

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: 14-0103	Period: From 01/01/2020 To 12/31/2020	Worksheet S Parts I-III Date/Time Prepared: 7/19/2021 1:49 pm
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PART I - COST REPORT STATUS

Provider use only	1. ☒ Electronically prepared cost report	Date: 7/19/2021	Time: 1:49 pm
	2. ☐ Manually prepared cost report		
	3. ☐ If this is an amended report enter the number of times the provider resubmitted this cost report		
	4. ☒ Medicare Utilization. Enter "F" for full or "L" for low.		
Contractor use only	5. ☒ Cost Report Status (1) As Submitted (2) Settled without Audit (3) Settled with Audit (4) Reopened (5) Amended	6. Date Received: 7. Contractor No. 8. ☒ Initial Report for this Provider CCN 9. ☒ Final Report for this Provider CCN	10. NPR Date: 11. Contractor's Vendor Code: 4 12. ☐ If line 5, column 1 is 4: Enter number of times reopened = 0-9.

PART II - CERTIFICATION

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

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

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by ST. BERNARD HOSPITAL (14-0103) 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) ROBERT SPRINGER

Officer or Administrator of Provider(s)

CFO

Title

(Dated when report is electronically signed.)

Date

Cost Center Description		Title V	Title XVIII		HIT	Title XIX	
			Part A	Part B			
		1.00	2.00	3.00	4.00	5.00	
	PART III - SETTLEMENT SUMMARY						
1.00	Hospital	0	287,200	-34,542	0	0	1.00
2.00	Subprovider - IPF	0	44,542	-2		0	2.00
3.00	Subprovider - IRF	0	0	0		0	3.00
5.00	Swing Bed - SNF	0	0	0		0	5.00
6.00	Swing Bed - NF	0				0	6.00
200.00	Total	0	331,742	-34,544	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: 14-0103		Period: From 01/01/2020 To 12/31/2020		Worksheet S-2 Part I Date/Time Prepared: 7/19/2021 1:49 pm	
1.00		2.00		3.00		4.00			
Hospital and Hospital Health Care Complex Address:									
1.00	Street: 326 W 64TH STREET			PO Box:				1.00	
2.00	City: CHICAGO			State: IL		Zip Code: 60621		County: COOK	
		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			ST. BERNARD HOSPITAL	140103	16974	1	07/01/1967	N
4.00	Subprovider - IPF			ST. BERNARD HOSPITAL PSYCH UNIT	14S103	16974	4	01/01/1994	N
5.00	Subprovider - IRF								P
6.00	Subprovider - (Other)								P
7.00	Swing Beds - SNF								
8.00	Swing Beds - NF								
9.00	Hospital-Based SNF								
10.00	Hospital-Based NF								
11.00	Hospital-Based OLTC								
12.00	Hospital-Based HHA								
13.00	Separately Certified ASC								
14.00	Hospital-Based Hospice								
15.00	Hospital-Based Health Clinic - RHC								
16.00	Hospital-Based Health Clinic - FQHC								
17.00	Hospital-Based (CMHC) I								
18.00	Renal Dialysis								
19.00	Other								
							From:	To:	
							1.00	2.00	
20.00	Cost Reporting Period (mm/dd/yyyy)						01/01/2020	12/31/2020	
21.00	Type of Control (see instructions)						1		
							1.00	2.00	
							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		
22.01	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		
22.02	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		
22.03	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	
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		
				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.			1,310	262	61	0	6,626	440

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

Provider CCN: 14-0103

Period:
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		In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of State Medicaid paid days	Out-of State Medicaid eligible unpaid	Medicaid HMO days	Other Medicaid days	
		1.00	2.00	3.00	4.00	5.00	6.00	
25.00	If this provider is an IRF, enter the in-state Medicaid paid days in column 1, the in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5.	0	0	0	0	0		25.00
						Urban/Rural S	Date of Geogr	
						1.00	2.00	
26.00	Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter "1" for urban or "2" for rural.					1		26.00
27.00	Enter your standard geographic classification (not wage) status at the end of the cost reporting period. Enter in column 1, "1" for urban or "2" for rural. If applicable, enter the effective date of the geographic reclassification in column 2.					1		27.00
35.00	If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period.					0		35.00
						Beginning:	Ending:	
						1.00	2.00	
36.00	Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.							36.00
37.00	If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status is in effect in the cost reporting period.					0		37.00
37.01	Is this hospital a former MDH that is eligible for the MDH transitional payment in accordance with FY 2016 OPPS final rule? Enter "Y" for yes or "N" for no. (see instructions)							37.01
38.00	If line 37 is 1, enter the beginning and ending dates of MDH status. If line 37 is greater than 1, subscript this line for the number of periods in excess of one and enter subsequent dates.							38.00
						Y/N	Y/N	
						1.00	2.00	
39.00	Does this facility qualify for the inpatient hospital payment adjustment for low volume hospitals in accordance with 42 CFR §412.101(b)(2)(i), (ii), or (iii)? Enter in column 1 "Y" for yes or "N" for no. Does the facility meet the mileage requirements in accordance with 42 CFR §412.101(b)(2)(i), (ii), or (iii)? Enter in column 2 "Y" for yes or "N" for no. (see instructions)					N	N	39.00
40.00	Is this hospital subject to the HAC program reduction adjustment? Enter "Y" for yes or "N" for no in column 1, for discharges prior to October 1. Enter "Y" for yes or "N" for no in column 2, for discharges on or after October 1. (see instructions)					Y	Y	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.					Y	Y	
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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Part I
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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.				Y		70.00	
71.00	If line 70 is yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost report filed on or before November 15, 2004? Enter "Y" for yes or "N" for no. (see 42 CFR 412.424(d)(1)(iii)(c)) Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)				N	N	0	71.00
Inpatient Rehabilitation Facility PPS								
75.00	Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF subprovider? Enter "Y" for yes and "N" for no.				N		75.00	
76.00	If line 75 is yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)						0	76.00

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-0103	Period: From 01/01/2020 To 12/31/2020	Worksheet S-2 Part I Date/Time Prepared: 7/19/2021 1:49 pm
		1.00	2.00	
111.00	If this facility qualifies as a CAH, did it participate in the Frontier Community Health Integration Project (FCHIP) demonstration for this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If the response to column 1 is Y, enter the integration prong of the FCHIP demo in which this CAH is participating in column 2. Enter all that apply: "A" for Ambulance services; "B" for additional beds; and/or "C" for tele-health services.	N		111.00
		1.00	2.00	3.00
112.00	Did this hospital participate in the Pennsylvania Rural Health Model demonstration for any portion of the current cost reporting period? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2, the date the hospital began participating in the demonstration. In column 3, enter the date the hospital ceased participation in the demonstration, if applicable.	N		112.00
Miscellaneous Cost Reporting Information				
115.00	Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in column 1. If column 1 is yes, enter the method used (A, B, or E only) in column 2. If column 2 is "E", enter in column 3 either "93" percent for short term hospital or "98" percent for long term care (includes psychiatric, rehabilitation and long term hospitals providers) based on the definition in CMS Pub.15-1, chapter 22, §2208.1.	N		0 115.00
116.00	Is this facility classified as a referral center? Enter "Y" for yes or "N" for no.	N		116.00
117.00	Is this facility legally required to carry malpractice insurance? Enter "Y" for yes or "N" for no.	N		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.	0		118.00
		Premiums	Losses	Insurance
		1.00	2.00	3.00
118.01	List amounts of malpractice premiums and paid losses:	746,349	0	0 118.01
		1.00	2.00	
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein.	N		118.02
119.00	DO NOT USE THIS LINE			119.00
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 1, "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2, "Y" for yes or "N" for no.	N	N	120.00
121.00	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter "Y" for yes or "N" for no.	Y		121.00
122.00	Does the cost report contain healthcare related taxes as defined in §1903(w)(3) of the Act? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2 the Worksheet A line number where these taxes are included.	N		122.00
Transplant Center Information				
125.00	Does this facility operate a transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.	N		125.00
126.00	If this is a Medicare certified kidney transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			126.00
127.00	If this is a Medicare certified heart transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			127.00
128.00	If this is a Medicare certified liver transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			128.00
129.00	If this is a Medicare certified lung transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			129.00
130.00	If this is a Medicare certified pancreas transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			130.00
131.00	If this is a Medicare certified intestinal transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			131.00
132.00	If this is a Medicare certified islet transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			132.00
133.00	Removed and reserved			133.00
134.00	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.			134.00
All Providers				
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)	N		140.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA				Provider CCN: 14-0103		Period: From 01/01/2020 To 12/31/2020		Worksheet S-2 Part I Date/Time Prepared: 7/19/2021 1:49 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:	Contractor's Name:		Contractor's Number:				141.00	
142.00	Street:	PO Box:						142.00	
143.00	City:	State:		Zip Code:				143.00	
								1.00	
144.00	Are provider based physicians' costs included in Worksheet A?							Y	144.00
								1.00	2.00
145.00	If costs for renal services are claimed on Wkst. A, line 74, are the costs for inpatient services only? Enter "Y" for yes or "N" for no in column 1. If column 1 is no, does the dialysis facility include Medicare utilization for this cost reporting period? Enter "Y" for yes or "N" for no in column 2.				Y				145.00
146.00	Has the cost allocation methodology changed from the previously filed cost report? Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, chapter 40, §4020) If yes, enter the approval date (mm/dd/yyyy) in column 2.				N				146.00
								1.00	
147.00	Was there a change in the statistical basis? Enter "Y" for yes or "N" for no.							N	147.00
148.00	Was there a change in the order of allocation? Enter "Y" for yes or "N" for no.							N	148.00
149.00	Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no.							N	149.00
				Part A	Part B	Title V	Title XIX		
				1.00	2.00	3.00	4.00		
Does this facility contain a provider that qualifies for an exemption from the application of the lower of costs or charges? Enter "Y" for yes or "N" for no for each component for Part A and Part B. (See 42 CFR §413.13)									
155.00	Hospital	N	N	N	N	N	155.00		
156.00	Subprovider - IPF	N	N	N	N	N	156.00		
157.00	Subprovider - IRF	N	N	N	N	N	157.00		
158.00	SUBPROVIDER						158.00		
159.00	SNF	N	N	N	N	N	159.00		
160.00	HOME HEALTH AGENCY	N	N	N	N	N	160.00		
161.00	CMHC		N	N	N	N	161.00		
								1.00	
Multicampus									
165.00	Is this hospital part of a Multicampus hospital that has one or more campuses in different CBSAs? Enter "Y" for yes or "N" for no.							N	165.00
		Name	County	State	Zip Code	CBSA	FTE/Campus		
		0	1.00	2.00	3.00	4.00	5.00		
166.00	If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions)						0.00		
								1.00	
Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act									
167.00	Is this provider a meaningful user under §1886(n)? Enter "Y" for yes or "N" for no.							Y	167.00
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)								168.00
168.01	If this provider is a CAH and is not a meaningful user, does this provider qualify for a hardship exception under §413.70(a)(6)(ii)? Enter "Y" for yes or "N" for no. (see instructions)								168.01
169.00	If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)							9.99	169.00
						Beginning	Ending		
						1.00	2.00		
170.00	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)								170.00
						1.00	2.00		
171.00	If line 167 is "Y", does this provider have any days for individuals enrolled in section 1876 Medicare cost plans reported on Wkst. S-3, Pt. I, line 2, col. 6? Enter "Y" for yes and "N" for no in column 1. If column 1 is yes, enter the number of section 1876 Medicare days in column 2. (see instructions)					N	0		171.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 14-0103	Period: From 01/01/2020 To 12/31/2020	Worksheet S-2 Part II Date/Time Prepared: 7/19/2021 1:49 pm	
			Y/N	Date	
			1.00	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	Date	V/I
			1.00	2.00	3.00
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.	N			2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)	N			3.00
			Y/N	Type	Date
			1.00	2.00	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	Legal Oper.	
			1.00	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.	Y			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.	Y			15.00
			Part A		Part B
			Y/N	Date	Y/N
			1.00	2.00	3.00
			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	04/20/2021	Y	04/20/2021
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	N		N	
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N		N	
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		N	

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE

Provider CCN: 14-0103

Period:
From 01/01/2020
To 12/31/2020Worksheet S-2
Part II
Date/Time Prepared:
7/19/2021 1:49 pm

		Description	Y/N	Y/N	
		0	1.00	3.00	
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:		N	N	20.00
		Y/N	Date	Y/N	Date
		1.00	2.00	3.00	4.00
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		N	21.00
				1.00	
COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)					
Capital Related Cost					
22.00	Have assets been relifed for Medicare purposes? If yes, see instructions				22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.				23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions				24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.				25.00
26.00	Were assets subject to Sec.2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.				26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.				27.00
Interest Expense					
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.				28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions				29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.				30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.				31.00
Purchased Services					
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.				32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.				33.00
Provider-Based Physicians					
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.				34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.				35.00
		Y/N	Date		
		1.00	2.00		
Home Office Costs					
36.00	Were home office costs claimed on the cost report?		N		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.	TONY	LEONE		41.00
42.00	Enter the employer/company name of the cost report preparer.	TONY LEONE, CPA			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	847/275-1023	TONY@LEONE-CONSULTING.COM		43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 14-0103	Period: From 01/01/2020 To 12/31/2020	Worksheet S-2 Part II Date/Time Prepared: 7/19/2021 1:49 pm
		3.00		
Cost Report Preparer Contact Information				
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	CONSULTANT		41.00
42.00	Enter the employer/company name of the cost report preparer.			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.			43.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 14-0103

Period:
From 01/01/2020
To 12/31/2020Worksheet S-3
Part I
Date/Time Prepared:
7/19/2021 1:49 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	104	40,726	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)		104	40,726	0.00	0	7.00
8.00 INTENSIVE CARE UNIT	31.00	10	3,660	0.00	0	8.00
9.00 CORONARY CARE UNIT						9.00
10.00 BURN INTENSIVE CARE UNIT						10.00
11.00 SURGICAL INTENSIVE CARE UNIT						11.00
12.00 OTHER SPECIAL CARE (SPECIFY)						12.00
13.00 NURSERY	43.00				0	13.00
14.00 Total (see instructions)		114	44,386	0.00	0	14.00
15.00 CAH visits					0	15.00
16.00 SUBPROVIDER - IPF	40.00	60	21,960		0	16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY						22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
24.10 HOSPICE (non-distinct part)	30.00					24.10
25.00 CMHC - CMHC						25.00
26.00 RURAL HEALTH CLINIC						26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	26.25
27.00 Total (sum of lines 14-26)		174			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: 14-0103

Period:
From 01/01/2020
To 12/31/2020Worksheet S-3
Part I
Date/Time Prepared:
7/19/2021 1:49 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)	3,140	1,587	12,261			1.00
2.00	HMO and other (see instructions)	2,082	6,732				2.00
3.00	HMO IPF Subprovider	0	7,016				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)	3,140	1,587	12,261			7.00
8.00	INTENSIVE CARE UNIT	601	232	3,233			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		148	413			13.00
14.00	Total (see instructions)	3,741	1,967	15,907	3.32	646.27	14.00
15.00	CAH visits	0	0	0			15.00
16.00	SUBPROVIDER - IPF	1,158	915	10,466	0.00	53.54	16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)			0			24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0.00	0.00	26.25
27.00	Total (sum of lines 14-26)				3.32	699.81	27.00
28.00	Observation Bed Days		0	2,103			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	3			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: 14-0103

Period:
From 01/01/2020
To 12/31/2020Worksheet S-3
Part I
Date/Time Prepared:
7/19/2021 1:49 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	579	338	2,889	1.00
2.00 HMO and other (see instructions)			332	1,391		2.00
3.00 HMO IPF Subprovider				1,302		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	579	338	2,889	14.00
15.00 CAH visits						15.00
16.00 SUBPROVIDER - IPF	0.00	0	175	176	1,905	16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY						22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
24.10 HOSPICE (non-distinct part)						24.10
25.00 CMHC - CMHC						25.00
26.00 RURAL HEALTH CLINIC						26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER	0.00					26.25
27.00 Total (sum of lines 14-26)	0.00					27.00
28.00 Observation Bed Days						28.00
29.00 Ambulance Trips						29.00
30.00 Employee discount days (see instruction)						30.00
31.00 Employee discount days - IRF						31.00
32.00 Labor & delivery days (see instructions)						32.00
32.01 Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00 LTCH non-covered days			0			33.00
33.01 LTCH site neutral days and discharges			0			33.01

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 14-0103

Period:
From 01/01/2020
To 12/31/2020Worksheet S-3
Part II
Date/Time Prepared:
7/19/2021 1:49 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	44,879,646	0	44,879,646	1,241,431.00	36.15
2.00	Non-physician anesthetist Part A		0	0	0	0.00	0.00
3.00	Non-physician anesthetist Part B		0	0	0	0.00	0.00
4.00	Physician-Part A - Administrative		0	0	0	0.00	0.00
4.01	Physicians - Part A - Teaching		0	0	0	0.00	0.00
5.00	Physician and Non Physician-Part B		0	0	0	0.00	0.00
6.00	Non-physician-Part B for hospital-based RHC and FQHC services		0	0	0	0.00	0.00
7.00	Interns & residents (in an approved program)	21.00	0	0	0	0.00	0.00
7.01	Contracted interns and residents (in an approved programs)		501,309	0	501,309	8,320.00	60.25
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)		4,514,236	463,271	4,977,507	163,551.00	30.43
OTHER WAGES & RELATED COSTS							
11.00	Contract labor: Direct Patient Care		4,629,711	0	4,629,711	66,612.00	69.50
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		83,095	0	83,095	554.00	149.99
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)		10,082,611	0	10,082,611		
18.00	Wage-related costs (other) (see instructions)						
19.00	Excluded areas		1,033,364	0	1,033,364		
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		0	0	0		
24.00	Wage-related costs (RHC/FQHC)		0	0	0		
25.00	Interns & residents (in an approved program)		0	0	0		
25.50	Home office wage-related (core)		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		

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 14-0103

Period:
From 01/01/2020
To 12/31/2020Worksheet S-3
Part II
Date/Time Prepared:
7/19/2021 1:49 pm

		Wkst. A Line Number	Amount Reported	Reclassificati on of Salaries (from Wkst. A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
25.53	Home office: Physicians Part A - Teaching - wage-related (core)		0	0	0			25.53
OVERHEAD COSTS - DIRECT SALARIES								
26.00	Employee Benefits Department	4.00	255,489	0	255,489	8,299.00	30.79	26.00
27.00	Administrative & General	5.00	5,660,237	0	5,660,237	166,338.00	34.03	27.00
28.00	Administrative & General under contract (see inst.)		1,029,367	0	1,029,367	9,632.00	106.87	28.00
29.00	Maintenance & Repairs	6.00	0	0	0	0.00	0.00	29.00
30.00	Operation of Plant	7.00	2,714,894	0	2,714,894	98,592.00	27.54	30.00
31.00	Laundry & Linen Service	8.00	89,366	0	89,366	5,179.00	17.26	31.00
32.00	Housekeeping	9.00	1,704,512	0	1,704,512	94,515.00	18.03	32.00
33.00	Housekeeping under contract (see instructions)		0	0	0	0.00	0.00	33.00
34.00	Dietary	10.00	978,663	-415,959	562,704	30,008.00	18.75	34.00
35.00	Dietary under contract (see instructions)		810,931	0	810,931	14,280.00	56.79	35.00
36.00	Cafeteria	11.00	0	373,595	373,595	22,512.00	16.60	36.00
37.00	Maintenance of Personnel	12.00	0	0	0	0.00	0.00	37.00
38.00	Nursing Administration	13.00	970,005	0	970,005	32,282.00	30.05	38.00
39.00	Central Services and Supply	14.00	443,010	0	443,010	19,926.00	22.23	39.00
40.00	Pharmacy	15.00	1,444,312	0	1,444,312	41,350.00	34.93	40.00
41.00	Medical Records & Medical Records Library	16.00	650,526	0	650,526	25,854.00	25.16	41.00
42.00	Social Service	17.00	0	0	0	0.00	0.00	42.00
43.00	Other General Service	18.00	0	0	0	0.00	0.00	43.00

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 14-0103

Period:
From 01/01/2020
To 12/31/2020Worksheet S-3
Part III
Date/Time Prepared:
7/19/2021 1:49 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)	46,218,635	0	46,218,635	1,257,023.00	36.77	1.00
2.00	Excluded area salaries (see instructions)	4,514,236	463,271	4,977,507	163,551.00	30.43	2.00
3.00	Subtotal salaries (line 1 minus line 2)	41,704,399	-463,271	41,241,128	1,093,472.00	37.72	3.00
4.00	Subtotal other wages & related costs (see inst.)	4,712,806	0	4,712,806	67,166.00	70.17	4.00
5.00	Subtotal wage-related costs (see inst.)	10,082,611	0	10,082,611	0.00	24.45	5.00
6.00	Total (sum of lines 3 thru 5)	56,499,816	-463,271	56,036,545	1,160,638.00	48.28	6.00
7.00	Total overhead cost (see instructions)	16,751,312	-42,364	16,708,948	568,767.00	29.38	7.00

HOSPITAL WAGE RELATED COSTS

Provider CCN: 14-0103

Period:
From 01/01/2020
To 12/31/2020Worksheet S-3
Part IV
Date/Time Prepared:
7/19/2021 1:49 pm

		Amount Reported	
		1.00	
PART IV - WAGE RELATED COSTS			
Part A - Core List			
RETIREMENT COST			
1.00	401K Employer Contributions	446,675	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)	6,639,216	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)	70,417	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)	105,348	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)	0	14.00
15.00	'Workers' Compensation Insurance	461,318	15.00
16.00	Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. Non cumulative portion)	0	16.00
TAXES			
17.00	FICA-Employers Portion Only	3,285,165	17.00
18.00	Medicare Taxes - Employers Portion Only	0	18.00
19.00	Unemployment Insurance	102,000	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	5,836	23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)	11,115,975	24.00
Part B - Other than Core Related Cost			
25.00	OTHER WAGE RELATED COST		25.00

HOSPITAL CONTRACT LABOR AND BENEFIT COST

Provider CCN: 14-0103

Period:
From 01/01/2020
To 12/31/2020Worksheet S-3
Part V
Date/Time Prepared:
7/19/2021 1:49 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	4,629,711	11,115,975	1.00
2.00	Hospital	4,629,711	10,082,611	2.00
3.00	Subprovider - IPF	0	853,824	3.00
4.00	Subprovider - IRF			4.00
5.00	Subprovider - (Other)	0	0	5.00
6.00	Swing Beds - SNF	0	0	6.00
7.00	Swing Beds - NF	0	0	7.00
8.00	Hospital-Based SNF			8.00
9.00	Hospital-Based NF			9.00
10.00	Hospital-Based OLTC			10.00
11.00	Hospital-Based HHA			11.00
12.00	Separately Certified ASC			12.00
13.00	Hospital-Based Hospice			13.00
14.00	Hospital-Based Health Clinic RHC			14.00
15.00	Hospital-Based Health Clinic FQHC			15.00
16.00	Hospital-Based-CMHC			16.00
17.00	Renal Dialysis	0	0	17.00
18.00	Other	0	179,540	18.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA

