

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: 14-0077	Period: From 01/01/2020 To 12/31/2020	Worksheet S Parts I-III Date/Time Prepared: 7/24/2021 3:36 pm
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PART I - COST REPORT STATUS

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

PART II - CERTIFICATION

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

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

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by TOUCHETTE REGIONAL HOSPITAL (14-0077) for the cost reporting period beginning 01/01/2020 and ending 12/31/2020 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

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

(Signed) _____

Officer or Administrator of Provider(s)

CHIEF FINANCIAL OFFICER

Title _____

Date _____

Cost Center Description		Title V	Title XVIII		HIT	Title XIX	
			Part A	Part B			
		1.00	2.00	3.00	4.00	5.00	
	PART III - SETTLEMENT SUMMARY						
1.00	Hospital	0	261,390	-14,275	0	0	1.00
2.00	Subprovider - IPF	0	0	0		0	2.00
3.00	Subprovider - IRF	0	0	0		0	3.00
5.00	Swing Bed - SNF	0	0	0		0	5.00
6.00	Swing Bed - NF	0				0	6.00
9.00	HOME HEALTH AGENCY I	0	0	0		0	9.00
200.00	Total	0	261,390	-14,275	0	0	200.00

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA				Provider CCN: 14-0077		Period: From 01/01/2020 To 12/31/2020		Worksheet S-2 Part I Date/Time Prepared: 7/24/2021 3:36 pm	
1.00		2.00		3.00		4.00			
Hospital and Hospital Health Care Complex Address:									
1.00	Street: 5900 BOND STREET			PO Box:				1.00	
2.00	City: CENTREVILLE			State: IL		Zip Code: 62207		County: ST. CLAIR	
		Component Name		CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N)	
								V	XVIII
								XIX	
Hospital and Hospital-Based Component Identification:									
3.00	Hospital			TOUCHETTE REGIONAL HOSPITAL	140077	41180	1	07/01/1966	N P N
4.00	Subprovider - IPF								4.00
5.00	Subprovider - IRF								5.00
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			SOUTHERN ILLINOIS HOME CARE	147315	41180		01/01/1996	N P N
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)						2		21.00
							1.00	2.00	3.00
Inpatient PPS Information									
22.00	Does this facility qualify and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.106(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no.					Y	N		22.00
22.01	Did this hospital receive interim uncompensated care payments for this cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)					Y	Y		22.01
22.02	Is this a newly merged hospital that requires final uncompensated care payments to be determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1.					N	N		22.02
22.03	Did this hospital receive a geographic reclassification from urban to rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no.					N	N	N	22.03
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.					3	N		23.00
				In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of State Medicaid paid days	Out-of State Medicaid eligible unpaid	Medicaid HMO days	Other Medicaid days
				1.00	2.00	3.00	4.00	5.00	6.00
24.00	If this provider is an IPPS hospital, enter the in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.			695	818	151	63	2,059	0

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

Provider CCN: 14-0077

Period:
From 01/01/2020
To 12/31/2020Worksheet S-2
Part I
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	In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of State Medicaid paid days	Out-of State Medicaid eligible unpaid	Medicaid HMO days	Other Medicaid days	
	1.00	2.00	3.00	4.00	5.00	6.00	
25.00 If this provider is an IRF, enter the in-state Medicaid paid days in column 1, the in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5.	0	0	0	0	0		25.00
					Urban/Rural St	Date of Geogra	
					1.00	2.00	
26.00 Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter "1" for urban or "2" for rural.					1		26.00
27.00 Enter your standard geographic classification (not wage) status at the end of the cost reporting period. Enter in column 1, "1" for urban or "2" for rural. If applicable, enter the effective date of the geographic reclassification in column 2.					1		27.00
35.00 If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period.					0		35.00
					Beginning:	Ending:	
					1.00	2.00	
36.00 Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.							36.00
37.00 If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status is in effect in the cost reporting period.					0		37.00
37.01 Is this hospital a former MDH that is eligible for the MDH transitional payment in accordance with FY 2016 OPPS final rule? Enter "Y" for yes or "N" for no. (see instructions)							37.01
38.00 If line 37 is 1, enter the beginning and ending dates of MDH status. If line 37 is greater than 1, subscript this line for the number of periods in excess of one and enter subsequent dates.							38.00
					Y/N	Y/N	
					1.00	2.00	
39.00 Does this facility qualify for the inpatient hospital payment adjustment for low volume hospitals in accordance with 42 CFR §412.101(b)(2)(i), (ii), or (iii)? Enter in column 1 "Y" for yes or "N" for no. Does the facility meet the mileage requirements in accordance with 42 CFR 412.101(b)(2)(i), (ii), or (iii)? Enter in column 2 "Y" for yes or "N" for no. (see instructions)					N	N	39.00
40.00 Is this hospital subject to the HAC program reduction adjustment? Enter "Y" for yes or "N" for no in column 1, for discharges prior to October 1. Enter "Y" for yes or "N" for no in column 2, for discharges on or after October 1. (see instructions)					N	N	40.00
					V	XVIII	XIX
					1.00	2.00	3.00
Prospective Payment System (PPS)-Capital							
45.00 Does this facility qualify and receive Capital payment for disproportionate share in accordance with 42 CFR Section §412.320? (see instructions)					N	Y	N
46.00 Is this facility eligible for additional payment exception for extraordinary circumstances pursuant to 42 CFR §412.348(f)? If yes, complete Wkst. L, Pt. III and Wkst. L-1, Pt. I through Pt. III.					N	N	N
47.00 Is this a new hospital under 42 CFR §412.300(b) PPS capital? Enter "Y" for yes or "N" for no.					N	N	N
48.00 Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.					N	N	N
Teaching Hospitals							
56.00 Is this a hospital involved in training residents in approved GME programs? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", are you impacted by CR 11642 (or subsequent CR), MA GME payment reduction? Enter "Y" for yes or "N" for no in column 2.					N		
57.00 If line 56 is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y" did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If column 2 is "N", complete Wkst. D, Parts III & IV and D-2, Pt. II, if applicable.					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.					N		60.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

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	Y/N	IME	Direct GME	IME	Direct GME	
	1.00	2.00	3.00	4.00	5.00	
61.00 Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions)	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

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

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			1.00		
Long Term Care Hospital PPS					
80.00	Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for no.	N		80.00	
81.00	Is this a LTCH co-located within another hospital for part or all of the cost reporting period? Enter "Y" for yes and "N" for no.	N		81.00	
TEFRA Providers					
85.00	Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no.	N		85.00	
86.00	Did this facility establish a new Other subprovider (excluded unit) under 42 CFR Section §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.			86.00	
87.00	Is this hospital an extended neoplastic disease care hospital classified under section 1886(d)(1)(B)(vi)? Enter "Y" for yes or "N" for no.	N		87.00	
			V 1.00	XIX 2.00	
Title V and XIX Services					
90.00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.	N	N	90.00	
91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.	N	N	91.00	
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.		N	92.00	
93.00	Does this facility operate an ICF/IID facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.	N	N	93.00	
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.	N	N	94.00	
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	95.00	
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.	N	N	96.00	
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	97.00	
98.00	Does title V or XIX follow Medicare (title XVIII) for the interns and residents post stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.00	
98.01	Does title V or XIX follow Medicare (title XVIII) for the reporting of charges on Wkst. C, Pt. I? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.01	
98.02	Does title V or XIX follow Medicare (title XVIII) for the calculation of observation bed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.02	
98.03	Does title V or XIX follow Medicare (title XVIII) for a critical access hospital (CAH) reimbursed 101% of inpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.03	
98.04	Does title V or XIX follow Medicare (title XVIII) for a CAH reimbursed 101% of outpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.04	
98.05	Does title V or XIX follow Medicare (title XVIII) and add back the RCE disallowance on Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.05	
98.06	Does title V or XIX follow Medicare (title XVIII) when cost reimbursed for Wkst. D, Pts. I through IV? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.06	
Rural Providers					
105.00	Does this hospital qualify as a CAH?	N		105.00	
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)			106.00	
107.00	Column 1: If line 105 is Y, is this facility eligible for cost reimbursement for I&R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) Column 2: If column 1 is Y and line 70 or line 75 is Y, do you train I&Rs in an approved medical education program in the CAH's excluded IPF and/or IRF unit(s)? Enter "Y" for yes or "N" for no in column 2. (see instructions)	N		107.00	
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	N		108.00	
		Physical 1.00	Occupational 2.00	Speech 3.00	Respiratory 4.00
109.00	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.	N	N	N	N
			1.00		
110.00	Did this hospital participate in the Rural Community Hospital Demonstration project (§410A Demonstration) for the current cost reporting period? Enter "Y" for yes or "N" for no. If yes, complete Worksheet E, Part A, lines 200 through 218, and Worksheet E-2, lines 200 through 215, as applicable.		N		

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-0077	Period: From 01/01/2020 To 12/31/2020	Worksheet S-2 Part I Date/Time Prepared: 7/24/2021 3:36 pm
		1.00	2.00	
111.00	If this facility qualifies as a CAH, did it participate in the Frontier Community Health Integration Project (FCHIP) demonstration for this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If the response to column 1 is Y, enter the integration prong of the FCHIP demo in which this CAH is participating in column 2. Enter all that apply: "A" for Ambulance services; "B" for additional beds; and/or "C" for tele-health services.	N		111.00
		1.00	2.00	3.00
112.00	Did this hospital participate in the Pennsylvania Rural Health Model demonstration for any portion of the current cost reporting period? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2, the date the hospital began participating in the demonstration. In column 3, enter the date the hospital ceased participation in the demonstration, if applicable.	N		112.00
Miscellaneous Cost Reporting Information				
115.00	Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in column 1. If column 1 is yes, enter the method used (A, B, or E only) in column 2. If column 2 is "E", enter in column 3 either "93" percent for short term hospital or "98" percent for long term care (includes psychiatric, rehabilitation and long term hospitals providers) based on the definition in CMS Pub.15-1, chapter 22, §2208.1.	N		0115.00
116.00	Is this facility classified as a referral center? Enter "Y" for yes or "N" for no.	N		116.00
117.00	Is this facility legally required to carry malpractice insurance? Enter "Y" for yes or "N" for no.	Y		117.00
118.00	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.	1		118.00
		Premiums	Losses	Insurance
		1.00	2.00	3.00
118.01	List amounts of malpractice premiums and paid losses:	1,362,914	0	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		140.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA				Provider CCN: 14-0077		Period: From 01/01/2020 To 12/31/2020		Worksheet S-2 Part I Date/Time Prepared: 7/24/2021 3:36 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: SOUTHERN ILLINOIS HEALTHCARE	Contractor's Name: NGS		Contractor's Number: 06101						
142.00	Street: 2041 GOOSE LAKE ROAD	PO Box:								
143.00	City: SAUGET	State:		Zip Code:		62206				
								1.00		
144.00	Are provider based physicians' costs included in Worksheet A?								Y	144.00
								1.00	2.00	
145.00	If costs for renal services are claimed on Wkst. A, line 74, are the costs for inpatient services only? Enter "Y" for yes or "N" for no in column 1. If column 1 is no, does the dialysis facility include Medicare utilization for this cost reporting period? Enter "Y" for yes or "N" for no in column 2.						Y		145.00	
146.00	Has the cost allocation methodology changed from the previously filed cost report? Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, chapter 40, §4020) If yes, enter the approval date (mm/dd/yyyy) in column 2.						N		146.00	
								1.00		
147.00	Was there a change in the statistical basis? Enter "Y" for yes or "N" for no.								N	147.00
148.00	Was there a change in the order of allocation? Enter "Y" for yes or "N" for no.								N	148.00
149.00	Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no.								N	149.00
				Part A	Part B	Title V	Title XIX			
				1.00	2.00	3.00	4.00			
Does this facility contain a provider that qualifies for an exemption from the application of the lower of costs or charges? Enter "Y" for yes or "N" for no for each component for Part A and Part B. (See 42 CFR §413.13)										
155.00	Hospital	N	N	N	N	N	N	N	155.00	
156.00	Subprovider - IPF	N	N	N	N	N	N	N	156.00	
157.00	Subprovider - IRF	N	N	N	N	N	N	N	157.00	
158.00	SUBPROVIDER								158.00	
159.00	SNF	N	N	N	N	N	N	N	159.00	
160.00	HOME HEALTH AGENCY	N	N	N	N	N	N	N	160.00	
161.00	CMHC		N	N	N	N	N	N	161.00	
								1.00		
Multicampus										
165.00	Is this hospital part of a Multicampus hospital that has one or more campuses in different CBSAs? Enter "Y" for yes or "N" for no.								N	165.00
		Name	County	State	Zip Code	CBSA	FTE/Campus			
		0	1.00	2.00	3.00	4.00	5.00			
166.00	If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions)						0.00		166.00	
								1.00		
Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act										
167.00	Is this provider a meaningful user under §1886(n)? Enter "Y" for yes or "N" for no.								Y	167.00
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)									168.00
168.01	If this provider is a CAH and is not a meaningful user, does this provider qualify for a hardship exception under §413.70(a)(6)(ii)? Enter "Y" for yes or "N" for no. (see instructions)									168.01
169.00	If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)								9.99	169.00
						Beginning	Ending			
						1.00	2.00			
170.00	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)									170.00
						1.00	2.00			
171.00	If line 167 is "Y", does this provider have any days for individuals enrolled in section 1876 Medicare cost plans reported on Wkst. S-3, Pt. I, line 2, col. 6? Enter "Y" for yes and "N" for no in column 1. If column 1 is yes, enter the number of section 1876 Medicare days in column 2. (see instructions)								N	0

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 14-0077	Period: From 01/01/2020 To 12/31/2020	Worksheet S-2 Part II Date/Time Prepared: 7/24/2021 3:36 pm
			Y/N 1.00	Date 2.00
General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format.				
COMPLETED BY ALL HOSPITALS				
Provider Organization and Operation				
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)	N		1.00
		Y/N 1.00	Date 2.00	V/I 3.00
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.	N		2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)	Y		3.00
		Y/N 1.00	Type 2.00	Date 3.00
Financial Data and Reports				
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	Y	A	4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.	N		5.00
			Y/N 1.00	Legal Oper. 2.00
Approved Educational Activities				
6.00	Column 1: Are costs claimed for nursing school? Column 2: If yes, is the provider is the legal operator of the program?	N		6.00
7.00	Are costs claimed for Allied Health Programs? If "Y" see instructions.	N		7.00
8.00	Were nursing school and/or allied health programs approved and/or renewed during the cost reporting period? If yes, see instructions.	N		8.00
9.00	Are costs claimed for Interns and Residents in an approved graduate medical education program in the current cost report? If yes, see instructions.	N		9.00
10.00	Was an approved Intern and Resident GME program initiated or renewed in the current cost reporting period? If yes, see instructions.	N		10.00
11.00	Are GME cost directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions.	N		11.00
			Y/N 1.00	
Bad Debts				
12.00	Is the provider seeking reimbursement for bad debts? If yes, see instructions.	Y		12.00
13.00	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.	N		13.00
14.00	If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.	N		14.00
Bed Complement				
15.00	Did total beds available change from the prior cost reporting period? If yes, see instructions.	N		15.00
		Part A		Part B
		Y/N 1.00	Date 2.00	Y/N 3.00
				Date 4.00
PS&R Data				
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)	Y	04/23/2021	16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	N		17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N		18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		19.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE

Provider CCN: 14-0077

Period:
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		Description	Y/N	Y/N	
		0	1.00	3.00	
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:		N	N	20.00
		Y/N	Date	Y/N	Date
		1.00	2.00	3.00	4.00
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		N	21.00
				1.00	
COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)					
Capital Related Cost					
22.00	Have assets been relifed for Medicare purposes? If yes, see instructions				22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.				23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions				24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.				25.00
26.00	Were assets subject to Sec.2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.				26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.				27.00
Interest Expense					
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.				28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions				29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.				30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.				31.00
Purchased Services					
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.				32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.				33.00
Provider-Based Physicians					
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.				34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.				35.00
		Y/N	Date		
		1.00	2.00		
Home Office Costs					
36.00	Were home office costs claimed on the cost report?				36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.				37.00
38.00	If line 36 is yes, was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.				38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.				39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.				40.00
		1.00	2.00		
Cost Report Preparer Contact Information					
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	KEVIN	WELLEN		41.00
42.00	Enter the employer/company name of the cost report preparer	CLIFTONLARSONALLEN			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	314-925-4300	KEVIN.WELLEN@CLACONNECT.COM		43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE

Provider CCN: 14-0077

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

VOLUNTARY CONTACT INFORMATION

Provider CCN: 14-0077

Period:
From 01/01/2020
To 12/31/2020Worksheet S-2
Part V
Date/Time Prepared:
7/24/2021 3:36 pm

		1.00	
Cost Report Preparer Contact Information			
1.00	First Name	KEVIN	1.00
2.00	Last Name	WELLEN	2.00
3.00	Title	DIRECTOR	3.00
4.00	Employer	CLIFTONLARSONALLEN, LLP	4.00
5.00	Phone Number	(314)925-4300	5.00
6.00	E-mail Address	KEVIN.WELLEN@CLACONNECT.COM	6.00
7.00	Department	HEALTHCARE	7.00
8.00	Mailing Address 1	600 WASHINGTON AVENUE	8.00
9.00	Mailing Address 2	SUITE 1800	9.00
10.00	City	ST. LOUIS	10.00
11.00	State	MO	11.00
12.00	Zip	63101	12.00
Officer or Administrator of Provider Contact Information			
13.00	First Name	JOHN	13.00
14.00	Last Name	JEFFRIES	14.00
15.00	Title	CFO	15.00
16.00	Employer	TOUCHETTE HOSPITAL	16.00
17.00	Phone Number		17.00
18.00	E-mail Address	JJEFFRIES@TOUCHETTE.ORG	18.00
19.00	Department	FINANCE	19.00
20.00	Mailing Address 1	5900 BOND STREET	20.00
21.00	Mailing Address 2		21.00
22.00	City	CENTREVILLE	22.00
23.00	State	IL	23.00
24.00	Zip	62207	24.00

Health Financial Systems		TOUCHETTE REGIONAL HOSPITAL		Non-CMS HFS Worksheet	
HFS Supplemental Information		Provider CCN: 14-0077	Period: From 01/01/2020 To 12/31/2020	Worksheet S-2 Part IX Date/Time Prepared: 7/24/2021 3:36 pm	
			Title V 1.00	Title XIX 2.00	
TITLES V AND/OR XIX FOLLOWING MEDICARE					
1.00	Do Title V or XIX follow Medicare (Title XVIII) for the Interns and Residence post stepdown adjustments on W/S B, Part I, column 25? Enter Y/N in column 1 for Title V and Y/N in column 2 for Title XIX. (see S-2, Part I, line 98)		Y	Y	1.00
2.00	Do Title V or XIX follow Medicare (Title XVIII) for the reporting of charges on W/S C, Part I (e.g. net of Physician's component)? Enter Y/N in column 1 for Title V and Y/N in column 2 for Title XIX. (see S-2, Part I, line 98.01)		Y	Y	2.00
3.00	Do Title V or XIX follow Medicare (Title XVIII) for the calculation of Observation Bed Cost on W/S D-1, Part IV, line 89? Enter Y/N in column 1 for Title V and Y/N in column 2 for Title XIX. (see S-2, Part I, line 98.02)		Y	Y	3.00
3.01	Do Title V or XIX use W/S D-1 for reimbursement?		N	N	3.01
3.02	Does Title XIX transfer managed care (HMO) days from Worksheet S-3, Part I, column 7, sum of lines 2, 3, and 4 to Worksheet E-4, column 2, line 26?			Y	3.02
			Inpatient 1.00	Outpatient 2.00	
CRITICAL ACCESS HOSPITALS					
4.00	Does Title V follow Medicare (Title XVIII) for Critical Access Hospitals (CAH) being reimbursed 101% of cost? Enter Y or N in column 1 for inpatient and Y or N in column 2 for outpatient. (see S-2, Part I, lines 98.03 and 98.04)		N	N	4.00
5.00	Does Title XIX follow Medicare (Title XVIII) for Critical Access Hospitals (CAH) being reimbursed 101% of cost? Enter Y or N in column 1 for inpatient and Y or N in column 2 for outpatient. (see S-2, Part I, lines 98.03 and 98.04)		N	N	5.00
			Title V 1.00	Title XIX 2.00	
RCE DISALLOWANCE					
6.00	Do Title V or XIX follow Medicare and add back the RCE Disallowance on W/S C, Part I column 4? Enter Y/N in column 1 for Title V and Y/N in column 2 for Title XIX. (see S-2, Part I, line 98.05)		Y	Y	6.00
PASS THROUGH COST					
7.00	Do Title V or XIX follow Medicare when cost reimbursed (payment system is "0") for worksheets D, parts I through IV? Enter Y/N in column 1 for Title V and Y/N in column 2 for Title XIX. (see S-2, Part I, line 98.06)		Y	Y	7.00
RHC					
8.00	Do Title V & XIX impute 20% coinsurance (M-3 Line 16.04)? Enter Y/N in column 1 for Title V and Y/N in column 2 for Title XIX.		N	N	8.00
FQHC					
9.00	For fiscal year beginning on/after 10/01/2014, use M-series for Title V and/or Title XIX? Enter Y/N in column 1 for Title V and Y/N in column 2 for Title XIX.		N	N	9.00
			State 1.00		
STATE MEDICAID FORMS					
10.00	Select the state when using state Medicaid forms.				

