

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: 14-0046	Period: From 01/01/2020 To 12/31/2020	Worksheet S Parts I-III Date/Time Prepared: 7/19/2021 3:13 pm
--	-----------------------	---	--

PART I - COST REPORT STATUS			
Provider use only	1. ☒ Electronically prepared cost report 2. ☐ Manually prepared cost report 3. ☐ If this is an amended report enter the number of times the provider resubmitted this cost report 4. ☐ Medicare Utilization. Enter "F" for full or "L" for low.		Date: 7/19/2021 Time: 3:13 pm
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 GOOD SAMARITAN HOSPITAL (14-0046) 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	566,254	128,749	0	0	1.00
2.00	Subprovider - IPF	0	0	0		0	2.00
3.00	Subprovider - IRF	0	65,398	0		0	3.00
5.00	Swing Bed - SNF	0	0	0		0	5.00
6.00	Swing Bed - NF	0				0	6.00
200.00	Total	0	631,652	128,749	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.

Health Financial Systems		SSM HEALTH GOOD SAMARITAN HOSPITAL		In Lieu of Form CMS-2552-10						
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA				Provider CCN: 14-0046		Period: From 01/01/2020 To 12/31/2020		Worksheet S-2 Part I Date/Time Prepared: 7/19/2021 3:13 pm		
1.00		2.00		3.00		4.00				
Hospital and Hospital Health Care Complex Address:										
1.00	Street: 1 GOOD SAMARITAN WAY		PO Box:				1.00			
2.00	City: MT. VERNON		State: IL		Zip Code: 62864		County: JEFFERSON			
		Component Name	CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N)			
							V	XVIII	XIX	
		1.00	2.00	3.00	4.00	5.00	6.00	7.00	8.00	
Hospital and Hospital-Based Component Identification:										
3.00	Hospital		SSM HEALTH GOOD SAMARITAN HOSPITAL	140046	99914	1	07/01/1966	N	P	P
4.00	Subprovider - IPF									4.00
5.00	Subprovider - IRF		GOOD SAMARITAN REHABILITATION UNIT	14T046	99914	5	01/01/1990	N	P	P
6.00	Subprovider - (Other)									6.00
7.00	Swing Beds - SNF									7.00
8.00	Swing Beds - NF									8.00
9.00	Hospital-Based SNF									9.00
10.00	Hospital-Based NF									10.00
11.00	Hospital-Based OLTC									11.00
12.00	Hospital-Based HHA									12.00
13.00	Separately Certified ASC									13.00
14.00	Hospital-Based Hospice									14.00
15.00	Hospital-Based Health Clinic - RHC									15.00
16.00	Hospital-Based Health Clinic - FQHC									16.00
17.00	Hospital-Based (CMHC) I									17.00
18.00	Renal Dialysis									18.00
19.00	Other									19.00
						From:	To:			
						1.00	2.00			
20.00	Cost Reporting Period (mm/dd/yyyy)					01/01/2020		12/31/2020		20.00
21.00	Type of Control (see instructions)					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
			In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of-State Medicaid paid days	Out-of-State Medicaid eligible unpaid	Medicaid HMO days	Other Medicaid days		
			1.00	2.00	3.00	4.00	5.00	6.00		
24.00	If this provider is an IPPS hospital, enter the in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.		864	313	0	2	3,791	266		

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

Provider CCN: 14-0046

Period:
From 01/01/2020
To 12/31/2020Worksheet S-2
Part I
Date/Time Prepared:
7/19/2021 3:13 pm

		In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of State Medicaid paid days	Out-of State Medicaid eligible unpaid	Medicaid HMO days	Other Medicaid days	
		1.00	2.00	3.00	4.00	5.00	6.00	
25.00	If this provider is an IRF, enter the in-state Medicaid paid days in column 1, the in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5.	58	41	0	0	163		25.00
						Urban/Rural S	Date of Geogr	
						1.00	2.00	
26.00	Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter "1" for urban or "2" for rural.					2		26.00
27.00	Enter your standard geographic classification (not wage) status at the end of the cost reporting period. Enter in column 1, "1" for urban or "2" for rural. If applicable, enter the effective date of the geographic reclassification in column 2.					2		27.00
35.00	If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period.					0		35.00
						Beginning:	Ending:	
						1.00	2.00	
36.00	Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.							36.00
37.00	If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status is in effect in the cost reporting period.					0		37.00
37.01	Is this hospital a former MDH that is eligible for the MDH transitional payment in accordance with FY 2016 OPPS final rule? Enter "Y" for yes or "N" for no. (see instructions)							37.01
38.00	If line 37 is 1, enter the beginning and ending dates of MDH status. If line 37 is greater than 1, subscript this line for the number of periods in excess of one and enter subsequent dates.							38.00
						Y/N	Y/N	
						1.00	2.00	
39.00	Does this facility qualify for the inpatient hospital payment adjustment for low volume hospitals in accordance with 42 CFR §412.101(b)(2)(i), (ii), or (iii)? Enter in column 1 "Y" for yes or "N" for no. Does the facility meet the mileage requirements in accordance with 42 CFR §412.101(b)(2)(i), (ii), or (iii)? Enter in column 2 "Y" for yes or "N" for no. (see instructions)					N	N	39.00
40.00	Is this hospital subject to the HAC program reduction adjustment? Enter "Y" for yes or "N" for no in column 1, for discharges prior to October 1. Enter "Y" for yes or "N" for no in column 2, for discharges on or after October 1. (see instructions)					N	N	40.00
						V	XVIII	XIX
						1.00	2.00	3.00
Prospective Payment System (PPS)-Capital								
45.00	Does this facility qualify and receive Capital payment for disproportionate share in accordance with 42 CFR Section §412.320? (see instructions)					N	N	N
46.00	Is this facility eligible for additional payment exception for extraordinary circumstances pursuant to 42 CFR §412.348(f)? If yes, complete Wkst. L, Pt. III and Wkst. L-1, Pt. I through Pt. III.					N	N	N
47.00	Is this a new hospital under 42 CFR §412.300(b) PPS capital? Enter "Y" for yes or "N" for no.					N	N	N
48.00	Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.					N	N	N
Teaching Hospitals								
56.00	Is this a hospital involved in training residents in approved GME programs? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", are you impacted by CR 11642 (or subsequent CR), MA GME payment reduction? Enter "Y" for yes or "N" for no in column 2.					N		
57.00	If line 56 is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y" did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If column 2 is "N", complete Wkst. D, Parts III & IV and D-2, Pt. II, if applicable.					N		
58.00	If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, chapter 21, §2148? If yes, complete Wkst. D-5.					N		
59.00	Are costs claimed on line 100 of Worksheet A? If yes, complete Wkst. D-2, Pt. I.					N		
				NAHE 413.85 Y/N	Worksheet A Line #	Pass-Through Qualification Criterion Code		
				1.00	2.00	3.00		
60.00	Are you claiming nursing and allied health education (NAHE) costs for any programs that meet the criteria under 42 CFR 413.85? (see instructions) Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", are you impacted by CR 11642 (or subsequent CR) NAHE MA payment adjustment? Enter "Y" for yes or "N" for no in column 2.			Y	N			60.00
60.01	If line 60 is yes, complete columns 2 and 3 for each program. (see instructions)					23.00	1	60.01

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

Provider CCN: 14-0046

Period:
From 01/01/2020
To 12/31/2020Worksheet S-2
Part I
Date/Time Prepared:
7/19/2021 3:13 pm

	Y/N	IME	Direct GME	IME	Direct GME	
	1.00	2.00	3.00	4.00	5.00	
61.00 Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions)	N			0.00	0.00	61.00
61.01 Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions)						61.01
61.02 Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions)						61.02
61.03 Enter the base line FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions)						61.03
61.04 Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period.(see instructions).						61.04
61.05 Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions)						61.05
61.06 Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)						61.06
	Program Name		Program Code	Unweighted IME FTE Count	Unweighted Direct GME FTE Count	
	1.00		2.00	3.00	4.00	
61.10 Of the FTEs in line 61.05, specify each new program specialty, if any, and the number of FTE residents for each new program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count.				0.00	0.00	61.10
61.20 Of the FTEs in line 61.05, specify each expanded program specialty, if any, and the number of FTE residents for each expanded program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count.				0.00	0.00	61.20
					1.00	
ACA Provisions Affecting the Health Resources and Services Administration (HRSA)						
62.00 Enter the number of FTE residents that your hospital trained in this cost reporting period for which your hospital received HRSA PCRE funding (see instructions)					0.00	62.00
62.01 Enter the number of FTE residents that rotated from a Teaching Health Center (THC) into your hospital during in this cost reporting period of HRSA THC program. (see instructions)					0.00	62.01
Teaching Hospitals that Claim Residents in Nonprovider Settings						
63.00 Has your facility trained residents in nonprovider settings during this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If yes, complete lines 64 through 67. (see instructions)					N	63.00
	Unweighted FTEs Nonprovider Site		Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))		
	1.00		2.00	3.00		
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: 14-0046

Period:
From 01/01/2020
To 12/31/2020Worksheet S-2
Part I
Date/Time Prepared:
7/19/2021 3:13 pm

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

MCRIF32 - 16.10.172.3

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-0046	Period: From 01/01/2020 To 12/31/2020	Worksheet S-2 Part I Date/Time Prepared: 7/19/2021 3:13 pm
		1.00	2.00	
111.00	If this facility qualifies as a CAH, did it participate in the Frontier Community Health Integration Project (FCHIP) demonstration for this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If the response to column 1 is Y, enter the integration prong of the FCHIP demo in which this CAH is participating in column 2. Enter all that apply: "A" for Ambulance services; "B" for additional beds; and/or "C" for tele-health services.	N		111.00
		1.00	2.00	3.00
112.00	Did this hospital participate in the Pennsylvania Rural Health Model demonstration for any portion of the current cost reporting period? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2, the date the hospital began participating in the demonstration. In column 3, enter the date the hospital ceased participation in the demonstration, if applicable.	N		112.00
Miscellaneous Cost Reporting Information				
115.00	Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in column 1. If column 1 is yes, enter the method used (A, B, or E only) in column 2. If column 2 is "E", enter in column 3 either "93" percent for short term hospital or "98" percent for long term care (includes psychiatric, rehabilitation and long term hospitals providers) based on the definition in CMS Pub.15-1, chapter 22, §2208.1.	N		0115.00
116.00	Is this facility classified as a referral center? Enter "Y" for yes or "N" for no.	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:	4,044,920	198	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	N	120.00
121.00	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter "Y" for yes or "N" for no.	Y		121.00
122.00	Does the cost report contain healthcare related taxes as defined in §1903(w)(3) of the Act? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2 the Worksheet A line number where these taxes are included.	N		122.00
Transplant Center Information				
125.00	Does this facility operate a transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.	N		125.00
126.00	If this is a Medicare certified kidney transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			126.00
127.00	If this is a Medicare certified heart transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			127.00
128.00	If this is a Medicare certified liver transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			128.00
129.00	If this is a Medicare certified lung transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			129.00
130.00	If this is a Medicare certified pancreas transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			130.00
131.00	If this is a Medicare certified intestinal transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			131.00
132.00	If this is a Medicare certified islet transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			132.00
133.00	Removed and reserved			133.00
134.00	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.			134.00
All Providers				
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)	Y	269020	140.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA				Provider CCN: 14-0046		Period: From 01/01/2020 To 12/31/2020		Worksheet S-2 Part I Date/Time Prepared: 7/19/2021 3:13 pm	
1.00		2.00		3.00					
If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number.									
141.00	Name: BRIAN SCHMEIDLER	Contractor's Name: A		Contractor's Number: 05301				141.00	
142.00	Street: 1195 CORPORATE LAKE DRIVE	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.			N		N		145.00	
146.00	Has the cost allocation methodology changed from the previously filed cost report? Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, chapter 40, §4020) If yes, enter the approval date (mm/dd/yyyy) in column 2.			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.							N	147.00
148.00	Was there a change in the order of allocation? Enter "Y" for yes or "N" for no.							N	148.00
149.00	Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no.							N	149.00
				Part A	Part B	Title V	Title XIX		
				1.00	2.00	3.00	4.00		
Does this facility contain a provider that qualifies for an exemption from the application of the lower of costs or charges? Enter "Y" for yes or "N" for no for each component for Part A and Part B. (See 42 CFR §413.13)									
155.00	Hospital	N		N		N		155.00	
156.00	Subprovider - IPF	N		N		N		156.00	
157.00	Subprovider - IRF	N		N		N		157.00	
158.00	SUBPROVIDER							158.00	
159.00	SNF	N		N		N		159.00	
160.00	HOME HEALTH AGENCY	N		N		N		160.00	
161.00	CMHC			N		N		161.00	
								1.00	
Multicampus									
165.00	Is this hospital part of a Multicampus hospital that has one or more campuses in different CBSAs? Enter "Y" for yes or "N" for no.							N	165.00
		Name	County	State	Zip Code	CBSA	FTE/Campus		
		0	1.00	2.00	3.00	4.00	5.00		
166.00	If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions)						0.00	166.00	
								1.00	
Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act									
167.00	Is this provider a meaningful user under §1886(n)? Enter "Y" for yes or "N" for no.							Y	167.00
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)								168.00
168.01	If this provider is a CAH and is not a meaningful user, does this provider qualify for a hardship exception under §413.70(a)(6)(ii)? Enter "Y" for yes or "N" for no. (see instructions)								168.01
169.00	If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)							0.00	169.00
						Beginning	Ending		
						1.00	2.00		
170.00	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)							170.00	
						1.00	2.00		
171.00	If line 167 is "Y", does this provider have any days for individuals enrolled in section 1876 Medicare cost plans reported on Wkst. S-3, Pt. I, line 2, col. 6? Enter "Y" for yes and "N" for no in column 1. If column 1 is yes, enter the number of section 1876 Medicare days in column 2. (see instructions)					N	0	171.00	

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 14-0046	Period: From 01/01/2020 To 12/31/2020	Worksheet S-2 Part II Date/Time Prepared: 7/19/2021 3:13 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.	Y		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		N
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	Y	03/28/2018	Y
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N		N
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		N

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 14-0046	Period: From 01/01/2020 To 12/31/2020	Worksheet S-2 Part II Date/Time Prepared: 7/19/2021 3:13 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
		Y/N	Date	Y/N
		1.00	2.00	3.00
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N	N	
				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.	BRIAN	SCHMEIDLER	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.	314-989-3524	BRIAN.SCHMEIDLER@SSMHEALTH.COM	43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE

Provider CCN: 14-0046

Period:
From 01/01/2020
To 12/31/2020Worksheet S-2
Part II
Date/Time Prepared:
7/19/2021 3:13 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.	REGIONAL DIRECTOR GOVERNMENT REIMBUR	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: 14-0046

Period:
From 01/01/2020
To 12/31/2020Worksheet S-3
Part I
Date/Time Prepared:
7/19/2021 3:13 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	99	36,135	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)		99	36,135	0.00	0	7.00
8.00 INTENSIVE CARE UNIT	31.00	16	5,840	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)		115	41,975	0.00	0	14.00
15.00 CAH visits					0	15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF	41.00	10	3,650		0	17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY						22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
24.10 HOSPICE (non-distinct part)	30.00					24.10
25.00 CMHC - CMHC						25.00
26.00 RURAL HEALTH CLINIC						26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	26.25
27.00 Total (sum of lines 14-26)		125			0	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)		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: 14-0046

Period:
From 01/01/2020
To 12/31/2020Worksheet S-3
Part I
Date/Time Prepared:
7/19/2021 3:13 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)	11,044	455	18,951			1.00
2.00	HMO and other (see instructions)	1,778	4,106				2.00
3.00	HMO IPF Subprovider	0	163				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)	11,044	455	18,951			7.00
8.00	INTENSIVE CARE UNIT	1,257	108	2,463			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		301	1,924			13.00
14.00	Total (see instructions)	12,301	864	23,338	0.00	763.00	14.00
15.00	CAH visits	0	0	0			15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF	1,639	64	2,387	0.00	0.00	17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)			0			24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0.00	0.00	26.25
27.00	Total (sum of lines 14-26)				0.00	763.00	27.00
28.00	Observation Bed Days		49	1,483			28.00
29.00	Ambulance Trips	0					29.00
30.00	Employee discount days (see instruction)			479			30.00
31.00	Employee discount days - IRF			0			31.00
32.00	Labor & delivery days (see instructions)	0	266	428			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: 14-0046

Period:
From 01/01/2020
To 12/31/2020Worksheet S-3
Part I
Date/Time Prepared:
7/19/2021 3:13 pm

Component	Full Time Equivalents	Discharges			Total All Patients	
	Nonpaid Workers	Title V	Title XVIII	Title XIX		
	11.00	12.00	13.00	14.00	15.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)		0	2,525	478	9,642	1.00
2.00 HMO and other (see instructions)			345	1,966		2.00
3.00 HMO IPF Subprovider				0		3.00
4.00 HMO IRF Subprovider				10		4.00
5.00 Hospital Adults & Peds. Swing Bed SNF						5.00
6.00 Hospital Adults & Peds. Swing Bed NF						6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)						7.00
8.00 INTENSIVE CARE UNIT						8.00
9.00 CORONARY CARE UNIT						9.00
10.00 BURN INTENSIVE CARE UNIT						10.00
11.00 SURGICAL INTENSIVE CARE UNIT						11.00
12.00 OTHER SPECIAL CARE (SPECIFY)						12.00
13.00 NURSERY						13.00
14.00 Total (see instructions)	0.00	0	2,525	478	9,642	14.00
15.00 CAH visits						15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF	0.00	0	118	0	168	17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY						22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
24.10 HOSPICE (non-distinct part)						24.10
25.00 CMHC - CMHC						25.00
26.00 RURAL HEALTH CLINIC						26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER	0.00					26.25
27.00 Total (sum of lines 14-26)	0.00					27.00
28.00 Observation Bed Days						28.00
29.00 Ambulance Trips						29.00
30.00 Employee discount days (see instruction)						30.00
31.00 Employee discount days - IRF						31.00
32.00 Labor & delivery days (see instructions)						32.00
32.01 Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00 LTCH non-covered days			0			33.00
33.01 LTCH site neutral days and discharges			0			33.01

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 14-0046

Period:
From 01/01/2020
To 12/31/2020Worksheet S-3
Part II
Date/Time Prepared:
7/19/2021 3:13 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	54,756,822	-1,746,776	53,010,046	1,495,129.00	35.46
2.00	Non-physician anesthetist Part A		0	0	0	0.00	2.00
3.00	Non-physician anesthetist Part B		0	0	0	0.00	3.00
4.00	Physician-Part A - Administrative		188,200	0	188,200	1,080.00	174.26
4.01	Physicians - Part A - Teaching		0	0	0	0.00	4.01
5.00	Physician and Non Physician-Part B		0	0	0	0.00	5.00
6.00	Non-physician-Part B for hospital-based RHC and FQHC services		0	0	0	0.00	6.00
7.00	Interns & residents (in an approved program)	21.00	0	0	0	0.00	7.00
7.01	Contracted interns and residents (in an approved programs)		0	0	0	0.00	7.01
8.00	Home office and/or related organization personnel		0	0	0	0.00	8.00
9.00	SNF	44.00	0	0	0	0.00	9.00
10.00	Excluded area salaries (see instructions)		2,204,029	0	2,204,029	53,723.00	41.03
OTHER WAGES & RELATED COSTS							
11.00	Contract labor: Direct Patient Care		2,192,752	0	2,192,752	24,148.00	90.80
12.00	Contract labor: Top level management and other management and administrative services		0	0	0	0.00	12.00
13.00	Contract labor: Physician-Part A - Administrative		567,800	0	567,800	2,904.00	195.52
14.00	Home office and/or related organization salaries and wage-related costs		0	0	0	0.00	14.00
14.01	Home office salaries		8,387,570	0	8,387,570	215,593.00	38.90
14.02	Related organization salaries		0	0	0	0.00	14.02
15.00	Home office: Physician Part A - Administrative		0	0	0	0.00	15.00
16.00	Home office and Contract Physicians Part A - Teaching		0	0	0	0.00	16.00
16.01	Home office Physicians Part A - Teaching		0	0	0	0.00	16.01
16.02	Home office contract Physicians Part A - Teaching		0	0	0	0.00	16.02
WAGE-RELATED COSTS							
17.00	Wage-related costs (core) (see instructions)		23,851,303	0	23,851,303		17.00
18.00	Wage-related costs (other) (see instructions)						18.00
19.00	Excluded areas		920,057	0	920,057		19.00
20.00	Non-physician anesthetist Part A		0	0	0		20.00
21.00	Non-physician anesthetist Part B		0	0	0		21.00
22.00	Physician Part A - Administrative		15,107	0	15,107		22.00
22.01	Physician Part A - Teaching		0	0	0		22.01
23.00	Physician Part B		0	0	0		23.00
24.00	Wage-related costs (RHC/FQHC)		0	0	0		24.00
25.00	Interns & residents (in an approved program)		0	0	0		25.00
25.50	Home office wage-related (core)		3,130,826	0	3,130,826		25.50
25.51	Related organization wage-related (core)		0	0	0		25.51
25.52	Home office: Physician Part A - Administrative - wage-related (core)		0	0	0		25.52

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 14-0046

Period:
From 01/01/2020
To 12/31/2020Worksheet S-3
Part II
Date/Time Prepared:
7/19/2021 3:13 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	777,111	0	777,111	2,643.00	294.03	26.00
27.00	Administrative & General	5.00	4,971,040	-1,342,377	3,628,663	152,486.00	23.80	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	923,041	-146,064	776,977	37,988.00	20.45	30.00
31.00	Laundry & Linen Service	8.00	109,148	0	109,148	7,356.00	14.84	31.00
32.00	Housekeeping	9.00	1,463,840	0	1,463,840	94,211.00	15.54	32.00
33.00	Housekeeping under contract (see instructions)		0	0	0	0.00	0.00	33.00
34.00	Dietary	10.00	1,060,368	-744,060	316,308	20,462.00	15.46	34.00
35.00	Dietary under contract (see instructions)		0	0	0	0.00	0.00	35.00
36.00	Cafeteria	11.00	0	744,060	744,060	48,135.00	15.46	36.00
37.00	Maintenance of Personnel	12.00	0	0	0	0.00	0.00	37.00
38.00	Nursing Administration	13.00	861,955	0	861,955	18,223.00	47.30	38.00
39.00	Central Services and Supply	14.00	408,809	0	408,809	22,191.00	18.42	39.00
40.00	Pharmacy	15.00	2,013,181	0	2,013,181	47,209.00	42.64	40.00
41.00	Medical Records & Medical Records Library	16.00	216,728	0	216,728	11,720.00	18.49	41.00
42.00	Social Service	17.00	883,029	0	883,029	27,592.00	32.00	42.00
43.00	Other General Service	18.00	0	0	0	0.00	0.00	43.00

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 14-0046

Period:
From 01/01/2020
To 12/31/2020Worksheet S-3
Part III
Date/Time Prepared:
7/19/2021 3:13 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)	57,658,122	-1,746,776	55,911,346	1,518,600.00	36.82	1.00
2.00	Excluded area salaries (see instructions)	2,204,029	0	2,204,029	53,723.00	41.03	2.00
3.00	Subtotal salaries (line 1 minus line 2)	55,454,093	-1,746,776	53,707,317	1,464,877.00	36.66	3.00
4.00	Subtotal other wages & related costs (see inst.)	11,148,122	0	11,148,122	242,645.00	45.94	4.00
5.00	Subtotal wage-related costs (see inst.)	26,997,236	0	26,997,236	0.00	50.27	5.00
6.00	Total (sum of lines 3 thru 5)	93,599,451	-1,746,776	91,852,675	1,707,522.00	53.79	6.00
7.00	Total overhead cost (see instructions)	16,589,550	-1,488,441	15,101,109	513,687.00	29.40	7.00

HOSPITAL WAGE RELATED COSTS

Provider CCN: 14-0046

Period:
From 01/01/2020
To 12/31/2020Worksheet S-3
Part IV
Date/Time Prepared:
7/19/2021 3:13 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)	16,496,202	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	3,897,311	17.00
18.00	Medicare Taxes - Employers Portion Only	0	18.00
19.00	Unemployment Insurance	106,869	19.00
20.00	State or Federal Unemployment Taxes	0	20.00
OTHER			
21.00	Executive Deferred Compensation (Other Than Retirement Cost Reported on lines 1 through 4 above. (see instructions))	0	21.00
22.00	Day Care Cost and Allowances	4,210,939	22.00
23.00	Tuition Reimbursement	105,360	23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)	24,816,681	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: 14-0046

