

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: 15-0011	Period: From 07/01/2019 To 06/30/2020	Worksheet S Parts I-III Date/Time Prepared: 11/20/2020 1:17 pm
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PART I - COST REPORT STATUS

Provider use only
 1. Electronically prepared cost report
 2. Manually prepared cost report
 3. If this is an amended report enter the number of times the provider resubmitted this cost report
 4. Medicare Utilization. Enter "F" for Full or "L" for Low.

Contractor use only
 5. Cost Report Status
 (1) As Submitted
 (2) Settled without Audit
 (3) Settled with Audit
 (4) Reopened
 (5) Amended

6. Date Received:
7. Contractor No.
8. Initial Report for this Provider CCN
9. Final Report for this Provider CCN

10. NPR Date:
11. Contractor's Vendor Code: 4
12. If line 5, column 1 is 4: Enter number of times reopened = 0-9.

Date: 11/20/2020 Time: 1:17 pm

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 MARION GENERAL HOSPITAL (15-0011) for the cost reporting period beginning 07/01/2019 and ending 06/30/2020 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

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

(Signed) TONY ROBERTS
Officer or Administrator of Provider(s)

CFO
Title

(Dated when report is electronically signed.)
Date

Cost Center Description	Title V	Title XVIII		HIT	Title XIX	
		Part A	Part B			
	1.00	2.00	3.00	4.00	5.00	
PART III - SETTLEMENT SUMMARY						
1.00 Hospital	0	398,899	-116,711	0	-881,688	1.00
2.00 Subprovider - IPF	0	0	0		0	2.00
3.00 Subprovider - IRF	0	20,113	0		10,336	3.00
4.00 SUBPROVIDER I						4.00
5.00 Swing Bed - SNF	0	0	0		0	5.00
6.00 Swing Bed - NF	0				0	6.00
200.00 Total	0	419,012	-116,711	0	-871,352	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: 15-0011		Period: From 07/01/2019 To 06/30/2020		Worksheet S-2 Part I Date/Time Prepared: 11/20/2020 1:17 pm					
1.00		2.00		3.00		4.00					
Hospital and Hospital Health Care Complex Address:											
1.00	Street: 441 WABASH AVENUE			PO Box:						1.00	
2.00	City: MARION			State: IN		Zip Code: 46952-		County: GRANT		2.00	
		Component Name		CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N)			
		1.00		2.00	3.00	4.00	5.00	6.00	7.00	8.00	
								V	XVIII	XIX	
Hospital and Hospital-Based Component Identification:											
3.00	Hospital		MARION GENERAL HOSPITAL	150011	99915	1	07/01/1966	N	P	0	3.00
4.00	Subprovider - IPF										4.00
5.00	Subprovider - IRF		MARION GENERAL HOSPITAL	15T011	99915	5	07/01/2005	N	P	0	5.00
6.00	Subprovider - (Other)		REHAB								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)						07/01/2019	06/30/2020		20.00	
21.00	Type of Control (see instructions)						2			21.00	
							1.00	2.00	3.00		
Inpatient PPS Information											
22.00	Does this facility qualify and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.106(c)(2) (Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no.					Y	N			22.00	
22.01	Did this hospital receive interim uncompensated care payments for this cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)					N	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 days	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.			577	491	0	0	3,419	0	24.00	

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 15-0011			Period: From 07/01/2019 To 06/30/2020		Worksheet S-2 Part I Date/Time Prepared: 11/20/2020 1:17 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.	11	24	0	0	123		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.					2		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.					2		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.					1		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.					07/01/2019	06/30/2020	36.00	
37.00	If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status is in effect in the cost reporting period.					0		37.00	
37.01	Is this hospital a former MDH that is eligible for the MDH transitional payment in accordance with FY 2016 OPPS final rule? Enter "Y" for yes or "N" for no. (see instructions)							37.01	
38.00	If line 37 is 1, enter the beginning and ending dates of MDH status. If line 37 is greater than 1, subscript this line for the number of periods in excess of one and enter subsequent dates.							38.00	
						Y/N	Y/N		
						1.00	2.00		
39.00	Does this facility qualify for the inpatient hospital payment adjustment for low volume hospitals in accordance with 42 CFR 412.101(b)(2)(i), (ii), or (iii)? Enter in column 1 "Y" for yes or "N" for no. Does the facility meet the mileage requirements in accordance with 42 CFR 412.101(b)(2)(i), (ii), or (iii)? Enter in column 2 "Y" for yes or "N" for no. (see instructions)					N	N	39.00	
40.00	Is this hospital subject to the HAC program reduction adjustment? Enter "Y" for yes or "N" for no in column 1, for discharges prior to October 1. Enter "Y" for yes or "N" for no in column 2, for discharges on or after October 1. (see instructions)					Y	Y	40.00	
						V	XVII	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			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.								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 Criteria on Code			
				1.00	2.00	3.00			
60.00	Are you claiming nursing and allied health education (NAHE) costs for any programs that meet the criteria under 42 CFR 413.85? (see instructions) Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", are you impacted by CR 11642 (or subsequent CR) NAHE MA payment adjustment? Enter "Y" for yes or "N" for no in column 2.			N				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)							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)						0.00	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)						0.00	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	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	61.20
						1.00		
62.00	ACA Provisions Affecting the Health Resources and Services Administration (HRSA) 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
63.00	Teaching Hospitals that Claim Residents in Nonprovider Settings Has your facility trained residents in nonprovider settings during this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If yes, complete lines 64 through 67. (see instructions)						N	63.00
			Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))			
			1.00	2.00	3.00			
64.00	Section 5504 of the ACA Base Year FTE Residents in Nonprovider Settings--This base year is your cost reporting period that begins on or after July 1, 2009 and before June 30, 2010. Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)						0.00	64.00
			0.00	0.00	0.000000			

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	Program Name	Program Code	Unwei ghted FTEs Nonprovi der Si te	Unwei ghted FTEs in Hospi tal	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	
			Unwei ghted FTEs Nonprovi der Si te	Unwei ghted FTEs in Hospi tal	Ratio (col . 1/ (col . 1 + col . 2))		
			1.00	2.00	3.00		
66.00	Section 5504 of the ACA Current Year FTE Residents in Nonprovider Settings--Effective for cost reporting periods beginning on or after July 1, 2010		0.00	0.00	0.000000	66.00	
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	Unwei ghted FTEs Nonprovi der Si te	Unwei ghted FTEs in Hospi tal	Ratio (col . 3/ (col . 3 + col . 4))		
	1.00	2.00	3.00	4.00	5.00		
67.00	Enter in column 1, the program name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)		0.00	0.00	0.000000	67.00	
					1.00	2.00	3.00
70.00	Inpatient Psychiatric Facility PPS 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
					1.00	2.00	3.00
75.00	Inpatient Rehabilitation Facility PPS Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF subprovider? Enter "Y" for yes and "N" for no.			Y			75.00

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 15-0011		Period: From 07/01/2019 To 06/30/2020		Worksheet S-2 Part I Date/Time Prepared: 11/20/2020 1:17 pm	
		Physical	Occupational	Speech	Respiratory		
		1.00	2.00	3.00	4.00		
109.00	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.	N	N	N	N	109.00	
						1.00	
110.00	Did this hospital participate in the Rural Community Hospital Demonstration project (\$410A Demonstration) for the current cost reporting period? Enter "Y" for yes or "N" for no. If yes, complete Worksheet E, Part A, lines 200 through 218, and Worksheet E-2, lines 200 through 215, as applicable.	N				110.00	
						1.00	2.00
111.00	If this facility qualifies as a CAH, did it participate in the Frontier Community Health Integration Project (FCHIP) demonstration for this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If the response to column 1 is Y, enter the integration prong of the FCHIP demo in which this CAH is participating in column 2. Enter all that apply: "A" for Ambulance services; "B" for additional beds; and/or "C" for tele-health services.	N				111.00	
						1.00	2.00
112.00	Did this hospital participate in the Pennsylvania Rural Health Model demonstration for any portion of the current cost reporting period? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2, the date the hospital began participating in the demonstration. In column 3, enter the date the hospital ceased participation in the demonstration, if applicable.	N				112.00	
Miscellaneous Cost Reporting Information							
115.00	Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in column 1. If column 1 is yes, enter the method used (A, B, or E only) in column 2. If column 2 is "E", enter in column 3 either "93" percent for short term hospital or "98" percent for long term care (includes psychiatric, rehabilitation and long term hospitals providers) based on the definition in CMS Pub.15-1, chapter 22, §2208.1.	N				115.00	
116.00	Is this facility classified as a referral center? Enter "Y" for yes or "N" for no.	Y				116.00	
117.00	Is this facility legally-required to carry malpractice insurance? Enter "Y" for yes or "N" for no.	Y				117.00	
118.00	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.	1				118.00	
		Premiums	Losses	Insurance			
		1.00	2.00	3.00			
118.01	List amounts of malpractice premiums and paid losses:	1,414,149		0	0	118.01	
						1.00	2.00
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein.	N				118.02	
119.00	DO NOT USE THIS LINE					119.00	
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 1, "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2, "Y" for yes or "N" for no.	N N				120.00	
121.00	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter "Y" for yes or "N" for no.	N				121.00	
122.00	Does the cost report contain healthcare related taxes as defined in §1903(w)(3) of the Act? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2 the Worksheet A line number where these taxes are included.	N				122.00	
Transplant Center Information							
125.00	Does this facility operate a transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.	N				125.00	
126.00	If this is a Medicare certified kidney transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					126.00	
127.00	If this is a Medicare certified heart transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					127.00	
128.00	If this is a Medicare certified liver transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					128.00	
129.00	If this is a Medicare certified lung transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					129.00	
130.00	If this is a Medicare certified pancreas transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					130.00	
131.00	If this is a Medicare certified intestinal transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					131.00	

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 15-0011		Period: From 07/01/2019 To 06/30/2020		Worksheet S-2 Part I Date/Time Prepared: 11/20/2020 1:17 pm	
		1.00	2.00				
132.00	If this is a Medicare certified islet transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.						132.00
133.00	Removed and reserved						133.00
134.00	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.						134.00
All Providers							
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)	N				140.00	
		1.00	2.00	3.00			
If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number.							
141.00	Name:	Contractor's Name:		Contractor's Number:		141.00	
142.00	Street:	PO Box:		Zip Code:		142.00	
143.00	City:	State:				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	
Multi campus							
165.00	Is this hospital part of a Multi campus hospital that has one or more campuses in different CBSAs? Enter "Y" for yes or "N" for no.			N		165.00	
		Name	County	State	Zip Code	CBSA	FTE/Campus
		0	1.00	2.00	3.00	4.00	5.00
166.00	If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions)						0.00
						1.00	
Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act							
167.00	Is this provider a meaningful user under §1886(n)? Enter "Y" for yes or "N" for no.					Y	
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)					0.00	

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 15-0011	Period: From 07/01/2019 To 06/30/2020	Worksheet S-2 Part I Date/Time Prepared: 11/20/2020 1:17 pm
			Beginning 1.00	Ending 2.00
170.00	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)			170.00
			1.00	2.00
171.00	If line 167 is "Y", does this provider have any days for individuals enrolled in section 1876 Medicare cost plans reported on Wkst. S-3, Pt. 1, line 2, col. 6? Enter "Y" for yes and "N" for no in column 1. If column 1 is yes, enter the number of section 1876 Medicare days in column 2. (see instructions)		N	0171.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 15-0011	Period: From 07/01/2019 To 06/30/2020	Worksheet S-2 Part II Date/Time Prepared: 11/20/2020 1:17 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		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.			Y	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		
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	09/29/2020	Y	09/29/2020	
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N		N		
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		N		

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 15-0011	Period: From 07/01/2019 To 06/30/2020	Worksheet S-2 Part II Date/Time Prepared: 11/20/2020 1:17 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 relieved for Medicare purposes? If yes, see instructions				22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.				23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions				24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.				25.00
26.00	Were assets subject to Sec. 2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.				26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.				27.00
Interest Expense					
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.				28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions				29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.				30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.				31.00
Purchased Services					
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.				32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.				33.00
Provider-Based Physicians					
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.				34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.				35.00
			Y/N	Date	
			1.00	2.00	
Home Office Costs					
36.00	Were home office costs claimed on the cost report?				36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.				37.00
38.00	If line 36 is yes, was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.				38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.				39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.				40.00
		1.00	2.00		
Cost Report Preparer Contact Information					
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	TINA		SEVERS	41.00
42.00	Enter the employer/company name of the cost report preparer.	BLUE AND CO., LLC			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	317-713-7946		TSEVERS@BLUEANDCO.COM	43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 15-0011	Period: From 07/01/2019 To 06/30/2020	Worksheet S-2 Part II Date/Time Prepared: 11/20/2020 1:17 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		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: 15-0011

Period:
From 07/01/2019
To 06/30/2020

Worksheet S-3
Part I
Date/Time Prepared:
11/20/2020 1:17 pm

Component	Worksheet A Line Number	No. of Beds	Bed Days Avai lable	CAH Hours	I/P Days / O/P Vi s i t s / Tri ps	
					Ti tle 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	87	31,842	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)		87	31,842	0.00	0	7.00
8.00 INTENSIVE CARE UNIT	31.00	26	9,516	0.00	0	8.00
9.00 CORONARY CARE UNIT						9.00
10.00 BURN INTENSIVE CARE UNIT						10.00
11.00 SURGICAL INTENSIVE CARE UNIT						11.00
12.00 OTHER SPECIAL CARE (SPECIFY)						12.00
13.00 NURSERY					0	13.00
14.00 Total (see instructions)		113	41,358	0.00	0	14.00
15.00 CAH visits					0	15.00
16.00 SUBPROVIDER - IPF	40.00	0	0		0	16.00
17.00 SUBPROVIDER - IRF	41.00	18	6,588		0	17.00
18.00 SUBPROVIDER	42.00	0	0		0	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)		131				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: 15-0011

Period:
From 07/01/2019
To 06/30/2020

Worksheet S-3
Part I
Date/Time Prepared:
11/20/2020 1:17 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)	4,589	577	11,311			1.00
2.00 HMO and other (see instructions)	3,261	3,910				2.00
3.00 HMO IPF Subprovider	0	0				3.00
4.00 HMO IRF Subprovider	177	147				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)	4,589	577	11,311			7.00
8.00 INTENSIVE CARE UNIT	851	0	3,206			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		0	1,616			13.00
14.00 Total (see instructions)	5,440	577	16,133	0.00	909.53	14.00
15.00 CAH visits	0	0	0			15.00
16.00 SUBPROVIDER - IPF	0	0	0	0.00	0.00	16.00
17.00 SUBPROVIDER - IRF	2,062	11	2,665	0.00	15.67	17.00
18.00 SUBPROVIDER		0	0	0.00	0.00	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)			159			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	925.20	27.00
28.00 Observation Bed Days		757	3,252			28.00
29.00 Ambulance Trips	1,244					29.00
30.00 Employee discount days (see instruction)			154			30.00
31.00 Employee discount days - IRF			0			31.00
32.00 Labor & delivery days (see instructions)	0	0	0			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: 15-0011

Period:
From 07/01/2019
To 06/30/2020

Worksheet S-3
Part I
Date/Time Prepared:
11/20/2020 1:17 pm

Component	Full Time Equivalents	Discharges			Total All Patients		
		Nonpaid Workers	Title V	Title XVIII			Title XIX
		11.00	12.00	13.00			14.00
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	1,511	146	4,387	1.00
2.00 HMO and other (see instructions)				764	1,133		2.00
3.00 HMO IPF Subprovider					0		3.00
4.00 HMO IRF Subprovider					13		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		1,511	146	4,387	14.00
15.00 CAH visits							15.00
16.00 SUBPROVIDER - IPF	0.00	0		0	0	0	16.00
17.00 SUBPROVIDER - IRF	0.00	0		204	1	263	17.00
18.00 SUBPROVIDER	0.00	0			0	0	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: 15-0011

Period:
From 07/01/2019
To 06/30/2020

Worksheet S-3
Part II
Date/Time Prepared:
11/20/2020 1:17 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	51,467,378	21,999,917	73,467,295	2,162,990.00	33.97
2.00	Non-physician anesthetist Part A		0	0	0	0.00	0.00
3.00	Non-physician anesthetist Part B		0	0	0	0.00	0.00
4.00	Physician-Part A - Administrative		557,125	0	557,125	3,136.00	177.65
4.01	Physicians - Part A - Teaching		0	0	0	0.00	0.00
5.00	Physician and Non-Physician-Part B		0	0	0	0.00	0.00
6.00	Non-physician-Part B for hospital-based RHC and FQHC services		0	0	0	0.00	0.00
7.00	Interns & residents (in an approved program)	21.00	0	0	0	0.00	0.00
7.01	Contracted interns and residents (in an approved programs)		0	0	0	0.00	0.00
8.00	Home office and/or related organization personnel		0	0	0	0.00	0.00
9.00	SNF	44.00	0	0	0	0.00	0.00
10.00	Excluded area salaries (see instructions)		9,587,957	14,194,999	23,782,956	661,226.00	35.97
OTHER WAGES & RELATED COSTS							
11.00	Contract Labor: Direct Patient Care		5,109,998	0	5,109,998	96,510.00	52.95
12.00	Contract Labor: Top level management and other management and administrative services		0	0	0	0.00	0.00
13.00	Contract Labor: Physician-Part A - Administrative		191,363	0	191,363	1,132.00	169.05
14.00	Home office and/or related organization salaries and wage-related costs		0	0	0	0.00	0.00
14.01	Home office salaries		0	0	0	0.00	0.00
14.02	Related organization salaries		0	0	0	0.00	0.00
15.00	Home office: Physician Part A - Administrative		0	0	0	0.00	0.00
16.00	Home office and Contract Physicians Part A - Teaching		0	0	0	0.00	0.00
16.01	Home office Physicians Part A - Teaching		0	0	0	0.00	0.00
16.02	Home office contract Physicians Part A - Teaching		0	0	0	0.00	0.00
WAGE-RELATED COSTS							
17.00	Wage-related costs (core) (see instructions)		14,163,506	0	14,163,506		
18.00	Wage-related costs (other) (see instructions)						
19.00	Excluded areas		7,449,459	0	7,449,459		
20.00	Non-physician anesthetist Part A		0	0	0		
21.00	Non-physician anesthetist Part B		0	0	0		
22.00	Physician Part A - Administrative		114,423	0	114,423		
22.01	Physician Part A - Teaching		0	0	0		
23.00	Physician Part B		0	0	0		
24.00	Wage-related costs (RHC/FQHC)		0	0	0		
25.00	Interns & residents (in an approved program)		0	0	0		
25.50	Home office wage-related (core)		0	0	0		
25.51	Related organization wage-related (core)		0	0	0		
25.52	Home office: Physician Part A - Administrative - wage-related (core)		0	0	0		

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 15-0011

Period:
From 07/01/2019
To 06/30/2020

Worksheet S-3
Part II
Date/Time Prepared:
11/20/2020 1:17 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	1,009,337	39,567	1,048,904	31,444.00	33.36	26.00
27.00	Administrative & General	11,270,831	3,539,155	14,809,986	374,029.00	39.60	27.00
28.00	Administrative & General under contract (see inst.)	1,454,245	0	1,454,245	10,866.00	133.83	28.00
29.00	Maintenance & Repairs	0	0	0	0.00	0.00	29.00
30.00	Operation of Plant	769,765	0	769,765	38,279.00	20.11	30.00
31.00	Laundry & Linen Service	0	0	0	0.00	0.00	31.00
32.00	Housekeeping	0	0	0	0.00	0.00	32.00
33.00	Housekeeping under contract (see instructions)	1,292,045	0	1,292,045	99,261.00	13.02	33.00
34.00	Dietary	19,193	0	19,193	314.00	61.12	34.00
35.00	Dietary under contract (see instructions)	307,734	0	307,734	19,922.00	15.45	35.00
36.00	Cafeteria	0	0	0	0.00	0.00	36.00
37.00	Maintenance of Personnel	0	0	0	0.00	0.00	37.00
38.00	Nursing Administration	1,203,959	-365,920	838,039	20,128.00	41.64	38.00
39.00	Central Services and Supply	153,997	7,639	161,636	8,590.00	18.82	39.00
40.00	Pharmacy	2,626,099	0	2,626,099	68,122.00	38.55	40.00
41.00	Medical Records & Medical Records Library	0	0	0	0.00	0.00	41.00
42.00	Social Service	0	0	0	0.00	0.00	42.00
43.00	Other General Service	0	0	0	0.00	0.00	43.00

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 15-0011

Period:
From 07/01/2019
To 06/30/2020

Worksheet S-3
Part III
Date/Time Prepared:
11/20/2020 1:17 pm

	Worksheet A Line Number	Amount Reported	Recl assi fi cat ion of Sal aries (from Worksheet A-6)	Adjusted Sal aries (col . 2 ± col . 3)	Paid Hours Related to Sal aries 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)	54,521,402	21,999,917	76,521,319	2,293,039.00	33.37	1.00
2.00	Excluded area salaries (see instructions)	9,587,957	14,194,999	23,782,956	661,226.00	35.97	2.00
3.00	Subtotal salaries (line 1 minus line 2)	44,933,445	7,804,918	52,738,363	1,631,813.00	32.32	3.00
4.00	Subtotal other wages & related costs (see inst.)	5,301,361	0	5,301,361	97,642.00	54.29	4.00
5.00	Subtotal wage-related costs (see inst.)	14,277,929	0	14,277,929	0.00	27.07	5.00
6.00	Total (sum of lines 3 thru 5)	64,512,735	7,804,918	72,317,653	1,729,455.00	41.82	6.00
7.00	Total overhead cost (see instructions)	20,107,205	3,220,441	23,327,646	670,955.00	34.77	7.00

HOSPITAL WAGE RELATED COSTS	Provider CCN: 15-0011	Period: From 07/01/2019 To 06/30/2020	Worksheet S-3 Part IV Date/Time Prepared: 11/20/2020 1:17 pm
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		Amount Reported	
		1.00	
PART IV - WAGE RELATED COSTS			
Part A - Core List			
RETIREMENT COST			
1.00	401K Employer Contributions	1,318,813	1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution	0	2.00
3.00	Nonqualified Defined Benefit Plan Cost (see instructions)	3,570,571	3.00
4.00	Qualified Defined Benefit Plan Cost (see instructions)	0	4.00
PLAN ADMINISTRATIVE COSTS (Paid to External Organization)			
5.00	401K/TSA Plan Administration fees	0	5.00
6.00	Legal/Accounting/Management Fees-Pension Plan	1,772,907	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)	9,303,514	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	0	10.00
11.00	Life Insurance (If employee is owner or beneficiary)	52,140	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)	354,298	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)	0	14.00
15.00	'Workers' Compensation Insurance	337,762	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	4,741,738	17.00
18.00	Medicare Taxes - Employers Portion Only	0	18.00
19.00	Unemployment Insurance	18,174	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	257,913	23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)	21,727,830	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: 15-0011	Period: From 07/01/2019 To 06/30/2020	Worksheet S-3 Part V Date/Time Prepared: 11/20/2020 1:17 pm
Cost Center Description		Contract Labor	Benefit Cost	
PART V - Contract Labor and Benefit Cost		1.00	2.00	
Hospital and Hospital-Based Component Identification:				
1.00	Total facility's contract labor and benefit cost	5,109,998	21,727,830	1.00
2.00	Hospital	5,109,998	21,727,830	2.00
3.00	Subprovider - IPF	0	0	3.00
4.00	Subprovider - IRF	0	0	4.00
5.00	Subprovider - (Other)	0	0	5.00
6.00	Swing Beds - SNF	0	0	6.00
7.00	Swing Beds - NF	0	0	7.00
8.00	Hospital-Based SNF			8.00
9.00	Hospital-Based NF			9.00
10.00	Hospital-Based OLTC			10.00
11.00	Hospital-Based HHA			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			17.00
18.00	Other	0	0	18.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA		Provider CCN: 15-0011	Period: From 07/01/2019 To 06/30/2020	Worksheet S-10 Date/Time Prepared: 11/20/2020 1:17 pm
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				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)		0.254891		1.00	
Medicaid (see instructions for each line)						
2.00	Net revenue from Medicaid		17,656,746		2.00	
3.00	Did you receive DSH or supplemental payments from Medicaid?				3.00	
4.00	If line 3 is yes, does line 2 include all DSH and/or supplemental payments from Medicaid?				4.00	
5.00	If line 4 is no, then enter DSH and/or supplemental payments from Medicaid		0		5.00	
6.00	Medicaid charges		85,001,555		6.00	
7.00	Medicaid cost (line 1 times line 6)		21,666,131		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)		4,009,385		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)		4,009,385		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)	13,756,688	4,894,920	18,651,608	20.00	
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	3,506,456	4,894,920	8,401,376	21.00	
22.00	Payments received from patients for amounts previously written off as charity care	448	2,831	3,279	22.00	
23.00	Cost of charity care (line 21 minus line 22)	3,506,008	4,892,089	8,398,097	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)			11,507,888	26.00	
27.00	Medicare reimbursable bad debts for the entire hospital complex (see instructions)			488,457	27.00	
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)			751,472	27.01	
28.00	Non-Medicare bad debt expense (see instructions)			10,756,416	28.00	
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)			3,004,729	29.00	
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)			11,402,826	30.00	
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)			15,412,211	31.00	

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 15-0011

Period:
From 07/01/2019
To 06/30/2020

Worksheet A
Date/Time Prepared:
11/20/2020 1:17 pm

Cost Center Description		Salaries	Other	Total (col. 1 + col. 2)	Reclassified (See A-6)	Reclassified Trial Balance (col. 3 +/- col. 4)		
		1.00	2.00	3.00	4.00	5.00		
GENERAL SERVICE COST CENTERS								
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT		13,201,863			1.00	
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	1,009,337	18,351,555	19,360,892	-1,062,234	4.00	
5.00	00500	ADMINISTRATIVE & GENERAL	11,270,831	29,019,117	40,289,948	39,567	5.00	
6.00	00600	MAINTENANCE & REPAIRS	0	0	0	301,152	6.00	
6.01	00601	CAFETERIA	0	0	0	0	6.01	
6.02	00602	CAFETERIA	0	0	0	1,425,589	6.02	
7.00	00700	OPERATION OF PLANT	769,765	4,426,565	5,196,330	0	7.00	
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0	466,569	8.00	
9.00	00900	HOUSEKEEPING	0	2,907,519	2,907,519	294,553	9.00	
10.00	01000	DIETARY	19,193	1,954,161	1,973,354	-285,673	10.00	
13.00	01300	NURSING ADMINISTRATION	1,203,959	70,422	1,274,381	-1,456,958	2,621,846	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	153,997	310,439	464,436	516,396	14.00	
15.00	01500	PHARMACY	2,626,099	11,212,684	13,838,783	-364,354	910,027	15.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	6,590,779	1,316,384	7,907,163	-982,247	6,924,916	30.00
31.00	03100	INTENSIVE CARE UNIT	1,794,784	511,398	2,306,182	-39,567	2,266,615	31.00
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	0	40.00
41.00	04100	SUBPROVIDER - IRF	976,301	857,369	1,833,670	0	1,833,670	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	0	42.00
43.00	04300	NURSERY	0	0	0	1,234,585	1,234,585	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	1,164,752	10,111,400	11,276,152	152,246	11,428,398	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,048,589	2,809,250	5,857,839	-959,524	4,898,315	54.00
57.00	05700	CT SCAN	0	0	0	910,635	910,635	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	480,243	480,243	58.00
59.00	05900	CARDIAC CATHETERIZATION	620,318	1,422,479	2,042,797	28,840	2,071,637	59.00
60.00	06000	LABORATORY	2,287,167	5,838,148	8,125,315	2,993	8,128,308	60.00
60.01	06001	ONCOLOGY	1,016,265	638,328	1,654,593	0	1,654,593	60.01
60.02	06002	RADIATION ONCOLOGY	0	0	0	0	0	60.02
65.00	06500	RESPIRATORY THERAPY	1,404,447	764,876	2,169,323	0	2,169,323	65.00
66.00	06600	PHYSICAL THERAPY	1,843,588	318,167	2,161,755	179	2,161,934	66.00
69.00	06900	ELECTROCARDIOLOGY	772,698	203,901	976,599	70,389	1,046,988	69.00
69.01	06901	CARDIAC REHAB	141,019	30,343	171,362	41,830	213,192	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	10,259,314	10,259,314	73.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	292,774	695,570	988,344	49,065	1,037,409	90.00
91.00	09100	EMERGENCY	3,849,060	7,109,340	10,958,400	-54,826	10,903,574	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	0	0	0	0	0	92.01
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	1,038,293	172,853	1,211,146	26,239	1,237,385	95.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE	0	0	0	0	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	43,894,015	114,254,131	158,148,146	328,444	158,476,590	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	13,172	13,172	28,422	41,594	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
192.01	19201	PACT REV PHYSICIANS	103,646	898,253	1,001,899	-370,001	631,898	192.01
192.02	19202	VISITOR MEALS	0	0	0	0	0	192.02
192.03	19203	GREAT BEGINNINGS/MATERNAL	88,667	4,348	93,015	11,076	104,091	192.03
192.04	19204	LIFELINE	0	0	0	0	0	192.04
192.05	19205	OWNED PROPERTIES	0	1,396,029	1,396,029	-1,060,872	335,157	192.05
192.06	19206	UROLOGY	352,430	911,968	1,264,398	37,059	1,301,457	192.06
192.07	19207	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.07
192.08	19211	PARI SH NURSING	57,507	13,921	71,428	3,428	74,856	192.08
192.09	19212	BIOTERRORISM GRANT	0	0	0	0	0	192.09
192.10	19214	BREAST PUMPS	0	0	0	0	0	192.10
192.11	19208	MGH EMERGENCY PHYSICIANS	0	0	0	0	0	192.11
192.12	19209	LUNG CENTER	128,125	682,670	810,795	25,473	836,268	192.12
192.13	19213	MGH EXPRESS	521,625	748,918	1,270,543	43,943	1,314,486	192.13
192.14	19210	MGH PHYS PRACT MGMT	1,138,540	728,830	1,867,370	37,995	1,905,365	192.14
192.15	19215	MGH MARION SURGEONS	447,141	1,563,917	2,011,058	65,399	2,076,457	192.15
192.16	19216	MGH MGH MED ONC	0	1,417,992	1,417,992	0	1,417,992	192.16
192.17	19217	MGH FMC SOUTH	802,146	1,822,510	2,624,656	371,796	2,996,452	192.17
192.18	19218	MGH FAIRM MED ASSOC	130,866	371,933	502,799	41,421	544,220	192.18
192.19	19219	MGH FMC MARION	282,770	574,039	856,809	34,220	891,029	192.19
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	MGH FMC NORTHWOOD	320,556	848,893	1,169,449	658	1,170,107	193.01