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 14-0077

Period:
From 01/01/2020
To 12/31/2020Worksheet S-3
Part I
Date/Time Prepared:
7/24/2021 3:36 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	123	45,018	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)		123	45,018	0.00	0	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	43.00				0	13.00
14.00 Total (see instructions)		123	45,018	0.00	0	14.00
15.00 CAH visits					0	15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY	101.00				0	22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
24.10 HOSPICE (non-distinct part)	30.00					24.10
25.00 CMHC - CMHC						25.00
26.00 RURAL HEALTH CLINIC						26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	26.25
27.00 Total (sum of lines 14-26)		123			0	27.00
28.00 Observation Bed Days					0	28.00
29.00 Ambulance Trips						29.00
30.00 Employee discount days (see instruction)						30.00
31.00 Employee discount days - IRF						31.00
32.00 Labor & delivery days (see instructions)		0	0			32.00
32.01 Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00 LTCH non-covered days						33.00
33.01 LTCH site neutral days and discharges						33.01

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 14-0077

Period:
From 01/01/2020
To 12/31/2020Worksheet S-3
Part I
Date/Time Prepared:
7/24/2021 3:36 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)	1,104	690	6,581			1.00
2.00	HMO and other (see instructions)	0	3,091				2.00
3.00	HMO IPF Subprovider	0	0				3.00
4.00	HMO IRF Subprovider	0	0				4.00
5.00	Hospital Adults & Peds. Swing Bed SNF	0	0	0			5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	0			6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	1,104	690	6,581			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		5	12			13.00
14.00	Total (see instructions)	1,104	695	6,593	0.00	373.11	14.00
15.00	CAH visits	0	0	0			15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY	274	0	2,881	0.00	6.62	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	379.73	27.00
28.00	Observation Bed Days		0	665			28.00
29.00	Ambulance Trips	0					29.00
30.00	Employee discount days (see instruction)			0			30.00
31.00	Employee discount days - IRF			0			31.00
32.00	Labor & delivery days (see instructions)	0	0	1			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: 14-0077

Period:
From 01/01/2020
To 12/31/2020Worksheet S-3
Part I
Date/Time Prepared:
7/24/2021 3:36 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	266	225	1,829	1.00
2.00 HMO and other (see instructions)			0	0		2.00
3.00 HMO IPF Subprovider				0		3.00
4.00 HMO IRF Subprovider				0		4.00
5.00 Hospital Adults & Peds. Swing Bed SNF						5.00
6.00 Hospital Adults & Peds. Swing Bed NF						6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)						7.00
8.00 INTENSIVE CARE UNIT						8.00
9.00 CORONARY CARE UNIT						9.00
10.00 BURN INTENSIVE CARE UNIT						10.00
11.00 SURGICAL INTENSIVE CARE UNIT						11.00
12.00 OTHER SPECIAL CARE (SPECIFY)						12.00
13.00 NURSERY						13.00
14.00 Total (see instructions)	0.00	0	266	225	1,829	14.00
15.00 CAH visits						15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY	0.00					22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
24.10 HOSPICE (non-distinct part)						24.10
25.00 CMHC - CMHC						25.00
26.00 RURAL HEALTH CLINIC						26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER	0.00					26.25
27.00 Total (sum of lines 14-26)	0.00					27.00
28.00 Observation Bed Days						28.00
29.00 Ambulance Trips						29.00
30.00 Employee discount days (see instruction)						30.00
31.00 Employee discount days - IRF						31.00
32.00 Labor & delivery days (see instructions)						32.00
32.01 Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00 LTCH non-covered days			0			33.00
33.01 LTCH site neutral days and discharges			0			33.01

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 14-0077

Period:
From 01/01/2020
To 12/31/2020Worksheet S-3
Part II
Date/Time Prepared:
7/24/2021 3:36 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	22,904,667	0	22,904,667	789,836.39	29.00
2.00	Non-physician anesthetist Part A		0	0	0	0.00	0.00
3.00	Non-physician anesthetist Part B		0	0	0	0.00	0.00
4.00	Physician-Part A - Administrative		0	0	0	0.00	0.00
4.01	Physicians - Part A - Teaching		0	0	0	0.00	0.00
5.00	Physician and Non Physician-Part B		378,815	0	378,815	4,394.20	86.21
6.00	Non-physician-Part B for hospital-based RHC and FQHC services		0	0	0	0.00	0.00
7.00	Interns & residents (in an approved program)	21.00	0	0	0	0.00	0.00
7.01	Contracted interns and residents (in an approved programs)		0	0	0	0.00	0.00
8.00	Home office and/or related organization personnel		0	0	0	0.00	0.00
9.00	SNF	44.00	0	0	0	0.00	0.00
10.00	Excluded area salaries (see instructions)		2,262,179	0	2,262,179	58,037.71	38.98
OTHER WAGES & RELATED COSTS							
11.00	Contract labor: Direct Patient Care		2,764,218	0	2,764,218	43,240.30	63.93
12.00	Contract labor: Top level management and other management and administrative services		0	0	0	0.00	0.00
13.00	Contract labor: Physician-Part A - Administrative		22,950	0	22,950	177.00	129.66
14.00	Home office and/or related organization salaries and wage-related costs		0	0	0	0.00	0.00
14.01	Home office salaries		0	0	0	0.00	0.00
14.02	Related organization salaries		0	0	0	0.00	0.00
15.00	Home office: Physician Part A - Administrative		0	0	0	0.00	0.00
16.00	Home office and Contract Physicians Part A - Teaching		0	0	0	0.00	0.00
16.01	Home office Physicians Part A - Teaching		0	0	0	0.00	0.00
16.02	Home office contract Physicians Part A - Teaching		0	0	0	0.00	0.00
WAGE-RELATED COSTS							
17.00	Wage-related costs (core) (see instructions)		4,426,637	0	4,426,637		
18.00	Wage-related costs (other) (see instructions)						
19.00	Excluded areas		403,163	0	403,163		
20.00	Non-physician anesthetist Part A		0	0	0		
21.00	Non-physician anesthetist Part B		0	0	0		
22.00	Physician Part A - Administrative		0	0	0		
22.01	Physician Part A - Teaching		0	0	0		
23.00	Physician Part B		39,804	0	39,804		
24.00	Wage-related costs (RHC/FQHC)		0	0	0		
25.00	Interns & residents (in an approved program)		0	0	0		
25.50	Home office wage-related (core)		0	0	0		
25.51	Related organization wage-related (core)		0	0	0		
25.52	Home office: Physician Part A - Administrative - wage-related (core)		0	0	0		
25.53	Home office: Physicians Part A - Teaching - wage-related (core)		0	0	0		

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 14-0077

Period:
From 01/01/2020
To 12/31/2020Worksheet S-3
Part II
Date/Time Prepared:
7/24/2021 3:36 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	
OVERHEAD COSTS - DIRECT SALARIES							
26.00	Employee Benefits Department	4.00	439,109	0	439,109	11,446.10	38.36 26.00
27.00	Administrative & General	5.00	4,575,018	0	4,575,018	151,433.24	30.21 27.00
28.00	Administrative & General under contract (see inst.)		442,097	0	442,097	2,210.51	200.00 28.00
29.00	Maintenance & Repairs	6.00	598,227	0	598,227	21,564.34	27.74 29.00
30.00	Operation of Plant	7.00	1,318,049	0	1,318,049	67,593.34	19.50 30.00
31.00	Laundry & Linen Service	8.00	27,553	0	27,553	2,139.98	12.88 31.00
32.00	Housekeeping	9.00	588,751	0	588,751	44,866.97	13.12 32.00
33.00	Housekeeping under contract (see instructions)		113,253	0	113,253	2,080.00	54.45 33.00
34.00	Dietary	10.00	449,362	-305,072	144,290	10,173.42	14.18 34.00
35.00	Dietary under contract (see instructions)		177,278	0	177,278	4,449.00	39.85 35.00
36.00	Cafeteria	11.00	0	305,072	305,072	21,509.66	14.18 36.00
37.00	Maintenance of Personnel	12.00	0	0	0	0.00	0.00 37.00
38.00	Nursing Administration	13.00	520,517	0	520,517	12,346.10	42.16 38.00
39.00	Central Services and Supply	14.00	81,519	0	81,519	4,968.33	16.41 39.00
40.00	Pharmacy	15.00	523,037	-523,037	0	0.00	0.00 40.00
41.00	Medical Records & Medical Records Library	16.00	624,989	0	624,989	28,810.13	21.69 41.00
42.00	Social Service	17.00	91,023	0	91,023	3,119.06	29.18 42.00
43.00	Other General Service	18.00	0	0	0	0.00	0.00 43.00

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 14-0077

Period:
From 01/01/2020
To 12/31/2020Worksheet S-3
Part III
Date/Time Prepared:
7/24/2021 3:36 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)	23,258,480	0	23,258,480	794,181.70	29.29	1.00
2.00	Excluded area salaries (see instructions)	2,262,179	0	2,262,179	58,037.71	38.98	2.00
3.00	Subtotal salaries (line 1 minus line 2)	20,996,301	0	20,996,301	736,143.99	28.52	3.00
4.00	Subtotal other wages & related costs (see inst.)	2,787,168	0	2,787,168	43,417.30	64.19	4.00
5.00	Subtotal wage-related costs (see inst.)	4,426,637	0	4,426,637	0.00	21.08	5.00
6.00	Total (sum of lines 3 thru 5)	28,210,106	0	28,210,106	779,561.29	36.19	6.00
7.00	Total overhead cost (see instructions)	10,569,782	-523,037	10,046,745	388,710.18	25.85	7.00

HOSPITAL WAGE RELATED COSTS

Provider CCN: 14-0077

Period:
From 01/01/2020
To 12/31/2020Worksheet S-3
Part IV
Date/Time Prepared:
7/24/2021 3:36 pm

		Amount Reported	
		1.00	
PART IV - WAGE RELATED COSTS			
Part A - Core List			
RETIREMENT COST			
1.00	401K Employer Contributions	564,947	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)	0	8.01
8.02	Health Insurance (Self Funded with a Third Party Administrator)	1,984,763	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)	110,063	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)	103,899	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)	0	14.00
15.00	'Workers' Compensation Insurance	273,190	15.00
16.00	Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. Non cumulative portion)	0	16.00
TAXES			
17.00	FICA-Employers Portion Only	1,687,286	17.00
18.00	Medicare Taxes - Employers Portion Only	0	18.00
19.00	Unemployment Insurance	137,234	19.00
20.00	State or Federal Unemployment Taxes	0	20.00
OTHER			
21.00	Executive Deferred Compensation (Other Than Retirement Cost Reported on lines 1 through 4 above. (see instructions))	0	21.00
22.00	Day Care Cost and Allowances	0	22.00
23.00	Tuition Reimbursement	8,223	23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)	4,869,605	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: 14-0077

Period:
From 01/01/2020
To 12/31/2020Worksheet S-3
Part V
Date/Time Prepared:
7/24/2021 3:36 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	2,897,729	4,869,605	1.00
2.00	Hospital	2,764,218	4,834,285	2.00
3.00	Subprovider - IPF			3.00
4.00	Subprovider - IRF			4.00
5.00	Subprovider - (Other)	0	0	5.00
6.00	Swing Beds - SNF	0	0	6.00
7.00	Swing Beds - NF	0	0	7.00
8.00	Hospital-Based SNF			8.00
9.00	Hospital-Based NF			9.00
10.00	Hospital-Based OLTC			10.00
11.00	Hospital-Based HHA	133,511	35,320	11.00
12.00	Separately Certified ASC			12.00
13.00	Hospital-Based Hospice			13.00
14.00	Hospital-Based Health Clinic RHC			14.00
15.00	Hospital-Based Health Clinic FQHC			15.00
16.00	Hospital-Based-CMHC			16.00
17.00	Renal Dialysis	0	0	17.00
18.00	Other	0	0	18.00

Health Financial Systems		TOUCHETTE REGIONAL HOSPITAL			In Lieu of Form CMS-2552-10	
HOME HEALTH AGENCY STATISTICAL DATA				Provider CCN: 14-0077 Component CCN: 14-7315	Period: From 01/01/2020 To 12/31/2020	Worksheet S-4 Date/Time Prepared: 7/24/2021 3:36 pm
				Home Health Agency I	PPS	
				1.00		
0.00	County	ST. CLAIR				0.00
		Title V	Title XVIII	Title XIX	Other	Total
		1.00	2.00	3.00	4.00	5.00
HOME HEALTH AGENCY STATISTICAL DATA						
1.00	Home Health Aide Hours	0	0	0	0	1.00
2.00	Unduplicated Census Count (see instructions)	0.00	24.00	92.00	144.00	2.00
		Number of Employees (Full Time Equivalent)				
		Enter the number of hours in your normal work week		Staff	Contract	Total
		0		1.00	2.00	3.00
HOME HEALTH AGENCY - NUMBER OF EMPLOYEES						
3.00	Administrator and Assistant Administrator(s)	40.00		0.00	0.00	3.00
4.00	Director(s) and Assistant Director(s)			0.00	0.00	4.00
5.00	Other Administrative Personnel			2.07	0.00	5.00
6.00	Direct Nursing Service			2.15	0.00	6.00
7.00	Nursing Supervisor			2.39	0.00	7.00
8.00	Physical Therapy Service			0.00	0.00	8.00
9.00	Physical Therapy Supervisor			0.00	0.00	9.00
10.00	Occupational Therapy Service			0.00	0.00	10.00
11.00	Occupational Therapy Supervisor			0.00	0.00	11.00
12.00	Speech Pathology Service			0.00	0.00	12.00
13.00	Speech Pathology Supervisor			0.00	0.00	13.00
14.00	Medical Social Service			0.01	0.00	14.00
15.00	Medical Social Service Supervisor			0.00	0.00	15.00
16.00	Home Health Aide			0.00	0.00	16.00
17.00	Home Health Aide Supervisor			0.00	0.00	17.00
18.00	Other (specify)			0.00	0.00	18.00
HOME HEALTH AGENCY CBSA CODES						
19.00	Enter in column 1 the number of CBSAs where you provided services during the cost reporting period.			1		19.00
20.00	List those CBSA code(s) in column 1 serviced during this cost reporting period (line 20 contains the first code).	41180				20.00
		Full Episodes		LUPA Episodes	PEP Only Episodes	Total (cols. 1-4)
		Without Outliers	With Outliers			
		1.00	2.00	3.00	4.00	5.00
PPS ACTIVITY DATA						
21.00	Skilled Nursing Visits	81	10	1	0	21.00
22.00	Skilled Nursing Visit Charges	15,162	1,720	250	0	22.00
23.00	Physical Therapy Visits	110	27	2	0	23.00
24.00	Physical Therapy Visit Charges	24,924	5,796	500	0	24.00
25.00	Occupational Therapy Visits	21	16	1	0	25.00
26.00	Occupational Therapy Visit Charges	5,144	3,470	200	0	26.00
27.00	Speech Pathology Visits	2	0	0	0	27.00
28.00	Speech Pathology Visit Charges	288	0	0	0	28.00
29.00	Medical Social Service Visits	2	1	0	0	29.00
30.00	Medical Social Service Visit Charges	500	192	0	0	30.00
31.00	Home Health Aide Visits	0	0	0	0	31.00
32.00	Home Health Aide Visit Charges	0	0	0	0	32.00
33.00	Total visits (sum of lines 21, 23, 25, 27, 29, and 31)	216	54	4	0	33.00
34.00	Other Charges	0	0	0	0	34.00
35.00	Total Charges (sum of lines 22, 24, 26, 28, 30, 32, and 34)	46,018	11,178	950	0	35.00
36.00	Total Number of Episodes (standard/non outlier)	28		4	0	36.00
37.00	Total Number of Outlier Episodes		3		0	37.00
38.00	Total Non-Routine Medical Supply Charges	107	15	0	0	38.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA		Provider CCN: 14-0077	Period: From 01/01/2020 To 12/31/2020	Worksheet S-10 Date/Time Prepared: 7/24/2021 3:36 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)		0.932717		1.00
Medicaid (see instructions for each line)					
2.00	Net revenue from Medicaid		7,922,685		2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?		Y		3.00
4.00	If line 3 is yes, does line 2 include all DSH and/or supplemental payments from Medicaid?		N		4.00
5.00	If line 4 is no, then enter DSH and/or supplemental payments from Medicaid		28,654,518		5.00
6.00	Medicaid charges		29,780,317		6.00
7.00	Medicaid cost (line 1 times line 6)		27,776,608		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		13,683		9.00
10.00	Stand-alone CHIP charges		54,027		10.00
11.00	Stand-alone CHIP cost (line 1 times line 10)		50,392		11.00
12.00	Difference between net revenue and costs for stand-alone CHIP (line 11 minus line 9; if < zero then enter zero)		36,709		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)		36,709		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)	0	0	0	20.00
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	0	0	0	21.00
22.00	Payments received from patients for amounts previously written off as charity care	0	0	0	22.00
23.00	Cost of charity care (line 21 minus line 22)	0	0	0	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)		0		26.00
27.00	Medicare reimbursable bad debts for the entire hospital complex (see instructions)		91,461		27.00
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)		140,709		27.01
28.00	Non-Medicare bad debt expense (see instructions)		-140,709		28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)		-81,994		29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)		-81,994		30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)		-45,285		31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-0077

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

Worksheet A

Date/Time Prepared:
7/24/2021 3:36 pm

Cost Center Description			Salaries	Other	Total (col. 1 + col. 2)	Reclassification ons (See A-6)	Reclassified Trial Balance (col. 3 + col. 4)	
			1.00	2.00	3.00	4.00	5.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT		1,295,085	1,295,085	153,561	1,448,646	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		526,640	526,640	88,321	614,961	2.00
3.00	00300	OTHER CAP REL COSTS		0	0	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	439,109	3,530,375	3,969,484	-36,729	3,932,755	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	4,575,018	9,115,038	13,690,056	219,659	13,909,715	5.00
6.00	00600	MAINTENANCE & REPAIRS	598,227	280,354	878,581	0	878,581	6.00
7.00	00700	OPERATION OF PLANT	1,318,049	855,825	2,173,874	0	2,173,874	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	27,553	80,992	108,545	0	108,545	8.00
9.00	00900	HOUSEKEEPING	588,751	379,953	968,704	0	968,704	9.00
10.00	01000	DIETARY	449,362	649,991	1,099,353	-746,351	353,002	10.00
11.00	01100	CAFETERIA	0	0	0	746,351	746,351	11.00
13.00	01300	NURSING ADMINISTRATION	520,517	50,512	571,029	0	571,029	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	81,519	10,436	91,955	0	91,955	14.00
15.00	01500	PHARMACY	523,037	562,966	1,086,003	-523,037	562,966	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	624,989	147,603	772,592	0	772,592	16.00
17.00	01700	SOCIAL SERVICE	91,023	11,115	102,138	0	102,138	17.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	4,538,983	2,305,344	6,844,327	342,725	7,187,052	30.00
43.00	04300	NURSERY	67,238	7,586	74,824	0	74,824	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	1,135,297	788,763	1,924,060	0	1,924,060	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	117,685	306,730	424,415	-325,020	99,395	52.00
53.00	05300	ANESTHESIOLOGY	0	776,173	776,173	0	776,173	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,295,598	569,045	1,864,643	0	1,864,643	54.00
60.00	06000	LABORATORY	578,075	2,074,361	2,652,436	0	2,652,436	60.00
65.00	06500	RESPIRATORY THERAPY	521,041	321,262	842,303	0	842,303	65.00
66.00	06600	PHYSICAL THERAPY	0	351,712	351,712	0	351,712	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	135,021	135,021	0	135,021	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	161,171	161,171	0	161,171	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	357,959	357,959	523,037	880,996	73.00
74.00	07400	RENAL DIALYSIS	0	28,042	28,042	0	28,042	74.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	462,719	398,653	861,372	0	861,372	76.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	2,088,698	3,995,769	6,084,467	0	6,084,467	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
OTHER REIMBURSABLE COST CENTERS								
101.00	10100	HOME HEALTH AGENCY	504,864	268,453	773,317	0	773,317	101.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE		461,541	461,541	-461,541	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	21,147,352	30,804,470	51,951,822	-19,024	51,932,798	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	1,406,569	3,040,047	4,446,616	19,024	4,465,640	192.00
194.00	07950	OTHER NONREIMBURSABLE - GRANT	114,580	12,648	127,228	0	127,228	194.00
194.01	07951	OTHER NONREIMBURSABLE - TRANSPORTATI	236,166	-32,810	203,356	0	203,356	194.01
200.00		TOTAL (SUM OF LINES 118 through 199)	22,904,667	33,824,355	56,729,022	0	56,729,022	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-0077