Period:
From 01/01/2020
To 12/31/2020Worksheet S-3
Part V
Date/Time Prepared:
7/19/2021 3:13 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	2,192,752	24,816,681	1.00
2.00	Hospital	2,192,752	23,896,624	2.00
3.00	Subprovider - IPF			3.00
4.00	Subprovider - IRF	0	0	4.00
5.00	Subprovider - (Other)	0	0	5.00
6.00	Swing Beds - SNF	0	0	6.00
7.00	Swing Beds - NF	0	0	7.00
8.00	Hospital-Based SNF			8.00
9.00	Hospital-Based NF			9.00
10.00	Hospital-Based OLTC			10.00
11.00	Hospital-Based HHA			11.00
12.00	Separately Certified ASC			12.00
13.00	Hospital-Based Hospice			13.00
14.00	Hospital-Based Health Clinic RHC			14.00
15.00	Hospital-Based Health Clinic FQHC			15.00
16.00	Hospital-Based-CMHC			16.00
17.00	Renal Dialysis	0	0	17.00
18.00	Other	0	920,057	18.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA		Provider CCN: 14-0046	Period: From 01/01/2020 To 12/31/2020	Worksheet S-10 Date/Time Prepared: 7/19/2021 3:13 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)		0.279947		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)	6,697,941	1,982,802	8,680,743	20.00
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	1,875,068	1,982,802	3,857,870	21.00
22.00	Payments received from patients for amounts previously written off as charity care	1,752,503	1,982,802	3,735,305	22.00
23.00	Cost of charity care (line 21 minus line 22)	122,565	0	122,565	23.00
				1.00	
24.00	Does the amount on line 20 column 2, include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?		N		24.00
25.00	If line 24 is yes, enter the charges for patient days beyond the indigent care program's length of stay limit		0		25.00
26.00	Total bad debt expense for the entire hospital complex (see instructions)			4,307,142	26.00
27.00	Medicare reimbursable bad debts for the entire hospital complex (see instructions)			1,115,195	27.00
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)			1,715,686	27.01
28.00	Non-Medicare bad debt expense (see instructions)			2,591,456	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)			1,325,961	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)			1,448,526	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)			1,448,526	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-0046

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

Worksheet A

Date/Time Prepared:
7/19/2021 3:13 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		13,858,939	13,858,939	207,969	14,066,908	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		5,320,677	5,320,677	0	5,320,677	2.00
3.00	00300	OTHER CAP REL COSTS		0	0	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	777,111	20,800,102	21,577,213	0	21,577,213	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	4,971,040	34,836,784	39,807,824	322,507	40,130,331	5.00
7.00	00700	OPERATION OF PLANT	923,041	4,710,957	5,633,998	331,369	5,965,367	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	109,148	494,674	603,822	0	603,822	8.00
9.00	00900	HOUSEKEEPING	1,463,840	661,497	2,125,337	-236,352	1,888,985	9.00
10.00	01000	DIETARY	1,060,368	1,101,617	2,161,985	-1,264,137	897,848	10.00
11.00	01100	CAFETERIA	0	0	0	1,264,137	1,264,137	11.00
13.00	01300	NURSING ADMINISTRATION	861,955	305,923	1,167,878	0	1,167,878	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	408,809	395,472	804,281	-35,196	769,085	14.00
15.00	01500	PHARMACY	2,013,181	13,270,001	15,283,182	-12,758,681	2,524,501	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	216,728	164,604	381,332	0	381,332	16.00
17.00	01700	SOCIAL SERVICE	883,029	343,212	1,226,241	0	1,226,241	17.00
23.00	02300	PARAMED ED PRGM-LABARATORY ED	68,417	8,398	76,815	0	76,815	23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	12,178,937	4,260,981	16,439,918	388,888	16,828,806	30.00
31.00	03100	INTENSIVE CARE UNIT	2,204,646	1,904,912	4,109,558	-1,149,454	2,960,104	31.00
41.00	04100	SUBPROVIDER - IRF	1,157,112	518,325	1,675,437	-42,805	1,632,632	41.00
43.00	04300	NURSERY	432,494	45,891	478,385	455,995	934,380	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	2,460,761	7,395,154	9,855,915	-5,516,312	4,339,603	50.00
51.00	05100	RECOVERY ROOM	417,104	78,063	495,167	-43,808	451,359	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	2,858,529	1,048,422	3,906,951	-1,303,859	2,603,092	52.00
53.00	05300	ANESTHESIOLOGY	58,988	5,386,866	5,445,854	-223,670	5,222,184	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,644,656	375,430	2,020,086	-127,010	1,893,076	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	1,149,282	399,515	1,548,797	-219,751	1,329,046	55.00
56.00	05600	RADIOISOTOPE	183,428	273,306	456,734	-9,803	446,931	56.00
57.00	05700	CT SCAN	437,484	130,329	567,813	-51,100	516,713	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	159,422	67,901	227,323	-13,916	213,407	58.00
59.00	05900	CARDIAC CATHETERIZATION	903,078	3,200,583	4,103,661	-2,892,637	1,211,024	59.00
60.00	06000	LABORATORY	2,221,676	3,473,782	5,695,458	-133,552	5,561,906	60.00
64.00	06400	INTRAVENOUS THERAPY	248,832	34,982	283,814	-14,353	269,461	64.00
65.00	06500	RESPIRATORY THERAPY	1,220,462	570,094	1,790,556	-254,407	1,536,149	65.00
66.00	06600	PHYSICAL THERAPY	922,310	112,272	1,034,582	-8,368	1,026,214	66.00
66.01	03951	CLINICAL NUTRITION	158,141	12,812	170,953	-2	170,951	66.01
67.00	06700	OCCUPATIONAL THERAPY	467,535	41,727	509,262	-3,825	505,437	67.00
68.00	06800	SPEECH PATHOLOGY	231,511	22,091	253,602	-2,042	251,560	68.00
69.00	06900	ELECTROCARDIOLOGY	702,611	991,720	1,694,331	-22,863	1,671,468	69.00
69.01	06901	CARDIAC REHABILITATION	187,841	35,413	223,254	-1,484	221,770	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	33,328	15,364	48,692	0	48,692	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	8,248,016	8,248,016	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	3,632,577	3,632,577	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	993,257	167,002	1,160,259	12,888,954	14,049,213	73.00
74.00	07400	RENAL DIALYSIS	52,500	621,409	673,909	-13,335	660,574	74.00
76.00	03950	ENDOSCOPY	14,275	40,282	54,557	-40,845	13,712	76.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	3,776,665	2,367,377	6,144,042	-383,542	5,760,500	90.00
91.00	09100	EMERGENCY	2,544,790	1,683,863	4,228,653	-347,810	3,880,843	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	53,778,322	131,548,725	185,327,047	625,493	185,952,540	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	29,787	2,916	32,703	0	32,703	190.00
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950	OTHER NRB COST CENTER	948,099	3,097,615	4,045,714	-625,493	3,420,221	194.00
194.01	07951	OTHER NRB COST CENTER	0	0	0	0	0	194.01
194.02	07952	NONREIMBURSABLE COST CENTER	0	0	0	0	0	194.02
194.03	07953	RETAIL PHARMACY	614	1,723,374	1,723,988	0	1,723,988	194.03
200.00		TOTAL (SUM OF LINES 118 through 199)	54,756,822	136,372,630	191,129,452	0	191,129,452	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-0046

Period:
From 01/01/2020
To 12/31/2020Worksheet A
Date/Time Prepared:
7/19/2021 3:13 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	-1,002,600	13,064,308	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	-5,737,556	-416,879	2.00
3.00	00300	OTHER CAP REL COSTS	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	12,466,947	34,044,160	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-25,109,975	15,020,356	5.00
7.00	00700	OPERATION OF PLANT	-31,508	5,933,859	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	603,822	8.00
9.00	00900	HOUSEKEEPING	-2,296	1,886,689	9.00
10.00	01000	DIETARY	0	897,848	10.00
11.00	01100	CAFETERIA	-608,926	655,211	11.00
13.00	01300	NURSING ADMINISTRATION	-764	1,167,114	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	769,085	14.00
15.00	01500	PHARMACY	-100,569	2,423,932	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-1,497	379,835	16.00
17.00	01700	SOCIAL SERVICE	0	1,226,241	17.00
23.00	02300	PARAMED ED PRGM-LABARATORY ED	0	76,815	23.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	-5,748,057	11,080,749	30.00
31.00	03100	INTENSIVE CARE UNIT	-808,814	2,151,290	31.00
41.00	04100	SUBPROVIDER - IRF	-758	1,631,874	41.00
43.00	04300	NURSERY	0	934,380	43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	-258,969	4,080,634	50.00
51.00	05100	RECOVERY ROOM	0	451,359	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	-247	2,602,845	52.00
53.00	05300	ANESTHESIOLOGY	-4,984,375	237,809	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-6,731	1,886,345	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	-543,910	785,136	55.00
56.00	05600	RADIOISOTOPE	0	446,931	56.00
57.00	05700	CT SCAN	-574	516,139	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	213,407	58.00
59.00	05900	CARDIAC CATHETERIZATION	-4,590	1,206,434	59.00
60.00	06000	LABORATORY	-207,157	5,354,749	60.00
64.00	06400	INTRAVENOUS THERAPY	-6,315	263,146	64.00
65.00	06500	RESPIRATORY THERAPY	-31,693	1,504,456	65.00
66.00	06600	PHYSICAL THERAPY	0	1,026,214	66.00
66.01	03951	CLINICAL NUTRITION	0	170,951	66.01
67.00	06700	OCCUPATIONAL THERAPY	0	505,437	67.00
68.00	06800	SPEECH PATHOLOGY	0	251,560	68.00
69.00	06900	ELECTROCARDIOLOGY	-709,490	961,978	69.00
69.01	06901	CARDIAC REHABILITATION	-10,133	211,637	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	-5,357	43,335	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	-669,426	7,578,590	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	3,632,577	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	-70	14,049,143	73.00
74.00	07400	RENAL DIALYSIS	-13,514	647,060	74.00
76.00	03950	ENDOSCOPY	-86	13,626	76.00
OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	-979,616	4,780,884	90.00
91.00	09100	EMERGENCY	-1,046,189	2,834,654	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)			92.00
SPECIAL PURPOSE COST CENTERS					
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-36,164,815	149,787,725	118.00
NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	32,703	190.00
191.00	19100	RESEARCH	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	192.00
193.00	19300	NONPAID WORKERS	0	0	193.00
194.00	07950	OTHER NRB COST CENTER	0	3,420,221	194.00
194.01	07951	OTHER NRB COST CENTER	0	0	194.01
194.02	07952	NONREIMBURSABLE COST CENTER	0	0	194.02
194.03	07953	RETAIL PHARMACY	0	1,723,988	194.03
200.00		TOTAL (SUM OF LINES 118 through 199)	-36,164,815	154,964,637	200.00

RECLASSIFICATIONS

Provider CCN: 14-0046

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

Worksheet A-6

Date/Time Prepared:
7/19/2021 3:13 pm

	Increases					
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
	A - OBSTETRICS RECALSS					
1.00	ADULTS & PEDIATRICS	30.00	740,182	471,599	1.00	
2.00	NURSERY	43.00	326,760	129,235	2.00	
3.00		0.00	0	0	3.00	
	0		1,066,942	600,834		
	B - UTILITIES					
1.00	OPERATION OF PLANT	7.00	0	331,369	1.00	
2.00		0.00	0	0	2.00	
	0		0	331,369		
	E - CAFETERIA					
1.00	CAFETERIA	11.00	744,060	520,077	1.00	
	0		744,060	520,077		
	H - INSURANCE					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	207,969	1.00	
	TOTALS		0	207,969		
	I - PUMP					
1.00	DELIVERY ROOM & LABOR ROOM	52.00	0	35,196	1.00	
	0		0	35,196		
	L - MEDICAL PLAZA					
1.00	ADMINISTRATIVE & GENERAL	5.00	0	625,493	1.00	
	0		0	625,493		
	N - MEDICAL SUPPLIES & IMPL DEVICES					
1.00	MEDICAL SUPPLIES CHARGED TO	71.00	0	8,248,016	1.00	
	PATIENTS					
2.00	IMPL. DEV. CHARGED TO	72.00	0	3,632,577	2.00	
	PATIENTS					
3.00	DRUGS CHARGED TO PATIENTS	73.00	0	12,963,025	3.00	
4.00		0.00	0	0	4.00	
5.00		0.00	0	0	5.00	
6.00		0.00	0	0	6.00	
7.00		0.00	0	0	7.00	
8.00		0.00	0	0	8.00	
9.00		0.00	0	0	9.00	
10.00		0.00	0	0	10.00	
11.00		0.00	0	0	11.00	
12.00		0.00	0	0	12.00	
13.00		0.00	0	0	13.00	
14.00		0.00	0	0	14.00	
15.00		0.00	0	0	15.00	
16.00		0.00	0	0	16.00	
17.00		0.00	0	0	17.00	
18.00		0.00	0	0	18.00	
19.00		0.00	0	0	19.00	
20.00		0.00	0	0	20.00	
21.00		0.00	0	0	21.00	
22.00		0.00	0	0	22.00	
23.00		0.00	0	0	23.00	
24.00		0.00	0	0	24.00	
25.00		0.00	0	0	25.00	
26.00		0.00	0	0	26.00	
27.00		0.00	0	0	27.00	
28.00		0.00	0	0	28.00	
	0		0	24,843,618		
	O - HOME OFFICE ADJUSTMENT					
1.00	ADMINISTRATIVE & GENERAL	5.00	0	1,342,377	1.00	
2.00	OPERATION OF PLANT	7.00	0	146,064	2.00	
3.00	CLINIC	90.00	0	258,335	3.00	
	TOTALS		0	1,746,776		
500.00	Grand Total: Increases		1,811,002	28,911,332	500.00	

RECLASSIFICATIONS

Provider CCN: 14-0046

Period:
From 01/01/2020
To 12/31/2020Worksheet A-6
Date/Time Prepared:
7/19/2021 3:13 pm

	Decreases						
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	A - OBSTETRICS RECALSS						
1.00	INTENSIVE CARE UNIT	31.00	342,602	315,887	0		1.00
2.00	DELIVERY ROOM & LABOR ROOM	52.00	718,761	284,274	0		2.00
3.00	DRUGS CHARGED TO PATIENTS	73.00	5,579	673	0		3.00
	0		1,066,942	600,834			
	B - UTILITIES						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	95,017	0		1.00
2.00	HOUSEKEEPING	9.00	0	236,352	0		2.00
	0		0	331,369			
	E - CAFETERIA						
1.00	DIETARY	10.00	744,060	520,077	0		1.00
	0		744,060	520,077			
	H - INSURANCE						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	207,969	12		1.00
	TOTALS		0	207,969			
	I - PUMP						
1.00	CENTRAL SERVICES & SUPPLY	14.00	0	35,196	0		1.00
	0		0	35,196			
	L - MEDICAL PLAZA						
1.00	OTHER NRB COST CENTER	194.00	0	625,493	0		1.00
	0		0	625,493			
	N - MEDICAL SUPPLIES & IMPL DEVICES						
1.00	PHARMACY	15.00	0	12,758,681	0		1.00
2.00	ADULTS & PEDIATRICS	30.00	0	822,893	0		2.00
3.00	INTENSIVE CARE UNIT	31.00	0	490,965	0		3.00
4.00	SUBPROVIDER - IRF	41.00	0	42,805	0		4.00
5.00	OPERATING ROOM	50.00	0	5,516,312	0		5.00
6.00	RECOVERY ROOM	51.00	0	43,808	0		6.00
7.00	DELIVERY ROOM & LABOR ROOM	52.00	0	336,020	0		7.00
8.00	ANESTHESIOLOGY	53.00	0	223,670	0		8.00
9.00	RADIOLOGY-DIAGNOSTIC	54.00	0	127,010	0		9.00
10.00	RADIOLOGY-THERAPEUTIC	55.00	0	219,751	0		10.00
11.00	RADIOISOTOPE	56.00	0	9,803	0		11.00
12.00	CT SCAN	57.00	0	51,100	0		12.00
13.00	MAGNETIC RESONANCE IMAGING (MRI)	58.00	0	13,916	0		13.00
14.00	CARDIAC CATHETERIZATION	59.00	0	2,892,637	0		14.00
15.00	LABORATORY	60.00	0	133,552	0		15.00
16.00	INTRAVENOUS THERAPY	64.00	0	14,353	0		16.00
17.00	RESPIRATORY THERAPY	65.00	0	254,407	0		17.00
18.00	PHYSICAL THERAPY	66.00	0	8,368	0		18.00
19.00	CLINICAL NUTRITION	66.01	0	2	0		19.00
20.00	OCCUPATIONAL THERAPY	67.00	0	3,825	0		20.00
21.00	SPEECH PATHOLOGY	68.00	0	2,042	0		21.00
22.00	ELECTROCARDIOLOGY	69.00	0	22,863	0		22.00
23.00	CARDIAC REHABILITATION	69.01	0	1,484	0		23.00
24.00	DRUGS CHARGED TO PATIENTS	73.00	0	67,819	0		24.00
25.00	RENAL DIALYSIS	74.00	0	13,335	0		25.00
26.00	ENDOSCOPY	76.00	0	40,845	0		26.00
27.00	CLINIC	90.00	0	383,542	0		27.00
28.00	EMERGENCY	91.00	0	347,810	0		28.00
	0		0	24,843,618			
	O - HOME OFFICE ADJUSTMENT						
1.00	ADMINISTRATIVE & GENERAL	5.00	1,342,377	0	0		1.00
2.00	OPERATION OF PLANT	7.00	146,064	0	0		2.00
3.00	CLINIC	90.00	258,335	0	0		3.00
	TOTALS		1,746,776	0			
500.00	Grand Total: Decreases		3,557,778	27,164,556			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-0046

Period:
From 01/01/2020
To 12/31/2020Worksheet A-7
Part I
Date/Time Prepared:
7/19/2021 3:13 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	590,251	0	0	0	0	1.00	
2.00	Land Improvements	6,818,606	455,178	0	455,178	0	2.00	
3.00	Buildings and Fixtures	158,560,904	186,640	0	186,640	0	3.00	
4.00	Building Improvements	20,205,341	-2,699	0	-2,699	0	4.00	
5.00	Fixed Equipment	15,445,349	2,685	0	2,685	0	5.00	
6.00	Movable Equipment	64,726,182	1,688,113	0	1,688,113	1,741,981	6.00	
7.00	HIT designated Assets	0	0	0	0	0	7.00	
8.00	Subtotal (sum of lines 1-7)	266,346,633	2,329,917	0	2,329,917	1,741,981	8.00	
9.00	Reconciling Items	0	0	0	0	0	9.00	
10.00	Total (line 8 minus line 9)	266,346,633	2,329,917	0	2,329,917	1,741,981	10.00	
		Ending Balance	Fully Depreciated Assets					
		6.00	7.00					
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES								
1.00	Land	590,251	0					1.00
2.00	Land Improvements	7,273,784	0					
3.00	Buildings and Fixtures	158,747,544	0					
4.00	Building Improvements	20,202,642	0					4.00
5.00	Fixed Equipment	15,448,034	0					
6.00	Movable Equipment	64,672,314	0					
7.00	HIT designated Assets	0	0					7.00
8.00	Subtotal (sum of lines 1-7)	266,934,569	0					
9.00	Reconciling Items	0	0					
10.00	Total (line 8 minus line 9)	266,934,569	0					10.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-0046

Period:
From 01/01/2020
To 12/31/2020Worksheet A-7
Part II
Date/Time Prepared:
7/19/2021 3:13 pm

Cost Center Description		SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	CAP REL COSTS-BLDG & FIXT	7,398,809	0	6,460,130	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	5,320,677	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	12,719,486	0	6,460,130	0	0	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)				
		14.00	15.00				
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	CAP REL COSTS-BLDG & FIXT	0	13,858,939				1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	5,320,677				2.00
3.00	Total (sum of lines 1-2)	0	19,179,616				3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-0046

Period:
From 01/01/2020
To 12/31/2020Worksheet A-7
Part III
Date/Time Prepared:
7/19/2021 3:13 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	202,262,255	0	202,262,255	0.797159	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	64,672,313	13,205,798	51,466,515	0.202841	0	2.00
3.00	Total (sum of lines 1-2)	266,934,568	13,205,798	253,728,770	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	6,396,209	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	6,220,331	0	2.00
3.00	Total (sum of lines 1-2)	0	0	0	12,616,540	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	6,460,130	207,969	0	0	13,064,308	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	-6,637,210	0	0	0	-416,879	2.00
3.00	Total (sum of lines 1-2)	-177,080	207,969	0	0	12,647,429	3.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 14-0046

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

Worksheet A-8

Date/Time Prepared:
7/19/2021 3:13 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				3.00	4.00	5.00	
1.00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)			0CAP REL COSTS-BLDG & FIXT	1.00	0	1.00
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)			0CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
3.00	Investment income - other (chapter 2)		0		0.00	0	3.00
4.00	Trade, quantity, and time discounts (chapter 8)		0		0.00	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)		0		0.00	0	5.00
6.00	Rental of provider space by suppliers (chapter 8)		0		0.00	0	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)	A	-24,882	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	-13,930,454			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	-8,222,950			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests		0		0.00	0	14.00
15.00	Rental of quarters to employee and others	B	-608,926	CAFETERIA	11.00	0	15.00
16.00	Sale of medical and surgical supplies to other than patients		0		0.00	0	16.00
17.00	Sale of drugs to other than patients	B	-100,569	PHARMACY	15.00	0	17.00
18.00	Sale of medical records and abstracts	B	-1,497	MEDICAL RECORDS & LIBRARY	16.00	0	18.00
19.00	Nursing and allied health education (tuition, fees, books, etc.)		0		0.00	0	19.00
20.00	Vending machines		0		0.00	0	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	0	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	RESPIRATORY THERAPY	65.00		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	PHYSICAL THERAPY	66.00		24.00
25.00	Utilization review - physicians' compensation (chapter 21)		0	*** Cost Center Deleted ***	114.00		25.00
26.00	Depreciation - CAP REL COSTS-BLDG & FIXT	B	-5,897	CAP REL COSTS-BLDG & FIXT	1.00	9	26.00
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP	B	-784	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	0	OCCUPATIONAL THERAPY	67.00		30.00
30.99	Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS	30.00		30.99
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	SPEECH PATHOLOGY	68.00		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest		0		0.00	0	32.00
33.00	MISC REVENUE	B	-10,155,794	ADMINISTRATIVE & GENERAL	5.00	0	33.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 14-0046