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 15-0011

Period:
From 07/01/2019
To 06/30/2020

Worksheet A

Date/Time Prepared:
11/20/2020 1:17 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	
193.02	19302	MGH FMC GAS CITY	220,016	622,700	842,716	72,507	915,223	193.02
193.03	19303	MGH HOSPITALISTS	-2,193	3,690,743	3,688,550	0	3,688,550	193.03
193.04	19304	MGH MAR FAM PRACT	1,022,884	2,096,493	3,119,377	0	3,119,377	193.04
193.05	19305	MGH FMC SWAYZEE	92,213	164,304	256,517	27,449	283,966	193.05
193.06	19306	MGH PEDIATRIC CTR	235,465	815,585	1,051,050	52,141	1,103,191	193.06
193.07	19307	MGH SPECIALTY PHYS	57,369	243,537	300,906	12,559	313,465	193.07
193.08	19308	MGH FMC CONVERSE	109,994	238,248	348,242	307	348,549	193.08
193.09	19309	MGH UPLAND HEALTH	483,933	1,235,646	1,719,579	3,712	1,723,291	193.09
193.10	19310	MGH MGH WOMENS CTR	0	0	0	0	0	193.10
193.11	19311	MGH MGH PSYCHIATRY	0	0	0	0	0	193.11
193.12	19312	OB/GYN	563,937	2,318,472	2,882,409	10,701	2,893,110	193.12
193.15	19315	MGH RIVER VIEW BLDG	0	0	0	0	0	193.15
193.16	19316	MGH NEONATOLOGY	0	889,400	889,400	0	889,400	193.16
193.18	19318	MGH WOUND CARE	0	24,160	24,160	0	24,160	193.18
194.00	07963	HEART FAILURE CLINIC	0	51,647	51,647	0	51,647	194.00
194.01	07950	MOW	0	0	0	0	0	194.01
194.02	07951	MENTAL HEALTH	0	0	0	0	0	194.02
194.03	07952	ADVERTISING	0	0	0	218,861	218,861	194.03
194.04	07953	MGH WORK SOLUTIONS	274,835	647,500	922,335	3,302	925,637	194.04
194.05	07954	MGH TAYLOR UNIVERSITY	19,886	90,866	110,752	0	110,752	194.05
194.06	07955	OPIOID IMPL GRANT	43,432	169,157	212,589	0	212,589	194.06
194.07	07956	ASTHMA GRANT	3,115	1,971	5,086	0	5,086	194.07
194.08	07957	MGH SMMP BLDG	0	0	0	0	0	194.08
194.09	07958	MGH AMBUCARE BLDG	0	0	0	0	0	194.09
194.10	07959	MGH 106 LYONS BLDG	0	7,573	7,573	0	7,573	194.10
194.11	07960	FAIRMOUNT	0	0	0	0	0	194.11
194.12	07961	GAS CITY	0	0	0	0	0	194.12
194.13	07969	LYONS	0	0	0	0	0	194.13
194.14	07964	WABASH	0	0	0	0	0	194.14
194.15	07965	TOBACCO GRANT	36,658	16,743	53,401	0	53,401	194.15
194.16	07966	HRSA NETWORK DEV PLANNING	1,934	9,176	11,110	0	11,110	194.16
194.17	07967	HRSA OPIOID PLANNING	13,652	100,043	113,695	0	113,695	194.17
194.18	07962	ECHO GRANT	0	80	80	0	80	194.18
194.19	07968	RURAL QI GRANT	22,214	85,294	107,508	0	107,508	194.19
200.00		TOTAL (SUM OF LINES 118 through 199)	51,467,378	139,770,862	191,238,240	0	191,238,240	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 15-0011

Period:
From 07/01/2019
To 06/30/2020

Worksheet A
Date/Time Prepared:
11/20/2020 1:17 pm

Cost Center Description		Adjustments (See A-8)	Net Expenses For Allocation	
		6.00	7.00	
GENERAL SERVICE COST CENTERS				
1.00	00100 NEW CAP REL COSTS-BLDG & FIXT	-84,005	12,055,624	1.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	-2,868,907	16,531,552	4.00
5.00	00500 ADMINISTRATIVE & GENERAL	-17,137,044	23,454,056	5.00
6.00	00600 MAINTENANCE & REPAIRS	0	0	6.00
6.01	00601 CAFETERIA	-7,084	1,418,505	6.01
6.02	00602 CAFETERIA	0	0	6.02
7.00	00700 OPERATION OF PLANT	-194,095	5,468,804	7.00
8.00	00800 LAUNDRY & LINEN SERVICE	-4,735	289,818	8.00
9.00	00900 HOUSEKEEPING	-90	2,621,756	9.00
10.00	01000 DIETARY	-171	516,225	10.00
13.00	01300 NURSING ADMINISTRATION	0	910,027	13.00
14.00	01400 CENTRAL SERVICES & SUPPLY	-821	472,768	14.00
15.00	01500 PHARMACY	-29,566	3,549,903	15.00
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000 ADULTS & PEDIATRICS	-7,610	6,917,306	30.00
31.00	03100 INTENSIVE CARE UNIT	-794	2,265,821	31.00
40.00	04000 SUBPROVIDER - IPF	0	0	40.00
41.00	04100 SUBPROVIDER - IRF	-64,799	1,768,871	41.00
42.00	04200 SUBPROVIDER	0	0	42.00
43.00	04300 NURSERY	0	1,234,585	43.00
ANCILLARY SERVICE COST CENTERS				
50.00	05000 OPERATING ROOM	-1,204,128	10,224,270	50.00
51.00	05100 RECOVERY ROOM	0	0	51.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	-172,037	4,726,278	54.00
57.00	05700 CT SCAN	0	910,635	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	480,243	58.00
59.00	05900 CARDIAC CATHETERIZATION	-46,817	2,024,820	59.00
60.00	06000 LABORATORY	-85,838	8,042,470	60.00
60.01	06001 ONCOLOGY	-5,178	1,649,415	60.01
60.02	06002 RADIATION ONCOLOGY	0	0	60.02
65.00	06500 RESPIRATORY THERAPY	-1,345	2,167,978	65.00
66.00	06600 PHYSICAL THERAPY	-124	2,161,810	66.00
69.00	06900 ELECTROCARDIOLOGY	-54,205	992,783	69.00
69.01	06901 CARDIAC REHAB	-166	213,026	69.01
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	10,259,314	73.00
OUTPATIENT SERVICE COST CENTERS				
90.00	09000 CLINIC	-1,108	1,036,301	90.00
91.00	09100 EMERGENCY	-5,176,089	5,727,485	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	92.00
92.01	09201 OBSERVATION BEDS (DISTINCT PART)	0	0	92.01
OTHER REIMBURSABLE COST CENTERS				
95.00	09500 AMBULANCE SERVICES	-64,112	1,173,273	95.00
SPECIAL PURPOSE COST CENTERS				
113.00	11300 INTEREST EXPENSE	0	0	113.00
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	-27,210,868	131,265,722	118.00
NONREIMBURSABLE COST CENTERS				
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	41,594	190.00
192.00	19200 PHYSICIANS' PRIVATE OFFICES	0	0	192.00
192.01	19201 PACT REV PHYSICIANS	0	631,898	192.01
192.02	19202 VISITOR MEALS	0	0	192.02
192.03	19203 GREAT BEGINNINGS/MATERNAL	0	104,091	192.03
192.04	19204 LI FELINE	0	0	192.04
192.05	19205 OWNED PROPERTIES	0	335,157	192.05
192.06	19206 UROLOGY	-60,182	1,241,275	192.06
192.07	19207 PHYSICIANS' PRIVATE OFFICES	0	0	192.07
192.08	19211 PARI SH NURSING	0	74,856	192.08
192.09	19212 BIOTERRORISM GRANT	0	0	192.09
192.10	19214 BREAST PUMPS	0	0	192.10
192.11	19208 MGH EMERGENCY PHYSICIANS	0	0	192.11
192.12	19209 LUNG CENTER	-49,272	786,996	192.12
192.13	19213 MGH EXPRESS	0	1,314,486	192.13
192.14	19210 MGH PHYS PRACT MGMT	-65,159	1,840,206	192.14
192.15	19215 MGH MARION SURGEONS	-115,214	1,961,243	192.15
192.16	19216 MGH MGH MED ONC	0	1,417,992	192.16
192.17	19217 MGH FMC SOUTH	-345,266	2,651,186	192.17
192.18	19218 MGH FAIRM MED ASSOC	-27,662	516,558	192.18
192.19	19219 MGH FMC MARION	-62,692	828,337	192.19
193.00	19300 NONPAID WORKERS	0	0	193.00
193.01	19301 MGH FMC NORTHWOOD	0	1,170,107	193.01
193.02	19302 MGH FMC GAS CITY	-147,786	767,437	193.02

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 15-0011

Period:
From 07/01/2019
To 06/30/2020

Worksheet A
Date/Time Prepared:
11/20/2020 1:17 pm

Cost Center Description			Adjustments (See A-8)	Net Expenses For Allocation	
			6.00	7.00	
193.03	19303	MGH HOSPITALISTS	0	3,688,550	193.03
193.04	19304	MGH MAR FAM PRACT	0	3,119,377	193.04
193.05	19305	MGH FMC SWAYZEE	-26,352	257,614	193.05
193.06	19306	MGH PEDIATRIC CTR	-67,608	1,035,583	193.06
193.07	19307	MGH SPECIALTY PHYS	-25,340	288,125	193.07
193.08	19308	MGH FMC CONVERSE	0	348,549	193.08
193.09	19309	MGH UPLAND HEALTH	0	1,723,291	193.09
193.10	19310	MGH MGH WOMENS CTR	0	0	193.10
193.11	19311	MGH MGH PSYCHIATRY	0	0	193.11
193.12	19312	OB/GYN	0	2,893,110	193.12
193.15	19315	MGH RIVER VIEW BLDG	0	0	193.15
193.16	19316	MGH NEONATOLOGY	0	889,400	193.16
193.18	19318	MGH WOUND CARE	0	24,160	193.18
194.00	07963	HEART FAILURE CLINIC	0	51,647	194.00
194.01	07950	MOW	0	0	194.01
194.02	07951	MENTAL HEALTH	0	0	194.02
194.03	07952	ADVERTISING	0	218,861	194.03
194.04	07953	MGH WORK SOLUTIONS	-36,975	888,662	194.04
194.05	07954	MGH TAYLOR UNIVERSITY	0	110,752	194.05
194.06	07955	OPIOID IMPL GRANT	0	212,589	194.06
194.07	07956	ASTHMA GRANT	0	5,086	194.07
194.08	07957	MGH SMMP BLDG	0	0	194.08
194.09	07958	MGH AMBUCARE BLDG	0	0	194.09
194.10	07959	MGH 106 LYONS BLDG	0	7,573	194.10
194.11	07960	FARMOUNT	0	0	194.11
194.12	07961	GAS CITY	0	0	194.12
194.13	07969	LYONS	0	0	194.13
194.14	07964	WABASH	0	0	194.14
194.15	07965	TOBACCO GRANT	0	53,401	194.15
194.16	07966	HRSA NETWORK DEV PLANNING	0	11,110	194.16
194.17	07967	HRSA OPIOID PLANNING	0	113,695	194.17
194.18	07962	ECHO GRANT	0	80	194.18
194.19	07968	RURAL QI GRANT	0	107,508	194.19
200.00		TOTAL (SUM OF LINES 118 through 199)	-28,240,376	162,997,864	200.00

RECLASSIFICATIONS

Provider CCN: 15-0011

Period:
From 07/01/2019
To 06/30/2020

Worksheet A-6
Date/Time Prepared:
11/20/2020 1:17 pm

		Increases			
Cost Center		Line #	Salary	Other	
2.00		3.00	4.00	5.00	
A - SATELLITE OFFICE					
1.00	ELECTROCARDIOLOGY	69.00	9,238	3,507	1.00
2.00	RADIOLOGY-DIAGNOSTIC	54.00	55,152	5,722	2.00
3.00	PHYSICAL THERAPY	66.00	142	37	3.00
TOTALS			64,532	9,266	
B - CAFETERIA					
1.00	ADMINISTRATIVE & GENERAL	5.00	0	57,544	1.00
2.00	CAFETERIA	6.01	0	1,425,589	2.00
TOTALS			0	1,483,133	
C - ADMIN DIRECTOR					
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	39,567	0	1.00
2.00	CENTRAL SERVICES & SUPPLY	14.00	9,153	0	2.00
3.00	ADULTS & PEDIATRICS	30.00	252,338	0	3.00
4.00	CARDIAC CATHETERIZATION	59.00	28,840	0	4.00
5.00	ELECTROCARDIOLOGY	69.00	43,260	0	5.00
6.00	CARDIAC REHAB	69.01	28,840	0	6.00
7.00	AMBULANCE SERVICES	95.00	26,239	0	7.00
8.00	GIFT, FLOWER, COFFEE SHOP & CANTEEN	190.00	28,422	0	8.00
9.00	GREAT BEGINNINGS/MATERNAL	192.03	11,076	0	9.00
10.00	MGH EXPRESS	192.13	28,587	0	10.00
TOTALS			496,322	0	
D - ADVERTISING					
1.00	ADVERTISING	194.03	111,868	106,993	1.00
TOTALS			111,868	106,993	
E - LEASED PROPERTY					
1.00	ADMINISTRATIVE & GENERAL	5.00	0	114,607	1.00
2.00	OPERATION OF PLANT	7.00	0	464,977	2.00
3.00	HOUSEKEEPING	9.00	0	8,529	3.00
4.00	DIETARY	10.00	0	25,585	4.00
5.00	OPERATING ROOM	50.00	0	152,246	5.00
6.00	RADIOLOGY-DIAGNOSTIC	54.00	0	299,998	6.00
7.00	CT SCAN	57.00	0	21,337	7.00
8.00	MAGNETIC RESONANCE IMAGING (MRI)	58.00	0	24,062	8.00
9.00	LABORATORY	60.00	0	74,045	9.00
10.00	ELECTROCARDIOLOGY	69.00	0	14,384	10.00
11.00	CARDIAC REHAB	69.01	0	12,990	11.00
12.00	CLINIC	90.00	0	49,065	12.00
13.00	PARISH NURSING	192.08	0	3,428	13.00
14.00	LUNG CENTER	192.12	0	25,473	14.00
15.00	MGH EXPRESS	192.13	0	15,356	15.00
16.00	MGH PHYS PRACT MGMT	192.14	0	37,995	16.00
17.00	MGH MARION SURGEONS	192.15	0	65,399	17.00
18.00	MGH FMC SOUTH	192.17	0	347,308	18.00
19.00	MGH FAIRM MED ASSOC	192.18	0	41,421	19.00
20.00	MGH FMC MARION	192.19	0	34,220	20.00
21.00	MGH WORK SOLUTIONS	194.04	0	3,302	21.00
22.00	UROLOGY	192.06	0	37,059	22.00
23.00	MGH FMC NORTHWOOD	193.01	0	658	23.00
24.00	MGH FMC GAS CITY	193.02	0	72,507	24.00
25.00	MGH FMC SWAYZEE	193.05	0	27,449	25.00
26.00	MGH PEDIATRIC CTR	193.06	0	52,141	26.00
27.00	MGH SPECIALTY PHYS	193.07	0	12,559	27.00
28.00	MGH FMC CONVERSE	193.08	0	307	28.00
29.00	MGH UPLAND HEALTH	193.09	0	3,712	29.00
30.00	OB/GYN	193.12	0	10,701	30.00
TOTALS			0	2,052,820	
F - PHARMACY RECLASS					
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	10,259,314	1.00
TOTALS			0	10,259,314	
G - CT/MRI RECLASS					
1.00	CT SCAN	57.00	464,550	423,223	1.00
2.00	MAGNETIC RESONANCE IMAGING (MRI)	58.00	237,810	216,654	2.00
TOTALS			702,360	639,877	
H - SHORT TERM DISABILITY					
1.00	NURSING ADMINISTRATION	13.00	0	1,566	1.00
2.00	CENTRAL SERVICES & SUPPLY	14.00	0	1,514	2.00
3.00	ADULTS & PEDIATRICS	30.00	0	7,008	3.00
4.00	CARDIAC CATHETERIZATION	59.00	0	14,866	4.00
5.00	ELECTROCARDIOLOGY	69.00	0	234	5.00
6.00	EMERGENCY	91.00	0	2,197	6.00
TOTALS			0	27,385	

RECLASSIFICATIONS

Provider CCN: 15-0011

Period:
From 07/01/2019
To 06/30/2020

Worksheet A-6

Date/Time Prepared:
11/20/2020 1:17 pm

		Increases				
Cost Center		Line #	Salary	Other		
2.00	3.00	4.00	5.00			
I - NURSERY RECLASS						
1.00	NURSERY	43.00	1,033,128	201,457	1.00	
	TOTALS		1,033,128	201,457		
J - SMMP HOUSEKEEPING RECLASS						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	15,436	1.00	
2.00	OPERATION OF PLANT	7.00	0	1,592	2.00	
3.00	HOUSEKEEPING	9.00	0	351	3.00	
4.00	DIETARY	10.00	0	590	4.00	
5.00	RADIOLOGY-DIAGNOSTIC	54.00	0	21,841	5.00	
6.00	CT SCAN	57.00	0	1,525	6.00	
7.00	MAGNETIC RESONANCE IMAGING (MRI)	58.00	0	1,717	7.00	
8.00	LABORATORY	60.00	0	2,746	8.00	
9.00	MGH FMC SOUTH	192.17	0	24,488	9.00	
	TOTALS		0	70,286		
K - LAUNDRY RECLASS						
1.00	LAUNDRY & LINEN SERVICE	8.00	0	294,553	1.00	
	TOTALS		0	294,553		
L - PHYSICIAN MEDICAL DIRECTOR						
1.00	ADMINISTRATIVE & GENERAL	5.00	370,001	0	1.00	
	TOTALS		370,001	0		
M - PHYSICIAN SALARY RECLASS						
1.00	ADMINISTRATIVE & GENERAL	5.00	3,318,597	0	1.00	
2.00	SUBPROVIDER - IRF	41.00	54,800	0	2.00	
3.00	RESPIRATORY THERAPY	65.00	5,450	0	3.00	
4.00	PHYSICAL THERAPY	66.00	3,067	0	4.00	
5.00	CARDIAC REHAB	69.01	16,193	0	5.00	
7.00	EMERGENCY	91.00	4,325,187	0	7.00	
8.00	PACT REV PHYSICIANS	192.01	718,291	0	8.00	
9.00	UROLOGY	192.06	501,743	0	9.00	
10.00	LUNG CENTER	192.12	500,899	0	10.00	
11.00	MGH EXPRESS	192.13	393,631	0	11.00	
12.00	MGH MARION SURGEONS	192.15	1,142,893	0	12.00	
13.00	MGH MGH MED ONC	192.16	1,155,509	0	13.00	
14.00	MGH FMC SOUTH	192.17	1,027,933	0	14.00	
15.00	MGH FAIRM MED ASSOC	192.18	183,424	0	15.00	
16.00	MGH FMC MARION	192.19	355,231	0	16.00	
17.00	MGH FMC NORTHWOOD	193.01	580,113	0	17.00	
18.00	MGH FMC GAS CITY	193.02	294,627	0	18.00	
19.00	MGH HOSPITALISTS	193.03	2,995,774	0	19.00	
20.00	MGH MAR FAM PRACT	193.04	1,254,344	0	20.00	
21.00	MGH FMC SWAYZEE	193.05	84,615	0	21.00	
22.00	MGH PEDIATRIC CTR	193.06	431,794	0	22.00	
23.00	MGH SPECIALTY PHYS	193.07	163,337	0	23.00	
24.00	MGH FMC CONVERSE	193.08	103,569	0	24.00	
25.00	MGH UPLAND HEALTH	193.09	634,161	0	25.00	
26.00	OB/GYN	193.12	1,411,772	0	26.00	
27.00	MGH WOUND CARE	193.18	19,758	0	27.00	
28.00	HEART FAILURE CLINIC	194.00	33,037	0	28.00	
29.00	MGH WORK SOLUTIONS	194.04	246,613	0	29.00	
30.00	MGH TAYLOR UNIVERSITY	194.05	70,940	0	30.00	
	TOTALS		22,027,302	0		
500.00	Grand Total: Increases		24,805,513	15,145,084	500.00	

RECLASSIFICATIONS

Provider CCN: 15-0011

Period:
From 07/01/2019
To 06/30/2020

Worksheet A-6
Date/Time Prepared:
11/20/2020 1:17 pm

		Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
A - SATELLITE OFFICE							
1.00	LABORATORY	60.00	64,532	9,266	0		1.00
2.00		0.00	0	0	0		2.00
3.00		0.00	0	0	0		3.00
	TOTALS		64,532	9,266			
B - CAFETERIA							
1.00	DIETARY	10.00	0	1,483,133	0		1.00
2.00		0.00	0	0	0		2.00
	TOTALS		0	1,483,133			
C - ADMINISTRATOR							
1.00	ADMINISTRATIVE & GENERAL	5.00	37,575	0	0		1.00
2.00	NURSING ADMINISTRATION	13.00	364,354	0	0		2.00
3.00	INTENSIVE CARE UNIT	31.00	39,567	0	0		3.00
4.00	EMERGENCY	91.00	54,826	0	0		4.00
5.00		0.00	0	0	0		5.00
6.00		0.00	0	0	0		6.00
7.00		0.00	0	0	0		7.00
8.00		0.00	0	0	0		8.00
9.00		0.00	0	0	0		9.00
10.00		0.00	0	0	0		10.00
	TOTALS		496,322	0			
D - ADVERTISING							
1.00	ADMINISTRATIVE & GENERAL	5.00	111,868	106,993	0		1.00
	TOTALS		111,868	106,993			
E - LEASED PROPERTY							
1.00	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	1,062,234	10		1.00
2.00	OWNED PROPERTIES	192.05	0	990,586	0		2.00
3.00		0.00	0	0	0		3.00
4.00		0.00	0	0	0		4.00
5.00		0.00	0	0	0		5.00
6.00		0.00	0	0	0		6.00
7.00		0.00	0	0	0		7.00
8.00		0.00	0	0	0		8.00
9.00		0.00	0	0	0		9.00
10.00		0.00	0	0	0		10.00
11.00		0.00	0	0	0		11.00
12.00		0.00	0	0	0		12.00
13.00		0.00	0	0	0		13.00
14.00		0.00	0	0	0		14.00
15.00		0.00	0	0	0		15.00
16.00		0.00	0	0	0		16.00
17.00		0.00	0	0	0		17.00
18.00		0.00	0	0	0		18.00
19.00		0.00	0	0	0		19.00
20.00		0.00	0	0	0		20.00
21.00		0.00	0	0	0		21.00
22.00		0.00	0	0	0		22.00
23.00		0.00	0	0	0		23.00
24.00		0.00	0	0	0		24.00
25.00		0.00	0	0	0		25.00
26.00		0.00	0	0	0		26.00
27.00		0.00	0	0	0		27.00
28.00		0.00	0	0	0		28.00
29.00		0.00	0	0	0		29.00
30.00		0.00	0	0	0		30.00
	TOTALS		0	2,052,820			
F - PHARMACY RECLASS							
1.00	PHARMACY	15.00	0	10,259,314	0		1.00
	TOTALS		0	10,259,314			
G - CT/MRI RECLASS							
1.00	RADIOLOGY-DIAGNOSTIC	54.00	702,360	639,877	0		1.00
2.00		0.00	0	0	0		2.00
	TOTALS		702,360	639,877			
H - SHORT TERM DISABILITY							
1.00	NURSING ADMINISTRATION	13.00	1,566	0	0		1.00
2.00	CENTRAL SERVICES & SUPPLY	14.00	1,514	0	0		2.00
3.00	ADULTS & PEDIATRICS	30.00	7,008	0	0		3.00
4.00	CARDIAC CATHETERIZATION	59.00	14,866	0	0		4.00
5.00	ELECTROCARDIOLOGY	69.00	234	0	0		5.00
6.00	EMERGENCY	91.00	2,197	0	0		6.00
	TOTALS		27,385	0			

RECLASSIFICATIONS

Provider CCN: 15-0011

Period:
From 07/01/2019
To 06/30/2020

Worksheet A-6

Date/Time Prepared:
11/20/2020 1:17 pm

		Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
I - NURSERY RECLASS							
1.00	ADULTS & PEDIATRICS	30.00	1,033,128	201,457	0		1.00
	TOTALS		1,033,128	201,457			
J - SMMP HOUSEKEEPING RECLASS							
1.00	OWNED PROPERTIES	192.05	0	70,286	0		1.00
2.00		0.00	0	0	0		2.00
3.00		0.00	0	0	0		3.00
4.00		0.00	0	0	0		4.00
5.00		0.00	0	0	0		5.00
6.00		0.00	0	0	0		6.00
7.00		0.00	0	0	0		7.00
8.00		0.00	0	0	0		8.00
9.00		0.00	0	0	0		9.00
	TOTALS		0	70,286			
K - LAUNDRY RECLASS							
1.00	HOUSEKEEPING	9.00	0	294,553	0		1.00
	TOTALS		0	294,553			
L - PHYSICIAN MEDICAL DIRECTOR							
1.00	PACT REV PHYSICIANS	192.01	370,001	0	0		1.00
	TOTALS		370,001	0			
M - PHYSICIAN SALARY RECLASS							
1.00	ADMINISTRATIVE & GENERAL	5.00	0	3,318,597	0		1.00
2.00	SUBPROVIDER - IRF	41.00	0	54,800	0		2.00
3.00	RESPIRATORY THERAPY	65.00	0	5,450	0		3.00
4.00	PHYSICAL THERAPY	66.00	0	3,067	0		4.00
5.00	CARDIAC REHAB	69.01	0	16,193	0		5.00
7.00	EMERGENCY	91.00	0	4,325,187	0		7.00
8.00	PACT REV PHYSICIANS	192.01	0	718,291	0		8.00
9.00	UROLOGY	192.06	0	501,743	0		9.00
10.00	LUNG CENTER	192.12	0	500,899	0		10.00
11.00	MGH EXPRESS	192.13	0	393,631	0		11.00
12.00	MGH MARION SURGEONS	192.15	0	1,142,893	0		12.00
13.00	MGH MGH MED ONC	192.16	0	1,155,509	0		13.00
14.00	MGH FMC SOUTH	192.17	0	1,027,933	0		14.00
15.00	MGH FAIRM MED ASSOC	192.18	0	183,424	0		15.00
16.00	MGH FMC MARION	192.19	0	355,231	0		16.00
17.00	MGH FMC NORTHWOOD	193.01	0	580,113	0		17.00
18.00	MGH FMC GAS CITY	193.02	0	294,627	0		18.00
19.00	MGH HOSPITALISTS	193.03	0	2,995,774	0		19.00
20.00	MGH MAR FAM PRACT	193.04	0	1,254,344	0		20.00
21.00	MGH FMC SWAYZEE	193.05	0	84,615	0		21.00
22.00	MGH PEDIATRIC CTR	193.06	0	431,794	0		22.00
23.00	MGH SPECIALTY PHYS	193.07	0	163,337	0		23.00
24.00	MGH FMC CONVERSE	193.08	0	103,569	0		24.00
25.00	MGH UPLAND HEALTH	193.09	0	634,161	0		25.00
26.00	OB/GYN	193.12	0	1,411,772	0		26.00
27.00	MGH WOUND CARE	193.18	0	19,758	0		27.00
28.00	HEART FAILURE CLINIC	194.00	0	33,037	0		28.00
29.00	MGH WORK SOLUTIONS	194.04	0	246,613	0		29.00
30.00	MGH TAYLOR UNIVERSITY	194.05	0	70,940	0		30.00
	TOTALS		0	22,027,302			
500.00	Grand Total: Decreases		2,805,596	37,145,001			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 15-0011

Period:
From 07/01/2019
To 06/30/2020

Worksheet A-7
Part I
Date/Time Prepared:
11/20/2020 1:17 pm

	Beginning Balances	Acquisitions			Disposals and Retirements	
		Purchases	Donation	Total		
		1.00	2.00	3.00		
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	5,191,830	0	0	0	1.00
2.00	Land Improvements	3,353,531	0	0	0	2.00
3.00	Buildings and Fixtures	139,652,631	3,074,848	0	3,074,848	3.00
4.00	Building Improvements	3,551,212	204,848	0	204,848	4.00
5.00	Fixed Equipment	3,509,530	0	0	0	5.00
6.00	Movable Equipment	72,737,687	4,779,102	0	4,779,102	6.00
7.00	HIT designated Assets	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	227,996,421	8,058,798	0	8,058,798	8.00
9.00	Reconciling Items	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	227,996,421	8,058,798	0	8,058,798	10.00
	Ending Balance		Fully Depreciated Assets			
	6.00		7.00			
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	5,191,830	0			1.00
2.00	Land Improvements	3,353,531	0			2.00
3.00	Buildings and Fixtures	142,726,768	0			3.00
4.00	Building Improvements	3,688,530	0			4.00
5.00	Fixed Equipment	3,509,530	0			5.00
6.00	Movable Equipment	74,450,541	0			6.00
7.00	HIT designated Assets	0	0			7.00
8.00	Subtotal (sum of lines 1-7)	232,920,730	0			8.00
9.00	Reconciling Items	0	0			9.00
10.00	Total (line 8 minus line 9)	232,920,730	0			10.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 15-0011

Period:
From 07/01/2019
To 06/30/2020

Worksheet A-7
Part II
Date/Time Prepared:
11/20/2020 1:17 pm

Cost Center Description		SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2							
1.00	NEW CAP REL COSTS-BLDG & FIXT	13,201,863	0	0	0	0	1.00
3.00	Total (sum of lines 1-2)	13,201,863	0	0	0	0	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)				
		14.00	15.00				
PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2							
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	13,201,863				1.00
3.00	Total (sum of lines 1-2)	0	13,201,863				3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 15-0011

Period:
From 07/01/2019
To 06/30/2020

Worksheet A-7
Part III
Date/Time Prepared:
11/20/2020 1:17 pm

Cost Center Description		COMPUTATION OF RATIOS			ALLOCATION OF OTHER CAPITAL		
		Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	
		1.00	2.00	3.00	4.00	5.00	
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	NEW CAP REL COSTS-BLDG & FIXT	227,996,425	0	227,996,425	1.000000	0	1.00
3.00	Total (sum of lines 1-2)	227,996,425	0	227,996,425	1.000000	0	3.00
Cost Center Description		ALLOCATION OF OTHER CAPITAL			SUMMARY OF CAPITAL		
		Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	Depreciation	Lease	
		6.00	7.00	8.00	9.00	10.00	
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	0	0	13,201,863	-1,062,234	1.00
3.00	Total (sum of lines 1-2)	0	0	0	13,201,863	-1,062,234	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	NEW CAP REL COSTS-BLDG & FIXT	-84,005	0	0	0	12,055,624	1.00
3.00	Total (sum of lines 1-2)	-84,005	0	0	0	12,055,624	3.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 15-0011

Period:
From 07/01/2019
To 06/30/2020

Worksheet A-8

Date/Time Prepared:
11/20/2020 1:17 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.	
			3.00	4.00	5.00	
1.00 Investment income - NEW CAP REL COSTS-BLDG & FIXT (chapter 2)			0NEW CAP REL COSTS-BLDG & FIXT	1.00	0	1.00
2.00 Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)			0*** Cost Center Deleted ***	2.00	0	2.00
3.00 Investment income - other (chapter 2)			0	0.00	0	3.00
4.00 Trade, quantity, and time discounts (chapter 8)			0	0.00	0	4.00
5.00 Refunds and rebates of expenses (chapter 8)			0	0.00	0	5.00
6.00 Rental of provider space by suppliers (chapter 8)			0	0.00	0	6.00
7.00 Telephone services (pay stations excluded) (chapter 21)			0	0.00	0	7.00
8.00 Television and radio service (chapter 21)			0	0.00	0	8.00
9.00 Parking lot (chapter 21)			0	0.00	0	9.00
10.00 Provider-based physician adjustment	A-8-2	-6,547,528			0	10.00
11.00 Sale of scrap, waste, etc. (chapter 23)			0	0.00	0	11.00
12.00 Related organization transactions (chapter 10)	A-8-1		0		0	12.00
13.00 Laundry and linen service			0	0.00	0	13.00
14.00 Cafeteria-employees and guests	B	-3,373	CAFETERIA	6.01	0	14.00
15.00 Rental of quarters to employees and others			0	0.00	0	15.00
16.00 Sale of medical and surgical supplies to other than patients			0	0.00	0	16.00
17.00 Sale of drugs to other than patients			0	0.00	0	17.00
18.00 Sale of medical records and abstracts			0	0.00	0	18.00
19.00 Nursing and allied health education (tuition, fees, books, etc.)			0	0.00	0	19.00
20.00 Vending machines			0	0.00	0	20.00
21.00 Income from imposition of interest, finance or penalty charges (chapter 21)			0	0.00	0	21.00
22.00 Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments			0	0.00	0	22.00
23.00 Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3		0RESPIRATORY THERAPY	65.00		23.00
24.00 Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3		0PHYSICAL THERAPY	66.00		24.00
25.00 Utilization review - physicians' compensation (chapter 21)			0*** Cost Center Deleted ***	114.00		25.00
26.00 Depreciation - NEW CAP REL COSTS-BLDG & FIXT			0NEW CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
27.00 Depreciation - CAP REL COSTS-MVBLE EQUIP			0*** Cost Center Deleted ***	2.00	0	27.00
28.00 Non-physician Anesthetist			0*** Cost Center Deleted ***	19.00		28.00
29.00 Physicians' assistant			0	0.00	0	29.00
30.00 Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3		0*** Cost Center Deleted ***	67.00		30.00
30.99 Hospice (non-distinct) (see instructions)			0ADULTS & PEDIATRICS	30.00		30.99

