

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: 14-0013	Period: From 01/01/2020 To 12/31/2020	Worksheet S Parts I-III Date/Time Prepared: 7/22/2021 3:42 pm
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PART I - COST REPORT STATUS

Provider use only	1. ☒ Electronically prepared cost report	Date: 7/22/2021	Time: 3:42 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 PROCTOR HOSPITAL (14-0013) 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	-59,676	-65,932	0	0	1.00
2.00	Subprovider - IPF	0	41,992	350		0	2.00
3.00	Subprovider - IRF	0	0	0		0	3.00
5.00	Swing Bed - SNF	0	0	0		0	5.00
6.00	Swing Bed - NF	0				0	6.00
7.00	SKILLED NURSING FACILITY	0	2,078	0		0	7.00
9.00	HOME HEALTH AGENCY I	0	0	0		0	9.00
200.00	Total	0	-15,606	-65,582	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: 14-0013		Period: From 01/01/2020 To 12/31/2020		Worksheet S-2 Part I Date/Time Prepared: 7/22/2021 3:42 pm	
1.00		2.00		3.00		4.00				
Hospital and Hospital Health Care Complex Address:										
1.00	Street: 5409 N. KNOXVILLE			PO Box:				1.00		
2.00	City: PEORIA			State: IL		Zip Code: 61614		County: PEORIA		
		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		PROCTOR HOSPITAL	140013	37900	1	08/01/1996	N	P	P
4.00	Subprovider - IPF		PROCTOR HOSPITAL	14S013	37900	4	11/30/2012	N	P	P
5.00	Subprovider - IRF									
6.00	Subprovider - (Other)									
7.00	Swing Beds - SNF									
8.00	Swing Beds - NF									
9.00	Hospital-Based SNF		PROCTOR HOSPITAL	145579	37900		11/03/1987	N	P	P
10.00	Hospital-Based NF									
11.00	Hospital-Based OLTC									
12.00	Hospital-Based HHA									
13.00	Separately Certified ASC									
14.00	Hospital-Based Hospice									
15.00	Hospital-Based Health Clinic - RHC									
16.00	Hospital-Based Health Clinic - FQHC									
17.00	Hospital-Based (CMHC) I									
18.00	Renal Dialysis		PROCTOR HOSPITAL	142337	37900		05/09/2019			
18.01	Renal Dialysis		PROCTOR HOSPITAL	142338	37900		05/26/2020			
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.					N				22.00
22.01	Did this hospital receive interim uncompensated care payments for this cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)					N	N			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.			0	122	0	0	558	0	24.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

Provider CCN: 14-0013

Period:
From 01/01/2020
To 12/31/2020Worksheet S-2
Part I
Date/Time Prepared:
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		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
46.00	Is this facility eligible for additional payment exception for extraordinary circumstances pursuant to 42 CFR §412.348(f)? If yes, complete Wkst. L, Pt. III and Wkst. L-1, Pt. I through Pt. III.					N	N	N
47.00	Is this a new hospital under 42 CFR §412.300(b) PPS capital? Enter "Y" for yes or "N" for no.					N	N	N
48.00	Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.					N	N	N
Teaching Hospitals								
56.00	Is this a hospital involved in training residents in approved GME programs? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", are you impacted by CR 11642 (or subsequent CR), MA GME payment reduction? Enter "Y" for yes or "N" for no in column 2.					N		
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.							
58.00	If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, chapter 21, §2148? If yes, complete Wkst. D-5.					N		
59.00	Are costs claimed on line 100 of Worksheet A? If yes, complete Wkst. D-2, Pt. I.					N		
				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: 14-0013

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From 01/01/2020
To 12/31/2020Worksheet S-2
Part I
Date/Time Prepared:
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	Y/N	IME	Direct GME	IME	Direct GME	
	1.00	2.00	3.00	4.00	5.00	
61.00 Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions)				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		
64.00 Section 5504 of the ACA Base Year FTE Residents in Nonprovider Settings--This base year is your cost reporting period that begins on or after July 1, 2009 and before June 30, 2010. Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)		0.00	0.00	0.000000		64.00

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	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	3.00			
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: 14-0013	Period: From 01/01/2020 To 12/31/2020	Worksheet S-2 Part I Date/Time Prepared: 7/22/2021 3:42 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.		N	92.00	
93.00	Does this facility operate an ICF/IID facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.	N	N	93.00	
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.	N	N	94.00	
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	95.00	
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.	N	N	96.00	
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	97.00	
98.00	Does title V or XIX follow Medicare (title XVIII) for the interns and residents post stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.00	
98.01	Does title V or XIX follow Medicare (title XVIII) for the reporting of charges on Wkst. C, Pt. I? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.01	
98.02	Does title V or XIX follow Medicare (title XVIII) for the calculation of observation bed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.02	
98.03	Does title V or XIX follow Medicare (title XVIII) for a critical access hospital (CAH) reimbursed 101% of inpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.03	
98.04	Does title V or XIX follow Medicare (title XVIII) for a CAH reimbursed 101% of outpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.04	
98.05	Does title V or XIX follow Medicare (title XVIII) and add back the RCE disallowance on Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.05	
98.06	Does title V or XIX follow Medicare (title XVIII) when cost reimbursed for Wkst. D, Pts. I through IV? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.06	
Rural Providers					
105.00	Does this hospital qualify as a CAH?	N		105.00	
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)			106.00	
107.00	Column 1: If line 105 is Y, is this facility eligible for cost reimbursement for I&R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) Column 2: If column 1 is Y and line 70 or line 75 is Y, do you train I&Rs in an approved medical education program in the CAH's excluded IPF and/or IRF unit(s)? Enter "Y" for yes or "N" for no in column 2. (see instructions)	N		107.00	
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: 14-0013	Period: From 01/01/2020 To 12/31/2020	Worksheet S-2 Part I Date/Time Prepared: 7/22/2021 3:42 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		0115.00
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:	1,427,009	0	2,014118.01
		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	HB0721	140.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA				Provider CCN: 14-0013		Period: From 01/01/2020 To 12/31/2020		Worksheet S-2 Part I Date/Time Prepared: 7/22/2021 3:42 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: PEORIA HOME OFFICE		Contractor's Name: NGS		Contractor's Number: 00131				141.00	
142.00	Street: 221 NE GLEN OAK		PO Box:						142.00	
143.00	City: PEORIA		State: IL		Zip Code: 61636				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.				N		N		145.00	
146.00	Has the cost allocation methodology changed from the previously filed cost report? Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, chapter 40, §4020) If yes, enter the approval date (mm/dd/yyyy) in column 2.				N				146.00	
								1.00		
147.00	Was there a change in the statistical basis? Enter "Y" for yes or "N" for no.								N	147.00
148.00	Was there a change in the order of allocation? Enter "Y" for yes or "N" for no.								N	148.00
149.00	Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no.								N	149.00
				Part A	Part B	Title V	Title XIX			
				1.00	2.00	3.00	4.00			
Does this facility contain a provider that qualifies for an exemption from the application of the lower of costs or charges? Enter "Y" for yes or "N" for no for each component for Part A and Part B. (See 42 CFR §413.13)										
155.00	Hospital			N	N	N	N			155.00
156.00	Subprovider - IPF			N	N	N	N			156.00
157.00	Subprovider - IRF			N	N	N	N			157.00
158.00	SUBPROVIDER									158.00
159.00	SNF			N	N	N	N			159.00
160.00	HOME HEALTH AGENCY			N	N	N	N			160.00
161.00	CMHC				N	N	N			161.00
								1.00		
Multicampus										
165.00	Is this hospital part of a Multicampus hospital that has one or more campuses in different CBSAs? Enter "Y" for yes or "N" for no.								N	165.00
		Name	County	State	Zip Code	CBSA	FTE/Campus			
		0	1.00	2.00	3.00	4.00	5.00			
166.00	If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions)						0.00			166.00
								1.00		
Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act										
167.00	Is this provider a meaningful user under §1886(n)? Enter "Y" for yes or "N" for no.								Y	167.00
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)									168.00
168.01	If this provider is a CAH and is not a meaningful user, does this provider qualify for a hardship exception under §413.70(a)(6)(ii)? Enter "Y" for yes or "N" for no. (see instructions)									168.01
169.00	If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)								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	171.00	

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 14-0013	Period: From 01/01/2020 To 12/31/2020	Worksheet S-2 Part II Date/Time Prepared: 7/22/2021 3:42 pm
			Y/N 1.00	Date 2.00
General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format.				
COMPLETED BY ALL HOSPITALS				
Provider Organization and Operation				
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)	N		1.00
		Y/N 1.00	Date 2.00	V/I 3.00
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.	N		2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)	N		3.00
		Y/N 1.00	Type 2.00	Date 3.00
Financial Data and Reports				
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	Y	A	4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.	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.		N	13.00
14.00	If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.		N	14.00
Bed Complement				
15.00	Did total beds available change from the prior cost reporting period? If yes, see instructions.		N	15.00
		Part A		Part B
		Y/N 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)	N		16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	Y	05/13/2021	17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N		18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		19.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE

Provider CCN: 14-0013

Period:
From 01/01/2020
To 12/31/2020Worksheet S-2
Part II
Date/Time Prepared:
7/22/2021 3:42 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				22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.				23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions				24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.				25.00
26.00	Were assets subject to Sec.2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.				26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.				27.00
Interest Expense					
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.				28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions				29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.				30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.				31.00
Purchased Services					
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.				32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.				33.00
Provider-Based Physicians					
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.				34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.				35.00
		Y/N	Date		
		1.00	2.00		
Home Office Costs					
36.00	Were home office costs claimed on the cost report?		Y		36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.		Y		37.00
38.00	If line 36 is yes, was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.		N		38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.		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.	KEITH	LYONS		41.00
42.00	Enter the employer/company name of the cost report preparer.	UNITYPOINT HEALTH			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	309-712-1132	JONATHAN.LYONS@UNITYPOINT.ORG		43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE

Provider CCN: 14-0013

Period:
From 01/01/2020
To 12/31/2020Worksheet S-2
Part II
Date/Time Prepared:
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		3.00	
Cost Report Preparer Contact Information			
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	SENIOR REIMBURSEMENT ANALYST	41.00
42.00	Enter the employer/company name of the cost report preparer.		42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.		43.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 14-0013

Period:
From 01/01/2020
To 12/31/2020Worksheet S-3
Part I
Date/Time Prepared:
7/22/2021 3:42 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	93	34,038	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)		93	34,038	0.00	0	7.00
8.00 INTENSIVE CARE UNIT	31.00	16	5,856	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)		109	39,894	0.00	0	14.00
15.00 CAH visits					0	15.00
16.00 SUBPROVIDER - IPF	40.00	18	6,588		0	16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY	44.00	43	15,738		0	19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY	101.00				0	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)		170				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: 14-0013

Period:
From 01/01/2020
To 12/31/2020Worksheet S-3
Part I
Date/Time Prepared:
7/22/2021 3:42 pm

Component		I/P Days / O/P Visits / Trips			Full Time Equivalents		
		Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
		6.00	7.00	8.00	9.00	10.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	4,446	635	8,859			1.00
2.00	HMO and other (see instructions)	2,731	0				2.00
3.00	HMO IPF Subprovider	0	0				3.00
4.00	HMO IRF Subprovider	0	0				4.00
5.00	Hospital Adults & Peds. Swing Bed SNF	0	0	0			5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	0			6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	4,446	635	8,859			7.00
8.00	INTENSIVE CARE UNIT	509	45	1,187			8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY		0	0			13.00
14.00	Total (see instructions)	4,955	680	10,046	0.00	431.49	14.00
15.00	CAH visits	0	0	0			15.00
16.00	SUBPROVIDER - IPF	2,528	0	3,528	0.00	28.54	16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY	6,116	0	8,907	0.00	43.26	19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY	0	0	0	0.00	0.00	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	503.29	27.00
28.00	Observation Bed Days		252	2,302			28.00
29.00	Ambulance Trips	0					29.00
30.00	Employee discount days (see instruction)			156			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: 14-0013

Period:
From 01/01/2020
To 12/31/2020Worksheet S-3
Part I
Date/Time Prepared:
7/22/2021 3:42 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	1,157	161	2,355	1.00
2.00 HMO and other (see instructions)			578	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	1,157	161	2,355	14.00
15.00 CAH visits						15.00
16.00 SUBPROVIDER - IPF	0.00	0	147	0	226	16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY	0.00					19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY	0.00					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: 14-0013

Period:
From 01/01/2020
To 12/31/2020Worksheet S-3
Part II
Date/Time Prepared:
7/22/2021 3:42 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	25,628,213	-143,405	25,484,808	992,388.00	25.68
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		0	0	0	0.00	0.00
4.01	Physicians - Part A - Teaching		0	0	0	0.00	0.00
5.00	Physician and Non Physician-Part B		0	0	0	0.00	0.00
6.00	Non-physician-Part B for hospital-based RHC and FQHC services		0	0	0	0.00	0.00
7.00	Interns & residents (in an approved program)	21.00	0	0	0	0.00	0.00
7.01	Contracted interns and residents (in an approved programs)		0	0	0	0.00	0.00
8.00	Home office and/or related organization personnel		0	0	0	0.00	0.00
9.00	SNF	44.00	2,089,356	-1,051,038	1,038,318	44,088.00	23.55
10.00	Excluded area salaries (see instructions)		2,067,034	184,215	2,251,249	101,811.00	22.11
OTHER WAGES & RELATED COSTS							
11.00	Contract labor: Direct Patient Care		3,167,453	0	3,167,453	67,230.00	47.11
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		0	0	0	0.00	0.00
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		7,739,308	0	7,739,308	214,431.00	36.09
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)		7,631,566	0	7,631,566		
18.00	Wage-related costs (other) (see instructions)						
19.00	Excluded areas		1,595,179	0	1,595,179		
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		0	0	0		
22.01	Physician Part A - Teaching		0	0	0		
23.00	Physician Part B		18,925	0	18,925		
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)		1,827,879	0	1,827,879		
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: 14-0013

Period:
From 01/01/2020
To 12/31/2020Worksheet S-3
Part II
Date/Time Prepared:
7/22/2021 3:42 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	398,716	0	398,716	15,526.00	25.68	26.00
27.00	Administrative & General	5.00	572,811	0	572,811	27,117.00	21.12	27.00
28.00	Administrative & General under contract (see inst.)		203,529	0	203,529	774.00	262.96	28.00
29.00	Maintenance & Repairs	6.00	0	0	0	0.00	0.00	29.00
30.00	Operation of Plant	7.00	1,085,947	0	1,085,947	45,079.00	24.09	30.00
31.00	Laundry & Linen Service	8.00	29,107	0	29,107	2,084.00	13.97	31.00
32.00	Housekeeping	9.00	875,767	0	875,767	57,542.00	15.22	32.00
33.00	Housekeeping under contract (see instructions)		0	0	0	0.00	0.00	33.00
34.00	Dietary	10.00	894,144	-571,008	323,136	16,373.00	19.74	34.00
35.00	Dietary under contract (see instructions)		0	0	0	0.00	0.00	35.00
36.00	Cafeteria	11.00	0	386,793	386,793	23,920.00	16.17	36.00
37.00	Maintenance of Personnel	12.00	0	0	0	0.00	0.00	37.00
38.00	Nursing Administration	13.00	83,269	0	83,269	2,765.00	30.12	38.00
39.00	Central Services and Supply	14.00	369,437	0	369,437	21,709.00	17.02	39.00
40.00	Pharmacy	15.00	973,172	0	973,172	27,685.00	35.15	40.00
41.00	Medical Records & Medical Records Library	16.00	0	0	0	0.00	0.00	41.00
42.00	Social Service	17.00	0	0	0	0.00	0.00	42.00
43.00	Other General Service	18.00	0	0	0	0.00	0.00	43.00

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 14-0013

Period:
From 01/01/2020
To 12/31/2020Worksheet S-3
Part III
Date/Time Prepared:
7/22/2021 3:42 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)	25,831,742	-143,405	25,688,337	993,162.00	25.87	1.00
2.00	Excluded area salaries (see instructions)	4,156,390	-866,823	3,289,567	145,899.00	22.55	2.00
3.00	Subtotal salaries (line 1 minus line 2)	21,675,352	723,418	22,398,770	847,263.00	26.44	3.00
4.00	Subtotal other wages & related costs (see inst.)	10,906,761	0	10,906,761	281,661.00	38.72	4.00
5.00	Subtotal wage-related costs (see inst.)	9,459,445	0	9,459,445	0.00	42.23	5.00
6.00	Total (sum of lines 3 thru 5)	42,041,558	723,418	42,764,976	1,128,924.00	37.88	6.00
7.00	Total overhead cost (see instructions)	5,485,899	-184,215	5,301,684	240,574.00	22.04	7.00

HOSPITAL WAGE RELATED COSTS

Provider CCN: 14-0013

Period:
From 01/01/2020
To 12/31/2020Worksheet S-3
Part IV
Date/Time Prepared:
7/22/2021 3:42 pm

		Amount Reported	
		1.00	
PART IV - WAGE RELATED COSTS			
Part A - Core List			
RETIREMENT COST			
1.00	401K Employer Contributions	921,774	1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution	0	2.00
3.00	Nonqualified Defined Benefit Plan Cost (see instructions)	0	3.00
4.00	Qualified Defined Benefit Plan Cost (see instructions)	2,164,167	4.00
PLAN ADMINISTRATIVE COSTS (Paid to External Organization)			
5.00	401K/TSA Plan Administration fees	0	5.00
6.00	Legal/Accounting/Management Fees-Pension Plan	0	6.00
7.00	Employee Managed Care Program Administration Fees	0	7.00
HEALTH AND INSURANCE COST			
8.00	Health Insurance (Purchased or Self Funded)	0	8.00
8.01	Health Insurance (Self Funded without a Third Party Administrator)	0	8.01
8.02	Health Insurance (Self Funded with a Third Party Administrator)	2,886,562	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	67,420	10.00
11.00	Life Insurance (If employee is owner or beneficiary)	15,611	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)	207,948	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)	0	14.00
15.00	'Workers' Compensation Insurance	1,020,446	15.00
16.00	Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. Non cumulative portion)	0	16.00
TAXES			
17.00	FICA-Employers Portion Only	1,849,796	17.00
18.00	Medicare Taxes - Employers Portion Only	0	18.00
19.00	Unemployment Insurance	73,642	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	38,303	23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)	9,245,669	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: 14-0013

Period:
From 01/01/2020
To 12/31/2020Worksheet S-3
Part V
Date/Time Prepared:
7/22/2021 3:42 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	0	0	8.00
9.00	Hospital-Based NF			9.00
10.00	Hospital-Based OLTC			10.00
11.00	Hospital-Based HHA	0	0	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: 14-0013	Period: From 01/01/2020 To 12/31/2020	Worksheet S-10 Date/Time Prepared: 7/22/2021 3:42 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)			0.180138 1.00
Medicaid (see instructions for each line)				
2.00	Net revenue from Medicaid			3,695,610 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?			4.00
5.00	If line 4 is no, then enter DSH and/or supplemental payments from Medicaid	195,344		5.00
6.00	Medicaid charges	52,695,154		6.00
7.00	Medicaid cost (line 1 times line 6)	9,492,400		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)	5,601,446		8.00
Children's Health Insurance Program (CHIP) (see instructions for each line)				
9.00	Net revenue from stand-alone CHIP	0		9.00
10.00	Stand-alone CHIP charges	0		10.00
11.00	Stand-alone CHIP cost (line 1 times line 10)	0		11.00
12.00	Difference between net revenue and costs for stand-alone CHIP (line 11 minus line 9; if < zero then enter zero)	0		12.00
Other state or local government indigent care program (see instructions for each line)				
13.00	Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9)	0		13.00
14.00	Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)	0		14.00
15.00	State or local indigent care program cost (line 1 times line 14)	0		15.00
16.00	Difference between net revenue and costs for state or local indigent care program (line 15 minus line 13; if < zero then enter zero)	0		16.00
Grants, donations and total unreimbursed cost for Medicaid, CHIP and state/local indigent care programs (see instructions for each line)				
17.00	Private grants, donations, or endowment income restricted to funding charity care	0		17.00
18.00	Government grants, appropriations or transfers for support of hospital operations	0		18.00
19.00	Total unreimbursed cost for Medicaid, CHIP and state and local indigent care programs (sum of lines 8, 12 and 16)	5,601,446		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)	3,443,235	1,721,741	5,164,976 20.00
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	620,257	1,721,741	2,341,998 21.00
22.00	Payments received from patients for amounts previously written off as charity care	0	0	0 22.00
23.00	Cost of charity care (line 21 minus line 22)	620,257	1,721,741	2,341,998 23.00
				1.00
24.00	Does the amount on line 20 column 2, include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?	N		24.00
25.00	If line 24 is yes, enter the charges for patient days beyond the indigent care program's length of stay limit	0		25.00
26.00	Total bad debt expense for the entire hospital complex (see instructions)	4,426,352		26.00
27.00	Medicare reimbursable bad debts for the entire hospital complex (see instructions)	229,848		27.00
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)	353,612		27.01
28.00	Non-Medicare bad debt expense (see instructions)	4,072,740		28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)	857,419		29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)	3,199,417		30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	8,800,863		31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-0013

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

Worksheet A

Date/Time Prepared:
7/22/2021 3:42 pm

Cost Center Description			Salaries	Other	Total (col. 1 + col. 2)	Reclassificati ons (See A-6)	Reclassified Trial Balance (col. 3 + col. 4)	
			1.00	2.00	3.00	4.00	5.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT		1,279,258	1,279,258	111,667	1,390,925	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		0	0	0	0	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	398,716	483,117	881,833	-1,362	880,471	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	572,811	6,561,844	7,134,655	-123,400	7,011,255	5.00
6.00	00600	MAINTENANCE & REPAIRS	0	1,776,473	1,776,473	-3	1,776,470	6.00
7.00	00700	OPERATION OF PLANT	1,085,947	2,483,490	3,569,437	-71	3,569,366	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	29,107	-7,178	21,929	0	21,929	8.00
9.00	00900	HOUSEKEEPING	875,767	677,753	1,553,520	-4,785	1,548,735	9.00
10.00	01000	DIETARY	894,144	835,749	1,729,893	-1,187,129	542,764	10.00
11.00	01100	CAFETERIA	0	0	0	800,612	800,612	11.00
13.00	01300	NURSING ADMINISTRATION	83,269	23,178	106,447	0	106,447	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	369,437	644,312	1,013,749	-155,869	857,880	14.00
15.00	01500	PHARMACY	973,172	3,121,683	4,094,855	-2,814,472	1,280,383	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	4,439,516	3,992,831	8,432,347	-2,838,596	5,593,751	30.00
31.00	03100	INTENSIVE CARE UNIT	847,757	585,793	1,433,550	-120,506	1,313,044	31.00
40.00	04000	SUBPROVIDER - IPF	1,401,764	808,524	2,210,288	-17,928	2,192,360	40.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
44.00	04400	SKILLED NURSING FACILITY	2,089,356	2,057,263	4,146,619	-2,140,009	2,006,610	44.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	2,508,199	28,631,811	31,140,010	-16,832,502	14,307,508	50.00
51.00	05100	RECOVERY ROOM	1,614,287	670,615	2,284,902	-144,529	2,140,373	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	70,366	454,484	524,850	-262,149	262,701	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,499,554	1,135,198	2,634,752	-417,688	2,217,064	54.00
57.00	05700	CT SCAN	406,721	440,561	847,282	-139,623	707,659	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	231,550	672,792	904,342	-53,577	850,765	58.00
60.00	06000	LABORATORY	1,194,023	2,443,795	3,637,818	-280,602	3,357,216	60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	0	0	0	143,405	143,405	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	1,135,532	1,135,532	64.00
65.00	06500	RESPIRATORY THERAPY	551,354	267,563	818,917	-110,190	708,727	65.00
66.00	06600	PHYSICAL THERAPY	0	621,547	621,547	987,484	1,609,031	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	750,758	750,758	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	275,141	275,141	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	11,549	5,546	17,095	-1,447	15,648	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	6,639,462	6,639,462	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	12,847,394	12,847,394	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	3,182,818	3,182,818	73.00
74.00	07400	RENAL DIALYSIS	260,623	635,472	896,095	-313,996	582,099	74.00
76.00	03950	ANCILLARY	0	0	0	-107	-107	76.00
76.01	03560	PULMONARY FUNCTION TESTING	0	0	0	23,676	23,676	76.01
76.02	03340	GASTRO INTESTINAL SERVICES	0	10,746	10,746	48,138	58,884	76.02
76.03	03140	CARDIOLOGY	385,616	630,136	1,015,752	-235,292	780,460	76.03
76.97	07697	CARDIAC REHABILITATION	389,125	127,769	516,894	-51,735	465,159	76.97
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	132,656	131,035	263,691	1,899,503	2,163,194	90.00
91.00	09100	EMERGENCY	1,646,557	2,147,145	3,793,702	-979,324	2,814,378	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
OTHER REIMBURSABLE COST CENTERS								
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	24,962,943	64,350,305	89,313,248	-381,301	88,931,947	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
194.00	07950	UN-USED SQR FT - HOSPITAL	0	0	0	0	0	194.00
194.01	07951	MEALS ON WHEELS	0	0	0	0	0	194.01
194.02	07952	MARKETING	0	0	0	0	0	194.02
194.03	07953	GUEST MEALS	0	0	0	0	0	194.03
194.04	07954	PHYSICIAN/OTHER MEALS	0	0	0	294,907	294,907	194.04
194.05	07955	FOUNDATION	0	0	0	0	0	194.05
194.06	07956	DAYCARE CENTER	665,270	318,019	983,289	86,394	1,069,683	194.06
194.07	07957	UN-USED SQR FT - POB	0	0	0	0	0	194.07
194.08	07958	SENIOR SERVICES	0	0	0	0	0	194.08
194.09	07959	ARC BROMENN	0	3,408	3,408	0	3,408	194.09
194.10	07960	ARC INGALLS	0	406	406	0	406	194.10
200.00		TOTAL (SUM OF LINES 118 through 199)	25,628,213	64,672,138	90,300,351	0	90,300,351	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-0013

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

Worksheet A

Date/Time Prepared:
7/22/2021 3:42 pm

Cost Center Description			Adjustments (See A-8)	Net Expenses For Allocation	
			6.00	7.00	
GENERAL SERVICE COST CENTERS					
1.00	00100	CAP REL COSTS-BLDG & FIXT	141,783	1,532,708	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	0	0	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-1,416,909	-536,438	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	11,261,767	18,273,022	5.00
6.00	00600	MAINTENANCE & REPAIRS	220,433	1,996,903	6.00
7.00	00700	OPERATION OF PLANT	23,001	3,592,367	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	-6,110	15,819	8.00
9.00	00900	HOUSEKEEPING	0	1,548,735	9.00
10.00	01000	DIETARY	24,813	567,577	10.00
11.00	01100	CAFETERIA	0	800,612	11.00
13.00	01300	NURSING ADMINISTRATION	1,639,464	1,745,911	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	-96,508	761,372	14.00
15.00	01500	PHARMACY	-19,493	1,260,890	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,081,651	1,081,651	16.00
17.00	01700	SOCIAL SERVICE	0	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	329,237	5,922,988	30.00
31.00	03100	INTENSIVE CARE UNIT	18,896	1,331,940	31.00
40.00	04000	SUBPROVIDER - IPF	-158,700	2,033,660	40.00
43.00	04300	NURSERY	0	0	43.00
44.00	04400	SKILLED NURSING FACILITY	23,173	2,029,783	44.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	-880,439	13,427,069	50.00
51.00	05100	RECOVERY ROOM	-500	2,139,873	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	52.00
53.00	05300	ANESTHESIOLOGY	69,420	332,121	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-32,066	2,184,998	54.00
57.00	05700	CT SCAN	147,472	855,131	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	24,230	874,995	58.00
60.00	06000	LABORATORY	-154,803	3,202,413	60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	0	143,405	63.00
64.00	06400	INTRAVENOUS THERAPY	0	1,135,532	64.00
65.00	06500	RESPIRATORY THERAPY	0	708,727	65.00
66.00	06600	PHYSICAL THERAPY	-1,528	1,607,503	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	750,758	67.00
68.00	06800	SPEECH PATHOLOGY	0	275,141	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	15,648	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	6,639,462	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	12,847,394	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	3,182,818	73.00
74.00	07400	RENAL DIALYSIS	-209,325	372,774	74.00
76.00	03950	ANCILLARY	0	-107	76.00
76.01	03560	PULMONARY FUNCTION TESTING	0	23,676	76.01
76.02	03340	GASTRO INTESTINAL SERVICES	12,427	71,311	76.02
76.03	03140	CARDIOLOGY	73,800	854,260	76.03
76.97	07697	CARDIAC REHABILITATION	50,123	515,282	76.97
OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	41,501	2,204,695	90.00
91.00	09100	EMERGENCY	-1,126,211	1,688,167	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART			92.00
OTHER REIMBURSABLE COST CENTERS					
101.00	10100	HOME HEALTH AGENCY	0	0	101.00
SPECIAL PURPOSE COST CENTERS					
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	11,080,599	100,012,546	118.00
NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	190.00
194.00	07950	UN-USED SQR FT - HOSPITAL	0	0	194.00
194.01	07951	MEALS ON WHEELS	0	0	194.01
194.02	07952	MARKETING	0	0	194.02
194.03	07953	GUEST MEALS	0	0	194.03
194.04	07954	PHYSICIAN/OTHER MEALS	0	294,907	194.04
194.05	07955	FOUNDATION	0	0	194.05
194.06	07956	DAYCARE CENTER	0	1,069,683	194.06
194.07	07957	UN-USED SQR FT - POB	0	0	194.07
194.08	07958	SENIOR SERVICES	0	0	194.08
194.09	07959	ARC BROMENN	0	3,408	194.09
194.10	07960	ARC INGALLS	17,873	18,279	194.10
200.00		TOTAL (SUM OF LINES 118 through 199)	11,098,472	101,398,823	200.00

RECLASSIFICATIONS

Provider CCN: 14-0013

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

Worksheet A-6

Date/Time Prepared:
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Increases					
	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
A - CAFETERIA RECLASS					
1.00	CAFETERIA	11.00	386,793	413,819	1.00
2.00	PHYSICIAN/OTHER MEALS	194.04	142,476	152,431	2.00
3.00	DAYCARE CENTER	194.06	41,739	44,655	3.00
	0		571,008	610,905	
D - INSURANCE					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	111,667	1.00
	TOTALS		0	111,667	
F - DRUGS RECLASS					
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	3,182,818	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
	0		0	3,182,818	
G - MED SUPPLIES RECLASS					
1.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	6,639,462	1.00
2.00	GASTRO INTESTINAL SERVICES	76.02	0	238	2.00
3.00		0.00	0	0	3.00
4.00		0.00	0	0	4.00
5.00		0.00	0	0	5.00
6.00		0.00	0	0	6.00
7.00		0.00	0	0	7.00
8.00		0.00	0	0	8.00
9.00		0.00	0	0	9.00
10.00		0.00	0	0	10.00
11.00		0.00	0	0	11.00
12.00		0.00	0	0	12.00
13.00		0.00	0	0	13.00
14.00		0.00	0	0	14.00
15.00		0.00	0	0	15.00
16.00		0.00	0	0	16.00
17.00		0.00	0	0	17.00
18.00		0.00	0	0	18.00
19.00		0.00	0	0	19.00
20.00		0.00	0	0	20.00
21.00		0.00	0	0	21.00
22.00		0.00	0	0	22.00
23.00		0.00	0	0	23.00
24.00		0.00	0	0	24.00
25.00		0.00	0	0	25.00
26.00		0.00	0	0	26.00
27.00		0.00	0	0	27.00
	0		0	6,639,700	
I - IMPLANTIBLE RECLASS					
1.00	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	12,847,394	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