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

Worksheet A-8

Date/Time Prepared:
7/19/2021 3:13 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	
33.01	MISC REVENUE	B	-66,196	OPERATION OF PLANT		7.00	0	33.01
33.02	MISC REVENUE	B	-2,296	HOUSEKEEPING		9.00	0	33.02
33.03	MISC REVENUE	B	-207,932	ADULTS & PEDIATRICS		30.00	0	33.03
33.04	MISC REVENUE	B	-6,731	RADIOLOGY-DIAGNOSTIC		54.00	0	33.04
33.05	MISC REVENUE	B	-535,239	RADIOLOGY-THERAPEUTIC		55.00	0	33.05
33.06	MISC REVENUE	B	-574	CT SCAN		57.00	0	33.06
33.07	MISC REVENUE	B	-119,384	LABORATORY		60.00	0	33.07
33.08	MISC REVENUE	B	-6,315	INTRAVENOUS THERAPY		64.00	0	33.08
33.09	MISC REVENUE	B	-16,847	RESPIRATORY THERAPY		65.00	0	33.09
33.10	MISC REVENUE	B	-696	ELECTROCARDIOLOGY		69.00	0	33.10
33.11	MISC REVENUE	B	-4,746	CARDIAC REHABILITATION		69.01	0	33.11
33.12	MISC REVENUE	B	-86	ENDOSCOPY		76.00	0	33.12
33.13	MISC REVENUE	B	-528,157	CLINIC		90.00	0	33.13
33.14	MISC REVENUE	B	-15,122	EMERGENCY		91.00	0	33.14
33.15	ADVERTISEMENT	A	-76	ADMINISTRATIVE & GENERAL		5.00	0	33.15
33.16	ADVERTISEMENT	A	-250	NURSING ADMINISTRATION		13.00	0	33.16
33.17	ADVERTISEMENT	A	-70	DRUGS CHARGED TO PATIENTS		73.00	0	33.17
33.18	ADVERTISEMENT	A	-3,079	CLINIC		90.00	0	33.18
33.19	RECRUITMENT	A	-203,241	ADMINISTRATIVE & GENERAL		5.00	0	33.19
33.20	RECRUITMENT	A	-60,417	ADULTS & PEDIATRICS		30.00	0	33.20
33.21	RECRUITMENT	A	-150	CLINIC		90.00	0	33.21
33.22	LOBBYING	A	-7,309	ADMINISTRATIVE & GENERAL		5.00	0	33.22
33.23	GIFTS	A	-48,549	EMPLOYEE BENEFITS DEPARTMENT		4.00	0	33.23
33.24	GIFTS	A	-31,624	ADMINISTRATIVE & GENERAL		5.00	0	33.24
33.25	GIFTS	A	-514	NURSING ADMINISTRATION		13.00	0	33.25
33.26	GIFTS	A	-105	ADULTS & PEDIATRICS		30.00	0	33.26
33.27	GIFTS	A	-1,823	INTENSIVE CARE UNIT		31.00	0	33.27
33.28	GIFTS	A	-758	SUBPROVIDER - IRF		41.00	0	33.28
33.29	GIFTS	A	-272	OPERATING ROOM		50.00	0	33.29
33.30	GIFTS	A	-247	DELIVERY ROOM & LABOR ROOM		52.00	0	33.30
33.31	GIFTS	A	-421	RADIOLOGY-THERAPEUTIC		55.00	0	33.31
33.32	GIFTS	A	-4,590	CARDIAC CATHETERIZATION		59.00	0	33.32
33.33	ENTERTAINMENT	A	-373	ADMINISTRATIVE & GENERAL		5.00	0	33.33
33.34	INTEREST REVENUE	A	-1,238,873	CAP REL COSTS-BLDG & FIXT		1.00	9	33.34
33.35	OTHER ADJUSTMENTS (SPECIFY) (3)		0			0.00	0	33.35
33.36	OTHER ADJUSTMENTS (SPECIFY) (3)		0			0.00	0	33.36
33.37	OTHER ADJUSTMENTS (SPECIFY) (3)		0			0.00	0	33.37
33.38	OTHER ADJUSTMENTS (SPECIFY) (3)		0			0.00	0	33.38
33.39	OTHER ADJUSTMENTS (SPECIFY) (3)		0			0.00	0	33.39
33.40	OTHER ADJUSTMENTS (SPECIFY) (3)		0			0.00	0	33.40
33.41	OTHER ADJUSTMENTS (SPECIFY) (3)		0			0.00	0	33.41
33.42	OTHER ADJUSTMENTS (SPECIFY) (3)		0			0.00	0	33.42
33.43	OTHER ADJUSTMENTS (SPECIFY) (3)		0			0.00	0	33.43
33.44	OTHER ADJUSTMENTS (SPECIFY) (3)		0			0.00	0	33.44
33.45	OTHER ADJUSTMENTS (SPECIFY) (3)		0			0.00	0	33.45
33.46	OTHER ADJUSTMENTS (SPECIFY) (3)		0			0.00	0	33.46
33.47	OTHER ADJUSTMENTS (SPECIFY) (3)		0			0.00	0	33.47
33.48	OTHER ADJUSTMENTS (SPECIFY) (3)		0			0.00	0	33.48
33.49	OTHER ADJUSTMENTS (SPECIFY) (3)		0			0.00	0	33.49
33.50	OTHER ADJUSTMENTS (SPECIFY) (3)		0			0.00	0	33.50
33.51	OTHER ADJUSTMENTS (SPECIFY) (3)		0			0.00	0	33.51
33.52	OTHER ADJUSTMENTS (SPECIFY) (3)		0			0.00	0	33.52

ADJUSTMENTS TO EXPENSES

Provider CCN: 14-0046

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

Worksheet A-8

Date/Time Prepared:
7/19/2021 3:13 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	
33.53	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	33.53
33.54	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	33.54
33.55	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	33.55
33.56	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	33.56
33.57	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	33.57
33.58	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	33.58
33.59	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	33.59
33.60	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	33.60
33.61	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	33.61
33.62	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	33.62
33.63	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	33.63
33.64	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	33.64
33.65	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	33.65
33.66	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	33.66
33.67	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	33.67
33.68	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	33.68
33.69	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	33.69
33.70	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	33.70
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-36,164,815				50.00

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

(2) Basis for adjustment (see instructions).

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

B. Amount Received - if cost cannot be determined.

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

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

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

Provider CCN: 14-0046

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

Worksheet A-8-1

Date/Time Prepared:
7/19/2021 3:13 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	242,170	0
2.00		2.00	CAP REL COSTS-MVBLE EQUIP	HOME OFFICE	900,438	0
3.00		2.00	CAP REL COSTS-MVBLE EQUIP	HOME OFFICE - INTEREST	0	6,637,210
4.00		4.00	EMPLOYEE BENEFITS DEPARTMENT	HOME OFFICE	14,689,697	2,174,201
4.01		5.00	ADMINISTRATIVE & GENERAL	HOME OFFICE	14,459,590	29,068,696
4.02		7.00	OPERATION OF PLANT	HOME OFFICE	0	-34,688
4.03		71.00	MEDICAL SUPPLIES CHARGED TO	HOME OFFICE	-669,426	0
5.00			TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.		29,622,469	37,845,419

* 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: 14-0046

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

Worksheet A-8-1

Date/Time Prepared:
7/19/2021 3:13 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	242,170	9		1.00
2.00	900,438	9		2.00
3.00	-6,637,210	11		3.00
4.00	12,515,496	0		4.00
4.01	-14,609,106	0		4.01
4.02	34,688	0		4.02
4.03	-669,426	0		4.03
5.00	-8,222,950			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: 14-0046

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

Worksheet A-8-2

Date/Time Prepared:
7/19/2021 3:13 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	77,570	77,570	0	211,500	0	1.00
2.00	30.00	ADULTS & PEDIATRICS	5,526,074	5,426,374	99,700	179,000	540	2.00
3.00	31.00	INTENSIVE CARE UNIT	814,922	797,372	17,550	211,500	78	3.00
4.00	41.00	SUBPROVIDER - IRF	38,051	0	38,051	211,500	480	4.00
5.00	50.00	OPERATING ROOM	258,697	258,697	0	246,400	0	5.00
6.00	53.00	ANESTHESIOLOGY	4,984,375	4,984,375	0	239,400	0	6.00
7.00	55.00	RADIOLOGY-THERAPEUTIC	8,250	8,250	0	271,900	0	7.00
8.00	56.00	RADIOISOTOPE	0	0	0	271,900	0	8.00
9.00	60.00	LABORATORY	147,842	66,242	81,600	260,300	480	9.00
10.00	65.00	RESPIRATORY THERAPY	22,252	4,702	17,550	197,500	78	10.00
11.00	69.00	ELECTROCARDIOLOGY	835,745	555,745	280,000	197,500	1,337	11.00
12.00	69.01	CARDIAC REHABILITATION	16,781	0	16,781	197,500	120	12.00
13.00	70.00	ELECTROENCEPHALOGRAPHY	10,200	0	10,200	197,500	51	13.00
14.00	74.00	RENAL DIALYSIS	42,000	0	42,000	197,500	300	14.00
15.00	90.00	CLINIC	448,230	448,230	0	179,000	0	15.00
16.00	91.00	EMERGENCY	1,075,817	971,817	104,000	179,000	520	16.00
200.00			14,306,806	13,599,374	707,432		3,984	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	0	0	0	0	0	1.00
2.00	30.00	ADULTS & PEDIATRICS	46,471	2,324	0	0	0	2.00
3.00	31.00	INTENSIVE CARE UNIT	7,931	397	0	0	0	3.00
4.00	41.00	SUBPROVIDER - IRF	48,808	2,440	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	60,069	3,003	0	0	0	9.00
10.00	65.00	RESPIRATORY THERAPY	7,406	370	0	0	0	10.00
11.00	69.00	ELECTROCARDIOLOGY	126,951	6,348	0	0	0	11.00
12.00	69.01	CARDIAC REHABILITATION	11,394	570	0	0	0	12.00
13.00	70.00	ELECTROENCEPHALOGRAPHY	4,843	242	0	0	0	13.00
14.00	74.00	RENAL DIALYSIS	28,486	1,424	0	0	0	14.00
15.00	90.00	CLINIC	0	0	0	0	0	15.00
16.00	91.00	EMERGENCY	44,750	2,238	0	0	0	16.00
200.00			387,109	19,356	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	0	0	77,570		1.00
2.00	30.00	ADULTS & PEDIATRICS	0	46,471	53,229	5,479,603		2.00
3.00	31.00	INTENSIVE CARE UNIT	0	7,931	9,619	806,991		3.00
4.00	41.00	SUBPROVIDER - IRF	0	48,808	0	0		4.00
5.00	50.00	OPERATING ROOM	0	0	0	258,697		5.00
6.00	53.00	ANESTHESIOLOGY	0	0	0	4,984,375		6.00
7.00	55.00	RADIOLOGY-THERAPEUTIC	0	0	0	8,250		7.00
8.00	56.00	RADIOISOTOPE	0	0	0	0		8.00
9.00	60.00	LABORATORY	0	60,069	21,531	87,773		9.00
10.00	65.00	RESPIRATORY THERAPY	0	7,406	10,144	14,846		10.00
11.00	69.00	ELECTROCARDIOLOGY	0	126,951	153,049	708,794		11.00
12.00	69.01	CARDIAC REHABILITATION	0	11,394	5,387	5,387		12.00
13.00	70.00	ELECTROENCEPHALOGRAPHY	0	4,843	5,357	5,357		13.00
14.00	74.00	RENAL DIALYSIS	0	28,486	13,514	13,514		14.00
15.00	90.00	CLINIC	0	0	0	448,230		15.00
16.00	91.00	EMERGENCY	0	44,750	59,250	1,031,067		16.00
200.00			0	387,109	331,080	13,930,454		200.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0046

Period:
From 01/01/2020
To 12/31/2020Worksheet B
Part I
Date/Time Prepared:
7/19/2021 3:13 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	13,064,308	13,064,308				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	-416,879		-416,879			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	34,044,160	330,044	0	34,374,204		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	15,020,356	1,760,347	0	3,380,284	20,160,987	5.00
7.00	00700	OPERATION OF PLANT	5,933,859	2,090,495	0	587,792	8,612,146	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	603,822	144,125	0	69,505	817,452	8.00
9.00	00900	HOUSEKEEPING	1,886,689	336,077	0	932,172	3,154,938	9.00
10.00	01000	DIETARY	897,848	129,753	0	473,817	1,501,418	10.00
11.00	01100	CAFETERIA	655,211	338,925	0	201,425	1,195,561	11.00
13.00	01300	NURSING ADMINISTRATION	1,167,114	64,300	0	548,892	1,780,306	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	769,085	0	0	260,329	1,029,414	14.00
15.00	01500	PHARMACY	2,423,932	114,500	0	1,281,992	3,820,424	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	379,835	137,414	0	138,012	655,261	16.00
17.00	01700	SOCIAL SERVICE	1,226,241	117,754	0	562,312	1,906,307	17.00
23.00	02300	PARAMED ED PRGM-LABORATORY ED	76,815	0	0	43,568	120,383	23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	11,080,749	1,899,930	0	8,226,861	21,207,540	30.00
31.00	03100	INTENSIVE CARE UNIT	2,151,290	593,618	0	1,185,748	3,930,656	31.00
41.00	04100	SUBPROVIDER - IRF	1,631,874	306,012	0	736,848	2,674,734	41.00
43.00	04300	NURSERY	934,380	36,302	0	483,492	1,454,174	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	4,080,634	1,065,143	0	1,567,010	6,712,787	50.00
51.00	05100	RECOVERY ROOM	451,359	0	0	265,611	716,970	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	2,602,845	327,434	0	1,362,602	4,292,881	52.00
53.00	05300	ANESTHESIOLOGY	237,809	8,677	0	37,563	284,049	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,886,345	758,962	0	1,047,315	3,692,622	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	785,136	0	0	731,862	1,516,998	55.00
56.00	05600	RADIOISOTOPE	446,931	0	0	116,807	563,738	56.00
57.00	05700	CT SCAN	516,139	130,736	0	278,589	925,464	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	213,407	73,588	0	101,520	388,515	58.00
59.00	05900	CARDIAC CATHETERIZATION	1,206,434	223,204	0	575,079	2,004,717	59.00
60.00	06000	LABORATORY	5,354,749	301,165	0	1,414,761	7,070,675	60.00
64.00	06400	INTRAVENOUS THERAPY	263,146	45,895	0	158,456	467,497	64.00
65.00	06500	RESPIRATORY THERAPY	1,504,456	49,895	0	777,189	2,331,540	65.00
66.00	06600	PHYSICAL THERAPY	1,026,214	126,770	0	587,326	1,740,310	66.00
66.01	03951	CLINICAL NUTRITION	170,951	0	0	100,704	271,655	66.01
67.00	06700	OCCUPATIONAL THERAPY	505,437	116,703	0	297,726	919,866	67.00
68.00	06800	SPEECH PATHOLOGY	251,560	23,083	0	147,426	422,069	68.00
69.00	06900	ELECTROCARDIOLOGY	961,978	593,855	0	447,422	2,003,255	69.00
69.01	06901	CARDIAC REHABILITATION	211,637	0	0	119,617	331,254	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	43,335	44,031	0	21,223	108,589	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	7,578,590	0	0	0	7,578,590	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	3,632,577	0	0	0	3,632,577	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	14,049,143	0	0	628,952	14,678,095	73.00
74.00	07400	RENAL DIALYSIS	647,060	0	0	33,432	680,492	74.00
76.00	03950	ENDOSCOPY	13,626	35,930	0	9,090	58,646	76.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	4,780,884	107,619	0	2,569,484	7,457,987	90.00
91.00	09100	EMERGENCY	2,834,654	528,233	0	1,620,520	4,983,407	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					0	92.00
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	149,787,725	12,960,519	0	34,130,335	149,856,946	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	32,703	48,234	0	18,968	99,905	190.00
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	12,236	0	0	12,236	192.00
193.00	19300	NONPAID WORKERS	0	0	0	224,510	224,510	193.00
194.00	07950	OTHER NRB COST CENTER	3,420,221	43,319	0	391	3,463,931	194.00
194.01	07951	OTHER NRB COST CENTER	0	0	0	0	0	194.01
194.02	07952	NONREIMBURSABLE COST CENTER	0	0	0	0	0	194.02
194.03	07953	RETAIL PHARMACY	1,723,988	0	0	0	1,723,988	194.03
200.00		Cross Foot Adjustments					0	200.00
201.00		Negative Cost Centers		0	-416,879	0	-416,879	201.00
202.00		TOTAL (sum lines 118 through 201)	154,964,637	13,064,308	-416,879	34,374,204	154,964,637	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0046

Period:
From 01/01/2020
To 12/31/2020Worksheet B
Part I
Date/Time Prepared:
7/19/2021 3:13 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	20,160,987					5.00
7.00	00700	OPERATION OF PLANT	1,284,045	9,896,191				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	121,880	160,556	1,099,888			8.00
9.00	00900	HOUSEKEEPING	470,392	374,392	0	3,999,722		9.00
10.00	01000	DIETARY	223,857	144,546	0	61,759	1,931,580	10.00
11.00	01100	CAFETERIA	178,255	377,564	0	161,320	0	11.00
13.00	01300	NURSING ADMINISTRATION	265,438	71,631	0	30,605	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	153,483	0	0	0	0	14.00
15.00	01500	PHARMACY	569,614	127,554	0	54,499	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	97,697	153,080	0	65,405	0	16.00
17.00	01700	SOCIAL SERVICE	284,225	131,179	0	56,048	0	17.00
23.00	02300	PARAMED ED PRGM-LABARATORY ED	17,949	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	3,161,993	2,116,536	797,001	904,318	1,537,976	30.00
31.00	03100	INTENSIVE CARE UNIT	586,049	661,294	103,584	282,547	199,886	31.00
41.00	04100	SUBPROVIDER - IRF	398,795	340,899	100,387	145,654	193,718	41.00
43.00	04300	NURSERY	216,813	40,441	80,916	17,279	0	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	1,000,856	1,186,576	0	506,981	0	50.00
51.00	05100	RECOVERY ROOM	106,898	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	640,056	364,763	18,000	155,850	0	52.00
53.00	05300	ANESTHESIOLOGY	42,351	9,667	0	4,130	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	550,559	845,488	0	361,247	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	226,180	0	0	0	0	55.00
56.00	05600	RADIOISOTOPE	84,052	0	0	0	0	56.00
57.00	05700	CT SCAN	137,984	145,641	0	62,227	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	57,926	81,977	0	35,026	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	298,897	248,651	0	106,240	0	59.00
60.00	06000	LABORATORY	1,054,216	335,499	0	143,347	0	60.00
64.00	06400	INTRAVENOUS THERAPY	69,702	51,127	0	21,845	0	64.00
65.00	06500	RESPIRATORY THERAPY	347,626	55,583	0	23,749	0	65.00
66.00	06600	PHYSICAL THERAPY	259,475	141,223	0	60,340	0	66.00
66.01	03951	CLINICAL NUTRITION	40,503	0	0	0	0	66.01
67.00	06700	OCCUPATIONAL THERAPY	137,149	130,008	0	55,548	0	67.00
68.00	06800	SPEECH PATHOLOGY	62,929	25,715	0	10,987	0	68.00
69.00	06900	ELECTROCARDIOLOGY	298,679	661,559	0	282,660	0	69.00
69.01	06901	CARDIAC REHABILITATION	49,389	0	0	0	0	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	16,190	49,050	0	20,958	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,129,945	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	541,606	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,188,460	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	101,459	0	0	0	0	74.00
76.00	03950	ENDOSCOPY	8,744	40,026	0	17,102	0	76.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	1,111,963	119,889	0	51,224	0	90.00
91.00	09100	EMERGENCY	743,011	588,455	0	251,426	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	19,337,290	9,780,569	1,099,888	3,950,321	1,931,580	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	14,896	53,733	0	22,958	0	190.00
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	1,824	13,631	0	5,824	0	192.00
193.00	19300	NONPAID WORKERS	33,474	0	0	0	0	193.00
194.00	07950	OTHER NRB COST CENTER	516,462	48,258	0	20,619	0	194.00
194.01	07951	OTHER NRB COST CENTER	0	0	0	0	0	194.01
194.02	07952	NONREIMBURSABLE COST CENTER	0	0	0	0	0	194.02
194.03	07953	RETAIL PHARMACY	257,041	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)	20,160,987	9,896,191	1,099,888	3,999,722	1,931,580	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0046

Period:
From 01/01/2020
To 12/31/2020Worksheet B
Part I
Date/Time Prepared:
7/19/2021 3:13 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	1,912,700					11.00
13.00	01300	NURSING ADMINISTRATION	36,543	2,184,523				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	17,332	0	1,200,229			14.00
15.00	01500	PHARMACY	85,351	0	8,519	4,665,961		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	9,188	0	0	0	980,631	16.00
17.00	01700	SOCIAL SERVICE	37,437	0	9	0	0	17.00
23.00	02300	PARAMED ED PRGM-LABARATORY ED	2,901	0	11	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	547,718	850,713	115,004	309	60,779	30.00
31.00	03100	INTENSIVE CARE UNIT	78,943	235,745	70,576	48	11,676	31.00
41.00	04100	SUBPROVIDER - IRF	49,057	78,568	6,191	0	6,515	41.00
43.00	04300	NURSERY	32,189	128,317	0	0	5,698	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	104,326	144,969	468,123	2,438	119,872	50.00
51.00	05100	RECOVERY ROOM	17,684	25,455	5,550	34	14,163	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	90,718	246,243	48,436	459	26,384	52.00
53.00	05300	ANESTHESIOLOGY	2,501	0	31,890	0	21,542	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	69,727	11,500	18,274	280	35,626	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	48,725	16,729	16,281	0	6,848	55.00
56.00	05600	RADIOISOTOPE	7,777	0	1,403	0	15,953	56.00
57.00	05700	CT SCAN	18,548	41	7,384	0	76,130	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	6,759	18	2,002	0	14,706	58.00
59.00	05900	CARDIAC CATHETERIZATION	38,287	43,786	229,397	83	69,191	59.00
60.00	06000	LABORATORY	94,190	65	19,291	63	131,501	60.00
64.00	06400	INTRAVENOUS THERAPY	10,549	12,333	2,058	0	863	64.00
65.00	06500	RESPIRATORY THERAPY	51,743	495	36,513	69	26,364	65.00
66.00	06600	PHYSICAL THERAPY	39,102	0	1,210	10	11,181	66.00
66.01	03951	CLINICAL NUTRITION	6,705	0	0	0	96	66.01
67.00	06700	OCCUPATIONAL THERAPY	19,822	0	555	0	5,181	67.00
68.00	06800	SPEECH PATHOLOGY	9,815	0	258	0	1,743	68.00
69.00	06900	ELECTROCARDIOLOGY	29,788	9,579	3,305	16	33,813	69.00
69.01	06901	CARDIAC REHABILITATION	7,964	10,903	215	0	1,007	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	1,413	0	0	0	498	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	28,536	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	73,620	0	0	32,367	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	41,874	0	9,834	4,633,413	145,073	73.00
74.00	07400	RENAL DIALYSIS	2,226	0	1,904	34	3,310	74.00
76.00	03950	ENDOSCOPY	605	1,391	5,906	0	762	76.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	171,068	87,249	40,254	28,661	20,628	90.00
91.00	09100	EMERGENCY	107,889	206,804	49,857	44	52,625	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	1,896,464	2,184,523	1,200,210	4,665,961	980,631	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	1,263	0	0	0	0	190.00
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
193.00	19300	NONPAID WORKERS	14,947	0	0	0	0	193.00
194.00	07950	OTHER NRB COST CENTER	26	0	19	0	0	194.00
194.01	07951	OTHER NRB COST CENTER	0	0	0	0	0	194.01
194.02	07952	NONREIMBURSABLE COST CENTER	0	0	0	0	0	194.02
194.03	07953	RETAIL 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)	1,912,700	2,184,523	1,200,229	4,665,961	980,631	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0046

Period:
From 01/01/2020
To 12/31/2020Worksheet B
Part I
Date/Time Prepared:
7/19/2021 3:13 pm

Cost Center Description			SOCIAL SERVICE	PARAMED ED PRGM-LABARATOR Y ED	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			17.00	23.00	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	2,415,205					17.00
23.00	02300	PARAMED ED PRGM-LABARATORY ED	0	141,244				23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	1,750,107	0	33,049,994	0	33,049,994	30.00
31.00	03100	INTENSIVE CARE UNIT	227,456	0	6,388,460	0	6,388,460	31.00
41.00	04100	SUBPROVIDER - IRF	220,437	0	4,214,955	0	4,214,955	41.00
43.00	04300	NURSERY	177,680	0	2,153,507	0	2,153,507	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	10,246,928	0	10,246,928	50.00
51.00	05100	RECOVERY ROOM	0	0	886,754	0	886,754	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	39,525	0	5,923,315	0	5,923,315	52.00
53.00	05300	ANESTHESIOLOGY	0	0	396,130	0	396,130	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	5,585,323	0	5,585,323	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	1,831,761	0	1,831,761	55.00
56.00	05600	RADIOISOTOPE	0	0	672,923	0	672,923	56.00
57.00	05700	CT SCAN	0	0	1,373,419	0	1,373,419	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	586,929	0	586,929	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	3,039,249	0	3,039,249	59.00
60.00	06000	LABORATORY	0	141,244	8,990,091	0	8,990,091	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	635,974	0	635,974	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	2,873,682	0	2,873,682	65.00
66.00	06600	PHYSICAL THERAPY	0	0	2,252,851	0	2,252,851	66.00
66.01	03951	CLINICAL NUTRITION	0	0	318,959	0	318,959	66.01
67.00	06700	OCCUPATIONAL THERAPY	0	0	1,268,129	0	1,268,129	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	533,516	0	533,516	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	3,322,654	0	3,322,654	69.00
69.01	06901	CARDIAC REHABILITATION	0	0	400,732	0	400,732	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	196,698	0	196,698	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	8,737,071	0	8,737,071	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	4,280,170	0	4,280,170	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	21,696,749	0	21,696,749	73.00
74.00	07400	RENAL DIALYSIS	0	0	789,425	0	789,425	74.00
76.00	03950	ENDOSCOPY	0	0	133,182	0	133,182	76.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	9,088,923	0	9,088,923	90.00
91.00	09100	EMERGENCY	0	0	6,983,518	0	6,983,518	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	2,415,205	141,244	148,851,971	0	148,851,971	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	192,755	0	192,755	190.00
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	33,515	0	33,515	192.00
193.00	19300	NONPAID WORKERS	0	0	272,931	0	272,931	193.00
194.00	07950	OTHER NRB COST CENTER	0	0	4,049,315	0	4,049,315	194.00
194.01	07951	OTHER NRB COST CENTER	0	0	0	0	0	194.01
194.02	07952	NONREIMBURSABLE COST CENTER	0	0	0	0	0	194.02
194.03	07953	RETAIL PHARMACY	0	0	1,981,029	0	1,981,029	194.03
200.00		Cross Foot Adjustments	0	0	0	0	0	200.00
201.00		Negative Cost Centers	0	0	-416,879	0	-416,879	201.00
202.00		TOTAL (sum lines 118 through 201)	2,415,205	141,244	154,964,637	0	154,964,637	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0046

