

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: 14-0002	Period: From 01/01/2020 To 12/31/2020	Worksheet S Parts I-III Date/Time Prepared: 5/28/2021 12:37 pm
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PART I - COST REPORT STATUS

Provider use only	1. ☒ Electronically prepared cost report	Date: 5/28/2021	Time: 12:37 pm
	2. ☐ Manually prepared cost report		
	3. ☐ If this is an amended report enter the number of times the provider resubmitted this cost report		
	4. ☒ Medicare Utilization. Enter "F" for full or "L" for low.		
Contractor use only	5. ☒ Cost Report Status (1) As Submitted (2) Settled without Audit (3) Settled with Audit (4) Reopened (5) Amended	6. Date Received: 7. Contractor No. 8. ☒ Initial Report for this Provider CCN 9. ☒ Final Report for this Provider CCN	10. NPR Date: 11. Contractor's Vendor Code: 4 12. ☐ If line 5, column 1 is 4: Enter number of times reopened = 0-9.

PART II - CERTIFICATION

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

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

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by ALTON MEMORIAL HOSPITAL (14-0002) for the cost reporting period beginning 01/01/2020 and ending 12/31/2020 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

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

(Signed)

Officer or Administrator of Provider(s)

Title

Date

Cost Center Description		Title V	Title XVIII		HIT	Title XIX	
			Part A	Part B			
		1.00	2.00	3.00	4.00	5.00	
	PART III - SETTLEMENT SUMMARY						
1.00	Hospital	0	139,896	-16,791	0	0	1.00
2.00	Subprovider - IPF	0	15,870	0		0	2.00
3.00	Subprovider - IRF	0	0	0		0	3.00
5.00	Swing Bed - SNF	0	0	0		0	5.00
6.00	Swing Bed - NF	0				0	6.00
200.00	Total	0	155,766	-16,791	0	0	200.00

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA					Provider CCN: 14-0002		Period: From 01/01/2020 To 12/31/2020		Worksheet S-2 Part I Date/Time Prepared: 5/28/2021 12:16 pm	
1.00		2.00		3.00		4.00				
Hospital and Hospital Health Care Complex Address:										
1.00	Street: ONE MEMORIAL DRIVE			PO Box:				1.00		
2.00	City: ALTON			State: IL		Zip Code: 62002-		County: MADISON 2.00		
		Component Name		CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N)		
								V	XVIII	XIX
		1.00		2.00	3.00	4.00	5.00	6.00	7.00	8.00
Hospital and Hospital-Based Component Identification:										
3.00	Hospital		ALTON MEMORIAL HOSPITAL	140002	41180	1	07/01/1966	N	P	P
4.00	Subprovider - IPF		ALTON MEMORIAL HOSPITAL	14S002	41180	4	01/01/2008	N	P	N
5.00	Subprovider - IRF		PSYCH							
6.00	Subprovider - (Other)									
7.00	Swing Beds - SNF									
8.00	Swing Beds - NF									
9.00	Hospital-Based SNF									
10.00	Hospital-Based NF									
11.00	Hospital-Based OLTC									
12.00	Hospital-Based HHA									
13.00	Separately Certified ASC									
14.00	Hospital-Based Hospice									
15.00	Hospital-Based Health Clinic - RHC									
16.00	Hospital-Based Health Clinic - FQHC									
17.00	Hospital-Based (CMHC) I									
18.00	Renal Dialysis									
19.00	Other									
							From:	To:		
							1.00	2.00		
20.00	Cost Reporting Period (mm/dd/yyyy)						01/01/2020	12/31/2020		20.00
21.00	Type of Control (see instructions)						2			21.00
							1.00	2.00	3.00	
Inpatient PPS Information										
22.00	Does this facility qualify and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.106(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no.					Y	N			22.00
22.01	Did this hospital receive interim uncompensated care payments for this cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)					Y	Y			22.01
22.02	Is this a newly merged hospital that requires final uncompensated care payments to be determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1.					N	N			22.02
22.03	Did this hospital receive a geographic reclassification from urban to rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no.					N	N	N		22.03
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.					3	N			23.00
				In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of State Medicaid paid days	Out-of State Medicaid eligible unpaid	Medicaid HMO days	Other Medicaid days	
				1.00	2.00	3.00	4.00	5.00	6.00	
24.00	If this provider is an IPPS hospital, enter the in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.			549	522	4	7	4,094	438	24.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA				Provider CCN: 14-0002		Period: From 01/01/2020 To 12/31/2020		Worksheet S-2 Part I Date/Time Prepared: 5/28/2021 12:16 pm		
				In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of State Medicaid paid days	Out-of State Medicaid eligible unpaid	Medicaid HMO days	Other Medicaid days	
				1.00	2.00	3.00	4.00	5.00	6.00	
25.00	If this provider is an IRF, enter the in-state Medicaid paid days in column 1, the in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5.			0	0	0	0	0	25.00	
							Urban/Rural S	Date of Geogr		
							1.00	2.00		
26.00	Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter "1" for urban or "2" for rural.						1		26.00	
27.00	Enter your standard geographic classification (not wage) status at the end of the cost reporting period. Enter in column 1, "1" for urban or "2" for rural. If applicable, enter the effective date of the geographic reclassification in column 2.						1		27.00	
35.00	If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period.						0		35.00	
							Beginning:	Ending:		
							1.00	2.00		
36.00	Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.								36.00	
37.00	If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status is in effect in the cost reporting period.						0		37.00	
37.01	Is this hospital a former MDH that is eligible for the MDH transitional payment in accordance with FY 2016 OPPS final rule? Enter "Y" for yes or "N" for no. (see instructions)								37.01	
38.00	If line 37 is 1, enter the beginning and ending dates of MDH status. If line 37 is greater than 1, subscript this line for the number of periods in excess of one and enter subsequent dates.								38.00	
							Y/N	Y/N		
							1.00	2.00		
39.00	Does this facility qualify for the inpatient hospital payment adjustment for low volume hospitals in accordance with 42 CFR §412.101(b)(2)(i), (ii), or (iii)? Enter in column 1 "Y" for yes or "N" for no. Does the facility meet the mileage requirements in accordance with 42 CFR §412.101(b)(2)(i), (ii), or (iii)? Enter in column 2 "Y" for yes or "N" for no. (see instructions)						N	N	39.00	
40.00	Is this hospital subject to the HAC program reduction adjustment? Enter "Y" for yes or "N" for no in column 1, for discharges prior to October 1. Enter "Y" for yes or "N" for no in column 2, for discharges on or after October 1. (see instructions)						N	N	40.00	
							V	XVIII	XIX	
							1.00	2.00	3.00	
Prospective Payment System (PPS)-Capital										
45.00	Does this facility qualify and receive Capital payment for disproportionate share in accordance with 42 CFR Section §412.320? (see instructions)						N	Y	N	45.00
46.00	Is this facility eligible for additional payment exception for extraordinary circumstances pursuant to 42 CFR §412.348(f)? If yes, complete Wkst. L, Pt. III and Wkst. L-1, Pt. I through Pt. III.						N	N	N	46.00
47.00	Is this a new hospital under 42 CFR §412.300(b) PPS capital? Enter "Y" for yes or "N" for no.						N	N	N	47.00
48.00	Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.						N	N	N	48.00
Teaching Hospitals										
56.00	Is this a hospital involved in training residents in approved GME programs? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", are you impacted by CR 11642 (or subsequent CR), MA GME payment reduction? Enter "Y" for yes or "N" for no in column 2.						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 Criterion Code			
					1.00	2.00	3.00			
60.00	Are you claiming nursing and allied health education (NAHE) costs for any programs that meet the criteria under 42 CFR 413.85? (see instructions) Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", are you impacted by CR 11642 (or subsequent CR) NAHE MA payment adjustment? Enter "Y" for yes or "N" for no in column 2.				N				60.00	

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

Provider CCN: 14-0002

Period:
From 01/01/2020
To 12/31/2020Worksheet S-2
Part I
Date/Time Prepared:
5/28/2021 12:16 pm

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

Provider CCN: 14-0002

Period:
From 01/01/2020
To 12/31/2020Worksheet S-2
Part I
Date/Time Prepared:
5/28/2021 12:16 pm

	Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))			
	1.00	2.00	3.00	4.00	5.00			
65.00	Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the program name associated with primary care FTEs for each primary care program in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)		0.00	0.00	0.000000	65.00		
			Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))			
			1.00	2.00	3.00			
Section 5504 of the ACA Current Year FTE Residents in Nonprovider Settings--Effective for cost reporting periods beginning on or after July 1, 2010								
66.00	Enter in column 1 the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)		0.00	0.00	0.000000	66.00		
			Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))			
			1.00	2.00	5.00			
67.00	Enter in column 1, the program name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)		0.00	0.00	0.000000	67.00		
					1.00	2.00	3.00	
Inpatient Psychiatric Facility PPS								
70.00	Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? Enter "Y" for yes or "N" for no.				Y		70.00	
71.00	If line 70 is yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost report filed on or before November 15, 2004? Enter "Y" for yes or "N" for no. (see 42 CFR 412.424(d)(1)(iii)(c)) Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)				N	N	0	71.00
Inpatient Rehabilitation Facility PPS								
75.00	Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF subprovider? Enter "Y" for yes and "N" for no.				N		75.00	
76.00	If line 75 is yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)						0	76.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-0002	Period: From 01/01/2020 To 12/31/2020	Worksheet S-2 Part I Date/Time Prepared: 5/28/2021 12:16 pm	
			1.00		
Long Term Care Hospital PPS					
80.00	Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for no.	N		80.00	
81.00	Is this a LTCH co-located within another hospital for part or all of the cost reporting period? Enter "Y" for yes and "N" for no.	N		81.00	
TEFRA Providers					
85.00	Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no.	N		85.00	
86.00	Did this facility establish a new Other subprovider (excluded unit) under 42 CFR Section §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.			86.00	
87.00	Is this hospital an extended neoplastic disease care hospital classified under section 1886(d)(1)(B)(vi)? Enter "Y" for yes or "N" for no.	N		87.00	
		V	XIX		
		1.00	2.00		
Title V and XIX Services					
90.00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.	N	Y	90.00	
91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.	N	N	91.00	
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.		Y	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	
		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
					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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-0002	Period: From 01/01/2020 To 12/31/2020	Worksheet S-2 Part I Date/Time Prepared: 5/28/2021 12:16 pm
		1.00	2.00	
111.00	If this facility qualifies as a CAH, did it participate in the Frontier Community Health Integration Project (FCHIP) demonstration for this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If the response to column 1 is Y, enter the integration prong of the FCHIP demo in which this CAH is participating in column 2. Enter all that apply: "A" for Ambulance services; "B" for additional beds; and/or "C" for tele-health services.	N		111.00
		1.00	2.00	3.00
112.00	Did this hospital participate in the Pennsylvania Rural Health Model demonstration for any portion of the current cost reporting period? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2, the date the hospital began participating in the demonstration. In column 3, enter the date the hospital ceased participation in the demonstration, if applicable.	N		112.00
Miscellaneous Cost Reporting Information				
115.00	Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in column 1. If column 1 is yes, enter the method used (A, B, or E only) in column 2. If column 2 is "E", enter in column 3 either "93" percent for short term hospital or "98" percent for long term care (includes psychiatric, rehabilitation and long term hospitals providers) based on the definition in CMS Pub.15-1, chapter 22, §2208.1.	N		0 115.00
116.00	Is this facility classified as a referral center? Enter "Y" for yes or "N" for no.	N		116.00
117.00	Is this facility legally required to carry malpractice insurance? Enter "Y" for yes or "N" for no.	Y		117.00
118.00	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.	2		118.00
		Premiums	Losses	Insurance
		1.00	2.00	3.00
118.01	List amounts of malpractice premiums and paid losses:	0	503,000	1,958,000 118.01
		1.00	2.00	
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein.	N		118.02
119.00	DO NOT USE THIS LINE			119.00
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 1, "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2, "Y" for yes or "N" for no.	N	N	120.00
121.00	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter "Y" for yes or "N" for no.	Y		121.00
122.00	Does the cost report contain healthcare related taxes as defined in §1903(w)(3) of the Act? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2 the Worksheet A line number where these taxes are included.	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
132.00	If this is a Medicare certified islet transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			132.00
133.00	Removed and reserved			133.00
134.00	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.			134.00
All Providers				
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)	Y	HB1804	140.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA				Provider CCN: 14-0002		Period: From 01/01/2020 To 12/31/2020		Worksheet S-2 Part I Date/Time Prepared: 5/28/2021 12:16 pm	
1.00		2.00		3.00					
If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number.									
141.00	Name: BJC HEALTH SYSTEM	Contractor's Name: WPS		Contractor's Number: 05301				141.00	
142.00	Street: 4901 FOREST PARK AVENUE	PO Box:						142.00	
143.00	City: ST. LOUIS	State: MO		Zip Code: 63108				143.00	
								1.00	
144.00	Are provider based physicians' costs included in Worksheet A?							Y	144.00
								1.00	2.00
145.00	If costs for renal services are claimed on Wkst. A, line 74, are the costs for inpatient services only? Enter "Y" for yes or "N" for no in column 1. If column 1 is no, does the dialysis facility include Medicare utilization for this cost reporting period? Enter "Y" for yes or "N" for no in column 2.							Y	145.00
146.00	Has the cost allocation methodology changed from the previously filed cost report? Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, chapter 40, §4020) If yes, enter the approval date (mm/dd/yyyy) in column 2.							N	146.00
								1.00	
147.00	Was there a change in the statistical basis? Enter "Y" for yes or "N" for no.							N	147.00
148.00	Was there a change in the order of allocation? Enter "Y" for yes or "N" for no.							N	148.00
149.00	Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no.							N	149.00
				Part A	Part B	Title V	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	N	155.00		
156.00	Subprovider - IPF	N	N	N	N	N	156.00		
157.00	Subprovider - IRF	N	N	N	N	N	157.00		
158.00	SUBPROVIDER						158.00		
159.00	SNF	N	N	N	N	N	159.00		
160.00	HOME HEALTH AGENCY	N	N	N	N	N	160.00		
161.00	CMHC		N	N	N	N	161.00		
								1.00	
Multicampus									
165.00	Is this hospital part of a Multicampus hospital that has one or more campuses in different CBSAs? Enter "Y" for yes or "N" for no.							N	165.00
		Name	County	State	Zip Code	CBSA	FTE/Campus		
		0	1.00	2.00	3.00	4.00	5.00		
166.00	If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions)						0.00		
								1.00	
Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act									
167.00	Is this provider a meaningful user under §1886(n)? Enter "Y" for yes or "N" for no.							Y	167.00
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)								168.00
168.01	If this provider is a CAH and is not a meaningful user, does this provider qualify for a hardship exception under §413.70(a)(6)(ii)? Enter "Y" for yes or "N" for no. (see instructions)							N	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	169.00
						Beginning	Ending		
						1.00	2.00		
170.00	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)								170.00
						1.00	2.00		
171.00	If line 167 is "Y", does this provider have any days for individuals enrolled in section 1876 Medicare cost plans reported on Wkst. S-3, Pt. I, line 2, col. 6? Enter "Y" for yes and "N" for no in column 1. If column 1 is yes, enter the number of section 1876 Medicare days in column 2. (see instructions)							N	0

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 14-0002	Period: From 01/01/2020 To 12/31/2020	Worksheet S-2 Part II Date/Time Prepared: 5/28/2021 12:16 pm
			Y/N 1.00	Date 2.00
General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format.				
COMPLETED BY ALL HOSPITALS				
Provider Organization and Operation				
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)	N		1.00
		Y/N 1.00	Date 2.00	V/I 3.00
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.	N		2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)	Y		3.00
		Y/N 1.00	Type 2.00	Date 3.00
Financial Data and Reports				
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	Y	A	4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.	N		5.00
			Y/N 1.00	Legal Oper. 2.00
Approved Educational Activities				
6.00	Column 1: Are costs claimed for nursing school? Column 2: If yes, is the provider is the legal operator of the program?	N		6.00
7.00	Are costs claimed for Allied Health Programs? If "Y" see instructions.	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.		Y	13.00
14.00	If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.		N	14.00
Bed Complement				
15.00	Did total beds available change from the prior cost reporting period? If yes, see instructions.		Y	15.00
		Part A		Part B
		Y/N 1.00	Date 2.00	Y/N 3.00
				Date 4.00
PS&R Data				
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)	Y	03/22/2021	Y
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	N		N
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N		Y
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: 14-0002

Period:
From 01/01/2020
To 12/31/2020Worksheet S-2
Part II
Date/Time Prepared:
5/28/2021 12:16 pm

		Description	Y/N	Y/N	
		0	1.00	3.00	
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:		N	N	20.00
		Y/N	Date	Y/N	Date
		1.00	2.00	3.00	4.00
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		N	21.00
				1.00	
COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)					
Capital Related Cost					
22.00	Have assets been relifed for Medicare purposes? If yes, see instructions		N		22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.		N		23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions		N		24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.		N		25.00
26.00	Were assets subject to Sec.2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.		N		26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.		N		27.00
Interest Expense					
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.		N		28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions		Y		29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.		N		30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.		N		31.00
Purchased Services					
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.		N		32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.		Y		33.00
Provider-Based Physicians					
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.		Y		34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.		Y		35.00
		Y/N	Date		
		1.00	2.00		
Home Office Costs					
36.00	Were home office costs claimed on the cost report?		Y		36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.		Y		37.00
38.00	If line 36 is yes, was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.		N		38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.		N		39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.		N		40.00
		1.00	2.00		
Cost Report Preparer Contact Information					
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	PAUL	BRADSHAW		41.00
42.00	Enter the employer/company name of the cost report preparer.	BJC HEALTHCARE			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	314-362-7419	PJB1541@BJC.ORG		43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 14-0002	Period: From 01/01/2020 To 12/31/2020	Worksheet S-2 Part II Date/Time Prepared: 5/28/2021 12:16 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.	REIMBURSEMENT 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

VOLUNTARY CONTACT INFORMATION

Provider CCN: 14-0002

Period:
From 01/01/2020
To 12/31/2020Worksheet S-2
Part V
Date/Time Prepared:
5/28/2021 12:16 pm

		1.00	
Cost Report Preparer Contact Information			
1.00	First Name	PAUL	1.00
2.00	Last Name	BRADSHAW	2.00
3.00	Title	REIMBURSEMENT MANAGER	3.00
4.00	Employer	BJC HEALTH CARE	4.00
5.00	Phone Number	(314)362-7419	5.00
6.00	E-mail Address	PAUL.BRADSHAW@BJC.ORG	6.00
7.00	Department	BJC @ THE COMMONS	7.00
8.00	Mailing Address 1	MAILSTOP 90-67-808	8.00
9.00	Mailing Address 2	4249 CLAYTON AVENUE	9.00
10.00	City	ST. LOUIS	10.00
11.00	State	MO	11.00
12.00	Zip	63110	12.00
Officer or Administrator of Provider Contact Information			
13.00	First Name		13.00
14.00	Last Name		14.00
15.00	Title		15.00
16.00	Employer		16.00
17.00	Phone Number		17.00
18.00	E-mail Address		18.00
19.00	Department		19.00
20.00	Mailing Address 1		20.00
21.00	Mailing Address 2		21.00
22.00	City		22.00
23.00	State		23.00
24.00	Zip		24.00

Health Financial Systems		ALTON MEMORIAL HOSPITAL		Non-CMS HFS Worksheet	
HFS Supplemental Information		Provider CCN: 14-0002	Period: From 01/01/2020 To 12/31/2020	Worksheet S-2 Part IX Date/Time Prepared: 5/28/2021 12:16 pm	
			Title V	Title XIX	
			1.00	2.00	
TITLES V AND/OR XIX FOLLOWING MEDICARE					
1.00	Do Title V or XIX follow Medicare (Title XVIII) for the Interns and Residence post stepdown adjustments on W/S B, Part I, column 25? Enter Y/N in column 1 for Title V and Y/N in column 2 for Title XIX. (see S-2, Part I, line 98)		Y	Y	1.00
2.00	Do Title V or XIX follow Medicare (Title XVIII) for the reporting of charges on W/S C, Part I (e.g. net of Physician's component)? Enter Y/N in column 1 for Title V and Y/N in column 2 for Title XIX. (see S-2, Part I, line 98.01)		Y	Y	2.00
3.00	Do Title V or XIX follow Medicare (Title XVIII) for the calculation of Observation Bed Cost on W/S D-1, Part IV, line 89? Enter Y/N in column 1 for Title V and Y/N in column 2 for Title XIX. (see S-2, Part I, line 98.02)		Y	Y	3.00
3.01	Do Title V or XIX use W/S D-1 for reimbursement?		N	N	3.01
3.02	Does Title XIX transfer managed care (HMO) days from Worksheet S-3, Part I, column 7, sum of lines 2, 3, and 4 to Worksheet E-4, column 2, line 26?			Y	3.02
			Inpatient	Outpatient	
			1.00	2.00	
CRITICAL ACCESS HOSPITALS					
4.00	Does Title V follow Medicare (Title XVIII) for Critical Access Hospitals (CAH) being reimbursed 101% of cost? Enter Y or N in column 1 for inpatient and Y or N in column 2 for outpatient. (see S-2, Part I, lines 98.03 and 98.04)		N	N	4.00
5.00	Does Title XIX follow Medicare (Title XVIII) for Critical Access Hospitals (CAH) being reimbursed 101% of cost? Enter Y or N in column 1 for inpatient and Y or N in column 2 for outpatient. (see S-2, Part I, lines 98.03 and 98.04)		N	N	5.00
			Title V	Title XIX	
			1.00	2.00	
RCE DISALLOWANCE					
6.00	Do Title V or XIX follow Medicare and add back the RCE Disallowance on W/S C, Part I column 4? Enter Y/N in column 1 for Title V and Y/N in column 2 for Title XIX. (see S-2, Part I, line 98.05)		Y	Y	6.00
PASS THROUGH COST					
7.00	Do Title V or XIX follow Medicare when cost reimbursed (payment system is "0") for worksheets D, parts I through IV? Enter Y/N in column 1 for Title V and Y/N in column 2 for Title XIX. (see S-2, Part I, line 98.06)		Y	Y	7.00
RHC					
8.00	Do Title V & XIX impute 20% coinsurance (M-3 Line 16.04)? Enter Y/N in column 1 for Title V and Y/N in column 2 for Title XIX.		N	N	8.00
FQHC					
9.00	For fiscal year beginning on/after 10/01/2014, use M-series for Title V and/or Title XIX? Enter Y/N in column 1 for Title V and Y/N in column 2 for Title XIX.		N	N	9.00
			State		
			1.00		
STATE MEDICAID FORMS					
10.00	Select the state when using state Medicaid forms.				10.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 14-0002

Period:
From 01/01/2020
To 12/31/2020Worksheet S-3
Part I
Date/Time Prepared:
5/28/2021 12:16 pm

Component	Worksheet A Line Number	No. of Beds	Bed Days Available	CAH Hours	I/P Days / O/P Visits / Trips	
					Title V	
	1.00	2.00	3.00	4.00	5.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30.00	109	39,894	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)		109	39,894	0.00	0	7.00
8.00 INTENSIVE CARE UNIT	31.00	12	4,392	0.00	0	8.00
9.00 CORONARY CARE UNIT						9.00
10.00 BURN INTENSIVE CARE UNIT						10.00
11.00 SURGICAL INTENSIVE CARE UNIT						11.00
12.00 OTHER SPECIAL CARE (SPECIFY)						12.00
13.00 NURSERY	43.00				0	13.00
14.00 Total (see instructions)		121	44,286	0.00	0	14.00
15.00 CAH visits					0	15.00
16.00 SUBPROVIDER - IPF	40.00	8	3,040		0	16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY						22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
24.10 HOSPICE (non-distinct part)	30.00					24.10
25.00 CMHC - CMHC						25.00
26.00 RURAL HEALTH CLINIC						26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	26.25
27.00 Total (sum of lines 14-26)		129			0	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: 14-0002

Period:
From 01/01/2020
To 12/31/2020Worksheet S-3
Part I
Date/Time Prepared:
5/28/2021 12:16 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)	9,258	616	23,380			1.00
2.00	HMO and other (see instructions)	6,301	4,789				2.00
3.00	HMO IPF Subprovider	355	0				3.00
4.00	HMO IRF Subprovider	0	0				4.00
5.00	Hospital Adults & Peds. Swing Bed SNF	0	0	0			5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	0			6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	9,258	616	23,380			7.00
8.00	INTENSIVE CARE UNIT	1,057	90	2,708			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		119	1,535			13.00
14.00	Total (see instructions)	10,315	825	27,623	0.00	707.70	14.00
15.00	CAH visits	0	0	0			15.00
16.00	SUBPROVIDER - IPF	462	0	845	0.00	7.40	16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)			0			24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0.00	0.00	26.25
27.00	Total (sum of lines 14-26)				0.00	715.10	27.00
28.00	Observation Bed Days		0	826			28.00
29.00	Ambulance Trips	0					29.00
30.00	Employee discount days (see instruction)			0			30.00
31.00	Employee discount days - IRF			0			31.00
32.00	Labor & delivery days (see instructions)	0	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: 14-0002

Period:
From 01/01/2020
To 12/31/2020Worksheet S-3
Part I
Date/Time Prepared:
5/28/2021 12:16 pm

Component	Full Time Equivalents	Discharges			Total All Patients	
	Nonpaid Workers	Title V	Title XVIII	Title XIX		
	11.00	12.00	13.00	14.00	15.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)		0	2,264	256	6,408	1.00
2.00 HMO and other (see instructions)			1,340	0		2.00
3.00 HMO IPF Subprovider				0		3.00
4.00 HMO IRF Subprovider				0		4.00
5.00 Hospital Adults & Peds. Swing Bed SNF						5.00
6.00 Hospital Adults & Peds. Swing Bed NF						6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)						7.00
8.00 INTENSIVE CARE UNIT						8.00
9.00 CORONARY CARE UNIT						9.00
10.00 BURN INTENSIVE CARE UNIT						10.00
11.00 SURGICAL INTENSIVE CARE UNIT						11.00
12.00 OTHER SPECIAL CARE (SPECIFY)						12.00
13.00 NURSERY						13.00
14.00 Total (see instructions)	0.00	0	2,264	256	6,408	14.00
15.00 CAH visits						15.00
16.00 SUBPROVIDER - IPF	0.00	0	0	0	85	16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY						22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
24.10 HOSPICE (non-distinct part)						24.10
25.00 CMHC - CMHC						25.00
26.00 RURAL HEALTH CLINIC						26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER	0.00					26.25
27.00 Total (sum of lines 14-26)	0.00					27.00
28.00 Observation Bed Days						28.00
29.00 Ambulance Trips						29.00
30.00 Employee discount days (see instruction)						30.00
31.00 Employee discount days - IRF						31.00
32.00 Labor & delivery days (see instructions)						32.00
32.01 Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00 LTCH non-covered days			0			33.00
33.01 LTCH site neutral days and discharges			0			33.01

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 14-0002

Period:
From 01/01/2020
To 12/31/2020Worksheet S-3
Part II
Date/Time Prepared:
5/28/2021 12:16 pm

	Wkst. A Line Number	Amount Reported	Reclassificati on of Salaries (from Wkst. A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
	1.00	2.00	3.00	4.00	5.00	6.00	
PART II - WAGE DATA							
SALARIES							
1.00	Total salaries (see instructions)	200.00	48,027,385	0	48,027,385	1,503,730.00	31.94
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		105,363	0	105,363	785.00	134.22
4.01	Physicians - Part A - Teaching		0	0	0	0.00	0.00
5.00	Physician and Non Physician-Part B		3,000	0	3,000	20.00	150.00
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)		6,109,997	8,212	6,118,209	268,509.00	22.79
OTHER WAGES & RELATED COSTS							
11.00	Contract labor: Direct Patient Care		975,128	0	975,128	13,099.00	74.44
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		175,005	0	175,005	1,062.00	164.79
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		8,676,983	0	8,676,983	218,533.00	39.71
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)		11,571,918	0	11,571,918		
18.00	Wage-related costs (other) (see instructions)						
19.00	Excluded areas		1,700,993	0	1,700,993		
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		25,459	0	25,459		
22.01	Physician Part A - Teaching		0	0	0		
23.00	Physician Part B		1,157	0	1,157		
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)		1,421,122	0	1,421,122		
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: 14-0002

Period:
From 01/01/2020
To 12/31/2020Worksheet S-3
Part II
Date/Time Prepared:
5/28/2021 12:16 pm

		Wkst. A Line Number	Amount Reported	Reclassificati on of Salaries (from Wkst. A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
25.53	Home office: Physicians Part A - Teaching - wage-related (core)		0	0	0			25.53
OVERHEAD COSTS - DIRECT SALARIES								
26.00	Employee Benefits Department	4.00	294,900	-25,528	269,372	7,840.00	34.36	26.00
27.00	Administrative & General	5.00	4,098,425	112,983	4,211,408	88,395.00	47.64	27.00
28.00	Administrative & General under contract (see inst.)		802,555	0	802,555	7,562.00	106.13	28.00
29.00	Maintenance & Repairs	6.00	0	0	0	0.00	0.00	29.00
30.00	Operation of Plant	7.00	908,252	-2,719	905,533	29,162.00	31.05	30.00
31.00	Laundry & Linen Service	8.00	0	0	0	0.00	0.00	31.00
32.00	Housekeeping	9.00	1,146,531	-2,641	1,143,890	73,432.00	15.58	32.00
33.00	Housekeeping under contract (see instructions)		0	0	0	0.00	0.00	33.00
34.00	Dietary	10.00	0	0	0	0.00	0.00	34.00
35.00	Dietary under contract (see instructions)		645,629	0	645,629	20,623.00	31.31	35.00
36.00	Cafeteria	11.00	0	0	0	0.00	0.00	36.00
37.00	Maintenance of Personnel	12.00	0	0	0	0.00	0.00	37.00
38.00	Nursing Administration	13.00	976,210	-2,616	973,594	18,012.00	54.05	38.00
39.00	Central Services and Supply	14.00	256,772	-377	256,395	13,896.00	18.45	39.00
40.00	Pharmacy	15.00	2,026,287	-5,404	2,020,883	43,856.00	46.08	40.00
41.00	Medical Records & Medical Records Library	16.00	0	0	0	0.00	0.00	41.00
42.00	Social Service	17.00	1,086,121	-3,192	1,082,929	29,315.00	36.94	42.00
43.00	Other General Service	18.00	0	0	0	0.00	0.00	43.00

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 14-0002

Period:
From 01/01/2020
To 12/31/2020Worksheet S-3
Part III
Date/Time Prepared:
5/28/2021 12:16 pm

	Worksheet A Line Number	Amount Reported	Reclassificati on of Salaries (from Worksheet A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
	1.00	2.00	3.00	4.00	5.00	6.00	
PART III - HOSPITAL WAGE INDEX SUMMARY							
1.00	Net salaries (see instructions)	49,472,569	0	49,472,569	1,531,895.00	32.30	1.00
2.00	Excluded area salaries (see instructions)	6,109,997	8,212	6,118,209	268,509.00	22.79	2.00
3.00	Subtotal salaries (line 1 minus line 2)	43,362,572	-8,212	43,354,360	1,263,386.00	34.32	3.00
4.00	Subtotal other wages & related costs (see inst.)	9,827,116	0	9,827,116	232,694.00	42.23	4.00
5.00	Subtotal wage-related costs (see inst.)	13,018,499	0	13,018,499	0.00	30.03	5.00
6.00	Total (sum of lines 3 thru 5)	66,208,187	-8,212	66,199,975	1,496,080.00	44.25	6.00
7.00	Total overhead cost (see instructions)	12,241,682	70,506	12,312,188	332,093.00	37.07	7.00

HOSPITAL WAGE RELATED COSTS

Provider CCN: 14-0002

Period:
From 01/01/2020
To 12/31/2020Worksheet S-3
Part IV
Date/Time Prepared:
5/28/2021 12:16 pm

		Amount Reported	
		1.00	
PART IV - WAGE RELATED COSTS			
Part A - Core List			
RETIREMENT COST			
1.00	401K Employer Contributions	1,849,356	1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution	0	2.00
3.00	Nonqualified Defined Benefit Plan Cost (see instructions)	0	3.00
4.00	Qualified Defined Benefit Plan Cost (see instructions)	843,353	4.00
PLAN ADMINISTRATIVE COSTS (Paid to External Organization)			
5.00	401K/TSA Plan Administration fees	0	5.00
6.00	Legal/Accounting/Management Fees-Pension Plan	0	6.00
7.00	Employee Managed Care Program Administration Fees	0	7.00
HEALTH AND INSURANCE COST			
8.00	Health Insurance (Purchased or Self Funded)	0	8.00
8.01	Health Insurance (Self Funded without a Third Party Administrator)	0	8.01
8.02	Health Insurance (Self Funded with a Third Party Administrator)	4,984,542	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	168,415	10.00
11.00	Life Insurance (If employee is owner or beneficiary)	-7,517	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)	578,034	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)	0	14.00
15.00	'Workers' Compensation Insurance	986,061	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	3,411,938	17.00
18.00	Medicare Taxes - Employers Portion Only	0	18.00
19.00	Unemployment Insurance	232,479	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	252,866	23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)	13,299,527	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: 14-0002