RECLASSIFICATIONS

Provider CCN: 14-0013

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

Worksheet A-6

Date/Time Prepared:
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Increases					
	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
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
	0		0	12,847,394	
J - BLOOD RECLASS					
1.00	BLOOD STORING, PROCESSING, & TRANS.	63.00	0	143,405	1.00
	0		0	143,405	
K - COST CENTER MAPPING					
1.00	OPERATING ROOM	50.00	94,632	35,655	1.00
2.00	ANESTHESIOLOGY	53.00	2,676	892	2.00
3.00	RADIOLOGY-DIAGNOSTIC	54.00	4,895	2,631	3.00
4.00	INTRAVENOUS THERAPY	64.00	586,868	548,664	4.00
5.00	RESPIRATORY THERAPY	65.00	35,800	11,307	5.00
6.00	PHYSICAL THERAPY	66.00	605,913	555,840	6.00
7.00	OCCUPATIONAL THERAPY	67.00	340,565	410,193	7.00
8.00	SPEECH PATHOLOGY	68.00	104,560	170,581	8.00
9.00	PULMONARY FUNCTION TESTING	76.01	17,718	5,958	9.00
10.00	GASTRO INTESTINAL SERVICES	76.02	21,870	26,030	10.00
11.00	CARDIOLOGY	76.03	132,134	121,615	11.00
12.00	CLINIC	90.00	1,002,291	911,392	12.00
	0		2,949,922	2,800,758	
500.00	Grand Total: Increases		3,520,930	26,336,647	500.00

RECLASSIFICATIONS

Provider CCN: 14-0013

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

Worksheet A-6

Date/Time Prepared:
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Decreases						
	Cost Center	Line #	Salary	Other	wkst. A-7 Ref.	
	6.00	7.00	8.00	9.00	10.00	
A - CAFETERIA RECLASS						
1.00	DIETARY	10.00	571,008	610,905	0	1.00
2.00		0.00	0	0	0	2.00
3.00		0.00	0	0	0	3.00
	0		571,008	610,905		
D - INSURANCE						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	111,667	12	1.00
	TOTALS		0	111,667		
F - DRUGS RECLASS						
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	1,237	0	1.00
2.00	ADMINISTRATIVE & GENERAL	5.00	0	30	0	2.00
3.00	DIETARY	10.00	0	4,772	0	3.00
4.00	CENTRAL SERVICES & SUPPLY	14.00	0	890	0	4.00
5.00	PHARMACY	15.00	0	2,753,149	0	5.00
6.00	ADULTS & PEDIATRICS	30.00	0	45,242	0	6.00
7.00	INTENSIVE CARE UNIT	31.00	0	11,231	0	7.00
8.00	SUBPROVIDER - IPF	40.00	0	196	0	8.00
9.00	SKILLED NURSING FACILITY	44.00	0	5,957	0	9.00
10.00	OPERATING ROOM	50.00	0	53,172	0	10.00
11.00	RECOVERY ROOM	51.00	0	48,327	0	11.00
12.00	ANESTHESIOLOGY	53.00	0	36,060	0	12.00
13.00	RADIOLOGY-DIAGNOSTIC	54.00	0	4,578	0	13.00
14.00	CT SCAN	57.00	0	11,400	0	14.00
15.00	MAGNETIC RESONANCE IMAGING (MRI)	58.00	0	42,431	0	15.00
16.00	LABORATORY	60.00	0	347	0	16.00
17.00	RESPIRATORY THERAPY	65.00	0	1,558	0	17.00
18.00	ELECTROENCEPHALOGRAPHY	70.00	0	45	0	18.00
19.00	RENAL DIALYSIS	74.00	0	87,828	0	19.00
20.00	ANCILLARY	76.00	0	107	0	20.00
21.00	CARDIOLOGY	76.03	0	6,190	0	21.00
22.00	CARDIAC REHABILITATION	76.97	0	21	0	22.00
23.00	CLINIC	90.00	0	8	0	23.00
24.00	EMERGENCY	91.00	0	68,042	0	24.00
	0		0	3,182,818		
G - MED SUPPLIES RECLASS						
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	125	0	1.00
2.00	ADMINISTRATIVE & GENERAL	5.00	0	11,703	0	2.00
3.00	MAINTENANCE & REPAIRS	6.00	0	3	0	3.00
4.00	OPERATION OF PLANT	7.00	0	71	0	4.00
5.00	HOUSEKEEPING	9.00	0	4,785	0	5.00
6.00	DIETARY	10.00	0	444	0	6.00
7.00	CENTRAL SERVICES & SUPPLY	14.00	0	92,417	0	7.00
8.00	PHARMACY	15.00	0	61,323	0	8.00
9.00	ADULTS & PEDIATRICS	30.00	0	284,629	0	9.00
10.00	INTENSIVE CARE UNIT	31.00	0	89,293	0	10.00
11.00	SUBPROVIDER - IPF	40.00	0	17,582	0	11.00
12.00	SKILLED NURSING FACILITY	44.00	0	117,463	0	12.00
13.00	OPERATING ROOM	50.00	0	4,589,270	0	13.00
14.00	RECOVERY ROOM	51.00	0	60,231	0	14.00
15.00	ANESTHESIOLOGY	53.00	0	187,209	0	15.00
16.00	RADIOLOGY-DIAGNOSTIC	54.00	0	270,635	0	16.00
17.00	CT SCAN	57.00	0	124,307	0	17.00
18.00	MAGNETIC RESONANCE IMAGING (MRI)	58.00	0	8,616	0	18.00
19.00	LABORATORY	60.00	0	136,850	0	19.00
20.00	RESPIRATORY THERAPY	65.00	0	80,815	0	20.00
21.00	PHYSICAL THERAPY	66.00	0	1,835	0	21.00
22.00	ELECTROENCEPHALOGRAPHY	70.00	0	1,402	0	22.00
23.00	RENAL DIALYSIS	74.00	0	225,259	0	23.00
24.00	CARDIOLOGY	76.03	0	110,660	0	24.00
25.00	CARDIAC REHABILITATION	76.97	0	4,607	0	25.00
26.00	CLINIC	90.00	0	912	0	26.00
27.00	EMERGENCY	91.00	0	157,254	0	27.00
	0		0	6,639,700		
I - IMPLANTIBLE RECLASS						
1.00	CENTRAL SERVICES & SUPPLY	14.00	0	62,562	0	1.00
2.00	ADULTS & PEDIATRICS	30.00	0	9,638	0	2.00
3.00	INTENSIVE CARE UNIT	31.00	0	6,084	0	3.00
4.00	SUBPROVIDER - IPF	40.00	0	150	0	4.00
5.00	SKILLED NURSING FACILITY	44.00	0	1,371	0	5.00
6.00	OPERATING ROOM	50.00	0	12,272,447	0	6.00
7.00	RECOVERY ROOM	51.00	0	35,971	0	7.00
8.00	ANESTHESIOLOGY	53.00	0	42,448	0	8.00

RECLASSIFICATIONS

Provider CCN: 14-0013

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

Worksheet A-6

Date/Time Prepared:
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Decreases						
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.	
	6.00	7.00	8.00	9.00	10.00	
9.00	RADIOLOGY-DIAGNOSTIC	54.00	0	39,350	0	9.00
10.00	CT SCAN	57.00	0	3,916	0	10.00
11.00	MAGNETIC RESONANCE IMAGING (MRI)	58.00	0	2,530	0	11.00
12.00	RENAL DIALYSIS	74.00	0	909	0	12.00
13.00	CARDIOLOGY	76.03	0	324,331	0	13.00
14.00	CLINIC	90.00	0	13,260	0	14.00
15.00	EMERGENCY	91.00	0	32,427	0	15.00
	0		0	12,847,394		
J - BLOOD RECLASS						
1.00	LABORATORY	60.00	143,405	0	0	1.00
	0		143,405	0		
K - COST CENTER MAPPING						
1.00	ADULTS & PEDIATRICS	30.00	1,328,583	1,170,504	0	1.00
2.00	INTENSIVE CARE UNIT	31.00	8,892	5,006	0	2.00
3.00	SKILLED NURSING FACILITY	44.00	1,051,038	964,180	0	3.00
4.00	OPERATING ROOM	50.00	21,870	26,030	0	4.00
5.00	RADIOLOGY-DIAGNOSTIC	54.00	82,351	28,300	0	5.00
6.00	RESPIRATORY THERAPY	65.00	56,070	18,854	0	6.00
7.00	PHYSICAL THERAPY	66.00	0	172,434	0	7.00
8.00	CARDIOLOGY	76.03	31,130	16,730	0	8.00
9.00	CARDIAC REHABILITATION	76.97	35,800	11,307	0	9.00
10.00	EMERGENCY	91.00	334,188	387,413	0	10.00
11.00		0.00	0	0	0	11.00
12.00		0.00	0	0	0	12.00
	0		2,949,922	2,800,758		
500.00	Grand Total: Decreases		3,664,335	26,193,242		500.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-0013

Period:
From 01/01/2020
To 12/31/2020Worksheet A-7
Part I
Date/Time Prepared:
7/22/2021 3:42 pm

		Beginning Balances	Acquisitions			Disposals and Retirements	
			Purchases	Donation	Total		
		1.00	2.00	3.00	4.00	5.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	6,081,907	0	0	0	0	1.00
2.00	Land Improvements	6,433,463	266,037	0	266,037	0	2.00
3.00	Buildings and Fixtures	71,464,320	3,920,424	0	3,920,424	454,134	3.00
4.00	Building Improvements	0	0	0	0	0	4.00
5.00	Fixed Equipment	20,721,686	0	0	0	0	5.00
6.00	Movable Equipment	65,491,855	529,545	0	529,545	854,456	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	170,193,231	4,716,006	0	4,716,006	1,308,590	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	170,193,231	4,716,006	0	4,716,006	1,308,590	10.00
		Ending Balance	Fully Depreciated Assets				
		6.00	7.00				
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	6,081,907	0				1.00
2.00	Land Improvements	6,699,500	0				2.00
3.00	Buildings and Fixtures	74,930,610	0				3.00
4.00	Building Improvements	0	0				4.00
5.00	Fixed Equipment	20,721,686	0				5.00
6.00	Movable Equipment	65,166,944	0				6.00
7.00	HIT designated Assets	0	0				7.00
8.00	Subtotal (sum of lines 1-7)	173,600,647	0				8.00
9.00	Reconciling Items	0	0				9.00
10.00	Total (line 8 minus line 9)	173,600,647	0				10.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-0013

Period:
From 01/01/2020
To 12/31/2020Worksheet A-7
Part II
Date/Time Prepared:
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Cost Center Description		SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	CAP REL COSTS-BLDG & FIXT	1,279,258	0	0	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	1,279,258	0	0	0	0	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Other	Total (1) (sum				
		Capital-Related Costs (see instructions)	of cols. 9 through 14)				
		14.00	15.00				
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	CAP REL COSTS-BLDG & FIXT	0	1,279,258				1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0				2.00
3.00	Total (sum of lines 1-2)	0	1,279,258				3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-0013

Period:
From 01/01/2020
To 12/31/2020Worksheet A-7
Part III
Date/Time Prepared:
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Cost Center Description		COMPUTATION OF RATIOS			ALLOCATION OF OTHER CAPITAL		
		Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	
		1.00	2.00	3.00	4.00	5.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	108,167,666	0	108,167,666	0.624040	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	65,166,944	0	65,166,944	0.375960	0	2.00
3.00	Total (sum of lines 1-2)	173,334,610	0	173,334,610	1.000000	0	3.00
Cost Center Description		ALLOCATION OF OTHER CAPITAL			SUMMARY OF CAPITAL		
		Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	Depreciation	Lease	
		6.00	7.00	8.00	9.00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	1,279,258	210,103	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	0	0	0	1,279,258	210,103	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	CAP REL COSTS-BLDG & FIXT	-68,320	111,667	0	0	1,532,708	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	-68,320	111,667	0	0	1,532,708	3.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 14-0013

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

Worksheet A-8

Date/Time Prepared:
7/22/2021 3:42 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 - CAP REL COSTS-BLDG & FIXT (chapter 2)			0CAP REL COSTS-BLDG & FIXT	1.00	0	1.00
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)			0CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
3.00	Investment income - other (chapter 2)		0		0.00	0	3.00
4.00	Trade, quantity, and time discounts (chapter 8)		0		0.00	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)		0		0.00	0	5.00
6.00	Rental of provider space by suppliers (chapter 8)		0		0.00	0	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)		0		0.00	0	7.00
8.00	Television and radio service (chapter 21)		0		0.00	0	8.00
9.00	Parking lot (chapter 21)		0		0.00	0	9.00
10.00	Provider-based physician adjustment	A-8-2	-1,702,453			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	15,016,264			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests		0		0.00	0	14.00
15.00	Rental of quarters to employee and others		0		0.00	0	15.00
16.00	Sale of medical and surgical supplies to other than patients		0		0.00	0	16.00
17.00	Sale of drugs to other than patients		0		0.00	0	17.00
18.00	Sale of medical records and abstracts		0		0.00	0	18.00
19.00	Nursing and allied health education (tuition, fees, books, etc.)		0		0.00	0	19.00
19.01	Nursing and allied health education (tuition, fees, books, etc.)		0		0.00	0	19.01
19.02	Nursing and allied health education (tuition, fees, books, etc.)		0		0.00	0	19.02
19.03	Nursing and allied health education (tuition, fees, books, etc.)		0		0.00	0	19.03
19.04	Nursing and allied health education (tuition, fees, books, etc.)		0		0.00	0	19.04
20.00	Vending machines		0		0.00	0	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	0	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3		0RESPIRATORY THERAPY	65.00		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3		0PHYSICAL THERAPY	66.00		24.00
25.00	Utilization review - physicians' compensation (chapter 21)			0*** Cost Center Deleted ***	114.00		25.00
26.00	Depreciation - CAP REL COSTS-BLDG & FIXT			0CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP			0CAP REL COSTS-MVBLE EQUIP	2.00	0	27.00
28.00	Non-physician Anesthetist			0*** Cost Center Deleted ***	19.00		28.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 14-0013

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

Worksheet A-8

Date/Time Prepared:
7/22/2021 3:42 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	
29.00	Physicians' assistant		0		0.00	0	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	OCCUPATIONAL THERAPY	67.00		30.00
30.99	Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS	30.00		30.99
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	SPEECH PATHOLOGY	68.00		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest		0		0.00	0	32.00
33.00	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	33.00
33.01	MISC REVENUE	B	-75,990	OPERATION OF PLANT	7.00	0	33.01
33.02	MISC REVENUE	B	-6,110	LAUNDRY & LINEN SERVICE	8.00	0	33.02
33.03	MISC REVENUE	B	-7,700	PHARMACY	15.00	0	33.03
33.04	MISC REVENUE	B	-57,603	ADULTS & PEDIATRICS	30.00	0	33.04
33.05	MISC REVENUE	B	-650	SUBPROVIDER - IPF	40.00	0	33.05
33.06	MISC REVENUE	B	-447,203	OPERATING ROOM	50.00	0	33.06
33.07	MISC REVENUE	B	-500	RECOVERY ROOM	51.00	0	33.07
33.08	MISC REVENUE	B	-1,083	RADIOLOGY-DIAGNOSTIC	54.00	0	33.08
33.09	MISC REVENUE	B	-1,528	PHYSICAL THERAPY	66.00	0	33.09
33.10	MISC REVENUE	B	-8,478	CARDIAC REHABILITATION	76.97	0	33.10
33.11	MISC REVENUE	B	-26,214	EMERGENCY	91.00	0	33.11
33.12	DEPR TO AHA	A	210,103	CAP REL COSTS-BLDG & FIXT	1.00	10	33.12
33.13	DEPR TO AHA	A	505	ADMINISTRATIVE & GENERAL	5.00	0	33.13
33.14	DEPR TO AHA	A	220,433	MAINTENANCE & REPAIRS	6.00	0	33.14
33.15	DEPR TO AHA	A	-33,731	OPERATION OF PLANT	7.00	0	33.15
33.16	DEPR TO AHA	A	24,813	DIETARY	10.00	0	33.16
33.17	DEPR TO AHA	A	-96,508	CENTRAL SERVICES & SUPPLY	14.00	0	33.17
33.18	DEPR TO AHA	A	-11,793	PHARMACY	15.00	0	33.18
33.19	DEPR TO AHA	A	77,229	ADULTS & PEDIATRICS	30.00	0	33.19
33.20	DEPR TO AHA	A	18,896	INTENSIVE CARE UNIT	31.00	0	33.20
33.21	DEPR TO AHA	A	27,977	SUBPROVIDER - IPF	40.00	0	33.21
33.22	DEPR TO AHA	A	23,197	SKILLED NURSING FACILITY	44.00	0	33.22
33.23	DEPR TO AHA	A	-158,736	OPERATING ROOM	50.00	0	33.23
33.24	DEPR TO AHA	A	69,420	ANESTHESIOLOGY	53.00	0	33.24
33.25	DEPR TO AHA	A	35,017	RADIOLOGY-DIAGNOSTIC	54.00	0	33.25
33.26	DEPR TO AHA	A	147,472	CT SCAN	57.00	0	33.26
33.27	DEPR TO AHA	A	24,230	MAGNETIC RESONANCE IMAGING (MRI)	58.00	0	33.27
33.28	DEPR TO AHA	A	-86,914	LABORATORY	60.00	0	33.28
33.29	DEPR TO AHA	A	-209,325	RENAL DIALYSIS	74.00	0	33.29
33.30	DEPR TO AHA	A	12,427	GASTRO INTESTINAL SERVICES	76.02	0	33.30
33.31	DEPR TO AHA	A	73,800	CARDIOLOGY	76.03	0	33.31
33.32	DEPR TO AHA	A	76,699	CARDIAC REHABILITATION	76.97	0	33.32
33.37	DEPR TO AHA	A	41,501	CLINIC	90.00	0	33.37
33.39	DEPR TO AHA	A	-9,001	EMERGENCY	91.00	0	33.39
33.40	DEPR TO AHA	A	17,873	ARC INGALLS	194.10	0	33.40
33.41	ADVERTISING	A	-39,976	ADULTS & PEDIATRICS	30.00	0	33.41
33.42	ADVERTISING	A	-1,081	EMERGENCY	91.00	0	33.42
33.43	POB SECURITY COST	A	-22,850	OPERATION OF PLANT	7.00	0	33.43
33.44	POB SECURITY COST	A	-5,713	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.44
33.45	SELF FUNDED INSURANCE	A	-1,864,599	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.45
33.46	NON-ALLOWABLE INTEREST	A	-143,645	CAP REL COSTS-BLDG & FIXT	1.00	11	33.46
33.47	OTHER ADJUSTMENTS (SPECIFY) (3)	A	0		0.00	0	33.47
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		11,098,472				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: 14-0013

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

Worksheet A-8-1

Date/Time Prepared:
7/22/2021 3:42 pm

	Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in wks. A, column 5	
	1.00	2.00	3.00	4.00	5.00	
A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:						
1.00	4.00	EMPLOYEE BENEFITS DEPARTMENT	HOME OFFICE ALLOCATION	453,403	0	1.00
2.00	16.00	MEDICAL RECORDS & LIBRARY	HOME OFFICE ALLOCATION	1,081,651	0	2.00
3.00	13.00	NURSING ADMINISTRATION	HOME OFFICE ALLOCATION	1,639,464	0	3.00
3.01	7.00	OPERATION OF PLANT	HOME OFFICE ALLOCATION	155,572	0	3.01
4.00	5.00	ADMINISTRATIVE & GENERAL	HOME OFFICE ALLOCATION	11,261,262	0	4.00
4.01	30.00	ADULTS & PEDIATRICS	HOME OFFICE ALLOCATION	349,587	0	4.01
4.02	1.00	CAP REL COSTS-BLDG & FIXT	HOME OFFICE ALLOCATION	640,700	565,375	4.02
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.			15,581,639	565,375	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		
	1.00	2.00	3.00	Name	Percentage of Ownership	5.00

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

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

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

6.00	B		100.00	UNITY POINT	100.00	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:					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: 14-0013

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

Worksheet A-8-1

Date/Time Prepared:
7/22/2021 3:42 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	453,403	0		1.00
2.00	1,081,651	0		2.00
3.00	1,639,464	0		3.00
3.01	155,572	0		3.01
4.00	11,261,262	0		4.00
4.01	349,587	0		4.01
4.02	75,325	11		4.02
5.00	15,016,264			5.00

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

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

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

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

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

6.00	HEALTH SYSTEM		6.00
7.00			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: 14-0013

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

Worksheet A-8-2

Date/Time Prepared:
7/22/2021 3:42 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	40.00	SUBPROVIDER - IPF	186,027	186,027	0	181,300	0	1.00
2.00	44.00	SKILLED NURSING FACILITY	24	24	0	181,300	0	2.00
3.00	50.00	OPERATING ROOM	274,500	274,500	0	246,400	0	3.00
4.00	54.00	RADIOLOGY-DIAGNOSTIC	66,000	66,000	0	271,900	0	4.00
5.00	60.00	LABORATORY	67,889	67,889	0	260,300	0	5.00
6.00	76.97	CARDIAC REHABILITATION	18,098	18,098	0	211,500	0	6.00
7.00	91.00	EMERGENCY	1,089,915	1,089,915	0	211,500	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			1,702,453	1,702,453	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	40.00	SUBPROVIDER - IPF	0	0	0	0	0	1.00
2.00	44.00	SKILLED NURSING FACILITY	0	0	0	0	0	2.00
3.00	50.00	OPERATING ROOM	0	0	0	0	0	3.00
4.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	4.00
5.00	60.00	LABORATORY	0	0	0	0	0	5.00
6.00	76.97	CARDIAC REHABILITATION	0	0	0	0	0	6.00
7.00	91.00	EMERGENCY	0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			0	0	0	0	0	200.00
	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment		
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00	40.00	SUBPROVIDER - IPF	0	0	0	186,027		1.00
2.00	44.00	SKILLED NURSING FACILITY	0	0	0	24		2.00
3.00	50.00	OPERATING ROOM	0	0	0	274,500		3.00
4.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	66,000		4.00
5.00	60.00	LABORATORY	0	0	0	67,889		5.00
6.00	76.97	CARDIAC REHABILITATION	0	0	0	18,098		6.00
7.00	91.00	EMERGENCY	0	0	0	1,089,915		7.00
8.00	0.00		0	0	0	0		8.00
9.00	0.00		0	0	0	0		9.00
10.00	0.00		0	0	0	0		10.00
200.00			0	0	0	1,702,453		200.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0013

Period:
From 01/01/2020
To 12/31/2020Worksheet B
Part I
Date/Time Prepared:
7/22/2021 3:42 pm

Cost Center Description			CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
			Net Expenses for Cost Allocation (from Wkst A col. 7)	BLDG & FIXT	MVBLE EQUIP		
			0	1.00	2.00	4.00	4A
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT	1,532,708	1,532,708			1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	0		0		2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-536,438	50,837	0	-485,601	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	18,273,022	187,524	0	0	5.00
6.00	00600	MAINTENANCE & REPAIRS	1,996,903	238,852	0	0	6.00
7.00	00700	OPERATION OF PLANT	3,592,367	17,005	0	0	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	15,819	13,779	0	0	8.00
9.00	00900	HOUSEKEEPING	1,548,735	23,347	0	0	9.00
10.00	01000	DIETARY	567,577	19,573	0	0	10.00
11.00	01100	CAFETERIA	800,612	51,947	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	1,745,911	7,090	0	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	761,372	0	0	0	14.00
15.00	01500	PHARMACY	1,260,890	11,802	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,081,651	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	0	512	0	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	5,922,988	234,948	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	1,331,940	32,582	0	0	31.00
40.00	04000	SUBPROVIDER - IPF	2,033,660	24,980	0	0	40.00
43.00	04300	NURSERY	0	0	0	0	43.00
44.00	04400	SKILLED NURSING FACILITY	2,029,783	80,984	0	0	44.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	13,427,069	151,401	0	0	50.00
51.00	05100	RECOVERY ROOM	2,139,873	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	332,121	2,482	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,184,998	98,129	0	0	54.00
57.00	05700	CT SCAN	855,131	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	874,995	0	0	0	58.00
60.00	06000	LABORATORY	3,202,413	41,706	0	0	60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	143,405	0	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	1,135,532	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	708,727	13,561	0	0	65.00
66.00	06600	PHYSICAL THERAPY	1,607,503	12,615	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	750,758	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	275,141	0	0	0	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	15,648	31,490	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	6,639,462	40,381	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	12,847,394	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	3,182,818	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	372,774	8,458	0	0	74.00
76.00	03950	ANCILLARY	-107	0	0	0	76.00
76.01	03560	PULMONARY FUNCTION TESTING	23,676	0	0	0	76.01
76.02	03340	GASTRO INTESTINAL SERVICES	71,311	0	0	0	76.02
76.03	03140	CARDIOLOGY	854,260	0	0	0	76.03
76.97	07697	CARDIAC REHABILITATION	515,282	0	0	0	76.97
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	2,204,695	34,501	0	0	90.00
91.00	09100	EMERGENCY	1,688,167	41,237	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				0	92.00
OTHER REIMBURSABLE COST CENTERS							
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS							
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	100,012,546	1,471,723	0	0	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	16,235	0	0	190.00
194.00	07950	UN-USED SQR FT - HOSPITAL	0	0	0	0	194.00
194.01	07951	MEALS ON WHEELS	0	0	0	0	194.01
194.02	07952	MARKETING	0	0	0	0	194.02
194.03	07953	GUEST MEALS	0	0	0	0	194.03
194.04	07954	PHYSICIAN/OTHER MEALS	294,907	0	0	0	194.04
194.05	07955	FOUNDATION	0	10,127	0	0	194.05
194.06	07956	DAYCARE CENTER	1,069,683	32,786	0	0	194.06
194.07	07957	UN-USED SQR FT - POB	0	1,837	0	0	194.07
194.08	07958	SENIOR SERVICES	0	0	0	0	194.08
194.09	07959	ARC BROMENN	3,408	0	0	0	194.09
194.10	07960	ARC INGALLS	18,279	0	0	0	194.10
200.00		Cross Foot Adjustments				0	200.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0013

Period:
From 01/01/2020
To 12/31/2020Worksheet B
Part I
Date/Time Prepared:
7/22/2021 3:42 pm

Cost Center Description			Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
				BLDG & FIXT	MVBLE EQUIP			
			0	1.00	2.00	4.00	4A	
201.00		Negative Cost Centers		0	0	-485,601	-485,601	201.00
202.00		TOTAL (sum lines 118 through 201)	101,398,823	1,532,708	0	-485,601	101,398,823	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0013

Period:
From 01/01/2020
To 12/31/2020Worksheet B
Part I
Date/Time Prepared:
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Cost Center Description			ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
			5.00	6.00	7.00	8.00	9.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	18,460,546					5.00
6.00	00600	MAINTENANCE & REPAIRS	494,741	2,730,496				6.00
7.00	00700	OPERATION OF PLANT	798,703	43,992	4,452,067			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	6,550	35,645	59,071	130,864		8.00
9.00	00900	HOUSEKEEPING	347,880	60,397	100,090	0	2,080,449	9.00
10.00	01000	DIETARY	129,928	50,634	83,910	0	40,665	10.00
11.00	01100	CAFETERIA	188,659	134,384	222,700	0	107,926	11.00
13.00	01300	NURSING ADMINISTRATION	387,915	18,341	30,395	0	14,730	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	168,481	0	0	0	0	14.00
15.00	01500	PHARMACY	281,629	30,532	50,598	0	24,521	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	239,354	0	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	113	1,325	2,195	0	1,064	17.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	1,362,665	607,798	1,007,238	51,569	488,131	30.00
31.00	03100	INTENSIVE CARE UNIT	301,950	84,287	139,681	6,910	67,693	31.00
40.00	04000	SUBPROVIDER - IPF	455,548	64,621	107,090	20,537	51,899	40.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
44.00	04400	SKILLED NURSING FACILITY	467,083	209,500	347,183	51,848	168,254	44.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	3,004,711	391,664	649,065	0	314,553	50.00
51.00	05100	RECOVERY ROOM	473,524	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	74,043	6,420	10,638	0	5,156	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	505,224	253,853	420,685	0	203,874	54.00
57.00	05700	CT SCAN	189,229	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	193,624	0	0	0	0	58.00
60.00	06000	LABORATORY	717,878	107,890	178,796	0	86,649	60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	31,734	0	0	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	251,277	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	159,832	35,080	58,135	0	28,174	65.00
66.00	06600	PHYSICAL THERAPY	358,509	32,635	54,082	0	26,210	66.00
67.00	06700	OCCUPATIONAL THERAPY	166,132	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	60,885	0	0	0	0	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	10,431	81,462	134,999	0	65,424	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1,478,156	104,463	173,116	0	83,896	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	2,842,948	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	704,313	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	84,361	21,880	36,260	0	17,572	74.00
76.00	03950	ANCILLARY	0	0	0	0	0	76.00
76.01	03560	PULMONARY FUNCTION TESTING	5,239	0	0	0	0	76.01
76.02	03340	GASTRO INTESTINAL SERVICES	15,780	0	0	0	0	76.02
76.03	03140	CARDIOLOGY	189,036	0	0	0	0	76.03
76.97	07697	CARDIAC REHABILITATION	114,025	0	0	0	0	76.97
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	495,503	89,252	147,909	0	71,680	90.00
91.00	09100	EMERGENCY	382,693	106,677	176,785	0	85,674	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
OTHER REIMBURSABLE COST CENTERS								
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	18,140,286	2,572,732	4,190,621	130,864	1,953,745	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	3,593	42,000	69,602	0	33,731	190.00
194.00	07950	UN-USED SQR FT - HOSPITAL	0	0	0	0	0	194.00
194.01	07951	MEALS ON WHEELS	0	0	0	0	0	194.01
194.02	07952	MARKETING	0	0	0	0	0	194.02
194.03	07953	GUEST MEALS	0	0	0	0	0	194.03
194.04	07954	PHYSICIAN/OTHER MEALS	65,259	0	0	0	0	194.04
194.05	07955	FOUNDATION	2,241	26,197	43,413	0	21,039	194.05
194.06	07956	DAYCARE CENTER	243,961	84,815	140,556	0	68,117	194.06
194.07	07957	UN-USED SQR FT - POB	407	4,752	7,875	0	3,817	194.07
194.08	07958	SENIOR SERVICES	0	0	0	0	0	194.08
194.09	07959	ARC BROMENN	754	0	0	0	0	194.09
194.10	07960	ARC INGALLS	4,045	0	0	0	0	194.10
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)	18,460,546	2,730,496	4,452,067	130,864	2,080,449	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0013

