

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: 14-0034	Period: From 01/01/2020 To 12/31/2020	Worksheet S Parts I-III Date/Time Prepared: 7/28/2021 12:17 pm
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PART I - COST REPORT STATUS

Provider use only	1. ☒ Electronically prepared cost report	Date: 7/28/2021	Time: 12:17 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 SSM HEALTH ST. MARY'S HOSPITAL (14-0034) 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) EILEEN LAMM
Officer or Administrator of Provider(s)

REG VP-FINANCE
Title

(Dated when report is electronically signed.)
Date

Cost Center Description		Title V	Title XVIII		HIT	Title XIX	
			Part A	Part B			
		1.00	2.00	3.00	4.00	5.00	
	PART III - SETTLEMENT SUMMARY						
1.00	Hospital	0	370,272	263,470	0	0	1.00
2.00	Subprovider - IPF	0	38,281	135		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
12.30	OOT I	0		0		0	12.30
200.00	Total	0	408,553	263,605	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: 14-0034		Period: From 01/01/2020 To 12/31/2020		Worksheet S-2 Part I Date/Time Prepared: 7/28/2021 12:17 pm	
1.00		2.00		3.00		4.00			
Hospital and Hospital Health Care Complex Address:									
1.00	Street: 400 NORTH PLEASANT AVENUE			PO Box:				1.00	
2.00	City: CENTRALIA			State: IL		Zip Code: 62801-		County: MARION 2.00	
		Component Name		CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N)	
								V	XVIII
								XIX	
Hospital and Hospital-Based Component Identification:									
3.00	Hospital			SSM HEALTH ST. MARY'S HOSPITAL	140034	99914	1	07/01/1966	N P P
4.00	Subprovider - IPF			SSM HEALTH ST. MARYS PSYCH	14S034	99914	4	01/01/2002	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								
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								
17.30	Hospital-Based (OOT) I			ST MARYS WORK SAFETY INSTITUTE	146668	99914		03/08/2000	N O N
18.00	Renal Dialysis								
19.00	Other								
							From:	To:	
							1.00	2.00	
20.00	Cost Reporting Period (mm/dd/yyyy)						01/01/2020	12/31/2020	20.00
21.00	Type of Control (see instructions)						1		21.00
							1.00	2.00	3.00
Inpatient PPS Information									
22.00	Does this facility qualify and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.106(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no.					Y	N		22.00
22.01	Did this hospital receive interim uncompensated care payments for this cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)					Y	Y		22.01
22.02	Is this a newly merged hospital that requires final uncompensated care payments to be determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1.					N	N		22.02
22.03	Did this hospital receive a geographic reclassification from urban to rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no.					N	N	N	22.03
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.					3	N		23.00

Worksheet S-2
Part I
Date/Time Prepared:
7/28/2021 12:17 pm

MCRIF32 - 16.10.172.3

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-0034		Period: From 01/01/2020 To 12/31/2020		Worksheet S-2 Part I Date/Time Prepared: 7/28/2021 12:17 pm	
		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
		Y/N	IME	Direct GME	IME	Direct GME	
		1.00	2.00	3.00	4.00	5.00	
61.00	Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions)	N			0.00	0.00	61.00
61.01	Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions)						61.01
61.02	Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions)						61.02
61.03	Enter the base line FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions)						61.03
61.04	Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period.(see instructions).						61.04
61.05	Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions)						61.05
61.06	Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)						61.06
		Program Name		Program Code	Unweighted IME FTE Count	Unweighted Direct GME FTE Count	
		1.00		2.00	3.00	4.00	
61.10	Of the FTEs in line 61.05, specify each new program specialty, if any, and the number of FTE residents for each new program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count.				0.00	0.00	61.10
61.20	Of the FTEs in line 61.05, specify each expanded program specialty, if any, and the number of FTE residents for each expanded program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count.				0.00	0.00	61.20
						1.00	
ACA Provisions Affecting the Health Resources and Services Administration (HRSA)							
62.00	Enter the number of FTE residents that your hospital trained in this cost reporting period for which your hospital received HRSA PCRE funding (see instructions)					0.00	62.00
62.01	Enter the number of FTE residents that rotated from a Teaching Health Center (THC) into your hospital during in this cost reporting period of HRSA THC program. (see instructions)					0.00	62.01
Teaching Hospitals that Claim Residents in Nonprovider Settings							
63.00	Has your facility trained residents in nonprovider settings during this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If yes, complete lines 64 through 67. (see instructions)					N	63.00
		Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))			
		1.00	2.00	3.00			
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	

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

Provider CCN: 14-0034

Period:
From 01/01/2020
To 12/31/2020Worksheet S-2
Part I
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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	
66.00	Section 5504 of the ACA Current Year FTE Residents in Nonprovider Settings--Effective for cost reporting periods beginning on or after July 1, 2010					
	Enter in column 1 the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)		0.00	0.00	0.000000	66.00
	Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))	
	1.00	2.00	3.00	4.00	5.00	
67.00	Enter in column 1, the program name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)		0.00	0.00	0.000000	67.00
			1.00	2.00	3.00	
70.00	Inpatient Psychiatric Facility PPS					
	Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? Enter "Y" for yes or "N" for no.	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

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			1.00		
Long Term Care Hospital PPS					
80.00	Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for no.	N		80.00	
81.00	Is this a LTCH co-located within another hospital for part or all of the cost reporting period? Enter "Y" for yes and "N" for no.	N		81.00	
TEFRA Providers					
85.00	Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no.	N		85.00	
86.00	Did this facility establish a new Other subprovider (excluded unit) under 42 CFR Section §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.			86.00	
87.00	Is this hospital an extended neoplastic disease care hospital classified under section 1886(d)(1)(B)(vi)? Enter "Y" for yes or "N" for no.	N		87.00	
		V	XIX		
		1.00	2.00		
Title V and XIX Services					
90.00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.	N	Y	90.00	
91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.	N	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)			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	110.00

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		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.	Y		116.00
117.00	Is this facility legally required to carry malpractice insurance? Enter "Y" for yes or "N" for no.	Y		117.00
118.00	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.	1		118.00
		Premiums	Losses	Insurance
		1.00	2.00	3.00
118.01	List amounts of malpractice premiums and paid losses:	51,150	8,268	0118.01
		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	Y	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	269020	140.00

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1.00		2.00		3.00					
If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number.									
141.00	Name: SSM HEALTH	Contractor's Name: A		Contractor's Number: 05301				141.00	
142.00	Street: 10101 WOODFIELD LANE	PO Box:						142.00	
143.00	City: ST. LOUIS	State: MO		Zip Code: 63132				143.00	
								1.00	
144.00	Are provider based physicians' costs included in Worksheet A?							Y	144.00
								1.00	2.00
145.00	If costs for renal services are claimed on Wkst. A, line 74, are the costs for inpatient services only? Enter "Y" for yes or "N" for no in column 1. If column 1 is no, does the dialysis facility include Medicare utilization for this cost reporting period? Enter "Y" for yes or "N" for no in column 2.							Y	145.00
146.00	Has the cost allocation methodology changed from the previously filed cost report? Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, chapter 40, §4020) If yes, enter the approval date (mm/dd/yyyy) in column 2.							Y	11/11/2019 146.00
								1.00	
147.00	Was there a change in the statistical basis? Enter "Y" for yes or "N" for no.							Y	147.00
148.00	Was there a change in the order of allocation? Enter "Y" for yes or "N" for no.							N	148.00
149.00	Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no.							N	149.00
				Part A	Part B	Title V	Title XIX		
				1.00	2.00	3.00	4.00		
Does this facility contain a provider that qualifies for an exemption from the application of the lower of costs or charges? Enter "Y" for yes or "N" for no for each component for Part A and Part B. (See 42 CFR §413.13)									
155.00	Hospital	N	N	N	N	N	N	155.00	
156.00	Subprovider - IPF	N	N	N	N	N	N	156.00	
157.00	Subprovider - IRF	N	N	N	N	N	N	157.00	
158.00	SUBPROVIDER							158.00	
159.00	SNF	N	N	N	N	N	N	159.00	
160.00	HOME HEALTH AGENCY	N	N	N	N	N	N	160.00	
161.00	CMHC		N	N	N	N	N	161.00	
161.01			N	N	N	N	N	161.01	
161.30	OOT		N	N	N	N	N	161.30	
								1.00	
Multicampus									
165.00	Is this hospital part of a Multicampus hospital that has one or more campuses in different CBSAs? Enter "Y" for yes or "N" for no.							N	165.00
		Name	County	State	Zip Code	CBSA	FTE/Campus		
		0	1.00	2.00	3.00	4.00	5.00		
166.00	If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions)						0.00	166.00	
								1.00	
Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act									
167.00	Is this provider a meaningful user under §1886(n)? Enter "Y" for yes or "N" for no.							Y	167.00
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)								168.00
168.01	If this provider is a CAH and is not a meaningful user, does this provider qualify for a hardship exception under §413.70(a)(6)(ii)? Enter "Y" for yes or "N" for no. (see instructions)								168.01
169.00	If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)							9.99	169.00
						Beginning	Ending		
						1.00	2.00		
170.00	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)								170.00
						1.00	2.00		
171.00	If line 167 is "Y", does this provider have any days for individuals enrolled in section 1876 Medicare cost plans reported on Wkst. S-3, Pt. I, line 2, col. 6? Enter "Y" for yes and "N" for no in column 1. If column 1 is yes, enter the number of section 1876 Medicare days in column 2. (see instructions)							N	0 171.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 14-0034	Period: From 01/01/2020 To 12/31/2020	Worksheet S-2 Part II Date/Time Prepared: 7/28/2021 12:17 pm
			Y/N 1.00	Date 2.00
General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format.				
COMPLETED BY ALL HOSPITALS				
Provider Organization and Operation				
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)	N		1.00
		Y/N 1.00	Date 2.00	V/I 3.00
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.	N		2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)	Y		3.00
		Y/N 1.00	Type 2.00	Date 3.00
Financial Data and Reports				
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	Y	A	4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.	N		5.00
			Y/N 1.00	Legal Oper. 2.00
Approved Educational Activities				
6.00	Column 1: Are costs claimed for nursing school? Column 2: If yes, is the provider is the legal operator of the program?	N		6.00
7.00	Are costs claimed for Allied Health Programs? If "Y" see instructions.	N		7.00
8.00	Were nursing school and/or allied health programs approved and/or renewed during the cost reporting period? If yes, see instructions.	N		8.00
9.00	Are costs claimed for Interns and Residents in an approved graduate medical education program in the current cost report? If yes, see instructions.	N		9.00
10.00	Was an approved Intern and Resident GME program initiated or renewed in the current cost reporting period? If yes, see instructions.	N		10.00
11.00	Are GME cost directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions.	N		11.00
			Y/N 1.00	
Bad Debts				
12.00	Is the provider seeking reimbursement for bad debts? If yes, see instructions.	Y		12.00
13.00	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.	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	04/03/2017	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: 14-0034

Period:
From 01/01/2020
To 12/31/2020Worksheet S-2
Part II
Date/Time Prepared:
7/28/2021 12:17 pm

		Description	Y/N	Y/N	
		0	1.00	3.00	
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:		N	N	20.00
		Y/N	Date	Y/N	Date
		1.00	2.00	3.00	4.00
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		N	21.00
				1.00	
COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)					
Capital Related Cost					
22.00	Have assets been 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.		Y		39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.		N		40.00
		1.00	2.00		
Cost Report Preparer Contact Information					
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	ERIC	LAMOND		41.00
42.00	Enter the employer/company name of the cost report preparer.	SSM HEALTH			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	314-989-3162	ERIC.LAMOND@SSMHEALTH.COM		43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE

Provider CCN: 14-0034

Period:
From 01/01/2020
To 12/31/2020Worksheet S-2
Part II
Date/Time Prepared:
7/28/2021 12:17 pm

		3.00	
Cost Report Preparer Contact Information			
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	MANAGER - GVERNEMENT REIMBURSEMENT	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: 14-0034

Period:
From 01/01/2020
To 12/31/2020Worksheet S-3
Part I
Date/Time Prepared:
7/28/2021 12:17 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	84	30,744	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)		84	30,744	0.00	0	7.00
8.00 INTENSIVE CARE UNIT	31.00	8	2,928	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)		92	33,672	0.00	0	14.00
15.00 CAH visits					0	15.00
16.00 SUBPROVIDER - IPF	40.00	24	8,784		0	16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY						22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
24.10 HOSPICE (non-distinct part)	30.00					24.10
25.00 CMHC - CMHC						25.00
25.30 CMHC - OOT	99.30				0	25.30
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)		116				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: 14-0034

Period:
From 01/01/2020
To 12/31/2020Worksheet S-3
Part I
Date/Time Prepared:
7/28/2021 12:17 pm

Component		I/P Days / O/P Visits / Trips			Full Time Equivalents		
		Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
		6.00	7.00	8.00	9.00	10.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	6,497	240	9,592			1.00
2.00	HMO and other (see instructions)	844	2,057				2.00
3.00	HMO IPF Subprovider	36	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)	6,497	240	9,592			7.00
8.00	INTENSIVE CARE UNIT	921	64	1,395			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		95	490			13.00
14.00	Total (see instructions)	7,418	399	11,477	0.00	498.00	14.00
15.00	CAH visits	0	0	0			15.00
16.00	SUBPROVIDER - IPF	1,219	456	5,152	0.00	33.00	16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)			0			24.10
25.00	CMHC - CMHC						25.00
25.30	CMHC - OOT	0	0	0	0.00	0.00	25.30
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	531.00	27.00
28.00	Observation Bed Days		53	1,909			28.00
29.00	Ambulance Trips	0					29.00
30.00	Employee discount days (see instruction)			124			30.00
31.00	Employee discount days - IRF			0			31.00
32.00	Labor & delivery days (see instructions)	0	105	118			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: 14-0034

Period:
From 01/01/2020
To 12/31/2020Worksheet S-3
Part I
Date/Time Prepared:
7/28/2021 12:17 pm

Component	Full Time Equivalents	Discharges			Total All Patients	
	Nonpaid Workers	Title V	Title XVIII	Title XIX		
	11.00	12.00	13.00	14.00	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	1,550	134	4,357	1.00
2.00 HMO and other (see instructions)			174	853		2.00
3.00 HMO IPF Subprovider				445		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	1,550	134	4,357	14.00
15.00 CAH visits						15.00
16.00 SUBPROVIDER - IPF	0.00	0	144	95	971	16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY						22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
24.10 HOSPICE (non-distinct part)						24.10
25.00 CMHC - CMHC						25.00
25.30 CMHC - OOT	0.00					25.30
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: 14-0034

Period:
From 01/01/2020
To 12/31/2020Worksheet S-3
Part II
Date/Time Prepared:
7/28/2021 12:17 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	33,178,390	0	33,178,390	942,561.00	35.20
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		214,160	0	214,160	1,788.00	119.78
4.01	Physicians - Part A - Teaching		0	0	0	0.00	0.00
5.00	Physician and Non Physician-Part B		0	0	0	0.00	0.00
6.00	Non-physician-Part B for hospital-based RHC and FQHC services		0	0	0	0.00	0.00
7.00	Interns & residents (in an approved program)	21.00	0	0	0	0.00	0.00
7.01	Contracted interns and residents (in an approved programs)		0	0	0	0.00	0.00
8.00	Home office and/or related organization personnel		0	0	0	0.00	0.00
9.00	SNF	44.00	0	0	0	0.00	0.00
10.00	Excluded area salaries (see instructions)		2,418,895	-2,826	2,416,069	62,725.00	38.52
OTHER WAGES & RELATED COSTS							
11.00	Contract labor: Direct Patient Care		971,225	0	971,225	9,491.00	102.33
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		122,880	0	122,880	636.00	193.21
14.00	Home office and/or related organization salaries and wage-related costs		0	0	0	0.00	0.00
14.01	Home office salaries		8,387,570	0	8,387,570	109,827.00	76.37
14.02	Related organization salaries		0	0	0	0.00	0.00
15.00	Home office: Physician Part A - Administrative		0	0	0	0.00	0.00
16.00	Home office and Contract Physicians Part A - Teaching		0	0	0	0.00	0.00
16.01	Home office Physicians Part A - Teaching		0	0	0	0.00	0.00
16.02	Home office contract Physicians Part A - Teaching		0	0	0	0.00	0.00
WAGE-RELATED COSTS							
17.00	Wage-related costs (core) (see instructions)		14,372,115	0	14,372,115		
18.00	Wage-related costs (other) (see instructions)						
19.00	Excluded areas		1,042,303	0	1,042,303		
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		24,812	0	24,812		
22.01	Physician Part A - Teaching		0	0	0		
23.00	Physician Part B		0	0	0		
24.00	Wage-related costs (RHC/FQHC)		0	0	0		
25.00	Interns & residents (in an approved program)		0	0	0		
25.50	Home office wage-related (core)		3,130,826	0	3,130,826		
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: 14-0034

Period:
From 01/01/2020
To 12/31/2020Worksheet S-3
Part II
Date/Time Prepared:
7/28/2021 12:17 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	650,796	0	650,796	3,002.00	216.79	26.00
27.00	Administrative & General	5.00	3,221,145	0	3,221,145	91,192.00	35.32	27.00
28.00	Administrative & General under contract (see inst.)		2,901,300	0	2,901,300	23,471.00	123.61	28.00
29.00	Maintenance & Repairs	6.00	0	0	0	0.00	0.00	29.00
30.00	Operation of Plant	7.00	758,974	0	758,974	25,924.00	29.28	30.00
31.00	Laundry & Linen Service	8.00	83,517	0	83,517	5,240.00	15.94	31.00
32.00	Housekeeping	9.00	927,056	0	927,056	62,084.00	14.93	32.00
33.00	Housekeeping under contract (see instructions)		0	0	0	0.00	0.00	33.00
34.00	Dietary	10.00	652,058	-457,549	194,509	25,942.00	7.50	34.00
35.00	Dietary under contract (see instructions)		0	0	0	0.00	0.00	35.00
36.00	Cafeteria	11.00	0	457,549	457,549	13,154.00	34.78	36.00
37.00	Maintenance of Personnel	12.00	0	0	0	0.00	0.00	37.00
38.00	Nursing Administration	13.00	895,352	0	895,352	18,960.00	47.22	38.00
39.00	Central Services and Supply	14.00	235,331	0	235,331	11,540.00	20.39	39.00
40.00	Pharmacy	15.00	1,169,037	0	1,169,037	28,035.00	41.70	40.00
41.00	Medical Records & Medical Records Library	16.00	162,667	0	162,667	9,716.00	16.74	41.00
42.00	Social Service	17.00	590,207	0	590,207	18,415.00	32.05	42.00
43.00	Other General Service	18.00	0	0	0	0.00	0.00	43.00

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 14-0034

Period:
From 01/01/2020
To 12/31/2020Worksheet S-3
Part III
Date/Time Prepared:
7/28/2021 12:17 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)	36,079,690	0	36,079,690	966,032.00	37.35	1.00
2.00	Excluded area salaries (see instructions)	2,418,895	-2,826	2,416,069	62,725.00	38.52	2.00
3.00	Subtotal salaries (line 1 minus line 2)	33,660,795	2,826	33,663,621	903,307.00	37.27	3.00
4.00	Subtotal other wages & related costs (see inst.)	9,481,675	0	9,481,675	119,954.00	79.04	4.00
5.00	Subtotal wage-related costs (see inst.)	17,527,753	0	17,527,753	0.00	52.07	5.00
6.00	Total (sum of lines 3 thru 5)	60,670,223	2,826	60,673,049	1,023,261.00	59.29	6.00
7.00	Total overhead cost (see instructions)	12,247,440	0	12,247,440	336,675.00	36.38	7.00

HOSPITAL WAGE RELATED COSTS		Provider CCN: 14-0034	Period: From 01/01/2020 To 12/31/2020	Worksheet S-3 Part IV Date/Time Prepared: 7/28/2021 12:17 pm
				Amount Reported
				1.00
PART IV - WAGE RELATED COSTS				
Part A - Core List				
RETIREMENT COST				
1.00	401K Employer Contributions			0 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)			0 4.00
PLAN ADMINISTRATIVE COSTS (Paid to External Organization)				
5.00	401K/TSA Plan Administration fees			0 5.00
6.00	Legal/Accounting/Management Fees-Pension Plan			0 6.00
7.00	Employee Managed Care Program Administration Fees			0 7.00
HEALTH AND INSURANCE COST				
8.00	Health Insurance (Purchased or Self Funded)			0 8.00
8.01	Health Insurance (Self Funded without a Third Party Administrator)	10,654,291		8.01
8.02	Health Insurance (Self Funded with a Third Party Administrator)			0 8.02
8.03	Health Insurance (Purchased)			0 8.03
9.00	Prescription Drug Plan			0 9.00
10.00	Dental, Hearing and Vision Plan			0 10.00
11.00	Life Insurance (If employee is owner or beneficiary)			0 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)			0 13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)			0 14.00
15.00	'Workers' Compensation Insurance			0 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	2,397,483		17.00
18.00	Medicare Taxes - Employers Portion Only			0 18.00
19.00	Unemployment Insurance	45,445		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))	2,325,715		21.00
22.00	Day Care Cost and Allowances	65,920		22.00
23.00	Tuition Reimbursement			0 23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)	15,488,854		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: 14-0034

Period:
From 01/01/2020
To 12/31/2020Worksheet S-3
Part V
Date/Time Prepared:
7/28/2021 12:17 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	971,225	15,488,854	1.00
2.00	Hospital	971,225	14,446,551	2.00
3.00	Subprovider - IPF	0	68,087	3.00
4.00	Subprovider - IRF			4.00
5.00	Subprovider - (Other)	0	0	5.00
6.00	Swing Beds - SNF	0	0	6.00
7.00	Swing Beds - NF	0	0	7.00
8.00	Hospital-Based SNF			8.00
9.00	Hospital-Based NF			9.00
10.00	Hospital-Based OLTC			10.00
11.00	Hospital-Based HHA			11.00
12.00	Separately Certified ASC			12.00
13.00	Hospital-Based Hospice			13.00
14.00	Hospital-Based Health Clinic RHC			14.00
15.00	Hospital-Based Health Clinic FQHC			15.00
16.00	Hospital-Based-CMHC			16.00
16.30	Hospital-Based-CMHC 30	0	0	16.30
17.00	Renal Dialysis	0	0	17.00
18.00	Other	0	974,216	18.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA

Provider CCN: 14-0034

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

Worksheet S-10

Date/Time Prepared:
7/28/2021 12:17 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)		0.255196	1.00
Medicaid (see instructions for each line)				
2.00	Net revenue from Medicaid		0	2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?			3.00
4.00	If line 3 is yes, does line 2 include all DSH and/or supplemental payments from Medicaid?			4.00
5.00	If line 4 is no, then enter DSH and/or supplemental payments from Medicaid		0	5.00
6.00	Medicaid charges		0	6.00
7.00	Medicaid cost (line 1 times line 6)		0	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)		0	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)		0	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)	2,618,130	1,277,305	3,895,435
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	668,136	1,277,305	1,945,441
22.00	Payments received from patients for amounts previously written off as charity care	0	0	0
23.00	Cost of charity care (line 21 minus line 22)	668,136	1,277,305	1,945,441
			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)		1,799,705	26.00
27.00	Medicare reimbursable bad debts for the entire hospital complex (see instructions)		695,551	27.00
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)		1,070,077	27.01
28.00	Non-Medicare bad debt expense (see instructions)		729,628	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)		560,724	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)		2,506,165	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)		2,506,165	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-0034

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

Worksheet A

Date/Time Prepared:
7/28/2021 12:17 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		3,616,931	3,616,931	170,468	3,787,399	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		2,484,510	2,484,510	0	2,484,510	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	650,796	13,026,143	13,676,939	0	13,676,939	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	3,221,145	18,299,313	21,520,458	-252,483	21,267,975	5.00
7.00	00700	OPERATION OF PLANT	758,974	3,298,050	4,057,024	215,973	4,272,997	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	83,517	281,206	364,723	-3,575	361,148	8.00
9.00	00900	HOUSEKEEPING	927,056	381,694	1,308,750	-116,797	1,191,953	9.00
10.00	01000	DIETARY	652,058	821,209	1,473,267	-1,029,413	443,854	10.00
11.00	01100	CAFETERIA	0	0	0	1,024,305	1,024,305	11.00
13.00	01300	NURSING ADMINISTRATION	895,352	277,960	1,173,312	0	1,173,312	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	235,331	233,114	468,445	-108,399	360,046	14.00
15.00	01500	PHARMACY	1,169,037	4,627,212	5,796,249	-4,295,012	1,501,237	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	162,667	90,474	253,141	0	253,141	16.00
17.00	01700	SOCIAL SERVICE	590,207	210,130	800,337	-2,322	798,015	17.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	5,430,275	1,216,543	6,646,818	528,991	7,175,809	30.00
31.00	03100	INTENSIVE CARE UNIT	1,877,098	848,900	2,725,998	-811,131	1,914,867	31.00
40.00	04000	SUBPROVIDER - IPF	2,156,095	254,588	2,410,683	-19,290	2,391,393	40.00
43.00	04300	NURSERY	0	0	0	232,314	232,314	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	1,803,732	2,721,985	4,525,717	-1,919,954	2,605,763	50.00
51.00	05100	RECOVERY ROOM	189,132	88,600	277,732	-8,846	268,886	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,139,012	242,836	1,381,848	-527,204	854,644	52.00
53.00	05300	ANESTHESIOLOGY	8,674	3,090,083	3,098,757	-109,221	2,989,536	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,190,636	238,277	1,428,913	-49,110	1,379,803	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	569,781	837,924	1,407,705	-2,269	1,405,436	55.00
56.00	05600	RADIOISOTOPE	121,430	264,321	385,751	-2,404	383,347	56.00
57.00	05700	CT SCAN	267,384	95,944	363,328	-42,407	320,921	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	97,542	32,732	130,274	-6,626	123,648	58.00
59.00	05900	CARDIAC CATHETERIZATION	57,672	112,255	169,927	-94,207	75,720	59.00
60.00	06000	LABORATORY	1,456,654	2,516,397	3,973,051	-57,561	3,915,490	60.00
64.00	06400	INTRAVENOUS THERAPY	304,384	75,092	379,476	-38,793	340,683	64.00
65.00	06500	RESPIRATORY THERAPY	1,022,548	281,186	1,303,734	-70,179	1,233,555	65.00
66.00	06600	PHYSICAL THERAPY	963,910	218,798	1,182,708	-5,521	1,177,187	66.00
66.01	03340	CLINICAL NUTRITION	114,376	9,094	123,470	0	123,470	66.01
67.00	06700	OCCUPATIONAL THERAPY	108,749	10,181	118,930	3,357	122,287	67.00
68.00	06800	SPEECH PATHOLOGY	88,284	8,983	97,267	371	97,638	68.00
69.00	06900	ELECTROCARDIOLOGY	792,422	390,242	1,182,664	-11,323	1,171,341	69.00
69.01	03140	CARDIAC REHABILITATION	80,963	7,668	88,631	-465	88,166	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	99,833	157,407	257,240	-4,802	252,438	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	3,039,072	3,039,072	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	437,910	437,910	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	4,312,991	4,312,991	73.00
74.00	07400	RENAL DIALYSIS	0	82,871	82,871	-448	82,423	74.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	1,614,283	452,266	2,066,549	-57,340	2,009,209	90.00
91.00	09100	EMERGENCY	2,014,581	1,982,941	3,997,522	-303,221	3,694,301	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
OTHER REIMBURSABLE COST CENTERS								
99.30	09930	OOT	172,079	12,306	184,385	-15,429	168,956	99.30
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	33,087,669	63,898,366	96,986,035	0	96,986,035	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	26,475	2,072	28,547	0	28,547	190.00
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	51,092	51,092	0	51,092	192.00
192.01	19201	PHYSICIANS' PRIVATE OFFICES	64,246	67,651	131,897	0	131,897	192.01
194.00	07950	NON-REIMBURSABLE	0	0	0	0	0	194.00
194.01	07951	NON-REIMBURSABLE	0	0	0	0	0	194.01
194.02	07952	NON-REIMBURSABLE	0	0	0	0	0	194.02
194.03	07953	CONTRACT PHARMACY	0	125,699	125,699	0	125,699	194.03
200.00		TOTAL (SUM OF LINES 118 through 199)	33,178,390	64,144,880	97,323,270	0	97,323,270	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-0034