Period:
From 01/01/2020
To 12/31/2020Worksheet S-3
Part V
Date/Time Prepared:
5/28/2021 12:16 pm

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

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA

Provider CCN: 14-0002

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

Worksheet S-10

Date/Time Prepared:
5/28/2021 12:16 pm

			1.00	
Uncompensated and indigent care cost computation				
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided by line 202 column 8)		0.224914	1.00
Medicaid (see instructions for each line)				
2.00	Net revenue from Medicaid		9,980,440	2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?		Y	3.00
4.00	If line 3 is yes, does line 2 include all DSH and/or supplemental payments from Medicaid?		N	4.00
5.00	If line 4 is no, then enter DSH and/or supplemental payments from Medicaid		3,168,095	5.00
6.00	Medicaid charges		86,144,082	6.00
7.00	Medicaid cost (line 1 times line 6)		19,375,010	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)		6,226,475	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		8,814,973	18.00
19.00	Total unreimbursed cost for Medicaid, CHIP and state and local indigent care programs (sum of lines 8, 12 and 16)		6,226,475	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)	9,301,385	1,867,126	11,168,511
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	2,092,012	1,867,126	3,959,138
22.00	Payments received from patients for amounts previously written off as charity care	0	0	0
23.00	Cost of charity care (line 21 minus line 22)	2,092,012	1,867,126	3,959,138
		1.00	2.00	3.00
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)		7,570,022	26.00
27.00	Medicare reimbursable bad debts for the entire hospital complex (see instructions)		644,702	27.00
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)		991,850	27.01
28.00	Non-Medicare bad debt expense (see instructions)		6,578,172	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)		1,826,671	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)		5,785,809	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)		12,012,284	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-0002

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

Worksheet A

Date/Time Prepared:
5/28/2021 12:16 pm

	Cost Center Description		Salaries	Other	Total (col. 1 + col. 2)	Reclassification (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		0	0	4,392,898	4,392,898	1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP		0	0	5,710,900	5,710,900	2.00
3.00	00300	OTHER CAPITAL RELATED COSTS		0	0	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	294,900	792,669	1,087,569	-27,054	1,060,515	4.00
4.03	00401	ADMITTING	0	17,473	17,473	-1,500	15,973	4.03
5.00	00500	ADMINISTRATIVE & GENERAL	4,098,425	41,401,837	45,500,262	-7,330,882	38,169,380	5.00
7.00	00700	OPERATION OF PLANT	908,252	2,482,154	3,390,406	-37,746	3,352,660	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	396,365	396,365	-262	396,103	8.00
9.00	00900	HOUSEKEEPING	1,146,531	609,505	1,756,036	-8,094	1,747,942	9.00
10.00	01000	DIETARY	0	2,600,552	2,600,552	-15,673	2,584,879	10.00
11.00	01100	CAFETERIA	0	2,247	2,247	0	2,247	11.00
13.00	01300	NURSING ADMINISTRATION	976,210	403,495	1,379,705	-61,367	1,318,338	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	256,772	445,720	702,492	-192,248	510,244	14.00
15.00	01500	PHARMACY	2,026,287	10,747,619	12,773,906	-313,405	12,460,501	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	17,184	17,184	-131	17,053	16.00
17.00	01700	SOCIAL SERVICE	1,086,121	728,055	1,814,176	-4,387	1,809,789	17.00
	INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	11,531,772	7,952,303	19,484,075	-1,515,282	17,968,793	30.00
31.00	03100	INTENSIVE CARE UNIT	2,539,441	1,246,214	3,785,655	-138,634	3,647,021	31.00
40.00	04000	SUBPROVIDER - IPF	741,942	297,865	1,039,807	-7,057	1,032,750	40.00
43.00	04300	NURSERY	0	0	0	948,345	948,345	43.00
	ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	2,683,824	11,609,147	14,292,971	-6,859,402	7,433,569	50.00
51.00	05100	RECOVERY ROOM	480,630	377,055	857,685	-137,251	720,434	51.00
53.00	05300	ANESTHESIOLOGY	41,756	224,520	266,276	-13,427	252,849	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,220,523	2,389,777	4,610,300	-664,031	3,946,269	54.00
56.00	05600	RADIOISOTOPE	172,793	250,471	423,264	-22,118	401,146	56.00
57.00	05700	CT SCAN	251,390	572,797	824,187	-240,495	583,692	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	218,571	185,401	403,972	-75,608	328,364	58.00
59.00	05900	CARDIAC CATHETERIZATION	607,906	2,056,654	2,664,560	-1,519,923	1,144,637	59.00
60.00	06000	LABORATORY	1,315,244	3,553,846	4,869,090	-493,086	4,376,004	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	261,703	670,773	932,476	307,121	1,239,597	63.00
65.00	06500	RESPIRATORY THERAPY	1,246,489	669,415	1,915,904	-107,661	1,808,243	65.00
66.00	06600	PHYSICAL THERAPY	1,405,889	579,338	1,985,227	-51,362	1,933,865	66.00
67.00	06700	OCCUPATIONAL THERAPY	360,298	105,965	466,263	18,128	484,391	67.00
68.00	06800	SPEECH PATHOLOGY	210,718	70,759	281,477	9,683	291,160	68.00
69.00	06900	ELECTROCARDIOLOGY	873,435	470,077	1,343,512	48,146	1,391,658	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	3,522,258	3,522,258	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	5,735,862	5,735,862	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	501,743	501,743	-18,090	483,653	74.00
76.00	03020	ONCOLOGY & PAIN MANAGEMENT	794,254	1,478,186	2,272,440	-75,698	2,196,742	76.00
76.01	03340	GASTRO INTESTINAL SERVICES	730,161	641,307	1,371,468	-66,164	1,305,304	76.01
76.02	03550	OP PSYCH	154,557	61,946	216,503	-1,498	215,005	76.02
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	64,518	64,518	76.98
	OUTPATIENT SERVICE COST CENTERS							
91.00	09100	EMERGENCY	3,022,536	1,668,041	4,690,577	-332,442	4,358,135	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
	OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	2,153,676	1,518,258	3,671,934	-421,763	3,250,171	95.00
	SPECIAL PURPOSE COST CENTERS							
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	44,813,006	99,796,733	144,609,739	4,118	144,613,857	118.00
	NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	16,544	81,604	98,148	-135	98,013	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
192.01	19201	TWIN RIVERS MRI	0	0	0	0	0	192.01
192.02	19202	PHYSICIAN PRACTICES	2,299,447	7,821,521	10,120,968	-2,268	10,118,700	192.02
193.00	19300	NONPAID WORKERS	83,447	36,530	119,977	0	119,977	193.00
193.01	19301	PHYSICIAN/PUBLIC RELATIONS	135,690	180,164	315,854	-561	315,293	193.01
193.02	19302	MEDICAL OFFICE BUILDING	200,803	655,508	856,311	0	856,311	193.02
193.03	19303	HOME CARE PHARMACY	299,283	1,407,434	1,706,717	-1,154	1,705,563	193.03
193.04	19304	MANAGEMENT SERVICES	0	0	0	0	0	193.04
193.05	19305	EUNICE SMITH NURSING HOME	0	0	0	0	0	193.05
193.06	19306	VACANT SPACE	0	0	0	0	0	193.06
193.07	19307	POB 2	179,165	1,205,605	1,384,770	0	1,384,770	193.07
193.08	19308	NON REIMBURSABLE MEALS	0	0	0	0	0	193.08
193.09	19309	COFFEE BAR	0	39,648	39,648	0	39,648	193.09
200.00		TOTAL (SUM OF LINES 118 through 199)	48,027,385	111,224,747	159,252,132	0	159,252,132	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-0002

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

Worksheet A

Date/Time Prepared:
5/28/2021 12:16 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	0	4,392,898	1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP	-28,338	5,682,562	2.00
3.00	00300	OTHER CAPITAL RELATED COSTS	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	25,639	1,086,154	4.00
4.03	00401	ADMITTING	0	15,973	4.03
5.00	00500	ADMINISTRATIVE & GENERAL	-6,899,968	31,269,412	5.00
7.00	00700	OPERATION OF PLANT	-494	3,352,166	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	396,103	8.00
9.00	00900	HOUSEKEEPING	0	1,747,942	9.00
10.00	01000	DIETARY	552,324	3,137,203	10.00
11.00	01100	CAFETERIA	-332,538	-330,291	11.00
13.00	01300	NURSING ADMINISTRATION	0	1,318,338	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	510,244	14.00
15.00	01500	PHARMACY	0	12,460,501	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-80	16,973	16.00
17.00	01700	SOCIAL SERVICE	0	1,809,789	17.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	-3,288,611	14,680,182	30.00
31.00	03100	INTENSIVE CARE UNIT	-241,992	3,405,029	31.00
40.00	04000	SUBPROVIDER - IPF	-27,000	1,005,750	40.00
43.00	04300	NURSERY	0	948,345	43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	-407,771	7,025,798	50.00
51.00	05100	RECOVERY ROOM	0	720,434	51.00
53.00	05300	ANESTHESIOLOGY	0	252,849	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-605,043	3,341,226	54.00
56.00	05600	RADIOISOTOPE	0	401,146	56.00
57.00	05700	CT SCAN	0	583,692	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	-2,513	325,851	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	1,144,637	59.00
60.00	06000	LABORATORY	-595	4,375,409	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	1,239,597	63.00
65.00	06500	RESPIRATORY THERAPY	0	1,808,243	65.00
66.00	06600	PHYSICAL THERAPY	0	1,933,865	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	484,391	67.00
68.00	06800	SPEECH PATHOLOGY	0	291,160	68.00
69.00	06900	ELECTROCARDIOLOGY	-97,807	1,293,851	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	3,522,258	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	5,735,862	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	483,653	74.00
76.00	03020	ONCOLOGY & PAIN MANAGEMENT	-861,193	1,335,549	76.00
76.01	03340	GASTRO INTESTINAL SERVICES	0	1,305,304	76.01
76.02	03550	OP PSYCH	0	215,005	76.02
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	64,518	76.98
OUTPATIENT SERVICE COST CENTERS					
91.00	09100	EMERGENCY	-112,058	4,246,077	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)			92.00
OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES	-8,850	3,241,321	95.00
SPECIAL PURPOSE COST CENTERS					
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-12,336,888	132,276,969	118.00
NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	98,013	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	192.00
192.01	19201	TWIN RIVERS MRI	0	0	192.01
192.02	19202	PHYSICIAN PRACTICES	0	10,118,700	192.02
193.00	19300	NONPAID WORKERS	0	119,977	193.00
193.01	19301	PHYSICIAN/PUBLIC RELATIONS	0	315,293	193.01
193.02	19302	MEDICAL OFFICE BUILDING	0	856,311	193.02
193.03	19303	HOME CARE PHARMACY	0	1,705,563	193.03
193.04	19304	MANAGEMENT SERVICES	0	0	193.04
193.05	19305	EUNICE SMITH NURSING HOME	0	0	193.05
193.06	19306	VACANT SPACE	0	0	193.06
193.07	19307	POB 2	0	1,384,770	193.07
193.08	19308	NON REIMBURSABLE MEALS	0	0	193.08
193.09	19309	COFFEE BAR	0	39,648	193.09
200.00		TOTAL (SUM OF LINES 118 through 199)	-12,336,888	146,915,244	200.00

COST CENTERS USED IN COST REPORT

Provider CCN: 14-0002

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

Worksheet Non-CMS W

Date/Time Prepared:
5/28/2021 12:16 pm

Cost Center Description		CMS Code	Standard Label For Non-Standard Codes	
		1.00	2.00	
GENERAL SERVICE COST CENTERS				
1.00	NEW CAP REL COSTS-BLDG & FIXT	00100		1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	00200		2.00
3.00	OTHER CAPITAL RELATED COSTS	00300		3.00
4.00	EMPLOYEE BENEFITS DEPARTMENT	00400		4.00
4.03	ADMITTING	00401		4.03
5.00	ADMINISTRATIVE & GENERAL	00500		5.00
7.00	OPERATION OF PLANT	00700		7.00
8.00	LAUNDRY & LINEN SERVICE	00800		8.00
9.00	HOUSEKEEPING	00900		9.00
10.00	DIETARY	01000		10.00
11.00	CAFETERIA	01100		11.00
13.00	NURSING ADMINISTRATION	01300		13.00
14.00	CENTRAL SERVICES & SUPPLY	01400		14.00
15.00	PHARMACY	01500		15.00
16.00	MEDICAL RECORDS & LIBRARY	01600		16.00
17.00	SOCIAL SERVICE	01700		17.00
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	ADULTS & PEDIATRICS	03000		30.00
31.00	INTENSIVE CARE UNIT	03100		31.00
40.00	SUBPROVIDER - IPF	04000		40.00
43.00	NURSERY	04300		43.00
ANCILLARY SERVICE COST CENTERS				
50.00	OPERATING ROOM	05000		50.00
51.00	RECOVERY ROOM	05100		51.00
53.00	ANESTHESIOLOGY	05300		53.00
54.00	RADIOLOGY-DIAGNOSTIC	05400		54.00
56.00	RADIOISOTOPE	05600		56.00
57.00	CT SCAN	05700		57.00
58.00	MAGNETIC RESONANCE IMAGING (MRI)	05800		58.00
59.00	CARDIAC CATHETERIZATION	05900		59.00
60.00	LABORATORY	06000		60.00
63.00	BLOOD STORING, PROCESSING & TRANS.	06300		63.00
65.00	RESPIRATORY THERAPY	06500		65.00
66.00	PHYSICAL THERAPY	06600		66.00
67.00	OCCUPATIONAL THERAPY	06700		67.00
68.00	SPEECH PATHOLOGY	06800		68.00
69.00	ELECTROCARDIOLOGY	06900		69.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	07100		71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	07200		72.00
73.00	DRUGS CHARGED TO PATIENTS	07300		73.00
74.00	RENAL DIALYSIS	07400		74.00
76.00	ONCOLOGY & PAIN MANAGEMENT	03020	ACUPUNCTURE	76.00
76.01	GASTRO INTESTINAL SERVICES	03340	GASTRO INTESTINAL SERVICES	76.01
76.02	OP PSYCH	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	76.02
76.98	HYPERBARIC OXYGEN THERAPY	07698	HYPERBARIC OXYGEN THERAPY	76.98
OUTPATIENT SERVICE COST CENTERS				
91.00	EMERGENCY	09100		91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	09200		92.00
OTHER REIMBURSABLE COST CENTERS				
95.00	AMBULANCE SERVICES	09500		95.00
SPECIAL PURPOSE COST CENTERS				
118.00	SUBTOTALS (SUM OF LINES 1 through 117)			118.00
NONREIMBURSABLE COST CENTERS				
190.00	GIFT, FLOWER, COFFEE SHOP & CANTEEN	19000		190.00
192.00	PHYSICIANS' PRIVATE OFFICES	19200		192.00
192.01	TWIN RIVERS MRI	19201		192.01
192.02	PHYSICIAN PRACTICES	19202		192.02
193.00	NONPAID WORKERS	19300		193.00
193.01	PHYSICIAN/PUBLIC RELATIONS	19301		193.01
193.02	MEDICAL OFFICE BUILDING	19302		193.02
193.03	HOME CARE PHARMACY	19303		193.03
193.04	MANAGEMENT SERVICES	19304		193.04
193.05	EUNICE SMITH NURSING HOME	19305		193.05
193.06	VACANT SPACE	19306		193.06
193.07	POB 2	19307		193.07
193.08	NON REIMBURSABLE MEALS	19308		193.08
193.09	COFFEE BAR	19309		193.09
200.00	TOTAL (SUM OF LINES 118 through 199)			200.00

RECLASSIFICATIONS

Provider CCN: 14-0002

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

Worksheet A-6

Date/Time Prepared:
5/28/2021 12:16 pm

	Increases					
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
	A - RECLASS DEPRECIATION					
1.00	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	4,270,564		1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	2.00	0	5,654,050		2.00
	0		0	9,924,614		
	B - RECLASS MEDICAL SUPPLIES					
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	9,258,120		1.00
2.00		0.00	0	0		2.00
3.00		0.00	0	0		3.00
4.00		0.00	0	0		4.00
5.00		0.00	0	0		5.00
6.00		0.00	0	0		6.00
7.00		0.00	0	0		7.00
8.00		0.00	0	0		8.00
9.00		0.00	0	0		9.00
10.00		0.00	0	0		10.00
11.00		0.00	0	0		11.00
12.00		0.00	0	0		12.00
13.00		0.00	0	0		13.00
14.00		0.00	0	0		14.00
15.00		0.00	0	0		15.00
16.00		0.00	0	0		16.00
17.00		0.00	0	0		17.00
18.00		0.00	0	0		18.00
19.00		0.00	0	0		19.00
20.00		0.00	0	0		20.00
21.00		0.00	0	0		21.00
22.00		0.00	0	0		22.00
23.00		0.00	0	0		23.00
24.00		0.00	0	0		24.00
25.00		0.00	0	0		25.00
	0		0	9,258,120		
	C - TO RECLASS LAB ADMIN					
1.00	BLOOD STORING, PROCESSING & TRANS.	63.00	81,198	230,417		1.00
	0		81,198	230,417		
	D - TO RECLASS DIRECTOR'S EXPENSE					
1.00	RECOVERY ROOM	51.00	29,203	2,234		1.00
2.00	ANESTHESIOLOGY	53.00	35,094	2,685		2.00
3.00	RADIOISOTOPE	56.00	2,381	182		3.00
4.00	OCCUPATIONAL THERAPY	67.00	23,170	1,772		4.00
5.00	SPEECH PATHOLOGY	68.00	9,489	726		5.00
6.00	ELECTROCARDIOLOGY	69.00	116,172	8,888		6.00
7.00	CT SCAN	57.00	23,547	1,801		7.00
8.00	GASTRO INTESTINAL SERVICES	76.01	28,423	2,175		8.00
9.00	AMBULANCE SERVICES	95.00	17,387	1,330		9.00
10.00	MAGNETIC RESONANCE IMAGING (MRI)	58.00	5,805	444		10.00
	0		290,671	22,237		
	E - TO RECLASS HYPERBARIC OXYGEN EXPENSE					
1.00	HYPERBARIC OXYGEN THERAPY	76.98	0	64,518		1.00
	0		0	64,518		
	F - TO RECLASS DEPRECIATION DEPT EXPENSE					
1.00	ADMINISTRATIVE & GENERAL	5.00	0	2,659,933		1.00
2.00		0.00	0	0		2.00
3.00		0.00	0	0		3.00
4.00		0.00	0	0		4.00
5.00		0.00	0	0		5.00
6.00		0.00	0	0		6.00
7.00		0.00	0	0		7.00
8.00		0.00	0	0		8.00
9.00		0.00	0	0		9.00
10.00		0.00	0	0		10.00
11.00		0.00	0	0		11.00
12.00		0.00	0	0		12.00
13.00		0.00	0	0		13.00
14.00		0.00	0	0		14.00
15.00		0.00	0	0		15.00
16.00		0.00	0	0		16.00
17.00		0.00	0	0		17.00
18.00		0.00	0	0		18.00
19.00		0.00	0	0		19.00

Date/Time Prepared:
5/28/2021 12:16 pm

MCRIF32 - 16.9.172.7

RECLASSIFICATIONS

Provider CCN: 14-0002

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

Worksheet A-6

Date/Time Prepared:
5/28/2021 12:16 pm

Increases						
Cost Center	Line #	Salary	Other			
2.00	3.00	4.00	5.00			
11.00	AMBULANCE SERVICES	95.00	1,000	0		11.00
12.00	PHYSICIAN PRACTICES	192.02	2,250	0		12.00
	TOTALS		24,750	0		
500.00	Grand Total: Increases		1,225,456	28,315,393		500.00

RECLASSIFICATIONS

Provider CCN: 14-0002

Period:
From 01/01/2020
To 12/31/2020Worksheet A-6
Date/Time Prepared:
5/28/2021 12:16 pm

	Decreases						
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	A - RECLASS DEPRECIATION						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	9,924,614	9		1.00
2.00		0.00	0	0	9		2.00
	0		0	9,924,614			
	B - RECLASS MEDICAL SUPPLIES						
1.00	CENTRAL SERVICES & SUPPLY	14.00	0	161,602	0		1.00
2.00	PHARMACY	15.00	0	303,750	0		2.00
3.00	ADULTS & PEDIATRICS	30.00	0	358,908	0		3.00
4.00	INTENSIVE CARE UNIT	31.00	0	111,538	0		4.00
5.00	SUBPROVIDER - IPF	40.00	0	2,469	0		5.00
6.00	MAGNETIC RESONANCE IMAGING (MRI)	58.00	0	671	0		6.00
7.00	OPERATING ROOM	50.00	0	6,276,177	0		7.00
8.00	RECOVERY ROOM	51.00	0	148,226	0		8.00
9.00	ANESTHESIOLOGY	53.00	0	40,005	0		9.00
10.00	RADIOLOGY-DIAGNOSTIC	54.00	0	47,314	0		10.00
11.00	RADIOISOTOPE	56.00	0	2,240	0		11.00
12.00	CT SCAN	57.00	0	17,554	0		12.00
13.00	CARDIAC CATHETERIZATION	59.00	0	1,279,653	0		13.00
14.00	LABORATORY	60.00	0	639	0		14.00
15.00	BLOOD STORING, PROCESSING & TRANS.	63.00	0	59	0		15.00
16.00	RESPIRATORY THERAPY	65.00	0	4,458	0		16.00
17.00	PHYSICAL THERAPY	66.00	0	8,333	0		17.00
18.00	OCCUPATIONAL THERAPY	67.00	0	5,934	0		18.00
19.00	ELECTROCARDIOLOGY	69.00	0	4,759	0		19.00
20.00	RENAL DIALYSIS	74.00	0	18,090	0		20.00
21.00	ONCOLOGY & PAIN MANAGEMENT	76.00	0	27,304	0		21.00
22.00	GASTRO INTESTINAL SERVICES	76.01	0	87,089	0		22.00
23.00	OP PSYCH	76.02	0	22	0		23.00
24.00	EMERGENCY	91.00	0	254,477	0		24.00
25.00	AMBULANCE SERVICES	95.00	0	96,849	0		25.00
	0		0	9,258,120			
	C - TO RECLASS LAB ADMIN						
1.00	LABORATORY	60.00	81,198	230,417	0		1.00
	0		81,198	230,417			
	D - TO RECLASS DIRECTOR'S EXPENSE						
1.00	OPERATING ROOM	50.00	92,720	7,094	0		1.00
2.00	RADIOLOGY-DIAGNOSTIC	54.00	31,733	2,427	0		2.00
3.00	RESPIRATORY THERAPY	65.00	52,737	4,035	0		3.00
4.00	PHYSICAL THERAPY	66.00	32,659	2,498	0		4.00
5.00	CARDIAC CATHETERIZATION	59.00	63,435	4,853	0		5.00
6.00	EMERGENCY	91.00	17,387	1,330	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
	0		290,671	22,237			
	E - TO RECLASS HYPERBARIC OXYGEN EXPENSE						
1.00	OPERATING ROOM	50.00	0	64,518	0		1.00
	0		0	64,518			
	F - TO RECLASS DEPRECIATION DEPT EXPENSE						
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	1,526	0		1.00
2.00	ADMITTING	4.03	0	1,500	0		2.00
3.00	OPERATION OF PLANT	7.00	0	35,027	0		3.00
4.00	LAUNDRY & LINEN SERVICE	8.00	0	262	0		4.00
5.00	HOUSEKEEPING	9.00	0	5,453	0		5.00
6.00	DIETARY	10.00	0	15,673	0		6.00
7.00	NURSING ADMINISTRATION	13.00	0	58,751	0		7.00
8.00	CENTRAL SERVICES & SUPPLY	14.00	0	30,269	0		8.00
9.00	PHARMACY	15.00	0	4,251	0		9.00
10.00	MEDICAL RECORDS & LIBRARY	16.00	0	131	0		10.00
11.00	SOCIAL SERVICE	17.00	0	1,195	0		11.00
12.00	ADULTS & PEDIATRICS	30.00	0	180,635	0		12.00
13.00	INTENSIVE CARE UNIT	31.00	0	20,001	0		13.00
14.00	SUBPROVIDER - IPF	40.00	0	4,373	0		14.00
15.00	OPERATING ROOM	50.00	0	417,932	0		15.00
16.00	RECOVERY ROOM	51.00	0	21,072	0		16.00
17.00	ANESTHESIOLOGY	53.00	0	11,087	0		17.00
18.00	RADIOLOGY-DIAGNOSTIC	54.00	0	576,566	0		18.00
19.00	RADIOISOTOPE	56.00	0	21,995	0		19.00
20.00	CT SCAN	57.00	0	247,779	0		20.00
21.00	MAGNETIC RESONANCE IMAGING (MRI)	58.00	0	80,723	0		21.00

RECLASSIFICATIONS

Provider CCN: 14-0002

Period:
From 01/01/2020
To 12/31/2020Worksheet A-6
Date/Time Prepared:
5/28/2021 12:16 pm

Decreases						
	Cost Center	Line #	Salary	Other	wkst. A-7 Ref.	
	6.00	7.00	8.00	9.00	10.00	
22.00	CARDIAC CATHETERIZATION	59.00	0	170,806	0	22.00
23.00	LABORATORY	60.00	0	177,167	0	23.00
24.00	BLOOD STORING, PROCESSING & TRANS.	63.00	0	3,944	0	24.00
25.00	RESPIRATORY THERAPY	65.00	0	42,636	0	25.00
26.00	PHYSICAL THERAPY	66.00	0	4,856	0	26.00
27.00	OCCUPATIONAL THERAPY	67.00	0	1,514	0	27.00
28.00	ELECTROCARDIOLOGY	69.00	0	70,744	0	28.00
29.00	ONCOLOGY & PAIN MANAGEMENT	76.00	0	49,485	0	29.00
30.00	GASTRO INTESTINAL SERVICES	76.01	0	9,251	0	30.00
31.00	OP PSYCH	76.02	0	1,476	0	31.00
32.00	EMERGENCY	91.00	0	53,064	0	32.00
33.00	AMBULANCE SERVICES	95.00	0	338,129	0	33.00
34.00	GIFT, FLOWER, COFFEE SHOP & CANTEEN	190.00	0	135	0	34.00
35.00	PHYSICIAN/PUBLIC RELATIONS	193.01	0	131	0	35.00
36.00	HOME CARE PHARMACY	193.03	0	394	0	36.00
	0			2,659,933		
G - TO RECLASS PROPERTY INSURANCE						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	179,184	0	1.00
	0			179,184		
H - TO RECLASS MEDICAL IMPLANTS						
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	5,735,862	0	1.00
	0			5,735,862		
I - TO RECLASS NURSERY COSTS						
1.00	ADULTS & PEDIATRICS	30.00	707,837	240,508	0	1.00
	0		707,837	240,508		
J - RECLASS ACCRUED PAYROLL SALARIES						
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	778	0	0	1.00
2.00	ADMINISTRATIVE & GENERAL	5.00	8,517	0	0	2.00
3.00	OPERATION OF PLANT	7.00	2,719	0	0	3.00
4.00	HOUSEKEEPING	9.00	3,141	0	0	4.00
5.00	NURSING ADMINISTRATION	13.00	2,616	0	0	5.00
6.00	CENTRAL SERVICES & SUPPLY	14.00	377	0	0	6.00
7.00	PHARMACY	15.00	5,404	0	0	7.00
8.00	SOCIAL SERVICE	17.00	3,192	0	0	8.00
9.00	ADULTS & PEDIATRICS	30.00	34,394	0	0	9.00
10.00	INTENSIVE CARE UNIT	31.00	7,595	0	0	10.00
11.00	SUBPROVIDER - IPF	40.00	215	0	0	11.00
12.00	OPERATING ROOM	50.00	5,461	0	0	12.00
13.00	RECOVERY ROOM	51.00	890	0	0	13.00
14.00	ANESTHESIOLOGY	53.00	114	0	0	14.00
15.00	RADIOLOGY-DIAGNOSTIC	54.00	5,991	0	0	15.00
16.00	RADIOISOTOPE	56.00	446	0	0	16.00
17.00	CT SCAN	57.00	510	0	0	17.00
18.00	MAGNETIC RESONANCE IMAGING (MRI)	58.00	463	0	0	18.00
19.00	CARDIAC CATHETERIZATION	59.00	1,176	0	0	19.00
20.00	LABORATORY	60.00	3,665	0	0	20.00
21.00	BLOOD STORING, PROCESSING & TRANS.	63.00	491	0	0	21.00
22.00	RESPIRATORY THERAPY	65.00	3,795	0	0	22.00
23.00	PHYSICAL THERAPY	66.00	3,016	0	0	23.00
24.00	OCCUPATIONAL THERAPY	67.00	866	0	0	24.00
25.00	SPEECH PATHOLOGY	68.00	532	0	0	25.00
26.00	ELECTROCARDIOLOGY	69.00	1,911	0	0	26.00
27.00	ONCOLOGY & PAIN MANAGEMENT	76.00	1,909	0	0	27.00
28.00	GASTRO INTESTINAL SERVICES	76.01	422	0	0	28.00
29.00	EMERGENCY	91.00	8,184	0	0	29.00
30.00	AMBULANCE SERVICES	95.00	6,502	0	0	30.00
31.00	PHYSICIAN PRACTICES	192.02	4,518	0	0	31.00
32.00	PHYSICIAN/PUBLIC RELATIONS	193.01	430	0	0	32.00
33.00	HOME CARE PHARMACY	193.03	760	0	0	33.00
	TOTALS		121,000	0		
K - TO RECLASS BONUS REFERRAL SALARIES						
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	24,750	0	0	1.00
2.00		0.00	0	0	0	2.00
3.00		0.00	0	0	0	3.00
4.00		0.00	0	0	0	4.00
5.00		0.00	0	0	0	5.00
6.00		0.00	0	0	0	6.00
7.00		0.00	0	0	0	7.00
8.00		0.00	0	0	0	8.00

RECLASSIFICATIONS

Provider CCN: 14-0002

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

Worksheet A-6

Date/Time Prepared:
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	Decreases				wkst. A-7 Ref.	
	Cost Center	Line #	Salary	Other		
	6.00	7.00	8.00	9.00	10.00	
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
	TOTALS		24,750	0		
500.00	Grand Total: Decreases		1,225,456	28,315,393		500.00