ADJUSTMENTS TO EXPENSES

Provider CCN: 15-0011

Period:
From 07/01/2019
To 06/30/2020

Worksheet A-8

Date/Time Prepared:
11/20/2020 1:17 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
31.00 Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	*** Cost Center Deleted ***	68.00		31.00
32.00 CAH HIT Adjustment for Depreciation and Interest		0		0.00		32.00
33.00 FINANCE BANK SERVICE CHARGES	A	-247,175	ADMINISTRATIVE & GENERAL	5.00		33.00
33.01 FINANCE DISCOUNT PAYMENTS	A	15,400	ADMINISTRATIVE & GENERAL	5.00		33.01
33.02 GAIN ON DISPOSAL	A	34,258	ADMINISTRATIVE & GENERAL	5.00		33.02
33.03 XIX ASSESSMENT FEE A/C 7200.7892	A	-12,060,945	ADMINISTRATIVE & GENERAL	5.00		33.03
33.04 SELF INSURANCE EXPENSE	A	-2,868,901	EMPLOYEE BENEFITS DEPARTMENT	4.00		33.04
33.05 DEPOSITION-OTHER	B	-2,000	ADMINISTRATIVE & GENERAL	5.00		33.05
33.06 RETURNED CHECK FEE	B	-400	ADMINISTRATIVE & GENERAL	5.00		33.06
33.07 PHYSICIAN PRIV APPLIC	B	-3,750	ADMINISTRATIVE & GENERAL	5.00		33.07
33.08 SALE OF MEDICAL RECORDS & ABSTRACTS	B	-38,928	ADMINISTRATIVE & GENERAL	5.00		33.08
33.09 CHILD SEAT SAFETY INSPECTION	B	-2,112	ADMINISTRATIVE & GENERAL	5.00		33.09
33.10 HEALTH SCREENING FEES - LAB	B	-1,618	LABORATORY	60.00		33.10
33.11 HEALTH SCREENING FEES - RAD	B	-15,435	RADIOLOGY-DIAGNOSTIC	54.00		33.11
33.12 MED STAFF OTHER SCREENING-MED STAFF	B	461	ADMINISTRATIVE & GENERAL	5.00		33.12
33.13 HEALTH SCREENS	B	-4,653	LABORATORY	60.00		33.13
33.14 HEALTH SCREENS	B	410	LABORATORY	60.00		33.14
33.15 REBATE	B	-5,187	ADMINISTRATIVE & GENERAL	5.00		33.15
33.16 REBATE	B	-73,290	ADMINISTRATIVE & GENERAL	5.00		33.16
33.17 RENTAL OF PROVIDER SPACE BY SUPPLIER	B	-1,200	ADMINISTRATIVE & GENERAL	5.00		33.17
33.18 RENT SPACE UPLAND	B	-18,819	LABORATORY	60.00		33.18
33.19 PAGER RENTAL	B	-950	ADMINISTRATIVE & GENERAL	5.00		33.19
33.20 SALE OF SCRAP, WASTE, ETC,	B	-2,806	ADMINISTRATIVE & GENERAL	5.00		33.20
33.21 PCC MARKETING AG	B	-1,508	ADMINISTRATIVE & GENERAL	5.00		33.21
33.22 EDUCATIONAL WORKSHOP	B	-550	ADMINISTRATIVE & GENERAL	5.00		33.22
33.23 OPT HEALTH LINEN SEV	B	-4,735	LAUNDRY & LINEN SERVICE	8.00		33.23
33.24 AMBULANCE SVC - ASSISTANTS	B	-56,375	AMBULANCE SERVICES	95.00		33.24
33.25 AMBULANCE SVC - CORONER SVC	B	-248	AMBULANCE SERVICES	95.00		33.25
33.26 AMBULANCE SVC - LINEN SERVICES	B	-4,608	AMBULANCE SERVICES	95.00		33.26
33.27 AMBULANCE SVC - COMMUNITY EVENT STAFF	B	-2,559	AMBULANCE SERVICES	95.00		33.27
33.28 CONTRACT ARU OTH ARU MEDICAL DIRECTO	B	-58,084	SUBPROVIDER - IRF	41.00		33.28
33.29 MGH UNCLAI MED OTH 125 MED/CHILD	B	-11,984	ADMINISTRATIVE & GENERAL	5.00		33.29
33.30 SCHOOL PHYS OTH SCHOOL PHYS	B	-6,625	ADMINISTRATIVE & GENERAL	5.00		33.30
33.31 PHLEBOTOMY	B	-7,380	LABORATORY	60.00		33.31
33.32 CPR TRAIN OTH AHA COMMUNITY	B	-13,758	ADMINISTRATIVE & GENERAL	5.00		33.32
33.33 CLINICAL STUDY- OTHER	B	-3,852	ONCOLOGY	60.01		33.33
33.34 SICK CHILD CARE PROGRAM	B	-858	ADULTS & PEDIATRICS	30.00		33.34
33.35 ONC. QUAL	B	-800	ADMINISTRATIVE & GENERAL	5.00		33.35
33.36 SETTLEMENTS	B	-10,799	ADMINISTRATIVE & GENERAL	5.00		33.36
33.37 UNCLAI MED OTHER MONIES RECOVERED	B	-537	ADMINISTRATIVE & GENERAL	5.00		33.37
33.38 VENDING MACHINES	B	-3,711	CAFETERIA	6.01		33.38
33.39 MISC REV	B	-62	ADMINISTRATIVE & GENERAL	5.00		33.39
33.40 TELEVISION AND RADIO SERVICE	A	-52,449	OPERATION OF PLANT	7.00		33.40
33.41 TELEPHONE SERVICE	A	-141,306	OPERATION OF PLANT	7.00		33.41
33.42 OPERATING INTEREST INCOME	B	-84,005	NEW CAP REL COSTS-BLDG & FIXT	1.00	11	33.42
33.43 LOBBYING COSTS	A	-24,769	ADMINISTRATIVE & GENERAL	5.00		33.43
33.44 LOBBYING COSTS	A	-307	PHARMACY	15.00		33.44
33.45 LOBBYING COSTS	A	-3	RADIOLOGY-DIAGNOSTIC	54.00		33.45
33.46 LOBBYING COSTS	A	-613	ONCOLOGY	60.01		33.46
33.47 ELIMINATING ENTRIES	A	-65,159	MGH PHYS PRACT MGMT	192.14		33.47
33.48 ELIMINATING ENTRIES	A	-36,975	MGH WORK SOLUTIONS	194.04		33.48
33.49 ELIMINATING ENTRIES	A	-49,272	LUNG CENTER	192.12		33.49
33.50 ELIMINATING ENTRIES	A	-115,214	MGH MARION SURGEONS	192.15		33.50
33.51 ELIMINATING ENTRIES	A	-345,266	MGH FMC SOUTH	192.17		33.51

Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted			Wkst. A-7 Ref.	
			Cost Center	Line #			
			1.00	2.00	3.00		
33.52 ELIMINATING ENTRIES	A	-27,662	MGH FAIRM MED ASSOC	192.18	0	33.52	
33.53 ELIMINATING ENTRIES	A	-62,692	MGH FMC MARION	192.19	0	33.53	
33.54 ELIMINATING ENTRIES	A	-147,786	MGH FMC GAS CITY	193.02	0	33.54	
33.55 ELIMINATING ENTRIES	A	-26,352	MGH FMC SWAYZEE	193.05	0	33.55	
33.56 ELIMINATING ENTRIES	A	-67,608	MGH PEDIATRIC CTR	193.06	0	33.56	
33.57 ELIMINATING ENTRIES	A	-60,182	UROLOGY	192.06	0	33.57	
33.58 ELIMINATING ENTRIES	A	-25,340	MGH SPECIALTY PHYS	193.07	0	33.58	
33.59 PHYSICIAN RECRUITMENT	A	-1,125,781	ADMINISTRATIVE & GENERAL	5.00	0	33.59	
33.60 ENTERTAINMENT EXP	A	-131	ADMINISTRATIVE & GENERAL	5.00	0	33.60	
33.61 EMPLOYEE USE OF AUTO	A	-1,873	ADMINISTRATIVE & GENERAL	5.00	0	33.61	
33.62 DONATIONS	A	-678,314	ADMINISTRATIVE & GENERAL	5.00	0	33.62	
33.63 VHA OPPORTUNITY	A	-6	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.63	
33.64 VHA OPPORTUNITY	A	-13,801	ADMINISTRATIVE & GENERAL	5.00	0	33.64	
33.65 VHA OPPORTUNITY	A	-340	OPERATION OF PLANT	7.00	0	33.65	
33.66 VHA OPPORTUNITY	A	-942	ADMINISTRATIVE & GENERAL	5.00	0	33.66	
33.67 VHA OPPORTUNITY	A	-90	HOUSEKEEPING	9.00	0	33.67	
33.68 VHA OPPORTUNITY	A	-171	DIETARY	10.00	0	33.68	
33.69 VHA OPPORTUNITY	A	-821	CENTRAL SERVICES & SUPPLY	14.00	0	33.69	
33.70 VHA OPPORTUNITY	A	-29,259	PHARMACY	15.00	0	33.70	
33.71 VHA OPPORTUNITY	A	-6,752	ADULTS & PEDIATRICS	30.00	0	33.71	
33.72 VHA OPPORTUNITY	A	-794	INTENSIVE CARE UNIT	31.00	0	33.72	
33.73 VHA OPPORTUNITY	A	-165	SUBPROVIDER - IRF	41.00	0	33.73	
33.74 VHA OPPORTUNITY	A	-39,810	OPERATING ROOM	50.00	0	33.74	
33.75 VHA OPPORTUNITY	A	-18,875	RADIOLOGY-DIAGNOSTIC	54.00	0	33.75	
33.76 VHA OPPORTUNITY	A	-46,817	CARDIAC CATHETERIZATION	59.00	0	33.76	
33.77 VHA OPPORTUNITY	A	-42,400	LABORATORY	60.00	0	33.77	
33.78 VHA OPPORTUNITY	A	-713	ONCOLOGY	60.01	0	33.78	
33.79 VHA OPPORTUNITY	A	-1,345	RESPIRATORY THERAPY	65.00	0	33.79	
33.80 VHA OPPORTUNITY	A	-124	PHYSICAL THERAPY	66.00	0	33.80	
33.81 VHA OPPORTUNITY	A	-403	ELECTROCARDIOLOGY	69.00	0	33.81	
33.82 VHA OPPORTUNITY	A	-166	CARDIAC REHAB	69.01	0	33.82	
33.83 VHA OPPORTUNITY	A	-1,108	CLINIC	90.00	0	33.83	
33.84 VHA OPPORTUNITY	A	-2,055	EMERGENCY	91.00	0	33.84	
33.85 VHA OPPORTUNITY	A	-322	AMBULANCE SERVICES	95.00	0	33.85	
33.86 ED ON CALL SVC A/C 7000.2512	A	-2,856,186	ADMINISTRATIVE & GENERAL	5.00	0	33.86	
33.87 MISC REV	B	-278	LABORATORY	60.00	0	33.87	
50.00 TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-28,240,376				50.00	

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

(2) Basis for adjustment (see instructions).

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

B. Amount Received - if cost cannot be determined.

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

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

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 15-0011

Period:
From 07/01/2019
To 06/30/2020

Worksheet A-8-2

Date/Time Prepared:
11/20/2020 1:17 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	41.00	SUBPROVIDER - IRF	6,550	6,550	0	0	0	1.00
2.00	69.00	ELECTROCARDIOLOGY	53,802	53,802	0	0	0	2.00
3.00	50.00	OPERATING ROOM	1,164,318	1,164,318	0	0	0	3.00
4.00	90.00	CLINIC	0	0	0	0	0	4.00
5.00	91.00	EMERGENCY	5,174,034	5,174,034	0	0	0	5.00
6.00	60.00	LABORATORY	11,100	11,100	0	0	0	6.00
7.00	54.00	RADIOLOGY-DIAGNOSTIC	137,724	137,724	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			6,547,528	6,547,528	0	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	41.00	SUBPROVIDER - IRF	0	0	0	0	0	1.00
2.00	69.00	ELECTROCARDIOLOGY	0	0	0	0	0	2.00
3.00	50.00	OPERATING ROOM	0	0	0	0	0	3.00
4.00	90.00	CLINIC	0	0	0	0	0	4.00
5.00	91.00	EMERGENCY	0	0	0	0	0	5.00
6.00	60.00	LABORATORY	0	0	0	0	0	6.00
7.00	54.00	RADIOLOGY-DIAGNOSTIC	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	41.00	SUBPROVIDER - IRF	0	0	0	6,550		1.00
2.00	69.00	ELECTROCARDIOLOGY	0	0	0	53,802		2.00
3.00	50.00	OPERATING ROOM	0	0	0	1,164,318		3.00
4.00	90.00	CLINIC	0	0	0	0		4.00
5.00	91.00	EMERGENCY	0	0	0	5,174,034		5.00
6.00	60.00	LABORATORY	0	0	0	11,100		6.00
7.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	137,724		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	6,547,528		200.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 15-0011

Period:
From 07/01/2019
To 06/30/2020

Worksheet B
Part I
Date/Time Prepared:
11/20/2020 1:17 pm

Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPI TAL RELATED COSTS	EMPLOYEE BENEFITS DEPARTMENT	Subtotal	ADM INI STRATI V E & GENERAL	
		NEW BLDG & FIXT				
	0	1.00	4.00	4A	5.00	
GENERAL SERVICE COST CENTERS						
1.00 00100	NEW CAP REL COSTS-BLDG & FIXT	12,055,624	12,055,624			1.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	16,531,552	299,988	16,831,540		4.00
5.00 00500	ADM INI STRATI VE & GENERAL	23,454,056	3,704,496	3,442,134	30,600,686	5.00
6.00 00600	MAINTENANCE & REPAIRS	0	0	0	0	6.00
6.01 00601	CAFETERIA	1,418,505	134,488	0	1,552,993	6.01
6.02 00602	CAFETERIA	0	0	0	0	6.02
7.00 00700	OPERATI ON OF PLANT	5,468,804	2,555,603	178,910	8,203,317	7.00
8.00 00800	LAUNDRY & LI NEN SERVICE	289,818	58,508	0	348,326	8.00
9.00 00900	HOUSEKEEPING	2,621,756	90,268	0	2,712,024	9.00
10.00 01000	DI ETARY	516,225	185,298	4,461	705,984	10.00
13.00 01300	NURSI NG ADM INI STRATI ON	910,027	19,272	194,778	1,124,077	13.00
14.00 01400	CENTRAL SERVICES & SUPPLY	472,768	65,984	37,568	576,320	14.00
15.00 01500	PHARMACY	3,549,903	85,007	610,361	4,245,271	15.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS	6,917,306	1,189,874	1,348,735	9,455,915	30.00
31.00 03100	INTENSIVE CARE UNIT	2,265,821	283,707	407,949	2,957,477	31.00
40.00 04000	SUBPROVIDER - I PF	0	0	0	0	40.00
41.00 04100	SUBPROVIDER - I RF	1,768,871	265,404	239,650	2,273,925	41.00
42.00 04200	SUBPROVIDER	0	0	0	0	42.00
43.00 04300	NURSERY	1,234,585	0	240,121	1,474,706	43.00
ANCILLARY SERVICE COST CENTERS						
50.00 05000	OPERATING ROOM	10,224,270	953,987	270,713	11,448,970	50.00
51.00 05100	RECOVERY ROOM	0	0	0	0	51.00
54.00 05400	RADIOLOGY-DI AGNOSTIC	4,726,278	572,785	558,131	5,857,194	54.00
57.00 05700	CT SCAN	910,635	41,673	107,971	1,060,279	57.00
58.00 05800	MAGNETIC RESONANCE IMAGING (MRI)	480,243	49,398	55,272	584,913	58.00
59.00 05900	CARDI AC CATHETERIZATI ON	2,024,820	139,555	147,423	2,311,798	59.00
60.00 06000	LABORATORY	8,042,470	362,622	516,587	8,921,679	60.00
60.01 06001	ONCOLOGY	1,649,415	0	236,201	1,885,616	60.01
60.02 06002	RADIATI ON ONCOLOGY	0	0	0	0	60.02
65.00 06500	RESPI RATORY THERAPY	2,167,978	123,357	327,690	2,619,025	65.00
66.00 06600	PHYSI CAL THERAPY	2,161,810	24,394	429,234	2,615,438	66.00
69.00 06900	ELECTROCARDIOLOGY	992,783	220,242	191,738	1,404,763	69.00
69.01 06901	CARDI AC REHAB	213,026	35,913	43,242	292,181	69.01
71.00 07100	MEDI CAL SUPPLI ES CHARGED TO PATIENTS	0	0	0	0	71.00
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	10,259,314	0	0	10,259,314	73.00
OUTPATIENT SERVICE COST CENTERS						
90.00 09000	CLINI C	1,036,301	135,540	68,047	1,239,888	90.00
91.00 09100	EMERGENCY	5,727,485	306,551	1,886,613	7,920,649	91.00
92.00 09200	OBSERVATI ON BEDS (NON-DI STI NCT PART)	0	0	0	0	92.00
92.01 09201	OBSERVATI ON BEDS (DI STI NCT PART)	0	0	0	0	92.01
OTHER REIMBURSABLE COST CENTERS						
95.00 09500	AMBULANCE SERVI CES	1,173,273	114,911	247,420	1,535,604	95.00
SPECIAL PURPOSE COST CENTERS						
113.00 11300	INTEREST EXPENSE					113.00
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	131,265,722	12,018,825	11,790,949	126,188,332	22,092,974
NONREIMBURSABLE COST CENTERS						
190.00 19000	GI FT, FLOWER, COFFEE SHOP & CANTEEN	41,594	36,799	6,606	84,999	190.00
192.00 19200	PHYSI CI ANS' PRI VATE OFFI CES	0	0	0	0	192.00
192.01 19201	PACT REV PHYSI CI ANS	631,898	0	105,039	736,937	192.01
192.02 19202	VI SI TOR MEALS	0	0	0	0	192.02
192.03 19203	GREAT BEGI NNI NGS/MATERNAL	104,091	0	23,182	127,273	192.03
192.04 19204	LI FELINE	0	0	0	0	192.04
192.05 19205	OWNED PROPERTI ES	335,157	0	0	335,157	192.05
192.06 19206	UROLOGY	1,241,275	0	198,528	1,439,803	192.06
192.07 19207	PHYSI CI ANS' PRI VATE OFFI CES	0	0	0	0	192.07
192.08 19211	PARI SH NURSI NG	74,856	0	13,366	88,222	192.08
192.09 19212	BI OTERRORI SM GRANT	0	0	0	0	192.09
192.10 19214	BREAST PUMPS	0	0	0	0	192.10
192.11 19208	MGH EMERGENCY PHYSI CI ANS	0	0	0	0	192.11
192.12 19209	LUNG CENTER	786,996	0	146,198	933,194	192.12
192.13 19213	MGH EXPRESS	1,314,486	0	219,369	1,533,855	192.13
192.14 19210	MGH PHYS PRACT MGMT	1,840,206	0	264,621	2,104,827	192.14
192.15 19215	MGH MARION SURGEONS	1,961,243	0	369,557	2,330,800	192.15
192.16 19216	MGH MGH MED ONC	1,417,992	0	268,565	1,686,557	192.16
192.17 19217	MGH FMC SOUTH	2,651,186	0	425,349	3,076,535	192.17
192.18 19218	MGH FAI RM MED ASSOC	516,558	0	73,048	589,606	192.18

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 15-0011

Period:
From 07/01/2019
To 06/30/2020

Worksheet B
Part I
Date/Time Prepared:
11/20/2020 1:17 pm

Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	Subtotal	ADMINISTRATIVE & GENERAL	
		NEW BLDG & FIXT					
	0	1.00		4.00	4A	5.00	
192.19 19219 MGH FMC MARION	828,337	0	0	148,285	976,622	225,725	192.19
193.00 19300 NONPAID WORKERS	0	0	0	0	0	0	193.00
193.01 19301 MGH FMC NORTHWOOD	1,170,107	0	0	209,334	1,379,441	318,827	193.01
193.02 19302 MGH FMC GAS CITY	767,437	0	0	119,614	887,051	205,022	193.02
193.03 19303 MGH HOSPITALISTS	3,688,550	0	0	695,771	4,384,321	1,013,339	193.03
193.04 19304 MGH MAR FAM PRACT	3,119,377	0	0	529,276	3,648,653	843,306	193.04
193.05 19305 MGH FMC SWAYZEE	257,614	0	0	41,099	298,713	69,041	193.05
193.06 19306 MGH PEDIATRIC CTR	1,035,583	0	0	155,085	1,190,668	275,197	193.06
193.07 19307 MGH SPECIALTY PHYS	288,125	0	0	51,297	339,422	78,450	193.07
193.08 19308 MGH FMC CONVERSE	348,549	0	0	49,637	398,186	92,032	193.08
193.09 19309 MGH UPLAND HEALTH	1,723,291	0	0	259,869	1,983,160	458,364	193.09
193.10 19310 MGH MGH WOMENS CTR	0	0	0	0	0	0	193.10
193.11 19311 MGH MGH PSYCHIATRY	0	0	0	0	0	0	193.11
193.12 19312 OB/GYN	2,893,110	0	0	459,196	3,352,306	774,812	193.12
193.15 19315 MGH RIVER VIEW BLDG	0	0	0	0	0	0	193.15
193.16 19316 MGH NEONATOLOGY	889,400	0	0	0	889,400	205,565	193.16
193.18 19318 MGH WOUND CARE	24,160	0	0	4,592	28,752	6,645	193.18
194.00 07963 HEART FAILURE CLINIC	51,647	0	0	7,678	59,325	13,712	194.00
194.01 07950 MOW	0	0	0	0	0	0	194.01
194.02 07951 MENTAL HEALTH	0	0	0	0	0	0	194.02
194.03 07952 ADVERTISING	218,861	0	0	26,000	244,861	56,594	194.03
194.04 07953 MGH WORK SOLUTIONS	888,662	0	0	121,195	1,009,857	233,406	194.04
194.05 07954 MGH TAYLOR UNIVERSITY	110,752	0	0	21,110	131,862	30,477	194.05
194.06 07955 OPIOID IMPL GRANT	212,589	0	0	10,095	222,684	51,469	194.06
194.07 07956 ASTHMA GRANT	5,086	0	0	724	5,810	1,343	194.07
194.08 07957 MGH SMMP BLDG	0	0	0	0	0	0	194.08
194.09 07958 MGH AMBUCARE BLDG	0	0	0	0	0	0	194.09
194.10 07959 MGH 106 LYONS BLDG	7,573	0	0	0	7,573	1,750	194.10
194.11 07960 FAIRMOUNT	0	0	0	0	0	0	194.11
194.12 07961 GAS CITY	0	0	0	0	0	0	194.12
194.13 07969 LYONS	0	0	0	0	0	0	194.13
194.14 07964 WABASH	0	0	0	0	0	0	194.14
194.15 07965 TOBACCO GRANT	53,401	0	0	8,520	61,921	14,312	194.15
194.16 07966 HRSA NETWORK DEV PLANNING	11,110	0	0	450	11,560	2,672	194.16
194.17 07967 HRSA OPIOID PLANNING	113,695	0	0	3,173	116,868	27,011	194.17
194.18 07962 ECHO GRANT	80	0	0	0	80	18	194.18
194.19 07968 RURAL QI GRANT	107,508	0	0	5,163	112,671	26,041	194.19
200.00 Cross Foot Adjustments					0		200.00
201.00 Negative Cost Centers					0		201.00
202.00 TOTAL (sum lines 118 through 201)	162,997,864	12,055,624		16,831,540	162,997,864	30,600,686	202.00

COST ALLOCATION - GENERAL SERVICE COSTS			Provider CCN: 15-0011		Period: From 07/01/2019 To 06/30/2020		Worksheet B Part I Date/Time Prepared: 11/20/2020 1:17 pm	
Cost Center Description			MAINTENANCE & REPAIRS	CAFETERIA	CAFETERIA	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	
			6.00	6.01	6.02	7.00	8.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS	0					6.00
6.01	00601	CAFETERIA	0	1,911,933				6.01
6.02	00602	CAFETERIA	0	1,857,516	1,857,516			6.02
7.00	00700	OPERATION OF PLANT	0	0	54,696	10,154,029		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0	110,816	539,650	8.00
9.00	00900	HOUSEKEEPING	0	0	0	170,971	0	9.00
10.00	01000	DIETARY	0	0	449	350,962	215	10.00
13.00	01300	NURSING ADMINISTRATION	0	0	28,761	36,502	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	12,274	124,976	202	14.00
15.00	01500	PHARMACY	0	0	97,339	161,006	0	15.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	0	0	274,433	2,253,666	113,607	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	79,814	537,351	23,066	31.00
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	0	40.00
41.00	04100	SUBPROVIDER - IRF	0	0	47,476	502,685	12,050	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	0	42.00
43.00	04300	NURSERY	0	0	46,562	0	0	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	161,587	1,806,887	80,936	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	129,512	1,084,877	36,919	54.00
57.00	05700	CT SCAN	0	0	24,220	78,930	18,709	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	12,398	93,562	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	30,764	264,323	5,345	59.00
60.00	06000	LABORATORY	0	0	124,058	686,819	0	60.00
60.01	06001	ONCOLOGY	0	0	0	0	2,927	60.01
60.02	06002	RADIATION ONCOLOGY	0	0	0	0	0	60.02
65.00	06500	RESPIRATORY THERAPY	0	0	57,836	233,642	3,967	65.00
66.00	06600	PHYSICAL THERAPY	0	0	33,206	46,204	13,092	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	48,199	417,147	3,960	69.00
69.01	06901	CARDIAC REHAB	0	0	8,248	68,021	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	15,322	256,718	2,181	90.00
91.00	09100	EMERGENCY	0	0	222,214	580,618	202,868	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	0	0	0	0	0	92.01
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	0	0	68,129	217,647	16,951	95.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	1,857,516	1,577,497	10,084,330	536,995	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	1,337	69,699	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
192.01	19201	PACT REV PHYSICIANS	0	0	17,788	0	0	192.01
192.02	19202	VISITOR MEALS	0	54,417	0	0	0	192.02
192.03	19203	GREAT BEGINNINGS/MATERNAL	0	0	0	0	0	192.03
192.04	19204	LIFELINE	0	0	0	0	0	192.04
192.05	19205	OWNED PROPERTIES	0	0	0	0	0	192.05
192.06	19206	UROLOGY	0	0	33,292	0	0	192.06
192.07	19207	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.07
192.08	19211	PARI SH NURSING	0	0	3,605	0	0	192.08
192.09	19212	BIOTERRORISM GRANT	0	0	0	0	0	192.09
192.10	19214	BREAST PUMPS	0	0	0	0	0	192.10
192.11	19208	MGH EMERGENCY PHYSICIANS	0	0	0	0	0	192.11
192.12	19209	LUNG CENTER	0	0	17,097	0	0	192.12
192.13	19213	MGH EXPRESS	0	0	0	0	0	192.13
192.14	19210	MGH PHYS PRACT MGMT	0	0	81,938	0	901	192.14
192.15	19215	MGH MARION SURGEONS	0	0	45,151	0	0	192.15
192.16	19216	MGH MGH MED ONC	0	0	0	0	0	192.16
192.17	19217	MGH FMC SOUTH	0	0	0	0	16	192.17
192.18	19218	MGH FAIRM MED ASSOC	0	0	0	0	25	192.18
192.19	19219	MGH FMC MARION	0	0	30,095	0	0	192.19
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	MGH FMC NORTHWOOD	0	0	0	0	0	193.01
193.02	19302	MGH FMC GAS CITY	0	0	0	0	27	193.02
193.03	19303	MGH HOSPITALISTS	0	0	0	0	0	193.03

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 15-0011

Period:
From 07/01/2019
To 06/30/2020

Worksheet B
Part I
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Cost Center Description		MAINTENANCE & REPAIRS	CAFETERIA	CAFETERIA	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	
		6.00	6.01	6.02	7.00	8.00	
193.04	19304	0	0	0	0	445	193.04
193.05	19305	0	0	0	0	25	193.05
193.06	19306	0	0	25,740	0	56	193.06
193.07	19307	0	0	8,902	0	28	193.07
193.08	19308	0	0	0	0	105	193.08
193.09	19309	0	0	0	0	946	193.09
193.10	19310	0	0	0	0	0	193.10
193.11	19311	0	0	0	0	0	193.11
193.12	19312	0	0	0	0	0	193.12
193.15	19315	0	0	0	0	0	193.15
193.16	19316	0	0	0	0	0	193.16
193.18	19318	0	0	0	0	0	193.18
194.00	07963	0	0	0	0	0	194.00
194.01	07950	0	0	0	0	0	194.01
194.02	07951	0	0	0	0	0	194.02
194.03	07952	0	0	6,173	0	0	194.03
194.04	07953	0	0	0	0	81	194.04
194.05	07954	0	0	0	0	0	194.05
194.06	07955	0	0	3,929	0	0	194.06
194.07	07956	0	0	153	0	0	194.07
194.08	07957	0	0	0	0	0	194.08
194.09	07958	0	0	0	0	0	194.09
194.10	07959	0	0	0	0	0	194.10
194.11	07960	0	0	0	0	0	194.11
194.12	07961	0	0	0	0	0	194.12
194.13	07969	0	0	0	0	0	194.13
194.14	07964	0	0	0	0	0	194.14
194.15	07965	0	0	2,179	0	0	194.15
194.16	07966	0	0	121	0	0	194.16
194.17	07967	0	0	769	0	0	194.17
194.18	07962	0	0	0	0	0	194.18
194.19	07968	0	0	1,750	0	0	194.19
200.00	Cross Foot Adjustments	0	0	0	0	0	200.00
201.00	Negative Cost Centers	0	0	0	0	0	201.00
202.00	TOTAL (sum lines 118 through 201)	0	1,911,933	1,857,516	10,154,029	539,650	202.00

COST ALLOCATION - GENERAL SERVICE COSTS			Provider CCN: 15-0011		Period: From 07/01/2019 To 06/30/2020		Worksheet B Part I Date/Time Prepared: 11/20/2020 1:17 pm	
Cost Center Description			HOUSEKEEPING	DIETARY	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	
			9.00	10.00	13.00	14.00	15.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
6.01	00601	CAFETERIA						6.01
6.02	00602	CAFETERIA						6.02
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING	3,509,820					9.00
10.00	01000	DIETARY	50,297	1,271,080				10.00
13.00	01300	NURSING ADMINISTRATION	15,718	0	1,464,864			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	78,590	0	0	925,566		14.00
15.00	01500	PHARMACY	44,010	0	0	0	5,528,827	15.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	930,503	817,997	351,623	99,816	0	30.00
31.00	03100	INTENSIVE CARE UNIT	176,041	130,746	102,263	36,297	0	31.00
40.00	04000	SUBPROVIDER - I/PF	0	0	0	0	0	40.00
41.00	04100	SUBPROVIDER - I/RF	150,892	133,662	60,830	9,074	0	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	0	42.00
43.00	04300	NURSERY	0	0	59,659	0	0	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	465,252	0	180,755	117,964	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	198,046	0	0	18,148	0	54.00
57.00	05700	CT SCAN	11,003	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	62,872	0	39,417	36,297	0	59.00
60.00	06000	LABORATORY	176,041	0	0	54,445	0	60.00
60.01	06001	ONCOLOGY	0	0	0	0	0	60.01
60.02	06002	RADIATION ONCOLOGY	0	0	0	0	0	60.02
65.00	06500	RESPIRATORY THERAPY	132,031	0	74,104	18,148	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	42,546	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	84,877	0	61,757	27,223	0	69.00
69.01	06901	CARDIAC REHAB	94,308	0	10,567	0	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	5,528,827	73.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	62,872	0	19,632	0	0	90.00
91.00	09100	EMERGENCY	704,165	19,881	284,718	45,371	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	0	0	0	0	0	92.01
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	22,005	0	87,293	9,074	0	95.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	3,459,523	1,102,286	1,375,164	471,857	5,528,827	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	6,287	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
192.01	19201	PACT REV PHYSICIANS	0	0	22,792	0	0	192.01
192.02	19202	VISITOR MEALS	0	0	0	0	0	192.02
192.03	19203	GREAT BEGINNINGS/MATERNAL	0	0	6,966	0	0	192.03
192.04	19204	LIFELINE	0	0	0	0	0	192.04
192.05	19205	OWNED PROPERTIES	0	0	0	0	0	192.05
192.06	19206	UROLOGY	0	0	0	36,297	0	192.06
192.07	19207	PHYSICIANS' PRIVATE OFFICES	12,574	0	0	0	0	192.07
192.08	19211	PARI SH NURSING	6,287	0	0	0	0	192.08
192.09	19212	BIOTERRORISM GRANT	0	0	0	0	0	192.09
192.10	19214	BREAST PUMPS	0	0	0	0	0	192.10
192.11	19208	MGH EMERGENCY PHYSICIANS	0	0	0	0	0	192.11
192.12	19209	LUNG CENTER	0	0	0	0	0	192.12
192.13	19213	MGH EXPRESS	0	0	59,942	18,148	0	192.13
192.14	19210	MGH PHYS PRACT MGMT	25,149	0	0	0	0	192.14
192.15	19215	MGH MARION SURGEONS	0	0	0	54,445	0	192.15
192.16	19216	MGH MGH MED ONC	0	0	0	0	0	192.16
192.17	19217	MGH FMC SOUTH	0	0	0	45,371	0	192.17
192.18	19218	MGH FAIRM MED ASSOC	0	0	0	0	0	192.18
192.19	19219	MGH FMC MARION	0	0	0	27,223	0	192.19
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	MGH FMC NORTHWOOD	0	0	0	9,074	0	193.01
193.02	19302	MGH FMC GAS CITY	0	0	0	9,074	0	193.02