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

Worksheet A

Date/Time Prepared:
7/28/2021 12:17 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	4,803	3,792,202	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	241,383	2,725,893	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-4,748,968	8,927,971	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-9,394,035	11,873,940	5.00
7.00	00700	OPERATION OF PLANT	-694,396	3,578,601	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	361,148	8.00
9.00	00900	HOUSEKEEPING	-47,266	1,144,687	9.00
10.00	01000	DIETARY	-450	443,404	10.00
11.00	01100	CAFETERIA	-235,157	789,148	11.00
13.00	01300	NURSING ADMINISTRATION	-413	1,172,899	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	-511	359,535	14.00
15.00	01500	PHARMACY	-22,117	1,479,120	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-1,432	251,709	16.00
17.00	01700	SOCIAL SERVICE	0	798,015	17.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	-752,179	6,423,630	30.00
31.00	03100	INTENSIVE CARE UNIT	-7,313	1,907,554	31.00
40.00	04000	SUBPROVIDER - IPF	-26,520	2,364,873	40.00
43.00	04300	NURSERY	0	232,314	43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	-89,781	2,515,982	50.00
51.00	05100	RECOVERY ROOM	0	268,886	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	854,644	52.00
53.00	05300	ANESTHESIOLOGY	-2,891,933	97,603	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-1,640	1,378,163	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	-748,308	657,128	55.00
56.00	05600	RADIOISOTOPE	-21,529	361,818	56.00
57.00	05700	CT SCAN	0	320,921	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	123,648	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	75,720	59.00
60.00	06000	LABORATORY	-363,427	3,552,063	60.00
64.00	06400	INTRAVENOUS THERAPY	0	340,683	64.00
65.00	06500	RESPIRATORY THERAPY	-38,086	1,195,469	65.00
66.00	06600	PHYSICAL THERAPY	-65,093	1,112,094	66.00
66.01	06340	CLINICAL NUTRITION	0	123,470	66.01
67.00	06700	OCCUPATIONAL THERAPY	0	122,287	67.00
68.00	06800	SPEECH PATHOLOGY	-2,530	95,108	68.00
69.00	06900	ELECTROCARDIOLOGY	-282,817	888,524	69.00
69.01	063140	CARDIAC REHABILITATION	-2,488	85,678	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	-140,136	112,302	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	-137,843	2,901,229	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	437,910	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	4,312,991	73.00
74.00	07400	RENAL DIALYSIS	0	82,423	74.00
OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	-28,999	1,980,210	90.00
91.00	09100	EMERGENCY	-1,421,131	2,273,170	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)			92.00
OTHER REIMBURSABLE COST CENTERS					
99.30	09930	OOT	0	168,956	99.30
SPECIAL PURPOSE COST CENTERS					
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-21,920,312	75,065,723	118.00
NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	28,547	190.00
191.00	19100	RESEARCH	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	51,092	192.00
192.01	19201	PHYSICIANS' PRIVATE OFFICES	0	131,897	192.01
194.00	07950	NON-REIMBURSABLE	0	0	194.00
194.01	07951	NON-REIMBURSABLE	0	0	194.01
194.02	07952	NON-REIMBURSABLE	0	0	194.02
194.03	07953	CONTRACT PHARMACY	0	125,699	194.03
200.00		TOTAL (SUM OF LINES 118 through 199)	-21,920,312	75,402,958	200.00

RECLASSIFICATIONS

Provider CCN: 14-0034

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 - NURSERY AND L&D					
1.00	ADULTS & PEDIATRICS	30.00	610,214	233,413		1.00
2.00	NURSERY	43.00	191,489	40,825		2.00
	0		801,703	274,238		
	C - MEALS					
1.00	CAFETERIA	11.00	457,549	566,756		1.00
	0		457,549	566,756		
	D - PUMP RECLASS					
1.00	ADULTS & PEDIATRICS	30.00	0	69,557		1.00
2.00	INTENSIVE CARE UNIT	31.00	0	10,760		2.00
3.00	OPERATING ROOM	50.00	0	5,357		3.00
4.00	DELIVERY ROOM & LABOR ROOM	52.00	0	6,876		4.00
5.00	CARDIAC CATHETERIZATION	59.00	0	2,668		5.00
6.00	DRUGS CHARGED TO PATIENTS	73.00	0	6,885		6.00
7.00	EMERGENCY	91.00	0	6,296		7.00
	0		0	108,399		
	L - UTILITIES					
1.00	OPERATION OF PLANT	7.00	0	215,973		1.00
2.00		0.00	0	0		2.00
3.00		0.00	0	0		3.00
4.00		0.00	0	0		4.00
5.00		0.00	0	0		5.00
6.00		0.00	0	0		6.00
7.00		0.00	0	0		7.00
	0		0	215,973		
	M - REAL ESTATE TAXES					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	4,000		1.00
	0		0	4,000		
	O - BUILDING INSURANCE					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	166,468		1.00
	TOTALS		0	166,468		
	P - CENTRAL SUPPLY AND IMPL DEV					
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	3,039,072		1.00
2.00	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	437,910		2.00
3.00		0.00	0	0		3.00
4.00		0.00	0	0		4.00
5.00		0.00	0	0		5.00
6.00		0.00	0	0		6.00
7.00		0.00	0	0		7.00
8.00		0.00	0	0		8.00
9.00		0.00	0	0		9.00
10.00		0.00	0	0		10.00
11.00		0.00	0	0		11.00
12.00		0.00	0	0		12.00
13.00		0.00	0	0		13.00
14.00		0.00	0	0		14.00
15.00		0.00	0	0		15.00
16.00		0.00	0	0		16.00
17.00		0.00	0	0		17.00
18.00		0.00	0	0		18.00
19.00		0.00	0	0		19.00
20.00		0.00	0	0		20.00
21.00		0.00	0	0		21.00
22.00		0.00	0	0		22.00
23.00		0.00	0	0		23.00
24.00		0.00	0	0		24.00
25.00		0.00	0	0		25.00
	0		0	3,476,982		
	R - PHARMACY					
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	4,306,106		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

RECLASSIFICATIONS

Provider CCN: 14-0034

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

Worksheet A-6

Date/Time Prepared:
7/28/2021 12:17 pm

Increases					
Cost Center	Line #	Salary	Other		
2.00	3.00	4.00	5.00		
14.00	0.00	0	0		14.00
		0	4,306,106		
S - REHAB ADMIN					
1.00	66.00	2,421	9,047		1.00
2.00	67.00	219	3,232		2.00
3.00	68.00	186	324		3.00
		2,826	12,603		
500.00	Grand Total: Increases	1,262,078	9,131,525		500.00

RECLASSIFICATIONS

Provider CCN: 14-0034

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 - NURSERY AND L&D						
1.00	INTENSIVE CARE UNIT	31.00	432,209	195,463	0		1.00
2.00	DELIVERY ROOM & LABOR ROOM	52.00	369,494	78,775	0		2.00
	0		801,703	274,238			
	C - MEALS						
1.00	DIETARY	10.00	457,549	566,756	0		1.00
	0		457,549	566,756			
	D - PUMP RECLASS						
1.00	CENTRAL SERVICES & SUPPLY	14.00	0	108,399	0		1.00
2.00		0.00	0	0	0		2.00
3.00		0.00	0	0	0		3.00
4.00		0.00	0	0	0		4.00
5.00		0.00	0	0	0		5.00
6.00		0.00	0	0	0		6.00
7.00		0.00	0	0	0		7.00
	0		0	108,399			
	L - UTILITIES						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	82,015	0		1.00
2.00	LAUNDRY & LINEN SERVICE	8.00	0	3,575	0		2.00
3.00	HOUSEKEEPING	9.00	0	116,797	0		3.00
4.00	RESPIRATORY THERAPY	65.00	0	11	0		4.00
5.00	PHYSICAL THERAPY	66.00	0	8,719	0		5.00
6.00	ELECTROCARDIOLOGY	69.00	0	11	0		6.00
7.00	CLINIC	90.00	0	4,845	0		7.00
	0		0	215,973			
	M - REAL ESTATE TAXES						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	4,000	12		1.00
	0		0	4,000			
	O - BUILDING INSURANCE						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	166,468	12		1.00
	TOTALS		0	166,468			
	P - CENTRAL SUPPLY AND IMPL DEV						
1.00	ADULTS & PEDIATRICS	30.00	0	383,058	0		1.00
2.00	INTENSIVE CARE UNIT	31.00	0	194,090	0		2.00
3.00	SUBPROVIDER - IPF	40.00	0	19,262	0		3.00
4.00	OPERATING ROOM	50.00	0	1,925,311	0		4.00
5.00	RECOVERY ROOM	51.00	0	8,846	0		5.00
6.00	DELIVERY ROOM & LABOR ROOM	52.00	0	85,499	0		6.00
7.00	ANESTHESIOLOGY	53.00	0	109,221	0		7.00
8.00	RADIOLOGY-DIAGNOSTIC	54.00	0	48,361	0		8.00
9.00	RADIOLOGY-THERAPEUTIC	55.00	0	2,269	0		9.00
10.00	RADIOISOTOPE	56.00	0	2,404	0		10.00
11.00	CT SCAN	57.00	0	42,407	0		11.00
12.00	MAGNETIC RESONANCE IMAGING (MRI)	58.00	0	6,626	0		12.00
13.00	CARDIAC CATHETERIZATION	59.00	0	96,836	0		13.00
14.00	LABORATORY	60.00	0	57,442	0		14.00
15.00	INTRAVENOUS THERAPY	64.00	0	38,041	0		15.00
16.00	RESPIRATORY THERAPY	65.00	0	70,168	0		16.00
17.00	PHYSICAL THERAPY	66.00	0	8,270	0		17.00
18.00	OCCUPATIONAL THERAPY	67.00	0	94	0		18.00
19.00	SPEECH PATHOLOGY	68.00	0	139	0		19.00
20.00	ELECTROCARDIOLOGY	69.00	0	11,232	0		20.00
21.00	CARDIAC REHABILITATION	69.01	0	465	0		21.00
22.00	ELECTROENCEPHALOGRAPHY	70.00	0	4,802	0		22.00
23.00	RENAL DIALYSIS	74.00	0	410	0		23.00
24.00	CLINIC	90.00	0	52,212	0		24.00
25.00	EMERGENCY	91.00	0	309,517	0		25.00
	0		0	3,476,982			
	R - PHARMACY						
1.00	PHARMACY	15.00	0	4,295,012	0		1.00
2.00	ADULTS & PEDIATRICS	30.00	0	1,135	0		2.00
3.00	INTENSIVE CARE UNIT	31.00	0	129	0		3.00
4.00	SUBPROVIDER - IPF	40.00	0	28	0		4.00
5.00	DELIVERY ROOM & LABOR ROOM	52.00	0	312	0		5.00
6.00	RADIOLOGY-DIAGNOSTIC	54.00	0	749	0		6.00
7.00	CARDIAC CATHETERIZATION	59.00	0	39	0		7.00
8.00	LABORATORY	60.00	0	119	0		8.00
9.00	INTRAVENOUS THERAPY	64.00	0	752	0		9.00
10.00	ELECTROCARDIOLOGY	69.00	0	80	0		10.00
11.00	RENAL DIALYSIS	74.00	0	38	0		11.00
12.00	CLINIC	90.00	0	283	0		12.00
13.00	DIETARY	10.00	0	5,108	0		13.00
14.00	SOCIAL SERVICE	17.00	0	2,322	0		14.00

RECLASSIFICATIONS

Provider CCN: 14-0034

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

Worksheet A-6

Date/Time Prepared:
7/28/2021 12:17 pm

	Decreases						7/26/2021 12:17 PM
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	0		0	4,306,106			
	S - REHAB ADMIN						
1.00	00T	99.30	2,826	12,603	0		1.00
2.00		0.00	0	0	0		2.00
3.00		0.00	0	0	0		3.00
	0		2,826	12,603			
500.00	Grand Total: Decreases		1,262,078	9,131,525			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-0034

Period:
From 01/01/2020
To 12/31/2020Worksheet A-7
Part I
Date/Time Prepared:
7/28/2021 12:17 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	1,259,000	3,713,424	0	3,713,424	0	1.00	
2.00	Land Improvements	667,527	0	0	0	0	2.00	
3.00	Buildings and Fixtures	42,506,121	0	0	0	0	3.00	
4.00	Building Improvements	0	0	0	0	0	4.00	
5.00	Fixed Equipment	5,477,616	5,268	0	5,268	0	5.00	
6.00	Movable Equipment	31,180,192	974,877	0	974,877	974,720	6.00	
7.00	HIT designated Assets	0	0	0	0	0	7.00	
8.00	Subtotal (sum of lines 1-7)	81,090,456	4,693,569	0	4,693,569	974,720	8.00	
9.00	Reconciling Items	0	0	0	0	0	9.00	
10.00	Total (line 8 minus line 9)	81,090,456	4,693,569	0	4,693,569	974,720	10.00	
		Ending Balance	Fully Depreciated Assets					
		6.00	7.00					
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES							
1.00	Land	4,972,424	1,259,000					1.00
2.00	Land Improvements	667,527	667,527					2.00
3.00	Buildings and Fixtures	42,506,121	46,219,545					3.00
4.00	Building Improvements	0	0					4.00
5.00	Fixed Equipment	5,482,884	5,482,884					5.00
6.00	Movable Equipment	31,180,349	33,129,789					6.00
7.00	HIT designated Assets	0	0					7.00
8.00	Subtotal (sum of lines 1-7)	84,809,305	86,758,745					8.00
9.00	Reconciling Items	0	0					9.00
10.00	Total (line 8 minus line 9)	84,809,305	86,758,745					10.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-0034

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	2,117,420	0	1,499,511	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2,484,510	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	4,601,930	0	1,499,511	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	3,616,931				1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	2,484,510				2.00
3.00	Total (sum of lines 1-2)	0	6,101,441				3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-0034

Period:
From 01/01/2020
To 12/31/2020Worksheet A-7
Part III
Date/Time Prepared:
7/28/2021 12:17 pm

Cost Center Description		COMPUTATION OF RATIOS			ALLOCATION OF OTHER CAPITAL		
		Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	
		1.00	2.00	3.00	4.00	5.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	53,628,556	0	53,628,556	0.618137	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	33,129,789	0	33,129,789	0.381863	0	2.00
3.00	Total (sum of lines 1-2)	86,758,345	0	86,758,345	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	2,122,223	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	2,929,683	0	2.00
3.00	Total (sum of lines 1-2)	0	0	0	5,051,906	0	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	1,499,511	170,468	0	0	3,792,202	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	-203,790	0	0	0	2,725,893	2.00
3.00	Total (sum of lines 1-2)	1,295,721	170,468	0	0	6,518,095	3.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 14-0034

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

Worksheet A-8

Date/Time Prepared:
7/28/2021 12:17 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)	B		0ADMINISTRATIVE & GENERAL	5.00	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)	A	-12,698	ADMINISTRATIVE & GENERAL	5.00	0	7.00
8.00	Television and radio service (chapter 21)			0	0.00	0	8.00
9.00	Parking lot (chapter 21)			0	0.00	0	9.00
10.00	Provider-based physician adjustment	A-8-2	-6,718,659			0	10.00
11.00	Sale of scrap, waste, etc. (chapter 23)			0	0.00	0	11.00
12.00	Related organization transactions (chapter 10)	A-8-1	-3,788,904			0	12.00
13.00	Laundry and linen service			0	0.00	0	13.00
14.00	Cafeteria-employees and guests	B	-235,157	CAFETERIA	11.00	0	14.00
15.00	Rental of quarters to employee and others			0	0.00	0	15.00
16.00	Sale of medical and surgical supplies to other than patients	B	-1,432	MEDICAL RECORDS & LIBRARY	16.00	0	16.00
17.00	Sale of drugs to other than patients			0	0.00	0	17.00
18.00	Sale of medical records and abstracts			0	0.00	0	18.00
19.00	Nursing and allied health education (tuition, fees, books, etc.)			0	0.00	0	19.00
20.00	Vending machines			0	0.00	0	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)			0	0.00	0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments			0	0.00	0	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3		0RESPIRATORY THERAPY	65.00		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3		0PHYSICAL THERAPY	66.00		24.00
25.00	Utilization review - physicians' compensation (chapter 21)			0*** Cost Center Deleted ***	114.00		25.00
26.00	Depreciation - CAP REL COSTS-BLDG & FIXT	A	-86,046	CAP REL COSTS-BLDG & FIXT	1.00	9	26.00
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP	A	-13,331	CAP REL COSTS-MVBLE EQUIP	2.00	9	27.00
28.00	Non-physician Anesthetist			0*** Cost Center Deleted ***	19.00		28.00
29.00	Physicians' assistant			0	0.00	0	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3		0OCCUPATIONAL THERAPY	67.00		30.00
30.99	Hospice (non-distinct) (see instructions)			0ADULTS & PEDIATRICS	30.00		30.99
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3		0SPEECH PATHOLOGY	68.00		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest			0	0.00	0	32.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 14-0034

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

Worksheet A-8

Date/Time Prepared:
7/28/2021 12:17 pm

Cost Center Description		Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted		Line #	Wkst. A-7 Ref.	
				Cost Center				
		1.00	2.00	3.00		4.00	5.00	
33.00	OTHER ADJUSTMENTS (SPECIFY) (3)		0			0.00	0	33.00
34.00	MISC REVENUE	B	-100	EMPLOYEE BENEFITS DEPARTMENT		4.00	0	34.00
34.01	MISC REVENUE	B	-9,942,349	ADMINISTRATIVE & GENERAL		5.00	0	34.01
34.02	MISC REVENUE	B	-712,243	OPERATION OF PLANT		7.00	0	34.02
34.03	MISC REVENUE	B	-47,266	HOUSEKEEPING		9.00	0	34.03
34.04	MISC REVENUE	B	-511	CENTRAL SERVICES & SUPPLY		14.00	0	34.04
34.05	MISC REVENUE	B	-22,117	PHARMACY		15.00	0	34.05
34.06	MISC REVENUE	B	50,263	ADULTS & PEDIATRICS		30.00	0	34.06
34.07	MISC REVENUE	B	-501	OPERATING ROOM		50.00	0	34.07
34.08	MISC REVENUE	B	-1,640	RADIOLOGY-DIAGNOSTIC		54.00	0	34.08
34.09	MISC REVENUE	B	-36,000	RADIOLOGY-THERAPEUTIC		55.00	0	34.09
34.10	MISC REVENUE	B	-104,263	LABORATORY		60.00	0	34.10
34.11	MISC REVENUE	B	-4,482	RESPIRATORY THERAPY		65.00	0	34.11
34.12	MISC REVENUE	B	-15,500	PHYSICAL THERAPY		66.00	0	34.12
34.13	MISC REVENUE	B	-2,530	SPEECH PATHOLOGY		68.00	0	34.13
34.14	MISC REVENUE	B	-2,488	CARDIAC REHABILITATION		69.01	0	34.14
34.15	MISC REVENUE	B	-7,049	CLINIC		90.00	0	34.15
34.16	MISC REVENUE	B	-15,122	EMERGENCY		91.00	0	34.16
34.17	MALPRACTICE	A	-18,000	ADMINISTRATIVE & GENERAL		5.00	0	34.17
34.18	ADVERTISEMENTS	A	-8,033	ADMINISTRATIVE & GENERAL		5.00	0	34.18
34.19	ADVERTISEMENTS	A	-250	NURSING ADMINISTRATION		13.00	0	34.19
45.00	ADVERTISEMENTS	A	-247	RADIOLOGY-THERAPEUTIC		55.00	0	45.00
45.01	ADVERTISEMENTS	A	-506	RESPIRATORY THERAPY		65.00	0	45.01
45.02	ADVERTISEMENTS	A	-13,063	CLINIC		90.00	0	45.02
45.03	GIFTS	A	-29,001	EMPLOYEE BENEFITS DEPARTMENT		4.00	0	45.03
45.04	GIFTS	A	-16,943	ADMINISTRATIVE & GENERAL		5.00	0	45.04
45.05	GIFTS	A	-450	DIETARY		10.00	0	45.05
45.06	GIFTS	A	-163	NURSING ADMINISTRATION		13.00	0	45.06
45.07	GIFTS	A	-269	OPERATING ROOM		50.00	0	45.07
45.08	GIFTS	A	-753	RADIOLOGY-THERAPEUTIC		55.00	0	45.08
45.09	GIFTS	A	-430	CLINIC		90.00	0	45.09
45.10	ENTERTAINMENT	A	-542	ADMINISTRATIVE & GENERAL		5.00	0	45.10
45.11	ENTERTAINMENT	A	-56	OPERATION OF PLANT		7.00	0	45.11
45.12	PHYSICIAN RECRUITMENT	A	-5,067	ADMINISTRATIVE & GENERAL		5.00	0	45.12
45.13	OTHER ADJUSTMENTS (SPECIFY) (3)		0			0.00	0	45.13
45.14	OTHER ADJUSTMENTS (SPECIFY) (3)		0			0.00	0	45.14
45.15	LOBBY EXPENSE	A	-24,356	ADMINISTRATIVE & GENERAL		5.00	0	45.15
45.16	WSI RENT	A	-49,593	PHYSICAL THERAPY		66.00	0	45.16
45.17	INTEREST REVENUE	A	-32,465	CAP REL COSTS-BLDG & FIXT		1.00	9	45.17
45.18	OTHER ADJUSTMENTS (SPECIFY) (3)		0			0.00	0	45.18
45.19	OTHER ADJUSTMENTS (SPECIFY) (3)		0			0.00	0	45.19
45.20	OTHER ADJUSTMENTS (SPECIFY) (3)		0			0.00	0	45.20
45.21	OTHER ADJUSTMENTS (SPECIFY) (3)		0			0.00	0	45.21
45.22	OTHER ADJUSTMENTS (SPECIFY) (3)		0			0.00	0	45.22
45.23	OTHER ADJUSTMENTS (SPECIFY) (3)		0			0.00	0	45.23
45.24	OTHER ADJUSTMENTS (SPECIFY) (3)		0			0.00	0	45.24
45.25	OTHER ADJUSTMENTS (SPECIFY) (3)		0			0.00	0	45.25
45.26	OTHER ADJUSTMENTS (SPECIFY) (3)		0			0.00	0	45.26
45.27	OTHER ADJUSTMENTS (SPECIFY) (3)		0			0.00	0	45.27
45.28	OTHER ADJUSTMENTS (SPECIFY) (3)		0			0.00	0	45.28
45.29	OTHER ADJUSTMENTS (SPECIFY) (3)		0			0.00	0	45.29
45.30	OTHER ADJUSTMENTS (SPECIFY) (3)		0			0.00	0	45.30
45.31	OTHER ADJUSTMENTS (SPECIFY) (3)		0			0.00	0	45.31

ADJUSTMENTS TO EXPENSES

Provider CCN: 14-0034

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

Worksheet A-8

Date/Time Prepared:
7/28/2021 12:17 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	
45.32	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	45.32
45.33	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	45.33
45.34	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	45.34
45.35	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	45.35
45.36	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	45.36
45.37	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	45.37
45.38	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	45.38
45.39	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	45.39
45.40	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	45.40
45.41	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	45.41
45.42	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	45.42
45.43	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	45.43
45.44	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	45.44
45.45	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	45.45
45.46	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	45.46
45.47	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	45.47
45.48	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	45.48
45.49	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	45.49
45.50	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	45.50
45.51	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	45.51
45.52	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	45.52
45.53	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	45.53
45.54	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	45.54
45.55	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	45.55
45.56	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	45.56
45.57	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	45.57
45.58	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	45.58
45.59	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	45.59
45.60	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	45.60
45.61	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	45.61
45.62	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	45.62
45.63	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	45.63
45.64	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	45.64
45.65	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	45.65
45.66	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	45.66

ADJUSTMENTS TO EXPENSES

Provider CCN: 14-0034

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

Worksheet A-8

Date/Time Prepared:
7/28/2021 12:17 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	
45.67	OTHER ADJUSTMENTS (SPECIFY)		0		0.00	0	45.67
	(3)						
45.68	OTHER ADJUSTMENTS (SPECIFY)		0		0.00	0	45.68
	(3)						
45.69	OTHER ADJUSTMENTS (SPECIFY)		0		0.00	0	45.69
	(3)						
45.70	OTHER ADJUSTMENTS (SPECIFY)		0		0.00	0	45.70
	(3)						
45.71	OTHER ADJUSTMENTS (SPECIFY)		0		0.00	0	45.71
	(3)						
45.72	OTHER ADJUSTMENTS (SPECIFY)		0		0.00	0	45.72
	(3)						
45.73	OTHER ADJUSTMENTS (SPECIFY)		0		0.00	0	45.73
	(3)						
45.74	OTHER ADJUSTMENTS (SPECIFY)		0		0.00	0	45.74
	(3)						
45.75	OTHER ADJUSTMENTS (SPECIFY)		0		0.00	0	45.75
	(3)						
45.76	OTHER ADJUSTMENTS (SPECIFY)		0		0.00	0	45.76
	(3)						
45.77	OTHER ADJUSTMENTS (SPECIFY)		0		0.00	0	45.77
	(3)						
45.78	OTHER ADJUSTMENTS (SPECIFY)		0		0.00	0	45.78
	(3)						
45.79	OTHER ADJUSTMENTS (SPECIFY)		0		0.00	0	45.79
	(3)						
45.80	OTHER ADJUSTMENTS (SPECIFY)		0		0.00	0	45.80
	(3)						
45.81	OTHER ADJUSTMENTS (SPECIFY)		0		0.00	0	45.81
	(3)						
45.82	OTHER ADJUSTMENTS (SPECIFY)		0		0.00	0	45.82
	(3)						
45.83	OTHER ADJUSTMENTS (SPECIFY)		0		0.00	0	45.83
	(3)						
45.84	OTHER ADJUSTMENTS (SPECIFY)		0		0.00	0	45.84
	(3)						
45.85	OTHER ADJUSTMENTS (SPECIFY)		0		0.00	0	45.85
	(3)						
45.86	OTHER ADJUSTMENTS (SPECIFY)		0		0.00	0	45.86
	(3)						
45.87	OTHER ADJUSTMENTS (SPECIFY)		0		0.00	0	45.87
	(3)						
45.88	OTHER ADJUSTMENTS (SPECIFY)		0		0.00	0	45.88
	(3)						
45.89	OTHER ADJUSTMENTS (SPECIFY)		0		0.00	0	45.89
	(3)						
45.90	OTHER ADJUSTMENTS (SPECIFY)		0		0.00	0	45.90
	(3)						
45.91	OTHER ADJUSTMENTS (SPECIFY)		0		0.00	0	45.91
	(3)						
45.92	OTHER ADJUSTMENTS (SPECIFY)		0		0.00	0	45.92
	(3)						
45.93	OTHER ADJUSTMENTS (SPECIFY)		0		0.00	0	45.93
	(3)						
45.94	OTHER ADJUSTMENTS (SPECIFY)		0		0.00	0	45.94
	(3)						
45.95	OTHER ADJUSTMENTS (SPECIFY)		0		0.00	0	45.95
	(3)						
45.96	OTHER ADJUSTMENTS (SPECIFY)		0		0.00	0	45.96
	(3)						
45.97	OTHER ADJUSTMENTS (SPECIFY)		0		0.00	0	45.97
	(3)						
45.98	OTHER ADJUSTMENTS (SPECIFY)		0		0.00	0	45.98
	(3)						
45.99	OTHER ADJUSTMENTS (SPECIFY)		0		0.00	0	45.99
	(3)						
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-21,920,312				50.00

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

(2) Basis for adjustment (see instructions).