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	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
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	892,287					10.00
11.00	01100	CAFETERIA	0	1,506,228				11.00
13.00	01300	NURSING ADMINISTRATION	0	6,464	2,210,846			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	28,676	0	958,529		14.00
15.00	01500	PHARMACY	0	75,540	0	0	1,735,512	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	351,620	241,424	478,765	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	47,113	65,702	130,291	0	0	31.00
40.00	04000	SUBPROVIDER - IPF	140,029	108,808	215,772	0	0	40.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
44.00	04400	SKILLED NURSING FACILITY	353,525	80,596	159,827	0	0	44.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	199,621	395,859	0	0	50.00
51.00	05100	RECOVERY ROOM	0	125,304	248,486	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	5,670	11,243	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	110,386	218,902	0	0	54.00
57.00	05700	CT SCAN	0	31,570	62,606	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	17,973	35,642	0	0	58.00
60.00	06000	LABORATORY	0	92,682	0	0	0	60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	0	0	0	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0	45,554	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	41,224	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	47,032	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	26,435	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	8,116	0	0	0	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	326,075	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	632,454	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	1,735,512	73.00
74.00	07400	RENAL DIALYSIS	0	19,642	0	0	0	74.00
76.00	03950	ANCILLARY	0	0	0	0	0	76.00
76.01	03560	PULMONARY FUNCTION TESTING	0	0	0	0	0	76.01
76.02	03340	GASTRO INTESTINAL SERVICES	0	0	0	0	0	76.02
76.03	03140	CARDIOLOGY	0	0	0	0	0	76.03
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	127,809	253,453	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
OTHER REIMBURSABLE COST CENTERS								
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	892,287	1,506,228	2,210,846	958,529	1,735,512	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
194.00	07950	UN-USED SQR FT - HOSPITAL	0	0	0	0	0	194.00
194.01	07951	MEALS ON WHEELS	0	0	0	0	0	194.01
194.02	07952	MARKETING	0	0	0	0	0	194.02
194.03	07953	GUEST MEALS	0	0	0	0	0	194.03
194.04	07954	PHYSICIAN/OTHER MEALS	0	0	0	0	0	194.04
194.05	07955	FOUNDATION	0	0	0	0	0	194.05
194.06	07956	DAYCARE CENTER	0	0	0	0	0	194.06
194.07	07957	UN-USED SQR FT - POB	0	0	0	0	0	194.07
194.08	07958	SENIOR SERVICES	0	0	0	0	0	194.08
194.09	07959	ARC BROMENN	0	0	0	0	0	194.09
194.10	07960	ARC INGALLS	0	0	0	0	0	194.10
200.00		Cross Foot Adjustments	0	0	0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	892,287	1,506,228	2,210,846	958,529	1,735,512	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0013

Period:
From 01/01/2020
To 12/31/2020Worksheet B
Part I
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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	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
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	1,321,005					16.00
17.00	01700	SOCIAL SERVICE	0	5,209				17.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	68,048	2,053	10,817,247	0	10,817,247	30.00
31.00	03100	INTENSIVE CARE UNIT	14,868	275	2,223,292	0	2,223,292	31.00
40.00	04000	SUBPROVIDER - IPF	20,896	817	3,244,657	0	3,244,657	40.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
44.00	04400	SKILLED NURSING FACILITY	20,497	2,064	3,971,144	0	3,971,144	44.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	278,428	0	18,812,371	0	18,812,371	50.00
51.00	05100	RECOVERY ROOM	59,535	0	3,046,722	0	3,046,722	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	73,464	0	521,237	0	521,237	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	50,654	0	4,046,705	0	4,046,705	54.00
57.00	05700	CT SCAN	90,228	0	1,228,764	0	1,228,764	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	38,041	0	1,160,275	0	1,160,275	58.00
60.00	06000	LABORATORY	78,201	0	4,506,215	0	4,506,215	60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	2,592	0	177,731	0	177,731	63.00
64.00	06400	INTRAVENOUS THERAPY	25,044	0	1,457,407	0	1,457,407	64.00
65.00	06500	RESPIRATORY THERAPY	21,187	0	1,065,920	0	1,065,920	65.00
66.00	06600	PHYSICAL THERAPY	18,562	0	2,157,148	0	2,157,148	66.00
67.00	06700	OCCUPATIONAL THERAPY	8,376	0	951,701	0	951,701	67.00
68.00	06800	SPEECH PATHOLOGY	3,168	0	347,310	0	347,310	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	308	0	339,762	0	339,762	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	53,606	0	8,899,155	0	8,899,155	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	154,489	0	16,477,285	0	16,477,285	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	61,223	0	5,683,866	0	5,683,866	73.00
74.00	07400	RENAL DIALYSIS	20,342	0	581,289	0	581,289	74.00
76.00	03950	ANCILLARY	0	0	-107	0	-107	76.00
76.01	03560	PULMONARY FUNCTION TESTING	1,104	0	30,019	0	30,019	76.01
76.02	03340	GASTRO INTESTINAL SERVICES	2,557	0	89,648	0	89,648	76.02
76.03	03140	CARDIOLOGY	33,464	0	1,076,760	0	1,076,760	76.03
76.97	07697	CARDIAC REHABILITATION	2,930	0	632,237	0	632,237	76.97
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	40,246	0	3,083,786	0	3,083,786	90.00
91.00	09100	EMERGENCY	78,947	0	2,941,442	0	2,941,442	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				0		92.00
OTHER REIMBURSABLE COST CENTERS								
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	1,321,005	5,209	99,570,988	0	99,570,988	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	165,161	0	165,161	190.00
194.00	07950	UN-USED SQR FT - HOSPITAL	0	0	0	0	0	194.00
194.01	07951	MEALS ON WHEELS	0	0	0	0	0	194.01
194.02	07952	MARKETING	0	0	0	0	0	194.02
194.03	07953	GUEST MEALS	0	0	0	0	0	194.03
194.04	07954	PHYSICIAN/OTHER MEALS	0	0	360,166	0	360,166	194.04
194.05	07955	FOUNDATION	0	0	103,017	0	103,017	194.05
194.06	07956	DAYCARE CENTER	0	0	1,639,918	0	1,639,918	194.06
194.07	07957	UN-USED SQR FT - POB	0	0	18,688	0	18,688	194.07
194.08	07958	SENIOR SERVICES	0	0	0	0	0	194.08
194.09	07959	ARC BROMENN	0	0	4,162	0	4,162	194.09
194.10	07960	ARC INGALLS	0	0	22,324	0	22,324	194.10
200.00		Cross Foot Adjustments	0	0	0	0	0	200.00
201.00		Negative Cost Centers	0	0	-485,601	0	-485,601	201.00
202.00		TOTAL (sum lines 118 through 201)	1,321,005	5,209	101,398,823	0	101,398,823	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0013

Period:
From 01/01/2020
To 12/31/2020Worksheet B
Part II
Date/Time Prepared:
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Cost Center Description			CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
			Directly Assigned New Capital Related Costs	BLDG & FIXT	MVBLE EQUIP		
			0	1.00	2.00	2A	4.00
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	6,171	50,837	0	57,008	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	19,157	187,524	0	206,681	5.00
6.00	00600	MAINTENANCE & REPAIRS	732,860	238,852	0	971,712	6.00
7.00	00700	OPERATION OF PLANT	183,426	17,005	0	200,431	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	13,779	0	13,779	8.00
9.00	00900	HOUSEKEEPING	18,054	23,347	0	41,401	9.00
10.00	01000	DIETARY	0	19,573	0	19,573	10.00
11.00	01100	CAFETERIA	0	51,947	0	51,947	11.00
13.00	01300	NURSING ADMINISTRATION	0	7,090	0	7,090	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	105,030	0	0	105,030	14.00
15.00	01500	PHARMACY	59,214	11,802	0	71,016	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	0	512	0	512	17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	115,021	234,948	0	349,969	30.00
31.00	03100	INTENSIVE CARE UNIT	65,206	32,582	0	97,788	31.00
40.00	04000	SUBPROVIDER - IPF	90,848	24,980	0	115,828	40.00
43.00	04300	NURSERY	0	0	0	0	43.00
44.00	04400	SKILLED NURSING FACILITY	82,960	80,984	0	163,944	44.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	368,662	151,401	0	520,063	50.00
51.00	05100	RECOVERY ROOM	18,333	0	0	18,333	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	196,461	2,482	0	198,943	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	254,859	98,129	0	352,988	54.00
57.00	05700	CT SCAN	306,390	0	0	306,390	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	567,142	0	0	567,142	58.00
60.00	06000	LABORATORY	23,367	41,706	0	65,073	60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	1,758	0	0	1,758	63.00
64.00	06400	INTRAVENOUS THERAPY	41,048	0	0	41,048	64.00
65.00	06500	RESPIRATORY THERAPY	26,180	13,561	0	39,741	65.00
66.00	06600	PHYSICAL THERAPY	52,998	12,615	0	65,613	66.00
67.00	06700	OCCUPATIONAL THERAPY	28,571	0	0	28,571	67.00
68.00	06800	SPEECH PATHOLOGY	9,075	0	0	9,075	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	31,490	0	31,490	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	56,143	40,381	0	96,524	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	8,458	0	8,458	74.00
76.00	03950	ANCILLARY	0	0	0	0	76.00
76.01	03560	PULMONARY FUNCTION TESTING	978	0	0	978	76.01
76.02	03340	GASTRO INTESTINAL SERVICES	27,646	0	0	27,646	76.02
76.03	03140	CARDIOLOGY	117,457	0	0	117,457	76.03
76.97	07697	CARDIAC REHABILITATION	77,859	0	0	77,859	76.97
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	230,277	34,501	0	264,778	90.00
91.00	09100	EMERGENCY	128,771	41,237	0	170,008	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				0	92.00
OTHER REIMBURSABLE COST CENTERS							
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS							
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	4,011,922	1,471,723	0	5,483,645	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	16,235	0	16,235	190.00
194.00	07950	UN-USED SQR FT - HOSPITAL	0	0	0	0	194.00
194.01	07951	MEALS ON WHEELS	0	0	0	0	194.01
194.02	07952	MARKETING	0	0	0	0	194.02
194.03	07953	GUEST MEALS	0	0	0	0	194.03
194.04	07954	PHYSICIAN/OTHER MEALS	0	0	0	0	194.04
194.05	07955	FOUNDATION	0	10,127	0	10,127	194.05
194.06	07956	DAYCARE CENTER	18,753	32,786	0	51,539	194.06
194.07	07957	UN-USED SQR FT - POB	0	1,837	0	1,837	194.07
194.08	07958	SENIOR SERVICES	0	0	0	0	194.08
194.09	07959	ARC BROMENN	0	0	0	0	194.09
194.10	07960	ARC INGALLS	0	0	0	0	194.10
200.00		Cross Foot Adjustments				0	200.00
201.00		Negative Cost Centers		0	0	0	201.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0013

Period:
From 01/01/2020
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Cost Center Description		Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
			BLDG & FIXT	MVBLE EQUIP			
		0	1.00	2.00	2A	4.00	
202.00	TOTAL (sum lines 118 through 201)	4,030,675	1,532,708	0	5,563,383	57,008	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0013

Period:
From 01/01/2020
To 12/31/2020Worksheet B
Part II
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Cost Center Description			ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
			5.00	6.00	7.00	8.00	9.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	206,681					5.00
6.00	00600	MAINTENANCE & REPAIRS	5,538	977,250				6.00
7.00	00700	OPERATION OF PLANT	8,940	15,745	225,116			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	73	12,758	2,987	29,597		8.00
9.00	00900	HOUSEKEEPING	3,894	21,616	5,061	0	71,972	9.00
10.00	01000	DIETARY	1,454	18,122	4,243	0	1,407	10.00
11.00	01100	CAFETERIA	2,112	48,096	11,261	0	3,734	11.00
13.00	01300	NURSING ADMINISTRATION	4,342	6,564	1,537	0	510	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	1,886	0	0	0	0	14.00
15.00	01500	PHARMACY	3,152	10,927	2,558	0	848	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	2,679	0	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	1	474	111	0	37	17.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	15,253	217,531	50,930	11,663	16,885	30.00
31.00	03100	INTENSIVE CARE UNIT	3,380	30,167	7,063	1,563	2,342	31.00
40.00	04000	SUBPROVIDER - IPF	5,099	23,128	5,415	4,645	1,795	40.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
44.00	04400	SKILLED NURSING FACILITY	5,228	74,981	17,555	11,726	5,821	44.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	33,677	140,177	32,820	0	10,882	50.00
51.00	05100	RECOVERY ROOM	5,300	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	829	2,298	538	0	178	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	5,655	90,855	21,272	0	7,053	54.00
57.00	05700	CT SCAN	2,118	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	2,167	0	0	0	0	58.00
60.00	06000	LABORATORY	8,036	38,614	9,041	0	2,998	60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	355	0	0	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	2,813	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	1,789	12,555	2,940	0	975	65.00
66.00	06600	PHYSICAL THERAPY	4,013	11,680	2,735	0	907	66.00
67.00	06700	OCCUPATIONAL THERAPY	1,860	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	682	0	0	0	0	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	117	29,155	6,826	0	2,263	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	16,546	37,387	8,753	0	2,902	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	31,823	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	7,884	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	944	7,831	1,833	0	608	74.00
76.00	03950	ANCILLARY	0	0	0	0	0	76.00
76.01	03560	PULMONARY FUNCTION TESTING	59	0	0	0	0	76.01
76.02	03340	GASTRO INTESTINAL SERVICES	177	0	0	0	0	76.02
76.03	03140	CARDIOLOGY	2,116	0	0	0	0	76.03
76.97	07697	CARDIAC REHABILITATION	1,276	0	0	0	0	76.97
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	5,546	31,944	7,479	0	2,480	90.00
91.00	09100	EMERGENCY	4,284	38,180	8,939	0	2,964	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
OTHER REIMBURSABLE COST CENTERS								
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	203,097	920,785	211,897	29,597	67,589	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	40	15,032	3,519	0	1,167	190.00
194.00	07950	UN-USED SQR FT - HOSPITAL	0	0	0	0	0	194.00
194.01	07951	MEALS ON WHEELS	0	0	0	0	0	194.01
194.02	07952	MARKETING	0	0	0	0	0	194.02
194.03	07953	GUEST MEALS	0	0	0	0	0	194.03
194.04	07954	PHYSICIAN/OTHER MEALS	730	0	0	0	0	194.04
194.05	07955	FOUNDATION	25	9,376	2,195	0	728	194.05
194.06	07956	DAYCARE CENTER	2,731	30,356	7,107	0	2,356	194.06
194.07	07957	UN-USED SQR FT - POB	5	1,701	398	0	132	194.07
194.08	07958	SENIOR SERVICES	0	0	0	0	0	194.08
194.09	07959	ARC BROMENN	8	0	0	0	0	194.09
194.10	07960	ARC INGALLS	45	0	0	0	0	194.10
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)	206,681	977,250	225,116	29,597	71,972	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0013

Period:
From 01/01/2020
To 12/31/2020Worksheet B
Part II
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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	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
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	44,799					10.00
11.00	01100	CAFETERIA	0	117,150				11.00
13.00	01300	NURSING ADMINISTRATION	0	503	20,546			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	2,230	0	109,146		14.00
15.00	01500	PHARMACY	0	5,875	0	0	94,376	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	17,654	18,783	4,444	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	2,365	5,110	1,211	0	0	31.00
40.00	04000	SUBPROVIDER - IPF	7,030	8,462	2,006	0	0	40.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
44.00	04400	SKILLED NURSING FACILITY	17,750	6,268	1,486	0	0	44.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	15,525	3,680	0	0	50.00
51.00	05100	RECOVERY ROOM	0	9,745	2,310	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	441	105	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	8,585	2,035	0	0	54.00
57.00	05700	CT SCAN	0	2,455	582	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	1,398	331	0	0	58.00
60.00	06000	LABORATORY	0	7,208	0	0	0	60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	0	0	0	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0	3,543	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	3,206	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	3,658	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	2,056	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	631	0	0	0	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	37,133	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	72,013	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	94,376	73.00
74.00	07400	RENAL DIALYSIS	0	1,528	0	0	0	74.00
76.00	03950	ANCILLARY	0	0	0	0	0	76.00
76.01	03560	PULMONARY FUNCTION TESTING	0	0	0	0	0	76.01
76.02	03340	GASTRO INTESTINAL SERVICES	0	0	0	0	0	76.02
76.03	03140	CARDIOLOGY	0	0	0	0	0	76.03
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	9,940	2,356	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
OTHER REIMBURSABLE COST CENTERS								
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	44,799	117,150	20,546	109,146	94,376	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
194.00	07950	UN-USED SQR FT - HOSPITAL	0	0	0	0	0	194.00
194.01	07951	MEALS ON WHEELS	0	0	0	0	0	194.01
194.02	07952	MARKETING	0	0	0	0	0	194.02
194.03	07953	GUEST MEALS	0	0	0	0	0	194.03
194.04	07954	PHYSICIAN/OTHER MEALS	0	0	0	0	0	194.04
194.05	07955	FOUNDATION	0	0	0	0	0	194.05
194.06	07956	DAYCARE CENTER	0	0	0	0	0	194.06
194.07	07957	UN-USED SQR FT - POB	0	0	0	0	0	194.07
194.08	07958	SENIOR SERVICES	0	0	0	0	0	194.08
194.09	07959	ARC BROMENN	0	0	0	0	0	194.09
194.10	07960	ARC INGALLS	0	0	0	0	0	194.10
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)	44,799	117,150	20,546	109,146	94,376	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0013

Period:
From 01/01/2020
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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	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
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	2,679					16.00
17.00	01700	SOCIAL SERVICE	0	1,135				17.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	142	447	703,701	0	703,701	30.00
31.00	03100	INTENSIVE CARE UNIT	31	60	151,080	0	151,080	31.00
40.00	04000	SUBPROVIDER - IPF	44	178	173,630	0	173,630	40.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
44.00	04400	SKILLED NURSING FACILITY	43	450	305,252	0	305,252	44.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	497	0	757,321	0	757,321	50.00
51.00	05100	RECOVERY ROOM	125	0	35,813	0	35,813	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	154	0	203,486	0	203,486	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	106	0	488,549	0	488,549	54.00
57.00	05700	CT SCAN	189	0	311,734	0	311,734	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	80	0	571,118	0	571,118	58.00
60.00	06000	LABORATORY	164	0	131,134	0	131,134	60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	5	0	2,118	0	2,118	63.00
64.00	06400	INTRAVENOUS THERAPY	52	0	47,456	0	47,456	64.00
65.00	06500	RESPIRATORY THERAPY	44	0	61,250	0	61,250	65.00
66.00	06600	PHYSICAL THERAPY	39	0	88,645	0	88,645	66.00
67.00	06700	OCCUPATIONAL THERAPY	18	0	32,505	0	32,505	67.00
68.00	06800	SPEECH PATHOLOGY	7	0	10,395	0	10,395	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	1	0	69,852	0	69,852	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	112	0	199,357	0	199,357	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	323	0	104,159	0	104,159	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	128	0	102,388	0	102,388	73.00
74.00	07400	RENAL DIALYSIS	43	0	21,245	0	21,245	74.00
76.00	03950	ANCILLARY	0	0	0	0	0	76.00
76.01	03560	PULMONARY FUNCTION TESTING	2	0	1,039	0	1,039	76.01
76.02	03340	GASTRO INTESTINAL SERVICES	5	0	27,828	0	27,828	76.02
76.03	03140	CARDIOLOGY	70	0	119,643	0	119,643	76.03
76.97	07697	CARDIAC REHABILITATION	6	0	79,141	0	79,141	76.97
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	84	0	312,311	0	312,311	90.00
91.00	09100	EMERGENCY	165	0	236,836	0	236,836	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				0		92.00
OTHER REIMBURSABLE COST CENTERS								
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	2,679	1,135	5,348,986	0	5,348,986	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	35,993	0	35,993	190.00
194.00	07950	UN-USED SQR FT - HOSPITAL	0	0	0	0	0	194.00
194.01	07951	MEALS ON WHEELS	0	0	0	0	0	194.01
194.02	07952	MARKETING	0	0	0	0	0	194.02
194.03	07953	GUEST MEALS	0	0	0	0	0	194.03
194.04	07954	PHYSICIAN/OTHER MEALS	0	0	730	0	730	194.04
194.05	07955	FOUNDATION	0	0	22,451	0	22,451	194.05
194.06	07956	DAYCARE CENTER	0	0	94,089	0	94,089	194.06
194.07	07957	UN-USED SQR FT - POB	0	0	4,073	0	4,073	194.07
194.08	07958	SENIOR SERVICES	0	0	0	0	0	194.08
194.09	07959	ARC BROMENN	0	0	8	0	8	194.09
194.10	07960	ARC INGALLS	0	0	45	0	45	194.10
200.00		Cross Foot Adjustments			0	0	0	200.00
201.00		Negative Cost Centers	0	0	57,008	0	57,008	201.00
202.00		TOTAL (sum lines 118 through 201)	2,679	1,135	5,563,383	0	5,563,383	202.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0013

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

Worksheet B-1

Date/Time Prepared:
7/22/2021 3:42 pm

Cost Center Description		CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALA RIE)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
		BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (SQUARE FEET)				
		1.00	2.00	4.00	5A	5.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT	428,033				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		428,033			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	14,197	14,197	25,229,129		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	52,369	52,369	572,811	-18,460,546	5.00
6.00	00600	MAINTENANCE & REPAIRS	66,704	66,704	0	0	6.00
7.00	00700	OPERATION OF PLANT	4,749	4,749	1,085,947	0	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	3,848	3,848	29,107	0	8.00
9.00	00900	HOUSEKEEPING	6,520	6,520	875,767	0	9.00
10.00	01000	DIETARY	5,466	5,466	323,136	0	10.00
11.00	01100	CAFETERIA	14,507	14,507	386,793	0	11.00
13.00	01300	NURSING ADMINISTRATION	1,980	1,980	83,269	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	369,437	0	14.00
15.00	01500	PHARMACY	3,296	3,296	973,172	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	143	143	0	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	65,613	65,613	3,110,294	0	30.00
31.00	03100	INTENSIVE CARE UNIT	9,099	9,099	846,438	0	31.00
40.00	04000	SUBPROVIDER - IPF	6,976	6,976	1,401,764	0	40.00
43.00	04300	NURSERY	0	0	0	0	43.00
44.00	04400	SKILLED NURSING FACILITY	22,616	22,616	1,038,318	0	44.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	42,281	42,281	2,571,701	0	50.00
51.00	05100	RECOVERY ROOM	0	0	1,614,287	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	693	693	73,042	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	27,404	27,404	1,422,098	0	54.00
57.00	05700	CT SCAN	0	0	406,721	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	231,550	0	58.00
60.00	06000	LABORATORY	11,647	11,647	1,194,023	0	60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	0	0	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	586,868	0	64.00
65.00	06500	RESPIRATORY THERAPY	3,787	3,787	531,083	0	65.00
66.00	06600	PHYSICAL THERAPY	3,523	3,523	605,913	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	340,565	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	104,560	0	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	8,794	8,794	11,549	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	11,277	11,277	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	2,362	2,362	253,050	0	74.00
76.00	03950	ANCILLARY	0	0	0	107	76.00
76.01	03560	PULMONARY FUNCTION TESTING	0	0	17,718	0	76.01
76.02	03340	GASTRO INTESTINAL SERVICES	0	0	0	0	76.02
76.03	03140	CARDIOLOGY	0	0	481,951	0	76.03
76.97	07697	CARDIAC REHABILITATION	0	0	389,125	0	76.97
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	9,635	9,635	800,760	0	90.00
91.00	09100	EMERGENCY	11,516	11,516	1,646,557	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					92.00
OTHER REIMBURSABLE COST CENTERS							
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS							
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	411,002	411,002	24,379,374	-18,460,439	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	4,534	4,534	0	0	190.00
194.00	07950	UN-USED SQR FT - HOSPITAL	0	0	0	0	194.00
194.01	07951	MEALS ON WHEELS	0	0	0	0	194.01
194.02	07952	MARKETING	0	0	0	0	194.02
194.03	07953	GUEST MEALS	0	0	0	0	194.03
194.04	07954	PHYSICIAN/OTHER MEALS	0	0	142,746	0	194.04
194.05	07955	FOUNDATION	2,828	2,828	0	0	194.05
194.06	07956	DAYCARE CENTER	9,156	9,156	707,009	0	194.06
194.07	07957	UN-USED SQR FT - POB	513	513	0	0	194.07
194.08	07958	SENIOR SERVICES	0	0	0	0	194.08
194.09	07959	ARC BROMENN	0	0	0	0	194.09
194.10	07960	ARC INGALLS	0	0	0	0	194.10
200.00		Cross Foot Adjustments					200.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0013

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

Worksheet B-1

Date/Time Prepared:
7/22/2021 3:42 pm

Cost Center Description		CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALA RIE)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
		BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (SQUARE FEET)				
		1.00	2.00	4.00	5A	5.00	
201.00	Negative Cost Centers						201.00
202.00	Cost to be allocated (per Wkst. B, Part I)	1,532,708	0	-485,601		18,460,546	202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	3.580817	0.000000	0.000000		0.221286	203.00
204.00	Cost to be allocated (per Wkst. B, Part II)			57,008		206,681	204.00
205.00	Unit cost multiplier (Wkst. B, Part II)			0.002260		0.002477	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: 14-0013

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

Worksheet B-1

Date/Time Prepared:
7/22/2021 3:42 pm

Cost Center Description			MAINTENANCE & REPAIRS (SQUARE FEET)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (PATIENT DA YS)	HOUSEKEEPING (SQUARE FEET)	DIETARY (PATIENT DA YS)	
			6.00	7.00	8.00	9.00	10.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS	294,763					6.00
7.00	00700	OPERATION OF PLANT	4,749	290,014				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	3,848	3,848	22,481			8.00
9.00	00900	HOUSEKEEPING	6,520	6,520	0	279,646		9.00
10.00	01000	DIETARY	5,466	5,466	0	5,466	22,481	10.00
11.00	01100	CAFETERIA	14,507	14,507	0	14,507	0	11.00
13.00	01300	NURSING ADMINISTRATION	1,980	1,980	0	1,980	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	0	14.00
15.00	01500	PHARMACY	3,296	3,296	0	3,296	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	143	143	0	143	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	65,613	65,613	8,859	65,613	8,859	30.00
31.00	03100	INTENSIVE CARE UNIT	9,099	9,099	1,187	9,099	1,187	31.00
40.00	04000	SUBPROVIDER - IPF	6,976	6,976	3,528	6,976	3,528	40.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
44.00	04400	SKILLED NURSING FACILITY	22,616	22,616	8,907	22,616	8,907	44.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	42,281	42,281	0	42,281	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	693	693	0	693	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	27,404	27,404	0	27,404	0	54.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
60.00	06000	LABORATORY	11,647	11,647	0	11,647	0	60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	0	0	0	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	3,787	3,787	0	3,787	0	65.00
66.00	06600	PHYSICAL THERAPY	3,523	3,523	0	3,523	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
70.00	07000	ELECTROENCEPHALOGRAPHY	8,794	8,794	0	8,794	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	11,277	11,277	0	11,277	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	2,362	2,362	0	2,362	0	74.00
76.00	03950	ANCILLARY	0	0	0	0	0	76.00
76.01	03560	PULMONARY FUNCTION TESTING	0	0	0	0	0	76.01
76.02	03340	GASTRO INTESTINAL SERVICES	0	0	0	0	0	76.02
76.03	03140	CARDIOLOGY	0	0	0	0	0	76.03
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	9,635	9,635	0	9,635	0	90.00
91.00	09100	EMERGENCY	11,516	11,516	0	11,516	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
OTHER REIMBURSABLE COST CENTERS								
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	277,732	272,983	22,481	262,615	22,481	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	4,534	4,534	0	4,534	0	190.00
194.00	07950	UN-USED SQR FT - HOSPITAL	0	0	0	0	0	194.00
194.01	07951	MEALS ON WHEELS	0	0	0	0	0	194.01
194.02	07952	MARKETING	0	0	0	0	0	194.02
194.03	07953	GUEST MEALS	0	0	0	0	0	194.03
194.04	07954	PHYSICIAN/OTHER MEALS	0	0	0	0	0	194.04
194.05	07955	FOUNDATION	2,828	2,828	0	2,828	0	194.05
194.06	07956	DAYCARE CENTER	9,156	9,156	0	9,156	0	194.06
194.07	07957	UN-USED SQR FT - POB	513	513	0	513	0	194.07
194.08	07958	SENIOR SERVICES	0	0	0	0	0	194.08
194.09	07959	ARC BROMENN	0	0	0	0	0	194.09
194.10	07960	ARC INGALLS	0	0	0	0	0	194.10
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)	2,730,496	4,452,067	130,864	2,080,449	892,287	202.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0013

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

Worksheet B-1

Date/Time Prepared:
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Cost Center Description		MAINTENANCE & REPAIRS (SQUARE FEET)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (PATIENT DA YS)	HOUSEKEEPING (SQUARE FEET)	DIETARY (PATIENT DA YS)	
		6.00	7.00	8.00	9.00	10.00	
203.00	Unit cost multiplier (Wkst. B, Part I)	9.263361	15.351214	5.821093	7.439581	39.690717	203.00
204.00	Cost to be allocated (per Wkst. B, Part II)	977,250	225,116	29,597	71,972	44,799	204.00
205.00	Unit cost multiplier (Wkst. B, Part II)	3.315375	0.776225	1.316534	0.257368	1.992749	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: 14-0013