COST ALLOCATION - GENERAL SERVICE COSTS

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Period:
From 07/01/2019
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Cost Center Description	HOUSEKEEPING	DIETARY	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	
	9.00	10.00	13.00	14.00	15.00	
193.03 19303 MGH HOSPITALISTS	0	0	0	0	0	0 193.03
193.04 19304 MGH MAR FAM PRACT	0	0	0	54,445	0	0 193.04
193.05 19305 MGH FMC SWAYZEE	0	0	0	9,074	0	0 193.05
193.06 19306 MGH PEDIATRIC CTR	0	0	0	9,074	0	0 193.06
193.07 19307 MGH SPECIALTY PHYS	0	0	0	0	0	0 193.07
193.08 19308 MGH FMC CONVERSE	0	0	0	9,074	0	0 193.08
193.09 19309 MGH UPLAND HEALTH	0	0	0	18,148	0	0 193.09
193.10 19310 MGH MGH WOMENS CTR	0	0	0	0	0	0 193.10
193.11 19311 MGH MGH PSYCHIATRY	0	0	0	0	0	0 193.11
193.12 19312 OB/GYN	0	0	0	136,114	0	0 193.12
193.15 19315 MGH RIVER VIEW BLDG	0	0	0	0	0	0 193.15
193.16 19316 MGH NEONATOLOGY	0	0	0	0	0	0 193.16
193.18 19318 MGH WOUND CARE	0	0	0	0	0	0 193.18
194.00 07963 HEART FAILURE CLINIC	0	0	0	0	0	0 194.00
194.01 07950 MOW	0	44,583	0	0	0	0 194.01
194.02 07951 MENTAL HEALTH	0	124,211	0	0	0	0 194.02
194.03 07952 ADVERTISING	0	0	0	0	0	0 194.03
194.04 07953 MGH WORK SOLUTIONS	0	0	0	18,148	0	0 194.04
194.05 07954 MGH TAYLOR UNIVERSITY	0	0	0	0	0	0 194.05
194.06 07955 OPIOID IMPL GRANT	0	0	0	0	0	0 194.06
194.07 07956 ASTHMA GRANT	0	0	0	0	0	0 194.07
194.08 07957 MGH SMMP BLDG	0	0	0	0	0	0 194.08
194.09 07958 MGH AMBUCARE BLDG	0	0	0	0	0	0 194.09
194.10 07959 MGH 106 LYONS BLDG	0	0	0	0	0	0 194.10
194.11 07960 FAIRMOUNT	0	0	0	0	0	0 194.11
194.12 07961 GAS CITY	0	0	0	0	0	0 194.12
194.13 07969 LYONS	0	0	0	0	0	0 194.13
194.14 07964 WABASH	0	0	0	0	0	0 194.14
194.15 07965 TOBACCO GRANT	0	0	0	0	0	0 194.15
194.16 07966 HRSA NETWORK DEV PLANNING	0	0	0	0	0	0 194.16
194.17 07967 HRSA OPIOID PLANNING	0	0	0	0	0	0 194.17
194.18 07962 ECHO GRANT	0	0	0	0	0	0 194.18
194.19 07968 RURAL QI GRANT	0	0	0	0	0	0 194.19
200.00						200.00
201.00						201.00
202.00						202.00
	Cross Foot Adjustments					
	Negative Cost Centers					
202.00	TOTAL (sum lines 118 through 201)	3,509,820	1,271,080	1,464,864	925,566	5,528,827 202.00

COST ALLOCATION - GENERAL SERVICE COSTS

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Cost Center Description		Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
		24.00	25.00	26.00	
GENERAL SERVICE COST CENTERS					
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT			1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT			4.00
5.00	00500	ADMINISTRATIVE & GENERAL			5.00
6.00	00600	MAINTENANCE & REPAIRS			6.00
6.01	00601	CAFETERIA			6.01
6.02	00602	CAFETERIA			6.02
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
13.00	01300	NURSING ADMINISTRATION			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY			14.00
15.00	01500	PHARMACY			15.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	16,483,087	0	16,483,087
31.00	03100	INTENSIVE CARE UNIT	4,726,611	0	4,726,611
40.00	04000	SUBPROVIDER - IPF	0	0	0
41.00	04100	SUBPROVIDER - IRF	3,716,162	0	3,716,162
42.00	04200	SUBPROVIDER	0	0	0
43.00	04300	NURSERY	1,921,773	0	1,921,773
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	16,908,518	0	16,908,518
51.00	05100	RECOVERY ROOM	0	0	0
54.00	05400	RADIOLOGY-DIAGNOSTIC	8,678,458	0	8,678,458
57.00	05700	CT SCAN	1,438,201	0	1,438,201
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	826,063	0	826,063
59.00	05900	CARDIAC CATHETERIZATION	3,285,137	0	3,285,137
60.00	06000	LABORATORY	12,025,092	0	12,025,092
60.01	06001	ONCOLOGY	2,324,362	0	2,324,362
60.02	06002	RADIATION ONCOLOGY	0	0	0
65.00	06500	RESPIRATORY THERAPY	3,744,083	0	3,744,083
66.00	06600	PHYSICAL THERAPY	3,354,987	0	3,354,987
69.00	06900	ELECTROCARDIOLOGY	2,372,606	0	2,372,606
69.01	06901	CARDIAC REHAB	540,856	0	540,856
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0
73.00	07300	DRUGS CHARGED TO PATIENTS	18,159,356	0	18,159,356
OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	1,883,186	0	1,883,186
91.00	09100	EMERGENCY	11,811,168	0	11,811,168
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	0	0	0
OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES	2,311,624	0	2,311,624
SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE	0	0	0
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	116,511,330	0	116,511,330
NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	181,968	0	181,968
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0
192.01	19201	PACT REV PHYSICIANS	947,844	0	947,844
192.02	19202	VISITOR MEALS	54,417	0	54,417
192.03	19203	GREAT BEGINNINGS/MATERNAL	163,655	0	163,655
192.04	19204	LIFELINE	0	0	0
192.05	19205	OWNED PROPERTIES	412,621	0	412,621
192.06	19206	UROLOGY	1,842,171	0	1,842,171
192.07	19207	PHYSICIANS' PRIVATE OFFICES	12,574	0	12,574
192.08	19211	PARI SH NURSING	118,505	0	118,505
192.09	19212	BIOTERRORISM GRANT	0	0	0
192.10	19214	BREAST PUMPS	0	0	0
192.11	19208	MGH EMERGENCY PHYSICIANS	0	0	0
192.12	19209	LUNG CENTER	1,165,978	0	1,165,978
192.13	19213	MGH EXPRESS	1,966,462	0	1,966,462
192.14	19210	MGH PHYS PRACT MGMT	2,699,299	0	2,699,299
192.15	19215	MGH MARION SURGEONS	2,969,109	0	2,969,109
192.16	19216	MGH MGH MED ONC	2,076,368	0	2,076,368
192.17	19217	MGH FMC SOUTH	3,832,995	0	3,832,995
192.18	19218	MGH FAIRMED ASSOC	725,905	0	725,905
192.19	19219	MGH FMC MARION	1,259,665	0	1,259,665
193.00	19300	NONPAID WORKERS	0	0	0

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Cost Center Description			Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			24.00	25.00	26.00	
193.01	19301	MGH FMC NORTHWOOD	1,707,342	0	1,707,342	193.01
193.02	19302	MGH FMC GAS CITY	1,101,174	0	1,101,174	193.02
193.03	19303	MGH HOSPITALISTS	5,397,660	0	5,397,660	193.03
193.04	19304	MGH MAR FAM PRACT	4,546,849	0	4,546,849	193.04
193.05	19305	MGH FMC SWAYZEE	376,853	0	376,853	193.05
193.06	19306	MGH PEDIATRIC CTR	1,500,735	0	1,500,735	193.06
193.07	19307	MGH SPECIALTY PHYS	426,802	0	426,802	193.07
193.08	19308	MGH FMC CONVERSE	499,397	0	499,397	193.08
193.09	19309	MGH UPLAND HEALTH	2,460,618	0	2,460,618	193.09
193.10	19310	MGH MGH WOMENS CTR	0	0	0	193.10
193.11	19311	MGH MGH PSYCHIATRY	0	0	0	193.11
193.12	19312	OB/GYN	4,263,232	0	4,263,232	193.12
193.15	19315	MGH RIVER VIEW BLDG	0	0	0	193.15
193.16	19316	MGH NEONATOLOGY	1,094,965	0	1,094,965	193.16
193.18	19318	MGH WOUND CARE	35,397	0	35,397	193.18
194.00	07963	HEART FAILURE CLINIC	73,037	0	73,037	194.00
194.01	07950	MOW	44,583	0	44,583	194.01
194.02	07951	MENTAL HEALTH	124,211	0	124,211	194.02
194.03	07952	ADVERTISING	307,628	0	307,628	194.03
194.04	07953	MGH WORK SOLUTIONS	1,261,492	0	1,261,492	194.04
194.05	07954	MGH TAYLOR UNIVERSITY	162,339	0	162,339	194.05
194.06	07955	OPIOID IMPL GRANT	278,082	0	278,082	194.06
194.07	07956	ASTHMA GRANT	7,306	0	7,306	194.07
194.08	07957	MGH SMMP BLDG	0	0	0	194.08
194.09	07958	MGH AMBUCARE BLDG	0	0	0	194.09
194.10	07959	MGH 106 LYONS BLDG	9,323	0	9,323	194.10
194.11	07960	FAIRMOUNT	0	0	0	194.11
194.12	07961	GAS CITY	0	0	0	194.12
194.13	07969	LYONS	0	0	0	194.13
194.14	07964	WABASH	0	0	0	194.14
194.15	07965	TOBACCO GRANT	78,412	0	78,412	194.15
194.16	07966	HRSA NETWORK DEV PLANNING	14,353	0	14,353	194.16
194.17	07967	HRSA OPIOID PLANNING	144,648	0	144,648	194.17
194.18	07962	ECHO GRANT	98	0	98	194.18
194.19	07968	RURAL QI GRANT	140,462	0	140,462	194.19
200.00		Cross Foot Adjustments	0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	162,997,864	0	162,997,864	202.00

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 15-0011	Period: From 07/01/2019 To 06/30/2020	Worksheet B Part II Date/Time Prepared: 11/20/2020 1:17 pm
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Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS DEPARTMENT	ADMINISTRATIVE & GENERAL	
		NEW BLDG & FIXT					
	0	1.00		2A	4.00	5.00	
GENERAL SERVICE COST CENTERS							
1.00 00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	0	299,988	299,988	299,988		4.00
5.00 00500	ADMINISTRATIVE & GENERAL	0	3,704,496	3,704,496	61,376	3,765,872	5.00
6.00 00600	MAINTENANCE & REPAIRS	0	0	0	0	0	6.00
6.01 00601	CAFETERIA	0	134,488	134,488	0	44,173	6.01
6.02 00602	CAFETERIA	0	0	0	0	0	6.02
7.00 00700	OPERATION OF PLANT	0	2,555,603	2,555,603	3,188	233,335	7.00
8.00 00800	LAUNDRY & LINEN SERVICE	0	58,508	58,508	0	9,908	8.00
9.00 00900	HOUSEKEEPING	0	90,268	90,268	0	77,141	9.00
10.00 01000	DIETARY	0	185,298	185,298	79	20,081	10.00
13.00 01300	NURSING ADMINISTRATION	0	19,272	19,272	3,471	31,973	13.00
14.00 01400	CENTRAL SERVICES & SUPPLY	0	65,984	65,984	669	16,393	14.00
15.00 01500	PHARMACY	0	85,007	85,007	10,877	120,752	15.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00 03000	ADULTS & PEDIATRICS	0	1,189,874	1,189,874	24,036	268,964	30.00
31.00 03100	INTENSIVE CARE UNIT	0	283,707	283,707	7,270	84,122	31.00
40.00 04000	SUBPROVIDER - I/PF	0	0	0	0	0	40.00
41.00 04100	SUBPROVIDER - I/RP	0	265,404	265,404	4,271	64,680	41.00
42.00 04200	SUBPROVIDER	0	0	0	0	0	42.00
43.00 04300	NURSERY	0	0	0	4,279	41,947	43.00
ANCILLARY SERVICE COST CENTERS							
50.00 05000	OPERATING ROOM	0	953,987	953,987	4,824	325,622	50.00
51.00 05100	RECOVERY ROOM	0	0	0	0	0	51.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	0	572,785	572,785	9,947	166,602	54.00
57.00 05700	CT SCAN	0	41,673	41,673	1,924	30,159	57.00
58.00 05800	MAGNETIC RESONANCE IMAGING (MRI)	0	49,398	49,398	985	16,637	58.00
59.00 05900	CARDIAC CATHETERIZATION	0	139,555	139,555	2,627	65,757	59.00
60.00 06000	LABORATORY	0	362,622	362,622	9,206	253,768	60.00
60.01 06001	ONCOLOGY	0	0	0	4,209	53,634	60.01
60.02 06002	RADIATION ONCOLOGY	0	0	0	0	0	60.02
65.00 06500	RESPIRATORY THERAPY	0	123,357	123,357	5,840	74,496	65.00
66.00 06600	PHYSICAL THERAPY	0	24,394	24,394	7,649	74,394	66.00
69.00 06900	ELECTROCARDIOLOGY	0	220,242	220,242	3,417	39,957	69.00
69.01 06901	CARDIAC REHAB	0	35,913	35,913	771	8,311	69.01
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	291,816	73.00
OUTPATIENT SERVICE COST CENTERS							
90.00 09000	CLINIC	0	135,540	135,540	1,213	35,267	90.00
91.00 09100	EMERGENCY	0	306,551	306,551	33,622	225,295	91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
92.01 09201	OBSERVATION BEDS (DISTINCT PART)	0	0	0	0	0	92.01
OTHER REIMBURSABLE COST CENTERS							
95.00 09500	AMBULANCE SERVICES	0	114,911	114,911	4,409	43,679	95.00
SPECIAL PURPOSE COST CENTERS							
113.00 11300	INTEREST EXPENSE						113.00
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	0	12,018,825	12,018,825	210,159	2,718,863	118.00
NONREIMBURSABLE COST CENTERS							
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	36,799	36,799	118	2,418	190.00
192.00 19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
192.01 19201	PACT REV PHYSICIANS	0	0	0	1,872	20,961	192.01
192.02 19202	VISITOR MEALS	0	0	0	0	0	192.02
192.03 19203	GREAT BEGINNINGS/MATERNAL	0	0	0	413	3,620	192.03
192.04 19204	LIFELINE	0	0	0	0	0	192.04
192.05 19205	OWNED PROPERTIES	0	0	0	0	9,533	192.05
192.06 19206	UROLOGY	0	0	0	3,538	40,954	192.06
192.07 19207	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.07
192.08 19211	PARI SH NURSING	0	0	0	238	2,509	192.08
192.09 19212	BIOTERRORISM GRANT	0	0	0	0	0	192.09
192.10 19214	BREAST PUMPS	0	0	0	0	0	192.10
192.11 19208	MGH EMERGENCY PHYSICIANS	0	0	0	0	0	192.11
192.12 19209	LUNG CENTER	0	0	0	2,605	26,544	192.12
192.13 19213	MGH EXPRESS	0	0	0	3,909	43,629	192.13
192.14 19210	MGH PHYS PRACT MGMT	0	0	0	4,716	59,870	192.14
192.15 19215	MGH MARION SURGEONS	0	0	0	6,586	66,297	192.15
192.16 19216	MGH MGH MED ONC	0	0	0	4,786	47,972	192.16
192.17 19217	MGH FMC SOUTH	0	0	0	7,580	87,509	192.17
192.18 19218	MGH FAIRM MED ASSOC	0	0	0	1,302	16,771	192.18
192.19 19219	MGH FMC MARION	0	0	0	2,643	27,779	192.19

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 15-0011

Period:
From 07/01/2019
To 06/30/2020

Worksheet B
Part II
Date/Time Prepared:
11/20/2020 1:17 pm

Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS DEPARTMENT	ADMINISTRATIVE & GENERAL	
		NEW BLDG & FIXT					
		0	1.00				
193.00 19300 NONPAID WORKERS	0	0	0	0	0	0	193.00
193.01 19301 MGH FMC NORTHWOOD	0	0	0	0	3,731	39,237	193.01
193.02 19302 MGH FMC GAS CITY	0	0	0	0	2,132	25,231	193.02
193.03 19303 MGH HOSPITALISTS	0	0	0	0	12,399	124,708	193.03
193.04 19304 MGH MAR FAM PRACT	0	0	0	0	9,432	103,782	193.04
193.05 19305 MGH FMC SWAYZEE	0	0	0	0	732	8,497	193.05
193.06 19306 MGH PEDIATRIC CTR	0	0	0	0	2,764	33,867	193.06
193.07 19307 MGH SPECIALTY PHYS	0	0	0	0	914	9,655	193.07
193.08 19308 MGH FMC CONVERSE	0	0	0	0	885	11,326	193.08
193.09 19309 MGH UPLAND HEALTH	0	0	0	0	4,631	56,409	193.09
193.10 19310 MGH MGH WOMENS CTR	0	0	0	0	0	0	193.10
193.11 19311 MGH MGH PSYCHIATRY	0	0	0	0	0	0	193.11
193.12 19312 OB/GYN	0	0	0	0	8,183	95,353	193.12
193.15 19315 MGH RIVER VIEW BLDG	0	0	0	0	0	0	193.15
193.16 19316 MGH NEONATOLOGY	0	0	0	0	0	25,298	193.16
193.18 19318 MGH WOUND CARE	0	0	0	0	82	818	193.18
194.00 07963 HEART FAILURE CLINIC	0	0	0	0	137	1,687	194.00
194.01 07950 MOW	0	0	0	0	0	0	194.01
194.02 07951 MENTAL HEALTH	0	0	0	0	0	0	194.02
194.03 07952 ADVERTISING	0	0	0	0	463	6,965	194.03
194.04 07953 MGH WORK SOLUTIONS	0	0	0	0	2,160	28,724	194.04
194.05 07954 MGH TAYLOR UNIVERSITY	0	0	0	0	376	3,751	194.05
194.06 07955 OPIOID IMPL GRANT	0	0	0	0	180	6,334	194.06
194.07 07956 ASTHMA GRANT	0	0	0	0	13	165	194.07
194.08 07957 MGH SMMP BLDG	0	0	0	0	0	0	194.08
194.09 07958 MGH AMBUCARE BLDG	0	0	0	0	0	0	194.09
194.10 07959 MGH 106 LYONS BLDG	0	0	0	0	0	215	194.10
194.11 07960 FAIRMOUNT	0	0	0	0	0	0	194.11
194.12 07961 GAS CITY	0	0	0	0	0	0	194.12
194.13 07969 LYONS	0	0	0	0	0	0	194.13
194.14 07964 WABASH	0	0	0	0	0	0	194.14
194.15 07965 TOBACCO GRANT	0	0	0	0	152	1,761	194.15
194.16 07966 HRSA NETWORK DEV PLANNING	0	0	0	0	8	329	194.16
194.17 07967 HRSA OPIOID PLANNING	0	0	0	0	57	3,324	194.17
194.18 07962 ECHO GRANT	0	0	0	0	0	2	194.18
194.19 07968 RURAL QI GRANT	0	0	0	0	92	3,205	194.19
200.00 Cross Foot Adjustments				0			200.00
201.00 Negative Cost Centers				0			201.00
202.00 TOTAL (sum lines 118 through 201)	0	12,055,624	12,055,624	299,988	3,765,872	202.00	

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 15-0011	Period: From 07/01/2019 To 06/30/2020	Worksheet B Part II Date/Time Prepared: 11/20/2020 1:17 pm			
Cost Center Description		MAINTENANCE & REPAIRS	CAFETERIA	CAFETERIA	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	
		6.00	6.01	6.02	7.00	8.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT					1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500	ADMINISTRATIVE & GENERAL					5.00
6.00	00600	MAINTENANCE & REPAIRS	0				6.00
6.01	00601	CAFETERIA	0	178,661			6.01
6.02	00602	CAFETERIA	0	173,576	173,576		6.02
7.00	00700	OPERATION OF PLANT	0	0	5,111	2,797,237	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0	30,528	98,944
9.00	00900	HOUSEKEEPING	0	0	0	47,099	0
10.00	01000	DIETARY	0	0	42	96,683	39
13.00	01300	NURSING ADMINISTRATION	0	0	2,688	10,056	0
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	1,147	34,429	37
15.00	01500	PHARMACY	0	0	9,096	44,354	0
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	0	0	25,643	620,841	20,830
31.00	03100	INTENSIVE CARE UNIT	0	0	7,458	148,030	4,229
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	0
41.00	04100	SUBPROVIDER - IRF	0	0	4,436	138,480	2,209
42.00	04200	SUBPROVIDER	0	0	0	0	0
43.00	04300	NURSERY	0	0	4,351	0	0
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	0	15,100	497,762	14,839
51.00	05100	RECOVERY ROOM	0	0	0	0	0
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	12,102	298,862	6,769
57.00	05700	CT SCAN	0	0	2,263	21,744	3,430
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	1,159	25,774	0
59.00	05900	CARDIAC CATHETERIZATION	0	0	2,875	72,816	980
60.00	06000	LABORATORY	0	0	11,593	189,205	0
60.01	06001	ONCOLOGY	0	0	0	0	537
60.02	06002	RADIATION ONCOLOGY	0	0	0	0	0
65.00	06500	RESPIRATORY THERAPY	0	0	5,404	64,364	727
66.00	06600	PHYSICAL THERAPY	0	0	3,103	12,728	2,400
69.00	06900	ELECTROCARDIOLOGY	0	0	4,504	114,916	726
69.01	06901	CARDIAC REHAB	0	0	771	18,738	0
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0	0	1,432	70,721	400
91.00	09100	EMERGENCY	0	0	20,765	159,949	37,196
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	0	0	0	0	0
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	0	0	6,366	59,957	3,108
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	173,576	147,409	2,778,036	98,456
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	125	19,201	0
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0
192.01	19201	PACT REV PHYSICIANS	0	0	1,662	0	0
192.02	19202	VISITOR MEALS	0	5,085	0	0	0
192.03	19203	GREAT BEGINNINGS/MATERNAL	0	0	0	0	0
192.04	19204	LIFELINE	0	0	0	0	0
192.05	19205	OWNED PROPERTIES	0	0	0	0	0
192.06	19206	UROLOGY	0	0	3,111	0	0
192.07	19207	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0
192.08	19211	PARI SH NURSING	0	0	337	0	0
192.09	19212	BIOTERRORISM GRANT	0	0	0	0	0
192.10	19214	BREAST PUMPS	0	0	0	0	0
192.11	19208	MGH EMERGENCY PHYSICIANS	0	0	0	0	0
192.12	19209	LUNG CENTER	0	0	1,598	0	0
192.13	19213	MGH EXPRESS	0	0	0	0	0
192.14	19210	MGH PHYS PRACT MGMT	0	0	7,657	0	165
192.15	19215	MGH MARION SURGEONS	0	0	4,219	0	0
192.16	19216	MGH MGH MED ONC	0	0	0	0	0
192.17	19217	MGH FMC SOUTH	0	0	0	0	3
192.18	19218	MGH FAIRM MED ASSOC	0	0	0	0	5
192.19	19219	MGH FMC MARION	0	0	2,812	0	0
193.00	19300	NONPAID WORKERS	0	0	0	0	0
193.01	19301	MGH FMC NORTHWOOD	0	0	0	0	0
193.02	19302	MGH FMC GAS CITY	0	0	0	0	5
193.03	19303	MGH HOSPITALISTS	0	0	0	0	0

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 15-0011

Period:
From 07/01/2019
To 06/30/2020

Worksheet B
Part II
Date/Time Prepared:
11/20/2020 1:17 pm

Cost Center Description		MAINTENANCE & REPAIRS	CAFETERIA	CAFETERIA	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	
		6.00	6.01	6.02	7.00	8.00	
193.04	19304	0	0	0	0	82	193.04
193.05	19305	0	0	0	0	5	193.05
193.06	19306	0	0	2,405	0	10	193.06
193.07	19307	0	0	832	0	5	193.07
193.08	19308	0	0	0	0	19	193.08
193.09	19309	0	0	0	0	174	193.09
193.10	19310	0	0	0	0	0	193.10
193.11	19311	0	0	0	0	0	193.11
193.12	19312	0	0	0	0	0	193.12
193.15	19315	0	0	0	0	0	193.15
193.16	19316	0	0	0	0	0	193.16
193.18	19318	0	0	0	0	0	193.18
194.00	07963	0	0	0	0	0	194.00
194.01	07950	0	0	0	0	0	194.01
194.02	07951	0	0	0	0	0	194.02
194.03	07952	0	0	577	0	0	194.03
194.04	07953	0	0	0	0	15	194.04
194.05	07954	0	0	0	0	0	194.05
194.06	07955	0	0	367	0	0	194.06
194.07	07956	0	0	14	0	0	194.07
194.08	07957	0	0	0	0	0	194.08
194.09	07958	0	0	0	0	0	194.09
194.10	07959	0	0	0	0	0	194.10
194.11	07960	0	0	0	0	0	194.11
194.12	07961	0	0	0	0	0	194.12
194.13	07969	0	0	0	0	0	194.13
194.14	07964	0	0	0	0	0	194.14
194.15	07965	0	0	204	0	0	194.15
194.16	07966	0	0	11	0	0	194.16
194.17	07967	0	0	72	0	0	194.17
194.18	07962	0	0	0	0	0	194.18
194.19	07968	0	0	164	0	0	194.19
200.00	Cross Foot Adjustments	0	0	0	0	0	200.00
201.00	Negative Cost Centers	0	0	0	0	0	201.00
202.00	TOTAL (sum lines 118 through 201)	0	178,661	173,576	2,797,237	98,944	202.00

ALLOCATION OF CAPITAL RELATED COSTS			Provider CCN: 15-0011		Period: From 07/01/2019 To 06/30/2020		Worksheet B Part II Date/Time Prepared: 11/20/2020 1:17 pm	
Cost Center Description			HOUSEKEEPING	DIETARY	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	
			9.00	10.00	13.00	14.00	15.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
6.01	00601	CAFETERIA						6.01
6.02	00602	CAFETERIA						6.02
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING	214,508					9.00
10.00	01000	DIETARY	3,074	305,296				10.00
13.00	01300	NURSING ADMINISTRATION	961	0	68,421			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	4,803	0	0	123,462		14.00
15.00	01500	PHARMACY	2,690	0	0	0	272,776	15.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	56,868	196,472	16,423	13,315	0	30.00
31.00	03100	INTENSIVE CARE UNIT	10,759	31,403	4,776	4,842	0	31.00
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	0	40.00
41.00	04100	SUBPROVIDER - IRF	9,222	32,104	2,841	1,210	0	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	0	42.00
43.00	04300	NURSERY	0	0	2,787	0	0	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	28,435	0	8,443	15,735	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	12,104	0	0	2,421	0	54.00
57.00	05700	CT SCAN	672	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	3,843	0	1,841	4,842	0	59.00
60.00	06000	LABORATORY	10,759	0	0	7,262	0	60.00
60.01	06001	ONCOLOGY	0	0	0	0	0	60.01
60.02	06002	RADIATION ONCOLOGY	0	0	0	0	0	60.02
65.00	06500	RESPIRATORY THERAPY	8,069	0	3,461	2,421	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	1,987	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	5,187	0	2,885	3,631	0	69.00
69.01	06901	CARDIAC REHAB	5,764	0	494	0	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	272,776	73.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	3,843	0	917	0	0	90.00
91.00	09100	EMERGENCY	43,036	4,775	13,299	6,052	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	0	0	0	0	0	92.01
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	1,345	0	4,077	1,210	0	95.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	211,434	264,754	64,231	62,941	272,776	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	384	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
192.01	19201	PACT REV PHYSICIANS	0	0	1,065	0	0	192.01
192.02	19202	VISITOR MEALS	0	0	0	0	0	192.02
192.03	19203	GREAT BEGINNINGS/MATERNAL	0	0	325	0	0	192.03
192.04	19204	LIFELINE	0	0	0	0	0	192.04
192.05	19205	OWNED PROPERTIES	0	0	0	0	0	192.05
192.06	19206	UROLOGY	0	0	0	4,842	0	192.06
192.07	19207	PHYSICIANS' PRIVATE OFFICES	769	0	0	0	0	192.07
192.08	19211	PARI SH NURSING	384	0	0	0	0	192.08
192.09	19212	BIOTERRORISM GRANT	0	0	0	0	0	192.09
192.10	19214	BREAST PUMPS	0	0	0	0	0	192.10
192.11	19208	MGH EMERGENCY PHYSICIANS	0	0	0	0	0	192.11
192.12	19209	LUNG CENTER	0	0	0	0	0	192.12
192.13	19213	MGH EXPRESS	0	0	2,800	2,421	0	192.13
192.14	19210	MGH PHYS PRACT MGMT	1,537	0	0	0	0	192.14
192.15	19215	MGH MARION SURGEONS	0	0	0	7,262	0	192.15
192.16	19216	MGH MGH MED ONC	0	0	0	0	0	192.16
192.17	19217	MGH FMC SOUTH	0	0	0	6,052	0	192.17
192.18	19218	MGH FAIRM MED ASSOC	0	0	0	0	0	192.18
192.19	19219	MGH FMC MARION	0	0	0	3,631	0	192.19
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	MGH FMC NORTHWOOD	0	0	0	1,210	0	193.01
193.02	19302	MGH FMC GAS CITY	0	0	0	1,210	0	193.02