ADJUSTMENTS TO EXPENSES

Provider CCN: 14-0034

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

Worksheet A-8

Date/Time Prepared:
7/28/2021 12:17 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	

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: 14-0034

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

Worksheet A-8-1

Date/Time Prepared:
7/28/2021 12:17 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		1.00	CAP REL COSTS-BLDG & FIXT	HOME OFFICE	123,314	0
2.00		2.00	CAP REL COSTS-MVBLE EQUIP	HOME OFFICE	458,504	0
3.00		2.00	CAP REL COSTS-MVBLE EQUIP	HOME OFFICE - INTEREST	0	203,790
4.00		4.00	EMPLOYEE BENEFITS DEPARTMENT	HOME OFFICE	8,088,110	12,807,977
4.01		5.00	ADMINISTRATIVE & GENERAL	HOME OFFICE	7,367,919	6,695,044
4.02		7.00	OPERATION OF PLANT	HOME OFFICE	0	-17,903
4.03		71.00	MEDICAL SUPPLIES CHARGED TO	HOME OFFICE	-137,843	0
5.00			TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.		15,900,004	19,688,908

* 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	4.00	5.00

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

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

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

6.00	G	SSM HEALTH	100.00	FRAN SISTERS	100.00	6.00
7.00	G	SSM HEALTH	100.00	FRAN SISTERS	100.00	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:	CHURCH				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: 14-0034

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

Worksheet A-8-1

Date/Time Prepared:
7/28/2021 12:17 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	123,314	9		1.00
2.00	458,504	9		2.00
3.00	-203,790	11		3.00
4.00	-4,719,867	0		4.00
4.01	672,875	0		4.01
4.02	17,903	0		4.02
4.03	-137,843	0		4.03
5.00	-3,788,904			5.00

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

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

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

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

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

6.00	HOME OFFICE		6.00
7.00	SSM HOSPITALS		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: 14-0034

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

Worksheet A-8-2

Date/Time Prepared:
7/28/2021 12:17 pm

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	5.00	ADMINISTRATIVE & GENERAL	144,672	1,172	143,500	211,500	1,040	1.00
2.00	30.00	ADULTS & PEDIATRICS	820,342	773,831	46,511	179,000	208	2.00
3.00	31.00	INTENSIVE CARE UNIT	7,313	7,313	0	211,500	0	3.00
4.00	40.00	SUBPROVIDER - IPF	26,520	26,520	0	181,300	0	4.00
5.00	50.00	OPERATING ROOM	89,011	89,011	0	246,400	0	5.00
6.00	53.00	ANESTHESIOLOGY	2,891,933	2,891,933	0	239,400	0	6.00
7.00	55.00	RADIOLOGY-THERAPEUTIC	711,308	711,308	0	271,900	0	7.00
8.00	56.00	RADIOISOTOPE	21,529	21,529	0	271,900	0	8.00
9.00	60.00	LABORATORY	277,185	252,705	24,480	260,300	144	9.00
10.00	65.00	RESPIRATORY THERAPY	37,941	27,741	10,200	197,500	51	10.00
11.00	69.00	ELECTROCARDIOLOGY	295,161	269,161	26,000	197,500	130	11.00
12.00	70.00	ELECTROENCEPHALOGRAPHY	144,979	134,779	10,200	197,500	51	12.00
13.00	90.00	CLINIC	32,606	8,457	24,149	179,000	540	13.00
14.00	91.00	EMERGENCY	1,428,384	1,376,384	52,000	179,000	260	14.00
200.00			6,928,884	6,591,844	337,040		2,424	200.00
	Wkst. A Line #	Cost Center/Physician Identifier	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	5.00	ADMINISTRATIVE & GENERAL	105,750	5,288	0	0	0	1.00
2.00	30.00	ADULTS & PEDIATRICS	17,900	895	0	0	0	2.00
3.00	31.00	INTENSIVE CARE UNIT	0	0	0	0	0	3.00
4.00	40.00	SUBPROVIDER - IPF	0	0	0	0	0	4.00
5.00	50.00	OPERATING ROOM	0	0	0	0	0	5.00
6.00	53.00	ANESTHESIOLOGY	0	0	0	0	0	6.00
7.00	55.00	RADIOLOGY-THERAPEUTIC	0	0	0	0	0	7.00
8.00	56.00	RADIOISOTOPE	0	0	0	0	0	8.00
9.00	60.00	LABORATORY	18,021	901	0	0	0	9.00
10.00	65.00	RESPIRATORY THERAPY	4,843	242	0	0	0	10.00
11.00	69.00	ELECTROCARDIOLOGY	12,344	617	0	0	0	11.00
12.00	70.00	ELECTROENCEPHALOGRAPHY	4,843	242	0	0	0	12.00
13.00	90.00	CLINIC	46,471	2,324	0	0	0	13.00
14.00	91.00	EMERGENCY	22,375	1,119	0	0	0	14.00
200.00			232,547	11,628	0	0	0	200.00
	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment		
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00	5.00	ADMINISTRATIVE & GENERAL	0	105,750	37,750	38,922		1.00
2.00	30.00	ADULTS & PEDIATRICS	0	17,900	28,611	802,442		2.00
3.00	31.00	INTENSIVE CARE UNIT	0	0	0	7,313		3.00
4.00	40.00	SUBPROVIDER - IPF	0	0	0	26,520		4.00
5.00	50.00	OPERATING ROOM	0	0	0	89,011		5.00
6.00	53.00	ANESTHESIOLOGY	0	0	0	2,891,933		6.00
7.00	55.00	RADIOLOGY-THERAPEUTIC	0	0	0	711,308		7.00
8.00	56.00	RADIOISOTOPE	0	0	0	21,529		8.00
9.00	60.00	LABORATORY	0	18,021	6,459	259,164		9.00
10.00	65.00	RESPIRATORY THERAPY	0	4,843	5,357	33,098		10.00
11.00	69.00	ELECTROCARDIOLOGY	0	12,344	13,656	282,817		11.00
12.00	70.00	ELECTROENCEPHALOGRAPHY	0	4,843	5,357	140,136		12.00
13.00	90.00	CLINIC	0	46,471	0	8,457		13.00
14.00	91.00	EMERGENCY	0	22,375	29,625	1,406,009		14.00
200.00			0	232,547	126,815	6,718,659		200.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0034

Period:
From 01/01/2020
To 12/31/2020Worksheet B
Part I
Date/Time Prepared:
7/28/2021 12:17 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	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT	3,792,202	3,792,202				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	2,725,893		2,725,893			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	8,927,971	20,684	14,868	8,963,523		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	11,873,940	1,144,601	822,759	889,397	14,730,697	5.00
7.00	00700	OPERATION OF PLANT	3,578,601	286,478	205,925	209,562	4,280,566	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	361,148	78,673	56,551	23,060	519,432	8.00
9.00	00900	HOUSEKEEPING	1,144,687	49,966	35,916	255,971	1,486,540	9.00
10.00	01000	DIETARY	443,404	28,035	20,152	20,150	511,741	10.00
11.00	01100	CAFETERIA	789,148	71,878	51,667	159,891	1,072,584	11.00
13.00	01300	NURSING ADMINISTRATION	1,172,899	7,069	5,081	247,217	1,432,266	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	359,535	4,639	3,334	64,978	432,486	14.00
15.00	01500	PHARMACY	1,479,120	0	0	322,785	1,801,905	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	251,709	42,720	30,708	44,914	370,051	16.00
17.00	01700	SOCIAL SERVICE	798,015	17,760	12,766	162,963	991,504	17.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	6,423,630	483,619	347,632	1,730,819	8,985,700	30.00
31.00	03100	INTENSIVE CARE UNIT	1,907,554	51,238	36,831	406,863	2,402,486	31.00
40.00	04000	SUBPROVIDER - IPF	2,364,873	63,298	45,500	595,324	3,068,995	40.00
43.00	04300	NURSERY	232,314	34,371	24,706	120,631	412,022	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	2,515,982	403,780	290,243	498,032	3,708,037	50.00
51.00	05100	RECOVERY ROOM	268,886	0	0	52,222	321,108	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	854,644	58,333	41,931	73,838	1,028,746	52.00
53.00	05300	ANESTHESIOLOGY	97,603	3,676	2,642	2,395	106,316	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,378,163	113,847	81,835	328,749	1,902,594	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	657,128	0	0	157,323	814,451	55.00
56.00	05600	RADIOISOTOPE	361,818	8,341	5,996	33,528	409,683	56.00
57.00	05700	CT SCAN	320,921	2,068	1,486	73,828	398,303	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	123,648	3,605	2,591	26,933	156,777	58.00
59.00	05900	CARDIAC CATHETERIZATION	75,720	22,018	15,827	15,924	129,489	59.00
60.00	06000	LABORATORY	3,552,063	52,528	37,758	402,200	4,044,549	60.00
64.00	06400	INTRAVENOUS THERAPY	340,683	9,375	6,739	84,044	440,841	64.00
65.00	06500	RESPIRATORY THERAPY	1,195,469	11,053	7,945	282,338	1,496,805	65.00
66.00	06600	PHYSICAL THERAPY	1,112,094	42,066	30,238	277,620	1,462,018	66.00
66.01	03340	CLINICAL NUTRITION	123,470	0	0	31,581	155,051	66.01
67.00	06700	OCCUPATIONAL THERAPY	122,287	0	0	31,316	153,603	67.00
68.00	06800	SPEECH PATHOLOGY	95,108	6,388	4,592	25,438	131,526	68.00
69.00	06900	ELECTROCARDIOLOGY	888,524	53,005	38,101	218,797	1,198,427	69.00
69.01	03140	CARDIAC REHABILITATION	85,678	0	0	22,355	108,033	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	112,302	19,483	14,004	27,565	173,354	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	2,901,229	0	0	0	2,901,229	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	437,910	0	0	0	437,910	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	4,312,991	0	0	0	4,312,991	73.00
74.00	07400	RENAL DIALYSIS	82,423	0	0	0	82,423	74.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	1,980,210	97,537	70,111	445,723	2,593,581	90.00
91.00	09100	EMERGENCY	2,273,170	95,893	68,929	556,250	2,994,242	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					0	92.00
OTHER REIMBURSABLE COST CENTERS								
99.30	09930	OOT	168,956	0	0	33,689	202,645	99.30
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	75,065,723	3,388,025	2,435,364	8,956,213	74,363,707	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	28,547	2,898	2,083	7,310	40,838	190.00
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	51,092	0	0	0	51,092	192.00
192.01	19201	PHYSICIANS' PRIVATE OFFICES	131,897	0	0	0	131,897	192.01
194.00	07950	NON-REIMBURSABLE	0	401,279	288,446	0	689,725	194.00
194.01	07951	NON-REIMBURSABLE	0	0	0	0	0	194.01
194.02	07952	NON-REIMBURSABLE	0	0	0	0	0	194.02
194.03	07953	CONTRACT PHARMACY	125,699	0	0	0	125,699	194.03
200.00		Cross Foot Adjustments					0	200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	75,402,958	3,792,202	2,725,893	8,963,523	75,402,958	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0034

Period:
From 01/01/2020
To 12/31/2020Worksheet B
Part I
Date/Time Prepared:
7/28/2021 12:17 pm

Cost Center Description			ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
			5.00	7.00	8.00	9.00	10.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	14,730,697					5.00
7.00	00700	OPERATION OF PLANT	1,039,283	5,319,849				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	126,113	178,824	824,369			8.00
9.00	00900	HOUSEKEEPING	360,919	113,572	0	1,961,031		9.00
10.00	01000	DIETARY	124,246	63,725	0	24,857	724,569	10.00
11.00	01100	CAFETERIA	260,414	163,380	0	63,729	0	11.00
13.00	01300	NURSING ADMINISTRATION	347,741	16,067	0	6,267	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	105,004	10,544	0	4,113	0	14.00
15.00	01500	PHARMACY	437,486	0	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	89,845	97,104	0	37,877	0	16.00
17.00	01700	SOCIAL SERVICE	240,728	40,368	0	15,746	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	2,181,668	1,099,272	475,516	428,787	417,948	30.00
31.00	03100	INTENSIVE CARE UNIT	583,302	116,464	69,156	45,429	60,784	31.00
40.00	04000	SUBPROVIDER - IPF	745,124	143,878	255,406	56,122	224,486	40.00
43.00	04300	NURSERY	100,035	78,125	24,291	30,474	21,351	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	900,278	917,798	0	358,000	0	50.00
51.00	05100	RECOVERY ROOM	77,962	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	249,770	132,592	0	51,719	0	52.00
53.00	05300	ANESTHESIOLOGY	25,813	8,355	0	3,259	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	461,933	258,776	0	100,940	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	197,741	0	0	0	0	55.00
56.00	05600	RADIOISOTOPE	99,467	18,959	0	7,395	0	56.00
57.00	05700	CT SCAN	96,704	4,700	0	1,833	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	38,064	8,194	0	3,196	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	31,439	50,048	0	19,522	0	59.00
60.00	06000	LABORATORY	981,980	119,397	0	46,572	0	60.00
64.00	06400	INTRAVENOUS THERAPY	107,032	21,309	0	8,312	0	64.00
65.00	06500	RESPIRATORY THERAPY	363,411	25,125	0	9,800	0	65.00
66.00	06600	PHYSICAL THERAPY	354,965	95,618	0	37,297	0	66.00
66.01	03340	CLINICAL NUTRITION	37,645	0	0	0	0	66.01
67.00	06700	OCCUPATIONAL THERAPY	37,293	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	31,933	14,520	0	5,664	0	68.00
69.00	06900	ELECTROCARDIOLOGY	290,967	120,481	0	46,995	0	69.00
69.01	03140	CARDIAC REHABILITATION	26,229	0	0	0	0	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	42,089	44,284	0	17,274	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	704,392	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	106,321	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,047,155	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	20,012	0	0	0	0	74.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	629,698	221,702	0	86,478	0	90.00
91.00	09100	EMERGENCY	726,975	217,967	0	85,021	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
OTHER REIMBURSABLE COST CENTERS								
99.30	09930	OOT	49,200	0	0	0	0	99.30
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	14,478,376	4,401,148	824,369	1,602,678	724,569	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	9,915	6,587	0	2,570	0	190.00
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	12,405	0	0	0	0	192.00
192.01	19201	PHYSICIANS' PRIVATE OFFICES	32,023	0	0	0	0	192.01
194.00	07950	NON-REIMBURSABLE	167,459	912,114	0	355,783	0	194.00
194.01	07951	NON-REIMBURSABLE	0	0	0	0	0	194.01
194.02	07952	NON-REIMBURSABLE	0	0	0	0	0	194.02
194.03	07953	CONTRACT PHARMACY	30,519	0	0	0	0	194.03
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	14,730,697	5,319,849	824,369	1,961,031	724,569	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0034

Period:
From 01/01/2020
To 12/31/2020Worksheet B
Part I
Date/Time Prepared:
7/28/2021 12:17 pm

Cost Center Description			CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
			11.00	13.00	14.00	15.00	16.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA	1,560,107					11.00
13.00	01300	NURSING ADMINISTRATION	52,081	1,854,422				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	13,689	0	565,836			14.00
15.00	01500	PHARMACY	68,001	0	0	2,307,392		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	9,462	0	8,176	0	612,515	16.00
17.00	01700	SOCIAL SERVICE	34,331	39,615	0	0	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	364,634	570,091	70,288	143,398	38,993	30.00
31.00	03100	INTENSIVE CARE UNIT	85,713	261,894	35,614	53,968	8,091	31.00
40.00	04000	SUBPROVIDER - IPF	125,416	195,408	3,513	3,744	13,758	40.00
43.00	04300	NURSERY	25,413	28,504	0	0	1,530	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	104,919	154,524	275,159	213,944	69,270	50.00
51.00	05100	RECOVERY ROOM	11,001	20,339	1,623	2,279	7,566	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	15,555	171,597	15,688	18,586	7,446	52.00
53.00	05300	ANESTHESIOLOGY	505	0	20,029	961,811	10,506	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	69,257	15,972	8,874	71,496	25,507	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	33,143	6,062	416	0	13,739	55.00
56.00	05600	RADIOISOTOPE	7,063	0	441	0	13,480	56.00
57.00	05700	CT SCAN	15,553	0	7,781	791,226	65,572	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	5,674	0	1,216	3,717	11,607	58.00
59.00	05900	CARDIAC CATHETERIZATION	3,355	2,963	16,023	1,167	425	59.00
60.00	06000	LABORATORY	84,731	0	10,540	9,958	100,909	60.00
64.00	06400	INTRAVENOUS THERAPY	17,705	21,479	6,980	26,536	3,079	64.00
65.00	06500	RESPIRATORY THERAPY	59,480	0	12,719	2,089	27,353	65.00
66.00	06600	PHYSICAL THERAPY	58,486	0	1,517	326	13,423	66.00
66.01	03340	CLINICAL NUTRITION	6,653	0	0	0	63	66.01
67.00	06700	OCCUPATIONAL THERAPY	6,597	0	17	0	1,459	67.00
68.00	06800	SPEECH PATHOLOGY	5,359	0	26	0	666	68.00
69.00	06900	ELECTROCARDIOLOGY	46,094	19,314	2,040	3,147	28,052	69.00
69.01	03140	CARDIAC REHABILITATION	4,709	5,583	85	0	685	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	5,807	0	881	0	2,305	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	13,961	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	3,046	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	65,648	73.00
74.00	07400	RENAL DIALYSIS	0	0	75	0	591	74.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	93,900	34,261	9,305	0	11,738	90.00
91.00	09100	EMERGENCY	117,184	256,557	56,794	0	52,047	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
OTHER REIMBURSABLE COST CENTERS								
99.30	09930	OOT	7,097	0	0	0	0	99.30
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	1,558,567	1,804,163	565,820	2,307,392	612,515	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	1,540	50,259	1	0	0	190.00
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	15	0	0	192.00
192.01	19201	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.01
194.00	07950	NON-REIMBURSABLE	0	0	0	0	0	194.00
194.01	07951	NON-REIMBURSABLE	0	0	0	0	0	194.01
194.02	07952	NON-REIMBURSABLE	0	0	0	0	0	194.02
194.03	07953	CONTRACT PHARMACY	0	0	0	0	0	194.03
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	1,560,107	1,854,422	565,836	2,307,392	612,515	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0034

Period:
From 01/01/2020
To 12/31/2020Worksheet B
Part I
Date/Time Prepared:
7/28/2021 12:17 pm

Cost Center Description			SOCIAL SERVICE	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			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
7.00	00700	OPERATION OF PLANT					7.00
8.00	00800	LAUNDRY & LINEN SERVICE					8.00
9.00	00900	HOUSEKEEPING					9.00
10.00	01000	DIETARY					10.00
11.00	01100	CAFETERIA					11.00
13.00	01300	NURSING ADMINISTRATION					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY					14.00
15.00	01500	PHARMACY					15.00
16.00	01600	MEDICAL RECORDS & LIBRARY					16.00
17.00	01700	SOCIAL SERVICE	1,362,292				17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	785,802	15,562,097	0	15,562,097	30.00
31.00	03100	INTENSIVE CARE UNIT	114,282	3,837,183	0	3,837,183	31.00
40.00	04000	SUBPROVIDER - IPF	422,066	5,257,916	0	5,257,916	40.00
43.00	04300	NURSERY	40,142	761,887	0	761,887	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	6,701,929	0	6,701,929	50.00
51.00	05100	RECOVERY ROOM	0	441,878	0	441,878	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	1,691,699	0	1,691,699	52.00
53.00	05300	ANESTHESIOLOGY	0	1,136,594	0	1,136,594	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	2,915,349	0	2,915,349	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	1,065,552	0	1,065,552	55.00
56.00	05600	RADIOISOTOPE	0	556,488	0	556,488	56.00
57.00	05700	CT SCAN	0	1,381,672	0	1,381,672	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	228,445	0	228,445	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	254,431	0	254,431	59.00
60.00	06000	LABORATORY	0	5,398,636	0	5,398,636	60.00
64.00	06400	INTRAVENOUS THERAPY	0	653,273	0	653,273	64.00
65.00	06500	RESPIRATORY THERAPY	0	1,996,782	0	1,996,782	65.00
66.00	06600	PHYSICAL THERAPY	0	2,023,650	0	2,023,650	66.00
66.01	03340	CLINICAL NUTRITION	0	199,412	0	199,412	66.01
67.00	06700	OCCUPATIONAL THERAPY	0	198,969	0	198,969	67.00
68.00	06800	SPEECH PATHOLOGY	0	189,694	0	189,694	68.00
69.00	06900	ELECTROCARDIOLOGY	0	1,755,517	0	1,755,517	69.00
69.01	03140	CARDIAC REHABILITATION	0	145,324	0	145,324	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0	285,994	0	285,994	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	3,619,582	0	3,619,582	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	547,277	0	547,277	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	5,425,794	0	5,425,794	73.00
74.00	07400	RENAL DIALYSIS	0	103,101	0	103,101	74.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0	3,680,663	0	3,680,663	90.00
91.00	09100	EMERGENCY	0	4,506,787	0	4,506,787	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)			0		92.00
OTHER REIMBURSABLE COST CENTERS							
99.30	09930	OOT	0	258,942	0	258,942	99.30
SPECIAL PURPOSE COST CENTERS							
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	1,362,292	72,782,517	0	72,782,517	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	111,710	0	111,710	190.00
191.00	19100	RESEARCH	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	63,512	0	63,512	192.00
192.01	19201	PHYSICIANS' PRIVATE OFFICES	0	163,920	0	163,920	192.01
194.00	07950	NON-REIMBURSABLE	0	2,125,081	0	2,125,081	194.00
194.01	07951	NON-REIMBURSABLE	0	0	0	0	194.01
194.02	07952	NON-REIMBURSABLE	0	0	0	0	194.02
194.03	07953	CONTRACT PHARMACY	0	156,218	0	156,218	194.03
200.00		Cross Foot Adjustments	0	0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	1,362,292	75,402,958	0	75,402,958	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0034