Period:
From 01/01/2020
To 12/31/2020Worksheet B
Part II
Date/Time Prepared:
7/19/2021 3:13 pm

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	330,044	0	330,044	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	9,577	1,760,347	0	1,769,924	5.00
7.00	00700	OPERATION OF PLANT	6,423	2,090,495	0	2,096,918	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	144,125	0	144,125	8.00
9.00	00900	HOUSEKEEPING	26,163	336,077	0	362,240	9.00
10.00	01000	DIETARY	0	129,753	0	129,753	10.00
11.00	01100	CAFETERIA	0	338,925	0	338,925	11.00
13.00	01300	NURSING ADMINISTRATION	0	64,300	0	64,300	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	48,498	0	0	48,498	14.00
15.00	01500	PHARMACY	247,396	114,500	0	361,896	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	137,414	0	137,414	16.00
17.00	01700	SOCIAL SERVICE	0	117,754	0	117,754	17.00
23.00	02300	PARAMED ED PRGM-LABARATORY ED	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	59,219	1,899,930	0	1,959,149	30.00
31.00	03100	INTENSIVE CARE UNIT	135	593,618	0	593,753	31.00
41.00	04100	SUBPROVIDER - IRF	4,822	306,012	0	310,834	41.00
43.00	04300	NURSERY	0	36,302	0	36,302	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	394,084	1,065,143	0	1,459,227	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	9	327,434	0	327,443	52.00
53.00	05300	ANESTHESIOLOGY	0	8,677	0	8,677	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	758,962	0	758,962	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	612	0	0	612	55.00
56.00	05600	RADIOISOTOPE	0	0	0	0	56.00
57.00	05700	CT SCAN	0	130,736	0	130,736	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	73,588	0	73,588	58.00
59.00	05900	CARDIAC CATHETERIZATION	88,650	223,204	0	311,854	59.00
60.00	06000	LABORATORY	0	301,165	0	301,165	60.00
64.00	06400	INTRAVENOUS THERAPY	0	45,895	0	45,895	64.00
65.00	06500	RESPIRATORY THERAPY	57,944	49,895	0	107,839	65.00
66.00	06600	PHYSICAL THERAPY	430	126,770	0	127,200	66.00
66.01	03951	CLINICAL NUTRITION	0	0	0	0	66.01
67.00	06700	OCCUPATIONAL THERAPY	0	116,703	0	116,703	67.00
68.00	06800	SPEECH PATHOLOGY	0	23,083	0	23,083	68.00
69.00	06900	ELECTROCARDIOLOGY	0	593,855	0	593,855	69.00
69.01	06901	CARDIAC REHABILITATION	0	0	0	0	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0	44,031	0	44,031	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
76.00	03950	ENDOSCOPY	0	35,930	0	35,930	76.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	1,101,948	107,619	0	1,209,567	90.00
91.00	09100	EMERGENCY	0	528,233	0	528,233	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				0	92.00
SPECIAL PURPOSE COST CENTERS							
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	2,045,910	12,960,519	0	15,006,429	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	48,234	0	48,234	190.00
191.00	19100	RESEARCH	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	12,236	0	12,236	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	193.00
194.00	07950	OTHER NRB COST CENTER	2,237,462	43,319	0	2,280,781	194.00
194.01	07951	OTHER NRB COST CENTER	0	0	0	0	194.01
194.02	07952	NONREIMBURSABLE COST CENTER	0	0	0	0	194.02
194.03	07953	RETAIL PHARMACY	0	0	0	0	194.03
200.00		Cross Foot Adjustments				0	200.00
201.00		Negative Cost Centers			-416,879	-416,879	201.00
202.00		TOTAL (sum lines 118 through 201)	4,283,372	13,064,308	-416,879	16,930,801	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0046

Period:
From 01/01/2020
To 12/31/2020Worksheet B
Part II
Date/Time Prepared:
7/19/2021 3:13 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	1,802,379					5.00
7.00	00700	OPERATION OF PLANT	114,791	2,217,352				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	10,896	35,974	191,662			8.00
9.00	00900	HOUSEKEEPING	42,052	83,887	0	497,129		9.00
10.00	01000	DIETARY	20,012	32,387	0	7,676	194,377	10.00
11.00	01100	CAFETERIA	15,936	84,597	0	20,051	0	11.00
13.00	01300	NURSING ADMINISTRATION	23,730	16,050	0	3,804	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	13,721	0	0	0	0	14.00
15.00	01500	PHARMACY	50,922	28,580	0	6,774	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	8,734	34,299	0	8,129	0	16.00
17.00	01700	SOCIAL SERVICE	25,409	29,392	0	6,966	0	17.00
23.00	02300	PARAMED ED PRGM-LABARATORY ED	1,605	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	282,698	474,234	138,882	112,397	154,768	30.00
31.00	03100	INTENSIVE CARE UNIT	52,392	148,170	18,050	35,118	20,115	31.00
41.00	04100	SUBPROVIDER - IRF	35,652	76,382	17,493	18,103	19,494	41.00
43.00	04300	NURSERY	19,383	9,061	14,100	2,148	0	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	89,475	265,866	0	63,013	0	50.00
51.00	05100	RECOVERY ROOM	9,556	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	57,220	81,729	3,137	19,371	0	52.00
53.00	05300	ANESTHESIOLOGY	3,786	2,166	0	513	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	49,219	189,441	0	44,900	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	20,220	0	0	0	0	55.00
56.00	05600	RADIOISOTOPE	7,514	0	0	0	0	56.00
57.00	05700	CT SCAN	12,336	32,633	0	7,734	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	5,179	18,368	0	4,353	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	26,721	55,713	0	13,205	0	59.00
60.00	06000	LABORATORY	94,245	75,172	0	17,817	0	60.00
64.00	06400	INTRAVENOUS THERAPY	6,231	11,456	0	2,715	0	64.00
65.00	06500	RESPIRATORY THERAPY	31,077	12,454	0	2,952	0	65.00
66.00	06600	PHYSICAL THERAPY	23,197	31,643	0	7,500	0	66.00
66.01	03951	CLINICAL NUTRITION	3,621	0	0	0	0	66.01
67.00	06700	OCCUPATIONAL THERAPY	12,261	29,130	0	6,904	0	67.00
68.00	06800	SPEECH PATHOLOGY	5,626	5,762	0	1,366	0	68.00
69.00	06900	ELECTROCARDIOLOGY	26,701	148,230	0	35,132	0	69.00
69.01	06901	CARDIAC REHABILITATION	4,415	0	0	0	0	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	1,447	10,990	0	2,605	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	101,015	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	48,419	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	195,644	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	9,070	0	0	0	0	74.00
76.00	03950	ENDOSCOPY	782	8,968	0	2,126	0	76.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	99,408	26,862	0	6,367	0	90.00
91.00	09100	EMERGENCY	66,424	131,850	0	31,250	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	1,728,742	2,191,446	191,662	490,989	194,377	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	1,332	12,039	0	2,853	0	190.00
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	163	3,054	0	724	0	192.00
193.00	19300	NONPAID WORKERS	2,992	0	0	0	0	193.00
194.00	07950	OTHER NRB COST CENTER	46,171	10,813	0	2,563	0	194.00
194.01	07951	OTHER NRB COST CENTER	0	0	0	0	0	194.01
194.02	07952	NONREIMBURSABLE COST CENTER	0	0	0	0	0	194.02
194.03	07953	RETAIL PHARMACY	22,979	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)	1,802,379	2,217,352	191,662	497,129	194,377	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0046

Period:
From 01/01/2020
To 12/31/2020Worksheet B
Part II
Date/Time Prepared:
7/19/2021 3:13 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	461,443					11.00
13.00	01300	NURSING ADMINISTRATION	8,816	121,970				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	4,181	0	68,899			14.00
15.00	01500	PHARMACY	20,591	0	489	481,561		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	2,217	0	0	0	192,118	16.00
17.00	01700	SOCIAL SERVICE	9,032	0	0	0	0	17.00
23.00	02300	PARAMED ED PRGM-LABARATORY ED	700	0	1	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	132,141	47,497	6,602	32	11,899	30.00
31.00	03100	INTENSIVE CARE UNIT	19,045	13,163	4,052	5	2,286	31.00
41.00	04100	SUBPROVIDER - IRF	11,835	4,387	355	0	1,275	41.00
43.00	04300	NURSERY	7,766	7,164	0	0	1,115	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	25,169	8,094	26,870	252	23,467	50.00
51.00	05100	RECOVERY ROOM	4,266	1,421	319	4	2,773	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	21,886	13,749	2,781	47	5,165	52.00
53.00	05300	ANESTHESIOLOGY	603	0	1,831	0	4,217	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	16,822	642	1,049	29	6,974	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	11,755	934	935	0	1,341	55.00
56.00	05600	RADIOISOTOPE	1,876	0	81	0	3,123	56.00
57.00	05700	CT SCAN	4,475	2	424	0	14,904	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	1,631	1	115	0	2,879	58.00
59.00	05900	CARDIAC CATHETERIZATION	9,237	2,445	13,169	9	13,545	59.00
60.00	06000	LABORATORY	22,723	4	1,107	6	25,744	60.00
64.00	06400	INTRAVENOUS THERAPY	2,545	689	118	0	169	64.00
65.00	06500	RESPIRATORY THERAPY	12,483	28	2,096	7	5,161	65.00
66.00	06600	PHYSICAL THERAPY	9,433	0	69	1	2,189	66.00
66.01	03951	CLINICAL NUTRITION	1,617	0	0	0	19	66.01
67.00	06700	OCCUPATIONAL THERAPY	4,782	0	32	0	1,014	67.00
68.00	06800	SPEECH PATHOLOGY	2,368	0	15	0	341	68.00
69.00	06900	ELECTROCARDIOLOGY	7,186	535	190	2	6,619	69.00
69.01	06901	CARDIAC REHABILITATION	1,921	609	12	0	197	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	341	0	0	0	97	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	5,586	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	4,110	0	0	6,336	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	10,102	0	565	478,201	28,546	73.00
74.00	07400	RENAL DIALYSIS	537	0	109	3	648	74.00
76.00	03950	ENDOSCOPY	146	78	339	0	149	76.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	41,270	4,871	2,311	2,958	4,038	90.00
91.00	09100	EMERGENCY	26,028	11,547	2,862	5	10,302	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	457,526	121,970	68,898	481,561	192,118	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	305	0	0	0	0	190.00
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
193.00	19300	NONPAID WORKERS	3,606	0	0	0	0	193.00
194.00	07950	OTHER NRB COST CENTER	6	0	1	0	0	194.00
194.01	07951	OTHER NRB COST CENTER	0	0	0	0	0	194.01
194.02	07952	NONREIMBURSABLE COST CENTER	0	0	0	0	0	194.02
194.03	07953	RETAIL 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)	461,443	121,970	68,899	481,561	192,118	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0046

Period:
From 01/01/2020
To 12/31/2020Worksheet B
Part II
Date/Time Prepared:
7/19/2021 3:13 pm

Cost Center Description			SOCIAL SERVICE	PARAMED ED PRGM-LABARATOR Y ED	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			17.00	23.00	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	193,952					17.00
23.00	02300	PARAMED ED PRGM-LABARATORY ED	0	2,724				23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	140,542		3,539,840	0	3,539,840	30.00
31.00	03100	INTENSIVE CARE UNIT	18,266		935,800	0	935,800	31.00
41.00	04100	SUBPROVIDER - IRF	17,702		520,587	0	520,587	41.00
43.00	04300	NURSERY	14,268		115,949	0	115,949	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0		1,976,478	0	1,976,478	50.00
51.00	05100	RECOVERY ROOM	0		20,889	0	20,889	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	3,174		548,785	0	548,785	52.00
53.00	05300	ANESTHESIOLOGY	0		22,154	0	22,154	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0		1,078,093	0	1,078,093	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0		42,824	0	42,824	55.00
56.00	05600	RADIOISOTOPE	0		13,715	0	13,715	56.00
57.00	05700	CT SCAN	0		205,919	0	205,919	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0		107,089	0	107,089	58.00
59.00	05900	CARDIAC CATHETERIZATION	0		451,419	0	451,419	59.00
60.00	06000	LABORATORY	0		551,566	0	551,566	60.00
64.00	06400	INTRAVENOUS THERAPY	0		71,339	0	71,339	64.00
65.00	06500	RESPIRATORY THERAPY	0		181,559	0	181,559	65.00
66.00	06600	PHYSICAL THERAPY	0		206,871	0	206,871	66.00
66.01	03951	CLINICAL NUTRITION	0		6,224	0	6,224	66.01
67.00	06700	OCCUPATIONAL THERAPY	0		173,685	0	173,685	67.00
68.00	06800	SPEECH PATHOLOGY	0		39,976	0	39,976	68.00
69.00	06900	ELECTROCARDIOLOGY	0		822,746	0	822,746	69.00
69.01	06901	CARDIAC REHABILITATION	0		8,302	0	8,302	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0		59,715	0	59,715	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0		106,601	0	106,601	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0		58,865	0	58,865	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0		719,097	0	719,097	73.00
74.00	07400	RENAL DIALYSIS	0		10,688	0	10,688	74.00
76.00	03950	ENDOSCOPY	0		48,605	0	48,605	76.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0		1,422,322	0	1,422,322	90.00
91.00	09100	EMERGENCY	0		824,060	0	824,060	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0		0	0	0	92.00
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	193,952	0	14,891,762	0	14,891,762	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0		64,945	0	64,945	190.00
191.00	19100	RESEARCH	0		0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0		16,177	0	16,177	192.00
193.00	19300	NONPAID WORKERS	0		8,754	0	8,754	193.00
194.00	07950	OTHER NRB COST CENTER	0		2,340,339	0	2,340,339	194.00
194.01	07951	OTHER NRB COST CENTER	0		0	0	0	194.01
194.02	07952	NONREIMBURSABLE COST CENTER	0		0	0	0	194.02
194.03	07953	RETAIL PHARMACY	0		22,979	0	22,979	194.03
200.00		Cross Foot Adjustments		2,724	2,724	0	2,724	200.00
201.00		Negative Cost Centers	0		-416,879	0	-416,879	201.00
202.00		TOTAL (sum lines 118 through 201)	193,952	2,724	16,930,801	0	16,930,801	202.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0046

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

Worksheet B-1

Date/Time Prepared:
7/19/2021 3:13 pm

Cost Center Description			CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
			BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (DOLLAR VALUE)				
			1.00	2.00	4.00	5A	5.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT	385,425					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		12,719,486				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	9,737	822	53,979,712			4.00
5.00	00500	ADMINISTRATIVE & GENERAL	51,934	344,520	5,308,244	-20,160,987	135,220,529	5.00
7.00	00700	OPERATION OF PLANT	61,674	7,898,094	923,041	0	8,612,146	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	4,252	974	109,148	0	817,452	8.00
9.00	00900	HOUSEKEEPING	9,915	16,242	1,463,840	0	3,154,938	9.00
10.00	01000	DIETARY	3,828	15,844	744,060	0	1,501,418	10.00
11.00	01100	CAFETERIA	9,999	0	316,308	0	1,195,561	11.00
13.00	01300	NURSING ADMINISTRATION	1,897	245,462	861,955	0	1,780,306	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	14,689	408,809	0	1,029,414	14.00
15.00	01500	PHARMACY	3,378	18,630	2,013,181	0	3,820,424	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	4,054	0	216,728	0	655,261	16.00
17.00	01700	SOCIAL SERVICE	3,474	0	883,029	0	1,906,307	17.00
23.00	02300	PARAMED ED PRGM-LABORATORY ED	0	0	68,417	0	120,383	23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	56,052	9,705	12,919,119	0	21,207,540	30.00
31.00	03100	INTENSIVE CARE UNIT	17,513	127,823	1,862,044	0	3,930,656	31.00
41.00	04100	SUBPROVIDER - IRF	9,028	189	1,157,112	0	2,674,734	41.00
43.00	04300	NURSERY	1,071	0	759,254	0	1,454,174	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	31,424	914,503	2,460,761	0	6,712,787	50.00
51.00	05100	RECOVERY ROOM	0	3,233	417,104	0	716,970	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	9,660	56,058	2,139,768	0	4,292,881	52.00
53.00	05300	ANESTHESIOLOGY	256	50,756	58,988	0	284,049	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	22,391	303,747	1,644,656	0	3,692,622	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	211,753	1,149,282	0	1,516,998	55.00
56.00	05600	RADIOISOTOPE	0	1,400	183,428	0	563,738	56.00
57.00	05700	CT SCAN	3,857	17,810	437,484	0	925,464	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	2,171	314,875	159,422	0	388,515	58.00
59.00	05900	CARDIAC CATHETERIZATION	6,585	96,705	903,078	0	2,004,717	59.00
60.00	06000	LABORATORY	8,885	80,052	2,221,676	0	7,070,675	60.00
64.00	06400	INTRAVENOUS THERAPY	1,354	0	248,832	0	467,497	64.00
65.00	06500	RESPIRATORY THERAPY	1,472	121,598	1,220,462	0	2,331,540	65.00
66.00	06600	PHYSICAL THERAPY	3,740	4,695	922,310	0	1,740,310	66.00
66.01	03951	CLINICAL NUTRITION	0	0	158,141	0	271,655	66.01
67.00	06700	OCCUPATIONAL THERAPY	3,443	1,253	467,535	0	919,866	67.00
68.00	06800	SPEECH PATHOLOGY	681	12,461	231,511	0	422,069	68.00
69.00	06900	ELECTROCARDIOLOGY	17,520	140,419	702,611	0	2,003,255	69.00
69.01	06901	CARDIAC REHABILITATION	0	4,947	187,841	0	331,254	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	1,299	3,365	33,328	0	108,589	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	7,578,590	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	3,632,577	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	6,488	987,678	0	14,678,095	73.00
74.00	07400	RENAL DIALYSIS	0	790	52,500	0	680,492	74.00
76.00	03950	ENDOSCOPY	1,060	25,311	14,275	0	58,646	76.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	3,175	177,212	4,035,000	0	7,457,987	90.00
91.00	09100	EMERGENCY	15,584	32,478	2,544,790	0	4,983,407	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	382,363	11,274,903	53,596,750	-20,160,987	129,695,959	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	1,423	4,840	29,787	0	99,905	190.00
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	361	329,407	0	0	12,236	192.00
193.00	19300	NONPAID WORKERS	0	1,110,336	352,561	0	224,510	193.00
194.00	07950	OTHER NRB COST CENTER	1,278	0	614	0	3,463,931	194.00
194.01	07951	OTHER NRB COST CENTER	0	0	0	0	0	194.01
194.02	07952	NONREIMBURSABLE COST CENTER	0	0	0	0	0	194.02
194.03	07953	RETAIL PHARMACY	0	0	0	0	1,723,988	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)	13,064,308	-416,879	34,374,204		20,160,987	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	33.895850	0.000000	0.636799		0.149097	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)			330,044		1,802,379	204.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0046

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

Worksheet B-1

Date/Time Prepared:
7/19/2021 3:13 pm

Cost Center Description			CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
			BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (DOLLAR VALUE)				
			1.00	2.00	4.00	5A	5.00	
205.00		Unit cost multiplier (Wkst. B, Part II)			0.006114		0.013329	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: 14-0046

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

Worksheet B-1

Date/Time Prepared:
7/19/2021 3:13 pm

Cost Center Description		OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (HOURS OF SERVICE)	DIETARY (MEALS SERVED)	CAFETERIA (MEALS SERVED)	
		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	262,080				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	4,252	26,153			8.00
9.00	00900	HOUSEKEEPING	9,915	0	247,913		9.00
10.00	01000	DIETARY	3,828	0	3,828	23,801	10.00
11.00	01100	CAFETERIA	9,999	0	9,999	0	11.00
13.00	01300	NURSING ADMINISTRATION	1,897	0	1,897	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	14.00
15.00	01500	PHARMACY	3,378	0	3,378	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	4,054	0	4,054	0	16.00
17.00	01700	SOCIAL SERVICE	3,474	0	3,474	0	17.00
23.00	02300	PARAMED ED PRGM-LABARATORY ED	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	56,052	18,951	56,052	18,951	30.00
31.00	03100	INTENSIVE CARE UNIT	17,513	2,463	17,513	2,463	31.00
41.00	04100	SUBPROVIDER - IRF	9,028	2,387	9,028	2,387	41.00
43.00	04300	NURSERY	1,071	1,924	1,071	0	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	31,424	0	31,424	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	9,660	428	9,660	0	52.00
53.00	05300	ANESTHESIOLOGY	256	0	256	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	22,391	0	22,391	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	3,857	0	3,857	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	2,171	0	2,171	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	6,585	0	6,585	0	59.00
60.00	06000	LABORATORY	8,885	0	8,885	0	60.00
64.00	06400	INTRAVENOUS THERAPY	1,354	0	1,354	0	64.00
65.00	06500	RESPIRATORY THERAPY	1,472	0	1,472	0	65.00
66.00	06600	PHYSICAL THERAPY	3,740	0	3,740	0	66.00
66.01	03951	CLINICAL NUTRITION	0	0	0	0	66.01
67.00	06700	OCCUPATIONAL THERAPY	3,443	0	3,443	0	67.00
68.00	06800	SPEECH PATHOLOGY	681	0	681	0	68.00
69.00	06900	ELECTROCARDIOLOGY	17,520	0	17,520	0	69.00
69.01	06901	CARDIAC REHABILITATION	0	0	0	0	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	1,299	0	1,299	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
76.00	03950	ENDOSCOPY	1,060	0	1,060	0	76.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	3,175	0	3,175	0	90.00
91.00	09100	EMERGENCY	15,584	0	15,584	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					92.00
SPECIAL PURPOSE COST CENTERS							
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	259,018	26,153	244,851	23,801	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	1,423	0	1,423	0	190.00
191.00	19100	RESEARCH	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	361	0	361	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	193.00
194.00	07950	OTHER NRB COST CENTER	1,278	0	1,278	0	194.00
194.01	07951	OTHER NRB COST CENTER	0	0	0	0	194.01
194.02	07952	NONREIMBURSABLE COST CENTER	0	0	0	0	194.02
194.03	07953	RETAIL 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)	9,896,191	1,099,888	3,999,722	1,931,580	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	37.760192	42.055902	16.133571	81.155414	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	2,217,352	191,662	497,129	194,377	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	8.460592	7.328490	2.005256	8.166758	205.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0046

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

Worksheet B-1

Date/Time Prepared:
7/19/2021 3:13 pm

Cost Center Description			OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (HOURS OF SERVICE)	DIETARY (MEALS SERVED)	CAFETERIA (MEALS SERVED)	
			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: 14-0046

