payment	0	53.00
54.00	Special add-on payments for new technologies	28,009	54.00
54.01	Islet isolation add-on payment	0	54.01
55.00	Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line 69)	0	55.00
56.00	Cost of physicians' services in a teaching hospital (see intructions)	0	56.00
57.00	Routine service other pass through costs (from Wkst. D, Pt. III, column 9, lines 30 through 35).	0	57.00
58.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 11 line 200)	0	58.00
59.00	Total (sum of amounts on lines 49 through 58)	11,382,216	59.00
60.00	Primary payer payments	0	60.00
61.00	Total amount payable for program beneficiaries (line 59 minus line 60)	11,382,216	61.00
62.00	Deductibles billed to program beneficiaries	914,980	62.00
63.00	Coinsurance billed to program beneficiaries	2,112	63.00
64.00	Allowable bad debts (see instructions)	84,586	64.00
65.00	Adjusted reimbursable bad debts (see instructions)	54,981	65.00
66.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	21,714	66.00
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)	10,520,105	67.00
68.00	Credits received from manufacturers for replaced devices for applicable to MS-DRGs (see instructions)	0	68.00
69.00	Outlier payments reconciliation (sum of lines 93, 95 and 96).(For SCH see instructions)	0	69.00
70.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	70.00
70.50	Rural Community Hospital Demonstration Project (§410A Demonstration) adjustment (see instructions)	0	70.50
70.87	Demonstration payment adjustment amount before sequestration	0	70.87
70.88	SCH or MDH volume decrease adjustment (contractor use only)	0	70.88
70.89	Pioneer ACO demonstration payment adjustment amount (see instructions)		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)	68,383	70.93
70.94	HRR adjustment amount (see instructions)	0	70.94
70.95	Recovery of accelerated depreciation	0	70.95

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0057	Period: From 01/01/2020 To 12/31/2020	Worksheet E Part A Date/Time Prepared: 7/28/2021 12:22 pm
	Title XVIII	Hospital	PPS

		FFY (yyyy)	Amount	
		0	1.00	
70.96	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period prior to 10/1)	2020	720,038	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)	2021	322,471	70.97
70.98	Low Volume Payment-3		0	70.98
70.99	HAC adjustment amount (see instructions)		0	70.99
71.00	Amount due provider (line 67 minus lines 68 plus/minus lines 69 & 70)		11,630,997	71.00
71.01	Sequestration adjustment (see instructions)		76,765	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		10,386,562	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)		1,167,670	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		301,882	75.00
	TO BE COMPLETED BY CONTRACTOR (lines 90 through 96)			
90.00	Operating outlier amount from Wkst. E, Pt. A, line 2, or sum of 2.03 plus 2.04 (see instructions)		0	90.00
91.00	Capital outlier from Wkst. L, Pt. I, line 2		0	91.00
92.00	Operating outlier reconciliation adjustment amount (see instructions)		0	92.00
93.00	Capital outlier reconciliation adjustment amount (see instructions)		0	93.00
94.00	The rate used to calculate the time value of money (see instructions)		0.00	94.00
95.00	Time value of money for operating expenses (see instructions)		0	95.00
96.00	Time value of money for capital related expenses (see instructions)		0	96.00

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

LOW VOLUME CALCULATION EXHIBIT 4 | Provider CCN: 15-0057 | Period: From 01/01/2020 To 12/31/2020 | Worksheet E Part A Exhibit 4 Date/Time Prepared: 7/28/2021 12:22 pm