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 15-0011

Period:
From 07/01/2019
To 06/30/2020

Worksheet B
Part II
Date/Time Prepared:
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Cost Center Description	HOUSEKEEPING	DIETARY	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	
	9.00	10.00	13.00	14.00	15.00	
193.03 19303 MGH HOSPITALISTS	0	0	0	0	0	0 193.03
193.04 19304 MGH MAR FAM PRACT	0	0	0	7,262	0	0 193.04
193.05 19305 MGH FMC SWAYZEE	0	0	0	1,210	0	0 193.05
193.06 19306 MGH PEDIATRIC CTR	0	0	0	1,210	0	0 193.06
193.07 19307 MGH SPECIALTY PHYS	0	0	0	0	0	0 193.07
193.08 19308 MGH FMC CONVERSE	0	0	0	1,210	0	0 193.08
193.09 19309 MGH UPLAND HEALTH	0	0	0	2,421	0	0 193.09
193.10 19310 MGH MGH WOMENS CTR	0	0	0	0	0	0 193.10
193.11 19311 MGH MGH PSYCHIATRY	0	0	0	0	0	0 193.11
193.12 19312 OB/GYN	0	0	0	18,159	0	0 193.12
193.15 19315 MGH RIVER VIEW BLDG	0	0	0	0	0	0 193.15
193.16 19316 MGH NEONATOLOGY	0	0	0	0	0	0 193.16
193.18 19318 MGH WOUND CARE	0	0	0	0	0	0 193.18
194.00 07963 HEART FAI LURE CLINIC	0	0	0	0	0	0 194.00
194.01 07950 MOW	0	10,708	0	0	0	0 194.01
194.02 07951 MENTAL HEALTH	0	29,834	0	0	0	0 194.02
194.03 07952 ADVERTISING	0	0	0	0	0	0 194.03
194.04 07953 MGH WORK SOLUTIONS	0	0	0	2,421	0	0 194.04
194.05 07954 MGH TAYLOR UNIVERSITY	0	0	0	0	0	0 194.05
194.06 07955 OPIOID IMPL GRANT	0	0	0	0	0	0 194.06
194.07 07956 ASTHMA GRANT	0	0	0	0	0	0 194.07
194.08 07957 MGH SMMP BLDG	0	0	0	0	0	0 194.08
194.09 07958 MGH AMBUCARE BLDG	0	0	0	0	0	0 194.09
194.10 07959 MGH 106 LYONS BLDG	0	0	0	0	0	0 194.10
194.11 07960 FAIRMOUNT	0	0	0	0	0	0 194.11
194.12 07961 GAS CITY	0	0	0	0	0	0 194.12
194.13 07969 LYONS	0	0	0	0	0	0 194.13
194.14 07964 WABASH	0	0	0	0	0	0 194.14
194.15 07965 TOBACCO GRANT	0	0	0	0	0	0 194.15
194.16 07966 HRSA NETWORK DEV PLANNING	0	0	0	0	0	0 194.16
194.17 07967 HRSA OPIOID PLANNING	0	0	0	0	0	0 194.17
194.18 07962 ECHO GRANT	0	0	0	0	0	0 194.18
194.19 07968 RURAL QI GRANT	0	0	0	0	0	0 194.19
200.00						200.00
201.00						201.00
202.00						202.00
	Cross Foot Adjustments					
	Negative Cost Centers					
202.00	TOTAL (sum lines 118 through 201)	214,508	305,296	68,421	123,462	272,776 202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 15-0011

Period:
From 07/01/2019
To 06/30/2020

Worksheet B
Part II
Date/Time Prepared:
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Cost Center Description		Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
		24.00	25.00	26.00	
GENERAL SERVICE COST CENTERS					
1.00	00100				1.00
4.00	00400				4.00
5.00	00500				5.00
6.00	00600				6.00
6.01	00601				6.01
6.02	00602				6.02
7.00	00700				7.00
8.00	00800				8.00
9.00	00900				9.00
10.00	01000				10.00
13.00	01300				13.00
14.00	01400				14.00
15.00	01500				15.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	2,433,266	0	2,433,266	30.00
31.00	03100	586,596	0	586,596	31.00
40.00	04000	0	0	0	40.00
41.00	04100	524,857	0	524,857	41.00
42.00	04200	0	0	0	42.00
43.00	04300	53,364	0	53,364	43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	1,864,747	0	1,864,747	50.00
51.00	05100	0	0	0	51.00
54.00	05400	1,081,592	0	1,081,592	54.00
57.00	05700	101,865	0	101,865	57.00
58.00	05800	93,953	0	93,953	58.00
59.00	05900	295,136	0	295,136	59.00
60.00	06000	844,415	0	844,415	60.00
60.01	06001	58,380	0	58,380	60.01
60.02	06002	0	0	0	60.02
65.00	06500	288,139	0	288,139	65.00
66.00	06600	126,655	0	126,655	66.00
69.00	06900	395,465	0	395,465	69.00
69.01	06901	70,762	0	70,762	69.01
71.00	07100	0	0	0	71.00
72.00	07200	0	0	0	72.00
73.00	07300	564,592	0	564,592	73.00
OUTPATIENT SERVICE COST CENTERS					
90.00	09000	249,333	0	249,333	90.00
91.00	09100	850,540	0	850,540	91.00
92.00	09200	0	0	0	92.00
92.01	09201	0	0	0	92.01
OTHER REIMBURSABLE COST CENTERS					
95.00	09500	239,062	0	239,062	95.00
SPECIAL PURPOSE COST CENTERS					
113.00	11300	0	0	0	113.00
118.00		10,722,719	0	10,722,719	118.00
NONREIMBURSABLE COST CENTERS					
190.00	19000	59,045	0	59,045	190.00
192.00	19200	0	0	0	192.00
192.01	19201	25,560	0	25,560	192.01
192.02	19202	5,085	0	5,085	192.02
192.03	19203	4,358	0	4,358	192.03
192.04	19204	0	0	0	192.04
192.05	19205	9,533	0	9,533	192.05
192.06	19206	52,445	0	52,445	192.06
192.07	19207	769	0	769	192.07
192.08	19211	3,468	0	3,468	192.08
192.09	19212	0	0	0	192.09
192.10	19214	0	0	0	192.10
192.11	19208	0	0	0	192.11
192.12	19209	30,747	0	30,747	192.12
192.13	19213	52,759	0	52,759	192.13
192.14	19210	73,945	0	73,945	192.14
192.15	19215	84,364	0	84,364	192.15
192.16	19216	52,758	0	52,758	192.16
192.17	19217	101,144	0	101,144	192.17
192.18	19218	18,078	0	18,078	192.18
192.19	19219	36,865	0	36,865	192.19
193.00	19300	0	0	0	193.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 15-0011

Period:
From 07/01/2019
To 06/30/2020

Worksheet B
Part II
Date/Time Prepared:
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Cost Center Description			Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			24.00	25.00	26.00	
193.01	19301	MGH FMC NORTHWOOD	44,178	0	44,178	193.01
193.02	19302	MGH FMC GAS CITY	28,578	0	28,578	193.02
193.03	19303	MGH HOSPITALISTS	137,107	0	137,107	193.03
193.04	19304	MGH MAR FAM PRACT	120,558	0	120,558	193.04
193.05	19305	MGH FMC SWAYZEE	10,444	0	10,444	193.05
193.06	19306	MGH PEDIATRIC CTR	40,256	0	40,256	193.06
193.07	19307	MGH SPECIALTY PHYS	11,406	0	11,406	193.07
193.08	19308	MGH FMC CONVERSE	13,440	0	13,440	193.08
193.09	19309	MGH UPLAND HEALTH	63,635	0	63,635	193.09
193.10	19310	MGH MGH WOMENS CTR	0	0	0	193.10
193.11	19311	MGH MGH PSYCHIATRY	0	0	0	193.11
193.12	19312	OB/GYN	121,695	0	121,695	193.12
193.15	19315	MGH RIVER VIEW BLDG	0	0	0	193.15
193.16	19316	MGH NEONATOLOGY	25,298	0	25,298	193.16
193.18	19318	MGH WOUND CARE	900	0	900	193.18
194.00	07963	HEART FAILURE CLINIC	1,824	0	1,824	194.00
194.01	07950	MOW	10,708	0	10,708	194.01
194.02	07951	MENTAL HEALTH	29,834	0	29,834	194.02
194.03	07952	ADVERTISING	8,005	0	8,005	194.03
194.04	07953	MGH WORK SOLUTIONS	33,320	0	33,320	194.04
194.05	07954	MGH TAYLOR UNIVERSITY	4,127	0	4,127	194.05
194.06	07955	OPIOID IMPL GRANT	6,881	0	6,881	194.06
194.07	07956	ASTHMA GRANT	192	0	192	194.07
194.08	07957	MGH SMMP BLDG	0	0	0	194.08
194.09	07958	MGH AMBUCARE BLDG	0	0	0	194.09
194.10	07959	MGH 106 LYONS BLDG	215	0	215	194.10
194.11	07960	FAIRMOUNT	0	0	0	194.11
194.12	07961	GAS CITY	0	0	0	194.12
194.13	07969	LYONS	0	0	0	194.13
194.14	07964	WABASH	0	0	0	194.14
194.15	07965	TOBACCO GRANT	2,117	0	2,117	194.15
194.16	07966	HRSA NETWORK DEV PLANNING	348	0	348	194.16
194.17	07967	HRSA OPIOID PLANNING	3,453	0	3,453	194.17
194.18	07962	ECHO GRANT	2	0	2	194.18
194.19	07968	RURAL QI GRANT	3,461	0	3,461	194.19
200.00		Cross Foot Adjustments	0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	12,055,624	0	12,055,624	202.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 15-0011

Period:
From 07/01/2019
To 06/30/2020

Worksheet B-1

Date/Time Prepared:
11/20/2020 1:17 pm

Cost Center Description	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	MAINTENANCE & REPAIRS (SQUARE FEET)	
	NEW BLDG & FIXT (SQUARE FEET)						
	1.00	4.00		5A	5.00	6.00	
GENERAL SERVICE COST CENTERS							
1.00 00100	NEW CAP REL COSTS-BLDG & FIXT	435,386					1.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	10,834	72,418,391				4.00
5.00 00500	ADMINISTRATIVE & GENERAL	133,787	14,809,986	-30,600,686	132,397,178		5.00
6.00 00600	MAINTENANCE & REPAIRS	0	0	0	0	290,765	6.00
6.01 00601	CAFETERIA	4,857	0	0	1,552,993	4,857	6.01
6.02 00602	CAFETERIA	0	0	0	0	0	6.02
7.00 00700	OPERATION OF PLANT	92,295	769,765	0	8,203,317	92,295	7.00
8.00 00800	LAUNDRY & LINEN SERVICE	2,113	0	0	348,326	2,113	8.00
9.00 00900	HOUSEKEEPING	3,260	0	0	2,712,024	3,260	9.00
10.00 01000	DIETARY	6,692	19,193	0	705,984	6,692	10.00
13.00 01300	NURSING ADMINISTRATION	696	838,039	0	1,124,077	696	13.00
14.00 01400	CENTRAL SERVICES & SUPPLY	2,383	161,636	0	576,320	2,383	14.00
15.00 01500	PHARMACY	3,070	2,626,099	0	4,245,271	3,070	15.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00 03000	ADULTS & PEDIATRICS	42,972	5,802,981	0	9,455,915	42,972	30.00
31.00 03100	INTENSIVE CARE UNIT	10,246	1,755,217	0	2,957,477	10,246	31.00
40.00 04000	SUBPROVIDER - I/PF	0	0	0	0	0	40.00
41.00 04100	SUBPROVIDER - I/RF	9,585	1,031,101	0	2,273,925	9,585	41.00
42.00 04200	SUBPROVIDER	0	0	0	0	0	42.00
43.00 04300	NURSERY	0	1,033,128	0	1,474,706	0	43.00
ANCILLARY SERVICE COST CENTERS							
50.00 05000	OPERATING ROOM	34,453	1,164,752	0	11,448,970	34,453	50.00
51.00 05100	RECOVERY ROOM	0	0	0	0	0	51.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	20,686	2,401,381	0	5,857,194	20,686	54.00
57.00 05700	CT SCAN	1,505	464,550	0	1,060,279	1,505	57.00
58.00 05800	MAGNETIC RESONANCE IMAGING (MRI)	1,784	237,810	0	584,913	1,784	58.00
59.00 05900	CARDIAC CATHETERIZATION	5,040	634,292	0	2,311,798	5,040	59.00
60.00 06000	LABORATORY	13,096	2,222,635	0	8,921,679	13,096	60.00
60.01 06001	ONCOLOGY	0	1,016,265	0	1,885,616	0	60.01
60.02 06002	RADIATION ONCOLOGY	0	0	0	0	0	60.02
65.00 06500	RESPIRATORY THERAPY	4,455	1,409,897	0	2,619,025	4,455	65.00
66.00 06600	PHYSICAL THERAPY	881	1,846,797	0	2,615,438	881	66.00
69.00 06900	ELECTROCARDIOLOGY	7,954	824,962	0	1,404,763	7,954	69.00
69.01 06901	CARDIAC REHAB	1,297	186,052	0	292,181	1,297	69.01
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	0	0	0	10,259,314	0	73.00
OUTPATIENT SERVICE COST CENTERS							
90.00 09000	CLINIC	4,895	292,774	0	1,239,888	4,895	90.00
91.00 09100	EMERGENCY	11,071	8,117,224	0	7,920,649	11,071	91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
92.01 09201	OBSERVATION BEDS (DISTINCT PART)	0	0	0	0	0	92.01
OTHER REIMBURSABLE COST CENTERS							
95.00 09500	AMBULANCE SERVICES	4,150	1,064,532	0	1,535,604	4,150	95.00
SPECIAL PURPOSE COST CENTERS							
113.00 11300	INTEREST EXPENSE						113.00
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	434,057	50,731,068	-30,600,686	95,587,646	289,436	118.00
NONREIMBURSABLE COST CENTERS							
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	1,329	28,422	0	84,999	1,329	190.00
192.00 19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
192.01 19201	PACT REV PHYSICIANS	0	451,936	0	736,937	0	192.01
192.02 19202	VISITOR MEALS	0	0	0	0	0	192.02
192.03 19203	GREAT BEGINNINGS/MATERNAL	0	99,743	0	127,273	0	192.03
192.04 19204	LIFELINE	0	0	0	0	0	192.04
192.05 19205	OWNED PROPERTIES	0	0	0	335,157	0	192.05
192.06 19206	UROLOGY	0	854,173	0	1,439,803	0	192.06
192.07 19207	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.07
192.08 19211	PARISH NURSING	0	57,507	0	88,222	0	192.08
192.09 19212	BIOERRORISM GRANT	0	0	0	0	0	192.09
192.10 19214	BREAST PUMPS	0	0	0	0	0	192.10
192.11 19208	MGH EMERGENCY PHYSICIANS	0	0	0	0	0	192.11
192.12 19209	LUNG CENTER	0	629,024	0	933,194	0	192.12
192.13 19213	MGH EXPRESS	0	943,843	0	1,533,855	0	192.13
192.14 19210	MGH PHYS PRACT MGMT	0	1,138,540	0	2,104,827	0	192.14
192.15 19215	MGH MARION SURGEONS	0	1,590,034	0	2,330,800	0	192.15
192.16 19216	MGH MGH MED ONC	0	1,155,509	0	1,686,557	0	192.16
192.17 19217	MGH FMC SOUTH	0	1,830,079	0	3,076,535	0	192.17
192.18 19218	MGH FAIRM MED ASSOC	0	314,290	0	589,606	0	192.18

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 15-0011

Period:
From 07/01/2019
To 06/30/2020

Worksheet B-1

Date/Time Prepared:
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Cost Center Description	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	MAINTENANCE & REPAIRS (SQUARE FEET)	
	NEW BLDG & FIXT (SQUARE FEET)	1.00					
192.19 19219 MGH FMC MARION	0		638,001	0	976,622	0	192.19
193.00 19300 NONPAID WORKERS	0		0	0	0	0	193.00
193.01 19301 MGH FMC NORTHWOOD	0		900,669	0	1,379,441	0	193.01
193.02 19302 MGH FMC GAS CITY	0		514,643	0	887,051	0	193.02
193.03 19303 MGH HOSPITALISTS	0		2,993,581	0	4,384,321	0	193.03
193.04 19304 MGH MAR FAM PRACT	0		2,277,228	0	3,648,653	0	193.04
193.05 19305 MGH FMC SWAYZEE	0		176,828	0	298,713	0	193.05
193.06 19306 MGH PEDIATRIC CTR	0		667,259	0	1,190,668	0	193.06
193.07 19307 MGH SPECIALTY PHYS	0		220,706	0	339,422	0	193.07
193.08 19308 MGH FMC CONVERSE	0		213,563	0	398,186	0	193.08
193.09 19309 MGH UPLAND HEALTH	0		1,118,094	0	1,983,160	0	193.09
193.10 19310 MGH MGH WOMENS CTR	0		0	0	0	0	193.10
193.11 19311 MGH MGH PSYCHIATRY	0		0	0	0	0	193.11
193.12 19312 OB/GYN	0		1,975,709	0	3,352,306	0	193.12
193.15 19315 MGH RIVER VIEW BLDG	0		0	0	0	0	193.15
193.16 19316 MGH NEONATOLOGY	0		0	0	889,400	0	193.16
193.18 19318 MGH WOUND CARE	0		19,758	0	28,752	0	193.18
194.00 07963 HEART FAILURE CLINIC	0		33,037	0	59,325	0	194.00
194.01 07950 MOW	0		0	0	0	0	194.01
194.02 07951 MENTAL HEALTH	0		0	0	0	0	194.02
194.03 07952 ADVERTISING	0		111,868	0	244,861	0	194.03
194.04 07953 MGH WORK SOLUTIONS	0		521,448	0	1,009,857	0	194.04
194.05 07954 MGH TAYLOR UNIVERSITY	0		90,826	0	131,862	0	194.05
194.06 07955 OPIOID IMPL GRANT	0		43,432	0	222,684	0	194.06
194.07 07956 ASTHMA GRANT	0		3,115	0	5,810	0	194.07
194.08 07957 MGH SMMP BLDG	0		0	0	0	0	194.08
194.09 07958 MGH AMBUCARE BLDG	0		0	0	0	0	194.09
194.10 07959 MGH 106 LYONS BLDG	0		0	0	7,573	0	194.10
194.11 07960 FAIRMOUNT	0		0	0	0	0	194.11
194.12 07961 GAS CITY	0		0	0	0	0	194.12
194.13 07969 LYONS	0		0	0	0	0	194.13
194.14 07964 WABASH	0		0	0	0	0	194.14
194.15 07965 TOBACCO GRANT	0		36,658	0	61,921	0	194.15
194.16 07966 HRSA NETWORK DEV PLANNING	0		1,934	0	11,560	0	194.16
194.17 07967 HRSA OPIOID PLANNING	0		13,652	0	116,868	0	194.17
194.18 07962 ECHO GRANT	0		0	0	80	0	194.18
194.19 07968 RURAL QI GRANT	0		22,214	0	112,671	0	194.19
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)	12,055,624		16,831,540		30,600,686	0	202.00
203.00 Unit cost multiplier (Wkst. B, Part I)	27.689508		0.232421		0.231128	0.000000	203.00
204.00 Cost to be allocated (per Wkst. B, Part II)			299,988		3,765,872	0	204.00
205.00 Unit cost multiplier (Wkst. B, Part II)			0.004142		0.028444	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: 15-0011		Period: From 07/01/2019 To 06/30/2020		Worksheet B-1		
Date/Time Prepared: 11/20/2020 1:17 pm								
Cost Center	Description	CAFETERIA (MEALS SERVED)	CAFETERIA (HOURS WORKED)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (HOURS OF SERVICE)		
		6.01	6.02	7.00	8.00	9.00		
GENERAL SERVICE COST CENTERS								
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT					1.00	
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00	
5.00	00500	ADMINISTRATIVE & GENERAL					5.00	
6.00	00600	MAINTENANCE & REPAIRS					6.00	
6.01	00601	CAFETERIA	215,484				6.01	
6.02	00602	CAFETERIA	209,351	1,299,971			6.02	
7.00	00700	OPERATION OF PLANT	0	38,279	193,613		7.00	
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	2,113	635,826	8.00	
9.00	00900	HOUSEKEEPING	0	0	3,260	0	58,058	9.00
10.00	01000	DIETARY	0	314	6,692	253	832	10.00
13.00	01300	NURSING ADMINISTRATION	0	20,128	696	0	260	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	8,590	2,383	238	1,300	14.00
15.00	01500	PHARMACY	0	68,122	3,070	0	728	15.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	0	192,059	42,972	133,854	15,392	30.00
31.00	03100	INTENSIVE CARE UNIT	0	55,857	10,246	27,177	2,912	31.00
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	0	40.00
41.00	04100	SUBPROVIDER - IRF	0	33,226	9,585	14,198	2,496	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	0	42.00
43.00	04300	NURSERY	0	32,586	0	0	0	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	113,086	34,453	95,360	7,696	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	90,638	20,686	43,499	3,276	54.00
57.00	05700	CT SCAN	0	16,950	1,505	22,043	182	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	8,677	1,784	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	21,530	5,040	6,298	1,040	59.00
60.00	06000	LABORATORY	0	86,821	13,096	0	2,912	60.00
60.01	06001	ONCOLOGY	0	0	0	3,449	0	60.01
60.02	06002	RADIATION ONCOLOGY	0	0	0	0	0	60.02
65.00	06500	RESPIRATORY THERAPY	0	40,476	4,455	4,674	2,184	65.00
66.00	06600	PHYSICAL THERAPY	0	23,239	881	15,425	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	33,732	7,954	4,666	1,404	69.00
69.01	06901	CARDIAC REHAB	0	5,772	1,297	0	1,560	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	10,723	4,895	2,570	1,040	90.00
91.00	09100	EMERGENCY	0	155,515	11,071	239,022	11,648	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	0	0	0	0	0	92.01
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	0	47,680	4,150	19,972	364	95.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	209,351	1,104,000	192,284	632,698	57,226	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	936	1,329	0	104	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
192.01	19201	PACT REV PHYSICIANS	0	12,449	0	0	0	192.01
192.02	19202	VISITOR MEALS	6,133	0	0	0	0	192.02
192.03	19203	GREAT BEGINNINGS/MATERNAL	0	0	0	0	0	192.03
192.04	19204	LIFELINE	0	0	0	0	0	192.04
192.05	19205	OWNED PROPERTIES	0	0	0	0	0	192.05
192.06	19206	UROLOGY	0	23,299	0	0	0	192.06
192.07	19207	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	208	192.07
192.08	19211	PARISH NURSING	0	2,523	0	0	104	192.08
192.09	19212	BIOTERRORISM GRANT	0	0	0	0	0	192.09
192.10	19214	BREAST PUMPS	0	0	0	0	0	192.10
192.11	19208	MGH EMERGENCY PHYSICIANS	0	0	0	0	0	192.11
192.12	19209	LUNG CENTER	0	11,965	0	0	0	192.12
192.13	19213	MGH EXPRESS	0	0	0	0	0	192.13
192.14	19210	MGH PHYS PRACT MGMT	0	57,344	0	1,061	416	192.14
192.15	19215	MGH MARION SURGEONS	0	31,599	0	0	0	192.15
192.16	19216	MGH MGH MED ONC	0	0	0	0	0	192.16
192.17	19217	MGH FMC SOUTH	0	0	0	19	0	192.17
192.18	19218	MGH FAIRM MED ASSOC	0	0	0	29	0	192.18
192.19	19219	MGH FMC MARION	0	21,062	0	0	0	192.19
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	MGH FMC NORTHWOOD	0	0	0	0	0	193.01

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 15-0011

Period:
From 07/01/2019
To 06/30/2020

Worksheet B-1

Date/Time Prepared:
11/20/2020 1:17 pm

Cost Center Description			CAFETERIA (MEALS SERVED)	CAFETERIA (HOURS WORKED)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (HOURS OF SERVICE)	
			6.01	6.02	7.00	8.00	9.00	
193.02	19302	MGH FMC GAS CITY	0	0	0	32	0	193.02
193.03	19303	MGH HOSPITALISTS	0	0	0	0	0	193.03
193.04	19304	MGH MAR FAM PRACT	0	0	0	524	0	193.04
193.05	19305	MGH FMC SWAYZEE	0	0	0	30	0	193.05
193.06	19306	MGH PEDIATRIC CTR	0	18,014	0	66	0	193.06
193.07	19307	MGH SPECIALTY PHYS	0	6,230	0	33	0	193.07
193.08	19308	MGH FMC CONVERSE	0	0	0	124	0	193.08
193.09	19309	MGH UPLAND HEALTH	0	0	0	1,115	0	193.09
193.10	19310	MGH MGH WOMENS CTR	0	0	0	0	0	193.10
193.11	19311	MGH MGH PSYCHIATRY	0	0	0	0	0	193.11
193.12	19312	OB/GYN	0	0	0	0	0	193.12
193.15	19315	MGH RIVER VIEW BLDG	0	0	0	0	0	193.15
193.16	19316	MGH NEONATOLOGY	0	0	0	0	0	193.16
193.18	19318	MGH WOUND CARE	0	0	0	0	0	193.18
194.00	07963	HEART FAILURE CLINIC	0	0	0	0	0	194.00
194.01	07950	MOW	0	0	0	0	0	194.01
194.02	07951	MENTAL HEALTH	0	0	0	0	0	194.02
194.03	07952	ADVERTISING	0	4,320	0	0	0	194.03
194.04	07953	MGH WORK SOLUTIONS	0	0	0	95	0	194.04
194.05	07954	MGH TAYLOR UNIVERSITY	0	0	0	0	0	194.05
194.06	07955	OPIOID IMPL GRANT	0	2,750	0	0	0	194.06
194.07	07956	ASTHMA GRANT	0	107	0	0	0	194.07
194.08	07957	MGH SMMP BLDG	0	0	0	0	0	194.08
194.09	07958	MGH AMBUCARE BLDG	0	0	0	0	0	194.09
194.10	07959	MGH 106 LYONS BLDG	0	0	0	0	0	194.10
194.11	07960	FAIRMOUNT	0	0	0	0	0	194.11
194.12	07961	GAS CITY	0	0	0	0	0	194.12
194.13	07969	LYONS	0	0	0	0	0	194.13
194.14	07964	WABASH	0	0	0	0	0	194.14
194.15	07965	TOBACCO GRANT	0	1,525	0	0	0	194.15
194.16	07966	HRSA NETWORK DEV PLANNING	0	85	0	0	0	194.16
194.17	07967	HRSA OPIOID PLANNING	0	538	0	0	0	194.17
194.18	07962	ECHO GRANT	0	0	0	0	0	194.18
194.19	07968	RURAL QI GRANT	0	1,225	0	0	0	194.19
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)	1,911,933	1,857,516	10,154,029	539,650	3,509,820	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	8.872738	1.428890	52.444975	0.848738	60.453684	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	178,661	173,576	2,797,237	98,944	214,508	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.829115	0.133523	14.447568	0.155615	3.694719	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: 15-0011

Period:
From 07/01/2019
To 06/30/2020

Worksheet B-1

Date/Time Prepared:
11/20/2020 1:17 pm

Cost Center Description		DIETARY (MEALS SERVED)	NURSING ADMINISTRATIVE (DIRECT NURSING HRS)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)		
		10.00	13.00	14.00	15.00		
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
4.00	00400						4.00
5.00	00500						5.00
6.00	00600						6.00
6.01	00601						6.01
6.02	00602						6.02
7.00	00700						7.00
8.00	00800						8.00
9.00	00900						9.00
10.00	01000						10.00
13.00	01300	74,099	0	800,120			13.00
14.00	01400		0		102		14.00
15.00	01500		0			100	15.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	47,686	192,059	11	0		30.00
31.00	03100	7,622	55,857	4	0		31.00
40.00	04000	0	0	0	0		40.00
41.00	04100	7,792	33,226	1	0		41.00
42.00	04200	0	0	0	0		42.00
43.00	04300	0	32,586	0	0		43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	0	98,730	13	0		50.00
51.00	05100	0	0	0	0		51.00
54.00	05400	0	0	2	0		54.00
57.00	05700	0	0	0	0		57.00
58.00	05800	0	0	0	0		58.00
59.00	05900	0	21,530	4	0		59.00
60.00	06000	0	0	6	0		60.00
60.01	06001	0	0	0	0		60.01
60.02	06002	0	0	0	0		60.02
65.00	06500	0	40,476	2	0		65.00
66.00	06600	0	23,239	0	0		66.00
69.00	06900	0	33,732	3	0		69.00
69.01	06901	0	5,772	0	0		69.01
71.00	07100	0	0	0	0		71.00
72.00	07200	0	0	0	0		72.00
73.00	07300	0	0	0	100		73.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	0	10,723	0	0		90.00
91.00	09100	1,159	155,515	5	0		91.00
92.00	09200	0	0	0	0		92.00
92.01	09201	0	0	0	0		92.01
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	0	47,680	1	0		95.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	0	0	0	0		113.00
118.00		64,259	751,125	52	100		118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	0	0	0	0		190.00
192.00	19200	0	0	0	0		192.00
192.01	19201	0	12,449	0	0		192.01
192.02	19202	0	0	0	0		192.02
192.03	19203	0	3,805	0	0		192.03
192.04	19204	0	0	0	0		192.04
192.05	19205	0	0	0	0		192.05
192.06	19206	0	0	4	0		192.06
192.07	19207	0	0	0	0		192.07
192.08	19211	0	0	0	0		192.08
192.09	19212	0	0	0	0		192.09
192.10	19214	0	0	0	0		192.10
192.11	19208	0	0	0	0		192.11
192.12	19209	0	0	0	0		192.12
192.13	19213	0	32,741	2	0		192.13
192.14	19210	0	0	0	0		192.14
192.15	19215	0	0	6	0		192.15
192.16	19216	0	0	0	0		192.16
192.17	19217	0	0	5	0		192.17
192.18	19218	0	0	0	0		192.18
192.19	19219	0	0	3	0		192.19
193.00	19300	0	0	0	0		193.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 15-0011

Period:
From 07/01/2019
To 06/30/2020

Worksheet B-1

Date/Time Prepared:
11/20/2020 1:17 pm

Cost Center Description			DIETARY (MEALS SERVED)	NURSING ADMINISTRATION (DIRECT NURSING HRS)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	
			10.00	13.00	14.00	15.00	
193.01	19301	MGH FMC NORTHWOOD	0	0	1	0	193.01
193.02	19302	MGH FMC GAS CITY	0	0	1	0	193.02
193.03	19303	MGH HOSPITALISTS	0	0	0	0	193.03
193.04	19304	MGH MAR FAM PRACT	0	0	6	0	193.04
193.05	19305	MGH FMC SWAYZEE	0	0	1	0	193.05
193.06	19306	MGH PEDIATRIC CTR	0	0	1	0	193.06
193.07	19307	MGH SPECIALTY PHYS	0	0	0	0	193.07
193.08	19308	MGH FMC CONVERSE	0	0	1	0	193.08
193.09	19309	MGH UPLAND HEALTH	0	0	2	0	193.09
193.10	19310	MGH MGH WOMENS CTR	0	0	0	0	193.10
193.11	19311	MGH MGH PSYCHIATRY	0	0	0	0	193.11
193.12	19312	OB/GYN	0	0	15	0	193.12
193.15	19315	MGH RIVER VIEW BLDG	0	0	0	0	193.15
193.16	19316	MGH NEONATOLOGY	0	0	0	0	193.16
193.18	19318	MGH WOUND CARE	0	0	0	0	193.18
194.00	07963	HEART FAILURE CLINIC	0	0	0	0	194.00
194.01	07950	MOW	2,599	0	0	0	194.01
194.02	07951	MENTAL HEALTH	7,241	0	0	0	194.02
194.03	07952	ADVERTISING	0	0	0	0	194.03
194.04	07953	MGH WORK SOLUTIONS	0	0	2	0	194.04
194.05	07954	MGH TAYLOR UNIVERSITY	0	0	0	0	194.05
194.06	07955	OPIOID IMPL GRANT	0	0	0	0	194.06
194.07	07956	ASTHMA GRANT	0	0	0	0	194.07
194.08	07957	MGH SMMP BLDG	0	0	0	0	194.08
194.09	07958	MGH AMBUCARE BLDG	0	0	0	0	194.09
194.10	07959	MGH 106 LYONS BLDG	0	0	0	0	194.10
194.11	07960	FAIRMOUNT	0	0	0	0	194.11
194.12	07961	GAS CITY	0	0	0	0	194.12
194.13	07969	LYONS	0	0	0	0	194.13
194.14	07964	WABASH	0	0	0	0	194.14
194.15	07965	TOBACCO GRANT	0	0	0	0	194.15
194.16	07966	HRSA NETWORK DEV PLANNING	0	0	0	0	194.16
194.17	07967	HRSA OPIOID PLANNING	0	0	0	0	194.17
194.18	07962	ECHO GRANT	0	0	0	0	194.18
194.19	07968	RURAL QI GRANT	0	0	0	0	194.19
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)	1,271,080	1,464,864	925,566	5,528,827	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	17.153808	1.830805	9,074.176471	55,288.270000	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	305,296	68,421	123,462	272,776	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	4.120110	0.085513	1,210.411765	2,727.760000	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: 15-0011