RECLASSIFICATIONS

Provider CCN: 14-0002

Period:
From 01/01/2020
To 12/31/2020Worksheet A-6
Non-CMS Worksheet
Date/Time Prepared:
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Increases					Decreases				
	Cost Center	Line #	Salary	Other	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	6.00	7.00	8.00	9.00	
A - RECLASS DEPRECIATION									
1.00	NEW CAP REL	1.00	0	4,270,564	ADMINISTRATIVE & GENERAL	5.00	0	9,924,614	1.00
2.00	COSTS-BLDG & FIXT	2.00	0	5,654,050		0.00	0	0	2.00
	NEW CAP REL								
	COSTS-MVBLE EQUIP		0	9,924,614			0	9,924,614	
	0								
B - RECLASS MEDICAL SUPPLIES									
1.00	MEDICAL SUPPLIES	71.00	0	9,258,120	CENTRAL SERVICES & SUPPLY	14.00	0	161,602	1.00
	CHARGED TO PATIENTS								
2.00		0.00	0	0	PHARMACY	15.00	0	303,750	2.00
3.00		0.00	0	0	ADULTS & PEDIATRICS	30.00	0	358,908	3.00
4.00		0.00	0	0	INTENSIVE CARE UNIT	31.00	0	111,538	4.00
5.00		0.00	0	0	SUBPROVIDER - IPF	40.00	0	2,469	5.00
6.00		0.00	0	0	MAGNETIC RESONANCE IMAGING (MRI)	58.00	0	671	6.00
7.00		0.00	0	0	OPERATING ROOM	50.00	0	6,276,177	7.00
8.00		0.00	0	0	RECOVERY ROOM	51.00	0	148,226	8.00
9.00		0.00	0	0	ANESTHESIOLOGY	53.00	0	40,005	9.00
10.00		0.00	0	0	RADIOLOGY-DIAGNOSTIC	54.00	0	47,314	10.00
11.00		0.00	0	0	RADIOISOTOPE	56.00	0	2,240	11.00
12.00		0.00	0	0	CT SCAN	57.00	0	17,554	12.00
13.00		0.00	0	0	CARDIAC CATHETERIZATION	59.00	0	1,279,653	13.00
14.00		0.00	0	0	LABORATORY	60.00	0	639	14.00
15.00		0.00	0	0	BLOOD STORING, PROCESSING & TRANS.	63.00	0	59	15.00
16.00		0.00	0	0	RESPIRATORY THERAPY	65.00	0	4,458	16.00
17.00		0.00	0	0	PHYSICAL THERAPY	66.00	0	8,333	17.00
18.00		0.00	0	0	OCCUPATIONAL THERAPY	67.00	0	5,934	18.00
19.00		0.00	0	0	ELECTROCARDIOLOGY	69.00	0	4,759	19.00
20.00		0.00	0	0	RENAL DIALYSIS	74.00	0	18,090	20.00
21.00		0.00	0	0	ONCOLOGY & PAIN MANAGEMENT	76.00	0	27,304	21.00
22.00		0.00	0	0	GASTRO INTESTINAL SERVICES	76.01	0	87,089	22.00
23.00		0.00	0	0	OP PSYCH	76.02	0	22	23.00
24.00		0.00	0	0	EMERGENCY	91.00	0	254,477	24.00
25.00		0.00	0	0	AMBULANCE SERVICES	95.00	0	96,849	25.00
	0		0	9,258,120	0		0	9,258,120	
C - TO RECLASS LAB ADMIN									
1.00	BLOOD STORING, PROCESSING & TRANS.	63.00	81,198	230,417	LABORATORY	60.00	81,198	230,417	1.00
	0		81,198	230,417	0		81,198	230,417	
D - TO RECLASS DIRECTOR'S EXPENSE									
1.00	RECOVERY ROOM	51.00	29,203	2,234	OPERATING ROOM	50.00	92,720	7,094	1.00
2.00	ANESTHESIOLOGY	53.00	35,094	2,685	RADIOLOGY-DIAGNOSTIC	54.00	31,733	2,427	2.00
3.00	RADIOISOTOPE	56.00	2,381	182	RESPIRATORY THERAPY	65.00	52,737	4,035	3.00
4.00	OCCUPATIONAL THERAPY	67.00	23,170	1,772	PHYSICAL THERAPY	66.00	32,659	2,498	4.00
5.00	SPEECH PATHOLOGY	68.00	9,489	726	CARDIAC CATHETERIZATION	59.00	63,435	4,853	5.00
6.00	ELECTROCARDIOLOGY	69.00	116,172	8,888	EMERGENCY	91.00	17,387	1,330	6.00
7.00	CT SCAN	57.00	23,547	1,801		0.00	0	0	7.00
8.00	GASTRO INTESTINAL SERVICES	76.01	28,423	2,175		0.00	0	0	8.00
9.00	AMBULANCE SERVICES	95.00	17,387	1,330		0.00	0	0	9.00
10.00	MAGNETIC RESONANCE IMAGING (MRI)	58.00	5,805	444		0.00	0	0	10.00
	0		290,671	22,237	0		290,671	22,237	
E - TO RECLASS HYPERBARIC OXYGEN EXPENSE									
1.00	HYPERBARIC OXYGEN THERAPY	76.98	0	64,518	OPERATING ROOM	50.00	0	64,518	1.00
	0		0	64,518	0		0	64,518	
F - TO RECLASS DEPRECIATION DEPT EXPENSE									
1.00	ADMINISTRATIVE & GENERAL	5.00	0	2,659,933	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	1,526	1.00
2.00		0.00	0	0	ADMITTING	4.03	0	1,500	2.00
3.00		0.00	0	0	OPERATION OF PLANT	7.00	0	35,027	3.00
4.00		0.00	0	0	LAUNDRY & LINEN SERVICE	8.00	0	262	4.00
5.00		0.00	0	0	HOUSEKEEPING	9.00	0	5,453	5.00
6.00		0.00	0	0	DIETARY	10.00	0	15,673	6.00
7.00		0.00	0	0	NURSING	13.00	0	58,751	7.00
8.00		0.00	0	0	ADMINISTRATION				
					CENTRAL SERVICES & SUPPLY	14.00	0	30,269	8.00

RECLASSIFICATIONS

Provider CCN: 14-0002

Period:
From 01/01/2020
To 12/31/2020Worksheet A-6
Non-CMS Worksheet
Date/Time Prepared:
5/28/2021 12:16 pm

Increases					Decreases				
Cost Center	Line #	Salary	Other		Cost Center	Line #	Salary	Other	
2.00	3.00	4.00	5.00		6.00	7.00	8.00	9.00	
9.00	0.00	0	0	0	PHARMACY	15.00	0	4,251	9.00
10.00	0.00	0	0	0	MEDICAL RECORDS & LIBRARY	16.00	0	131	10.00
11.00	0.00	0	0	0	SOCIAL SERVICE	17.00	0	1,195	11.00
12.00	0.00	0	0	0	ADULTS & PEDIATRICS	30.00	0	180,635	12.00
13.00	0.00	0	0	0	INTENSIVE CARE UNIT	31.00	0	20,001	13.00
14.00	0.00	0	0	0	SUBPROVIDER - IPF	40.00	0	4,373	14.00
15.00	0.00	0	0	0	OPERATING ROOM	50.00	0	417,932	15.00
16.00	0.00	0	0	0	RECOVERY ROOM	51.00	0	21,072	16.00
17.00	0.00	0	0	0	ANESTHESIOLOGY	53.00	0	11,087	17.00
18.00	0.00	0	0	0	RADIOLOGY-DIAGNOSTIC	54.00	0	576,566	18.00
19.00	0.00	0	0	0	RADIOISOTOPE	56.00	0	21,995	19.00
20.00	0.00	0	0	0	CT SCAN	57.00	0	247,779	20.00
21.00	0.00	0	0	0	MAGNETIC RESONANCE IMAGING (MRI)	58.00	0	80,723	21.00
22.00	0.00	0	0	0	CARDIAC CATHETERIZATION	59.00	0	170,806	22.00
23.00	0.00	0	0	0	LABORATORY	60.00	0	177,167	23.00
24.00	0.00	0	0	0	BLOOD STORING, PROCESSING & TRANS.	63.00	0	3,944	24.00
25.00	0.00	0	0	0	RESPIRATORY THERAPY	65.00	0	42,636	25.00
26.00	0.00	0	0	0	PHYSICAL THERAPY	66.00	0	4,856	26.00
27.00	0.00	0	0	0	OCCUPATIONAL THERAPY	67.00	0	1,514	27.00
28.00	0.00	0	0	0	ELECTROCARDIOLOGY	69.00	0	70,744	28.00
29.00	0.00	0	0	0	ONCOLOGY & PAIN MANAGEMENT	76.00	0	49,485	29.00
30.00	0.00	0	0	0	GASTRO INTESTINAL SERVICES	76.01	0	9,251	30.00
31.00	0.00	0	0	0	OP PSYCH	76.02	0	1,476	31.00
32.00	0.00	0	0	0	EMERGENCY	91.00	0	53,064	32.00
33.00	0.00	0	0	0	AMBULANCE SERVICES	95.00	0	338,129	33.00
34.00	0.00	0	0	0	GIFT, FLOWER, COFFEE SHOP & CANTEEN	190.00	0	135	34.00
35.00	0.00	0	0	0	PHYSICIAN/PUBLIC RELATIONS	193.01	0	131	35.00
36.00	0.00	0	0	0	HOME CARE PHARMACY	193.03	0	394	36.00
0		0	2,659,933	0			0	2,659,933	
G - TO RECLASS PROPERTY INSURANCE									
1.00	OTHER CAPITAL RELATED COSTS	3.00	0	179,184	ADMINISTRATIVE & GENERAL	5.00	0	179,184	1.00
0		0	179,184	0			0	179,184	
H - TO RECLASS MEDICAL IMPLANTS									
1.00	IMPL. DEV. CHARGED TO PATIENT	72.00	0	5,735,862	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	5,735,862	1.00
0		0	5,735,862	0			0	5,735,862	
I - TO RECLASS NURSERY COSTS									
1.00	NURSERY	43.00	707,837	240,508	ADULTS & PEDIATRICS	30.00	707,837	240,508	1.00
0		0	707,837	240,508			707,837	240,508	
J - RECLASS ACCRUED PAYROLL SALARIES									
1.00	ADMINISTRATIVE & GENERAL	5.00	121,000	0	EMPLOYEE BENEFITS DEPARTMENT	4.00	778	0	1.00
2.00		0.00	0	0	ADMINISTRATIVE & GENERAL	5.00	8,517	0	2.00
3.00		0.00	0	0	OPERATION OF PLANT	7.00	2,719	0	3.00
4.00		0.00	0	0	HOUSEKEEPING	9.00	3,141	0	4.00
5.00		0.00	0	0	NURSING	13.00	2,616	0	5.00
6.00		0.00	0	0	ADMINISTRATION				
7.00		0.00	0	0	CENTRAL SERVICES & SUPPLY	14.00	377	0	6.00
8.00		0.00	0	0	PHARMACY	15.00	5,404	0	7.00
9.00		0.00	0	0	SOCIAL SERVICE	17.00	3,192	0	8.00
10.00		0.00	0	0	ADULTS & PEDIATRICS	30.00	34,394	0	9.00
11.00		0.00	0	0	INTENSIVE CARE UNIT	31.00	7,595	0	10.00
12.00		0.00	0	0	SUBPROVIDER - IPF	40.00	215	0	11.00
13.00		0.00	0	0	OPERATING ROOM	50.00	5,461	0	12.00
14.00		0.00	0	0	RECOVERY ROOM	51.00	890	0	13.00
15.00		0.00	0	0	ANESTHESIOLOGY	53.00	114	0	14.00
16.00		0.00	0	0	RADIOLOGY-DIAGNOSTIC	54.00	5,991	0	15.00
17.00		0.00	0	0	RADIOISOTOPE	56.00	446	0	16.00
18.00		0.00	0	0	CT SCAN	57.00	510	0	17.00
19.00		0.00	0	0	MAGNETIC RESONANCE IMAGING (MRI)	58.00	463	0	18.00
20.00		0.00	0	0	CARDIAC CATHETERIZATION	59.00	1,176	0	19.00
20.00		0.00	0	0	LABORATORY	60.00	3,665	0	20.00

RECLASSIFICATIONS

Provider CCN: 14-0002

Period:
From 01/01/2020
To 12/31/2020Worksheet A-6
Non-CMS Worksheet
Date/Time Prepared:
5/28/2021 12:16 pm

	Increases				Decreases				
	Cost Center	Line #	Salary	Other	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	6.00	7.00	8.00	9.00	
21.00		0.00	0	0	BLOOD STORING, PROCESSING & TRANS.	63.00	491	0	21.00
22.00		0.00	0	0	RESPIRATORY THERAPY	65.00	3,795	0	22.00
23.00		0.00	0	0	PHYSICAL THERAPY	66.00	3,016	0	23.00
24.00		0.00	0	0	OCCUPATIONAL THERAPY	67.00	866	0	24.00
25.00		0.00	0	0	SPEECH PATHOLOGY	68.00	532	0	25.00
26.00		0.00	0	0	ELECTROCARDIOLOGY	69.00	1,911	0	26.00
27.00		0.00	0	0	ONCOLOGY & PAIN MANAGEMENT	76.00	1,909	0	27.00
28.00		0.00	0	0	GASTRO INTESTINAL SERVICES	76.01	422	0	28.00
29.00		0.00	0	0	EMERGENCY	91.00	8,184	0	29.00
30.00		0.00	0	0	AMBULANCE SERVICES	95.00	6,502	0	30.00
31.00		0.00	0	0	PHYSICIAN PRACTICES	192.02	4,518	0	31.00
32.00		0.00	0	0	PHYSICIAN/PUBLIC RELATIONS	193.01	430	0	32.00
33.00		0.00	0	0	HOME CARE PHARMACY	193.03	760	0	33.00
	TOTALS		121,000	0	TOTALS		121,000	0	
	K - TO RECLASS BONUS REFERRAL SALARIES								
1.00	ADMINISTRATIVE & GENERAL	5.00	500	0	EMPLOYEE BENEFITS DEPARTMENT	4.00	24,750	0	1.00
2.00	HOUSEKEEPING	9.00	500	0		0.00	0	0	2.00
3.00	ADULTS & PEDIATRICS	30.00	7,000	0		0.00	0	0	3.00
4.00	INTENSIVE CARE UNIT	31.00	500	0		0.00	0	0	4.00
5.00	OPERATING ROOM	50.00	4,500	0		0.00	0	0	5.00
6.00	RECOVERY ROOM	51.00	1,500	0		0.00	0	0	6.00
7.00	OCCUPATIONAL THERAPY	67.00	1,500	0		0.00	0	0	7.00
8.00	ELECTROCARDIOLOGY	69.00	500	0		0.00	0	0	8.00
9.00	ONCOLOGY & PAIN MANAGEMENT	76.00	3,000	0		0.00	0	0	9.00
10.00	EMERGENCY	91.00	2,000	0		0.00	0	0	10.00
11.00	AMBULANCE SERVICES	95.00	1,000	0		0.00	0	0	11.00
12.00	PHYSICIAN PRACTICES	192.02	2,250	0		0.00	0	0	12.00
	TOTALS		24,750	0	TOTALS		24,750	0	
500.00	Grand Total: Increases		1,225,456	28,315,393	Grand Total: Decreases		1,225,456	28,315,393	500.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-0002

Period:
From 01/01/2020
To 12/31/2020Worksheet A-7
Part I
Date/Time Prepared:
5/28/2021 12:16 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	177,168	0	0	0	0	1.00
2.00	Land Improvements	5,948,826	614,973	0	614,973	0	2.00
3.00	Buildings and Fixtures	104,418,529	5,007,096	0	5,007,096	0	3.00
4.00	Building Improvements	15,227,389	5,687,759	0	5,687,759	0	4.00
5.00	Fixed Equipment	1,086,031	9,010	0	9,010	0	5.00
6.00	Movable Equipment	57,335,953	5,221,805	0	5,221,805	2,114,275	6.00
7.00	HIT designated Assets	1,948,959	1,820,600	0	1,820,600	0	7.00
8.00	Subtotal (sum of lines 1-7)	186,142,855	18,361,243	0	18,361,243	2,114,275	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	186,142,855	18,361,243	0	18,361,243	2,114,275	10.00
		Ending Balance	Fully Depreciated Assets				
		6.00	7.00				
		PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES					
1.00	Land	177,168	0				1.00
2.00	Land Improvements	6,563,799	0				2.00
3.00	Buildings and Fixtures	109,425,625	0				3.00
4.00	Building Improvements	20,915,148	0				4.00
5.00	Fixed Equipment	1,095,041	0				5.00
6.00	Movable Equipment	60,443,483	0				6.00
7.00	HIT designated Assets	3,769,559	0				7.00
8.00	Subtotal (sum of lines 1-7)	202,389,823	0				8.00
9.00	Reconciling Items	0	0				9.00
10.00	Total (line 8 minus line 9)	202,389,823	0				10.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-0002

Period:
From 01/01/2020
To 12/31/2020Worksheet A-7
Part II
Date/Time Prepared:
5/28/2021 12:16 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	0	0	0	0	0	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	0	0	0	0	0	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)				
		14.00	15.00				
		PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2					
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	0				1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0				2.00
3.00	Total (sum of lines 1-2)	0	0				3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-0002

Period:
From 01/01/2020
To 12/31/2020Worksheet A-7
Part III
Date/Time Prepared:
5/28/2021 12:16 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	138,176,781	0	138,176,781	0.682726	122,334	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	64,213,042	0	64,213,042	0.317274	56,850	2.00
3.00	Total (sum of lines 1-2)	202,389,823	0	202,389,823	1.000000	179,184	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	122,334	4,270,564	0	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0	56,850	5,625,712	0	2.00
3.00	Total (sum of lines 1-2)	0	0	179,184	9,896,276	0	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	122,334	0	0	4,392,898	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	56,850	0	0	5,682,562	2.00
3.00	Total (sum of lines 1-2)	0	179,184	0	0	10,075,460	3.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 14-0002

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

Worksheet A-8

Date/Time Prepared:
5/28/2021 12:16 pm

Cost Center Description		Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted		Wkst. A-7 Ref.	
				Cost Center	Line #		
		1.00	2.00	3.00	4.00	5.00	
1.00	Investment income - NEW CAP REL COSTS-BLDG & FIXT (chapter 2)			0 NEW CAP REL COSTS-BLDG & FIXT	1.00	0	1.00
2.00	Investment income - NEW CAP REL COSTS-MVBLE EQUIP (chapter 2)			0 NEW CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
3.00	Investment income - other (chapter 2)		0		0.00	0	3.00
4.00	Trade, quantity, and time discounts (chapter 8)		0		0.00	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)		0		0.00	0	5.00
6.00	Rental of provider space by suppliers (chapter 8)		0		0.00	0	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)		0		0.00	0	7.00
8.00	Television and radio service (chapter 21)	A	-494	OPERATION OF PLANT	7.00	0	8.00
9.00	Parking lot (chapter 21)		0		0.00	0	9.00
10.00	Provider-based physician adjustment	A-8-2	-6,705,754			0	10.00
11.00	Sale of scrap, waste, etc. (chapter 23)		0		0.00	0	11.00
12.00	Related organization transactions (chapter 10)	A-8-1	-3,140,743			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests	B	-332,538	CAFETERIA	11.00	0	14.00
15.00	Rental of quarters to employee and others		0		0.00	0	15.00
16.00	Sale of medical and surgical supplies to other than patients		0		0.00	0	16.00
17.00	Sale of drugs to other than patients		0		0.00	0	17.00
18.00	Sale of medical records and abstracts		0		0.00	0	18.00
19.00	Nursing and allied health education (tuition, fees, books, etc.)		0		0.00	0	19.00
20.00	Vending machines		0		0.00	0	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	0	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3		0 RESPIRATORY THERAPY	65.00		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3		0 PHYSICAL THERAPY	66.00		24.00
25.00	Utilization review - physicians' compensation (chapter 21)			0 *** Cost Center Deleted ***	114.00		25.00
26.00	Depreciation - NEW CAP REL COSTS-BLDG & FIXT			0 NEW CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
27.00	Depreciation - NEW CAP REL COSTS-MVBLE EQUIP			0 NEW CAP REL COSTS-MVBLE EQUIP	2.00	0	27.00
28.00	Non-physician Anesthetist			0 *** Cost Center Deleted ***	19.00		28.00
29.00	Physicians' assistant			0	0.00	0	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3		0 OCCUPATIONAL THERAPY	67.00		30.00
30.99	Hospice (non-distinct) (see instructions)			0 ADULTS & PEDIATRICS	30.00		30.99
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3		0 SPEECH PATHOLOGY	68.00		31.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 14-0002

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

Worksheet A-8

Date/Time Prepared:
5/28/2021 12:16 pm

Cost Center Description		Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted		Wkst. A-7 Ref.	
				Cost Center	Line #		
		1.00	2.00	3.00	4.00	5.00	
32.00	CAH HIT Adjustment for Depreciation and Interest		0		0.00	0	32.00
33.00	ASSOCIATION DUES	A	-26,786	ADMINISTRATIVE & GENERAL	5.00	0	33.00
33.01	OTHER REVENUE -MRI	A	-2,513	MAGNETIC RESONANCE IMAGING (MRI)	58.00	0	33.01
33.02	ELIMINATE FINANCING COSTS	A	-2,695	ADMINISTRATIVE & GENERAL	5.00	0	33.02
33.03	NON OPERATING DONATIONS	B	-8,109	ADMINISTRATIVE & GENERAL	5.00	0	33.03
33.04	OTHER NON OPERATING REVENUE	B	-21,872	ADMINISTRATIVE & GENERAL	5.00	0	33.04
33.05	MALPRACTICE EXPENSE	A	-1,958,000	ADMINISTRATIVE & GENERAL	5.00	0	33.05
33.06	ESH DIETARY COSTS	A	569,339	DIETARY	10.00	0	33.06
33.07	OTHER REVENUE - A&G	B	-215,587	ADMINISTRATIVE & GENERAL	5.00	0	33.07
33.08	OTHER REVENUE MEDICAL RECORDS	B	-80	MEDICAL RECORDS & LIBRARY	16.00	0	33.08
33.09	OTHER REVENUE - DIETARY	B	-17,015	DIETARY	10.00	0	33.09
33.10	ACCELERATED DEPRECIATION	B	-28,338	NEW CAP REL COSTS-MVBLE EQUIP	2.00	9	33.10
33.11	PENSION EXPENSE	A	25,639	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.11
33.12	DISALLOWED INTEREST EXPENSE	A	-329,491	ADMINISTRATIVE & GENERAL	5.00	0	33.12
33.13	OTHER REVENUE - ONCOLOGY	B	-600	ONCOLOGY & PAIN MANAGEMENT	76.00	0	33.13
33.14	OTHER REVENUE - EKG	B	-97,807	ELECTROCARDIOLOGY	69.00	0	33.14
33.15	OTHER REVENUE - AMBULANCE	B	-8,850	AMBULANCE SERVICES	95.00	0	33.15
33.16	ABESTOS ABATEMENT	A	-34,594	ADMINISTRATIVE & GENERAL	5.00	0	33.16
33.17	OTHER ADJUSTMENTS (SPECIFY (3))	A	0		0.00	0	33.17
33.19	OTHER ADJUSTMENTS (SPECIFY (3))		0		0.00	0	33.19
33.20	OTHER ADJUSTMENTS (SPECIFY (3))		0		0.00	0	33.20
33.21	OTHER ADJUSTMENTS (SPECIFY (3))		0		0.00	0	33.21
33.22	OTHER ADJUSTMENTS (SPECIFY (3))		0		0.00	0	33.22
33.23	OTHER ADJUSTMENTS (SPECIFY (3))		0		0.00	0	33.23
33.24	OTHER ADJUSTMENTS (SPECIFY (3))		0		0.00	0	33.24
33.25	OTHER ADJUSTMENTS (SPECIFY (3))		0		0.00	0	33.25
33.26	OTHER ADJUSTMENTS (SPECIFY (3))		0		0.00	0	33.26
33.27	OTHER ADJUSTMENTS (SPECIFY (3))		0		0.00	0	33.27
33.28	OTHER ADJUSTMENTS (SPECIFY (3))		0		0.00	0	33.28
33.29	OTHER ADJUSTMENTS (SPECIFY (3))		0		0.00	0	33.29
33.30	OTHER ADJUSTMENTS (SPECIFY (3))		0		0.00	0	33.30
33.31	OTHER ADJUSTMENTS (SPECIFY (3))		0		0.00	0	33.31
33.32	OTHER ADJUSTMENTS (SPECIFY (3))		0		0.00	0	33.32
33.33	OTHER ADJUSTMENTS (SPECIFY (3))		0		0.00	0	33.33
33.34	OTHER ADJUSTMENTS (SPECIFY (3))		0		0.00	0	33.34
33.35	OTHER ADJUSTMENTS (SPECIFY (3))		0		0.00	0	33.35
34.00	OTHER ADJUSTMENTS (SPECIFY)		0		0.00	0	34.00
35.00	OTHER ADJUSTMENTS (SPECIFY)		0		0.00	0	35.00
36.00	OTHER ADJUSTMENTS (SPECIFY)		0		0.00	0	36.00
37.00	OTHER ADJUSTMENTS (SPECIFY)		0		0.00	0	37.00
38.00	OTHER ADJUSTMENTS (SPECIFY)		0		0.00	0	38.00
39.00	OTHER ADJUSTMENTS (SPECIFY)		0		0.00	0	39.00
40.00	OTHER ADJUSTMENTS (SPECIFY)		0		0.00	0	40.00
41.00	OTHER ADJUSTMENTS (SPECIFY)		0		0.00	0	41.00
42.00	OTHER ADJUSTMENTS (SPECIFY)		0		0.00	0	42.00
43.00	OTHER ADJUSTMENTS (SPECIFY)		0		0.00	0	43.00
44.00	OTHER ADJUSTMENTS (SPECIFY)		0		0.00	0	44.00
45.00	OTHER ADJUSTMENTS (SPECIFY)		0		0.00	0	45.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 14-0002

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

Worksheet A-8

Date/Time Prepared:
5/28/2021 12:16 pm

Cost Center Description		Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted		Wkst. A-7 Ref.	
				Cost Center	Line #		
		1.00	2.00	3.00	4.00	5.00	
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-12,336,888				50.00

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

(2) Basis for adjustment (see instructions).

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

B. Amount Received - if cost cannot be determined.

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

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

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

Provider CCN: 14-0002

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

Worksheet A-8-1

Date/Time Prepared:
5/28/2021 12:16 pm

	Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in wks. A, column 5	
	1.00	2.00	3.00	4.00	5.00	
A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:						
1.00	5.00	ADMINISTRATIVE & GENERAL	BJC HEALTH SYSTEM	17,373,009	20,630,659	1.00
2.00	5.00	ADMINISTRATIVE & GENERAL	CHRISTIAN HEALTH SERVICES	18,748	0	2.00
3.00	5.00	ADMINISTRATIVE & GENERAL	TELEPHONE FACILITIES CORP	72,022	72,273	3.00
4.00	60.00	LABORATORY	BARNES JEWISH LAB	889,988	732,676	4.00
4.01	60.00	LABORATORY	CHILDREN'S HOSPITAL LAB	28,445	44,552	4.01
4.02	60.00	LABORATORY	MISSOURI BAPTIST HOSPITAL LA	4,081	8,381	4.02
4.03	50.00	OPERATING ROOM	MIDWEST SURGICAL TECHNOLOGIE	76,499	115,140	4.03
4.04	50.00	OPERATING ROOM	MIDWEST LITHOTRIPSY	7,571	7,425	4.04
4.05	0.00			0	0	4.05
5.00	0		0	18,470,363	21,611,106	5.00

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

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

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

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

6.00	G	BJC HEALTHCARE	100.00	0.00	6.00
7.00			0.00	0.00	7.00
8.00			0.00	0.00	8.00
9.00			0.00	0.00	9.00
10.00			0.00	0.00	10.00
100.00	G. Other (financial or non-financial) specify:	HOME OFFICE		0.00	100.00

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

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

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

Provider CCN: 14-0002

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

Worksheet A-8-1

Date/Time Prepared:
5/28/2021 12:16 pm

	Net Adjustments (col. 4 minus col. 5)*	Wkst. A-7 Ref.		
	6.00	7.00		
A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:				
1.00	-3,257,650	0		1.00
2.00	18,748	0		2.00
3.00	-251	0		3.00
4.00	157,312	0		4.00
4.01	-16,107	0		4.01
4.02	-4,300	0		4.02
4.03	-38,641	0		4.03
4.04	146	0		4.04
4.05	0	0		4.05
5.00	-3,140,743			5.00

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

	Related Organization(s) and/or Home Office	
	Type of Business	
	6.00	
B. INTERRELATIONSHIP TO RELATED ORGANIZATION(S) AND/OR HOME OFFICE:		

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

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

6.00			6.00
7.00			7.00
8.00			8.00
9.00			9.00
10.00			10.00
100.00			100.00

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

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

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 14-0002

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

Worksheet A-8-2

Date/Time Prepared:
5/28/2021 12:16 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	0.00		0	0	0	0	0	1.00
2.00	0.00		0	0	0	0	0	2.00
3.00	5.00	AGGREGATE-ADMINISTRATIVE & GENERAL	1,063,681	1,063,681	0	0	0	3.00
4.00	30.00	DR. A	3,000	3,000	0	0	0	4.00
5.00	30.00	AGGREGATE-ADULTS & PEDIATRICS	2,626,891	2,626,891	0	0	0	5.00
6.00	30.00	AGGREGATE-ADULTS & PEDIATRICS	336,672	336,672	0	0	0	6.00
7.00	31.00	AGGREGATE-INTENSIVE CARE UNIT	241,992	241,992	0	0	0	7.00
8.00	40.00	AGGREGATE-SUBPROVIDER - IPF	27,000	27,000	0	0	0	8.00
9.00	50.00	AGGREGATE-OPERATING ROOM	369,276	369,276	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
11.00	54.00	AGGREGATE-RADIOLOGY-DIAGNOSTIC	600,000	600,000	0	0	0	11.00
12.00	54.00	DR. B	5,043	5,043	0	0	0	12.00
13.00	60.00	AGGREGATE-LABORATORY	137,500	137,500	0	0	0	13.00
20.00	76.00	AGGREGATE-ONCOLOGY & PAIN MANAGEMENT	786,016	786,016	0	0	0	20.00
21.00	76.00	AGGREGATE-ONCOLOGY & PAIN MANAGEMENT	74,577	74,577	0	0	0	21.00
23.00	91.00	AGGREGATE-EMERGENCY	112,058	112,058	0	0	0	23.00
25.00	30.00	AGGREGATE-ADULTS & PEDIATRICS	308,573	308,573	0	0	0	25.00
26.00	30.00	AGGREGATE-ADULTS & PEDIATRICS	13,475	13,475	0	0	0	26.00
200.00			6,705,754	6,705,754	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	0.00		0	0	0	0	0	1.00
2.00	0.00		0	0	0	0	0	2.00
3.00	5.00	AGGREGATE-ADMINISTRATIVE & GENERAL	0	0	0	0	0	3.00
4.00	30.00	DR. A	0	0	0	0	0	4.00
5.00	30.00	AGGREGATE-ADULTS & PEDIATRICS	0	0	0	0	0	5.00
6.00	30.00	AGGREGATE-ADULTS & PEDIATRICS	0	0	0	0	0	6.00
7.00	31.00	AGGREGATE-INTENSIVE CARE UNIT	0	0	0	0	0	7.00
8.00	40.00	AGGREGATE-SUBPROVIDER - IPF	0	0	0	0	0	8.00
9.00	50.00	AGGREGATE-OPERATING ROOM	0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
11.00	54.00	AGGREGATE-RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	11.00
12.00	54.00	DR. B	0	0	0	0	0	12.00
13.00	60.00	AGGREGATE-LABORATORY	0	0	0	0	0	13.00
20.00	76.00	AGGREGATE-ONCOLOGY & PAIN MANAGEMENT	0	0	0	0	0	20.00
21.00	76.00	AGGREGATE-ONCOLOGY & PAIN MANAGEMENT	0	0	0	0	0	21.00
23.00	91.00	AGGREGATE-EMERGENCY	0	0	0	0	0	23.00
25.00	30.00	AGGREGATE-ADULTS & PEDIATRICS	0	0	0	0	0	25.00
26.00	30.00	AGGREGATE-ADULTS & PEDIATRICS	0	0	0	0	0	26.00
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	0.00		0	0	0	0		1.00
2.00	0.00		0	0	0	0		2.00
3.00	5.00	AGGREGATE-ADMINISTRATIVE & GENERAL	0	0	0	1,063,681		3.00
4.00	30.00	DR. A	0	0	0	3,000		4.00
5.00	30.00	AGGREGATE-ADULTS & PEDIATRICS	0	0	0	2,626,891		5.00

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 14-0002

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

Worksheet A-8-2

Date/Time Prepared:
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	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment		
	1.00	2.00	15.00	16.00	17.00	18.00		
6.00	30.00	AGGREGATE-ADULTS & PEDIATRICS	0	0	0	336,672		6.00
7.00	31.00	AGGREGATE-INTENSIVE CARE UNIT	0	0	0	241,992		7.00
8.00	40.00	AGGREGATE-SUBPROVIDER - IPF	0	0	0	27,000		8.00
9.00	50.00	AGGREGATE-OPERATING ROOM	0	0	0	369,276		9.00
10.00	0.00		0	0	0	0		10.00
11.00	54.00	AGGREGATE-RADIOLOGY-DIAGNOSTIC	0	0	0	600,000		11.00
12.00	54.00	DR. B	0	0	0	5,043		12.00
13.00	60.00	AGGREGATE-LABORATORY	0	0	0	137,500		13.00
20.00	76.00	AGGREGATE-ONCOLOGY & PAIN MANAGEMENT	0	0	0	786,016		20.00
21.00	76.00	AGGREGATE-ONCOLOGY & PAIN MANAGEMENT	0	0	0	74,577		21.00
23.00	91.00	AGGREGATE-EMERGENCY	0	0	0	112,058		23.00
25.00	30.00	AGGREGATE-ADULTS & PEDIATRICS	0	0	0	308,573		25.00
26.00	30.00	AGGREGATE-ADULTS & PEDIATRICS	0	0	0	13,475		26.00
200.00			0	0	0	6,705,754		200.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0002

Period:
From 01/01/2020
To 12/31/2020Worksheet B
Part I
Date/Time Prepared:
5/28/2021 12:16 pm