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

Worksheet B-1

Date/Time Prepared:
7/19/2021 3:13 pm

Cost Center Description			NURSING ADMINISTRATION (DIRECT NURS. HRS.)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (TIME SPENT)	SOCIAL SERVICE (TIME SPENT)	
			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	1,107,221					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	8,271,657				14.00
15.00	01500	PHARMACY	0	58,708	12,686,500			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	518,795,059		16.00
17.00	01700	SOCIAL SERVICE	0	59	0	0	26,153	17.00
23.00	02300	PARAMED ED PRGM-LABARATORY ED	0	79	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	431,182	792,579	840	32,158,408	18,951	30.00
31.00	03100	INTENSIVE CARE UNIT	119,487	486,389	130	6,177,579	2,463	31.00
41.00	04100	SUBPROVIDER - IRF	39,822	42,665	0	3,446,975	2,387	41.00
43.00	04300	NURSERY	65,037	0	0	3,014,600	1,924	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	73,477	3,226,166	6,629	63,424,485	0	50.00
51.00	05100	RECOVERY ROOM	12,902	38,249	93	7,493,875	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	124,808	333,806	1,249	13,959,834	428	52.00
53.00	05300	ANESTHESIOLOGY	0	219,779	0	11,397,900	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	5,829	125,943	761	18,849,744	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	8,479	112,202	0	3,623,385	0	55.00
56.00	05600	RADIOISOTOPE	0	9,668	0	8,440,675	0	56.00
57.00	05700	CT SCAN	21	50,890	0	40,280,358	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	9	13,796	0	7,780,882	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	22,193	1,580,946	226	36,608,825	0	59.00
60.00	06000	LABORATORY	33	132,951	171	69,577,226	0	60.00
64.00	06400	INTRAVENOUS THERAPY	6,251	14,180	0	456,415	0	64.00
65.00	06500	RESPIRATORY THERAPY	251	251,640	187	13,949,110	0	65.00
66.00	06600	PHYSICAL THERAPY	0	8,340	28	5,915,750	0	66.00
66.01	03951	CLINICAL NUTRITION	0	2	0	50,600	0	66.01
67.00	06700	OCCUPATIONAL THERAPY	0	3,822	0	2,741,268	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	1,781	0	922,199	0	68.00
69.00	06900	ELECTROCARDIOLOGY	4,855	22,776	44	17,890,483	0	69.00
69.01	06901	CARDIAC REHABILITATION	5,526	1,484	0	532,580	0	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	263,245	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	15,098,608	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	37,314	0	0	17,125,455	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	67,776	12,598,002	76,701,567	0	73.00
74.00	07400	RENAL DIALYSIS	0	13,120	92	1,751,430	0	74.00
76.00	03950	ENDOSCOPY	705	40,704	0	403,230	0	76.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	44,222	277,423	77,929	10,914,430	0	90.00
91.00	09100	EMERGENCY	104,818	343,600	119	27,843,938	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	1,107,221	8,271,523	12,686,500	518,795,059	26,153	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950	OTHER NRB COST CENTER	0	134	0	0	0	194.00
194.01	07951	OTHER NRB COST CENTER	0	0	0	0	0	194.01
194.02	07952	NONREIMBURSABLE COST CENTER	0	0	0	0	0	194.02
194.03	07953	RETAIL 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)	2,184,523	1,200,229	4,665,961	980,631	2,415,205	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	1.972978	0.145101	0.367789	0.001890	92.349061	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	121,970	68,899	481,561	192,118	193,952	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.110159	0.008330	0.037959	0.000370	7.416052	205.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0046

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

Worksheet B-1

Date/Time Prepared:
7/19/2021 3:13 pm

Cost Center Description		NURSING ADMINISTRATION (DIRECT NURS. HRS.)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (TIME SPENT)	SOCIAL SERVICE (TIME SPENT)	
206.00		13.00	14.00	15.00	16.00	17.00	206.00
207.00	NAHE adjustment amount to be allocated (per Wkst. B-2) NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0046

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

Worksheet B-1

Date/Time Prepared:
7/19/2021 3:13 pm

Cost Center Description			PARAMED ED PRGM-LABARATOR Y ED (ASSIGNED TIME)	
			23.00	
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		17.00
23.00	02300	PARAMED ED PRGM-LABARATORY ED	100	23.00
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	31.00
41.00	04100	SUBPROVIDER - IRF	0	41.00
43.00	04300	NURSERY	0	43.00
ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	50.00
51.00	05100	RECOVERY ROOM	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	52.00
53.00	05300	ANESTHESIOLOGY	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	55.00
56.00	05600	RADIOISOTOPE	0	56.00
57.00	05700	CT SCAN	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	59.00
60.00	06000	LABORATORY	100	60.00
64.00	06400	INTRAVENOUS THERAPY	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	65.00
66.00	06600	PHYSICAL THERAPY	0	66.00
66.01	03951	CLINICAL NUTRITION	0	66.01
67.00	06700	OCCUPATIONAL THERAPY	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	69.00
69.01	06901	CARDIAC REHABILITATION	0	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	73.00
74.00	07400	RENAL DIALYSIS	0	74.00
76.00	03950	ENDOSCOPY	0	76.00
OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0	90.00
91.00	09100	EMERGENCY	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)		92.00
SPECIAL PURPOSE COST CENTERS				
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	100	118.00
NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	190.00
191.00	19100	RESEARCH	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	192.00
193.00	19300	NONPAID WORKERS	0	193.00
194.00	07950	OTHER NRB COST CENTER	0	194.00
194.01	07951	OTHER NRB COST CENTER	0	194.01
194.02	07952	NONREIMBURSABLE COST CENTER	0	194.02
194.03	07953	RETAIL PHARMACY	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)	141,244	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	1,412.440000	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	2,724	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	27.240000	205.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0046

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

Worksheet B-1

Date/Time Prepared:
7/19/2021 3:13 pm

Cost Center Description		PARAMED ED PRGM-LABARATOR Y ED (ASSIGNED TIME)		
		23.00		
206.00	NAHE adjustment amount to be allocated (per Wkst. B-2)	0		206.00
207.00	NAHE unit cost multiplier (Wkst. D, Parts III and IV)	0.000000		207.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0046

Period:
From 01/01/2020
To 12/31/2020Worksheet C
Part I
Date/Time Prepared:
7/19/2021 3:13 pm

			Title XVIII		Hospital		PPS	
Cost Center Description			Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs		Total Costs	
					Total Costs	RCE Disallowance		
			1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	33,049,994		33,049,994	53,229	33,103,223	30.00
31.00	03100	INTENSIVE CARE UNIT	6,388,460		6,388,460	9,619	6,398,079	31.00
41.00	04100	SUBPROVIDER - IRF	4,214,955		4,214,955	0	4,214,955	41.00
43.00	04300	NURSERY	2,153,507		2,153,507	0	2,153,507	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	10,246,928		10,246,928	0	10,246,928	50.00
51.00	05100	RECOVERY ROOM	886,754		886,754	0	886,754	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	5,923,315		5,923,315	0	5,923,315	52.00
53.00	05300	ANESTHESIOLOGY	396,130		396,130	0	396,130	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	5,585,323		5,585,323	0	5,585,323	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	1,831,761		1,831,761	0	1,831,761	55.00
56.00	05600	RADIOISOTOPE	672,923		672,923	0	672,923	56.00
57.00	05700	CT SCAN	1,373,419		1,373,419	0	1,373,419	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	586,929		586,929	0	586,929	58.00
59.00	05900	CARDIAC CATHETERIZATION	3,039,249		3,039,249	0	3,039,249	59.00
60.00	06000	LABORATORY	8,990,091		8,990,091	21,531	9,011,622	60.00
64.00	06400	INTRAVENOUS THERAPY	635,974		635,974	0	635,974	64.00
65.00	06500	RESPIRATORY THERAPY	2,873,682	0	2,873,682	10,144	2,883,826	65.00
66.00	06600	PHYSICAL THERAPY	2,252,851	0	2,252,851	0	2,252,851	66.00
66.01	03951	CLINICAL NUTRITION	318,959	0	318,959	0	318,959	66.01
67.00	06700	OCCUPATIONAL THERAPY	1,268,129	0	1,268,129	0	1,268,129	67.00
68.00	06800	SPEECH PATHOLOGY	533,516	0	533,516	0	533,516	68.00
69.00	06900	ELECTROCARDIOLOGY	3,322,654		3,322,654	153,049	3,475,703	69.00
69.01	06901	CARDIAC REHABILITATION	400,732		400,732	5,387	406,119	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	196,698		196,698	5,357	202,055	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	8,737,071		8,737,071	0	8,737,071	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	4,280,170		4,280,170	0	4,280,170	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	21,696,749		21,696,749	0	21,696,749	73.00
74.00	07400	RENAL DIALYSIS	789,425		789,425	13,514	802,939	74.00
76.00	03950	ENDOSCOPY	133,182		133,182	0	133,182	76.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	9,088,923		9,088,923	0	9,088,923	90.00
91.00	09100	EMERGENCY	6,983,518		6,983,518	59,250	7,042,768	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	2,402,475		2,402,475		2,402,475	92.00
200.00		Subtotal (see instructions)	151,254,446	0	151,254,446	331,080	151,585,526	200.00
201.00		Less Observation Beds	2,402,475		2,402,475		2,402,475	201.00
202.00		Total (see instructions)	148,851,971	0	148,851,971	331,080	149,183,051	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0046

Period:
From 01/01/2020
To 12/31/2020Worksheet C
Part I
Date/Time Prepared:
7/19/2021 3:13 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	32,429,012		32,429,012		30.00	
31.00	03100	INTENSIVE CARE UNIT	6,324,244		6,324,244		31.00	
41.00	04100	SUBPROVIDER - IRF	3,486,560		3,486,560		41.00	
43.00	04300	NURSERY	3,045,995		3,045,995		43.00	
	ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	26,177,749	39,768,425	65,946,174	0.155383	0.000000	50.00
51.00	05100	RECOVERY ROOM	3,499,470	4,267,975	7,767,445	0.114163	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	12,957,424	1,871,823	14,829,247	0.399435	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	5,294,445	6,531,195	11,825,640	0.033498	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	5,425,550	14,085,444	19,510,994	0.286265	0.000000	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	506,870	3,159,280	3,666,150	0.499642	0.000000	55.00
56.00	05600	RADIOISOTOPE	1,499,245	7,144,035	8,643,280	0.077855	0.000000	56.00
57.00	05700	CT SCAN	10,646,285	30,672,174	41,318,459	0.033240	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	1,317,907	6,813,926	8,131,833	0.072177	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	19,817,825	17,335,325	37,153,150	0.081803	0.000000	59.00
60.00	06000	LABORATORY	32,843,456	38,297,945	71,141,401	0.126369	0.000000	60.00
64.00	06400	INTRAVENOUS THERAPY	4,185	472,620	476,805	1.333824	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	12,094,055	2,064,265	14,158,320	0.202968	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	3,878,285	2,243,395	6,121,680	0.368012	0.000000	66.00
66.01	03951	CLINICAL NUTRITION	0	53,810	53,810	5.927504	0.000000	66.01
67.00	06700	OCCUPATIONAL THERAPY	2,179,331	631,183	2,810,514	0.451209	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	552,735	393,359	946,094	0.563914	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	7,602,060	10,597,093	18,199,153	0.182572	0.000000	69.00
69.01	06901	CARDIAC REHABILITATION	1,240	531,340	532,580	0.752435	0.000000	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	225,370	40,595	265,965	0.739563	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	9,403,114	5,695,494	15,098,608	0.578667	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	9,373,818	7,751,637	17,125,455	0.249930	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	31,120,106	45,633,511	76,753,617	0.282680	0.000000	73.00
74.00	07400	RENAL DIALYSIS	1,660,350	91,080	1,751,430	0.450732	0.000000	74.00
76.00	03950	ENDOSCOPY	50,860	369,650	420,510	0.316715	0.000000	76.00
	OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	11,130	11,131,211	11,142,341	0.815710	0.000000	90.00
91.00	09100	EMERGENCY	6,473,480	22,028,258	28,501,738	0.245021	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	353,382	1,782,537	2,135,919	1.124797	0.000000	92.00
200.00		Subtotal (see instructions)	250,255,538	281,458,585	531,714,123			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	250,255,538	281,458,585	531,714,123			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0046

Period:
From 01/01/2020
To 12/31/2020Worksheet C
Part I
Date/Time Prepared:
7/19/2021 3:13 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
41.00	04100	SUBPROVIDER - IRF				41.00
43.00	04300	NURSERY				43.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.155383			50.00
51.00	05100	RECOVERY ROOM	0.114163			51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.399435			52.00
53.00	05300	ANESTHESIOLOGY	0.033498			53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.286265			54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.499642			55.00
56.00	05600	RADIOISOTOPE	0.077855			56.00
57.00	05700	CT SCAN	0.033240			57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.072177			58.00
59.00	05900	CARDIAC CATHETERIZATION	0.081803			59.00
60.00	06000	LABORATORY	0.126672			60.00
64.00	06400	INTRAVENOUS THERAPY	1.333824			64.00
65.00	06500	RESPIRATORY THERAPY	0.203684			65.00
66.00	06600	PHYSICAL THERAPY	0.368012			66.00
66.01	03951	CLINICAL NUTRITION	5.927504			66.01
67.00	06700	OCCUPATIONAL THERAPY	0.451209			67.00
68.00	06800	SPEECH PATHOLOGY	0.563914			68.00
69.00	06900	ELECTROCARDIOLOGY	0.190982			69.00
69.01	06901	CARDIAC REHABILITATION	0.762550			69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0.759705			70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.578667			71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.249930			72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.282680			73.00
74.00	07400	RENAL DIALYSIS	0.458448			74.00
76.00	03950	ENDOSCOPY	0.316715			76.00
OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.815710			90.00
91.00	09100	EMERGENCY	0.247100			91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.124797			92.00
200.00		Subtotal (see instructions)				200.00
201.00		Less Observation Beds				201.00
202.00		Total (see instructions)				202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0046

Period:
From 01/01/2020
To 12/31/2020Worksheet C
Part I
Date/Time Prepared:
7/19/2021 3:13 pm

			Title XIX		Hospital		PPS	
Cost Center Description			Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs		Total Costs	
					Total Costs	RCE Disallowance		
			1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	33,049,994		33,049,994	53,229	33,103,223	30.00
31.00	03100	INTENSIVE CARE UNIT	6,388,460		6,388,460	9,619	6,398,079	31.00
41.00	04100	SUBPROVIDER - IRF	4,214,955		4,214,955	0	4,214,955	41.00
43.00	04300	NURSERY	2,153,507		2,153,507	0	2,153,507	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	10,246,928		10,246,928	0	10,246,928	50.00
51.00	05100	RECOVERY ROOM	886,754		886,754	0	886,754	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	5,923,315		5,923,315	0	5,923,315	52.00
53.00	05300	ANESTHESIOLOGY	396,130		396,130	0	396,130	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	5,585,323		5,585,323	0	5,585,323	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	1,831,761		1,831,761	0	1,831,761	55.00
56.00	05600	RADIOISOTOPE	672,923		672,923	0	672,923	56.00
57.00	05700	CT SCAN	1,373,419		1,373,419	0	1,373,419	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	586,929		586,929	0	586,929	58.00
59.00	05900	CARDIAC CATHETERIZATION	3,039,249		3,039,249	0	3,039,249	59.00
60.00	06000	LABORATORY	8,990,091		8,990,091	21,531	9,011,622	60.00
64.00	06400	INTRAVENOUS THERAPY	635,974		635,974	0	635,974	64.00
65.00	06500	RESPIRATORY THERAPY	2,873,682	0	2,873,682	10,144	2,883,826	65.00
66.00	06600	PHYSICAL THERAPY	2,252,851	0	2,252,851	0	2,252,851	66.00
66.01	03951	CLINICAL NUTRITION	318,959	0	318,959	0	318,959	66.01
67.00	06700	OCCUPATIONAL THERAPY	1,268,129	0	1,268,129	0	1,268,129	67.00
68.00	06800	SPEECH PATHOLOGY	533,516	0	533,516	0	533,516	68.00
69.00	06900	ELECTROCARDIOLOGY	3,322,654		3,322,654	153,049	3,475,703	69.00
69.01	06901	CARDIAC REHABILITATION	400,732		400,732	5,387	406,119	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	196,698		196,698	5,357	202,055	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	8,737,071		8,737,071	0	8,737,071	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	4,280,170		4,280,170	0	4,280,170	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	21,696,749		21,696,749	0	21,696,749	73.00
74.00	07400	RENAL DIALYSIS	789,425		789,425	13,514	802,939	74.00
76.00	03950	ENDOSCOPY	133,182		133,182	0	133,182	76.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	9,088,923		9,088,923	0	9,088,923	90.00
91.00	09100	EMERGENCY	6,983,518		6,983,518	59,250	7,042,768	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	2,402,475		2,402,475		2,402,475	92.00
200.00		Subtotal (see instructions)	151,254,446	0	151,254,446	331,080	151,585,526	200.00
201.00		Less Observation Beds	2,402,475		2,402,475		2,402,475	201.00
202.00		Total (see instructions)	148,851,971	0	148,851,971	331,080	149,183,051	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0046

Period:
From 01/01/2020
To 12/31/2020Worksheet C
Part I
Date/Time Prepared:
7/19/2021 3:13 pm

			Title XIX			Hospital		PPS	
Cost Center Description			Charges			Cost or Other Ratio	TEFRA Inpatient Ratio		
			Inpatient	Outpatient	Total (col. 6 + col. 7)				
			6.00	7.00	8.00				
	INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	32,429,012		32,429,012			30.00	
31.00	03100	INTENSIVE CARE UNIT	6,324,244		6,324,244			31.00	
41.00	04100	SUBPROVIDER - IRF	3,486,560		3,486,560			41.00	
43.00	04300	NURSERY	3,045,995		3,045,995			43.00	
	ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	26,177,749	39,768,425	65,946,174	0.155383	0.000000	50.00	
51.00	05100	RECOVERY ROOM	3,499,470	4,267,975	7,767,445	0.114163	0.000000	51.00	
52.00	05200	DELIVERY ROOM & LABOR ROOM	12,957,424	1,871,823	14,829,247	0.399435	0.000000	52.00	
53.00	05300	ANESTHESIOLOGY	5,294,445	6,531,195	11,825,640	0.033498	0.000000	53.00	
54.00	05400	RADIOLOGY-DIAGNOSTIC	5,425,550	14,085,444	19,510,994	0.286265	0.000000	54.00	
55.00	05500	RADIOLOGY-THERAPEUTIC	506,870	3,159,280	3,666,150	0.499642	0.000000	55.00	
56.00	05600	RADIOISOTOPE	1,499,245	7,144,035	8,643,280	0.077855	0.000000	56.00	
57.00	05700	CT SCAN	10,646,285	30,672,174	41,318,459	0.033240	0.000000	57.00	
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	1,317,907	6,813,926	8,131,833	0.072177	0.000000	58.00	
59.00	05900	CARDIAC CATHETERIZATION	19,817,825	17,335,325	37,153,150	0.081803	0.000000	59.00	
60.00	06000	LABORATORY	32,843,456	38,297,945	71,141,401	0.126369	0.000000	60.00	
64.00	06400	INTRAVENOUS THERAPY	4,185	472,620	476,805	1.333824	0.000000	64.00	
65.00	06500	RESPIRATORY THERAPY	12,094,055	2,064,265	14,158,320	0.202968	0.000000	65.00	
66.00	06600	PHYSICAL THERAPY	3,878,285	2,243,395	6,121,680	0.368012	0.000000	66.00	
66.01	03951	CLINICAL NUTRITION	0	53,810	53,810	5.927504	0.000000	66.01	
67.00	06700	OCCUPATIONAL THERAPY	2,179,331	631,183	2,810,514	0.451209	0.000000	67.00	
68.00	06800	SPEECH PATHOLOGY	552,735	393,359	946,094	0.563914	0.000000	68.00	
69.00	06900	ELECTROCARDIOLOGY	7,602,060	10,597,093	18,199,153	0.182572	0.000000	69.00	
69.01	06901	CARDIAC REHABILITATION	1,240	531,340	532,580	0.752435	0.000000	69.01	
70.00	07000	ELECTROENCEPHALOGRAPHY	225,370	40,595	265,965	0.739563	0.000000	70.00	
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	9,403,114	5,695,494	15,098,608	0.578667	0.000000	71.00	
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	9,373,818	7,751,637	17,125,455	0.249930	0.000000	72.00	
73.00	07300	DRUGS CHARGED TO PATIENTS	31,120,106	45,633,511	76,753,617	0.282680	0.000000	73.00	
74.00	07400	RENAL DIALYSIS	1,660,350	91,080	1,751,430	0.450732	0.000000	74.00	
76.00	03950	ENDOSCOPY	50,860	369,650	420,510	0.316715	0.000000	76.00	
	OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	11,130	11,131,211	11,142,341	0.815710	0.000000	90.00	
91.00	09100	EMERGENCY	6,473,480	22,028,258	28,501,738	0.245021	0.000000	91.00	
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	353,382	1,782,537	2,135,919	1.124797	0.000000	92.00	
200.00		Subtotal (see instructions)	250,255,538	281,458,585	531,714,123			200.00	
201.00		Less Observation Beds						201.00	
202.00		Total (see instructions)	250,255,538	281,458,585	531,714,123			202.00	

COMPUTATION OF RATIO OF COSTS TO CHARGES			Provider CCN: 14-0046	Period: From 01/01/2020 To 12/31/2020	Worksheet C Part I Date/Time Prepared: 7/19/2021 3:13 pm
			Title XIX	Hospital	PPS
Cost Center Description		PPS Inpatient Ratio			
		11.00			
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS			30.00
31.00	03100	INTENSIVE CARE UNIT			31.00
41.00	04100	SUBPROVIDER - IRF			41.00
43.00	04300	NURSERY			43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0.155383		50.00
51.00	05100	RECOVERY ROOM	0.114163		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.399435		52.00
53.00	05300	ANESTHESIOLOGY	0.033498		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.286265		54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.499642		55.00
56.00	05600	RADIOISOTOPE	0.077855		56.00
57.00	05700	CT SCAN	0.033240		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.072177		58.00
59.00	05900	CARDIAC CATHETERIZATION	0.081803		59.00
60.00	06000	LABORATORY	0.126672		60.00
64.00	06400	INTRAVENOUS THERAPY	1.333824		64.00
65.00	06500	RESPIRATORY THERAPY	0.203684		65.00
66.00	06600	PHYSICAL THERAPY	0.368012		66.00
66.01	03951	CLINICAL NUTRITION	5.927504		66.01
67.00	06700	OCCUPATIONAL THERAPY	0.451209		67.00
68.00	06800	SPEECH PATHOLOGY	0.563914		68.00
69.00	06900	ELECTROCARDIOLOGY	0.190982		69.00
69.01	06901	CARDIAC REHABILITATION	0.762550		69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0.759705		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.578667		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.249930		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.282680		73.00
74.00	07400	RENAL DIALYSIS	0.458448		74.00
76.00	03950	ENDOSCOPY	0.316715		76.00
OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	0.815710		90.00
91.00	09100	EMERGENCY	0.247100		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.124797		92.00
200.00		Subtotal (see instructions)			200.00
201.00		Less Observation Beds			201.00
202.00		Total (see instructions)			202.00

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

Provider CCN: 14-0046

Period:
From 01/01/2020
To 12/31/2020Worksheet C
Part II
Date/Time Prepared:
7/19/2021 3:13 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	10,246,928	1,976,478	8,270,450	0	0
51.00	05100	RECOVERY ROOM	886,754	20,889	865,865	0	0
52.00	05200	DELIVERY ROOM & LABOR ROOM	5,923,315	548,785	5,374,530	0	0
53.00	05300	ANESTHESIOLOGY	396,130	22,154	373,976	0	0
54.00	05400	RADIOLOGY-DIAGNOSTIC	5,585,323	1,078,093	4,507,230	0	0
55.00	05500	RADIOLOGY-THERAPEUTIC	1,831,761	42,824	1,788,937	0	0
56.00	05600	RADIOISOTOPE	672,923	13,715	659,208	0	0
57.00	05700	CT SCAN	1,373,419	205,919	1,167,500	0	0
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	586,929	107,089	479,840	0	0
59.00	05900	CARDIAC CATHETERIZATION	3,039,249	451,419	2,587,830	0	0
60.00	06000	LABORATORY	8,990,091	551,566	8,438,525	0	0
64.00	06400	INTRAVENOUS THERAPY	635,974	71,339	564,635	0	0
65.00	06500	RESPIRATORY THERAPY	2,873,682	181,559	2,692,123	0	0
66.00	06600	PHYSICAL THERAPY	2,252,851	206,871	2,045,980	0	0
66.01	03951	CLINICAL NUTRITION	318,959	6,224	312,735	0	0
67.00	06700	OCCUPATIONAL THERAPY	1,268,129	173,685	1,094,444	0	0
68.00	06800	SPEECH PATHOLOGY	533,516	39,976	493,540	0	0
69.00	06900	ELECTROCARDIOLOGY	3,322,654	822,746	2,499,908	0	0
69.01	06901	CARDIAC REHABILITATION	400,732	8,302	392,430	0	0
70.00	07000	ELECTROENCEPHALOGRAPHY	196,698	59,715	136,983	0	0
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	8,737,071	106,601	8,630,470	0	0
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	4,280,170	58,865	4,221,305	0	0
73.00	07300	DRUGS CHARGED TO PATIENTS	21,696,749	719,097	20,977,652	0	0
74.00	07400	RENAL DIALYSIS	789,425	10,688	778,737	0	0
76.00	03950	ENDOSCOPY	133,182	48,605	84,577	0	0
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	9,088,923	1,422,322	7,666,601	0	0
91.00	09100	EMERGENCY	6,983,518	824,060	6,159,458	0	0
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	2,402,475	256,904	2,145,571	0	0
200.00		Subtotal (sum of lines 50 thru 199)	105,447,530	10,036,490	95,411,040	0	0
201.00		Less Observation Beds	2,402,475	256,904	2,145,571	0	0
202.00		Total (line 200 minus line 201)	103,045,055	9,779,586	93,265,469	0	0