Period:
From 07/01/2019
To 06/30/2020

Worksheet C
Part I
Date/Time Prepared:
11/20/2020 1:17 pm

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		
Title XVIII Hospital PPS								
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	16,483,087		16,483,087	0	16,483,087	30.00
31.00	03100	INTENSIVE CARE UNIT	4,726,611		4,726,611	0	4,726,611	31.00
40.00	04000	SUBPROVIDER - IPF	0		0	0	0	40.00
41.00	04100	SUBPROVIDER - IRF	3,716,162		3,716,162	0	3,716,162	41.00
42.00	04200	SUBPROVIDER	0		0	0	0	42.00
43.00	04300	NURSERY	1,921,773		1,921,773	0	1,921,773	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	16,908,518		16,908,518	0	16,908,518	50.00
51.00	05100	RECOVERY ROOM	0		0	0	0	51.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	8,678,458		8,678,458	0	8,678,458	54.00
57.00	05700	CT SCAN	1,438,201		1,438,201	0	1,438,201	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	826,063		826,063	0	826,063	58.00
59.00	05900	CARDIAC CATHETERIZATION	3,285,137		3,285,137	0	3,285,137	59.00
60.00	06000	LABORATORY	12,025,092		12,025,092	0	12,025,092	60.00
60.01	06001	ONCOLOGY	2,324,362		2,324,362	0	2,324,362	60.01
60.02	06002	RADIATION ONCOLOGY	0		0	0	0	60.02
65.00	06500	RESPIRATORY THERAPY	3,744,083	0	3,744,083	0	3,744,083	65.00
66.00	06600	PHYSICAL THERAPY	3,354,987	0	3,354,987	0	3,354,987	66.00
69.00	06900	ELECTROCARDIOLOGY	2,372,606		2,372,606	0	2,372,606	69.00
69.01	06901	CARDIAC REHAB	540,856		540,856	0	540,856	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0		0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0		0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	18,159,356		18,159,356	0	18,159,356	73.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	1,883,186		1,883,186	0	1,883,186	90.00
91.00	09100	EMERGENCY	11,811,168		11,811,168	0	11,811,168	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	3,680,776		3,680,776	0	3,680,776	92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	0		0	0	0	92.01
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	2,311,624		2,311,624	0	2,311,624	95.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	120,192,106	0	120,192,106	0	120,192,106	200.00
201.00		Less Observation Beds	3,680,776		3,680,776		3,680,776	201.00
202.00		Total (see instructions)	116,511,330	0	116,511,330	0	116,511,330	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 15-0011	Period: From 07/01/2019 To 06/30/2020	Worksheet C Part I Date/Time Prepared: 11/20/2020 1:17 pm
		Title XVIII	Hospital	PPS

Cost Center Description	Charges			Cost or Other Ratio	TEFRA Inpatient Ratio	
	Inpatient	Outpatient	Total (col. 6 + col. 7)			
	6.00	7.00	8.00			
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	14,516,394		14,516,394	30.00
31.00	03100	INTENSIVE CARE UNIT	5,957,576		5,957,576	31.00
40.00	04000	SUBPROVIDER - IPF	0		0	40.00
41.00	04100	SUBPROVIDER - IRF	3,401,928		3,401,928	41.00
42.00	04200	SUBPROVIDER	0		0	42.00
43.00	04300	NURSERY	2,386,088		2,386,088	43.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	31,101,252	75,827,381	106,928,633	50.00
51.00	05100	RECOVERY ROOM	0	0	0	51.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,706,992	27,455,792	29,162,784	54.00
57.00	05700	CT SCAN	5,398,249	31,877,299	37,275,548	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	331,380	3,332,488	3,663,868	58.00
59.00	05900	CARDIAC CATHETERIZATION	2,924,967	6,153,343	9,078,310	59.00
60.00	06000	LABORATORY	3,695,025	15,005,416	18,700,441	60.00
60.01	06001	ONCOLOGY	38,975	7,803,508	7,842,483	60.01
60.02	06002	RADIATION ONCOLOGY	0	0	0	60.02
65.00	06500	RESPIRATORY THERAPY	2,351,971	5,759,187	8,111,158	65.00
66.00	06600	PHYSICAL THERAPY	4,531,306	6,156,478	10,687,784	66.00
69.00	06900	ELECTROCARDIOLOGY	3,704,862	9,150,318	12,855,180	69.00
69.01	06901	CARDIAC REHAB	0	857,220	857,220	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	6,723,934	89,526,770	96,250,704	73.00
OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	5,000	2,348,861	2,353,861	90.00
91.00	09100	EMERGENCY	11,698,307	62,767,720	74,466,027	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	8,171,988	8,171,988	92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	0	0	0	92.01
OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	4,434,365	4,434,365	95.00
SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE				113.00
200.00		Subtotal (see instructions)	100,474,206	356,628,134	457,102,340	200.00
201.00		Less Observation Beds				201.00
202.00		Total (see instructions)	100,474,206	356,628,134	457,102,340	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 15-0011	Period: From 07/01/2019 To 06/30/2020	Worksheet C Part I Date/Time Prepared: 11/20/2020 1:17 pm
Cost Center Description		PPS Inpatient Ratio	Title XVIII	Hospital PPS
		11.00		
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		30.00
31.00	03100	INTENSIVE CARE UNIT		31.00
40.00	04000	SUBPROVIDER - I PF		40.00
41.00	04100	SUBPROVIDER - I RF		41.00
42.00	04200	SUBPROVIDER		42.00
43.00	04300	NURSERY		43.00
ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.158129	50.00
51.00	05100	RECOVERY ROOM	0.000000	51.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.297587	54.00
57.00	05700	CT SCAN	0.038583	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.225462	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.361867	59.00
60.00	06000	LABORATORY	0.643038	60.00
60.01	06001	ONCOLOGY	0.296381	60.01
60.02	06002	RADIATION ONCOLOGY	0.000000	60.02
65.00	06500	RESPIRATORY THERAPY	0.461597	65.00
66.00	06600	PHYSICAL THERAPY	0.313909	66.00
69.00	06900	ELECTROCARDIOLOGY	0.184564	69.00
69.01	06901	CARDIAC REHAB	0.630942	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.188667	73.00
OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0.800041	90.00
91.00	09100	EMERGENCY	0.158611	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.450414	92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	0.000000	92.01
OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES	0.521298	95.00
SPECIAL PURPOSE COST CENTERS				
113.00	11300	INTEREST EXPENSE		113.00
200.00		Subtotal (see instructions)		200.00
201.00		Less Observation Beds		201.00
202.00		Total (see instructions)		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 15-0011

Period:
From 07/01/2019
To 06/30/2020

Worksheet C
Part I
Date/Time Prepared:
11/20/2020 1:17 pm

		Title XIX		Hospital		Cost	
Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs				
			Total Costs	RCE Disallowance	Total Costs		
	1.00	2.00	3.00	4.00	5.00		
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000 ADULTS & PEDIATRICS	16,483,087		16,483,087	0	16,483,087	30.00
31.00	03100 INTENSIVE CARE UNIT	4,726,611		4,726,611	0	4,726,611	31.00
40.00	04000 SUBPROVIDER - IPF	0		0	0	0	40.00
41.00	04100 SUBPROVIDER - IRF	3,716,162		3,716,162	0	3,716,162	41.00
42.00	04200 SUBPROVIDER	0		0	0	0	42.00
43.00	04300 NURSERY	1,921,773		1,921,773	0	1,921,773	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	16,908,518		16,908,518	0	16,908,518	50.00
51.00	05100 RECOVERY ROOM	0		0	0	0	51.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	8,678,458		8,678,458	0	8,678,458	54.00
57.00	05700 CT SCAN	1,438,201		1,438,201	0	1,438,201	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	826,063		826,063	0	826,063	58.00
59.00	05900 CARDIAC CATHETERIZATION	3,285,137		3,285,137	0	3,285,137	59.00
60.00	06000 LABORATORY	12,025,092		12,025,092	0	12,025,092	60.00
60.01	06001 ONCOLOGY	2,324,362		2,324,362	0	2,324,362	60.01
60.02	06002 RADIATION ONCOLOGY	0		0	0	0	60.02
65.00	06500 RESPIRATORY THERAPY	3,744,083	0	3,744,083	0	3,744,083	65.00
66.00	06600 PHYSICAL THERAPY	3,354,987	0	3,354,987	0	3,354,987	66.00
69.00	06900 ELECTROCARDIOLOGY	2,372,606		2,372,606	0	2,372,606	69.00
69.01	06901 CARDIAC REHAB	540,856		540,856	0	540,856	69.01
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0		0	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0		0	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	18,159,356		18,159,356	0	18,159,356	73.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000 CLINIC	1,883,186		1,883,186	0	1,883,186	90.00
91.00	09100 EMERGENCY	11,811,168		11,811,168	0	11,811,168	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	3,680,776		3,680,776	0	3,680,776	92.00
92.01	09201 OBSERVATION BEDS (DISTINCT PART)	0		0	0	0	92.01
OTHER REIMBURSABLE COST CENTERS							
95.00	09500 AMBULANCE SERVICES	2,311,624		2,311,624	0	2,311,624	95.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300 INTEREST EXPENSE						113.00
200.00	Subtotal (see instructions)	120,192,106	0	120,192,106	0	120,192,106	200.00
201.00	Less Observation Beds	3,680,776		3,680,776		3,680,776	201.00
202.00	Total (see instructions)	116,511,330	0	116,511,330	0	116,511,330	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 15-0011

Period:
From 07/01/2019
To 06/30/2020

Worksheet C
Part I
Date/Time Prepared:
11/20/2020 1:17 pm

		Title XIX			Hospital	Cost	
Cost Center Description	Charges			Cost or Other Ratio	TEFRA Inpatient Ratio		
	Inpatient	Outpatient	Total (col. 6 + col. 7)				
	6.00	7.00	8.00				9.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	14,516,394		14,516,394		30.00
31.00	03100	INTENSIVE CARE UNIT	5,957,576		5,957,576		31.00
40.00	04000	SUBPROVIDER - IPF	0		0		40.00
41.00	04100	SUBPROVIDER - IRF	3,401,928		3,401,928		41.00
42.00	04200	SUBPROVIDER	0		0		42.00
43.00	04300	NURSERY	2,386,088		2,386,088		43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	31,101,252	75,827,381	106,928,633	0.158129	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0.000000	51.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,706,992	27,455,792	29,162,784	0.297587	54.00
57.00	05700	CT SCAN	5,398,249	31,877,299	37,275,548	0.038583	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	331,380	3,332,488	3,663,868	0.225462	58.00
59.00	05900	CARDIAC CATHETERIZATION	2,924,967	6,153,343	9,078,310	0.361867	59.00
60.00	06000	LABORATORY	3,695,025	15,005,416	18,700,441	0.643038	60.00
60.01	06001	ONCOLOGY	38,975	7,803,508	7,842,483	0.296381	60.01
60.02	06002	RADIATION ONCOLOGY	0	0	0	0.000000	60.02
65.00	06500	RESPIRATORY THERAPY	2,351,971	5,759,187	8,111,158	0.461597	65.00
66.00	06600	PHYSICAL THERAPY	4,531,306	6,156,478	10,687,784	0.313909	66.00
69.00	06900	ELECTROCARDIOLOGY	3,704,862	9,150,318	12,855,180	0.184564	69.00
69.01	06901	CARDIAC REHAB	0	857,220	857,220	0.630942	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	6,723,934	89,526,770	96,250,704	0.188667	73.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	5,000	2,348,861	2,353,861	0.800041	90.00
91.00	09100	EMERGENCY	11,698,307	62,767,720	74,466,027	0.158611	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	8,171,988	8,171,988	0.450414	92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	0	0	0	0.000000	92.01
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	0	4,434,365	4,434,365	0.521298	95.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
200.00		Subtotal (see instructions)	100,474,206	356,628,134	457,102,340		200.00
201.00		Less Observation Beds					201.00
202.00		Total (see instructions)	100,474,206	356,628,134	457,102,340		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 15-0011	Period: From 07/01/2019 To 06/30/2020	Worksheet C Part I Date/Time Prepared: 11/20/2020 1:17 pm
Cost Center Description		PPS Inpatient Ratio	Title XIX	Hospital
		11.00		Cost
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000 ADULTS & PEDIATRICS			30.00
31.00	03100 INTENSIVE CARE UNIT			31.00
40.00	04000 SUBPROVIDER - IPF			40.00
41.00	04100 SUBPROVIDER - IRF			41.00
42.00	04200 SUBPROVIDER			42.00
43.00	04300 NURSERY			43.00
ANCILLARY SERVICE COST CENTERS				
50.00	05000 OPERATING ROOM	0.000000		50.00
51.00	05100 RECOVERY ROOM	0.000000		51.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.000000		54.00
57.00	05700 CT SCAN	0.000000		57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0.000000		58.00
59.00	05900 CARDIAC CATHETERIZATION	0.000000		59.00
60.00	06000 LABORATORY	0.000000		60.00
60.01	06001 ONCOLOGY	0.000000		60.01
60.02	06002 RADIATION ONCOLOGY	0.000000		60.02
65.00	06500 RESPIRATORY THERAPY	0.000000		65.00
66.00	06600 PHYSICAL THERAPY	0.000000		66.00
69.00	06900 ELECTROCARDIOLOGY	0.000000		69.00
69.01	06901 CARDIAC REHAB	0.000000		69.01
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000		71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.000000		72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.000000		73.00
OUTPATIENT SERVICE COST CENTERS				
90.00	09000 CLINIC	0.000000		90.00
91.00	09100 EMERGENCY	0.000000		91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.000000		92.00
92.01	09201 OBSERVATION BEDS (DISTINCT PART)	0.000000		92.01
OTHER REIMBURSABLE COST CENTERS				
95.00	09500 AMBULANCE SERVICES	0.000000		95.00
SPECIAL PURPOSE COST CENTERS				
113.00	11300 INTEREST EXPENSE			113.00
200.00	Subtotal (see instructions)			200.00
201.00	Less Observation Beds			201.00
202.00	Total (see instructions)			202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS		Provider CCN: 15-0011	Period: From 07/01/2019 To 06/30/2020	Worksheet D Part I Date/Time Prepared: 11/20/2020 1:17 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	2,433,266	0	2,433,266	14,563	167.09	30.00
31.00	INTENSIVE CARE UNIT	586,596		586,596	3,206	182.97	31.00
40.00	SUBPROVIDER - IPF	0	0	0	0	0.00	40.00
41.00	SUBPROVIDER - IRF	524,857	0	524,857	2,665	196.94	41.00
42.00	SUBPROVIDER	0	0	0	0	0.00	42.00
43.00	NURSERY	53,364		53,364	1,616	33.02	43.00
200.00	Total (lines 30 through 199)	3,598,083		3,598,083	22,050		200.00
INPATIENT ROUTINE SERVICE COST CENTERS							
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	4,589	766,776				
31.00	INTENSIVE CARE UNIT	851	155,707				
40.00	SUBPROVIDER - IPF	0	0				
41.00	SUBPROVIDER - IRF	2,062	406,090				
42.00	SUBPROVIDER	0	0				
43.00	NURSERY	0	0				
200.00	Total (lines 30 through 199)	7,502	1,328,573				

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS	Provider CCN: 15-0011	Period: From 07/01/2019 To 06/30/2020	Worksheet D Part II Date/Time Prepared: 11/20/2020 1:17 pm
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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	
Title XVIII Hospital PPS							
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	1,864,747	106,928,633	0.017439	10,281,100	179,292	50.00
51.00	05100 RECOVERY ROOM	0	0	0.000000	0	0	51.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	1,081,592	29,162,784	0.037088	699,374	25,938	54.00
57.00	05700 CT SCAN	101,865	37,275,548	0.002733	2,530,471	6,916	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	93,953	3,663,868	0.025643	154,628	3,965	58.00
59.00	05900 CARDIAC CATHETERIZATION	295,136	9,078,310	0.032510	953,463	30,997	59.00
60.00	06000 LABORATORY	844,415	18,700,441	0.045155	1,489,358	67,252	60.00
60.01	06001 ONCOLOGY	58,380	7,842,483	0.007444	20,043	149	60.01
60.02	06002 RADIATION ONCOLOGY	0	0	0.000000	0	0	60.02
65.00	06500 RESPIRATORY THERAPY	288,139	8,111,158	0.035524	839,086	29,808	65.00
66.00	06600 PHYSICAL THERAPY	126,655	10,687,784	0.011850	822,346	9,745	66.00
69.00	06900 ELECTROCARDIOLOGY	395,465	12,855,180	0.030763	1,711,157	52,640	69.00
69.01	06901 CARDIAC REHAB	70,762	857,220	0.082548	0	0	69.01
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0.000000	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0.000000	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	564,592	96,250,704	0.005866	2,477,557	14,533	73.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000 CLINIC	249,333	2,353,861	0.105925	4,753	503	90.00
91.00	09100 EMERGENCY	850,540	74,466,027	0.011422	4,640,847	53,008	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	543,364	8,171,988	0.066491	0	0	92.00
92.01	09201 OBSERVATION BEDS (DISTINCT PART)	0	0	0.000000	0	0	92.01
OTHER REIMBURSABLE COST CENTERS							
95.00	09500 AMBULANCE SERVICES						95.00
200.00	Total (lines 50 through 199)	7,428,938	426,405,989		26,624,183	474,746	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 15-0011	Period: From 07/01/2019 To 06/30/2020	Worksheet D Part III Date/Time Prepared: 11/20/2020 1:17 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	
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00	
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	0	40.00	
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00	
42.00	04200	SUBPROVIDER	0	0	0	0	0	42.00	
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 col.s. 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	14,563	0.00	4,589	30.00	
31.00	03100	INTENSIVE CARE UNIT	0	0	3,206	0.00	851	31.00	
40.00	04000	SUBPROVIDER - IPF	0	0	0	0.00	0	40.00	
41.00	04100	SUBPROVIDER - IRF	0	0	2,665	0.00	2,062	41.00	
42.00	04200	SUBPROVIDER	0	0	0	0.00	0	42.00	
43.00	04300	NURSERY	0	0	1,616	0.00	0	43.00	
200.00		Total (lines 30 through 199)	0	0	22,050	0.00	7,502	200.00	
Cost Center Description			Inpatient Program Pass-Through Cost (col. 7 x col. 8)						
			9.00						
INPATIENT ROUTINE SERVICE COST CENTERS									
30.00	03000	ADULTS & PEDIATRICS	0						30.00
31.00	03100	INTENSIVE CARE UNIT	0						31.00
40.00	04000	SUBPROVIDER - IPF	0						40.00
41.00	04100	SUBPROVIDER - IRF	0						41.00
42.00	04200	SUBPROVIDER	0						42.00
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: 15-0011

Period:
From 07/01/2019
To 06/30/2020

Worksheet D
Part IV
Date/Time Prepared:
11/20/2020 1:17 pm

Cost Center Description		Title XVIII					Hospital		PPS
		Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health			
		1.00	2A	2.00	3A	3.00			
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00	
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00	
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00	
57.00	05700	CT SCAN	0	0	0	0	0	57.00	
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00	
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00	
60.00	06000	LABORATORY	0	0	0	0	0	60.00	
60.01	06001	ONCOLOGY	0	0	0	0	0	60.01	
60.02	06002	RADIATION ONCOLOGY	0	0	0	0	0	60.02	
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00	
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00	
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00	
69.01	06901	CARDIAC REHAB	0	0	0	0	0	69.01	
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00	
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00	
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00	
OUTPATIENT SERVICE COST CENTERS									
90.00	09000	CLINIC	0	0	0	0	0	90.00	
91.00	09100	EMERGENCY	0	0	0	0	0	91.00	
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00	
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	0	0	0	0	0	92.01	
OTHER REIMBURSABLE COST CENTERS									
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00	
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: 15-0011	Period: From 07/01/2019 To 06/30/2020	Worksheet D Part IV Date/Time Prepared: 11/20/2020 1:17 pm
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Cost Center Description	Title XVIII		Hospital		Ratio of Cost to Charges (col. 5 ÷ col. 7) (see instructions)	
	All Other Medical Education Cost	Total Cost (sum of col. 1, 2, 3, and 4)	Total Outpatient Cost (sum of col. 2, 3, and 4)	Total Charges (from Wkst. C, Part I, col. 8)		
	4.00	5.00	6.00	7.00	8.00	
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	0	0	0	106,928,633	0.000000	50.00
51.00 05100 RECOVERY ROOM	0	0	0	0	0.000000	51.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	0	0	0	29,162,784	0.000000	54.00
57.00 05700 CT SCAN	0	0	0	37,275,548	0.000000	57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	3,663,868	0.000000	58.00
59.00 05900 CARDIAC CATHETERIZATION	0	0	0	9,078,310	0.000000	59.00
60.00 06000 LABORATORY	0	0	0	18,700,441	0.000000	60.00
60.01 06001 ONCOLOGY	0	0	0	7,842,483	0.000000	60.01
60.02 06002 RADIATION ONCOLOGY	0	0	0	0	0.000000	60.02
65.00 06500 RESPIRATORY THERAPY	0	0	0	8,111,158	0.000000	65.00
66.00 06600 PHYSICAL THERAPY	0	0	0	10,687,784	0.000000	66.00
69.00 06900 ELECTROCARDIOLOGY	0	0	0	12,855,180	0.000000	69.00
69.01 06901 CARDIAC REHAB	0	0	0	857,220	0.000000	69.01
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0.000000	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0.000000	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0	0	96,250,704	0.000000	73.00
OUTPATIENT SERVICE COST CENTERS						
90.00 09000 CLINIC	0	0	0	2,353,861	0.000000	90.00
91.00 09100 EMERGENCY	0	0	0	74,466,027	0.000000	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	8,171,988	0.000000	92.00
92.01 09201 OBSERVATION BEDS (DISTINCT PART)	0	0	0	0	0.000000	92.01
OTHER REIMBURSABLE COST CENTERS						
95.00 09500 AMBULANCE SERVICES						95.00
200.00 Total (lines 50 through 199)	0	0	0	426,405,989		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 15-0011	Period: From 07/01/2019 To 06/30/2020	Worksheet D Part IV Date/Time Prepared: 11/20/2020 1:17 pm
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Cost Center Description		Title XVIII			Hospital		PPS
		Outpatient Ratio of Cost to Charges (col. 6 + col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
		9.00	10.00	11.00	12.00	13.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	0.000000	10,281,100	0	17,149,713	0	50.00
51.00	05100 RECOVERY ROOM	0.000000	0	0	0	0	51.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.000000	699,374	0	6,472,764	0	54.00
57.00	05700 CT SCAN	0.000000	2,530,471	0	7,785,088	0	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0.000000	154,628	0	963,980	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	0.000000	953,463	0	2,224,224	0	59.00
60.00	06000 LABORATORY	0.000000	1,489,358	0	2,091,341	0	60.00
60.01	06001 ONCOLOGY	0.000000	20,043	0	2,690,646	0	60.01
60.02	06002 RADIATION ONCOLOGY	0.000000	0	0	0	0	60.02
65.00	06500 RESPIRATORY THERAPY	0.000000	839,086	0	1,650,915	0	65.00
66.00	06600 PHYSICAL THERAPY	0.000000	822,346	0	96,131	0	66.00
69.00	06900 ELECTROCARDIOLOGY	0.000000	1,711,157	0	2,500,522	0	69.00
69.01	06901 CARDIAC REHAB	0.000000	0	0	435,900	0	69.01
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	0	0	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	0	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.000000	2,477,557	0	33,515,213	0	73.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000 CLINIC	0.000000	4,753	0	740,787	0	90.00
91.00	09100 EMERGENCY	0.000000	4,640,847	0	11,313,446	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	0	0	1,426,786	0	92.00
92.01	09201 OBSERVATION BEDS (DISTINCT PART)	0.000000	0	0	0	0	92.01
OTHER REIMBURSABLE COST CENTERS							
95.00	09500 AMBULANCE SERVICES						95.00
200.00	Total (lines 50 through 199)		26,624,183	0	91,057,456	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 15-0011	Period: From 07/01/2019 To 06/30/2020	Worksheet D Part V Date/Time Prepared: 11/20/2020 1:17 pm
	Title XVIII	Hospital	PPS

Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges			Costs			
		PPS Reimbursed Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	PPS Services (see inst.)			
	1.00	2.00	3.00	4.00	5.00			
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0.158129	17,149,713	0	0	2,711,867	50.00
51.00	05100	RECOVERY ROOM	0.000000	0	0	0	0	51.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.297587	6,472,764	0	0	1,926,210	54.00
57.00	05700	CT SCAN	0.038583	7,785,088	0	0	300,372	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.225462	963,980	0	0	217,341	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.361867	2,224,224	0	0	804,873	59.00
60.00	06000	LABORATORY	0.643038	2,091,341	7	0	1,344,812	60.00
60.01	06001	ONCOLOGY	0.296381	2,690,646	0	0	797,456	60.01
60.02	06002	RADIATION ONCOLOGY	0.000000	0	0	0	0	60.02
65.00	06500	RESPIRATORY THERAPY	0.461597	1,650,915	0	0	762,057	65.00
66.00	06600	PHYSICAL THERAPY	0.313909	96,131	0	0	30,176	66.00
69.00	06900	ELECTROCARDIOLOGY	0.184564	2,500,522	0	0	461,506	69.00
69.01	06901	CARDIAC REHAB	0.630942	435,900	0	0	275,028	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.188667	33,515,213	0	6,251	6,323,215	73.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0.800041	740,787	0	0	592,660	90.00
91.00	09100	EMERGENCY	0.158611	11,313,446	0	0	1,794,437	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.450414	1,426,786	0	0	642,644	92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	0.000000	0	0	0	0	92.01
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	0.521298		0			95.00
200.00		Subtotal (see instructions)		91,057,456	7	6,251	18,984,654	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 - line 201)		91,057,456	7	6,251	18,984,654	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 15-0011	Period: From 07/01/2019 To 06/30/2020	Worksheet D Part V Date/Time Prepared: 11/20/2020 1:17 pm
	Title XVIII	Hospital	PPS

Cost Center Description	Costs			
	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
	6.00	7.00		
ANCILLARY SERVICE COST CENTERS				
50.00	05000 OPERATING ROOM	0	0	50.00
51.00	05100 RECOVERY ROOM	0	0	51.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	0	54.00
57.00	05700 CT SCAN	0	0	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	0	0	59.00
60.00	06000 LABORATORY	5	0	60.00
60.01	06001 ONCOLOGY	0	0	60.01
60.02	06002 RADIATION ONCOLOGY	0	0	60.02
65.00	06500 RESPIRATORY THERAPY	0	0	65.00
66.00	06600 PHYSICAL THERAPY	0	0	66.00
69.00	06900 ELECTROCARDIOLOGY	0	0	69.00
69.01	06901 CARDIAC REHAB	0	0	69.01
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	1,179	73.00
OUTPATIENT SERVICE COST CENTERS				
90.00	09000 CLINIC	0	0	90.00
91.00	09100 EMERGENCY	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	92.00
92.01	09201 OBSERVATION BEDS (DISTINCT PART)	0	0	92.01
OTHER REIMBURSABLE COST CENTERS				
95.00	09500 AMBULANCE SERVICES	0	0	95.00
200.00	Subtotal (see instructions)	5	1,179	200.00
201.00	Less PBP Clinic Lab. Services-Program Only Charges	0		201.00
202.00	Net Charges (line 200 - line 201)	5	1,179	202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS		Provider CCN: 15-0011 Component CCN: 15-T011		Period: From 07/01/2019 To 06/30/2020		Worksheet D Part II Date/Time Prepared: 11/20/2020 1:17 pm		
Title XVIII				Subprovider - IRF		PPS		
Cost Center Description		Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 + col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)		
		1.00	2.00	3.00	4.00	5.00		
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	1,864,747	106,928,633	0.017439	32,675	570	50.00
51.00	05100	RECOVERY ROOM	0	0	0.000000	0	0	51.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,081,592	29,162,784	0.037088	34,133	1,266	54.00
57.00	05700	CT SCAN	101,865	37,275,548	0.002733	66,124	181	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	93,953	3,663,868	0.025643	12,344	317	58.00
59.00	05900	CARDIAC CATHETERIZATION	295,136	9,078,310	0.032510	4,504	146	59.00
60.00	06000	LABORATORY	844,415	18,700,441	0.045155	82,546	3,727	60.00
60.01	06001	ONCOLOGY	58,380	7,842,483	0.007444	1,349	10	60.01
60.02	06002	RADIATION ONCOLOGY	0	0	0.000000	0	0	60.02
65.00	06500	RESPIRATORY THERAPY	288,139	8,111,158	0.035524	68,129	2,420	65.00
66.00	06600	PHYSICAL THERAPY	126,655	10,687,784	0.011850	2,165,273	25,658	66.00
69.00	06900	ELECTROCARDIOLOGY	395,465	12,855,180	0.030763	44,301	1,363	69.00
69.01	06901	CARDIAC REHAB	70,762	857,220	0.082548	0	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0.000000	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0.000000	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	564,592	96,250,704	0.005866	319,976	1,877	73.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	249,333	2,353,861	0.105925	97	10	90.00
91.00	09100	EMERGENCY	850,540	74,466,027	0.011422	116,586	1,332	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	8,171,988	0.000000	0	0	92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	0	0	0.000000	0	0	92.01
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)	6,885,574	426,405,989		2,948,037	38,877	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 15-0011 Component CCN: 15-T011	Period: From 07/01/2019 To 06/30/2020	Worksheet D Part IV Date/Time Prepared: 11/20/2020 1:17 pm
Title XVIII		Subprovider - IRF	PPS

Cost Center Description		Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health	
		1.00	2A	2.00	3A	3.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	0	0	0	0	0	50.00
51.00	05100 RECOVERY ROOM	0	0	0	0	0	51.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
57.00	05700 CT SCAN	0	0	0	0	0	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000 LABORATORY	0	0	0	0	0	60.00
60.01	06001 ONCOLOGY	0	0	0	0	0	60.01
60.02	06002 RADIATION ONCOLOGY	0	0	0	0	0	60.02
65.00	06500 RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600 PHYSICAL THERAPY	0	0	0	0	0	66.00
69.00	06900 ELECTROCARDIOLOGY	0	0	0	0	0	69.00
69.01	06901 CARDIAC REHAB	0	0	0	0	0	69.01
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000 CLINIC	0	0	0	0	0	90.00
91.00	09100 EMERGENCY	0	0	0	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
92.01	09201 OBSERVATION BEDS (DISTINCT PART)	0	0	0	0	0	92.01
OTHER REIMBURSABLE COST CENTERS							
95.00	09500 AMBULANCE SERVICES	0	0	0	0	0	95.00
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: 15-0011 Component CCN: 15-T011	Period: From 07/01/2019 To 06/30/2020	Worksheet D Part IV Date/Time Prepared: 11/20/2020 1:17 pm
Title XVIII		Subprovider - IRF	PPS