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

Worksheet B-1

Date/Time Prepared:
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Cost Center Description			CAFETERIA (GROSS SALA RIE)	NURSING ADMINISTRATION (NURSING SA LARIE)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS CHAR GES)	
			11.00	13.00	14.00	15.00	16.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
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	19,404,710					11.00
13.00	01300	NURSING ADMINISTRATION	83,269	14,362,770				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	369,437	0	19,471,168			14.00
15.00	01500	PHARMACY	973,172	0	0	3,182,818		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	552,749,112	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	3,110,294	3,110,294	0	0	28,471,912	30.00
31.00	03100	INTENSIVE CARE UNIT	846,438	846,438	0	0	6,221,033	31.00
40.00	04000	SUBPROVIDER - IPF	1,401,764	1,401,764	0	0	8,743,129	40.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
44.00	04400	SKILLED NURSING FACILITY	1,038,318	1,038,318	0	0	8,576,313	44.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	2,571,701	2,571,701	0	0	116,525,827	50.00
51.00	05100	RECOVERY ROOM	1,614,287	1,614,287	0	0	24,910,060	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	73,042	73,042	0	0	30,737,884	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,422,098	1,422,098	0	0	21,194,103	54.00
57.00	05700	CT SCAN	406,721	406,721	0	0	37,752,326	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	231,550	231,550	0	0	15,916,596	58.00
60.00	06000	LABORATORY	1,194,023	0	0	0	32,719,937	60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	0	0	0	0	1,084,576	63.00
64.00	06400	INTRAVENOUS THERAPY	586,868	0	0	0	10,478,656	64.00
65.00	06500	RESPIRATORY THERAPY	531,083	0	0	0	8,864,748	65.00
66.00	06600	PHYSICAL THERAPY	605,913	0	0	0	7,766,368	66.00
67.00	06700	OCCUPATIONAL THERAPY	340,565	0	0	0	3,504,471	67.00
68.00	06800	SPEECH PATHOLOGY	104,560	0	0	0	1,325,510	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	128,981	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	6,623,774	0	22,429,086	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	12,847,394	0	64,639,740	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	3,182,818	25,616,117	73.00
74.00	07400	RENAL DIALYSIS	253,050	0	0	0	8,511,439	74.00
76.00	03950	ANCILLARY	0	0	0	0	0	76.00
76.01	03560	PULMONARY FUNCTION TESTING	0	0	0	0	461,756	76.01
76.02	03340	GASTRO INTESTINAL SERVICES	0	0	0	0	1,069,784	76.02
76.03	03140	CARDIOLOGY	0	0	0	0	14,001,550	76.03
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	1,225,878	76.97
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0	0	16,839,185	90.00
91.00	09100	EMERGENCY	1,646,557	1,646,557	0	0	33,032,147	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
OTHER REIMBURSABLE COST CENTERS								
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	19,404,710	14,362,770	19,471,168	3,182,818	552,749,112	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
194.00	07950	UN-USED SQR FT - HOSPITAL	0	0	0	0	0	194.00
194.01	07951	MEALS ON WHEELS	0	0	0	0	0	194.01
194.02	07952	MARKETING	0	0	0	0	0	194.02
194.03	07953	GUEST MEALS	0	0	0	0	0	194.03
194.04	07954	PHYSICIAN/OTHER MEALS	0	0	0	0	0	194.04
194.05	07955	FOUNDATION	0	0	0	0	0	194.05
194.06	07956	DAYCARE CENTER	0	0	0	0	0	194.06
194.07	07957	UN-USED SQR FT - POB	0	0	0	0	0	194.07
194.08	07958	SENIOR SERVICES	0	0	0	0	0	194.08
194.09	07959	ARC BROMENN	0	0	0	0	0	194.09
194.10	07960	ARC INGALLS	0	0	0	0	0	194.10
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0013

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

Worksheet B-1

Date/Time Prepared:
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Cost Center Description		CAFETERIA (GROSS SALA RIE)	NURSING ADMINISTRATION (NURSING SA LARIE)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS CHAR GES)	
		11.00	13.00	14.00	15.00	16.00	
202.00	Cost to be allocated (per Wkst. B, Part I)	1,506,228	2,210,846	958,529	1,735,512	1,321,005	202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	0.077622	0.153929	0.049228	0.545275	0.002390	203.00
204.00	Cost to be allocated (per Wkst. B, Part II)	117,150	20,546	109,146	94,376	2,679	204.00
205.00	Unit cost multiplier (Wkst. B, Part II)	0.006037	0.001431	0.005606	0.029652	0.000005	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: 14-0013

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 DA YS)	
		17.00	
GENERAL SERVICE COST CENTERS			
1.00	00100	CAP REL COSTS-BLDG & FIXT	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	5.00
6.00	00600	MAINTENANCE & REPAIRS	6.00
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
		22,481	
INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS	30.00
31.00	03100	INTENSIVE CARE UNIT	31.00
40.00	04000	SUBPROVIDER - IPF	40.00
43.00	04300	NURSERY	43.00
44.00	04400	SKILLED NURSING FACILITY	44.00
		8,859	
		1,187	
		3,528	
		0	
		8,907	
ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	50.00
51.00	05100	RECOVERY ROOM	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	52.00
53.00	05300	ANESTHESIOLOGY	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	54.00
57.00	05700	CT SCAN	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	58.00
60.00	06000	LABORATORY	60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	63.00
64.00	06400	INTRAVENOUS THERAPY	64.00
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
70.00	07000	ELECTROENCEPHALOGRAPHY	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	73.00
74.00	07400	RENAL DIALYSIS	74.00
76.00	03950	ANCILLARY	76.00
76.01	03560	PULMONARY FUNCTION TESTING	76.01
76.02	03340	GASTRO INTESTINAL SERVICES	76.02
76.03	03140	CARDIOLOGY	76.03
76.97	07697	CARDIAC REHABILITATION	76.97
OUTPATIENT SERVICE COST CENTERS			
90.00	09000	CLINIC	90.00
91.00	09100	EMERGENCY	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	92.00
OTHER REIMBURSABLE COST CENTERS			
101.00	10100	HOME HEALTH AGENCY	101.00
SPECIAL PURPOSE COST CENTERS			
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	118.00
		22,481	
NONREIMBURSABLE COST CENTERS			
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	190.00
194.00	07950	UN-USED SQR FT - HOSPITAL	194.00
194.01	07951	MEALS ON WHEELS	194.01
194.02	07952	MARKETING	194.02
194.03	07953	GUEST MEALS	194.03
194.04	07954	PHYSICIAN/OTHER MEALS	194.04
194.05	07955	FOUNDATION	194.05
194.06	07956	DAYCARE CENTER	194.06
194.07	07957	UN-USED SQR FT - POB	194.07
194.08	07958	SENIOR SERVICES	194.08
194.09	07959	ARC BROMENN	194.09
194.10	07960	ARC INGALLS	194.10
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
		5,209	

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0013

Period:
From 01/01/2020
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Cost Center Description		SOCIAL SERVICE	
		(PATIENT DAYS)	
		17.00	
203.00	Unit cost multiplier (Wkst. B, Part I)	0.231707	203.00
204.00	Cost to be allocated (per Wkst. B, Part II)	1,135	204.00
205.00	Unit cost multiplier (Wkst. B, Part II)	0.050487	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: 14-0013

Period:
From 01/01/2020
To 12/31/2020Worksheet C
Part I
Date/Time Prepared:
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				Title XVIII		Hospital		PPS	
Cost Center Description			Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs				
					Total Costs	RCE Disallowance	Total Costs		
			1.00	2.00	3.00	4.00	5.00		
INPATIENT ROUTINE SERVICE COST CENTERS									
30.00	03000	ADULTS & PEDIATRICS	10,817,247		10,817,247	0	10,817,247	30.00	
31.00	03100	INTENSIVE CARE UNIT	2,223,292		2,223,292	0	2,223,292	31.00	
40.00	04000	SUBPROVIDER - IPF	3,244,657		3,244,657	0	3,244,657	40.00	
43.00	04300	NURSERY	0		0	0	0	43.00	
44.00	04400	SKILLED NURSING FACILITY	3,971,144		3,971,144	0	3,971,144	44.00	
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM	18,812,371		18,812,371	0	18,812,371	50.00	
51.00	05100	RECOVERY ROOM	3,046,722		3,046,722	0	3,046,722	51.00	
52.00	05200	DELIVERY ROOM & LABOR ROOM	0		0	0	0	52.00	
53.00	05300	ANESTHESIOLOGY	521,237		521,237	0	521,237	53.00	
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,046,705		4,046,705	0	4,046,705	54.00	
57.00	05700	CT SCAN	1,228,764		1,228,764	0	1,228,764	57.00	
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	1,160,275		1,160,275	0	1,160,275	58.00	
60.00	06000	LABORATORY	4,506,215		4,506,215	0	4,506,215	60.00	
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	177,731		177,731	0	177,731	63.00	
64.00	06400	INTRAVENOUS THERAPY	1,457,407		1,457,407	0	1,457,407	64.00	
65.00	06500	RESPIRATORY THERAPY	1,065,920	0	1,065,920	0	1,065,920	65.00	
66.00	06600	PHYSICAL THERAPY	2,157,148	0	2,157,148	0	2,157,148	66.00	
67.00	06700	OCCUPATIONAL THERAPY	951,701	0	951,701	0	951,701	67.00	
68.00	06800	SPEECH PATHOLOGY	347,310	0	347,310	0	347,310	68.00	
70.00	07000	ELECTROENCEPHALOGRAPHY	339,762		339,762	0	339,762	70.00	
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	8,899,155		8,899,155	0	8,899,155	71.00	
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	16,477,285		16,477,285	0	16,477,285	72.00	
73.00	07300	DRUGS CHARGED TO PATIENTS	5,683,866		5,683,866	0	5,683,866	73.00	
74.00	07400	RENAL DIALYSIS	581,289		581,289	0	581,289	74.00	
76.00	03950	ANCILLARY	0		0	0	0	76.00	
76.01	03560	PULMONARY FUNCTION TESTING	30,019		30,019	0	30,019	76.01	
76.02	03340	GASTRO INTESTINAL SERVICES	89,648		89,648	0	89,648	76.02	
76.03	03140	CARDIOLOGY	1,076,760		1,076,760	0	1,076,760	76.03	
76.97	07697	CARDIAC REHABILITATION	632,237		632,237	0	632,237	76.97	
OUTPATIENT SERVICE COST CENTERS									
90.00	09000	CLINIC	3,083,786		3,083,786	0	3,083,786	90.00	
91.00	09100	EMERGENCY	2,941,442		2,941,442	0	2,941,442	91.00	
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	2,231,098		2,231,098	0	2,231,098	92.00	
OTHER REIMBURSABLE COST CENTERS									
101.00	10100	HOME HEALTH AGENCY	0		0	0	0	101.00	
200.00		Subtotal (see instructions)	101,802,193	0	101,802,193	0	101,802,193	200.00	
201.00		Less Observation Beds	2,231,098		2,231,098	0	2,231,098	201.00	
202.00		Total (see instructions)	99,571,095	0	99,571,095	0	99,571,095	202.00	

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0013

Period:
From 01/01/2020
To 12/31/2020Worksheet C
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			Title XVIII		Hospital	PPS	
Cost Center Description			Charges			Cost or Other Ratio	TEFRA Inpatient Ratio
			Inpatient	Outpatient	Total (col. 6 + col. 7)		
			6.00	7.00	8.00		
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	24,644,958		24,644,958		30.00
31.00	03100	INTENSIVE CARE UNIT	6,221,033		6,221,033		31.00
40.00	04000	SUBPROVIDER - IPF	8,743,129		8,743,129		40.00
43.00	04300	NURSERY	0		0		43.00
44.00	04400	SKILLED NURSING FACILITY	8,576,313		8,576,313		44.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	11,481,961	105,043,866	116,525,827	0.161444	0.000000
51.00	05100	RECOVERY ROOM	2,611,277	22,298,783	24,910,060	0.122309	0.000000
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0.000000	0.000000
53.00	05300	ANESTHESIOLOGY	3,195,646	27,542,238	30,737,884	0.016957	0.000000
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,773,157	17,420,946	21,194,103	0.190935	0.000000
57.00	05700	CT SCAN	7,494,340	30,257,986	37,752,326	0.032548	0.000000
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	1,858,454	14,058,142	15,916,596	0.072897	0.000000
60.00	06000	LABORATORY	12,547,195	20,172,742	32,719,937	0.137721	0.000000
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	873,173	211,403	1,084,576	0.163871	0.000000
64.00	06400	INTRAVENOUS THERAPY	1,887,962	8,590,694	10,478,656	0.139083	0.000000
65.00	06500	RESPIRATORY THERAPY	7,963,526	901,222	8,864,748	0.120243	0.000000
66.00	06600	PHYSICAL THERAPY	6,288,782	1,477,586	7,766,368	0.277755	0.000000
67.00	06700	OCCUPATIONAL THERAPY	3,381,607	122,864	3,504,471	0.271568	0.000000
68.00	06800	SPEECH PATHOLOGY	1,194,841	130,669	1,325,510	0.262020	0.000000
70.00	07000	ELECTROENCEPHALOGRAPHY	93,382	35,599	128,981	2.634202	0.000000
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	6,067,060	16,362,026	22,429,086	0.396769	0.000000
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	15,343,544	49,296,196	64,639,740	0.254910	0.000000
73.00	07300	DRUGS CHARGED TO PATIENTS	9,898,768	15,717,349	25,616,117	0.221886	0.000000
74.00	07400	RENAL DIALYSIS	0	8,511,439	8,511,439	0.068295	0.000000
76.00	03950	ANCILLARY	0	0	0	0.000000	0.000000
76.01	03560	PULMONARY FUNCTION TESTING	365,242	96,514	461,756	0.065011	0.000000
76.02	03340	GASTRO INTESTINAL SERVICES	871,494	198,290	1,069,784	0.083800	0.000000
76.03	03140	CARDIOLOGY	6,536,229	7,465,321	14,001,550	0.076903	0.000000
76.97	07697	CARDIAC REHABILITATION	0	1,225,878	1,225,878	0.515742	0.000000
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	1,689,548	15,149,637	16,839,185	0.183132	0.000000
91.00	09100	EMERGENCY	6,124,421	26,907,726	33,032,147	0.089048	0.000000
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	711,337	3,115,617	3,826,954	0.582996	0.000000
OTHER REIMBURSABLE COST CENTERS							
101.00	10100	HOME HEALTH AGENCY	0	0	0		101.00
200.00		Subtotal (see instructions)	160,438,379	392,310,733	552,749,112		200.00
201.00		Less Observation Beds					201.00
202.00		Total (see instructions)	160,438,379	392,310,733	552,749,112		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES			Provider CCN: 14-0013	Period: From 01/01/2020 To 12/31/2020	Worksheet C Part I Date/Time Prepared: 7/22/2021 3:42 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
44.00	04400	SKILLED NURSING FACILITY			44.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0.161444		50.00
51.00	05100	RECOVERY ROOM	0.122309		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000		52.00
53.00	05300	ANESTHESIOLOGY	0.016957		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.190935		54.00
57.00	05700	CT SCAN	0.032548		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.072897		58.00
60.00	06000	LABORATORY	0.137721		60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	0.163871		63.00
64.00	06400	INTRAVENOUS THERAPY	0.139083		64.00
65.00	06500	RESPIRATORY THERAPY	0.120243		65.00
66.00	06600	PHYSICAL THERAPY	0.277755		66.00
67.00	06700	OCCUPATIONAL THERAPY	0.271568		67.00
68.00	06800	SPEECH PATHOLOGY	0.262020		68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	2.634202		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.396769		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.254910		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.221886		73.00
74.00	07400	RENAL DIALYSIS	0.068295		74.00
76.00	03950	ANCILLARY	0.000000		76.00
76.01	03560	PULMONARY FUNCTION TESTING	0.065011		76.01
76.02	03340	GASTRO INTESTINAL SERVICES	0.083800		76.02
76.03	03140	CARDIOLOGY	0.076903		76.03
76.97	07697	CARDIAC REHABILITATION	0.515742		76.97
OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	0.183132		90.00
91.00	09100	EMERGENCY	0.089048		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.582996		92.00
OTHER REIMBURSABLE COST CENTERS					
101.00	10100	HOME HEALTH AGENCY			101.00
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: 14-0013

Period:
From 01/01/2020
To 12/31/2020Worksheet C
Part I
Date/Time Prepared:
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			Title XIX		Hospital		PPS	
Cost Center Description			Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Total Costs	Costs		
						RCE Disallowance	Total Costs	
			1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	10,817,247		10,817,247	0	10,817,247	30.00
31.00	03100	INTENSIVE CARE UNIT	2,223,292		2,223,292	0	2,223,292	31.00
40.00	04000	SUBPROVIDER - IPF	3,244,657		3,244,657	0	3,244,657	40.00
43.00	04300	NURSERY	0		0	0	0	43.00
44.00	04400	SKILLED NURSING FACILITY	3,971,144		3,971,144	0	3,971,144	44.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	18,812,371		18,812,371	0	18,812,371	50.00
51.00	05100	RECOVERY ROOM	3,046,722		3,046,722	0	3,046,722	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0		0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	521,237		521,237	0	521,237	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,046,705		4,046,705	0	4,046,705	54.00
57.00	05700	CT SCAN	1,228,764		1,228,764	0	1,228,764	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	1,160,275		1,160,275	0	1,160,275	58.00
60.00	06000	LABORATORY	4,506,215		4,506,215	0	4,506,215	60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	177,731		177,731	0	177,731	63.00
64.00	06400	INTRAVENOUS THERAPY	1,457,407		1,457,407	0	1,457,407	64.00
65.00	06500	RESPIRATORY THERAPY	1,065,920	0	1,065,920	0	1,065,920	65.00
66.00	06600	PHYSICAL THERAPY	2,157,148	0	2,157,148	0	2,157,148	66.00
67.00	06700	OCCUPATIONAL THERAPY	951,701	0	951,701	0	951,701	67.00
68.00	06800	SPEECH PATHOLOGY	347,310	0	347,310	0	347,310	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	339,762		339,762	0	339,762	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	8,899,155		8,899,155	0	8,899,155	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	16,477,285		16,477,285	0	16,477,285	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	5,683,866		5,683,866	0	5,683,866	73.00
74.00	07400	RENAL DIALYSIS	581,289		581,289	0	581,289	74.00
76.00	03950	ANCILLARY	0		0	0	0	76.00
76.01	03560	PULMONARY FUNCTION TESTING	30,019		30,019	0	30,019	76.01
76.02	03340	GASTRO INTESTINAL SERVICES	89,648		89,648	0	89,648	76.02
76.03	03140	CARDIOLOGY	1,076,760		1,076,760	0	1,076,760	76.03
76.97	07697	CARDIAC REHABILITATION	632,237		632,237	0	632,237	76.97
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	3,083,786		3,083,786	0	3,083,786	90.00
91.00	09100	EMERGENCY	2,941,442		2,941,442	0	2,941,442	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	2,231,098		2,231,098	0	2,231,098	92.00
OTHER REIMBURSABLE COST CENTERS								
101.00	10100	HOME HEALTH AGENCY	0		0	0	0	101.00
200.00		Subtotal (see instructions)	101,802,193	0	101,802,193	0	101,802,193	200.00
201.00		Less Observation Beds	2,231,098		2,231,098	0	2,231,098	201.00
202.00		Total (see instructions)	99,571,095	0	99,571,095	0	99,571,095	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0013

Period:
From 01/01/2020
To 12/31/2020Worksheet C
Part I
Date/Time Prepared:
7/22/2021 3:42 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	24,644,958		24,644,958		30.00
31.00	03100	INTENSIVE CARE UNIT	6,221,033		6,221,033		31.00
40.00	04000	SUBPROVIDER - IPF	8,743,129		8,743,129		40.00
43.00	04300	NURSERY	0		0		43.00
44.00	04400	SKILLED NURSING FACILITY	8,576,313		8,576,313		44.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	11,481,961	105,043,866	116,525,827	0.161444	0.000000
51.00	05100	RECOVERY ROOM	2,611,277	22,298,783	24,910,060	0.122309	0.000000
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0.000000	0.000000
53.00	05300	ANESTHESIOLOGY	3,195,646	27,542,238	30,737,884	0.016957	0.000000
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,773,157	17,420,946	21,194,103	0.190935	0.000000
57.00	05700	CT SCAN	7,494,340	30,257,986	37,752,326	0.032548	0.000000
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	1,858,454	14,058,142	15,916,596	0.072897	0.000000
60.00	06000	LABORATORY	12,547,195	20,172,742	32,719,937	0.137721	0.000000
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	873,173	211,403	1,084,576	0.163871	0.000000
64.00	06400	INTRAVENOUS THERAPY	1,887,962	8,590,694	10,478,656	0.139083	0.000000
65.00	06500	RESPIRATORY THERAPY	7,963,526	901,222	8,864,748	0.120243	0.000000
66.00	06600	PHYSICAL THERAPY	6,288,782	1,477,586	7,766,368	0.277755	0.000000
67.00	06700	OCCUPATIONAL THERAPY	3,381,607	122,864	3,504,471	0.271568	0.000000
68.00	06800	SPEECH PATHOLOGY	1,194,841	130,669	1,325,510	0.262020	0.000000
70.00	07000	ELECTROENCEPHALOGRAPHY	93,382	35,599	128,981	2.634202	0.000000
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	6,067,060	16,362,026	22,429,086	0.396769	0.000000
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	15,343,544	49,296,196	64,639,740	0.254910	0.000000
73.00	07300	DRUGS CHARGED TO PATIENTS	9,898,768	15,717,349	25,616,117	0.221886	0.000000
74.00	07400	RENAL DIALYSIS	0	8,511,439	8,511,439	0.068295	0.000000
76.00	03950	ANCILLARY	0	0	0	0.000000	0.000000
76.01	03560	PULMONARY FUNCTION TESTING	365,242	96,514	461,756	0.065011	0.000000
76.02	03340	GASTRO INTESTINAL SERVICES	871,494	198,290	1,069,784	0.083800	0.000000
76.03	03140	CARDIOLOGY	6,536,229	7,465,321	14,001,550	0.076903	0.000000
76.97	07697	CARDIAC REHABILITATION	0	1,225,878	1,225,878	0.515742	0.000000
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	1,689,548	15,149,637	16,839,185	0.183132	0.000000
91.00	09100	EMERGENCY	6,124,421	26,907,726	33,032,147	0.089048	0.000000
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	711,337	3,115,617	3,826,954	0.582996	0.000000
OTHER REIMBURSABLE COST CENTERS							
101.00	10100	HOME HEALTH AGENCY	0	0	0		101.00
200.00		Subtotal (see instructions)	160,438,379	392,310,733	552,749,112		200.00
201.00		Less Observation Beds					201.00
202.00		Total (see instructions)	160,438,379	392,310,733	552,749,112		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES			Provider CCN: 14-0013	Period: From 01/01/2020 To 12/31/2020	Worksheet C Part I Date/Time Prepared: 7/22/2021 3:42 pm
			Title XIX	Hospital	PPS
Cost Center Description			PPS Inpatient Ratio		
			11.00		
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS			30.00
31.00	03100	INTENSIVE CARE UNIT			31.00
40.00	04000	SUBPROVIDER - IPF			40.00
43.00	04300	NURSERY			43.00
44.00	04400	SKILLED NURSING FACILITY			44.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0.161444		50.00
51.00	05100	RECOVERY ROOM	0.122309		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000		52.00
53.00	05300	ANESTHESIOLOGY	0.016957		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.190935		54.00
57.00	05700	CT SCAN	0.032548		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.072897		58.00
60.00	06000	LABORATORY	0.137721		60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	0.163871		63.00
64.00	06400	INTRAVENOUS THERAPY	0.139083		64.00
65.00	06500	RESPIRATORY THERAPY	0.120243		65.00
66.00	06600	PHYSICAL THERAPY	0.277755		66.00
67.00	06700	OCCUPATIONAL THERAPY	0.271568		67.00
68.00	06800	SPEECH PATHOLOGY	0.262020		68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	2.634202		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.396769		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.254910		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.221886		73.00
74.00	07400	RENAL DIALYSIS	0.068295		74.00
76.00	03950	ANCILLARY	0.000000		76.00
76.01	03560	PULMONARY FUNCTION TESTING	0.065011		76.01
76.02	03340	GASTRO INTESTINAL SERVICES	0.083800		76.02
76.03	03140	CARDIOLOGY	0.076903		76.03
76.97	07697	CARDIAC REHABILITATION	0.515742		76.97
OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	0.183132		90.00
91.00	09100	EMERGENCY	0.089048		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.582996		92.00
OTHER REIMBURSABLE COST CENTERS					
101.00	10100	HOME HEALTH AGENCY			101.00
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: 14-0013

Period:
From 01/01/2020
To 12/31/2020Worksheet C
Part II
Date/Time Prepared:
7/22/2021 3:42 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	18,812,371	757,321	18,055,050	0	0	50.00
51.00	05100	RECOVERY ROOM	3,046,722	35,813	3,010,909	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	521,237	203,486	317,751	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,046,705	488,549	3,558,156	0	0	54.00
57.00	05700	CT SCAN	1,228,764	311,734	917,030	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	1,160,275	571,118	589,157	0	0	58.00
60.00	06000	LABORATORY	4,506,215	131,134	4,375,081	0	0	60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	177,731	2,118	175,613	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	1,457,407	47,456	1,409,951	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	1,065,920	61,250	1,004,670	0	0	65.00
66.00	06600	PHYSICAL THERAPY	2,157,148	88,645	2,068,503	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	951,701	32,505	919,196	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	347,310	10,395	336,915	0	0	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	339,762	69,852	269,910	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	8,899,155	199,357	8,699,798	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	16,477,285	104,159	16,373,126	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	5,683,866	102,388	5,581,478	0	0	73.00
74.00	07400	RENAL DIALYSIS	581,289	21,245	560,044	0	0	74.00
76.00	03950	ANCILLARY	0	0	0	0	0	76.00
76.01	03560	PULMONARY FUNCTION TESTING	30,019	1,039	28,980	0	0	76.01
76.02	03340	GASTRO INTESTINAL SERVICES	89,648	27,828	61,820	0	0	76.02
76.03	03140	CARDIOLOGY	1,076,760	119,643	957,117	0	0	76.03
76.97	07697	CARDIAC REHABILITATION	632,237	79,141	553,096	0	0	76.97
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	3,083,786	312,311	2,771,475	0	0	90.00
91.00	09100	EMERGENCY	2,941,442	236,836	2,704,606	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	2,231,098	145,142	2,085,956	0	0	92.00
OTHER REIMBURSABLE COST CENTERS								
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
200.00		Subtotal (sum of lines 50 thru 199)	81,545,853	4,160,465	77,385,388	0	0	200.00
201.00		Less Observation Beds	2,231,098	145,142	2,085,956	0	0	201.00
202.00		Total (line 200 minus line 201)	79,314,755	4,015,323	75,299,432	0	0	202.00

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

Provider CCN: 14-0013

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

Worksheet C
Part II
Date/Time Prepared:
7/22/2021 3:42 pm

			Title XIX		Hospital	PPS
Cost Center Description			Cost Net of Capital and Operating Cost Reduction	Total Charges (Worksheet C, Part I, column 8)	Outpatient Cost to Charge Ratio (col. 6 / col. 7)	
			6.00	7.00	8.00	
	ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	18,812,371	116,525,827	0.161444	50.00
51.00	05100	RECOVERY ROOM	3,046,722	24,910,060	0.122309	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	521,237	30,737,884	0.016957	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,046,705	21,194,103	0.190935	54.00
57.00	05700	CT SCAN	1,228,764	37,752,326	0.032548	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	1,160,275	15,916,596	0.072897	58.00
60.00	06000	LABORATORY	4,506,215	32,719,937	0.137721	60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	177,731	1,084,576	0.163871	63.00
64.00	06400	INTRAVENOUS THERAPY	1,457,407	10,478,656	0.139083	64.00
65.00	06500	RESPIRATORY THERAPY	1,065,920	8,864,748	0.120243	65.00
66.00	06600	PHYSICAL THERAPY	2,157,148	7,766,368	0.277755	66.00
67.00	06700	OCCUPATIONAL THERAPY	951,701	3,504,471	0.271568	67.00
68.00	06800	SPEECH PATHOLOGY	347,310	1,325,510	0.262020	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	339,762	128,981	2.634202	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	8,899,155	22,429,086	0.396769	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	16,477,285	64,639,740	0.254910	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	5,683,866	25,616,117	0.221886	73.00
74.00	07400	RENAL DIALYSIS	581,289	8,511,439	0.068295	74.00
76.00	03950	ANCILLARY	0	0	0.000000	76.00
76.01	03560	PULMONARY FUNCTION TESTING	30,019	461,756	0.065011	76.01
76.02	03340	GASTRO INTESTINAL SERVICES	89,648	1,069,784	0.083800	76.02
76.03	03140	CARDIOLOGY	1,076,760	14,001,550	0.076903	76.03
76.97	07697	CARDIAC REHABILITATION	632,237	1,225,878	0.515742	76.97
	OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	3,083,786	16,839,185	0.183132	90.00
91.00	09100	EMERGENCY	2,941,442	33,032,147	0.089048	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	2,231,098	3,826,954	0.582996	92.00
	OTHER REIMBURSABLE COST CENTERS					
101.00	10100	HOME HEALTH AGENCY	0	0	0.000000	101.00
200.00		Subtotal (sum of lines 50 thru 199)	81,545,853	504,563,679		200.00
201.00		Less Observation Beds	2,231,098	0		201.00
202.00		Total (line 200 minus line 201)	79,314,755	504,563,679		202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