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

Provider CCN: 14-0046

Period:
From 01/01/2020
To 12/31/2020Worksheet C
Part II
Date/Time Prepared:
7/19/2021 3:13 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	10,246,928	65,946,174	0.155383	50.00
51.00	05100	RECOVERY ROOM	886,754	7,767,445	0.114163	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	5,923,315	14,829,247	0.399435	52.00
53.00	05300	ANESTHESIOLOGY	396,130	11,825,640	0.033498	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	5,585,323	19,510,994	0.286265	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	1,831,761	3,666,150	0.499642	55.00
56.00	05600	RADIOISOTOPE	672,923	8,643,280	0.077855	56.00
57.00	05700	CT SCAN	1,373,419	41,318,459	0.033240	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	586,929	8,131,833	0.072177	58.00
59.00	05900	CARDIAC CATHETERIZATION	3,039,249	37,153,150	0.081803	59.00
60.00	06000	LABORATORY	8,990,091	71,141,401	0.126369	60.00
64.00	06400	INTRAVENOUS THERAPY	635,974	476,805	1.333824	64.00
65.00	06500	RESPIRATORY THERAPY	2,873,682	14,158,320	0.202968	65.00
66.00	06600	PHYSICAL THERAPY	2,252,851	6,121,680	0.368012	66.00
66.01	03951	CLINICAL NUTRITION	318,959	53,810	5.927504	66.01
67.00	06700	OCCUPATIONAL THERAPY	1,268,129	2,810,514	0.451209	67.00
68.00	06800	SPEECH PATHOLOGY	533,516	946,094	0.563914	68.00
69.00	06900	ELECTROCARDIOLOGY	3,322,654	18,199,153	0.182572	69.00
69.01	06901	CARDIAC REHABILITATION	400,732	532,580	0.752435	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	196,698	265,965	0.739563	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	8,737,071	15,098,608	0.578667	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	4,280,170	17,125,455	0.249930	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	21,696,749	76,753,617	0.282680	73.00
74.00	07400	RENAL DIALYSIS	789,425	1,751,430	0.450732	74.00
76.00	03950	ENDOSCOPY	133,182	420,510	0.316715	76.00
	OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	9,088,923	11,142,341	0.815710	90.00
91.00	09100	EMERGENCY	6,983,518	28,501,738	0.245021	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	2,402,475	2,135,919	1.124797	92.00
200.00		Subtotal (sum of lines 50 thru 199)	105,447,530	486,428,312		200.00
201.00		Less Observation Beds	2,402,475	0		201.00
202.00		Total (line 200 minus line 201)	103,045,055	486,428,312		202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

Provider CCN: 14-0046

Period:
From 01/01/2020
To 12/31/2020Worksheet D
Part I
Date/Time Prepared:
7/19/2021 3:13 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	3,539,840	0	3,539,840	20,434	173.23	30.00
31.00	INTENSIVE CARE UNIT	935,800		935,800	2,463	379.94	31.00
41.00	SUBPROVIDER - IRF	520,587	0	520,587	2,387	218.09	41.00
43.00	NURSERY	115,949		115,949	1,924	60.26	43.00
200.00	Total (lines 30 through 199)	5,112,176		5,112,176	27,208		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	11,044	1,913,152				
31.00	INTENSIVE CARE UNIT	1,257	477,585				
41.00	SUBPROVIDER - IRF	1,639	357,450				
43.00	NURSERY	0	0				
200.00	Total (lines 30 through 199)	13,940	2,748,187				

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 14-0046

Period:
From 01/01/2020
To 12/31/2020Worksheet D
Part II
Date/Time Prepared:
7/19/2021 3:13 pm

			Title XVIII		Hospital	PPS		
Cost Center Description			Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	1,976,478	65,946,174	0.029971	16,782,279	502,982	50.00
51.00	05100	RECOVERY ROOM	20,889	7,767,445	0.002689	1,786,085	4,803	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	548,785	14,829,247	0.037007	7,272	269	52.00
53.00	05300	ANESTHESIOLOGY	22,154	11,825,640	0.001873	2,690,255	5,039	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,078,093	19,510,994	0.055256	2,045,195	113,009	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	42,824	3,666,150	0.011681	0	0	55.00
56.00	05600	RADIOISOTOPE	13,715	8,643,280	0.001587	787,815	1,250	56.00
57.00	05700	CT SCAN	205,919	41,318,459	0.004984	5,894,380	29,378	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	107,089	8,131,833	0.013169	734,385	9,671	58.00
59.00	05900	CARDIAC CATHETERIZATION	451,419	37,153,150	0.012150	7,916,070	96,180	59.00
60.00	06000	LABORATORY	551,566	71,141,401	0.007753	16,340,151	126,685	60.00
64.00	06400	INTRAVENOUS THERAPY	71,339	476,805	0.149619	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	181,559	14,158,320	0.012823	6,877,029	88,184	65.00
66.00	06600	PHYSICAL THERAPY	206,871	6,121,680	0.033793	1,665,350	56,277	66.00
66.01	03951	CLINICAL NUTRITION	6,224	53,810	0.115666	0	0	66.01
67.00	06700	OCCUPATIONAL THERAPY	173,685	2,810,514	0.061798	548,258	33,881	67.00
68.00	06800	SPEECH PATHOLOGY	39,976	946,094	0.042254	159,245	6,729	68.00
69.00	06900	ELECTROCARDIOLOGY	822,746	18,199,153	0.045208	5,303,044	239,740	69.00
69.01	06901	CARDIAC REHABILITATION	8,302	532,580	0.015588	930	14	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	59,715	265,965	0.224522	139,580	31,339	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	106,601	15,098,608	0.007060	5,140,873	36,295	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	58,865	17,125,455	0.003437	5,959,112	20,481	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	719,097	76,753,617	0.009369	15,979,935	149,716	73.00
74.00	07400	RENAL DIALYSIS	10,688	1,751,430	0.006102	1,110,915	6,779	74.00
76.00	03950	ENDOSCOPY	48,605	420,510	0.115586	0	0	76.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	1,422,322	11,142,341	0.127650	985	126	90.00
91.00	09100	EMERGENCY	824,060	28,501,738	0.028913	3,845,270	111,178	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	256,904	2,135,919	0.120278	222,895	26,809	92.00
200.00	Total (lines 50 through 199)		10,036,490	486,428,312		101,937,308	1,696,814	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS					Provider CCN: 14-0046		Period: From 01/01/2020 To 12/31/2020		Worksheet D Part III Date/Time Prepared: 7/19/2021 3:13 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
41.00	04100	SUBPROVIDER - IRF		0	0	0	0	0	0	41.00
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	20,434	0.00	11,044		30.00
31.00	03100	INTENSIVE CARE UNIT			0	2,463	0.00	1,257		31.00
41.00	04100	SUBPROVIDER - IRF		0	0	2,387	0.00	1,639		41.00
43.00	04300	NURSERY			0	1,924	0.00	0		43.00
200.00		Total (lines 30 through 199)			0	27,208		13,940		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
41.00	04100	SUBPROVIDER - IRF		0						41.00
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: 14-0046

Period:
From 01/01/2020
To 12/31/2020Worksheet D
Part IV
Date/Time Prepared:
7/19/2021 3:13 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	141,244	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	03951	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	06901	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
76.00	03950	ENDOSCOPY	0	0	0	0	76.00
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	141,244	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

Provider CCN: 14-0046

Period:
From 01/01/2020
To 12/31/2020Worksheet D
Part IV
Date/Time Prepared:
7/19/2021 3:13 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	65,946,174	0.000000	50.00
51.00	05100	RECOVERY ROOM	0	0	0	7,767,445	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	14,829,247	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	11,825,640	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	19,510,994	0.000000	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	3,666,150	0.000000	55.00
56.00	05600	RADIOISOTOPE	0	0	0	8,643,280	0.000000	56.00
57.00	05700	CT SCAN	0	0	0	41,318,459	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	8,131,833	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	37,153,150	0.000000	59.00
60.00	06000	LABORATORY	0	141,244	141,244	71,141,401	0.001985	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	476,805	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	14,158,320	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	6,121,680	0.000000	66.00
66.01	03951	CLINICAL NUTRITION	0	0	0	53,810	0.000000	66.01
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	2,810,514	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	946,094	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	18,199,153	0.000000	69.00
69.01	06901	CARDIAC REHABILITATION	0	0	0	532,580	0.000000	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	265,965	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	15,098,608	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	17,125,455	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	76,753,617	0.000000	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	1,751,430	0.000000	74.00
76.00	03950	ENDOSCOPY	0	0	0	420,510	0.000000	76.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0	11,142,341	0.000000	90.00
91.00	09100	EMERGENCY	0	0	0	28,501,738	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	2,135,919	0.000000	92.00
200.00		Total (lines 50 through 199)	0	141,244	141,244	486,428,312		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-0046

Period:
From 01/01/2020
To 12/31/2020Worksheet D
Part IV
Date/Time Prepared:
7/19/2021 3:13 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	16,782,279	0	16,305,213	0
51.00	05100	RECOVERY ROOM	0.000000	1,786,085	0	3,154,380	0
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	7,272	0	3,270	0
53.00	05300	ANESTHESIOLOGY	0.000000	2,690,255	0	2,719,790	0
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	2,045,195	0	4,403,231	0
55.00	05500	RADIOLOGY-THERAPEUTIC	0.000000	0	0	794,965	0
56.00	05600	RADIOISOTOPE	0.000000	787,815	0	3,633,625	0
57.00	05700	CT SCAN	0.000000	5,894,380	0	12,504,760	0
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000	734,385	0	2,632,610	0
59.00	05900	CARDIAC CATHETERIZATION	0.000000	7,916,070	0	6,471,895	0
60.00	06000	LABORATORY	0.001985	16,340,151	32,435	8,418,770	16,711
64.00	06400	INTRAVENOUS THERAPY	0.000000	0	0	123,875	0
65.00	06500	RESPIRATORY THERAPY	0.000000	6,877,029	0	643,820	0
66.00	06600	PHYSICAL THERAPY	0.000000	1,665,350	0	29,260	0
66.01	03951	CLINICAL NUTRITION	0.000000	0	0	0	0
67.00	06700	OCCUPATIONAL THERAPY	0.000000	548,258	0	5,610	0
68.00	06800	SPEECH PATHOLOGY	0.000000	159,245	0	6,591	0
69.00	06900	ELECTROCARDIOLOGY	0.000000	5,303,044	0	5,961,875	0
69.01	06901	CARDIAC REHABILITATION	0.000000	930	0	299,460	0
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	139,580	0	9,905	0
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	5,140,873	0	2,585,660	0
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	5,959,112	0	4,695,430	0
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	15,979,935	0	25,081,270	0
74.00	07400	RENAL DIALYSIS	0.000000	1,110,915	0	1,395	0
76.00	03950	ENDOSCOPY	0.000000	0	0	67,265	0
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0.000000	985	0	234	0
91.00	09100	EMERGENCY	0.000000	3,845,270	0	8,804,712	0
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	222,895	0	790,448	0
200.00		Total (lines 50 through 199)		101,937,308	32,435	110,149,319	16,711

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST			Provider CCN: 14-0046		Period: From 01/01/2020 To 12/31/2020		Worksheet D Part V Date/Time Prepared: 7/19/2021 3:13 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	0.155383	16,305,213	0	0	2,533,553	50.00
51.00	05100	RECOVERY ROOM	0.114163	3,154,380	0	0	360,113	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.399435	3,270	0	0	1,306	52.00
53.00	05300	ANESTHESIOLOGY	0.033498	2,719,790	0	0	91,108	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.286265	4,403,231	0	0	1,260,491	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.499642	794,965	0	0	397,198	55.00
56.00	05600	RADIOISOTOPE	0.077855	3,633,625	0	0	282,896	56.00
57.00	05700	CT SCAN	0.033240	12,504,760	0	0	415,658	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.072177	2,632,610	0	0	190,014	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.081803	6,471,895	0	0	529,420	59.00
60.00	06000	LABORATORY	0.126369	8,418,770	0	0	1,063,872	60.00
64.00	06400	INTRAVENOUS THERAPY	1.333824	123,875	0	0	165,227	64.00
65.00	06500	RESPIRATORY THERAPY	0.202968	643,820	0	0	130,675	65.00
66.00	06600	PHYSICAL THERAPY	0.368012	29,260	0	0	10,768	66.00
66.01	03951	CLINICAL NUTRITION	5.927504	0	0	0	0	66.01
67.00	06700	OCCUPATIONAL THERAPY	0.451209	5,610	0	0	2,531	67.00
68.00	06800	SPEECH PATHOLOGY	0.563914	6,591	0	0	3,717	68.00
69.00	06900	ELECTROCARDIOLOGY	0.182572	5,961,875	0	0	1,088,471	69.00
69.01	06901	CARDIAC REHABILITATION	0.752435	299,460	0	0	225,324	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0.739563	9,905	0	0	7,325	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.578667	2,585,660	0	0	1,496,236	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.249930	4,695,430	0	0	1,173,529	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.282680	25,081,270	0	125,106	7,089,973	73.00
74.00	07400	RENAL DIALYSIS	0.450732	1,395	0	0	629	74.00
76.00	03950	ENDOSCOPY	0.316715	67,265	0	0	21,304	76.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0.815710	234	0	0	191	90.00
91.00	09100	EMERGENCY	0.245021	8,804,712	0	0	2,157,339	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.124797	790,448	0	0	889,094	92.00
200.00		Subtotal (see instructions)		110,149,319	0	125,106	21,587,962	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 - line 201)		110,149,319	0	125,106	21,587,962	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-0046

Period:
From 01/01/2020
To 12/31/2020Worksheet D
Part V
Date/Time Prepared:
7/19/2021 3:13 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	03951	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	06901	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	35,365		73.00
74.00	07400	RENAL DIALYSIS	0	0		74.00
76.00	03950	ENDOSCOPY	0	0		76.00
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	35,365		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	0	35,365		202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 14-0046

Period:

Worksheet D

Component CCN: 14-T046

From 01/01/2020

Part II

To 12/31/2020

Date/Time Prepared:
7/19/2021 3:13 pm

Title XVIII

Subprovider -
IRF

PPS

Cost Center Description		Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
		1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	1,976,478	65,946,174	0.029971	24,820	744	50.00
51.00	05100 RECOVERY ROOM	20,889	7,767,445	0.002689	5,500	15	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	548,785	14,829,247	0.037007	0	0	52.00
53.00	05300 ANESTHESIOLOGY	22,154	11,825,640	0.001873	2,870	5	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	1,078,093	19,510,994	0.055256	35,575	1,966	54.00
55.00	05500 RADIOLOGY-THERAPEUTIC	42,824	3,666,150	0.011681	0	0	55.00
56.00	05600 RADIOISOTOPE	13,715	8,643,280	0.001587	9,925	16	56.00
57.00	05700 CT SCAN	205,919	41,318,459	0.004984	44,515	222	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	107,089	8,131,833	0.013169	21,395	282	58.00
59.00	05900 CARDIAC CATHETERIZATION	451,419	37,153,150	0.012150	0	0	59.00
60.00	06000 LABORATORY	551,566	71,141,401	0.007753	340,250	2,638	60.00
64.00	06400 INTRAVENOUS THERAPY	71,339	476,805	0.149619	0	0	64.00
65.00	06500 RESPIRATORY THERAPY	181,559	14,158,320	0.012823	234,145	3,002	65.00
66.00	06600 PHYSICAL THERAPY	206,871	6,121,680	0.033793	1,773,193	59,922	66.00
66.01	03951 CLINICAL NUTRITION	6,224	53,810	0.115666	0	0	66.01
67.00	06700 OCCUPATIONAL THERAPY	173,685	2,810,514	0.061798	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	39,976	946,094	0.042254	225,085	9,511	68.00
69.00	06900 ELECTROCARDIOLOGY	822,746	18,199,153	0.045208	30,615	1,384	69.00
69.01	06901 CARDIAC REHABILITATION	8,302	532,580	0.015588	0	0	69.01
70.00	07000 ELECTROENCEPHALOGRAPHY	59,715	265,965	0.224522	0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	106,601	15,098,608	0.007060	70,214	496	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	58,865	17,125,455	0.003437	358	1	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	719,097	76,753,617	0.009369	409,052	3,832	73.00
74.00	07400 RENAL DIALYSIS	10,688	1,751,430	0.006102	114,300	697	74.00
76.00	03950 ENDOSCOPY	48,605	420,510	0.115586	0	0	76.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000 CLINIC	1,422,322	11,142,341	0.127650	0	0	90.00
91.00	09100 EMERGENCY	824,060	28,501,738	0.028913	340,870	9,856	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	2,135,919	0.000000	0	0	92.00
200.00	Total (lines 50 through 199)	9,779,586	486,428,312		3,682,682	94,589	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

Provider CCN: 14-0046
Component CCN: 14-T046

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

Worksheet D
Part IV
Date/Time Prepared:
7/19/2021 3:13 pm

			Title XVIII		Subprovider - IRF		PPS	
Cost Center Description			Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health	
			1.00	2A	2.00	3A	3.00	
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
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	141,244	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	03951	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	06901	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
76.00	03950	ENDOSCOPY	0	0	0	0	0	76.00
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	141,244	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS			Provider CCN: 14-0046 Component CCN: 14-T046		Period: From 01/01/2020 To 12/31/2020		Worksheet D Part IV Date/Time Prepared: 7/19/2021 3:13 pm	
			Title XVIII		Subprovider - IRF		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	65,946,174	0.000000	50.00
51.00	05100	RECOVERY ROOM	0	0	0	7,767,445	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	14,829,247	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	11,825,640	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	19,510,994	0.000000	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	3,666,150	0.000000	55.00
56.00	05600	RADIOISOTOPE	0	0	0	8,643,280	0.000000	56.00
57.00	05700	CT SCAN	0	0	0	41,318,459	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	8,131,833	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	37,153,150	0.000000	59.00
60.00	06000	LABORATORY	0	141,244	141,244	71,141,401	0.001985	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	476,805	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	14,158,320	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	6,121,680	0.000000	66.00
66.01	03951	CLINICAL NUTRITION	0	0	0	53,810	0.000000	66.01
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	2,810,514	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	946,094	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	18,199,153	0.000000	69.00
69.01	06901	CARDIAC REHABILITATION	0	0	0	532,580	0.000000	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	265,965	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	15,098,608	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	17,125,455	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	76,753,617	0.000000	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	1,751,430	0.000000	74.00
76.00	03950	ENDOSCOPY	0	0	0	420,510	0.000000	76.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0	11,142,341	0.000000	90.00
91.00	09100	EMERGENCY	0	0	0	28,501,738	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	2,135,919	0.000000	92.00
200.00		Total (lines 50 through 199)	0	141,244	141,244	486,428,312		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS				Provider CCN: 14-0046 Component CCN: 14-T046		Period: From 01/01/2020 To 12/31/2020		Worksheet D Part IV Date/Time Prepared: 7/19/2021 3:13 pm	
				Title XVIII		Subprovider - IRF		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	24,820	0	0	0	50.00
51.00	05100	RECOVERY ROOM		0.000000	5,500	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	2,870	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC		0.000000	35,575	0	0	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC		0.000000	0	0	0	0	55.00
56.00	05600	RADIOISOTOPE		0.000000	9,925	0	0	0	56.00
57.00	05700	CT SCAN		0.000000	44,515	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)		0.000000	21,395	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION		0.000000	0	0	0	0	59.00
60.00	06000	LABORATORY		0.001985	340,250	675	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY		0.000000	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY		0.000000	234,145	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY		0.000000	1,773,193	0	0	0	66.00
66.01	03951	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	225,085	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY		0.000000	30,615	0	0	0	69.00
69.01	06901	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	70,214	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS		0.000000	358	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS		0.000000	409,052	0	0	0	73.00
74.00	07400	RENAL DIALYSIS		0.000000	114,300	0	0	0	74.00
76.00	03950	ENDOSCOPY		0.000000	0	0	0	0	76.00
OUTPATIENT SERVICE COST CENTERS									
90.00	09000	CLINIC		0.000000	0	0	0	0	90.00
91.00	09100	EMERGENCY		0.000000	340,870	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)			3,682,682	675	0	0	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

Provider CCN: 14-0046

Period:
From 01/01/2020
To 12/31/2020Worksheet D
Part I
Date/Time Prepared:
7/19/2021 3:13 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	3,539,840	0	3,539,840	20,434	173.23	30.00	
31.00	INTENSIVE CARE UNIT	935,800		935,800	2,463	379.94	31.00	
41.00	SUBPROVIDER - IRF	520,587	0	520,587	2,387	218.09	41.00	
43.00	NURSERY	115,949		115,949	1,924	60.26	43.00	
200.00	Total (lines 30 through 199)	5,112,176		5,112,176	27,208		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	455	78,820					30.00
31.00	INTENSIVE CARE UNIT	108	41,034					31.00
41.00	SUBPROVIDER - IRF	64	13,958					41.00
43.00	NURSERY	301	18,138					43.00
200.00	Total (lines 30 through 199)	928	151,950					200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 14-0046

Period:
From 01/01/2020
To 12/31/2020Worksheet D
Part II
Date/Time Prepared:
7/19/2021 3:13 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	1,976,478	65,946,174	0.029971	0	0 50.00
51.00	05100	RECOVERY ROOM	20,889	7,767,445	0.002689	0	0 51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	548,785	14,829,247	0.037007	0	0 52.00
53.00	05300	ANESTHESIOLOGY	22,154	11,825,640	0.001873	0	0 53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,078,093	19,510,994	0.055256	0	0 54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	42,824	3,666,150	0.011681	0	0 55.00
56.00	05600	RADIOISOTOPE	13,715	8,643,280	0.001587	0	0 56.00
57.00	05700	CT SCAN	205,919	41,318,459	0.004984	0	0 57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	107,089	8,131,833	0.013169	0	0 58.00
59.00	05900	CARDIAC CATHETERIZATION	451,419	37,153,150	0.012150	0	0 59.00
60.00	06000	LABORATORY	551,566	71,141,401	0.007753	0	0 60.00
64.00	06400	INTRAVENOUS THERAPY	71,339	476,805	0.149619	0	0 64.00
65.00	06500	RESPIRATORY THERAPY	181,559	14,158,320	0.012823	0	0 65.00
66.00	06600	PHYSICAL THERAPY	206,871	6,121,680	0.033793	0	0 66.00
66.01	03951	CLINICAL NUTRITION	6,224	53,810	0.115666	0	0 66.01
67.00	06700	OCCUPATIONAL THERAPY	173,685	2,810,514	0.061798	0	0 67.00
68.00	06800	SPEECH PATHOLOGY	39,976	946,094	0.042254	0	0 68.00
69.00	06900	ELECTROCARDIOLOGY	822,746	18,199,153	0.045208	0	0 69.00
69.01	06901	CARDIAC REHABILITATION	8,302	532,580	0.015588	0	0 69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	59,715	265,965	0.224522	0	0 70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	106,601	15,098,608	0.007060	0	0 71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	58,865	17,125,455	0.003437	0	0 72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	719,097	76,753,617	0.009369	0	0 73.00
74.00	07400	RENAL DIALYSIS	10,688	1,751,430	0.006102	0	0 74.00
76.00	03950	ENDOSCOPY	48,605	420,510	0.115586	0	0 76.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	1,422,322	11,142,341	0.127650	0	0 90.00
91.00	09100	EMERGENCY	824,060	28,501,738	0.028913	0	0 91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	256,904	2,135,919	0.120278	0	0 92.00
200.00		Total (lines 50 through 199)	10,036,490	486,428,312		0	0 200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS					Provider CCN: 14-0046		Period: From 01/01/2020 To 12/31/2020		Worksheet D Part III Date/Time Prepared: 7/19/2021 3:13 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	
41.00	04100	SUBPROVIDER - IRF		0	0	0	0	0	0	41.00	
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	20,434	0.00	455		30.00	
31.00	03100	INTENSIVE CARE UNIT			0	2,463	0.00	108		31.00	
41.00	04100	SUBPROVIDER - IRF		0	0	2,387	0.00	64		41.00	
43.00	04300	NURSERY			0	1,924	0.00	301		43.00	
200.00		Total (lines 30 through 199)			0	27,208		928		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	
41.00	04100	SUBPROVIDER - IRF		0						41.00	
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: 14-0046