Period:
From 01/01/2020
To 12/31/2020Worksheet A
Date/Time Prepared:
7/24/2021 3:36 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	-554	1,448,092	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	-5,238	609,723	2.00
3.00	00300	OTHER CAP REL COSTS	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	3,932,755	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-2,412,094	11,497,621	5.00
6.00	00600	MAINTENANCE & REPAIRS	0	878,581	6.00
7.00	00700	OPERATION OF PLANT	0	2,173,874	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	108,545	8.00
9.00	00900	HOUSEKEEPING	0	968,704	9.00
10.00	01000	DIETARY	0	353,002	10.00
11.00	01100	CAFETERIA	-222,912	523,439	11.00
13.00	01300	NURSING ADMINISTRATION	-51	570,978	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	91,955	14.00
15.00	01500	PHARMACY	0	562,966	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-29,881	742,711	16.00
17.00	01700	SOCIAL SERVICE	0	102,138	17.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	-899,334	6,287,718	30.00
43.00	04300	NURSERY	0	74,824	43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	-5,418	1,918,642	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	-65,000	34,395	52.00
53.00	05300	ANESTHESIOLOGY	-766,405	9,768	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	1,864,643	54.00
60.00	06000	LABORATORY	0	2,652,436	60.00
65.00	06500	RESPIRATORY THERAPY	-38,538	803,765	65.00
66.00	06600	PHYSICAL THERAPY	0	351,712	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	135,021	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	161,171	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	880,996	73.00
74.00	07400	RENAL DIALYSIS	0	28,042	74.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	-100,028	761,344	76.00
OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	0	0	90.00
91.00	09100	EMERGENCY	-3,343,114	2,741,353	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	92.00
OTHER REIMBURSABLE COST CENTERS					
101.00	10100	HOME HEALTH AGENCY	-1,250	772,067	101.00
SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE	0	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-7,889,817	44,042,981	118.00
NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	4,465,640	192.00
194.00	07950	OTHER NONREIMBURSABLE - GRANT	0	127,228	194.00
194.01	07951	OTHER NONREIMBURSABLE - TRANSPORTATI	0	203,356	194.01
200.00		TOTAL (SUM OF LINES 118 through 199)	-7,889,817	48,839,205	200.00

COST CENTERS USED IN COST REPORT

Provider CCN: 14-0077

Period:
From 01/01/2020
To 12/31/2020Worksheet Non-CMS Wo
Date/Time Prepared:
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Cost Center Description		CMS Code	Standard Label For Non-Standard Codes	
		1.00	2.00	
GENERAL SERVICE COST CENTERS				
1.00	CAP REL COSTS-BLDG & FIXT	00100		1.00
2.00	CAP REL COSTS-MVBLE EQUIP	00200		2.00
3.00	OTHER CAP REL COSTS	00300		3.00
4.00	EMPLOYEE BENEFITS DEPARTMENT	00400		4.00
5.00	ADMINISTRATIVE & GENERAL	00500		5.00
6.00	MAINTENANCE & REPAIRS	00600		6.00
7.00	OPERATION OF PLANT	00700		7.00
8.00	LAUNDRY & LINEN SERVICE	00800		8.00
9.00	HOUSEKEEPING	00900		9.00
10.00	DIETARY	01000		10.00
11.00	CAFETERIA	01100		11.00
13.00	NURSING ADMINISTRATION	01300		13.00
14.00	CENTRAL SERVICES & SUPPLY	01400		14.00
15.00	PHARMACY	01500		15.00
16.00	MEDICAL RECORDS & LIBRARY	01600		16.00
17.00	SOCIAL SERVICE	01700		17.00
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	ADULTS & PEDIATRICS	03000		30.00
43.00	NURSERY	04300		43.00
ANCILLARY SERVICE COST CENTERS				
50.00	OPERATING ROOM	05000		50.00
52.00	DELIVERY ROOM & LABOR ROOM	05200		52.00
53.00	ANESTHESIOLOGY	05300		53.00
54.00	RADIOLOGY-DIAGNOSTIC	05400		54.00
60.00	LABORATORY	06000		60.00
65.00	RESPIRATORY THERAPY	06500		65.00
66.00	PHYSICAL THERAPY	06600		66.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	07100		71.00
72.00	IMPL. DEV. CHARGED TO PATIENTS	07200		72.00
73.00	DRUGS CHARGED TO PATIENTS	07300		73.00
74.00	RENAL DIALYSIS	07400		74.00
76.00	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	76.00
OUTPATIENT SERVICE COST CENTERS				
90.00	CLINIC	09000		90.00
91.00	EMERGENCY	09100		91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	09200		92.00
OTHER REIMBURSABLE COST CENTERS				
101.00	HOME HEALTH AGENCY	10100		101.00
SPECIAL PURPOSE COST CENTERS				
113.00	INTEREST EXPENSE	11300		113.00
118.00	SUBTOTALS (SUM OF LINES 1 through 117)			118.00
NONREIMBURSABLE COST CENTERS				
190.00	GIFT, FLOWER, COFFEE SHOP & CANTEEN	19000		190.00
192.00	PHYSICIANS' PRIVATE OFFICES	19200		192.00
194.00	OTHER NONREIMBURSABLE - GRANT	07950		194.00
194.01	OTHER NONREIMBURSABLE - TRANSPORTATI	07951		194.01
200.00	TOTAL (SUM OF LINES 118 through 199)			200.00

RECLASSIFICATIONS

Provider CCN: 14-0077

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

Worksheet A-6

Date/Time Prepared:
7/24/2021 3:36 pm

	Increases					
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
1.00	A - CAFETERIA COSTS					1.00
	CAFETERIA	11.00	305,072	441,279		
	0		305,072	441,279		
1.00	B - ER & HOSPITALIST PHYSICIAN BENEFITS					1.00
	ADULTS & PEDIATRICS	30.00	0	17,705		
	0		0	17,705		
1.00	C - CLINIC PHYSICIAN BENEFITS					1.00
	PHYSICIANS' PRIVATE OFFICES	192.00	0	19,024		
	0		0	19,024		
1.00	D - INTEREST EXPENSE					1.00
	CAP REL COSTS-MVBLE EQUIP	2.00	0	33,365		
	ADMINISTRATIVE & GENERAL	5.00	0	399,801		
3.00	CAP REL COSTS-BLDG & FIXT	1.00	0	28,375	3.00	
	0		0	461,541		
	E - PROPERTY INSURANCE					
1.00	OTHER CAP REL COSTS	3.00	0	180,142	1.00	
	0	0.00	0	0		
	0		0	180,142		
1.00	F - POST PARTUM FROM LABOR & DELIVERY					1.00
	ADULTS & PEDIATRICS	30.00	106,423	218,597		
	0		106,423	218,597		
1.00	G - PHARMACY SALARIES					1.00
	DRUGS CHARGED TO PATIENTS	73.00	523,037	0		
	0		523,037	0		
500.00	Grand Total: Increases		934,532	1,338,288	500.00	

RECLASSIFICATIONS

Provider CCN: 14-0077

Period:
From 01/01/2020
To 12/31/2020Worksheet A-6
Date/Time Prepared:
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	Decreases						
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
1.00	A - CAFETERIA COSTS						1.00
	DIETARY	10.00	305,072	441,279	0		
	0		305,072	441,279			
1.00	B - ER & HOSPITALIST PHYSICIAN BENEFITS						1.00
	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	17,705	0		
	0		0	17,705			
1.00	C - CLINIC PHYSICIAN BENEFITS						1.00
	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	19,024	0		
	0		0	19,024			
1.00 2.00 3.00	D - INTEREST EXPENSE						1.00 2.00 3.00
	INTEREST EXPENSE	113.00	0	461,541	11		
		0.00	0	0	0		
		0.00	0	0	11		
	0		0	461,541			
1.00 2.00	E - PROPERTY INSURANCE						1.00 2.00
	ADMINISTRATIVE & GENERAL	5.00	0	180,142	12		
		0.00	0	0	12		
	0		0	180,142			
1.00	F - POST PARTUM FROM LABOR & DELIVERY						1.00
	DELIVERY ROOM & LABOR ROOM	52.00	106,423	218,597	0		
	0		106,423	218,597			
1.00	G - PHARMACY SALARIES						1.00
	PHARMACY	15.00	523,037	0	0		
	0		523,037	0			
500.00	Grand Total: Decreases			934,532	1,338,288		500.00

RECLASSIFICATIONS

Provider CCN: 14-0077

Period:
From 01/01/2020
To 12/31/2020Worksheet A-6
Non-CMS Worksheet
Date/Time Prepared:
7/24/2021 3:36 pm

Increases					Decreases				
Cost Center	Line #	Salary	Other		Cost Center	Line #	Salary	Other	
2.00	3.00	4.00	5.00		6.00	7.00	8.00	9.00	
A - CAFETERIA COSTS									
1.00	CAFETERIA	11.00	305,072	441,279	DIETARY	10.00	305,072	441,279	1.00
	0		305,072	441,279	0		305,072	441,279	
B - ER & HOSPITALIST PHYSICIAN BENEFITS									
1.00	ADULTS & PEDIATRICS	30.00	0	17,705	EMPLOYEE BENEFITS	4.00	0	17,705	1.00
	0		0	17,705	DEPARTMENT		0	17,705	
C - CLINIC PHYSICIAN BENEFITS									
1.00	PHYSICIANS' PRIVATE	192.00	0	19,024	EMPLOYEE BENEFITS	4.00	0	19,024	1.00
	OFFICES		0	19,024	DEPARTMENT		0	19,024	
	0		0	19,024	0		0	19,024	
D - INTEREST EXPENSE									
1.00	CAP REL COSTS-MVBLE	2.00	0	33,365	INTEREST EXPENSE	113.00	0	461,541	1.00
	EQUIP		0						
2.00	ADMINISTRATIVE &	5.00	0	399,801		0.00	0	0	2.00
	GENERAL								
3.00	CAP REL COSTS-BLDG &	1.00	0	28,375		0.00	0	0	3.00
	FIXT		0						
	0		0	461,541	0		0	461,541	
E - PROPERTY INSURANCE									
1.00	OTHER CAP REL COSTS	3.00	0	180,142	ADMINISTRATIVE &	5.00	0	180,142	1.00
			0	180,142	GENERAL		0	180,142	
	0		0	180,142	0		0	180,142	
F - POST PARTUM FROM LABOR & DELIVERY									
1.00	ADULTS & PEDIATRICS	30.00	106,423	218,597	DELIVERY ROOM & LABOR	52.00	106,423	218,597	1.00
	0		106,423	218,597	ROOM		106,423	218,597	
	0				0				
G - PHARMACY SALARIES									
1.00	DRUGS CHARGED TO	73.00	523,037	0	PHARMACY	15.00	523,037	0	1.00
	PATIENTS			0				0	
	0		523,037	0	0		523,037	0	
500.00	Grand Total: Increases		934,532	1,338,288	Grand Total: Decreases		934,532	1,338,288	500.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-0077

Period:
From 01/01/2020
To 12/31/2020Worksheet A-7
Part I
Date/Time Prepared:
7/24/2021 3:36 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	2,222,647	0	0	0	0	1.00	
2.00	Land Improvements	307,583	0	0	0	0	2.00	
3.00	Buildings and Fixtures	30,677,647	278,802	0	278,802	0	3.00	
4.00	Building Improvements	0	0	0	0	0	4.00	
5.00	Fixed Equipment	788,179	0	0	0	0	5.00	
6.00	Movable Equipment	13,779,111	1,267,238	0	1,267,238	0	6.00	
7.00	HIT designated Assets	0	0	0	0	0	7.00	
8.00	Subtotal (sum of lines 1-7)	47,775,167	1,546,040	0	1,546,040	0	8.00	
9.00	Reconciling Items	-486,565	-109,336	0	-109,336	0	9.00	
10.00	Total (line 8 minus line 9)	48,261,732	1,655,376	0	1,655,376	0	10.00	
		Ending Balance	Fully Depreciated Assets					
		6.00	7.00					
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES							
1.00	Land	2,222,647	0				1.00	
2.00	Land Improvements	307,583	0				2.00	
3.00	Buildings and Fixtures	30,956,449	0				3.00	
4.00	Building Improvements	0	0				4.00	
5.00	Fixed Equipment	788,179	0				5.00	
6.00	Movable Equipment	15,046,349	0				6.00	
7.00	HIT designated Assets	0	0				7.00	
8.00	Subtotal (sum of lines 1-7)	49,321,207	0				8.00	
9.00	Reconciling Items	-595,901	0				9.00	
10.00	Total (line 8 minus line 9)	49,917,108	0				10.00	

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-0077

Period:
From 01/01/2020
To 12/31/2020Worksheet A-7
Part II
Date/Time Prepared:
7/24/2021 3:36 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	1,295,085	0	0	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	526,640	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	1,821,725	0	0	0	0	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Other	Total (1) (sum				
		Capital-Related Costs (see instructions)	of cols. 9 through 14)				
		14.00	15.00				
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	CAP REL COSTS-BLDG & FIXT	0	1,295,085				1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	526,640				2.00
3.00	Total (sum of lines 1-2)	0	1,821,725				3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-0077

Period:
From 01/01/2020
To 12/31/2020Worksheet A-7
Part III
Date/Time Prepared:
7/24/2021 3:36 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	34,274,858	0	34,274,858	0.694931	125,186	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	15,046,349	0	15,046,349	0.305069	54,956	2.00
3.00	Total (sum of lines 1-2)	49,321,207	0	49,321,207	1.000000	180,142	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	125,186	1,295,085	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	54,956	522,053	0	2.00
3.00	Total (sum of lines 1-2)	0	0	180,142	1,817,138	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	27,821	125,186	0	0	1,448,092	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	32,714	54,956	0	0	609,723	2.00
3.00	Total (sum of lines 1-2)	60,535	180,142	0	0	2,057,815	3.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 14-0077

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

Worksheet A-8

Date/Time Prepared:
7/24/2021 3:36 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		1.00	2.00	3.00	4.00	5.00	
1.00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)	B	-554	CAP REL COSTS-BLDG & FIXT	1.00	11	1.00
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)	B	-651	CAP REL COSTS-MVBLE EQUIP	2.00	11	2.00
3.00	Investment income - other (chapter 2)	B	-7,806	ADMINISTRATIVE & GENERAL	5.00	0	3.00
4.00	Trade, quantity, and time discounts (chapter 8)	B	-740	ADMINISTRATIVE & GENERAL	5.00	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)	B	-6,541	ADMINISTRATIVE & GENERAL	5.00	0	5.00
6.00	Rental of provider space by suppliers (chapter 8)		0		0.00	0	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)		0		0.00	0	7.00
8.00	Television and radio service (chapter 21)	A	-26,617	ADMINISTRATIVE & GENERAL	5.00	0	8.00
9.00	Parking lot (chapter 21)		0		0.00	0	9.00
10.00	Provider-based physician adjustment	A-8-2	-5,169,951			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	-96,636			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests	B	-222,912	CAFETERIA	11.00	0	14.00
15.00	Rental of quarters to employee and others		0		0.00	0	15.00
16.00	Sale of medical and surgical supplies to other than patients		0		0.00	0	16.00
17.00	Sale of drugs to other than patients	B	-51	NURSING ADMINISTRATION	13.00	0	17.00
18.00	Sale of medical records and abstracts	B	-29,881	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		0	CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	27.00
28.00	Non-physician Anesthetist		0	*** Cost Center Deleted ***	19.00		28.00
29.00	Physicians' assistant		0		0.00	0	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	*** Cost Center Deleted ***	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	*** Cost Center Deleted ***	68.00		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest		0		0.00	0	32.00
33.00	MISC INCOME	B	-112,202	ADMINISTRATIVE & GENERAL	5.00	0	33.00
33.01	OTHER INCOME	B	-35,465	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	76.00	0	33.01

ADJUSTMENTS TO EXPENSES

Provider CCN: 14-0077

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

Worksheet A-8

Date/Time Prepared:
7/24/2021 3:36 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	
33.02	LOBBYING COSTS	A	-14,389	ADMINISTRATIVE & GENERAL	5.00	0	33.02
34.00	MARKETING COSTS - OTHER EXPENSES	A	-60,517	ADMINISTRATIVE & GENERAL	5.00	0	34.00
35.00	NON-ALLOWABLE ADVERTISING	A	-1,250	HOME HEALTH AGENCY	101.00	0	35.00
35.01	NON-ALLOWABLE ADVERTISING	A	-620	ADMINISTRATIVE & GENERAL	5.00	0	35.01
35.02	NON-ALLOWABLE ADVERTISING	A	-11,421	ADULTS & PEDIATRICS	30.00	0	35.02
36.00	NON-ALLOWABLE ADVERTISING	A	-1,000	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	76.00	0	36.00
37.00	PROVIDER TAX	A	-2,086,026	ADMINISTRATIVE & GENERAL	5.00	0	37.00
38.00	AMORTIZE EQUIPMENT INSURANCE PROCEED	A	-4,587	CAP REL COSTS-MVBLE EQUIP	2.00	9	38.00
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-7,889,817				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: 14-0077

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

Worksheet A-8-1

Date/Time Prepared:
7/24/2021 3:36 pm

	Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in wks. A, column 5	
	1.00	2.00	3.00	4.00	5.00	
	A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:					
1.00	5.00	ADMINISTRATIVE & GENERAL	SIHF SERVICES	0	96,636	1.00
2.00	0.00			0	0	2.00
3.00	0.00			0	0	3.00
4.00	0.00			0	0	4.00
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.			0	96,636	5.00

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

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

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

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

6.00	B	SIHF	100.00	SIHF	100.00	6.00
7.00			0.00		0.00	7.00
8.00			0.00		0.00	8.00
9.00			0.00		0.00	9.00
10.00			0.00		0.00	10.00
100.00	G. Other (financial or non-financial) specify:					100.00

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

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

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

Provider CCN: 14-0077

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

Worksheet A-8-1

Date/Time Prepared:
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	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	-96,636	0		1.00
2.00	0	0		2.00
3.00	0	0		3.00
4.00	0	0		4.00
5.00	-96,636			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	NOT FOR PROFIT		6.00
7.00			7.00
8.00			8.00
9.00			9.00
10.00			10.00
100.00			100.00

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

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

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 14-0077

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

Worksheet A-8-2

Date/Time Prepared:
7/24/2021 3:36 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	30.00	ADULTS & PEDIATRICS	895,604	884,654	10,950	197,500	81	1.00
2.00	50.00	OPERATING ROOM	5,418	5,418	0	246,400	0	2.00
3.00	52.00	DELIVERY ROOM & LABOR ROOM	65,000	65,000	0	237,100	0	3.00
4.00	53.00	ANESTHESIOLOGY	766,405	766,405	0	239,400	0	4.00
5.00	65.00	RESPIRATORY THERAPY	38,538	38,538	0	211,500	0	5.00
6.00	76.00	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	71,931	59,931	12,000	181,300	96	6.00
7.00	91.00	EMERGENCY	3,343,114	3,343,114	0	211,500	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			5,186,010	5,163,060	22,950		177	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	30.00	ADULTS & PEDIATRICS	7,691	385	0	0	0	1.00
2.00	50.00	OPERATING ROOM	0	0	0	0	0	2.00
3.00	52.00	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	3.00
4.00	53.00	ANESTHESIOLOGY	0	0	0	0	0	4.00
5.00	65.00	RESPIRATORY THERAPY	0	0	0	0	0	5.00
6.00	76.00	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	8,368	418	0	0	0	6.00
7.00	91.00	EMERGENCY	0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			16,059	803	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	30.00	ADULTS & PEDIATRICS	0	7,691	3,259	887,913		1.00
2.00	50.00	OPERATING ROOM	0	0	0	5,418		2.00
3.00	52.00	DELIVERY ROOM & LABOR ROOM	0	0	0	65,000		3.00
4.00	53.00	ANESTHESIOLOGY	0	0	0	766,405		4.00
5.00	65.00	RESPIRATORY THERAPY	0	0	0	38,538		5.00
6.00	76.00	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	8,368	3,632	63,563		6.00
7.00	91.00	EMERGENCY	0	0	0	3,343,114		7.00
8.00	0.00		0	0	0	0		8.00
9.00	0.00		0	0	0	0		9.00
10.00	0.00		0	0	0	0		10.00
200.00			0	16,059	6,891	5,169,951		200.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0077