Provider CCN: 14-0103

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

Worksheet S-10

Date/Time Prepared:
7/19/2021 1:49 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)		0.543253	1.00
Medicaid (see instructions for each line)				
2.00	Net revenue from Medicaid		25,946,160	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?		Y	4.00
5.00	If line 4 is no, then enter DSH and/or supplemental payments from Medicaid		0	5.00
6.00	Medicaid charges		88,668,056	6.00
7.00	Medicaid cost (line 1 times line 6)		48,169,187	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)		22,223,027	8.00
Children's Health Insurance Program (CHIP) (see instructions for each line)				
9.00	Net revenue from stand-alone CHIP		0	9.00
10.00	Stand-alone CHIP charges		0	10.00
11.00	Stand-alone CHIP cost (line 1 times line 10)		0	11.00
12.00	Difference between net revenue and costs for stand-alone CHIP (line 11 minus line 9; if < zero then enter zero)		0	12.00
Other state or local government indigent care program (see instructions for each line)				
13.00	Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9)		0	13.00
14.00	Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)		0	14.00
15.00	State or local indigent care program cost (line 1 times line 14)		0	15.00
16.00	Difference between net revenue and costs for state or local indigent care program (line 15 minus line 13; if < zero then enter zero)		0	16.00
Grants, donations and total unreimbursed cost for Medicaid, CHIP and state/local indigent care programs (see instructions for each line)				
17.00	Private grants, donations, or endowment income restricted to funding charity care		0	17.00
18.00	Government grants, appropriations or transfers for support of hospital operations		0	18.00
19.00	Total unreimbursed cost for Medicaid, CHIP and state and local indigent care programs (sum of lines 8, 12 and 16)		22,223,027	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)	10,222,520	537,188	10,759,708
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	5,553,415	537,188	6,090,603
22.00	Payments received from patients for amounts previously written off as charity care	0	0	0
23.00	Cost of charity care (line 21 minus line 22)	5,553,415	537,188	6,090,603
			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)		2,309,581	26.00
27.00	Medicare reimbursable bad debts for the entire hospital complex (see instructions)		456,157	27.00
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)		701,779	27.01
28.00	Non-Medicare bad debt expense (see instructions)		1,607,802	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)		1,119,065	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)		7,209,668	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)		29,432,695	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-0103

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

Worksheet A

Date/Time Prepared:
7/19/2021 1:49 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		4,956,428	4,956,428	-2,018,745	2,937,683	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		0	0	2,397,621	2,397,621	2.00
3.00	00300	OTHER CAP REL COSTS		0	0	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	255,489	8,027,632	8,283,121	0	8,283,121	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	5,660,237	9,618,664	15,278,901	-61,555	15,217,346	5.00
6.00	00600	MAINTENANCE & REPAIRS	0	0	0	0	0	6.00
7.00	00700	OPERATION OF PLANT	2,714,894	3,321,336	6,036,230	-326,295	5,709,935	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	89,366	286,709	376,075	0	376,075	8.00
9.00	00900	HOUSEKEEPING	1,704,512	440,733	2,145,245	0	2,145,245	9.00
10.00	01000	DIETARY	978,663	1,715,229	2,693,892	-1,194,989	1,498,903	10.00
11.00	01100	CAFETERIA	0	0	0	1,150,483	1,150,483	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	970,005	165,113	1,135,118	0	1,135,118	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	443,010	569,695	1,012,705	8,379	1,021,084	14.00
15.00	01500	PHARMACY	1,444,312	1,195,272	2,639,584	-981,806	1,657,778	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	650,526	364,859	1,015,385	0	1,015,385	16.00
17.00	01700	SOCIAL SERVICE	0	2,278,590	2,278,590	0	2,278,590	17.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	501,309	501,309	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0	22.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	7,657,560	6,259,372	13,916,932	-2,195,219	11,721,713	30.00
31.00	03100	INTENSIVE CARE UNIT	2,185,673	744,583	2,930,256	-252,503	2,677,753	31.00
40.00	04000	SUBPROVIDER - IPF	3,682,800	1,030,601	4,713,401	341,648	5,055,049	40.00
43.00	04300	NURSERY	0	249,023	249,023	-1,621	247,402	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	1,294,451	644,946	1,939,397	-476,632	1,462,765	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	189	11,063	11,252	67,127	78,379	52.00
53.00	05300	ANESTHESIOLOGY	33,775	2,245,418	2,279,193	-60,693	2,218,500	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,853,978	2,087,930	4,941,908	-74,006	4,867,902	54.00
60.00	06000	LABORATORY	2,282,331	2,971,715	5,254,046	-44,562	5,209,484	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	1,031,810	544,048	1,575,858	-232,253	1,343,605	65.00
66.00	06600	PHYSICAL THERAPY	549,609	143,449	693,058	-2,392	690,666	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	3,507,606	3,507,606	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	296,018	296,018	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	1,191,221	1,191,221	73.00
74.00	07400	RENAL DIALYSIS	0	347,806	347,806	-10,993	336,813	74.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	2,139,908	2,284,453	4,424,361	223,902	4,648,263	90.00
90.01	09001	PARTIAL HOSPITALIZATION PROGRAM	255,771	24,920	280,691	-313	280,378	90.01
91.00	09100	EMERGENCY	5,169,341	5,353,141	10,522,482	-1,303,504	9,218,978	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE		52,581	52,581	-52,581	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	44,048,210	57,935,309	101,983,519	394,652	102,378,171	118.00
NONREIMBURSABLE COST CENTERS								
192.00	19200	PHYSICIANS' PRIVATE OFFICES	179,974	99,118	279,092	63,124	342,216	192.00
192.01	19201	ADULT MOBILE UNIT	36,965	179,181	216,146	-146,355	69,791	192.01
194.00	07950	OUTPATIENT PHARMACY	517,829	1,335,110	1,852,939	-372,976	1,479,963	194.00
194.01	07951	PUBLIC RELATIONS	0	0	0	61,555	61,555	194.01
194.02	07952	FUNDRAISING	96,668	7,420	104,088	0	104,088	194.02
200.00		TOTAL (SUM OF LINES 118 through 199)	44,879,646	59,556,138	104,435,784	0	104,435,784	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-0103

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

Worksheet A

Date/Time Prepared:
7/19/2021 1:49 pm

Cost Center Description			Adjustments (See A-8) 6.00	Net Expenses For Allocation 7.00	
GENERAL SERVICE COST CENTERS					
1.00	00100	CAP REL COSTS-BLDG & FIXT	-75,707	2,861,976	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	-28,915	2,368,706	2.00
3.00	00300	OTHER CAP REL COSTS	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-123,700	8,159,421	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-1,004,800	14,212,546	5.00
6.00	00600	MAINTENANCE & REPAIRS	0	0	6.00
7.00	00700	OPERATION OF PLANT	-124,860	5,585,075	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	376,075	8.00
9.00	00900	HOUSEKEEPING	-45,076	2,100,169	9.00
10.00	01000	DIETARY	0	1,498,903	10.00
11.00	01100	CAFETERIA	-403,215	747,268	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	-68,762	1,066,356	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	1,021,084	14.00
15.00	01500	PHARMACY	0	1,657,778	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-24,857	990,528	16.00
17.00	01700	SOCIAL SERVICE	0	2,278,590	17.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	501,309	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	22.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	-2,237,492	9,484,221	30.00
31.00	03100	INTENSIVE CARE UNIT	-12,000	2,665,753	31.00
40.00	04000	SUBPROVIDER - IPF	-625,198	4,429,851	40.00
43.00	04300	NURSERY	-146,865	100,537	43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	1,462,765	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	78,379	52.00
53.00	05300	ANESTHESIOLOGY	-2,167,450	51,050	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-805,690	4,062,212	54.00
60.00	06000	LABORATORY	0	5,209,484	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	-24,000	1,319,605	65.00
66.00	06600	PHYSICAL THERAPY	0	690,666	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	3,507,606	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	296,018	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	1,191,221	73.00
74.00	07400	RENAL DIALYSIS	0	336,813	74.00
76.97	07697	CARDIAC REHABILITATION	0	0	76.97
OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	-3,264,252	1,384,011	90.00
90.01	09001	PARTIAL HOSPITALIZATION PROGRAM	0	280,378	90.01
91.00	09100	EMERGENCY	-3,406,025	5,812,953	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART			92.00
SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE	0	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-14,588,864	87,789,307	118.00
NONREIMBURSABLE COST CENTERS					
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	342,216	192.00
192.01	19201	ADULT MOBILE UNIT	0	69,791	192.01
194.00	07950	OUTPATIENT PHARMACY	0	1,479,963	194.00
194.01	07951	PUBLIC RELATIONS	0	61,555	194.01
194.02	07952	FUNDRAISING	0	104,088	194.02
200.00		TOTAL (SUM OF LINES 118 through 199)	-14,588,864	89,846,920	200.00

RECLASSIFICATIONS

Provider CCN: 14-0103

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

Worksheet A-6

Date/Time Prepared:
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	Increases					
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
	A - RECLASSIFY POST PARTUM					
1.00	NURSERY	43.00	76,819	20,543		1.00
2.00	DELIVERY ROOM & LABOR ROOM	52.00	60,737	16,243		2.00
	TOTALS		137,556	36,786		
	B - RECLASSIFY INTERNS & RESIDENTS					
1.00	I&R SERVICES-SALARY & FRINGES APPRV	21.00	0	501,309		1.00
	TOTALS		0	501,309		
	C - RECLASSIFY MEDICAL SUPPLIES					
1.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	3,803,624		1.00
2.00	CENTRAL SERVICES & SUPPLY	14.00	0	8,387		2.00
3.00	PHARMACY	15.00	0	9,562		3.00
4.00		0.00	0	0		4.00
5.00		0.00	0	0		5.00
6.00		0.00	0	0		6.00
7.00		0.00	0	0		7.00
8.00		0.00	0	0		8.00
9.00		0.00	0	0		9.00
10.00		0.00	0	0		10.00
11.00		0.00	0	0		11.00
12.00		0.00	0	0		12.00
13.00		0.00	0	0		13.00
14.00		0.00	0	0		14.00
15.00		0.00	0	0		15.00
16.00		0.00	0	0		16.00
17.00		0.00	0	0		17.00
18.00		0.00	0	0		18.00
19.00		0.00	0	0		19.00
20.00		0.00	0	0		20.00
	TOTALS		0	3,821,573		
	D - RECLASSIFY DRUGS SOLD					
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	1,191,221		1.00
2.00		0.00	0	0		2.00
3.00		0.00	0	0		3.00
4.00		0.00	0	0		4.00
5.00		0.00	0	0		5.00
6.00		0.00	0	0		6.00
7.00		0.00	0	0		7.00
8.00		0.00	0	0		8.00
10.00		0.00	0	0		10.00
11.00		0.00	0	0		11.00
13.00		0.00	0	0		13.00
15.00		0.00	0	0		15.00
	TOTALS		0	1,191,221		
	E - RECLASSIFY PSYCH DIETARY COSTS					
1.00	SUBPROVIDER - IPF	40.00	42,364	2,142		1.00
	TOTALS		42,364	2,142		
	G - RECLASSIFY EMERGENCY ROOM					
1.00	SUBPROVIDER - IPF	40.00	362,176	27,706		1.00
	TOTALS		362,176	27,706		
	H - RECLASSIFY DEPRECIATION					
1.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	2,345,040		1.00
	TOTALS		0	2,345,040		
	I - RECLASSIFY PROPERTY INSURANCE					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	326,295		1.00
	TOTALS		0	326,295		
	J - RECLASSIFY INTEREST EXPENSE					
1.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	52,581		1.00
	TOTALS		0	52,581		
	L - RECLASSIFY CAFETERIA COSTS					
1.00	CAFETERIA	11.00	373,595	776,888		1.00
	TOTALS		373,595	776,888		
	O - ACC RECLASS					
1.00	PHYSICIANS' PRIVATE OFFICES	192.00	58,731	4,493		1.00
	TOTALS		58,731	4,493		
	P - RECLASS PR COSTS					
1.00	PUBLIC RELATIONS	194.01	0	61,555		1.00
	TOTALS		0	61,555		
	Q - RECLASS IMPLANT COSTS					
1.00	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	296,018		1.00
	TOTALS		0	296,018		

RECLASSIFICATIONS

Provider CCN: 14-0103

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

Worksheet A-6

Date/Time Prepared:
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	Increases					
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
1.00	R - OP BEHAVIORAL HEALTH					
	CLINIC	90.00	0	82,026		
	TOTALS		0	82,026		
1.00	S - 340B DRUGS RECLASS					
	CLINIC	90.00	0	372,177		
	TOTALS		0	372,177		
500.00	Grand Total: Increases		974,422	9,897,810		

RECLASSIFICATIONS

Provider CCN: 14-0103

Period:
From 01/01/2020
To 12/31/2020Worksheet A-6
Date/Time Prepared:
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	Decreases				Wkst. A-7 Ref.		
	Cost Center	Line #	Salary	Other			
	6.00	7.00	8.00	9.00			
	A - RECLASSIFY POST PARTUM						
1.00	ADULTS & PEDIATRICS	30.00	76,819	20,543	0	1.00	
2.00	ADULTS & PEDIATRICS	30.00	60,737	16,243	0	2.00	
	TOTALS		137,556	36,786			
	B - RECLASSIFY INTERNS & RESIDENTS						
1.00	EMERGENCY	91.00	0	501,309	0	1.00	
	TOTALS		0	501,309			
	C - RECLASSIFY MEDICAL SUPPLIES						
1.00	ADULTS & PEDIATRICS	30.00		1,823,671	0	1.00	
2.00	INTENSIVE CARE UNIT	31.00		252,291	0	2.00	
3.00	SUBPROVIDER - IPF	40.00		10,504	0	3.00	
4.00	NURSERY	43.00		98,937	0	4.00	
5.00	OPERATING ROOM	50.00		476,525	0	5.00	
6.00	DELIVERY ROOM & LABOR ROOM	52.00		9,644	0	6.00	
7.00	ANESTHESIOLOGY	53.00		60,693	0	7.00	
8.00	RADIOLOGY-DIAGNOSTIC	54.00		71,206	0	8.00	
9.00	RADIOLOGY-DIAGNOSTIC	54.00		2,686	0	9.00	
10.00	LABORATORY	60.00		44,537	0	10.00	
11.00	RESPIRATORY THERAPY	65.00		232,253	0	11.00	
12.00	PHYSICAL THERAPY	66.00		2,392	0	12.00	
13.00	RENAL DIALYSIS	74.00		10,993	0	13.00	
14.00	CLINIC	90.00		166,361	0	14.00	
15.00	PARTIAL HOSPITALIZATION PROGRAM	90.01		313	0	15.00	
16.00	EMERGENCY	91.00		411,313	0	16.00	
17.00	PHYSICIANS' PRIVATE OFFICES	192.00		100	0	17.00	
18.00	ADULT MOBILE UNIT	192.01		146,355	0	18.00	
19.00	OUTPATIENT PHARMACY	194.00		799	0	19.00	
20.00	EMERGENCY				0	20.00	
	TOTALS		0	3,821,573			
	D - RECLASSIFY DRUGS SOLD						
1.00	CENTRAL SERVICES & SUPPLY	14.00	0	8	0	1.00	
2.00	PHARMACY	15.00	0	991,368	0	2.00	
3.00	ADULTS & PEDIATRICS	30.00	0	197,206	0	3.00	
4.00	INTENSIVE CARE UNIT	31.00	0	212	0	4.00	
5.00	SUBPROVIDER - IPF	40.00	0	210	0	5.00	
6.00	NURSERY	43.00	0	46	0	6.00	
7.00	OPERATING ROOM	50.00	0	107	0	7.00	
8.00	DELIVERY ROOM & LABOR ROOM	52.00	0	209	0	8.00	
10.00	RADIOLOGY-DIAGNOSTIC	54.00	0	114	0	10.00	
11.00	LABORATORY	60.00	0	25	0	11.00	
13.00	CLINIC	90.00	0	716	0	13.00	
15.00	EMERGENCY	91.00	0	1,000	0	15.00	
	TOTALS		0	1,191,221			
	E - RECLASSIFY PSYCH DIETARY COSTS						
1.00	DIETARY	10.00	42,364	2,142	0	1.00	
	TOTALS		42,364	2,142			
	G - RECLASSIFY EMERGENCY ROOM						
1.00	EMERGENCY	91.00	362,176	27,706	0	1.00	
	TOTALS		362,176	27,706			
	H - RECLASSIFY DEPRECIATION						
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	2,345,040	9	1.00	
	TOTALS		0	2,345,040			
	I - RECLASSIFY PROPERTY INSURANCE						
1.00	OPERATION OF PLANT	7.00	0	326,295	12	1.00	
	TOTALS		0	326,295			
	J - RECLASSIFY INTEREST EXPENSE						
1.00	INTEREST EXPENSE	113.00	0	52,581	11	1.00	
	TOTALS		0	52,581			
	L - RECLASSIFY CAFETERIA COSTS						
1.00	DIETARY	10.00	373,595	776,888	0	1.00	
	TOTALS		373,595	776,888			
	O - ACC RECLASS						
1.00	CLINIC	90.00	58,731	4,493	0	1.00	
	TOTALS		58,731	4,493			
	P - RECLASS PR COSTS						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	61,555	0	1.00	
	TOTALS		0	61,555			
	Q - RECLASS IMPLANT COSTS						
1.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	296,018	0	1.00	
	TOTALS		0	296,018			

RECLASSIFICATIONS

Provider CCN: 14-0103

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

Worksheet A-6

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Decreases						
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.	
	6.00	7.00	8.00	9.00	10.00	
	R - OP BEHAVIORAL HEALTH					
1.00	SUBPROVIDER - IPF	40.00	0	82,026	0	1.00
	TOTALS		0	82,026		
	S - 340B DRUGS RECLASS					
1.00	OUTPATIENT PHARMACY	194.00	0	372,177	0	1.00
	TOTALS		0	372,177		
500.00	Grand Total: Decreases		974,422	9,897,810		500.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-0103

Period:
From 01/01/2020
To 12/31/2020Worksheet A-7
Part I
Date/Time Prepared:
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		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	2,192,754	0	0	0	0	1.00	
2.00	Land Improvements	4,649,270	34,521	0	34,521	0	2.00	
3.00	Buildings and Fixtures	85,573,798	3,864,452	0	3,864,452	0	3.00	
4.00	Building Improvements	0	0	0	0	0	4.00	
5.00	Fixed Equipment	0	0	0	0	0	5.00	
6.00	Movable Equipment	57,624,357	1,296,665	0	1,296,665	0	6.00	
7.00	HIT designated Assets	0	0	0	0	0	7.00	
8.00	Subtotal (sum of lines 1-7)	150,040,179	5,195,638	0	5,195,638	0	8.00	
9.00	Reconciling Items	0	0	0	0	0	9.00	
10.00	Total (line 8 minus line 9)	150,040,179	5,195,638	0	5,195,638	0	10.00	
		Ending Balance	Fully Depreciated Assets					
		6.00	7.00					
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES							
1.00	Land	2,192,754	0				1.00	
2.00	Land Improvements	4,683,791	0				2.00	
3.00	Buildings and Fixtures	89,438,250	0				3.00	
4.00	Building Improvements	0	0				4.00	
5.00	Fixed Equipment	0	0				5.00	
6.00	Movable Equipment	58,921,022	0				6.00	
7.00	HIT designated Assets	0	0				7.00	
8.00	Subtotal (sum of lines 1-7)	155,235,817	0				8.00	
9.00	Reconciling Items	0	0				9.00	
10.00	Total (line 8 minus line 9)	155,235,817	0				10.00	

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-0103

Period:
From 01/01/2020
To 12/31/2020Worksheet A-7
Part II
Date/Time Prepared:
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Cost Center Description		SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	CAP REL COSTS-BLDG & FIXT	4,956,428	0	0	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	4,956,428	0	0	0	0	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)				
		14.00	15.00				
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	CAP REL COSTS-BLDG & FIXT	0	4,956,428				1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0				2.00
3.00	Total (sum of lines 1-2)	0	4,956,428				3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-0103

Period:
From 01/01/2020
To 12/31/2020Worksheet A-7
Part III
Date/Time Prepared:
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Cost Center Description		COMPUTATION OF RATIOS			ALLOCATION OF OTHER CAPITAL		
		Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	
		1.00	2.00	3.00	4.00	5.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	96,314,794	0	96,314,794	0.620442	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	58,921,023	0	58,921,023	0.379558	0	2.00
3.00	Total (sum of lines 1-2)	155,235,817	0	155,235,817	1.000000	0	3.00
Cost Center Description		ALLOCATION OF OTHER CAPITAL			SUMMARY OF CAPITAL		
		Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	Depreciation	Lease	
		6.00	7.00	8.00	9.00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	2,588,262	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	2,316,125	0	2.00
3.00	Total (sum of lines 1-2)	0	0	0	4,904,387	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	-52,581	326,295	0	0	2,861,976	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	52,581	0	0	0	2,368,706	2.00
3.00	Total (sum of lines 1-2)	0	326,295	0	0	5,230,682	3.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 14-0103

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

Worksheet A-8

Date/Time Prepared:
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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		B	2.00	3.00	4.00	5.00	
1.00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)	B	-52,581	CAP REL COSTS-BLDG & FIXT	1.00	11	1.00
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
3.00	Investment income - other (chapter 2)		0		0.00	0	3.00
4.00	Trade, quantity, and time discounts (chapter 8)		0		0.00	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)		0		0.00	0	5.00
6.00	Rental of provider space by suppliers (chapter 8)		0		0.00	0	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)		0		0.00	0	7.00
8.00	Television and radio service (chapter 21)		0		0.00	0	8.00
9.00	Parking lot (chapter 21)		0		0.00	0	9.00
10.00	Provider-based physician adjustment	A-8-2	-10,802,475			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	0			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests	B	-382,714	CAFETERIA	11.00	0	14.00
15.00	Rental of quarters to employee and others		0		0.00	0	15.00
16.00	Sale of medical and surgical supplies to other than patients		0		0.00	0	16.00
17.00	Sale of drugs to other than patients		0		0.00	0	17.00
18.00	Sale of medical records and abstracts	B	-24,857	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	B	-20,501	CAFETERIA	11.00	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 REVENUE OFFSET	B	-53,298	ADMINISTRATIVE & GENERAL	5.00	0	33.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 14-0103

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

Worksheet A-8

Date/Time Prepared:
7/19/2021 1:49 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	
34.00	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	34.00
35.00	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	35.00
38.00	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	38.00
39.00	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	39.00
40.00	MEDICAL GROUP REVENUE	B	-326,656	ADMINISTRATIVE & GENERAL	5.00	0	40.00
41.00	ER PHYSICIAN BILLING EXPENSE	A	-205,958	EMERGENCY	91.00	0	41.00
42.00	OFFSET DENTAL CLINIC COSTS	A	-1,095,808	CLINIC	90.00	0	42.00
42.01	PEDS VAN	A	-254,114	CLINIC	90.00	0	42.01
43.00	OFFSET OTHER LOBBYING COSTS	A	-162,000	ADMINISTRATIVE & GENERAL	5.00	0	43.00
45.00	OFFSET SPECIAL NEEDS CLINIC	A	-330,617	CLINIC	90.00	0	45.00
45.01	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	45.01
45.02	OFFSET OH RELATED TO CLINICS	A	-123,700	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	45.02
45.03	OFFSET OH RELATED TO CLINICS	A	-443,108	ADMINISTRATIVE & GENERAL	5.00	0	45.03
45.04	OFFSET OH RELATED TO CLINICS	A	-23,126	CAP REL COSTS-BLDG & FIXT	1.00	9	45.04
45.05	OFFSET OH RELATED TO CLINICS	A	-28,915	CAP REL COSTS-MVBLE EQUIP	2.00	9	45.05
45.06	OFFSET OH RELATED TO CLINICS	A	-124,860	OPERATION OF PLANT	7.00	0	45.06
45.07	OFFSET OH RELATED TO CLINICS	A	-45,076	HOUSEKEEPING	9.00	0	45.07
45.08	OFFSET OH RELATED TO CLINICS	A	-68,762	NURSING ADMINISTRATION	13.00	0	45.08
45.09	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	45.09
45.10	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	45.10
45.11	LOBBY DUES	A	-19,738	ADMINISTRATIVE & GENERAL	5.00	0	45.11
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-14,588,864				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.