Cost Center Description		Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	ADMITTING	
			NEW BLDG & FIXT	NEW MVBLE EQUIP			
		0	1.00	2.00	4.00	4.03	
GENERAL SERVICE COST CENTERS							
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT	4,392,898	4,392,898			1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP	5,682,562	5,682,562			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	1,086,154	23,927	1,534	1,111,615	4.00
4.03	00401	ADMITTING	15,973	52,805	1,508	0	4.03
5.00	00500	ADMINISTRATIVE & GENERAL	31,269,412	247,501	3,430,603	98,025	5.00
7.00	00700	OPERATION OF PLANT	3,352,166	1,709,009	8,817	21,077	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	396,103	10,699	263	0	8.00
9.00	00900	HOUSEKEEPING	1,747,942	25,299	5,483	26,625	9.00
10.00	01000	DIETARY	3,137,203	104,998	9,371	0	10.00
11.00	01100	CAFETERIA	-330,291	45,403	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	1,318,338	4,815	47,671	22,661	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	510,244	43,341	29,108	5,968	14.00
15.00	01500	PHARMACY	12,460,501	26,942	4,274	47,038	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	16,973	51,657	132	0	16.00
17.00	01700	SOCIAL SERVICE	1,809,789	5,097	1,202	25,206	17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	14,680,182	533,723	179,094	251,302	30.00
31.00	03100	INTENSIVE CARE UNIT	3,405,029	53,379	20,110	58,943	31.00
40.00	04000	SUBPROVIDER - IPF	1,005,750	29,783	4,397	17,264	40.00
43.00	04300	NURSERY	948,345	0	0	16,476	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	7,025,798	201,387	405,460	60,288	50.00
51.00	05100	RECOVERY ROOM	720,434	32,885	21,187	11,881	51.00
53.00	05300	ANESTHESIOLOGY	252,849	2,373	11,147	1,786	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,341,226	106,204	554,756	50,807	54.00
56.00	05600	RADIOISOTOPE	401,146	9,736	22,115	4,067	56.00
57.00	05700	CT SCAN	583,692	5,534	162,013	6,388	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	325,851	46,755	552	5,212	58.00
59.00	05900	CARDIAC CATHETERIZATION	1,144,637	17,128	57,145	12,646	59.00
60.00	06000	LABORATORY	4,375,409	139,877	159,204	28,638	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	1,239,597	3,540	3,966	7,970	63.00
65.00	06500	RESPIRATORY THERAPY	1,808,243	14,998	42,869	27,702	65.00
66.00	06600	PHYSICAL THERAPY	1,933,865	52,766	4,882	31,893	66.00
67.00	06700	OCCUPATIONAL THERAPY	484,391	14,210	1,522	8,940	67.00
68.00	06800	SPEECH PATHOLOGY	291,160	4,863	0	5,113	68.00
69.00	06900	ELECTROCARDIOLOGY	1,293,851	49,138	68,544	22,997	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	3,522,258	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	5,735,862	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	483,653	2,723	0	0	74.00
76.00	03020	ONCOLOGY & PAIN MANAGEMENT	1,335,549	17,284	41,205	18,512	76.00
76.01	03340	GASTRO INTESTINAL SERVICES	1,305,304	33,284	9,301	17,647	76.01
76.02	03550	OP PSYCH	215,005	37,758	1,484	3,597	76.02
76.98	07698	HYPERBARIC OXYGEN THERAPY	64,518	0	0	0	76.98
OUTPATIENT SERVICE COST CENTERS							
91.00	09100	EMERGENCY	4,246,077	161,713	31,141	69,804	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	3,241,321	9,493	339,974	50,406	95.00
SPECIAL PURPOSE COST CENTERS							
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	132,276,969	3,932,027	5,682,034	1,036,879	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	98,013	10,077	0	385	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	132	0	192.00
192.01	19201	TWIN RIVERS MRI	0	0	0	0	192.01
192.02	19202	PHYSICIAN PRACTICES	10,118,700	0	0	53,469	192.02
193.00	19300	NONPAID WORKERS	119,977	15,524	0	1,942	193.00
193.01	19301	PHYSICIAN/PUBLIC RELATIONS	315,293	10,125	0	3,148	193.01
193.02	19302	MEDICAL OFFICE BUILDING	856,311	0	0	4,674	193.02
193.03	19303	HOME CARE PHARMACY	1,705,563	4,678	396	6,948	193.03
193.04	19304	MANAGEMENT SERVICES	0	0	0	0	193.04
193.05	19305	EUNICE SMITH NURSING HOME	0	0	0	0	193.05
193.06	19306	VACANT SPACE	0	418,697	0	0	193.06
193.07	19307	POB 2	1,384,770	0	0	4,170	193.07
193.08	19308	NON REIMBURSABLE MEALS	0	0	0	0	193.08
193.09	19309	COFFEE BAR	39,648	1,770	0	0	193.09
200.00		Cross Foot Adjustments					200.00
201.00		Negative Cost Centers		0	0	0	201.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0002

Period:
From 01/01/2020
To 12/31/2020Worksheet B
Part I
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Cost Center Description		Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	ADMITTING	
			NEW BLDG & FIXT	NEW MVBLE EQUIP			
		0	1.00	2.00	4.00	4.03	
202.00	TOTAL (sum lines 118 through 201)	146,915,244	4,392,898	5,682,562	1,111,615	70,286	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0002

Period:
From 01/01/2020
To 12/31/2020Worksheet B
Part I
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Cost Center Description			Subtotal	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
			4A.03	5.00	7.00	8.00	9.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
4.03	00401	ADMITTING						4.03
5.00	00500	ADMINISTRATIVE & GENERAL	35,045,541	35,045,541				5.00
7.00	00700	OPERATION OF PLANT	5,091,069	1,590,832	6,681,901			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	407,065	127,198	30,297	564,560		8.00
9.00	00900	HOUSEKEEPING	1,805,349	564,126	71,639	0	2,441,114	9.00
10.00	01000	DIETARY	3,251,572	1,016,035	297,324	0	110,305	10.00
11.00	01100	CAFETERIA	-284,888	0	128,570	0	47,698	11.00
13.00	01300	NURSING ADMINISTRATION	1,393,485	435,429	13,634	0	5,058	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	588,661	183,942	122,731	8,986	45,532	14.00
15.00	01500	PHARMACY	12,538,755	3,918,047	76,293	0	28,304	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	68,762	21,486	146,280	0	54,269	16.00
17.00	01700	SOCIAL SERVICE	1,841,294	575,358	14,432	0	5,354	17.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	15,651,697	4,890,800	1,511,355	240,461	560,701	30.00
31.00	03100	INTENSIVE CARE UNIT	3,539,348	1,105,958	151,155	29,460	56,077	31.00
40.00	04000	SUBPROVIDER - IPF	1,057,491	330,440	84,336	2,990	31,288	40.00
43.00	04300	NURSERY	965,280	301,626	0	0	0	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	7,698,623	2,405,627	570,273	69,578	211,567	50.00
51.00	05100	RECOVERY ROOM	787,516	246,079	93,122	0	34,548	51.00
53.00	05300	ANESTHESIOLOGY	269,512	84,216	6,720	0	2,493	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,058,822	1,268,280	300,739	35,522	111,572	54.00
56.00	05600	RADIOISOTOPE	437,527	136,716	27,570	0	10,228	56.00
57.00	05700	CT SCAN	762,202	238,169	15,672	13,491	5,814	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	379,498	118,584	132,398	1,831	49,119	58.00
59.00	05900	CARDIAC CATHETERIZATION	1,232,827	385,228	48,503	2,797	17,994	59.00
60.00	06000	LABORATORY	4,709,712	1,471,667	396,092	0	146,947	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	1,256,114	392,504	10,026	0	3,719	63.00
65.00	06500	RESPIRATORY THERAPY	1,895,186	592,198	42,471	0	15,756	65.00
66.00	06600	PHYSICAL THERAPY	2,024,645	632,651	149,419	10,579	55,433	66.00
67.00	06700	OCCUPATIONAL THERAPY	509,347	159,158	40,240	0	14,929	67.00
68.00	06800	SPEECH PATHOLOGY	301,252	94,134	13,771	0	5,109	68.00
69.00	06900	ELECTROCARDIOLOGY	1,439,173	449,706	139,146	8,540	51,622	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	3,523,400	1,100,974	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	5,738,432	1,793,117	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	4,849	1,515	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	486,615	152,055	7,712	0	2,861	74.00
76.00	03020	ONCOLOGY & PAIN MANAGEMENT	1,413,396	441,651	48,943	0	18,158	76.00
76.01	03340	GASTRO INTESTINAL SERVICES	1,366,635	427,039	94,251	22,706	34,966	76.01
76.02	03550	OP PSYCH	257,916	80,592	106,921	2	39,667	76.02
76.98	07698	HYPERBARIC OXYGEN THERAPY	64,650	20,202	0	0	0	76.98
OUTPATIENT SERVICE COST CENTERS								
91.00	09100	EMERGENCY	4,518,890	1,412,040	457,926	97,325	169,887	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0					92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	3,643,614	1,138,538	26,882	20,292	9,973	95.00
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	131,740,834	30,303,917	5,376,843	564,560	1,956,948	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	108,475	33,896	28,534	0	10,586	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	132	41	0	0	0	192.00
192.01	19201	TWIN RIVERS MRI	0	0	0	0	0	192.01
192.02	19202	PHYSICIAN PRACTICES	10,172,169	3,178,549	0	0	0	192.02
193.00	19300	NONPAID WORKERS	137,443	42,948	43,958	0	16,308	193.00
193.01	19301	PHYSICIAN/PUBLIC RELATIONS	328,566	102,669	28,672	0	10,637	193.01
193.02	19302	MEDICAL OFFICE BUILDING	860,985	269,036	0	0	0	193.02
193.03	19303	HOME CARE PHARMACY	1,717,585	536,702	13,248	0	4,915	193.03
193.04	19304	MANAGEMENT SERVICES	0	0	0	0	0	193.04
193.05	19305	EUNICE SMITH NURSING HOME	0	0	0	0	0	193.05
193.06	19306	VACANT SPACE	418,697	130,832	1,185,633	0	439,860	193.06
193.07	19307	POB 2	1,388,940	434,009	0	0	0	193.07
193.08	19308	NON REIMBURSABLE MEALS	0	0	0	0	0	193.08
193.09	19309	COFFEE BAR	41,418	12,942	5,013	0	1,860	193.09
200.00		Cross Foot Adjustments	0					200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	146,915,244	35,045,541	6,681,901	564,560	2,441,114	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0002

Period:
From 01/01/2020
To 12/31/2020Worksheet B
Part I
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Cost Center Description			DIETARY	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	
			10.00	11.00	13.00	14.00	15.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
4.03	00401	ADMITTING						4.03
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY	4,675,236					10.00
11.00	01100	CAFETERIA	2,077,206	1,968,586				11.00
13.00	01300	NURSING ADMINISTRATION	0	32,213	1,879,819			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	20,905	0	970,757		14.00
15.00	01500	PHARMACY	0	66,769	0	0	16,628,168	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	0	44,692	0	0	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	1,092,990	501,151	1,336,456	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	126,595	94,516	257,950	0	0	31.00
40.00	04000	SUBPROVIDER - IPF	39,503	23,439	63,927	0	0	40.00
43.00	04300	NURSERY	0	28,507	77,789	0	0	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	114,186	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0	17,674	0	0	0	51.00
53.00	05300	ANESTHESIOLOGY	0	4,498	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	109,910	0	0	0	54.00
56.00	05600	RADIOISOTOPE	0	6,620	0	0	0	56.00
57.00	05700	CT SCAN	0	12,416	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	9,027	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	20,968	0	0	0	59.00
60.00	06000	LABORATORY	0	85,615	0	0	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	15,647	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	0	50,014	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	48,208	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	14,697	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	6,937	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	50,077	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	425,403	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	545,354	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	16,628,168	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.00	03020	ONCOLOGY & PAIN MANAGEMENT	0	36,932	66,116	0	0	76.00
76.01	03340	GASTRO INTESTINAL SERVICES	0	29,362	77,581	0	0	76.01
76.02	03550	OP PSYCH	0	7,380	0	0	0	76.02
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
OUTPATIENT SERVICE COST CENTERS								
91.00	09100	EMERGENCY	0	134,204	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	0	157,484	0	0	0	95.00
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	3,336,294	1,744,048	1,879,819	970,757	16,628,168	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	1,647	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
192.01	19201	TWIN RIVERS MRI	0	0	0	0	0	192.01
192.02	19202	PHYSICIAN PRACTICES	0	168,982	0	0	0	192.02
193.00	19300	NONPAID WORKERS	0	4,561	0	0	0	193.00
193.01	19301	PHYSICIAN/PUBLIC RELATIONS	0	3,294	0	0	0	193.01
193.02	19302	MEDICAL OFFICE BUILDING	0	15,900	0	0	0	193.02
193.03	19303	HOME CARE PHARMACY	0	14,063	0	0	0	193.03
193.04	19304	MANAGEMENT SERVICES	0	0	0	0	0	193.04
193.05	19305	EUNICE SMITH NURSING HOME	1,120,561	0	0	0	0	193.05
193.06	19306	VACANT SPACE	0	0	0	0	0	193.06
193.07	19307	POB 2	0	16,091	0	0	0	193.07
193.08	19308	NON REIMBURSABLE MEALS	218,381	0	0	0	0	193.08
193.09	19309	COFFEE BAR	0	0	0	0	0	193.09
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	4,675,236	1,968,586	1,879,819	970,757	16,628,168	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0002

Period:
From 01/01/2020
To 12/31/2020Worksheet B
Part I
Date/Time Prepared:
5/28/2021 12:16 pm

Cost Center Description			MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			16.00	17.00	24.00	25.00	26.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
4.03	00401	ADMITTING						4.03
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY						15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	290,797					16.00
17.00	01700	SOCIAL SERVICE	0	2,481,130				17.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	30,565	2,037,685	27,853,861	0	27,853,861	30.00
31.00	03100	INTENSIVE CARE UNIT	7,799	236,016	5,604,874	0	5,604,874	31.00
40.00	04000	SUBPROVIDER - IPF	1,226	73,646	1,708,286	0	1,708,286	40.00
43.00	04300	NURSERY	1,895	133,783	1,508,880	0	1,508,880	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	23,516	0	11,093,370	0	11,093,370	50.00
51.00	05100	RECOVERY ROOM	4,666	0	1,183,605	0	1,183,605	51.00
53.00	05300	ANESTHESIOLOGY	5,607	0	373,046	0	373,046	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	24,091	0	5,908,936	0	5,908,936	54.00
56.00	05600	RADIOISOTOPE	1,912	0	620,573	0	620,573	56.00
57.00	05700	CT SCAN	18,906	0	1,066,670	0	1,066,670	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	4,661	0	695,118	0	695,118	58.00
59.00	05900	CARDIAC CATHETERIZATION	5,255	0	1,713,572	0	1,713,572	59.00
60.00	06000	LABORATORY	27,211	0	6,837,244	0	6,837,244	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	4,302	0	1,682,312	0	1,682,312	63.00
65.00	06500	RESPIRATORY THERAPY	5,680	0	2,601,305	0	2,601,305	65.00
66.00	06600	PHYSICAL THERAPY	5,122	0	2,926,057	0	2,926,057	66.00
67.00	06700	OCCUPATIONAL THERAPY	1,173	0	739,544	0	739,544	67.00
68.00	06800	SPEECH PATHOLOGY	480	0	421,683	0	421,683	68.00
69.00	06900	ELECTROCARDIOLOGY	19,190	0	2,157,454	0	2,157,454	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	4,720	0	5,054,497	0	5,054,497	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	10,620	0	8,087,523	0	8,087,523	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	20,042	0	16,654,574	0	16,654,574	73.00
74.00	07400	RENAL DIALYSIS	989	0	650,232	0	650,232	74.00
76.00	03020	ONCOLOGY & PAIN MANAGEMENT	3,494	0	2,028,690	0	2,028,690	76.00
76.01	03340	GASTRO INTESTINAL SERVICES	4,541	0	2,057,081	0	2,057,081	76.01
76.02	03550	OP PSYCH	298	0	492,776	0	492,776	76.02
76.98	07698	HYPERBARIC OXYGEN THERAPY	547	0	85,399	0	85,399	76.98
OUTPATIENT SERVICE COST CENTERS								
91.00	09100	EMERGENCY	42,287	0	6,832,559	0	6,832,559	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				0		92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	10,002	0	5,006,785	0	5,006,785	95.00
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	290,797	2,481,130	123,646,506	0	123,646,506	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	183,138	0	183,138	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	173	0	173	192.00
192.01	19201	TWIN RIVERS MRI	0	0	0	0	0	192.01
192.02	19202	PHYSICIAN PRACTICES	0	0	13,519,700	0	13,519,700	192.02
193.00	19300	NONPAID WORKERS	0	0	245,218	0	245,218	193.00
193.01	19301	PHYSICIAN/PUBLIC RELATIONS	0	0	473,838	0	473,838	193.01
193.02	19302	MEDICAL OFFICE BUILDING	0	0	1,145,921	0	1,145,921	193.02
193.03	19303	HOME CARE PHARMACY	0	0	2,286,513	0	2,286,513	193.03
193.04	19304	MANAGEMENT SERVICES	0	0	0	0	0	193.04
193.05	19305	EUNICE SMITH NURSING HOME	0	0	1,120,561	0	1,120,561	193.05
193.06	19306	VACANT SPACE	0	0	2,175,022	0	2,175,022	193.06
193.07	19307	POB 2	0	0	1,839,040	0	1,839,040	193.07
193.08	19308	NON REIMBURSABLE MEALS	0	0	218,381	0	218,381	193.08
193.09	19309	COFFEE BAR	0	0	61,233	0	61,233	193.09
200.00		Cross Foot Adjustments			0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	290,797	2,481,130	146,915,244	0	146,915,244	202.00

COST ALLOCATION STATISTICS

Provider CCN: 14-0002

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

Worksheet Non-CMS W

Date/Time Prepared:
5/28/2021 12:16 pm

Cost Center Description		Statistics Code	Statistics Description	
		1.00	2.00	
GENERAL SERVICE COST CENTERS				
1.00	NEW CAP REL COSTS-BLDG & FIXT	1	SQUARE FEET	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	4	DOLLAR VALUE	2.00
4.00	EMPLOYEE BENEFITS DEPARTMENT	5	GROSS SALARIES	4.00
4.03	ADMITTING	7	GROSS REVENUE	4.03
5.00	ADMINISTRATIVE & GENERAL	-21	ACCUM. COST	5.00
7.00	OPERATION OF PLANT	1	SQUARE FEET	7.00
8.00	LAUNDRY & LINEN SERVICE	12	POUNDS OF LAUNDRY	8.00
9.00	HOUSEKEEPING	1	SQUARE FEET	9.00
10.00	DIETARY	14	MEALS SERVED	10.00
11.00	CAFETERIA	15	FTE'S	11.00
13.00	NURSING ADMINISTRATION	16	HOURS OF SERVICE	13.00
14.00	CENTRAL SERVICES & SUPPLY	17	COSTED REQUISITIONS	14.00
15.00	PHARMACY	18	COSTED REQUISITIONS	15.00
16.00	MEDICAL RECORDS & LIBRARY	7	GROSS REVENUE	16.00
17.00	SOCIAL SERVICE	20	PATIENT DAYS	17.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0002

Period:
From 01/01/2020
To 12/31/2020Worksheet B
Part II
Date/Time Prepared:
5/28/2021 12:16 pm

Cost Center Description		Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
			NEW BLDG & FIXT	NEW MVBLE EQUIP			
		0	1.00	2.00	2A	4.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	4,785	23,927	1,534	30,246	4.00
4.03	00401	ADMITTING	3,464	52,805	1,508	57,777	4.03
5.00	00500	ADMINISTRATIVE & GENERAL	745,472	247,501	3,430,603	4,423,576	5.00
7.00	00700	OPERATION OF PLANT	3,435	1,709,009	8,817	1,721,261	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	10,699	263	10,962	8.00
9.00	00900	HOUSEKEEPING	473	25,299	5,483	31,255	9.00
10.00	01000	DIETARY	8,303	104,998	9,371	122,672	10.00
11.00	01100	CAFETERIA	0	45,403	0	45,403	11.00
13.00	01300	NURSING ADMINISTRATION	0	4,815	47,671	52,486	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	435	43,341	29,108	72,884	14.00
15.00	01500	PHARMACY	116,340	26,942	4,274	147,556	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	3,490	51,657	132	55,279	16.00
17.00	01700	SOCIAL SERVICE	2,653	5,097	1,202	8,952	17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	223,743	533,723	179,094	936,560	30.00
31.00	03100	INTENSIVE CARE UNIT	2,202	53,379	20,110	75,691	31.00
40.00	04000	SUBPROVIDER - IPF	1,707	29,783	4,397	35,887	40.00
43.00	04300	NURSERY	0	0	0	0	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	283,783	201,387	405,460	890,630	50.00
51.00	05100	RECOVERY ROOM	412	32,885	21,187	54,484	51.00
53.00	05300	ANESTHESIOLOGY	4,472	2,373	11,147	17,992	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	106,204	554,756	660,960	54.00
56.00	05600	RADIOISOTOPE	0	9,736	22,115	31,851	56.00
57.00	05700	CT SCAN	0	5,534	162,013	167,547	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	1,866	46,755	552	49,173	58.00
59.00	05900	CARDIAC CATHETERIZATION	462	17,128	57,145	74,735	59.00
60.00	06000	LABORATORY	16,464	139,877	159,204	315,545	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	3,540	3,966	7,506	63.00
65.00	06500	RESPIRATORY THERAPY	44,263	14,998	42,869	102,130	65.00
66.00	06600	PHYSICAL THERAPY	2,654	52,766	4,882	60,302	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	14,210	1,522	15,732	67.00
68.00	06800	SPEECH PATHOLOGY	0	4,863	0	4,863	68.00
69.00	06900	ELECTROCARDIOLOGY	2,751	49,138	68,544	120,433	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	2,723	0	2,723	74.00
76.00	03020	ONCOLOGY & PAIN MANAGEMENT	5,762	17,284	41,205	64,251	76.00
76.01	03340	GASTRO INTESTINAL SERVICES	3,868	33,284	9,301	46,453	76.01
76.02	03550	OP PSYCH	3,334	37,758	1,484	42,576	76.02
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	76.98
OUTPATIENT SERVICE COST CENTERS							
91.00	09100	EMERGENCY	3,599	161,713	31,141	196,453	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				0	92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	-792	9,493	339,974	348,675	95.00
SPECIAL PURPOSE COST CENTERS							
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	1,489,400	3,932,027	5,682,034	11,103,461	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	10,077	0	10,077	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	132	132	192.00
192.01	19201	TWIN RIVERS MRI	0	0	0	0	192.01
192.02	19202	PHYSICIAN PRACTICES	0	0	0	0	192.02
193.00	19300	NONPAID WORKERS	0	15,524	0	15,524	193.00
193.01	19301	PHYSICIAN/PUBLIC RELATIONS	0	10,125	0	10,125	193.01
193.02	19302	MEDICAL OFFICE BUILDING	0	0	0	0	193.02
193.03	19303	HOME CARE PHARMACY	533	4,678	396	5,607	193.03
193.04	19304	MANAGEMENT SERVICES	0	0	0	0	193.04
193.05	19305	EUNICE SMITH NURSING HOME	0	0	0	0	193.05
193.06	19306	VACANT SPACE	0	418,697	0	418,697	193.06
193.07	19307	POB 2	0	0	0	0	193.07
193.08	19308	NON REIMBURSABLE MEALS	0	0	0	0	193.08
193.09	19309	COFFEE BAR	0	1,770	0	1,770	193.09
200.00		Cross Foot Adjustments				0	200.00
201.00		Negative Cost Centers				0	201.00
202.00		TOTAL (sum lines 118 through 201)	1,489,933	4,392,898	5,682,562	11,565,393	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0002

Period:
From 01/01/2020
To 12/31/2020Worksheet B
Part II
Date/Time Prepared:
5/28/2021 12:16 pm

Cost Center Description			ADMITTING	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
			4.03	5.00	7.00	8.00	9.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
4.03	00401	ADMITTING	57,777					4.03
5.00	00500	ADMINISTRATIVE & GENERAL	0	4,426,242				5.00
7.00	00700	OPERATION OF PLANT	0	200,924	1,922,758			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	16,065	8,718	35,745		8.00
9.00	00900	HOUSEKEEPING	0	71,250	20,614	0	123,843	9.00
10.00	01000	DIETARY	0	128,327	85,557	0	5,596	10.00
11.00	01100	CAFETERIA	0	0	36,997	0	2,420	11.00
13.00	01300	NURSING ADMINISTRATION	0	54,995	3,923	0	257	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	23,232	35,316	569	2,310	14.00
15.00	01500	PHARMACY	0	494,855	21,954	0	1,436	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	2,714	42,093	0	2,753	16.00
17.00	01700	SOCIAL SERVICE	0	72,669	4,153	0	272	17.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	6,067	617,658	434,903	15,225	28,447	30.00
31.00	03100	INTENSIVE CARE UNIT	1,548	139,684	43,496	1,865	2,845	31.00
40.00	04000	SUBPROVIDER - IPF	243	41,735	24,268	189	1,587	40.00
43.00	04300	NURSERY	376	38,096	0	0	0	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	4,668	303,834	164,100	4,405	10,733	50.00
51.00	05100	RECOVERY ROOM	926	31,080	26,796	0	1,753	51.00
53.00	05300	ANESTHESIOLOGY	1,113	10,637	1,934	0	126	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,782	160,185	86,540	2,249	5,660	54.00
56.00	05600	RADIOISOTOPE	379	17,267	7,934	0	519	56.00
57.00	05700	CT SCAN	3,753	30,081	4,510	854	295	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	925	14,977	38,098	116	2,492	58.00
59.00	05900	CARDIAC CATHETERIZATION	1,043	48,655	13,957	177	913	59.00
60.00	06000	LABORATORY	5,401	185,873	113,978	0	7,455	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	854	49,574	2,885	0	189	63.00
65.00	06500	RESPIRATORY THERAPY	1,127	74,795	12,221	0	799	65.00
66.00	06600	PHYSICAL THERAPY	1,017	79,905	42,996	670	2,812	66.00
67.00	06700	OCCUPATIONAL THERAPY	233	20,102	11,579	0	757	67.00
68.00	06800	SPEECH PATHOLOGY	95	11,889	3,963	0	259	68.00
69.00	06900	ELECTROCARDIOLOGY	3,809	56,798	40,040	541	2,619	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	937	139,055	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	2,108	226,473	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	3,978	191	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	196	19,205	2,219	0	145	74.00
76.00	03020	ONCOLOGY & PAIN MANAGEMENT	694	55,781	14,084	0	921	76.00
76.01	03340	GASTRO INTESTINAL SERVICES	901	53,936	27,121	1,438	1,774	76.01
76.02	03550	OP PSYCH	59	10,179	30,767	0	2,012	76.02
76.98	07698	HYPERBARIC OXYGEN THERAPY	109	2,551	0	0	0	76.98
OUTPATIENT SERVICE COST CENTERS								
91.00	09100	EMERGENCY	8,451	178,343	131,771	6,162	8,619	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	1,985	143,799	7,735	1,285	506	95.00
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	57,777	3,827,369	1,547,220	35,745	99,281	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	4,281	8,211	0	537	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	5	0	0	0	192.00
192.01	19201	TWIN RIVERS MRI	0	0	0	0	0	192.01
192.02	19202	PHYSICIAN PRACTICES	0	401,455	0	0	0	192.02
193.00	19300	NONPAID WORKERS	0	5,424	12,649	0	827	193.00
193.01	19301	PHYSICIAN/PUBLIC RELATIONS	0	12,967	8,251	0	540	193.01
193.02	19302	MEDICAL OFFICE BUILDING	0	33,980	0	0	0	193.02
193.03	19303	HOME CARE PHARMACY	0	67,786	3,812	0	249	193.03
193.04	19304	MANAGEMENT SERVICES	0	0	0	0	0	193.04
193.05	19305	EUNICE SMITH NURSING HOME	0	0	0	0	0	193.05
193.06	19306	VACANT SPACE	0	16,524	341,173	0	22,315	193.06
193.07	19307	POB 2	0	54,816	0	0	0	193.07
193.08	19308	NON REIMBURSABLE MEALS	0	0	0	0	0	193.08
193.09	19309	COFFEE BAR	0	1,635	1,442	0	94	193.09
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	57,777	4,426,242	1,922,758	35,745	123,843	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0002

Period:
From 01/01/2020
To 12/31/2020Worksheet B
Part II
Date/Time Prepared:
5/28/2021 12:16 pm

Cost Center Description			DIETARY	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	
			10.00	11.00	13.00	14.00	15.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
4.03	00401	ADMITTING						4.03
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY	342,152					10.00
11.00	01100	CAFETERIA	152,018	202,810				11.00
13.00	01300	NURSING ADMINISTRATION	0	3,319	115,596			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	2,154	0	136,627		14.00
15.00	01500	PHARMACY	0	6,879	0	0	673,959	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	0	4,604	0	0	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	79,989	51,629	82,183	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	9,265	9,737	15,862	0	0	31.00
40.00	04000	SUBPROVIDER - IPF	2,891	2,415	3,931	0	0	40.00
43.00	04300	NURSERY	0	2,937	4,783	0	0	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	11,764	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0	1,821	0	0	0	51.00
53.00	05300	ANESTHESIOLOGY	0	463	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	11,323	0	0	0	54.00
56.00	05600	RADIOISOTOPE	0	682	0	0	0	56.00
57.00	05700	CT SCAN	0	1,279	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	930	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	2,160	0	0	0	59.00
60.00	06000	LABORATORY	0	8,820	0	0	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	1,612	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	0	5,153	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	4,967	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	1,514	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	715	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	5,159	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	59,871	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	76,756	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	673,959	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.00	03020	ONCOLOGY & PAIN MANAGEMENT	0	3,805	4,066	0	0	76.00
76.01	03340	GASTRO INTESTINAL SERVICES	0	3,025	4,771	0	0	76.01
76.02	03550	OP PSYCH	0	760	0	0	0	76.02
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
OUTPATIENT SERVICE COST CENTERS								
91.00	09100	EMERGENCY	0	13,826	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	0	16,225	0	0	0	95.00
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	244,163	179,677	115,596	136,627	673,959	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	170	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
192.01	19201	TWIN RIVERS MRI	0	0	0	0	0	192.01
192.02	19202	PHYSICIAN PRACTICES	0	17,409	0	0	0	192.02
193.00	19300	NONPAID WORKERS	0	470	0	0	0	193.00
193.01	19301	PHYSICIAN/PUBLIC RELATIONS	0	339	0	0	0	193.01
193.02	19302	MEDICAL OFFICE BUILDING	0	1,638	0	0	0	193.02
193.03	19303	HOME CARE PHARMACY	0	1,449	0	0	0	193.03
193.04	19304	MANAGEMENT SERVICES	0	0	0	0	0	193.04
193.05	19305	EUNICE SMITH NURSING HOME	82,007	0	0	0	0	193.05
193.06	19306	VACANT SPACE	0	0	0	0	0	193.06
193.07	19307	POB 2	0	1,658	0	0	0	193.07
193.08	19308	NON REIMBURSABLE MEALS	15,982	0	0	0	0	193.08
193.09	19309	COFFEE BAR	0	0	0	0	0	193.09
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	34,028	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	342,152	236,838	115,596	136,627	673,959	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0002

Period:
From 01/01/2020
To 12/31/2020Worksheet B
Part II
Date/Time Prepared:
5/28/2021 12:16 pm

Cost Center Description			MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			16.00	17.00	24.00	25.00	26.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
4.03	00401	ADMITTING						4.03
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY						15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	102,839					16.00
17.00	01700	SOCIAL SERVICE	0	91,335				17.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	10,805	75,011	2,345,327	0	2,345,327	30.00
31.00	03100	INTENSIVE CARE UNIT	2,757	8,688	313,041	0	313,041	31.00
40.00	04000	SUBPROVIDER - IPF	433	2,711	116,760	0	116,760	40.00
43.00	04300	NURSERY	670	4,925	52,235	0	52,235	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	8,313	0	1,400,087	0	1,400,087	50.00
51.00	05100	RECOVERY ROOM	1,649	0	118,832	0	118,832	51.00
53.00	05300	ANESTHESIOLOGY	1,982	0	34,296	0	34,296	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	8,516	0	941,597	0	941,597	54.00
56.00	05600	RADIOISOTOPE	676	0	59,419	0	59,419	56.00
57.00	05700	CT SCAN	6,683	0	215,176	0	215,176	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	1,648	0	108,501	0	108,501	58.00
59.00	05900	CARDIAC CATHETERIZATION	1,857	0	143,841	0	143,841	59.00
60.00	06000	LABORATORY	9,619	0	647,470	0	647,470	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	1,521	0	64,358	0	64,358	63.00
65.00	06500	RESPIRATORY THERAPY	2,008	0	198,986	0	198,986	65.00
66.00	06600	PHYSICAL THERAPY	1,811	0	195,347	0	195,347	66.00
67.00	06700	OCCUPATIONAL THERAPY	415	0	50,575	0	50,575	67.00
68.00	06800	SPEECH PATHOLOGY	170	0	22,093	0	22,093	68.00
69.00	06900	ELECTROCARDIOLOGY	6,784	0	236,808	0	236,808	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,669	0	201,532	0	201,532	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	3,754	0	309,091	0	309,091	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	7,085	0	685,213	0	685,213	73.00
74.00	07400	RENAL DIALYSIS	350	0	24,838	0	24,838	74.00
76.00	03020	ONCOLOGY & PAIN MANAGEMENT	1,235	0	145,340	0	145,340	76.00
76.01	03340	GASTRO INTESTINAL SERVICES	1,605	0	141,504	0	141,504	76.01
76.02	03550	OP PSYCH	105	0	86,556	0	86,556	76.02
76.98	07698	HYPERBARIC OXYGEN THERAPY	193	0	2,853	0	2,853	76.98
OUTPATIENT SERVICE COST CENTERS								
91.00	09100	EMERGENCY	14,990	0	560,513	0	560,513	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				0		92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	3,536	0	525,117	0	525,117	95.00
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	102,839	91,335	9,947,306	0	9,947,306	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	23,286	0	23,286	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	137	0	137	192.00
192.01	19201	TWIN RIVERS MRI	0	0	0	0	0	192.01
192.02	19202	PHYSICIAN PRACTICES	0	0	420,318	0	420,318	192.02
193.00	19300	NONPAID WORKERS	0	0	34,947	0	34,947	193.00
193.01	19301	PHYSICIAN/PUBLIC RELATIONS	0	0	32,308	0	32,308	193.01
193.02	19302	MEDICAL OFFICE BUILDING	0	0	35,745	0	35,745	193.02
193.03	19303	HOME CARE PHARMACY	0	0	79,092	0	79,092	193.03
193.04	19304	MANAGEMENT SERVICES	0	0	0	0	0	193.04
193.05	19305	EUNICE SMITH NURSING HOME	0	0	82,007	0	82,007	193.05
193.06	19306	VACANT SPACE	0	0	798,709	0	798,709	193.06
193.07	19307	POB 2	0	0	56,587	0	56,587	193.07
193.08	19308	NON REIMBURSABLE MEALS	0	0	15,982	0	15,982	193.08
193.09	19309	COFFEE BAR	0	0	4,941	0	4,941	193.09
200.00		Cross Foot Adjustments			0	0	0	200.00
201.00		Negative Cost Centers	0	0	34,028	0	34,028	201.00
202.00		TOTAL (sum lines 118 through 201)	102,839	91,335	11,565,393	0	11,565,393	202.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0002