Cost Center Description		All Other Medical Education Cost	Total Cost (sum of col s. 1, 2, 3, and 4)	Total Outpatient Cost (sum of col s. 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	106,928,633	0.000000	50.00
51.00	05100 RECOVERY ROOM	0	0	0	0	0.000000	51.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	0	0	29,162,784	0.000000	54.00
57.00	05700 CT SCAN	0	0	0	37,275,548	0.000000	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	3,663,868	0.000000	58.00
59.00	05900 CARDIAC CATHETERIZATION	0	0	0	9,078,310	0.000000	59.00
60.00	06000 LABORATORY	0	0	0	18,700,441	0.000000	60.00
60.01	06001 ONCOLOGY	0	0	0	7,842,483	0.000000	60.01
60.02	06002 RADIATION ONCOLOGY	0	0	0	0	0.000000	60.02
65.00	06500 RESPIRATORY THERAPY	0	0	0	8,111,158	0.000000	65.00
66.00	06600 PHYSICAL THERAPY	0	0	0	10,687,784	0.000000	66.00
69.00	06900 ELECTROCARDIOLOGY	0	0	0	12,855,180	0.000000	69.00
69.01	06901 CARDIAC REHAB	0	0	0	857,220	0.000000	69.01
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0.000000	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0.000000	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	0	96,250,704	0.000000	73.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000 CLINIC	0	0	0	2,353,861	0.000000	90.00
91.00	09100 EMERGENCY	0	0	0	74,466,027	0.000000	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	8,171,988	0.000000	92.00
92.01	09201 OBSERVATION BEDS (DISTINCT PART)	0	0	0	0	0.000000	92.01
OTHER REIMBURSABLE COST CENTERS							
95.00	09500 AMBULANCE SERVICES						95.00
200.00	Total (lines 50 through 199)	0	0	0	426,405,989		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS		Provider CCN: 15-0011 Component CCN: 15-T011	Period: From 07/01/2019 To 06/30/2020	Worksheet D Part IV Date/Time Prepared: 11/20/2020 1:17 pm PPS		
Cost Center Description		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	32,675	0	0	50.00
51.00	05100 RECOVERY ROOM	0.000000	0	0	0	51.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.000000	34,133	0	0	54.00
57.00	05700 CT SCAN	0.000000	66,124	0	0	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0.000000	12,344	0	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	0.000000	4,504	0	0	59.00
60.00	06000 LABORATORY	0.000000	82,546	0	0	60.00
60.01	06001 ONCOLOGY	0.000000	1,349	0	0	60.01
60.02	06002 RADIATION ONCOLOGY	0.000000	0	0	0	60.02
65.00	06500 RESPIRATORY THERAPY	0.000000	68,129	0	0	65.00
66.00	06600 PHYSICAL THERAPY	0.000000	2,165,273	0	0	66.00
69.00	06900 ELECTROCARDIOLOGY	0.000000	44,301	0	0	69.00
69.01	06901 CARDIAC REHAB	0.000000	0	0	0	69.01
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	0	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.000000	319,976	0	0	73.00
OUTPATIENT SERVICE COST CENTERS						
90.00	09000 CLINIC	0.000000	97	0	0	90.00
91.00	09100 EMERGENCY	0.000000	116,586	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	0	0	0	92.00
92.01	09201 OBSERVATION BEDS (DISTINCT PART)	0.000000	0	0	0	92.01
OTHER REIMBURSABLE COST CENTERS						
95.00	09500 AMBULANCE SERVICES					95.00
200.00	Total (lines 50 through 199)		2,948,037	0	0	200.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 15-0011	Period: From 07/01/2019 To 06/30/2020	Worksheet D-1 Date/Time Prepared: 11/20/2020 1:17 pm
Cost Center Description		Title XVIII	Hospital	PPS
		1.00		
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		14,563	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		14,563	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)		11,311	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions)		4,589	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)		16,483,087	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)		16,483,087	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)		16,483,087	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)		1,131.85	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		5,194,060	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)		5,194,060	41.00

COMPUTATION OF INPATIENT OPERATING COST			Provider CCN: 15-0011	Period: From 07/01/2019 To 06/30/2020	Worksheet D-1 Date/Time Prepared: 11/20/2020 1:17 pm	
Title XVIII			Hospital		PPS	
Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
	1.00	2.00	3.00	4.00	5.00	
42.00 NURSERY (title V & XIX only)	0	0	0.00	0	0	42.00
Intensive Care Type Inpatient Hospital Units						
43.00 INTENSIVE CARE UNIT	4,726,611	3,206	1,474.30	851	1,254,629	43.00
44.00 CORONARY CARE UNIT						44.00
45.00 BURN INTENSIVE CARE UNIT						45.00
46.00 SURGICAL INTENSIVE CARE UNIT						46.00
47.00 OTHER SPECIAL CARE (SPECIFY)						47.00
Cost Center Description						
					1.00	
48.00 Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					5,443,647	48.00
49.00 Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					11,892,336	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)					922,483	50.00
51.00 Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					474,746	51.00
52.00 Total Program excludable cost (sum of lines 50 and 51)					1,397,229	52.00
53.00 Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					10,495,107	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)					3,252	87.00
88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					1,131.85	88.00
89.00 Observation bed cost (line 87 x line 88) (see instructions)					3,680,776	89.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 15-0011		Period: From 07/01/2019 To 06/30/2020		Worksheet D-1 Date/Time Prepared: 11/20/2020 1:17 pm	
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)	PPS
		1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00	Capital-related cost	2,433,266	16,483,087	0.147622	3,680,776	543,364	90.00
91.00	Nursing School cost	0	16,483,087	0.000000	3,680,776	0	91.00
92.00	Allied health cost	0	16,483,087	0.000000	3,680,776	0	92.00
93.00	All other Medical Education	0	16,483,087	0.000000	3,680,776	0	93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 15-0011 Component CCN: 15-T011	Period: From 07/01/2019 To 06/30/2020	Worksheet D-1 Date/Time Prepared: 11/20/2020 1:17 pm
		Title XVIII	Subprovider - IRF	PPS
Cost Center Description				1.00
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		2,665	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		2,665	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.		0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)		2,665	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)		2,062	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)		3,716,162	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)		3,716,162	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)		3,716,162	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)		1,394.43	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		2,875,315	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)		2,875,315	41.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 15-0011 Component CCN: 15-T011		Period: From 07/01/2019 To 06/30/2020		Worksheet D-1 Date/Time Prepared: 11/20/2020 1:17 pm	
		Title XVIII		Subprovider - IRF		PPS	
Cost Center Description		Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)	0	0	0.00	0	0	
Intensive Care Type Inpatient Hospital Units							
43.00	INTENSIVE CARE UNIT	0	0	0.00	0	0	
44.00	CORONARY CARE UNIT						
45.00	BURN INTENSIVE CARE UNIT						
46.00	SURGICAL INTENSIVE CARE UNIT						
47.00	OTHER SPECIAL CARE (SPECIFY)						
Cost Center Description							
		1.00					
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					874,031	
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					3,749,346	
PASS THROUGH COST ADJUSTMENTS							
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)					406,090	
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					38,877	
52.00	Total Program excludable cost (sum of lines 50 and 51)					444,967	
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthesiologist, and medical education costs (line 49 minus line 52)					3,304,379	
TARGET AMOUNT AND LIMIT COMPUTATION							
54.00	Program discharges					0	
55.00	Target amount per discharge					0.00	
56.00	Target amount (line 54 x line 55)					0	
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)					0	
58.00	Bonus payment (see instructions)					0	
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket					0.00	
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket					0.00	
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)					0	
62.00	Relief payment (see instructions)					0	
63.00	Allowable Inpatient cost plus incentive payment (see instructions)					0	
PROGRAM INPATIENT ROUTINE SWING BED COST							
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)					0	
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					0	
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)					0	
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)					0	
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)					0	
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)					0	
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY							
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)					70.00	
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)					71.00	
72.00	Program routine service cost (line 9 x line 71)					72.00	
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)					73.00	
74.00	Total Program general inpatient routine service costs (line 72 + line 73)					74.00	
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)					75.00	
76.00	Per diem capital-related costs (line 75 ÷ line 2)					76.00	
77.00	Program capital-related costs (line 9 x line 76)					77.00	
78.00	Inpatient routine service cost (line 74 minus line 77)					78.00	
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)					79.00	
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)					80.00	
81.00	Inpatient routine service cost per diem limitation					81.00	
82.00	Inpatient routine service cost limitation (line 9 x line 81)					82.00	
83.00	Reasonable inpatient routine service costs (see instructions)					83.00	
84.00	Program inpatient ancillary services (see instructions)					84.00	
85.00	Utilization review - physician compensation (see instructions)					85.00	
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)					86.00	
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
87.00	Total observation bed days (see instructions)					0	
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					0.00	
89.00	Observation bed cost (line 87 x line 88) (see instructions)					0	

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 15-0011 Component CCN: 15-T011		Period: From 07/01/2019 To 06/30/2020		Worksheet D-1 Date/Time Prepared: 11/20/2020 1:17 pm	
		Title XVIII		Subprovider - IRF		PPS	
Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)		
	1.00	2.00	3.00	4.00	5.00		
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00	Capital-related cost	524,857	3,716,162	0.141236	0	0	90.00
91.00	Nursing School cost	0	3,716,162	0.000000	0	0	91.00
92.00	Allied health cost	0	3,716,162	0.000000	0	0	92.00
93.00	All other Medical Education	0	3,716,162	0.000000	0	0	93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 15-0011	Period: From 07/01/2019 To 06/30/2020	Worksheet D-1 Date/Time Prepared: 11/20/2020 1:17 pm
Cost Center Description		Title XIX	Hospital	Cost
		1.00		
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		14,563	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		14,563	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)		11,311	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)		577	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)		0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period		0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)		0	14.00
15.00	Total nursery days (title V or XIX only)		1,616	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)		16,483,087	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)		16,483,087	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)		16,483,087	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)		1,131.85	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		653,077	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)		653,077	41.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 15-0011		Period: From 07/01/2019 To 06/30/2020		Worksheet D-1			
		Title XIX		Hospital		Cost			
Cost Center Description		Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)			
		1.00	2.00	3.00	4.00	5.00			
42.00	NURSERY (title V & XIX only)	1,921,773	1,616	1,189.22	0	0	42.00		
Intensive Care Type Inpatient Hospital Units									
43.00	INTENSIVE CARE UNIT	4,726,611	3,206	1,474.30	0	0	43.00		
44.00	CORONARY CARE UNIT						44.00		
45.00	BURN INTENSIVE CARE UNIT						45.00		
46.00	SURGICAL INTENSIVE CARE UNIT						46.00		
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00		
Cost Center Description									
		1.00							
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	421,281						48.00	
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	1,074,358						49.00	
PASS THROUGH COST ADJUSTMENTS									
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)							0	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)							0	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)							0	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthesiologist, and medical education costs (line 49 minus line 52)							0	53.00
TARGET AMOUNT AND LIMIT COMPUTATION									
54.00	Program discharges							0	54.00
55.00	Target amount per discharge							0.00	55.00
56.00	Target amount (line 54 x line 55)							0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)							0	57.00
58.00	Bonus payment (see instructions)							0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket							0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket							0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)							0	61.00
62.00	Relief payment (see instructions)							0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)							0	63.00
PROGRAM INPATIENT ROUTINE SWING BED COST									
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)							0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)							0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)							0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)							0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)							0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)							0	69.00
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY									
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)								70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)								71.00
72.00	Program routine service cost (line 9 x line 71)								72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)								73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)								74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)								75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)								76.00
77.00	Program capital-related costs (line 9 x line 76)								77.00
78.00	Inpatient routine service cost (line 74 minus line 77)								78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)								79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)								80.00
81.00	Inpatient routine service cost per diem limitation								81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)								82.00
83.00	Reasonable inpatient routine service costs (see instructions)								83.00
84.00	Program inpatient ancillary services (see instructions)								84.00
85.00	Utilization review - physician compensation (see instructions)								85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)								86.00
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST									
87.00	Total observation bed days (see instructions)							3,252	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)							1,131.85	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)							3,680,776	89.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 15-0011		Period: From 07/01/2019 To 06/30/2020		Worksheet D-1 Date/Time Prepared: 11/20/2020 1:17 pm	
Cost Center Description		Cost	Routine Cost (from line 21)	column 1 + column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00	Capital-related cost	2,433,266	16,483,087	0.147622	3,680,776	543,364	90.00
91.00	Nursing School cost	0	16,483,087	0.000000	3,680,776	0	91.00
92.00	Allied health cost	0	16,483,087	0.000000	3,680,776	0	92.00
93.00	All other Medical Education	0	16,483,087	0.000000	3,680,776	0	93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 15-0011 Component CCN: 15-T011	Period: From 07/01/2019 To 06/30/2020	Worksheet D-1 Date/Time Prepared: 11/20/2020 1:17 pm
		Title XIX	Subprovider - IRF	Cost
Cost Center Description				1.00
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)			2,665 1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)			2,665 2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.			0 3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)			2,665 4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period			0 5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)			0 6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period			0 7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)			0 8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions)			11 9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)			0 10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)			0 11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period			0 12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)			0 13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)			0 14.00
15.00	Total nursery days (title V or XIX only)			1,616 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)			3,716,162 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)			3,716,162 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)			3,716,162 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)			1,394.43 38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)			15,339 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)			15,339 41.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 15-0011 Component CCN: 15-T011		Period: From 07/01/2019 To 06/30/2020		Worksheet D-1 Date/Time Prepared: 11/20/2020 1:17 pm	
Cost Center Description		Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)	0	0	0.00	0	0	
Intensive Care Type Inpatient Hospital Units							
43.00	INTENSIVE CARE UNIT	0	0	0.00	0	0	
44.00	CORONARY CARE UNIT						
45.00	BURN INTENSIVE CARE UNIT						
46.00	SURGICAL INTENSIVE CARE UNIT						
47.00	OTHER SPECIAL CARE (SPECIFY)						
Cost Center Description							
		1.00					
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	12,737					
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	28,076					
PASS THROUGH COST ADJUSTMENTS							
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)	0					
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	0					
52.00	Total Program excludable cost (sum of lines 50 and 51)	0					
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthesiologist, and medical education costs (line 49 minus line 52)	0					
TARGET AMOUNT AND LIMIT COMPUTATION							
54.00	Program discharges	0					
55.00	Target amount per discharge	0.00					
56.00	Target amount (line 54 x line 55)	0					
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)	0					
58.00	Bonus payment (see instructions)	0					
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket	0.00					
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket	0.00					
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)	0					
62.00	Relief payment (see instructions)	0					
63.00	Allowable Inpatient cost plus incentive payment (see instructions)	0					
PROGRAM INPATIENT ROUTINE SWING BED COST							
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)	0					
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)	0					
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)	0					
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)	0					
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)	0					
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)	0					
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY							
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)	70.00					
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)	71.00					
72.00	Program routine service cost (line 9 x line 71)	72.00					
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)	73.00					
74.00	Total Program general inpatient routine service costs (line 72 + line 73)	74.00					
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)	75.00					
76.00	Per diem capital-related costs (line 75 ÷ line 2)	76.00					
77.00	Program capital-related costs (line 9 x line 76)	77.00					
78.00	Inpatient routine service cost (line 74 minus line 77)	78.00					
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)	79.00					
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)	80.00					
81.00	Inpatient routine service cost per diem limitation	81.00					
82.00	Inpatient routine service cost limitation (line 9 x line 81)	82.00					
83.00	Reasonable inpatient routine service costs (see instructions)	83.00					
84.00	Program inpatient ancillary services (see instructions)	84.00					
85.00	Utilization review - physician compensation (see instructions)	85.00					
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)	86.00					
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
87.00	Total observation bed days (see instructions)	0					
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	0.00					
89.00	Observation bed cost (line 87 x line 88) (see instructions)	0					

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 15-0011 Component CCN: 15-T011		Period: From 07/01/2019 To 06/30/2020		Worksheet D-1 Date/Time Prepared: 11/20/2020 1:17 pm	
		Title XIX		Subprovider - IRF		Cost	
Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)		
	1.00	2.00	3.00	4.00	5.00		
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00	Capital-related cost	524,857	3,716,162	0.141236	0	0	90.00
91.00	Nursing School cost	0	3,716,162	0.000000	0	0	91.00
92.00	Allied health cost	0	3,716,162	0.000000	0	0	92.00
93.00	All other Medical Education	0	3,716,162	0.000000	0	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 15-0011	Period: From 07/01/2019 To 06/30/2020	Worksheet D-3 Date/Time Prepared: 11/20/2020 1:17 pm	
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		5,736,888	30.00
31.00	03100	INTENSIVE CARE UNIT		1,844,968	31.00
40.00	04000	SUBPROVIDER - IPF		0	40.00
41.00	04100	SUBPROVIDER - IRF		0	41.00
42.00	04200	SUBPROVIDER		0	42.00
43.00	04300	NURSERY			43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0.158129	10,281,100	50.00
51.00	05100	RECOVERY ROOM	0.000000	0	51.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.297587	699,374	54.00
57.00	05700	CT SCAN	0.038583	2,530,471	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.225462	154,628	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.361867	953,463	59.00
60.00	06000	LABORATORY	0.643038	1,489,358	60.00
60.01	06001	ONCOLOGY	0.296381	20,043	60.01
60.02	06002	RADIATION ONCOLOGY	0.000000	0	60.02
65.00	06500	RESPIRATORY THERAPY	0.461597	839,086	65.00
66.00	06600	PHYSICAL THERAPY	0.313909	822,346	66.00
69.00	06900	ELECTROCARDIOLOGY	0.184564	1,711,157	69.00
69.01	06901	CARDIAC REHAB	0.630942	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.188667	2,477,557	73.00
OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	0.800041	4,753	90.00
91.00	09100	EMERGENCY	0.158611	4,640,847	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.450414	0	92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	0.000000	0	92.01
OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES			95.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		26,624,183	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)		26,624,183	202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 15-0011 Component CCN: 15-T011	Period: From 07/01/2019 To 06/30/2020	Worksheet D-3 Date/Time Prepared: 11/20/2020 1:17 pm	
		Title XVIII	Subprovider - IRF	PPS	
Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDIATRICS		0		30.00
31.00	03100 INTENSIVE CARE UNIT		0		31.00
40.00	04000 SUBPROVIDER - IPF		0		40.00
41.00	04100 SUBPROVIDER - IRF		2,707,407		41.00
42.00	04200 SUBPROVIDER		0		42.00
43.00	04300 NURSERY				43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.158129	32,675	5,167	50.00
51.00	05100 RECOVERY ROOM	0.000000	0	0	51.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.297587	34,133	10,158	54.00
57.00	05700 CT SCAN	0.038583	66,124	2,551	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0.225462	12,344	2,783	58.00
59.00	05900 CARDIAC CATHETERIZATION	0.361867	4,504	1,630	59.00
60.00	06000 LABORATORY	0.643038	82,546	53,080	60.00
60.01	06001 ONCOLOGY	0.296381	1,349	400	60.01
60.02	06002 RADIATION ONCOLOGY	0.000000	0	0	60.02
65.00	06500 RESPIRATORY THERAPY	0.461597	68,129	31,448	65.00
66.00	06600 PHYSICAL THERAPY	0.313909	2,165,273	679,699	66.00
69.00	06900 ELECTROCARDIOLOGY	0.184564	44,301	8,176	69.00
69.01	06901 CARDIAC REHAB	0.630942	0	0	69.01
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.188667	319,976	60,369	73.00
OUTPATIENT SERVICE COST CENTERS					
90.00	09000 CLINIC	0.800041	97	78	90.00
91.00	09100 EMERGENCY	0.158611	116,586	18,492	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.450414	0	0	92.00
92.01	09201 OBSERVATION BEDS (DISTINCT PART)	0.000000	0	0	92.01
OTHER REIMBURSABLE COST CENTERS					
95.00	09500 AMBULANCE SERVICES				95.00
200.00	Total (sum of lines 50 through 94 and 96 through 98)		2,948,037	874,031	200.00
201.00	Less PBP Clinic Laboratory Services-Program only charges (line 61)		0		201.00
202.00	Net charges (line 200 minus line 201)		2,948,037		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 15-0011	Period: From 07/01/2019 To 06/30/2020	Worksheet D-3 Date/Time Prepared: 11/20/2020 1:17 pm	
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		836,543	30.00
31.00	03100	INTENSIVE CARE UNIT		166,608	31.00
40.00	04000	SUBPROVIDER - IPF		0	40.00
41.00	04100	SUBPROVIDER - IRF		0	41.00
42.00	04200	SUBPROVIDER		0	42.00
43.00	04300	NURSERY		0	43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0.158129	690,873	50.00
51.00	05100	RECOVERY ROOM	0.000000	0	51.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.297587	75,302	54.00
57.00	05700	CT SCAN	0.038583	163,586	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.225462	7,597	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.361867	131,997	59.00
60.00	06000	LABORATORY	0.643038	138,060	60.00
60.01	06001	ONCOLOGY	0.296381	0	60.01
60.02	06002	RADIATION ONCOLOGY	0.000000	0	60.02
65.00	06500	RESPIRATORY THERAPY	0.461597	50,009	65.00
66.00	06600	PHYSICAL THERAPY	0.313909	17,370	66.00
69.00	06900	ELECTROCARDIOLOGY	0.184564	95,850	69.00
69.01	06901	CARDIAC REHAB	0.630942	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.188667	175,100	73.00
OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	0.800041	0	90.00
91.00	09100	EMERGENCY	0.158611	414,811	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.450414	0	92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	0.000000	0	92.01
OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES			95.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		1,960,555	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)		1,960,555	202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 15-0011 Component CCN: 15-T011	Period: From 07/01/2019 To 06/30/2020	Worksheet D-3 Date/Time Prepared: 11/20/2020 1:17 pm	
Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDIATRICS		0		30.00
31.00	03100 INTENSIVE CARE UNIT		0		31.00
40.00	04000 SUBPROVIDER - IPF		0		40.00
41.00	04100 SUBPROVIDER - IRF		31,927		41.00
42.00	04200 SUBPROVIDER		0		42.00
43.00	04300 NURSERY		0		43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.158129	0	0	50.00
51.00	05100 RECOVERY ROOM	0.000000	0	0	51.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.297587	2,830	842	54.00
57.00	05700 CT SCAN	0.038583	0	0	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0.225462	0	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	0.361867	0	0	59.00
60.00	06000 LABORATORY	0.643038	2,115	1,360	60.00
60.01	06001 ONCOLOGY	0.296381	0	0	60.01
60.02	06002 RADIATION ONCOLOGY	0.000000	0	0	60.02
65.00	06500 RESPIRATORY THERAPY	0.461597	218	101	65.00
66.00	06600 PHYSICAL THERAPY	0.313909	22,995	7,218	66.00
69.00	06900 ELECTROCARDIOLOGY	0.184564	0	0	69.00
69.01	06901 CARDIAC REHAB	0.630942	0	0	69.01
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.188667	17,046	3,216	73.00
OUTPATIENT SERVICE COST CENTERS					
90.00	09000 CLINIC	0.800041	0	0	90.00
91.00	09100 EMERGENCY	0.158611	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.450414	0	0	92.00
92.01	09201 OBSERVATION BEDS (DISTINCT PART)	0.000000	0	0	92.01
OTHER REIMBURSABLE COST CENTERS					
95.00	09500 AMBULANCE SERVICES				95.00
200.00	Total (sum of lines 50 through 94 and 96 through 98)		45,204	12,737	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)		45,204		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 15-0011	Period: From 07/01/2019 To 06/30/2020	Worksheet E Part A Date/Time Prepared: 11/20/2020 1:17 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)		2,993,580	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1 (see instructions)		8,319,055	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)		57,128	2.03
2.04	Outlier payments for discharges occurring on or after October 1 (see instructions)		36,882	2.04
3.00	Managed Care Simulated Payments		0	3.00
4.00	Bed days available divided by number of days in the cost reporting period (see instructions)		103.68	4.00
Indirect Medical Education Adjustment				
5.00	FTE count for allopathic and osteopathic programs for the most recent cost reporting period ending on or before 12/31/1996. (see instructions)		0.00	5.00
6.00	FTE count for allopathic and osteopathic programs that meet the criteria for an add-on to the cap for new programs in accordance with 42 CFR 413.79(e)		0.00	6.00
7.00	MMA Section 422 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(1)		0.00	7.00
7.01	ACA § 5503 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(2) If the cost report straddles July 1, 2011 then see instructions.		0.00	7.01
8.00	Adjustment (increase or decrease) to the FTE count for allopathic and osteopathic programs for affiliated programs in accordance with 42 CFR 413.75(b), 413.79(c)(2)(iv), 64 FR 26340 (May 12, 1998), and 67 FR 50069 (August 1, 2002).		0.00	8.00
8.01	The amount of increase if the hospital was awarded FTE cap slots under § 5503 of the ACA. If the cost report straddles July 1, 2011, see instructions.		0.00	8.01
8.02	The amount of increase if the hospital was awarded FTE cap slots from a closed teaching hospital under § 5506 of ACA. (see instructions)		0.00	8.02
9.00	Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus lines (8, 8.01 and 8.02) (see instructions)		0.00	9.00
10.00	FTE count for allopathic and osteopathic programs in the current year from your records		0.00	10.00
11.00	FTE count for residents in dental and podiatric programs.		0.00	11.00
12.00	Current year allowable FTE (see instructions)		0.00	12.00
13.00	Total allowable FTE count for the prior year.		0.00	13.00
14.00	Total allowable FTE count for the penultimate year if that year ended on or after September 30, 1997, otherwise enter zero.		0.00	14.00
15.00	Sum of lines 12 through 14 divided by 3.		0.00	15.00
16.00	Adjustment for residents in initial years of the program		0.00	16.00
17.00	Adjustment for residents displaced by program or hospital closure		0.00	17.00
18.00	Adjusted rolling average FTE count		0.00	18.00
19.00	Current year resident to bed ratio (line 18 divided by line 4).		0.000000	19.00
20.00	Prior year resident to bed ratio (see instructions)		0.000000	20.00
21.00	Enter the lesser of lines 19 or 20 (see instructions)		0.000000	21.00
22.00	IME payment adjustment (see instructions)		0	22.00
22.01	IME payment adjustment - Managed Care (see instructions)		0	22.01
Indirect Medical Education Adjustment for the Add-on for § 422 of the MMA				
23.00	Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 CFR 412.105 (f)(1)(iv)(C).		0.00	23.00
24.00	IME FTE Resident Count Over Cap (see instructions)		0.00	24.00
25.00	If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see instructions)		0.00	25.00
26.00	Resident to bed ratio (divide line 25 by line 4)		0.000000	26.00
27.00	IME payments adjustment factor. (see instructions)		0.000000	27.00
28.00	IME add-on adjustment amount (see instructions)		0	28.00
28.01	IME add-on adjustment amount - Managed Care (see instructions)		0	28.01
29.00	Total IME payment (sum of lines 22 and 28)		0	29.00
29.01	Total IME payment - Managed Care (sum of lines 22.01 and 28.01)		0	29.01
Disproportionate Share Adjustment				
30.00	Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)		5.62	30.00
31.00	Percentage of Medicaid patient days (see instructions)		27.55	31.00
32.00	Sum of lines 30 and 31		33.17	32.00
33.00	Allowable disproportionate share percentage (see instructions)		16.57	33.00
34.00	Disproportionate share adjustment (see instructions)		468,626	34.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 15-0011	Period: From 07/01/2019 To 06/30/2020	Worksheet E Part A Date/Time Prepared: 11/20/2020 1:17 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)	8,272,872,447	8,350,599,096	35.00
35.01	Factor 3 (see instructions)	0.000277059	0.000307154	35.01
35.02	Hospital uncompensated care payment (If line 34 is zero, enter zero on this line) (see instructions)	2,292,074	2,564,920	35.02
35.03	Pro rata share of the hospital uncompensated care payment amount (see instructions)	577,729	1,920,186	35.03
36.00	Total uncompensated care (sum of columns 1 and 2 on line 35.03)	2,497,915		36.00
Additional payment for high percentage of ESRD beneficiary discharges (lines 40 through 46)				
40.00	Total Medicare discharges on Worksheet S-3, Part I excluding discharges for MS-DRGs 652, 682, 683, 684 and 685 (see instructions)	0		40.00
		Before 1/1	On/After 1/1	
		1.00	1.01	
41.00	Total ESRD Medicare discharges excluding MS-DRGs 652, 682, 683, 684 and 685. (see instructions)	0	0	41.00
41.01	Total ESRD Medicare covered and paid discharges excluding MS-DRGs 652, 682, 683, 684 and 685. (see instructions)	0	0	41.01
42.00	Divide line 41 by line 40 (if less than 10%, you do not qualify for adjustment)	0.00		42.00
43.00	Total Medicare ESRD inpatient days excluding MS-DRGs 652, 682, 683, 684 and 685. (see instructions)	0		43.00
44.00	Ratio of average length of stay to one week (line 43 divided by line 41 divided by 7 days)	0.000000		44.00
45.00	Average weekly cost for dialysis treatments (see instructions)	0.00	0.00	45.00
46.00	Total additional payment (line 45 times line 44 times line 41.01)	0		46.00
47.00	Subtotal (see instructions)	14,373,186		47.00
48.00	Hospital specific payments (to be completed by SCH and MDH, small rural hospitals only. (see instructions)	12,318,865		48.00
			Amount	
			1.00	
49.00	Total payment for inpatient operating costs (see instructions)		14,373,186	49.00
50.00	Payment for inpatient program capital (from Wkst. L, Pt. I and Pt. II, as applicable)		927,543	50.00
51.00	Exception payment for inpatient program capital (Wkst. L, Pt. III, see instructions)		0	51.00
52.00	Direct graduate medical education payment (from Wkst. E-4, line 49 see instructions).		0	52.00
53.00	Nursing and Allied Health Managed Care payment		0	53.00
54.00	Special add-on payments for new technologies		0	54.00
54.01	Islet isolation add-on payment		0	54.01
55.00	Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line 69)		0	55.00
56.00	Cost of physicians' services in a teaching hospital (see instructions)		0	56.00
57.00	Routine service other pass through costs (from Wkst. D, Pt. III, column 9, lines 30 through 35).		0	57.00
58.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 11 line 200)		0	58.00
59.00	Total (sum of amounts on lines 49 through 58)		15,300,729	59.00
60.00	Primary payer payments		6,606	60.00
61.00	Total amount payable for program beneficiaries (line 59 minus line 60)		15,294,123	61.00
62.00	Deductibles billed to program beneficiaries		1,556,632	62.00
63.00	Coinsurance billed to program beneficiaries		21,791	63.00
64.00	Allowable bad debts (see instructions)		154,461	64.00
65.00	Adjusted reimbursable bad debts (see instructions)		100,400	65.00
66.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		27,241	66.00
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)		13,816,100	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	BILLING CORRECTION		18,025	70.00
70.50	Rural Community Hospital Demonstration Project (\$410A Demonstration) adjustment (see instructions)		0	70.50
70.87	Demonstration payment adjustment amount before sequestration		0	70.87
70.88	SCH or MDH volume decrease adjustment (contractor use only)		0	70.88
70.89	Pioneer ACO demonstration payment adjustment amount (see instructions)		0	70.89
70.90	HSP bonus payment HVBP adjustment amount (see instructions)		0	70.90
70.91	HSP bonus payment HRR adjustment amount (see instructions)		0	70.91
70.92	Bundled Model 1 discount amount (see instructions)		0	70.92
70.93	HVBP payment adjustment amount (see instructions)		61,917	70.93
70.94	HRR adjustment amount (see instructions)		-17,669	70.94
70.95	Recovery of accelerated depreciation		0	70.95