Period:
From 01/01/2020
To 12/31/2020Worksheet B
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Cost Center Description			CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
			Net Expenses for Cost Allocation (from Wkst A col. 7)	BLDG & FIXT	MVBLE EQUIP		
			0	1.00	2.00	4.00	4A
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT	1,448,092	1,448,092			1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	609,723		609,723		2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	3,932,755	9,240	3,891	3,945,886	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	11,497,621	81,863	34,469	845,463	5.00
6.00	00600	MAINTENANCE & REPAIRS	878,581	68,970	29,040	110,552	6.00
7.00	00700	OPERATION OF PLANT	2,173,874	223,278	94,012	243,575	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	108,545	11,086	4,668	5,092	8.00
9.00	00900	HOUSEKEEPING	968,704	21,538	9,069	108,801	9.00
10.00	01000	DIETARY	353,002	61,398	25,852	26,665	10.00
11.00	01100	CAFETERIA	523,439	22,252	9,369	56,377	11.00
13.00	01300	NURSING ADMINISTRATION	570,978	35,175	14,811	96,192	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	91,955	18,253	7,685	15,065	14.00
15.00	01500	PHARMACY	562,966	15,285	6,436	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	742,711	26,600	11,200	115,498	16.00
17.00	01700	SOCIAL SERVICE	102,138	4,714	1,985	16,821	17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	6,287,718	394,688	166,184	788,763	30.00
43.00	04300	NURSERY	74,824	14,312	6,026	12,426	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	1,918,642	129,683	54,603	209,803	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	34,395	2,551	1,074	2,081	52.00
53.00	05300	ANESTHESIOLOGY	9,768	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,864,643	37,706	15,876	239,427	54.00
60.00	06000	LABORATORY	2,652,436	38,758	16,319	106,828	60.00
65.00	06500	RESPIRATORY THERAPY	803,765	35,661	15,015	96,288	65.00
66.00	06600	PHYSICAL THERAPY	351,712	30,709	12,930	0	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	135,021	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	161,171	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	880,996	0	0	96,657	73.00
74.00	07400	RENAL DIALYSIS	28,042	0	0	0	74.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	761,344	50,460	21,246	85,510	76.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0	0	0	0	90.00
91.00	09100	EMERGENCY	2,741,353	108,761	45,794	385,991	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					92.00
OTHER REIMBURSABLE COST CENTERS							
101.00	10100	HOME HEALTH AGENCY	772,067	0	0	93,299	101.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	44,042,981	1,442,941	607,554	3,757,174	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	4,465,640	0	0	123,895	192.00
194.00	07950	OTHER NONREIMBURSABLE - GRANT	127,228	0	0	21,174	194.00
194.01	07951	OTHER NONREIMBURSABLE - TRANSPORTATI	203,356	5,151	2,169	43,643	194.01
200.00		Cross Foot Adjustments					200.00
201.00		Negative Cost Centers		0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	48,839,205	1,448,092	609,723	3,945,886	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0077

Period:
From 01/01/2020
To 12/31/2020Worksheet B
Part I
Date/Time Prepared:
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Cost Center Description			ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
			5.00	6.00	7.00	8.00	9.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	12,459,416					5.00
6.00	00600	MAINTENANCE & REPAIRS	372,327	1,459,470				6.00
7.00	00700	OPERATION OF PLANT	936,599	252,999	3,924,337			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	44,314	12,562	40,862	227,129		8.00
9.00	00900	HOUSEKEEPING	379,508	24,405	79,382	0	1,591,407	9.00
10.00	01000	DIETARY	159,911	69,570	226,294	0	5,890	10.00
11.00	01100	CAFETERIA	209,406	25,214	82,016	0	23,559	11.00
13.00	01300	NURSING ADMINISTRATION	245,613	39,857	129,645	0	23,559	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	45,536	20,682	67,274	0	17,669	14.00
15.00	01500	PHARMACY	200,245	17,319	56,336	0	14,724	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	306,867	30,140	98,039	0	14,724	16.00
17.00	01700	SOCIAL SERVICE	43,036	5,342	17,376	0	8,835	17.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	2,615,648	447,229	1,454,709	111,292	595,336	30.00
43.00	04300	NURSERY	36,847	16,217	52,751	0	0	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	792,069	146,946	477,976	6,815	250,502	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	13,734	2,890	9,401	0	0	52.00
53.00	05300	ANESTHESIOLOGY	3,345	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	738,957	42,725	138,974	34,069	91,338	54.00
60.00	06000	LABORATORY	963,861	43,917	142,851	0	44,220	60.00
65.00	06500	RESPIRATORY THERAPY	325,608	40,408	131,438	2,272	44,220	65.00
66.00	06600	PHYSICAL THERAPY	135,401	34,796	113,184	11,357	50,110	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	46,242	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	55,198	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	334,829	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	9,604	0	0	0	0	74.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	314,590	57,177	185,981	0	58,944	76.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	1,123,991	123,238	400,862	61,324	294,722	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
OTHER REIMBURSABLE COST CENTERS								
101.00	10100	HOME HEALTH AGENCY	296,372	0	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	10,749,658	1,453,633	3,905,351	227,129	1,538,352	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	1,571,833	0	0	0	44,220	192.00
194.00	07950	OTHER NONREIMBURSABLE - GRANT	50,825	0	0	0	0	194.00
194.01	07951	OTHER NONREIMBURSABLE - TRANSPORTATI	87,100	5,837	18,986	0	8,835	194.01
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)	12,459,416	1,459,470	3,924,337	227,129	1,591,407	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0077

Period:
From 01/01/2020
To 12/31/2020Worksheet B
Part I
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Cost Center Description			DIETARY	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	
			10.00	11.00	13.00	14.00	15.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY	928,582					10.00
11.00	01100	CAFETERIA	0	951,632				11.00
13.00	01300	NURSING ADMINISTRATION	0	26,376	1,182,206			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	10,601	21,686	316,406		14.00
15.00	01500	PHARMACY	0	27,353	0	227	900,891	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	61,580	0	145	0	16.00
17.00	01700	SOCIAL SERVICE	0	6,657	0	23	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	928,582	308,586	611,222	53,091	7,529	30.00
43.00	04300	NURSERY	0	3,510	7,167	175	83	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	67,478	137,857	27,281	11,770	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	579	1,157	636	138	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	4,053	71	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	83,687	0	8,639	15,871	54.00
60.00	06000	LABORATORY	0	56,225	0	13,133	1,511	60.00
65.00	06500	RESPIRATORY THERAPY	0	36,543	0	9,648	7,009	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	1,289	0	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	59,126	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	70,546	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	790,528	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	97	35	74.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	35,132	71,779	550	0	76.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	132,748	271,183	56,836	30,637	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
OTHER REIMBURSABLE COST CENTERS								
101.00	10100	HOME HEALTH AGENCY	0	0	60,155	2,466	207	101.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	928,582	857,055	1,182,206	307,961	865,389	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	48,012	0	7,924	35,502	192.00
194.00	07950	OTHER NONREIMBURSABLE - GRANT	0	12,302	0	5	0	194.00
194.01	07951	OTHER NONREIMBURSABLE - TRANSPORTATI	0	34,263	0	516	0	194.01
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)	928,582	951,632	1,182,206	316,406	900,891	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0077

Period:
From 01/01/2020
To 12/31/2020Worksheet B
Part I
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Cost Center Description			MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			16.00	17.00	24.00	25.00	26.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY						15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,407,504					16.00
17.00	01700	SOCIAL SERVICE	0	206,927				17.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	1,236,464	114,942	16,121,983	0	16,121,983	30.00
43.00	04300	NURSERY	1,514	1,348	227,200	0	227,200	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	25,924	4,257,349	0	4,257,349	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	218	68,854	0	68,854	52.00
53.00	05300	ANESTHESIOLOGY	0	0	17,237	0	17,237	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	3,311,912	0	3,311,912	54.00
60.00	06000	LABORATORY	0	0	4,080,059	0	4,080,059	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	1,547,875	0	1,547,875	65.00
66.00	06600	PHYSICAL THERAPY	0	0	741,488	0	741,488	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	240,389	0	240,389	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	286,915	0	286,915	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	2,103,010	0	2,103,010	73.00
74.00	07400	RENAL DIALYSIS	0	0	37,778	0	37,778	74.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	13,498	1,656,211	0	1,656,211	76.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	169,526	50,997	5,997,963	0	5,997,963	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				0		92.00
OTHER REIMBURSABLE COST CENTERS								
101.00	10100	HOME HEALTH AGENCY	0	0	1,224,566	0	1,224,566	101.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	1,407,504	206,927	41,920,789	0	41,920,789	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	6,297,026	0	6,297,026	192.00
194.00	07950	OTHER NONREIMBURSABLE - GRANT	0	0	211,534	0	211,534	194.00
194.01	07951	OTHER NONREIMBURSABLE - TRANSPORTATI	0	0	409,856	0	409,856	194.01
200.00		Cross Foot Adjustments			0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	1,407,504	206,927	48,839,205	0	48,839,205	202.00

COST ALLOCATION STATISTICS

Provider CCN: 14-0077

Period:
From 01/01/2020
To 12/31/2020Worksheet Non-CMS Wo
Date/Time Prepared:
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Cost Center Description		Statistics Code	Statistics Description	
		1.00	2.00	
GENERAL SERVICE COST CENTERS				
1.00	CAP REL COSTS-BLDG & FIXT	1	SQUARE FEET	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	1	SQUARE FEET	2.00
4.00	EMPLOYEE BENEFITS DEPARTMENT	4	GROSS SALARIES	4.00
5.00	ADMINISTRATIVE & GENERAL	-5	ACCUM. COST	5.00
6.00	MAINTENANCE & REPAIRS	1	SQUARE FEET	6.00
7.00	OPERATION OF PLANT	1	SQUARE FEET	7.00
8.00	LAUNDRY & LINEN SERVICE	8	POUNDS OF LAUNDRY	8.00
9.00	HOUSEKEEPING	9	HOURS OF SERVICE	9.00
10.00	DIETARY	10	MEALS SERVED	10.00
11.00	CAFETERIA	11	MEALS SERVED	11.00
13.00	NURSING ADMINISTRATION	13	DIRECT NURS. HRS.	13.00
14.00	CENTRAL SERVICES & SUPPLY	14	COSTED REQUIS.	14.00
15.00	PHARMACY	15	COSTED REQUIS.	15.00
16.00	MEDICAL RECORDS & LIBRARY	16	TIME SPENT	16.00
17.00	SOCIAL SERVICE	17	TIME SPENT	17.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0077

Period:
From 01/01/2020
To 12/31/2020Worksheet B
Part II
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Cost Center Description			CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
			Directly Assigned New Capital Related Costs	BLDG & FIXT	MVBLE EQUIP		
			0	1.00	2.00	2A	4.00
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	9,240	3,891	13,131	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	131,458	81,863	34,469	247,790	5.00
6.00	00600	MAINTENANCE & REPAIRS	0	68,970	29,040	98,010	6.00
7.00	00700	OPERATION OF PLANT	6,431	223,278	94,012	323,721	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	11,086	4,668	15,754	8.00
9.00	00900	HOUSEKEEPING	0	21,538	9,069	30,607	9.00
10.00	01000	DIETARY	0	61,398	25,852	87,250	10.00
11.00	01100	CAFETERIA	0	22,252	9,369	31,621	11.00
13.00	01300	NURSING ADMINISTRATION	0	35,175	14,811	49,986	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	18,253	7,685	25,938	14.00
15.00	01500	PHARMACY	74,463	15,285	6,436	96,184	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	26,600	11,200	37,800	16.00
17.00	01700	SOCIAL SERVICE	0	4,714	1,985	6,699	17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	3,253	394,688	166,184	564,125	30.00
43.00	04300	NURSERY	0	14,312	6,026	20,338	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	91,001	129,683	54,603	275,287	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	2,551	1,074	3,625	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	120,931	37,706	15,876	174,513	54.00
60.00	06000	LABORATORY	0	38,758	16,319	55,077	60.00
65.00	06500	RESPIRATORY THERAPY	10,246	35,661	15,015	60,922	65.00
66.00	06600	PHYSICAL THERAPY	0	30,709	12,930	43,639	66.00
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	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	38,789	50,460	21,246	110,495	76.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	108,761	45,794	154,555	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS							
101.00	10100	HOME HEALTH AGENCY	6,665	0	0	6,665	101.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	483,237	1,442,941	607,554	2,533,732	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	182,412	0	0	182,412	192.00
194.00	07950	OTHER NONREIMBURSABLE - GRANT	3,612	0	0	3,612	194.00
194.01	07951	OTHER NONREIMBURSABLE - TRANSPORTATI	0	5,151	2,169	7,320	194.01
200.00		Cross Foot Adjustments				0	200.00
201.00		Negative Cost Centers				0	201.00
202.00		TOTAL (sum lines 118 through 201)	669,261	1,448,092	609,723	2,727,076	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0077

Period:
From 01/01/2020
To 12/31/2020Worksheet B
Part II
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Cost Center Description			ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
			5.00	6.00	7.00	8.00	9.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	250,603					5.00
6.00	00600	MAINTENANCE & REPAIRS	7,489	105,867				6.00
7.00	00700	OPERATION OF PLANT	18,840	18,352	361,724			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	891	911	3,766	21,339		8.00
9.00	00900	HOUSEKEEPING	7,634	1,770	7,317	0	47,690	9.00
10.00	01000	DIETARY	3,217	5,046	20,859	0	176	10.00
11.00	01100	CAFETERIA	4,212	1,829	7,560	0	706	11.00
13.00	01300	NURSING ADMINISTRATION	4,940	2,891	11,950	0	706	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	916	1,500	6,201	0	529	14.00
15.00	01500	PHARMACY	4,028	1,256	5,193	0	441	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	6,173	2,186	9,037	0	441	16.00
17.00	01700	SOCIAL SERVICE	866	388	1,602	0	265	17.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	52,597	32,444	134,086	10,457	17,842	30.00
43.00	04300	NURSERY	741	1,176	4,862	0	0	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	15,932	10,659	44,057	640	7,507	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	276	210	867	0	0	52.00
53.00	05300	ANESTHESIOLOGY	67	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	14,864	3,099	12,810	3,201	2,737	54.00
60.00	06000	LABORATORY	19,388	3,186	13,167	0	1,325	60.00
65.00	06500	RESPIRATORY THERAPY	6,550	2,931	12,115	213	1,325	65.00
66.00	06600	PHYSICAL THERAPY	2,724	2,524	10,433	1,067	1,502	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	930	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1,110	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	6,735	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	193	0	0	0	0	74.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	6,328	4,147	17,143	0	1,766	76.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	22,609	8,939	36,949	5,761	8,832	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
OTHER REIMBURSABLE COST CENTERS								
101.00	10100	HOME HEALTH AGENCY	5,962	0	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	216,212	105,444	359,974	21,339	46,100	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	31,617	0	0	0	1,325	192.00
194.00	07950	OTHER NONREIMBURSABLE - GRANT	1,022	0	0	0	0	194.00
194.01	07951	OTHER NONREIMBURSABLE - TRANSPORTATI	1,752	423	1,750	0	265	194.01
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)	250,603	105,867	361,724	21,339	47,690	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0077

Period:
From 01/01/2020
To 12/31/2020Worksheet B
Part II
Date/Time Prepared:
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Cost Center Description			DIETARY	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	
			10.00	11.00	13.00	14.00	15.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY	116,637					10.00
11.00	01100	CAFETERIA	0	46,116				11.00
13.00	01300	NURSING ADMINISTRATION	0	1,278	72,071			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	514	1,322	36,970		14.00
15.00	01500	PHARMACY	0	1,326	0	27	108,455	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	2,984	0	17	0	16.00
17.00	01700	SOCIAL SERVICE	0	323	0	3	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	116,637	14,954	37,262	6,203	906	30.00
43.00	04300	NURSERY	0	170	437	20	10	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	3,270	8,404	3,188	1,417	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	28	71	74	17	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	474	9	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	4,055	0	1,009	1,911	54.00
60.00	06000	LABORATORY	0	2,725	0	1,535	182	60.00
65.00	06500	RESPIRATORY THERAPY	0	1,771	0	1,127	844	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	151	0	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	6,909	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	8,242	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	95,168	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	11	4	74.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	1,702	4,376	64	0	76.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	6,433	16,532	6,641	3,688	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
OTHER REIMBURSABLE COST CENTERS								
101.00	10100	HOME HEALTH AGENCY	0	0	3,667	288	25	101.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	116,637	41,533	72,071	35,983	104,181	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	2,327	0	926	4,274	192.00
194.00	07950	OTHER NONREIMBURSABLE - GRANT	0	596	0	1	0	194.00
194.01	07951	OTHER NONREIMBURSABLE - TRANSPORTATI	0	1,660	0	60	0	194.01
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)	116,637	46,116	72,071	36,970	108,455	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0077

Period:
From 01/01/2020
To 12/31/2020Worksheet B
Part II
Date/Time Prepared:
7/24/2021 3:36 pm

Cost Center Description			MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			16.00	17.00	24.00	25.00	26.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY						15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	59,022					16.00
17.00	01700	SOCIAL SERVICE	0	10,202				17.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	51,849	5,668	1,047,655	0	1,047,655	30.00
43.00	04300	NURSERY	64	66	27,925	0	27,925	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	1,278	372,337	0	372,337	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	11	5,186	0	5,186	52.00
53.00	05300	ANESTHESIOLOGY	0	0	550	0	550	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	218,996	0	218,996	54.00
60.00	06000	LABORATORY	0	0	96,941	0	96,941	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	88,118	0	88,118	65.00
66.00	06600	PHYSICAL THERAPY	0	0	62,040	0	62,040	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	7,839	0	7,839	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	9,352	0	9,352	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	102,225	0	102,225	73.00
74.00	07400	RENAL DIALYSIS	0	0	208	0	208	74.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	665	146,971	0	146,971	76.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	7,109	2,514	281,847	0	281,847	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				0		92.00
OTHER REIMBURSABLE COST CENTERS								
101.00	10100	HOME HEALTH AGENCY	0	0	16,917	0	16,917	101.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	59,022	10,202	2,485,107	0	2,485,107	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	223,293	0	223,293	192.00
194.00	07950	OTHER NONREIMBURSABLE - GRANT	0	0	5,301	0	5,301	194.00
194.01	07951	OTHER NONREIMBURSABLE - TRANSPORTATI	0	0	13,375	0	13,375	194.01
200.00		Cross Foot Adjustments			0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	59,022	10,202	2,727,076	0	2,727,076	202.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0077

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

Worksheet B-1

Date/Time Prepared:
7/24/2021 3:36 pm

Cost Center Description			CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
			BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (SQUARE FEET)				
			1.00	2.00	4.00	5A	5.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT	145,900					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		145,900				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	931	931	21,352,205			4.00
5.00	00500	ADMINISTRATIVE & GENERAL	8,248	8,248	4,575,018	-12,459,416	36,379,789	5.00
6.00	00600	MAINTENANCE & REPAIRS	6,949	6,949	598,227	0	1,087,143	6.00
7.00	00700	OPERATION OF PLANT	22,496	22,496	1,318,049	0	2,734,739	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	1,117	1,117	27,553	0	129,391	8.00
9.00	00900	HOUSEKEEPING	2,170	2,170	588,751	0	1,108,112	9.00
10.00	01000	DIETARY	6,186	6,186	144,290	0	466,917	10.00
11.00	01100	CAFETERIA	2,242	2,242	305,072	0	611,437	11.00
13.00	01300	NURSING ADMINISTRATION	3,544	3,544	520,517	0	717,156	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	1,839	1,839	81,519	0	132,958	14.00
15.00	01500	PHARMACY	1,540	1,540	0	0	584,687	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	2,680	2,680	624,989	0	896,009	16.00
17.00	01700	SOCIAL SERVICE	475	475	91,023	0	125,658	17.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	39,766	39,766	4,268,197	0	7,637,353	30.00
43.00	04300	NURSERY	1,442	1,442	67,238	0	107,588	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	13,066	13,066	1,135,297	0	2,312,731	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	257	257	11,262	0	40,101	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	9,768	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,799	3,799	1,295,598	0	2,157,652	54.00
60.00	06000	LABORATORY	3,905	3,905	578,075	0	2,814,341	60.00
65.00	06500	RESPIRATORY THERAPY	3,593	3,593	521,041	0	950,729	65.00
66.00	06600	PHYSICAL THERAPY	3,094	3,094	0	0	395,351	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	135,021	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	161,171	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	523,037	0	977,653	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	28,042	74.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	5,084	5,084	462,719	0	918,560	76.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	10,958	10,958	2,088,698	0	3,281,899	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
OTHER REIMBURSABLE COST CENTERS								
101.00	10100	HOME HEALTH AGENCY	0	0	504,864	0	865,366	101.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	145,381	145,381	20,331,034	-12,459,416	31,387,533	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	670,425	0	4,589,535	192.00
194.00	07950	OTHER NONREIMBURSABLE - GRANT	0	0	114,580	0	148,402	194.00
194.01	07951	OTHER NONREIMBURSABLE - TRANSPORTATI	519	519	236,166	0	254,319	194.01
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	1,448,092	609,723	3,945,886		12,459,416	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	9.925236	4.179047	0.184800		0.342482	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)			13,131		250,603	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)			0.000615		0.006889	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: 14-0077