Period:
From 01/01/2020
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Cost Center Description			CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
			Directly Assigned New Capital Related Costs	BLDG & FIXT	MVBLE EQUIP		
			0	1.00	2.00	2A	4.00
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	20,684	14,868	35,552	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	4,798	1,144,601	822,759	1,972,158	5.00
7.00	00700	OPERATION OF PLANT	249	286,478	205,925	492,652	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	78,673	56,551	135,224	8.00
9.00	00900	HOUSEKEEPING	56,734	49,966	35,916	142,616	9.00
10.00	01000	DIETARY	0	28,035	20,152	48,187	10.00
11.00	01100	CAFETERIA	0	71,878	51,667	123,545	11.00
13.00	01300	NURSING ADMINISTRATION	0	7,069	5,081	12,150	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	22,559	4,639	3,334	30,532	14.00
15.00	01500	PHARMACY	108,720	0	0	108,720	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	42,720	30,708	73,428	16.00
17.00	01700	SOCIAL SERVICE	0	17,760	12,766	30,526	17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	450	483,619	347,632	831,701	30.00
31.00	03100	INTENSIVE CARE UNIT	0	51,238	36,831	88,069	31.00
40.00	04000	SUBPROVIDER - IPF	0	63,298	45,500	108,798	40.00
43.00	04300	NURSERY	0	34,371	24,706	59,077	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	12,685	403,780	290,243	706,708	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	58,333	41,931	100,264	52.00
53.00	05300	ANESTHESIOLOGY	0	3,676	2,642	6,318	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	113,847	81,835	195,682	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	55.00
56.00	05600	RADIOISOTOPE	0	8,341	5,996	14,337	56.00
57.00	05700	CT SCAN	0	2,068	1,486	3,554	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	3,605	2,591	6,196	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	22,018	15,827	37,845	59.00
60.00	06000	LABORATORY	0	52,528	37,758	90,286	60.00
64.00	06400	INTRAVENOUS THERAPY	0	9,375	6,739	16,114	64.00
65.00	06500	RESPIRATORY THERAPY	37,135	11,053	7,945	56,133	65.00
66.00	06600	PHYSICAL THERAPY	69,124	42,066	30,238	141,428	66.00
66.01	03340	CLINICAL NUTRITION	0	0	0	0	66.01
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	6,388	4,592	10,980	68.00
69.00	06900	ELECTROCARDIOLOGY	14,380	53,005	38,101	105,486	69.00
69.01	03140	CARDIAC REHABILITATION	41,462	0	0	41,462	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	3,474	19,483	14,004	36,961	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	74.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0	97,537	70,111	167,648	90.00
91.00	09100	EMERGENCY	0	95,893	68,929	164,822	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				0	92.00
OTHER REIMBURSABLE COST CENTERS							
99.30	09930	OOT	0	0	0	0	99.30
SPECIAL PURPOSE COST CENTERS							
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	371,770	3,388,025	2,435,364	6,195,159	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	2,898	2,083	4,981	190.00
191.00	19100	RESEARCH	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	192.00
192.01	19201	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	192.01
194.00	07950	NON-REIMBURSABLE		401,279	288,446	689,725	194.00
194.01	07951	NON-REIMBURSABLE	0	0	0	0	194.01
194.02	07952	NON-REIMBURSABLE	0	0	0	0	194.02
194.03	07953	CONTRACT PHARMACY	0	0	0	0	194.03
200.00		Cross Foot Adjustments				0	200.00
201.00		Negative Cost Centers		0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	371,770	3,792,202	2,725,893	6,889,865	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0034

Period:
From 01/01/2020
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Cost Center Description			ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
			5.00	7.00	8.00	9.00	10.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	1,975,685					5.00
7.00	00700	OPERATION OF PLANT	139,388	632,871				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	16,914	21,274	173,503			8.00
9.00	00900	HOUSEKEEPING	48,406	13,511	0	205,548		9.00
10.00	01000	DIETARY	16,664	7,581	0	2,605	75,117	10.00
11.00	01100	CAFETERIA	34,927	19,436	0	6,680	0	11.00
13.00	01300	NURSING ADMINISTRATION	46,639	1,911	0	657	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	14,083	1,254	0	431	0	14.00
15.00	01500	PHARMACY	58,675	0	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	12,050	11,552	0	3,970	0	16.00
17.00	01700	SOCIAL SERVICE	32,286	4,802	0	1,650	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	292,612	130,775	100,080	44,945	43,329	30.00
31.00	03100	INTENSIVE CARE UNIT	78,232	13,855	14,555	4,762	6,302	31.00
40.00	04000	SUBPROVIDER - IPF	99,936	17,116	53,755	5,882	23,273	40.00
43.00	04300	NURSERY	13,417	9,294	5,113	3,194	2,213	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	120,745	109,185	0	37,524	0	50.00
51.00	05100	RECOVERY ROOM	10,456	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	33,499	15,774	0	5,421	0	52.00
53.00	05300	ANESTHESIOLOGY	3,462	994	0	342	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	61,954	30,785	0	10,580	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	26,521	0	0	0	0	55.00
56.00	05600	RADIOISOTOPE	13,341	2,255	0	775	0	56.00
57.00	05700	CT SCAN	12,970	559	0	192	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	5,105	975	0	335	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	4,217	5,954	0	2,046	0	59.00
60.00	06000	LABORATORY	131,703	14,204	0	4,882	0	60.00
64.00	06400	INTRAVENOUS THERAPY	14,355	2,535	0	871	0	64.00
65.00	06500	RESPIRATORY THERAPY	48,740	2,989	0	1,027	0	65.00
66.00	06600	PHYSICAL THERAPY	47,608	11,375	0	3,909	0	66.00
66.01	03340	CLINICAL NUTRITION	5,049	0	0	0	0	66.01
67.00	06700	OCCUPATIONAL THERAPY	5,002	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	4,283	1,727	0	594	0	68.00
69.00	06900	ELECTROCARDIOLOGY	39,024	14,333	0	4,926	0	69.00
69.01	03140	CARDIAC REHABILITATION	3,518	0	0	0	0	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	5,645	5,268	0	1,811	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	94,473	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	14,260	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	140,444	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	2,684	0	0	0	0	74.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	84,455	26,375	0	9,064	0	90.00
91.00	09100	EMERGENCY	97,502	25,930	0	8,912	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
OTHER REIMBURSABLE COST CENTERS								
99.30	09930	OOT	6,599	0	0	0	0	99.30
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	1,941,843	523,578	173,503	167,987	75,117	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	1,330	784	0	269	0	190.00
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	1,664	0	0	0	0	192.00
192.01	19201	PHYSICIANS' PRIVATE OFFICES	4,295	0	0	0	0	192.01
194.00	07950	NON-REIMBURSABLE	22,460	108,509	0	37,292	0	194.00
194.01	07951	NON-REIMBURSABLE	0	0	0	0	0	194.01
194.02	07952	NON-REIMBURSABLE	0	0	0	0	0	194.02
194.03	07953	CONTRACT PHARMACY	4,093	0	0	0	0	194.03
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	1,975,685	632,871	173,503	205,548	75,117	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0034

Period:
From 01/01/2020
To 12/31/2020Worksheet B
Part II
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Cost Center Description			CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
			11.00	13.00	14.00	15.00	16.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA	185,222					11.00
13.00	01300	NURSING ADMINISTRATION	6,183	68,520				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	1,625	0	48,183			14.00
15.00	01500	PHARMACY	8,073	0	0	176,748		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,123	0	696	0	102,997	16.00
17.00	01700	SOCIAL SERVICE	4,076	1,464	0	0	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	43,289	21,064	5,985	10,984	6,553	30.00
31.00	03100	INTENSIVE CARE UNIT	10,176	9,677	3,033	4,134	1,360	31.00
40.00	04000	SUBPROVIDER - IPF	14,890	7,220	299	287	2,312	40.00
43.00	04300	NURSERY	3,017	1,053	0	0	257	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	12,457	5,710	23,432	16,388	11,642	50.00
51.00	05100	RECOVERY ROOM	1,306	752	138	175	1,272	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,847	6,340	1,336	1,424	1,251	52.00
53.00	05300	ANESTHESIOLOGY	60	0	1,706	73,674	1,766	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	8,223	590	756	5,477	4,287	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	3,935	224	35	0	2,309	55.00
56.00	05600	RADIOISOTOPE	839	0	38	0	2,266	56.00
57.00	05700	CT SCAN	1,847	0	663	60,609	11,020	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	674	0	104	285	1,951	58.00
59.00	05900	CARDIAC CATHETERIZATION	398	109	1,364	89	71	59.00
60.00	06000	LABORATORY	10,060	0	898	763	17,015	60.00
64.00	06400	INTRAVENOUS THERAPY	2,102	794	594	2,033	517	64.00
65.00	06500	RESPIRATORY THERAPY	7,062	0	1,083	160	4,597	65.00
66.00	06600	PHYSICAL THERAPY	6,944	0	129	25	2,256	66.00
66.01	03340	CLINICAL NUTRITION	790	0	0	0	11	66.01
67.00	06700	OCCUPATIONAL THERAPY	783	0	1	0	245	67.00
68.00	06800	SPEECH PATHOLOGY	636	0	2	0	112	68.00
69.00	06900	ELECTROCARDIOLOGY	5,472	714	174	241	4,715	69.00
69.01	03140	CARDIAC REHABILITATION	559	206	7	0	115	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	689	0	75	0	387	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	2,346	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	512	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	11,033	73.00
74.00	07400	RENAL DIALYSIS	0	0	6	0	99	74.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	11,148	1,266	792	0	1,973	90.00
91.00	09100	EMERGENCY	13,913	9,480	4,836	0	8,747	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
OTHER REIMBURSABLE COST CENTERS								
99.30	09930	OOT	843	0	0	0	0	99.30
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	185,039	66,663	48,182	176,748	102,997	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	183	1,857	0	0	0	190.00
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	1	0	0	192.00
192.01	19201	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.01
194.00	07950	NON-REIMBURSABLE	0	0	0	0	0	194.00
194.01	07951	NON-REIMBURSABLE	0	0	0	0	0	194.01
194.02	07952	NON-REIMBURSABLE	0	0	0	0	0	194.02
194.03	07953	CONTRACT PHARMACY	0	0	0	0	0	194.03
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	185,222	68,520	48,183	176,748	102,997	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0034

Period:
From 01/01/2020
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Cost Center Description			SOCIAL SERVICE	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			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
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	75,450				17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	43,522	1,581,708	0	1,581,708	30.00
31.00	03100	INTENSIVE CARE UNIT	6,329	242,098	0	242,098	31.00
40.00	04000	SUBPROVIDER - IPF	23,376	359,505	0	359,505	40.00
43.00	04300	NURSERY	2,223	99,336	0	99,336	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	1,045,766	0	1,045,766	50.00
51.00	05100	RECOVERY ROOM	0	14,306	0	14,306	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	167,449	0	167,449	52.00
53.00	05300	ANESTHESIOLOGY	0	88,331	0	88,331	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	319,638	0	319,638	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	33,648	0	33,648	55.00
56.00	05600	RADIOISOTOPE	0	33,984	0	33,984	56.00
57.00	05700	CT SCAN	0	91,707	0	91,707	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	15,732	0	15,732	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	52,156	0	52,156	59.00
60.00	06000	LABORATORY	0	271,406	0	271,406	60.00
64.00	06400	INTRAVENOUS THERAPY	0	40,248	0	40,248	64.00
65.00	06500	RESPIRATORY THERAPY	0	122,911	0	122,911	65.00
66.00	06600	PHYSICAL THERAPY	0	214,775	0	214,775	66.00
66.01	03340	CLINICAL NUTRITION	0	5,975	0	5,975	66.01
67.00	06700	OCCUPATIONAL THERAPY	0	6,155	0	6,155	67.00
68.00	06800	SPEECH PATHOLOGY	0	18,435	0	18,435	68.00
69.00	06900	ELECTROCARDIOLOGY	0	175,953	0	175,953	69.00
69.01	03140	CARDIAC REHABILITATION	0	45,956	0	45,956	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0	50,945	0	50,945	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	96,819	0	96,819	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	14,772	0	14,772	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	151,477	0	151,477	73.00
74.00	07400	RENAL DIALYSIS	0	2,789	0	2,789	74.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0	304,489	0	304,489	90.00
91.00	09100	EMERGENCY	0	336,348	0	336,348	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)			0		92.00
OTHER REIMBURSABLE COST CENTERS							
99.30	09930	OOT	0	7,576	0	7,576	99.30
SPECIAL PURPOSE COST CENTERS							
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	75,450	6,012,393	0	6,012,393	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	9,433	0	9,433	190.00
191.00	19100	RESEARCH	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	1,665	0	1,665	192.00
192.01	19201	PHYSICIANS' PRIVATE OFFICES	0	4,295	0	4,295	192.01
194.00	07950	NON-REIMBURSABLE	0	857,986	0	857,986	194.00
194.01	07951	NON-REIMBURSABLE	0	0	0	0	194.01
194.02	07952	NON-REIMBURSABLE	0	0	0	0	194.02
194.03	07953	CONTRACT PHARMACY	0	4,093	0	4,093	194.03
200.00		Cross Foot Adjustments	0	0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	75,450	6,889,865	0	6,889,865	202.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0034

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

Worksheet B-1

Date/Time Prepared:
7/28/2021 12:17 pm

Cost Center Description			CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	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	429,194					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		429,194				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	2,341	2,341	32,463,347			4.00
5.00	00500	ADMINISTRATIVE & GENERAL	129,544	129,544	3,221,146	-14,730,697	60,672,261	5.00
7.00	00700	OPERATION OF PLANT	32,423	32,423	758,974	0	4,280,566	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	8,904	8,904	83,517	0	519,432	8.00
9.00	00900	HOUSEKEEPING	5,655	5,655	927,056	0	1,486,540	9.00
10.00	01000	DIETARY	3,173	3,173	72,978	0	511,741	10.00
11.00	01100	CAFETERIA	8,135	8,135	579,080	0	1,072,584	11.00
13.00	01300	NURSING ADMINISTRATION	800	800	895,352	0	1,432,266	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	525	525	235,331	0	432,486	14.00
15.00	01500	PHARMACY	0	0	1,169,037	0	1,801,905	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	4,835	4,835	162,667	0	370,051	16.00
17.00	01700	SOCIAL SERVICE	2,010	2,010	590,207	0	991,504	17.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	54,735	54,735	6,268,529	0	8,985,700	30.00
31.00	03100	INTENSIVE CARE UNIT	5,799	5,799	1,473,545	0	2,402,486	31.00
40.00	04000	SUBPROVIDER - IPF	7,164	7,164	2,156,095	0	3,068,995	40.00
43.00	04300	NURSERY	3,890	3,890	436,891	0	412,022	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	45,699	45,699	1,803,732	0	3,708,037	50.00
51.00	05100	RECOVERY ROOM	0	0	189,132	0	321,108	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	6,602	6,602	267,420	0	1,028,746	52.00
53.00	05300	ANESTHESIOLOGY	416	416	8,674	0	106,316	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	12,885	12,885	1,190,636	0	1,902,594	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	569,781	0	814,451	55.00
56.00	05600	RADIOISOTOPE	944	944	121,430	0	409,683	56.00
57.00	05700	CT SCAN	234	234	267,384	0	398,303	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	408	408	97,542	0	156,777	58.00
59.00	05900	CARDIAC CATHETERIZATION	2,492	2,492	57,672	0	129,489	59.00
60.00	06000	LABORATORY	5,945	5,945	1,456,654	0	4,044,549	60.00
64.00	06400	INTRAVENOUS THERAPY	1,061	1,061	304,384	0	440,841	64.00
65.00	06500	RESPIRATORY THERAPY	1,251	1,251	1,022,548	0	1,496,805	65.00
66.00	06600	PHYSICAL THERAPY	4,761	4,761	1,005,461	0	1,462,018	66.00
66.01	03340	CLINICAL NUTRITION	0	0	114,376	0	155,051	66.01
67.00	06700	OCCUPATIONAL THERAPY	0	0	113,417	0	153,603	67.00
68.00	06800	SPEECH PATHOLOGY	723	723	92,131	0	131,526	68.00
69.00	06900	ELECTROCARDIOLOGY	5,999	5,999	792,422	0	1,198,427	69.00
69.01	03140	CARDIAC REHABILITATION	0	0	80,963	0	108,033	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	2,205	2,205	99,833	0	173,354	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	2,901,229	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	437,910	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	4,312,991	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	82,423	74.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	11,039	11,039	1,614,283	0	2,593,581	90.00
91.00	09100	EMERGENCY	10,853	10,853	2,014,581	0	2,994,242	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
OTHER REIMBURSABLE COST CENTERS								
99.30	09930	OOT	0	0	122,011	0	202,645	99.30
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	383,450	383,450	32,436,872	-14,730,697	59,633,010	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	328	328	26,475	0	40,838	190.00
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	51,092	192.00
192.01	19201	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	131,897	192.01
194.00	07950	NON-REIMBURSABLE	45,416	45,416	0	0	689,725	194.00
194.01	07951	NON-REIMBURSABLE	0	0	0	0	0	194.01
194.02	07952	NON-REIMBURSABLE	0	0	0	0	0	194.02
194.03	07953	CONTRACT PHARMACY	0	0	0	0	125,699	194.03
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)	3,792,202	2,725,893	8,963,523		14,730,697	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	8.835636	6.351191	0.276112		0.242791	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)			35,552		1,975,685	204.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0034

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

Worksheet B-1

Date/Time Prepared:
7/28/2021 12:17 pm

Cost Center Description			CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
			BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (SQUARE FEET)				
			1.00	2.00	4.00	5A	5.00	
205.00		Unit cost multiplier (Wkst. B, Part II)			0.001095		0.032563	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: 14-0034

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

Worksheet B-1

Date/Time Prepared:
7/28/2021 12:17 pm

Cost Center Description		OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (TOTAL PATIENT DAYS)	HOUSEKEEPING (SQUARE FEET)	DIETARY (TOTAL PATIENT DAYS)	CAFETERIA (GROSS SALARIES)	
		7.00	8.00	9.00	10.00	11.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500	ADMINISTRATIVE & GENERAL					5.00
7.00	00700	OPERATION OF PLANT	264,886				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	8,904	16,629			8.00
9.00	00900	HOUSEKEEPING	5,655	0	250,327		9.00
10.00	01000	DIETARY	3,173	0	3,173	16,629	10.00
11.00	01100	CAFETERIA	8,135	0	8,135	0	11.00
13.00	01300	NURSING ADMINISTRATION	800	0	800	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	525	0	525	0	14.00
15.00	01500	PHARMACY	0	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	4,835	0	4,835	0	16.00
17.00	01700	SOCIAL SERVICE	2,010	0	2,010	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	54,735	9,592	54,735	9,592	30.00
31.00	03100	INTENSIVE CARE UNIT	5,799	1,395	5,799	1,395	31.00
40.00	04000	SUBPROVIDER - IPF	7,164	5,152	7,164	5,152	40.00
43.00	04300	NURSERY	3,890	490	3,890	490	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	45,699	0	45,699	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	6,602	0	6,602	0	52.00
53.00	05300	ANESTHESIOLOGY	416	0	416	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	12,885	0	12,885	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	55.00
56.00	05600	RADIOISOTOPE	944	0	944	0	56.00
57.00	05700	CT SCAN	234	0	234	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	408	0	408	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	2,492	0	2,492	0	59.00
60.00	06000	LABORATORY	5,945	0	5,945	0	60.00
64.00	06400	INTRAVENOUS THERAPY	1,061	0	1,061	0	64.00
65.00	06500	RESPIRATORY THERAPY	1,251	0	1,251	0	65.00
66.00	06600	PHYSICAL THERAPY	4,761	0	4,761	0	66.00
66.01	03340	CLINICAL NUTRITION	0	0	0	0	66.01
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	723	0	723	0	68.00
69.00	06900	ELECTROCARDIOLOGY	5,999	0	5,999	0	69.00
69.01	03140	CARDIAC REHABILITATION	0	0	0	0	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	2,205	0	2,205	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	74.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	11,039	0	11,039	0	90.00
91.00	09100	EMERGENCY	10,853	0	10,853	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					92.00
OTHER REIMBURSABLE COST CENTERS							
99.30	09930	OOT	0	0	0	0	99.30
SPECIAL PURPOSE COST CENTERS							
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	219,142	16,629	204,583	16,629	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	328	0	328	0	190.00
191.00	19100	RESEARCH	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	192.00
192.01	19201	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	192.01
194.00	07950	NON-REIMBURSABLE	45,416	0	45,416	0	194.00
194.01	07951	NON-REIMBURSABLE	0	0	0	0	194.01
194.02	07952	NON-REIMBURSABLE	0	0	0	0	194.02
194.03	07953	CONTRACT PHARMACY	0	0	0	0	194.03
200.00		Cross Foot Adjustments					200.00
201.00		Negative Cost Centers					201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	5,319,849	824,369	1,961,031	724,569	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	20.083542	49.574178	7.833877	43.572614	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	632,871	173,503	205,548	75,117	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	2.389220	10.433760	0.821118	4.517229	205.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0034

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

Worksheet B-1

Date/Time Prepared:
7/28/2021 12:17 pm

Cost Center Description			OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (TOTAL PATIENT DAYS)	HOUSEKEEPING (SQUARE FEET)	DIETARY (TOTAL PATIENT DAYS)	CAFETERIA (GROSS SALARIES)	
			7.00	8.00	9.00	10.00	11.00	
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: 14-0034

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

Worksheet B-1

Date/Time Prepared:
7/28/2021 12:17 pm

Cost Center Description			NURSING ADMINISTRATION (DIRECT NURS. HRS.)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)	SOCIAL SERVICE (TOTAL PATIENT DAYS)	
			13.00	14.00	15.00	16.00	17.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION	631,389					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	3,083,719				14.00
15.00	01500	PHARMACY	0	0	85,040			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	44,558	0	285,202,542		16.00
17.00	01700	SOCIAL SERVICE	13,488	0	0	0	16,629	17.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	194,103	383,059	5,285	18,153,142	9,592	30.00
31.00	03100	INTENSIVE CARE UNIT	89,169	194,090	1,989	3,766,745	1,395	31.00
40.00	04000	SUBPROVIDER - IPF	66,532	19,148	138	6,405,015	5,152	40.00
43.00	04300	NURSERY	9,705	0	0	712,475	490	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	52,612	1,499,555	7,885	32,248,679	0	50.00
51.00	05100	RECOVERY ROOM	6,925	8,846	84	3,522,190	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	58,425	85,499	685	3,466,310	0	52.00
53.00	05300	ANESTHESIOLOGY	0	109,157	35,448	4,891,190	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	5,438	48,362	2,635	11,874,949	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	2,064	2,269	0	6,395,953	0	55.00
56.00	05600	RADIOISOTOPE	0	2,403	0	6,275,695	0	56.00
57.00	05700	CT SCAN	0	42,406	29,161	30,527,197	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	6,626	137	5,403,647	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	1,009	87,325	43	197,710	0	59.00
60.00	06000	LABORATORY	0	57,442	367	47,023,899	0	60.00
64.00	06400	INTRAVENOUS THERAPY	7,313	38,041	978	1,433,295	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	69,318	77	12,734,306	0	65.00
66.00	06600	PHYSICAL THERAPY	0	8,270	12	6,249,013	0	66.00
66.01	03340	CLINICAL NUTRITION	0	0	0	29,545	0	66.01
67.00	06700	OCCUPATIONAL THERAPY	0	93	0	679,217	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	139	0	310,150	0	68.00
69.00	06900	ELECTROCARDIOLOGY	6,576	11,116	116	13,059,661	0	69.00
69.01	03140	CARDIAC REHABILITATION	1,901	465	0	318,990	0	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0	4,802	0	1,073,220	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	6,499,721	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	1,418,000	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	30,562,271	0	73.00
74.00	07400	RENAL DIALYSIS	0	410	0	275,340	0	74.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	11,665	50,713	0	5,464,653	0	90.00
91.00	09100	EMERGENCY	87,352	309,517	0	24,230,364	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
OTHER REIMBURSABLE COST CENTERS								
99.30	09930	OOT	0	0	0	0	0	99.30
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	614,277	3,083,629	85,040	285,202,542	16,629	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	17,112	7	0	0	0	190.00
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	83	0	0	0	192.00
192.01	19201	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.01
194.00	07950	NON-REIMBURSABLE	0	0	0	0	0	194.00
194.01	07951	NON-REIMBURSABLE	0	0	0	0	0	194.01
194.02	07952	NON-REIMBURSABLE	0	0	0	0	0	194.02
194.03	07953	CONTRACT PHARMACY	0	0	0	0	0	194.03
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	1,854,422	565,836	2,307,392	612,515	1,362,292	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	2.937051	0.183491	27.133020	0.002148	81.922665	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	68,520	48,183	176,748	102,997	75,450	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.108523	0.015625	2.078410	0.000361	4.537254	205.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0034