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

Worksheet B-1

Date/Time Prepared:
5/28/2021 12:16 pm

Cost Center Description			CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	ADMITTING (GROSS REVENUE)	Reconciliation	
			NEW BLDG & FIXT (SQUARE FEET)	NEW MVBLE EQUIP (DOLLAR VALUE)				
			1.00	2.00				
GENERAL SERVICE COST CENTERS								
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT	451,642					1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP		5,651,727				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	2,460	1,526	47,758,013			4.00
4.03	00401	ADMITTING	5,429	1,500	0	549,749,038		4.03
5.00	00500	ADMINISTRATIVE & GENERAL	25,446	3,411,988	4,211,408	0	-35,045,541	5.00
7.00	00700	OPERATION OF PLANT	175,706	8,769	905,533	0	0	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	1,100	262	0	0	0	8.00
9.00	00900	HOUSEKEEPING	2,601	5,453	1,143,890	0	0	9.00
10.00	01000	DIETARY	10,795	9,320	0	0	0	10.00
11.00	01100	CAFETERIA	4,668	0	0	0	284,888	11.00
13.00	01300	NURSING ADMINISTRATION	495	47,412	973,594	0	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	4,456	28,950	256,395	0	0	14.00
15.00	01500	PHARMACY	2,770	4,251	2,020,883	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	5,311	131	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	524	1,195	1,082,929	0	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	54,873	178,122	10,796,541	57,779,497	0	30.00
31.00	03100	INTENSIVE CARE UNIT	5,488	20,001	2,532,346	14,742,564	0	31.00
40.00	04000	SUBPROVIDER - IPF	3,062	4,373	741,727	2,317,936	0	40.00
43.00	04300	NURSERY	0	0	707,837	3,582,253	0	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	20,705	403,260	2,590,143	44,453,161	0	50.00
51.00	05100	RECOVERY ROOM	3,381	21,072	510,443	8,820,769	0	51.00
53.00	05300	ANESTHESIOLOGY	244	11,087	76,736	10,599,980	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	10,919	551,746	2,182,799	45,540,680	0	54.00
56.00	05600	RADIOISOTOPE	1,001	21,995	174,728	3,613,903	0	56.00
57.00	05700	CT SCAN	569	161,134	274,427	35,739,970	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	4,807	549	223,913	8,810,802	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	1,761	56,835	543,295	9,933,024	0	59.00
60.00	06000	LABORATORY	14,381	158,340	1,230,381	51,439,416	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	364	3,944	342,410	8,132,050	0	63.00
65.00	06500	RESPIRATORY THERAPY	1,542	42,636	1,190,137	10,737,664	0	65.00
66.00	06600	PHYSICAL THERAPY	5,425	4,856	1,370,214	9,682,107	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	1,461	1,514	384,102	2,217,306	0	67.00
68.00	06800	SPEECH PATHOLOGY	500	0	219,675	908,102	0	68.00
69.00	06900	ELECTROCARDIOLOGY	5,052	68,172	988,016	36,275,800	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	8,922,679	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	20,075,517	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	37,886,633	0	73.00
74.00	07400	RENAL DIALYSIS	280	0	0	1,869,951	0	74.00
76.00	03020	ONCOLOGY & PAIN MANAGEMENT	1,777	40,981	795,345	6,605,790	0	76.00
76.01	03340	GASTRO INTESTINAL SERVICES	3,422	9,251	758,162	8,585,063	0	76.01
76.02	03550	OP PSYCH	3,882	1,476	154,557	562,819	0	76.02
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	1,034,040	0	76.98
OUTPATIENT SERVICE COST CENTERS								
91.00	09100	EMERGENCY	16,626	30,972	2,998,965	79,971,838	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	976	338,129	2,165,561	18,907,724	0	95.00
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	404,259	5,651,202	44,547,092	549,749,038	-34,760,653	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	1,036	0	16,544	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	131	0	0	0	192.00
192.01	19201	TWIN RIVERS MRI	0	0	0	0	0	192.01
192.02	19202	PHYSICIAN PRACTICES	0	0	2,297,179	0	0	192.02
193.00	19300	NONPAID WORKERS	1,596	0	83,447	0	0	193.00
193.01	19301	PHYSICIAN/PUBLIC RELATIONS	1,041	0	135,260	0	0	193.01
193.02	19302	MEDICAL OFFICE BUILDING	0	0	200,803	0	0	193.02
193.03	19303	HOME CARE PHARMACY	481	394	298,523	0	0	193.03
193.04	19304	MANAGEMENT SERVICES	0	0	0	0	0	193.04
193.05	19305	EUNICE SMITH NURSING HOME	0	0	0	0	0	193.05
193.06	19306	VACANT SPACE	43,047	0	0	0	0	193.06
193.07	19307	POB 2	0	0	179,165	0	0	193.07
193.08	19308	NON REIMBURSABLE MEALS	0	0	0	0	0	193.08
193.09	19309	COFFEE BAR	182	0	0	0	0	193.09
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0002

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

Worksheet B-1

Date/Time Prepared:
5/28/2021 12:16 pm

Cost Center Description			CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	ADMITTING (GROSS REVENUE)	Reconciliation	
			NEW BLDG & FIXT (SQUARE FEET)	NEW MVBLE EQUIP (DOLLAR VALUE)				
			1.00	2.00	4.00	4.03	5A	
202.00		Cost to be allocated (per Wkst. B, Part I)	4,392,898	5,682,562	1,111,615	70,286		202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	9.726505	1.005456	0.023276	0.000128		203.00
204.00		Cost to be allocated (per Wkst. B, Part II)			30,246	57,777		204.00
205.00		Unit cost multiplier (Wkst. B, Part II)			0.000633	0.000105		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: 14-0002

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

Worksheet B-1

Date/Time Prepared:
5/28/2021 12:16 pm

Cost Center Description		ADMINISTRATIVE & GENERAL (ACCU. COST)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	
		5.00	7.00	8.00	9.00	10.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
4.03	00401	ADMITTING					4.03
5.00	00500	ADMINISTRATIVE & GENERAL	112,154,591				5.00
7.00	00700	OPERATION OF PLANT	5,091,069	242,601			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	407,065	1,100	538,444		8.00
9.00	00900	HOUSEKEEPING	1,805,349	2,601	0	238,900	9.00
10.00	01000	DIETARY	3,251,572	10,795	0	10,795	297,772 10.00
11.00	01100	CAFETERIA	0	4,668	0	4,668	132,300 11.00
13.00	01300	NURSING ADMINISTRATION	1,393,485	495	0	495	0 13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	588,661	4,456	8,570	4,456	0 14.00
15.00	01500	PHARMACY	12,538,755	2,770	0	2,770	0 15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	68,762	5,311	0	5,311	0 16.00
17.00	01700	SOCIAL SERVICE	1,841,294	524	0	524	0 17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	15,651,697	54,873	229,337	54,873	69,614 30.00
31.00	03100	INTENSIVE CARE UNIT	3,539,348	5,488	28,097	5,488	8,063 31.00
40.00	04000	SUBPROVIDER - IPF	1,057,491	3,062	2,852	3,062	2,516 40.00
43.00	04300	NURSERY	965,280	0	0	0	0 43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	7,698,623	20,705	66,359	20,705	0 50.00
51.00	05100	RECOVERY ROOM	787,516	3,381	0	3,381	0 51.00
53.00	05300	ANESTHESIOLOGY	269,512	244	0	244	0 53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,058,822	10,919	33,879	10,919	0 54.00
56.00	05600	RADIOISOTOPE	437,527	1,001	0	1,001	0 56.00
57.00	05700	CT SCAN	762,202	569	12,867	569	0 57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	379,498	4,807	1,746	4,807	0 58.00
59.00	05900	CARDIAC CATHETERIZATION	1,232,827	1,761	2,668	1,761	0 59.00
60.00	06000	LABORATORY	4,709,712	14,381	0	14,381	0 60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	1,256,114	364	0	364	0 63.00
65.00	06500	RESPIRATORY THERAPY	1,895,186	1,542	0	1,542	0 65.00
66.00	06600	PHYSICAL THERAPY	2,024,645	5,425	10,090	5,425	0 66.00
67.00	06700	OCCUPATIONAL THERAPY	509,347	1,461	0	1,461	0 67.00
68.00	06800	SPEECH PATHOLOGY	301,252	500	0	500	0 68.00
69.00	06900	ELECTROCARDIOLOGY	1,439,173	5,052	8,145	5,052	0 69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	3,523,400	0	0	0	0 71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	5,738,432	0	0	0	0 72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	4,849	0	0	0	0 73.00
74.00	07400	RENAL DIALYSIS	486,615	280	0	280	0 74.00
76.00	03020	ONCOLOGY & PAIN MANAGEMENT	1,413,396	1,777	0	1,777	0 76.00
76.01	03340	GASTRO INTESTINAL SERVICES	1,366,635	3,422	21,656	3,422	0 76.01
76.02	03550	OP PSYCH	257,916	3,882	2	3,882	0 76.02
76.98	07698	HYPERBARIC OXYGEN THERAPY	64,650	0	0	0	0 76.98
OUTPATIENT SERVICE COST CENTERS							
91.00	09100	EMERGENCY	4,518,890	16,626	92,823	16,626	0 91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	3,643,614	976	19,353	976	0 95.00
SPECIAL PURPOSE COST CENTERS							
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	96,980,181	195,218	538,444	191,517	212,493 118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	108,475	1,036	0	1,036	0 190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	132	0	0	0	0 192.00
192.01	19201	TWIN RIVERS MRI	0	0	0	0	0 192.01
192.02	19202	PHYSICIAN PRACTICES	10,172,169	0	0	0	0 192.02
193.00	19300	NONPAID WORKERS	137,443	1,596	0	1,596	0 193.00
193.01	19301	PHYSICIAN/PUBLIC RELATIONS	328,566	1,041	0	1,041	0 193.01
193.02	19302	MEDICAL OFFICE BUILDING	860,985	0	0	0	0 193.02
193.03	19303	HOME CARE PHARMACY	1,717,585	481	0	481	0 193.03
193.04	19304	MANAGEMENT SERVICES	0	0	0	0	0 193.04
193.05	19305	EUNICE SMITH NURSING HOME	0	0	0	0	71,370 193.05
193.06	19306	VACANT SPACE	418,697	43,047	0	43,047	0 193.06
193.07	19307	POB 2	1,388,940	0	0	0	0 193.07
193.08	19308	NON REIMBURSABLE MEALS	0	0	0	0	13,909 193.08
193.09	19309	COFFEE BAR	41,418	182	0	182	0 193.09
200.00		Cross Foot Adjustments					200.00
201.00		Negative Cost Centers					201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	35,045,541	6,681,901	564,560	2,441,114	4,675,236 202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.312475	27.542760	1.048503	10.218141	15.700724 203.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0002

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

Worksheet B-1

Date/Time Prepared:
5/28/2021 12:16 pm

Cost Center Description			ADMINISTRATIVE & GENERAL (ACCUM. COST)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	
			5.00	7.00	8.00	9.00	10.00	
204.00		Cost to be allocated (per Wkst. B, Part II)	4,426,242	1,922,758	35,745	123,843	342,152	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.039466	7.925598	0.066386	0.518388	1.149040	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: 14-0002

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

Worksheet B-1

Date/Time Prepared:
5/28/2021 12:16 pm

Cost Center Description			CAFETERIA (FTE'S)	NURSING ADMINISTRATION (HOURS OF SERVICE)	CENTRAL SERVICES & SUPPLY (COSTED REQUISITIONS)	PHARMACY (COSTED REQUISITIONS)	MEDICAL RECORDS & LIBRARY (GROSS REVENUE)	
			11.00	13.00	14.00	15.00	16.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
4.03	00401	ADMITTING						4.03
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA	62,151					11.00
13.00	01300	NURSING ADMINISTRATION	1,017	452,381				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	660	0	10,210,166			14.00
15.00	01500	PHARMACY	2,108	0	0	100		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	549,749,038	16.00
17.00	01700	SOCIAL SERVICE	1,411	0	0	0	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	15,822	321,620	0	0	57,779,497	30.00
31.00	03100	INTENSIVE CARE UNIT	2,984	62,076	0	0	14,742,564	31.00
40.00	04000	SUBPROVIDER - IPF	740	15,384	0	0	2,317,936	40.00
43.00	04300	NURSERY	900	18,720	0	0	3,582,253	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	3,605	0	0	0	44,453,161	50.00
51.00	05100	RECOVERY ROOM	558	0	0	0	8,820,769	51.00
53.00	05300	ANESTHESIOLOGY	142	0	0	0	10,599,980	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,470	0	0	0	45,540,680	54.00
56.00	05600	RADIOISOTOPE	209	0	0	0	3,613,903	56.00
57.00	05700	CT SCAN	392	0	0	0	35,739,970	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	285	0	0	0	8,810,802	58.00
59.00	05900	CARDIAC CATHETERIZATION	662	0	0	0	9,933,024	59.00
60.00	06000	LABORATORY	2,703	0	0	0	51,439,416	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	494	0	0	0	8,132,050	63.00
65.00	06500	RESPIRATORY THERAPY	1,579	0	0	0	10,737,664	65.00
66.00	06600	PHYSICAL THERAPY	1,522	0	0	0	9,682,107	66.00
67.00	06700	OCCUPATIONAL THERAPY	464	0	0	0	2,217,306	67.00
68.00	06800	SPEECH PATHOLOGY	219	0	0	0	908,102	68.00
69.00	06900	ELECTROCARDIOLOGY	1,581	0	0	0	36,275,800	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	4,474,304	0	8,922,679	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	5,735,862	0	20,075,517	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	100	37,886,633	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	1,869,951	74.00
76.00	03020	ONCOLOGY & PAIN MANAGEMENT	1,166	15,911	0	0	6,605,790	76.00
76.01	03340	GASTRO INTESTINAL SERVICES	927	18,670	0	0	8,585,063	76.01
76.02	03550	OP PSYCH	233	0	0	0	562,819	76.02
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	1,034,040	76.98
OUTPATIENT SERVICE COST CENTERS								
91.00	09100	EMERGENCY	4,237	0	0	0	79,971,838	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	4,972	0	0	0	18,907,724	95.00
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	55,062	452,381	10,210,166	100	549,749,038	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	52	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
192.01	19201	TWIN RIVERS MRI	0	0	0	0	0	192.01
192.02	19202	PHYSICIAN PRACTICES	5,335	0	0	0	0	192.02
193.00	19300	NONPAID WORKERS	144	0	0	0	0	193.00
193.01	19301	PHYSICIAN/PUBLIC RELATIONS	104	0	0	0	0	193.01
193.02	19302	MEDICAL OFFICE BUILDING	502	0	0	0	0	193.02
193.03	19303	HOME CARE PHARMACY	444	0	0	0	0	193.03
193.04	19304	MANAGEMENT SERVICES	0	0	0	0	0	193.04
193.05	19305	EUNICE SMITH NURSING HOME	0	0	0	0	0	193.05
193.06	19306	VACANT SPACE	0	0	0	0	0	193.06
193.07	19307	POB 2	508	0	0	0	0	193.07
193.08	19308	NON REIMBURSABLE MEALS	0	0	0	0	0	193.08
193.09	19309	COFFEE BAR	0	0	0	0	0	193.09
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)	1,968,586	1,879,819	970,757	16,628,168	290,797	202.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0002

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

Worksheet B-1

Date/Time Prepared:
5/28/2021 12:16 pm

Cost Center Description		CAFETERIA (FTE'S)	NURSING ADMINISTRATION (HOURS OF SERVICE)	CENTRAL SERVICES & SUPPLY (COSTED REQUISITIONS)	PHARMACY (COSTED REQUISITIONS)	MEDICAL RECORDS & LIBRARY (GROSS REVENUE)	
		11.00	13.00	14.00	15.00	16.00	
203.00	Unit cost multiplier (Wkst. B, Part I)	31.674245	4.155389	0.095077	166,281.680000	0.000529	203.00
204.00	Cost to be allocated (per Wkst. B, Part II)	236,838	115,596	136,627	673,959	102,839	204.00
205.00	Unit cost multiplier (Wkst. B, Part II)	3.263182	0.255528	0.013381	6,739.590000	0.000187	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: 14-0002

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

Worksheet B-1

Date/Time Prepared:
5/28/2021 12:16 pm

Cost Center Description		SOCIAL SERVICE	
		(PATIENT DAYS)	
		17.00	
GENERAL SERVICE COST CENTERS			
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT	1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	4.00
4.03	00401	ADMITTING	4.03
5.00	00500	ADMINISTRATIVE & GENERAL	5.00
7.00	00700	OPERATION OF PLANT	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	8.00
9.00	00900	HOUSEKEEPING	9.00
10.00	01000	DIETARY	10.00
11.00	01100	CAFETERIA	11.00
13.00	01300	NURSING ADMINISTRATION	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	14.00
15.00	01500	PHARMACY	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	16.00
17.00	01700	SOCIAL SERVICE	17.00
		28,468	
INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS	30.00
31.00	03100	INTENSIVE CARE UNIT	31.00
40.00	04000	SUBPROVIDER - IPF	40.00
43.00	04300	NURSERY	43.00
		23,380	
		2,708	
		845	
		1,535	
ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	50.00
51.00	05100	RECOVERY ROOM	51.00
53.00	05300	ANESTHESIOLOGY	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	54.00
56.00	05600	RADIOISOTOPE	56.00
57.00	05700	CT SCAN	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	58.00
59.00	05900	CARDIAC CATHETERIZATION	59.00
60.00	06000	LABORATORY	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	63.00
65.00	06500	RESPIRATORY THERAPY	65.00
66.00	06600	PHYSICAL THERAPY	66.00
67.00	06700	OCCUPATIONAL THERAPY	67.00
68.00	06800	SPEECH PATHOLOGY	68.00
69.00	06900	ELECTROCARDIOLOGY	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	73.00
74.00	07400	RENAL DIALYSIS	74.00
76.00	03020	ONCOLOGY & PAIN MANAGEMENT	76.00
76.01	03340	GASTRO INTESTINAL SERVICES	76.01
76.02	03550	OP PSYCH	76.02
76.98	07698	HYPERBARIC OXYGEN THERAPY	76.98
OUTPATIENT SERVICE COST CENTERS			
91.00	09100	EMERGENCY	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	92.00
OTHER REIMBURSABLE COST CENTERS			
95.00	09500	AMBULANCE SERVICES	95.00
SPECIAL PURPOSE COST CENTERS			
118.00	SUBTOTALS (SUM OF LINES 1 through 117)		118.00
		28,468	
NONREIMBURSABLE COST CENTERS			
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	192.00
192.01	19201	TWIN RIVERS MRI	192.01
192.02	19202	PHYSICIAN PRACTICES	192.02
193.00	19300	NONPAID WORKERS	193.00
193.01	19301	PHYSICIAN/PUBLIC RELATIONS	193.01
193.02	19302	MEDICAL OFFICE BUILDING	193.02
193.03	19303	HOME CARE PHARMACY	193.03
193.04	19304	MANAGEMENT SERVICES	193.04
193.05	19305	EUNICE SMITH NURSING HOME	193.05
193.06	19306	VACANT SPACE	193.06
193.07	19307	POB 2	193.07
193.08	19308	NON REIMBURSABLE MEALS	193.08
193.09	19309	COFFEE BAR	193.09
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)		202.00
203.00	Unit cost multiplier (Wkst. B, Part I)		203.00
		2,481,130	
		87.155051	

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0002

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

Worksheet B-1

Date/Time Prepared:
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Cost Center Description			SOCIAL SERVICE	
			(PATIENT DAYS)	
			17.00	
204.00	Cost to be allocated (per Wkst. B, Part II)		91,335	204.00
205.00	Unit cost multiplier (Wkst. B, Part II)		3.208339	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: 14-0002

Period:
From 01/01/2020
To 12/31/2020Worksheet C
Part I
Date/Time Prepared:
5/28/2021 12:16 pm

			Title XVIII	Hospital	PPS	
Cost Center Description		Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs		
				Total Costs	RCE Disallowance	
		1.00	2.00	3.00	4.00	5.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	27,853,861	27,853,861	0	27,853,861 30.00
31.00	03100	INTENSIVE CARE UNIT	5,604,874	5,604,874	0	5,604,874 31.00
40.00	04000	SUBPROVIDER - IPF	1,708,286	1,708,286	0	1,708,286 40.00
43.00	04300	NURSERY	1,508,880	1,508,880	0	1,508,880 43.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	11,093,370	11,093,370	0	11,093,370 50.00
51.00	05100	RECOVERY ROOM	1,183,605	1,183,605	0	1,183,605 51.00
53.00	05300	ANESTHESIOLOGY	373,046	373,046	0	373,046 53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	5,908,936	5,908,936	0	5,908,936 54.00
56.00	05600	RADIOISOTOPE	620,573	620,573	0	620,573 56.00
57.00	05700	CT SCAN	1,066,670	1,066,670	0	1,066,670 57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	695,118	695,118	0	695,118 58.00
59.00	05900	CARDIAC CATHETERIZATION	1,713,572	1,713,572	0	1,713,572 59.00
60.00	06000	LABORATORY	6,837,244	6,837,244	0	6,837,244 60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	1,682,312	1,682,312	0	1,682,312 63.00
65.00	06500	RESPIRATORY THERAPY	2,601,305	2,601,305	0	2,601,305 65.00
66.00	06600	PHYSICAL THERAPY	2,926,057	2,926,057	0	2,926,057 66.00
67.00	06700	OCCUPATIONAL THERAPY	739,544	739,544	0	739,544 67.00
68.00	06800	SPEECH PATHOLOGY	421,683	421,683	0	421,683 68.00
69.00	06900	ELECTROCARDIOLOGY	2,157,454	2,157,454	0	2,157,454 69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	5,054,497	5,054,497	0	5,054,497 71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	8,087,523	8,087,523	0	8,087,523 72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	16,654,574	16,654,574	0	16,654,574 73.00
74.00	07400	RENAL DIALYSIS	650,232	650,232	0	650,232 74.00
76.00	03020	ONCOLOGY & PAIN MANAGEMENT	2,028,690	2,028,690	0	2,028,690 76.00
76.01	03340	GASTRO INTESTINAL SERVICES	2,057,081	2,057,081	0	2,057,081 76.01
76.02	03550	OP PSYCH	492,776	492,776	0	492,776 76.02
76.98	07698	HYPERBARIC OXYGEN THERAPY	85,399	85,399	0	85,399 76.98
OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	6,832,559	6,832,559	0	6,832,559 91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	950,478	950,478	0	950,478 92.00
OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	5,006,785	5,006,785	0	5,006,785 95.00
200.00		Subtotal (see instructions)	124,596,984	124,596,984	0	124,596,984 200.00
201.00		Less Observation Beds	950,478	950,478	0	950,478 201.00
202.00		Total (see instructions)	123,646,506	123,646,506	0	123,646,506 202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0002

Period:
From 01/01/2020
To 12/31/2020Worksheet C
Part I
Date/Time Prepared:
5/28/2021 12:16 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	56,291,722		56,291,722		30.00
31.00	03100	INTENSIVE CARE UNIT	14,742,564		14,742,564		31.00
40.00	04000	SUBPROVIDER - IPF	2,317,936		2,317,936		40.00
43.00	04300	NURSERY	3,582,253		3,582,253		43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	10,205,845	34,247,316	44,453,161	0.249552	50.00
51.00	05100	RECOVERY ROOM	1,572,138	7,248,631	8,820,769	0.134184	51.00
53.00	05300	ANESTHESIOLOGY	2,978,930	7,621,050	10,599,980	0.035193	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	5,724,378	39,816,302	45,540,680	0.129751	54.00
56.00	05600	RADIOISOTOPE	711,361	2,902,542	3,613,903	0.171718	56.00
57.00	05700	CT SCAN	10,259,134	25,480,836	35,739,970	0.029845	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	1,257,605	7,553,197	8,810,802	0.078894	58.00
59.00	05900	CARDIAC CATHETERIZATION	3,351,241	5,617,913	8,969,154	0.191052	59.00
60.00	06000	LABORATORY	22,903,836	28,535,580	51,439,416	0.132918	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	3,802,847	4,329,203	8,132,050	0.206874	63.00
65.00	06500	RESPIRATORY THERAPY	9,671,139	1,066,525	10,737,664	0.242260	65.00
66.00	06600	PHYSICAL THERAPY	1,606,182	8,075,925	9,682,107	0.302213	66.00
67.00	06700	OCCUPATIONAL THERAPY	707,279	1,510,027	2,217,306	0.333533	67.00
68.00	06800	SPEECH PATHOLOGY	214,891	693,211	908,102	0.464356	68.00
69.00	06900	ELECTROCARDIOLOGY	11,092,026	25,183,774	36,275,800	0.059474	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	3,413,132	6,473,417	9,886,549	0.511250	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	6,361,776	13,713,741	20,075,517	0.402855	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	10,421,150	27,465,483	37,886,633	0.439590	73.00
74.00	07400	RENAL DIALYSIS	1,826,348	43,603	1,869,951	0.347727	74.00
76.00	03020	ONCOLOGY & PAIN MANAGEMENT	17,432	6,588,358	6,605,790	0.307108	76.00
76.01	03340	GASTRO INTESTINAL SERVICES	1,860,355	6,724,708	8,585,063	0.239612	76.01
76.02	03550	OP PSYCH	337	562,482	562,819	0.875550	76.02
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	1,034,040	1,034,040	0.082588	76.98
OUTPATIENT SERVICE COST CENTERS							
91.00	09100	EMERGENCY	17,265,207	62,706,631	79,971,838	0.085437	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	14,775	1,473,000	1,487,775	0.638859	92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	23,573	18,884,151	18,907,724	0.264801	95.00
200.00		Subtotal (see instructions)	204,197,392	345,551,646	549,749,038		200.00
201.00		Less Observation Beds					201.00
202.00		Total (see instructions)	204,197,392	345,551,646	549,749,038		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES			Provider CCN: 14-0002	Period: From 01/01/2020 To 12/31/2020	Worksheet C Part I Date/Time Prepared: 5/28/2021 12:16 pm
			Title XVIII	Hospital	PPS
Cost Center Description			PPS Inpatient Ratio		
			11.00		
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS			30.00
31.00	03100	INTENSIVE CARE UNIT			31.00
40.00	04000	SUBPROVIDER - IPF			40.00
43.00	04300	NURSERY			43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0.249552		50.00
51.00	05100	RECOVERY ROOM	0.134184		51.00
53.00	05300	ANESTHESIOLOGY	0.035193		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.129751		54.00
56.00	05600	RADIOISOTOPE	0.171718		56.00
57.00	05700	CT SCAN	0.029845		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.078894		58.00
59.00	05900	CARDIAC CATHETERIZATION	0.191052		59.00
60.00	06000	LABORATORY	0.132918		60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.206874		63.00
65.00	06500	RESPIRATORY THERAPY	0.242260		65.00
66.00	06600	PHYSICAL THERAPY	0.302213		66.00
67.00	06700	OCCUPATIONAL THERAPY	0.333533		67.00
68.00	06800	SPEECH PATHOLOGY	0.464356		68.00
69.00	06900	ELECTROCARDIOLOGY	0.059474		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.511250		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.402855		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.439590		73.00
74.00	07400	RENAL DIALYSIS	0.347727		74.00
76.00	03020	ONCOLOGY & PAIN MANAGEMENT	0.307108		76.00
76.01	03340	GASTRO INTESTINAL SERVICES	0.239612		76.01
76.02	03550	OP PSYCH	0.875550		76.02
76.98	07698	HYPERBARIC OXYGEN THERAPY	0.082588		76.98
OUTPATIENT SERVICE COST CENTERS					
91.00	09100	EMERGENCY	0.085437		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.638859		92.00
OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES	0.264801		95.00
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: 14-0002

Period:
From 01/01/2020
To 12/31/2020Worksheet C
Part I
Date/Time Prepared:
5/28/2021 12:16 pm

			Title XIX	Hospital	PPS	
Cost Center Description		Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs		
				Total Costs	RCE Disallowance	
		1.00	2.00	3.00	4.00	5.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	27,853,861	27,853,861	0	27,853,861 30.00
31.00	03100	INTENSIVE CARE UNIT	5,604,874	5,604,874	0	5,604,874 31.00
40.00	04000	SUBPROVIDER - IPF	1,708,286	1,708,286	0	1,708,286 40.00
43.00	04300	NURSERY	1,508,880	1,508,880	0	1,508,880 43.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	11,093,370	11,093,370	0	11,093,370 50.00
51.00	05100	RECOVERY ROOM	1,183,605	1,183,605	0	1,183,605 51.00
53.00	05300	ANESTHESIOLOGY	373,046	373,046	0	373,046 53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	5,908,936	5,908,936	0	5,908,936 54.00
56.00	05600	RADIOISOTOPE	620,573	620,573	0	620,573 56.00
57.00	05700	CT SCAN	1,066,670	1,066,670	0	1,066,670 57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	695,118	695,118	0	695,118 58.00
59.00	05900	CARDIAC CATHETERIZATION	1,713,572	1,713,572	0	1,713,572 59.00
60.00	06000	LABORATORY	6,837,244	6,837,244	0	6,837,244 60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	1,682,312	1,682,312	0	1,682,312 63.00
65.00	06500	RESPIRATORY THERAPY	2,601,305	2,601,305	0	2,601,305 65.00
66.00	06600	PHYSICAL THERAPY	2,926,057	2,926,057	0	2,926,057 66.00
67.00	06700	OCCUPATIONAL THERAPY	739,544	739,544	0	739,544 67.00
68.00	06800	SPEECH PATHOLOGY	421,683	421,683	0	421,683 68.00
69.00	06900	ELECTROCARDIOLOGY	2,157,454	2,157,454	0	2,157,454 69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	5,054,497	5,054,497	0	5,054,497 71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	8,087,523	8,087,523	0	8,087,523 72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	16,654,574	16,654,574	0	16,654,574 73.00
74.00	07400	RENAL DIALYSIS	650,232	650,232	0	650,232 74.00
76.00	03020	ONCOLOGY & PAIN MANAGEMENT	2,028,690	2,028,690	0	2,028,690 76.00
76.01	03340	GASTRO INTESTINAL SERVICES	2,057,081	2,057,081	0	2,057,081 76.01
76.02	03550	OP PSYCH	492,776	492,776	0	492,776 76.02
76.98	07698	HYPERBARIC OXYGEN THERAPY	85,399	85,399	0	85,399 76.98
OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	6,832,559	6,832,559	0	6,832,559 91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	950,478	950,478	0	950,478 92.00
OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	5,006,785	5,006,785	0	5,006,785 95.00
200.00		Subtotal (see instructions)	124,596,984	124,596,984	0	124,596,984 200.00
201.00		Less Observation Beds	950,478	950,478	0	950,478 201.00
202.00		Total (see instructions)	123,646,506	123,646,506	0	123,646,506 202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0002

Period:
From 01/01/2020
To 12/31/2020Worksheet C
Part I
Date/Time Prepared:
5/28/2021 12:16 pm