Title XVIII | Hospital | PPS

		W/S E, Part A line	Amounts (from E, Part A)	Pre/Post Entitlement	Period Prior to 10/01	Period On/After 10/01	Total (Col 2 through 4)	
		0	1.00	2.00	3.00	4.00	5.00	
1.00	DRG amounts other than outlier payments	1.00	0	0	0	0	0	1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1	1.01	5,814,942	0	5,814,942		5,814,942	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	2,630,317	0		2,630,317	2,630,317	1.02
1.03	DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October 1	1.03	0	0	0		0	1.03
1.04	DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1	1.04	0	0		0	0	1.04
2.00	Outlier payments for discharges (see instructions)	2.00						2.00
2.01	Outlier payments for discharges for Model 4 BPCI	2.02	0	0	0	0	0	2.01
2.02	Outlier payments for discharges occurring prior to October 1 (see instructions)	2.03	10,349	0	10,349		10,349	2.02
2.03	Outlier payments for discharges occurring on or after October 1 (see instructions)	2.04	9,585	0		9,585	9,585	2.03
3.00	Operating outlier reconciliation	2.01	0	0	0	0	0	3.00
4.00	Managed care simulated payments	3.00	4,626,513	0	3,181,220	1,445,293	4,626,513	4.00
	Indirect Medical Education Adjustment							
5.00	Amount from Worksheet E, Part A, line 21 (see instructions)	21.00	0.000105	0.000105	0.000105	0.000105		5.00
6.00	IME payment adjustment (see instructions)	22.00	490	0	337	153	490	6.00
6.01	IME payment adjustment for managed care (see instructions)	22.01	268	0	184	84	268	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	0.000000		7.00
8.00	IME adjustment (see instructions)	28.00	0	0	0	0	0	8.00
8.01	IME payment adjustment add on for managed care (see instructions)	28.01	0	0	0	0	0	8.01
9.00	Total IME payment (sum of lines 6 and 8)	29.00	490	0	337	153	490	9.00
9.01	Total IME payment for managed care (sum of lines 6.01 and 8.01)	29.01	268	0	184	84	268	9.01
	Disproportionate Share Adjustment							
10.00	Allowable disproportionate share percentage (see instructions)	33.00	0.0750	0.0750	0.0750	0.0750		10.00
11.00	Disproportionate share adjustment (see instructions)	34.00	158,349	0	109,030	49,319	158,349	11.00
11.01	Uncompensated care payments	36.00	2,071,199	0	1,433,472	637,727	2,071,199	11.01
	Additional payment for high percentage of ESRD beneficiary discharges							
12.00	Total ESRD additional payment (see instructions)	46.00	0	0	0	0	0	12.00
13.00	Subtotal (see instructions)	47.00	10,695,231	0	7,368,130	3,327,101	10,695,231	13.00
14.00	Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see instructions)	48.00	0	0	0	0	0	14.00
15.00	Total payment for inpatient operating costs (see instructions)	49.00	10,695,499	0	7,368,314	3,327,185	10,695,499	15.00
16.00	Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable)	50.00	658,708	0	493,131	165,577	658,708	16.00

LOW VOLUME CALCULATION EXHIBIT 4 | Provider CCN: 15-0057 | Period: From 01/01/2020 To 12/31/2020 | Worksheet E Part A Exhibit 4 Date/Time Prepared: 7/28/2021 12:22 pm