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

Worksheet B-1

Date/Time Prepared:
7/28/2021 12:17 pm

Cost Center Description		NURSING ADMINISTRATION (DIRECT NURS. HRS.)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)	SOCIAL SERVICE (TOTAL PATIENT DAYS)	
206.00	NAHE adjustment amount to be allocated (per Wkst. B-2)	13.00	14.00	15.00	16.00	17.00	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: 14-0034	Period: From 01/01/2020 To 12/31/2020	Worksheet C Part I Date/Time Prepared: 7/28/2021 12:17 pm	
					Title XVIII	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	15,562,097		15,562,097	28,611	15,590,708	30.00
31.00	03100	INTENSIVE CARE UNIT	3,837,183		3,837,183	0	3,837,183	31.00
40.00	04000	SUBPROVIDER - IPF	5,257,916		5,257,916	0	5,257,916	40.00
43.00	04300	NURSERY	761,887		761,887	0	761,887	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	6,701,929		6,701,929	0	6,701,929	50.00
51.00	05100	RECOVERY ROOM	441,878		441,878	0	441,878	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,691,699		1,691,699	0	1,691,699	52.00
53.00	05300	ANESTHESIOLOGY	1,136,594		1,136,594	0	1,136,594	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,915,349		2,915,349	0	2,915,349	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	1,065,552		1,065,552	0	1,065,552	55.00
56.00	05600	RADIOISOTOPE	556,488		556,488	0	556,488	56.00
57.00	05700	CT SCAN	1,381,672		1,381,672	0	1,381,672	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	228,445		228,445	0	228,445	58.00
59.00	05900	CARDIAC CATHETERIZATION	254,431		254,431	0	254,431	59.00
60.00	06000	LABORATORY	5,398,636		5,398,636	6,459	5,405,095	60.00
64.00	06400	INTRAVENOUS THERAPY	653,273		653,273	0	653,273	64.00
65.00	06500	RESPIRATORY THERAPY	1,996,782	0	1,996,782	5,357	2,002,139	65.00
66.00	06600	PHYSICAL THERAPY	2,023,650	0	2,023,650	0	2,023,650	66.00
66.01	03340	CLINICAL NUTRITION	199,412	0	199,412	0	199,412	66.01
67.00	06700	OCCUPATIONAL THERAPY	198,969	0	198,969	0	198,969	67.00
68.00	06800	SPEECH PATHOLOGY	189,694	0	189,694	0	189,694	68.00
69.00	06900	ELECTROCARDIOLOGY	1,755,517		1,755,517	13,656	1,769,173	69.00
69.01	03140	CARDIAC REHABILITATION	145,324		145,324	0	145,324	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	285,994		285,994	5,357	291,351	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	3,619,582		3,619,582	0	3,619,582	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	547,277		547,277	0	547,277	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	5,425,794		5,425,794	0	5,425,794	73.00
74.00	07400	RENAL DIALYSIS	103,101		103,101	0	103,101	74.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	3,680,663		3,680,663	0	3,680,663	90.00
91.00	09100	EMERGENCY	4,506,787		4,506,787	29,625	4,536,412	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	2,587,840		2,587,840		2,587,840	92.00
OTHER REIMBURSABLE COST CENTERS								
99.30	09930	OOT	258,942		258,942		258,942	99.30
200.00		Subtotal (see instructions)	75,370,357	0	75,370,357	89,065	75,459,422	200.00
201.00		Less Observation Beds	2,587,840		2,587,840		2,587,840	201.00
202.00		Total (see instructions)	72,782,517	0	72,782,517	89,065	72,871,582	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0034

Period:
From 01/01/2020
To 12/31/2020Worksheet C
Part I
Date/Time Prepared:
7/28/2021 12:17 pm

			Title XVIII		Hospital	PPS		
Cost Center Description			Charges			Cost or Other Ratio	TEFRA Inpatient Ratio	
			Inpatient	Outpatient	Total (col. 6 + col. 7)			
			6.00	7.00	8.00			
	INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	16,088,453		16,088,453			30.00
31.00	03100	INTENSIVE CARE UNIT	3,766,745		3,766,745			31.00
40.00	04000	SUBPROVIDER - IPF	6,405,015		6,405,015			40.00
43.00	04300	NURSERY	712,475		712,475			43.00
	ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	8,598,022	23,650,657	32,248,679	0.207820	0.000000	50.00
51.00	05100	RECOVERY ROOM	1,166,910	2,355,280	3,522,190	0.125455	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	2,840,736	625,574	3,466,310	0.488040	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	2,024,925	2,866,265	4,891,190	0.232376	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,986,660	9,888,289	11,874,949	0.245504	0.000000	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	135,525	6,260,428	6,395,953	0.166598	0.000000	55.00
56.00	05600	RADIOISOTOPE	360,455	5,915,240	6,275,695	0.088674	0.000000	56.00
57.00	05700	CT SCAN	6,007,352	24,519,845	30,527,197	0.045260	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	586,377	4,817,270	5,403,647	0.042276	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	62,770	134,940	197,710	1.286890	0.000000	59.00
60.00	06000	LABORATORY	16,427,364	30,596,535	47,023,899	0.114806	0.000000	60.00
64.00	06400	INTRAVENOUS THERAPY	6,625	1,426,670	1,433,295	0.455784	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	8,131,915	4,602,391	12,734,306	0.156803	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	919,015	5,329,998	6,249,013	0.323835	0.000000	66.00
66.01	03340	CLINICAL NUTRITION	0	29,545	29,545	6.749433	0.000000	66.01
67.00	06700	OCCUPATIONAL THERAPY	158,570	520,647	679,217	0.292939	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	76,630	233,520	310,150	0.611620	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	3,658,210	9,401,451	13,059,661	0.134423	0.000000	69.00
69.01	03140	CARDIAC REHABILITATION	0	318,990	318,990	0.455575	0.000000	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	144,055	929,165	1,073,220	0.266482	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,159,561	5,340,160	6,499,721	0.556883	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1,026,949	391,051	1,418,000	0.385950	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	13,434,844	17,127,427	30,562,271	0.177532	0.000000	73.00
74.00	07400	RENAL DIALYSIS	261,490	13,850	275,340	0.374450	0.000000	74.00
	OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	2,430	5,462,223	5,464,653	0.673540	0.000000	90.00
91.00	09100	EMERGENCY	5,241,550	18,988,814	24,230,364	0.185997	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	368,870	1,695,819	2,064,689	1.253380	0.000000	92.00
	OTHER REIMBURSABLE COST CENTERS							
99.30	09930	OOT	0	0	0			99.30
200.00		Subtotal (see instructions)	101,760,498	183,442,044	285,202,542			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	101,760,498	183,442,044	285,202,542			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0034

Period:
From 01/01/2020
To 12/31/2020Worksheet C
Part I
Date/Time Prepared:
7/28/2021 12:17 pm

Cost Center Description			PPS Inpatient Ratio	Title XVIII	Hospital	PPS
			11.00			
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS				30.00
31.00	03100	INTENSIVE CARE UNIT				31.00
40.00	04000	SUBPROVIDER - IPF				40.00
43.00	04300	NURSERY				43.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.207820			50.00
51.00	05100	RECOVERY ROOM	0.125455			51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.488040			52.00
53.00	05300	ANESTHESIOLOGY	0.232376			53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.245504			54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.166598			55.00
56.00	05600	RADIOISOTOPE	0.088674			56.00
57.00	05700	CT SCAN	0.045260			57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.042276			58.00
59.00	05900	CARDIAC CATHETERIZATION	1.286890			59.00
60.00	06000	LABORATORY	0.114944			60.00
64.00	06400	INTRAVENOUS THERAPY	0.455784			64.00
65.00	06500	RESPIRATORY THERAPY	0.157224			65.00
66.00	06600	PHYSICAL THERAPY	0.323835			66.00
66.01	03340	CLINICAL NUTRITION	6.749433			66.01
67.00	06700	OCCUPATIONAL THERAPY	0.292939			67.00
68.00	06800	SPEECH PATHOLOGY	0.611620			68.00
69.00	06900	ELECTROCARDIOLOGY	0.135469			69.00
69.01	03140	CARDIAC REHABILITATION	0.455575			69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0.271474			70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.556883			71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.385950			72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.177532			73.00
74.00	07400	RENAL DIALYSIS	0.374450			74.00
OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.673540			90.00
91.00	09100	EMERGENCY	0.187220			91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.253380			92.00
OTHER REIMBURSABLE COST CENTERS						
99.30	09930	OOT				99.30
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: 14-0034	Period: From 01/01/2020 To 12/31/2020	Worksheet C Part I Date/Time Prepared: 7/28/2021 12:17 pm	
					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	15,562,097		15,562,097	28,611	15,590,708	30.00
31.00	03100	INTENSIVE CARE UNIT	3,837,183		3,837,183	0	3,837,183	31.00
40.00	04000	SUBPROVIDER - IPF	5,257,916		5,257,916	0	5,257,916	40.00
43.00	04300	NURSERY	761,887		761,887	0	761,887	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	6,701,929		6,701,929	0	6,701,929	50.00
51.00	05100	RECOVERY ROOM	441,878		441,878	0	441,878	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,691,699		1,691,699	0	1,691,699	52.00
53.00	05300	ANESTHESIOLOGY	1,136,594		1,136,594	0	1,136,594	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,915,349		2,915,349	0	2,915,349	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	1,065,552		1,065,552	0	1,065,552	55.00
56.00	05600	RADIOISOTOPE	556,488		556,488	0	556,488	56.00
57.00	05700	CT SCAN	1,381,672		1,381,672	0	1,381,672	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	228,445		228,445	0	228,445	58.00
59.00	05900	CARDIAC CATHETERIZATION	254,431		254,431	0	254,431	59.00
60.00	06000	LABORATORY	5,398,636		5,398,636	6,459	5,405,095	60.00
64.00	06400	INTRAVENOUS THERAPY	653,273		653,273	0	653,273	64.00
65.00	06500	RESPIRATORY THERAPY	1,996,782	0	1,996,782	5,357	2,002,139	65.00
66.00	06600	PHYSICAL THERAPY	2,023,650	0	2,023,650	0	2,023,650	66.00
66.01	03340	CLINICAL NUTRITION	199,412	0	199,412	0	199,412	66.01
67.00	06700	OCCUPATIONAL THERAPY	198,969	0	198,969	0	198,969	67.00
68.00	06800	SPEECH PATHOLOGY	189,694	0	189,694	0	189,694	68.00
69.00	06900	ELECTROCARDIOLOGY	1,755,517		1,755,517	13,656	1,769,173	69.00
69.01	03140	CARDIAC REHABILITATION	145,324		145,324	0	145,324	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	285,994		285,994	5,357	291,351	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	3,619,582		3,619,582	0	3,619,582	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	547,277		547,277	0	547,277	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	5,425,794		5,425,794	0	5,425,794	73.00
74.00	07400	RENAL DIALYSIS	103,101		103,101	0	103,101	74.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	3,680,663		3,680,663	0	3,680,663	90.00
91.00	09100	EMERGENCY	4,506,787		4,506,787	29,625	4,536,412	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	2,587,840		2,587,840		2,587,840	92.00
OTHER REIMBURSABLE COST CENTERS								
99.30	09930	OOT	258,942		258,942		258,942	99.30
200.00		Subtotal (see instructions)	75,370,357	0	75,370,357	89,065	75,459,422	200.00
201.00		Less Observation Beds	2,587,840		2,587,840		2,587,840	201.00
202.00		Total (see instructions)	72,782,517	0	72,782,517	89,065	72,871,582	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES				Provider CCN: 14-0034		Period: From 01/01/2020 To 12/31/2020		Worksheet C Part I Date/Time Prepared: 7/28/2021 12:17 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			
				9.00					
INPATIENT ROUTINE SERVICE COST CENTERS									
30.00	03000	ADULTS & PEDIATRICS	16,088,453		16,088,453				30.00
31.00	03100	INTENSIVE CARE UNIT	3,766,745		3,766,745				31.00
40.00	04000	SUBPROVIDER - IPF	6,405,015		6,405,015				40.00
43.00	04300	NURSERY	712,475		712,475				43.00
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM	8,598,022	23,650,657	32,248,679	0.207820	0.000000		50.00
51.00	05100	RECOVERY ROOM	1,166,910	2,355,280	3,522,190	0.125455	0.000000		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	2,840,736	625,574	3,466,310	0.488040	0.000000		52.00
53.00	05300	ANESTHESIOLOGY	2,024,925	2,866,265	4,891,190	0.232376	0.000000		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,986,660	9,888,289	11,874,949	0.245504	0.000000		54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	135,525	6,260,428	6,395,953	0.166598	0.000000		55.00
56.00	05600	RADIOISOTOPE	360,455	5,915,240	6,275,695	0.088674	0.000000		56.00
57.00	05700	CT SCAN	6,007,352	24,519,845	30,527,197	0.045260	0.000000		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	586,377	4,817,270	5,403,647	0.042276	0.000000		58.00
59.00	05900	CARDIAC CATHETERIZATION	62,770	134,940	197,710	1.286890	0.000000		59.00
60.00	06000	LABORATORY	16,427,364	30,596,535	47,023,899	0.114806	0.000000		60.00
64.00	06400	INTRAVENOUS THERAPY	6,625	1,426,670	1,433,295	0.455784	0.000000		64.00
65.00	06500	RESPIRATORY THERAPY	8,131,915	4,602,391	12,734,306	0.156803	0.000000		65.00
66.00	06600	PHYSICAL THERAPY	919,015	5,329,998	6,249,013	0.323835	0.000000		66.00
66.01	03340	CLINICAL NUTRITION	0	29,545	29,545	6.749433	0.000000		66.01
67.00	06700	OCCUPATIONAL THERAPY	158,570	520,647	679,217	0.292939	0.000000		67.00
68.00	06800	SPEECH PATHOLOGY	76,630	233,520	310,150	0.611620	0.000000		68.00
69.00	06900	ELECTROCARDIOLOGY	3,658,210	9,401,451	13,059,661	0.134423	0.000000		69.00
69.01	03140	CARDIAC REHABILITATION	0	318,990	318,990	0.455575	0.000000		69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	144,055	929,165	1,073,220	0.266482	0.000000		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,159,561	5,340,160	6,499,721	0.556883	0.000000		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1,026,949	391,051	1,418,000	0.385950	0.000000		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	13,434,844	17,127,427	30,562,271	0.177532	0.000000		73.00
74.00	07400	RENAL DIALYSIS	261,490	13,850	275,340	0.374450	0.000000		74.00
OUTPATIENT SERVICE COST CENTERS									
90.00	09000	CLINIC	2,430	5,462,223	5,464,653	0.673540	0.000000		90.00
91.00	09100	EMERGENCY	5,241,550	18,988,814	24,230,364	0.185997	0.000000		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	368,870	1,695,819	2,064,689	1.253380	0.000000		92.00
OTHER REIMBURSABLE COST CENTERS									
99.30	09930	OOT	0	0	0				99.30
200.00		Subtotal (see instructions)	101,760,498	183,442,044	285,202,542				200.00
201.00		Less Observation Beds							201.00
202.00		Total (see instructions)	101,760,498	183,442,044	285,202,542				202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0034

Period:
From 01/01/2020
To 12/31/2020Worksheet C
Part I
Date/Time Prepared:
7/28/2021 12:17 pm

Cost Center Description			PPS Inpatient Ratio	Title XIX	Hospital	PPS
			11.00			
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS				30.00
31.00	03100	INTENSIVE CARE UNIT				31.00
40.00	04000	SUBPROVIDER - IPF				40.00
43.00	04300	NURSERY				43.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.207820			50.00
51.00	05100	RECOVERY ROOM	0.125455			51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.488040			52.00
53.00	05300	ANESTHESIOLOGY	0.232376			53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.245504			54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.166598			55.00
56.00	05600	RADIOISOTOPE	0.088674			56.00
57.00	05700	CT SCAN	0.045260			57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.042276			58.00
59.00	05900	CARDIAC CATHETERIZATION	1.286890			59.00
60.00	06000	LABORATORY	0.114944			60.00
64.00	06400	INTRAVENOUS THERAPY	0.455784			64.00
65.00	06500	RESPIRATORY THERAPY	0.157224			65.00
66.00	06600	PHYSICAL THERAPY	0.323835			66.00
66.01	03340	CLINICAL NUTRITION	6.749433			66.01
67.00	06700	OCCUPATIONAL THERAPY	0.292939			67.00
68.00	06800	SPEECH PATHOLOGY	0.611620			68.00
69.00	06900	ELECTROCARDIOLOGY	0.135469			69.00
69.01	03140	CARDIAC REHABILITATION	0.455575			69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0.271474			70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.556883			71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.385950			72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.177532			73.00
74.00	07400	RENAL DIALYSIS	0.374450			74.00
OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.673540			90.00
91.00	09100	EMERGENCY	0.187220			91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.253380			92.00
OTHER REIMBURSABLE COST CENTERS						
99.30	09930	OOT				99.30
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: 14-0034

Period:
From 01/01/2020
To 12/31/2020Worksheet C
Part II
Date/Time Prepared:
7/28/2021 12:17 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	6,701,929	1,045,766	5,656,163	0	50.00
51.00	05100	RECOVERY ROOM	441,878	14,306	427,572	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,691,699	167,449	1,524,250	0	52.00
53.00	05300	ANESTHESIOLOGY	1,136,594	88,331	1,048,263	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,915,349	319,638	2,595,711	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	1,065,552	33,648	1,031,904	0	55.00
56.00	05600	RADIOISOTOPE	556,488	33,984	522,504	0	56.00
57.00	05700	CT SCAN	1,381,672	91,707	1,289,965	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	228,445	15,732	212,713	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	254,431	52,156	202,275	0	59.00
60.00	06000	LABORATORY	5,398,636	271,406	5,127,230	0	60.00
64.00	06400	INTRAVENOUS THERAPY	653,273	40,248	613,025	0	64.00
65.00	06500	RESPIRATORY THERAPY	1,996,782	122,911	1,873,871	0	65.00
66.00	06600	PHYSICAL THERAPY	2,023,650	214,775	1,808,875	0	66.00
66.01	03340	CLINICAL NUTRITION	199,412	5,975	193,437	0	66.01
67.00	06700	OCCUPATIONAL THERAPY	198,969	6,155	192,814	0	67.00
68.00	06800	SPEECH PATHOLOGY	189,694	18,435	171,259	0	68.00
69.00	06900	ELECTROCARDIOLOGY	1,755,517	175,953	1,579,564	0	69.00
69.01	03140	CARDIAC REHABILITATION	145,324	45,956	99,368	0	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	285,994	50,945	235,049	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	3,619,582	96,819	3,522,763	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	547,277	14,772	532,505	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	5,425,794	151,477	5,274,317	0	73.00
74.00	07400	RENAL DIALYSIS	103,101	2,789	100,312	0	74.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	3,680,663	304,489	3,376,174	0	90.00
91.00	09100	EMERGENCY	4,506,787	336,348	4,170,439	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	2,587,840	262,542	2,325,298	0	92.00
OTHER REIMBURSABLE COST CENTERS							
99.30	09930	OOT	258,942	7,576	251,366	0	99.30
200.00		Subtotal (sum of lines 50 thru 199)	49,951,274	3,992,288	45,958,986	0	200.00
201.00		Less Observation Beds	2,587,840	262,542	2,325,298	0	201.00
202.00		Total (line 200 minus line 201)	47,363,434	3,729,746	43,633,688	0	202.00

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

Provider CCN: 14-0034

Period:
From 01/01/2020
To 12/31/2020Worksheet C
Part II
Date/Time Prepared:
7/28/2021 12:17 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	6,701,929	32,248,679	0.207820	50.00
51.00	05100	RECOVERY ROOM	441,878	3,522,190	0.125455	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,691,699	3,466,310	0.488040	52.00
53.00	05300	ANESTHESIOLOGY	1,136,594	4,891,190	0.232376	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,915,349	11,874,949	0.245504	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	1,065,552	6,395,953	0.166598	55.00
56.00	05600	RADIOISOTOPE	556,488	6,275,695	0.088674	56.00
57.00	05700	CT SCAN	1,381,672	30,527,197	0.045260	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	228,445	5,403,647	0.042276	58.00
59.00	05900	CARDIAC CATHETERIZATION	254,431	197,710	1.286890	59.00
60.00	06000	LABORATORY	5,398,636	47,023,899	0.114806	60.00
64.00	06400	INTRAVENOUS THERAPY	653,273	1,433,295	0.455784	64.00
65.00	06500	RESPIRATORY THERAPY	1,996,782	12,734,306	0.156803	65.00
66.00	06600	PHYSICAL THERAPY	2,023,650	6,249,013	0.323835	66.00
66.01	03340	CLINICAL NUTRITION	199,412	29,545	6.749433	66.01
67.00	06700	OCCUPATIONAL THERAPY	198,969	679,217	0.292939	67.00
68.00	06800	SPEECH PATHOLOGY	189,694	310,150	0.611620	68.00
69.00	06900	ELECTROCARDIOLOGY	1,755,517	13,059,661	0.134423	69.00
69.01	03140	CARDIAC REHABILITATION	145,324	318,990	0.455575	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	285,994	1,073,220	0.266482	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	3,619,582	6,499,721	0.556883	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	547,277	1,418,000	0.385950	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	5,425,794	30,562,271	0.177532	73.00
74.00	07400	RENAL DIALYSIS	103,101	275,340	0.374450	74.00
	OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	3,680,663	5,464,653	0.673540	90.00
91.00	09100	EMERGENCY	4,506,787	24,230,364	0.185997	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	2,587,840	2,064,689	1.253380	92.00
	OTHER REIMBURSABLE COST CENTERS					
99.30	09930	OOT	258,942	0	0.000000	99.30
200.00		Subtotal (sum of lines 50 thru 199)	49,951,274	258,229,854		200.00
201.00		Less Observation Beds	2,587,840	0		201.00
202.00		Total (line 200 minus line 201)	47,363,434	258,229,854		202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

Provider CCN: 14-0034

Period:
From 01/01/2020
To 12/31/2020Worksheet D
Part I
Date/Time Prepared:
7/28/2021 12:17 pm

			Title XVIII		Hospital	PPS	
Cost Center Description		Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)	
		1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	ADULTS & PEDIATRICS	1,581,708	0	1,581,708	11,501	137.53	30.00
31.00	INTENSIVE CARE UNIT	242,098		242,098	1,395	173.55	31.00
40.00	SUBPROVIDER - IPF	359,505	0	359,505	5,152	69.78	40.00
43.00	NURSERY	99,336		99,336	490	202.73	43.00
200.00	Total (lines 30 through 199)	2,282,647		2,282,647	18,538		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	6,497	893,532				
31.00	INTENSIVE CARE UNIT	921	159,840				
40.00	SUBPROVIDER - IPF	1,219	85,062				
43.00	NURSERY	0	0				
200.00	Total (lines 30 through 199)	8,637	1,138,434				

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 14-0034

Period:
From 01/01/2020
To 12/31/2020Worksheet D
Part II
Date/Time Prepared:
7/28/2021 12:17 pm

Cost Center Description			Title XVIII		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	1,045,766	32,248,679	0.032428	2,651,305	85,977	50.00
51.00	05100	RECOVERY ROOM	14,306	3,522,190	0.004062	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	167,449	3,466,310	0.048308	1,090	53	52.00
53.00	05300	ANESTHESIOLOGY	88,331	4,891,190	0.018059	377,555	6,818	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	319,638	11,874,949	0.026917	1,203,810	32,403	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	33,648	6,395,953	0.005261	0	0	55.00
56.00	05600	RADIOISOTOPE	33,984	6,275,695	0.005415	188,795	1,022	56.00
57.00	05700	CT SCAN	91,707	30,527,197	0.003004	3,691,095	11,088	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	15,732	5,403,647	0.002911	315,505	918	58.00
59.00	05900	CARDIAC CATHETERIZATION	52,156	197,710	0.263801	29,100	7,677	59.00
60.00	06000	LABORATORY	271,406	47,023,899	0.005772	9,057,484	52,280	60.00
64.00	06400	INTRAVENOUS THERAPY	40,248	1,433,295	0.028081	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	122,911	12,734,306	0.009652	4,078,255	39,363	65.00
66.00	06600	PHYSICAL THERAPY	214,775	6,249,013	0.034369	789,675	27,140	66.00
66.01	03340	CLINICAL NUTRITION	5,975	29,545	0.202234	0	0	66.01
67.00	06700	OCCUPATIONAL THERAPY	6,155	679,217	0.009062	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	18,435	310,150	0.059439	52,700	3,132	68.00
69.00	06900	ELECTROCARDIOLOGY	175,953	13,059,661	0.013473	2,339,897	31,525	69.00
69.01	03140	CARDIAC REHABILITATION	45,956	318,990	0.144067	0	0	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	50,945	1,073,220	0.047469	1,155	55	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	96,819	6,499,721	0.014896	2,545	38	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	14,772	1,418,000	0.010417	218,842	2,280	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	151,477	30,562,271	0.004956	8,292,605	41,098	73.00
74.00	07400	RENAL DIALYSIS	2,789	275,340	0.010129	155,445	1,575	74.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	304,489	5,464,653	0.055720	545	30	90.00
91.00	09100	EMERGENCY	336,348	24,230,364	0.013881	2,910,358	40,399	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	262,542	2,064,689	0.127158	266,552	33,894	92.00
200.00		Total (lines 50 through 199)	3,984,712	258,229,854		36,624,313	418,765	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS					Provider CCN: 14-0034		Period: From 01/01/2020 To 12/31/2020		Worksheet D Part III Date/Time Prepared: 7/28/2021 12:17 pm		
					Title XVIII		Hospital		PPS		
Cost Center Description					Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health Cost	All Other Medical Education Cost		
					1A	1.00	2A	2.00	3.00		
INPATIENT ROUTINE SERVICE COST CENTERS											
30.00	03000	ADULTS & PEDIATRICS		0	0	0	0	0	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	
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	11,501	0.00	6,497		30.00	
31.00	03100	INTENSIVE CARE UNIT			0	1,395	0.00	921		31.00	
40.00	04000	SUBPROVIDER - IPF		0	0	5,152	0.00	1,219		40.00	
43.00	04300	NURSERY			0	490	0.00	0		43.00	
200.00		Total (lines 30 through 199)			0	18,538		8,637		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	
200.00		Total (lines 30 through 199)		0						200.00	

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

Provider CCN: 14-0034

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

Worksheet D
Part IV
Date/Time Prepared:
7/28/2021 12:17 pm

Cost Center Description		Title XVIII		Hospital		PPS	
		Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health	
		1.00	2A	2.00	3A	3.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	0	0	0	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
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	55.00
56.00	05600	RADIOISOTOPE	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	59.00
60.00	06000	LABORATORY	0	0	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	66.00
66.01	03340	CLINICAL NUTRITION	0	0	0	0	66.01
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	69.00
69.01	03140	CARDIAC REHABILITATION	0	0	0	0	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	74.00
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: 14-0034