			Title XIX		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	56,291,722		56,291,722		30.00
31.00	03100	INTENSIVE CARE UNIT	14,742,564		14,742,564		31.00
40.00	04000	SUBPROVIDER - IPF	2,317,936		2,317,936		40.00
43.00	04300	NURSERY	3,582,253		3,582,253		43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	10,205,845	34,247,316	44,453,161	0.249552	50.00
51.00	05100	RECOVERY ROOM	1,572,138	7,248,631	8,820,769	0.134184	51.00
53.00	05300	ANESTHESIOLOGY	2,978,930	7,621,050	10,599,980	0.035193	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	5,724,378	39,816,302	45,540,680	0.129751	54.00
56.00	05600	RADIOISOTOPE	711,361	2,902,542	3,613,903	0.171718	56.00
57.00	05700	CT SCAN	10,259,134	25,480,836	35,739,970	0.029845	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	1,257,605	7,553,197	8,810,802	0.078894	58.00
59.00	05900	CARDIAC CATHETERIZATION	3,351,241	5,617,913	8,969,154	0.191052	59.00
60.00	06000	LABORATORY	22,903,836	28,535,580	51,439,416	0.132918	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	3,802,847	4,329,203	8,132,050	0.206874	63.00
65.00	06500	RESPIRATORY THERAPY	9,671,139	1,066,525	10,737,664	0.242260	65.00
66.00	06600	PHYSICAL THERAPY	1,606,182	8,075,925	9,682,107	0.302213	66.00
67.00	06700	OCCUPATIONAL THERAPY	707,279	1,510,027	2,217,306	0.333533	67.00
68.00	06800	SPEECH PATHOLOGY	214,891	693,211	908,102	0.464356	68.00
69.00	06900	ELECTROCARDIOLOGY	11,092,026	25,183,774	36,275,800	0.059474	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	3,413,132	6,473,417	9,886,549	0.511250	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	6,361,776	13,713,741	20,075,517	0.402855	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	10,421,150	27,465,483	37,886,633	0.439590	73.00
74.00	07400	RENAL DIALYSIS	1,826,348	43,603	1,869,951	0.347727	74.00
76.00	03020	ONCOLOGY & PAIN MANAGEMENT	17,432	6,588,358	6,605,790	0.307108	76.00
76.01	03340	GASTRO INTESTINAL SERVICES	1,860,355	6,724,708	8,585,063	0.239612	76.01
76.02	03550	OP PSYCH	337	562,482	562,819	0.875550	76.02
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	1,034,040	1,034,040	0.082588	76.98
OUTPATIENT SERVICE COST CENTERS							
91.00	09100	EMERGENCY	17,265,207	62,706,631	79,971,838	0.085437	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	14,775	1,473,000	1,487,775	0.638859	92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	23,573	18,884,151	18,907,724	0.264801	95.00
200.00		Subtotal (see instructions)	204,197,392	345,551,646	549,749,038		200.00
201.00		Less Observation Beds					201.00
202.00		Total (see instructions)	204,197,392	345,551,646	549,749,038		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0002

Period:
From 01/01/2020
To 12/31/2020Worksheet C
Part I
Date/Time Prepared:
5/28/2021 12:16 pm

Cost Center Description			PPS Inpatient Ratio	Title XIX	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 - IPF				40.00
43.00	04300	NURSERY				43.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.249552			50.00
51.00	05100	RECOVERY ROOM	0.134184			51.00
53.00	05300	ANESTHESIOLOGY	0.035193			53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.129751			54.00
56.00	05600	RADIOISOTOPE	0.171718			56.00
57.00	05700	CT SCAN	0.029845			57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.078894			58.00
59.00	05900	CARDIAC CATHETERIZATION	0.191052			59.00
60.00	06000	LABORATORY	0.132918			60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.206874			63.00
65.00	06500	RESPIRATORY THERAPY	0.242260			65.00
66.00	06600	PHYSICAL THERAPY	0.302213			66.00
67.00	06700	OCCUPATIONAL THERAPY	0.333533			67.00
68.00	06800	SPEECH PATHOLOGY	0.464356			68.00
69.00	06900	ELECTROCARDIOLOGY	0.059474			69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.511250			71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.402855			72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.439590			73.00
74.00	07400	RENAL DIALYSIS	0.347727			74.00
76.00	03020	ONCOLOGY & PAIN MANAGEMENT	0.307108			76.00
76.01	03340	GASTRO INTESTINAL SERVICES	0.239612			76.01
76.02	03550	OP PSYCH	0.875550			76.02
76.98	07698	HYPERBARIC OXYGEN THERAPY	0.082588			76.98
OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0.085437			91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.638859			92.00
OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0.264801			95.00
200.00		Subtotal (see instructions)				200.00
201.00		Less Observation Beds				201.00
202.00		Total (see instructions)				202.00

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

Provider CCN: 14-0002

Period:
From 01/01/2020
To 12/31/2020Worksheet C
Part II
Date/Time Prepared:
5/28/2021 12:16 pm

Cost Center Description			Title XIX		Hospital	PPS	
			Total Cost (Wkst. B, Part I, col. 26)	Capital Cost (Wkst. B, Part II col. 26)	Operating Cost Net of Capital Cost (col. 1 - col. 2)	Capital Reduction	Operating Cost Reduction Amount
			1.00	2.00	3.00	4.00	5.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	11,093,370	1,400,087	9,693,283	0	0
51.00	05100	RECOVERY ROOM	1,183,605	118,832	1,064,773	0	0
53.00	05300	ANESTHESIOLOGY	373,046	34,296	338,750	0	0
54.00	05400	RADIOLOGY-DIAGNOSTIC	5,908,936	941,597	4,967,339	0	0
56.00	05600	RADIOISOTOPE	620,573	59,419	561,154	0	0
57.00	05700	CT SCAN	1,066,670	215,176	851,494	0	0
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	695,118	108,501	586,617	0	0
59.00	05900	CARDIAC CATHETERIZATION	1,713,572	143,841	1,569,731	0	0
60.00	06000	LABORATORY	6,837,244	647,470	6,189,774	0	0
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	1,682,312	64,358	1,617,954	0	0
65.00	06500	RESPIRATORY THERAPY	2,601,305	198,986	2,402,319	0	0
66.00	06600	PHYSICAL THERAPY	2,926,057	195,347	2,730,710	0	0
67.00	06700	OCCUPATIONAL THERAPY	739,544	50,575	688,969	0	0
68.00	06800	SPEECH PATHOLOGY	421,683	22,093	399,590	0	0
69.00	06900	ELECTROCARDIOLOGY	2,157,454	236,808	1,920,646	0	0
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	5,054,497	201,532	4,852,965	0	0
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	8,087,523	309,091	7,778,432	0	0
73.00	07300	DRUGS CHARGED TO PATIENTS	16,654,574	685,213	15,969,361	0	0
74.00	07400	RENAL DIALYSIS	650,232	24,838	625,394	0	0
76.00	03020	ONCOLOGY & PAIN MANAGEMENT	2,028,690	145,340	1,883,350	0	0
76.01	03340	GASTRO INTESTINAL SERVICES	2,057,081	141,504	1,915,577	0	0
76.02	03550	OP PSYCH	492,776	86,556	406,220	0	0
76.98	07698	HYPERBARIC OXYGEN THERAPY	85,399	2,853	82,546	0	0
OUTPATIENT SERVICE COST CENTERS							
91.00	09100	EMERGENCY	6,832,559	560,513	6,272,046	0	0
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	950,478	80,031	870,447	0	0
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	5,006,785	525,117	4,481,668	0	0
200.00		Subtotal (sum of lines 50 thru 199)	87,921,083	7,199,974	80,721,109	0	0
201.00		Less Observation Beds	950,478	80,031	870,447	0	0
202.00		Total (line 200 minus line 201)	86,970,605	7,119,943	79,850,662	0	0

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

Provider CCN: 14-0002

Period:
From 01/01/2020
To 12/31/2020Worksheet C
Part II
Date/Time Prepared:
5/28/2021 12:16 pm

Cost Center Description			Title XIX		Hospital	PPS
			Cost Net of Capital and Operating Cost Reduction	Total Charges (Worksheet C, Part I, column 8)	Outpatient Cost to Charge Ratio (col. 6 / col. 7)	
			6.00	7.00	8.00	
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	11,093,370	44,453,161	0.249552	50.00
51.00	05100	RECOVERY ROOM	1,183,605	8,820,769	0.134184	51.00
53.00	05300	ANESTHESIOLOGY	373,046	10,599,980	0.035193	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	5,908,936	45,540,680	0.129751	54.00
56.00	05600	RADIOISOTOPE	620,573	3,613,903	0.171718	56.00
57.00	05700	CT SCAN	1,066,670	35,739,970	0.029845	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	695,118	8,810,802	0.078894	58.00
59.00	05900	CARDIAC CATHETERIZATION	1,713,572	8,969,154	0.191052	59.00
60.00	06000	LABORATORY	6,837,244	51,439,416	0.132918	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	1,682,312	8,132,050	0.206874	63.00
65.00	06500	RESPIRATORY THERAPY	2,601,305	10,737,664	0.242260	65.00
66.00	06600	PHYSICAL THERAPY	2,926,057	9,682,107	0.302213	66.00
67.00	06700	OCCUPATIONAL THERAPY	739,544	2,217,306	0.333533	67.00
68.00	06800	SPEECH PATHOLOGY	421,683	908,102	0.464356	68.00
69.00	06900	ELECTROCARDIOLOGY	2,157,454	36,275,800	0.059474	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	5,054,497	9,886,549	0.511250	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	8,087,523	20,075,517	0.402855	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	16,654,574	37,886,633	0.439590	73.00
74.00	07400	RENAL DIALYSIS	650,232	1,869,951	0.347727	74.00
76.00	03020	ONCOLOGY & PAIN MANAGEMENT	2,028,690	6,605,790	0.307108	76.00
76.01	03340	GASTRO INTESTINAL SERVICES	2,057,081	8,585,063	0.239612	76.01
76.02	03550	OP PSYCH	492,776	562,819	0.875550	76.02
76.98	07698	HYPERBARIC OXYGEN THERAPY	85,399	1,034,040	0.082588	76.98
OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	6,832,559	79,971,838	0.085437	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	950,478	1,487,775	0.638859	92.00
OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	5,006,785	18,907,724	0.264801	95.00
200.00		Subtotal (sum of lines 50 thru 199)	87,921,083	472,814,563		200.00
201.00		Less Observation Beds	950,478	0		201.00
202.00		Total (line 200 minus line 201)	86,970,605	472,814,563		202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

Provider CCN: 14-0002

Period:
From 01/01/2020
To 12/31/2020Worksheet D
Part I
Date/Time Prepared:
5/28/2021 12:16 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	2,345,327	0	2,345,327	24,206	96.89	30.00
31.00	INTENSIVE CARE UNIT	313,041		313,041	2,708	115.60	31.00
40.00	SUBPROVIDER - IPF	116,760	0	116,760	845	138.18	40.00
43.00	NURSERY	52,235		52,235	1,535	34.03	43.00
200.00	Total (lines 30 through 199)	2,827,363		2,827,363	29,294		200.00
Cost Center Description		Inpatient Program days	Inpatient Program Capital Cost (col. 5 x col. 6)				
		6.00	7.00				
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	ADULTS & PEDIATRICS	9,258	897,008				
31.00	INTENSIVE CARE UNIT	1,057	122,189				
40.00	SUBPROVIDER - IPF	462	63,839				
43.00	NURSERY	0	0				
200.00	Total (lines 30 through 199)	10,777	1,083,036				

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS				Provider CCN: 14-0002	Period: From 01/01/2020 To 12/31/2020	Worksheet D Part II Date/Time Prepared: 5/28/2021 12:16 pm		
				Title XVIII		Hospital		PPS
Cost Center Description			Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
	ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	1,400,087	44,453,161	0.031496	4,563,358	143,728	50.00
51.00	05100	RECOVERY ROOM	118,832	8,820,769	0.013472	707,385	9,530	51.00
53.00	05300	ANESTHESIOLOGY	34,296	10,599,980	0.003235	1,248,866	4,040	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	941,597	45,540,680	0.020676	1,725,766	35,682	54.00
56.00	05600	RADIOISOTOPE	59,419	3,613,903	0.016442	289,994	4,768	56.00
57.00	05700	CT SCAN	215,176	35,739,970	0.006021	4,103,080	24,705	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	108,501	8,810,802	0.012315	503,123	6,196	58.00
59.00	05900	CARDIAC CATHETERIZATION	143,841	8,969,154	0.016037	662,038	10,617	59.00
60.00	06000	LABORATORY	647,470	51,439,416	0.012587	9,930,603	124,996	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	64,358	8,132,050	0.007914	508,317	4,023	63.00
65.00	06500	RESPIRATORY THERAPY	198,986	10,737,664	0.018532	4,071,475	75,453	65.00
66.00	06600	PHYSICAL THERAPY	195,347	9,682,107	0.020176	783,913	15,816	66.00
67.00	06700	OCCUPATIONAL THERAPY	50,575	2,217,306	0.022809	354,103	8,077	67.00
68.00	06800	SPEECH PATHOLOGY	22,093	908,102	0.024329	107,065	2,605	68.00
69.00	06900	ELECTROCARDIOLOGY	236,808	36,275,800	0.006528	5,387,036	35,167	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	201,532	9,886,549	0.020384	1,523,258	31,050	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	309,091	20,075,517	0.015396	2,720,501	41,885	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	685,213	37,886,633	0.018086	5,993,824	108,404	73.00
74.00	07400	RENAL DIALYSIS	24,838	1,869,951	0.013283	1,114,880	14,809	74.00
76.00	03020	ONCOLOGY & PAIN MANAGEMENT	145,340	6,605,790	0.022002	7,054	155	76.00
76.01	03340	GASTRO INTESTINAL SERVICES	141,504	8,585,063	0.016483	588,861	9,706	76.01
76.02	03550	OP PSYCH	86,556	562,819	0.153790	337	52	76.02
76.98	07698	HYPERBARIC OXYGEN THERAPY	2,853	1,034,040	0.002759	0	0	76.98
	OUTPATIENT SERVICE COST CENTERS							
91.00	09100	EMERGENCY	560,513	79,971,838	0.007009	6,569,872	46,048	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	80,031	1,487,775	0.053792	8,325	448	92.00
	OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)	6,674,857	453,906,839		53,473,034	757,960	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS					Provider CCN: 14-0002		Period: From 01/01/2020 To 12/31/2020		Worksheet D Part III Date/Time Prepared: 5/28/2021 12:16 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	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	0	0	31.00
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	0	0	0	40.00
43.00	04300	NURSERY	0	0	0	0	0	0	0	43.00
200.00		Total (lines 30 through 199)	0	0	0	0	0	0	0	200.00
Cost Center Description					Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days	
					4.00	5.00	6.00	7.00	8.00	
INPATIENT ROUTINE SERVICE COST CENTERS										
30.00	03000	ADULTS & PEDIATRICS	0	0	24,206	0.00	9,258	30.00		
31.00	03100	INTENSIVE CARE UNIT	0	0	2,708	0.00	1,057	31.00		
40.00	04000	SUBPROVIDER - IPF	0	0	845	0.00	462	40.00		
43.00	04300	NURSERY	0	0	1,535	0.00	0	43.00		
200.00		Total (lines 30 through 199)	0	0	29,294		10,777	200.00		
Cost Center Description					Inpatient Program Pass-Through Cost (col. 7 x col. 8)	PSA Adj. All Other Medical Education Cost				
					9.00	13.00				
INPATIENT ROUTINE SERVICE COST CENTERS										
30.00	03000	ADULTS & PEDIATRICS	0	0						30.00
31.00	03100	INTENSIVE CARE UNIT	0	0						31.00
40.00	04000	SUBPROVIDER - IPF	0	0						40.00
43.00	04300	NURSERY	0	0						43.00
200.00		Total (lines 30 through 199)	0	0						200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS			Provider CCN: 14-0002		Period: From 01/01/2020 To 12/31/2020		Worksheet D Part IV Date/Time Prepared: 5/28/2021 12:16 pm	
			Title XVIII		Hospital		PPS	
Cost Center Description			Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health	
			1.00	2A	2.00	3A	3.00	
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.00	03020	ONCOLOGY & PAIN MANAGEMENT	0	0	0	0	0	76.00
76.01	03340	GASTRO INTESTINAL SERVICES	0	0	0	0	0	76.01
76.02	03550	OP PSYCH	0	0	0	0	0	76.02
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
OUTPATIENT SERVICE COST CENTERS								
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0		0		0	92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES						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: 14-0002

Period:
From 01/01/2020
To 12/31/2020Worksheet D
Part IV
Date/Time Prepared:
5/28/2021 12:16 pm

				Title XVIII		Hospital	PPS	
Cost Center Description			All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7) (see instructions)	
			4.00	5.00	6.00	7.00	8.00	
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	0	44,453,161	0.000000	50.00
51.00	05100	RECOVERY ROOM	0	0	0	8,820,769	0.000000	51.00
53.00	05300	ANESTHESIOLOGY	0	0	0	10,599,980	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	45,540,680	0.000000	54.00
56.00	05600	RADIOISOTOPE	0	0	0	3,613,903	0.000000	56.00
57.00	05700	CT SCAN	0	0	0	35,739,970	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	8,810,802	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	8,969,154	0.000000	59.00
60.00	06000	LABORATORY	0	0	0	51,439,416	0.000000	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	8,132,050	0.000000	63.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	10,737,664	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	9,682,107	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	2,217,306	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	908,102	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	36,275,800	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	9,886,549	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	20,075,517	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	37,886,633	0.000000	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	1,869,951	0.000000	74.00
76.00	03020	ONCOLOGY & PAIN MANAGEMENT	0	0	0	6,605,790	0.000000	76.00
76.01	03340	GASTRO INTESTINAL SERVICES	0	0	0	8,585,063	0.000000	76.01
76.02	03550	OP PSYCH	0	0	0	562,819	0.000000	76.02
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	1,034,040	0.000000	76.98
OUTPATIENT SERVICE COST CENTERS								
91.00	09100	EMERGENCY	0	0	0	79,971,838	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	1,487,775	0.000000	92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)	0	0	0	453,906,839		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-0002

Period:
From 01/01/2020
To 12/31/2020Worksheet D
Part IV
Date/Time Prepared:
5/28/2021 12:16 pm

Cost Center Description		Title XVIII			Hospital		PPS	
		Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)		
		9.00	10.00	11.00	12.00	13.00		
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0.000000	4,563,358	0	10,926,850	0	50.00
51.00	05100	RECOVERY ROOM	0.000000	707,385	0	1,926,430	0	51.00
53.00	05300	ANESTHESIOLOGY	0.000000	1,248,866	0	1,813,367	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	1,725,766	0	9,961,399	0	54.00
56.00	05600	RADIOISOTOPE	0.000000	289,994	0	1,108,040	0	56.00
57.00	05700	CT SCAN	0.000000	4,103,080	0	6,994,386	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000	503,123	0	2,149,481	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	662,038	0	1,165,057	0	59.00
60.00	06000	LABORATORY	0.000000	9,930,603	0	3,963,251	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.000000	508,317	0	187,785	0	63.00
65.00	06500	RESPIRATORY THERAPY	0.000000	4,071,475	0	263,809	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	783,913	0	712	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	354,103	0	107	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	107,065	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	5,387,036	0	10,217,873	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	1,523,258	0	1,831,119	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.000000	2,720,501	0	4,695,993	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	5,993,824	0	16,343,031	0	73.00
74.00	07400	RENAL DIALYSIS	0.000000	1,114,880	0	0	0	74.00
76.00	03020	ONCOLOGY & PAIN MANAGEMENT	0.000000	7,054	0	2,534,630	0	76.00
76.01	03340	GASTRO INTESTINAL SERVICES	0.000000	588,861	0	1,584,551	0	76.01
76.02	03550	OP PSYCH	0.000000	337	0	451,647	0	76.02
76.98	07698	HYPERBARIC OXYGEN THERAPY	0.000000	0	0	480,480	0	76.98
OUTPATIENT SERVICE COST CENTERS								
91.00	09100	EMERGENCY	0.000000	6,569,872	0	9,354,511	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	8,325	0	407,128	0	92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)		53,473,034	0	88,361,637	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS				Provider CCN: 14-0002		Period: From 01/01/2020 To 12/31/2020		Worksheet D Part IV Date/Time Prepared: 5/28/2021 12:16 pm	
				Title XVIII		Hospital		PPS	
Cost Center Description				PSA Adj. Non Physician Anesthetist Cost	PSA Adj. All Other Medical Education Cost				
				21.00	24.00				
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM	0	0					
51.00	05100	RECOVERY ROOM	0	0					
53.00	05300	ANESTHESIOLOGY	0	0					
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0					
56.00	05600	RADIOISOTOPE	0	0					
57.00	05700	CT SCAN	0	0					
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0					
59.00	05900	CARDIAC CATHETERIZATION	0	0					
60.00	06000	LABORATORY	0	0					
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0					
65.00	06500	RESPIRATORY THERAPY	0	0					
66.00	06600	PHYSICAL THERAPY	0	0					
67.00	06700	OCCUPATIONAL THERAPY	0	0					
68.00	06800	SPEECH PATHOLOGY	0	0					
69.00	06900	ELECTROCARDIOLOGY	0	0					
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0					
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0					
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0					
74.00	07400	RENAL DIALYSIS	0	0					
76.00	03020	ONCOLOGY & PAIN MANAGEMENT	0	0					
76.01	03340	GASTRO INTESTINAL SERVICES	0	0					
76.02	03550	OP PSYCH	0	0					
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0					
OUTPATIENT SERVICE COST CENTERS									
91.00	09100	EMERGENCY	0	0					
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0					
OTHER REIMBURSABLE COST CENTERS									
95.00	09500	AMBULANCE SERVICES							
200.00		Total (lines 50 through 199)	0	0					

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST				Provider CCN: 14-0002		Period: From 01/01/2020 To 12/31/2020		Worksheet D Part V Date/Time Prepared: 5/28/2021 12:16 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		0.249552	10,926,850	0	0	2,726,817	50.00
51.00	05100	RECOVERY ROOM		0.134184	1,926,430	0	0	258,496	51.00
53.00	05300	ANESTHESIOLOGY		0.035193	1,813,367	0	0	63,818	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC		0.129751	9,961,399	0	0	1,292,501	54.00
56.00	05600	RADIOISOTOPE		0.171718	1,108,040	0	0	190,270	56.00
57.00	05700	CT SCAN		0.029845	6,994,386	0	0	208,747	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)		0.078894	2,149,481	0	0	169,581	58.00
59.00	05900	CARDIAC CATHETERIZATION		0.191052	1,165,057	0	0	222,586	59.00
60.00	06000	LABORATORY		0.132918	3,963,251	0	0	526,787	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.		0.206874	187,785	0	0	38,848	63.00
65.00	06500	RESPIRATORY THERAPY		0.242260	263,809	0	0	63,910	65.00
66.00	06600	PHYSICAL THERAPY		0.302213	712	0	0	215	66.00
67.00	06700	OCCUPATIONAL THERAPY		0.333533	107	0	0	36	67.00
68.00	06800	SPEECH PATHOLOGY		0.464356	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY		0.059474	10,217,873	0	0	607,698	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS		0.511250	1,831,119	0	0	936,160	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT		0.402855	4,695,993	0	0	1,891,804	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS		0.439590	16,343,031	0	25,628	7,184,233	73.00
74.00	07400	RENAL DIALYSIS		0.347727	0	0	0	0	74.00
76.00	03020	ONCOLOGY & PAIN MANAGEMENT		0.307108	2,534,630	0	0	778,405	76.00
76.01	03340	GASTRO INTESTINAL SERVICES		0.239612	1,584,551	0	0	379,677	76.01
76.02	03550	OP PSYCH		0.875550	451,647	0	0	395,440	76.02
76.98	07698	HYPERBARIC OXYGEN THERAPY		0.082588	480,480	0	0	39,682	76.98
OUTPATIENT SERVICE COST CENTERS									
91.00	09100	EMERGENCY		0.085437	9,354,511	0	0	799,221	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)		0.638859	407,128	0	0	260,097	92.00
OTHER REIMBURSABLE COST CENTERS									
95.00	09500	AMBULANCE SERVICES		0.264801		0			95.00
200.00		Subtotal (see instructions)			88,361,637	0	25,628	19,035,029	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges				0	0		201.00
202.00		Net Charges (line 200 - line 201)			88,361,637	0	25,628	19,035,029	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST			Provider CCN: 14-0002		Period: From 01/01/2020 To 12/31/2020	Worksheet D Part V Date/Time Prepared: 5/28/2021 12:16 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
53.00	05300	ANESTHESIOLOGY	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0		54.00
56.00	05600	RADIOISOTOPE	0	0		56.00
57.00	05700	CT SCAN	0	0		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0		58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0		59.00
60.00	06000	LABORATORY	0	0		60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0		63.00
65.00	06500	RESPIRATORY THERAPY	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	11,266		73.00
74.00	07400	RENAL DIALYSIS	0	0		74.00
76.00	03020	ONCOLOGY & PAIN MANAGEMENT	0	0		76.00
76.01	03340	GASTRO INTESTINAL SERVICES	0	0		76.01
76.02	03550	OP PSYCH	0	0		76.02
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0		76.98
OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0		92.00
OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0			95.00
200.00		Subtotal (see instructions)	0	11,266		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	0	11,266		202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS				Provider CCN: 14-0002		Period: From 01/01/2020 To 12/31/2020		Worksheet D Part II Date/Time Prepared: 5/28/2021 12:16 pm	
				Component CCN: 14-S002					
				Title XVIII		Subprovider - IPF		PPS	
Cost Center Description			Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)		
			1.00	2.00	3.00	4.00	5.00		
	ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	1,400,087	44,453,161	0.031496	0	0	50.00	
51.00	05100	RECOVERY ROOM	118,832	8,820,769	0.013472	0	0	51.00	
53.00	05300	ANESTHESIOLOGY	34,296	10,599,980	0.003235	0	0	53.00	
54.00	05400	RADIOLOGY-DIAGNOSTIC	941,597	45,540,680	0.020676	9,434	195	54.00	
56.00	05600	RADIOISOTOPE	59,419	3,613,903	0.016442	0	0	56.00	
57.00	05700	CT SCAN	215,176	35,739,970	0.006021	38,448	231	57.00	
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	108,501	8,810,802	0.012315	0	0	58.00	
59.00	05900	CARDIAC CATHETERIZATION	143,841	8,969,154	0.016037	0	0	59.00	
60.00	06000	LABORATORY	647,470	51,439,416	0.012587	74,286	935	60.00	
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	64,358	8,132,050	0.007914	0	0	63.00	
65.00	06500	RESPIRATORY THERAPY	198,986	10,737,664	0.018532	8,848	164	65.00	
66.00	06600	PHYSICAL THERAPY	195,347	9,682,107	0.020176	8,414	170	66.00	
67.00	06700	OCCUPATIONAL THERAPY	50,575	2,217,306	0.022809	1,766	40	67.00	
68.00	06800	SPEECH PATHOLOGY	22,093	908,102	0.024329	652	16	68.00	
69.00	06900	ELECTROCARDIOLOGY	236,808	36,275,800	0.006528	6,838	45	69.00	
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	201,532	9,886,549	0.020384	4	0	71.00	
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	309,091	20,075,517	0.015396	0	0	72.00	
73.00	07300	DRUGS CHARGED TO PATIENTS	685,213	37,886,633	0.018086	19,383	351	73.00	
74.00	07400	RENAL DIALYSIS	24,838	1,869,951	0.013283	0	0	74.00	
76.00	03020	ONCOLOGY & PAIN MANAGEMENT	145,340	6,605,790	0.022002	0	0	76.00	
76.01	03340	GASTRO INTESTINAL SERVICES	141,504	8,585,063	0.016483	0	0	76.01	
76.02	03550	OP PSYCH	86,556	562,819	0.153790	0	0	76.02	
76.98	07698	HYPERBARIC OXYGEN THERAPY	2,853	1,034,040	0.002759	0	0	76.98	
	OUTPATIENT SERVICE COST CENTERS								
91.00	09100	EMERGENCY	560,513	79,971,838	0.007009	87,267	612	91.00	
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	1,487,775	0.000000	0	0	92.00	
	OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES						95.00	
200.00		Total (lines 50 through 199)	6,594,826	453,906,839		255,340	2,759	200.00	

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS				Provider CCN: 14-0002 Component CCN: 14-S002		Period: From 01/01/2020 To 12/31/2020		Worksheet D Part IV Date/Time Prepared: 5/28/2021 12:16 pm	
				Title XVIII		Subprovider - IPF		PPS	
Cost Center Description				Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health	
				1.00	2A	2.00	3A	3.00	
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM		0	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM		0	0	0	0	0	51.00
53.00	05300	ANESTHESIOLOGY		0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC		0	0	0	0	0	54.00
56.00	05600	RADIOISOTOPE		0	0	0	0	0	56.00
57.00	05700	CT SCAN		0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)		0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION		0	0	0	0	0	59.00
60.00	06000	LABORATORY		0	0	0	0	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.		0	0	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY		0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY		0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY		0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY		0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY		0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS		0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT		0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS		0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS		0	0	0	0	0	74.00
76.00	03020	ONCOLOGY & PAIN MANAGEMENT		0	0	0	0	0	76.00
76.01	03340	GASTRO INTESTINAL SERVICES		0	0	0	0	0	76.01
76.02	03550	OP PSYCH		0	0	0	0	0	76.02
76.98	07698	HYPERBARIC OXYGEN THERAPY		0	0	0	0	0	76.98
OUTPATIENT SERVICE COST CENTERS									
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
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: 14-0002 Component CCN: 14-S002		Period: From 01/01/2020 To 12/31/2020		Worksheet D Part IV Date/Time Prepared: 5/28/2021 12:16 pm	
				Title XVIII		Subprovider - IPF		PPS	
Cost Center Description				All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7) (see instructions)	
				4.00	5.00	6.00	7.00	8.00	
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM		0	0	0	44,453,161	0.000000	50.00
51.00	05100	RECOVERY ROOM		0	0	0	8,820,769	0.000000	51.00
53.00	05300	ANESTHESIOLOGY		0	0	0	10,599,980	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC		0	0	0	45,540,680	0.000000	54.00
56.00	05600	RADIOISOTOPE		0	0	0	3,613,903	0.000000	56.00
57.00	05700	CT SCAN		0	0	0	35,739,970	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)		0	0	0	8,810,802	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION		0	0	0	8,969,154	0.000000	59.00
60.00	06000	LABORATORY		0	0	0	51,439,416	0.000000	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.		0	0	0	8,132,050	0.000000	63.00
65.00	06500	RESPIRATORY THERAPY		0	0	0	10,737,664	0.000000	65.00
66.00	06600	PHYSICAL THERAPY		0	0	0	9,682,107	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY		0	0	0	2,217,306	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY		0	0	0	908,102	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY		0	0	0	36,275,800	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS		0	0	0	9,886,549	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT		0	0	0	20,075,517	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS		0	0	0	37,886,633	0.000000	73.00
74.00	07400	RENAL DIALYSIS		0	0	0	1,869,951	0.000000	74.00
76.00	03020	ONCOLOGY & PAIN MANAGEMENT		0	0	0	6,605,790	0.000000	76.00
76.01	03340	GASTRO INTESTINAL SERVICES		0	0	0	8,585,063	0.000000	76.01
76.02	03550	OP PSYCH		0	0	0	562,819	0.000000	76.02
76.98	07698	HYPERBARIC OXYGEN THERAPY		0	0	0	1,034,040	0.000000	76.98
OUTPATIENT SERVICE COST CENTERS									
91.00	09100	EMERGENCY		0	0	0	79,971,838	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)		0	0	0	1,487,775	0.000000	92.00
OTHER REIMBURSABLE COST CENTERS									
95.00	09500	AMBULANCE SERVICES							95.00
200.00		Total (lines 50 through 199)		0	0	0	453,906,839		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS				Provider CCN: 14-0002 Component CCN: 14-S002		Period: From 01/01/2020 To 12/31/2020		Worksheet D Part IV Date/Time Prepared: 5/28/2021 12:16 pm	
				Title XVIII		Subprovider - IPF		PPS	
Cost Center Description				Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
				9.00	10.00	11.00	12.00	13.00	
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM		0.000000	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM		0.000000	0	0	0	0	51.00
53.00	05300	ANESTHESIOLOGY		0.000000	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC		0.000000	9,434	0	0	0	54.00
56.00	05600	RADIOISOTOPE		0.000000	0	0	0	0	56.00
57.00	05700	CT SCAN		0.000000	38,448	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)		0.000000	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION		0.000000	0	0	0	0	59.00
60.00	06000	LABORATORY		0.000000	74,286	0	0	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.		0.000000	0	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY		0.000000	8,848	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY		0.000000	8,414	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY		0.000000	1,766	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY		0.000000	652	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY		0.000000	6,838	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS		0.000000	4	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT		0.000000	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS		0.000000	19,383	0	0	0	73.00
74.00	07400	RENAL DIALYSIS		0.000000	0	0	0	0	74.00
76.00	03020	ONCOLOGY & PAIN MANAGEMENT		0.000000	0	0	0	0	76.00
76.01	03340	GASTRO INTESTINAL SERVICES		0.000000	0	0	0	0	76.01
76.02	03550	OP PSYCH		0.000000	0	0	0	0	76.02
76.98	07698	HYPERBARIC OXYGEN THERAPY		0.000000	0	0	0	0	76.98
OUTPATIENT SERVICE COST CENTERS									
91.00	09100	EMERGENCY		0.000000	87,267	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)		0.000000	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS									
95.00	09500	AMBULANCE SERVICES							95.00
200.00		Total (lines 50 through 199)			255,340	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS				Provider CCN: 14-0002 Component CCN: 14-S002		Period: From 01/01/2020 To 12/31/2020		Worksheet D Part IV Date/Time Prepared: 5/28/2021 12:16 pm	
				Title XVIII		Subprovider - IPF		PPS	
Cost Center Description				PSA Adj. Non Physician Anesthetist Cost	PSA Adj. All Other Medical Education Cost				
				21.00	24.00				
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM	0	0				50.00	
51.00	05100	RECOVERY ROOM	0	0				51.00	
53.00	05300	ANESTHESIOLOGY	0	0				53.00	
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0				54.00	
56.00	05600	RADIOISOTOPE	0	0				56.00	
57.00	05700	CT SCAN	0	0				57.00	
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0				58.00	
59.00	05900	CARDIAC CATHETERIZATION	0	0				59.00	
60.00	06000	LABORATORY	0	0				60.00	
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0				63.00	
65.00	06500	RESPIRATORY THERAPY	0	0				65.00	
66.00	06600	PHYSICAL THERAPY	0	0				66.00	
67.00	06700	OCCUPATIONAL THERAPY	0	0				67.00	
68.00	06800	SPEECH PATHOLOGY	0	0				68.00	
69.00	06900	ELECTROCARDIOLOGY	0	0				69.00	
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0				71.00	
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0				72.00	
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0				73.00	
74.00	07400	RENAL DIALYSIS	0	0				74.00	
76.00	03020	ONCOLOGY & PAIN MANAGEMENT	0	0				76.00	
76.01	03340	GASTRO INTESTINAL SERVICES	0	0				76.01	
76.02	03550	OP PSYCH	0	0				76.02	
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0				76.98	
OUTPATIENT SERVICE COST CENTERS									
91.00	09100	EMERGENCY	0	0				91.00	
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0				92.00	
OTHER REIMBURSABLE COST CENTERS									
95.00	09500	AMBULANCE SERVICES						95.00	
200.00		Total (lines 50 through 199)	0	0				200.00	