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 14-0103

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

Worksheet A-8-2

Date/Time Prepared:
7/19/2021 1:49 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	2,237,492	2,237,492	0	0	0	1.00
2.00	31.00	INTENSIVE CARE UNIT	12,000	12,000	0	0	0	2.00
3.00	40.00	SUBPROVIDER - IPF	625,198	625,198	0	0	0	3.00
4.00	43.00	NURSERY	146,865	146,865	0	0	0	4.00
5.00	53.00	ANESTHESIOLOGY	2,167,450	2,167,450	0	0	0	5.00
6.00	54.00	RADIOLOGY-DIAGNOSTIC	805,690	805,690	0	0	0	6.00
7.00	65.00	RESPIRATORY THERAPY	24,000	24,000	0	0	0	7.00
8.00	90.00	CLINIC	1,583,713	1,583,713	0	0	0	8.00
9.00	91.00	EMERGENCY	3,200,067	3,200,067	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			10,802,475	10,802,475	0	0	0	200.00
	Wkst. A Line #	Cost Center/Physician Identifier	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	30.00	ADULTS & PEDIATRICS	0	0	0	0	0	1.00
2.00	31.00	INTENSIVE CARE UNIT	0	0	0	0	0	2.00
3.00	40.00	SUBPROVIDER - IPF	0	0	0	0	0	3.00
4.00	43.00	NURSERY	0	0	0	0	0	4.00
5.00	53.00	ANESTHESIOLOGY	0	0	0	0	0	5.00
6.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	6.00
7.00	65.00	RESPIRATORY THERAPY	0	0	0	0	0	7.00
8.00	90.00	CLINIC	0	0	0	0	0	8.00
9.00	91.00	EMERGENCY	0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			0	0	0	0	0	200.00
	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment		
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00	30.00	ADULTS & PEDIATRICS	0	0	0	2,237,492		1.00
2.00	31.00	INTENSIVE CARE UNIT	0	0	0	12,000		2.00
3.00	40.00	SUBPROVIDER - IPF	0	0	0	625,198		3.00
4.00	43.00	NURSERY	0	0	0	146,865		4.00
5.00	53.00	ANESTHESIOLOGY	0	0	0	2,167,450		5.00
6.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	805,690		6.00
7.00	65.00	RESPIRATORY THERAPY	0	0	0	24,000		7.00
8.00	90.00	CLINIC	0	0	0	1,583,713		8.00
9.00	91.00	EMERGENCY	0	0	0	3,200,067		9.00
10.00	0.00		0	0	0	0		10.00
200.00			0	0	0	10,802,475		200.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0103

Period:
From 01/01/2020
To 12/31/2020Worksheet B
Part I
Date/Time Prepared:
7/19/2021 1:49 pm

Cost Center Description			CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
			Net Expenses for Cost Allocation (from Wkst A col. 7)	BLDG & FIXT	MVBLE EQUIP		
			0	1.00	2.00	4.00	4A
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT	2,861,976	2,861,976			1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	2,368,706		2,368,706		2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	8,159,421	7,659	6,339	8,173,419	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	14,212,546	889,682	736,340	1,036,735	5.00
6.00	00600	MAINTENANCE & REPAIRS	0	0	0	0	6.00
7.00	00700	OPERATION OF PLANT	5,585,075	349,693	289,423	497,263	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	376,075	14,507	12,007	16,368	8.00
9.00	00900	HOUSEKEEPING	2,100,169	33,080	27,378	312,200	9.00
10.00	01000	DIETARY	1,498,903	41,823	34,615	103,065	10.00
11.00	01100	CAFETERIA	747,268	17,807	14,738	68,428	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	1,066,356	30,342	25,112	177,667	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	1,021,084	20,404	16,888	81,142	14.00
15.00	01500	PHARMACY	1,657,778	17,041	14,104	264,542	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	990,528	19,147	15,847	119,151	16.00
17.00	01700	SOCIAL SERVICE	2,278,590	10,939	9,054	0	17.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	501,309	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	22.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	9,484,221	225,423	186,571	1,377,388	30.00
31.00	03100	INTENSIVE CARE UNIT	2,665,753	51,212	42,385	400,330	31.00
40.00	04000	SUBPROVIDER - IPF	4,429,851	145,874	120,732	748,641	40.00
43.00	04300	NURSERY	100,537	13,837	11,452	14,070	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	1,462,765	100,707	83,349	237,093	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	78,379	41,230	34,124	11,159	52.00
53.00	05300	ANESTHESIOLOGY	51,050	3,561	2,948	6,186	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,062,212	80,283	66,446	522,737	54.00
60.00	06000	LABORATORY	5,209,484	66,663	55,174	418,034	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	1,319,605	52,877	43,764	188,987	65.00
66.00	06600	PHYSICAL THERAPY	690,666	41,785	34,583	100,667	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	3,507,606	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	296,018	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,191,221	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	336,813	0	0	0	74.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	76.97
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	1,384,011	96,737	80,064	381,190	90.00
90.01	09001	PARTIAL HOSPITALIZATION PROGRAM	280,378	12,139	10,047	46,847	90.01
91.00	09100	EMERGENCY	5,812,953	88,235	73,028	880,485	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					92.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	87,789,307	2,472,687	2,046,512	8,010,375	118.00
NONREIMBURSABLE COST CENTERS							
192.00	19200	PHYSICIANS' PRIVATE OFFICES	342,216	380,992	315,327	43,721	192.00
192.01	19201	ADULT MOBILE UNIT	69,791	0	0	6,771	192.01
194.00	07950	OUTPATIENT PHARMACY	1,479,963	8,297	6,867	94,846	194.00
194.01	07951	PUBLIC RELATIONS	61,555	0	0	0	194.01
194.02	07952	FUNDRAISING	104,088	0	0	17,706	194.02
200.00		Cross Foot Adjustments					200.00
201.00		Negative Cost Centers					201.00
202.00		TOTAL (sum lines 118 through 201)	89,846,920	2,861,976	2,368,706	8,173,419	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0103

Period:
From 01/01/2020
To 12/31/2020Worksheet B
Part I
Date/Time Prepared:
7/19/2021 1:49 pm

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	16,875,303					5.00
6.00	00600	MAINTENANCE & REPAIRS	0	0				6.00
7.00	00700	OPERATION OF PLANT	1,554,390	0	8,275,844			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	96,887	0	74,342	590,186		8.00
9.00	00900	HOUSEKEEPING	571,861	0	169,518	0	3,214,206	9.00
10.00	01000	DIETARY	388,145	0	214,325	0	85,768	10.00
11.00	01100	CAFETERIA	196,163	0	91,251	0	36,516	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	300,514	0	155,486	0	62,222	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	263,523	0	104,563	0	41,843	14.00
15.00	01500	PHARMACY	451,754	0	87,326	0	34,946	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	264,715	0	98,119	0	39,265	16.00
17.00	01700	SOCIAL SERVICE	531,566	0	56,059	0	22,433	17.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	115,932	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0	22.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	2,607,144	0	1,155,192	274,382	462,280	30.00
31.00	03100	INTENSIVE CARE UNIT	730,701	0	262,437	72,349	105,021	31.00
40.00	04000	SUBPROVIDER - IPF	1,259,222	0	747,539	234,213	299,147	40.00
43.00	04300	NURSERY	32,352	0	70,908	9,242	28,375	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	435,670	0	516,075	0	206,521	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	38,133	0	211,284	0	84,551	52.00
53.00	05300	ANESTHESIOLOGY	14,742	0	18,250	0	7,303	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,094,238	0	411,414	0	164,638	54.00
60.00	06000	LABORATORY	1,329,584	0	341,619	0	136,708	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	371,223	0	270,973	0	108,437	65.00
66.00	06600	PHYSICAL THERAPY	200,663	0	214,129	0	85,689	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	811,162	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	68,457	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	275,479	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	77,891	0	0	0	0	74.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	449,103	0	495,732	0	198,380	90.00
90.01	09001	PARTIAL HOSPITALIZATION PROGRAM	80,804	0	62,208	0	24,894	90.01
91.00	09100	EMERGENCY	1,585,204	0	452,167	0	180,946	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	16,197,222	0	6,280,916	590,186	2,415,883	118.00
NONREIMBURSABLE COST CENTERS								
192.00	19200	PHYSICIANS' PRIVATE OFFICES	250,280	0	1,952,410	0	781,308	192.00
192.01	19201	ADULT MOBILE UNIT	17,706	0	0	0	0	192.01
194.00	07950	OUTPATIENT PHARMACY	367,694	0	42,518	0	17,015	194.00
194.01	07951	PUBLIC RELATIONS	14,235	0	0	0	0	194.01
194.02	07952	FUNDRAISING	28,166	0	0	0	0	194.02
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)	16,875,303	0	8,275,844	590,186	3,214,206	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0103

Period:
From 01/01/2020
To 12/31/2020Worksheet B
Part I
Date/Time Prepared:
7/19/2021 1:49 pm

Cost Center Description			DIETARY	CAFETERIA	MAINTENANCE OF PERSONNEL	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	
			10.00	11.00	12.00	13.00	14.00	
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	2,366,644					10.00
11.00	01100	CAFETERIA	0	1,172,171				11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0			12.00
13.00	01300	NURSING ADMINISTRATION	0	36,732	0	1,854,431		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	22,674	0	52,491	1,624,612	14.00
15.00	01500	PHARMACY	0	47,052	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	29,419	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0	22.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	1,068,308	251,540	0	582,365	0	30.00
31.00	03100	INTENSIVE CARE UNIT	234,702	54,602	0	126,410	0	31.00
40.00	04000	SUBPROVIDER - IPF	1,063,634	157,296	0	364,168	0	40.00
43.00	04300	NURSERY	0	2,627	0	6,104	0	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	41,371	0	95,779	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	2,083	0	4,987	0	52.00
53.00	05300	ANESTHESIOLOGY	0	2,154	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	94,482	0	0	0	54.00
60.00	06000	LABORATORY	0	73,773	0	0	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0	42,720	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	16,118	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	1,507,305	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	117,307	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
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	101,843	0	235,785	0	90.00
90.01	09001	PARTIAL HOSPITALIZATION PROGRAM	0	6,887	0	15,946	0	90.01
91.00	09100	EMERGENCY	0	159,994	0	370,396	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	2,366,644	1,143,367	0	1,854,431	1,624,612	118.00
NONREIMBURSABLE COST CENTERS								
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	8,355	0	0	0	192.00
192.01	19201	ADULT MOBILE UNIT	0	0	0	0	0	192.01
194.00	07950	OUTPATIENT PHARMACY	0	18,011	0	0	0	194.00
194.01	07951	PUBLIC RELATIONS	0	0	0	0	0	194.01
194.02	07952	FUNDRAISING	0	2,438	0	0	0	194.02
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)	2,366,644	1,172,171	0	1,854,431	1,624,612	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0103

Period:
From 01/01/2020
To 12/31/2020Worksheet B
Part I
Date/Time Prepared:
7/19/2021 1:49 pm

Cost Center Description		PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	INTERNS & RESIDENTS		
					SERVICES-SALAR Y & FRINGES	SERVICES-OTHER PRGM COSTS	
					APPRV	APPRV	
		15.00	16.00	17.00	21.00	22.00	
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
12.00	01200	MAINTENANCE OF PERSONNEL					12.00
13.00	01300	NURSING ADMINISTRATION					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY					14.00
15.00	01500	PHARMACY	2,574,543				15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	1,576,191			16.00
17.00	01700	SOCIAL SERVICE	0	0	2,908,641		17.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	617,241	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	22.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	0	188,970	1,352,249	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	77,655	356,563	0	31.00
40.00	04000	SUBPROVIDER - IPF	0	140,385	1,154,280	0	40.00
43.00	04300	NURSERY	0	7,981	45,549	0	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	50,607	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	4,884	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	17,945	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	172,644	0	0	54.00
60.00	06000	LABORATORY	0	393,213	0	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0	111,780	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	10,725	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	66,051	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	10,654	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,574,543	96,938	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	20,017	0	0	74.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	76.97
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0	13,055	0	0	90.00
90.01	09001	PARTIAL HOSPITALIZATION PROGRAM	0	452	0	0	90.01
91.00	09100	EMERGENCY	0	192,235	0	617,241	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					92.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	2,574,543	1,576,191	2,908,641	617,241	118.00
NONREIMBURSABLE COST CENTERS							
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	192.00
192.01	19201	ADULT MOBILE UNIT	0	0	0	0	192.01
194.00	07950	OUTPATIENT PHARMACY	0	0	0	0	194.00
194.01	07951	PUBLIC RELATIONS	0	0	0	0	194.01
194.02	07952	FUNDRAISING	0	0	0	0	194.02
200.00		Cross Foot Adjustments					200.00
201.00		Negative Cost Centers	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	2,574,543	1,576,191	2,908,641	617,241	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0103

Period:
From 01/01/2020
To 12/31/2020Worksheet B
Part I
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Cost Center Description			Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			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
12.00	01200	MAINTENANCE OF PERSONNEL				12.00
13.00	01300	NURSING ADMINISTRATION				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY				14.00
15.00	01500	PHARMACY				15.00
16.00	01600	MEDICAL RECORDS & LIBRARY				16.00
17.00	01700	SOCIAL SERVICE				17.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV				21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV				22.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	19,216,033	0	19,216,033	30.00
31.00	03100	INTENSIVE CARE UNIT	5,180,120	0	5,180,120	31.00
40.00	04000	SUBPROVIDER - IPF	10,864,982	0	10,864,982	40.00
43.00	04300	NURSERY	343,034	0	343,034	43.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	3,229,937	0	3,229,937	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	510,814	0	510,814	52.00
53.00	05300	ANESTHESIOLOGY	124,139	0	124,139	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	6,669,094	0	6,669,094	54.00
60.00	06000	LABORATORY	8,024,252	0	8,024,252	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	2,510,366	0	2,510,366	65.00
66.00	06600	PHYSICAL THERAPY	1,395,025	0	1,395,025	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	5,892,124	0	5,892,124	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	492,436	0	492,436	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	4,138,181	0	4,138,181	73.00
74.00	07400	RENAL DIALYSIS	434,721	0	434,721	74.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	76.97
OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	3,435,900	0	3,435,900	90.00
90.01	09001	PARTIAL HOSPITALIZATION PROGRAM	540,602	0	540,602	90.01
91.00	09100	EMERGENCY	10,412,884	-617,241	9,795,643	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART		0		92.00
SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE				113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	83,414,644	-617,241	82,797,403	118.00
NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	4,074,609	0	4,074,609	192.00
192.01	19201	ADULT MOBILE UNIT	94,268	0	94,268	192.01
194.00	07950	OUTPATIENT PHARMACY	2,035,211	0	2,035,211	194.00
194.01	07951	PUBLIC RELATIONS	75,790	0	75,790	194.01
194.02	07952	FUNDRAISING	152,398	0	152,398	194.02
200.00		Cross Foot Adjustments	0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	89,846,920	-617,241	89,229,679	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0103

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	196	7,659	6,339	14,194	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	62,713	889,682	736,340	1,688,735	5.00
6.00	00600	MAINTENANCE & REPAIRS	0	0	0	0	6.00
7.00	00700	OPERATION OF PLANT	17,225	349,693	289,423	656,341	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	14,507	12,007	26,514	8.00
9.00	00900	HOUSEKEEPING	0	33,080	27,378	60,458	9.00
10.00	01000	DIETARY	2,470	41,823	34,615	78,908	10.00
11.00	01100	CAFETERIA	0	17,807	14,738	32,545	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	1,717	30,342	25,112	57,171	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	158,752	20,404	16,888	196,044	14.00
15.00	01500	PHARMACY	1,323	17,041	14,104	32,468	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	3,124	19,147	15,847	38,118	16.00
17.00	01700	SOCIAL SERVICE	1,913	10,939	9,054	21,906	17.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	22.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	68,221	225,423	186,571	480,215	30.00
31.00	03100	INTENSIVE CARE UNIT	251	51,212	42,385	93,848	31.00
40.00	04000	SUBPROVIDER - IPF	641	145,874	120,732	267,247	40.00
43.00	04300	NURSERY	740	13,837	11,452	26,029	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	10,940	100,707	83,349	194,996	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	507	41,230	34,124	75,861	52.00
53.00	05300	ANESTHESIOLOGY	0	3,561	2,948	6,509	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,667	80,283	66,446	151,396	54.00
60.00	06000	LABORATORY	129,637	66,663	55,174	251,474	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	104,656	52,877	43,764	201,297	65.00
66.00	06600	PHYSICAL THERAPY	2,929	41,785	34,583	79,297	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	74.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	76.97
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	3,531	96,737	80,064	180,332	90.00
90.01	09001	PARTIAL HOSPITALIZATION PROGRAM	1,163	12,139	10,047	23,349	90.01
91.00	09100	EMERGENCY	4,828	88,235	73,028	166,091	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				0	92.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	582,144	2,472,687	2,046,512	5,101,343	118.00
NONREIMBURSABLE COST CENTERS							
192.00	19200	PHYSICIANS' PRIVATE OFFICES	7,040	380,992	315,327	703,359	192.00
192.01	19201	ADULT MOBILE UNIT	0	0	0	0	192.01
194.00	07950	OUTPATIENT PHARMACY	2,484	8,297	6,867	17,648	194.00
194.01	07951	PUBLIC RELATIONS	0	0	0	0	194.01
194.02	07952	FUNDRAISING	0	0	0	0	194.02
200.00		Cross Foot Adjustments				0	200.00
201.00		Negative Cost Centers				0	201.00
202.00		TOTAL (sum lines 118 through 201)	591,668	2,861,976	2,368,706	5,822,350	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0103

Period:
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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	1,690,535					5.00
6.00	00600	MAINTENANCE & REPAIRS	0	0				6.00
7.00	00700	OPERATION OF PLANT	155,716	0	812,920			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	9,706	0	7,302	43,550		8.00
9.00	00900	HOUSEKEEPING	57,288	0	16,651	0	134,939	9.00
10.00	01000	DIETARY	38,884	0	21,053	0	3,601	10.00
11.00	01100	CAFETERIA	19,651	0	8,963	0	1,533	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	30,105	0	15,273	0	2,612	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	26,399	0	10,271	0	1,757	14.00
15.00	01500	PHARMACY	45,256	0	8,578	0	1,467	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	26,519	0	9,638	0	1,648	16.00
17.00	01700	SOCIAL SERVICE	53,251	0	5,507	0	942	17.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	11,614	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0	22.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	261,175	0	113,472	20,246	19,407	30.00
31.00	03100	INTENSIVE CARE UNIT	73,200	0	25,779	5,339	4,409	31.00
40.00	04000	SUBPROVIDER - IPF	126,147	0	73,429	17,283	12,559	40.00
43.00	04300	NURSERY	3,241	0	6,965	682	1,191	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	43,645	0	50,693	0	8,670	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	3,820	0	20,754	0	3,550	52.00
53.00	05300	ANESTHESIOLOGY	1,477	0	1,793	0	307	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	109,619	0	40,412	0	6,912	54.00
60.00	06000	LABORATORY	133,195	0	33,557	0	5,739	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	37,188	0	26,617	0	4,552	65.00
66.00	06600	PHYSICAL THERAPY	20,102	0	21,033	0	3,597	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	81,261	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	6,858	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	27,597	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	7,803	0	0	0	0	74.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	44,990	0	48,695	0	8,328	90.00
90.01	09001	PARTIAL HOSPITALIZATION PROGRAM	8,095	0	6,111	0	1,045	90.01
91.00	09100	EMERGENCY	158,803	0	44,415	0	7,596	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	1,622,605	0	616,961	43,550	101,422	118.00
NONREIMBURSABLE COST CENTERS								
192.00	19200	PHYSICIANS' PRIVATE OFFICES	25,073	0	191,783	0	32,803	192.00
192.01	19201	ADULT MOBILE UNIT	1,774	0	0	0	0	192.01
194.00	07950	OUTPATIENT PHARMACY	36,835	0	4,176	0	714	194.00
194.01	07951	PUBLIC RELATIONS	1,426	0	0	0	0	194.01
194.02	07952	FUNDRAISING	2,822	0	0	0	0	194.02
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	1,690,535	0	812,920	43,550	134,939	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0103

Period:
From 01/01/2020
To 12/31/2020Worksheet B
Part II
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Cost Center Description			DIETARY	CAFETERIA	MAINTENANCE OF PERSONNEL	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	
			10.00	11.00	12.00	13.00	14.00	
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	142,625					10.00
11.00	01100	CAFETERIA	0	62,811				11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0			12.00
13.00	01300	NURSING ADMINISTRATION	0	1,968	0	107,437		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	1,215	0	3,041	238,868	14.00
15.00	01500	PHARMACY	0	2,521	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	1,576	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0	22.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	64,381	13,479	0	33,739	0	30.00
31.00	03100	INTENSIVE CARE UNIT	14,144	2,926	0	7,324	0	31.00
40.00	04000	SUBPROVIDER - IPF	64,100	8,429	0	21,098	0	40.00
43.00	04300	NURSERY	0	141	0	354	0	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	2,217	0	5,549	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	112	0	289	0	52.00
53.00	05300	ANESTHESIOLOGY	0	115	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	5,063	0	0	0	54.00
60.00	06000	LABORATORY	0	3,953	0	0	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0	2,289	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	864	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	221,620	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	17,248	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
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	5,457	0	13,660	0	90.00
90.01	09001	PARTIAL HOSPITALIZATION PROGRAM	0	369	0	924	0	90.01
91.00	09100	EMERGENCY	0	8,573	0	21,459	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	142,625	61,267	0	107,437	238,868	118.00
NONREIMBURSABLE COST CENTERS								
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	448	0	0	0	192.00
192.01	19201	ADULT MOBILE UNIT	0	0	0	0	0	192.01
194.00	07950	OUTPATIENT PHARMACY	0	965	0	0	0	194.00
194.01	07951	PUBLIC RELATIONS	0	0	0	0	0	194.01
194.02	07952	FUNDRAISING	0	131	0	0	0	194.02
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)	142,625	62,811	0	107,437	238,868	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0103

Period:
From 01/01/2020
To 12/31/2020Worksheet B
Part II
Date/Time Prepared:
7/19/2021 1:49 pm

Cost Center Description			PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	INTERNS & RESIDENTS		
						SERVICES-SALAR Y & FRINGES APPRV	SERVICES-OTHER PRGM COSTS APPRV	
			15.00	16.00	17.00	21.00	22.00	
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
12.00	01200	MAINTENANCE OF PERSONNEL						12.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY	90,749					15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	77,706				16.00
17.00	01700	SOCIAL SERVICE	0	0	81,606			17.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	11,614		21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0		0	22.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	0	9,319	37,939			30.00
31.00	03100	INTENSIVE CARE UNIT	0	3,829	10,004			31.00
40.00	04000	SUBPROVIDER - IPF	0	6,923	32,385			40.00
43.00	04300	NURSERY	0	394	1,278			43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	2,496	0			50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	241	0			52.00
53.00	05300	ANESTHESIOLOGY	0	885	0			53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	8,514	0			54.00
60.00	06000	LABORATORY	0	19,369	0			60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0			62.30
65.00	06500	RESPIRATORY THERAPY	0	5,512	0			65.00
66.00	06600	PHYSICAL THERAPY	0	529	0			66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0			69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	3,257	0			71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	525	0			72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	90,749	4,780	0			73.00
74.00	07400	RENAL DIALYSIS	0	987	0			74.00
76.97	07697	CARDIAC REHABILITATION	0	0	0			76.97
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	644	0			90.00
90.01	09001	PARTIAL HOSPITALIZATION PROGRAM	0	22	0			90.01
91.00	09100	EMERGENCY	0	9,480	0			91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	90,749	77,706	81,606	0	0	118.00
NONREIMBURSABLE COST CENTERS								
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0			192.00
192.01	19201	ADULT MOBILE UNIT	0	0	0			192.01
194.00	07950	OUTPATIENT PHARMACY	0	0	0			194.00
194.01	07951	PUBLIC RELATIONS	0	0	0			194.01
194.02	07952	FUNDRAISING	0	0	0			194.02
200.00		Cross Foot Adjustments				11,614	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	90,749	77,706	81,606	11,614	0	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0103

Period:
From 01/01/2020
To 12/31/2020Worksheet B
Part II
Date/Time Prepared:
7/19/2021 1:49 pm