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 15-0011	Period: From 07/01/2019 To 06/30/2020	Worksheet E Part A Date/Time Prepared: 11/20/2020 1:17 pm	
		Title XVIII	Hospital	PPS	
		FFY (yyyy)	Amount		
70.96	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period prior to 10/1)	0	1.00	0	70.96
70.97	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period ending on or after 10/1)	0		0	70.97
70.98	Low Volume Payment-3			0	70.98
70.99	HAC adjustment amount (see instructions)			153,449	70.99
71.00	Amount due provider (line 67 minus lines 68 plus/minus lines 69 & 70)			13,724,924	71.00
71.01	Sequestration adjustment (see instructions)			229,206	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			13,096,819	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)			398,899	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			241,941	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)				90.00
91.00	Capital outlier from Wkst. L, Pt. I, line 2			0	91.00
92.00	Operating outlier reconciliation adjustment amount (see instructions)			0	92.00
93.00	Capital outlier reconciliation adjustment amount (see instructions)			0	93.00
94.00	The rate used to calculate the time value of money (see instructions)			0.00	94.00
95.00	Time value of money for operating expenses (see instructions)			0	95.00
96.00	Time value of money for capital related expenses (see instructions)			0	96.00
			Prior to 10/1	On/After 10/1	
			1.00	2.00	
HSP Bonus Payment Amount					
100.00	HSP bonus amount (see instructions)			0	100.00
HVBP Adjustment for HSP Bonus Payment					
101.00	HVBP adjustment factor (see instructions)		0.0000000000	0.0000000000	101.00
102.00	HVBP adjustment amount for HSP bonus payment (see instructions)			0	102.00
HRR Adjustment for HSP Bonus Payment					
103.00	HRR adjustment factor (see instructions)		0.0000	0.0000	103.00
104.00	HRR adjustment amount for HSP bonus payment (see instructions)			0	104.00
Rural Community Hospital Demonstration Project (§410A Demonstration) Adjustment					
200.00	Is this the first year of the current 5-year demonstration period under the 21st Century Cures Act? Enter "Y" for yes or "N" for no.				200.00
Cost Reimbursement					
201.00	Medicare inpatient service costs (from Wkst. D-1, Pt. II, line 49)				201.00
202.00	Medicare discharges (see instructions)				202.00
203.00	Case-mix adjustment factor (see instructions)				203.00
Computation of Demonstration Target Amount Limitation (N/A in first year of the current 5-year demonstration period)					
204.00	Medicare target amount				204.00
205.00	Case-mix adjusted target amount (line 203 times line 204)				205.00
206.00	Medicare inpatient routine cost cap (line 202 times line 205)				206.00
Adjustment to Medicare Part A Inpatient Reimbursement					
207.00	Program reimbursement under the §410A Demonstration (see instructions)				207.00
208.00	Medicare Part A inpatient service costs (from Wkst. E, Pt. A, line 59)				208.00
209.00	Adjustment to Medicare IPPS payments (see instructions)				209.00
210.00	Reserved for future use				210.00
211.00	Total adjustment to Medicare IPPS payments (see instructions)				211.00
Comparison of PPS versus Cost Reimbursement					
212.00	Total adjustment to Medicare Part A IPPS payments (from line 211)				212.00
213.00	Low-volume adjustment (see instructions)				213.00
218.00	Net Medicare Part A IPPS adjustment (difference between PPS and cost reimbursement) (line 212 minus line 213) (see instructions)				218.00

LOW VOLUME CALCULATION EXHIBIT 4

Provider CCN: 15-0011

Period:
From 07/01/2019
To 06/30/2020

Worksheet E
Part A Exhibit 4
Date/Time Prepared:
11/20/2020 1:17 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	2,993,580	0	2,993,580		2,993,580	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	8,319,055	0		8,319,055	8,319,055	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	57,128	0	57,128		57,128	2.02
2.03	Outlier payments for discharges occurring on or after October 1 (see instructions)	2.04	36,882	0		36,882	36,882	2.03
3.00	Operating outlier reconciliation	2.01	0	0	0	0	0	3.00
4.00	Managed care simulated payments	3.00	0	0	0	0	0	4.00
Indirect Medical Education Adjustment								
5.00	Amount from Worksheet E, Part A, line 21 (see instructions)	21.00	0.000000	0.000000	0.000000	0.000000		5.00
6.00	IME payment adjustment (see instructions)	22.00	0	0	0	0	0	6.00
6.01	IME payment adjustment for managed care (see instructions)	22.01	0	0	0	0	0	6.01
Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA								
7.00	IME payment adjustment factor (see instructions)	27.00	0.000000	0.000000	0.000000	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	0	0	0	0	0	9.00
9.01	Total IME payment for managed care (sum of lines 6.01 and 8.01)	29.01	0	0	0	0	0	9.01
Disproportionate Share Adjustment								
10.00	Allowable disproportionate share percentage (see instructions)	33.00	0.1657	0.1657	0.1657	0.1657		10.00
11.00	Disproportionate share adjustment (see instructions)	34.00	468,626	0	124,009	344,617	468,626	11.00
11.01	Uncompensated care payments	36.00	2,497,915	0	577,729	1,920,186	2,497,915	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	14,373,186	0	3,752,446	10,620,740	14,373,186	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	14,373,186	0	3,752,446	10,620,740	14,373,186	15.00

LOW VOLUME CALCULATION EXHIBIT 4

Provider CCN: 15-0011

Period:
From 07/01/2019
To 06/30/2020

Worksheet E
Part A Exhibit 4
Date/Time Prepared:
11/20/2020 1:17 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	
16.00	Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable)	50.00	927,543	0	257,458	670,085	927,543	16.00
17.00	Special add-on payments for new technologies	54.00	0	0	0	0	0	17.00
17.01	Net organ acquisition cost							17.01
17.02	Credits received from manufacturers for replaced devices for applicable MS-DRGs	68.00	0	0	0	0	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	4,009,904	11,290,825	15,300,729	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	902,996	0	243,570	659,426	902,996	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	24,547	0	13,888	10,659	24,547	21.00
21.01	Model 4 BPCI Capital DRG outlier payments	2.01	0	0	0	0	0	21.01
22.00	Indirect medical education percentage (see instructions)	5.00	0.0000	0.0000	0.0000	0.0000		22.00
23.00	Indirect medical education adjustment (see instructions)	6.00	0	0	0	0	0	23.00
24.00	Allowable disproportionate share percentage (see instructions)	10.00	0.0000	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	927,543	0	257,458	670,085	927,543	26.00
		W/S E, Part A line	(Amounts to E, Part A)					
		0	1.00	2.00	3.00	4.00	5.00	
27.00	Low volume adjustment factor				0.000000	0.000000		27.00
28.00	Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)	70.96			0		0	28.00
29.00	Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)	70.97				0	0	29.00
100.00	Transfer low volume adjustments to Wkst. E, Pt. A.		Y					100.00

HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULATION EXHIBIT 5		Provider CCN: 15-0011		Period: From 07/01/2019 To 06/30/2020		Worksheet E Part A Exhibit 5 Date/Time Prepared: 11/20/2020 1:17 pm	
		Title XVIII		Hospital		PPS	
		Wkst. E, Pt. A, line	Amt. from Wkst. E, Pt. A)	Period to 10/01	Period on after 10/01	Total (cols. 2 and 3)	
		0	1.00	2.00	3.00	4.00	
1.00	DRG amounts other than outlier payments	1.00					1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1	1.01	2,993,580	2,993,580		2,993,580	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	8,319,055		8,319,055	8,319,055	1.02
1.03	DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October 1	1.03	0	0		0	1.03
1.04	DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1	1.04	0		0	0	1.04
2.00	Outlier payments for discharges (see instructions)	2.00					2.00
2.01	Outlier payments for discharges for Model 4 BPCI	2.02	0	0	0	0	2.01
2.02	Outlier payments for discharges occurring prior to October 1 (see instructions)	2.03	57,128	57,128		57,128	2.02
2.03	Outlier payments for discharges occurring on or after October 1 (see instructions)	2.04	36,882		36,882	36,882	2.03
3.00	Operating outlier reconciliation	2.01	0	0	0	0	3.00
4.00	Managed care simulated payments	3.00	0	0	0	0	4.00
Indirect Medical Education Adjustment							
5.00	Amount from Worksheet E, Part A, line 21 (see instructions)	21.00	0.000000	0.000000	0.000000		5.00
6.00	IME payment adjustment (see instructions)	22.00	0	0	0	0	6.00
6.01	IME payment adjustment for managed care (see instructions)	22.01	0	0	0	0	6.01
Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA							
7.00	IME payment adjustment factor (see instructions)	27.00	0.000000	0.000000	0.000000		7.00
8.00	IME adjustment (see instructions)	28.00	0	0	0	0	8.00
8.01	IME payment adjustment add on for managed care (see instructions)	28.01	0	0	0	0	8.01
9.00	Total IME payment (sum of lines 6 and 8)	29.00	0	0	0	0	9.00
9.01	Total IME payment for managed care (sum of lines 6.01 and 8.01)	29.01	0	0	0	0	9.01
Disproportionate Share Adjustment							
10.00	Allowable disproportionate share percentage (see instructions)	33.00	0.1657	0.1657	0.1657		10.00
11.00	Disproportionate share adjustment (see instructions)	34.00	468,626	124,009	344,617	468,626	11.00
11.01	Uncompensated care payments	36.00	2,497,915	577,729	1,920,186	2,497,915	11.01
Additional payment for high percentage of ESRD beneficiary discharges							
12.00	Total ESRD additional payment (see instructions)	46.00	0	0	0	0	12.00
13.00	Subtotal (see instructions)	47.00	14,373,186	3,752,446	10,620,740	14,373,186	13.00
14.00	Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see instructions)	48.00	0	0	0	0	14.00
15.00	Total payment for inpatient operating costs (see instructions)	49.00	14,373,186	3,752,446	10,620,740	14,373,186	15.00
16.00	Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable)	50.00	927,543	257,458	670,085	927,543	16.00
17.00	Special add-on payments for new technologies	54.00	0	0	0	0	17.00
17.01	Net organ acquisition cost						17.01
17.02	Credits received from manufacturers for replaced devices for applicable MS-DRGs	68.00	0	0	0	0	17.02
18.00	Capital outlier reconciliation adjustment amount (see instructions)	93.00	0	0	0	0	18.00
19.00	SUBTOTAL			4,009,904	11,290,825	15,300,729	19.00

HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULATION EXHIBIT 5		Provider CCN: 15-0011		Period: From 07/01/2019 To 06/30/2020		Worksheet E Part A Exhibit 5 Date/Time Prepared: 11/20/2020 1:17 pm	
			Title XVIII		Hospital		PPS

		Wkst. L, line	(Amt. from Wkst. L)				
		0	1.00	2.00	3.00	4.00	
20.00	Capital DRG other than outlier	1.00	902,996	243,570	659,426	902,996	20.00
20.01	Model 4 BPCI Capital DRG other than outlier	1.01	0	0	0	0	20.01
21.00	Capital DRG outlier payments	2.00	24,547	13,888	10,659	24,547	21.00
21.01	Model 4 BPCI Capital DRG outlier payments	2.01	0	0	0	0	21.01
22.00	Indirect medical education percentage (see instructions)	5.00	0.0000	0.0000	0.0000		22.00
23.00	Indirect medical education adjustment (see instructions)	6.00	0	0	0	0	23.00
24.00	Allowable disproportionate share percentage (see instructions)	10.00	0.0000	0.0000	0.0000		24.00
25.00	Disproportionate share adjustment (see instructions)	11.00	0	0	0	0	25.00
26.00	Total prospective capital payments (see instructions)	12.00	927,543	257,458	670,085	927,543	26.00
		Wkst. E, Pt. A, line	(Amt. from Wkst. E, Pt. A)				
		0	1.00	2.00	3.00	4.00	
27.00							27.00
28.00	Low volume adjustment prior to October 1	70.96	0	0		0	28.00
29.00	Low volume adjustment on or after October 1	70.97	0		0	0	29.00
30.00	HVBP payment adjustment (see instructions)	70.93	61,917	17,824	44,093	61,917	30.00
30.01	HVBP payment adjustment for HSP bonus payment (see instructions)	70.90	0	0	0	0	30.01
31.00	HRR adjustment (see instructions)	70.94	-17,669	-2,694	-14,975	-17,669	31.00
31.01	HRR adjustment for HSP bonus payment (see instructions)	70.91	0	0	0	0	31.01
						(Amt. to Wkst. E, Pt. A)	
		0	1.00	2.00	3.00	4.00	
32.00	HAC Reduction Program adjustment (see instructions)	70.99		40,250	113,199	153,449	32.00
100.00	Transfer HAC Reduction Program adjustment to Wkst. E, Pt. A.		Y				100.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 15-0011	Period: From 07/01/2019 To 06/30/2020	Worksheet E Part B Date/Time Prepared: 11/20/2020 1:17 pm
		Title XVIII	Hospital	PPS
				1.00
PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)		1,184	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)		18,984,654	2.00
3.00	OPPS payments		16,971,754	3.00
4.00	Outlier payment (see instructions)		84,267	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)		1,184	11.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
12.00	Ancillary service charges		6,258	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)		6,258	14.00
Customary charges				
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis		0	15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)		0	16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)		0.000000	17.00
18.00	Total customary charges (see instructions)		6,258	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)		5,074	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)		1,184	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)		17,056,021	24.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25.00	Deductibles and coinsurance amounts (for CAH, see instructions)		1	25.00
26.00	Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)		3,245,137	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)		13,812,067	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)		13,812,067	30.00
31.00	Primary payer payments		1,772	31.00
32.00	Subtotal (line 30 minus line 31)		13,810,295	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)		597,011	34.00
35.00	Adjusted reimbursable bad debts (see instructions)		388,057	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		349,116	36.00
37.00	Subtotal (see instructions)		14,198,352	37.00
38.00	MSP-LCC reconciliation amount from PS&R		4	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)		3,200	39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION		0	39.99
40.00	Subtotal (see instructions)		14,198,348	40.00
40.01	Sequestration adjustment (see instructions)		237,112	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		14,077,947	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)		-116,711	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: 15-0011

Period:
From 07/01/2019
To 06/30/2020

Worksheet E-1
Part I
Date/Time Prepared:
11/20/2020 1:17 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		12,980,910		13,576,213	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	06/30/2020	115,909	06/30/2020	501,734	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)		115,909		501,734	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)		13,096,819		14,077,947	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		398,899		0	6.01	
6.02	SETTLEMENT TO PROGRAM		0		116,711	6.02	
7.00	Total Medicare program liability (see instructions)		13,495,718		13,961,236	7.00	
				Contractor Number	NPR Date (Mo/Day/Yr)		
		0		1.00	2.00		
8.00	Name of Contractor						8.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 15-0011
Component CCN: 15-T011

Period:
From 07/01/2019
To 06/30/2020

Worksheet E-1
Part I
Date/Time Prepared:
11/20/2020 1:17 pm
PPS

Title XVIII

Subprovider -
IRF

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider					1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		3,794,777		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)		3,794,777		0	4.00
TO BE COMPLETED BY CONTRACTOR						
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
Program to Provider						
5.01	TENTATIVE TO PROVIDER		0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
Provider to Program						
5.50	TENTATIVE TO PROGRAM		0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		20,113		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		3,814,890		0	7.00
				Contractor Number	NPR Date (Mo/Day/Yr)	
		0		1.00	2.00	
8.00	Name of Contractor					8.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT		Provider CCN: 15-0011	Period: From 07/01/2019 To 06/30/2020	Worksheet E-1 Part II Date/Time Prepared: 11/20/2020 1:17 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 IPSS & 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: 15-0011 Component CCN: 15-T011	Period: From 07/01/2019 To 06/30/2020	Worksheet E-3 Part III Date/Time Prepared: 11/20/2020 1:17 pm
		Title XVIII	Subprovider - IRF	PPS
				1.00
PART III - MEDICARE PART A SERVICES - IRF PPS				
1.00	Net Federal PPS Payment (see instructions)			3,815,164 1.00
2.00	Medicare SSI ratio (IRF PPS only) (see instructions)			0.0285 2.00
3.00	Inpatient Rehabilitation LIP Payments (see instructions)			103,391 3.00
4.00	Outlier Payments			28,028 4.00
5.00	Unweighted intern and resident FTE count in the most recent cost reporting period ending on or prior to November 15, 2004 (see instructions)			0.00 5.00
5.01	Cap increases for the unweighted intern and resident FTE count for residents that were displaced by program or hospital closure, that would not be counted without a temporary cap adjustment under 42 CFR §412.424(d)(1)(iii)(F)(1) or (2) (see instructions)			0.00 5.01
6.00	New Teaching program adjustment. (see instructions)			0.00 6.00
7.00	Current year's unweighted FTE count of I&R excluding FTEs in the new program growth period of a "new teaching program" (see instructions)			0.00 7.00
8.00	Current year's unweighted I&R FTE count for residents within the new program growth period of a "new teaching program" (see instructions)			0.00 8.00
9.00	Intern and resident count for IRF PPS medical education adjustment (see instructions)			0.00 9.00
10.00	Average Daily Census (see instructions)			7.281421 10.00
11.00	Teaching Adjustment Factor (see instructions)			0.000000 11.00
12.00	Teaching Adjustment (see instructions)			0 12.00
13.00	Total PPS Payment (see instructions)			3,946,583 13.00
14.00	Nursing and Allied Health Managed Care payments (see instruction)			0 14.00
15.00	Organ acquisition (DO NOT USE THIS LINE)			0 15.00
16.00	Cost of physicians' services in a teaching hospital (see instructions)			0 16.00
17.00	Subtotal (see instructions)			3,946,583 17.00
18.00	Primary payer payments			0 18.00
19.00	Subtotal (line 17 less line 18).			3,946,583 19.00
20.00	Deductibles			63,492 20.00
21.00	Subtotal (line 19 minus line 20)			3,883,091 21.00
22.00	Coinurance			3,410 22.00
23.00	Subtotal (line 21 minus line 22)			3,879,681 23.00
24.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)			0 24.00
25.00	Adjusted reimbursable bad debts (see instructions)			0 25.00
26.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			0 26.00
27.00	Subtotal (sum of lines 23 and 25)			3,879,681 27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 49)			0 28.00
29.00	Other pass through costs (see instructions)			0 29.00
30.00	Outlier payments reconciliation			0 30.00
31.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0 31.00
31.50	Pioneer ACO demonstration payment adjustment (see instructions)			0 31.50
31.99	Demonstration payment adjustment amount before sequestration			0 31.99
32.00	Total amount payable to the provider (see instructions)			3,879,681 32.00
32.01	Sequestration adjustment (see instructions)			64,791 32.01
32.02	Demonstration payment adjustment amount after sequestration			0 32.02
33.00	Interim payments			3,794,777 33.00
34.00	Tentative settlement (for contractor use only)			0 34.00
35.00	Balance due provider/program (line 32 minus lines 32.01, 32.02, 33, and 34)			20,113 35.00
36.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2			0 36.00
TO BE COMPLETED BY CONTRACTOR				
50.00	Original outlier amount from Wkst. E-3, Pt. III, line 4			28,028 50.00
51.00	Outlier reconciliation adjustment amount (see instructions)			0 51.00
52.00	The rate used to calculate the Time Value of Money			0.00 52.00
53.00	Time Value of Money (see instructions)			0 53.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 15-0011	Period: From 07/01/2019 To 06/30/2020	Worksheet E-3 Part VII Date/Time Prepared: 11/20/2020 1:17 pm	
		Title XIX	Hospital	Cost	
			Inpatient	Outpatient	
			1.00	2.00	
PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR XIX SERVICES					
COMPUTATION OF NET COST OF COVERED SERVICES					
1.00	Inpatient hospital/SNF/NF services		1,074,358		1.00
2.00	Medical and other services			0	2.00
3.00	Organ acquisition (certified transplant centers only)		0		3.00
4.00	Subtotal (sum of lines 1, 2 and 3)		1,074,358	0	4.00
5.00	Inpatient primary payer payments		0		5.00
6.00	Outpatient primary payer payments			0	6.00
7.00	Subtotal (line 4 less sum of lines 5 and 6)		1,074,358	0	7.00
COMPUTATION OF LESSER OF COST OR CHARGES					
Reasonable Charges					
8.00	Routine service charges		1,003,151		8.00
9.00	Ancillary service charges		1,960,555	0	9.00
10.00	Organ acquisition charges, net of revenue		0		10.00
11.00	Incentive from target amount computation		0		11.00
12.00	Total reasonable charges (sum of lines 8 through 11)		2,963,706	0	12.00
CUSTOMARY CHARGES					
13.00	Amount actually collected from patients liable for payment for services on a charge basis		0	0	13.00
14.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)		0	0	14.00
15.00	Ratio of line 13 to line 14 (not to exceed 1.000000)		0.000000	0.000000	15.00
16.00	Total customary charges (see instructions)		2,963,706	0	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)		1,889,348	0	17.00
18.00	Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 16) (see instructions)		0	0	18.00
19.00	Interns and Residents (see instructions)		0	0	19.00
20.00	Cost of physicians' services in a teaching hospital (see instructions)		0	0	20.00
21.00	Cost of covered services (enter the lesser of line 4 or line 16)		1,074,358	0	21.00
PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be completed for PPS providers.					
22.00	Other than outlier payments		0	0	22.00
23.00	Outlier payments		0	0	23.00
24.00	Program capital payments		0		24.00
25.00	Capital exception payments (see instructions)		0		25.00
26.00	Routine and Ancillary service other pass through costs		0	0	26.00
27.00	Subtotal (sum of lines 22 through 26)		0	0	27.00
28.00	Customary charges (title V or XIX PPS covered services only)		0	0	28.00
29.00	Titles V or XIX (sum of lines 21 and 27)		1,074,358	0	29.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT					
30.00	Excess of reasonable cost (from line 18)		0	0	30.00
31.00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)		1,074,358	0	31.00
32.00	Deductibles		0		32.00
33.00	Coinurance		0		33.00
34.00	Allowable bad debts (see instructions)		0		34.00
35.00	Utilization review		0		35.00
36.00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)		1,074,358	0	36.00
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	0	37.00
38.00	Subtotal (line 36 ± line 37)		1,074,358	0	38.00
39.00	Direct graduate medical education payments (from Wkst. E-4)		0		39.00
40.00	Total amount payable to the provider (sum of lines 38 and 39)		1,074,358	0	40.00
41.00	Interim payments		1,956,046	0	41.00
42.00	Balance due provider/program (line 40 minus line 41)		-881,688	0	42.00
43.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, chapter 1, §115.2		0	0	43.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 15-0011 Component CCN: 15-T011	Period: From 07/01/2019 To 06/30/2020	Worksheet E-3 Part VII Date/Time Prepared: 11/20/2020 1:17 pm
		Title XIX	Subprovider - IRF	Cost
		Inpatient 1.00	Outpatient 2.00	
PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR XIX SERVICES				
COMPUTATION OF NET COST OF COVERED SERVICES				
1.00	Inpatient hospital/SNF/NF services	28,076		1.00
2.00	Medical and other services		0	2.00
3.00	Organ acquisition (certified transplant centers only)	0		3.00
4.00	Subtotal (sum of lines 1, 2 and 3)	28,076	0	4.00
5.00	Inpatient primary payer payments	0		5.00
6.00	Outpatient primary payer payments		0	6.00
7.00	Subtotal (line 4 less sum of lines 5 and 6)	28,076	0	7.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable Charges				
8.00	Routine service charges	31,925		8.00
9.00	Ancillary service charges	45,204	0	9.00
10.00	Organ acquisition charges, net of revenue	0		10.00
11.00	Incentive from target amount computation	0		11.00
12.00	Total reasonable charges (sum of lines 8 through 11)	77,129	0	12.00
CUSTOMARY CHARGES				
13.00	Amount actually collected from patients liable for payment for services on a charge basis	0	0	13.00
14.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)	0	0	14.00
15.00	Ratio of line 13 to line 14 (not to exceed 1.000000)	0.000000	0.000000	15.00
16.00	Total customary charges (see instructions)	77,129	0	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)	49,053	0	17.00
18.00	Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 16) (see instructions)	0	0	18.00
19.00	Interns and Residents (see instructions)	0	0	19.00
20.00	Cost of physicians' services in a teaching hospital (see instructions)	0	0	20.00
21.00	Cost of covered services (enter the lesser of line 4 or line 16)	28,076	0	21.00
PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be completed for PPS providers.				
22.00	Other than outlier payments	0	0	22.00
23.00	Outlier payments	0	0	23.00
24.00	Program capital payments	0	0	24.00
25.00	Capital exception payments (see instructions)	0	0	25.00
26.00	Routine and Ancillary service other pass through costs	0	0	26.00
27.00	Subtotal (sum of lines 22 through 26)	0	0	27.00
28.00	Customary charges (title V or XIX PPS covered services only)	0	0	28.00
29.00	Titles V or XIX (sum of lines 21 and 27)	28,076	0	29.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT				
30.00	Excess of reasonable cost (from line 18)	0	0	30.00
31.00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)	28,076	0	31.00
32.00	Deductibles	0	0	32.00
33.00	Coinurance	0	0	33.00
34.00	Allowable bad debts (see instructions)	0	0	34.00
35.00	Utilization review	0	0	35.00
36.00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)	28,076	0	36.00
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	37.00
38.00	Subtotal (line 36 ± line 37)	28,076	0	38.00
39.00	Direct graduate medical education payments (from Wkst. E-4)	0	0	39.00
40.00	Total amount payable to the provider (sum of lines 38 and 39)	28,076	0	40.00
41.00	Interim payments	17,740	0	41.00
42.00	Balance due provider/program (line 40 minus line 41)	10,336	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: 15-0011

Period:
From 07/01/2019
To 06/30/2020

Worksheet G

Date/Time Prepared:
11/20/2020 1:17 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	36,653,746	0	0	0	1.00
2.00	Temporary investments	0	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	57,423,541	0	0	0	4.00
5.00	Other receivable	3,634,855	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-34,719,717	0	0	0	6.00
7.00	Inventory	2,264,928	0	0	0	7.00
8.00	Prepaid expenses	2,400,003	0	0	0	8.00
9.00	Other current assets	872,264	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)	68,529,620	0	0	0	11.00
FIXED ASSETS						
12.00	Land	5,191,829	0	0	0	12.00
13.00	Land improvements	3,353,531	0	0	0	13.00
14.00	Accumulated depreciation	-2,958,310	0	0	0	14.00
15.00	Buildings	142,659,238	0	0	0	15.00
16.00	Accumulated depreciation	-86,215,059	0	0	0	16.00
17.00	Leasehold improvements	3,756,061	0	0	0	17.00
18.00	Accumulated depreciation	-3,015,667	0	0	0	18.00
19.00	Fixed equipment	3,509,530	0	0	0	19.00
20.00	Accumulated depreciation	-1,139,248	0	0	0	20.00
21.00	Automobiles and trucks	1,059,245	0	0	0	21.00
22.00	Accumulated depreciation	-794,629	0	0	0	22.00
23.00	Major movable equipment	72,943,656	0	0	0	23.00
24.00	Accumulated depreciation	-60,786,612	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	447,636	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	78,011,201	0	0	0	30.00
OTHER ASSETS						
31.00	Investments	259,954,827	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	14,763,315	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	274,718,142	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	421,258,963	0	0	0	36.00
CURRENT LIABILITIES						
37.00	Accounts payable	5,105,279	0	0	0	37.00
38.00	Salaries, wages, and fees payable	8,460,371	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	0	0	0	42.00
43.00	Due to other funds	0	0	0	0	43.00
44.00	Other current liabilities	27,005,110	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	40,570,760	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	81,401,314	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	81,401,314	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	121,972,074	0	0	0	51.00
CAPITAL ACCOUNTS						
52.00	General fund balance	299,286,889				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)	299,286,889	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	421,258,963	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 15-0011

Period:
From 07/01/2019
To 06/30/2020

Worksheet G-1

Date/Time Prepared:
11/20/2020 1:17 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		292,793,930		0		1.00
2.00	Net income (loss) (From Wkst. G-3, line 29)		6,492,956		0		2.00
3.00	Total (sum of line 1 and line 2)		299,286,886				3.00
4.00	Additions (credit adjustments) ROUND	3		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)		3		0		10.00
11.00	Subtotal (line 3 plus line 10)		299,286,889		0		11.00
12.00	Deductions (debit adjustments) (specify)	0		0		0	12.00
13.00		0		0		0	13.00
14.00		0		0		0	14.00
15.00		0		0		0	15.00
16.00		0		0		0	16.00
17.00		0		0		0	17.00
18.00	Total deductions (sum of lines 12-17)		0		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		299,286,889		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) ROUND		0				4.00
5.00			0				5.00
6.00			0				6.00
7.00			0				7.00
8.00			0				8.00
9.00			0				9.00
10.00	Total additions (sum of line 4-9)	0		0			10.00
11.00	Subtotal (line 3 plus line 10)	0		0			11.00
12.00	Deductions (debit adjustments) (specify)		0				12.00
13.00			0				13.00
14.00			0				14.00
15.00			0				15.00
16.00			0				16.00
17.00			0				17.00
18.00	Total deductions (sum of lines 12-17)	0		0			18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)	0		0			19.00

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES

Provider CCN: 15-0011

Period:
From 07/01/2019
To 06/30/2020

Worksheet G-2
Parts I & II
Date/Time Prepared:
11/20/2020 1:17 pm

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
PART I - PATIENT REVENUES					
General Inpatient Routine Services					
1.00	Hospital	16,018,376		16,018,376	1.00
2.00	SUBPROVIDER - IPF	0		0	2.00
3.00	SUBPROVIDER - IRF	3,401,928		3,401,928	3.00
4.00	SUBPROVIDER	0		0	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)	19,420,304		19,420,304	10.00
Intensive Care Type Inpatient Hospital Services					
11.00	INTENSIVE CARE UNIT	5,983,592		5,983,592	11.00
12.00	CORONARY CARE UNIT				12.00
13.00	BURN INTENSIVE CARE UNIT				13.00
14.00	SURGICAL INTENSIVE CARE UNIT				14.00
15.00	OTHER SPECIAL CARE (SPECIFY)				15.00
16.00	Total intensive care type inpatient hospital services (sum of lines 11-15)	5,983,592		5,983,592	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	25,403,896		25,403,896	17.00
18.00	Ancillary services	75,710,573	0	75,710,573	18.00
19.00	Outpatient services	0	356,141,817	356,141,817	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	0	4,451,579	4,451,579	23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	PROFESSIONAL FEES	0	63,265,875	63,265,875	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	101,114,469	423,859,271	524,973,740	28.00
PART II - OPERATING EXPENSES					
29.00	Operating expenses (per Wkst. A, column 3, line 200)		191,238,240		29.00
30.00	ELIMINATIONS	-1,029,506			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)		-1,029,506		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)		190,208,734		43.00

STATEMENT OF REVENUES AND EXPENSES

Provider CCN: 15-0011

Period:
From 07/01/2019
To 06/30/2020

Worksheet G-3

Date/Time Prepared:
11/20/2020 1:17 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	524,973,740	1.00
2.00	Less contractual allowances and discounts on patients' accounts	341,311,020	2.00
3.00	Net patient revenues (line 1 minus line 2)	183,662,720	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	190,208,734	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-6,546,014	5.00
OTHER INCOME			
6.00	Contributions, donations, bequests, etc	0	6.00
7.00	Income from investments	6,199,840	7.00
8.00	Revenues from telephone and other miscellaneous communication services	0	8.00
9.00	Revenue from television and radio service	0	9.00
10.00	Purchase discounts	0	10.00
11.00	Rebates and refunds of expenses	0	11.00
12.00	Parking lot receipts	0	12.00
13.00	Revenue from laundry and linen service	0	13.00
14.00	Revenue from meals sold to employees and guests	0	14.00
15.00	Revenue from rental of living quarters	0	15.00
16.00	Revenue from sale of medical and surgical supplies to other than patients	0	16.00
17.00	Revenue from sale of drugs to other than patients	0	17.00
18.00	Revenue from sale of medical records and abstracts	0	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	0	20.00
21.00	Rental of vending machines	0	21.00
22.00	Rental of hospital space	0	22.00
23.00	Governmental appropriations	0	23.00
24.00	OTHER OPERATING REVENUE	6,748,959	24.00
24.50	COVID-19 PHE Funding	0	24.50
25.00	Total other income (sum of lines 6-24)	12,948,799	25.00
26.00	Total (line 5 plus line 25)	6,402,785	26.00
27.00	BAD DEBT EXPENSE	-90,171	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	-90,171	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	6,492,956	29.00

CALCULATION OF CAPITAL PAYMENT		Provider CCN: 15-0011	Period: From 07/01/2019 To 06/30/2020	Worksheet L Parts I-III Date/Time Prepared: 11/20/2020 1:17 pm
		Title VIII	Hospital	PPS
				1.00
PART I - FULLY PROSPECTIVE METHOD				
CAPITAL FEDERAL AMOUNT				
1.00	Capital DRG other than outlier		902,996	1.00
1.01	Model 4 BPCI Capital DRG other than outlier		0	1.01
2.00	Capital DRG outlier payments		24,547	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)		40.08	3.00
4.00	Number of interns & residents (see instructions)		0.00	4.00
5.00	Indirect medical education percentage (see instructions)		0.00	5.00
6.00	Indirect medical education adjustment (multiply line 5 by the sum of lines 1 and 1.01, columns 1 and 1.01)(see instructions)		0	6.00
7.00	Percentage of SSI recipient patient days to Medicare Part A patient days (Worksheet E, part A line 30) (see instructions)		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)		927,543	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