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		W/S E, Part A line	Amounts (from E, Part A)	Pre/Post Entitlement	Period Prior to 10/01	Period On/After 10/01	Total (Col 2 through 4)	
		0	1.00	2.00	3.00	4.00	5.00	
17.00	Special add-on payments for new technologies	54.00	28,009	0	0	28,009	28,009	17.00
17.01	Net organ aquisition cost							17.01
17.02	Credits received from manufacturers for replaced devices for applicable MS-DRGs	68.00	0	0	0	0	0	17.02
18.00	Capital outlier reconciliation adjustment amount (see instructions)	93.00	0	0	0	0	0	18.00
19.00	SUBTOTAL			0	7,861,445	3,520,771	11,382,216	19.00
		W/S L, line	(Amounts from L)					
		0	1.00	2.00	3.00	4.00	5.00	
20.00	Capital DRG other than outlier	1.00	656,064	0	491,152	164,912	656,064	20.00
20.01	Model 4 BPCI Capital DRG other than outlier	1.01	0	0	0	0	0	20.01
21.00	Capital DRG outlier payments	2.00	2,513	0	1,881	632	2,513	21.00
21.01	Model 4 BPCI Capital DRG outlier payments	2.01	0	0	0	0	0	21.01
22.00	Indirect medical education percentage (see instructions)	5.00	0.0002	0.0002	0.0002	0.0002		22.00
23.00	Indirect medical education adjustment (see instructions)	6.00	131	0	98	33	131	23.00
24.00	Allowable disproportionate share percentage (see instructions)	10.00	0.0000	0.0000	0.0000	0.0000		24.00
25.00	Disproportionate share adjustment (see instructions)	11.00	0	0	0	0	0	25.00
26.00	Total prospective capital payments (see instructions)	12.00	658,708	0	493,131	165,577	658,708	26.00
		W/S E, Part A line	(Amounts to E, Part A)					
		0	1.00	2.00	3.00	4.00	5.00	
27.00	Low volume adjustment factor				0.091591	0.091591		27.00
28.00	Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)	70.96			720,038		720,038	28.00
29.00	Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)	70.97				322,471	322,471	29.00
100.00	Transfer low volume adjustments to Wkst. E, Pt. A.		Y					100.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0057	Period: From 01/01/2020 To 12/31/2020	Worksheet E Part B Date/Time Prepared: 7/28/2021 12:22 pm
	Title XVIII	Hospital	PPS

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	6,401	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)	16,030,380	2.00
3.00	OPPS payments	12,806,076	3.00
4.00	Outlier payment (see instructions)	5,463	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)	6,401	11.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
12.00	Ancillary service charges	32,909	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)	32,909	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)	32,909	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)	26,508	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)	6,401	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)	12,811,539	24.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
25.00	Deductibles and coinsurance amounts (for CAH, see instructions)	345	25.00
26.00	Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)	2,162,056	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)	10,655,539	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)	10,655,539	30.00
31.00	Primary payer payments	523	31.00
32.00	Subtotal (line 30 minus line 31)	10,655,016	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)	256,602	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	166,791	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	107,886	36.00
37.00	Subtotal (see instructions)	10,821,807	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)	10,821,807	40.00
40.01	Sequestration adjustment (see instructions)	71,424	40.01
40.02	Demonstration payment adjustment amount after sequestration	0	40.02
40.03	Sequestration adjustment-PARHM pass-throughs		40.03
41.00	Interim payments	10,756,584	41.00
41.01	Interim payments-PARHM		41.01
42.00	Tentative settlement (for contractors use only)	0	42.00
42.01	Tentative settlement-PARHM (for contractor use only)		42.01
43.00	Balance due provider/program (see instructions)	-6,201	43.00
43.01	Balance due provider/program-PARHM (see instructions)		43.01
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	44.00
	TO BE COMPLETED BY CONTRACTOR		
90.00	Original outlier amount (see instructions)	0	90.00
91.00	Outlier reconciliation adjustment amount (see instructions)	0	91.00
92.00	The rate used to calculate the Time Value of Money	0.00	92.00
93.00	Time Value of Money (see instructions)	0	93.00
94.00	Total (sum of lines 91 and 93)	0	94.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 15-0057 | Period: From 01/01/2020 To 12/31/2020 | Worksheet E-1 Part I | Date/Time Prepared: 7/28/2021 12:22 pm

Title XVIII | Hospital | PPS

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		10,386,562		10,756,584	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)		10,386,562		10,756,584	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		1,167,670		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		6,201	6.02
7.00	Total Medicare program liability (see instructions)		11,554,232		10,750,383	7.00

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

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT	Provider CCN: 15-0057	Period: From 01/01/2020 To 12/31/2020	Worksheet E-1 Part II Date/Time Prepared: 7/28/2021 12:22 pm
	Title XVIII	Hospital	PPS

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

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0057	Period: From 01/01/2020 To 12/31/2020	Worksheet E-3 Part VII Date/Time Prepared: 7/28/2021 12:22 pm
	Title XIX	Hospital	PPS