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

Worksheet B-1

Date/Time Prepared:
7/24/2021 3:36 pm

Cost Center Description			MAINTENANCE & REPAIRS (SQUARE FEET)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (HOURS OF SERVICE)	DIETARY (MEALS SERVED)	
			6.00	7.00	8.00	9.00	10.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS	129,772					6.00
7.00	00700	OPERATION OF PLANT	22,496	107,276				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	1,117	1,117	134,053			8.00
9.00	00900	HOUSEKEEPING	2,170	2,170	0	34,045		9.00
10.00	01000	DIETARY	6,186	6,186	0	126	22,065	10.00
11.00	01100	CAFETERIA	2,242	2,242	0	504	0	11.00
13.00	01300	NURSING ADMINISTRATION	3,544	3,544	0	504	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	1,839	1,839	0	378	0	14.00
15.00	01500	PHARMACY	1,540	1,540	0	315	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	2,680	2,680	0	315	0	16.00
17.00	01700	SOCIAL SERVICE	475	475	0	189	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	39,766	39,766	65,685	12,736	22,065	30.00
43.00	04300	NURSERY	1,442	1,442	0	0	0	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	13,066	13,066	4,022	5,359	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	257	257	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,799	3,799	20,108	1,954	0	54.00
60.00	06000	LABORATORY	3,905	3,905	0	946	0	60.00
65.00	06500	RESPIRATORY THERAPY	3,593	3,593	1,341	946	0	65.00
66.00	06600	PHYSICAL THERAPY	3,094	3,094	6,703	1,072	0	66.00
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	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	5,084	5,084	0	1,261	0	76.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	10,958	10,958	36,194	6,305	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
OTHER REIMBURSABLE COST CENTERS								
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	129,253	106,757	134,053	32,910	22,065	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	946	0	192.00
194.00	07950	OTHER NONREIMBURSABLE - GRANT	0	0	0	0	0	194.00
194.01	07951	OTHER NONREIMBURSABLE - TRANSPORTATI	519	519	0	189	0	194.01
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	1,459,470	3,924,337	227,129	1,591,407	928,582	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	11.246417	36.581686	1.694322	46.744221	42.083934	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	105,867	361,724	21,339	47,690	116,637	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.815792	3.371901	0.159183	1.400793	5.286064	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: 14-0077

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

Worksheet B-1

Date/Time Prepared:
7/24/2021 3:36 pm

Cost Center Description			CAFETERIA (MEALS SERVED)	NURSING ADMINISTRATION (DIRECT NURS. HRS.)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (TIME SPENT)	
			11.00	13.00	14.00	15.00	16.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA	26,302					11.00
13.00	01300	NURSING ADMINISTRATION	729	270,835				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	293	4,968	722,896			14.00
15.00	01500	PHARMACY	756	0	519	457,344		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,702	0	332	0	28,810	16.00
17.00	01700	SOCIAL SERVICE	184	0	52	0	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	8,529	140,027	121,297	3,822	25,309	30.00
43.00	04300	NURSERY	97	1,642	400	42	31	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	1,865	31,582	62,330	5,975	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	16	265	1,452	70	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	9,261	36	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,313	0	19,738	8,057	0	54.00
60.00	06000	LABORATORY	1,554	0	30,006	767	0	60.00
65.00	06500	RESPIRATORY THERAPY	1,010	0	22,044	3,558	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	2,945	0	0	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	135,087	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	161,171	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	401,318	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	221	18	0	74.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	971	16,444	1,257	0	0	76.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	3,669	62,126	129,854	15,553	3,470	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
OTHER REIMBURSABLE COST CENTERS								
101.00	10100	HOME HEALTH AGENCY	0	13,781	5,635	105	0	101.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	23,688	270,835	703,601	439,321	28,810	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	1,327	0	18,105	18,023	0	192.00
194.00	07950	OTHER NONREIMBURSABLE - GRANT	340	0	12	0	0	194.00
194.01	07951	OTHER NONREIMBURSABLE - TRANSPORTATI	947	0	1,178	0	0	194.01
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)	951,632	1,182,206	316,406	900,891	1,407,504	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	36.180975	4.365041	0.437692	1.969832	48.854703	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	46,116	72,071	36,970	108,455	59,022	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	1.753327	0.266107	0.051142	0.237141	2.048664	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: 14-0077

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

Worksheet B-1

Date/Time Prepared:
7/24/2021 3:36 pm

Cost Center Description			SOCIAL SERVICE (TIME SPENT)	
			17.00	
GENERAL SERVICE COST CENTERS				
1.00	00100	CAP REL COSTS-BLDG & FIXT		1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT		4.00
5.00	00500	ADMINISTRATIVE & GENERAL		5.00
6.00	00600	MAINTENANCE & REPAIRS		6.00
7.00	00700	OPERATION OF PLANT		7.00
8.00	00800	LAUNDRY & LINEN SERVICE		8.00
9.00	00900	HOUSEKEEPING		9.00
10.00	01000	DIETARY		10.00
11.00	01100	CAFETERIA		11.00
13.00	01300	NURSING ADMINISTRATION		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY		14.00
15.00	01500	PHARMACY		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY		16.00
17.00	01700	SOCIAL SERVICE	252,086	17.00
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	140,027	30.00
43.00	04300	NURSERY	1,642	43.00
ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	31,582	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	265	52.00
53.00	05300	ANESTHESIOLOGY	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	54.00
60.00	06000	LABORATORY	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	65.00
66.00	06600	PHYSICAL THERAPY	0	66.00
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	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	16,444	76.00
OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0	90.00
91.00	09100	EMERGENCY	62,126	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)		92.00
OTHER REIMBURSABLE COST CENTERS				
101.00	10100	HOME HEALTH AGENCY	0	101.00
SPECIAL PURPOSE COST CENTERS				
113.00	11300	INTEREST EXPENSE		113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	252,086	118.00
NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	192.00
194.00	07950	OTHER NONREIMBURSABLE - GRANT	0	194.00
194.01	07951	OTHER NONREIMBURSABLE - TRANSPORTATI	0	194.01
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)	206,927	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.820859	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	10,202	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.040470	205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)		206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)		207.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0077

Period:
From 01/01/2020
To 12/31/2020Worksheet C
Part I
Date/Time Prepared:
7/24/2021 3:36 pm

				Title XVIII		Hospital		PPS	
Cost Center Description			Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs				
					Total Costs	RCE		Total Costs	
						Disallowance			
			1.00	2.00	3.00	4.00	5.00		
INPATIENT ROUTINE SERVICE COST CENTERS									
30.00	03000	ADULTS & PEDIATRICS	16,121,983		16,121,983	3,259	16,125,242	30.00	
43.00	04300	NURSERY	227,200		227,200	0	227,200	43.00	
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM	4,257,349		4,257,349	0	4,257,349	50.00	
52.00	05200	DELIVERY ROOM & LABOR ROOM	68,854		68,854	0	68,854	52.00	
53.00	05300	ANESTHESIOLOGY	17,237		17,237	0	17,237	53.00	
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,311,912		3,311,912	0	3,311,912	54.00	
60.00	06000	LABORATORY	4,080,059		4,080,059	0	4,080,059	60.00	
65.00	06500	RESPIRATORY THERAPY	1,547,875	0	1,547,875	0	1,547,875	65.00	
66.00	06600	PHYSICAL THERAPY	741,488	0	741,488	0	741,488	66.00	
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	240,389		240,389	0	240,389	71.00	
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	286,915		286,915	0	286,915	72.00	
73.00	07300	DRUGS CHARGED TO PATIENTS	2,103,010		2,103,010	0	2,103,010	73.00	
74.00	07400	RENAL DIALYSIS	37,778		37,778	0	37,778	74.00	
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	1,656,211		1,656,211	3,632	1,659,843	76.00	
OUTPATIENT SERVICE COST CENTERS									
90.00	09000	CLINIC	0		0	0	0	90.00	
91.00	09100	EMERGENCY	5,997,963		5,997,963	0	5,997,963	91.00	
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1,479,891		1,479,891		1,479,891	92.00	
OTHER REIMBURSABLE COST CENTERS									
101.00	10100	HOME HEALTH AGENCY	1,224,566		1,224,566		1,224,566	101.00	
SPECIAL PURPOSE COST CENTERS									
113.00	11300	INTEREST EXPENSE						113.00	
200.00		Subtotal (see instructions)	43,400,680	0	43,400,680	6,891	43,407,571	200.00	
201.00		Less Observation Beds	1,479,891		1,479,891		1,479,891	201.00	
202.00		Total (see instructions)	41,920,789	0	41,920,789	6,891	41,927,680	202.00	

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0077

Period:
From 01/01/2020
To 12/31/2020Worksheet C
Part I
Date/Time Prepared:
7/24/2021 3:36 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	9,695,326		9,695,326			30.00	
43.00	04300	NURSERY	11,155		11,155			43.00	
	ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	101,467	1,378,567	1,480,034	2.876521	0.000000	50.00	
52.00	05200	DELIVERY ROOM & LABOR ROOM	8,742	9,732	18,474	3.727076	0.000000	52.00	
53.00	05300	ANESTHESIOLOGY	32,416	460,695	493,111	0.034956	0.000000	53.00	
54.00	05400	RADIOLOGY-DIAGNOSTIC	403,974	4,894,485	5,298,459	0.625071	0.000000	54.00	
60.00	06000	LABORATORY	1,513,351	13,197,211	14,710,562	0.277356	0.000000	60.00	
65.00	06500	RESPIRATORY THERAPY	182,577	770,012	952,589	1.624914	0.000000	65.00	
66.00	06600	PHYSICAL THERAPY	16,091	945,791	961,882	0.770872	0.000000	66.00	
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	66,867	463,981	530,848	0.452840	0.000000	71.00	
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	11,947	164,256	176,203	1.628321	0.000000	72.00	
73.00	07300	DRUGS CHARGED TO PATIENTS	302,500	519,411	821,911	2.558683	0.000000	73.00	
74.00	07400	RENAL DIALYSIS	4,326	3,090	7,416	5.094121	0.000000	74.00	
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	804,619	804,619	2.058379	0.000000	76.00	
	OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0	0.000000	0.000000	90.00	
91.00	09100	EMERGENCY	906,473	7,033,485	7,939,958	0.755415	0.000000	91.00	
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	483,230	483,230	3.062498	0.000000	92.00	
	OTHER REIMBURSABLE COST CENTERS								
101.00	10100	HOME HEALTH AGENCY	0	559,026	559,026			101.00	
	SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00	
200.00		Subtotal (see instructions)	13,257,212	31,687,591	44,944,803			200.00	
201.00		Less Observation Beds						201.00	
202.00		Total (see instructions)	13,257,212	31,687,591	44,944,803			202.00	

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0077

Period:
From 01/01/2020
To 12/31/2020Worksheet C
Part I
Date/Time Prepared:
7/24/2021 3:36 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
43.00	04300	NURSERY			43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	2.876521		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	3.727076		52.00
53.00	05300	ANESTHESIOLOGY	0.034956		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.625071		54.00
60.00	06000	LABORATORY	0.277356		60.00
65.00	06500	RESPIRATORY THERAPY	1.624914		65.00
66.00	06600	PHYSICAL THERAPY	0.770872		66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.452840		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1.628321		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2.558683		73.00
74.00	07400	RENAL DIALYSIS	5.094121		74.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	2.062893		76.00
OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	0.000000		90.00
91.00	09100	EMERGENCY	0.755415		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	3.062498		92.00
OTHER REIMBURSABLE COST CENTERS					
101.00	10100	HOME HEALTH AGENCY			101.00
SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE			113.00
200.00		Subtotal (see instructions)			200.00
201.00		Less Observation Beds			201.00
202.00		Total (see instructions)			202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

Provider CCN: 14-0077

Period:
From 01/01/2020
To 12/31/2020Worksheet D
Part I
Date/Time Prepared:
7/24/2021 3:36 pm

Cost Center Description			Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)	
			1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	ADULTS & PEDIATRICS		1,047,655	0	1,047,655	7,246	144.58	30.00
43.00	NURSERY		27,925		27,925	12	2,327.08	43.00
200.00	Total (lines 30 through 199)		1,075,580		1,075,580	7,258		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		1,104	159,616				
43.00	NURSERY		0	0				
200.00	Total (lines 30 through 199)		1,104	159,616	200.00			

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 14-0077

Period:
From 01/01/2020
To 12/31/2020Worksheet D
Part II
Date/Time Prepared:
7/24/2021 3:36 pm

Cost Center Description			Title XVIII		Hospital	PPS	
			Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)
			1.00	2.00	3.00	4.00	5.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	372,337	1,480,034	0.251573	11,572	2,911
52.00	05200	DELIVERY ROOM & LABOR ROOM	5,186	18,474	0.280719	0	0
53.00	05300	ANESTHESIOLOGY	550	493,111	0.001115	3,984	4
54.00	05400	RADIOLOGY-DIAGNOSTIC	218,996	5,298,459	0.041332	70,497	2,914
60.00	06000	LABORATORY	96,941	14,710,562	0.006590	238,615	1,572
65.00	06500	RESPIRATORY THERAPY	88,118	952,589	0.092504	52,045	4,814
66.00	06600	PHYSICAL THERAPY	62,040	961,882	0.064499	4,312	278
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	7,839	530,848	0.014767	25,766	380
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	9,352	176,203	0.053075	1,351	72
73.00	07300	DRUGS CHARGED TO PATIENTS	102,225	821,911	0.124375	58,542	7,281
74.00	07400	RENAL DIALYSIS	208	7,416	0.028047	1,236	35
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	146,971	804,619	0.182659	0	0
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0	0	0.000000	0	0
91.00	09100	EMERGENCY	281,847	7,939,958	0.035497	169,303	6,010
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	96,149	483,230	0.198972	0	0
200.00		Total (lines 50 through 199)	1,488,759	34,679,296		637,223	26,271

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS					Provider CCN: 14-0077		Period: From 01/01/2020 To 12/31/2020		Worksheet D Part III Date/Time Prepared: 7/24/2021 3:36 pm	
					Title XVIII		Hospital		PPS	
Cost Center Description			Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health Cost	All Other Medical Education Cost			
			1A	1.00	2A	2.00	3.00			
INPATIENT ROUTINE SERVICE COST CENTERS										
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	0	30.00		
43.00	04300	NURSERY	0	0	0	0	0	43.00		
200.00		Total (lines 30 through 199)	0	0	0	0	0	200.00		
Cost Center Description			Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of 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	7,246	0.00	1,104	30.00		
43.00	04300	NURSERY		0	12	0.00	0	43.00		
200.00		Total (lines 30 through 199)		0	7,258		1,104	200.00		
Cost Center Description			Inpatient Program Pass-Through Cost (col. 7 x col. 8)	PSA Adj. All Other Medical Education Cost						
			9.00	13.00						
INPATIENT ROUTINE SERVICE COST CENTERS										
30.00	03000	ADULTS & PEDIATRICS	0	0					30.00	
43.00	04300	NURSERY	0	0					43.00	
200.00		Total (lines 30 through 199)	0	0					200.00	

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

Provider CCN: 14-0077

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

Worksheet D
Part IV
Date/Time Prepared:
7/24/2021 3:36 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
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
60.00	06000	LABORATORY	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	66.00
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	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	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	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

Provider CCN: 14-0077

Period:
From 01/01/2020
To 12/31/2020Worksheet D
Part IV
Date/Time Prepared:
7/24/2021 3:36 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	1,480,034	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	18,474	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	493,111	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	5,298,459	0.000000	54.00
60.00	06000	LABORATORY	0	0	0	14,710,562	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	952,589	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	961,882	0.000000	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	530,848	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	176,203	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	821,911	0.000000	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	7,416	0.000000	74.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0	0	804,619	0.000000	76.00
	OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0	0	0	0	0.000000	90.00
91.00	09100	EMERGENCY	0	0	0	7,939,958	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	483,230	0.000000	92.00
200.00		Total (lines 50 through 199)	0	0	0	34,679,296		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-0077

Period:
From 01/01/2020
To 12/31/2020Worksheet D
Part IV
Date/Time Prepared:
7/24/2021 3:36 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	11,572	0	147,958	0
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	0	1,035	0
53.00	05300	ANESTHESIOLOGY	0.000000	3,984	0	39,588	0
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	70,497	0	363,538	0
60.00	06000	LABORATORY	0.000000	238,615	0	251,315	0
65.00	06500	RESPIRATORY THERAPY	0.000000	52,045	0	67,525	0
66.00	06600	PHYSICAL THERAPY	0.000000	4,312	0	365	0
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	25,766	0	54,349	0
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	1,351	0	18,088	0
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	58,542	0	44,315	0
74.00	07400	RENAL DIALYSIS	0.000000	1,236	0	1,624	0
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0.000000	0	0	25,022	0
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0.000000	0	0	0	0
91.00	09100	EMERGENCY	0.000000	169,303	0	485,316	0
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	0	0	46,475	0
200.00		Total (lines 50 through 199)		637,223	0	1,546,513	0

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

Provider CCN: 14-0077

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

Worksheet D
Part IV
Date/Time Prepared:
7/24/2021 3:36 pm

				Title XVIII		Hospital		PPS		
Cost Center Description				PSA Adj. Non Physician Anesthetist Cost	PSA Adj. All Other Medical Education Cost					
				21.00	24.00					
	ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM		0	0				50.00	
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	
60.00	06000	LABORATORY		0	0				60.00	
65.00	06500	RESPIRATORY THERAPY		0	0				65.00	
66.00	06600	PHYSICAL THERAPY		0	0				66.00	
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS		0	0				71.00	
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS		0	0				72.00	
73.00	07300	DRUGS CHARGED TO PATIENTS		0	0				73.00	
74.00	07400	RENAL DIALYSIS		0	0				74.00	
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES		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		Total (lines 50 through 199)		0	0				200.00	

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-0077

Period:
From 01/01/2020
To 12/31/2020Worksheet D
Part V
Date/Time Prepared:
7/24/2021 3:36 pm

				Title XVIII		Hospital		PPS	
Cost Center Description			Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges		Costs		PPS Services (see inst.)	
				PPS Reimbursed Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)			
			1.00	2.00	3.00	4.00	5.00		
	ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	2.876521	147,958	0	0	425,604	50.00	
52.00	05200	DELIVERY ROOM & LABOR ROOM	3.727076	1,035	0	0	3,858	52.00	
53.00	05300	ANESTHESIOLOGY	0.034956	39,588	0	1,384	53.00	53.00	
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.625071	363,538	0	0	227,237	54.00	
60.00	06000	LABORATORY	0.277356	251,315	0	0	69,704	60.00	
65.00	06500	RESPIRATORY THERAPY	1.624914	67,525	0	0	109,722	65.00	
66.00	06600	PHYSICAL THERAPY	0.770872	365	0	0	281	66.00	
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.452840	54,349	0	0	24,611	71.00	
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1.628321	18,088	0	0	29,453	72.00	
73.00	07300	DRUGS CHARGED TO PATIENTS	2.558683	44,315	0	756	113,388	73.00	
74.00	07400	RENAL DIALYSIS	5.094121	1,624	0	0	8,273	74.00	
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	2.058379	25,022	0	0	51,505	76.00	
OUTPATIENT SERVICE COST CENTERS									
90.00	09000	CLINIC	0.000000	0	0	0	0	90.00	
91.00	09100	EMERGENCY	0.755415	485,316	0	0	366,615	91.00	
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	3.062498	46,475	0	0	142,330	92.00	
200.00		Subtotal (see instructions)		1,546,513	0	756	1,573,965	200.00	
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00	
202.00		Net Charges (line 200 - line 201)		1,546,513	0	756	1,573,965	202.00	