Provider CCN: 14-0013

Period:
From 01/01/2020
To 12/31/2020Worksheet D
Part I
Date/Time Prepared:
7/22/2021 3:42 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	703,701	0	703,701	11,161	63.05	30.00	
31.00	INTENSIVE CARE UNIT	151,080		151,080	1,187	127.28	31.00	
40.00	SUBPROVIDER - IPF	173,630	0	173,630	3,528	49.21	40.00	
43.00	NURSERY	0		0	0	0.00	43.00	
44.00	SKILLED NURSING FACILITY	305,252		305,252	8,907	34.27	44.00	
200.00	Total (lines 30 through 199)	1,333,663		1,333,663	24,783		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	4,446	280,320					30.00
31.00	INTENSIVE CARE UNIT	509	64,786					31.00
40.00	SUBPROVIDER - IPF	2,528	124,403					40.00
43.00	NURSERY	0	0					43.00
44.00	SKILLED NURSING FACILITY	6,116	209,595					44.00
200.00	Total (lines 30 through 199)	13,599	679,104					200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS				Provider CCN: 14-0013	Period: From 01/01/2020 To 12/31/2020	Worksheet D Part II Date/Time Prepared: 7/22/2021 3:42 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	757,321	116,525,827	0.006499	5,133,550	33,363	50.00
51.00	05100	RECOVERY ROOM	35,813	24,910,060	0.001438	1,114,310	1,602	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0.000000	0	0	52.00
53.00	05300	ANESTHESIOLOGY	203,486	30,737,884	0.006620	1,394,333	9,230	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	488,549	21,194,103	0.023051	1,743,684	40,194	54.00
57.00	05700	CT SCAN	311,734	37,752,326	0.008257	3,272,556	27,021	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	571,118	15,916,596	0.035882	718,817	25,793	58.00
60.00	06000	LABORATORY	131,134	32,719,937	0.004008	4,881,580	19,565	60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	2,118	1,084,576	0.001953	397,616	777	63.00
64.00	06400	INTRAVENOUS THERAPY	47,456	10,478,656	0.004529	870,866	3,944	64.00
65.00	06500	RESPIRATORY THERAPY	61,250	8,864,748	0.006909	2,377,636	16,427	65.00
66.00	06600	PHYSICAL THERAPY	88,645	7,766,368	0.011414	633,880	7,235	66.00
67.00	06700	OCCUPATIONAL THERAPY	32,505	3,504,471	0.009275	267,987	2,486	67.00
68.00	06800	SPEECH PATHOLOGY	10,395	1,325,510	0.007842	150,157	1,178	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	69,852	128,981	0.541568	33,394	18,085	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	199,357	22,429,086	0.008888	2,800,726	24,893	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	104,159	64,639,740	0.001611	7,226,195	11,641	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	102,388	25,616,117	0.003997	3,700,884	14,792	73.00
74.00	07400	RENAL DIALYSIS	21,245	8,511,439	0.002496	0	0	74.00
76.00	03950	ANCILLARY	0	0	0.000000	0	0	76.00
76.01	03560	PULMONARY FUNCTION TESTING	1,039	461,756	0.002250	166,594	375	76.01
76.02	03340	GASTRO INTESTINAL SERVICES	27,828	1,069,784	0.026013	452,586	11,773	76.02
76.03	03140	CARDIOLOGY	119,643	14,001,550	0.008545	2,754,294	23,535	76.03
76.97	07697	CARDIAC REHABILITATION	79,141	1,225,878	0.064559	0	0	76.97
	OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	312,311	16,839,185	0.018547	208,913	3,875	90.00
91.00	09100	EMERGENCY	236,836	33,032,147	0.007170	2,974,523	21,327	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	145,142	3,826,954	0.037926	669,955	25,409	92.00
200.00		Total (lines 50 through 199)	4,160,465	504,563,679		43,945,036	344,520	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS					Provider CCN: 14-0013		Period: From 01/01/2020 To 12/31/2020		Worksheet D Part III Date/Time Prepared: 7/22/2021 3:42 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	30.00		
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	0	31.00		
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	0	0	40.00		
43.00	04300	NURSERY	0	0	0	0	0	0	43.00		
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	0	44.00		
200.00	Total (lines 30 through 199)		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	11,161	0.00	4,446		30.00		
31.00	03100	INTENSIVE CARE UNIT	0	0	1,187	0.00	509		31.00		
40.00	04000	SUBPROVIDER - IPF	0	0	3,528	0.00	2,528		40.00		
43.00	04300	NURSERY	0	0	0	0.00	0		43.00		
44.00	04400	SKILLED NURSING FACILITY	0	0	8,907	0.00	6,116		44.00		
200.00	Total (lines 30 through 199)		0	0	24,783		13,599		200.00		
Cost Center Description			Inpatient Program Pass-Through Cost (col. 7 x col. 8)								
			9.00								
INPATIENT ROUTINE SERVICE COST CENTERS											
30.00	03000	ADULTS & PEDIATRICS	0								30.00
31.00	03100	INTENSIVE CARE UNIT	0								31.00
40.00	04000	SUBPROVIDER - IPF	0								40.00
43.00	04300	NURSERY	0								43.00
44.00	04400	SKILLED NURSING FACILITY	0								44.00
200.00	Total (lines 30 through 199)		0								200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

Provider CCN: 14-0013

Period:
From 01/01/2020
To 12/31/2020Worksheet D
Part IV
Date/Time Prepared:
7/22/2021 3:42 pm

Cost Center Description		Title XVIII		Hospital		PPS	
		Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health	
		1.00	2A	2.00	3A	3.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	54.00
57.00	05700	CT SCAN	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	58.00
60.00	06000	LABORATORY	0	0	0	0	60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	0	0	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	74.00
76.00	03950	ANCILLARY	0	0	0	0	76.00
76.01	03560	PULMONARY FUNCTION TESTING	0	0	0	0	76.01
76.02	03340	GASTRO INTESTINAL SERVICES	0	0	0	0	76.02
76.03	03140	CARDIOLOGY	0	0	0	0	76.03
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	76.97
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	92.00
200.00		Total (lines 50 through 199)	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS			Provider CCN: 14-0013		Period: From 01/01/2020 To 12/31/2020		Worksheet D Part IV Date/Time Prepared: 7/22/2021 3:42 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	116,525,827	0.000000	50.00
51.00	05100	RECOVERY ROOM	0	0	0	24,910,060	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	30,737,884	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	21,194,103	0.000000	54.00
57.00	05700	CT SCAN	0	0	0	37,752,326	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	15,916,596	0.000000	58.00
60.00	06000	LABORATORY	0	0	0	32,719,937	0.000000	60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	0	0	0	1,084,576	0.000000	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	10,478,656	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	8,864,748	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	7,766,368	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	3,504,471	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	1,325,510	0.000000	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	128,981	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	22,429,086	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	64,639,740	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	25,616,117	0.000000	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	8,511,439	0.000000	74.00
76.00	03950	ANCILLARY	0	0	0	0	0.000000	76.00
76.01	03560	PULMONARY FUNCTION TESTING	0	0	0	461,756	0.000000	76.01
76.02	03340	GASTRO INTESTINAL SERVICES	0	0	0	1,069,784	0.000000	76.02
76.03	03140	CARDIOLOGY	0	0	0	14,001,550	0.000000	76.03
76.97	07697	CARDIAC REHABILITATION	0	0	0	1,225,878	0.000000	76.97
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0	16,839,185	0.000000	90.00
91.00	09100	EMERGENCY	0	0	0	33,032,147	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	3,826,954	0.000000	92.00
200.00		Total (lines 50 through 199)	0	0	0	504,563,679		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-0013

Period:
From 01/01/2020
To 12/31/2020Worksheet D
Part IV
Date/Time Prepared:
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Cost Center Description		Title XVIII			Hospital		PPS	
		Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)		
		9.00	10.00	11.00	12.00	13.00		
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0.000000	5,133,550	0	29,558,235	0	50.00
51.00	05100	RECOVERY ROOM	0.000000	1,114,310	0	5,196,905	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	1,394,333	0	6,714,856	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	1,743,684	0	4,600,001	0	54.00
57.00	05700	CT SCAN	0.000000	3,272,556	0	9,807,078	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000	718,817	0	3,879,633	0	58.00
60.00	06000	LABORATORY	0.000000	4,881,580	0	3,067,222	0	60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	0.000000	397,616	0	53,461	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0.000000	870,866	0	2,012,183	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.000000	2,377,636	0	279,833	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	633,880	0	196,574	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	267,987	0	12,499	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	150,157	0	10,647	0	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	33,394	0	9,684	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	2,800,726	0	4,248,709	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	7,226,195	0	15,283,431	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	3,700,884	0	4,350,981	0	73.00
74.00	07400	RENAL DIALYSIS	0.000000	0	0	0	0	74.00
76.00	03950	ANCILLARY	0.000000	0	0	0	0	76.00
76.01	03560	PULMONARY FUNCTION TESTING	0.000000	166,594	0	36,049	0	76.01
76.02	03340	GASTRO INTESTINAL SERVICES	0.000000	452,586	0	64,743	0	76.02
76.03	03140	CARDIOLOGY	0.000000	2,754,294	0	2,394,780	0	76.03
76.97	07697	CARDIAC REHABILITATION	0.000000	0	0	520,342	0	76.97
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0.000000	208,913	0	1,673,443	0	90.00
91.00	09100	EMERGENCY	0.000000	2,974,523	0	6,164,828	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	669,955	0	1,073,506	0	92.00
200.00		Total (lines 50 through 199)		43,945,036	0	101,209,623	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST				Provider CCN: 14-0013		Period: From 01/01/2020 To 12/31/2020		Worksheet D Part V Date/Time Prepared: 7/22/2021 3:42 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		0.161444	29,558,235	0	0	4,772,000	50.00
51.00	05100	RECOVERY ROOM		0.122309	5,196,905	0	0	635,628	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM		0.000000	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY		0.016957	6,714,856	0	0	113,864	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC		0.190935	4,600,001	0	0	878,301	54.00
57.00	05700	CT SCAN		0.032548	9,807,078	0	0	319,201	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)		0.072897	3,879,633	0	0	282,814	58.00
60.00	06000	LABORATORY		0.137721	3,067,222	0	0	422,421	60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.		0.163871	53,461	0	0	8,761	63.00
64.00	06400	INTRAVENOUS THERAPY		0.139083	2,012,183	0	0	279,860	64.00
65.00	06500	RESPIRATORY THERAPY		0.120243	279,833	0	0	33,648	65.00
66.00	06600	PHYSICAL THERAPY		0.277755	196,574	0	0	54,599	66.00
67.00	06700	OCCUPATIONAL THERAPY		0.271568	12,499	0	0	3,394	67.00
68.00	06800	SPEECH PATHOLOGY		0.262020	10,647	0	0	2,790	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY		2.634202	9,684	0	0	25,510	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT		0.396769	4,248,709	0	0	1,685,756	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS		0.254910	15,283,431	0	0	3,895,899	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS		0.221886	4,350,981	0	14,651	965,422	73.00
74.00	07400	RENAL DIALYSIS		0.068295	0	0	0	0	74.00
76.00	03950	ANCILLARY		0.000000	0	0	0	0	76.00
76.01	03560	PULMONARY FUNCTION TESTING		0.065011	36,049	0	0	2,344	76.01
76.02	03340	GASTRO INTESTINAL SERVICES		0.083800	64,743	0	0	5,425	76.02
76.03	03140	CARDIOLOGY		0.076903	2,394,780	0	0	184,166	76.03
76.97	07697	CARDIAC REHABILITATION		0.515742	520,342	0	0	268,362	76.97
OUTPATIENT SERVICE COST CENTERS									
90.00	09000	CLINIC		0.183132	1,673,443	0	170	306,461	90.00
91.00	09100	EMERGENCY		0.089048	6,164,828	0	0	548,966	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART		0.582996	1,073,506	0	0	625,850	92.00
200.00		Subtotal (see instructions)			101,209,623	0	14,821	16,321,442	200.00
201.00		Less PBP Clinic Lab. Services-Program				0	0		201.00
		Only Charges							
202.00		Net Charges (line 200 - line 201)			101,209,623	0	14,821	16,321,442	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-0013

Period:
From 01/01/2020
To 12/31/2020Worksheet D
Part V
Date/Time Prepared:
7/22/2021 3:42 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
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0		52.00
53.00	05300	ANESTHESIOLOGY	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0		54.00
57.00	05700	CT SCAN	0	0		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0		58.00
60.00	06000	LABORATORY	0	0		60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	0	0		63.00
64.00	06400	INTRAVENOUS THERAPY	0	0		64.00
65.00	06500	RESPIRATORY THERAPY	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0		68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	3,251		73.00
74.00	07400	RENAL DIALYSIS	0	0		74.00
76.00	03950	ANCILLARY	0	0		76.00
76.01	03560	PULMONARY FUNCTION TESTING	0	0		76.01
76.02	03340	GASTRO INTESTINAL SERVICES	0	0		76.02
76.03	03140	CARDIOLOGY	0	0		76.03
76.97	07697	CARDIAC REHABILITATION	0	0		76.97
	OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	0	31		90.00
91.00	09100	EMERGENCY	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0		92.00
200.00		Subtotal (see instructions)	0	3,282		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	0	3,282		202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS					Provider CCN: 14-0013 Component CCN: 14-S013	Period: From 01/01/2020 To 12/31/2020	Worksheet D Part II Date/Time Prepared: 7/22/2021 3:42 pm	
					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	757,321	116,525,827	0.006499	0	0	50.00
51.00	05100	RECOVERY ROOM	35,813	24,910,060	0.001438	5,628	8	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0.000000	0	0	52.00
53.00	05300	ANESTHESIOLOGY	203,486	30,737,884	0.006620	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	488,549	21,194,103	0.023051	78,357	1,806	54.00
57.00	05700	CT SCAN	311,734	37,752,326	0.008257	275,172	2,272	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	571,118	15,916,596	0.035882	6,696	240	58.00
60.00	06000	LABORATORY	131,134	32,719,937	0.004008	427,549	1,714	60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	2,118	1,084,576	0.001953	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	47,456	10,478,656	0.004529	44,571	202	64.00
65.00	06500	RESPIRATORY THERAPY	61,250	8,864,748	0.006909	250,024	1,727	65.00
66.00	06600	PHYSICAL THERAPY	88,645	7,766,368	0.011414	118,739	1,355	66.00
67.00	06700	OCCUPATIONAL THERAPY	32,505	3,504,471	0.009275	13,808	128	67.00
68.00	06800	SPEECH PATHOLOGY	10,395	1,325,510	0.007842	43,611	342	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	69,852	128,981	0.541568	3,228	1,748	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	199,357	22,429,086	0.008888	60,240	535	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	104,159	64,639,740	0.001611	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	102,388	25,616,117	0.003997	138,487	554	73.00
74.00	07400	RENAL DIALYSIS	21,245	8,511,439	0.002496	0	0	74.00
76.00	03950	ANCILLARY	0	0	0.000000	0	0	76.00
76.01	03560	PULMONARY FUNCTION TESTING	1,039	461,756	0.002250	3,567	8	76.01
76.02	03340	GASTRO INTESTINAL SERVICES	27,828	1,069,784	0.026013	0	0	76.02
76.03	03140	CARDIOLOGY	119,643	14,001,550	0.008545	64,292	549	76.03
76.97	07697	CARDIAC REHABILITATION	79,141	1,225,878	0.064559	0	0	76.97
	OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	312,311	16,839,185	0.018547	22,225	412	90.00
91.00	09100	EMERGENCY	236,836	33,032,147	0.007170	267,480	1,918	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	3,826,954	0.000000	0	0	92.00
200.00		Total (lines 50 through 199)	4,015,323	504,563,679		1,823,674	15,518	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS				Provider CCN: 14-0013 Component CCN: 14-S013		Period: From 01/01/2020 To 12/31/2020		Worksheet D Part IV Date/Time Prepared: 7/22/2021 3:42 pm	
				Title XVIII		Subprovider - IPF		PPS	
Cost Center Description				Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health	
				1.00	2A	2.00	3A	3.00	
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM		0	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM		0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM		0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY		0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC		0	0	0	0	0	54.00
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
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
64.00	06400	INTRAVENOUS THERAPY		0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY		0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY		0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY		0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY		0	0	0	0	0	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY		0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT		0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS		0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS		0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS		0	0	0	0	0	74.00
76.00	03950	ANCILLARY		0	0	0	0	0	76.00
76.01	03560	PULMONARY FUNCTION TESTING		0	0	0	0	0	76.01
76.02	03340	GASTRO INTESTINAL SERVICES		0	0	0	0	0	76.02
76.03	03140	CARDIOLOGY		0	0	0	0	0	76.03
76.97	07697	CARDIAC REHABILITATION		0	0	0	0	0	76.97
OUTPATIENT SERVICE COST CENTERS									
90.00	09000	CLINIC		0	0	0	0	0	90.00
91.00	09100	EMERGENCY		0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART		0	0	0	0	0	92.00
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: 14-0013 Component CCN: 14-S013		Period: From 01/01/2020 To 12/31/2020		Worksheet D Part IV Date/Time Prepared: 7/22/2021 3:42 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	116,525,827	0.000000	50.00
51.00	05100	RECOVERY ROOM	0	0	0	24,910,060	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	30,737,884	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	21,194,103	0.000000	54.00
57.00	05700	CT SCAN	0	0	0	37,752,326	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	15,916,596	0.000000	58.00
60.00	06000	LABORATORY	0	0	0	32,719,937	0.000000	60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	0	0	0	1,084,576	0.000000	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	10,478,656	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	8,864,748	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	7,766,368	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	3,504,471	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	1,325,510	0.000000	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	128,981	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	22,429,086	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	64,639,740	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	25,616,117	0.000000	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	8,511,439	0.000000	74.00
76.00	03950	ANCILLARY	0	0	0	0	0.000000	76.00
76.01	03560	PULMONARY FUNCTION TESTING	0	0	0	461,756	0.000000	76.01
76.02	03340	GASTRO INTESTINAL SERVICES	0	0	0	1,069,784	0.000000	76.02
76.03	03140	CARDIOLOGY	0	0	0	14,001,550	0.000000	76.03
76.97	07697	CARDIAC REHABILITATION	0	0	0	1,225,878	0.000000	76.97
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0	16,839,185	0.000000	90.00
91.00	09100	EMERGENCY	0	0	0	33,032,147	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	3,826,954	0.000000	92.00
200.00		Total (lines 50 through 199)	0	0	0	504,563,679		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS				Provider CCN: 14-0013 Component CCN: 14-S013		Period: From 01/01/2020 To 12/31/2020		Worksheet D Part IV Date/Time Prepared: 7/22/2021 3:42 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	0	50.00
51.00	05100	RECOVERY ROOM	0.000000	5,628	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	78,357	0	834	0	0	54.00
57.00	05700	CT SCAN	0.000000	275,172	0	3,574	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000	6,696	0	0	0	0	58.00
60.00	06000	LABORATORY	0.000000	427,549	0	0	0	0	60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	0.000000	0	0	0	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0.000000	44,571	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.000000	250,024	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	118,739	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	13,808	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	43,611	0	0	0	0	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	3,228	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	60,240	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	138,487	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0.000000	0	0	0	0	0	74.00
76.00	03950	ANCILLARY	0.000000	0	0	0	0	0	76.00
76.01	03560	PULMONARY FUNCTION TESTING	0.000000	3,567	0	376	0	0	76.01
76.02	03340	GASTRO INTESTINAL SERVICES	0.000000	0	0	0	0	0	76.02
76.03	03140	CARDIOLOGY	0.000000	64,292	0	852	0	0	76.03
76.97	07697	CARDIAC REHABILITATION	0.000000	0	0	0	0	0	76.97
OUTPATIENT SERVICE COST CENTERS									
90.00	09000	CLINIC	0.000000	22,225	0	1,318	0	0	90.00
91.00	09100	EMERGENCY	0.000000	267,480	0	5,382	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	0	0	0	0	0	92.00
200.00		Total (lines 50 through 199)			1,823,674	0	12,336	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST			Provider CCN: 14-0013 Component CCN: 14-S013		Period: From 01/01/2020 To 12/31/2020		Worksheet D Part V Date/Time Prepared: 7/22/2021 3:42 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	0.161444	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0.122309	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.016957	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.190935	834	0	0	159	54.00
57.00	05700	CT SCAN	0.032548	3,574	0	0	116	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.072897	0	0	0	0	58.00
60.00	06000	LABORATORY	0.137721	0	0	0	0	60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	0.163871	0	0	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0.139083	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.120243	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.277755	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.271568	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.262020	0	0	0	0	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	2.634202	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.396769	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.254910	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.221886	0	0	3,921	0	73.00
74.00	07400	RENAL DIALYSIS	0.068295	0	0	0	0	74.00
76.00	03950	ANCILLARY	0.000000	0	0	0	0	76.00
76.01	03560	PULMONARY FUNCTION TESTING	0.065011	376	0	0	24	76.01
76.02	03340	GASTRO INTESTINAL SERVICES	0.083800	0	0	0	0	76.02
76.03	03140	CARDIOLOGY	0.076903	852	0	0	66	76.03
76.97	07697	CARDIAC REHABILITATION	0.515742	0	0	0	0	76.97
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0.183132	1,318	0	0	241	90.00
91.00	09100	EMERGENCY	0.089048	5,382	0	0	479	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.582996	0	0	0	0	92.00
200.00		Subtotal (see instructions)		12,336	0	3,921	1,085	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 - line 201)		12,336	0	3,921	1,085	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST			Provider CCN: 14-0013 Component CCN: 14-S013		Period: From 01/01/2020 To 12/31/2020		Worksheet D Part V Date/Time Prepared: 7/22/2021 3:42 pm		
			Title XVIII		Subprovider - IPF		PPS		
Cost Center Description			Costs						
			Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)					
			6.00	7.00					
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM	0	0					50.00
51.00	05100	RECOVERY ROOM	0	0					51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0					52.00
53.00	05300	ANESTHESIOLOGY	0	0					53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0					54.00
57.00	05700	CT SCAN	0	0					57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0					58.00
60.00	06000	LABORATORY	0	0					60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	0	0					63.00
64.00	06400	INTRAVENOUS THERAPY	0	0					64.00
65.00	06500	RESPIRATORY THERAPY	0	0					65.00
66.00	06600	PHYSICAL THERAPY	0	0					66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0					67.00
68.00	06800	SPEECH PATHOLOGY	0	0					68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0					70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0					71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0					72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	870					73.00
74.00	07400	RENAL DIALYSIS	0	0					74.00
76.00	03950	ANCILLARY	0	0					76.00
76.01	03560	PULMONARY FUNCTION TESTING	0	0					76.01
76.02	03340	GASTRO INTESTINAL SERVICES	0	0					76.02
76.03	03140	CARDIOLOGY	0	0					76.03
76.97	07697	CARDIAC REHABILITATION	0	0					76.97
OUTPATIENT SERVICE COST CENTERS									
90.00	09000	CLINIC	0	0					90.00
91.00	09100	EMERGENCY	0	0					91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0					92.00
200.00		Subtotal (see instructions)	0	870					200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0						201.00
202.00		Net Charges (line 200 - line 201)	0	870					202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-0013

Period:

Worksheet D

Component CCN: 14-5579

From 01/01/2020
To 12/31/2020Part V
Date/Time Prepared:
7/22/2021 3:42 pm

Title XVIII

Skilled Nursing
Facility

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	0.161444	0	0	0	0 50.00
51.00	05100 RECOVERY ROOM	0.122309	0	0	0	0 51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.000000	0	0	0	0 52.00
53.00	05300 ANESTHESIOLOGY	0.016957	0	0	0	0 53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.190935	0	0	0	0 54.00
57.00	05700 CT SCAN	0.032548	0	0	0	0 57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0.072897	0	0	0	0 58.00
60.00	06000 LABORATORY	0.137721	0	0	0	0 60.00
63.00	06300 BLOOD STORING, PROCESSING, & TRANS.	0.163871	0	0	0	0 63.00
64.00	06400 INTRAVENOUS THERAPY	0.139083	0	0	0	0 64.00
65.00	06500 RESPIRATORY THERAPY	0.120243	0	0	0	0 65.00
66.00	06600 PHYSICAL THERAPY	0.277755	0	0	0	0 66.00
67.00	06700 OCCUPATIONAL THERAPY	0.271568	0	0	0	0 67.00
68.00	06800 SPEECH PATHOLOGY	0.262020	0	0	0	0 68.00
70.00	07000 ELECTROENCEPHALOGRAPHY	2.634202	0	0	0	0 70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.396769	0	0	0	0 71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.254910	0	0	0	0 72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.221886	0	0	741	0 73.00
74.00	07400 RENAL DIALYSIS	0.068295	0	0	0	0 74.00
76.00	03950 ANCILLARY	0.000000	0	0	0	0 76.00
76.01	03560 PULMONARY FUNCTION TESTING	0.065011	0	0	0	0 76.01
76.02	03340 GASTRO INTESTINAL SERVICES	0.083800	0	0	0	0 76.02
76.03	03140 CARDIOLOGY	0.076903	0	0	0	0 76.03
76.97	07697 CARDIAC REHABILITATION	0.515742	0	0	0	0 76.97
OUTPATIENT SERVICE COST CENTERS						
90.00	09000 CLINIC	0.183132	0	0	0	0 90.00
91.00	09100 EMERGENCY	0.089048	0	0	0	0 91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0.582996	0	0	0	0 92.00
200.00	Subtotal (see instructions)		0	0	741	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	741	0 202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-0013

Period:

Worksheet D

Component CCN: 14-5579

From 01/01/2020
To 12/31/2020Part V
Date/Time Prepared:
7/22/2021 3:42 pm

Title XVIII

Skilled Nursing
Facility

PPS

	Cost Center Description	Costs			
		Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
		6.00	7.00		
	ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	54.00
57.00	05700	CT SCAN	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	58.00
60.00	06000	LABORATORY	0	0	60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	164	73.00
74.00	07400	RENAL DIALYSIS	0	0	74.00
76.00	03950	ANCILLARY	0	0	76.00
76.01	03560	PULMONARY FUNCTION TESTING	0	0	76.01
76.02	03340	GASTRO INTESTINAL SERVICES	0	0	76.02
76.03	03140	CARDIOLOGY	0	0	76.03
76.97	07697	CARDIAC REHABILITATION	0	0	76.97
	OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0	0	90.00
91.00	09100	EMERGENCY	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	92.00
200.00		Subtotal (see instructions)	0	164	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0		201.00
202.00		Net Charges (line 200 - line 201)	0	164	202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

Provider CCN: 14-0013

Period:
From 01/01/2020
To 12/31/2020Worksheet D
Part I
Date/Time Prepared:
7/22/2021 3:42 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	703,701	0	703,701	11,161	63.05	30.00	
31.00	INTENSIVE CARE UNIT	151,080		151,080	1,187	127.28	31.00	
40.00	SUBPROVIDER - IPF	173,630	0	173,630	3,528	49.21	40.00	
43.00	NURSERY	0		0	0	0.00	43.00	
44.00	SKILLED NURSING FACILITY	305,252		305,252	8,907	34.27	44.00	
200.00	Total (lines 30 through 199)	1,333,663		1,333,663	24,783		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	635	40,037					30.00
31.00	INTENSIVE CARE UNIT	45	5,728					31.00
40.00	SUBPROVIDER - IPF	0	0					40.00
43.00	NURSERY	0	0					43.00
44.00	SKILLED NURSING FACILITY	0	0					44.00
200.00	Total (lines 30 through 199)	680	45,765					200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 14-0013

Period:
From 01/01/2020
To 12/31/2020Worksheet D
Part II
Date/Time Prepared:
7/22/2021 3:42 pm

Cost Center Description		Title XIX		Hospital		PPS	
		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	757,321	116,525,827	0.006499	0	0 50.00
51.00	05100	RECOVERY ROOM	35,813	24,910,060	0.001438	0	0 51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0.000000	0	0 52.00
53.00	05300	ANESTHESIOLOGY	203,486	30,737,884	0.006620	0	0 53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	488,549	21,194,103	0.023051	0	0 54.00
57.00	05700	CT SCAN	311,734	37,752,326	0.008257	0	0 57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	571,118	15,916,596	0.035882	0	0 58.00
60.00	06000	LABORATORY	131,134	32,719,937	0.004008	0	0 60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	2,118	1,084,576	0.001953	0	0 63.00
64.00	06400	INTRAVENOUS THERAPY	47,456	10,478,656	0.004529	0	0 64.00
65.00	06500	RESPIRATORY THERAPY	61,250	8,864,748	0.006909	0	0 65.00
66.00	06600	PHYSICAL THERAPY	88,645	7,766,368	0.011414	0	0 66.00
67.00	06700	OCCUPATIONAL THERAPY	32,505	3,504,471	0.009275	0	0 67.00
68.00	06800	SPEECH PATHOLOGY	10,395	1,325,510	0.007842	0	0 68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	69,852	128,981	0.541568	0	0 70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	199,357	22,429,086	0.008888	0	0 71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	104,159	64,639,740	0.001611	0	0 72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	102,388	25,616,117	0.003997	0	0 73.00
74.00	07400	RENAL DIALYSIS	21,245	8,511,439	0.002496	0	0 74.00
76.00	03950	ANCILLARY	0	0	0.000000	0	0 76.00
76.01	03560	PULMONARY FUNCTION TESTING	1,039	461,756	0.002250	0	0 76.01
76.02	03340	GASTRO INTESTINAL SERVICES	27,828	1,069,784	0.026013	0	0 76.02
76.03	03140	CARDIOLOGY	119,643	14,001,550	0.008545	0	0 76.03
76.97	07697	CARDIAC REHABILITATION	79,141	1,225,878	0.064559	0	0 76.97
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	312,311	16,839,185	0.018547	0	0 90.00
91.00	09100	EMERGENCY	236,836	33,032,147	0.007170	0	0 91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	145,142	3,826,954	0.037926	0	0 92.00
200.00		Total (lines 50 through 199)	4,160,465	504,563,679		0	0 200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS					Provider CCN: 14-0013		Period: From 01/01/2020 To 12/31/2020		Worksheet D Part III Date/Time Prepared: 7/22/2021 3:42 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	30.00		
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	0	31.00		
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	0	0	40.00		
43.00	04300	NURSERY	0	0	0	0	0	0	43.00		
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	0	44.00		
200.00	Total (lines 30 through 199)		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	11,161	0.00	635		30.00		
31.00	03100	INTENSIVE CARE UNIT		0	1,187	0.00	45		31.00		
40.00	04000	SUBPROVIDER - IPF	0	0	3,528	0.00	0		40.00		
43.00	04300	NURSERY		0	0	0.00	0		43.00		
44.00	04400	SKILLED NURSING FACILITY		0	8,907	0.00	0		44.00		
200.00	Total (lines 30 through 199)			0	24,783		680		200.00		
Cost Center Description			Inpatient Program Pass-Through Cost (col. 7 x col. 8)								
			9.00								
INPATIENT ROUTINE SERVICE COST CENTERS											
30.00	03000	ADULTS & PEDIATRICS	0								30.00
31.00	03100	INTENSIVE CARE UNIT	0								31.00
40.00	04000	SUBPROVIDER - IPF	0								40.00
43.00	04300	NURSERY	0								43.00
44.00	04400	SKILLED NURSING FACILITY	0								44.00
200.00	Total (lines 30 through 199)		0								200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

Provider CCN: 14-0013

Period:
From 01/01/2020
To 12/31/2020Worksheet D
Part IV
Date/Time Prepared:
7/22/2021 3:42 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
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
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
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
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.00	03950	ANCILLARY	0	0	0	0	0	76.00
76.01	03560	PULMONARY FUNCTION TESTING	0	0	0	0	0	76.01
76.02	03340	GASTRO INTESTINAL SERVICES	0	0	0	0	0	76.02
76.03	03140	CARDIOLOGY	0	0	0	0	0	76.03
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	0	92.00
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: 14-0013

Period:
From 01/01/2020
To 12/31/2020Worksheet D
Part IV
Date/Time Prepared:
7/22/2021 3:42 pm

				Title XIX		Hospital	PPS	
Cost Center Description			All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7) (see instructions)	
			4.00	5.00	6.00	7.00	8.00	
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	0	116,525,827	0.000000	50.00
51.00	05100	RECOVERY ROOM	0	0	0	24,910,060	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	30,737,884	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	21,194,103	0.000000	54.00
57.00	05700	CT SCAN	0	0	0	37,752,326	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	15,916,596	0.000000	58.00
60.00	06000	LABORATORY	0	0	0	32,719,937	0.000000	60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	0	0	0	1,084,576	0.000000	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	10,478,656	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	8,864,748	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	7,766,368	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	3,504,471	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	1,325,510	0.000000	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	128,981	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	22,429,086	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	64,639,740	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	25,616,117	0.000000	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	8,511,439	0.000000	74.00
76.00	03950	ANCILLARY	0	0	0	0	0.000000	76.00
76.01	03560	PULMONARY FUNCTION TESTING	0	0	0	461,756	0.000000	76.01
76.02	03340	GASTRO INTESTINAL SERVICES	0	0	0	1,069,784	0.000000	76.02
76.03	03140	CARDIOLOGY	0	0	0	14,001,550	0.000000	76.03
76.97	07697	CARDIAC REHABILITATION	0	0	0	1,225,878	0.000000	76.97
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0	16,839,185	0.000000	90.00
91.00	09100	EMERGENCY	0	0	0	33,032,147	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	3,826,954	0.000000	92.00
200.00		Total (lines 50 through 199)	0	0	0	504,563,679		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