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

Worksheet D
Part IV
Date/Time Prepared:
7/28/2021 12:17 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	32,248,679	0.000000	50.00	
51.00	05100	RECOVERY ROOM	0	0	0	3,522,190	0.000000	51.00	
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	3,466,310	0.000000	52.00	
53.00	05300	ANESTHESIOLOGY	0	0	0	4,891,190	0.000000	53.00	
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	11,874,949	0.000000	54.00	
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	6,395,953	0.000000	55.00	
56.00	05600	RADIOISOTOPE	0	0	0	6,275,695	0.000000	56.00	
57.00	05700	CT SCAN	0	0	0	30,527,197	0.000000	57.00	
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	5,403,647	0.000000	58.00	
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	197,710	0.000000	59.00	
60.00	06000	LABORATORY	0	0	0	47,023,899	0.000000	60.00	
64.00	06400	INTRAVENOUS THERAPY	0	0	0	1,433,295	0.000000	64.00	
65.00	06500	RESPIRATORY THERAPY	0	0	0	12,734,306	0.000000	65.00	
66.00	06600	PHYSICAL THERAPY	0	0	0	6,249,013	0.000000	66.00	
66.01	03340	CLINICAL NUTRITION	0	0	0	29,545	0.000000	66.01	
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	679,217	0.000000	67.00	
68.00	06800	SPEECH PATHOLOGY	0	0	0	310,150	0.000000	68.00	
69.00	06900	ELECTROCARDIOLOGY	0	0	0	13,059,661	0.000000	69.00	
69.01	03140	CARDIAC REHABILITATION	0	0	0	318,990	0.000000	69.01	
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	1,073,220	0.000000	70.00	
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	6,499,721	0.000000	71.00	
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	1,418,000	0.000000	72.00	
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	30,562,271	0.000000	73.00	
74.00	07400	RENAL DIALYSIS	0	0	0	275,340	0.000000	74.00	
	OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0	5,464,653	0.000000	90.00	
91.00	09100	EMERGENCY	0	0	0	24,230,364	0.000000	91.00	
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	2,064,689	0.000000	92.00	
200.00		Total (lines 50 through 199)	0	0	0	258,229,854		200.00	

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-0034

Period:
From 01/01/2020
To 12/31/2020Worksheet D
Part IV
Date/Time Prepared:
7/28/2021 12:17 pm

Cost Center Description		Title XVIII			Hospital		PPS
		Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
		9.00	10.00	11.00	12.00	13.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0.000000	2,651,305	0	7,602,991	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	1,090	0	2,180	0 52.00
53.00	05300	ANESTHESIOLOGY	0.000000	377,555	0	976,175	0 53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	1,203,810	0	5,144,110	0 54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.000000	0	0	0	0 55.00
56.00	05600	RADIOISOTOPE	0.000000	188,795	0	2,715,600	0 56.00
57.00	05700	CT SCAN	0.000000	3,691,095	0	9,588,845	0 57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000	315,505	0	1,985,620	0 58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	29,100	0	40,070	0 59.00
60.00	06000	LABORATORY	0.000000	9,057,484	0	5,630,690	0 60.00
64.00	06400	INTRAVENOUS THERAPY	0.000000	0	0	161,965	0 64.00
65.00	06500	RESPIRATORY THERAPY	0.000000	4,078,255	0	2,177,869	0 65.00
66.00	06600	PHYSICAL THERAPY	0.000000	789,675	0	25,910	0 66.00
66.01	03340	CLINICAL NUTRITION	0.000000	0	0	0	0 66.01
67.00	06700	OCCUPATIONAL THERAPY	0.000000	0	0	0	0 67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	52,700	0	128,604	0 68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	2,339,897	0	4,083,040	0 69.00
69.01	03140	CARDIAC REHABILITATION	0.000000	0	0	96,410	0 69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	1,155	0	49,750	0 70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	2,545	0	252,583	0 71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	218,842	0	146,096	0 72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	8,292,605	0	10,504,242	0 73.00
74.00	07400	RENAL DIALYSIS	0.000000	155,445	0	8,390	0 74.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0.000000	545	0	156,124	0 90.00
91.00	09100	EMERGENCY	0.000000	2,910,358	0	6,804,308	0 91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	266,552	0	943,574	0 92.00
200.00		Total (lines 50 through 199)		36,624,313	0	59,225,146	0 200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST				Provider CCN: 14-0034	Period: From 01/01/2020 To 12/31/2020	Worksheet D Part V Date/Time Prepared: 7/28/2021 12:17 pm		
				Title XVIII	Hospital	PPS		
Cost Center Description			Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges		Costs		
				PPS Reimbursed Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0.207820	7,602,991	0	0	1,580,054	50.00
51.00	05100	RECOVERY ROOM	0.125455	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.488040	2,180	0	0	1,064	52.00
53.00	05300	ANESTHESIOLOGY	0.232376	976,175	0	0	226,840	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.245504	5,144,110	0	0	1,262,900	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.166598	0	0	0	0	55.00
56.00	05600	RADIOISOTOPE	0.088674	2,715,600	0	0	240,803	56.00
57.00	05700	CT SCAN	0.045260	9,588,845	0	0	433,991	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.042276	1,985,620	0	0	83,944	58.00
59.00	05900	CARDIAC CATHETERIZATION	1.286890	40,070	0	0	51,566	59.00
60.00	06000	LABORATORY	0.114806	5,630,690	0	0	646,437	60.00
64.00	06400	INTRAVENOUS THERAPY	0.455784	161,965	0	0	73,821	64.00
65.00	06500	RESPIRATORY THERAPY	0.156803	2,177,869	0	0	341,496	65.00
66.00	06600	PHYSICAL THERAPY	0.323835	25,910	0	0	8,391	66.00
66.01	03340	CLINICAL NUTRITION	6.749433	0	0	0	0	66.01
67.00	06700	OCCUPATIONAL THERAPY	0.292939	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.611620	128,604	0	0	78,657	68.00
69.00	06900	ELECTROCARDIOLOGY	0.134423	4,083,040	0	0	548,854	69.00
69.01	03140	CARDIAC REHABILITATION	0.455575	96,410	0	0	43,922	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0.266482	49,750	0	0	13,257	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.556883	252,583	0	0	140,659	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.385950	146,096	0	0	56,386	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.177532	10,504,242	0	92,154	1,864,839	73.00
74.00	07400	RENAL DIALYSIS	0.374450	8,390	0	0	3,142	74.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0.673540	156,124	0	0	105,156	90.00
91.00	09100	EMERGENCY	0.185997	6,804,308	0	0	1,265,581	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.253380	943,574	0	0	1,182,657	92.00
200.00		Subtotal (see instructions)		59,225,146		92,154	10,254,417	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges				0		201.00
202.00		Net Charges (line 200 - line 201)		59,225,146	0	92,154	10,254,417	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-0034

Period:
From 01/01/2020
To 12/31/2020Worksheet D
Part V
Date/Time Prepared:
7/28/2021 12:17 pm

			Title XVIII		Hospital	PPS
	Cost Center Description	Costs				
		Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)			
		6.00	7.00			
	ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	0		50.00
51.00	05100	RECOVERY ROOM	0	0		51.00
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
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0		55.00
56.00	05600	RADIOISOTOPE	0	0		56.00
57.00	05700	CT SCAN	0	0		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0		58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0		59.00
60.00	06000	LABORATORY	0	0		60.00
64.00	06400	INTRAVENOUS THERAPY	0	0		64.00
65.00	06500	RESPIRATORY THERAPY	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0		66.00
66.01	03340	CLINICAL NUTRITION	0	0		66.01
67.00	06700	OCCUPATIONAL THERAPY	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0		69.00
69.01	03140	CARDIAC REHABILITATION	0	0		69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	16,360		73.00
74.00	07400	RENAL DIALYSIS	0	0		74.00
	OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	0	0		90.00
91.00	09100	EMERGENCY	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0		92.00
200.00		Subtotal (see instructions)	0	16,360		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	0	16,360		202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS				Provider CCN: 14-0034	Period: From 01/01/2020 To 12/31/2020	Worksheet D Part II Date/Time Prepared: 7/28/2021 12:17 pm		
				Component CCN: 14-S034				
				Title XVIII		Subprovider - IPF	PPS	
	Cost Center Description		Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
	ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	1,045,766	32,248,679	0.032428	0	0	50.00
51.00	05100	RECOVERY ROOM	14,306	3,522,190	0.004062	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	167,449	3,466,310	0.048308	0	0	52.00
53.00	05300	ANESTHESIOLOGY	88,331	4,891,190	0.018059	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	319,638	11,874,949	0.026917	10,060	271	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	33,648	6,395,953	0.005261	0	0	55.00
56.00	05600	RADIOISOTOPE	33,984	6,275,695	0.005415	0	0	56.00
57.00	05700	CT SCAN	91,707	30,527,197	0.003004	50,425	151	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	15,732	5,403,647	0.002911	18,795	55	58.00
59.00	05900	CARDIAC CATHETERIZATION	52,156	197,710	0.263801	0	0	59.00
60.00	06000	LABORATORY	271,406	47,023,899	0.005772	286,385	1,653	60.00
64.00	06400	INTRAVENOUS THERAPY	40,248	1,433,295	0.028081	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	122,911	12,734,306	0.009652	104,065	1,004	65.00
66.00	06600	PHYSICAL THERAPY	214,775	6,249,013	0.034369	5,780	199	66.00
66.01	03340	CLINICAL NUTRITION	5,975	29,545	0.202234	0	0	66.01
67.00	06700	OCCUPATIONAL THERAPY	6,155	679,217	0.009062	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	18,435	310,150	0.059439	205	12	68.00
69.00	06900	ELECTROCARDIOLOGY	175,953	13,059,661	0.013473	23,710	319	69.00
69.01	03140	CARDIAC REHABILITATION	45,956	318,990	0.144067	0	0	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	50,945	1,073,220	0.047469	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	96,819	6,499,721	0.014896	25,560	381	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	14,772	1,418,000	0.010417	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	151,477	30,562,271	0.004956	121,893	604	73.00
74.00	07400	RENAL DIALYSIS	2,789	275,340	0.010129	0	0	74.00
	OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	304,489	5,464,653	0.055720	0	0	90.00
91.00	09100	EMERGENCY	336,348	24,230,364	0.013881	95,940	1,332	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	2,064,689	0.000000	0	0	92.00
200.00		Total (lines 50 through 199)	3,722,170	258,229,854		742,818	5,981	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS				Provider CCN: 14-0034 Component CCN: 14-S034		Period: From 01/01/2020 To 12/31/2020		Worksheet D Part IV Date/Time Prepared: 7/28/2021 12:17 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
55.00	05500	RADIOLOGY-THERAPEUTIC		0	0	0	0	0	55.00
56.00	05600	RADIOISOTOPE		0	0	0	0	0	56.00
57.00	05700	CT SCAN		0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)		0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION		0	0	0	0	0	59.00
60.00	06000	LABORATORY		0	0	0	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY		0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY		0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY		0	0	0	0	0	66.00
66.01	03340	CLINICAL NUTRITION		0	0	0	0	0	66.01
67.00	06700	OCCUPATIONAL THERAPY		0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY		0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY		0	0	0	0	0	69.00
69.01	03140	CARDIAC REHABILITATION		0	0	0	0	0	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY		0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS		0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS		0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS		0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS		0	0	0	0	0	74.00
OUTPATIENT SERVICE COST CENTERS									
90.00	09000	CLINIC		0	0	0	0	0	90.00
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: 14-0034 Component CCN: 14-S034		Period: From 01/01/2020 To 12/31/2020		Worksheet D Part IV Date/Time Prepared: 7/28/2021 12:17 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	32,248,679	0.000000	50.00
51.00	05100	RECOVERY ROOM		0	0	0	3,522,190	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM		0	0	0	3,466,310	0.000000	52.00
53.00	05300	ANESTHESIOLOGY		0	0	0	4,891,190	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC		0	0	0	11,874,949	0.000000	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC		0	0	0	6,395,953	0.000000	55.00
56.00	05600	RADIOISOTOPE		0	0	0	6,275,695	0.000000	56.00
57.00	05700	CT SCAN		0	0	0	30,527,197	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)		0	0	0	5,403,647	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION		0	0	0	197,710	0.000000	59.00
60.00	06000	LABORATORY		0	0	0	47,023,899	0.000000	60.00
64.00	06400	INTRAVENOUS THERAPY		0	0	0	1,433,295	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY		0	0	0	12,734,306	0.000000	65.00
66.00	06600	PHYSICAL THERAPY		0	0	0	6,249,013	0.000000	66.00
66.01	03340	CLINICAL NUTRITION		0	0	0	29,545	0.000000	66.01
67.00	06700	OCCUPATIONAL THERAPY		0	0	0	679,217	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY		0	0	0	310,150	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY		0	0	0	13,059,661	0.000000	69.00
69.01	03140	CARDIAC REHABILITATION		0	0	0	318,990	0.000000	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY		0	0	0	1,073,220	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS		0	0	0	6,499,721	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS		0	0	0	1,418,000	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS		0	0	0	30,562,271	0.000000	73.00
74.00	07400	RENAL DIALYSIS		0	0	0	275,340	0.000000	74.00
OUTPATIENT SERVICE COST CENTERS									
90.00	09000	CLINIC		0	0	0	5,464,653	0.000000	90.00
91.00	09100	EMERGENCY		0	0	0	24,230,364	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)		0	0	0	2,064,689	0.000000	92.00
200.00		Total (lines 50 through 199)		0	0	0	258,229,854		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS				Provider CCN: 14-0034 Component CCN: 14-S034		Period: From 01/01/2020 To 12/31/2020		Worksheet D Part IV Date/Time Prepared: 7/28/2021 12:17 pm	
				Title XVIII		Subprovider - IPF		PPS	
Cost Center Description				Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
				9.00	10.00	11.00	12.00	13.00	
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM		0.000000	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM		0.000000	0	0	0	0	51.00
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	10,060	0	0	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC		0.000000	0	0	0	0	55.00
56.00	05600	RADIOISOTOPE		0.000000	0	0	0	0	56.00
57.00	05700	CT SCAN		0.000000	50,425	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)		0.000000	18,795	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION		0.000000	0	0	0	0	59.00
60.00	06000	LABORATORY		0.000000	286,385	0	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY		0.000000	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY		0.000000	104,065	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY		0.000000	5,780	0	0	0	66.00
66.01	03340	CLINICAL NUTRITION		0.000000	0	0	0	0	66.01
67.00	06700	OCCUPATIONAL THERAPY		0.000000	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY		0.000000	205	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY		0.000000	23,710	0	0	0	69.00
69.01	03140	CARDIAC REHABILITATION		0.000000	0	0	0	0	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY		0.000000	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS		0.000000	25,560	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	121,893	0	0	0	73.00
74.00	07400	RENAL DIALYSIS		0.000000	0	0	0	0	74.00
OUTPATIENT SERVICE COST CENTERS									
90.00	09000	CLINIC		0.000000	0	0	179,660	0	90.00
91.00	09100	EMERGENCY		0.000000	95,940	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)			742,818	0	179,660	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST				Provider CCN: 14-0034 Component CCN: 14-S034		Period: From 01/01/2020 To 12/31/2020		Worksheet D Part V Date/Time Prepared: 7/28/2021 12:17 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	0.207820	0	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0.125455	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.488040	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.232376	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.245504	0	0	0	0	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.166598	0	0	0	0	0	55.00
56.00	05600	RADIOISOTOPE	0.088674	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0.045260	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.042276	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	1.286890	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0.114806	0	0	0	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0.455784	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.156803	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.323835	0	0	0	0	0	66.00
66.01	03340	CLINICAL NUTRITION	6.749433	0	0	0	0	0	66.01
67.00	06700	OCCUPATIONAL THERAPY	0.292939	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.611620	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.134423	0	0	0	0	0	69.00
69.01	03140	CARDIAC REHABILITATION	0.455575	0	0	0	0	0	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0.266482	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.556883	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.385950	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.177532	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0.374450	0	0	0	0	0	74.00
OUTPATIENT SERVICE COST CENTERS									
90.00	09000	CLINIC	0.673540	179,660	0	0	121,008	90.00	
91.00	09100	EMERGENCY	0.185997	0	0	0	0	91.00	
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.253380	0	0	0	0	92.00	
200.00		Subtotal (see instructions)		179,660	0	0	121,008	200.00	
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00	
202.00		Net Charges (line 200 - line 201)		179,660	0	0	121,008	202.00	

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST			Provider CCN: 14-0034 Component CCN: 14-S034		Period: From 01/01/2020 To 12/31/2020		Worksheet D Part V Date/Time Prepared: 7/28/2021 12:17 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
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0					55.00
56.00	05600	RADIOISOTOPE	0	0					56.00
57.00	05700	CT SCAN	0	0					57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0					58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0					59.00
60.00	06000	LABORATORY	0	0					60.00
64.00	06400	INTRAVENOUS THERAPY	0	0					64.00
65.00	06500	RESPIRATORY THERAPY	0	0					65.00
66.00	06600	PHYSICAL THERAPY	0	0					66.00
66.01	03340	CLINICAL NUTRITION	0	0					66.01
67.00	06700	OCCUPATIONAL THERAPY	0	0					67.00
68.00	06800	SPEECH PATHOLOGY	0	0					68.00
69.00	06900	ELECTROCARDIOLOGY	0	0					69.00
69.01	03140	CARDIAC REHABILITATION	0	0					69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0					70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0					71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0					72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0					73.00
74.00	07400	RENAL DIALYSIS	0	0					74.00
OUTPATIENT SERVICE COST CENTERS									
90.00	09000	CLINIC	0	0					90.00
91.00	09100	EMERGENCY	0	0					91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0					92.00
200.00		Subtotal (see instructions)	0	0					200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0						201.00
202.00		Net Charges (line 200 - line 201)	0	0					202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

Provider CCN: 14-0034

Period:
From 01/01/2020
To 12/31/2020Worksheet D
Part I
Date/Time Prepared:
7/28/2021 12:17 pm

			Title XIX		Hospital	PPS	
Cost Center Description		Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	1,581,708	0	1,581,708	11,501	137.53	30.00
31.00	INTENSIVE CARE UNIT	242,098		242,098	1,395	173.55	31.00
40.00	SUBPROVIDER - IPF	359,505	0	359,505	5,152	69.78	40.00
43.00	NURSERY	99,336		99,336	490	202.73	43.00
200.00	Total (lines 30 through 199)	2,282,647		2,282,647	18,538		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	240	33,007				30.00
31.00	INTENSIVE CARE UNIT	64	11,107				31.00
40.00	SUBPROVIDER - IPF	456	31,820				40.00
43.00	NURSERY	95	19,259				43.00
200.00	Total (lines 30 through 199)	855	95,193				200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 14-0034

Period:
From 01/01/2020
To 12/31/2020Worksheet D
Part II
Date/Time Prepared:
7/28/2021 12:17 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	1,045,766	32,248,679	0.032428	0	0 50.00
51.00	05100	RECOVERY ROOM	14,306	3,522,190	0.004062	0	0 51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	167,449	3,466,310	0.048308	0	0 52.00
53.00	05300	ANESTHESIOLOGY	88,331	4,891,190	0.018059	0	0 53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	319,638	11,874,949	0.026917	0	0 54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	33,648	6,395,953	0.005261	0	0 55.00
56.00	05600	RADIOISOTOPE	33,984	6,275,695	0.005415	0	0 56.00
57.00	05700	CT SCAN	91,707	30,527,197	0.003004	0	0 57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	15,732	5,403,647	0.002911	0	0 58.00
59.00	05900	CARDIAC CATHETERIZATION	52,156	197,710	0.263801	0	0 59.00
60.00	06000	LABORATORY	271,406	47,023,899	0.005772	0	0 60.00
64.00	06400	INTRAVENOUS THERAPY	40,248	1,433,295	0.028081	0	0 64.00
65.00	06500	RESPIRATORY THERAPY	122,911	12,734,306	0.009652	0	0 65.00
66.00	06600	PHYSICAL THERAPY	214,775	6,249,013	0.034369	0	0 66.00
66.01	03340	CLINICAL NUTRITION	5,975	29,545	0.202234	0	0 66.01
67.00	06700	OCCUPATIONAL THERAPY	6,155	679,217	0.009062	0	0 67.00
68.00	06800	SPEECH PATHOLOGY	18,435	310,150	0.059439	0	0 68.00
69.00	06900	ELECTROCARDIOLOGY	175,953	13,059,661	0.013473	0	0 69.00
69.01	03140	CARDIAC REHABILITATION	45,956	318,990	0.144067	0	0 69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	50,945	1,073,220	0.047469	0	0 70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	96,819	6,499,721	0.014896	0	0 71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	14,772	1,418,000	0.010417	0	0 72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	151,477	30,562,271	0.004956	0	0 73.00
74.00	07400	RENAL DIALYSIS	2,789	275,340	0.010129	0	0 74.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	304,489	5,464,653	0.055720	0	0 90.00
91.00	09100	EMERGENCY	336,348	24,230,364	0.013881	0	0 91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	262,542	2,064,689	0.127158	0	0 92.00
200.00		Total (lines 50 through 199)	3,984,712	258,229,854		0	0 200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS					Provider CCN: 14-0034		Period: From 01/01/2020 To 12/31/2020		Worksheet D Part III Date/Time Prepared: 7/28/2021 12:17 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	
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	11,501	0.00		240	30.00	
31.00	03100	INTENSIVE CARE UNIT			0	1,395	0.00		64	31.00	
40.00	04000	SUBPROVIDER - IPF		0	0	5,152	0.00		456	40.00	
43.00	04300	NURSERY			0	490	0.00		95	43.00	
200.00		Total (lines 30 through 199)			0	18,538			855	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	
200.00		Total (lines 30 through 199)		0						200.00	

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

Provider CCN: 14-0034

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

Worksheet D
Part IV
Date/Time Prepared:
7/28/2021 12:17 pm

Cost Center Description		Title XIX		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
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	55.00
56.00	05600	RADIOISOTOPE	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	59.00
60.00	06000	LABORATORY	0	0	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	66.00
66.01	03340	CLINICAL NUTRITION	0	0	0	0	66.01
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	69.00
69.01	03140	CARDIAC REHABILITATION	0	0	0	0	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	74.00
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: 14-0034

Period:
From 01/01/2020
To 12/31/2020Worksheet D
Part IV
Date/Time Prepared:
7/28/2021 12:17 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	32,248,679	0.000000	50.00
51.00	05100	RECOVERY ROOM	0	0	0	3,522,190	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	3,466,310	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	4,891,190	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	11,874,949	0.000000	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	6,395,953	0.000000	55.00
56.00	05600	RADIOISOTOPE	0	0	0	6,275,695	0.000000	56.00
57.00	05700	CT SCAN	0	0	0	30,527,197	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	5,403,647	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	197,710	0.000000	59.00
60.00	06000	LABORATORY	0	0	0	47,023,899	0.000000	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	1,433,295	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	12,734,306	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	6,249,013	0.000000	66.00
66.01	03340	CLINICAL NUTRITION	0	0	0	29,545	0.000000	66.01
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	679,217	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	310,150	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	13,059,661	0.000000	69.00
69.01	03140	CARDIAC REHABILITATION	0	0	0	318,990	0.000000	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	1,073,220	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	6,499,721	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	1,418,000	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	30,562,271	0.000000	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	275,340	0.000000	74.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0	5,464,653	0.000000	90.00
91.00	09100	EMERGENCY	0	0	0	24,230,364	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	2,064,689	0.000000	92.00
200.00		Total (lines 50 through 199)	0	0	0	258,229,854		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-0034