Cost Center Description			Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			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
12.00	01200	MAINTENANCE OF PERSONNEL				12.00
13.00	01300	NURSING ADMINISTRATION				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY				14.00
15.00	01500	PHARMACY				15.00
16.00	01600	MEDICAL RECORDS & LIBRARY				16.00
17.00	01700	SOCIAL SERVICE				17.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV				21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV				22.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,055,766	0	1,055,766	30.00
31.00	03100	INTENSIVE CARE UNIT	241,497	0	241,497	31.00
40.00	04000	SUBPROVIDER - IPF	630,900	0	630,900	40.00
43.00	04300	NURSERY	40,299	0	40,299	43.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	308,678	0	308,678	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	104,646	0	104,646	52.00
53.00	05300	ANESTHESIOLOGY	11,097	0	11,097	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	322,824	0	322,824	54.00
60.00	06000	LABORATORY	448,013	0	448,013	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	277,783	0	277,783	65.00
66.00	06600	PHYSICAL THERAPY	125,597	0	125,597	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	306,138	0	306,138	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	24,631	0	24,631	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	123,126	0	123,126	73.00
74.00	07400	RENAL DIALYSIS	8,790	0	8,790	74.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	76.97
OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	302,768	0	302,768	90.00
90.01	09001	PARTIAL HOSPITALIZATION PROGRAM	39,996	0	39,996	90.01
91.00	09100	EMERGENCY	417,946	0	417,946	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART		0		92.00
SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE				113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	4,790,495	0	4,790,495	118.00
NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	953,542	0	953,542	192.00
192.01	19201	ADULT MOBILE UNIT	1,786	0	1,786	192.01
194.00	07950	OUTPATIENT PHARMACY	60,503	0	60,503	194.00
194.01	07951	PUBLIC RELATIONS	1,426	0	1,426	194.01
194.02	07952	FUNDRAISING	2,984	0	2,984	194.02
200.00		Cross Foot Adjustments	11,614	0	11,614	200.00
201.00		Negative Cost Centers	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	5,822,350	0	5,822,350	202.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0103

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

Worksheet B-1

Date/Time Prepared:
7/19/2021 1:49 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	448,423					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		448,423				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	1,200	1,200	44,624,157			4.00
5.00	00500	ADMINISTRATIVE & GENERAL	139,398	139,398	5,660,237	-16,875,303	72,971,617	5.00
6.00	00600	MAINTENANCE & REPAIRS	0	0	0	0	0	6.00
7.00	00700	OPERATION OF PLANT	54,791	54,791	2,714,894	0	6,721,454	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	2,273	2,273	89,366	0	418,957	8.00
9.00	00900	HOUSEKEEPING	5,183	5,183	1,704,512	0	2,472,827	9.00
10.00	01000	DIETARY	6,553	6,553	562,704	0	1,678,406	10.00
11.00	01100	CAFETERIA	2,790	2,790	373,595	0	848,241	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	4,754	4,754	970,005	0	1,299,477	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	3,197	3,197	443,010	0	1,139,518	14.00
15.00	01500	PHARMACY	2,670	2,670	1,444,312	0	1,953,465	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	3,000	3,000	650,526	0	1,144,673	16.00
17.00	01700	SOCIAL SERVICE	1,714	1,714	0	0	2,298,583	17.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	501,309	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0	22.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	35,320	35,320	7,520,004	0	11,273,603	30.00
31.00	03100	INTENSIVE CARE UNIT	8,024	8,024	2,185,673	0	3,159,680	31.00
40.00	04000	SUBPROVIDER - IPF	22,856	22,856	4,087,340	0	5,445,098	40.00
43.00	04300	NURSERY	2,168	2,168	76,819	0	139,896	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	15,779	15,779	1,294,451	0	1,883,914	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	6,460	6,460	60,926	0	164,892	52.00
53.00	05300	ANESTHESIOLOGY	558	558	33,775	0	63,745	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	12,579	12,579	2,853,978	0	4,731,678	54.00
60.00	06000	LABORATORY	10,445	10,445	2,282,331	0	5,749,355	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	8,285	8,285	1,031,810	0	1,605,233	65.00
66.00	06600	PHYSICAL THERAPY	6,547	6,547	549,609	0	867,701	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	3,507,606	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	296,018	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	1,191,221	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	336,813	74.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	15,157	15,157	2,081,177	0	1,942,002	90.00
90.01	09001	PARTIAL HOSPITALIZATION PROGRAM	1,902	1,902	255,771	0	349,411	90.01
91.00	09100	EMERGENCY	13,825	13,825	4,807,165	0	6,854,701	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	387,428	387,428	43,733,990	-16,875,303	70,039,477	118.00
NONREIMBURSABLE COST CENTERS								
192.00	19200	PHYSICIANS' PRIVATE OFFICES	59,695	59,695	238,705	0	1,082,256	192.00
192.01	19201	ADULT MOBILE UNIT	0	0	36,965	0	76,562	192.01
194.00	07950	OUTPATIENT PHARMACY	1,300	1,300	517,829	0	1,589,973	194.00
194.01	07951	PUBLIC RELATIONS	0	0	0	0	61,555	194.01
194.02	07952	FUNDRAISING	0	0	96,668	0	121,794	194.02
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	2,861,976	2,368,706	8,173,419		16,875,303	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	6.382313	5.282303	0.183161		0.231258	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)			14,194		1,690,535	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)			0.000318		0.023167	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: 14-0103

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

Worksheet B-1

Date/Time Prepared:
7/19/2021 1:49 pm

Cost Center Description		MAINTENANCE & REPAIRS (SQUARE FEET)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (TOTAL PATIENT DAYS)	HOUSEKEEPING (SQUARE FEET)	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	0				6.00
7.00	00700	OPERATION OF PLANT	0	253,034			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	2,273	26,373		8.00
9.00	00900	HOUSEKEEPING	0	5,183	0	245,578	9.00
10.00	01000	DIETARY	0	6,553	0	6,553	81,506 10.00
11.00	01100	CAFETERIA	0	2,790	0	2,790	0 11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0 12.00
13.00	01300	NURSING ADMINISTRATION	0	4,754	0	4,754	0 13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	3,197	0	3,197	0 14.00
15.00	01500	PHARMACY	0	2,670	0	2,670	0 15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	3,000	0	3,000	0 16.00
17.00	01700	SOCIAL SERVICE	0	1,714	0	1,714	0 17.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	0 21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0 22.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	0	35,320	12,261	35,320	36,792 30.00
31.00	03100	INTENSIVE CARE UNIT	0	8,024	3,233	8,024	8,083 31.00
40.00	04000	SUBPROVIDER - IPF	0	22,856	10,466	22,856	36,631 40.00
43.00	04300	NURSERY	0	2,168	413	2,168	0 43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	15,779	0	15,779	0 50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	6,460	0	6,460	0 52.00
53.00	05300	ANESTHESIOLOGY	0	558	0	558	0 53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	12,579	0	12,579	0 54.00
60.00	06000	LABORATORY	0	10,445	0	10,445	0 60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0 62.30
65.00	06500	RESPIRATORY THERAPY	0	8,285	0	8,285	0 65.00
66.00	06600	PHYSICAL THERAPY	0	6,547	0	6,547	0 66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0 69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0 71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0 72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0 73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0 74.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0 76.97
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0	15,157	0	15,157	0 90.00
90.01	09001	PARTIAL HOSPITALIZATION PROGRAM	0	1,902	0	1,902	0 90.01
91.00	09100	EMERGENCY	0	13,825	0	13,825	0 91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					92.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	192,039	26,373	184,583	81,506 118.00
NONREIMBURSABLE COST CENTERS							
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	59,695	0	59,695	0 192.00
192.01	19201	ADULT MOBILE UNIT	0	0	0	0	0 192.01
194.00	07950	OUTPATIENT PHARMACY	0	1,300	0	1,300	0 194.00
194.01	07951	PUBLIC RELATIONS	0	0	0	0	0 194.01
194.02	07952	FUNDRAISING	0	0	0	0	0 194.02
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)	0	8,275,844	590,186	3,214,206	2,366,644 202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.000000	32.706451	22.378417	13.088330	29.036439 203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	0	812,920	43,550	134,939	142,625 204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.000000	3.212691	1.651310	0.549475	1.749871 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: 14-0103

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

Worksheet B-1

Date/Time Prepared:
7/19/2021 1:49 pm

Cost Center Description			CAFETERIA (FTES)	MAINTENANCE OF PERSONNEL (NUMBER HOUSED)	NURSING ADMINISTRATION (DIRECT NRSNG HRS)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	
			11.00	12.00	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						10.00
11.00	01100	CAFETERIA	49,526					11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0				12.00
13.00	01300	NURSING ADMINISTRATION	1,552	0	703,951			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	958	0	19,926	4,099,640		14.00
15.00	01500	PHARMACY	1,988	0	0	0	100	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,243	0	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0	22.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	10,628	0	221,069	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	2,307	0	47,986	0	0	31.00
40.00	04000	SUBPROVIDER - IPF	6,646	0	138,240	0	0	40.00
43.00	04300	NURSERY	111	0	2,317	0	0	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	1,748	0	36,358	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	88	0	1,893	0	0	52.00
53.00	05300	ANESTHESIOLOGY	91	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,992	0	0	0	0	54.00
60.00	06000	LABORATORY	3,117	0	0	0	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	1,805	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	681	0	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	3,803,622	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	296,018	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	100	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	4,303	0	89,505	0	0	90.00
90.01	09001	PARTIAL HOSPITALIZATION PROGRAM	291	0	6,053	0	0	90.01
91.00	09100	EMERGENCY	6,760	0	140,604	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	48,309	0	703,951	4,099,640	100	118.00
NONREIMBURSABLE COST CENTERS								
192.00	19200	PHYSICIANS' PRIVATE OFFICES	353	0	0	0	0	192.00
192.01	19201	ADULT MOBILE UNIT	0	0	0	0	0	192.01
194.00	07950	OUTPATIENT PHARMACY	761	0	0	0	0	194.00
194.01	07951	PUBLIC RELATIONS	0	0	0	0	0	194.01
194.02	07952	FUNDRAISING	103	0	0	0	0	194.02
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)	1,172,171	0	1,854,431	1,624,612	2,574,543	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	23.667791	0.000000	2.634318	0.396282	25,745.430000	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	62,811	0	107,437	238,868	90,749	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	1.268243	0.000000	0.152620	0.058266	907.490000	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: 14-0103

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

Worksheet B-1

Date/Time Prepared:
7/19/2021 1:49 pm

Cost Center Description			MEDICAL RECORDS & LIBRARY (GROSS REVENUE)	SOCIAL SERVICE (TOTAL PATIENT DAYS)	INTERNS & RESIDENTS			
					SERVICES-SALAR Y & FRINGES APPRV (ASSIGNED TIME)	SERVICES-OTHER PRGM COSTS APPRV (ASSIGNED TIME)		
			16.00	17.00	21.00	22.00		
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
12.00	01200	MAINTENANCE OF PERSONNEL						12.00
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	152,410,325					16.00
17.00	01700	SOCIAL SERVICE	0	26,373				17.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	100			21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0		0		22.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	18,272,137	12,261	0	0		30.00
31.00	03100	INTENSIVE CARE UNIT	7,508,728	3,233	0	0		31.00
40.00	04000	SUBPROVIDER - IPF	13,574,225	10,466	0	0		40.00
43.00	04300	NURSERY	771,698	413	0	0		43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	4,893,367	0	0	0		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	472,290	0	0	0		52.00
53.00	05300	ANESTHESIOLOGY	1,735,129	0	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	16,693,462	0	0	0		54.00
60.00	06000	LABORATORY	38,024,462	0	0	0		60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0		62.30
65.00	06500	RESPIRATORY THERAPY	10,808,375	0	0	0		65.00
66.00	06600	PHYSICAL THERAPY	1,037,027	0	0	0		66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	6,386,715	0	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1,030,143	0	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	9,373,262	0	0	0		73.00
74.00	07400	RENAL DIALYSIS	1,935,467	0	0	0		74.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0		76.97
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	1,262,317	0	0	0		90.00
90.01	09001	PARTIAL HOSPITALIZATION PROGRAM	43,725	0	0	0		90.01
91.00	09100	EMERGENCY	18,587,796	0	100	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	152,410,325	26,373	100	0		118.00
NONREIMBURSABLE COST CENTERS								
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0		192.00
192.01	19201	ADULT MOBILE UNIT	0	0	0	0		192.01
194.00	07950	OUTPATIENT PHARMACY	0	0	0	0		194.00
194.01	07951	PUBLIC RELATIONS	0	0	0	0		194.01
194.02	07952	FUNDRAISING	0	0	0	0		194.02
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)	1,576,191	2,908,641	617,241	0		202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.010342	110.288591	6,172.410000	0.000000		203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	77,706	81,606	11,614	0		204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.000510	3.094301	116.140000	0.000000		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: 14-0103

Period:
From 01/01/2020
To 12/31/2020Worksheet C
Part I
Date/Time Prepared:
7/19/2021 1:49 pm

			Title XVIII		Hospital		PPS	
Cost Center Description			Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs		Total Costs	
					Total Costs	RCE Disallowance		
			1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	19,216,033		19,216,033	0	19,216,033	30.00
31.00	03100	INTENSIVE CARE UNIT	5,180,120		5,180,120	0	5,180,120	31.00
40.00	04000	SUBPROVIDER - IPF	10,864,982		10,864,982	0	10,864,982	40.00
43.00	04300	NURSERY	343,034		343,034	0	343,034	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	3,229,937		3,229,937	0	3,229,937	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	510,814		510,814	0	510,814	52.00
53.00	05300	ANESTHESIOLOGY	124,139		124,139	0	124,139	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	6,669,094		6,669,094	0	6,669,094	54.00
60.00	06000	LABORATORY	8,024,252		8,024,252	0	8,024,252	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0		0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	2,510,366	0	2,510,366	0	2,510,366	65.00
66.00	06600	PHYSICAL THERAPY	1,395,025	0	1,395,025	0	1,395,025	66.00
69.00	06900	ELECTROCARDIOLOGY	0		0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	5,892,124		5,892,124	0	5,892,124	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	492,436		492,436	0	492,436	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	4,138,181		4,138,181	0	4,138,181	73.00
74.00	07400	RENAL DIALYSIS	434,721		434,721	0	434,721	74.00
76.97	07697	CARDIAC REHABILITATION	0		0	0	0	76.97
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	3,435,900		3,435,900	0	3,435,900	90.00
90.01	09001	PARTIAL HOSPITALIZATION PROGRAM	540,602		540,602	0	540,602	90.01
91.00	09100	EMERGENCY	9,795,643		9,795,643	0	9,795,643	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	2,813,372		2,813,372	0	2,813,372	92.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	85,610,775	0	85,610,775	0	85,610,775	200.00
201.00		Less Observation Beds	2,813,372		2,813,372		2,813,372	201.00
202.00		Total (see instructions)	82,797,403	0	82,797,403	0	82,797,403	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0103

Period:
From 01/01/2020
To 12/31/2020Worksheet C
Part I
Date/Time Prepared:
7/19/2021 1:49 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						9.00	10.00	
30.00	03000	ADULTS & PEDIATRICS	15,166,616		15,166,616			30.00
31.00	03100	INTENSIVE CARE UNIT	7,508,728		7,508,728			31.00
40.00	04000	SUBPROVIDER - IPF	13,574,225		13,574,225			40.00
43.00	04300	NURSERY	771,698		771,698			43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	1,741,958	3,151,409	4,893,367	0.660064	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	339,527	132,763	472,290	1.081569	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	565,573	1,169,556	1,735,129	0.071545	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,966,577	11,726,885	16,693,462	0.399503	0.000000	54.00
60.00	06000	LABORATORY	17,542,372	20,482,090	38,024,462	0.211029	0.000000	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0.000000	0.000000	62.30
65.00	06500	RESPIRATORY THERAPY	8,244,218	2,564,157	10,808,375	0.232261	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	520,312	516,715	1,037,027	1.345216	0.000000	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0.000000	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	4,306,114	2,080,601	6,386,715	0.922559	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	652,333	377,810	1,030,143	0.478027	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	7,224,065	2,149,197	9,373,262	0.441488	0.000000	73.00
74.00	07400	RENAL DIALYSIS	1,723,247	212,220	1,935,467	0.224608	0.000000	74.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0.000000	0.000000	76.97
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	168,693	1,093,624	1,262,317	2.721899	0.000000	90.00
90.01	09001	PARTIAL HOSPITALIZATION PROGRAM	525	43,200	43,725	12.363682	0.000000	90.01
91.00	09100	EMERGENCY	3,676,262	14,911,534	18,587,796	0.526993	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	31,602	3,073,919	3,105,521	0.905926	0.000000	92.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	88,724,645	63,685,680	152,410,325			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	88,724,645	63,685,680	152,410,325			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0103

Period:
From 01/01/2020
To 12/31/2020Worksheet C
Part I
Date/Time Prepared:
7/19/2021 1:49 pm

Cost Center Description			PPS Inpatient Ratio	Title XVIII	Hospital	PPS
			11.00			
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS				30.00
31.00	03100	INTENSIVE CARE UNIT				31.00
40.00	04000	SUBPROVIDER - IPF				40.00
43.00	04300	NURSERY				43.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.660064			50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1.081569			52.00
53.00	05300	ANESTHESIOLOGY	0.071545			53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.399503			54.00
60.00	06000	LABORATORY	0.211029			60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0.000000			62.30
65.00	06500	RESPIRATORY THERAPY	0.232261			65.00
66.00	06600	PHYSICAL THERAPY	1.345216			66.00
69.00	06900	ELECTROCARDIOLOGY	0.000000			69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.922559			71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.478027			72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.441488			73.00
74.00	07400	RENAL DIALYSIS	0.224608			74.00
76.97	07697	CARDIAC REHABILITATION	0.000000			76.97
OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	2.721899			90.00
90.01	09001	PARTIAL HOSPITALIZATION PROGRAM	12.363682			90.01
91.00	09100	EMERGENCY	0.526993			91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.905926			92.00
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

Worksheet C
Part I
Date/Time Prepared:
7/19/2021 1:49 pm

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COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0103

Period:
From 01/01/2020
To 12/31/2020Worksheet C
Part I
Date/Time Prepared:
7/19/2021 1:49 pm

			Title XIX			Hospital		PPS	
Cost Center Description			Charges			Cost or Other Ratio	TEFRA Inpatient Ratio		
			Inpatient	Outpatient	Total (col. 6 + col. 7)				
			6.00	7.00	8.00				
INPATIENT ROUTINE SERVICE COST CENTERS									
30.00	03000	ADULTS & PEDIATRICS	15,166,616		15,166,616			30.00	
31.00	03100	INTENSIVE CARE UNIT	7,508,728		7,508,728			31.00	
40.00	04000	SUBPROVIDER - IPF	13,574,225		13,574,225			40.00	
43.00	04300	NURSERY	771,698		771,698			43.00	
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM	1,741,958	3,151,409	4,893,367	0.660064	0.000000	50.00	
52.00	05200	DELIVERY ROOM & LABOR ROOM	339,527	132,763	472,290	1.081569	0.000000	52.00	
53.00	05300	ANESTHESIOLOGY	565,573	1,169,556	1,735,129	0.071545	0.000000	53.00	
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,966,577	11,726,885	16,693,462	0.399503	0.000000	54.00	
60.00	06000	LABORATORY	17,542,372	20,482,090	38,024,462	0.211029	0.000000	60.00	
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0.000000	0.000000	62.30	
65.00	06500	RESPIRATORY THERAPY	8,244,218	2,564,157	10,808,375	0.232261	0.000000	65.00	
66.00	06600	PHYSICAL THERAPY	520,312	516,715	1,037,027	1.345216	0.000000	66.00	
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0.000000	0.000000	69.00	
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	4,306,114	2,080,601	6,386,715	0.922559	0.000000	71.00	
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	652,333	377,810	1,030,143	0.478027	0.000000	72.00	
73.00	07300	DRUGS CHARGED TO PATIENTS	7,224,065	2,149,197	9,373,262	0.441488	0.000000	73.00	
74.00	07400	RENAL DIALYSIS	1,723,247	212,220	1,935,467	0.224608	0.000000	74.00	
76.97	07697	CARDIAC REHABILITATION	0	0	0	0.000000	0.000000	76.97	
OUTPATIENT SERVICE COST CENTERS									
90.00	09000	CLINIC	168,693	1,093,624	1,262,317	2.721899	0.000000	90.00	
90.01	09001	PARTIAL HOSPITALIZATION PROGRAM	525	43,200	43,725	12.363682	0.000000	90.01	
91.00	09100	EMERGENCY	3,676,262	14,911,534	18,587,796	0.526993	0.000000	91.00	
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	31,602	3,073,919	3,105,521	0.905926	0.000000	92.00	
SPECIAL PURPOSE COST CENTERS									
113.00	11300	INTEREST EXPENSE						113.00	
200.00		Subtotal (see instructions)	88,724,645	63,685,680	152,410,325			200.00	
201.00		Less Observation Beds						201.00	
202.00		Total (see instructions)	88,724,645	63,685,680	152,410,325			202.00	

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0103

Period:
From 01/01/2020
To 12/31/2020Worksheet C
Part I
Date/Time Prepared:
7/19/2021 1:49 pm

Cost Center Description			PPS Inpatient Ratio	Title XIX	Hospital	PPS
			11.00			
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS				30.00
31.00	03100	INTENSIVE CARE UNIT				31.00
40.00	04000	SUBPROVIDER - IPF				40.00
43.00	04300	NURSERY				43.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.660064			50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1.081569			52.00
53.00	05300	ANESTHESIOLOGY	0.071545			53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.399503			54.00
60.00	06000	LABORATORY	0.211029			60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0.000000			62.30
65.00	06500	RESPIRATORY THERAPY	0.232261			65.00
66.00	06600	PHYSICAL THERAPY	1.345216			66.00
69.00	06900	ELECTROCARDIOLOGY	0.000000			69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.922559			71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.478027			72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.441488			73.00
74.00	07400	RENAL DIALYSIS	0.224608			74.00
76.97	07697	CARDIAC REHABILITATION	0.000000			76.97
OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	2.721899			90.00
90.01	09001	PARTIAL HOSPITALIZATION PROGRAM	12.363682			90.01
91.00	09100	EMERGENCY	0.526993			91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.905926			92.00
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

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

Provider CCN: 14-0103

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

Worksheet C
Part II
Date/Time Prepared:
7/19/2021 1:49 pm

Cost Center Description		Title XIX			Hospital	PPS	
		Total Cost (Wkst. B, Part I, col. 26)	Capital Cost (Wkst. B, Part II col. 26)	Operating Cost Net of Capital Cost (col. 1 - col. 2)	Capital Reduction	Operating Cost Reduction Amount	
		1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	3,229,937	308,678	2,921,259	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	510,814	104,646	406,168	0	52.00
53.00	05300	ANESTHESIOLOGY	124,139	11,097	113,042	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	6,669,094	322,824	6,346,270	0	54.00
60.00	06000	LABORATORY	8,024,252	448,013	7,576,239	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	2,510,366	277,783	2,232,583	0	65.00
66.00	06600	PHYSICAL THERAPY	1,395,025	125,597	1,269,428	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	5,892,124	306,138	5,585,986	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	492,436	24,631	467,805	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	4,138,181	123,126	4,015,055	0	73.00
74.00	07400	RENAL DIALYSIS	434,721	8,790	425,931	0	74.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	76.97
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	3,435,900	302,768	3,133,132	0	90.00
90.01	09001	PARTIAL HOSPITALIZATION PROGRAM	540,602	39,996	500,606	0	90.01
91.00	09100	EMERGENCY	9,795,643	417,946	9,377,697	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	2,813,372	154,572	2,658,800	0	92.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
200.00		Subtotal (sum of lines 50 thru 199)	50,006,606	2,976,605	47,030,001	0	200.00
201.00		Less Observation Beds	2,813,372	154,572	2,658,800	0	201.00
202.00		Total (line 200 minus line 201)	47,193,234	2,822,033	44,371,201	0	202.00

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

Provider CCN: 14-0103

Period:
From 01/01/2020
To 12/31/2020Worksheet C
Part II
Date/Time Prepared:
7/19/2021 1:49 pm

				Title XIX		Hospital	PPS	
Cost Center Description			Cost Net of Capital and Operating Cost Reduction	Total Charges (Worksheet C, Part I, column 8)	Outpatient Cost to Charge Ratio (col. 6 / col. 7)			
	ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	3,229,937	4,893,367	0.660064			50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	510,814	472,290	1.081569			52.00
53.00	05300	ANESTHESIOLOGY	124,139	1,735,129	0.071545			53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	6,669,094	16,693,462	0.399503			54.00
60.00	06000	LABORATORY	8,024,252	38,024,462	0.211029			60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0.000000			62.30
65.00	06500	RESPIRATORY THERAPY	2,510,366	10,808,375	0.232261			65.00
66.00	06600	PHYSICAL THERAPY	1,395,025	1,037,027	1.345216			66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0.000000			69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	5,892,124	6,386,715	0.922559			71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	492,436	1,030,143	0.478027			72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	4,138,181	9,373,262	0.441488			73.00
74.00	07400	RENAL DIALYSIS	434,721	1,935,467	0.224608			74.00
76.97	07697	CARDIAC REHABILITATION	0	0	0.000000			76.97
	OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	3,435,900	1,262,317	2.721899			90.00
90.01	09001	PARTIAL HOSPITALIZATION PROGRAM	540,602	43,725	12.363682			90.01
91.00	09100	EMERGENCY	9,795,643	18,587,796	0.526993			91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	2,813,372	3,105,521	0.905926			92.00
	SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (sum of lines 50 thru 199)	50,006,606	115,389,058				200.00
201.00		Less Observation Beds	2,813,372	0				201.00
202.00		Total (line 200 minus line 201)	47,193,234	115,389,058				202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