Period:
From 01/01/2020
To 12/31/2020Worksheet D
Part IV
Date/Time Prepared:
7/19/2021 3:13 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	141,244	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	03951	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	06901	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
76.00	03950	ENDOSCOPY	0	0	0	0	76.00
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	141,244	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS			Provider CCN: 14-0046		Period: From 01/01/2020 To 12/31/2020		Worksheet D Part IV Date/Time Prepared: 7/19/2021 3:13 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	65,946,174	0.000000	50.00
51.00	05100	RECOVERY ROOM	0	0	0	7,767,445	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	14,829,247	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	11,825,640	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	19,510,994	0.000000	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	3,666,150	0.000000	55.00
56.00	05600	RADIOISOTOPE	0	0	0	8,643,280	0.000000	56.00
57.00	05700	CT SCAN	0	0	0	41,318,459	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	8,131,833	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	37,153,150	0.000000	59.00
60.00	06000	LABORATORY	0	141,244	141,244	71,141,401	0.001985	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	476,805	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	14,158,320	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	6,121,680	0.000000	66.00
66.01	03951	CLINICAL NUTRITION	0	0	0	53,810	0.000000	66.01
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	2,810,514	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	946,094	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	18,199,153	0.000000	69.00
69.01	06901	CARDIAC REHABILITATION	0	0	0	532,580	0.000000	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	265,965	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	15,098,608	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	17,125,455	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	76,753,617	0.000000	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	1,751,430	0.000000	74.00
76.00	03950	ENDOSCOPY	0	0	0	420,510	0.000000	76.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0	11,142,341	0.000000	90.00
91.00	09100	EMERGENCY	0	0	0	28,501,738	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	2,135,919	0.000000	92.00
200.00		Total (lines 50 through 199)	0	141,244	141,244	486,428,312		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-0046

Period:
From 01/01/2020
To 12/31/2020Worksheet D
Part IV
Date/Time Prepared:
7/19/2021 3:13 pm

				Title XIX		Hospital		PPS	
Cost Center Description			Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)		
								9.00	10.00
	ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0.000000	0	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0.000000	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	0	0	0	0	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.000000	0	0	0	0	0	55.00
56.00	05600	RADIOISOTOPE	0.000000	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0.000000	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0.001985	0	0	0	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0.000000	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.000000	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	0	0	0	0	0	66.00
66.01	03951	CLINICAL NUTRITION	0.000000	0	0	0	0	0	66.01
67.00	06700	OCCUPATIONAL THERAPY	0.000000	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	0	0	0	0	0	69.00
69.01	06901	CARDIAC REHABILITATION	0.000000	0	0	0	0	0	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0.000000	0	0	0	0	0	74.00
76.00	03950	ENDOSCOPY	0.000000	0	0	0	0	0	76.00
	OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0.000000	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0.000000	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	0	0	0	0	0	92.00
200.00		Total (lines 50 through 199)		0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS					Provider CCN: 14-0046	Period: From 01/01/2020 To 12/31/2020	Worksheet D Part II Date/Time Prepared: 7/19/2021 3:13 pm	
					Component CCN: 14-T046			
					Title XIX		Subprovider - IRF	PPS
Cost Center Description			Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
	ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	1,976,478	65,946,174	0.029971	0	0	50.00
51.00	05100	RECOVERY ROOM	20,889	7,767,445	0.002689	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	548,785	14,829,247	0.037007	0	0	52.00
53.00	05300	ANESTHESIOLOGY	22,154	11,825,640	0.001873	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,078,093	19,510,994	0.055256	0	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	42,824	3,666,150	0.011681	0	0	55.00
56.00	05600	RADIOISOTOPE	13,715	8,643,280	0.001587	0	0	56.00
57.00	05700	CT SCAN	205,919	41,318,459	0.004984	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	107,089	8,131,833	0.013169	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	451,419	37,153,150	0.012150	0	0	59.00
60.00	06000	LABORATORY	551,566	71,141,401	0.007753	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY	71,339	476,805	0.149619	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	181,559	14,158,320	0.012823	0	0	65.00
66.00	06600	PHYSICAL THERAPY	206,871	6,121,680	0.033793	0	0	66.00
66.01	03951	CLINICAL NUTRITION	6,224	53,810	0.115666	0	0	66.01
67.00	06700	OCCUPATIONAL THERAPY	173,685	2,810,514	0.061798	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	39,976	946,094	0.042254	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	822,746	18,199,153	0.045208	0	0	69.00
69.01	06901	CARDIAC REHABILITATION	8,302	532,580	0.015588	0	0	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	59,715	265,965	0.224522	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	106,601	15,098,608	0.007060	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	58,865	17,125,455	0.003437	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	719,097	76,753,617	0.009369	0	0	73.00
74.00	07400	RENAL DIALYSIS	10,688	1,751,430	0.006102	0	0	74.00
76.00	03950	ENDOSCOPY	48,605	420,510	0.115586	0	0	76.00
	OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	1,422,322	11,142,341	0.127650	0	0	90.00
91.00	09100	EMERGENCY	824,060	28,501,738	0.028913	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	2,135,919	0.000000	0	0	92.00
200.00		Total (lines 50 through 199)	9,779,586	486,428,312		0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

Provider CCN: 14-0046
Component CCN: 14-T046

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

Worksheet D
Part IV
Date/Time Prepared:
7/19/2021 3:13 pm

			Title XIX		Subprovider - IRF		PPS	
Cost Center Description			Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health	
			1.00	2A	2.00	3A	3.00	
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
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	141,244	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	03951	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	06901	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
76.00	03950	ENDOSCOPY	0	0	0	0	0	76.00
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	141,244	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS			Provider CCN: 14-0046 Component CCN: 14-T046		Period: From 01/01/2020 To 12/31/2020		Worksheet D Part IV Date/Time Prepared: 7/19/2021 3:13 pm	
			Title XIX		Subprovider - IRF		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	65,946,174	0.000000	50.00
51.00	05100	RECOVERY ROOM	0	0	0	7,767,445	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	14,829,247	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	11,825,640	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	19,510,994	0.000000	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	3,666,150	0.000000	55.00
56.00	05600	RADIOISOTOPE	0	0	0	8,643,280	0.000000	56.00
57.00	05700	CT SCAN	0	0	0	41,318,459	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	8,131,833	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	37,153,150	0.000000	59.00
60.00	06000	LABORATORY	0	141,244	141,244	71,141,401	0.001985	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	476,805	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	14,158,320	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	6,121,680	0.000000	66.00
66.01	03951	CLINICAL NUTRITION	0	0	0	53,810	0.000000	66.01
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	2,810,514	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	946,094	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	18,199,153	0.000000	69.00
69.01	06901	CARDIAC REHABILITATION	0	0	0	532,580	0.000000	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	265,965	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	15,098,608	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	17,125,455	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	76,753,617	0.000000	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	1,751,430	0.000000	74.00
76.00	03950	ENDOSCOPY	0	0	0	420,510	0.000000	76.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0	11,142,341	0.000000	90.00
91.00	09100	EMERGENCY	0	0	0	28,501,738	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	2,135,919	0.000000	92.00
200.00		Total (lines 50 through 199)	0	141,244	141,244	486,428,312		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS				Provider CCN: 14-0046 Component CCN: 14-T046		Period: From 01/01/2020 To 12/31/2020		Worksheet D Part IV Date/Time Prepared: 7/19/2021 3:13 pm	
				Title XIX		Subprovider - IRF		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		0.001985	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	03951	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	06901	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
76.00	03950	ENDOSCOPY		0.000000	0	0	0	0	76.00
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: 14-0046	Period: From 01/01/2020 To 12/31/2020	Worksheet D-1 Date/Time Prepared: 7/19/2021 3:13 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)		20,434	1.00	
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		20,434	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)		18,951	4.00	
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		0	5.00	
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	6.00	
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		0	7.00	
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	8.00	
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions)		11,044	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)		33,103,223	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)		33,103,223	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)		33,103,223	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)		1,620.01	38.00	
39.00	Program general inpatient routine service cost (line 9 x line 38)		17,891,390	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)		17,891,390	41.00	

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-0046

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

Worksheet D-1

Date/Time Prepared:
7/19/2021 3:13 pm

		Title XVIII		Hospital	PPS	
Cost Center Description		Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)
		1.00	2.00	3.00	4.00	5.00
42.00	NURSERY (title V & XIX only)	0	0	0.00	0	0
Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	6,398,079	2,463	2,597.68	1,257	3,265,284
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)					20,680,470
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					41,837,144
PASS THROUGH COST ADJUSTMENTS						
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)					2,390,737
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					1,729,249
52.00	Total Program excludable cost (sum of lines 50 and 51)					4,119,986
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					37,717,158
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)					1,483
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					1,620.01
89.00	Observation bed cost (line 87 x line 88) (see instructions)					2,402,475

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-0046

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

Worksheet D-1

Date/Time Prepared:
7/19/2021 3:13 pm

		Title XVIII		Hospital	PPS	
Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
	1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00 Capital-related cost	3,539,840	33,103,223	0.106933	2,402,475	256,904	90.00
91.00 Nursing School cost	0	33,103,223	0.000000	2,402,475	0	91.00
92.00 Allied health cost	0	33,103,223	0.000000	2,402,475	0	92.00
93.00 All other Medical Education	0	33,103,223	0.000000	2,402,475	0	93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-0046 Component CCN: 14-T046	Period: From 01/01/2020 To 12/31/2020	Worksheet D-1 Date/Time Prepared: 7/19/2021 3:13 pm
		Title XVIII	Subprovider - IRF	PPS
Cost Center Description			1.00	
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		2,387	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		2,387	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.		0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)		2,387	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)		1,639	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)		4,214,955	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)		4,214,955	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)		4,214,955	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)		1,765.80	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		2,894,146	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)		0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)		2,894,146	41.00

COMPUTATION OF INPATIENT OPERATING COST				Provider CCN: 14-0046 Component CCN: 14-T046	Period: From 01/01/2020 To 12/31/2020	Worksheet D-1 Date/Time Prepared: 7/19/2021 3:13 pm	
				Title XVIII	Subprovider - IRF	PPS	
	Cost Center Description	Total	Total	Average Per	Program Days	Program Cost (col. 3 x col. 4)	
		Inpatient Cost	Inpatient Days	Diem (col. 1 ÷ col. 2)			
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)	0	0	0.00	0	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)					1,187,667	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					4,081,813	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)					357,450	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					95,264	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)					452,714	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					3,629,099	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: 14-0046 Component CCN: 14-T046		Period: From 01/01/2020 To 12/31/2020		Worksheet D-1 Date/Time Prepared: 7/19/2021 3:13 pm	
		Title XVIII		Subprovider - IRF		PPS	
Cost Center Description		Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00	Capital-related cost	520,587	4,214,955	0.123510	0	0	90.00
91.00	Nursing School cost	0	4,214,955	0.000000	0	0	91.00
92.00	Allied health cost	0	4,214,955	0.000000	0	0	92.00
93.00	All other Medical Education	0	4,214,955	0.000000	0	0	93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-0046	Period: From 01/01/2020 To 12/31/2020	Worksheet D-1 Date/Time Prepared: 7/19/2021 3:13 pm	
		Title XIX	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)			20,434	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)			20,434	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)			18,951	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)			455	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)			0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)			0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period			0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)			0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)			0	14.00
15.00	Total nursery days (title V or XIX only)			1,924	15.00
16.00	Nursery days (title V or XIX only)			301	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)			33,103,223	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)			33,103,223	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)			33,103,223	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)			1,620.01	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)			737,105	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)			737,105	41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-0046

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

Worksheet D-1

Date/Time Prepared:
7/19/2021 3:13 pm

			Title XIX		Hospital	PPS		
Cost Center Description		Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)		
		1.00	2.00	3.00	4.00	5.00		
42.00	NURSERY (title V & XIX only)	2,153,507	1,924	1,119.29	301	336,906	42.00	
Intensive Care Type Inpatient Hospital Units								
43.00	INTENSIVE CARE UNIT	6,398,079	2,463	2,597.68	108	280,549	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)						1,354,560	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)						137,992	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)						137,992	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)						1,216,568	53.00
TARGET AMOUNT AND LIMIT COMPUTATION								
54.00	Program discharges						0	54.00
55.00	Target amount per discharge						0.00	55.00
56.00	Target amount (line 54 x line 55)						0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)						0	57.00
58.00	Bonus payment (see instructions)						0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket						0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket						0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)						0	61.00
62.00	Relief payment (see instructions)						0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)						0	63.00
PROGRAM INPATIENT ROUTINE SWING BED COST								
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)						0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)						0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)						0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)						0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)						0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)						0	69.00
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY								
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)							70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)							71.00
72.00	Program routine service cost (line 9 x line 71)							72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)							73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)							74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)							75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)							76.00
77.00	Program capital-related costs (line 9 x line 76)							77.00
78.00	Inpatient routine service cost (line 74 minus line 77)							78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)							79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)							80.00
81.00	Inpatient routine service cost per diem limitation							81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)							82.00
83.00	Reasonable inpatient routine service costs (see instructions)							83.00
84.00	Program inpatient ancillary services (see instructions)							84.00
85.00	Utilization review - physician compensation (see instructions)							85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)							86.00
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST								
87.00	Total observation bed days (see instructions)						1,483	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)						1,620.01	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)						2,402,475	89.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-0046

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

Worksheet D-1

Date/Time Prepared:
7/19/2021 3:13 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	3,539,840	33,103,223	0.106933	2,402,475	256,904
91.00	Nursing School cost	0	33,103,223	0.000000	2,402,475	0
92.00	Allied health cost	0	33,103,223	0.000000	2,402,475	0
93.00	All other Medical Education	0	33,103,223	0.000000	2,402,475	0

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-0046 Component CCN: 14-T046	Period: From 01/01/2020 To 12/31/2020	Worksheet D-1 Date/Time Prepared: 7/19/2021 3:13 pm
		Title XIX	Subprovider - IRF	PPS
Cost Center Description			1.00	
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		2,387	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		2,387	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.		0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)		2,387	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)		64	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)		0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period		0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)		0	14.00
15.00	Total nursery days (title V or XIX only)		1,924	15.00
16.00	Nursery days (title V or XIX only)		301	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)		4,214,955	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)		4,214,955	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)		4,214,955	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)		1,765.80	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		113,011	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)		113,011	41.00

COMPUTATION OF INPATIENT OPERATING COST				Provider CCN: 14-0046 Component CCN: 14-T046	Period: From 01/01/2020 To 12/31/2020	Worksheet D-1 Date/Time Prepared: 7/19/2021 3:13 pm	
				Title XIX		Subprovider - IRF	PPS
	Cost Center Description	Total	Total	Average Per	Program Days	Program Cost (col. 3 x col. 4)	
		Inpatient Cost	Inpatient Days	Diem (col. 1 ÷ col. 2)			
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)	0	0	0.00	0		42.00
Intensive Care Type Inpatient Hospital Units							
43.00	INTENSIVE CARE UNIT	0	0	0.00	0	0	43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00
Cost Center Description							
							1.00
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					0	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					113,011	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)					13,958	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)					13,958	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					99,053	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: 14-0046 Component CCN: 14-T046		Period: From 01/01/2020 To 12/31/2020		Worksheet D-1 Date/Time Prepared: 7/19/2021 3:13 pm	
		Title XIX		Subprovider - IRF		PPS	
Cost Center Description		Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00	Capital-related cost	520,587	4,214,955	0.123510	0	0	90.00
91.00	Nursing School cost	0	4,214,955	0.000000	0	0	91.00
92.00	Allied health cost	0	4,214,955	0.000000	0	0	92.00
93.00	All other Medical Education	0	4,214,955	0.000000	0	0	93.00

Health Financial Systems		SSM HEALTH GOOD SAMARITAN HOSPITAL		In Lieu of Form CMS-2552-10	
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT			Provider CCN: 14-0046	Period: From 01/01/2020 To 12/31/2020	Worksheet D-3 Date/Time Prepared: 7/19/2021 3:13 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		16,309,685	30.00
31.00	03100	INTENSIVE CARE UNIT		2,997,445	31.00
41.00	04100	SUBPROVIDER - IRF		0	41.00
43.00	04300	NURSERY			43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0.155383	16,782,279	50.00
51.00	05100	RECOVERY ROOM	0.114163	1,786,085	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.399435	7,272	52.00
53.00	05300	ANESTHESIOLOGY	0.033498	2,690,255	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.286265	2,045,195	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.499642	0	55.00
56.00	05600	RADIOISOTOPE	0.077855	787,815	56.00
57.00	05700	CT SCAN	0.033240	5,894,380	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.072177	734,385	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.081803	7,916,070	59.00
60.00	06000	LABORATORY	0.126672	16,340,151	60.00
64.00	06400	INTRAVENOUS THERAPY	1.333824	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.203684	6,877,029	65.00
66.00	06600	PHYSICAL THERAPY	0.368012	1,665,350	66.00
66.01	03951	CLINICAL NUTRITION	5.927504	0	66.01
67.00	06700	OCCUPATIONAL THERAPY	0.451209	548,258	67.00
68.00	06800	SPEECH PATHOLOGY	0.563914	159,245	68.00
69.00	06900	ELECTROCARDIOLOGY	0.190982	5,303,044	69.00
69.01	06901	CARDIAC REHABILITATION	0.762550	930	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0.759705	139,580	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.578667	5,140,873	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.249930	5,959,112	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.282680	15,979,935	73.00
74.00	07400	RENAL DIALYSIS	0.458448	1,110,915	74.00
76.00	03950	ENDOSCOPY	0.316715	0	76.00
OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	0.815710	985	90.00
91.00	09100	EMERGENCY	0.247100	3,845,270	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.124797	222,895	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		101,937,308	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)		101,937,308	202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 14-0046 Component CCN: 14-T046	Period: From 01/01/2020 To 12/31/2020	Worksheet D-3 Date/Time Prepared: 7/19/2021 3:13 pm	
		Title XVIII	Subprovider - IRF	PPS	
Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDIATRICS		0		30.00
31.00	03100 INTENSIVE CARE UNIT		0		31.00
41.00	04100 SUBPROVIDER - IRF		2,231,935		41.00
43.00	04300 NURSERY				43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.155383	24,820	3,857	50.00
51.00	05100 RECOVERY ROOM	0.114163	5,500	628	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.399435	0	0	52.00
53.00	05300 ANESTHESIOLOGY	0.033498	2,870	96	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.286265	35,575	10,184	54.00
55.00	05500 RADIOLOGY-THERAPEUTIC	0.499642	0	0	55.00
56.00	05600 RADIOISOTOPE	0.077855	9,925	773	56.00
57.00	05700 CT SCAN	0.033240	44,515	1,480	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0.072177	21,395	1,544	58.00
59.00	05900 CARDIAC CATHETERIZATION	0.081803	0	0	59.00
60.00	06000 LABORATORY	0.126672	340,250	43,100	60.00
64.00	06400 INTRAVENOUS THERAPY	1.333824	0	0	64.00
65.00	06500 RESPIRATORY THERAPY	0.203684	234,145	47,692	65.00
66.00	06600 PHYSICAL THERAPY	0.368012	1,773,193	652,556	66.00
66.01	03951 CLINICAL NUTRITION	5.927504	0	0	66.01
67.00	06700 OCCUPATIONAL THERAPY	0.451209	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0.563914	225,085	126,929	68.00
69.00	06900 ELECTROCARDIOLOGY	0.190982	30,615	5,847	69.00
69.01	06901 CARDIAC REHABILITATION	0.762550	0	0	69.01
70.00	07000 ELECTROENCEPHALOGRAPHY	0.759705	0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.578667	70,214	40,631	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.249930	358	89	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.282680	409,052	115,631	73.00
74.00	07400 RENAL DIALYSIS	0.458448	114,300	52,401	74.00
76.00	03950 ENDOSCOPY	0.316715	0	0	76.00
OUTPATIENT SERVICE COST CENTERS					
90.00	09000 CLINIC	0.815710	0	0	90.00
91.00	09100 EMERGENCY	0.247100	340,870	84,229	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	1.124797	0	0	92.00
200.00	Total (sum of lines 50 through 94 and 96 through 98)		3,682,682	1,187,667	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)		3,682,682		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0046	Period: From 01/01/2020 To 12/31/2020	Worksheet E Part A Date/Time Prepared: 7/19/2021 3:13 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)		18,312,915	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1 (see instructions)		6,883,806	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)		384,101	2.03
2.04	Outlier payments for discharges occurring on or after October 1 (see instructions)		106,454	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)		110.63	4.00
Indirect Medical Education Adjustment				
5.00	FTE count for allopathic and osteopathic programs for the most recent cost reporting period ending on or before 12/31/1996.(see instructions)		0.00	5.00
6.00	FTE count for allopathic and osteopathic programs that meet the criteria for an add-on to the cap for new programs in accordance with 42 CFR 413.79(e)		0.00	6.00
7.00	MMA Section 422 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(1)		0.00	7.00
7.01	ACA § 5503 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(2) If the cost report straddles July 1, 2011 then see instructions.		0.00	7.01
8.00	Adjustment (increase or decrease) to the FTE count for allopathic and osteopathic programs for affiliated programs in accordance with 42 CFR 413.75(b), 413.79(c)(2)(iv), 64 FR 26340 (May 12, 1998), and 67 FR 50069 (August 1, 2002).		0.00	8.00
8.01	The amount of increase if the hospital was awarded FTE cap slots under § 5503 of the ACA. If the cost report straddles July 1, 2011, see instructions.		0.00	8.01
8.02	The amount of increase if the hospital was awarded FTE cap slots from a closed teaching hospital under § 5506 of ACA. (see instructions)		0.00	8.02
9.00	Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus lines (8, 8.01 and 8.02) (see instructions)		0.00	9.00
10.00	FTE count for allopathic and osteopathic programs in the current year from your records		0.00	10.00
11.00	FTE count for residents in dental and podiatric programs.		0.00	11.00
12.00	Current year allowable FTE (see instructions)		0.00	12.00
13.00	Total allowable FTE count for the prior year.		0.00	13.00
14.00	Total allowable FTE count for the penultimate year if that year ended on or after September 30, 1997, otherwise enter zero.		0.00	14.00
15.00	Sum of lines 12 through 14 divided by 3.		0.00	15.00
16.00	Adjustment for residents in initial years of the program		0.00	16.00
17.00	Adjustment for residents displaced by program or hospital closure		0.00	17.00
18.00	Adjusted rolling average FTE count		0.00	18.00
19.00	Current year resident to bed ratio (line 18 divided by line 4).		0.000000	19.00
20.00	Prior year resident to bed ratio (see instructions)		0.000000	20.00
21.00	Enter the lesser of lines 19 or 20 (see instructions)		0.000000	21.00
22.00	IME payment adjustment (see instructions)		0	22.00
22.01	IME payment adjustment - Managed Care (see instructions)		0	22.01
Indirect Medical Education Adjustment for the Add-on for § 422 of the MMA				
23.00	Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 CFR 412.105 (f)(1)(iv)(C) .		0.00	23.00
24.00	IME FTE Resident Count Over Cap (see instructions)		0.00	24.00
25.00	If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see instructions)		0.00	25.00
26.00	Resident to bed ratio (divide line 25 by line 4)		0.000000	26.00
27.00	IME payments adjustment factor. (see instructions)		0.000000	27.00
28.00	IME add-on adjustment amount (see instructions)		0	28.00
28.01	IME add-on adjustment amount - Managed Care (see instructions)		0	28.01
29.00	Total IME payment (sum of lines 22 and 28)		0	29.00
29.01	Total IME payment - Managed Care (sum of lines 22.01 and 28.01)		0	29.01
Disproportionate Share Adjustment				
30.00	Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)		4.66	30.00
31.00	Percentage of Medicaid patient days (see instructions)		21.60	31.00
32.00	Sum of lines 30 and 31		26.26	32.00
33.00	Allowable disproportionate share percentage (see instructions)		11.80	33.00
34.00	Disproportionate share adjustment (see instructions)		743,303	34.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0046	Period: From 01/01/2020 To 12/31/2020	Worksheet E Part A Date/Time Prepared: 7/19/2021 3:13 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)		8,350,615,413	8,290,014,521
35.01	Factor 3 (see instructions)		0.000144602	0.000187594
35.02	Hospital uncompensated care payment (If line 34 is zero, enter zero on this line) (see instructions)		1,207,516	1,555,154
35.03	Pro rata share of the hospital uncompensated care payment amount (see instructions)		903,988	391,984
36.00	Total uncompensated care (sum of columns 1 and 2 on line 35.03)		1,295,972	
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)		0.0000000	
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)		27,726,551	
48.00	Hospital specific payments (to be completed by SCH and MDH, small rural hospitals only. (see instructions))		0	
			Amount	
			1.00	
49.00	Total payment for inpatient operating costs (see instructions)		27,726,551	49.00
50.00	Payment for inpatient program capital (from Wkst. L, Pt. I and Pt. II, as applicable)		2,081,247	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		185,254	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)		32,435	58.00
59.00	Total (sum of amounts on lines 49 through 58)		30,025,487	59.00
60.00	Primary payer payments		14,273	60.00
61.00	Total amount payable for program beneficiaries (line 59 minus line 60)		30,011,214	61.00
62.00	Deductibles billed to program beneficiaries		2,473,036	62.00
63.00	Coinurance billed to program beneficiaries		56,672	63.00
64.00	Allowable bad debts (see instructions)		863,893	64.00
65.00	Adjusted reimbursable bad debts (see instructions)		561,530	65.00
66.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		692,433	66.00
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)		28,043,036	67.00
68.00	Credits received from manufacturers for replaced devices for applicable to MS-DRGs (see instructions)		0	68.00
69.00	Outlier payments reconciliation (sum of lines 93, 95 and 96). (For SCH see instructions)		0	69.00
70.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	70.00
70.50	Rural Community Hospital Demonstration Project (\$410A Demonstration) adjustment (see instructions)		0	70.50
70.87	Demonstration payment adjustment amount before sequestration		0	70.87
70.88	SCH or MDH volume decrease adjustment (contractor use only)		0	70.88
70.89	Pioneer ACO demonstration payment adjustment amount (see instructions)		0	70.89
70.90	HSP bonus payment HVBP adjustment amount (see instructions)		0	70.90
70.91	HSP bonus payment HRR adjustment amount (see instructions)		0	70.91
70.92	Bundled Model 1 discount amount (see instructions)		0	70.92
70.93	HVBP payment adjustment amount (see instructions)		-57,685	70.93
70.94	HRR adjustment amount (see instructions)		-166,534	70.94
70.95	Recovery of accelerated depreciation		0	70.95