Period:
From 01/01/2020
To 12/31/2020Worksheet D
Part IV
Date/Time Prepared:
7/28/2021 12:17 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	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
55.00	05500	RADIOLOGY-THERAPEUTIC	0.000000	0	0	0	0	55.00
56.00	05600	RADIOISOTOPE	0.000000	0	0	0	0	56.00
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
59.00	05900	CARDIAC CATHETERIZATION	0.000000	0	0	0	0	59.00
60.00	06000	LABORATORY	0.000000	0	0	0	0	60.00
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
66.01	03340	CLINICAL NUTRITION	0.000000	0	0	0	0	66.01
67.00	06700	OCCUPATIONAL THERAPY	0.000000	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	0	0	0	0	69.00
69.01	03140	CARDIAC REHABILITATION	0.000000	0	0	0	0	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0.000000	0	0	0	0	74.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0.000000	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 ANCILLARY SERVICE CAPITAL COSTS				Provider CCN: 14-0034 Component CCN: 14-S034		Period: From 01/01/2020 To 12/31/2020		Worksheet D Part II Date/Time Prepared: 7/28/2021 12:17 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		1,045,766	32,248,679	0.032428	0	0	50.00
51.00	05100	RECOVERY ROOM		14,306	3,522,190	0.004062	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM		167,449	3,466,310	0.048308	0	0	52.00
53.00	05300	ANESTHESIOLOGY		88,331	4,891,190	0.018059	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC		319,638	11,874,949	0.026917	0	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC		33,648	6,395,953	0.005261	0	0	55.00
56.00	05600	RADIOISOTOPE		33,984	6,275,695	0.005415	0	0	56.00
57.00	05700	CT SCAN		91,707	30,527,197	0.003004	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)		15,732	5,403,647	0.002911	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION		52,156	197,710	0.263801	0	0	59.00
60.00	06000	LABORATORY		271,406	47,023,899	0.005772	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY		40,248	1,433,295	0.028081	0	0	64.00
65.00	06500	RESPIRATORY THERAPY		122,911	12,734,306	0.009652	0	0	65.00
66.00	06600	PHYSICAL THERAPY		214,775	6,249,013	0.034369	0	0	66.00
66.01	03340	CLINICAL NUTRITION		5,975	29,545	0.202234	0	0	66.01
67.00	06700	OCCUPATIONAL THERAPY		6,155	679,217	0.009062	0	0	67.00
68.00	06800	SPEECH PATHOLOGY		18,435	310,150	0.059439	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY		175,953	13,059,661	0.013473	0	0	69.00
69.01	03140	CARDIAC REHABILITATION		45,956	318,990	0.144067	0	0	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY		50,945	1,073,220	0.047469	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS		96,819	6,499,721	0.014896	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS		14,772	1,418,000	0.010417	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS		151,477	30,562,271	0.004956	0	0	73.00
74.00	07400	RENAL DIALYSIS		2,789	275,340	0.010129	0	0	74.00
OUTPATIENT SERVICE COST CENTERS									
90.00	09000	CLINIC		304,489	5,464,653	0.055720	0	0	90.00
91.00	09100	EMERGENCY		336,348	24,230,364	0.013881	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)		0	2,064,689	0.000000	0	0	92.00
200.00		Total (lines 50 through 199)		3,722,170	258,229,854		0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS				Provider CCN: 14-0034 Component CCN: 14-S034		Period: From 01/01/2020 To 12/31/2020		Worksheet D Part IV Date/Time Prepared: 7/28/2021 12:17 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
55.00	05500	RADIOLOGY-THERAPEUTIC		0	0	0	0	0	55.00
56.00	05600	RADIOISOTOPE		0	0	0	0	0	56.00
57.00	05700	CT SCAN		0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)		0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION		0	0	0	0	0	59.00
60.00	06000	LABORATORY		0	0	0	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY		0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY		0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY		0	0	0	0	0	66.00
66.01	03340	CLINICAL NUTRITION		0	0	0	0	0	66.01
67.00	06700	OCCUPATIONAL THERAPY		0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY		0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY		0	0	0	0	0	69.00
69.01	03140	CARDIAC REHABILITATION		0	0	0	0	0	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY		0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS		0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS		0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS		0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS		0	0	0	0	0	74.00
OUTPATIENT SERVICE COST CENTERS									
90.00	09000	CLINIC		0	0	0	0	0	90.00
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: 14-0034 Component CCN: 14-S034		Period: From 01/01/2020 To 12/31/2020		Worksheet D Part IV Date/Time Prepared: 7/28/2021 12:17 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	32,248,679	0.000000	50.00
51.00	05100	RECOVERY ROOM		0	0	0	3,522,190	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM		0	0	0	3,466,310	0.000000	52.00
53.00	05300	ANESTHESIOLOGY		0	0	0	4,891,190	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC		0	0	0	11,874,949	0.000000	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC		0	0	0	6,395,953	0.000000	55.00
56.00	05600	RADIOISOTOPE		0	0	0	6,275,695	0.000000	56.00
57.00	05700	CT SCAN		0	0	0	30,527,197	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)		0	0	0	5,403,647	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION		0	0	0	197,710	0.000000	59.00
60.00	06000	LABORATORY		0	0	0	47,023,899	0.000000	60.00
64.00	06400	INTRAVENOUS THERAPY		0	0	0	1,433,295	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY		0	0	0	12,734,306	0.000000	65.00
66.00	06600	PHYSICAL THERAPY		0	0	0	6,249,013	0.000000	66.00
66.01	03340	CLINICAL NUTRITION		0	0	0	29,545	0.000000	66.01
67.00	06700	OCCUPATIONAL THERAPY		0	0	0	679,217	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY		0	0	0	310,150	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY		0	0	0	13,059,661	0.000000	69.00
69.01	03140	CARDIAC REHABILITATION		0	0	0	318,990	0.000000	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY		0	0	0	1,073,220	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS		0	0	0	6,499,721	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS		0	0	0	1,418,000	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS		0	0	0	30,562,271	0.000000	73.00
74.00	07400	RENAL DIALYSIS		0	0	0	275,340	0.000000	74.00
OUTPATIENT SERVICE COST CENTERS									
90.00	09000	CLINIC		0	0	0	5,464,653	0.000000	90.00
91.00	09100	EMERGENCY		0	0	0	24,230,364	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)		0	0	0	2,064,689	0.000000	92.00
200.00		Total (lines 50 through 199)		0	0	0	258,229,854		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS				Provider CCN: 14-0034 Component CCN: 14-S034		Period: From 01/01/2020 To 12/31/2020		Worksheet D Part IV Date/Time Prepared: 7/28/2021 12:17 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
55.00	05500	RADIOLOGY-THERAPEUTIC		0.000000	0	0	0	0	55.00
56.00	05600	RADIOISOTOPE		0.000000	0	0	0	0	56.00
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
59.00	05900	CARDIAC CATHETERIZATION		0.000000	0	0	0	0	59.00
60.00	06000	LABORATORY		0.000000	0	0	0	0	60.00
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
66.01	03340	CLINICAL NUTRITION		0.000000	0	0	0	0	66.01
67.00	06700	OCCUPATIONAL THERAPY		0.000000	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY		0.000000	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY		0.000000	0	0	0	0	69.00
69.01	03140	CARDIAC REHABILITATION		0.000000	0	0	0	0	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY		0.000000	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS		0.000000	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS		0.000000	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS		0.000000	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS		0.000000	0	0	0	0	74.00
OUTPATIENT SERVICE COST CENTERS									
90.00	09000	CLINIC		0.000000	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

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-0034	Period: From 01/01/2020 To 12/31/2020	Worksheet D-1 Date/Time Prepared: 7/28/2021 12:17 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)			11,501	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)			11,501	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.			9,530	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)			62	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)			6,497	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)			15,590,708	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)			15,590,708	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)			16,088,451	28.00
29.00	Private room charges (excluding swing-bed charges)			15,985,330	29.00
30.00	Semi-private room charges (excluding swing-bed charges)			103,121	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)			0.969062	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)			1,677.37	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)			1,663.24	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)			14.13	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)			13.69	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)			130,466	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)			15,460,242	37.00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY				
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS				
38.00	Adjusted general inpatient routine service cost per diem (see instructions)			1,355.60	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)			8,807,333	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)			8,807,333	41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-0034

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

Worksheet D-1

Date/Time Prepared:
7/28/2021 12:17 pm

Cost Center Description		Title XVIII		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	3,837,183	1,395	2,750.67	921	2,533,367
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)					5,952,567
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					17,293,267
PASS THROUGH COST ADJUSTMENTS						
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)					1,053,372
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					418,765
52.00	Total Program excludable cost (sum of lines 50 and 51)					1,472,137
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					15,821,130
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)					1,909
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					1,355.60
89.00	Observation bed cost (line 87 x line 88) (see instructions)					2,587,840

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-0034

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

Worksheet D-1

Date/Time Prepared:
7/28/2021 12:17 pm

Cost Center Description		Title XVIII		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	1,581,708	15,590,708	0.101452	2,587,840	262,542
91.00	Nursing School cost	0	15,590,708	0.000000	2,587,840	0
92.00	Allied health cost	0	15,590,708	0.000000	2,587,840	0
93.00	All other Medical Education	0	15,590,708	0.000000	2,587,840	0

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-0034 Component CCN: 14-S034	Period: From 01/01/2020 To 12/31/2020	Worksheet D-1 Date/Time Prepared: 7/28/2021 12:17 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)		5,152	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		5,152	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.		4	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)		5,148	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions)		1,219	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)		0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period		0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)		0	14.00
15.00	Total nursery days (title V or XIX only)		0	15.00
16.00	Nursery days (title V or XIX only)		0	16.00
SWING BED ADJUSTMENT				
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period		0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)		5,257,916	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)		0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)		0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)		0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)		0	25.00
26.00	Total swing-bed cost (see instructions)		0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)		5,257,916	27.00
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)		6,405,015	28.00
29.00	Private room charges (excluding swing-bed charges)		4,972	29.00
30.00	Semi-private room charges (excluding swing-bed charges)		6,400,043	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		0.820906	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)		1,243.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)		1,243.21	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)		0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)		0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)		0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)		5,257,916	37.00
PART II - HOSPITAL AND SUBPROVIDERS ONLY				
PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS				
38.00	Adjusted general inpatient routine service cost per diem (see instructions)		1,020.56	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		1,244,063	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)		1,244,063	41.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-0034 Component CCN: 14-S034		Period: From 01/01/2020 To 12/31/2020		Worksheet D-1 Date/Time Prepared: 7/28/2021 12:17 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)					113,872	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					1,357,935	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)					85,062	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					5,981	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)					91,043	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					1,266,892	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: 14-0034 Component CCN: 14-S034		Period: From 01/01/2020 To 12/31/2020		Worksheet D-1 Date/Time Prepared: 7/28/2021 12:17 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	359,505	5,257,916	0.068374	0	0	90.00
91.00	Nursing School cost	0	5,257,916	0.000000	0	0	91.00
92.00	Allied health cost	0	5,257,916	0.000000	0	0	92.00
93.00	All other Medical Education	0	5,257,916	0.000000	0	0	93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-0034	Period: From 01/01/2020 To 12/31/2020	Worksheet D-1 Date/Time Prepared: 7/28/2021 12:17 pm
Cost Center Description		Title XIX	Hospital	PPS
				1.00
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		11,501	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		11,501	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)		9,592	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)		240	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)		490	15.00
16.00	Nursery days (title V or XIX only)		95	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)		15,590,708	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)		15,590,708	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)		15,590,708	37.00
PART II - HOSPITAL AND SUBPROVIDERS ONLY				
PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS				
38.00	Adjusted general inpatient routine service cost per diem (see instructions)		1,355.60	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		325,344	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)		325,344	41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-0034

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

Worksheet D-1

Date/Time Prepared:
7/28/2021 12:17 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)	761,887	490	1,554.87	95	147,713
Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	3,837,183	1,395	2,750.67	64	176,043
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)					649,100
PASS THROUGH COST ADJUSTMENTS						
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)					63,373
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)					63,373
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					585,727
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)					1,909
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					1,355.60
89.00	Observation bed cost (line 87 x line 88) (see instructions)					2,587,840

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-0034

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

Worksheet D-1

Date/Time Prepared:
7/28/2021 12:17 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	1,581,708	15,590,708	0.101452	2,587,840	262,542
91.00	Nursing School cost	0	15,590,708	0.000000	2,587,840	0
92.00	Allied health cost	0	15,590,708	0.000000	2,587,840	0
93.00	All other Medical Education	0	15,590,708	0.000000	2,587,840	0

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-0034 Component CCN: 14-S034	Period: From 01/01/2020 To 12/31/2020	Worksheet D-1 Date/Time Prepared: 7/28/2021 12:17 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)		5,152	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		5,152	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.		0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)		5,152	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)		456	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)		490	15.00
16.00	Nursery days (title V or XIX only)		95	16.00
SWING BED ADJUSTMENT				
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period		0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)		5,257,916	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)		0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)		0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)		0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)		0	25.00
26.00	Total swing-bed cost (see instructions)		0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)		5,257,916	27.00
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)		0	28.00
29.00	Private room charges (excluding swing-bed charges)		0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)		0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)		0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)		0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)		0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)		0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)		0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)		5,257,916	37.00
PART II - HOSPITAL AND SUBPROVIDERS ONLY				
PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS				
38.00	Adjusted general inpatient routine service cost per diem (see instructions)		1,020.56	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		465,375	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)		465,375	41.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-0034 Component CCN: 14-S034		Period: From 01/01/2020 To 12/31/2020		Worksheet D-1 Date/Time Prepared: 7/28/2021 12:17 pm	
		Title XIX		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)					0	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					465,375	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)					31,820	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)					31,820	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					433,555	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: 14-0034 Component CCN: 14-S034		Period: From 01/01/2020 To 12/31/2020		Worksheet D-1 Date/Time Prepared: 7/28/2021 12:17 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	359,505	5,257,916	0.068374	0	0	90.00
91.00	Nursing School cost	0	5,257,916	0.000000	0	0	91.00
92.00	Allied health cost	0	5,257,916	0.000000	0	0	92.00
93.00	All other Medical Education	0	5,257,916	0.000000	0	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT			Provider CCN: 14-0034	Period: From 01/01/2020 To 12/31/2020	Worksheet D-3 Date/Time Prepared: 7/28/2021 12:17 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		9,314,950		30.00
31.00	03100	INTENSIVE CARE UNIT		2,073,025		31.00
40.00	04000	SUBPROVIDER - IPF		526,110		40.00
43.00	04300	NURSERY				43.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.207820	2,651,305	550,994	50.00
51.00	05100	RECOVERY ROOM	0.125455	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.488040	1,090	532	52.00
53.00	05300	ANESTHESIOLOGY	0.232376	377,555	87,735	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.245504	1,203,810	295,540	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.166598	0	0	55.00
56.00	05600	RADIOISOTOPE	0.088674	188,795	16,741	56.00
57.00	05700	CT SCAN	0.045260	3,691,095	167,059	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.042276	315,505	13,338	58.00
59.00	05900	CARDIAC CATHETERIZATION	1.286890	29,100	37,448	59.00
60.00	06000	LABORATORY	0.114944	9,057,484	1,041,103	60.00
64.00	06400	INTRAVENOUS THERAPY	0.455784	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.157224	4,078,255	641,200	65.00
66.00	06600	PHYSICAL THERAPY	0.323835	789,675	255,724	66.00
66.01	03340	CLINICAL NUTRITION	6.749433	0	0	66.01
67.00	06700	OCCUPATIONAL THERAPY	0.292939	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.611620	52,700	32,232	68.00
69.00	06900	ELECTROCARDIOLOGY	0.135469	2,339,897	316,984	69.00
69.01	03140	CARDIAC REHABILITATION	0.455575	0	0	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0.271474	1,155	314	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.556883	2,545	1,417	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.385950	218,842	84,462	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.177532	8,292,605	1,472,203	73.00
74.00	07400	RENAL DIALYSIS	0.374450	155,445	58,206	74.00
OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.673540	545	367	90.00
91.00	09100	EMERGENCY	0.187220	2,910,358	544,877	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.253380	266,552	334,091	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		36,624,313	5,952,567	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)		36,624,313		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 14-0034 Component CCN: 14-S034	Period: From 01/01/2020 To 12/31/2020	Worksheet D-3 Date/Time Prepared: 7/28/2021 12:17 pm	
		Title XVIII	Subprovider - IPF	PPS	
Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDIATRICS		0		30.00
31.00	03100 INTENSIVE CARE UNIT		0		31.00
40.00	04000 SUBPROVIDER - IPF		1,508,835		40.00
43.00	04300 NURSERY				43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.207820	0	0	50.00
51.00	05100 RECOVERY ROOM	0.125455	0	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.488040	0	0	52.00
53.00	05300 ANESTHESIOLOGY	0.232376	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.245504	10,060	2,470	54.00
55.00	05500 RADIOLOGY-THERAPEUTIC	0.166598	0	0	55.00
56.00	05600 RADIOISOTOPE	0.088674	0	0	56.00
57.00	05700 CT SCAN	0.045260	50,425	2,282	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0.042276	18,795	795	58.00
59.00	05900 CARDIAC CATHETERIZATION	1.286890	0	0	59.00
60.00	06000 LABORATORY	0.114944	286,385	32,918	60.00
64.00	06400 INTRAVENOUS THERAPY	0.455784	0	0	64.00
65.00	06500 RESPIRATORY THERAPY	0.157224	104,065	16,362	65.00
66.00	06600 PHYSICAL THERAPY	0.323835	5,780	1,872	66.00
66.01	03340 CLINICAL NUTRITION	6.749433	0	0	66.01
67.00	06700 OCCUPATIONAL THERAPY	0.292939	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0.611620	205	125	68.00
69.00	06900 ELECTROCARDIOLOGY	0.135469	23,710	3,212	69.00
69.01	03140 CARDIAC REHABILITATION	0.455575	0	0	69.01
70.00	07000 ELECTROENCEPHALOGRAPHY	0.271474	0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.556883	25,560	14,234	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.385950	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.177532	121,893	21,640	73.00
74.00	07400 RENAL DIALYSIS	0.374450	0	0	74.00
OUTPATIENT SERVICE COST CENTERS					
90.00	09000 CLINIC	0.673540	0	0	90.00
91.00	09100 EMERGENCY	0.187220	95,940	17,962	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	1.253380	0	0	92.00
200.00	Total (sum of lines 50 through 94 and 96 through 98)		742,818	113,872	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)		742,818		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0034	Period: From 01/01/2020 To 12/31/2020	Worksheet E Part A Date/Time Prepared: 7/28/2021 12:17 pm
		Title XVIII	Hospital	PPS
				1.00
PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS				
1.00	DRG Amounts Other than Outlier Payments		0	1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1 (see instructions)		8,762,895	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1 (see instructions)		3,773,632	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)		130,347	2.03
2.04	Outlier payments for discharges occurring on or after October 1 (see instructions)		31,010	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)		86.78	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)		3.85	30.00
31.00	Percentage of Medicaid patient days (see instructions)		21.85	31.00
32.00	Sum of lines 30 and 31		25.70	32.00
33.00	Allowable disproportionate share percentage (see instructions)		10.44	33.00
34.00	Disproportionate share adjustment (see instructions)		327,204	34.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0034	Period: From 01/01/2020 To 12/31/2020	Worksheet E Part A Date/Time Prepared: 7/28/2021 12:17 pm
		Title XVIII	Hospital	PPS
			Prior to 10/1	On/After 10/1
			1.00	2.00
Uncompensated Care Adjustment				
35.00	Total uncompensated care amount (see instructions)		8,350,647,496	8,290,014,521
35.01	Factor 3 (see instructions)		0.000074348	0.000095614
35.02	Hospital uncompensated care payment (If line 34 is zero, enter zero on this line) (see instructions)		620,854	792,643
35.03	Pro rata share of the hospital uncompensated care payment amount (see instructions)		464,792	199,790
36.00	Total uncompensated care (sum of columns 1 and 2 on line 35.03)		664,582	
Additional payment for high percentage of ESRD beneficiary discharges (lines 40 through 46)				
40.00	Total Medicare discharges, excluding MS-DRGs 652, 682, 683, 684 and 685. (see instructions)		0	
41.00	Total ESRD Medicare discharges excluding MS-DRGs 652, 682, 683, 684 and 685. (see instructions)		0	
41.01	Total ESRD Medicare covered and paid discharges excluding MS-DRGs 652, 682, 683, 684 and 685. (see instructions)		0	
42.00	Divide line 41 by line 40 (if less than 10%, you do not qualify for adjustment)		0.00	
43.00	Total Medicare ESRD inpatient days excluding MS-DRGs 652, 682, 683, 684 and 685. (see instructions)		0	
44.00	Ratio of average length of stay to one week (line 43 divided by line 41 divided by 7 days)		0.000000	
45.00	Average weekly cost for dialysis treatments (see instructions)		0.00	
46.00	Total additional payment (line 45 times line 44 times line 41.01)		0	
47.00	Subtotal (see instructions)		13,689,670	
48.00	Hospital specific payments (to be completed by SCH and MDH, small rural hospitals only. (see instructions))		14,932,333	
			Amount	
			1.00	
49.00	Total payment for inpatient operating costs (see instructions)		14,621,667	49.00
50.00	Payment for inpatient program capital (from Wkst. L, Pt. I and Pt. II, as applicable)		979,944	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		195,779	54.00
54.01	Islet isolation add-on payment		0	54.01
55.00	Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line 69)		0	55.00
56.00	Cost of physicians' services in a teaching hospital (see instructions)		0	56.00
57.00	Routine service other pass through costs (from Wkst. D, Pt. III, column 9, lines 30 through 35).		0	57.00
58.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 11 line 200)		0	58.00
59.00	Total (sum of amounts on lines 49 through 58)		15,797,390	59.00
60.00	Primary payer payments		3,471	60.00
61.00	Total amount payable for program beneficiaries (line 59 minus line 60)		15,793,919	61.00
62.00	Deductibles billed to program beneficiaries		1,542,596	62.00
63.00	Coinurance billed to program beneficiaries		31,328	63.00
64.00	Allowable bad debts (see instructions)		604,238	64.00
65.00	Adjusted reimbursable bad debts (see instructions)		392,755	65.00
66.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		488,788	66.00
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)		14,612,750	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)		7,778	70.90
70.91	HSP bonus payment HRR adjustment amount (see instructions)		-419	70.91
70.92	Bundled Model 1 discount amount (see instructions)		0	70.92
70.93	HVBP payment adjustment amount (see instructions)		107,126	70.93
70.94	HRR adjustment amount (see instructions)		-5,257	70.94
70.95	Recovery of accelerated depreciation		0	70.95

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0034	Period: From 01/01/2020 To 12/31/2020	Worksheet E Part A Date/Time Prepared: 7/28/2021 12:17 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)		14,721,978	71.00
71.01	Sequestration adjustment (see instructions)		97,165	71.01
71.02	Demonstration payment adjustment amount after sequestration		0	71.02
71.03	Sequestration adjustment-PARHM pass-throughs		0	71.03
72.00	Interim payments		14,254,541	72.00
72.01	Interim payments-PARHM		0	72.01
73.00	Tentative settlement (for contractor use only)		0	73.00
73.01	Tentative settlement-PARHM (for contractor use only)		0	73.01
74.00	Balance due provider/program (line 71 minus lines 71.01, 71.02, 72, and 73)		370,272	74.00
74.01	Balance due provider/program-PARHM (see instructions)		0	74.01
75.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		322,815	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)		697,725	234,272
HVPB Adjustment for HSP Bonus Payment				
101.00	HVPB adjustment factor (see instructions)	1.0080619968	1.0091899972	101.00
102.00	HVPB adjustment amount for HSP bonus payment (see instructions)	5,625	2,153	102.00
HRR Adjustment for HSP Bonus Payment				
103.00	HRR adjustment factor (see instructions)	0.9994	1.0000	103.00
104.00	HRR adjustment amount for HSP bonus payment (see instructions)	-419	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: 14-0034

Period:
From 01/01/2020
To 12/31/2020Worksheet E
Part A Exhibit 4
Date/Time Prepared:
7/28/2021 12:17 pm

		Title XVIII		Hospital		PPS	
		W/S E, Part A line	Amounts (from E, Part A)	Pre/Post Entitlement	Period Prior to 10/01	Period On/After 10/01	Total (Col 2 through 4)
		0	1.00	2.00	3.00	4.00	5.00
1.00	DRG amounts other than outlier payments	1.00	0	0	0	0	0
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1	1.01	8,762,895	0	8,762,895		8,762,895
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	3,773,632	0		3,773,632	3,773,632
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	130,347	0	130,347		130,347
2.03	Outlier payments for discharges occurring on or after October 1 (see instructions)	2.04	31,010	0		31,010	31,010
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	0.1044	0.1044	0.1044	0.1044	
11.00	Disproportionate share adjustment (see instructions)	34.00	327,204	0	228,712	98,492	327,204
11.01	Uncompensated care payments	36.00	664,582	0	664,582	0	664,582
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	13,689,670	0	9,786,536	3,903,134	13,689,670
14.00	Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see instructions)	48.00	14,932,333	0	0	0	0
15.00	Total payment for inpatient operating costs (see instructions)	49.00	14,621,667	0	10,718,533	3,903,134	14,621,667
16.00	Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable)	50.00	979,944	0	703,767	276,177	979,944

LOW VOLUME CALCULATION EXHIBIT 4

Provider CCN: 14-0034

Period:
From 01/01/2020
To 12/31/2020Worksheet E
Part A Exhibit 4
Date/Time Prepared:
7/28/2021 12:17 pm

				Title XVIII		Hospital	PPS	
		W/S E, Part A line	Amounts (from E, Part A)	Pre/Post Entitlement	Period Prior to 10/01	Period On/After 10/01	Total (Col 2 through 4)	
		0	1.00	2.00	3.00	4.00	5.00	
17.00	Special add-on payments for new technologies	54.00	195,779	0	0	195,779	195,779	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	11,422,300	4,375,090	15,797,390	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	965,056	0	692,031	273,025	965,056	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	14,888	0	11,736	3,152	14,888	21.00
21.01	Model 4 BPCI Capital DRG outlier payments	2.01	0	0	0	0	0	21.01
22.00	Indirect medical education percentage (see instructions)	5.00	0.0000	0.0000	0.0000	0.0000		22.00
23.00	Indirect medical education adjustment (see instructions)	6.00	0	0	0	0	0	23.00
24.00	Allowable disproportionate share percentage (see instructions)	10.00	0.0000	0.0000	0.0000	0.0000		24.00
25.00	Disproportionate share adjustment (see instructions)	11.00	0	0	0	0	0	25.00
26.00	Total prospective capital payments (see instructions)	12.00	979,944	0	703,767	276,177	979,944	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: 14-0034

Period:
From 01/01/2020
To 12/31/2020Worksheet E
Part A Exhibit 5
Date/Time Prepared:
7/28/2021 12:17 pm

		Title XVIII		Hospital		PPS	
		Wkst. E, Pt. A, line	Amt. from Wkst. E, Pt. A)	Period to 10/01	Period on after 10/01	Total (cols. 2 and 3)	
		0	1.00	2.00	3.00	4.00	
1.00	DRG amounts other than outlier payments	1.00					1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1	1.01	8,762,895	8,762,895		8,762,895	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	3,773,632		3,773,632	3,773,632	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	130,347	130,347		130,347	2.02
2.03	Outlier payments for discharges occurring on or after October 1 (see instructions)	2.04	31,010		31,010	31,010	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	0.1044	0.1044	0.1044		10.00
11.00	Disproportionate share adjustment (see instructions)	34.00	327,204	228,712	98,492	327,204	11.00
11.01	Uncompensated care payments	36.00	664,582	3,393	0	3,393	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	13,689,670	9,786,536	3,903,134	13,689,670	13.00
14.00	Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see instructions)	48.00	14,932,333	0	0	0	14.00
15.00	Total payment for inpatient operating costs (see instructions)	49.00	14,621,667	10,718,533	3,903,134	14,621,667	15.00
16.00	Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable)	50.00	979,944	703,767	276,177	979,944	16.00
17.00	Special add-on payments for new technologies	54.00	195,779	0	195,779	195,779	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			11,422,300	4,375,090	15,797,390	19.00

HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULATION EXHIBIT 5

Provider CCN: 14-0034

Period:
From 01/01/2020
To 12/31/2020Worksheet E
Part A Exhibit 5
Date/Time Prepared:
7/28/2021 12:17 pm