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST				Provider CCN: 14-0077		Period: From 01/01/2020 To 12/31/2020		Worksheet D Part V Date/Time Prepared: 7/24/2021 3:36 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
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
60.00	06000	LABORATORY	0	0					60.00
65.00	06500	RESPIRATORY THERAPY	0	0					65.00
66.00	06600	PHYSICAL THERAPY	0	0					66.00
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	1,934					73.00
74.00	07400	RENAL DIALYSIS	0	0					74.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	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	1,934					200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0						201.00
202.00		Net Charges (line 200 - line 201)	0	1,934					202.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-0077	Period: From 01/01/2020 To 12/31/2020	Worksheet D-1 Date/Time Prepared: 7/24/2021 3:36 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)		7,246	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		7,246	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)		6,581	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)		1,104	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)		0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period		0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)		0	14.00
15.00	Total nursery days (title V or XIX only)		0	15.00
16.00	Nursery days (title V or XIX only)		0	16.00
SWING BED ADJUSTMENT				
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period		0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)		16,125,242	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)		0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)		0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)		0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)		0	25.00
26.00	Total swing-bed cost (see instructions)		0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)		16,125,242	27.00
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)		0	28.00
29.00	Private room charges (excluding swing-bed charges)		0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)		0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)		0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)		0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)		0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)		0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)		0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)		16,125,242	37.00
PART II - HOSPITAL AND SUBPROVIDERS ONLY				
PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS				
38.00	Adjusted general inpatient routine service cost per diem (see instructions)		2,225.40	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		2,456,842	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)		2,456,842	41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-0077

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

Worksheet D-1

Date/Time Prepared:
7/24/2021 3:36 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					
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)					529,414
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					2,986,256
	PASS THROUGH COST ADJUSTMENTS					
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)					159,616
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					26,271
52.00	Total Program excludable cost (sum of lines 50 and 51)					185,887
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					2,800,369
	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)					
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)					
72.00	Program routine service cost (line 9 x line 71)					
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)					
74.00	Total Program general inpatient routine service costs (line 72 + line 73)					
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)					
76.00	Per diem capital-related costs (line 75 ÷ line 2)					
77.00	Program capital-related costs (line 9 x line 76)					
78.00	Inpatient routine service cost (line 74 minus line 77)					
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)					
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)					
81.00	Inpatient routine service cost per diem limitation					
82.00	Inpatient routine service cost limitation (line 9 x line 81)					
83.00	Reasonable inpatient routine service costs (see instructions)					
84.00	Program inpatient ancillary services (see instructions)					
85.00	Utilization review - physician compensation (see instructions)					
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)					
	PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST					
87.00	Total observation bed days (see instructions)					665
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					2,225.40
89.00	Observation bed cost (line 87 x line 88) (see instructions)					1,479,891

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-0077

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

Worksheet D-1

Date/Time Prepared:
7/24/2021 3:36 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	1,047,655	16,125,242	0.064970	1,479,891	96,149	90.00
91.00 Nursing School cost	0	16,125,242	0.000000	1,479,891	0	91.00
92.00 Allied health cost	0	16,125,242	0.000000	1,479,891	0	92.00
93.00 All other Medical Education	0	16,125,242	0.000000	1,479,891	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT			Provider CCN: 14-0077	Period: From 01/01/2020 To 12/31/2020	Worksheet D-3 Date/Time Prepared: 7/24/2021 3:36 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		1,588,294		30.00
43.00	04300	NURSERY				43.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2.876521	11,572	33,287	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	3.727076	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.034956	3,984	139	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.625071	70,497	44,066	54.00
60.00	06000	LABORATORY	0.277356	238,615	66,181	60.00
65.00	06500	RESPIRATORY THERAPY	1.624914	52,045	84,569	65.00
66.00	06600	PHYSICAL THERAPY	0.770872	4,312	3,324	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.452840	25,766	11,668	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1.628321	1,351	2,200	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2.558683	58,542	149,790	73.00
74.00	07400	RENAL DIALYSIS	5.094121	1,236	6,296	74.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	2.062893	0	0	76.00
OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.000000	0	0	90.00
91.00	09100	EMERGENCY	0.755415	169,303	127,894	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	3.062498	0	0	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		637,223	529,414	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)		637,223		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0077	Period: From 01/01/2020 To 12/31/2020	Worksheet E Part A Date/Time Prepared: 7/24/2021 3:36 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)		1,702,217		1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1 (see instructions)		0		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)		9,990		2.03
2.04	Outlier payments for discharges occurring on or after October 1 (see instructions)		0		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)		121.18		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)		or	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)			24.99	30.00
31.00	Percentage of Medicaid patient days (see instructions)			57.42	31.00
32.00	Sum of lines 30 and 31			82.41	32.00
33.00	Allowable disproportionate share percentage (see instructions)			57.20	33.00
34.00	Disproportionate share adjustment (see instructions)			243,417	34.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0077	Period: From 01/01/2020 To 12/31/2020	Worksheet E Part A Date/Time Prepared: 7/24/2021 3:36 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)		8,350,599,096	8,290,014,521	35.00
35.01	Factor 3 (see instructions)		0.000105606	0.000122775	35.01
35.02	Hospital uncompensated care payment (If line 34 is zero, enter zero on this line) (see instructions)		881,870	1,017,808	35.02
35.03	Pro rata share of the hospital uncompensated care payment amount (see instructions)		660,198	256,544	35.03
36.00	Total uncompensated care (sum of columns 1 and 2 on line 35.03)		916,742		36.00
Additional payment for high percentage of ESRD beneficiary discharges (lines 40 through 46)					
40.00	Total Medicare discharges, excluding MS-DRGs 652, 682, 683, 684 and 685. (see instructions)		0		40.00
41.00	Total ESRD Medicare discharges excluding MS-DRGs 652, 682, 683, 684 and 685. (see instructions)		0		41.00
41.01	Total ESRD Medicare covered and paid discharges excluding MS-DRGs 652, 682, 683, 684 and 685. (see instructions)		0		41.01
42.00	Divide line 41 by line 40 (if less than 10%, you do not qualify for adjustment)		0.00		42.00
43.00	Total Medicare ESRD inpatient days excluding MS-DRGs 652, 682, 683, 684 and 685. (see instructions)		0		43.00
44.00	Ratio of average length of stay to one week (line 43 divided by line 41 divided by 7 days)		0.000000		44.00
45.00	Average weekly cost for dialysis treatments (see instructions)		0.00		45.00
46.00	Total additional payment (line 45 times line 44 times line 41.01)		0		46.00
47.00	Subtotal (see instructions)		2,872,366		47.00
48.00	Hospital specific payments (to be completed by SCH and MDH, small rural hospitals only. (see instructions)		0		48.00
				Amount	
				1.00	
49.00	Total payment for inpatient operating costs (see instructions)			2,872,366	49.00
50.00	Payment for inpatient program capital (from Wkst. L, Pt. I and Pt. II, as applicable)			160,716	50.00
51.00	Exception payment for inpatient program capital (Wkst. L, Pt. III, see instructions)			0	51.00
52.00	Direct graduate medical education payment (from Wkst. E-4, line 49 see instructions).			0	52.00
53.00	Nursing and Allied Health Managed Care payment			0	53.00
54.00	Special add-on payments for new technologies			0	54.00
54.01	Islet isolation add-on payment			0	54.01
55.00	Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line 69)			0	55.00
56.00	Cost of physicians' services in a teaching hospital (see instructions)			0	56.00
57.00	Routine service other pass through costs (from Wkst. D, Pt. III, column 9, lines 30 through 35).			0	57.00
58.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 11 line 200)			0	58.00
59.00	Total (sum of amounts on lines 49 through 58)			3,033,082	59.00
60.00	Primary payer payments			0	60.00
61.00	Total amount payable for program beneficiaries (line 59 minus line 60)			3,033,082	61.00
62.00	Deductibles billed to program beneficiaries			209,572	62.00
63.00	Coinurance billed to program beneficiaries			29,920	63.00
64.00	Allowable bad debts (see instructions)			105,558	64.00
65.00	Adjusted reimbursable bad debts (see instructions)			68,613	65.00
66.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			105,558	66.00
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)			2,862,203	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)			25,915	70.93
70.94	HRR adjustment amount (see instructions)			-640	70.94
70.95	Recovery of accelerated depreciation			0	70.95

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0077	Period: From 01/01/2020 To 12/31/2020	Worksheet E Part A Date/Time Prepared: 7/24/2021 3:36 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)		2,887,478	71.00
71.01	Sequestration adjustment (see instructions)		19,057	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		2,607,031	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)		261,390	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		0	75.00
TO BE COMPLETED BY CONTRACTOR (lines 90 through 96)				
90.00	Operating outlier amount from Wkst. E, Pt. A, line 2, or sum of 2.03 plus 2.04 (see instructions)		0	90.00
91.00	Capital outlier from Wkst. L, Pt. I, line 2		0	91.00
92.00	Operating outlier reconciliation adjustment amount (see instructions)		0	92.00
93.00	Capital outlier reconciliation adjustment amount (see instructions)		0	93.00
94.00	The rate used to calculate the time value of money (see instructions)		0.00	94.00
95.00	Time value of money for operating expenses (see instructions)		0	95.00
96.00	Time value of money for capital related expenses (see instructions)		0	96.00
		Prior to 10/1	On/After 10/1	
		1.00	2.00	
HSP Bonus Payment Amount				
100.00	HSP bonus amount (see instructions)		0	100.00
HVBP Adjustment for HSP Bonus Payment				
101.00	HVBP adjustment factor (see instructions)	0.0000000000	0.0000000000	101.00
102.00	HVBP adjustment amount for HSP bonus payment (see instructions)		0	102.00
HRR Adjustment for HSP Bonus Payment				
103.00	HRR adjustment factor (see instructions)	0.0000	0.0000	103.00
104.00	HRR adjustment amount for HSP bonus payment (see instructions)		0	104.00
Rural Community Hospital Demonstration Project (§410A Demonstration) Adjustment				
200.00	Is this the first year of the current 5-year demonstration period under the 21st Century Cures Act? Enter "Y" for yes or "N" for no.			200.00
Cost Reimbursement				
201.00	Medicare inpatient service costs (from Wkst. D-1, Pt. II, line 49)			201.00
202.00	Medicare discharges (see instructions)			202.00
203.00	Case-mix adjustment factor (see instructions)			203.00
Computation of Demonstration Target Amount Limitation (N/A in first year of the current 5-year demonstration period)				
204.00	Medicare target amount			204.00
205.00	Case-mix adjusted target amount (line 203 times line 204)			205.00
206.00	Medicare inpatient routine cost cap (line 202 times line 205)			206.00
Adjustment to Medicare Part A Inpatient Reimbursement				
207.00	Program reimbursement under the §410A Demonstration (see instructions)			207.00
208.00	Medicare Part A inpatient service costs (from Wkst. E, Pt. A, line 59)			208.00
209.00	Adjustment to Medicare IPPS payments (see instructions)			209.00
210.00	Reserved for future use			210.00
211.00	Total adjustment to Medicare IPPS payments (see instructions)			211.00
Comparison of PPS versus Cost Reimbursement				
212.00	Total adjustment to Medicare Part A IPPS payments (from line 211)			212.00
213.00	Low-volume adjustment (see instructions)			213.00
218.00	Net Medicare Part A IPPS adjustment (difference between PPS and cost reimbursement) (line 212 minus line 213) (see instructions)			218.00

CALCULATION OF DSH PAYMENT PERCENTAGE

Provider CCN: 14-0077

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

Worksheet DSH

Date/Time Prepared:
7/24/2021 3:36 pm

		Title XVIII		Hospital		PPS	
		Original .mcrcx Values	Adjusted .mcrcx Values	HFS Look Up	Override Value	Revised Value	
		1.00	2.00	3.00	4.00	5.00	
CALCULATION OF THE DSH PAYMENT PERCENTAGE							
1.00	Percentage of SSI patient days to Medicare Part A days (Previous from E, Part A, line 30 - Revised from CMS)	24.99	0.00	0.00	0.00	0.00	1.00
2.00	Percentage of Medicaid patient days to total days (From line 27)	57.42	0.00			57.42	2.00
3.00	Sum of lines 1 and 2, if less than 15% DSH Payment Percentage = 0	82.41	0.00			57.42	3.00
4.00	Provider Type * (urban, rural, SCH, RRC, pickle - If pickle worksheet NA)	Urban				Urban	4.00
5.00	Bed days available divided by number of days in the cost reporting period (Worksheet E, Part A, Line 4)	121.18	0.00			121.18	5.00
6.00	Disproportionate Share Payment Percentage (transferred from Worksheet E, Part A, line 33)	57.20	0.00			36.59	6.00
7.00	Qualify for Operating DSH Eligibility (DPP 15% or more)?	Yes				Yes	7.00
8.00	S-2, Line 22	Yes				Yes	8.00
9.00	Qualify for Capital DSH Eligibility (Urban with 100 or more beds)?	Yes				No	9.00
10.00	S-2, Line 45	Yes				Yes	10.00
11.00	Is the provider reimbursed under the fully prospective method? (Worksheet L, Part I, line 1 greater than -0-)	Yes				Yes	11.00
12.00	Percentage of SSI patient days to Medicare Part A days (Previous from L, Part I, line 7 - Revised from CMS)	24.99	0.00	0.00	0.00	0.00	12.00
13.00	Is this an IRF provider or a provider with an IRF excluded unit (Worksheet S-2, line 75, column 1 = "Y")	No				No	13.00
14.00	Medicare SSI ratio (Previous from E-3, Part III, line 2 - Revised from CMS)	0.00	0.00	0.00	0.00	0.00	14.00
CALCULATION OF THE PERCENTAGE OF MEDICAID DAYS TO TOTAL DAYS							
15.00	In-State Medicaid paid days (Worksheet S-2, line 24, column 1)	695	0			695	15.00
16.00	In-State Medicaid eligible unpaid paid days (Worksheet S-2, line 24, column 2)	818	0			818	16.00
17.00	Out-of-State Medicaid paid days (Worksheet S-2, line 24, column 3)	151	0			151	17.00
18.00	Out-of-State Medicaid eligible unpaid days (Worksheet S-2, line 24, column 4)	63	0			63	18.00
18.01	N/A	0	0			0	18.01
19.00	Medicaid HMO days (Worksheet S-2, line 24, column 5)	2,059	0			2,059	19.00
20.00	Other Medicaid days (Worksheet S-2, line 24, column 6)	0	0			0	20.00
21.00	Total Medicaid patient days for the DSH calculation (sum of lines 15-20)	3,786	0			3,786	21.00
22.00	Total patient days (Worksheet S-3, Part I, Column 8, Line 14)	6,593	0			6,593	22.00
23.00	Plus total labor room days (Worksheet S-3, Part I, Column 8, Line 32)	1	0			1	23.00
24.00	Plus total employee discount days (Worksheet S-3, Part I, Column 8, Line 30)	0	0			0	24.00
25.00	Less total Swing-bed SNF and NF patient days (Worksheet S-3, Part I, Column 8, Lines 5 and 6)	0	0			0	25.00
26.00	Total Medicaid patient days for the DSH calculation (sum of lines 22-24, less line 25)	6,594	0			6,594	26.00
27.00	Percentage of Medicaid patient days to total days (Line 21 divided by line 26)	57.42	0.00			57.42	27.00

CALCULATION OF DSH PAYMENT PERCENTAGE				Provider CCN: 14-0077		Period: From 01/01/2020 To 12/31/2020		Worksheet DSH Date/Time Prepared: 7/24/2021 3:36 pm	
				Title XVIII		Hospital		PPS	
		Original .mcrx Values		Adjusted .mcax Values		Revised			
		Condition	Percentage	Condition	Percentage	Condition			
		1.00	2.00	3.00	4.00	5.00			
CALCULATION OF MAXIMUM DSH PAYMENT PERCENTAGE									
28.00	If line 3 is greater than 20.2% - 5.88% plus 82.5% of the difference between 20.2% and line 3	True	57.20		0.00	True		28.00	
29.00	If line 3 is less than 20.2% - 2.5% plus 65% of the difference between 15% and line 3	False	0.00		0.00	False		29.00	
30.00	Line 28 or 29 as applicable		57.20		0.00			30.00	
31.00	If Urban and fewer than 100 beds, Rural and fewer than 500 beds, or an SCH with less than 100 beds the lower of line 30 or .1200, if RRC, MDH or otherwise enter line 30.		57.20		0.00			31.00	
		Original .mcrx Values	Adjusted .mcax Values	HFS Look Up	Override Value	Revised Value			
		1.00	2.00	3.00	4.00	5.00			
DETERMINATION OF PROVIDER TYPE									
32.00	Does the hospital qualify under the Pickle ammendment? (Worksheet S-2, Part I, Line 22, column 2 = "Y")	False				False		32.00	
33.00	Is This a Rural Referral Center? (Worksheet S-2, Part I, line 116, column 1 = "Y")	False				False		33.00	
34.00	Is this a Medicare Dependant Hospital? (Worksheet S-2, Part I, Line 37 greater than -0-)	False				False		34.00	
35.00	Is this a Sole Community hospital? (Worksheet S-2, Part I, Line 35 greater than -0-)	False				False		35.00	
36.00	Is this an Urban or Rural hospital? (Worksheet S-2, Part I, Line 26, Column 1, Urban=1, Rural=2)	Urban				Urban		36.00	

CALCULATION OF DSH PAYMENT PERCENTAGE		Provider CCN: 14-0077	Period: From 01/01/2020 To 12/31/2020	Worksheet DSH Date/Time Prepared: 7/24/2021 3:36 pm
		Title XVIII	Hospital	PPS
		Revised Percentage 6.00		
CALCULATION OF MAXIMUM DSH PAYMENT PERCENTAGE				
28.00	If line 3 is greater than 20.2% - 5.88% plus 82.5% of the difference between 20.2% and line 3	36.59	28.00	
29.00	If line 3 is less than 20.2% - 2.5% plus 65% of the difference between 15% and line 3	0.00	29.00	
30.00	Line 28 or 29 as applicable	36.59	30.00	
31.00	If Urban and fewer than 100 beds, Rural and fewer than 500 beds, or an SCH with less than 100 beds the lower of line 30 or .1200, if RRC, MDH or otherwise enter line 30.	36.59	31.00	

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0077	Period: From 01/01/2020 To 12/31/2020	Worksheet E Part B Date/Time Prepared: 7/24/2021 3:36 pm
		Title XVIII	Hospital	PPS
				1.00
PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)		1,934	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)		1,573,965	2.00
3.00	OPPS payments		543,872	3.00
4.00	Outlier payment (see instructions)		2,875	4.00
4.01	Outlier reconciliation amount (see instructions)		0	4.01
5.00	Enter the hospital specific payment to cost ratio (see instructions)		0.000	5.00
6.00	Line 2 times line 5		0	6.00
7.00	Sum of lines 3, 4, and 4.01, divided by line 6		0.00	7.00
8.00	Transitional corridor payment (see instructions)		0	8.00
9.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200		0	9.00
10.00	Organ acquisitions		0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)		1,934	11.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
12.00	Ancillary service charges		756	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)		756	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)		756	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)		0	19.00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)		1,178	20.00
21.00	Lesser of cost or charges (see instructions)		756	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)		546,747	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)		127,464	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)		420,039	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)		420,039	30.00
31.00	Primary payer payments		0	31.00
32.00	Subtotal (line 30 minus line 31)		420,039	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)		35,151	34.00
35.00	Adjusted reimbursable bad debts (see instructions)		22,848	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		35,151	36.00
37.00	Subtotal (see instructions)		442,887	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)		442,887	40.00
40.01	Sequestration adjustment (see instructions)		2,923	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		454,239	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)		-14,275	43.00
43.01	Balance due provider/program-PARHM (see instructions)		0	43.01
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		0	44.00
TO BE COMPLETED BY CONTRACTOR				
90.00	Original outlier amount (see instructions)		0	90.00
91.00	Outlier reconciliation adjustment amount (see instructions)		0	91.00
92.00	The rate used to calculate the Time Value of Money		0.00	92.00
93.00	Time Value of Money (see instructions)		0	93.00
94.00	Total (sum of lines 91 and 93)		0	94.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 14-0077	Period: From 01/01/2020 To 12/31/2020	Worksheet E Part B Date/Time Prepared: 7/24/2021 3:36 pm
	Title XVIII	Hospital	PPS
			Overrides
			1.00
WORKSHEET OVERRIDE VALUES			
112.00	Override of Ancillary service charges (line 12)		0112.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 14-0077