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST				Provider CCN: 14-0002 Component CCN: 14-S002		Period: From 01/01/2020 To 12/31/2020		Worksheet D Part V Date/Time Prepared: 5/28/2021 12:16 pm	
				Title XVIII		Subprovider - IPF		PPS	
Cost Center Description			Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges			Costs		
				PPS Reimbursed Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	PPS Services (see inst.)		
			1.00	2.00	3.00	4.00	5.00		
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM	0.249552	0	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0.134184	0	0	0	0	0	51.00
53.00	05300	ANESTHESIOLOGY	0.035193	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.129751	0	0	0	0	0	54.00
56.00	05600	RADIOISOTOPE	0.171718	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0.029845	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.078894	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.191052	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0.132918	0	0	0	0	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.206874	0	0	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	0.242260	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.302213	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.333533	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.464356	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.059474	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.511250	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.402855	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.439590	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0.347727	0	0	0	0	0	74.00
76.00	03020	ONCOLOGY & PAIN MANAGEMENT	0.307108	0	0	0	0	0	76.00
76.01	03340	GASTRO INTESTINAL SERVICES	0.239612	0	0	0	0	0	76.01
76.02	03550	OP PSYCH	0.875550	0	0	0	0	0	76.02
76.98	07698	HYPERBARIC OXYGEN THERAPY	0.082588	0	0	0	0	0	76.98
OUTPATIENT SERVICE COST CENTERS									
91.00	09100	EMERGENCY	0.085437	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.638859	0	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS									
95.00	09500	AMBULANCE SERVICES	0.264801		0				95.00
200.00		Subtotal (see instructions)		0	0	0	0	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0	0		201.00
202.00		Net Charges (line 200 - line 201)		0	0	0	0	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST			Provider CCN: 14-0002		Period: From 01/01/2020 To 12/31/2020	Worksheet D Part V Date/Time Prepared: 5/28/2021 12:16 pm
			Component CCN: 14-S002			
			Title XVIII		Subprovider - IPF	PPS
Cost Center Description	Costs					
	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)				
	6.00	7.00				
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0		50.00
51.00	05100	RECOVERY ROOM	0	0		51.00
53.00	05300	ANESTHESIOLOGY	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0		54.00
56.00	05600	RADIOISOTOPE	0	0		56.00
57.00	05700	CT SCAN	0	0		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0		58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0		59.00
60.00	06000	LABORATORY	0	0		60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0		63.00
65.00	06500	RESPIRATORY THERAPY	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0		73.00
74.00	07400	RENAL DIALYSIS	0	0		74.00
76.00	03020	ONCOLOGY & PAIN MANAGEMENT	0	0		76.00
76.01	03340	GASTRO INTESTINAL SERVICES	0	0		76.01
76.02	03550	OP PSYCH	0	0		76.02
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0		76.98
OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0		92.00
OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0			95.00
200.00		Subtotal (see instructions)	0	0		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	0	0		202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

Provider CCN: 14-0002

Period:
From 01/01/2020
To 12/31/2020Worksheet D
Part I
Date/Time Prepared:
5/28/2021 12:16 pm

			Title XIX		Hospital	PPS	
Cost Center Description		Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)	
		1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	ADULTS & PEDIATRICS	2,345,327	0	2,345,327	24,206	96.89	30.00
31.00	INTENSIVE CARE UNIT	313,041		313,041	2,708	115.60	31.00
40.00	SUBPROVIDER - IPF	116,760	0	116,760	845	138.18	40.00
43.00	NURSERY	52,235		52,235	1,535	34.03	43.00
200.00	Total (lines 30 through 199)	2,827,363		2,827,363	29,294		200.00
Cost Center Description		Inpatient Program days	Inpatient Program Capital Cost (col. 5 x col. 6)				
		6.00	7.00				
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	ADULTS & PEDIATRICS	616	59,684				
31.00	INTENSIVE CARE UNIT	90	10,404				
40.00	SUBPROVIDER - IPF	0	0				
43.00	NURSERY	119	4,050				
200.00	Total (lines 30 through 199)	825	74,138				

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS				Provider CCN: 14-0002	Period: From 01/01/2020 To 12/31/2020	Worksheet D Part II Date/Time Prepared: 5/28/2021 12:16 pm		
				Title XIX		Hospital	PPS	
Cost Center Description		Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)		
		1.00	2.00	3.00	4.00	5.00		
	ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	1,400,087	44,453,161	0.031496	268,613	8,460	50.00	
51.00	05100 RECOVERY ROOM	118,832	8,820,769	0.013472	20,700	279	51.00	
53.00	05300 ANESTHESIOLOGY	34,296	10,599,980	0.003235	41,600	135	53.00	
54.00	05400 RADIOLOGY-DIAGNOSTIC	941,597	45,540,680	0.020676	117,504	2,430	54.00	
56.00	05600 RADIOISOTOPE	59,419	3,613,903	0.016442	14,050	231	56.00	
57.00	05700 CT SCAN	215,176	35,739,970	0.006021	201,079	1,211	57.00	
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	108,501	8,810,802	0.012315	32,533	401	58.00	
59.00	05900 CARDIAC CATHETERIZATION	143,841	8,969,154	0.016037	189,240	3,035	59.00	
60.00	06000 LABORATORY	647,470	51,439,416	0.012587	519,205	6,535	60.00	
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	64,358	8,132,050	0.007914	105,740	837	63.00	
65.00	06500 RESPIRATORY THERAPY	198,986	10,737,664	0.018532	87,029	1,613	65.00	
66.00	06600 PHYSICAL THERAPY	195,347	9,682,107	0.020176	21,198	428	66.00	
67.00	06700 OCCUPATIONAL THERAPY	50,575	2,217,306	0.022809	8,993	205	67.00	
68.00	06800 SPEECH PATHOLOGY	22,093	908,102	0.024329	2,573	63	68.00	
69.00	06900 ELECTROCARDIOLOGY	236,808	36,275,800	0.006528	203,491	1,328	69.00	
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	201,532	9,886,549	0.020384	9,807	200	71.00	
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	309,091	20,075,517	0.015396	0	0	72.00	
73.00	07300 DRUGS CHARGED TO PATIENTS	685,213	37,886,633	0.018086	178,960	3,237	73.00	
74.00	07400 RENAL DIALYSIS	24,838	1,869,951	0.013283	3,492	46	74.00	
76.00	03020 ONCOLOGY & PAIN MANAGEMENT	145,340	6,605,790	0.022002	0	0	76.00	
76.01	03340 GASTRO INTESTINAL SERVICES	141,504	8,585,063	0.016483	34,485	568	76.01	
76.02	03550 OP PSYCH	86,556	562,819	0.153790	0	0	76.02	
76.98	07698 HYPERBARIC OXYGEN THERAPY	2,853	1,034,040	0.002759	0	0	76.98	
	OUTPATIENT SERVICE COST CENTERS							
91.00	09100 EMERGENCY	560,513	79,971,838	0.007009	424,397	2,975	91.00	
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	80,031	1,487,775	0.053792	0	0	92.00	
	OTHER REIMBURSABLE COST CENTERS							
95.00	09500 AMBULANCE SERVICES						95.00	
200.00	Total (lines 50 through 199)	6,674,857	453,906,839		2,484,689	34,217	200.00	

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS					Provider CCN: 14-0002		Period: From 01/01/2020 To 12/31/2020		Worksheet D Part III Date/Time Prepared: 5/28/2021 12:16 pm	
					Title XIX		Hospital		PPS	
Cost Center Description					Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health Cost	All Other Medical Education Cost	
					1A	1.00	2A	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS										
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	0	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	0	0	31.00
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	0	0	0	40.00
43.00	04300	NURSERY	0	0	0	0	0	0	0	43.00
200.00		Total (lines 30 through 199)	0	0	0	0	0	0	0	200.00
Cost Center Description					Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days	
					4.00	5.00	6.00	7.00	8.00	
INPATIENT ROUTINE SERVICE COST CENTERS										
30.00	03000	ADULTS & PEDIATRICS	0	0	24,206	0.00	616	30.00		
31.00	03100	INTENSIVE CARE UNIT	0	0	2,708	0.00	90	31.00		
40.00	04000	SUBPROVIDER - IPF	0	0	845	0.00	0	40.00		
43.00	04300	NURSERY	0	0	1,535	0.00	119	43.00		
200.00		Total (lines 30 through 199)	0	0	29,294		825	200.00		
Cost Center Description					Inpatient Program Pass-Through Cost (col. 7 x col. 8)	PSA Adj. All Other Medical Education Cost				
					9.00	13.00				
INPATIENT ROUTINE SERVICE COST CENTERS										
30.00	03000	ADULTS & PEDIATRICS	0	0						30.00
31.00	03100	INTENSIVE CARE UNIT	0	0						31.00
40.00	04000	SUBPROVIDER - IPF	0	0						40.00
43.00	04300	NURSERY	0	0						43.00
200.00		Total (lines 30 through 199)	0	0						200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS			Provider CCN: 14-0002		Period: From 01/01/2020 To 12/31/2020		Worksheet D Part IV Date/Time Prepared: 5/28/2021 12:16 pm	
			Title XIX		Hospital		PPS	
Cost Center Description			Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health	
			1.00	2A	2.00	3A	3.00	
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.00	03020	ONCOLOGY & PAIN MANAGEMENT	0	0	0	0	0	76.00
76.01	03340	GASTRO INTESTINAL SERVICES	0	0	0	0	0	76.01
76.02	03550	OP PSYCH	0	0	0	0	0	76.02
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
OUTPATIENT SERVICE COST CENTERS								
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0		0		0	92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES						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: 14-0002

Period:
From 01/01/2020
To 12/31/2020Worksheet D
Part IV
Date/Time Prepared:
5/28/2021 12:16 pm

				Title XIX		Hospital	PPS	
Cost Center Description			All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7) (see instructions)	
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	0	44,453,161	0.000000	50.00
51.00	05100	RECOVERY ROOM	0	0	0	8,820,769	0.000000	51.00
53.00	05300	ANESTHESIOLOGY	0	0	0	10,599,980	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	45,540,680	0.000000	54.00
56.00	05600	RADIOISOTOPE	0	0	0	3,613,903	0.000000	56.00
57.00	05700	CT SCAN	0	0	0	35,739,970	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	8,810,802	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	8,969,154	0.000000	59.00
60.00	06000	LABORATORY	0	0	0	51,439,416	0.000000	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	8,132,050	0.000000	63.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	10,737,664	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	9,682,107	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	2,217,306	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	908,102	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	36,275,800	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	9,886,549	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	20,075,517	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	37,886,633	0.000000	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	1,869,951	0.000000	74.00
76.00	03020	ONCOLOGY & PAIN MANAGEMENT	0	0	0	6,605,790	0.000000	76.00
76.01	03340	GASTRO INTESTINAL SERVICES	0	0	0	8,585,063	0.000000	76.01
76.02	03550	OP PSYCH	0	0	0	562,819	0.000000	76.02
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	1,034,040	0.000000	76.98
OUTPATIENT SERVICE COST CENTERS								
91.00	09100	EMERGENCY	0	0	0	79,971,838	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	1,487,775	0.000000	92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)	0	0	0	453,906,839		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-0002

Period:
From 01/01/2020
To 12/31/2020Worksheet D
Part IV
Date/Time Prepared:
5/28/2021 12:16 pm

				Title XIX		Hospital		PPS		
Cost Center Description			Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)			
										9.00
	ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM	0.000000	268,613	0	0	0	0	50.00	
51.00	05100	RECOVERY ROOM	0.000000	20,700	0	0	0	0	51.00	
53.00	05300	ANESTHESIOLOGY	0.000000	41,600	0	0	0	0	53.00	
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	117,504	0	0	0	0	54.00	
56.00	05600	RADIOISOTOPE	0.000000	14,050	0	0	0	0	56.00	
57.00	05700	CT SCAN	0.000000	201,079	0	0	0	0	57.00	
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000	32,533	0	0	0	0	58.00	
59.00	05900	CARDIAC CATHETERIZATION	0.000000	189,240	0	0	0	0	59.00	
60.00	06000	LABORATORY	0.000000	519,205	0	0	0	0	60.00	
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.000000	105,740	0	0	0	0	63.00	
65.00	06500	RESPIRATORY THERAPY	0.000000	87,029	0	0	0	0	65.00	
66.00	06600	PHYSICAL THERAPY	0.000000	21,198	0	0	0	0	66.00	
67.00	06700	OCCUPATIONAL THERAPY	0.000000	8,993	0	0	0	0	67.00	
68.00	06800	SPEECH PATHOLOGY	0.000000	2,573	0	0	0	0	68.00	
69.00	06900	ELECTROCARDIOLOGY	0.000000	203,491	0	0	0	0	69.00	
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	9,807	0	0	0	0	71.00	
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.000000	0	0	0	0	0	72.00	
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	178,960	0	0	0	0	73.00	
74.00	07400	RENAL DIALYSIS	0.000000	3,492	0	0	0	0	74.00	
76.00	03020	ONCOLOGY & PAIN MANAGEMENT	0.000000	0	0	0	0	0	76.00	
76.01	03340	GASTRO INTESTINAL SERVICES	0.000000	34,485	0	0	0	0	76.01	
76.02	03550	OP PSYCH	0.000000	0	0	0	0	0	76.02	
76.98	07698	HYPERBARIC OXYGEN THERAPY	0.000000	0	0	0	0	0	76.98	
	OUTPATIENT SERVICE COST CENTERS									
91.00	09100	EMERGENCY	0.000000	424,397	0	0	0	0	91.00	
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	0	0	0	0	0	92.00	
	OTHER REIMBURSABLE COST CENTERS									
95.00	09500	AMBULANCE SERVICES							95.00	
200.00		Total (lines 50 through 199)		2,484,689	0	0	0	0	200.00	

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

Provider CCN: 14-0002

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

Worksheet D
Part IV
Date/Time Prepared:
5/28/2021 12:16 pm

			Title XIX		Hospital	PPS
Cost Center Description			PSA Adj. Non Physician Anesthetist Cost	PSA Adj. All Other Medical Education Cost		
			21.00	24.00		
	ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	0		50.00
51.00	05100	RECOVERY ROOM	0	0		51.00
53.00	05300	ANESTHESIOLOGY	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0		54.00
56.00	05600	RADIOISOTOPE	0	0		56.00
57.00	05700	CT SCAN	0	0		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0		58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0		59.00
60.00	06000	LABORATORY	0	0		60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0		63.00
65.00	06500	RESPIRATORY THERAPY	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0		73.00
74.00	07400	RENAL DIALYSIS	0	0		74.00
76.00	03020	ONCOLOGY & PAIN MANAGEMENT	0	0		76.00
76.01	03340	GASTRO INTESTINAL SERVICES	0	0		76.01
76.02	03550	OP PSYCH	0	0		76.02
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0		76.98
	OUTPATIENT SERVICE COST CENTERS					
91.00	09100	EMERGENCY	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0		92.00
	OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES				95.00
200.00		Total (lines 50 through 199)	0	0		200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST				Provider CCN: 14-0002		Period: From 01/01/2020 To 12/31/2020		Worksheet D Part V Date/Time Prepared: 5/28/2021 12:16 pm	
				Title XIX		Hospital		PPS	
Cost Center Description				Cost to Charge Ratio From Worksheet C, Part I, col. 9	PPS Reimbursed Services (see inst.)	Charges		Costs	
						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		0.249552	0	441,559	0	0	50.00
51.00	05100	RECOVERY ROOM		0.134184	0	90,390	0	0	51.00
53.00	05300	ANESTHESIOLOGY		0.035193	0	67,200	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC		0.129751	0	676,536	0	0	54.00
56.00	05600	RADIOISOTOPE		0.171718	0	22,032	0	0	56.00
57.00	05700	CT SCAN		0.029845	0	464,307	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)		0.078894	0	51,466	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION		0.191052	0	62,136	0	0	59.00
60.00	06000	LABORATORY		0.132918	0	506,509	0	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.		0.206874	0	115,140	0	0	63.00
65.00	06500	RESPIRATORY THERAPY		0.242260	0	19,273	0	0	65.00
66.00	06600	PHYSICAL THERAPY		0.302213	0	111,291	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY		0.333533	0	8,828	0	0	67.00
68.00	06800	SPEECH PATHOLOGY		0.464356	0	8,809	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY		0.059474	0	166,898	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS		0.511250	0	892	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT		0.402855	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS		0.439590	0	259,770	0	0	73.00
74.00	07400	RENAL DIALYSIS		0.347727	0	0	0	0	74.00
76.00	03020	ONCOLOGY & PAIN MANAGEMENT		0.307108	0	37,288	0	0	76.00
76.01	03340	GASTRO INTESTINAL SERVICES		0.239612	0	25,363	0	0	76.01
76.02	03550	OP PSYCH		0.875550	0	0	0	0	76.02
76.98	07698	HYPERBARIC OXYGEN THERAPY		0.082588	0	0	0	0	76.98
OUTPATIENT SERVICE COST CENTERS									
91.00	09100	EMERGENCY		0.085437	0	2,311,506	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)		0.638859	0	64,989	0	0	92.00
OTHER REIMBURSABLE COST CENTERS									
95.00	09500	AMBULANCE SERVICES		0.264801	0	607,466	0	0	95.00
200.00		Subtotal (see instructions)			0	6,119,648	0	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges				0	0	0	201.00
202.00		Net Charges (line 200 - line 201)			0	6,119,648	0	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST			Provider CCN: 14-0002		Period: From 01/01/2020 To 12/31/2020	Worksheet D Part V Date/Time Prepared: 5/28/2021 12:16 pm
			Title XIX		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	110,192	0		50.00
51.00	05100	RECOVERY ROOM	12,129	0		51.00
53.00	05300	ANESTHESIOLOGY	2,365	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	87,781	0		54.00
56.00	05600	RADIOISOTOPE	3,783	0		56.00
57.00	05700	CT SCAN	13,857	0		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	4,060	0		58.00
59.00	05900	CARDIAC CATHETERIZATION	11,871	0		59.00
60.00	06000	LABORATORY	67,324	0		60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	23,819	0		63.00
65.00	06500	RESPIRATORY THERAPY	4,669	0		65.00
66.00	06600	PHYSICAL THERAPY	33,634	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	2,944	0		67.00
68.00	06800	SPEECH PATHOLOGY	4,091	0		68.00
69.00	06900	ELECTROCARDIOLOGY	9,926	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	456	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	114,192	0		73.00
74.00	07400	RENAL DIALYSIS	0	0		74.00
76.00	03020	ONCOLOGY & PAIN MANAGEMENT	11,451	0		76.00
76.01	03340	GASTRO INTESTINAL SERVICES	6,077	0		76.01
76.02	03550	OP PSYCH	0	0		76.02
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0		76.98
OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	197,488	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	41,519	0		92.00
OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	160,858			95.00
200.00		Subtotal (see instructions)	924,486	0		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	924,486	0		202.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-0002	Period: From 01/01/2020 To 12/31/2020	Worksheet D-1 Date/Time Prepared: 5/28/2021 12:16 pm	
		Title XVIII	Hospital	PPS	
Cost Center Description				1.00	
	PART I - ALL PROVIDER COMPONENTS				
	INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)			24,206	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)			24,206	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)			23,380	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)			9,258	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)			27,853,861	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)			27,853,861	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)			27,853,861	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)			1,150.70	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)			10,653,181	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)			10,653,181	41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-0002

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

Worksheet D-1

Date/Time Prepared:
5/28/2021 12:16 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
Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	5,604,874	2,708	2,069.75	1,057	2,187,726
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)					10,584,025
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					23,424,932
PASS THROUGH COST ADJUSTMENTS						
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)					1,019,197
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					757,960
52.00	Total Program excludable cost (sum of lines 50 and 51)					1,777,157
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					21,647,775
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)					826
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					1,150.70
89.00	Observation bed cost (line 87 x line 88) (see instructions)					950,478

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-0002

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

Worksheet D-1

Date/Time Prepared:
5/28/2021 12:16 pm

		Title XVIII		Hospital	PPS	
Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
	1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00 Capital-related cost	2,345,327	27,853,861	0.084201	950,478	80,031	90.00
91.00 Nursing School cost	0	27,853,861	0.000000	950,478	0	91.00
92.00 Allied health cost	0	27,853,861	0.000000	950,478	0	92.00
93.00 All other Medical Education	0	27,853,861	0.000000	950,478	0	93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-0002 Component CCN: 14-S002	Period: From 01/01/2020 To 12/31/2020	Worksheet D-1 Date/Time Prepared: 5/28/2021 12:16 pm
		Title XVIII	Subprovider - IPF	PPS
Cost Center Description			1.00	
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		845	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		845	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)		845	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)		462	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)		1,708,286	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)		1,708,286	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)		1,708,286	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)		2,021.64	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		933,998	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)		933,998	41.00

COMPUTATION OF INPATIENT OPERATING COST			Provider CCN: 14-0002	Period: From 01/01/2020 To 12/31/2020	Worksheet D-1
			Component CCN: 14-S002		Date/Time Prepared: 5/28/2021 12:16 pm
			Title XVIII	Subprovider - IPF	PPS
Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)
	1.00	2.00	3.00	4.00	5.00
42.00 NURSERY (title V & XIX only)	0	0	0.00	0	0
Intensive Care Type Inpatient Hospital Units					
43.00 INTENSIVE CARE UNIT	0	0	0.00	0	0
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)					34,210
49.00 Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					968,208
PASS THROUGH COST ADJUSTMENTS					
50.00 Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)					63,839
51.00 Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					2,759
52.00 Total Program excludable cost (sum of lines 50 and 51)					66,598
53.00 Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					901,610
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: 14-0002 Component CCN: 14-S002		Period: From 01/01/2020 To 12/31/2020		Worksheet D-1 Date/Time Prepared: 5/28/2021 12:16 pm	
			Title XVIII		Subprovider - IPF		PPS	
Cost Center Description			Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
			1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00	Capital-related cost	116,760	1,708,286	0.068349	0	0	90.00	
91.00	Nursing School cost	0	1,708,286	0.000000	0	0	91.00	
92.00	Allied health cost	0	1,708,286	0.000000	0	0	92.00	
93.00	All other Medical Education	0	1,708,286	0.000000	0	0	93.00	

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-0002	Period: From 01/01/2020 To 12/31/2020	Worksheet D-1 Date/Time Prepared: 5/28/2021 12:16 pm
Cost Center Description		Title XIX	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)		24,206	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		24,206	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)		23,380	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)		616	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)		1,535	15.00
16.00	Nursery days (title V or XIX only)		119	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)		27,853,861	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)		27,853,861	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)		27,853,861	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)		1,150.70	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		708,831	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)		708,831	41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-0002

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

Worksheet D-1

Date/Time Prepared:
5/28/2021 12:16 pm

Cost Center Description		Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Hospital Program Days	Program Cost (col. 3 x col. 4)	PPS	
		1.00	2.00	3.00	4.00	5.00		
42.00	NURSERY (title V & XIX only)	1,508,880	1,535	982.98	119	116,975	42.00	
Intensive Care Type Inpatient Hospital Units								
43.00	INTENSIVE CARE UNIT	5,604,874	2,708	2,069.75	90	186,278	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)						397,749	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)						1,409,833	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)						74,138	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)						34,217	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)						108,355	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)						1,301,478	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)						826	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)						1,150.70	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)						950,478	89.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-0002

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

Worksheet D-1

Date/Time Prepared:
5/28/2021 12:16 pm

Cost Center Description		Title XIX		Hospital	PPS	
		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	2,345,327	27,853,861	0.084201	950,478	80,031
91.00	Nursing School cost	0	27,853,861	0.000000	950,478	0
92.00	Allied health cost	0	27,853,861	0.000000	950,478	0
93.00	All other Medical Education	0	27,853,861	0.000000	950,478	0

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT			Provider CCN: 14-0002	Period: From 01/01/2020 To 12/31/2020	Worksheet D-3 Date/Time Prepared: 5/28/2021 12:16 pm	
			Title XVIII	Hospital	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		20,823,809		30.00
31.00	03100	INTENSIVE CARE UNIT		6,120,462		31.00
40.00	04000	SUBPROVIDER - IPF		0		40.00
43.00	04300	NURSERY				43.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.249552	4,563,358	1,138,795	50.00
51.00	05100	RECOVERY ROOM	0.134184	707,385	94,920	51.00
53.00	05300	ANESTHESIOLOGY	0.035193	1,248,866	43,951	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.129751	1,725,766	223,920	54.00
56.00	05600	RADIOISOTOPE	0.171718	289,994	49,797	56.00
57.00	05700	CT SCAN	0.029845	4,103,080	122,456	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.078894	503,123	39,693	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.191052	662,038	126,484	59.00
60.00	06000	LABORATORY	0.132918	9,930,603	1,319,956	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.206874	508,317	105,158	63.00
65.00	06500	RESPIRATORY THERAPY	0.242260	4,071,475	986,356	65.00
66.00	06600	PHYSICAL THERAPY	0.302213	783,913	236,909	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.333533	354,103	118,105	67.00
68.00	06800	SPEECH PATHOLOGY	0.464356	107,065	49,716	68.00
69.00	06900	ELECTROCARDIOLOGY	0.059474	5,387,036	320,389	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.511250	1,523,258	778,766	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.402855	2,720,501	1,095,967	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.439590	5,993,824	2,634,825	73.00
74.00	07400	RENAL DIALYSIS	0.347727	1,114,880	387,674	74.00
76.00	03020	ONCOLOGY & PAIN MANAGEMENT	0.307108	7,054	2,166	76.00
76.01	03340	GASTRO INTESTINAL SERVICES	0.239612	588,861	141,098	76.01
76.02	03550	OP PSYCH	0.875550	337	295	76.02
76.98	07698	HYPERBARIC OXYGEN THERAPY	0.082588	0	0	76.98
OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0.085437	6,569,872	561,310	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.638859	8,325	5,319	92.00
OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES				95.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		53,473,034	10,584,025	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)		53,473,034		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 14-0002 Component CCN: 14-S002	Period: From 01/01/2020 To 12/31/2020	Worksheet D-3 Date/Time Prepared: 5/28/2021 12:16 pm	
		Title XVIII	Subprovider - IPF	PPS	
Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDIATRICS		0		30.00
31.00	03100 INTENSIVE CARE UNIT		0		31.00
40.00	04000 SUBPROVIDER - IPF		1,255,444		40.00
43.00	04300 NURSERY				43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.249552	0	0	50.00
51.00	05100 RECOVERY ROOM	0.134184	0	0	51.00
53.00	05300 ANESTHESIOLOGY	0.035193	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.129751	9,434	1,224	54.00
56.00	05600 RADIOISOTOPE	0.171718	0	0	56.00
57.00	05700 CT SCAN	0.029845	38,448	1,147	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0.078894	0	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	0.191052	0	0	59.00
60.00	06000 LABORATORY	0.132918	74,286	9,874	60.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0.206874	0	0	63.00
65.00	06500 RESPIRATORY THERAPY	0.242260	8,848	2,144	65.00
66.00	06600 PHYSICAL THERAPY	0.302213	8,414	2,543	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.333533	1,766	589	67.00
68.00	06800 SPEECH PATHOLOGY	0.464356	652	303	68.00
69.00	06900 ELECTROCARDIOLOGY	0.059474	6,838	407	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.511250	4	2	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	0.402855	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.439590	19,383	8,521	73.00
74.00	07400 RENAL DIALYSIS	0.347727	0	0	74.00
76.00	03020 ONCOLOGY & PAIN MANAGEMENT	0.307108	0	0	76.00
76.01	03340 GASTRO INTESTINAL SERVICES	0.239612	0	0	76.01
76.02	03550 OP PSYCH	0.875550	0	0	76.02
76.98	07698 HYPERBARIC OXYGEN THERAPY	0.082588	0	0	76.98
OUTPATIENT SERVICE COST CENTERS					
91.00	09100 EMERGENCY	0.085437	87,267	7,456	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.638859	0	0	92.00
OTHER REIMBURSABLE COST CENTERS					
95.00	09500 AMBULANCE SERVICES				95.00
200.00	Total (sum of lines 50 through 94 and 96 through 98)		255,340	34,210	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)		255,340		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT			Provider CCN: 14-0002	Period: From 01/01/2020 To 12/31/2020	Worksheet D-3 Date/Time Prepared: 5/28/2021 12:16 pm	
			Title XIX	Hospital	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		1,293,610		30.00
31.00	03100	INTENSIVE CARE UNIT		154,640		31.00
40.00	04000	SUBPROVIDER - IPF		0		40.00
43.00	04300	NURSERY		252,400		43.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.249552	268,613	67,033	50.00
51.00	05100	RECOVERY ROOM	0.134184	20,700	2,778	51.00
53.00	05300	ANESTHESIOLOGY	0.035193	41,600	1,464	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.129751	117,504	15,246	54.00
56.00	05600	RADIOISOTOPE	0.171718	14,050	2,413	56.00
57.00	05700	CT SCAN	0.029845	201,079	6,001	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.078894	32,533	2,567	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.191052	189,240	36,155	59.00
60.00	06000	LABORATORY	0.132918	519,205	69,012	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.206874	105,740	21,875	63.00
65.00	06500	RESPIRATORY THERAPY	0.242260	87,029	21,084	65.00
66.00	06600	PHYSICAL THERAPY	0.302213	21,198	6,406	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.333533	8,993	2,999	67.00
68.00	06800	SPEECH PATHOLOGY	0.464356	2,573	1,195	68.00
69.00	06900	ELECTROCARDIOLOGY	0.059474	203,491	12,102	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.511250	9,807	5,014	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.402855	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.439590	178,960	78,669	73.00
74.00	07400	RENAL DIALYSIS	0.347727	3,492	1,214	74.00
76.00	03020	ONCOLOGY & PAIN MANAGEMENT	0.307108	0	0	76.00
76.01	03340	GASTRO INTESTINAL SERVICES	0.239612	34,485	8,263	76.01
76.02	03550	OP PSYCH	0.875550	0	0	76.02
76.98	07698	HYPERBARIC OXYGEN THERAPY	0.082588	0	0	76.98
OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0.085437	424,397	36,259	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.638859	0	0	92.00
OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES				95.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		2,484,689	397,749	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)		2,484,689		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT

Provider CCN: 14-0002

Period:
From 01/01/2020
To 12/31/2020Worksheet E
Part A
Date/Time Prepared:
5/28/2021 12:16 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)			14,156,858	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1 (see instructions)			5,651,710	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)			90,541	2.03
2.04	Outlier payments for discharges occurring on or after October 1 (see instructions)			91,587	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)			118.74	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)			4.62	30.00
31.00	Percentage of Medicaid patient days (see instructions)			20.32	31.00
32.00	Sum of lines 30 and 31			24.94	32.00
33.00	Allowable disproportionate share percentage (see instructions)			9.79	33.00
34.00	Disproportionate share adjustment (see instructions)			484,815	34.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0002	Period: From 01/01/2020 To 12/31/2020	Worksheet E Part A Date/Time Prepared: 5/28/2021 12:16 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)		0	0	35.00
35.01	Factor 3 (see instructions)	0.000000000	0.000000000		35.01
35.02	Hospital uncompensated care payment (If line 34 is zero, enter zero on this line) (see instructions)	1,037,263	1,318,831		35.02
35.03	Pro rata share of the hospital uncompensated care payment amount (see instructions)	776,530	332,418		35.03
36.00	Total uncompensated care (sum of columns 1 and 2 on line 35.03)	1,108,948			36.00
Additional payment for high percentage of ESRD beneficiary discharges (lines 40 through 46)					
40.00	Total Medicare discharges, excluding MS-DRGs 652, 682, 683, 684 and 685. (see instructions)		0		40.00
41.00	Total ESRD Medicare discharges excluding MS-DRGs 652, 682, 683, 684 and 685. (see instructions)		0		41.00
41.01	Total ESRD Medicare covered and paid discharges excluding MS-DRGs 652, 682, 683, 684 and 685. (see instructions)		0		41.01
42.00	Divide line 41 by line 40 (if less than 10%, you do not qualify for adjustment)	0.00			42.00
43.00	Total Medicare ESRD inpatient days excluding MS-DRGs 652, 682, 683, 684 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			45.00
46.00	Total additional payment (line 45 times line 44 times line 41.01)		0		46.00
47.00	Subtotal (see instructions)	21,584,459			47.00
48.00	Hospital specific payments (to be completed by SCH and MDH, small rural hospitals only. (see instructions)		0		48.00
				Amount	
				1.00	
49.00	Total payment for inpatient operating costs (see instructions)		21,584,459		49.00
50.00	Payment for inpatient program capital (from Wkst. L, Pt. I and Pt. II, as applicable)		1,631,062		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		93,194		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)		23,308,715		59.00
60.00	Primary payer payments		0		60.00
61.00	Total amount payable for program beneficiaries (line 59 minus line 60)		23,308,715		61.00
62.00	Deductibles billed to program beneficiaries		2,240,524		62.00
63.00	Coinurance billed to program beneficiaries		11,968		63.00
64.00	Allowable bad debts (see instructions)		470,872		64.00
65.00	Adjusted reimbursable bad debts (see instructions)		306,067		65.00
66.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		252,263		66.00
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)		21,362,290		67.00
68.00	Credits received from manufacturers for replaced devices for applicable to MS-DRGs (see instructions)		0		68.00
69.00	Outlier payments reconciliation (sum of lines 93, 95 and 96). (For SCH see instructions)		0		69.00
70.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0		70.00
70.50	Rural Community Hospital Demonstration Project (\$410A Demonstration) adjustment (see instructions)		0		70.50
70.87	Demonstration payment adjustment amount before sequestration		0		70.87
70.88	SCH or MDH volume decrease adjustment (contractor use only)		0		70.88
70.89	Pioneer ACO demonstration payment adjustment amount (see instructions)		0		70.89
70.90	HSP bonus payment HVBP adjustment amount (see instructions)		0		70.90
70.91	HSP bonus payment HRR adjustment amount (see instructions)		0		70.91
70.92	Bundled Model 1 discount amount (see instructions)		0		70.92
70.93	HVBP payment adjustment amount (see instructions)		88,438		70.93
70.94	HRR adjustment amount (see instructions)		-498,098		70.94
70.95	Recovery of accelerated depreciation		0		70.95

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0002	Period: From 01/01/2020 To 12/31/2020	Worksheet E Part A Date/Time Prepared: 5/28/2021 12:16 pm	
		Title XVIII	Hospital	PPS	
		FFY (yyyy)	Amount		
		0	1.00		
70.96	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period prior to 10/1)	0	0	70.96	
70.97	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period ending on or after 10/1)	0	0	70.97	
70.98	Low Volume Payment-3		0	70.98	
70.99	HAC adjustment amount (see instructions)		0	70.99	
71.00	Amount due provider (line 67 minus lines 68 plus/minus lines 69 & 70)		20,952,630	71.00	
71.01	Sequestration adjustment (see instructions)		138,287	71.01	
71.02	Demonstration payment adjustment amount after sequestration		0	71.02	
71.03	Sequestration adjustment-PARHM pass-throughs		0	71.03	
72.00	Interim payments		20,674,447	72.00	
72.01	Interim payments-PARHM		0	72.01	
73.00	Tentative settlement (for contractor use only)		0	73.00	
73.01	Tentative settlement-PARHM (for contractor use only)		0	73.01	
74.00	Balance due provider/program (line 71 minus lines 71.01, 71.02, 72, and 73)		139,896	74.00	
74.01	Balance due provider/program-PARHM (see instructions)		0	74.01	
75.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		1,407,178	75.00	
TO BE COMPLETED BY CONTRACTOR (lines 90 through 96)					
90.00	Operating outlier amount from Wkst. E, Pt. A, line 2, or sum of 2.03 plus 2.04 (see instructions)		0	90.00	
91.00	Capital outlier from Wkst. L, Pt. I, line 2		0	91.00	
92.00	Operating outlier reconciliation adjustment amount (see instructions)		0	92.00	
93.00	Capital outlier reconciliation adjustment amount (see instructions)		0	93.00	
94.00	The rate used to calculate the time value of money (see instructions)		0.00	94.00	
95.00	Time value of money for operating expenses (see instructions)		0	95.00	
96.00	Time value of money for capital related expenses (see instructions)		0	96.00	
			Prior to 10/1	On/After 10/1	
			1.00	2.00	
HSP Bonus Payment Amount					
100.00	HSP bonus amount (see instructions)		0	0	100.00
HVPB Adjustment for HSP Bonus Payment					
101.00	HVPB adjustment factor (see instructions)		0.0000000000	0.0000000000	101.00
102.00	HVPB adjustment amount for HSP bonus payment (see instructions)		0	0	102.00
HRR Adjustment for HSP Bonus Payment					
103.00	HRR adjustment factor (see instructions)		0.0000	0.0000	103.00
104.00	HRR adjustment amount for HSP bonus payment (see instructions)		0	0	104.00
Rural Community Hospital Demonstration Project (\$410A Demonstration) Adjustment					
200.00	Is this the first year of the current 5-year demonstration period under the 21st Century Cures Act? Enter "Y" for yes or "N" for no.				200.00
Cost Reimbursement					
201.00	Medicare inpatient service costs (from Wkst. D-1, Pt. II, line 49)				201.00
202.00	Medicare discharges (see instructions)				202.00
203.00	Case-mix adjustment factor (see instructions)				203.00
Computation of Demonstration Target Amount Limitation (N/A in first year of the current 5-year demonstration period)					
204.00	Medicare target amount				204.00
205.00	Case-mix adjusted target amount (line 203 times line 204)				205.00
206.00	Medicare inpatient routine cost cap (line 202 times line 205)				206.00
Adjustment to Medicare Part A Inpatient Reimbursement					
207.00	Program reimbursement under the \$410A Demonstration (see instructions)				207.00
208.00	Medicare Part A inpatient service costs (from Wkst. E, Pt. A, line 59)				208.00
209.00	Adjustment to Medicare IPPS payments (see instructions)				209.00
210.00	Reserved for future use				210.00
211.00	Total adjustment to Medicare IPPS payments (see instructions)				211.00
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

CALCULATION OF DSH PAYMENT PERCENTAGE

Provider CCN: 14-0002

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

Worksheet DSH

Date/Time Prepared:
5/28/2021 12:16 pm

		Title XVIII		Hospital		PPS	
		Original .mcrcx Values	Adjusted .mcrcx Values	HFS Look Up	Override Value	Revised Value	
		1.00	2.00	3.00	4.00	5.00	
CALCULATION OF THE DSH PAYMENT PERCENTAGE							
1.00	Percentage of SSI patient days to Medicare Part A days (Previous from E, Part A, line 30 - Revised from CMS)	4.62	0.00	0.00	0.00	0.00	1.00
2.00	Percentage of Medicaid patient days to total days (From line 27)	20.32	0.00			20.32	2.00
3.00	Sum of lines 1 and 2, if less than 15% DSH Payment Percentage = 0	24.94	0.00			20.32	3.00
4.00	Provider Type * (urban, rural, SCH, RRC, pickle - If pickle worksheet NA)	Urban				Urban	4.00
5.00	Bed days available divided by number of days in the cost reporting period (Worksheet E, Part A, Line 4)	118.74	0.00			118.74	5.00
6.00	Disproportionate Share Payment Percentage (transferred from Worksheet E, Part A, line 33)	9.79	0.00			5.98	6.00
7.00	Qualify for Operating DSH Eligibility (DPP 15% or more)?	Yes				Yes	7.00
8.00	S-2, Line 22	Yes				Yes	8.00
9.00	Qualify for Capital DSH Eligibility (Urban with 100 or more beds)?	Yes				No	9.00
10.00	S-2, Line 45	Yes				Yes	10.00
11.00	Is the provider reimbursed under the fully prospective method? (Worksheet L, Part I, line 1 greater than -0-)	Yes				Yes	11.00
12.00	Percentage of SSI patient days to Medicare Part A days (Previous from L, Part I, line 7 - Revised from CMS)	4.62	0.00	0.00	0.00	0.00	12.00
13.00	Is this an IRF provider or a provider with an IRF excluded unit (Worksheet S-2, line 75, column 1 = "Y")	No				No	13.00
14.00	Medicare SSI ratio (Previous from E-3, Part III, line 2 - Revised from CMS)	0.00	0.00	0.00	0.00	0.00	14.00
CALCULATION OF THE PERCENTAGE OF MEDICAID DAYS TO TOTAL DAYS							
15.00	In-State Medicaid paid days (Worksheet S-2, line 24, column 1)	549	0			549	15.00
16.00	In-State Medicaid eligible unpaid paid days (Worksheet S-2, line 24, column 2)	522	0			522	16.00
17.00	Out-of-State Medicaid paid days (Worksheet S-2, line 24, column 3)	4	0			4	17.00
18.00	Out-of-State Medicaid eligible unpaid days (Worksheet S-2, line 24, column 4)	7	0			7	18.00
18.01	N/A	0	0			0	18.01
19.00	Medicaid HMO days (Worksheet S-2, line 24, column 5)	4,094	0			4,094	19.00
20.00	Other Medicaid days (Worksheet S-2, line 24, column 6)	438	0			438	20.00
21.00	Total Medicaid patient days for the DSH calculation (sum of lines 15-20)	5,614	0			5,614	21.00
22.00	Total patient days (Worksheet S-3, Part I, Column 8, Line 14)	27,623	0			27,623	22.00
23.00	Plus total labor room days (Worksheet S-3, Part I, Column 8, Line 32)	0	0			0	23.00
24.00	Plus total employee discount days (Worksheet S-3, Part I, Column 8, Line 30)	0	0			0	24.00
25.00	Less total Swing-bed SNF and NF patient days (Worksheet S-3, Part I, Column 8, Lines 5 and 6)	0	0			0	25.00
26.00	Total Medicaid patient days for the DSH calculation (sum of lines 22-24, less line 25)	27,623	0			27,623	26.00
27.00	Percentage of Medicaid patient days to total days (Line 21 divided by line 26)	20.32	0.00			20.32	27.00

CALCULATION OF DSH PAYMENT PERCENTAGE			Provider CCN: 14-0002		Period: From 01/01/2020 To 12/31/2020		Worksheet DSH Date/Time Prepared: 5/28/2021 12:16 pm	
			Title XVIII		Hospital		PPS	
			Original .mcrx Values		Adjusted .mcax Values		Revised	
			Condition	Percentage	Condition	Percentage	Condition	
			1.00	2.00	3.00	4.00	5.00	
CALCULATION OF MAXIMUM DSH PAYMENT PERCENTAGE								
28.00	If line 3 is greater than 20.2% - 5.88% plus 82.5% of the difference between 20.2% and line 3	True	9.79		0.00	True	28.00	
29.00	If line 3 is less than 20.2% - 2.5% plus 65% of the difference between 15% and line 3	False	0.00		0.00	False	29.00	
30.00	Line 28 or 29 as applicable		9.79		0.00		30.00	
31.00	If Urban and fewer than 100 beds, Rural and fewer than 500 beds, or an SCH with less than 100 beds the lower of line 30 or .1200, if RRC, MDH or otherwise enter line 30.		9.79		0.00		31.00	
			Original .mcrx Values	Adjusted .mcax Values	HFS Look Up	Override Value	Revised Value	
			1.00	2.00	3.00	4.00	5.00	
DETERMINATION OF PROVIDER TYPE								
32.00	Does the hospital qualify under the Pickle ammendment? (Worksheet S-2, Part I, Line 22, column 2 = "Y")	False				False	32.00	
33.00	Is This a Rural Referral Center? (Worksheet S-2, Part I, line 116, column 1 = "Y")	False				False	33.00	
34.00	Is this a Medicare Dependant Hospital? (Worksheet S-2, Part I, Line 37 greater than -0-)	False				False	34.00	
35.00	Is this a Sole Community hospital? (Worksheet S-2, Part I, Line 35 greater than -0-)	False				False	35.00	
36.00	Is this an Urban or Rural hospital? (Worksheet S-2, Part I, Line 26, Column 1, Urban=1, Rural=2)	Urban				Urban	36.00	

CALCULATION OF DSH PAYMENT PERCENTAGE

Provider CCN: 14-0002

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

Worksheet DSH

Date/Time Prepared:
5/28/2021 12:16 pm

Title XVIII

Hospital

PPS

		Revised		
		Percentage		
		6.00		
	CALCULATION OF MAXIMUM DSH PAYMENT PERCENTAGE			
28.00	If line 3 is greater than 20.2% - 5.88% plus 82.5% of the difference between 20.2% and line 3	5.98		28.00
29.00	If line 3 is less than 20.2% - 2.5% plus 65% of the difference between 15% and line 3	0.00		29.00
30.00	Line 28 or 29 as applicable	5.98		30.00
31.00	If Urban and fewer than 100 beds, Rural and fewer than 500 beds, or an SCH with less than 100 beds the lower of line 30 or .1200, if RRC, MDH or otherwise enter line 30.	5.98		31.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0002	Period: From 01/01/2020 To 12/31/2020	Worksheet E Part B Date/Time Prepared: 5/28/2021 12:16 pm
		Title XVIII	Hospital	PPS
		1.00		
PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)		11,266	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)		19,035,029	2.00
3.00	OPPS payments		15,805,995	3.00
4.00	Outlier payment (see instructions)		27,058	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)		11,266	11.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
12.00	Ancillary service charges		25,628	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)		25,628	14.00
Customary charges				
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis		0	15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a chargebasis had such payment been made in accordance with 42 CFR §413.13(e)		0	16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)		0.000000	17.00
18.00	Total customary charges (see instructions)		25,628	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)		14,362	19.00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)		0	20.00
21.00	Lesser of cost or charges (see instructions)		11,266	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)		15,833,053	24.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25.00	Deductibles and coinsurance amounts (for CAH, see instructions)		0	25.00
26.00	Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)		2,864,922	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)		12,979,397	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)		12,979,397	30.00
31.00	Primary payer payments		7,177	31.00
32.00	Subtotal (line 30 minus line 31)		12,972,220	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)		502,876	34.00
35.00	Adjusted reimbursable bad debts (see instructions)		326,869	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		303,898	36.00
37.00	Subtotal (see instructions)		13,299,089	37.00
38.00	MSP-LCC reconciliation amount from PS&R		0	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	39.00
39.50	Pioneer ACO demonstration payment adjustment (see instructions)		0	39.50
39.97	Demonstration payment adjustment amount before sequestration		0	39.97
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)		0	39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION		0	39.99
40.00	Subtotal (see instructions)		13,299,089	40.00
40.01	Sequestration adjustment (see instructions)		87,774	40.01
40.02	Demonstration payment adjustment amount after sequestration		0	40.02
40.03	Sequestration adjustment-PARHM pass-throughs		0	40.03
41.00	Interim payments		13,228,106	41.00
41.01	Interim payments-PARHM		0	41.01
42.00	Tentative settlement (for contractors use only)		0	42.00
42.01	Tentative settlement-PARHM (for contractor use only)		0	42.01
43.00	Balance due provider/program (see instructions)		-16,791	43.00
43.01	Balance due provider/program-PARHM (see instructions)		0	43.01
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		0	44.00
TO BE COMPLETED BY CONTRACTOR				
90.00	Original outlier amount (see instructions)		0	90.00
91.00	Outlier reconciliation adjustment amount (see instructions)		0	91.00
92.00	The rate used to calculate the Time Value of Money		0.00	92.00
93.00	Time Value of Money (see instructions)		0	93.00
94.00	Total (sum of lines 91 and 93)		0	94.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 14-0002	Period: From 01/01/2020 To 12/31/2020	Worksheet E Part B Date/Time Prepared: 5/28/2021 12:16 pm
	Title XVIII	Hospital	PPS
			Overrides
			1.00
WORKSHEET OVERRIDE VALUES			
112.00	Override of Ancillary service charges (line 12)		0112.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0002 Component CCN: 14-S002	Period: From 01/01/2020 To 12/31/2020	Worksheet E Part B Date/Time Prepared: 5/28/2021 12:16 pm
		Title XVIII	Subprovider - IPF	PPS
				1.00
PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)		0	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)		0	2.00
3.00	OPPS payments		0	3.00
4.00	Outlier payment (see instructions)		0	4.00
4.01	Outlier reconciliation amount (see instructions)		0	4.01
5.00	Enter the hospital specific payment to cost ratio (see instructions)		0.000	5.00
6.00	Line 2 times line 5		0	6.00
7.00	Sum of lines 3, 4, and 4.01, divided by line 6		0.00	7.00
8.00	Transitional corridor payment (see instructions)		0	8.00
9.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200		0	9.00
10.00	Organ acquisitions		0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)		0	11.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
12.00	Ancillary service charges		0	12.00
13.00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, line 69)		0	13.00
14.00	Total reasonable charges (sum of lines 12 and 13)		0	14.00
Customary charges				
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis		0	15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)		0	16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)		0.000000	17.00
18.00	Total customary charges (see instructions)		0	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)		0	19.00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)		0	20.00
21.00	Lesser of cost or charges (see instructions)		0	21.00
22.00	Interns and residents (see instructions)		0	22.00
23.00	Cost of physicians' services in a teaching hospital (see instructions)		0	23.00
24.00	Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)		0	24.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25.00	Deductibles and coinsurance amounts (for CAH, see instructions)		0	25.00
26.00	Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)		0	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)		0	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)		0	30.00
31.00	Primary payer payments		0	31.00
32.00	Subtotal (line 30 minus line 31)		0	32.00
ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)				
33.00	Composite rate ESRD (from Wkst. I-5, line 11)		0	33.00
34.00	Allowable bad debts (see instructions)		0	34.00
35.00	Adjusted reimbursable bad debts (see instructions)		0	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		0	36.00
37.00	Subtotal (see instructions)		0	37.00
38.00	MSP-LCC reconciliation amount from PS&R		0	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	39.00
39.50	Pioneer ACO demonstration payment adjustment (see instructions)		39.50	
39.97	Demonstration payment adjustment amount before sequestration		0	39.97
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)		0	39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION		0	39.99
40.00	Subtotal (see instructions)		0	40.00
40.01	Sequestration adjustment (see instructions)		0	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		0	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)		0	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

CALCULATION OF REIMBURSEMENT SETTLEMENT

Provider CCN: 14-0002 Component CCN: 14-S002		Period: From 01/01/2020 To 12/31/2020	Worksheet E Part B Date/Time Prepared: 5/28/2021 12:16 pm	
Title XVIII		Subprovider - IPF	PPS	
			Overrides	
			1.00	
WORKSHEET OVERRIDE VALUES				
112.00	Override of Ancillary service charges (line 12)			0 112.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 14-0002

Period:
From 01/01/2020
To 12/31/2020Worksheet E-1
Part I
Date/Time Prepared:
5/28/2021 12:16 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		20,674,447		13,228,106	1.00	
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00	
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00	
Program to Provider							
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01	
3.02			0		0	3.02	
3.03			0		0	3.03	
3.04			0		0	3.04	
3.05			0		0	3.05	
Provider to Program							
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50	
3.51			0		0	3.51	
3.52			0		0	3.52	
3.53			0		0	3.53	
3.54			0		0	3.54	
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99	
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		20,674,447		13,228,106	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		139,896		0	6.01	
6.02	SETTLEMENT TO PROGRAM		0		16,791	6.02	
7.00	Total Medicare program liability (see instructions)		20,814,343		13,211,315	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: 14-0002

Period:

Worksheet E-1

Component CCN: 14-S002

From 01/01/2020
To 12/31/2020Part I
Date/Time Prepared:
5/28/2021 12:16 pm

Title XVIII

Subprovider -
IPF

PPS

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		405,236		0	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
Program to Provider						
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
Provider to Program						
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		405,236		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		15,870		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		421,106		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: 14-0002

Period:
From 01/01/2020
To 12/31/2020Worksheet E-1
Part II
Date/Time Prepared:
5/28/2021 12:16 pm

		Title XVIII	Hospital	PPS
				1.00
TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS				
HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION				
1.00	Total hospital discharges as defined in AARA §4102 from Wkst. S-3, Pt. I col. 15 line 14			1.00
2.00	Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, 8-12			2.00
3.00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2			3.00
4.00	Total inpatient days from S-3, Pt. I col. 8 sum of lines 1, 8-12			4.00
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200			5.00
6.00	Total hospital charity care charges from Wkst. S-10, col. 3 line 20			6.00
7.00	CAH only - The reasonable cost incurred for the purchase of certified HIT technology Wkst. S-2, Pt. I line 168			7.00
8.00	Calculation of the HIT incentive payment (see instructions)			8.00
9.00	Sequestration adjustment amount (see instructions)			9.00
10.00	Calculation of the HIT incentive payment after sequestration (see instructions)			10.00
INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH				
30.00	Initial/interim HIT payment adjustment (see instructions)			30.00
31.00	Other Adjustment (specify)			31.00
32.00	Balance due provider (line 8 (or line 10) minus line 30 and line 31) (see instructions)			32.00
				Overrides
				1.00
CONTRACTOR OVERRIDES				
108.00	Override of HIT payment			108.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0002	Period: From 01/01/2020 To 12/31/2020	Worksheet E-3 Part II Date/Time Prepared: 5/28/2021 12:16 pm
		Component CCN: 14-S002		
		Title XVIII	Subprovider - IPF	PPS
				1.00
PART II - MEDICARE PART A SERVICES - IPF PPS				
1.00	Net Federal IPF PPS Payments (excluding outlier, ECT, and medical education payments)		447,162	1.00
2.00	Net IPF PPS Outlier Payments		0	2.00
3.00	Net IPF PPS ECT Payments		0	3.00
4.00	Unweighted intern and resident FTE count in the most recent cost report filed on or before November 15, 2004. (see instructions)		0.00	4.00
4.01	Cap increases for the unweighted intern and resident FTE count for residents that were displaced by program or hospital closure, that would not be counted without a temporary cap adjustment under 42 CFR §412.424(d)(1)(iii)(F)(1) or (2) (see instructions)		0.00	4.01
5.00	New Teaching program adjustment. (see instructions)		0.00	5.00
6.00	Current year's unweighted FTE count of I&R excluding FTEs in the new program growth period of a "new teaching program" (see instructions)		0.00	6.00
7.00	Current year's unweighted I&R FTE count for residents within the new program growth period of a "new teaching program" (see instructions)		0.00	7.00
8.00	Intern and resident count for IPF PPS medical education adjustment (see instructions)		0.00	8.00
9.00	Average Daily Census (see instructions)		2.308743	9.00
10.00	Teaching Adjustment Factor $\{((1 + (\text{line 8/line 9})) \text{ raised to the power of } .5150 - 1)\}$.		0.000000	10.00
11.00	Teaching Adjustment (line 1 multiplied by line 10).		0	11.00
12.00	Adjusted Net IPF PPS Payments (sum of lines 1, 2, 3 and 11)		447,162	12.00
13.00	Nursing and Allied Health Managed Care payment (see instruction)		0	13.00
14.00	Organ acquisition (DO NOT USE THIS LINE)		0	14.00
15.00	Cost of physicians' services in a teaching hospital (see instructions)		0	15.00
16.00	Subtotal (see instructions)		447,162	16.00
17.00	Primary payer payments		0	17.00
18.00	Subtotal (line 16 less line 17).		447,162	18.00
19.00	Deductibles		35,024	19.00
20.00	Subtotal (line 18 minus line 19)		412,138	20.00
21.00	Coinurance		0	21.00
22.00	Subtotal (line 20 minus line 21)		412,138	22.00
23.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)		18,102	23.00
24.00	Adjusted reimbursable bad debts (see instructions)		11,766	24.00
25.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		1,364	25.00
26.00	Subtotal (sum of lines 22 and 24)		423,904	26.00
27.00	Direct graduate medical education payments (see instructions)		0	27.00
28.00	Other pass through costs (see instructions)		0	28.00
29.00	Outlier payments reconciliation		0	29.00
30.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	30.00
30.50	Pioneer ACO demonstration payment adjustment (see instructions)		0	30.50
30.99	Demonstration payment adjustment amount before sequestration		0	30.99
31.00	Total amount payable to the provider (see instructions)		423,904	31.00
31.01	Sequestration adjustment (see instructions)		2,798	31.01
31.02	Demonstration payment adjustment amount after sequestration		0	31.02
32.00	Interim payments		405,236	32.00
33.00	Tentative settlement (for contractor use only)		0	33.00
34.00	Balance due provider/program (line 31 minus lines 31.01, 31.02, 32 and 33)		15,870	34.00
35.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		0	35.00
TO BE COMPLETED BY CONTRACTOR				
50.00	Original outlier amount from Worksheet E-3, Part II, line 2		0	50.00
51.00	Outlier reconciliation adjustment amount (see instructions)		0	51.00
52.00	The rate used to calculate the Time Value of Money		0.00	52.00
53.00	Time Value of Money (see instructions)		0	53.00

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

Provider CCN: 14-0002

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

Worksheet G

Date/Time Prepared:
5/28/2021 12:16 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	617,290	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	25,561,842	0	0	0	4.00
5.00 Other receivable	1,333,245	0	0	0	5.00
6.00 Allowances for uncollectible notes and accounts receivable	-6,183,397	0	0	0	6.00
7.00 Inventory	2,252,414	0	0	0	7.00
8.00 Prepaid expenses	375,612	0	0	0	8.00
9.00 Other current assets	124,178	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)	24,081,184	0	0	0	11.00
FIXED ASSETS					
12.00 Land	177,168	0	0	0	12.00
13.00 Land improvements	6,563,799	0	0	0	13.00
14.00 Accumulated depreciation	-5,142,212	0	0	0	14.00
15.00 Buildings	133,259,167	0	0	0	15.00
16.00 Accumulated depreciation	-90,678,041	0	0	0	16.00
17.00 Leasehold improvements	0	0	0	0	17.00
18.00 Accumulated depreciation	0	0	0	0	18.00
19.00 Fixed equipment	1,095,041	0	0	0	19.00
20.00 Accumulated depreciation	-902,584	0	0	0	20.00
21.00 Automobiles and trucks	0	0	0	0	21.00
22.00 Accumulated depreciation	0	0	0	0	22.00
23.00 Major movable equipment	60,443,483	0	0	0	23.00
24.00 Accumulated depreciation	-49,152,163	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	3,769,559	0	0	0	27.00
28.00 Accumulated depreciation	-2,336,547	0	0	0	28.00
29.00 Minor equipment-nondepreciable	0	0	0	0	29.00
30.00 Total fixed assets (sum of lines 12-29)	57,096,670	0	0	0	30.00
OTHER ASSETS					
31.00 Investments	0	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	12,346,134	0	0	0	34.00
35.00 Total other assets (sum of lines 31-34)	12,346,134	0	0	0	35.00
36.00 Total assets (sum of lines 11, 30, and 35)	93,523,988	0	0	0	36.00
CURRENT LIABILITIES					
37.00 Accounts payable	1,140,434	0	0	0	37.00
38.00 Salaries, wages, and fees payable	5,654,221	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	28,869,587	0	0	0	44.00
45.00 Total current liabilities (sum of lines 37 thru 44)	35,664,242	0	0	0	45.00
LONG TERM LIABILITIES					
46.00 Mortgage payable	0	0	0	0	46.00
47.00 Notes payable	0	0	0	0	47.00
48.00 Unsecured loans	0	0	0	0	48.00
49.00 Other long term liabilities	3,930,158	0	0	0	49.00
50.00 Total long term liabilities (sum of lines 46 thru 49)	3,930,158	0	0	0	50.00
51.00 Total liabilities (sum of lines 45 and 50)	39,594,400	0	0	0	51.00
CAPITAL ACCOUNTS					
52.00 General fund balance	53,929,588	0	0	0	52.00
53.00 Specific purpose fund	0	0	0	0	53.00
54.00 Donor created - endowment fund balance - restricted	0	0	0	0	54.00
55.00 Donor created - endowment fund balance - unrestricted	0	0	0	0	55.00
56.00 Governing body created - endowment fund balance	0	0	0	0	56.00
57.00 Plant fund balance - invested in plant	0	0	0	0	57.00
58.00 Plant fund balance - reserve for plant improvement, replacement, and expansion	0	0	0	0	58.00
59.00 Total fund balances (sum of lines 52 thru 58)	53,929,588	0	0	0	59.00
60.00 Total liabilities and fund balances (sum of lines 51 and 59)	93,523,988	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 14-0002

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

Worksheet G-1

Date/Time Prepared:
5/28/2021 12:16 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		83,840,177		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		-8,176,241				2.00
3.00	Total (sum of line 1 and line 2)		75,663,936		0		3.00
4.00	CHAGE IN RESTRICTED ASSETS	1,042,637		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)		1,042,637		0		10.00
11.00	Subtotal (line 3 plus line 10)		76,706,573		0		11.00
12.00	TRANSFER TO BJC	22,776,985		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)		22,776,985		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		53,929,588		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	CHAGE IN RESTRICTED ASSETS		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	TRANSFER TO BJC		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: 14-0002

Period:
From 01/01/2020
To 12/31/2020Worksheet G-2
Parts I & II
Date/Time Prepared:
5/28/2021 12:16 pm

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
PART I - PATIENT REVENUES					
General Inpatient Routine Services					
1.00	Hospital	59,873,975		59,873,975	1.00
2.00	SUBPROVIDER - IPF	2,317,936		2,317,936	2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	0		0	5.00
6.00	Swing bed - NF	0		0	6.00
7.00	SKILLED NURSING FACILITY				7.00
8.00	NURSING FACILITY				8.00
9.00	OTHER LONG TERM CARE				9.00
10.00	Total general inpatient care services (sum of lines 1-9)	62,191,911		62,191,911	10.00
Intensive Care Type Inpatient Hospital Services					
11.00	INTENSIVE CARE UNIT	14,742,564		14,742,564	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)	14,742,564		14,742,564	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	76,934,475		76,934,475	17.00
18.00	Ancillary services	125,328,468	328,914,682	454,243,150	18.00
19.00	Outpatient services	0	0	0	19.00
20.00	RURAL HEALTH CLINIC	0	0	0	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY				22.00
23.00	AMBULANCE SERVICES	23,573	18,884,151	18,907,724	23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	OTHER (SPECIFY)	0	0	0	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	202,286,516	347,798,833	550,085,349	28.00
PART II - OPERATING EXPENSES					
29.00	Operating expenses (per Wkst. A, column 3, line 200)		159,252,132		29.00
30.00	ADD (SPECIFY)	0			30.00
31.00		0			31.00
32.00		0			32.00
33.00		0			33.00
34.00		0			34.00
35.00		0			35.00
36.00	Total additions (sum of lines 30-35)		0		36.00
37.00	NON OPERATING EXPENSES	12,584,962			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)		12,584,962		42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer to Wkst. G-3, line 4)		146,667,170		43.00

STATEMENT OF REVENUES AND EXPENSES

Provider CCN: 14-0002

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

Worksheet G-3

Date/Time Prepared:
5/28/2021 12:16 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	550,085,349	1.00
2.00	Less contractual allowances and discounts on patients' accounts	408,230,582	2.00
3.00	Net patient revenues (line 1 minus line 2)	141,854,767	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	146,667,170	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-4,812,403	5.00
OTHER INCOME			
6.00	Contributions, donations, bequests, etc	151,717	6.00
7.00	Income from investments	88,316	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	379,151	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	BJC OVERHEAD OTHER OPERATING REVENUE	241,816	24.00
24.01	EUNICE SMITH NET INCOME	716,541	24.01
24.02	BJC ACO OPERATIONS	2,187	24.02
24.03	OTHER OPERATING REVENUE	2,417,229	24.03
24.50	COVID-19 PHE Funding	8,076,639	24.50
25.00	Total other income (sum of lines 6-24)	12,073,596	25.00
26.00	Total (line 5 plus line 25)	7,261,193	26.00
27.00	PHYSICIAN PRACTICE OPERATIONS	15,247,122	27.00
27.01	POB NET LOSS	190,312	27.01
27.02	OTHER EXPENSES (SPECIFY)	0	27.02
28.00	Total other expenses (sum of line 27 and subscripts)	15,437,434	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	-8,176,241	29.00

CALCULATION OF CAPITAL PAYMENT		Provider CCN: 14-0002	Period: From 01/01/2020 To 12/31/2020	Worksheet L Parts I-III Date/Time Prepared: 5/28/2021 12:16 pm
		Title XVIII	Hospital	PPS
		1.00		
PART I - FULLY PROSPECTIVE METHOD				
CAPITAL FEDERAL AMOUNT				
1.00	Capital DRG other than outlier		1,526,666	1.00
1.01	Model 4 BPCI Capital DRG other than outlier		0	1.01
2.00	Capital DRG outlier payments		25,315	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)		71.28	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)		4.62	7.00
8.00	Percentage of Medicaid patient days to total days (see instructions)		20.32	8.00
9.00	Sum of lines 7 and 8		24.94	9.00
10.00	Allowable disproportionate share percentage (see instructions)		5.18	10.00
11.00	Disproportionate share adjustment (see instructions)		79,081	11.00
12.00	Total prospective capital payments (see instructions)		1,631,062	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