		Inpatient	Outpatient	
		1.00	2.00	
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR XIX SERVICES			
	COMPUTATION OF NET COST OF COVERED SERVICES			
1.00	Inpatient hospital/SNF/NF services	0		1.00
2.00	Medical and other services		567,878	2.00
3.00	Organ acquisition (certified transplant centers only)	0		3.00
4.00	Subtotal (sum of lines 1, 2 and 3)	0	567,878	4.00
5.00	Inpatient primary payer payments	0		5.00
6.00	Outpatient primary payer payments		0	6.00
7.00	Subtotal (line 4 less sum of lines 5 and 6)	0	567,878	7.00
	COMPUTATION OF LESSER OF COST OR CHARGES			
	Reasonable Charges			
8.00	Routine service charges	0		8.00
9.00	Ancillary service charges	1,049,939	4,797,967	9.00
10.00	Organ acquisition charges, net of revenue	0		10.00
11.00	Incentive from target amount computation	0		11.00
12.00	Total reasonable charges (sum of lines 8 through 11)	1,049,939	4,797,967	12.00
	CUSTOMARY CHARGES			
13.00	Amount actually collected from patients liable for payment for services on a charge basis	0	0	13.00
14.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)	0	0	14.00
15.00	Ratio of line 13 to line 14 (not to exceed 1.000000)	0.000000	0.000000	15.00
16.00	Total customary charges (see instructions)	1,049,939	4,797,967	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)	1,049,939	4,230,089	17.00
18.00	Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 16) (see instructions)	0	0	18.00
19.00	Interns and Residents (see instructions)	0	0	19.00
20.00	Cost of physicians' services in a teaching hospital (see instructions)	0	0	20.00
21.00	Cost of covered services (enter the lesser of line 4 or line 16)	0	567,878	21.00
	PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be completed for PPS providers.			
22.00	Other than outlier payments	0	0	22.00
23.00	Outlier payments	0	0	23.00
24.00	Program capital payments	0		24.00
25.00	Capital exception payments (see instructions)	0		25.00
26.00	Routine and Ancillary service other pass through costs	0	0	26.00
27.00	Subtotal (sum of lines 22 through 26)	0	0	27.00
28.00	Customary charges (title V or XIX PPS covered services only)	0	0	28.00
29.00	Titles V or XIX (sum of lines 21 and 27)	0	567,878	29.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT			
30.00	Excess of reasonable cost (from line 18)	0	0	30.00
31.00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)	0	567,878	31.00
32.00	Deductibles	0	0	32.00
33.00	Coinsurance	0	0	33.00
34.00	Allowable bad debts (see instructions)	0	0	34.00
35.00	Utilization review	0		35.00
36.00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)	0	567,878	36.00
37.00	TO ZERO OUT MEDICAID	0	-567,878	37.00
38.00	Subtotal (line 36 ± line 37)	0	0	38.00
39.00	Direct graduate medical education payments (from Wkst. E-4)	0		39.00
40.00	Total amount payable to the provider (sum of lines 38 and 39)	0	0	40.00
41.00	Interim payments	0	0	41.00
42.00	Balance due provider/program (line 40 minus line 41)	0	0	42.00
43.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, chapter 1, §115.2	0	0	43.00

BALANCE SHEET (If you are nonproprietary and do not maintain fund-type accounting records, complete the General Fund column only) | Provider CCN: 15-0057 | Period: From 01/01/2020 To 12/31/2020 | Worksheet G | Date/Time Prepared: 7/28/2021 12:22 pm