Provider CCN: 14-0103

Period:
From 01/01/2020
To 12/31/2020Worksheet D
Part I
Date/Time Prepared:
7/19/2021 1:49 pm

			Title XVIII		Hospital	PPS	
Cost Center Description		Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	1,055,766	0	1,055,766	14,364	73.50	30.00
31.00	INTENSIVE CARE UNIT	241,497		241,497	3,233	74.70	31.00
40.00	SUBPROVIDER - IPF	630,900	0	630,900	10,466	60.28	40.00
43.00	NURSERY	40,299		40,299	413	97.58	43.00
200.00	Total (lines 30 through 199)	1,968,462		1,968,462	28,476		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	3,140	230,790				30.00
31.00	INTENSIVE CARE UNIT	601	44,895				31.00
40.00	SUBPROVIDER - IPF	1,158	69,804				40.00
43.00	NURSERY	0	0				43.00
200.00	Total (lines 30 through 199)	4,899	345,489				200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS				Provider CCN: 14-0103	Period: From 01/01/2020 To 12/31/2020	Worksheet D Part II Date/Time Prepared: 7/19/2021 1:49 pm		
				Title XVIII		PPS		
Cost Center Description			Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
	ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	308,678	4,893,367	0.063081	82,489	5,203	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	104,646	472,290	0.221571	3,568	791	52.00
53.00	05300	ANESTHESIOLOGY	11,097	1,735,129	0.006395	152,259	974	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	322,824	16,693,462	0.019338	1,056,849	20,437	54.00
60.00	06000	LABORATORY	448,013	38,024,462	0.011782	1,876,325	22,107	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0.000000	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	277,783	10,808,375	0.025701	1,624,741	41,757	65.00
66.00	06600	PHYSICAL THERAPY	125,597	1,037,027	0.121113	161,928	19,612	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0.000000	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	306,138	6,386,715	0.047934	3,315,857	158,942	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	24,631	1,030,143	0.023910	118,767	2,840	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	123,126	9,373,262	0.013136	1,622,230	21,310	73.00
74.00	07400	RENAL DIALYSIS	8,790	1,935,467	0.004542	595,395	2,704	74.00
76.97	07697	CARDIAC REHABILITATION	0	0	0.000000	0	0	76.97
	OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	302,768	1,262,317	0.239851	817	196	90.00
90.01	09001	PARTIAL HOSPITALIZATION PROGRAM	39,996	43,725	0.914717	0	0	90.01
91.00	09100	EMERGENCY	417,946	18,587,796	0.022485	593,716	13,350	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	154,572	3,105,521	0.049773	23,814	1,185	92.00
200.00		Total (lines 50 through 199)	2,976,605	115,389,058		11,228,755	311,408	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS					Provider CCN: 14-0103		Period: From 01/01/2020 To 12/31/2020		Worksheet D Part III Date/Time Prepared: 7/19/2021 1:49 pm	
					Title XVIII		Hospital		PPS	
Cost Center Description					Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health Cost	All Other Medical Education Cost	
					1A	1.00	2A	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS										
30.00	03000	ADULTS & PEDIATRICS		0	0	0	0	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT		0	0	0	0	0	0	31.00
40.00	04000	SUBPROVIDER - IPF		0	0	0	0	0	0	40.00
43.00	04300	NURSERY		0	0	0	0	0	0	43.00
200.00		Total (lines 30 through 199)		0	0	0	0	0	0	200.00
Cost Center Description					Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days	
					4.00	5.00	6.00	7.00	8.00	
INPATIENT ROUTINE SERVICE COST CENTERS										
30.00	03000	ADULTS & PEDIATRICS		0	0	14,364	0.00	3,140		30.00
31.00	03100	INTENSIVE CARE UNIT			0	3,233	0.00	601		31.00
40.00	04000	SUBPROVIDER - IPF		0	0	10,466	0.00	1,158		40.00
43.00	04300	NURSERY			0	413	0.00	0		43.00
200.00		Total (lines 30 through 199)			0	28,476		4,899		200.00
Cost Center Description					Inpatient Program Pass-Through Cost (col. 7 x col. 8)					
					9.00					
INPATIENT ROUTINE SERVICE COST CENTERS										
30.00	03000	ADULTS & PEDIATRICS		0						30.00
31.00	03100	INTENSIVE CARE UNIT		0						31.00
40.00	04000	SUBPROVIDER - IPF		0						40.00
43.00	04300	NURSERY		0						43.00
200.00		Total (lines 30 through 199)		0						200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS			Provider CCN: 14-0103		Period: From 01/01/2020 To 12/31/2020		Worksheet D Part IV Date/Time Prepared: 7/19/2021 1:49 pm	
			Title XVIII		Hospital		PPS	
Cost Center Description			Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health	
			1.00	2A	2.00	3A	3.00	
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	PARTIAL HOSPITALIZATION PROGRAM	0	0	0	0	0	90.01
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	0	92.00
200.00		Total (lines 50 through 199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

Provider CCN: 14-0103

Period:
From 01/01/2020
To 12/31/2020Worksheet D
Part IV
Date/Time Prepared:
7/19/2021 1:49 pm

Cost Center Description			Title XVIII		Hospital		PPS
			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	4,893,367	0.000000
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	472,290	0.000000
53.00	05300	ANESTHESIOLOGY	0	0	0	1,735,129	0.000000
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	16,693,462	0.000000
60.00	06000	LABORATORY	0	0	0	38,024,462	0.000000
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0.000000
65.00	06500	RESPIRATORY THERAPY	0	0	0	10,808,375	0.000000
66.00	06600	PHYSICAL THERAPY	0	0	0	1,037,027	0.000000
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0.000000
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	6,386,715	0.000000
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	1,030,143	0.000000
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	9,373,262	0.000000
74.00	07400	RENAL DIALYSIS	0	0	0	1,935,467	0.000000
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0.000000
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0	0	0	1,262,317	0.000000
90.01	09001	PARTIAL HOSPITALIZATION PROGRAM	0	0	0	43,725	0.000000
91.00	09100	EMERGENCY	0	0	0	18,587,796	0.000000
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	3,105,521	0.000000
200.00		Total (lines 50 through 199)	0	0	0	115,389,058	

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-0103

Period:
From 01/01/2020
To 12/31/2020Worksheet D
Part IV
Date/Time Prepared:
7/19/2021 1:49 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	82,489	0	45,867	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	3,568	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	152,259	0	82,695	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	1,056,849	0	874,663	0	54.00
60.00	06000	LABORATORY	0.000000	1,876,325	0	1,027,793	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0.000000	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0.000000	1,624,741	0	254,609	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	161,928	0	2,088	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	3,315,857	0	243,485	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	118,767	0	16,730	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	1,622,230	0	184,378	0	73.00
74.00	07400	RENAL DIALYSIS	0.000000	595,395	0	58,824	0	74.00
76.97	07697	CARDIAC REHABILITATION	0.000000	0	0	0	0	76.97
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0.000000	817	0	131,993	0	90.00
90.01	09001	PARTIAL HOSPITALIZATION PROGRAM	0.000000	0	0	5,208	0	90.01
91.00	09100	EMERGENCY	0.000000	593,716	0	976,946	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	23,814	0	272,727	0	92.00
200.00		Total (lines 50 through 199)		11,228,755	0	4,178,006	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-0103

Period:
From 01/01/2020
To 12/31/2020Worksheet D
Part V
Date/Time Prepared:
7/19/2021 1:49 pm

				Title XVIII		Hospital		PPS		
Cost Center Description				Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges		Costs			
					PPS Reimbursed Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	PPS Services (see inst.)		
				1.00	2.00	3.00	4.00	5.00		
	ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM	0.660064	45,867	0	0	30,275	50.00		
52.00	05200	DELIVERY ROOM & LABOR ROOM	1.081569	0	0	0	0	52.00		
53.00	05300	ANESTHESIOLOGY	0.071545	82,695	0	0	5,916	53.00		
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.399503	874,663	0	0	349,430	54.00		
60.00	06000	LABORATORY	0.211029	1,027,793	0	0	216,894	60.00		
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0.000000	0	0	0	0	62.30		
65.00	06500	RESPIRATORY THERAPY	0.232261	254,609	0	0	59,136	65.00		
66.00	06600	PHYSICAL THERAPY	1.345216	2,088	0	0	2,809	66.00		
69.00	06900	ELECTROCARDIOLOGY	0.000000	0	0	0	0	69.00		
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.922559	243,485	0	0	224,629	71.00		
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.478027	16,730	0	0	7,997	72.00		
73.00	07300	DRUGS CHARGED TO PATIENTS	0.441488	184,378	0	0	81,401	73.00		
74.00	07400	RENAL DIALYSIS	0.224608	58,824	0	0	13,212	74.00		
76.97	07697	CARDIAC REHABILITATION	0.000000	0	0	0	0	76.97		
OUTPATIENT SERVICE COST CENTERS										
90.00	09000	CLINIC	2.721899	131,993	0	0	359,272	90.00		
90.01	09001	PARTIAL HOSPITALIZATION PROGRAM	12.363682	5,208	0	0	64,390	90.01		
91.00	09100	EMERGENCY	0.526993	976,946	0	0	514,844	91.00		
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.905926	272,727	0	0	247,070	92.00		
200.00		Subtotal (see instructions)		4,178,006	0	0	2,177,275	200.00		
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00		
202.00		Net Charges (line 200 - line 201)		4,178,006	0	0	2,177,275	202.00		

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-0103

Period:
From 01/01/2020
To 12/31/2020Worksheet D
Part V
Date/Time Prepared:
7/19/2021 1:49 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
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0		62.30
65.00	06500	RESPIRATORY THERAPY	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0		66.00
69.00	06900	ELECTROCARDIOLOGY	0	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0		73.00
74.00	07400	RENAL DIALYSIS	0	0		74.00
76.97	07697	CARDIAC REHABILITATION	0	0		76.97
	OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	0	0		90.00
90.01	09001	PARTIAL HOSPITALIZATION PROGRAM	0	0		90.01
91.00	09100	EMERGENCY	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0		92.00
200.00		Subtotal (see instructions)	0	0		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	0	0		202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS				Provider CCN: 14-0103 Component CCN: 14-S103		Period: From 01/01/2020 To 12/31/2020		Worksheet D Part II Date/Time Prepared: 7/19/2021 1:49 pm	
				Title XVIII		Subprovider - IPF		PPS	
Cost Center Description			Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)		
			1.00	2.00	3.00	4.00	5.00		
	ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	308,678	4,893,367	0.063081	2,324	147	50.00	
52.00	05200	DELIVERY ROOM & LABOR ROOM	104,646	472,290	0.221571	11,480	2,544	52.00	
53.00	05300	ANESTHESIOLOGY	11,097	1,735,129	0.006395	871	6	53.00	
54.00	05400	RADIOLOGY-DIAGNOSTIC	322,824	16,693,462	0.019338	28,005	542	54.00	
60.00	06000	LABORATORY	448,013	38,024,462	0.011782	350,007	4,124	60.00	
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0.000000	0	0	62.30	
65.00	06500	RESPIRATORY THERAPY	277,783	10,808,375	0.025701	13,751	353	65.00	
66.00	06600	PHYSICAL THERAPY	125,597	1,037,027	0.121113	204	25	66.00	
69.00	06900	ELECTROCARDIOLOGY	0	0	0.000000	0	0	69.00	
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	306,138	6,386,715	0.047934	6,388	306	71.00	
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	24,631	1,030,143	0.023910	0	0	72.00	
73.00	07300	DRUGS CHARGED TO PATIENTS	123,126	9,373,262	0.013136	98,243	1,291	73.00	
74.00	07400	RENAL DIALYSIS	8,790	1,935,467	0.004542	0	0	74.00	
76.97	07697	CARDIAC REHABILITATION	0	0	0.000000	0	0	76.97	
	OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	302,768	1,262,317	0.239851	0	0	90.00	
90.01	09001	PARTIAL HOSPITALIZATION PROGRAM	39,996	43,725	0.914717	0	0	90.01	
91.00	09100	EMERGENCY	417,946	18,587,796	0.022485	116,972	2,630	91.00	
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	3,105,521	0.000000	0	0	92.00	
200.00		Total (lines 50 through 199)	2,822,033	115,389,058		628,245	11,968	200.00	

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS			Provider CCN: 14-0103 Component CCN: 14-S103		Period: From 01/01/2020 To 12/31/2020		Worksheet D Part IV Date/Time Prepared: 7/19/2021 1:49 pm	
			Title XVIII		Subprovider - IPF		PPS	
Cost Center Description			Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health	
			1.00	2A	2.00	3A	3.00	
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	PARTIAL HOSPITALIZATION PROGRAM	0	0	0	0	0	90.01
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	0	92.00
200.00		Total (lines 50 through 199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS				Provider CCN: 14-0103 Component CCN: 14-S103		Period: From 01/01/2020 To 12/31/2020		Worksheet D Part IV Date/Time Prepared: 7/19/2021 1:49 pm	
				Title XVIII		Subprovider - IPF		PPS	
Cost Center Description				All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7) (see instructions)	
				4.00	5.00	6.00	7.00	8.00	
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM		0	0	0	4,893,367	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM		0	0	0	472,290	0.000000	52.00
53.00	05300	ANESTHESIOLOGY		0	0	0	1,735,129	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC		0	0	0	16,693,462	0.000000	54.00
60.00	06000	LABORATORY		0	0	0	38,024,462	0.000000	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS		0	0	0	0	0.000000	62.30
65.00	06500	RESPIRATORY THERAPY		0	0	0	10,808,375	0.000000	65.00
66.00	06600	PHYSICAL THERAPY		0	0	0	1,037,027	0.000000	66.00
69.00	06900	ELECTROCARDIOLOGY		0	0	0	0	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT		0	0	0	6,386,715	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS		0	0	0	1,030,143	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS		0	0	0	9,373,262	0.000000	73.00
74.00	07400	RENAL DIALYSIS		0	0	0	1,935,467	0.000000	74.00
76.97	07697	CARDIAC REHABILITATION		0	0	0	0	0.000000	76.97
OUTPATIENT SERVICE COST CENTERS									
90.00	09000	CLINIC		0	0	0	1,262,317	0.000000	90.00
90.01	09001	PARTIAL HOSPITALIZATION PROGRAM		0	0	0	43,725	0.000000	90.01
91.00	09100	EMERGENCY		0	0	0	18,587,796	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART		0	0	0	3,105,521	0.000000	92.00
200.00		Total (lines 50 through 199)		0	0	0	115,389,058		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS				Provider CCN: 14-0103 Component CCN: 14-S103		Period: From 01/01/2020 To 12/31/2020		Worksheet D Part IV Date/Time Prepared: 7/19/2021 1:49 pm	
				Title XVIII		Subprovider - IPF		PPS	
Cost Center Description				Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
				9.00	10.00	11.00	12.00	13.00	
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM		0.000000	2,324	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM		0.000000	11,480	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY		0.000000	871	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC		0.000000	28,005	0	969	0	54.00
60.00	06000	LABORATORY		0.000000	350,007	0	0	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS		0.000000	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY		0.000000	13,751	0	2,760	0	65.00
66.00	06600	PHYSICAL THERAPY		0.000000	204	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY		0.000000	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT		0.000000	6,388	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS		0.000000	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS		0.000000	98,243	0	0	0	73.00
74.00	07400	RENAL DIALYSIS		0.000000	0	0	0	0	74.00
76.97	07697	CARDIAC REHABILITATION		0.000000	0	0	0	0	76.97
OUTPATIENT SERVICE COST CENTERS									
90.00	09000	CLINIC		0.000000	0	0	0	0	90.00
90.01	09001	PARTIAL HOSPITALIZATION PROGRAM		0.000000	0	0	0	0	90.01
91.00	09100	EMERGENCY		0.000000	116,972	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART		0.000000	0	0	0	0	92.00
200.00		Total (lines 50 through 199)			628,245	0	3,729	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST			Provider CCN: 14-0103 Component CCN: 14-S103		Period: From 01/01/2020 To 12/31/2020		Worksheet D Part V Date/Time Prepared: 7/19/2021 1:49 pm	
			Title XVIII		Subprovider - IPF		PPS	
Cost Center Description			Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges		Costs		
				PPS Reimbursed Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0.660064	0	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1.081569	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.071545	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.399503	969	0	0	387	54.00
60.00	06000	LABORATORY	0.211029	0	0	0	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0.000000	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0.232261	2,760	0	0	641	65.00
66.00	06600	PHYSICAL THERAPY	1.345216	0	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.922559	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.478027	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.441488	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0.224608	0	0	0	0	74.00
76.97	07697	CARDIAC REHABILITATION	0.000000	0	0	0	0	76.97
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	2.721899	0	0	0	0	90.00
90.01	09001	PARTIAL HOSPITALIZATION PROGRAM	12.363682	0	0	0	0	90.01
91.00	09100	EMERGENCY	0.526993	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.905926	0	0	0	0	92.00
200.00		Subtotal (see instructions)		3,729	0	0	1,028	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 - line 201)		3,729	0	0	1,028	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-0103

Period:

Worksheet D

Component CCN: 14-S103

From 01/01/2020
To 12/31/2020Part V
Date/Time Prepared:
7/19/2021 1:49 pm

Title XVIII

Subprovider -
IPF

PPS

Cost Center Description		Costs			
		Cost	Cost		
		Reimbursed	Reimbursed		
		Services Subject To Ded. & Coins. (see inst.)	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
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	74.00
76.97	07697	CARDIAC REHABILITATION	0	0	76.97
OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	0	0	90.00
90.01	09001	PARTIAL HOSPITALIZATION PROGRAM	0	0	90.01
91.00	09100	EMERGENCY	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	92.00
200.00		Subtotal (see instructions)	0	0	200.00
201.00		Less PBP Clinic Lab. Services-Program	0		201.00
		Only Charges			
202.00		Net Charges (line 200 - line 201)	0	0	202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

Provider CCN: 14-0103

Period:
From 01/01/2020
To 12/31/2020Worksheet D
Part I
Date/Time Prepared:
7/19/2021 1:49 pm

Title XIX			Hospital		PPS			
Cost Center Description		Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)		
		1.00	2.00	3.00	4.00	5.00		
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	ADULTS & PEDIATRICS	1,055,766	0	1,055,766	14,364	73.50	30.00	
31.00	INTENSIVE CARE UNIT	241,497		241,497	3,233	74.70	31.00	
40.00	SUBPROVIDER - IPF	630,900	0	630,900	10,466	60.28	40.00	
43.00	NURSERY	40,299		40,299	413	97.58	43.00	
200.00	Total (lines 30 through 199)	1,968,462		1,968,462	28,476		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	1,587	116,645					30.00
31.00	INTENSIVE CARE UNIT	232	17,330					31.00
40.00	SUBPROVIDER - IPF	915	55,156					40.00
43.00	NURSERY	148	14,442					43.00
200.00	Total (lines 30 through 199)	2,882	203,573					200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 14-0103

Period:
From 01/01/2020
To 12/31/2020Worksheet D
Part II
Date/Time Prepared:
7/19/2021 1:49 pm

Cost Center Description			Title XIX		Hospital	PPS	
			Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)
			1.00	2.00	3.00	4.00	5.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	308,678	4,893,367	0.063081	0	0 50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	104,646	472,290	0.221571	0	0 52.00
53.00	05300	ANESTHESIOLOGY	11,097	1,735,129	0.006395	0	0 53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	322,824	16,693,462	0.019338	0	0 54.00
60.00	06000	LABORATORY	448,013	38,024,462	0.011782	0	0 60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0.000000	0	0 62.30
65.00	06500	RESPIRATORY THERAPY	277,783	10,808,375	0.025701	0	0 65.00
66.00	06600	PHYSICAL THERAPY	125,597	1,037,027	0.121113	0	0 66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0.000000	0	0 69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	306,138	6,386,715	0.047934	0	0 71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	24,631	1,030,143	0.023910	0	0 72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	123,126	9,373,262	0.013136	0	0 73.00
74.00	07400	RENAL DIALYSIS	8,790	1,935,467	0.004542	0	0 74.00
76.97	07697	CARDIAC REHABILITATION	0	0	0.000000	0	0 76.97
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	302,768	1,262,317	0.239851	0	0 90.00
90.01	09001	PARTIAL HOSPITALIZATION PROGRAM	39,996	43,725	0.914717	0	0 90.01
91.00	09100	EMERGENCY	417,946	18,587,796	0.022485	0	0 91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	154,572	3,105,521	0.049773	0	0 92.00
200.00		Total (lines 50 through 199)	2,976,605	115,389,058		0	0 200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS					Provider CCN: 14-0103		Period: From 01/01/2020 To 12/31/2020		Worksheet D Part III Date/Time Prepared: 7/19/2021 1:49 pm		
					Title XIX		Hospital		PPS		
Cost Center Description					Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health Cost	All Other Medical Education Cost		
					1A	1.00	2A	2.00	3.00		
INPATIENT ROUTINE SERVICE COST CENTERS											
30.00	03000	ADULTS & PEDIATRICS		0	0	0	0	0	0	30.00	
31.00	03100	INTENSIVE CARE UNIT		0	0	0	0	0	0	31.00	
40.00	04000	SUBPROVIDER - IPF		0	0	0	0	0	0	40.00	
43.00	04300	NURSERY		0	0	0	0	0	0	43.00	
200.00		Total (lines 30 through 199)		0	0	0	0	0	0	200.00	
Cost Center Description					Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days		
					4.00	5.00	6.00	7.00	8.00		
INPATIENT ROUTINE SERVICE COST CENTERS											
30.00	03000	ADULTS & PEDIATRICS		0	0	14,364	0.00	1,587		30.00	
31.00	03100	INTENSIVE CARE UNIT		0	0	3,233	0.00	232		31.00	
40.00	04000	SUBPROVIDER - IPF		0	0	10,466	0.00	915		40.00	
43.00	04300	NURSERY		0	0	413	0.00	148		43.00	
200.00		Total (lines 30 through 199)		0	0	28,476		2,882		200.00	
Cost Center Description					Inpatient Program Pass-Through Cost (col. 7 x col. 8)						
					9.00						
INPATIENT ROUTINE SERVICE COST CENTERS											
30.00	03000	ADULTS & PEDIATRICS		0						30.00	
31.00	03100	INTENSIVE CARE UNIT		0						31.00	
40.00	04000	SUBPROVIDER - IPF		0						40.00	
43.00	04300	NURSERY		0						43.00	
200.00		Total (lines 30 through 199)		0						200.00	

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

Provider CCN: 14-0103

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

Worksheet D
Part IV
Date/Time Prepared:
7/19/2021 1:49 pm

Cost Center Description			Title XIX		Hospital		PPS	
			Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health	
			1.00	2A	2.00	3A	3.00	
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	PARTIAL HOSPITALIZATION PROGRAM	0	0	0	0	0	90.01
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	0	92.00
200.00		Total (lines 50 through 199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

Provider CCN: 14-0103

Period:
From 01/01/2020
To 12/31/2020Worksheet D
Part IV
Date/Time Prepared:
7/19/2021 1:49 pm