Provider CCN: 14-0013

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

Worksheet D
Part IV
Date/Time Prepared:
7/22/2021 3:42 pm

Cost Center Description		Title XIX		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	0	0	0
51.00	05100	RECOVERY ROOM	0.000000	0	0	0
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	0	0
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	0
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	0	0	0
57.00	05700	CT SCAN	0.000000	0	0	0
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000	0	0	0
60.00	06000	LABORATORY	0.000000	0	0	0
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	0.000000	0	0	0
64.00	06400	INTRAVENOUS THERAPY	0.000000	0	0	0
65.00	06500	RESPIRATORY THERAPY	0.000000	0	0	0
66.00	06600	PHYSICAL THERAPY	0.000000	0	0	0
67.00	06700	OCCUPATIONAL THERAPY	0.000000	0	0	0
68.00	06800	SPEECH PATHOLOGY	0.000000	0	0	0
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	0	0	0
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	0	0	0
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	0	0
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	0	0	0
74.00	07400	RENAL DIALYSIS	0.000000	0	0	0
76.00	03950	ANCILLARY	0.000000	0	0	0
76.01	03560	PULMONARY FUNCTION TESTING	0.000000	0	0	0
76.02	03340	GASTRO INTESTINAL SERVICES	0.000000	0	0	0
76.03	03140	CARDIOLOGY	0.000000	0	0	0
76.97	07697	CARDIAC REHABILITATION	0.000000	0	0	0
OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.000000	0	0	0
91.00	09100	EMERGENCY	0.000000	0	0	0
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	0	0	0
200.00		Total (lines 50 through 199)		0	0	0

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS					Provider CCN: 14-0013 Component CCN: 14-S013	Period: From 01/01/2020 To 12/31/2020	Worksheet D Part II Date/Time Prepared: 7/22/2021 3:42 pm	
					Title XIX		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	757,321	116,525,827	0.006499	0	0	50.00
51.00	05100	RECOVERY ROOM	35,813	24,910,060	0.001438	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0.000000	0	0	52.00
53.00	05300	ANESTHESIOLOGY	203,486	30,737,884	0.006620	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	488,549	21,194,103	0.023051	0	0	54.00
57.00	05700	CT SCAN	311,734	37,752,326	0.008257	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	571,118	15,916,596	0.035882	0	0	58.00
60.00	06000	LABORATORY	131,134	32,719,937	0.004008	0	0	60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	2,118	1,084,576	0.001953	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	47,456	10,478,656	0.004529	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	61,250	8,864,748	0.006909	0	0	65.00
66.00	06600	PHYSICAL THERAPY	88,645	7,766,368	0.011414	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	32,505	3,504,471	0.009275	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	10,395	1,325,510	0.007842	0	0	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	69,852	128,981	0.541568	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	199,357	22,429,086	0.008888	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	104,159	64,639,740	0.001611	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	102,388	25,616,117	0.003997	0	0	73.00
74.00	07400	RENAL DIALYSIS	21,245	8,511,439	0.002496	0	0	74.00
76.00	03950	ANCILLARY	0	0	0.000000	0	0	76.00
76.01	03560	PULMONARY FUNCTION TESTING	1,039	461,756	0.002250	0	0	76.01
76.02	03340	GASTRO INTESTINAL SERVICES	27,828	1,069,784	0.026013	0	0	76.02
76.03	03140	CARDIOLOGY	119,643	14,001,550	0.008545	0	0	76.03
76.97	07697	CARDIAC REHABILITATION	79,141	1,225,878	0.064559	0	0	76.97
	OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	312,311	16,839,185	0.018547	0	0	90.00
91.00	09100	EMERGENCY	236,836	33,032,147	0.007170	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	3,826,954	0.000000			92.00
200.00		Total (lines 50 through 199)	4,015,323	504,563,679		0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS				Provider CCN: 14-0013 Component CCN: 14-S013		Period: From 01/01/2020 To 12/31/2020		Worksheet D Part IV Date/Time Prepared: 7/22/2021 3:42 pm	
				Title XIX		Subprovider - IPF		PPS	
Cost Center Description				Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health	
				1.00	2A	2.00	3A	3.00	
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM		0	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM		0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM		0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY		0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC		0	0	0	0	0	54.00
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
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
64.00	06400	INTRAVENOUS THERAPY		0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY		0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY		0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY		0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY		0	0	0	0	0	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY		0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT		0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS		0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS		0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS		0	0	0	0	0	74.00
76.00	03950	ANCILLARY		0	0	0	0	0	76.00
76.01	03560	PULMONARY FUNCTION TESTING		0	0	0	0	0	76.01
76.02	03340	GASTRO INTESTINAL SERVICES		0	0	0	0	0	76.02
76.03	03140	CARDIOLOGY		0	0	0	0	0	76.03
76.97	07697	CARDIAC REHABILITATION		0	0	0	0	0	76.97
OUTPATIENT SERVICE COST CENTERS									
90.00	09000	CLINIC		0	0	0	0	0	90.00
91.00	09100	EMERGENCY		0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART		0	0	0	0	0	92.00
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: 14-0013 Component CCN: 14-S013		Period: From 01/01/2020 To 12/31/2020		Worksheet D Part IV Date/Time Prepared: 7/22/2021 3:42 pm	
				Title XIX		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	116,525,827	0.000000	50.00
51.00	05100	RECOVERY ROOM		0	0	0	24,910,060	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM		0	0	0	0	0.000000	52.00
53.00	05300	ANESTHESIOLOGY		0	0	0	30,737,884	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC		0	0	0	21,194,103	0.000000	54.00
57.00	05700	CT SCAN		0	0	0	37,752,326	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)		0	0	0	15,916,596	0.000000	58.00
60.00	06000	LABORATORY		0	0	0	32,719,937	0.000000	60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.		0	0	0	1,084,576	0.000000	63.00
64.00	06400	INTRAVENOUS THERAPY		0	0	0	10,478,656	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY		0	0	0	8,864,748	0.000000	65.00
66.00	06600	PHYSICAL THERAPY		0	0	0	7,766,368	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY		0	0	0	3,504,471	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY		0	0	0	1,325,510	0.000000	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY		0	0	0	128,981	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT		0	0	0	22,429,086	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS		0	0	0	64,639,740	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS		0	0	0	25,616,117	0.000000	73.00
74.00	07400	RENAL DIALYSIS		0	0	0	8,511,439	0.000000	74.00
76.00	03950	ANCILLARY		0	0	0	0	0.000000	76.00
76.01	03560	PULMONARY FUNCTION TESTING		0	0	0	461,756	0.000000	76.01
76.02	03340	GASTRO INTESTINAL SERVICES		0	0	0	1,069,784	0.000000	76.02
76.03	03140	CARDIOLOGY		0	0	0	14,001,550	0.000000	76.03
76.97	07697	CARDIAC REHABILITATION		0	0	0	1,225,878	0.000000	76.97
OUTPATIENT SERVICE COST CENTERS									
90.00	09000	CLINIC		0	0	0	16,839,185	0.000000	90.00
91.00	09100	EMERGENCY		0	0	0	33,032,147	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART		0	0	0	3,826,954	0.000000	92.00
200.00		Total (lines 50 through 199)		0	0	0	504,563,679		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS				Provider CCN: 14-0013 Component CCN: 14-S013		Period: From 01/01/2020 To 12/31/2020		Worksheet D Part IV Date/Time Prepared: 7/22/2021 3:42 pm	
				Title XIX		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
52.00	05200	DELIVERY ROOM & LABOR ROOM		0.000000	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY		0.000000	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC		0.000000	0	0	0	0	54.00
57.00	05700	CT SCAN		0.000000	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)		0.000000	0	0	0	0	58.00
60.00	06000	LABORATORY		0.000000	0	0	0	0	60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.		0.000000	0	0	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY		0.000000	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY		0.000000	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY		0.000000	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY		0.000000	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY		0.000000	0	0	0	0	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY		0.000000	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT		0.000000	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS		0.000000	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS		0.000000	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS		0.000000	0	0	0	0	74.00
76.00	03950	ANCILLARY		0.000000	0	0	0	0	76.00
76.01	03560	PULMONARY FUNCTION TESTING		0.000000	0	0	0	0	76.01
76.02	03340	GASTRO INTESTINAL SERVICES		0.000000	0	0	0	0	76.02
76.03	03140	CARDIOLOGY		0.000000	0	0	0	0	76.03
76.97	07697	CARDIAC REHABILITATION		0.000000	0	0	0	0	76.97
OUTPATIENT SERVICE COST CENTERS									
90.00	09000	CLINIC		0.000000	0	0	0	0	90.00
91.00	09100	EMERGENCY		0.000000	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART		0.000000	0	0	0	0	92.00
200.00		Total (lines 50 through 199)			0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS				Provider CCN: 14-0013 Component CCN: 14-5579		Period: From 01/01/2020 To 12/31/2020		Worksheet D Part IV Date/Time Prepared: 7/22/2021 3:42 pm	
				Title XIX		Skilled Nursing Facility		PPS	
Cost Center Description				Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health	
				1.00	2A	2.00	3A	3.00	
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM		0	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM		0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM		0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY		0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC		0	0	0	0	0	54.00
57.00	05700	CT SCAN		0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)		0	0	0	0	0	58.00
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
64.00	06400	INTRAVENOUS THERAPY		0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY		0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY		0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY		0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY		0	0	0	0	0	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY		0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT		0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS		0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS		0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS		0	0	0	0	0	74.00
76.00	03950	ANCILLARY		0	0	0	0	0	76.00
76.01	03560	PULMONARY FUNCTION TESTING		0	0	0	0	0	76.01
76.02	03340	GASTRO INTESTINAL SERVICES		0	0	0	0	0	76.02
76.03	03140	CARDIOLOGY		0	0	0	0	0	76.03
76.97	07697	CARDIAC REHABILITATION		0	0	0	0	0	76.97
OUTPATIENT SERVICE COST CENTERS									
90.00	09000	CLINIC		0	0	0	0	0	90.00
91.00	09100	EMERGENCY		0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART		0	0	0	0	0	92.00
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: 14-0013 Component CCN: 14-5579		Period: From 01/01/2020 To 12/31/2020		Worksheet D Part IV Date/Time Prepared: 7/22/2021 3:42 pm	
				Title XIX		Skilled Nursing Facility		PPS	
Cost Center Description				All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7) (see instructions)	
				4.00	5.00	6.00	7.00	8.00	
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM		0	0	0	116,525,827	0.000000	50.00
51.00	05100	RECOVERY ROOM		0	0	0	24,910,060	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM		0	0	0	0	0.000000	52.00
53.00	05300	ANESTHESIOLOGY		0	0	0	30,737,884	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC		0	0	0	21,194,103	0.000000	54.00
57.00	05700	CT SCAN		0	0	0	37,752,326	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)		0	0	0	15,916,596	0.000000	58.00
60.00	06000	LABORATORY		0	0	0	32,719,937	0.000000	60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.		0	0	0	1,084,576	0.000000	63.00
64.00	06400	INTRAVENOUS THERAPY		0	0	0	10,478,656	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY		0	0	0	8,864,748	0.000000	65.00
66.00	06600	PHYSICAL THERAPY		0	0	0	7,766,368	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY		0	0	0	3,504,471	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY		0	0	0	1,325,510	0.000000	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY		0	0	0	128,981	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT		0	0	0	22,429,086	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS		0	0	0	64,639,740	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS		0	0	0	25,616,117	0.000000	73.00
74.00	07400	RENAL DIALYSIS		0	0	0	8,511,439	0.000000	74.00
76.00	03950	ANCILLARY		0	0	0	0	0.000000	76.00
76.01	03560	PULMONARY FUNCTION TESTING		0	0	0	461,756	0.000000	76.01
76.02	03340	GASTRO INTESTINAL SERVICES		0	0	0	1,069,784	0.000000	76.02
76.03	03140	CARDIOLOGY		0	0	0	14,001,550	0.000000	76.03
76.97	07697	CARDIAC REHABILITATION		0	0	0	1,225,878	0.000000	76.97
OUTPATIENT SERVICE COST CENTERS									
90.00	09000	CLINIC		0	0	0	16,839,185	0.000000	90.00
91.00	09100	EMERGENCY		0	0	0	33,032,147	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART		0	0	0	3,826,954	0.000000	92.00
200.00		Total (lines 50 through 199)		0	0	0	504,563,679		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS				Provider CCN: 14-0013 Component CCN: 14-5579		Period: From 01/01/2020 To 12/31/2020		Worksheet D Part IV Date/Time Prepared: 7/22/2021 3:42 pm	
				Title XIX		Skilled Nursing Facility		PPS	
Cost Center Description				Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
				9.00	10.00	11.00	12.00	13.00	
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM	0.000000	0	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0.000000	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	0	0	0	0	0	54.00
57.00	05700	CT SCAN	0.000000	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000	0	0	0	0	0	58.00
60.00	06000	LABORATORY	0.000000	0	0	0	0	0	60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	0.000000	0	0	0	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0.000000	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.000000	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	0	0	0	0	0	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0.000000	0	0	0	0	0	74.00
76.00	03950	ANCILLARY	0.000000	0	0	0	0	0	76.00
76.01	03560	PULMONARY FUNCTION TESTING	0.000000	0	0	0	0	0	76.01
76.02	03340	GASTRO INTESTINAL SERVICES	0.000000	0	0	0	0	0	76.02
76.03	03140	CARDIOLOGY	0.000000	0	0	0	0	0	76.03
76.97	07697	CARDIAC REHABILITATION	0.000000	0	0	0	0	0	76.97
OUTPATIENT SERVICE COST CENTERS									
90.00	09000	CLINIC	0.000000	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0.000000	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	0	0	0	0	0	92.00
200.00		Total (lines 50 through 199)		0	0	0	0	0	200.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-0013	Period: From 01/01/2020 To 12/31/2020	Worksheet D-1 Date/Time Prepared: 7/22/2021 3:42 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)		11,161	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		11,161	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)		8,859	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions)		4,446	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)		10,817,247	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)		10,817,247	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)		10,817,247	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)		969.20	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		4,309,063	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)		0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)		4,309,063	41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-0013

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

Worksheet D-1

Date/Time Prepared:
7/22/2021 3:42 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	2,223,292	1,187	1,873.03	509	953,372
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)					7,729,911
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					12,992,346
PASS THROUGH COST ADJUSTMENTS						
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)					345,106
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					344,520
52.00	Total Program excludable cost (sum of lines 50 and 51)					689,626
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					12,302,720
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)					2,302
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					969.20
89.00	Observation bed cost (line 87 x line 88) (see instructions)					2,231,098

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-0013

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

Worksheet D-1

Date/Time Prepared:
7/22/2021 3:42 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	703,701	10,817,247	0.065054	2,231,098	145,142	90.00
91.00 Nursing School cost	0	10,817,247	0.000000	2,231,098	0	91.00
92.00 Allied health cost	0	10,817,247	0.000000	2,231,098	0	92.00
93.00 All other Medical Education	0	10,817,247	0.000000	2,231,098	0	93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-0013 Component CCN: 14-S013	Period: From 01/01/2020 To 12/31/2020	Worksheet D-1 Date/Time Prepared: 7/22/2021 3:42 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)		3,528	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		3,528	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)		3,528	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions)		2,528	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)		0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period		0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)		0	14.00
15.00	Total nursery days (title V or XIX only)		0	15.00
16.00	Nursery days (title V or XIX only)		0	16.00
SWING BED ADJUSTMENT				
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period		0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)		3,244,657	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)		0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)		0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)		0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)		0	25.00
26.00	Total swing-bed cost (see instructions)		0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)		3,244,657	27.00
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)		0	28.00
29.00	Private room charges (excluding swing-bed charges)		0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)		0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)		0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)		0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)		0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)		0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)		0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)		3,244,657	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)		919.69	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		2,324,976	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)		0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)		2,324,976	41.00

COMPUTATION OF INPATIENT OPERATING COST				Provider CCN: 14-0013 Component CCN: 14-S013	Period: From 01/01/2020 To 12/31/2020	Worksheet D-1 Date/Time Prepared: 7/22/2021 3:42 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	42.00
Intensive Care Type Inpatient Hospital Units							
43.00	INTENSIVE CARE UNIT	0	0	0.00	0	0	43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00
Cost Center Description							
							1.00
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					264,592	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					2,589,568	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)					124,403	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					15,518	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)					139,921	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					2,449,647	53.00
TARGET AMOUNT AND LIMIT COMPUTATION							
54.00	Program discharges					0	54.00
55.00	Target amount per discharge					0.00	55.00
56.00	Target amount (line 54 x line 55)					0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)					0	57.00
58.00	Bonus payment (see instructions)					0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket					0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket					0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)					0	61.00
62.00	Relief payment (see instructions)					0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)					0	63.00
PROGRAM INPATIENT ROUTINE SWING BED COST							
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)					0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)					0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)					0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)					0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)					0	69.00
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY							
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)						70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)						71.00
72.00	Program routine service cost (line 9 x line 71)						72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)						73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)						74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)						75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)						76.00
77.00	Program capital-related costs (line 9 x line 76)						77.00
78.00	Inpatient routine service cost (line 74 minus line 77)						78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)						79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)						80.00
81.00	Inpatient routine service cost per diem limitation						81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)						82.00
83.00	Reasonable inpatient routine service costs (see instructions)						83.00
84.00	Program inpatient ancillary services (see instructions)						84.00
85.00	Utilization review - physician compensation (see instructions)						85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)						86.00
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
87.00	Total observation bed days (see instructions)					0	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					0.00	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)					0	89.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-0013 Component CCN: 14-S013		Period: From 01/01/2020 To 12/31/2020		Worksheet D-1 Date/Time Prepared: 7/22/2021 3:42 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	173,630	3,244,657	0.053513	0	0	90.00
91.00	Nursing School cost	0	3,244,657	0.000000	0	0	91.00
92.00	Allied health cost	0	3,244,657	0.000000	0	0	92.00
93.00	All other Medical Education	0	3,244,657	0.000000	0	0	93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-0013 Component CCN: 14-5579	Period: From 01/01/2020 To 12/31/2020	Worksheet D-1 Date/Time Prepared: 7/22/2021 3:42 pm
		Title XVIII	Skilled Nursing Facility	PPS
Cost Center Description			1.00	
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		8,907	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		8,907	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)		8,907	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions)		6,116	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)		0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period		0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)		0	14.00
15.00	Total nursery days (title V or XIX only)		0	15.00
16.00	Nursery days (title V or XIX only)		0	16.00
SWING BED ADJUSTMENT				
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period		0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)		3,971,144	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)		0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)		0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)		0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)		0	25.00
26.00	Total swing-bed cost (see instructions)		0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)		3,971,144	27.00
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)		0	28.00
29.00	Private room charges (excluding swing-bed charges)		0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)		0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)		0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)		0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)		0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)		0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)		0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)		3,971,144	37.00
PART II - HOSPITAL AND SUBPROVIDERS ONLY				
PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS				
38.00	Adjusted general inpatient routine service cost per diem (see instructions)			38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)			39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)			40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)			41.00

COMPUTATION OF INPATIENT OPERATING COST				Provider CCN: 14-0013	Period: From 01/01/2020 To 12/31/2020	Worksheet D-1	
				Component CCN: 14-5579		Date/Time Prepared: 7/22/2021 3:42 pm	
				Title XVIII		Skilled Nursing Facility	PPS
Cost Center Description			Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)
			1.00	2.00	3.00	4.00	5.00
42.00	NURSERY (title V & XIX only)						42.00
Intensive Care Type Inpatient Hospital Units							
43.00	INTENSIVE CARE UNIT						43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00
Cost Center Description							
							1.00
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)						48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)						49.00
PASS THROUGH COST ADJUSTMENTS							
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)						50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)						51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)						52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)						53.00
TARGET AMOUNT AND LIMIT COMPUTATION							
54.00	Program discharges						54.00
55.00	Target amount per discharge						55.00
56.00	Target amount (line 54 x line 55)						56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)						57.00
58.00	Bonus payment (see instructions)						58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket						59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket						60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)						61.00
62.00	Relief payment (see instructions)						62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)						63.00
PROGRAM INPATIENT ROUTINE SWING BED COST							
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)						64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)						65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)						66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)						67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)						68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)						69.00
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY							
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)						3,971,144 70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)						445.85 71.00
72.00	Program routine service cost (line 9 x line 71)						2,726,819 72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)						0 73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)						2,726,819 74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)						0 75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)						0.00 76.00
77.00	Program capital-related costs (line 9 x line 76)						0 77.00
78.00	Inpatient routine service cost (line 74 minus line 77)						0 78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)						0 79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)						0 80.00
81.00	Inpatient routine service cost per diem limitation						0.00 81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)						0 82.00
83.00	Reasonable inpatient routine service costs (see instructions)						2,726,819 83.00
84.00	Program inpatient ancillary services (see instructions)						2,209,620 84.00
85.00	Utilization review - physician compensation (see instructions)						0 85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)						4,936,439 86.00
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
87.00	Total observation bed days (see instructions)						0 87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)						0.00 88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)						0 89.00

COMPUTATION OF INPATIENT OPERATING COST			Provider CCN: 14-0013 Component CCN: 14-5579		Period: From 01/01/2020 To 12/31/2020		Worksheet D-1 Date/Time Prepared: 7/22/2021 3:42 pm
			Title XVIII		Skilled Nursing Facility		PPS
Cost Center Description		Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00	Capital-related cost	0	0	0.000000	0	0	90.00
91.00	Nursing School cost	0	0	0.000000	0	0	91.00
92.00	Allied health cost	0	0	0.000000	0	0	92.00
93.00	All other Medical Education	0	0	0.000000	0	0	93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-0013	Period: From 01/01/2020 To 12/31/2020	Worksheet D-1 Date/Time Prepared: 7/22/2021 3:42 pm
Cost Center Description		Title XIX	Hospital	PPS
PART I - ALL PROVIDER COMPONENTS				1.00
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)			11,161 1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)			11,161 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)			8,859 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)			635 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)			10,817,247 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)			10,817,247 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)			10,817,247 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)			969.20 38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)			615,442 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)			615,442 41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-0013

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

Worksheet D-1

Date/Time Prepared:
7/22/2021 3:42 pm

Cost Center Description		Title XIX		Hospital		PPS
		Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)
		1.00	2.00	3.00	4.00	5.00
42.00	NURSERY (title V & XIX only)	0	0	0.00	0	0
	Intensive Care Type Inpatient Hospital Units					
43.00	INTENSIVE CARE UNIT	2,223,292	1,187	1,873.03	45	84,286
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)					0
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					699,728
	PASS THROUGH COST ADJUSTMENTS					
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)					45,765
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					0
52.00	Total Program excludable cost (sum of lines 50 and 51)					45,765
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					653,963
	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)					2,302
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					969.20
89.00	Observation bed cost (line 87 x line 88) (see instructions)					2,231,098

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-0013

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

Worksheet D-1

Date/Time Prepared:
7/22/2021 3:42 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	703,701	10,817,247	0.065054	2,231,098	145,142
91.00	Nursing School cost	0	10,817,247	0.000000	2,231,098	0
92.00	Allied health cost	0	10,817,247	0.000000	2,231,098	0
93.00	All other Medical Education	0	10,817,247	0.000000	2,231,098	0

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-0013 Component CCN: 14-S013	Period: From 01/01/2020 To 12/31/2020	Worksheet D-1 Date/Time Prepared: 7/22/2021 3:42 pm
		Title XIX	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)		3,528	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		3,528	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)		3,528	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)		0	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)		0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period		0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)		0	14.00
15.00	Total nursery days (title V or XIX only)		0	15.00
16.00	Nursery days (title V or XIX only)		0	16.00
SWING BED ADJUSTMENT				
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period		0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)		3,244,657	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)		0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)		0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)		0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)		0	25.00
26.00	Total swing-bed cost (see instructions)		0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)		3,244,657	27.00
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)		0	28.00
29.00	Private room charges (excluding swing-bed charges)		0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)		0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)		0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)		0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)		0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)		0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)		0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)		3,244,657	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)		919.69	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		0	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)		0	41.00

COMPUTATION OF INPATIENT OPERATING COST				Provider CCN: 14-0013 Component CCN: 14-S013	Period: From 01/01/2020 To 12/31/2020	Worksheet D-1 Date/Time Prepared: 7/22/2021 3:42 pm	
				Title XIX		Subprovider - IPF	PPS
Cost Center Description		Total	Total	Average Per	Program Days	Program Cost (col. 3 x col. 4)	
		Inpatient Cost	Inpatient Days	Diem (col. 1 ÷ col. 2)			
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)	0	0	0.00	0		42.00
Intensive Care Type Inpatient Hospital Units							
43.00	INTENSIVE CARE UNIT	0	0	0.00	0	0	43.00
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)					0	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					0	49.00
PASS THROUGH COST ADJUSTMENTS							
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)					0	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					0	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)					0	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					0	53.00
TARGET AMOUNT AND LIMIT COMPUTATION							
54.00	Program discharges					0	54.00
55.00	Target amount per discharge					0.00	55.00
56.00	Target amount (line 54 x line 55)					0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)					0	57.00
58.00	Bonus payment (see instructions)					0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket					0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket					0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)					0	61.00
62.00	Relief payment (see instructions)					0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)					0	63.00
PROGRAM INPATIENT ROUTINE SWING BED COST							
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)					0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)					0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)					0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)					0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)					0	69.00
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY							
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)						70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)						71.00
72.00	Program routine service cost (line 9 x line 71)						72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)						73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)						74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)						75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)						76.00
77.00	Program capital-related costs (line 9 x line 76)						77.00
78.00	Inpatient routine service cost (line 74 minus line 77)						78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)						79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)						80.00
81.00	Inpatient routine service cost per diem limitation						81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)						82.00
83.00	Reasonable inpatient routine service costs (see instructions)						83.00
84.00	Program inpatient ancillary services (see instructions)						84.00
85.00	Utilization review - physician compensation (see instructions)						85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)						86.00
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
87.00	Total observation bed days (see instructions)					0	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					0.00	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)					0	89.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-0013 Component CCN: 14-S013		Period: From 01/01/2020 To 12/31/2020		Worksheet D-1 Date/Time Prepared: 7/22/2021 3:42 pm	
		Title XIX		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	173,630	3,244,657	0.053513	0	0	90.00
91.00	Nursing School cost	0	3,244,657	0.000000	0	0	91.00
92.00	Allied health cost	0	3,244,657	0.000000	0	0	92.00
93.00	All other Medical Education	0	3,244,657	0.000000	0	0	93.00

Health Financial Systems		PROCTOR HOSPITAL		In Lieu of Form CMS-2552-10	
COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-0013	Period: From 01/01/2020 To 12/31/2020	Worksheet D-1	
		Component CCN: 14-5579		Date/Time Prepared: 7/22/2021 3:42 pm	
		Title XIX	Skilled Nursing Facility	PPS	
Cost Center Description				1.00	
PART I - ALL PROVIDER COMPONENTS					
INPATIENT DAYS					
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		8,907	1.00	
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		8,907	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)		8,907	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)		0	9.00	
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)		0	10.00	
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	11.00	
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period		0	12.00	
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	13.00	
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)		0	14.00	
15.00	Total nursery days (title V or XIX only)		0	15.00	
16.00	Nursery days (title V or XIX only)		0	16.00	
SWING BED ADJUSTMENT					
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		0.00	17.00	
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		0.00	18.00	
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period		0.00	19.00	
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		0.00	20.00	
21.00	Total general inpatient routine service cost (see instructions)		3,971,144	21.00	
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)		0	22.00	
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)		0	23.00	
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)		0	24.00	
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)		0	25.00	
26.00	Total swing-bed cost (see instructions)		0	26.00	
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)		3,971,144	27.00	
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT					
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)		0	28.00	
29.00	Private room charges (excluding swing-bed charges)		0	29.00	
30.00	Semi-private room charges (excluding swing-bed charges)		0	30.00	
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		0.000000	31.00	
32.00	Average private room per diem charge (line 29 ÷ line 3)		0.00	32.00	
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)		0.00	33.00	
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)		0.00	34.00	
35.00	Average per diem private room cost differential (line 34 x line 31)		0.00	35.00	
36.00	Private room cost differential adjustment (line 3 x line 35)		0	36.00	
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)		3,971,144	37.00	
PART II - HOSPITAL AND SUBPROVIDERS ONLY					
PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS					
38.00	Adjusted general inpatient routine service cost per diem (see instructions)			38.00	
39.00	Program general inpatient routine service cost (line 9 x line 38)			39.00	
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)			40.00	
41.00	Total Program general inpatient routine service cost (line 39 + line 40)			41.00	

COMPUTATION OF INPATIENT OPERATING COST				Provider CCN: 14-0013	Period: From 01/01/2020 To 12/31/2020	Worksheet D-1		
				Component CCN: 14-5579		Date/Time Prepared: 7/22/2021 3:42 pm		
				Title XIX		Skilled Nursing Facility	PPS	
Cost Center Description		Total	Total	Average Per	Program Days	Program Cost (col. 3 x col. 4)		
		Inpatient Cost	Inpatient Days	Diem (col. 1 ÷ col. 2)				
		1.00	2.00	3.00	4.00	5.00		
42.00	NURSERY (title V & XIX only)						42.00	
Intensive Care Type Inpatient Hospital Units								
43.00	INTENSIVE CARE UNIT						43.00	
44.00	CORONARY CARE UNIT						44.00	
45.00	BURN INTENSIVE CARE UNIT						45.00	
46.00	SURGICAL INTENSIVE CARE UNIT						46.00	
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00	
Cost Center Description								
						1.00		
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)						48.00	
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)						49.00	
PASS THROUGH COST ADJUSTMENTS								
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)						50.00	
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)							
52.00	Total Program excludable cost (sum of lines 50 and 51)							
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)							
TARGET AMOUNT AND LIMIT COMPUTATION								
54.00	Program discharges						54.00	
55.00	Target amount per discharge							
56.00	Target amount (line 54 x line 55)							
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)							
58.00	Bonus payment (see instructions)							
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket							
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket							
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)							
62.00	Relief payment (see instructions)							
63.00	Allowable Inpatient cost plus incentive payment (see instructions)							
PROGRAM INPATIENT ROUTINE SWING BED COST								
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)						64.00	
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)							
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)							
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)							
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)						68.00	
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)							
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)						3,971,144	70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)						445.85	71.00
72.00	Program routine service cost (line 9 x line 71)						0	72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)						0	73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)						0	74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)						305,252	75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)						34.27	76.00
77.00	Program capital-related costs (line 9 x line 76)						0	77.00
78.00	Inpatient routine service cost (line 74 minus line 77)						0	78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)						0	79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)						0	80.00
81.00	Inpatient routine service cost per diem limitation						0.00	81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)						0	82.00
83.00	Reasonable inpatient routine service costs (see instructions)						0	83.00
84.00	Program inpatient ancillary services (see instructions)						0	84.00
85.00	Utilization review - physician compensation (see instructions)						0	85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)						0	86.00
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST								
87.00	Total observation bed days (see instructions)						0	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)						0.00	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)						0	89.00