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
	CURRENT ASSETS					
1.00	Cash on hand in banks	-22,901	0	0	0	1.00
2.00	Temporary investments	14,519,384	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	25,741,379	0	0	0	4.00
5.00	Other receivable	0	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-5,954,726	0	0	0	6.00
7.00	Inventory	1,276,710	0	0	0	7.00
8.00	Prepaid expenses	931,186	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)	36,491,032	0	0	0	11.00
	FIXED ASSETS					
12.00	Land	0	0	0	0	12.00
13.00	Land improvements	2,639,290	0	0	0	13.00
14.00	Accumulated depreciation	-1,666,471	0	0	0	14.00
15.00	Buildings	63,285,635	0	0	0	15.00
16.00	Accumulated depreciation	-26,943,852	0	0	0	16.00
17.00	Leasehold improvements	2,174,884	0	0	0	17.00
18.00	Accumulated depreciation	-1,666,072	0	0	0	18.00
19.00	Fixed equipment	0	0	0	0	19.00
20.00	Accumulated depreciation	-16,679,174	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	76,370,106	0	0	0	23.00
24.00	Accumulated depreciation	-21,807,507	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)	75,706,839	0	0	0	30.00
	OTHER ASSETS					
31.00	Investments	2,153,665	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	0	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	2,153,665	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	114,351,536	0	0	0	36.00
	CURRENT LIABILITIES					
37.00	Accounts payable	5,710,288	0	0	0	37.00
38.00	Salaries, wages, and fees payable	3,073,763	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	0	0	0	0	40.00
41.00	Deferred income	0	0	0	0	41.00
42.00	Accelerated payments	0				42.00
43.00	Due to other funds	16,786,015	0	0	0	43.00
44.00	Other current liabilities	-3,018,117	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	22,551,949	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	-3,481,272	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	-3,481,272	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	19,070,677	0	0	0	51.00
	CAPITAL ACCOUNTS					
52.00	General fund balance	95,280,859				52.00
53.00	Specific purpose fund		0			53.00
54.00	Donor created - endowment fund balance - restricted			0		54.00
55.00	Donor created - endowment fund balance - unrestricted			0		55.00
56.00	Governing body created - endowment fund balance			0		56.00
57.00	Plant fund balance - invested in plant				0	57.00
58.00	Plant fund balance - reserve for plant improvement, replacement, and expansion				0	58.00
59.00	Total fund balances (sum of lines 52 thru 58)	95,280,859	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	114,351,536	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES | Provider CCN: 15-0057 | Period: From 01/01/2020 To 12/31/2020 | Worksheet G-1 | Date/Time Prepared: 7/28/2021 12:22 pm

		General Fund		Special Purpose Fund		Endowment Fund	
		1.00	2.00	3.00	4.00	5.00	
1.00	Fund balances at beginning of period		90,666,498		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		56,369,504				2.00
3.00	Total (sum of line 1 and line 2)		147,036,002		0		3.00
4.00	Additions (credit adjustments) (specify)	0		0		0	4.00
5.00		0		0		0	5.00
6.00		0		0		0	6.00
7.00		0		0		0	7.00
8.00		0		0		0	8.00
9.00		0		0		0	9.00
10.00	Total additions (sum of line 4-9)		0		0		10.00
11.00	Subtotal (line 3 plus line 10)		147,036,002		0		11.00
12.00	FUND EQUITY CHANGES	51,725,143		0		0	12.00
13.00		0		0		0	13.00
14.00		0		0		0	14.00
15.00		0		0		0	15.00
16.00		0		0		0	16.00
17.00		0		0		0	17.00
18.00	Total deductions (sum of lines 12-17)		51,725,143		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		95,310,859		0		19.00

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

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES | Provider CCN: 15-0057 | Period: From 01/01/2020 To 12/31/2020 | Worksheet G-2 Parts I & II | Date/Time Prepared: 7/28/2021 12:22 pm