Cost Center Description			Title XIX		Hospital		PPS
			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	4,893,367	0.000000
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	472,290	0.000000
53.00	05300	ANESTHESIOLOGY	0	0	0	1,735,129	0.000000
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	16,693,462	0.000000
60.00	06000	LABORATORY	0	0	0	38,024,462	0.000000
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0.000000
65.00	06500	RESPIRATORY THERAPY	0	0	0	10,808,375	0.000000
66.00	06600	PHYSICAL THERAPY	0	0	0	1,037,027	0.000000
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0.000000
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	6,386,715	0.000000
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	1,030,143	0.000000
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	9,373,262	0.000000
74.00	07400	RENAL DIALYSIS	0	0	0	1,935,467	0.000000
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0.000000
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0	0	0	1,262,317	0.000000
90.01	09001	PARTIAL HOSPITALIZATION PROGRAM	0	0	0	43,725	0.000000
91.00	09100	EMERGENCY	0	0	0	18,587,796	0.000000
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	3,105,521	0.000000
200.00		Total (lines 50 through 199)	0	0	0	115,389,058	

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-0103

Period:
From 01/01/2020
To 12/31/2020Worksheet D
Part IV
Date/Time Prepared:
7/19/2021 1:49 pm

Cost Center Description			Title XIX		Hospital		PPS
			Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)
			9.00	10.00	11.00	12.00	13.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0.000000	0	0	0	0 50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	0	0	0 52.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	0	0 53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	0	0	0	0 54.00
60.00	06000	LABORATORY	0.000000	0	0	0	0 60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0.000000	0	0	0	0 62.30
65.00	06500	RESPIRATORY THERAPY	0.000000	0	0	0	0 65.00
66.00	06600	PHYSICAL THERAPY	0.000000	0	0	0	0 66.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	0	0	0	0 69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	0	0	0	0 71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	0	0	0 72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	0	0	0	0 73.00
74.00	07400	RENAL DIALYSIS	0.000000	0	0	0	0 74.00
76.97	07697	CARDIAC REHABILITATION	0.000000	0	0	0	0 76.97
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0.000000	0	0	0	0 90.00
90.01	09001	PARTIAL HOSPITALIZATION PROGRAM	0.000000	0	0	0	0 90.01
91.00	09100	EMERGENCY	0.000000	0	0	0	0 91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	0	0	0	0 92.00
200.00		Total (lines 50 through 199)		0	0	0	0 200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS				Provider CCN: 14-0103 Component CCN: 14-S103		Period: From 01/01/2020 To 12/31/2020		Worksheet D Part II Date/Time Prepared: 7/19/2021 1:49 pm	
				Title XIX		Subprovider - IPF		PPS	
Cost Center Description				Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
				1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM		308,678	4,893,367	0.063081	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM		104,646	472,290	0.221571	0	0	52.00
53.00	05300	ANESTHESIOLOGY		11,097	1,735,129	0.006395	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC		322,824	16,693,462	0.019338	0	0	54.00
60.00	06000	LABORATORY		448,013	38,024,462	0.011782	0	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS		0	0	0.000000	0	0	62.30
65.00	06500	RESPIRATORY THERAPY		277,783	10,808,375	0.025701	0	0	65.00
66.00	06600	PHYSICAL THERAPY		125,597	1,037,027	0.121113	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY		0	0	0.000000	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT		306,138	6,386,715	0.047934	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS		24,631	1,030,143	0.023910	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS		123,126	9,373,262	0.013136	0	0	73.00
74.00	07400	RENAL DIALYSIS		8,790	1,935,467	0.004542	0	0	74.00
76.97	07697	CARDIAC REHABILITATION		0	0	0.000000	0	0	76.97
OUTPATIENT SERVICE COST CENTERS									
90.00	09000	CLINIC		302,768	1,262,317	0.239851	0	0	90.00
90.01	09001	PARTIAL HOSPITALIZATION PROGRAM		39,996	43,725	0.914717	0	0	90.01
91.00	09100	EMERGENCY		417,946	18,587,796	0.022485	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART		0	3,105,521	0.000000	0	0	92.00
200.00		Total (lines 50 through 199)		2,822,033	115,389,058		0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS			Provider CCN: 14-0103 Component CCN: 14-S103		Period: From 01/01/2020 To 12/31/2020		Worksheet D Part IV Date/Time Prepared: 7/19/2021 1:49 pm	
			Title XIX		Subprovider - IPF		PPS	
Cost Center Description			Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health	
			1.00	2A	2.00	3A	3.00	
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	PARTIAL HOSPITALIZATION PROGRAM	0	0	0	0	0	90.01
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	0	92.00
200.00		Total (lines 50 through 199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS			Provider CCN: 14-0103 Component CCN: 14-S103		Period: From 01/01/2020 To 12/31/2020		Worksheet D Part IV Date/Time Prepared: 7/19/2021 1:49 pm	
			Title XIX		Subprovider - IPF		PPS	
Cost Center Description			All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7) (see instructions)	
			4.00	5.00	6.00	7.00	8.00	
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	0	4,893,367	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	472,290	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	1,735,129	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	16,693,462	0.000000	54.00
60.00	06000	LABORATORY	0	0	0	38,024,462	0.000000	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0.000000	62.30
65.00	06500	RESPIRATORY THERAPY	0	0	0	10,808,375	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	1,037,027	0.000000	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	6,386,715	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	1,030,143	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	9,373,262	0.000000	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	1,935,467	0.000000	74.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0.000000	76.97
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0	1,262,317	0.000000	90.00
90.01	09001	PARTIAL HOSPITALIZATION PROGRAM	0	0	0	43,725	0.000000	90.01
91.00	09100	EMERGENCY	0	0	0	18,587,796	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	3,105,521	0.000000	92.00
200.00		Total (lines 50 through 199)	0	0	0	115,389,058		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

Provider CCN: 14-0103

Component CCN: 14-S103

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

Worksheet D
Part IV
Date/Time Prepared:
7/19/2021 1:49 pm

				Title XIX		Subprovider - IPF	PPS	
Cost Center Description			Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
			9.00	10.00	11.00	12.00	13.00	
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0.000000	0	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	0	0	0	0	54.00
60.00	06000	LABORATORY	0.000000	0	0	0	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0.000000	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0.000000	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	0	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0.000000	0	0	0	0	74.00
76.97	07697	CARDIAC REHABILITATION	0.000000	0	0	0	0	76.97
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0.000000	0	0	0	0	90.00
90.01	09001	PARTIAL HOSPITALIZATION PROGRAM	0.000000	0	0	0	0	90.01
91.00	09100	EMERGENCY	0.000000	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	0	0	0	0	92.00
200.00		Total (lines 50 through 199)		0	0	0	0	200.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-0103	Period: From 01/01/2020 To 12/31/2020	Worksheet D-1 Date/Time Prepared: 7/19/2021 1:49 pm	
Cost Center Description		Title XVIII	Hospital	PPS	
				1.00	
PART I - ALL PROVIDER COMPONENTS					
INPATIENT DAYS					
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)			14,364	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)			14,364	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)			12,261	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)			3,140	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)			19,216,033	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)			19,216,033	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)			19,216,033	37.00
PART II - HOSPITAL AND SUBPROVIDERS ONLY					
PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS					
38.00	Adjusted general inpatient routine service cost per diem (see instructions)			1,337.79	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)			4,200,661	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)			0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)			4,200,661	41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-0103

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

Worksheet D-1

Date/Time Prepared:
7/19/2021 1:49 pm

Cost Center Description		Title XVIII		Hospital		PPS
		Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)
		1.00	2.00	3.00	4.00	5.00
42.00	NURSERY (title V & XIX only)	0	0	0.00	0	0
Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	5,180,120	3,233	1,602.26	601	962,958
44.00	CORONARY CARE UNIT					
45.00	BURN INTENSIVE CARE UNIT					
46.00	SURGICAL INTENSIVE CARE UNIT					
47.00	OTHER SPECIAL CARE (SPECIFY)					
Cost Center Description						
						1.00
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					5,785,020
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					10,948,639
PASS THROUGH COST ADJUSTMENTS						
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)					275,685
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					311,408
52.00	Total Program excludable cost (sum of lines 50 and 51)					587,093
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					10,361,546
TARGET AMOUNT AND LIMIT COMPUTATION						
54.00	Program discharges					0
55.00	Target amount per discharge					0.00
56.00	Target amount (line 54 x line 55)					0
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)					0
58.00	Bonus payment (see instructions)					0
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket					0.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket					0.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)					0
62.00	Relief payment (see instructions)					0
63.00	Allowable Inpatient cost plus incentive payment (see instructions)					0
PROGRAM INPATIENT ROUTINE SWING BED COST						
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)					0
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					0
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)					0
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)					0
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)					0
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)					0
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY						
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)					70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)					71.00
72.00	Program routine service cost (line 9 x line 71)					72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)					73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)					74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)					75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)					76.00
77.00	Program capital-related costs (line 9 x line 76)					77.00
78.00	Inpatient routine service cost (line 74 minus line 77)					78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)					79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)					80.00
81.00	Inpatient routine service cost per diem limitation					81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)					82.00
83.00	Reasonable inpatient routine service costs (see instructions)					83.00
84.00	Program inpatient ancillary services (see instructions)					84.00
85.00	Utilization review - physician compensation (see instructions)					85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)					86.00
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
87.00	Total observation bed days (see instructions)					2,103
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					1,337.79
89.00	Observation bed cost (line 87 x line 88) (see instructions)					2,813,372

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-0103

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

Worksheet D-1

Date/Time Prepared:
7/19/2021 1:49 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	1,055,766	19,216,033	0.054942	2,813,372	154,572	90.00
91.00 Nursing School cost	0	19,216,033	0.000000	2,813,372	0	91.00
92.00 Allied health cost	0	19,216,033	0.000000	2,813,372	0	92.00
93.00 All other Medical Education	0	19,216,033	0.000000	2,813,372	0	93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-0103 Component CCN: 14-S103	Period: From 01/01/2020 To 12/31/2020	Worksheet D-1 Date/Time Prepared: 7/19/2021 1:49 pm
		Title XVIII	Subprovider - IPF	PPS
Cost Center Description			1.00	
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		10,466	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		10,466	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)		10,466	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)		1,158	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)		0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period		0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)		0	14.00
15.00	Total nursery days (title V or XIX only)		0	15.00
16.00	Nursery days (title V or XIX only)		0	16.00
SWING BED ADJUSTMENT				
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period		0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)		10,864,982	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)		0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)		0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)		0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)		0	25.00
26.00	Total swing-bed cost (see instructions)		0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)		10,864,982	27.00
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)		0	28.00
29.00	Private room charges (excluding swing-bed charges)		0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)		0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)		0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)		0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)		0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)		0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)		0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)		10,864,982	37.00
PART II - HOSPITAL AND SUBPROVIDERS ONLY				
PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS				
38.00	Adjusted general inpatient routine service cost per diem (see instructions)		1,038.12	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		1,202,143	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)		0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)		1,202,143	41.00

COMPUTATION OF INPATIENT OPERATING COST				Provider CCN: 14-0103	Period: From 01/01/2020 To 12/31/2020	Worksheet D-1	
				Component CCN: 14-S103		Date/Time Prepared: 7/19/2021 1:49 pm	
				Title XVIII		Subprovider - IPF	PPS
	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)	0	0	0.00	0		42.00
Intensive Care Type Inpatient Hospital Units							
43.00	INTENSIVE CARE UNIT	0	0	0.00	0	0	43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00
Cost Center Description							
							1.00
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					213,439	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					1,415,582	49.00
PASS THROUGH COST ADJUSTMENTS							
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)					69,804	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					11,968	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)					81,772	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					1,333,810	53.00
TARGET AMOUNT AND LIMIT COMPUTATION							
54.00	Program discharges					0	54.00
55.00	Target amount per discharge					0.00	55.00
56.00	Target amount (line 54 x line 55)					0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)					0	57.00
58.00	Bonus payment (see instructions)					0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket					0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket					0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)					0	61.00
62.00	Relief payment (see instructions)					0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)					0	63.00
PROGRAM INPATIENT ROUTINE SWING BED COST							
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)					0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)					0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)					0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)					0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)					0	69.00
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY							
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)						70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)						71.00
72.00	Program routine service cost (line 9 x line 71)						72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)						73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)						74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)						75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)						76.00
77.00	Program capital-related costs (line 9 x line 76)						77.00
78.00	Inpatient routine service cost (line 74 minus line 77)						78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)						79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)						80.00
81.00	Inpatient routine service cost per diem limitation						81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)						82.00
83.00	Reasonable inpatient routine service costs (see instructions)						83.00
84.00	Program inpatient ancillary services (see instructions)						84.00
85.00	Utilization review - physician compensation (see instructions)						85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)						86.00
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
87.00	Total observation bed days (see instructions)					0	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					0.00	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)					0	89.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-0103 Component CCN: 14-S103		Period: From 01/01/2020 To 12/31/2020	Worksheet D-1 Date/Time Prepared: 7/19/2021 1:49 pm	
		Title XVIII		Subprovider - IPF	PPS	
Cost Center Description		Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)
		1.00	2.00	3.00	4.00	5.00
COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	630,900	10,864,982	0.058067	0	0 90.00
91.00	Nursing School cost	0	10,864,982	0.000000	0	0 91.00
92.00	Allied health cost	0	10,864,982	0.000000	0	0 92.00
93.00	All other Medical Education	0	10,864,982	0.000000	0	0 93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-0103	Period: From 01/01/2020 To 12/31/2020	Worksheet D-1 Date/Time Prepared: 7/19/2021 1:49 pm
Cost Center Description		Title XIX	Hospital	PPS
				1.00
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		14,364	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		14,364	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)		12,261	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)		1,587	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)		413	15.00
16.00	Nursery days (title V or XIX only)		148	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)		19,216,033	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)		19,216,033	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)		19,216,033	37.00
PART II - HOSPITAL AND SUBPROVIDERS ONLY				
PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS				
38.00	Adjusted general inpatient routine service cost per diem (see instructions)		1,337.79	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		2,123,073	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)		2,123,073	41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-0103

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

Worksheet D-1

Date/Time Prepared:
7/19/2021 1:49 pm

Cost Center Description		Title XIX		Hospital		PPS
		Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)
		1.00	2.00	3.00	4.00	5.00
42.00	NURSERY (title V & XIX only)	343,034	413	830.59	148	122,927
Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	5,180,120	3,233	1,602.26	232	371,724
44.00	CORONARY CARE UNIT					
45.00	BURN INTENSIVE CARE UNIT					
46.00	SURGICAL INTENSIVE CARE UNIT					
47.00	OTHER SPECIAL CARE (SPECIFY)					
Cost Center Description						
						1.00
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					0
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					2,617,724
PASS THROUGH COST ADJUSTMENTS						
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)					148,417
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					0
52.00	Total Program excludable cost (sum of lines 50 and 51)					148,417
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					2,469,307
TARGET AMOUNT AND LIMIT COMPUTATION						
54.00	Program discharges					0
55.00	Target amount per discharge					0.00
56.00	Target amount (line 54 x line 55)					0
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)					0
58.00	Bonus payment (see instructions)					0
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket					0.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket					0.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)					0
62.00	Relief payment (see instructions)					0
63.00	Allowable Inpatient cost plus incentive payment (see instructions)					0
PROGRAM INPATIENT ROUTINE SWING BED COST						
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)					0
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					0
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)					0
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)					0
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)					0
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)					0
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY						
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)					70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)					71.00
72.00	Program routine service cost (line 9 x line 71)					72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)					73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)					74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)					75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)					76.00
77.00	Program capital-related costs (line 9 x line 76)					77.00
78.00	Inpatient routine service cost (line 74 minus line 77)					78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)					79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)					80.00
81.00	Inpatient routine service cost per diem limitation					81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)					82.00
83.00	Reasonable inpatient routine service costs (see instructions)					83.00
84.00	Program inpatient ancillary services (see instructions)					84.00
85.00	Utilization review - physician compensation (see instructions)					85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)					86.00
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
87.00	Total observation bed days (see instructions)					2,103
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					1,337.79
89.00	Observation bed cost (line 87 x line 88) (see instructions)					2,813,372

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-0103

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

Worksheet D-1

Date/Time Prepared:
7/19/2021 1:49 pm

Cost Center Description		Title XIX		Hospital	PPS	
		Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00
COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	1,055,766	19,216,033	0.054942	2,813,372	154,572
91.00	Nursing School cost	0	19,216,033	0.000000	2,813,372	0
92.00	Allied health cost	0	19,216,033	0.000000	2,813,372	0
93.00	All other Medical Education	0	19,216,033	0.000000	2,813,372	0

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-0103 Component CCN: 14-S103	Period: From 01/01/2020 To 12/31/2020	Worksheet D-1 Date/Time Prepared: 7/19/2021 1:49 pm
		Title XIX	Subprovider - IPF	PPS
Cost Center Description			1.00	
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		10,466	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		10,466	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)		10,466	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)		915	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)		413	15.00
16.00	Nursery days (title V or XIX only)		148	16.00
SWING BED ADJUSTMENT				
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period		0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)		10,864,982	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)		0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)		0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)		0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)		0	25.00
26.00	Total swing-bed cost (see instructions)		0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)		10,864,982	27.00
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)		0	28.00
29.00	Private room charges (excluding swing-bed charges)		0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)		0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)		0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)		0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)		0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)		0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)		0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)		10,864,982	37.00
PART II - HOSPITAL AND SUBPROVIDERS ONLY				
PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS				
38.00	Adjusted general inpatient routine service cost per diem (see instructions)		1,038.12	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		949,880	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)		949,880	41.00

COMPUTATION OF INPATIENT OPERATING COST			Provider CCN: 14-0103	Period: From 01/01/2020 To 12/31/2020	Worksheet D-1
			Component CCN: 14-S103		Date/Time Prepared: 7/19/2021 1:49 pm
			Title XIX	Subprovider - IPF	PPS
Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)
	1.00	2.00	3.00	4.00	5.00
42.00 NURSERY (title V & XIX only)	0	0	0.00	0	0
Intensive Care Type Inpatient Hospital Units					
43.00 INTENSIVE CARE UNIT	0	0	0.00	0	0
44.00 CORONARY CARE UNIT					
45.00 BURN INTENSIVE CARE UNIT					
46.00 SURGICAL INTENSIVE CARE UNIT					
47.00 OTHER SPECIAL CARE (SPECIFY)					
Cost Center Description					1.00
48.00 Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					0
49.00 Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					949,880
PASS THROUGH COST ADJUSTMENTS					
50.00 Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)					55,156
51.00 Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					0
52.00 Total Program excludable cost (sum of lines 50 and 51)					55,156
53.00 Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					894,724
TARGET AMOUNT AND LIMIT COMPUTATION					
54.00 Program discharges					0
55.00 Target amount per discharge					0.00
56.00 Target amount (line 54 x line 55)					0
57.00 Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)					0
58.00 Bonus payment (see instructions)					0
59.00 Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket					0.00
60.00 Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket					0.00
61.00 If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)					0
62.00 Relief payment (see instructions)					0
63.00 Allowable Inpatient cost plus incentive payment (see instructions)					0
PROGRAM INPATIENT ROUTINE SWING BED COST					
64.00 Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)					0
65.00 Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					0
66.00 Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)					0
67.00 Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)					0
68.00 Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)					0
69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)					0
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY					
70.00 Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)					70.00
71.00 Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)					71.00
72.00 Program routine service cost (line 9 x line 71)					72.00
73.00 Medically necessary private room cost applicable to Program (line 14 x line 35)					73.00
74.00 Total Program general inpatient routine service costs (line 72 + line 73)					74.00
75.00 Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)					75.00
76.00 Per diem capital-related costs (line 75 ÷ line 2)					76.00
77.00 Program capital-related costs (line 9 x line 76)					77.00
78.00 Inpatient routine service cost (line 74 minus line 77)					78.00
79.00 Aggregate charges to beneficiaries for excess costs (from provider records)					79.00
80.00 Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)					80.00
81.00 Inpatient routine service cost per diem limitation					81.00
82.00 Inpatient routine service cost limitation (line 9 x line 81)					82.00
83.00 Reasonable inpatient routine service costs (see instructions)					83.00
84.00 Program inpatient ancillary services (see instructions)					84.00
85.00 Utilization review - physician compensation (see instructions)					85.00
86.00 Total Program inpatient operating costs (sum of lines 83 through 85)					86.00
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST					
87.00 Total observation bed days (see instructions)					0
88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					0.00
89.00 Observation bed cost (line 87 x line 88) (see instructions)					0

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-0103 Component CCN: 14-S103		Period: From 01/01/2020 To 12/31/2020	Worksheet D-1 Date/Time Prepared: 7/19/2021 1:49 pm	
		Title XIX		Subprovider - IPF	PPS	
Cost Center Description		Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)
		1.00	2.00	3.00	4.00	5.00
COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	630,900	10,864,982	0.058067	0	0 90.00
91.00	Nursing School cost	0	10,864,982	0.000000	0	0 91.00
92.00	Allied health cost	0	10,864,982	0.000000	0	0 92.00
93.00	All other Medical Education	0	10,864,982	0.000000	0	0 93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT			Provider CCN: 14-0103	Period: From 01/01/2020 To 12/31/2020	Worksheet D-3 Date/Time Prepared: 7/19/2021 1:49 pm	
Cost Center Description			Title XVIII	Hospital	PPS	
			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		4,363,390		30.00
31.00	03100	INTENSIVE CARE UNIT		1,822,330		31.00
40.00	04000	SUBPROVIDER - IPF		0		40.00
43.00	04300	NURSERY				43.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.660064	82,489	54,448	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1.081569	3,568	3,859	52.00
53.00	05300	ANESTHESIOLOGY	0.071545	152,259	10,893	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.399503	1,056,849	422,214	54.00
60.00	06000	LABORATORY	0.211029	1,876,325	395,959	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0.000000	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0.232261	1,624,741	377,364	65.00
66.00	06600	PHYSICAL THERAPY	1.345216	161,928	217,828	66.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.922559	3,315,857	3,059,074	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.478027	118,767	56,774	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.441488	1,622,230	716,195	73.00
74.00	07400	RENAL DIALYSIS	0.224608	595,395	133,730	74.00
76.97	07697	CARDIAC REHABILITATION	0.000000	0	0	76.97
OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	2.721899	817	2,224	90.00
90.01	09001	PARTIAL HOSPITALIZATION PROGRAM	12.363682	0	0	90.01
91.00	09100	EMERGENCY	0.526993	593,716	312,884	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.905926	23,814	21,574	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		11,228,755	5,785,020	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)		11,228,755		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 14-0103 Component CCN: 14-S103	Period: From 01/01/2020 To 12/31/2020	Worksheet D-3 Date/Time Prepared: 7/19/2021 1:49 pm	
		Title XVIII	Subprovider - IPF	PPS	
Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDIATRICS		0		30.00
31.00	03100 INTENSIVE CARE UNIT		0		31.00
40.00	04000 SUBPROVIDER - IPF		1,375,592		40.00
43.00	04300 NURSERY				43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.660064	2,324	1,534	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	1.081569	11,480	12,416	52.00
53.00	05300 ANESTHESIOLOGY	0.071545	871	62	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.399503	28,005	11,188	54.00
60.00	06000 LABORATORY	0.211029	350,007	73,862	60.00
62.30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0.000000	0	0	62.30
65.00	06500 RESPIRATORY THERAPY	0.232261	13,751	3,194	65.00
66.00	06600 PHYSICAL THERAPY	1.345216	204	274	66.00
69.00	06900 ELECTROCARDIOLOGY	0.000000	0	0	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.922559	6,388	5,893	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.478027	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.441488	98,243	43,373	73.00
74.00	07400 RENAL DIALYSIS	0.224608	0	0	74.00
76.97	07697 CARDIAC REHABILITATION	0.000000	0	0	76.97
OUTPATIENT SERVICE COST CENTERS					
90.00	09000 CLINIC	2.721899	0	0	90.00
90.01	09001 PARTIAL HOSPITALIZATION PROGRAM	12.363682	0	0	90.01
91.00	09100 EMERGENCY	0.526993	116,972	61,643	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0.905926	0	0	92.00
200.00	Total (sum of lines 50 through 94 and 96 through 98)		628,245	213,439	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)		628,245		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 14-0103	Period: From 01/01/2020 To 12/31/2020	Worksheet D-3 Date/Time Prepared: 7/19/2021 1:49 pm	
Cost Center Description		Title XIX	Hospital	PPS	
		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS		0	30.00
31.00	03100	INTENSIVE CARE UNIT		0	31.00
40.00	04000	SUBPROVIDER - IPF		0	40.00
43.00	04300	NURSERY		0	43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0.660064	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1.081569	0	52.00
53.00	05300	ANESTHESIOLOGY	0.071545	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.399503	0	54.00
60.00	06000	LABORATORY	0.211029	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0.000000	0	62.30
65.00	06500	RESPIRATORY THERAPY	0.232261	0	65.00
66.00	06600	PHYSICAL THERAPY	1.345216	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.922559	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.478027	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.441488	0	73.00
74.00	07400	RENAL DIALYSIS	0.224608	0	74.00
76.97	07697	CARDIAC REHABILITATION	0.000000	0	76.97
OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	2.721899	0	90.00
90.01	09001	PARTIAL HOSPITALIZATION PROGRAM	12.363682	0	90.01
91.00	09100	EMERGENCY	0.526993	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.905926	0	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		0	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)		0	202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 14-0103 Component CCN: 14-S103	Period: From 01/01/2020 To 12/31/2020	Worksheet D-3 Date/Time Prepared: 7/19/2021 1:49 pm	
		Title XIX	Subprovider - IPF	PPS	
Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDIATRICS		0		30.00
31.00	03100 INTENSIVE CARE UNIT		0		31.00
40.00	04000 SUBPROVIDER - IPF		0		40.00
43.00	04300 NURSERY		0		43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.660064	0	0	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	1.081569	0	0	52.00
53.00	05300 ANESTHESIOLOGY	0.071545	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.399503	0	0	54.00
60.00	06000 LABORATORY	0.211029	0	0	60.00
62.30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0.000000	0	0	62.30
65.00	06500 RESPIRATORY THERAPY	0.232261	0	0	65.00
66.00	06600 PHYSICAL THERAPY	1.345216	0	0	66.00
69.00	06900 ELECTROCARDIOLOGY	0.000000	0	0	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.922559	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.478027	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.441488	0	0	73.00
74.00	07400 RENAL DIALYSIS	0.224608	0	0	74.00
76.97	07697 CARDIAC REHABILITATION	0.000000	0	0	76.97
OUTPATIENT SERVICE COST CENTERS					
90.00	09000 CLINIC	2.721899	0	0	90.00
90.01	09001 PARTIAL HOSPITALIZATION PROGRAM	12.363682	0	0	90.01
91.00	09100 EMERGENCY	0.526993	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0.905926	0	0	92.00
200.00	Total (sum of lines 50 through 94 and 96 through 98)		0	0	200.00
201.00	Less PBP Clinic Laboratory Services-Program only charges (line 61)		0	0	201.00
202.00	Net charges (line 200 minus line 201)		0	0	202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT

Provider CCN: 14-0103

Period:
From 01/01/2020
To 12/31/2020Worksheet E
Part A
Date/Time Prepared:
7/19/2021 1:49 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)			4,117,857	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1 (see instructions)			1,152,967	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)			169,751	2.03
2.04	Outlier payments for discharges occurring on or after October 1 (see instructions)			27,016	2.04
3.00	Managed Care Simulated Payments			2,914,620	3.00
4.00	Bed days available divided by number of days in the cost reporting period (see instructions)			115.53	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)			3.03	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)			3.03	9.00
10.00	FTE count for allopathic and osteopathic programs in the current year from your records			3.32	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)			3.03	12.00
13.00	Total allowable FTE count for the prior year.			3.03	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.			3.03	14.00
15.00	Sum of lines 12 through 14 divided by 3.			3.03	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			3.03	18.00
19.00	Current year resident to bed ratio (line 18 divided by line 4).			0.026227	19.00
20.00	Prior year resident to bed ratio (see instructions)			0.022033	20.00
21.00	Enter the lesser of lines 19 or 20 (see instructions)			0.022033	21.00
22.00	IME payment adjustment (see instructions)			63,086	22.00
22.01	IME payment adjustment - Managed Care (see instructions)			34,885	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)			0.29	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)			63,086	29.00
29.01	Total IME payment - Managed Care (sum of lines 22.01 and 28.01)			34,885	29.01
Disproportionate Share Adjustment					
30.00	Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)			25.49	30.00
31.00	Percentage of Medicaid patient days (see instructions)			54.68	31.00
32.00	Sum of lines 30 and 31			80.17	32.00
33.00	Allowable disproportionate share percentage (see instructions)			55.36	33.00
34.00	Disproportionate share adjustment (see instructions)			729,483	34.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0103	Period: From 01/01/2020 To 12/31/2020	Worksheet E Part A Date/Time Prepared: 7/19/2021 1:49 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)		0.000163718	0.000170722	35.01
35.02	Hospital uncompensated care payment (If line 34 is zero, enter zero on this line) (see instructions)		1,367,146	1,415,287	35.02
35.03	Pro rata share of the hospital uncompensated care payment amount (see instructions)		1,023,492	356,730	35.03
36.00	Total uncompensated care (sum of columns 1 and 2 on line 35.03)		1,380,222		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)		7,640,382		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)			7,675,267	49.00
50.00	Payment for inpatient program capital (from Wkst. L, Pt. I and Pt. II, as applicable)			496,264	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).			69,551	52.00
53.00	Nursing and Allied Health Managed Care payment			0	53.00
54.00	Special add-on payments for new technologies			13,926	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)			8,255,008	59.00
60.00	Primary payer payments			0	60.00
61.00	Total amount payable for program beneficiaries (line 59 minus line 60)			8,255,008	61.00
62.00	Deductibles billed to program beneficiaries			517,484	62.00
63.00	Coinurance billed to program beneficiaries			56,672	63.00
64.00	Allowable bad debts (see instructions)			420,675	64.00
65.00	Adjusted reimbursable bad debts (see instructions)			273,439	65.00
66.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			268,307	66.00
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)			7,954,291	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)			10,556	70.93
70.94	HRR adjustment amount (see instructions)			-47,000	70.94
70.95	Recovery of accelerated depreciation			0	70.95

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0103	Period: From 01/01/2020 To 12/31/2020	Worksheet E Part A Date/Time Prepared: 7/19/2021 1:49 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)		81,490	70.99
71.00	Amount due provider (line 67 minus lines 68 plus/minus lines 69 & 70)		7,836,357	71.00
71.01	Sequestration adjustment (see instructions)		51,720	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		7,497,437	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)		287,200	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		227,321	75.00
TO BE COMPLETED BY CONTRACTOR (lines 90 through 96)				
90.00	Operating outlier amount from Wkst. E, Pt. A, line 2, or sum of 2.03 plus 2.04 (see instructions)		0	90.00
91.00	Capital outlier from Wkst. L, Pt. I, line 2		0	91.00
92.00	Operating outlier reconciliation adjustment amount (see instructions)		0	92.00
93.00	Capital outlier reconciliation adjustment amount (see instructions)		0	93.00
94.00	The rate used to calculate the time value of money (see instructions)		0.00	94.00
95.00	Time value of money for operating expenses (see instructions)		0	95.00
96.00	Time value of money for capital related expenses (see instructions)		0	96.00
		Prior to 10/1	On/After 10/1	
		1.00	2.00	
HSP Bonus Payment Amount				
100.00	HSP bonus amount (see instructions)		0	100.00
HVBP Adjustment for HSP Bonus Payment				
101.00	HVBP adjustment factor (see instructions)	0.0000000000	0.0000000000	101.00
102.00	HVBP adjustment amount for HSP bonus payment (see instructions)		0	102.00
HRR Adjustment for HSP Bonus Payment				
103.00	HRR adjustment factor (see instructions)	0.0000	0.0000	103.00
104.00	HRR adjustment amount for HSP bonus payment (see instructions)		0	104.00
Rural Community Hospital Demonstration Project (\$410A Demonstration) Adjustment				
200.00	Is this the first year of the current 5-year demonstration period under the 21st Century Cures Act? Enter "Y" for yes or "N" for no.			200.00
Cost Reimbursement				
201.00	Medicare inpatient service costs (from Wkst. D-1, Pt. II, line 49)			201.00
202.00	Medicare discharges (see instructions)			202.00
203.00	Case-mix adjustment factor (see instructions)			203.00
Computation of Demonstration Target Amount Limitation (N/A in first year of the current 5-year demonstration period)				
204.00	Medicare target amount			204.00
205.00	Case-mix adjusted target amount (line 203 times line 204)			205.00
206.00	Medicare inpatient routine cost cap (line 202 times line 205)			206.00
Adjustment to Medicare Part A Inpatient Reimbursement				
207.00	Program reimbursement under the \$410A Demonstration (see instructions)			207.00
208.00	Medicare Part A inpatient service costs (from Wkst. E, Pt. A, line 59)			208.00
209.00	Adjustment to Medicare IPPS payments (see instructions)			209.00
210.00	Reserved for future use			210.00
211.00	Total adjustment to Medicare IPPS payments (see instructions)			211.00
Comparison of PPS versus Cost Reimbursement				
212.00	Total adjustment to Medicare Part A IPPS payments (from line 211)			212.00
213.00	Low-volume adjustment (see instructions)			213.00
218.00	Net Medicare Part A IPPS adjustment (difference between PPS and cost reimbursement) (line 212 minus line 213) (see instructions)			218.00

LOW VOLUME CALCULATION EXHIBIT 4

Provider CCN: 14-0103

Period:
From 01/01/2020
To 12/31/2020Worksheet E
Part A Exhibit 4
Date/Time Prepared:
7/19/2021 1:49 pm

		Title XVIII		Hospital		PPS	
		W/S E, Part A line	Amounts (from E, Part A)	Pre/Post Entitlement	Period Prior to 10/01	Period On/After 10/01	Total (Col 2 through 4)
		0	1.00	2.00	3.00	4.00	5.00
1.00	DRG amounts other than outlier payments	1.00	0	0	0	0	0
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1	1.01	4,117,857	0	4,117,857		4,117,857
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	1,152,967	0		1,152,967	1,152,967
1.03	DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October 1	1.03	0	0	0		0
1.04	DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1	1.04	0	0		0	0
2.00	Outlier payments for discharges (see instructions)	2.00					
2.01	Outlier payments for discharges for Model 4 BPCI	2.02	0	0	0	0	0
2.02	Outlier payments for discharges occurring prior to October 1 (see instructions)	2.03	169,751	0	169,751		169,751
2.03	Outlier payments for discharges occurring on or after October 1 (see instructions)	2.04	27,016	0		27,016	27,016
3.00	Operating outlier reconciliation	2.01	0	0	0	0	0
4.00	Managed care simulated payments	3.00	2,914,620	0	2,349,853	564,767	2,914,620
Indirect Medical Education Adjustment							
5.00	Amount from Worksheet E, Part A, line 21 (see instructions)	21.00	0.022033	0.022033	0.022033	0.022033	
6.00	IME payment adjustment (see instructions)	22.00	63,086	0	49,286	13,800	63,086
6.01	IME payment adjustment for managed care (see instructions)	22.01	34,885	0	28,125	6,760	34,885
Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA							
7.00	IME payment adjustment factor (see instructions)	27.00	0.000000	0.000000	0.000000	0.000000	
8.00	IME adjustment (see instructions)	28.00	0	0	0	0	0
8.01	IME payment adjustment add on for managed care (see instructions)	28.01	0	0	0	0	0
9.00	Total IME payment (sum of lines 6 and 8)	29.00	63,086	0	49,286	13,800	63,086
9.01	Total IME payment for managed care (sum of lines 6.01 and 8.01)	29.01	34,885	0	28,125	6,760	34,885
Disproportionate Share Adjustment							
10.00	Allowable disproportionate share percentage (see instructions)	33.00	0.5536	0.5536	0.5536	0.5536	
11.00	Disproportionate share adjustment (see instructions)	34.00	729,483	0	569,912	159,571	729,483
11.01	Uncompensated care payments	36.00	1,380,222	0	3,924,680	0	3,924,680
Additional payment for high percentage of ESRD beneficiary discharges							
12.00	Total ESRD additional payment (see instructions)	46.00	0	0	0	0	0
13.00	Subtotal (see instructions)	47.00	7,640,382	0	6,287,028	1,353,354	7,640,382
14.00	Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see instructions)	48.00	0	0	0	0	0
15.00	Total payment for inpatient operating costs (see instructions)	49.00	7,675,267	0	6,315,153	1,360,114	7,675,267
16.00	Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable)	50.00	496,264	0	389,983	106,281	496,264

LOW VOLUME CALCULATION EXHIBIT 4

Provider CCN: 14-0103

Period:
From 01/01/2020
To 12/31/2020Worksheet E
Part A Exhibit 4
Date/Time Prepared:
7/19/2021 1:49 pm

				Title XVIII		Hospital	PPS	
		W/S E, Part A line	Amounts (from E, Part A)	Pre/Post Entitlement	Period Prior to 10/01	Period On/After 10/01	Total (Col 2 through 4)	
		0	1.00	2.00	3.00	4.00	5.00	
17.00	Special add-on payments for new technologies	54.00	13,926	0	0	13,926	13,926	17.00
17.01	Net organ aquisition cost							17.01
17.02	Credits received from manufacturers for replaced devices for applicable MS-DRGs	68.00	0	0	0	0	0	17.02
18.00	Capital outlier reconciliation adjustment amount (see instructions)	93.00	0	0	0	0	0	18.00
19.00	SUBTOTAL			0	6,705,136	1,480,321	8,185,457	19.00
		W/S L, line	(Amounts from L)					
		0	1.00	2.00	3.00	4.00	5.00	
20.00	Capital DRG other than outlier	1.00	407,765	0	319,884	87,881	407,765	20.00
20.01	Model 4 BPCI Capital DRG other than outlier	1.01	0	0	0	0	0	20.01
21.00	Capital DRG outlier payments	2.00	8,333	0	7,211	1,122	8,333	21.00
21.01	Model 4 BPCI Capital DRG outlier payments	2.01	0	0	0	0	0	21.01
22.00	Indirect medical education percentage (see instructions)	5.00	0.0204	0.0204	0.0204	0.0204		22.00
23.00	Indirect medical education adjustment (see instructions)	6.00	8,318	0	6,525	1,793	8,318	23.00
24.00	Allowable disproportionate share percentage (see instructions)	10.00	0.1762	0.1762	0.1762	0.1762		24.00
25.00	Disproportionate share adjustment (see instructions)	11.00	71,848	0	56,363	15,485	71,848	25.00
26.00	Total prospective capital payments (see instructions)	12.00	496,264	0	389,983	106,281	496,264	26.00
		W/S E, Part A line	(Amounts to E, Part A)					
		0	1.00	2.00	3.00	4.00	5.00	
27.00	Low volume adjustment factor				0.027321	0.027321		27.00
28.00	Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)	70.96			183,191		183,191	28.00
29.00	Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)	70.97				40,444	40,444	29.00
100.00	Transfer low volume adjustments to Wkst. E, Pt. A.		Y					100.00

HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULATION EXHIBIT 5

Provider CCN: 14-0103

Period:
From 01/01/2020
To 12/31/2020Worksheet E
Part A Exhibit 5
Date/Time Prepared:
7/19/2021 1:49 pm

		Title XVIII		Hospital		PPS	
		Wkst. E, Pt. A, line	Amt. from Wkst. E, Pt. A)	Period to 10/01	Period on after 10/01	Total (cols. 2 and 3)	
		0	1.00	2.00	3.00	4.00	
1.00	DRG amounts other than outlier payments	1.00					1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1	1.01	4,117,857	4,117,857		4,117,857	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	1,152,967		1,152,967	1,152,967	1.02
1.03	DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October 1	1.03	0	0		0	1.03
1.04	DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1	1.04	0		0	0	1.04
2.00	Outlier payments for discharges (see instructions)	2.00					2.00
2.01	Outlier payments for discharges for Model 4 BPCI	2.02	0	0	0	0	2.01
2.02	Outlier payments for discharges occurring prior to October 1 (see instructions)	2.03	169,751	169,751		169,751	2.02
2.03	Outlier payments for discharges occurring on or after October 1 (see instructions)	2.04	27,016		27,016	27,016	2.03
3.00	Operating outlier reconciliation	2.01	0	0	0	0	3.00
4.00	Managed care simulated payments	3.00	2,914,620	2,349,853	564,767	2,914,620	4.00
Indirect Medical Education Adjustment							
5.00	Amount from Worksheet E, Part A, line 21 (see instructions)	21.00	0.022033	0.022033	0.022033		5.00
6.00	IME payment adjustment (see instructions)	22.00	63,086	49,286	13,800	63,086	6.00
6.01	IME payment adjustment for managed care (see instructions)	22.01	34,885	28,125	6,760	34,885	6.01
Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA							
7.00	IME payment adjustment factor (see instructions)	27.00	0.000000	0.000000	0.000000		7.00
8.00	IME adjustment (see instructions)	28.00	0	0	0	0	8.00
8.01	IME payment adjustment add on for managed care (see instructions)	28.01	0	0	0	0	8.01
9.00	Total IME payment (sum of lines 6 and 8)	29.00	63,086	49,286	13,800	63,086	9.00
9.01	Total IME payment for managed care (sum of lines 6.01 and 8.01)	29.01	34,885	28,125	6,760	34,885	9.01
Disproportionate Share Adjustment							
10.00	Allowable disproportionate share percentage (see instructions)	33.00	0.5536	0.5536	0.5536		10.00
11.00	Disproportionate share adjustment (see instructions)	34.00	729,483	569,912	159,571	729,483	11.00
11.01	Uncompensated care payments	36.00	1,380,222	1,023,492	356,730	1,380,222	11.01
Additional payment for high percentage of ESRD beneficiary discharges							
12.00	Total ESRD additional payment (see instructions)	46.00	0	0	0	0	12.00
13.00	Subtotal (see instructions)	47.00	7,640,382	5,930,298	1,710,084	7,640,382	13.00
14.00	Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see instructions)	48.00	0	0	0	0	14.00
15.00	Total payment for inpatient operating costs (see instructions)	49.00	7,675,267	5,958,423	1,716,844	7,675,267	15.00
16.00	Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable)	50.00	496,264	389,983	106,281	496,264	16.00
17.00	Special add-on payments for new technologies	54.00	13,926	0	13,926	13,926	17.00
17.01	Net organ acquisition cost						17.01
17.02	Credits received from manufacturers for replaced devices for applicable MS-DRGs	68.00	0	0	0	0	17.02
18.00	Capital outlier reconciliation adjustment amount (see instructions)	93.00	0	0	0	0	18.00
19.00	SUBTOTAL			6,348,406	1,837,051	8,185,457	19.00

HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULATION EXHIBIT 5

Provider CCN: 14-0103

Period:
From 01/01/2020
To 12/31/2020Worksheet E
Part A Exhibit 5
Date/Time Prepared:
7/19/2021 1:49 pm

		Title XVIII		Hospital		PPS	
		Wkst. L, line	(Amt. from Wkst. L)				
		0	1.00	2.00	3.00	4.00	
20.00	Capital DRG other than outlier	1.00	407,765	319,884	87,881	407,765	20.00
20.01	Model 4 BPCI Capital DRG other than outlier	1.01	0	0	0	0	20.01
21.00	Capital DRG outlier payments	2.00	8,333	7,211	1,122	8,333	21.00
21.01	Model 4 BPCI Capital DRG outlier payments	2.01	0	0	0	0	21.01
22.00	Indirect medical education percentage (see instructions)	5.00	0.0204	0.0204	0.0204		22.00
23.00	Indirect medical education adjustment (see instructions)	6.00	8,318	6,525	1,793	8,318	23.00
24.00	Allowable disproportionate share percentage (see instructions)	10.00	0.1762	0.1762	0.1762		24.00
25.00	Disproportionate share adjustment (see instructions)	11.00	71,848	56,363	15,485	71,848	25.00
26.00	Total prospective capital payments (see instructions)	12.00	496,264	389,983	106,281	496,264	26.00
		Wkst. E, Pt. A, line	(Amt. from Wkst. E, Pt. A)				
		0	1.00	2.00	3.00	4.00	
27.00							27.00
28.00	Low volume adjustment prior to October 1	70.96	0	0		0	28.00
29.00	Low volume adjustment on or after October 1	70.97	0		0	0	29.00
30.00	HVBP payment adjustment (see instructions)	70.93	10,556	14,212	-3,656	10,556	30.00
30.01	HVBP payment adjustment for HSP bonus payment (see instructions)	70.90	0	0	0	0	30.01
31.00	HRR adjustment (see instructions)	70.94	-47,000	-39,532	-7,468	-47,000	31.00
31.01	HRR adjustment for HSP bonus payment (see instructions)	70.91	0	0	0	0	31.01
						(Amt. to Wkst. E, Pt. A)	
		0	1.00	2.00	3.00	4.00	
32.00	HAC Reduction Program adjustment (see instructions)	70.99		63,231	18,259	81,490	32.00
100.00	Transfer HAC Reduction Program adjustment to Wkst. E, Pt. A.		Y				100.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0103	Period: From 01/01/2020 To 12/31/2020	Worksheet E Part B Date/Time Prepared: 7/19/2021 1:49 pm
		Title XVIII	Hospital	PPS
				1.00
PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)		0	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)		2,177,275	2.00
3.00	OPPS payments		1,206,115	3.00
4.00	Outlier payment (see instructions)		14,407	4.00
4.01	Outlier reconciliation amount (see instructions)		0	4.01
5.00	Enter the hospital specific payment to cost ratio (see instructions)		0.000	5.00
6.00	Line 2 times line 5		0	6.00
7.00	Sum of lines 3, 4, and 4.01, divided by line 6		0.00	7.00
8.00	Transitional corridor payment (see instructions)		0	8.00
9.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200		0	9.00
10.00	Organ acquisitions		0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)		0	11.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
12.00	Ancillary service charges		0	12.00
13.00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, line 69)		0	13.00
14.00	Total reasonable charges (sum of lines 12 and 13)		0	14.00
Customary charges				
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis		0	15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a chargebasis had such payment been made in accordance with 42 CFR §413.13(e)		0	16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)		0.000000	17.00
18.00	Total customary charges (see instructions)		0	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)		0	19.00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)		0	20.00
21.00	Lesser of cost or charges (see instructions)		0	21.00
22.00	Interns and residents (see instructions)		0	22.00
23.00	Cost of physicians' services in a teaching hospital (see instructions)		0	23.00
24.00	Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)		1,220,522	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)		252,899	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)		967,623	27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 50)		12,253	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)		979,876	30.00
31.00	Primary payer payments		0	31.00
32.00	Subtotal (line 30 minus line 31)		979,876	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)		215,492	34.00
35.00	Adjusted reimbursable bad debts (see instructions)		140,070	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		159,376	36.00
37.00	Subtotal (see instructions)		1,119,946	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)		1,119,946	40.00
40.01	Sequestration adjustment (see instructions)		7,392	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		1,147,096	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)		-34,542	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: 14-0103	Period: From 01/01/2020 To 12/31/2020	Worksheet E Part B Date/Time Prepared: 7/19/2021 1:49 pm
		Component CCN: 14-S103		
		Title XVIII	Subprovider - IPF	PPS
				1.00
PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)		0	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)		1,028	2.00
3.00	OPPS payments		951	3.00
4.00	Outlier payment (see instructions)		0	4.00
4.01	Outlier reconciliation amount (see instructions)		0	4.01
5.00	Enter the hospital specific payment to cost ratio (see instructions)		0.000	5.00
6.00	Line 2 times line 5		0	6.00
7.00	Sum of lines 3, 4, and 4.01, divided by line 6		0.00	7.00
8.00	Transitional corridor payment (see instructions)		0	8.00
9.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200		0	9.00
10.00	Organ acquisitions		0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)		0	11.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
12.00	Ancillary service charges		0	12.00
13.00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, line 69)		0	13.00
14.00	Total reasonable charges (sum of lines 12 and 13)		0	14.00
Customary charges				
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis		0	15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)		0	16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)		0.000000	17.00
18.00	Total customary charges (see instructions)		0	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)		0	19.00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)		0	20.00
21.00	Lesser of cost or charges (see instructions)		0	21.00
22.00	Interns and residents (see instructions)		0	22.00
23.00	Cost of physicians' services in a teaching hospital (see instructions)		0	23.00
24.00	Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)		951	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)		190	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)		761	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)		761	30.00
31.00	Primary payer payments		0	31.00
32.00	Subtotal (line 30 minus line 31)		761	32.00
ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)				
33.00	Composite rate ESRD (from Wkst. I-5, line 11)		0	33.00
34.00	Allowable bad debts (see instructions)		0	34.00
35.00	Adjusted reimbursable bad debts (see instructions)		0	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		0	36.00
37.00	Subtotal (see instructions)		761	37.00
38.00	MSP-LCC reconciliation amount from PS&R		0	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	39.00
39.50	Pioneer ACO demonstration payment adjustment (see instructions)		39.50	
39.97	Demonstration payment adjustment amount before sequestration		0	39.97
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)		0	39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION		0	39.99
40.00	Subtotal (see instructions)		761	40.00
40.01	Sequestration adjustment (see instructions)		5	40.01
40.02	Demonstration payment adjustment amount after sequestration		0	40.02
40.03	Sequestration adjustment-PARHM pass-throughs		40.03	
41.00	Interim payments		758	41.00
41.01	Interim payments-PARHM		41.01	
42.00	Tentative settlement (for contractors use only)		0	42.00
42.01	Tentative settlement-PARHM (for contractor use only)		42.01	
43.00	Balance due provider/program (see instructions)		-2	43.00
43.01	Balance due provider/program-PARHM (see instructions)		43.01	
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		0	44.00
TO BE COMPLETED BY CONTRACTOR				
90.00	Original outlier amount (see instructions)		0	90.00
91.00	Outlier reconciliation adjustment amount (see instructions)		0	91.00
92.00	The rate used to calculate the Time Value of Money		0.00	92.00
93.00	Time Value of Money (see instructions)		0	93.00
94.00	Total (sum of lines 91 and 93)		0	94.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 14-0103