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0046	Period: From 01/01/2020 To 12/31/2020	Worksheet E Part A Date/Time Prepared: 7/19/2021 3:13 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)		27,818,817	71.00
71.01	Sequestration adjustment (see instructions)		183,604	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		27,068,959	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)		566,254	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		702,264	75.00
TO BE COMPLETED BY CONTRACTOR (lines 90 through 96)				
90.00	Operating outlier amount from Wkst. E, Pt. A, line 2, or sum of 2.03 plus 2.04 (see instructions)		0	90.00
91.00	Capital outlier from Wkst. L, Pt. I, line 2		0	91.00
92.00	Operating outlier reconciliation adjustment amount (see instructions)		0	92.00
93.00	Capital outlier reconciliation adjustment amount (see instructions)		0	93.00
94.00	The rate used to calculate the time value of money (see instructions)		0.00	94.00
95.00	Time value of money for operating expenses (see instructions)		0	95.00
96.00	Time value of money for capital related expenses (see instructions)		0	96.00
		Prior to 10/1	On/After 10/1	
		1.00	2.00	
HSP Bonus Payment Amount				
100.00	HSP bonus amount (see instructions)		0	100.00
HVBP Adjustment for HSP Bonus Payment				
101.00	HVBP adjustment factor (see instructions)	0.0000000000	0.0000000000	101.00
102.00	HVBP adjustment amount for HSP bonus payment (see instructions)		0	102.00
HRR Adjustment for HSP Bonus Payment				
103.00	HRR adjustment factor (see instructions)	0.0000	0.0000	103.00
104.00	HRR adjustment amount for HSP bonus payment (see instructions)		0	104.00
Rural Community Hospital Demonstration Project (\$410A Demonstration) Adjustment				
200.00	Is this the first year of the current 5-year demonstration period under the 21st Century Cures Act? Enter "Y" for yes or "N" for no.			200.00
Cost Reimbursement				
201.00	Medicare inpatient service costs (from Wkst. D-1, Pt. II, line 49)			201.00
202.00	Medicare discharges (see instructions)			202.00
203.00	Case-mix adjustment factor (see instructions)			203.00
Computation of Demonstration Target Amount Limitation (N/A in first year of the current 5-year demonstration period)				
204.00	Medicare target amount			204.00
205.00	Case-mix adjusted target amount (line 203 times line 204)			205.00
206.00	Medicare inpatient routine cost cap (line 202 times line 205)			206.00
Adjustment to Medicare Part A Inpatient Reimbursement				
207.00	Program reimbursement under the \$410A Demonstration (see instructions)			207.00
208.00	Medicare Part A inpatient service costs (from Wkst. E, Pt. A, line 59)			208.00
209.00	Adjustment to Medicare IPPS payments (see instructions)			209.00
210.00	Reserved for future use			210.00
211.00	Total adjustment to Medicare IPPS payments (see instructions)			211.00
Comparison of PPS versus Cost Reimbursement				
212.00	Total adjustment to Medicare Part A IPPS payments (from line 211)			212.00
213.00	Low-volume adjustment (see instructions)			213.00
218.00	Net Medicare Part A IPPS adjustment (difference between PPS and cost reimbursement) (line 212 minus line 213) (see instructions)			218.00

LOW VOLUME CALCULATION EXHIBIT 4

Provider CCN: 14-0046

Period:
From 01/01/2020
To 12/31/2020Worksheet E
Part A Exhibit 4
Date/Time Prepared:
7/19/2021 3:13 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	18,312,915	0	18,312,915		18,312,915
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	6,883,806	0		6,883,806	6,883,806
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	384,101	0	384,101		384,101
2.03	Outlier payments for discharges occurring on or after October 1 (see instructions)	2.04	106,454	0		106,454	106,454
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	0.1180	0.1180	0.1180	0.1180	
11.00	Disproportionate share adjustment (see instructions)	34.00	743,303	0	540,231	203,072	743,303
11.01	Uncompensated care payments	36.00	1,295,972	0	903,988	391,984	1,295,972
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	27,726,551	0	20,141,235	7,585,316	27,726,551
14.00	Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see instructions)	48.00	0	0	0	0	0
15.00	Total payment for inpatient operating costs (see instructions)	49.00	27,726,551	0	20,141,235	7,585,316	27,726,551
16.00	Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable)	50.00	2,081,247	0	-532,329	2,613,576	2,081,247

LOW VOLUME CALCULATION EXHIBIT 4

Provider CCN: 14-0046

Period:
From 01/01/2020
To 12/31/2020Worksheet E
Part A Exhibit 4
Date/Time Prepared:
7/19/2021 3:13 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	185,254	0	16,632	168,622	185,254	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	19,625,538	10,367,514	29,993,052	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	1,952,892	0	-508,214	2,461,106	1,952,892	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	128,355	0	-24,115	152,470	128,355	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	2,081,247	0	-532,329	2,613,576	2,081,247	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: 14-0046

Period:
From 01/01/2020
To 12/31/2020Worksheet E
Part A Exhibit 5
Date/Time Prepared:
7/19/2021 3:13 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	18,312,915	18,312,915		18,312,915	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	6,883,806		6,883,806	6,883,806	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	384,101	384,101		384,101	2.02
2.03	Outlier payments for discharges occurring on or after October 1 (see instructions)	2.04	106,454		106,454	106,454	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	0.1180	0.1180	0.1180		10.00
11.00	Disproportionate share adjustment (see instructions)	34.00	743,303	540,231	203,072	743,303	11.00
11.01	Uncompensated care payments	36.00	1,295,972	903,988	391,984	1,295,972	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	27,726,551	20,141,235	7,585,316	27,726,551	13.00
14.00	Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see instructions)	48.00	0	0	0	0	14.00
15.00	Total payment for inpatient operating costs (see instructions)	49.00	27,726,551	20,141,235	7,585,316	27,726,551	15.00
16.00	Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable)	50.00	2,081,247	-532,329	2,613,576	2,081,247	16.00
17.00	Special add-on payments for new technologies	54.00	185,254	16,632	168,622	185,254	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			19,625,538	10,367,514	29,993,052	19.00

HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULATION EXHIBIT 5

Provider CCN: 14-0046

Period:
From 01/01/2020
To 12/31/2020Worksheet E
Part A Exhibit 5
Date/Time Prepared:
7/19/2021 3:13 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	1,952,892	-508,214	2,461,106	1,952,892	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	128,355	-24,115	152,470	128,355	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	2,081,247	-532,329	2,613,576	2,081,247	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	-57,685	-85,170	27,485	-57,685	30.00
30.01	HVBP payment adjustment for HSP bonus payment (see instructions)	70.90	0	0	0	0	30.01
31.00	HRR adjustment (see instructions)	70.94	-166,534	-122,809	-43,725	-166,534	31.00
31.01	HRR adjustment for HSP bonus payment (see instructions)	70.91	0	0	0	0	31.01
						(Amt. to Wkst. E, Pt. A)	
		0	1.00	2.00	3.00	4.00	
32.00	HAC Reduction Program adjustment (see instructions)	70.99		0	0	0	32.00
100.00	Transfer HAC Reduction Program adjustment to Wkst. E, Pt. A.		N				100.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0046	Period: From 01/01/2020 To 12/31/2020	Worksheet E Part B Date/Time Prepared: 7/19/2021 3:13 pm
		Title XVIII	Hospital	PPS
				1.00
PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)		35,365	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)		21,571,251	2.00
3.00	OPPS payments		20,089,026	3.00
4.00	Outlier payment (see instructions)		178,737	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		16,711	9.00
10.00	Organ acquisitions		0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)		35,365	11.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
12.00	Ancillary service charges		125,106	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)		125,106	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)		125,106	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)		89,741	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)		35,365	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)		20,284,474	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)		3,655,560	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)		16,664,279	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)		16,664,279	30.00
31.00	Primary payer payments		337	31.00
32.00	Subtotal (line 30 minus line 31)		16,663,942	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)		850,385	34.00
35.00	Adjusted reimbursable bad debts (see instructions)		552,750	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		638,230	36.00
37.00	Subtotal (see instructions)		17,216,692	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)		17,216,692	40.00
40.01	Sequestration adjustment (see instructions)		113,630	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		16,974,313	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)		128,749	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: 14-0046

Period:
From 01/01/2020
To 12/31/2020Worksheet E-1
Part I
Date/Time Prepared:
7/19/2021 3:13 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		26,618,756		16,540,604	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		450,203		433,709	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)		27,068,959		16,974,313	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		566,254		128,749	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		27,635,213		17,103,062	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: 14-0046
 Component CCN: 14-T046

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

 Worksheet E-1
 Part I
 Date/Time Prepared:
 7/19/2021 3:13 pm

		Title XVIII		Subprovider - IRF		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					0	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		3,040,714			0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)						3.00
Program to Provider							
3.01	ADJUSTMENTS TO PROVIDER		0			0	3.01
3.02			0			0	3.02
3.03			0			0	3.03
3.04			0			0	3.04
3.05			0			0	3.05
Provider to Program							
3.50	ADJUSTMENTS TO PROGRAM		0			0	3.50
3.51			0			0	3.51
3.52			0			0	3.52
3.53			0			0	3.53
3.54			0			0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0			0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		3,040,714			0	4.00
TO BE COMPLETED BY CONTRACTOR							
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)						5.00
Program to Provider							
5.01	TENTATIVE TO PROVIDER		0			0	5.01
5.02			0			0	5.02
5.03			0			0	5.03
Provider to Program							
5.50	TENTATIVE TO PROGRAM		0			0	5.50
5.51			0			0	5.51
5.52			0			0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0			0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)						6.00
6.01	SETTLEMENT TO PROVIDER		65,398			0	6.01
6.02	SETTLEMENT TO PROGRAM		0			0	6.02
7.00	Total Medicare program liability (see instructions)		3,106,112			0	7.00
				Contractor Number	NPR Date (Mo/Day/Yr)		
		0		1.00	2.00		
8.00	Name of Contractor						

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT

Provider CCN: 14-0046

Period:
From 01/01/2020
To 12/31/2020Worksheet E-1
Part II
Date/Time Prepared:
7/19/2021 3:13 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: 14-0046 Component CCN: 14-T046	Period: From 01/01/2020 To 12/31/2020	Worksheet E-3 Part III Date/Time Prepared: 7/19/2021 3:13 pm
		Title XVIII	Subprovider - IRF	PPS
				1.00
PART III - MEDICARE PART A SERVICES - IRF PPS				
1.00	Net Federal PPS Payment (see instructions)			2,664,405 1.00
2.00	Medicare SSI ratio (IRF PPS only) (see instructions)			0.0413 2.00
3.00	Inpatient Rehabilitation LIP Payments (see instructions)			121,763 3.00
4.00	Outlier Payments			346,031 4.00
5.00	Unweighted intern and resident FTE count in the most recent cost reporting period ending on or prior to November 15, 2004 (see instructions)			0.00 5.00
5.01	Cap increases for the unweighted intern and resident FTE count for residents that were displaced by program or hospital closure, that would not be counted without a temporary cap adjustment under 42 CFR §412.424(d)(1)(iii)(F)(1) or (2) (see instructions)			0.00 5.01
6.00	New Teaching program adjustment. (see instructions)			0.00 6.00
7.00	Current year's unweighted FTE count of I&R excluding FTEs in the new program growth period of a "new teaching program" (see instructions)			0.00 7.00
8.00	Current year's unweighted I&R FTE count for residents within the new program growth period of a "new teaching program" (see instructions)			0.00 8.00
9.00	Intern and resident count for IRF PPS medical education adjustment (see instructions)			0.00 9.00
10.00	Average Daily Census (see instructions)			6.521858 10.00
11.00	Teaching Adjustment Factor (see instructions)			0.000000 11.00
12.00	Teaching Adjustment (see instructions)			0 12.00
13.00	Total PPS Payment (see instructions)			3,132,199 13.00
14.00	Nursing and Allied Health Managed Care payments (see instruction)			0 14.00
15.00	Organ acquisition (DO NOT USE THIS LINE)			0 15.00
16.00	Cost of physicians' services in a teaching hospital (see instructions)			0 16.00
17.00	Subtotal (see instructions)			3,132,199 17.00
18.00	Primary payer payments			0 18.00
19.00	Subtotal (line 17 less line 18).			3,132,199 19.00
20.00	Deductibles			7,040 20.00
21.00	Subtotal (line 19 minus line 20)			3,125,159 21.00
22.00	Coinsurance			0 22.00
23.00	Subtotal (line 21 minus line 22)			3,125,159 23.00
24.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)			1,408 24.00
25.00	Adjusted reimbursable bad debts (see instructions)			915 25.00
26.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			1,408 26.00
27.00	Subtotal (sum of lines 23 and 25)			3,126,074 27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 49)			0 28.00
29.00	Other pass through costs (see instructions)			675 29.00
30.00	Outlier payments reconciliation			0 30.00
31.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0 31.00
31.50	Pioneer ACO demonstration payment adjustment (see instructions)			0 31.50
31.99	Demonstration payment adjustment amount before sequestration			0 31.99
32.00	Total amount payable to the provider (see instructions)			3,126,749 32.00
32.01	Sequestration adjustment (see instructions)			20,637 32.01
32.02	Demonstration payment adjustment amount after sequestration			0 32.02
33.00	Interim payments			3,040,714 33.00
34.00	Tentative settlement (for contractor use only)			0 34.00
35.00	Balance due provider/program (line 32 minus lines 32.01, 32.02, 33, and 34)			65,398 35.00
36.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2			0 36.00
TO BE COMPLETED BY CONTRACTOR				
50.00	Original outlier amount from Wkst. E-3, Pt. III, line 4			346,031 50.00
51.00	Outlier reconciliation adjustment amount (see instructions)			0 51.00
52.00	The rate used to calculate the Time Value of Money			0.00 52.00
53.00	Time Value of Money (see instructions)			0 53.00

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

Provider CCN: 14-0046

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

Worksheet G

Date/Time Prepared:
7/19/2021 3:13 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	935,946	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	22,111,544	0	0	0	4.00
5.00 Other receivable	2,422,599	0	0	0	5.00
6.00 Allowances for uncollectible notes and accounts receivable	0	0	0	0	6.00
7.00 Inventory	4,338,755	0	0	0	7.00
8.00 Prepaid expenses	1,991,050	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)	31,799,894	0	0	0	11.00
FIXED ASSETS					
12.00 Land	590,251	0	0	0	12.00
13.00 Land improvements	6,818,606	0	0	0	13.00
14.00 Accumulated depreciation	-5,450,991	0	0	0	14.00
15.00 Buildings	172,439,782	0	0	0	15.00
16.00 Accumulated depreciation	-54,691,110	0	0	0	16.00
17.00 Leasehold improvements	19,337,638	0	0	0	17.00
18.00 Accumulated depreciation	-7,130,658	0	0	0	18.00
19.00 Fixed equipment	18,560,389	0	0	0	19.00
20.00 Accumulated depreciation	-9,900,689	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	52,292,988	0	0	0	23.00
24.00 Accumulated depreciation	-41,100,796	0	0	0	24.00
25.00 Minor equipment depreciable	23,079	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)	151,788,489	0	0	0	30.00
OTHER ASSETS					
31.00 Investments	5,346,979	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	98,642,918	1,361,651	25,000	0	34.00
35.00 Total other assets (sum of lines 31-34)	103,989,897	1,361,651	25,000	0	35.00
36.00 Total assets (sum of lines 11, 30, and 35)	287,578,280	1,361,651	25,000	0	36.00
CURRENT LIABILITIES					
37.00 Accounts payable	25,462,257	0	0	0	37.00
38.00 Salaries, wages, and fees payable	5,322,751	0	0	0	38.00
39.00 Payroll taxes payable	-1,591	0	0	0	39.00
40.00 Notes and loans payable (short term)	1,946,933	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	-21,759,566	0	0	0	44.00
45.00 Total current liabilities (sum of lines 37 thru 44)	10,970,784	0	0	0	45.00
LONG TERM LIABILITIES					
46.00 Mortgage payable	0	0	0	0	46.00
47.00 Notes payable	164,590,150	0	0	0	47.00
48.00 Unsecured loans	0	0	0	0	48.00
49.00 Other long term liabilities	7,433,265	0	0	0	49.00
50.00 Total long term liabilities (sum of lines 46 thru 49)	172,023,415	0	0	0	50.00
51.00 Total liabilities (sum of lines 45 and 50)	182,994,199	0	0	0	51.00
CAPITAL ACCOUNTS					
52.00 General fund balance	104,584,081				52.00
53.00 Specific purpose fund		1,361,651			53.00
54.00 Donor created - endowment fund balance - restricted			25,000		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)	104,584,081	1,361,651	25,000	0	59.00
60.00 Total liabilities and fund balances (sum of lines 51 and 59)	287,578,280	1,361,651	25,000	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 14-0046

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

Worksheet G-1

Date/Time Prepared:
7/19/2021 3:13 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		92,877,407		555,207		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		11,643,565				2.00
3.00	Total (sum of line 1 and line 2)		104,520,972		555,207		3.00
4.00	Additions	370,951		806,445		25,000	4.00
5.00	CORPORATE OFFICE	68,750		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)		439,701		806,445		10.00
11.00	Subtotal (line 3 plus line 10)		104,960,673		1,361,652		11.00
12.00	Deductions	370,951		0		0	12.00
13.00		0		0		0	13.00
14.00		0		0		0	14.00
15.00	TRANSFER TO OTHER RELATED ORGANIZATI	5,636		0		0	15.00
16.00		0		0		0	16.00
17.00		0		0		0	17.00
18.00	Total deductions (sum of lines 12-17)		376,587		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		104,584,086		1,361,652		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	CORPORATE OFFICE		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)	25,000		0			10.00
11.00	Subtotal (line 3 plus line 10)	25,000		0			11.00
12.00	Deductions		0				12.00
13.00			0				13.00
14.00			0				14.00
15.00	TRANSFER TO OTHER RELATED ORGANIZATI		0				15.00
16.00			0				16.00
17.00			0				17.00
18.00	Total deductions (sum of lines 12-17)	0		0			18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)	25,000		0			19.00

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES

Provider CCN: 14-0046

Period:
From 01/01/2020
To 12/31/2020Worksheet G-2
Parts I & II
Date/Time Prepared:
7/19/2021 3:13 pm

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
PART I - PATIENT REVENUES					
General Inpatient Routine Services					
1.00	Hospital	35,475,007		35,475,007	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF	3,486,560		3,486,560	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)	38,961,567		38,961,567	10.00
Intensive Care Type Inpatient Hospital Services					
11.00	INTENSIVE CARE UNIT	6,324,244		6,324,244	11.00
12.00	CORONARY CARE UNIT				12.00
13.00	BURN INTENSIVE CARE UNIT				13.00
14.00	SURGICAL INTENSIVE CARE UNIT				14.00
15.00	OTHER SPECIAL CARE (SPECIFY)				15.00
16.00	Total intensive care type inpatient hospital services (sum of lines 11-15)	6,324,244		6,324,244	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	45,285,811		45,285,811	17.00
18.00	Ancillary services	198,131,735	246,516,579	444,648,314	18.00
19.00	Outpatient services	6,837,992	34,942,006	41,779,998	19.00
20.00	RURAL HEALTH CLINIC	0	0	0	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY				22.00
23.00	AMBULANCE SERVICES				23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	EMPLOYEE HEALTH INSURANCE AND OTHER	16,437,429	16,301,984	32,739,413	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	266,692,967	297,760,569	564,453,536	28.00
PART II - OPERATING EXPENSES					
29.00	Operating expenses (per Wkst. A, column 3, line 200)		191,129,452		29.00
30.00	ADD (SPECIFY)	0			30.00
31.00		0			31.00
32.00		0			32.00
33.00		0			33.00
34.00		0			34.00
35.00		0			35.00
36.00	Total additions (sum of lines 30-35)		0		36.00
37.00	DEDUCT (SPECIFY)	0			37.00
38.00		0			38.00
39.00		0			39.00
40.00		0			40.00
41.00		0			41.00
42.00	Total deductions (sum of lines 37-41)		0		42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer to Wkst. G-3, line 4)		191,129,452		43.00

STATEMENT OF REVENUES AND EXPENSES

Provider CCN: 14-0046

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

Worksheet G-3

Date/Time Prepared:
7/19/2021 3:13 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	564,453,536	1.00
2.00	Less contractual allowances and discounts on patients' accounts	388,167,361	2.00
3.00	Net patient revenues (line 1 minus line 2)	176,286,175	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	191,129,452	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-14,843,277	5.00
OTHER INCOME			
6.00	Contributions, donations, bequests, etc	3,531	6.00
7.00	Income from investments	9,021,841	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	601,765	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	1,477	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	342,402	22.00
23.00	Governmental appropriations	0	23.00
24.00	OTHER INCOME	18,636,592	24.00
24.50	COVID-19 PHE Funding	0	24.50
25.00	Total other income (sum of lines 6-24)	28,607,608	25.00
26.00	Total (line 5 plus line 25)	13,764,331	26.00
27.00	PENSION	2,120,766	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	2,120,766	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	11,643,565	29.00

CALCULATION OF CAPITAL PAYMENT		Provider CCN: 14-0046	Period: From 01/01/2020 To 12/31/2020	Worksheet L Parts I-III Date/Time Prepared: 7/19/2021 3:13 pm
		Title XVIII	Hospital	PPS
		1.00		
PART I - FULLY PROSPECTIVE METHOD				
CAPITAL FEDERAL AMOUNT				
1.00	Capital DRG other than outlier		1,952,892	1.00
1.01	Model 4 BPCI Capital DRG other than outlier		0	1.01
2.00	Capital DRG outlier payments		128,355	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)		60.99	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)		2,081,247	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