	Cost Center Description	Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospital	12,588,550		12,588,550	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	0		0	5.00
6.00	Swing bed - NF	0		0	6.00
7.00	SKILLED NURSING FACILITY				7.00
8.00	NURSING FACILITY				8.00
9.00	OTHER LONG TERM CARE				9.00
10.00	Total general inpatient care services (sum of lines 1-9)	12,588,550		12,588,550	10.00
	Intensive Care Type Inpatient Hospital Services				
11.00	INTENSIVE CARE UNIT				11.00
12.00	CORONARY CARE UNIT				12.00
13.00	BURN INTENSIVE CARE UNIT				13.00
14.00	SURGICAL INTENSIVE CARE UNIT	3,984,892		3,984,892	14.00
15.00	OTHER SPECIAL CARE (SPECIFY)				15.00
16.00	Total intensive care type inpatient hospital services (sum of lines 11-15)	3,984,892		3,984,892	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	16,573,442		16,573,442	17.00
18.00	Ancillary services	92,152,510	291,563,569	383,716,079	18.00
19.00	Outpatient services	10,935,417	86,714,494	97,649,911	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	OTHER REVENUE	14,233	27,071,156	27,085,389	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	119,675,602	405,349,219	525,024,821	28.00
	PART II - OPERATING EXPENSES				
29.00	Operating expenses (per Wkst. A, column 3, line 200)		91,437,560		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)		91,437,560		43.00

STATEMENT OF REVENUES AND EXPENSES | Provider CCN: 15-0057 | Period: From 01/01/2020 To 12/31/2020 | Worksheet G-3 | Date/Time Prepared: 7/28/2021 12:22 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	525,024,821	1.00
2.00	Less contractual allowances and discounts on patients' accounts	384,948,469	2.00
3.00	Net patient revenues (line 1 minus line 2)	140,076,352	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	91,437,560	4.00
5.00	Net income from service to patients (line 3 minus line 4)	48,638,792	5.00
	OTHER INCOME		
6.00	Contributions, donations, bequests, etc	632	6.00
7.00	Income from investments	0	7.00
8.00	Revenues from telephone and other miscellaneous communication services	0	8.00
9.00	Revenue from television and radio service	0	9.00
10.00	Purchase discounts	616,304	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	196,986	14.00
15.00	Revenue from rental of living quarters	0	15.00
16.00	Revenue from sale of medical and surgical supplies to other than patients	0	16.00
17.00	Revenue from sale of drugs to other than patients	0	17.00
18.00	Revenue from sale of medical records and abstracts	0	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	82,857	20.00
21.00	Rental of vending machines	916	21.00
22.00	Rental of hospital space	1,291,728	22.00
23.00	Governmental appropriations	0	23.00
24.00	OTHER OPERATING REVENUE	5,541,289	24.00
24.50	COVID-19 PHE Funding	0	24.50
25.00	Total other income (sum of lines 6-24)	7,730,712	25.00
26.00	Total (line 5 plus line 25)	56,369,504	26.00
27.00	OTHER EXPENSES (SPECIFY)	0	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	0	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	56,369,504	29.00

CALCULATION OF CAPITAL PAYMENT	Provider CCN: 15-0057	Period: From 01/01/2020 To 12/31/2020	Worksheet L Parts I-III Date/Time Prepared: 7/28/2021 12:22 pm
	Title XVIII	Hospital	PPS

		1.00	
	PART I - FULLY PROSPECTIVE METHOD		
	CAPITAL FEDERAL AMOUNT		
1.00	Capital DRG other than outlier	656,064	1.00
1.01	Model 4 BPCI Capital DRG other than outlier	0	1.01
2.00	Capital DRG outlier payments	2,513	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)	17.53	3.00
4.00	Number of interns & residents (see instructions)	0.01	4.00
5.00	Indirect medical education percentage (see instructions)	0.02	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)	131	6.00
7.00	Percentage of SSI recipient patient days to Medicare Part A patient days (Worksheet E, part A line 30) (see instructions)	0.00	7.00
8.00	Percentage of Medicaid patient days to total days (see instructions)	0.00	8.00
9.00	Sum of lines 7 and 8	0.00	9.00
10.00	Allowable disproportionate share percentage (see instructions)	0.00	10.00
11.00	Disproportionate share adjustment (see instructions)	0	11.00
12.00	Total prospective capital payments (see instructions)	658,708	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