		Title XVIII		Hospital		PPS	
		Wkst. L, line	(Amt. from Wkst. L)				
		0	1.00	2.00	3.00	4.00	
20.00	Capital DRG other than outlier	1.00	965,056	692,031	273,025	965,056	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	14,888	11,736	3,152	14,888	21.00
21.01	Model 4 BPCI Capital DRG outlier payments	2.01	0	0	0	0	21.01
22.00	Indirect medical education percentage (see instructions)	5.00	0.0000	0.0000	0.0000		22.00
23.00	Indirect medical education adjustment (see instructions)	6.00	0	0	0	0	23.00
24.00	Allowable disproportionate share percentage (see instructions)	10.00	0.0000	0.0000	0.0000		24.00
25.00	Disproportionate share adjustment (see instructions)	11.00	0	0	0	0	25.00
26.00	Total prospective capital payments (see instructions)	12.00	979,944	703,767	276,177	979,944	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	107,126	70,647	36,479	107,126	30.00
30.01	HVBP payment adjustment for HSP bonus payment (see instructions)	70.90	7,778	5,625	2,153	7,778	30.01
31.00	HRR adjustment (see instructions)	70.94	-5,257	-5,257	0	-5,257	31.00
31.01	HRR adjustment for HSP bonus payment (see instructions)	70.91	-419	-419	0	-419	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

Health Financial Systems		SSM HEALTH ST. MARY'S HOSPITAL		In Lieu of Form CMS-2552-10	
CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0034	Period: From 01/01/2020 To 12/31/2020	Worksheet E Part B Date/Time Prepared: 7/28/2021 12:17 pm	
		Title XVIII	Hospital	PPS	
				1.00	
PART B - MEDICAL AND OTHER HEALTH SERVICES					
1.00	Medical and other services (see instructions)			16,360	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)			10,254,417	2.00
3.00	OPPS payments			8,862,048	3.00
4.00	Outlier payment (see instructions)			11,589	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)			16,360	11.00
COMPUTATION OF LESSER OF COST OR CHARGES					
Reasonable charges					
12.00	Ancillary service charges			92,154	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)			92,154	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)			92,154	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)			75,794	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)			16,360	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)			8,873,637	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)			1,762,073	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)			7,127,924	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)			7,127,924	30.00
31.00	Primary payer payments			601	31.00
32.00	Subtotal (line 30 minus line 31)			7,127,323	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)			412,407	34.00
35.00	Adjusted reimbursable bad debts (see instructions)			268,065	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			287,682	36.00
37.00	Subtotal (see instructions)			7,395,388	37.00
38.00	MSP-LCC reconciliation amount from PS&R			0	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	39.00
39.50	Pioneer ACO demonstration payment adjustment (see instructions)			0	39.50
39.97	Demonstration payment adjustment amount before sequestration			0	39.97
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)			0	39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION			0	39.99
40.00	Subtotal (see instructions)			7,395,388	40.00
40.01	Sequestration adjustment (see instructions)			48,810	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			7,083,108	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)			263,470	43.00
43.01	Balance due provider/program-PARHM (see instructions)			0	43.01
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2			0	44.00
TO BE COMPLETED BY CONTRACTOR					
90.00	Original outlier amount (see instructions)			0	90.00
91.00	Outlier reconciliation adjustment amount (see instructions)			0	91.00
92.00	The rate used to calculate the Time Value of Money			0.00	92.00
93.00	Time Value of Money (see instructions)			0	93.00
94.00	Total (sum of lines 91 and 93)			0	94.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0034 Component CCN: 14-S034	Period: From 01/01/2020 To 12/31/2020	Worksheet E Part B Date/Time Prepared: 7/28/2021 12:17 pm
		Title XVIII	Subprovider - IPF	PPS
			1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES			
1.00	Medical and other services (see instructions)		0	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)		121,008	2.00
3.00	OPPS payments		48,821	3.00
4.00	Outlier payment (see instructions)		0	4.00
4.01	Outlier reconciliation amount (see instructions)		0	4.01
5.00	Enter the hospital specific payment to cost ratio (see instructions)		0.000	5.00
6.00	Line 2 times line 5		0	6.00
7.00	Sum of lines 3, 4, and 4.01, divided by line 6		0.00	7.00
8.00	Transitional corridor payment (see instructions)		0	8.00
9.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200		0	9.00
10.00	Organ acquisitions		0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)		0	11.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
12.00	Ancillary service charges		0	12.00
13.00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, line 69)		0	13.00
14.00	Total reasonable charges (sum of lines 12 and 13)		0	14.00
Customary charges				
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis		0	15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a chargebasis had such payment been made in accordance with 42 CFR §413.13(e)		0	16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)		0.000000	17.00
18.00	Total customary charges (see instructions)		0	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)		0	19.00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)		0	20.00
21.00	Lesser of cost or charges (see instructions)		0	21.00
22.00	Interns and residents (see instructions)		0	22.00
23.00	Cost of physicians' services in a teaching hospital (see instructions)		0	23.00
24.00	Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)		48,821	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)		11,628	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)		37,193	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)		37,193	30.00
31.00	Primary payer payments		0	31.00
32.00	Subtotal (line 30 minus line 31)		37,193	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)		37,193	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)		37,193	40.00
40.01	Sequestration adjustment (see instructions)		245	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		36,813	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)		135	43.00
43.01	Balance due provider/program-PARHM (see instructions)		0	43.01
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		0	44.00
TO BE COMPLETED BY CONTRACTOR				
90.00	Original outlier amount (see instructions)		0	90.00
91.00	Outlier reconciliation adjustment amount (see instructions)		0	91.00
92.00	The rate used to calculate the Time Value of Money		0.00	92.00
93.00	Time Value of Money (see instructions)		0	93.00
94.00	Total (sum of lines 91 and 93)		0	94.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 14-0034

Period:
From 01/01/2020
To 12/31/2020Worksheet E-1
Part I
Date/Time Prepared:
7/28/2021 12:17 pm

		Title XVIII		Hospital		PPS	
		Inpatient Part A		Part B			
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount		
		1.00	2.00	3.00	4.00		
1.00	Total interim payments paid to provider		14,254,541		7,083,108	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)		14,254,541		7,083,108	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		370,272		263,470	6.01	
6.02	SETTLEMENT TO PROGRAM		0		0	6.02	
7.00	Total Medicare program liability (see instructions)		14,624,813		7,346,578	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: 14-0034
 Component CCN: 14-S034

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

 Worksheet E-1
 Part I
 Date/Time Prepared:
 7/28/2021 12:17 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		991,615		36,813	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)		0		0	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)		991,615		36,813	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		38,281		135	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		1,029,896		36,948	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: 14-0034

Period:
From 01/01/2020
To 12/31/2020Worksheet E-1
Part II
Date/Time Prepared:
7/28/2021 12:17 pm

Title XVIII

Hospital

PPS

1.00

TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS

HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION

1.00	Total hospital discharges as defined in AARA §4102 from Wkst. S-3, Pt. I col. 15 line 14	1.00
2.00	Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, 8-12	2.00
3.00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2	3.00
4.00	Total inpatient days from S-3, Pt. I col. 8 sum of lines 1, 8-12	4.00
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200	5.00
6.00	Total hospital charity care charges from Wkst. S-10, col. 3 line 20	6.00
7.00	CAH only - The reasonable cost incurred for the purchase of certified HIT technology Wkst. S-2, Pt. I line 168	7.00
8.00	Calculation of the HIT incentive payment (see instructions)	8.00
9.00	Sequestration adjustment amount (see instructions)	9.00
10.00	Calculation of the HIT incentive payment after sequestration (see instructions)	10.00
INPATIENT HOSPITAL SERVICES UNDER THE 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: 14-0034 Component CCN: 14-S034	Period: From 01/01/2020 To 12/31/2020	Worksheet E-3 Part II Date/Time Prepared: 7/28/2021 12:17 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)			1,158,823 1.00
2.00	Net IPF PPS Outlier Payments			0 2.00
3.00	Net IPF PPS ECT Payments			0 3.00
4.00	Unweighted intern and resident FTE count in the most recent cost report filed on or before November 15, 2004. (see instructions)			0.00 4.00
4.01	Cap increases for the unweighted intern and resident FTE count for residents that were displaced by program or hospital closure, that would not be counted without a temporary cap adjustment under 42 CFR §412.424(d)(1)(iii)(F)(1) or (2) (see instructions)			0.00 4.01
5.00	New Teaching program adjustment. (see instructions)			0.00 5.00
6.00	Current year's unweighted FTE count of I&R excluding FTEs in the new program growth period of a "new teaching program" (see instructions)			0.00 6.00
7.00	Current year's unweighted I&R FTE count for residents within the new program growth period of a "new teaching program" (see instructions)			0.00 7.00
8.00	Intern and resident count for IPF PPS medical education adjustment (see instructions)			0.00 8.00
9.00	Average Daily Census (see instructions)			14.076503 9.00
10.00	Teaching Adjustment Factor $\{((1 + (\text{line 8/line 9})) \text{ raised to the power of } .5150 - 1)\}$.			0.000000 10.00
11.00	Teaching Adjustment (line 1 multiplied by line 10).			0 11.00
12.00	Adjusted Net IPF PPS Payments (sum of lines 1, 2, 3 and 11)			1,158,823 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)			1,158,823 16.00
17.00	Primary payer payments			0 17.00
18.00	Subtotal (line 16 less line 17).			1,158,823 18.00
19.00	Deductibles			127,952 19.00
20.00	Subtotal (line 18 minus line 19)			1,030,871 20.00
21.00	Coinsurance			28,864 21.00
22.00	Subtotal (line 20 minus line 21)			1,002,007 22.00
23.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)			53,432 23.00
24.00	Adjusted reimbursable bad debts (see instructions)			34,731 24.00
25.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			34,976 25.00
26.00	Subtotal (sum of lines 22 and 24)			1,036,738 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)			1,036,738 31.00
31.01	Sequestration adjustment (see instructions)			6,842 31.01
31.02	Demonstration payment adjustment amount after sequestration			0 31.02
32.00	Interim payments			991,615 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)			38,281 34.00
35.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2			0 35.00
TO BE COMPLETED BY CONTRACTOR				
50.00	Original outlier amount from Worksheet E-3, Part II, line 2			0 50.00
51.00	Outlier reconciliation adjustment amount (see instructions)			0 51.00
52.00	The rate used to calculate the Time Value of Money			0.00 52.00
53.00	Time Value of Money (see instructions)			0 53.00

DIRECT GRADUATE MEDICAL EDUCATION (GME) & ESRD OUTPATIENT DIRECT MEDICAL EDUCATION COSTS		Provider CCN: 14-0034	Period: From 01/01/2020 To 12/31/2020	Worksheet E-4 Date/Time Prepared: 7/28/2021 12:17 pm	
		Title XVIII	Hospital	PPS	
				1.00	
COMPUTATION OF TOTAL DIRECT GME AMOUNT					
1.00	Unweighted resident FTE count for allopathic and osteopathic programs for cost reporting periods ending on or before December 31, 1996.			0.00	1.00
2.00	Unweighted FTE resident cap add-on for new programs per 42 CFR 413.79(e)(1) (see instructions)			0.00	2.00
3.00	Amount of reduction to Direct GME cap under section 422 of MMA			0.00	3.00
3.01	Direct GME cap reduction amount under ACA §5503 in accordance with 42 CFR §413.79 (m). (see instructions for cost reporting periods straddling 7/1/2011)			0.00	3.01
4.00	Adjustment (plus or minus) to the FTE cap for allopathic and osteopathic programs due to a Medicare GME affiliation agreement (42 CFR §413.75(b) and § 413.79 (f))			0.00	4.00
4.01	ACA Section 5503 increase to the Direct GME FTE Cap (see instructions for cost reporting periods straddling 7/1/2011)			0.00	4.01
4.02	ACA Section 5506 number of additional direct GME FTE cap slots (see instructions for cost reporting periods straddling 7/1/2011)			0.00	4.02
5.00	FTE adjusted cap (line 1 plus line 2 minus line 3 and 3.01 plus or minus line 4 plus lines 4.01 and 4.02 plus applicable subscripts)			0.00	5.00
6.00	Unweighted resident FTE count for allopathic and osteopathic programs for the current year from your records (see instructions)			0.00	6.00
7.00	Enter the lesser of line 5 or line 6			0.00	7.00
		Primary Care	Other	Total	
		1.00	2.00	3.00	
8.00	Weighted FTE count for physicians in an allopathic and osteopathic program for the current year.	0.00	0.00	0.00	8.00
9.00	If line 6 is less than 5 enter the amount from line 8, otherwise multiply line 8 times the result of line 5 divided by the amount on line 6.	0.00	0.00	0.00	9.00
10.00	Weighted dental and podiatric resident FTE count for the current year		0.00		10.00
10.01	Unweighted dental and podiatric resident FTE count for the current year		0.00		10.01
11.00	Total weighted FTE count	0.00	0.00		11.00
12.00	Total weighted resident FTE count for the prior cost reporting year (see instructions)	0.00	0.00		12.00
13.00	Total weighted resident FTE count for the penultimate cost reporting year (see instructions)	0.00	0.00		13.00
14.00	Rolling average FTE count (sum of lines 11 through 13 divided by 3).	0.00	0.00		14.00
15.00	Adjustment for residents in initial years of new programs	0.00	0.00		15.00
15.01	Unweighted adjustment for residents in initial years of new programs	0.00	0.00		15.01
16.00	Adjustment for residents displaced by program or hospital closure	0.00	0.00		16.00
16.01	Unweighted adjustment for residents displaced by program or hospital closure	0.00	0.00		16.01
17.00	Adjusted rolling average FTE count	0.00	0.00		17.00
18.00	Per resident amount	0.00	0.00		18.00
19.00	Approved amount for resident costs	0	0	0	19.00
				1.00	
20.00	Additional unweighted allopathic and osteopathic direct GME FTE resident cap slots received under 42 Sec. 413.79(c)(4)			0.00	20.00
21.00	Direct GME FTE unweighted resident count over cap (see instructions)			0.00	21.00
22.00	Allowable additional direct GME FTE Resident Count (see instructions)			0.00	22.00
23.00	Enter the locality adjustment national average per resident amount (see instructions)			0.00	23.00
24.00	Multiply line 22 time line 23			0	24.00
25.00	Total direct GME amount (sum of lines 19 and 24)			0	25.00
		Inpatient Part A	Managed Care	Total	
		1.00	2.00	3.00	
COMPUTATION OF PROGRAM PATIENT LOAD					
26.00	Inpatient Days (see instructions) (Title XIX - see S-2 Part IX, line 3.02, column 2)	8,637	880		26.00
27.00	Total Inpatient Days (see instructions)	16,257	16,257		27.00
28.00	Ratio of inpatient days to total inpatient days	0.531279	0.054131		28.00
29.00	Program direct GME amount	0	0	0	29.00
29.01	Percent reduction for MA DGME				29.01
30.00	Reduction for direct GME payments for Medicare Advantage		0	0	30.00
31.00	Net Program direct GME amount			0	31.00

DIRECT GRADUATE MEDICAL EDUCATION (GME) & ESRD OUTPATIENT DIRECT MEDICAL EDUCATION COSTS		Provider CCN: 14-0034	Period: From 01/01/2020 To 12/31/2020	Worksheet E-4 Date/Time Prepared: 7/28/2021 12:17 pm	
		Title XVIII	Hospital	PPS	
				1.00	
	DIRECT MEDICAL EDUCATION COSTS FOR ESRD COMPOSITE RATE - TITLE XVIII ONLY (NURSING SCHOOL AND PARAMEDICAL EDUCATION COSTS)				
32.00	Renal dialysis direct medical education costs (from Wkst. B, Pt. I, sum of col. 20 and 23, lines 74 and 94)			0	32.00
33.00	Renal dialysis and home dialysis total charges (Wkst. C, Pt. I, col. 8, sum of lines 74 and 94)			275,340	33.00
34.00	Ratio of direct medical education costs to total charges (line 32 ÷ line 33)			0.000000	34.00
35.00	Medicare outpatient ESRD charges (see instructions)			0	35.00
36.00	Medicare outpatient ESRD direct medical education costs (line 34 x line 35)			0	36.00
APPORTIONMENT BASED ON MEDICARE REASONABLE COST - TITLE XVIII ONLY					
Part A Reasonable Cost					
37.00	Reasonable cost (see instructions)			18,651,202	37.00
38.00	Organ acquisition costs (Wkst. D-4, Pt. III, col. 1, line 69)			0	38.00
39.00	Cost of physicians' services in a teaching hospital (see instructions)			0	39.00
40.00	Primary payer payments (see instructions)			3,471	40.00
41.00	Total Part A reasonable cost (sum of lines 37 through 39 minus line 40)			18,647,731	41.00
Part B Reasonable Cost					
42.00	Reasonable cost (see instructions)			10,391,785	42.00
43.00	Primary payer payments (see instructions)			601	43.00
44.00	Total Part B reasonable cost (line 42 minus line 43)			10,391,184	44.00
45.00	Total reasonable cost (sum of lines 41 and 44)			29,038,915	45.00
46.00	Ratio of Part A reasonable cost to total reasonable cost (line 41 ÷ line 45)			0.642163	46.00
47.00	Ratio of Part B reasonable cost to total reasonable cost (line 44 ÷ line 45)			0.357837	47.00
ALLOCATION OF MEDICARE DIRECT GME COSTS BETWEEN PART A AND PART B					
48.00	Total program GME payment (line 31)			0	48.00
49.00	Part A Medicare GME payment (line 46 x 48) (title XVIII only) (see instructions)			0	49.00
50.00	Part B Medicare GME payment (line 47 x 48) (title XVIII only) (see instructions)			0	50.00

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

Provider CCN: 14-0034

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

Worksheet G

Date/Time Prepared:
7/28/2021 12:17 pm

	General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
	1.00	2.00	3.00	4.00	
CURRENT ASSETS					
1.00 Cash on hand in banks	154,423	0	0	0	1.00
2.00 Temporary investments	0	0	0	0	2.00
3.00 Notes receivable	0	0	0	0	3.00
4.00 Accounts receivable	14,907,391	0	0	0	4.00
5.00 Other receivable	720,360	0	0	0	5.00
6.00 Allowances for uncollectible notes and accounts receivable	0	0	0	0	6.00
7.00 Inventory	2,348,049	0	0	0	7.00
8.00 Prepaid expenses	533,255	0	0	0	8.00
9.00 Other current assets	0	0	0	0	9.00
10.00 Due from other funds	0	0	0	0	10.00
11.00 Total current assets (sum of lines 1-10)	18,663,478	0	0	0	11.00
FIXED ASSETS					
12.00 Land	1,259,000	0	0	0	12.00
13.00 Land improvements	714,463	0	0	0	13.00
14.00 Accumulated depreciation	-669,875	0	0	0	14.00
15.00 Buildings	45,409,412	0	0	0	15.00
16.00 Accumulated depreciation	-18,512,704	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	5,973,223	0	0	0	19.00
20.00 Accumulated depreciation	-2,994,737	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	31,943,546	0	0	0	23.00
24.00 Accumulated depreciation	-21,974,405	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)	41,147,923	0	0	0	30.00
OTHER ASSETS					
31.00 Investments	1,008,096	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	158,218	822,359	0	0	34.00
35.00 Total other assets (sum of lines 31-34)	1,166,314	822,359	0	0	35.00
36.00 Total assets (sum of lines 11, 30, and 35)	60,977,715	822,359	0	0	36.00
CURRENT LIABILITIES					
37.00 Accounts payable	13,922,966	0	0	0	37.00
38.00 Salaries, wages, and fees payable	3,264,189	0	0	0	38.00
39.00 Payroll taxes payable	-11,768	0	0	0	39.00
40.00 Notes and loans payable (short term)	524,768	0	0	0	40.00
41.00 Deferred income	0	0	0	0	41.00
42.00 Accelerated payments	0	0	0	0	42.00
43.00 Due to other funds	0	0	0	0	43.00
44.00 Other current liabilities	-34,863,665	0	0	0	44.00
45.00 Total current liabilities (sum of lines 37 thru 44)	-17,163,510	0	0	0	45.00
LONG TERM LIABILITIES					
46.00 Mortgage payable	0	0	0	0	46.00
47.00 Notes payable	46,538,000	0	0	0	47.00
48.00 Unsecured loans	0	0	0	0	48.00
49.00 Other long term liabilities	13,194,761	0	0	0	49.00
50.00 Total long term liabilities (sum of lines 46 thru 49)	59,732,761	0	0	0	50.00
51.00 Total liabilities (sum of lines 45 and 50)	42,569,251	0	0	0	51.00
CAPITAL ACCOUNTS					
52.00 General fund balance	18,408,464				52.00
53.00 Specific purpose fund		822,359			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)	18,408,464	822,359	0	0	59.00
60.00 Total liabilities and fund balances (sum of lines 51 and 59)	60,977,715	822,359	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 14-0034

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

Worksheet G-1

Date/Time Prepared:
7/28/2021 12:17 pm

		General Fund		Special Purpose Fund		Endowment Fund	
		1.00	2.00	3.00	4.00	5.00	
1.00	Fund balances at beginning of period		3,409,442		1,138,379		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		15,030,821				2.00
3.00	Total (sum of line 1 and line 2)		18,440,263		1,138,379		3.00
4.00	Additions	410,934		80,525		0	4.00
5.00		0		0		0	5.00
6.00		0		0		0	6.00
7.00		0		0		0	7.00
8.00		0		0		0	8.00
9.00		0		0		0	9.00
10.00	Total additions (sum of line 4-9)		410,934		80,525		10.00
11.00	Subtotal (line 3 plus line 10)		18,851,197		1,218,904		11.00
12.00	Deductions	435,984		394,750		0	12.00
13.00		0		0		0	13.00
14.00		0		0		0	14.00
15.00	DEDUCTIONS	6,749		0		0	15.00
16.00	DEDUCTIONS	0		1,795		0	16.00
17.00		0		0		0	17.00
18.00	Total deductions (sum of lines 12-17)		442,733		396,545		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		18,408,464		822,359		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		0				4.00
5.00			0				5.00
6.00			0				6.00
7.00			0				7.00
8.00			0				8.00
9.00			0				9.00
10.00	Total additions (sum of line 4-9)	0		0			10.00
11.00	Subtotal (line 3 plus line 10)	0		0			11.00
12.00	Deductions		0				12.00
13.00			0				13.00
14.00			0				14.00
15.00	DEDUCTIONS		0				15.00
16.00	DEDUCTIONS		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: 14-0034

Period:
From 01/01/2020
To 12/31/2020Worksheet G-2
Parts I & II
Date/Time Prepared:
7/28/2021 12:17 pm

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
PART I - PATIENT REVENUES					
General Inpatient Routine Services					
1.00	Hospital	16,800,929		16,800,929	1.00
2.00	SUBPROVIDER - IPF	6,405,015		6,405,015	2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	0		0	5.00
6.00	Swing bed - NF	0		0	6.00
7.00	SKILLED NURSING FACILITY				7.00
8.00	NURSING FACILITY				8.00
9.00	OTHER LONG TERM CARE				9.00
10.00	Total general inpatient care services (sum of lines 1-9)	23,205,944		23,205,944	10.00
Intensive Care Type Inpatient Hospital Services					
11.00	INTENSIVE CARE UNIT	3,766,745		3,766,745	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)	3,766,745		3,766,745	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	26,972,689		26,972,689	17.00
18.00	Ancillary services	69,174,959	157,295,186	226,470,145	18.00
19.00	Outpatient services	5,612,850	26,146,857	31,759,707	19.00
20.00	RURAL HEALTH CLINIC	0	0	0	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY				22.00
23.00	AMBULANCE SERVICES				23.00
24.00	CMHC				24.00
24.30	OOT	0	0	0	24.30
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	OTHER	5,464,622	10,724,776	16,189,398	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	107,225,120	194,166,819	301,391,939	28.00
PART II - OPERATING EXPENSES					
29.00	Operating expenses (per Wkst. A, column 3, line 200)		97,323,270		29.00
30.00	ADD	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	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)		97,323,270		43.00

STATEMENT OF REVENUES AND EXPENSES

Provider CCN: 14-0034

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

Worksheet G-3

Date/Time Prepared:
7/28/2021 12:17 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	301,391,939	1.00
2.00	Less contractual allowances and discounts on patients' accounts	199,641,231	2.00
3.00	Net patient revenues (line 1 minus line 2)	101,750,708	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	97,323,270	4.00
5.00	Net income from service to patients (line 3 minus line 4)	4,427,438	5.00
OTHER INCOME			
6.00	Contributions, donations, bequests, etc	536,364	6.00
7.00	Income from investments	19,186	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	231,253	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	1,432	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	226,744	22.00
23.00	Governmental appropriations	0	23.00
24.00	OTHER INCOME	10,836,584	24.00
24.50	COVID-19 PHE Funding	0	24.50
25.00	Total other income (sum of lines 6-24)	11,851,563	25.00
26.00	Total (line 5 plus line 25)	16,279,001	26.00
27.00	OTHER EXPENSES	1,248,180	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	1,248,180	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	15,030,821	29.00

CALCULATION OF CAPITAL PAYMENT		Provider CCN: 14-0034	Period: From 01/01/2020 To 12/31/2020	Worksheet L Parts I-III Date/Time Prepared: 7/28/2021 12:17 pm
		Title XVIII	Hospital	PPS
		1.00		
PART I - FULLY PROSPECTIVE METHOD				
CAPITAL FEDERAL AMOUNT				
1.00	Capital DRG other than outlier		965,056	1.00
1.01	Model 4 BPCI Capital DRG other than outlier		0	1.01
2.00	Capital DRG outlier payments		14,888	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)		30.68	3.00
4.00	Number of interns & residents (see instructions)		0.00	4.00
5.00	Indirect medical education percentage (see instructions)		0.00	5.00
6.00	Indirect medical education adjustment (multiply line 5 by the sum of lines 1 and 1.01, columns 1 and 1.01)(see instructions)		0	6.00
7.00	Percentage of SSI recipient patient days to Medicare Part A patient days (Worksheet E, part A line 30) (see instructions)		0.00	7.00
8.00	Percentage of Medicaid patient days to total days (see instructions)		0.00	8.00
9.00	Sum of lines 7 and 8		0.00	9.00
10.00	Allowable disproportionate share percentage (see instructions)		0.00	10.00
11.00	Disproportionate share adjustment (see instructions)		0	11.00
12.00	Total prospective capital payments (see instructions)		979,944	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