COMPUTATION OF INPATIENT OPERATING COST				Provider CCN: 14-0013 Component CCN: 14-5579		Period: From 01/01/2020 To 12/31/2020		Worksheet D-1 Date/Time Prepared: 7/22/2021 3:42 pm	
				Title XIX		Skilled Nursing Facility		PPS	
Cost Center Description				Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
				1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH COST									
90.00	Capital-related cost			0	0	0.000000	0	0	90.00
91.00	Nursing School cost			0	0	0.000000	0	0	91.00
92.00	Allied health cost			0	0	0.000000	0	0	92.00
93.00	All other Medical Education			0	0	0.000000	0	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT			Provider CCN: 14-0013	Period: From 01/01/2020 To 12/31/2020	Worksheet D-3 Date/Time Prepared: 7/22/2021 3:42 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		12,549,651		30.00
31.00	03100	INTENSIVE CARE UNIT		2,634,187		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	0.161444	5,133,550	828,781	50.00
51.00	05100	RECOVERY ROOM	0.122309	1,114,310	136,290	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.016957	1,394,333	23,644	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.190935	1,743,684	332,930	54.00
57.00	05700	CT SCAN	0.032548	3,272,556	106,515	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.072897	718,817	52,400	58.00
60.00	06000	LABORATORY	0.137721	4,881,580	672,296	60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	0.163871	397,616	65,158	63.00
64.00	06400	INTRAVENOUS THERAPY	0.139083	870,866	121,123	64.00
65.00	06500	RESPIRATORY THERAPY	0.120243	2,377,636	285,894	65.00
66.00	06600	PHYSICAL THERAPY	0.277755	633,880	176,063	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.271568	267,987	72,777	67.00
68.00	06800	SPEECH PATHOLOGY	0.262020	150,157	39,344	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	2.634202	33,394	87,967	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.396769	2,800,726	1,111,241	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.254910	7,226,195	1,842,029	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.221886	3,700,884	821,174	73.00
74.00	07400	RENAL DIALYSIS	0.068295	0	0	74.00
76.00	03950	ANCILLARY	0.000000	0	0	76.00
76.01	03560	PULMONARY FUNCTION TESTING	0.065011	166,594	10,830	76.01
76.02	03340	GASTRO INTESTINAL SERVICES	0.083800	452,586	37,927	76.02
76.03	03140	CARDIOLOGY	0.076903	2,754,294	211,813	76.03
76.97	07697	CARDIAC REHABILITATION	0.515742	0	0	76.97
OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.183132	208,913	38,259	90.00
91.00	09100	EMERGENCY	0.089048	2,974,523	264,875	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.582996	669,955	390,581	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		43,945,036	7,729,911	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)		43,945,036		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 14-0013 Component CCN: 14-S013	Period: From 01/01/2020 To 12/31/2020	Worksheet D-3 Date/Time Prepared: 7/22/2021 3:42 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		6,183,688		40.00
43.00	04300 NURSERY				43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.161444	0	0	50.00
51.00	05100 RECOVERY ROOM	0.122309	5,628	688	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.000000	0	0	52.00
53.00	05300 ANESTHESIOLOGY	0.016957	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.190935	78,357	14,961	54.00
57.00	05700 CT SCAN	0.032548	275,172	8,956	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0.072897	6,696	488	58.00
60.00	06000 LABORATORY	0.137721	427,549	58,882	60.00
63.00	06300 BLOOD STORING, PROCESSING, & TRANS.	0.163871	0	0	63.00
64.00	06400 INTRAVENOUS THERAPY	0.139083	44,571	6,199	64.00
65.00	06500 RESPIRATORY THERAPY	0.120243	250,024	30,064	65.00
66.00	06600 PHYSICAL THERAPY	0.277755	118,739	32,980	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.271568	13,808	3,750	67.00
68.00	06800 SPEECH PATHOLOGY	0.262020	43,611	11,427	68.00
70.00	07000 ELECTROENCEPHALOGRAPHY	2.634202	3,228	8,503	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.396769	60,240	23,901	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.254910	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.221886	138,487	30,728	73.00
74.00	07400 RENAL DIALYSIS	0.068295	0	0	74.00
76.00	03950 ANCILLARY	0.000000	0	0	76.00
76.01	03560 PULMONARY FUNCTION TESTING	0.065011	3,567	232	76.01
76.02	03340 GASTRO INTESTINAL SERVICES	0.083800	0	0	76.02
76.03	03140 CARDIOLOGY	0.076903	64,292	4,944	76.03
76.97	07697 CARDIAC REHABILITATION	0.515742	0	0	76.97
OUTPATIENT SERVICE COST CENTERS					
90.00	09000 CLINIC	0.183132	22,225	4,070	90.00
91.00	09100 EMERGENCY	0.089048	267,480	23,819	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0.582996	0	0	92.00
200.00	Total (sum of lines 50 through 94 and 96 through 98)		1,823,674	264,592	200.00
201.00	Less PBP Clinic Laboratory Services-Program only charges (line 61)		0	0	201.00
202.00	Net charges (line 200 minus line 201)		1,823,674		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 14-0013 Component CCN: 14-5579	Period: From 01/01/2020 To 12/31/2020	Worksheet D-3 Date/Time Prepared: 7/22/2021 3:42 pm	
		Title XVIII	Skilled Nursing Facility	PPS	
Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDIATRICS		0		30.00
31.00	03100 INTENSIVE CARE UNIT		0		31.00
40.00	04000 SUBPROVIDER - IPF		0		40.00
43.00	04300 NURSERY				43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.161444	4,048	654	50.00
51.00	05100 RECOVERY ROOM	0.122309	4,523	553	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.000000	0	0	52.00
53.00	05300 ANESTHESIOLOGY	0.016957	3,544	60	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.190935	139,023	26,544	54.00
57.00	05700 CT SCAN	0.032548	4,729	154	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0.072897	0	0	58.00
60.00	06000 LABORATORY	0.137721	787,024	108,390	60.00
63.00	06300 BLOOD STORING, PROCESSING, & TRANS.	0.163871	16,445	2,695	63.00
64.00	06400 INTRAVENOUS THERAPY	0.139083	4,571	636	64.00
65.00	06500 RESPIRATORY THERAPY	0.120243	1,827,928	219,796	65.00
66.00	06600 PHYSICAL THERAPY	0.277755	3,272,392	908,923	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.271568	2,086,079	566,512	67.00
68.00	06800 SPEECH PATHOLOGY	0.262020	583,618	152,920	68.00
70.00	07000 ELECTROENCEPHALOGRAPHY	2.634202	0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.396769	7,936	3,149	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.254910	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.221886	829,732	184,106	73.00
74.00	07400 RENAL DIALYSIS	0.068295	0	0	74.00
76.00	03950 ANCILLARY	0.000000	0	0	76.00
76.01	03560 PULMONARY FUNCTION TESTING	0.065011	9,639	627	76.01
76.02	03340 GASTRO INTESTINAL SERVICES	0.083800	0	0	76.02
76.03	03140 CARDIOLOGY	0.076903	25,486	1,960	76.03
76.97	07697 CARDIAC REHABILITATION	0.515742	0	0	76.97
OUTPATIENT SERVICE COST CENTERS					
90.00	09000 CLINIC	0.183132	167,371	30,651	90.00
91.00	09100 EMERGENCY	0.089048	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0.582996	2,212	1,290	92.00
200.00	Total (sum of lines 50 through 94 and 96 through 98)		9,776,300	2,209,620	200.00
201.00	Less PBP Clinic Laboratory Services-Program only charges (line 61)		0	0	201.00
202.00	Net charges (line 200 minus line 201)		9,776,300		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0013	Period: From 01/01/2020 To 12/31/2020	Worksheet E Part A Date/Time Prepared: 7/22/2021 3:42 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)		6,513,088	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1 (see instructions)		2,743,761	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)		29,094	2.03
2.04	Outlier payments for discharges occurring on or after October 1 (see instructions)		7,097	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)		102.71	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)		0.00	30.00
31.00	Percentage of Medicaid patient days (see instructions)		6.67	31.00
32.00	Sum of lines 30 and 31		6.67	32.00
33.00	Allowable disproportionate share percentage (see instructions)		0.00	33.00
34.00	Disproportionate share adjustment (see instructions)		0	34.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0013	Period: From 01/01/2020 To 12/31/2020	Worksheet E Part A Date/Time Prepared: 7/22/2021 3:42 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)		0	0	35.02
35.03	Pro rata share of the hospital uncompensated care payment amount (see instructions)		0	0	35.03
36.00	Total uncompensated care (sum of columns 1 and 2 on line 35.03)		0		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)	9,293,040			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)		9,293,040		49.00
50.00	Payment for inpatient program capital (from Wkst. L, Pt. I and Pt. II, as applicable)		732,609		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		3,734		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)		10,029,383		59.00
60.00	Primary payer payments		0		60.00
61.00	Total amount payable for program beneficiaries (line 59 minus line 60)		10,029,383		61.00
62.00	Deductibles billed to program beneficiaries		1,230,108		62.00
63.00	Coinurance billed to program beneficiaries		11,616		63.00
64.00	Allowable bad debts (see instructions)		117,707		64.00
65.00	Adjusted reimbursable bad debts (see instructions)		76,510		65.00
66.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		63,644		66.00
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)		8,864,169		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)		17,414		70.93
70.94	HRR adjustment amount (see instructions)		-121,906		70.94
70.95	Recovery of accelerated depreciation		0		70.95

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0013	Period: From 01/01/2020 To 12/31/2020	Worksheet E Part A Date/Time Prepared: 7/22/2021 3:42 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)		8,759,677	71.00
71.01	Sequestration adjustment (see instructions)		57,814	71.01
71.02	Demonstration payment adjustment amount after sequestration		88,126	71.02
71.03	Sequestration adjustment-PARHM pass-throughs			71.03
72.00	Interim payments		8,673,413	72.00
72.01	Interim payments-PARHM			72.01
73.00	Tentative settlement (for contractor use only)		0	73.00
73.01	Tentative settlement-PARHM (for contractor use only)			73.01
74.00	Balance due provider/program (line 71 minus lines 71.01, 71.02, 72, and 73)		-59,676	74.00
74.01	Balance due provider/program-PARHM (see instructions)			74.01
75.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		0	75.00
TO BE COMPLETED BY CONTRACTOR (lines 90 through 96)				
90.00	Operating outlier amount from Wkst. E, Pt. A, line 2, or sum of 2.03 plus 2.04 (see instructions)		0	90.00
91.00	Capital outlier from Wkst. L, Pt. I, line 2		0	91.00
92.00	Operating outlier reconciliation adjustment amount (see instructions)		0	92.00
93.00	Capital outlier reconciliation adjustment amount (see instructions)		0	93.00
94.00	The rate used to calculate the time value of money (see instructions)		0.00	94.00
95.00	Time value of money for operating expenses (see instructions)		0	95.00
96.00	Time value of money for capital related expenses (see instructions)		0	96.00
		Prior to 10/1	On/After 10/1	
		1.00	2.00	
HSP Bonus Payment Amount				
100.00	HSP bonus amount (see instructions)		0	100.00
HVBP Adjustment for HSP Bonus Payment				
101.00	HVBP adjustment factor (see instructions)	0.0000000000	0.0000000000	101.00
102.00	HVBP adjustment amount for HSP bonus payment (see instructions)		0	102.00
HRR Adjustment for HSP Bonus Payment				
103.00	HRR adjustment factor (see instructions)	0.0000	0.0000	103.00
104.00	HRR adjustment amount for HSP bonus payment (see instructions)		0	104.00
Rural Community Hospital Demonstration Project (\$410A Demonstration) Adjustment				
200.00	Is this the first year of the current 5-year demonstration period under the 21st Century Cures Act? Enter "Y" for yes or "N" for no.			200.00
Cost Reimbursement				
201.00	Medicare inpatient service costs (from Wkst. D-1, Pt. II, line 49)			201.00
202.00	Medicare discharges (see instructions)			202.00
203.00	Case-mix adjustment factor (see instructions)			203.00
Computation of Demonstration Target Amount Limitation (N/A in first year of the current 5-year demonstration period)				
204.00	Medicare target amount			204.00
205.00	Case-mix adjusted target amount (line 203 times line 204)			205.00
206.00	Medicare inpatient routine cost cap (line 202 times line 205)			206.00
Adjustment to Medicare Part A Inpatient Reimbursement				
207.00	Program reimbursement under the \$410A Demonstration (see instructions)			207.00
208.00	Medicare Part A inpatient service costs (from Wkst. E, Pt. A, line 59)			208.00
209.00	Adjustment to Medicare IPPS payments (see instructions)			209.00
210.00	Reserved for future use			210.00
211.00	Total adjustment to Medicare IPPS payments (see instructions)			211.00
Comparison of PPS versus Cost Reimbursement				
212.00	Total adjustment to Medicare Part A IPPS payments (from line 211)			212.00
213.00	Low-volume adjustment (see instructions)			213.00
218.00	Net Medicare Part A IPPS adjustment (difference between PPS and cost reimbursement) (line 212 minus line 213) (see instructions)			218.00

LOW VOLUME CALCULATION EXHIBIT 4

Provider CCN: 14-0013

Period:
From 01/01/2020
To 12/31/2020Worksheet E
Part A Exhibit 4
Date/Time Prepared:
7/22/2021 3:42 pm

		Title XVIII		Hospital		PPS	
		W/S E, Part A line	Amounts (from E, Part A)	Pre/Post Entitlement	Period Prior to 10/01	Period On/After 10/01	Total (Col 2 through 4)
		0	1.00	2.00	3.00	4.00	5.00
1.00	DRG amounts other than outlier payments	1.00	0	0	0	0	0
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1	1.01	6,513,088	0	6,513,088		6,513,088
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	2,743,761	0		2,743,761	2,743,761
1.03	DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October 1	1.03	0	0	0		0
1.04	DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1	1.04	0	0		0	0
2.00	Outlier payments for discharges (see instructions)	2.00					
2.01	Outlier payments for discharges for Model 4 BPCI	2.02	0	0	0	0	0
2.02	Outlier payments for discharges occurring prior to October 1 (see instructions)	2.03	29,094	0	29,094		29,094
2.03	Outlier payments for discharges occurring on or after October 1 (see instructions)	2.04	7,097	0		7,097	7,097
3.00	Operating outlier reconciliation	2.01	0	0	0	0	0
4.00	Managed care simulated payments	3.00	0	0	0	0	0
Indirect Medical Education Adjustment							
5.00	Amount from Worksheet E, Part A, line 21 (see instructions)	21.00	0.000000	0.000000	0.000000	0.000000	
6.00	IME payment adjustment (see instructions)	22.00	0	0	0	0	0
6.01	IME payment adjustment for managed care (see instructions)	22.01	0	0	0	0	0
Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA							
7.00	IME payment adjustment factor (see instructions)	27.00	0.000000	0.000000	0.000000	0.000000	
8.00	IME adjustment (see instructions)	28.00	0	0	0	0	0
8.01	IME payment adjustment add on for managed care (see instructions)	28.01	0	0	0	0	0
9.00	Total IME payment (sum of lines 6 and 8)	29.00	0	0	0	0	0
9.01	Total IME payment for managed care (sum of lines 6.01 and 8.01)	29.01	0	0	0	0	0
Disproportionate Share Adjustment							
10.00	Allowable disproportionate share percentage (see instructions)	33.00	0.0000	0.0000	0.0000	0.0000	
11.00	Disproportionate share adjustment (see instructions)	34.00	0	0	0	0	0
11.01	Uncompensated care payments	36.00	0	0	0	0	0
Additional payment for high percentage of ESRD beneficiary discharges							
12.00	Total ESRD additional payment (see instructions)	46.00	0	0	0	0	0
13.00	Subtotal (see instructions)	47.00	9,293,040	0	6,542,182	2,750,858	9,293,040
14.00	Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see instructions)	48.00	0	0	0	0	0
15.00	Total payment for inpatient operating costs (see instructions)	49.00	9,293,040	0	6,542,182	2,750,858	9,293,040
16.00	Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable)	50.00	732,609	0	-211,219	943,828	732,609

LOW VOLUME CALCULATION EXHIBIT 4

Provider CCN: 14-0013

Period:
From 01/01/2020
To 12/31/2020Worksheet E
Part A Exhibit 4
Date/Time Prepared:
7/22/2021 3:42 pm

				Title XVIII		Hospital	PPS	
		W/S E, Part A line	Amounts (from E, Part A)	Pre/Post Entitlement	Period Prior to 10/01	Period On/After 10/01	Total (Col 2 through 4)	
		0	1.00	2.00	3.00	4.00	5.00	
17.00	Special add-on payments for new technologies	54.00	3,734	0	0	3,734	3,734	17.00
17.01	Net organ aquisition cost							17.01
17.02	Credits received from manufacturers for replaced devices for applicable MS-DRGs	68.00	0	0	0	0	0	17.02
18.00	Capital outlier reconciliation adjustment amount (see instructions)	93.00	0	0	0	0	0	18.00
19.00	SUBTOTAL			0	6,330,963	3,698,420	10,029,383	19.00
		W/S L, line	(Amounts from L)					
		0	1.00	2.00	3.00	4.00	5.00	
20.00	Capital DRG other than outlier	1.00	721,047	0	-208,008	929,055	721,047	20.00
20.01	Model 4 BPCI Capital DRG other than outlier	1.01	0	0	0	0	0	20.01
21.00	Capital DRG outlier payments	2.00	1,756	0	-382	2,138	1,756	21.00
21.01	Model 4 BPCI Capital DRG outlier payments	2.01	0	0	0	0	0	21.01
22.00	Indirect medical education percentage (see instructions)	5.00	0.0000	0.0000	0.0000	0.0000		22.00
23.00	Indirect medical education adjustment (see instructions)	6.00	0	0	0	0	0	23.00
24.00	Allowable disproportionate share percentage (see instructions)	10.00	0.0136	0.0136	0.0136	0.0136		24.00
25.00	Disproportionate share adjustment (see instructions)	11.00	9,806	0	-2,829	12,635	9,806	25.00
26.00	Total prospective capital payments (see instructions)	12.00	732,609	0	-211,219	943,828	732,609	26.00
		W/S E, Part A line	(Amounts to E, Part A)					
		0	1.00	2.00	3.00	4.00	5.00	
27.00	Low volume adjustment factor				0.000000	0.000000		27.00
28.00	Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)	70.96			0		0	28.00
29.00	Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)	70.97				0	0	29.00
100.00	Transfer low volume adjustments to Wkst. E, Pt. A.		Y					100.00

HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULATION EXHIBIT 5

Provider CCN: 14-0013

Period:
From 01/01/2020
To 12/31/2020Worksheet E
Part A Exhibit 5
Date/Time Prepared:
7/22/2021 3:42 pm

		Title XVIII		Hospital		PPS	
		Wkst. E, Pt. A, line	Amt. from Wkst. E, Pt. A)	Period to 10/01	Period on after 10/01	Total (cols. 2 and 3)	
		0	1.00	2.00	3.00	4.00	
1.00	DRG amounts other than outlier payments	1.00					1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1	1.01	6,513,088	6,513,088		6,513,088	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	2,743,761		2,743,761	2,743,761	1.02
1.03	DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October 1	1.03	0	0		0	1.03
1.04	DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1	1.04	0		0	0	1.04
2.00	Outlier payments for discharges (see instructions)	2.00					2.00
2.01	Outlier payments for discharges for Model 4 BPCI	2.02	0	0	0	0	2.01
2.02	Outlier payments for discharges occurring prior to October 1 (see instructions)	2.03	29,094	29,094		29,094	2.02
2.03	Outlier payments for discharges occurring on or after October 1 (see instructions)	2.04	7,097		7,097	7,097	2.03
3.00	Operating outlier reconciliation	2.01	0	0	0	0	3.00
4.00	Managed care simulated payments	3.00	0	0	0	0	4.00
Indirect Medical Education Adjustment							
5.00	Amount from Worksheet E, Part A, line 21 (see instructions)	21.00	0.000000	0.000000	0.000000		5.00
6.00	IME payment adjustment (see instructions)	22.00	0	0	0	0	6.00
6.01	IME payment adjustment for managed care (see instructions)	22.01	0	0	0	0	6.01
Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA							
7.00	IME payment adjustment factor (see instructions)	27.00	0.000000	0.000000	0.000000		7.00
8.00	IME adjustment (see instructions)	28.00	0	0	0	0	8.00
8.01	IME payment adjustment add on for managed care (see instructions)	28.01	0	0	0	0	8.01
9.00	Total IME payment (sum of lines 6 and 8)	29.00	0	0	0	0	9.00
9.01	Total IME payment for managed care (sum of lines 6.01 and 8.01)	29.01	0	0	0	0	9.01
Disproportionate Share Adjustment							
10.00	Allowable disproportionate share percentage (see instructions)	33.00	0.0000	0.0000	0.0000		10.00
11.00	Disproportionate share adjustment (see instructions)	34.00	0	0	0	0	11.00
11.01	Uncompensated care payments	36.00	0	0	0	0	11.01
Additional payment for high percentage of ESRD beneficiary discharges							
12.00	Total ESRD additional payment (see instructions)	46.00	0	0	0	0	12.00
13.00	Subtotal (see instructions)	47.00	9,293,040	6,542,182	2,750,858	9,293,040	13.00
14.00	Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see instructions)	48.00	0	0	0	0	14.00
15.00	Total payment for inpatient operating costs (see instructions)	49.00	9,293,040	6,542,182	2,750,858	9,293,040	15.00
16.00	Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable)	50.00	732,609	-211,219	943,828	732,609	16.00
17.00	Special add-on payments for new technologies	54.00	3,734	0	3,734	3,734	17.00
17.01	Net organ acquisition cost						17.01
17.02	Credits received from manufacturers for replaced devices for applicable MS-DRGs	68.00	0	0	0	0	17.02
18.00	Capital outlier reconciliation adjustment amount (see instructions)	93.00	0	0	0	0	18.00
19.00	SUBTOTAL			6,330,963	3,698,420	10,029,383	19.00

HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULATION EXHIBIT 5

Provider CCN: 14-0013

Period:
From 01/01/2020
To 12/31/2020Worksheet E
Part A Exhibit 5
Date/Time Prepared:
7/22/2021 3:42 pm

		Title XVIII		Hospital		PPS	
		Wkst. L, line	(Amt. from Wkst. L)				
		0	1.00	2.00	3.00	4.00	
20.00	Capital DRG other than outlier	1.00	721,047	-208,008	929,055	721,047	20.00
20.01	Model 4 BPCI Capital DRG other than outlier	1.01	0	0	0	0	20.01
21.00	Capital DRG outlier payments	2.00	1,756	-382	2,138	1,756	21.00
21.01	Model 4 BPCI Capital DRG outlier payments	2.01	0	0	0	0	21.01
22.00	Indirect medical education percentage (see instructions)	5.00	0.0000	0.0000	0.0000		22.00
23.00	Indirect medical education adjustment (see instructions)	6.00	0	0	0	0	23.00
24.00	Allowable disproportionate share percentage (see instructions)	10.00	0.0136	0.0136	0.0136		24.00
25.00	Disproportionate share adjustment (see instructions)	11.00	9,806	-2,829	12,635	9,806	25.00
26.00	Total prospective capital payments (see instructions)	12.00	732,609	-211,219	943,828	732,609	26.00
		Wkst. E, Pt. A, line	(Amt. from Wkst. E, Pt. A)				
		0	1.00	2.00	3.00	4.00	
27.00							27.00
28.00	Low volume adjustment prior to October 1	70.96	0	0		0	28.00
29.00	Low volume adjustment on or after October 1	70.97	0		0	0	29.00
30.00	HVBP payment adjustment (see instructions)	70.93	17,414	-31,484	48,898	17,414	30.00
30.01	HVBP payment adjustment for HSP bonus payment (see instructions)	70.90	0	0	0	0	30.01
31.00	HRR adjustment (see instructions)	70.94	-121,906	-117,235	-4,671	-121,906	31.00
31.01	HRR adjustment for HSP bonus payment (see instructions)	70.91	0	0	0	0	31.01
						(Amt. to Wkst. E, Pt. A)	
		0	1.00	2.00	3.00	4.00	
32.00	HAC Reduction Program adjustment (see instructions)	70.99		0	0	0	32.00
100.00	Transfer HAC Reduction Program adjustment to Wkst. E, Pt. A.		N				100.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0013	Period: From 01/01/2020 To 12/31/2020	Worksheet E Part B Date/Time Prepared: 7/22/2021 3:42 pm
		Title XVIII	Hospital	PPS
				1.00
PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)		3,282	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)		16,321,442	2.00
3.00	OPPS payments		12,078,398	3.00
4.00	Outlier payment (see instructions)		17,675	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)		3,282	11.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
12.00	Ancillary service charges		14,821	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)		14,821	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)		14,821	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)		11,539	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)		3,282	21.00
22.00	Interns and residents (see instructions)		0	22.00
23.00	Cost of physicians' services in a teaching hospital (see instructions)		0	23.00
24.00	Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)		12,096,073	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)		2,064,738	26.00
27.00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions)		10,034,617	27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 50)		0	28.00
29.00	ESRD direct medical education costs (from Wkst. E-4, line 36)		0	29.00
30.00	Subtotal (sum of lines 27 through 29)		10,034,617	30.00
31.00	Primary payer payments		732	31.00
32.00	Subtotal (line 30 minus line 31)		10,033,885	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)		169,185	34.00
35.00	Adjusted reimbursable bad debts (see instructions)		109,970	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		121,851	36.00
37.00	Subtotal (see instructions)		10,143,855	37.00
38.00	MSP-LCC reconciliation amount from PS&R		-202	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)		2,880	39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION		0	39.99
40.00	Subtotal (see instructions)		10,144,057	40.00
40.01	Sequestration adjustment (see instructions)		66,951	40.01
40.02	Demonstration payment adjustment amount after sequestration		93,292	40.02
40.03	Sequestration adjustment-PARHM pass-throughs			40.03
41.00	Interim payments		10,049,746	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)		-65,932	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)			93.00
94.00	Total (sum of lines 91 and 93)		0	94.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0013 Component CCN: 14-S013	Period: From 01/01/2020 To 12/31/2020	Worksheet E Part B Date/Time Prepared: 7/22/2021 3:42 pm
		Title XVIII	Subprovider - IPF	PPS
		1.00		
PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)		870	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)		1,085	2.00
3.00	OPPS payments		1,839	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)		870	11.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
12.00	Ancillary service charges		3,921	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)		3,921	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)		3,921	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)		3,051	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)		870	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)		1,839	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)		142	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)		2,567	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)		2,567	30.00
31.00	Primary payer payments		0	31.00
32.00	Subtotal (line 30 minus line 31)		2,567	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)		2,567	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)		2,567	40.00
40.01	Sequestration adjustment (see instructions)		17	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		2,200	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)		350	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

Health Financial Systems		PROCTOR HOSPITAL		In Lieu of Form CMS-2552-10	
CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0013 Component CCN: 14-5579	Period: From 01/01/2020 To 12/31/2020	Worksheet E Part B Date/Time Prepared: 7/22/2021 3:42 pm	
		Title XVIII	Skilled Nursing Facility	PPS	
				1.00	
PART B - MEDICAL AND OTHER HEALTH SERVICES					
1.00	Medical and other services (see instructions)		164	1.00	
2.00	Medical and other services reimbursed under OPPS (see instructions)		0	2.00	
3.00	OPPS payments			3.00	
4.00	Outlier payment (see instructions)			4.00	
4.01	Outlier reconciliation amount (see instructions)			4.01	
5.00	Enter the hospital specific payment to cost ratio (see instructions)			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)		164	11.00	
COMPUTATION OF LESSER OF COST OR CHARGES					
Reasonable charges					
12.00	Ancillary service charges		741	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)		741	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)		741	18.00	
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)		577	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)		164	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)			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)		164	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)		164	30.00	
31.00	Primary payer payments		0	31.00	
32.00	Subtotal (line 30 minus line 31)		164	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)		164	37.00	
38.00	MSP-LCC reconciliation amount from PS&R			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)		164	40.00	
40.01	Sequestration adjustment (see instructions)		1	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		163	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)			90.00	
91.00	Outlier reconciliation adjustment amount (see instructions)			91.00	
92.00	The rate used to calculate the Time Value of Money			92.00	
93.00	Time Value of Money (see instructions)			93.00	
94.00	Total (sum of lines 91 and 93)			94.00	