Period:
From 01/01/2020
To 12/31/2020Worksheet E-1
Part I
Date/Time Prepared:
7/24/2021 3:36 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		2,708,610		530,235	1.00	
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00	
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00	
Program to Provider							
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01	
3.02			0		0	3.02	
3.03			0		0	3.03	
3.04			0		0	3.04	
3.05			0		0	3.05	
Provider to Program							
3.50	ADJUSTMENTS TO PROGRAM	12/21/2020	101,579	12/21/2020	75,996	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)		-101,579		-75,996	3.99	
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		2,607,031		454,239	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		261,390		0	6.01	
6.02	SETTLEMENT TO PROGRAM		0		14,275	6.02	
7.00	Total Medicare program liability (see instructions)		2,868,421		439,964	7.00	
				Contractor Number	NPR Date (Mo/Day/Yr)		
		0		1.00	2.00		
8.00	Name of Contractor					8.00	

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT		Provider CCN: 14-0077	Period: From 01/01/2020 To 12/31/2020	Worksheet E-1 Part II Date/Time Prepared: 7/24/2021 3:36 pm	
		Title XVIII	Hospital	PPS	
				1.00	
TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS					
HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION					
1.00	Total hospital discharges as defined in AARA §4102 from Wkst. S-3, Pt. I col. 15 line 14				1.00
2.00	Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, 8-12				2.00
3.00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2				3.00
4.00	Total inpatient days from S-3, Pt. I col. 8 sum of lines 1, 8-12				4.00
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200				5.00
6.00	Total hospital charity care charges from Wkst. S-10, col. 3 line 20				6.00
7.00	CAH only - The reasonable cost incurred for the purchase of certified HIT technology Wkst. S-2, Pt. I line 168				7.00
8.00	Calculation of the HIT incentive payment (see instructions)				8.00
9.00	Sequestration adjustment amount (see instructions)				9.00
10.00	Calculation of the HIT incentive payment after sequestration (see instructions)				10.00
INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH					
30.00	Initial/interim HIT payment adjustment (see instructions)				30.00
31.00	Other Adjustment (specify)				31.00
32.00	Balance due provider (line 8 (or line 10) minus line 30 and line 31) (see instructions)				32.00
				Overrides	
				1.00	
CONTRACTOR OVERRIDES					
108.00	Override of HIT payment				108.00

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

Provider CCN: 14-0077

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

Worksheet G

Date/Time Prepared:
7/24/2021 3:36 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	23,440,317	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	3,240,285	0	0	0	4.00
5.00	Other receivable	418,657	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	0	0	0	0	6.00
7.00	Inventory	399,031	0	0	0	7.00
8.00	Prepaid expenses	1,018,419	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)	28,516,709	0	0	0	11.00
FIXED ASSETS						
12.00	Land	2,222,647	0	0	0	12.00
13.00	Land improvements	307,583	0	0	0	13.00
14.00	Accumulated depreciation	-289,841	0	0	0	14.00
15.00	Buildings	30,956,449	0	0	0	15.00
16.00	Accumulated depreciation	-17,232,179	0	0	0	16.00
17.00	Leasehold improvements	0	0	0	0	17.00
18.00	Accumulated depreciation	0	0	0	0	18.00
19.00	Fixed equipment	788,179	0	0	0	19.00
20.00	Accumulated depreciation	-305,438	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	15,046,349	0	0	0	23.00
24.00	Accumulated depreciation	-12,486,192	0	0	0	24.00
25.00	Minor equipment depreciable	0	0	0	0	25.00
26.00	Accumulated depreciation	0	0	0	0	26.00
27.00	HIT designated Assets	0	0	0	0	27.00
28.00	Accumulated depreciation	0	0	0	0	28.00
29.00	Minor equipment-nondepreciable	595,900	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	19,603,457	0	0	0	30.00
OTHER ASSETS						
31.00	Investments	0	0	0	0	31.00
32.00	Deposits on leases	0	0	0	0	32.00
33.00	Due from owners/officers	0	0	0	0	33.00
34.00	Other assets	988,639	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	988,639	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	49,108,805	0	0	0	36.00
CURRENT LIABILITIES						
37.00	Accounts payable	3,246,643	0	0	0	37.00
38.00	Salaries, wages, and fees payable	1,773,243	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	969,375	0	0	0	40.00
41.00	Deferred income	14,164,661	0	0	0	41.00
42.00	Accelerated payments	1,750,000	0	0	0	42.00
43.00	Due to other funds	0	0	0	0	43.00
44.00	Other current liabilities	986,391	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	22,890,313	0	0	0	45.00
LONG TERM LIABILITIES						
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	13,171,427	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	3,026,596	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	16,198,023	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	39,088,336	0	0	0	51.00
CAPITAL ACCOUNTS						
52.00	General fund balance	10,020,469				52.00
53.00	Specific purpose fund		0			53.00
54.00	Donor created - endowment fund balance - restricted			0		54.00
55.00	Donor created - endowment fund balance - unrestricted			0		55.00
56.00	Governing body created - endowment fund balance			0		56.00
57.00	Plant fund balance - invested in plant				0	57.00
58.00	Plant fund balance - reserve for plant improvement, replacement, and expansion				0	58.00
59.00	Total fund balances (sum of lines 52 thru 58)	10,020,469	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	49,108,805	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 14-0077

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

Worksheet G-1

Date/Time Prepared:
7/24/2021 3:36 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		8,885,909		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		244,964				2.00
3.00	Total (sum of line 1 and line 2)		9,130,873		0		3.00
4.00	CAPITAL GRANTS	946,596		0		0	4.00
5.00		0		0		0	5.00
6.00		0		0		0	6.00
7.00		0		0		0	7.00
8.00		0		0		0	8.00
9.00		0		0		0	9.00
10.00	Total additions (sum of line 4-9)		946,596		0		10.00
11.00	Subtotal (line 3 plus line 10)		10,077,469		0		11.00
12.00	TRANSFER TO RELATED PARTY	57,000		0		0	12.00
13.00		0		0		0	13.00
14.00		0		0		0	14.00
15.00		0		0		0	15.00
16.00		0		0		0	16.00
17.00		0		0		0	17.00
18.00	Total deductions (sum of lines 12-17)		57,000		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		10,020,469		0		19.00
		Endowment Fund		Plant Fund			
		6.00	7.00	8.00			
1.00	Fund balances at beginning of period	0		0			1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)						2.00
3.00	Total (sum of line 1 and line 2)	0		0			3.00
4.00	CAPITAL GRANTS		0				4.00
5.00			0				5.00
6.00			0				6.00
7.00			0				7.00
8.00			0				8.00
9.00			0				9.00
10.00	Total additions (sum of line 4-9)	0		0			10.00
11.00	Subtotal (line 3 plus line 10)	0		0			11.00
12.00	TRANSFER TO RELATED PARTY		0				12.00
13.00			0				13.00
14.00			0				14.00
15.00			0				15.00
16.00			0				16.00
17.00			0				17.00
18.00	Total deductions (sum of lines 12-17)	0		0			18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)	0		0			19.00

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES

Provider CCN: 14-0077

Period:
From 01/01/2020
To 12/31/2020Worksheet G-2
Parts I & II
Date/Time Prepared:
7/24/2021 3:36 pm

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
PART I - PATIENT REVENUES					
General Inpatient Routine Services					
1.00	Hospital	9,706,481		9,706,481	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	0		0	5.00
6.00	Swing bed - NF	0		0	6.00
7.00	SKILLED NURSING FACILITY				7.00
8.00	NURSING FACILITY				8.00
9.00	OTHER LONG TERM CARE				9.00
10.00	Total general inpatient care services (sum of lines 1-9)	9,706,481		9,706,481	10.00
Intensive Care Type Inpatient Hospital Services					
11.00	INTENSIVE CARE UNIT				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)	0		0	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	9,706,481		9,706,481	17.00
18.00	Ancillary services	2,644,258	23,611,850	26,256,108	18.00
19.00	Outpatient services	906,473	7,516,715	8,423,188	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		559,026	559,026	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	PHYSICIAN PRIVATE OFFICES	1,547,104	7,430,075	8,977,179	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	14,804,316	39,117,666	53,921,982	28.00
PART II - OPERATING EXPENSES					
29.00	Operating expenses (per Wkst. A, column 3, line 200)		56,729,022		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)		56,729,022		43.00

STATEMENT OF REVENUES AND EXPENSES

Provider CCN: 14-0077

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

Worksheet G-3

Date/Time Prepared:
7/24/2021 3:36 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	53,921,982	1.00
2.00	Less contractual allowances and discounts on patients' accounts	4,588,959	2.00
3.00	Net patient revenues (line 1 minus line 2)	49,333,023	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	56,729,022	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-7,395,999	5.00
OTHER INCOME			
6.00	Contributions, donations, bequests, etc	3,834	6.00
7.00	Income from investments	9,012	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	740	10.00
11.00	Rebates and refunds of expenses	6,541	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	222,912	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	51	17.00
18.00	Revenue from sale of medical records and abstracts	29,881	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	17,172	22.00
23.00	Governmental appropriations	0	23.00
24.00	GRANT INCOME	1,257,269	24.00
24.01	MISC INCOME	279,613	24.01
24.50	COVID-19 PHE Funding	5,813,938	24.50
25.00	Total other income (sum of lines 6-24)	7,640,963	25.00
26.00	Total (line 5 plus line 25)	244,964	26.00
27.00	OTHER EXPENSES (SPECIFY)	0	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	0	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	244,964	29.00

ANALYSIS OF HOSPITAL-BASED HOME HEALTH AGENCY COSTS Provider CCN: 14-0077 Period: From 01/01/2020 To 12/31/2020 Worksheet H

HHA CCN: 14-7315 Date/Time Prepared: 7/24/2021 3:36 pm

					Home Health Agency I	PPS
	Salaries	Employee Benefits	Transportation (see instructions)	Contracted/Purchased Services	Other Costs	Total (sum of cols. 1 thru 5)
	1.00	2.00	3.00	4.00	5.00	6.00
GENERAL SERVICE COST CENTERS						
1.00	Capital Related - Bldg. & Fixtures		0		6,665	6,665
2.00	Capital Related - Movable Equipment		0		0	0
3.00	Plant Operation & Maintenance	0	0	0	0	0
4.00	Transportation	0	0	0	0	0
5.00	Administrative and General	337,287	23,596	12,102	0	445,542
HHA REIMBURSABLE SERVICES						
6.00	Skilled Nursing Care	166,357	11,638	5,969	0	183,964
7.00	Physical Therapy	0	0	0	95,066	95,066
8.00	Occupational Therapy	0	0	0	28,454	28,454
9.00	Speech Pathology	0	0	0	12,172	12,172
10.00	Medical Social Services	1,220	85	44	0	1,349
11.00	Home Health Aide	0	0	0	0	0
12.00	Supplies (see instructions)	0	0	0	105	105
13.00	Drugs	0	0	0	0	0
14.00	DME	0	0	0	0	0
HHA NONREIMBURSABLE SERVICES						
15.00	Home Dialysis Aide Services	0	0	0	0	0
16.00	Respiratory Therapy	0	0	0	0	0
17.00	Private Duty Nursing	0	0	0	0	0
18.00	Clinic	0	0	0	0	0
19.00	Health Promotion Activities	0	0	0	0	0
20.00	Day Care Program	0	0	0	0	0
21.00	Home Delivered Meals Program	0	0	0	0	0
22.00	Homemaker Service	0	0	0	0	0
23.00	All Others (specify)	0	0	0	0	0
23.50	Telemedicine	0	0	0	0	0
24.00	Total (sum of lines 1-23)	504,864	35,319	18,115	135,692	773,317
	Reclassification	Reclassified Trial Balance (col. 6 + col.7)	Adjustments	Net Expenses for Allocation (col. 8 + col. 9)		
	7.00	8.00	9.00	10.00		
GENERAL SERVICE COST CENTERS						
1.00	Capital Related - Bldg. & Fixtures	0	6,665	0	6,665	1.00
2.00	Capital Related - Movable Equipment	0	0	0	0	2.00
3.00	Plant Operation & Maintenance	0	0	0	0	3.00
4.00	Transportation	0	0	0	0	4.00
5.00	Administrative and General	0	445,542	-1,250	444,292	5.00
HHA REIMBURSABLE SERVICES						
6.00	Skilled Nursing Care	0	183,964	0	183,964	6.00
7.00	Physical Therapy	0	95,066	0	95,066	7.00
8.00	Occupational Therapy	0	28,454	0	28,454	8.00
9.00	Speech Pathology	0	12,172	0	12,172	9.00
10.00	Medical Social Services	0	1,349	0	1,349	10.00
11.00	Home Health Aide	0	0	0	0	11.00
12.00	Supplies (see instructions)	0	105	0	105	12.00
13.00	Drugs	0	0	0	0	13.00
14.00	DME	0	0	0	0	14.00
HHA NONREIMBURSABLE SERVICES						
15.00	Home Dialysis Aide Services	0	0	0	0	15.00
16.00	Respiratory Therapy	0	0	0	0	16.00
17.00	Private Duty Nursing	0	0	0	0	17.00
18.00	Clinic	0	0	0	0	18.00
19.00	Health Promotion Activities	0	0	0	0	19.00
20.00	Day Care Program	0	0	0	0	20.00
21.00	Home Delivered Meals Program	0	0	0	0	21.00
22.00	Homemaker Service	0	0	0	0	22.00
23.00	All Others (specify)	0	0	0	0	23.00
23.50	Telemedicine	0	0	0	0	23.50
24.00	Total (sum of lines 1-23)	0	773,317	-1,250	772,067	24.00

Column, 6 line 24 should agree with the Worksheet A, column 3, line 101, or subscript as applicable.

COST ALLOCATION - HHA GENERAL SERVICE COST

Provider CCN: 14-0077

Period:

Worksheet H-1

HHA CCN: 14-7315

From 01/01/2020
To 12/31/2020Part I
Date/Time Prepared:
7/24/2021 3:36 pmHome Health
Agency I

PPS

		Net Expenses for Cost Allocation (from Wkst. H, col. 10)	Capital Related Costs		Plant Operation & Maintenance	Transportation	Subtotal (cols. 0-4)	
			Bldgs & Fixtures	Movable Equipment				
			0	1.00	2.00	3.00	4.00	
	GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. & Fixtures	6,665	6,665				0	1.00
2.00	Capital Related - Movable Equipment	0		0			0	2.00
3.00	Plant Operation & Maintenance	0	0	0	0		0	3.00
4.00	Transportation	0	0	0	0	0		4.00
5.00	Administrative and General	444,292	6,665	0	0	0	450,957	5.00
	HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	183,964	0	0	0	0	183,964	6.00
7.00	Physical Therapy	95,066	0	0	0	0	95,066	7.00
8.00	Occupational Therapy	28,454	0	0	0	0	28,454	8.00
9.00	Speech Pathology	12,172	0	0	0	0	12,172	9.00
10.00	Medical Social Services	1,349	0	0	0	0	1,349	10.00
11.00	Home Health Aide	0	0	0	0	0	0	11.00
12.00	Supplies (see instructions)	105	0	0	0	0	105	12.00
13.00	Drugs	0	0	0	0	0	0	13.00
14.00	DME	0	0	0	0	0	0	14.00
	HHA NONREIMBURSABLE SERVICES							
15.00	Home Dialysis Aide Services	0	0	0	0	0	0	15.00
16.00	Respiratory Therapy	0	0	0	0	0	0	16.00
17.00	Private Duty Nursing	0	0	0	0	0	0	17.00
18.00	Clinic	0	0	0	0	0	0	18.00
19.00	Health Promotion Activities	0	0	0	0	0	0	19.00
20.00	Day Care Program	0	0	0	0	0	0	20.00
21.00	Home Delivered Meals Program	0	0	0	0	0	0	21.00
22.00	Homemaker Service	0	0	0	0	0	0	22.00
23.00	All Others (specify)	0	0	0	0	0	0	23.00
23.50	Telemedicine	0	0	0	0	0	0	23.50
24.00	Total (sum of lines 1-23)	772,067	6,665	0	0	0	772,067	24.00
		Administrative & General	Total (cols. 4A + 5)					
		5.00	6.00					
	GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. & Fixtures							1.00
2.00	Capital Related - Movable Equipment							2.00
3.00	Plant Operation & Maintenance							3.00
4.00	Transportation							4.00
5.00	Administrative and General	450,957						5.00
	HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	258,354	442,318					6.00
7.00	Physical Therapy	133,508	228,574					7.00
8.00	Occupational Therapy	39,960	68,414					8.00
9.00	Speech Pathology	17,094	29,266					9.00
10.00	Medical Social Services	1,894	3,243					10.00
11.00	Home Health Aide	0	0					11.00
12.00	Supplies (see instructions)	147	252					12.00
13.00	Drugs	0	0					13.00
14.00	DME	0	0					14.00
	HHA NONREIMBURSABLE SERVICES							
15.00	Home Dialysis Aide Services	0	0					15.00
16.00	Respiratory Therapy	0	0					16.00
17.00	Private Duty Nursing	0	0					17.00
18.00	Clinic	0	0					18.00
19.00	Health Promotion Activities	0	0					19.00
20.00	Day Care Program	0	0					20.00
21.00	Home Delivered Meals Program	0	0					21.00
22.00	Homemaker Service	0	0					22.00
23.00	All Others (specify)	0	0					23.00
23.50	Telemedicine	0	0					23.50
24.00	Total (sum of lines 1-23)		772,067					24.00

COST ALLOCATION - HHA STATISTICAL BASIS

Provider CCN: 14-0077

Period:

Worksheet H-1

HHA CCN: 14-7315

From 01/01/2020
To 12/31/2020Part II
Date/Time Prepared:
7/24/2021 3:36 pmHome Health
Agency I

PPS

	Capital Related Costs		Plant Operation & Maintenance (SQUARE FEET)	Transportation (MILEAGE)	Reconciliation	Administrative & General (ACCUM. COST)	
	Bldgs & Fixtures (SQUARE FEET)	Movable Equipment (DOLLAR VALUE)					
	1.00	2.00	3.00	4.00	5A.00	5.00	
GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. & Fixtures	6,665			0		1.00
2.00	Capital Related - Movable Equipment		0		0		2.00
3.00	Plant Operation & Maintenance	0	0	0	0		3.00
4.00	Transportation (see instructions)	0	0	0	0		4.00
5.00	Administrative and General	6,665	0	0	0	-450,957	5.00
						321,110	
HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	0	0	0	0	183,964	6.00
7.00	Physical Therapy	0	0	0	0	95,066	7.00
8.00	Occupational Therapy	0	0	0	0	28,454	8.00
9.00	Speech Pathology	0	0	0	0	12,172	9.00
10.00	Medical Social Services	0	0	0	0	1,349	10.00
11.00	Home Health Aide	0	0	0	0	0	11.00
12.00	Supplies (see instructions)	0	0	0	0	105	12.00
13.00	Drugs	0	0	0	0	0	13.00
14.00	DME	0	0	0	0	0	14.00
HHA NONREIMBURSABLE SERVICES							
15.00	Home Dialysis Aide Services	0	0	0	0	0	15.00
16.00	Respiratory Therapy	0	0	0	0	0	16.00
17.00	Private Duty Nursing	0	0	0	0	0	17.00
18.00	Clinic	0	0	0	0	0	18.00
19.00	Health Promotion Activities	0	0	0	0	0	19.00
20.00	Day Care Program	0	0	0	0	0	20.00
21.00	Home Delivered Meals Program	0	0	0	0	0	21.00
22.00	Homemaker Service	0	0	0	0	0	22.00
23.00	All Others (specify)	0	0	0	0	0	23.00
23.50	Telemedicine	0	0	0	0	0	23.50
24.00	Total (sum of lines 1-23)	6,665	0	0	0	-450,957	24.00
25.00	Cost To Be Allocated (per Worksheet H-1, Part I)	6,665	0	0	0	450,957	25.00
26.00	Unit Cost Multiplier	1.000000	0.000000	0.000000	0.000000	1.404369	26.00

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

Provider CCN: 14-0077

Period:

Worksheet H-2

HHA CCN: 14-7315

From 01/01/2020
To 12/31/2020Part I
Date/Time Prepared:
7/24/2021 3:36 pmHome Health
Agency I

PPS

Cost Center Description		HHA Trial Balance (1)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	Subtotal		
			BLDG & FIXT	MVBLE EQUIP			ADMINISTRATIVE & GENERAL	
		0	1.00	2.00	4.00	4A	5.00	
1.00	Administrative and General	0	0	0	62,331	62,331	21,347	1.00
2.00	Skilled Nursing Care	442,318	0	0	30,743	473,061	162,015	2.00
3.00	Physical Therapy	228,574	0	0	0	228,574	78,282	3.00
4.00	Occupational Therapy	68,414	0	0	0	68,414	23,431	4.00
5.00	Speech Pathology	29,266	0	0	0	29,266	10,023	5.00
6.00	Medical Social Services	3,243	0	0	225	3,468	1,188	6.00
7.00	Home Health Aide	0	0	0	0	0	0	7.00
8.00	Supplies (see instructions)	252	0	0	0	252	86	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
19.50	Telemedicine	0	0	0	0	0	0	19.50
20.00	Total (sum of lines 1-19) (2)	772,067	0	0	93,299	865,366	296,372	20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.					0.000000		21.00
Cost Center Description		MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	
		6.00	7.00	8.00	9.00	10.00	11.00	
1.00	Administrative and General	0	0	0	0	0	0	1.00
2.00	Skilled Nursing Care	0	0	0	0	0	0	2.00
3.00	Physical Therapy	0	0	0	0	0	0	3.00
4.00	Occupational Therapy	0	0	0	0	0	0	4.00
5.00	Speech Pathology	0	0	0	0	0	0	5.00
6.00	Medical Social Services	0	0	0	0	0	0	6.00
7.00	Home Health Aide	0	0	0	0	0	0	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
19.50	Telemedicine	0	0	0	0	0	0	19.50
20.00	Total (sum of lines 1-19) (2)	0	0	0	0	0	0	20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.							21.00

(1) Column 0, line 20 must agree with Wkst. A, column 7, line 101.