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 14-0013

Period:
From 01/01/2020
To 12/31/2020Worksheet E-1
Part I
Date/Time Prepared:
7/22/2021 3:42 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		8,673,413		10,049,746	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)		8,673,413		10,049,746	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		0		0	6.01
6.02	SETTLEMENT TO PROGRAM		59,676		65,932	6.02
7.00	Total Medicare program liability (see instructions)		8,613,737		9,983,814	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: 14-0013 Component CCN: 14-S013		Period: From 01/01/2020 To 12/31/2020		Worksheet E-1 Part I Date/Time Prepared: 7/22/2021 3:42 pm	
		Title XVIII		Subprovider - IPF		PPS	
		Inpatient Part A		Part B			
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount		
		1.00	2.00	3.00	4.00		
1.00	Total interim payments paid to provider					1.00	
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		2,086,925		2,200	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)		2,086,925		2,200	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		41,992		350	6.01	
6.02	SETTLEMENT TO PROGRAM		0		0	6.02	
7.00	Total Medicare program liability (see instructions)		2,128,917		2,550	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: 14-0013 Component CCN: 14-5579		Period: From 01/01/2020 To 12/31/2020		Worksheet E-1 Part I Date/Time Prepared: 7/22/2021 3:42 pm	
		Title XVIII		Skilled Nursing Facility		PPS	
		Inpatient Part A		Part B			
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount		
		1.00	2.00	3.00	4.00		
1.00	Total interim payments paid to provider						1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		3,069,160		163		2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)						3.00
Program to Provider							
3.01	ADJUSTMENTS TO PROVIDER		0		0		3.01
3.02			0		0		3.02
3.03			0		0		3.03
3.04			0		0		3.04
3.05			0		0		3.05
Provider to Program							
3.50	ADJUSTMENTS TO PROGRAM		0		0		3.50
3.51			0		0		3.51
3.52			0		0		3.52
3.53			0		0		3.53
3.54			0		0		3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0		3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		3,069,160		163		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		2,092		0		6.01
6.02	SETTLEMENT TO PROGRAM		0		0		6.02
7.00	Total Medicare program liability (see instructions)		3,071,252		163		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: 14-0013	Period: From 01/01/2020 To 12/31/2020	Worksheet E-1 Part II Date/Time Prepared: 7/22/2021 3:42 pm	
		Title XVIII	Hospital	PPS	
				1.00	
TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS					
HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION					
1.00	Total hospital discharges as defined in AARA §4102 from Wkst. S-3, Pt. I col. 15 line 14				1.00
2.00	Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, 8-12				2.00
3.00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2				3.00
4.00	Total inpatient days from S-3, Pt. I col. 8 sum of lines 1, 8-12				4.00
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200				5.00
6.00	Total hospital charity care charges from Wkst. S-10, col. 3 line 20				6.00
7.00	CAH only - The reasonable cost incurred for the purchase of certified HIT technology Wkst. S-2, Pt. I line 168				7.00
8.00	Calculation of the HIT incentive payment (see instructions)				8.00
9.00	Sequestration adjustment amount (see instructions)				9.00
10.00	Calculation of the HIT incentive payment after sequestration (see instructions)				10.00
INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH					
30.00	Initial/interim HIT payment adjustment (see instructions)				30.00
31.00	Other Adjustment (specify)				31.00
32.00	Balance due provider (line 8 (or line 10) minus line 30 and line 31) (see instructions)				32.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0013 Component CCN: 14-S013	Period: From 01/01/2020 To 12/31/2020	Worksheet E-3 Part II Date/Time Prepared: 7/22/2021 3:42 pm
		Title XVIII	Subprovider - IPF	PPS
				1.00
PART II - MEDICARE PART A SERVICES - IPF PPS				
1.00	Net Federal IPF PPS Payments (excluding outlier, ECT, and medical education payments)			2,283,970 1.00
2.00	Net IPF PPS Outlier Payments			15,287 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)			9.639344 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)			2,299,257 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)			2,299,257 16.00
17.00	Primary payer payments			0 17.00
18.00	Subtotal (line 16 less line 17).			2,299,257 18.00
19.00	Deductibles			137,632 19.00
20.00	Subtotal (line 18 minus line 19)			2,161,625 20.00
21.00	Coinsurance			59,840 21.00
22.00	Subtotal (line 20 minus line 21)			2,101,785 22.00
23.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)			63,501 23.00
24.00	Adjusted reimbursable bad debts (see instructions)			41,276 24.00
25.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			22,613 25.00
26.00	Subtotal (sum of lines 22 and 24)			2,143,061 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)			2,143,061 31.00
31.01	Sequestration adjustment (see instructions)			14,144 31.01
31.02	Demonstration payment adjustment amount after sequestration			0 31.02
32.00	Interim payments			2,086,925 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)			41,992 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			15,287 50.00
51.00	Outlier reconciliation adjustment amount (see instructions)			0 51.00
52.00	The rate used to calculate the Time Value of Money			0.00 52.00
53.00	Time Value of Money (see instructions)			0 53.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0013 Component CCN: 14-5579	Period: From 01/01/2020 To 12/31/2020	Worksheet E-3 Part VI Date/Time Prepared: 7/22/2021 3:42 pm
		Title XVIII	Skilled Nursing Facility	PPS
				1.00
PART VI - CALCULATION OF REIMBURSEMENT SETTLEMENT - ALL OTHER HEALTH SERVICES FOR TITLE XVIII PART A PPS SNF SERVICES				
PROSPECTIVE PAYMENT AMOUNT (SEE INSTRUCTIONS)				
1.00	Resource Utilization Group Payment (RUGS)		3,428,789	1.00
2.00	Routine service other pass through costs		0	2.00
3.00	Ancillary service other pass through costs		0	3.00
4.00	Subtotal (sum of lines 1 through 3)		3,428,789	4.00
COMPUTATION OF NET COST OF COVERED SERVICES				
5.00	Medical and other services (Do not use this line as vaccine costs are included in line 1 of W/S E, Part B. This line is now shaded.)			5.00
6.00	Deductible		0	6.00
7.00	Coinsurance		287,738	7.00
8.00	Allowable bad debts (see instructions)		3,219	8.00
9.00	Reimbursable bad debts for dual eligible beneficiaries (see instructions)		0	9.00
10.00	Adjusted reimbursable bad debts (see instructions)		2,092	10.00
11.00	Utilization review		0	11.00
12.00	Subtotal (sum of lines 4, 5 minus lines 6 and 7, plus lines 10 and 11)(see instructions)		3,143,143	12.00
13.00	Inpatient primary payer payments		0	13.00
14.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	14.00
14.50	Pioneer ACO demonstration payment adjustment (see instructions)		0	14.50
14.99	Demonstration payment adjustment amount before sequestration		0	14.99
15.00	Subtotal (see instructions)		3,143,143	15.00
15.01	Sequestration adjustment (see instructions)		25,848	15.01
15.02	Demonstration payment adjustment amount after sequestration		46,043	15.02
15.75	Sequestration for non-claims based amounts (see instructions)		14	15.75
16.00	Interim payments		3,069,160	16.00
17.00	Tentative settlement (for contractor use only)		0	17.00
18.00	Balance due provider/program (line 15 minus lines 15.01, 15.02, 15.75, 16, and 17)		2,078	18.00
19.00	Protested amounts (nonallowable cost report items) in accordance with CMS 19 Pub. 15-2, chapter 1, §115.2		0	19.00

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

Provider CCN: 14-0013

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

Worksheet G

Date/Time Prepared:
7/22/2021 3:42 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	10,107,122	0	0	0	1.00
2.00	Temporary investments	2,722,920	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	16,408,026	0	0	0	4.00
5.00	Other receivable	1,902,052	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	0	0	0	0	6.00
7.00	Inventory	0	0	0	0	7.00
8.00	Prepaid expenses	2,945,273	0	0	0	8.00
9.00	Other current assets	812,624	0	0	0	9.00
10.00	Due from other funds	26,818,521	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	61,716,538	0	0	0	11.00
FIXED ASSETS						
12.00	Land	6,081,907	0	0	0	12.00
13.00	Land improvements	1,148,071	0	0	0	13.00
14.00	Accumulated depreciation	-6,408,617	0	0	0	14.00
15.00	Buildings	35,666,580	0	0	0	15.00
16.00	Accumulated depreciation	-52,299,590	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	3,276,790	0	0	0	19.00
20.00	Accumulated depreciation	-19,186,079	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	127,427,299	0	0	0	23.00
24.00	Accumulated depreciation	-53,285,922	0	0	0	24.00
25.00	Minor equipment depreciable	0	0	0	0	25.00
26.00	Accumulated depreciation	0	0	0	0	26.00
27.00	HIT designated Assets	0	0	0	0	27.00
28.00	Accumulated depreciation	0	0	0	0	28.00
29.00	Minor equipment-nondepreciable	0	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	42,420,439	0	0	0	30.00
OTHER ASSETS						
31.00	Investments	13,079,121	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	6,844,412	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	19,923,533	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	124,060,510	0	0	0	36.00
CURRENT LIABILITIES						
37.00	Accounts payable	7,972,138	0	0	0	37.00
38.00	Salaries, wages, and fees payable	1,829,748	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	22,279,653	0	0	0	43.00
44.00	Other current liabilities	3,219,745	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	35,301,284	0	0	0	45.00
LONG TERM LIABILITIES						
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	20,000	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	22,574,259	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	22,594,259	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	57,895,543	0	0	0	51.00
CAPITAL ACCOUNTS						
52.00	General fund balance	66,164,969				52.00
53.00	Specific purpose fund		0			53.00
54.00	Donor created - endowment fund balance - restricted			0		54.00
55.00	Donor created - endowment fund balance - unrestricted			0		55.00
56.00	Governing body created - endowment fund balance			0		56.00
57.00	Plant fund balance - invested in plant				0	57.00
58.00	Plant fund balance - reserve for plant improvement, replacement, and expansion				0	58.00
59.00	Total fund balances (sum of lines 52 thru 58)	66,164,969	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	124,060,512	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 14-0013

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

Worksheet G-1

Date/Time Prepared:
7/22/2021 3:42 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		59,184,354		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		6,727,258				2.00
3.00	Total (sum of line 1 and line 2)		65,911,612		0		3.00
4.00	Additions (credit adjustments) (specify)	0		0		0	4.00
5.00	CHANGE IN FUND BALANCE	-49,413		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)		-49,413		0		10.00
11.00	Subtotal (line 3 plus line 10)		65,862,199		0		11.00
12.00	Deductions (debit adjustments) (specify)	0		0		0	12.00
13.00	CHANGE IN TEMP OR PERM REST	-302,771		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)		-302,771		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		66,164,970		0		19.00
		Endowment Fund		Plant Fund			
		6.00	7.00	8.00			
1.00	Fund balances at beginning of period	0		0			1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)						2.00
3.00	Total (sum of line 1 and line 2)	0		0			3.00
4.00	Additions (credit adjustments) (specify)		0				4.00
5.00	CHANGE IN FUND BALANCE		0				5.00
6.00			0				6.00
7.00			0				7.00
8.00			0				8.00
9.00			0				9.00
10.00	Total additions (sum of line 4-9)	0		0			10.00
11.00	Subtotal (line 3 plus line 10)	0		0			11.00
12.00	Deductions (debit adjustments) (specify)		0				12.00
13.00	CHANGE IN TEMP OR PERM REST		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: 14-0013

Period:
From 01/01/2020
To 12/31/2020Worksheet G-2
Parts I & II
Date/Time Prepared:
7/22/2021 3:42 pm

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
PART I - PATIENT REVENUES					
General Inpatient Routine Services					
1.00	Hospital	25,989,607		25,989,607	1.00
2.00	SUBPROVIDER - IPF	8,748,207		8,748,207	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	17,329,239		17,329,239	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)	52,067,053		52,067,053	10.00
Intensive Care Type Inpatient Hospital Services					
11.00	INTENSIVE CARE UNIT	6,738,017		6,738,017	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)	6,738,017		6,738,017	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	58,805,070		58,805,070	17.00
18.00	Ancillary services	103,551,366	0	103,551,366	18.00
19.00	Outpatient services	0	401,590,714	401,590,714	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		0	0	22.00
23.00	AMBULANCE SERVICES				23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	OTHER (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)	162,356,436	401,590,714	563,947,150	28.00
PART II - OPERATING EXPENSES					
29.00	Operating expenses (per Wkst. A, column 3, line 200)		90,300,351		29.00
30.00	ADD (SPECIFY)	0			30.00
31.00		0			31.00
32.00		0			32.00
33.00		0			33.00
34.00		0			34.00
35.00		0			35.00
36.00	Total additions (sum of lines 30-35)		0		36.00
37.00	DEDUCT (SPECIFY)	0			37.00
38.00		0			38.00
39.00		0			39.00
40.00		0			40.00
41.00		0			41.00
42.00	Total deductions (sum of lines 37-41)		0		42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer to Wkst. G-3, line 4)		90,300,351		43.00

STATEMENT OF REVENUES AND EXPENSES

Provider CCN: 14-0013

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

Worksheet G-3

Date/Time Prepared:
7/22/2021 3:42 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	563,947,150	1.00
2.00	Less contractual allowances and discounts on patients' accounts	454,800,445	2.00
3.00	Net patient revenues (line 1 minus line 2)	109,146,705	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	90,300,351	4.00
5.00	Net income from service to patients (line 3 minus line 4)	18,846,354	5.00
OTHER INCOME			
6.00	Contributions, donations, bequests, etc	0	6.00
7.00	Income from investments	54,633	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	369,879	14.00
15.00	Revenue from rental of living quarters	0	15.00
16.00	Revenue from sale of medical and surgical supplies to other than patients	0	16.00
17.00	Revenue from sale of drugs to other than patients	0	17.00
18.00	Revenue from sale of medical records and abstracts	0	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	0	20.00
21.00	Rental of vending machines	0	21.00
22.00	Rental of hospital space	0	22.00
23.00	Governmental appropriations	0	23.00
24.00	OTHER PROCTOR & HOME OFFICE REVENUE	5,466,453	24.00
24.50	COVID-19 PHE Funding	2,573,815	24.50
25.00	Total other income (sum of lines 6-24)	8,464,780	25.00
26.00	Total (line 5 plus line 25)	27,311,134	26.00
27.00	PEORIA HOME OFFICE EXPENSES	20,583,876	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	20,583,876	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	6,727,258	29.00

ANALYSIS OF RENAL DIALYSIS DEPARTMENT COSTS

Provider CCN: 14-0013

Period:

Worksheet I-1

Component CCN: 14-2337

From 01/01/2020
To 12/31/2020Date/Time Prepared:
7/22/2021 3:42 pm

		Renal Dialysis			
		Total Costs	Basis	Statistics	FTEs per 2080 Hours
		1.00	2.00	3.00	4.00
1.00	REGISTERED NURSES	203,097	HOURS OF SERVICE	5,353.00	2.57
2.00	LICENSED PRACTICAL NURSES	11,064	HOURS OF SERVICE	505.00	0.24
3.00	NURSES AIDES	0	HOURS OF SERVICE	0.00	0.00
4.00	TECHNICIANS	44,501	HOURS OF SERVICE	2,870.00	1.38
5.00	SOCIAL WORKERS	657	HOURS OF SERVICE	21.00	0.01
6.00	DIETICIANS	0	HOURS OF SERVICE	0.00	0.00
7.00	PHYSICIANS	0	ACCUMULATED COST		7.00
8.00	NON-PATIENT CARE SALARY	1,305	ACCUMULATED COST		8.00
9.00	SUBTOTAL (SUM OF LINES 1-8)	260,624			9.00
10.00	EMPLOYEE BENEFITS	71,086	SALARY		10.00
11.00	CAPITAL RELATED COSTS-BLDGS. & FIXTURES	184,343	SQUARE FEET		11.00
12.00	CAPITAL RELATED COSTS-MOV. EQUIP.	25,642	PERCENTAGE OF TIME		12.00
13.00	MACHINE COSTS & REPAIRS	0	PERCENTAGE OF TIME		13.00
14.00	SUPPLIES	226,158	REQUISITIONS		14.00
15.00	DRUGS	87,828	REQUISITIONS		15.00
16.00	OTHER	40,405	ACCUMULATED COST		16.00
17.00	SUBTOTAL (SUM OF LINES 9-16)*	896,086			17.00
18.00	CAPITAL RELATED COSTS-BLDGS. & FIXTURES	8,458	SQUARE FEET		18.00
19.00	CAPITAL RELATED COSTS-MOV. EQUIP.	0	PERCENTAGE OF TIME		19.00
20.00	EMPLOYEE BENEFITS DEPARTMENT	0	SALARY		20.00
21.00	ADMINISTRATIVE & GENERAL	84,361	ACCUMULATED COST		21.00
22.00	MAINT./REPAIRS-OPER-HOUSEKEEPING	75,712	SQUARE FEET		22.00
23.00	MEDICAL EDUCATION PROGRAM COSTS	0			23.00
24.00	CENTRAL SERVICE & SUPPLIES	0	REQUISITIONS		24.00
25.00	PHARMACY	0	REQUISITIONS		25.00
26.00	OTHER ALLOCATED COSTS	39,984	ACCUMULATED COST		26.00
27.00	SUBTOTAL (SUM OF LINES 17-26)*	1,104,601			27.00
28.00	LABORATORY (SEE INSTRUCTIONS)	0	CHARGES	0	28.00
29.00	RESPIRATORY THERAPY (SEE INSTRUCTIONS)	0	CHARGES	0	29.00
30.00	ANCILLARY	0	CHARGES	0	30.00
30.01	PULMONARY FUNCTION TESTING	0	CHARGES	0	30.01
30.02	GASTRO INTESTINAL SERVICES	0	CHARGES	0	30.02
30.03	CARDIOLOGY	0	CHARGES	0	30.03
30.97	CARDIAC REHABILITATION	0	CHARGES	0	30.97
31.00	TOTAL COSTS (SUM OF LINES 27-30)	1,104,601			31.00

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

ALLOCATION OF RENAL DEPARTMENT COSTS TO TREATMENT MODALITIES

Provider CCN: 14-0013

Period:

Worksheet I-2

Component CCN: 14-2337

From 01/01/2020
To 12/31/2020Date/Time Prepared:
7/22/2021 3:42 pm

		Capital Related Costs		Direct Patient Care Salary		Renal Dialysis		
		Building	Equipment	RNs	Other	Employee Benefits Department	Drugs	
		1.00	2.00	3.00	4.00	5.00	6.00	
1.00	Total Renal Department Costs	268,513	25,642	203,097	56,222	71,086	87,828	1.00
MAINTENANCE								
2.00	Hemodialysis	85,054	8,122	64,333	17,809	22,517	27,820	2.00
2.01	AKI-Hemodialysis	0	0	0	0	0	0	2.01
3.00	Intermittent Peritoneal	0	0	0	0	0	0	3.00
3.01	AKI-Intermittent Peritoneal	0	0	0	0	0	0	3.01
TRAINING								
4.00	Hemodialysis	0	0	0	0	0	0	4.00
5.00	Intermittent Peritoneal	0	0	0	0	0	0	5.00
6.00	CAPD	0	0	0	0	0	0	6.00
7.00	CCPD	0	0	0	0	0	0	7.00
HOME								
8.00	Hemodialysis	183,459	17,520	138,764	38,413	48,569	60,008	8.00
9.00	Intermittent Peritoneal	0	0	0	0	0	0	9.00
10.00	CAPD	0	0	0	0	0	0	10.00
11.00	CCPD	0	0	0	0	0	0	11.00
OTHER BILLABLE SERVICES								
12.00	Inpatient Dialysis	0	0	0	0	0	0	12.00
13.00	Method II Home Patient	0	0	0	0	0	0	13.00
14.00	ESAs (included in Renal Department)						0	14.00
15.00								15.00
16.00	Other	0	0	0	0	0	0	16.00
17.00	Total (sum of lines 2 through 16)	268,513	25,642	203,097	56,222	71,086	87,828	17.00
18.00	Medical Educational Program Costs							18.00
19.00	Total Renal Costs (line 17 + line 18)							19.00
		Medical Supplies	Routine Ancillary Services	Subtotal (sum of cols. 1-8)	Overhead	Total (col. 9 + col. 10)		
		7.00	8.00	9.00	10.00	11.00		
1.00	Total Renal Department Costs	226,158	0	938,546	166,055	1,104,601		1.00
MAINTENANCE								
2.00	Hemodialysis	71,637	0	297,292	52,599	349,891		2.00
2.01	AKI-Hemodialysis	0	0	0	0	0		2.01
3.00	Intermittent Peritoneal	0	0	0	0	0		3.00
3.01	AKI-Intermittent Peritoneal	0	0	0	0	0		3.01
TRAINING								
4.00	Hemodialysis	0	0	0	0	0		4.00
5.00	Intermittent Peritoneal	0	0	0	0	0		5.00
6.00	CAPD	0	0	0	0	0		6.00
7.00	CCPD	0	0	0	0	0		7.00
HOME								
8.00	Hemodialysis	154,521	0	641,254	113,456	754,710		8.00
9.00	Intermittent Peritoneal	0	0	0	0	0		9.00
10.00	CAPD	0	0	0	0	0		10.00
11.00	CCPD	0	0	0	0	0		11.00
OTHER BILLABLE SERVICES								
12.00	Inpatient Dialysis	0	0	0	0	0		12.00
13.00	Method II Home Patient	0	0	0	0	0		13.00
14.00	ESAs (included in Renal Department)							14.00
15.00								15.00
16.00	Other	0	0	0	0	0		16.00
17.00	Total (sum of lines 2 through 16)	226,158	0	938,546	166,055	1,104,601		17.00
18.00	Medical Educational Program Costs					0		18.00
19.00	Total Renal Costs (line 17 + line 18)					1,104,601		19.00

DIRECT AND INDIRECT RENAL DIALYSIS COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0013
Component CCN: 14-2337Period:
From 01/01/2020
To 12/31/2020Worksheet I-3
Date/Time Prepared:
7/22/2021 3:42 pm

		Capital Related Costs		Direct Patient Care Salary		Renal Dialysis	
		Building (Square Feet)	Equipment (%) of Time)	RNs (Hours)	Other (Hours)	Employee Benefits Department (Salary)	
		0	1.00	2.00	3.00	4.00	5.00
1.00	Total Renal Department Costs	268,513	25,642	203,097	56,222	71,086	1.00
MAINTENANCE							
2.00	Hemodialysis	85,054	8,122.00	64,333.00	17,809.00	22,517	2.00
2.01	AKI-Hemodialysis	0	0.00	0.00	0.00	0	2.01
3.00	Intermittent Peritoneal	0	0.00	0.00	0.00	0	3.00
3.01	AKI-Intermittent Peritoneal	0	0.00	0.00	0.00	0	3.01
TRAINING							
4.00	Hemodialysis	0	0.00	0.00	0.00	0	4.00
5.00	Intermittent Peritoneal	0	0.00	0.00	0.00	0	5.00
6.00	CAPD	0	0.00	0.00	0.00	0	6.00
7.00	CCPD	0	0.00	0.00	0.00	0	7.00
HOME							
8.00	Hemodialysis	183,459	17,520.00	138,764.00	38,413.00	48,569	8.00
9.00	Intermittent Peritoneal	0	0.00	0.00	0.00	0	9.00
10.00	CAPD	0	0.00	0.00	0.00	0	10.00
11.00	CCPD	0	0.00	0.00	0.00	0	11.00
OTHER BILLABLE SERVICES							
12.00	Inpatient Dialysis Treatments	0	0.00	0.00	0.00	0	12.00
13.00	Method II Home Patient	0	0.00	0.00	0.00	0	13.00
14.00	ESAs						14.00
15.00							15.00
16.00	Other	0	0.00	0.00	0.00	0	16.00
17.00	Total Statistical Basis	268,513	25,642.00	203,097.00	56,222.00	71,086	17.00
18.00	Unit Cost Multiplier (line 1 ÷ line 17)	1.000000	1.000000	1.000000	1.000000	1.000000	18.00
		Drugs (Requist.)	Medical Supplies (Requist.)	Routine Ancillary Services (Charges)	Subtotal	Overhead (Accum. Cost)	
		6.00	7.00	8.00	9.00	10.00	
1.00	Total Renal Department Costs	87,828	226,158	0	938,546	166,055	1.00
MAINTENANCE							
2.00	Hemodialysis	27,820	71,637	0			2.00
2.01	AKI-Hemodialysis	0	0	0			2.01
3.00	Intermittent Peritoneal	0	0	0			3.00
3.01	AKI-Intermittent Peritoneal	0	0	0			3.01
TRAINING							
4.00	Hemodialysis	0	0	0			4.00
5.00	Intermittent Peritoneal	0	0	0			5.00
6.00	CAPD	0	0	0			6.00
7.00	CCPD	0	0	0			7.00
HOME							
8.00	Hemodialysis	60,008	154,521	0			8.00
9.00	Intermittent Peritoneal	0	0	0			9.00
10.00	CAPD	0	0	0			10.00
11.00	CCPD	0	0	0			11.00
OTHER BILLABLE SERVICES							
12.00	Inpatient Dialysis Treatments	0	0	0			12.00
13.00	Method II Home Patient	0	0	0			13.00
14.00	ESAs						14.00
15.00							15.00
16.00	Other	0	0	0			16.00
17.00	Total Statistical Basis	87,828	226,158	0		938,546	17.00
18.00	Unit Cost Multiplier (line 1 ÷ line 17)	1.000000	1.000000	0.000000		0.176928	18.00

COMPUTATION OF AVERAGE COST PER TREATMENT FOR OUTPATIENT RENAL DIALYSIS

Provider CCN: 14-0013
Component CCN: 14-2337Period:
From 01/01/2020
To 12/31/2020Worksheet I-4
Date/Time Prepared:
7/22/2021 3:42 pm

		Rate 0		Renal Dialysis		7/22/2022 3:42 pm	
		Number of Total Treatments	Total Cost (from Wkst. I-2, col. 11)	Average Cost of Treatments (col. 2 ÷ col. 1)	Number of Program Treatments	Total Program Expenses (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
1.00	Maintenance - Hemodialysis	64	349,891	5,467.05	53	289,754	1.00
2.00	Maintenance - Peritoneal Dialysis	0	0	0.00	0	0	2.00
3.00	Training - Hemodialysis	0	0	0.00	0	0	3.00
4.00	Training - Peritoneal Dialysis	0	0	0.00	0	0	4.00
5.00	Training - CAPD	0	0	0.00	0	0	5.00
6.00	Training - CCPD	0	0	0.00	0	0	6.00
7.00	Home Program - Hemodialysis	1,576	754,710	478.88	1,312	628,291	7.00
8.00	Home Program - Peritoneal Dialysis	0	0	0.00	0	0	8.00
		Patient Weeks			Patient Weeks		
		1.00	2.00	3.00	4.00	5.00	
9.00	Home Program - CAPD	0	0	0.00	0	0	9.00
10.00	Home Program - CCPD	0	0	0.00	0	0	10.00
11.00	Totals (sum of lines 1 through 8, cols. 1 and 4) (sum of lines 1 through 10, cols. 2, 5, and 6) (see instruction)	1,640	1,104,601		1,365	918,045	11.00
12.00	Total treatments (sum of lines 1 through 8 plus (sum of lines 9 and 10 times 3)) (see instruction)	1,640					12.00
ADDITIONAL RENAL FACILITY NUMBERS							
20.00	PROCTOR HOSPITAL	142338					20.00
		Total Program Payment	Average Payment Rate (col. 6 ÷ col. 4)				
		6.00	7.00				
1.00	Maintenance - Hemodialysis	128,473	2,424.02				
2.00	Maintenance - Peritoneal Dialysis	0	0.00				
3.00	Training - Hemodialysis	0	0.00				
4.00	Training - Peritoneal Dialysis	0	0.00				
5.00	Training - CAPD	0	0.00				
6.00	Training - CCPD	0	0.00				
7.00	Home Program - Hemodialysis	277,115	211.22				
8.00	Home Program - Peritoneal Dialysis	0	0.00				
		6.00	7.00				
9.00	Home Program - CAPD	0	0.00				
10.00	Home Program - CCPD	0	0.00				
11.00	Totals (sum of lines 1 through 8, cols. 1 and 4) (sum of lines 1 through 10, cols. 2, 5, and 6) (see instruction)	405,588					
12.00	Total treatments (sum of lines 1 through 8 plus (sum of lines 9 and 10 times 3)) (see instruction)						
ADDITIONAL RENAL FACILITY NUMBERS							
20.00	PROCTOR HOSPITAL						20.00

CALCULATION OF REIMBURSABLE BAD DEBTS - TITLE XVIII - PART B		Provider CCN: 14-0013	Period: From 01/01/2020 To 12/31/2020	Worksheet I-5 Date/Time Prepared: 7/22/2021 3:42 pm
		1.00	2.00	
PART I - CALCULATION OF REIMBURSABLE BAD DEBTS - TITLE XVIII - PART B				
1.00	Total expenses related to care of program beneficiaries (see instructions)	918,045		1.00
2.00	Total payment due (from Wkst. I-4, col. 6, line 11) (see instructions)	405,588	405,588	2.00
2.01	Total payment due (from Wkst. I-4, col. 6.01, line 11) (see instructions)			2.01
2.02	Total payment due (from Wkst. I-4, col. 6.02, line 11) (see instructions)			2.02
2.03	Total payment due (see instructions)	405,588	405,588	2.03
2.04	Outlier payments	0		2.04
3.00	Deductibles billed to Medicare (Part B) patients (see instructions)	0	0	3.00
3.01	Deductibles billed to Medicare (Part B) patients (see instructions)			3.01
3.02	Deductibles billed to Medicare (Part B) patients (see instructions)			3.02
3.03	Total deductibles billed to Medicare (Part B) patients (see instructions)	0	0	3.03
4.00	Coinsurance billed to Medicare (Part B) patients	0	0	4.00
4.01	Coinsurance billed to Medicare (Part B) patients (see instructions)			4.01
4.02	Coinsurance billed to Medicare (Part B) patients (see instructions)			4.02
4.03	Total coinsurance billed to Medicare (Part B) patients (see instructions)	0	0	4.03
5.00	Bad debts for deductibles and coinsurance, net of bad debt recoveries	0	0	5.00
5.01	Transition period 1 (75-25%) bad debts for deductibles and coinsurance net of bad debt recoveries for services rendered on or after 1/1/2011 but before 1/1/2012	0	0	5.01
5.02	Transition period 2 (50-50%) bad debts for deductibles and coinsurance net of bad debt recoveries for services rendered on or after 1/1/2012 but before 1/1/2013	0	0	5.02
5.03	Transition period 3 (25-75%) bad debts for deductibles and coinsurance net of bad debt recoveries for services rendered on or after 1/1/2013 but before 1/1/2014	0	0	5.03
5.04	100% PPS bad debts for deductibles and coinsurance net of bad debt recoveries for services rendered on or after 1/1/2014	0	0	5.04
5.05	Allowable bad debts (sum of lines 5 through line 5.04)	0	0	5.05
6.00	Adjusted reimbursable bad debts (see instructions)	0		6.00
7.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	0		7.00
8.00	Net deductibles and coinsurance billed to Medicare (Part B) patients (see instructions)	0	0	8.00
9.00	Program payment (see instructions)	0	324,470	9.00
10.00	Unrecovered from Medicare (Part B) patients (see instructions)			10.00
11.00	Reimbursable bad debts (see instructions) (transfer to Worksheet E, Part B, line 33)	0		11.00
PART II - CALCULATION OF FACILITY SPECIFIC COMPOSITE COST PERCENTAGE				
12.00	Total allowable expenses (see instructions)	1,104,601		12.00
13.00	Total composite costs (from Wkst. I-4, col. 2, line 11)	1,104,601		13.00
14.00	Facility specific composite cost percentage (line 13 divided by line 12)	1.000000		14.00

CALCULATION OF CAPITAL PAYMENT		Provider CCN: 14-0013	Period: From 01/01/2020 To 12/31/2020	Worksheet L Parts I-III Date/Time Prepared: 7/22/2021 3:42 pm
		Title XVIII	Hospital	PPS
		1.00		
PART I - FULLY PROSPECTIVE METHOD				
CAPITAL FEDERAL AMOUNT				
1.00	Capital DRG other than outlier		721,047	1.00
1.01	Model 4 BPCI Capital DRG other than outlier		0	1.01
2.00	Capital DRG outlier payments		1,756	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)		27.87	3.00
4.00	Number of interns & residents (see instructions)		0.00	4.00
5.00	Indirect medical education percentage (see instructions)		0.00	5.00
6.00	Indirect medical education adjustment (multiply line 5 by the sum of lines 1 and 1.01, columns 1 and 1.01)(see instructions)		0	6.00
7.00	Percentage of SSI recipient patient days to Medicare Part A patient days (Worksheet E, part A line 30) (see instructions)		0.00	7.00
8.00	Percentage of Medicaid patient days to total days (see instructions)		6.67	8.00
9.00	Sum of lines 7 and 8		6.67	9.00
10.00	Allowable disproportionate share percentage (see instructions)		1.36	10.00
11.00	Disproportionate share adjustment (see instructions)		9,806	11.00
12.00	Total prospective capital payments (see instructions)		732,609	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