(2) Columns 0 through 26, line 20 must agree with the corresponding columns of Wkst. B, Part I, line 101.

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

Provider CCN: 14-0077

Period:

Worksheet H-2

HHA CCN: 14-7315

From 01/01/2020
To 12/31/2020Part I
Date/Time Prepared:
7/24/2021 3:36 pm

Cost Center Description		NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	Home Health Agency I SOCIAL SERVICE	Subtotal	
		13.00	14.00	15.00	16.00	17.00	24.00	
1.00	Administrative and General	40,503	2,466	0	0	0	126,647	1.00
2.00	Skilled Nursing Care	19,525	0	0	0	0	654,601	2.00
3.00	Physical Therapy	0	0	0	0	0	306,856	3.00
4.00	Occupational Therapy	0	0	0	0	0	91,845	4.00
5.00	Speech Pathology	0	0	0	0	0	39,289	5.00
6.00	Medical Social Services	127	0	0	0	0	4,783	6.00
7.00	Home Health Aide	0	0	0	0	0	0	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	338	8.00
9.00	Drugs	0	0	207	0	0	207	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
19.50	Telemedicine	0	0	0	0	0	0	19.50
20.00	Total (sum of lines 1-19) (2)	60,155	2,466	207	0	0	1,224,566	20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.							21.00
Cost Center Description		Intern & Residents Cost & Post Stepdown Adjustments	Subtotal	Allocated HHA A&G (see Part II)	Total HHA Costs			
		25.00	26.00	27.00	28.00			
1.00	Administrative and General	0	126,647					1.00
2.00	Skilled Nursing Care	0	654,601	75,509	730,110			2.00
3.00	Physical Therapy	0	306,856	35,396	342,252			3.00
4.00	Occupational Therapy	0	91,845	10,595	102,440			4.00
5.00	Speech Pathology	0	39,289	4,532	43,821			5.00
6.00	Medical Social Services	0	4,783	552	5,335			6.00
7.00	Home Health Aide	0	0	0	0			7.00
8.00	Supplies (see instructions)	0	338	39	377			8.00
9.00	Drugs	0	207	24	231			9.00
10.00	DME	0	0	0	0			10.00
11.00	Home Dialysis Aide Services	0	0	0	0			11.00
12.00	Respiratory Therapy	0	0	0	0			12.00
13.00	Private Duty Nursing	0	0	0	0			13.00
14.00	Clinic	0	0	0	0			14.00
15.00	Health Promotion Activities	0	0	0	0			15.00
16.00	Day Care Program	0	0	0	0			16.00
17.00	Home Delivered Meals Program	0	0	0	0			17.00
18.00	Homemaker Service	0	0	0	0			18.00
19.00	All Others (specify)	0	0	0	0			19.00
19.50	Telemedicine	0	0	0	0			19.50
20.00	Total (sum of lines 1-19) (2)	0	1,224,566	126,647	1,224,566			20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.			0.115352				21.00

(1) Column 0, line 20 must agree with Wkst. A, column 7, line 101.

(2) Columns 0 through 26, line 20 must agree with the corresponding columns of Wkst. B, Part I, line 101.

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS

Provider CCN: 14-0077

Period:

Worksheet H-2

HHA CCN: 14-7315

From 01/01/2020
To 12/31/2020Part II
Date/Time Prepared:
7/24/2021 3:36 pmHome Health
Agency I

PPS

Cost Center Description		CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	MAINTENANCE & REPAIRS (SQUARE FEET)	
		BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (SQUARE FEET)					
		1.00	2.00	4.00	5A	5.00	6.00	
1.00	Administrative and General	0	0	337,287	0	62,331	0	1.00
2.00	Skilled Nursing Care	0	0	166,357	0	473,061	0	2.00
3.00	Physical Therapy	0	0	0	0	228,574	0	3.00
4.00	Occupational Therapy	0	0	0	0	68,414	0	4.00
5.00	Speech Pathology	0	0	0	0	29,266	0	5.00
6.00	Medical Social Services	0	0	1,220	0	3,468	0	6.00
7.00	Home Health Aide	0	0	0	0	0	0	7.00
8.00	Supplies (see instructions)	0	0	0	0	252	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
19.50	Telemedicine	0	0	0	0	0	0	19.50
20.00	Total (sum of lines 1-19)	0	0	504,864		865,366	0	20.00
21.00	Total cost to be allocated	0	0	93,299		296,372	0	21.00
22.00	Unit cost multiplier	0.000000	0.000000	0.184800		0.342482	0.000000	22.00
Cost Center Description		OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (HOURS OF SERVICE)	DIETARY (MEALS SERVED)	CAFETERIA (MEALS SERVED)	NURSING ADMINISTRATION (DIRECT NURS. HRS.)	
		7.00	8.00	9.00	10.00	11.00	13.00	
1.00	Administrative and General	0	0	0	0	0	9,279	1.00
2.00	Skilled Nursing Care	0	0	0	0	0	4,473	2.00
3.00	Physical Therapy	0	0	0	0	0	0	3.00
4.00	Occupational Therapy	0	0	0	0	0	0	4.00
5.00	Speech Pathology	0	0	0	0	0	0	5.00
6.00	Medical Social Services	0	0	0	0	0	29	6.00
7.00	Home Health Aide	0	0	0	0	0	0	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
19.50	Telemedicine	0	0	0	0	0	0	19.50
20.00	Total (sum of lines 1-19)	0	0	0	0	0	13,781	20.00
21.00	Total cost to be allocated	0	0	0	0	0	60,155	21.00
22.00	Unit cost multiplier	0.000000	0.000000	0.000000	0.000000	0.000000	4.365068	22.00

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS

Provider CCN: 14-0077

Period:

Worksheet H-2

HHA CCN: 14-7315

From 01/01/2020
To 12/31/2020Part II
Date/Time Prepared:
7/24/2021 3:36 pmHome Health
Agency I

PPS

Cost Center Description		CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (TIME SPENT)	SOCIAL SERVICE (TIME SPENT)			
		14.00	15.00	16.00	17.00			
1.00	Administrative and General	5,635	0	0	0			1.00
2.00	Skilled Nursing Care	0	0	0	0			2.00
3.00	Physical Therapy	0	0	0	0			3.00
4.00	Occupational Therapy	0	0	0	0			4.00
5.00	Speech Pathology	0	0	0	0			5.00
6.00	Medical Social Services	0	0	0	0			6.00
7.00	Home Health Aide	0	0	0	0			7.00
8.00	Supplies (see instructions)	0	0	0	0			8.00
9.00	Drugs	0	105	0	0			9.00
10.00	DME	0	0	0	0			10.00
11.00	Home Dialysis Aide Services	0	0	0	0			11.00
12.00	Respiratory Therapy	0	0	0	0			12.00
13.00	Private Duty Nursing	0	0	0	0			13.00
14.00	Clinic	0	0	0	0			14.00
15.00	Health Promotion Activities	0	0	0	0			15.00
16.00	Day Care Program	0	0	0	0			16.00
17.00	Home Delivered Meals Program	0	0	0	0			17.00
18.00	Homemaker Service	0	0	0	0			18.00
19.00	All Others (specify)	0	0	0	0			19.00
19.50	Telemedicine	0	0	0	0			19.50
20.00	Total (sum of lines 1-19)	5,635	105	0	0			20.00
21.00	Total cost to be allocated	2,466	207	0	0			21.00
22.00	Unit cost multiplier	0.437622	1.971429	0.000000	0.000000			22.00

APPORTIONMENT OF PATIENT SERVICE COSTS

Provider CCN: 14-0077

Period:

Worksheet H-3

HHA CCN: 14-7315

From 01/01/2020
To 12/31/2020Part I
Date/Time Prepared:
7/24/2021 3:36 pm

				Title XVIII		Home Health Agency I	PPS		
Cost Center Description		From, Wkst. H-2, Part I, col. 28, line	Facility Costs (from Wkst. H-2, Part I)	Shared Ancillary Costs (from Part II)	Total HHA Costs (cols. 1 + 2)	Total Visits	Average Cost Per Visit (col. 3 ÷ col. 4)		
		0	1.00	2.00	3.00	4.00	5.00		
PART I - COMPUTATION OF LESSER OF AGGREGATE PROGRAM COST, AGGREGATE OF THE PROGRAM LIMITATION COST, OR BENEFICIARY COST LIMITATION									
Cost Per Visit Computation									
1.00	Skilled Nursing Care	2.00	730,110		730,110	1,241	588.32	1.00	
2.00	Physical Therapy	3.00	342,252	0	342,252	1,140	300.22	2.00	
3.00	Occupational Therapy	4.00	102,440	0	102,440	341	300.41	3.00	
4.00	Speech Pathology	5.00	43,821	0	43,821	146	300.14	4.00	
5.00	Medical Social Services	6.00	5,335		5,335	13	410.38	5.00	
6.00	Home Health Aide	7.00	0		0	0	0.00	6.00	
7.00	Total (sum of lines 1-6)		1,223,958	0	1,223,958	2,881		7.00	
Cost Center Description		Cost Limits	CBSA No. (1)	Part A	Program Visits				
					Part B				
					Not Subject to Deductibles & Coinsurance	Subject to Deductibles			
		0	1.00	2.00	3.00	4.00	5.00		
Limitation Cost Computation									
8.00	Skilled Nursing Care		41180	0	92			8.00	
9.00	Physical Therapy		41180	0	139			9.00	
10.00	Occupational Therapy		41180	0	38			10.00	
11.00	Speech Pathology		41180	0	2			11.00	
12.00	Medical Social Services		41180	0	3			12.00	
13.00	Home Health Aide		41180	0	0			13.00	
14.00	Total (sum of lines 8-13)			0	274			14.00	
Cost Center Description		From Wkst. H-2 Part I, col. 28, line	Facility Costs (from Wkst. H-2, Part I)	Shared Ancillary Costs (from Part II)	Total HHA Costs (cols. 1 + 2)	Total Charges (from HHA Records)	Ratio (col. 3 ÷ col. 4)		
		0	1.00	2.00	3.00	4.00	5.00		
Supplies and Drugs Cost Computations									
15.00	Cost of Medical Supplies	8.00	377	55	432	122	3.540984	15.00	
16.00	Cost of Drugs	9.00	231	0	231	0	0.000000	16.00	
Cost Center Description		Part A	Program Visits		Cost of Services				
			Part B						
			Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance	Part A	Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance		
			6.00	7.00	8.00	9.00	10.00	11.00	
PART I - COMPUTATION OF LESSER OF AGGREGATE PROGRAM COST, AGGREGATE OF THE PROGRAM LIMITATION COST, OR BENEFICIARY COST LIMITATION									
Cost Per Visit Computation									
1.00	Skilled Nursing Care	0	92		0	54,125		1.00	
2.00	Physical Therapy	0	139		0	41,731		2.00	
3.00	Occupational Therapy	0	38		0	11,416		3.00	
4.00	Speech Pathology	0	2		0	600		4.00	
5.00	Medical Social Services	0	3		0	1,231		5.00	
6.00	Home Health Aide	0	0		0	0		6.00	
7.00	Total (sum of lines 1-6)	0	274		0	109,103		7.00	
Cost Center Description									
		6.00	7.00	8.00	9.00	10.00	11.00		
Limitation Cost Computation									
8.00	Skilled Nursing Care							8.00	
9.00	Physical Therapy							9.00	
10.00	Occupational Therapy							10.00	
11.00	Speech Pathology							11.00	
12.00	Medical Social Services							12.00	
13.00	Home Health Aide							13.00	
14.00	Total (sum of lines 8-13)							14.00	

APPORTIONMENT OF PATIENT SERVICE COSTS

Provider CCN: 14-0077

Period:

Worksheet H-3

HHA CCN: 14-7315

From 01/01/2020
To 12/31/2020Part I
Date/Time Prepared:
7/24/2021 3:36 pm

Title XVIII

Home Health
Agency I

PPS

Cost Center Description		Program Covered Charges			Cost of Services	Agency 1		
		Part A	Part B		Part A	Part B		
			Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance		Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance	
			6.00	7.00		8.00	9.00	
	Supplies and Drugs Cost Computations							
15.00	Cost of Medical Supplies	0	0	122	0	0	432	15.00
16.00	Cost of Drugs		0	0		0	0	16.00
Cost Center Description		Total Program Cost (sum of cols. 9-10)						
		12.00						
PART I - COMPUTATION OF LESSER OF AGGREGATE PROGRAM COST, AGGREGATE OF THE PROGRAM LIMITATION COST, OR BENEFICIARY COST LIMITATION								
Cost Per Visit Computation								
1.00	Skilled Nursing Care	54,125						1.00
2.00	Physical Therapy	41,731						2.00
3.00	Occupational Therapy	11,416						3.00
4.00	Speech Pathology	600						4.00
5.00	Medical Social Services	1,231						5.00
6.00	Home Health Aide	0						6.00
7.00	Total (sum of lines 1-6)	109,103						7.00
Cost Center Description								
		12.00						
Limitation Cost Computation								
8.00	Skilled Nursing Care							8.00
9.00	Physical Therapy							9.00
10.00	Occupational Therapy							10.00
11.00	Speech Pathology							11.00
12.00	Medical Social Services							12.00
13.00	Home Health Aide							13.00
14.00	Total (sum of lines 8-13)							14.00

APPORTIONMENT OF PATIENT SERVICE COSTS

Provider CCN: 14-0077

Period:

Worksheet H-3

HHA CCN: 14-7315

From 01/01/2020
To 12/31/2020Part II
Date/Time Prepared:
7/24/2021 3:36 pm

Title XVIII

Home Health
Agency I

PPS

Cost Center Description	From Wkst. C, Part I, col. 9, line	Cost to Charge Ratio	Total HHA Charge (from provider records)	HHA Shared Ancillary Costs (col. 1 x col. 2)	Transfer to Part I as Indicated		
	0	1.00	2.00	3.00	4.00		
PART II - APPORTIONMENT OF COST OF HHA SERVICES FURNISHED BY SHARED HOSPITAL DEPARTMENTS							
1.00 Physical Therapy	66.00	0.770872	0	0	col. 2, line 2.00		1.00
2.00 Occupational Therapy							2.00
3.00 Speech Pathology							3.00
4.00 Cost of Medical Supplies	71.00	0.452840	122	55	col. 2, line 15.00		4.00
5.00 Cost of Drugs	73.00	2.558683	0	0	col. 2, line 16.00		5.00

CALCULATION OF HHA REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0077 HHA CCN: 14-7315	Period: From 01/01/2020 To 12/31/2020	Worksheet H-4 Part I-II Date/Time Prepared: 7/24/2021 3:36 pm
		Title XVIII	Home Health Agency I	PPS
		Part A	Part B	
			Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance
		1.00	2.00	3.00
PART I - COMPUTATION OF THE LESSER OF REASONABLE COST OR CUSTOMARY CHARGES				
Reasonable Cost of Part A & Part B Services				
1.00	Reasonable cost of services (see instructions)	0	0	0
2.00	Total charges	0	0	0
Customary Charges				
3.00	Amount actually collected from patients liable for payment for services on a charge basis (from your records)	0	0	0
4.00	Amount that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(b)	0	0	0
5.00	Ratio of line 3 to line 4 (not to exceed 1.000000)	0.000000	0.000000	0.000000
6.00	Total customary charges (see instructions)	0	0	0
7.00	Excess of total customary charges over total reasonable cost (complete only if line 6 exceeds line 1)	0	0	0
8.00	Excess of reasonable cost over customary charges (complete only if line 1 exceeds line 6)	0	0	0
9.00	Primary payer amounts	0	0	0
			Part A Services	Part B Services
			1.00	2.00
PART II - COMPUTATION OF HHA REIMBURSEMENT SETTLEMENT				
10.00	Total reasonable cost (see instructions)		0	0
11.00	Total PPS Reimbursement - Full Episodes without Outliers		0	59,649
12.00	Total PPS Reimbursement - Full Episodes with Outliers		0	8,832
13.00	Total PPS Reimbursement - LUPA Episodes		0	612
14.00	Total PPS Reimbursement - PEP Episodes		0	0
15.00	Total PPS Outlier Reimbursement - Full Episodes with Outliers		0	0
16.00	Total PPS Outlier Reimbursement - PEP Episodes		0	0
17.00	Total Other Payments		0	0
18.00	DME Payments		0	0
19.00	Oxygen Payments		0	0
20.00	Prosthetic and Orthotic Payments		0	0
21.00	Part B deductibles billed to Medicare patients (exclude coinsurance)		0	0
22.00	Subtotal (sum of lines 10 thru 20 minus line 21)		0	69,093
23.00	Excess reasonable cost (from line 8)		0	0
24.00	Subtotal (line 22 minus line 23)		0	69,093
25.00	Coinsurance billed to program patients (from your records)		0	0
26.00	Net cost (line 24 minus line 25)		0	69,093
27.00	Reimbursable bad debts (from your records)			
28.00	Reimbursable bad debts for dual eligible beneficiaries (see instructions)			
29.00	Total costs - current cost reporting period (line 26 plus line 27)		0	69,093
30.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	0
30.50	Pioneer ACO demonstration payment adjustment (see instructions)		0	0
30.99	Demonstration payment adjustment amount before sequestration		0	0
31.00	Subtotal (see instructions)		0	69,093
31.01	Sequestration adjustment (see instructions)		0	81
31.02	Demonstration payment adjustment amount after sequestration		0	0
32.00	Interim payments (see instructions)		0	69,012
33.00	Tentative settlement (for contractor use only)		0	0
34.00	Balance due provider/program (line 31 minus lines 31.01, 32, and 33)		0	0
35.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		0	0

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED HHAS FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES		Provider CCN: 14-0077 HHA CCN: 14-7315		Period: From 01/01/2020 To 12/31/2020		Worksheet H-5 Date/Time Prepared: 7/24/2021 3:36 pm	
				Home Health Agency I		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		69,012	1.00	
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00	
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00	
Program to Provider							
3.01			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			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. H-4, Part II, column as appropriate, line 32)		0		69,012	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			0		0	5.01	
5.02			0		0	5.02	
5.03			0		0	5.03	
Provider to Program							
5.50			0		0	5.50	
5.51			0		0	5.51	
5.52			0		0	5.52	
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99	
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00	
6.01	SETTLEMENT TO PROVIDER		0		0	6.01	
6.02	SETTLEMENT TO PROGRAM		0		0	6.02	
7.00	Total Medicare program liability (see instructions)		0		69,012	7.00	
				Contractor Number	NPR Date (Mo/Day/Yr)		
		0		1.00	2.00		
8.00	Name of Contractor					8.00	

CALCULATION OF CAPITAL PAYMENT		Provider CCN: 14-0077	Period: From 01/01/2020 To 12/31/2020	Worksheet L Parts I-III Date/Time Prepared: 7/24/2021 3:36 pm
		Title XVIII	Hospital	PPS
		1.00		
PART I - FULLY PROSPECTIVE METHOD				
CAPITAL FEDERAL AMOUNT				
1.00	Capital DRG other than outlier		135,471	1.00
1.01	Model 4 BPCI Capital DRG other than outlier		0	1.01
2.00	Capital DRG outlier payments		643	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)		17.98	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)		24.99	7.00
8.00	Percentage of Medicaid patient days to total days (see instructions)		57.42	8.00
9.00	Sum of lines 7 and 8		82.41	9.00
10.00	Allowable disproportionate share percentage (see instructions)		18.16	10.00
11.00	Disproportionate share adjustment (see instructions)		24,602	11.00
12.00	Total prospective capital payments (see instructions)		160,716	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