Period:
From 01/01/2020
To 12/31/2020Worksheet E-1
Part I
Date/Time Prepared:
7/19/2021 1:49 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		6,905,506		961,637	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		395,531		126,959	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	08/12/2020	196,400	08/12/2020	58,500	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
Provider to Program						
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		196,400		58,500	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)		7,497,437		1,147,096	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		287,200		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		34,542	6.02
7.00	Total Medicare program liability (see instructions)		7,784,637		1,112,554	7.00
				Contractor Number	NPR Date (Mo/Day/Yr)	
		0		1.00	2.00	
8.00	Name of Contractor					8.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED		Provider CCN: 14-0103 Component CCN: 14-S103		Period: From 01/01/2020 To 12/31/2020		Worksheet E-1 Part I Date/Time Prepared: 7/19/2021 1:49 pm	
		Title XVIII		Subprovider - IPF		PPS	
		Inpatient Part A		Part B			
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount		
		1.00	2.00	3.00	4.00		
1.00	Total interim payments paid to provider						1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		922,377		758		2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)						3.00
Program to Provider							
3.01	ADJUSTMENTS TO PROVIDER		0		0		3.01
3.02			0		0		3.02
3.03			0		0		3.03
3.04			0		0		3.04
3.05			0		0		3.05
Provider to Program							
3.50	ADJUSTMENTS TO PROGRAM		0		0		3.50
3.51			0		0		3.51
3.52			0		0		3.52
3.53			0		0		3.53
3.54			0		0		3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0		3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		922,377		758		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		44,542		0		6.01
6.02	SETTLEMENT TO PROGRAM		0		2		6.02
7.00	Total Medicare program liability (see instructions)		966,919		756		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: 14-0103	Period: From 01/01/2020 To 12/31/2020	Worksheet E-1 Part II Date/Time Prepared: 7/19/2021 1:49 pm
		Title XVIII	Hospital	PPS
				1.00
TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS				
HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION				
1.00	Total hospital discharges as defined in AARA §4102 from Wkst. S-3, Pt. I col. 15 line 14			1.00
2.00	Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, 8-12			2.00
3.00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2			3.00
4.00	Total inpatient days from S-3, Pt. I col. 8 sum of lines 1, 8-12			4.00
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200			5.00
6.00	Total hospital charity care charges from Wkst. S-10, col. 3 line 20			6.00
7.00	CAH only - The reasonable cost incurred for the purchase of certified HIT technology Wkst. S-2, Pt. I line 168			7.00
8.00	Calculation of the HIT incentive payment (see instructions)			8.00
9.00	Sequestration adjustment amount (see instructions)			9.00
10.00	Calculation of the HIT incentive payment after sequestration (see instructions)			10.00
INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH				
30.00	Initial/interim HIT payment adjustment (see instructions)			30.00
31.00	Other Adjustment (specify)			31.00
32.00	Balance due provider (line 8 (or line 10) minus line 30 and line 31) (see instructions)			32.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0103 Component CCN: 14-S103	Period: From 01/01/2020 To 12/31/2020	Worksheet E-3 Part II Date/Time Prepared: 7/19/2021 1:49 pm
		Title XVIII	Subprovider - IPF	PPS
				1.00
PART II - MEDICARE PART A SERVICES - IPF PPS				
1.00	Net Federal IPF PPS Payments (excluding outlier, ECT, and medical education payments)			1,092,263 1.00
2.00	Net IPF PPS Outlier Payments			0 2.00
3.00	Net IPF PPS ECT Payments			0 3.00
4.00	Unweighted intern and resident FTE count in the most recent cost report filed on or before November 15, 2004. (see instructions)			0.00 4.00
4.01	Cap increases for the unweighted intern and resident FTE count for residents that were displaced by program or hospital closure, that would not be counted without a temporary cap adjustment under 42 CFR §412.424(d)(1)(iii)(F)(1) or (2) (see instructions)			0.00 4.01
5.00	New Teaching program adjustment. (see instructions)			0.00 5.00
6.00	Current year's unweighted FTE count of I&R excluding FTEs in the new program growth period of a "new teaching program" (see instructions)			0.00 6.00
7.00	Current year's unweighted I&R FTE count for residents within the new program growth period of a "new teaching program" (see instructions)			0.00 7.00
8.00	Intern and resident count for IPF PPS medical education adjustment (see instructions)			0.00 8.00
9.00	Average Daily Census (see instructions)			28.595628 9.00
10.00	Teaching Adjustment Factor $\{((1 + (\text{line 8/line 9})) \text{ raised to the power of } .5150 - 1)\}$.			0.000000 10.00
11.00	Teaching Adjustment (line 1 multiplied by line 10).			0 11.00
12.00	Adjusted Net IPF PPS Payments (sum of lines 1, 2, 3 and 11)			1,092,263 12.00
13.00	Nursing and Allied Health Managed Care payment (see instruction)			0 13.00
14.00	Organ acquisition (DO NOT USE THIS LINE)			0 14.00
15.00	Cost of physicians' services in a teaching hospital (see instructions)			0 15.00
16.00	Subtotal (see instructions)			1,092,263 16.00
17.00	Primary payer payments			0 17.00
18.00	Subtotal (line 16 less line 17).			1,092,263 18.00
19.00	Deductibles			99,968 19.00
20.00	Subtotal (line 18 minus line 19)			992,295 20.00
21.00	Coinsurance			61,600 21.00
22.00	Subtotal (line 20 minus line 21)			930,695 22.00
23.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)			65,612 23.00
24.00	Adjusted reimbursable bad debts (see instructions)			42,648 24.00
25.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			26,744 25.00
26.00	Subtotal (sum of lines 22 and 24)			973,343 26.00
27.00	Direct graduate medical education payments (see instructions)			0 27.00
28.00	Other pass through costs (see instructions)			0 28.00
29.00	Outlier payments reconciliation			0 29.00
30.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0 30.00
30.50	Pioneer ACO demonstration payment adjustment (see instructions)			0 30.50
30.99	Demonstration payment adjustment amount before sequestration			0 30.99
31.00	Total amount payable to the provider (see instructions)			973,343 31.00
31.01	Sequestration adjustment (see instructions)			6,424 31.01
31.02	Demonstration payment adjustment amount after sequestration			0 31.02
32.00	Interim payments			922,377 32.00
33.00	Tentative settlement (for contractor use only)			0 33.00
34.00	Balance due provider/program (line 31 minus lines 31.01, 31.02, 32 and 33)			44,542 34.00
35.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2			0 35.00
TO BE COMPLETED BY CONTRACTOR				
50.00	Original outlier amount from Worksheet E-3, Part II, line 2			0 50.00
51.00	Outlier reconciliation adjustment amount (see instructions)			0 51.00
52.00	The rate used to calculate the Time Value of Money			0.00 52.00
53.00	Time Value of Money (see instructions)			0 53.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0103	Period: From 01/01/2020 To 12/31/2020	Worksheet E-3 Part VII Date/Time Prepared: 7/19/2021 1:49 pm	
		Title XIX	Hospital	PPS	
			Inpatient	Outpatient	
			1.00	2.00	
PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR XIX SERVICES					
COMPUTATION OF NET COST OF COVERED SERVICES					
1.00	Inpatient hospital/SNF/NF services		0		1.00
2.00	Medical and other services			0	2.00
3.00	Organ acquisition (certified transplant centers only)		0		3.00
4.00	Subtotal (sum of lines 1, 2 and 3)		0	0	4.00
5.00	Inpatient primary payer payments		0		5.00
6.00	Outpatient primary payer payments			0	6.00
7.00	Subtotal (line 4 less sum of lines 5 and 6)		0	0	7.00
COMPUTATION OF LESSER OF COST OR CHARGES					
Reasonable Charges					
8.00	Routine service charges		14,141,517		8.00
9.00	Ancillary service charges		0	0	9.00
10.00	Organ acquisition charges, net of revenue		0		10.00
11.00	Incentive from target amount computation		0		11.00
12.00	Total reasonable charges (sum of lines 8 through 11)		14,141,517	0	12.00
CUSTOMARY CHARGES					
13.00	Amount actually collected from patients liable for payment for services on a charge basis		0	0	13.00
14.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)		0	0	14.00
15.00	Ratio of line 13 to line 14 (not to exceed 1.000000)		0.000000	0.000000	15.00
16.00	Total customary charges (see instructions)		14,141,517	0	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)		14,141,517	0	17.00
18.00	Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 16) (see instructions)		0	0	18.00
19.00	Interns and Residents (see instructions)		0	0	19.00
20.00	Cost of physicians' services in a teaching hospital (see instructions)		0	0	20.00
21.00	Cost of covered services (enter the lesser of line 4 or line 16)		0	0	21.00
PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be completed for PPS providers.					
22.00	Other than outlier payments		0	0	22.00
23.00	Outlier payments		0	0	23.00
24.00	Program capital payments		0		24.00
25.00	Capital exception payments (see instructions)		0		25.00
26.00	Routine and Ancillary service other pass through costs		0	0	26.00
27.00	Subtotal (sum of lines 22 through 26)		0	0	27.00
28.00	Customary charges (title V or XIX PPS covered services only)		0		28.00
29.00	Titles V or XIX (sum of lines 21 and 27)		0	0	29.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT					
30.00	Excess of reasonable cost (from line 18)		0	0	30.00
31.00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)		0	0	31.00
32.00	Deductibles		0	0	32.00
33.00	Coinsurance		0	0	33.00
34.00	Allowable bad debts (see instructions)		0	0	34.00
35.00	Utilization review		0		35.00
36.00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)		0	0	36.00
37.00	LESS INPATIENT COSTS		0	0	37.00
38.00	Subtotal (line 36 ± line 37)		0	0	38.00
39.00	Direct graduate medical education payments (from Wkst. E-4)		0		39.00
40.00	Total amount payable to the provider (sum of lines 38 and 39)		0	0	40.00
41.00	Interim payments		0	0	41.00
42.00	Balance due provider/program (line 40 minus line 41)		0	0	42.00
43.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, chapter 1, §115.2		0	0	43.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0103 Component CCN: 14-S103	Period: From 01/01/2020 To 12/31/2020	Worksheet E-3 Part VII Date/Time Prepared: 7/19/2021 1:49 pm
		Title XIX	Subprovider - IPF	PPS
		Inpatient 1.00	Outpatient 2.00	
PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR XIX SERVICES				
COMPUTATION OF NET COST OF COVERED SERVICES				
1.00	Inpatient hospital/SNF/NF services	0		1.00
2.00	Medical and other services		0	2.00
3.00	Organ acquisition (certified transplant centers only)	0		3.00
4.00	Subtotal (sum of lines 1, 2 and 3)	0	0	4.00
5.00	Inpatient primary payer payments	0		5.00
6.00	Outpatient primary payer payments		0	6.00
7.00	Subtotal (line 4 less sum of lines 5 and 6)	0	0	7.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable Charges				
8.00	Routine service charges	5,474,388		8.00
9.00	Ancillary service charges	0	0	9.00
10.00	Organ acquisition charges, net of revenue	0		10.00
11.00	Incentive from target amount computation	0		11.00
12.00	Total reasonable charges (sum of lines 8 through 11)	5,474,388	0	12.00
CUSTOMARY CHARGES				
13.00	Amount actually collected from patients liable for payment for services on a charge basis	0	0	13.00
14.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)	0	0	14.00
15.00	Ratio of line 13 to line 14 (not to exceed 1.000000)	0.000000	0.000000	15.00
16.00	Total customary charges (see instructions)	5,474,388	0	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)	5,474,388	0	17.00
18.00	Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 16) (see instructions)	0	0	18.00
19.00	Interns and Residents (see instructions)	0	0	19.00
20.00	Cost of physicians' services in a teaching hospital (see instructions)	0	0	20.00
21.00	Cost of covered services (enter the lesser of line 4 or line 16)	0	0	21.00
PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be completed for PPS providers.				
22.00	Other than outlier payments	0	0	22.00
23.00	Outlier payments	0	0	23.00
24.00	Program capital payments	0	0	24.00
25.00	Capital exception payments (see instructions)	0	0	25.00
26.00	Routine and Ancillary service other pass through costs	0	0	26.00
27.00	Subtotal (sum of lines 22 through 26)	0	0	27.00
28.00	Customary charges (title V or XIX PPS covered services only)	0	0	28.00
29.00	Titles V or XIX (sum of lines 21 and 27)	0	0	29.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT				
30.00	Excess of reasonable cost (from line 18)	0	0	30.00
31.00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)	0	0	31.00
32.00	Deductibles	0	0	32.00
33.00	Coinurance	0	0	33.00
34.00	Allowable bad debts (see instructions)	0	0	34.00
35.00	Utilization review	0	0	35.00
36.00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)	0	0	36.00
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	37.00
38.00	Subtotal (line 36 ± line 37)	0	0	38.00
39.00	Direct graduate medical education payments (from Wkst. E-4)	0	0	39.00
40.00	Total amount payable to the provider (sum of lines 38 and 39)	0	0	40.00
41.00	Interim payments	0	0	41.00
42.00	Balance due provider/program (line 40 minus line 41)	0	0	42.00
43.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, chapter 1, §115.2	0	0	43.00

DIRECT GRADUATE MEDICAL EDUCATION (GME) & ESRD OUTPATIENT DIRECT MEDICAL EDUCATION COSTS		Provider CCN: 14-0103	Period: From 01/01/2020 To 12/31/2020	Worksheet E-4 Date/Time Prepared: 7/19/2021 1:49 pm	
		Title XVIII	Hospital	PPS	
				1.00	
COMPUTATION OF TOTAL DIRECT GME AMOUNT					
1.00	Unweighted resident FTE count for allopathic and osteopathic programs for cost reporting periods ending on or before December 31, 1996.			3.03	1.00
2.00	Unweighted FTE resident cap add-on for new programs per 42 CFR 413.79(e)(1) (see instructions)			0.00	2.00
3.00	Amount of reduction to Direct GME cap under section 422 of MMA			0.00	3.00
3.01	Direct GME cap reduction amount under ACA §5503 in accordance with 42 CFR §413.79 (m). (see instructions for cost reporting periods straddling 7/1/2011)			0.00	3.01
4.00	Adjustment (plus or minus) to the FTE cap for allopathic and osteopathic programs due to a Medicare GME affiliation agreement (42 CFR §413.75(b) and § 413.79 (f))			0.00	4.00
4.01	ACA Section 5503 increase to the Direct GME FTE Cap (see instructions for cost reporting periods straddling 7/1/2011)			0.00	4.01
4.02	ACA Section 5506 number of additional direct GME FTE cap slots (see instructions for cost reporting periods straddling 7/1/2011)			0.00	4.02
5.00	FTE adjusted cap (line 1 plus line 2 minus line 3 and 3.01 plus or minus line 4 plus lines 4.01 and 4.02 plus applicable subscripts)			3.03	5.00
6.00	Unweighted resident FTE count for allopathic and osteopathic programs for the current year from your records (see instructions)			3.32	6.00
7.00	Enter the lesser of line 5 or line 6			3.03	7.00
		Primary Care	Other	Total	
		1.00	2.00	3.00	
8.00	Weighted FTE count for physicians in an allopathic and osteopathic program for the current year.	0.00	3.32	3.32	8.00
9.00	If line 6 is less than 5 enter the amount from line 8, otherwise multiply line 8 times the result of line 5 divided by the amount on line 6.	0.00	3.03	3.03	9.00
10.00	Weighted dental and podiatric resident FTE count for the current year		0.00		10.00
10.01	Unweighted dental and podiatric resident FTE count for the current year		0.00		10.01
11.00	Total weighted FTE count	0.00	3.03		11.00
12.00	Total weighted resident FTE count for the prior cost reporting year (see instructions)	0.00	3.03		12.00
13.00	Total weighted resident FTE count for the penultimate cost reporting year (see instructions)	0.00	3.03		13.00
14.00	Rolling average FTE count (sum of lines 11 through 13 divided by 3).	0.00	3.03		14.00
15.00	Adjustment for residents in initial years of new programs	0.00	0.00		15.00
15.01	Unweighted adjustment for residents in initial years of new programs	0.00	0.00		15.01
16.00	Adjustment for residents displaced by program or hospital closure	0.00	0.00		16.00
16.01	Unweighted adjustment for residents displaced by program or hospital closure	0.00	0.00		16.01
17.00	Adjusted rolling average FTE count	0.00	3.03		17.00
18.00	Per resident amount	0.00	102,549.49		18.00
19.00	Approved amount for resident costs	0	310,725	310,725	19.00
				1.00	
20.00	Additional unweighted allopathic and osteopathic direct GME FTE resident cap slots received under 42 Sec. 413.79(c)(4)			0.00	20.00
21.00	Direct GME FTE unweighted resident count over cap (see instructions)			0.29	21.00
22.00	Allowable additional direct GME FTE Resident Count (see instructions)			0.00	22.00
23.00	Enter the locality adjustment national average per resident amount (see instructions)			0.00	23.00
24.00	Multiply line 22 time line 23			0	24.00
25.00	Total direct GME amount (sum of lines 19 and 24)			310,725	25.00
		Inpatient Part	Managed Care	Total	
		A			
		1.00	2.00	3.00	
COMPUTATION OF PROGRAM PATIENT LOAD					
26.00	Inpatient Days (see instructions) (Title XIX - see S-2 Part IX, line 3.02, column 2)	4,899	2,082		26.00
27.00	Total Inpatient Days (see instructions)	25,963	25,963		27.00
28.00	Ratio of inpatient days to total inpatient days	0.188692	0.080191		28.00
29.00	Program direct GME amount	58,631	24,917	83,548	29.00
29.01	Percent reduction for MA DGME		7.00		29.01
30.00	Reduction for direct GME payments for Medicare Advantage		1,744	1,744	30.00
31.00	Net Program direct GME amount			81,804	31.00

DIRECT GRADUATE MEDICAL EDUCATION (GME) & ESRD OUTPATIENT DIRECT MEDICAL EDUCATION COSTS		Provider CCN: 14-0103	Period: From 01/01/2020 To 12/31/2020	Worksheet E-4 Date/Time Prepared: 7/19/2021 1:49 pm	
		Title XVIII	Hospital	PPS	
				1.00	
	DIRECT MEDICAL EDUCATION COSTS FOR ESRD COMPOSITE RATE - TITLE XVIII ONLY (NURSING SCHOOL AND PARAMEDICAL EDUCATION COSTS)				
32.00	Renal dialysis direct medical education costs (from Wkst. B, Pt. I, sum of col. 20 and 23, lines 74 and 94)			0	32.00
33.00	Renal dialysis and home dialysis total charges (Wkst. C, Pt. I, col. 8, sum of lines 74 and 94)			1,935,467	33.00
34.00	Ratio of direct medical education costs to total charges (line 32 ÷ line 33)			0.000000	34.00
35.00	Medicare outpatient ESRD charges (see instructions)			0	35.00
36.00	Medicare outpatient ESRD direct medical education costs (line 34 x line 35)			0	36.00
APPORTIONMENT BASED ON MEDICARE REASONABLE COST - TITLE XVIII ONLY					
Part A Reasonable Cost					
37.00	Reasonable cost (see instructions)			12,364,221	37.00
38.00	Organ acquisition costs (Wkst. D-4, Pt. III, col. 1, line 69)			0	38.00
39.00	Cost of physicians' services in a teaching hospital (see instructions)			0	39.00
40.00	Primary payer payments (see instructions)			0	40.00
41.00	Total Part A reasonable cost (sum of lines 37 through 39 minus line 40)			12,364,221	41.00
Part B Reasonable Cost					
42.00	Reasonable cost (see instructions)			2,178,303	42.00
43.00	Primary payer payments (see instructions)			0	43.00
44.00	Total Part B reasonable cost (line 42 minus line 43)			2,178,303	44.00
45.00	Total reasonable cost (sum of lines 41 and 44)			14,542,524	45.00
46.00	Ratio of Part A reasonable cost to total reasonable cost (line 41 ÷ line 45)			0.850211	46.00
47.00	Ratio of Part B reasonable cost to total reasonable cost (line 44 ÷ line 45)			0.149789	47.00
ALLOCATION OF MEDICARE DIRECT GME COSTS BETWEEN PART A AND PART B					
48.00	Total program GME payment (line 31)			81,804	48.00
49.00	Part A Medicare GME payment (line 46 x 48) (title XVIII only) (see instructions)			69,551	49.00
50.00	Part B Medicare GME payment (line 47 x 48) (title XVIII only) (see instructions)			12,253	50.00

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

Provider CCN: 14-0103

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

Worksheet G

Date/Time Prepared:
7/19/2021 1:49 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	26,139,076	0	0	0	1.00
2.00 Temporary investments	0	0	0	0	2.00
3.00 Notes receivable	0	0	0	0	3.00
4.00 Accounts receivable	14,704,629	0	0	0	4.00
5.00 Other receivable	760,000	0	0	0	5.00
6.00 Allowances for uncollectible notes and accounts receivable	0	0	0	0	6.00
7.00 Inventory	1,215,934	0	0	0	7.00
8.00 Prepaid expenses	1,018,988	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)	43,838,627	0	0	0	11.00
FIXED ASSETS					
12.00 Land	6,876,544	0	0	0	12.00
13.00 Land improvements	0	0	0	0	13.00
14.00 Accumulated depreciation	0	0	0	0	14.00
15.00 Buildings	89,438,250	0	0	0	15.00
16.00 Accumulated depreciation	-52,844,850	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	0	0	0	0	19.00
20.00 Accumulated depreciation	0	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	58,938,479	0	0	0	23.00
24.00 Accumulated depreciation	-47,082,420	0	0	0	24.00
25.00 Minor equipment depreciable	0	0	0	0	25.00
26.00 Accumulated depreciation	0	0	0	0	26.00
27.00 HIT designated Assets	0	0	0	0	27.00
28.00 Accumulated depreciation	0	0	0	0	28.00
29.00 Minor equipment-nondepreciable	0	0	0	0	29.00
30.00 Total fixed assets (sum of lines 12-29)	55,326,003	0	0	0	30.00
OTHER ASSETS					
31.00 Investments	28,949	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	14,189,669	0	0	0	34.00
35.00 Total other assets (sum of lines 31-34)	14,218,618	0	0	0	35.00
36.00 Total assets (sum of lines 11, 30, and 35)	113,383,248	0	0	0	36.00
CURRENT LIABILITIES					
37.00 Accounts payable	1,971,483	0	0	0	37.00
38.00 Salaries, wages, and fees payable	7,427,896	0	0	0	38.00
39.00 Payroll taxes payable	197,903	0	0	0	39.00
40.00 Notes and loans payable (short term)	13,934,848	0	0	0	40.00
41.00 Deferred income	0	0	0	0	41.00
42.00 Accelerated payments	0	0	0	0	42.00
43.00 Due to other funds	0	0	0	0	43.00
44.00 Other current liabilities	3,767,062	0	0	0	44.00
45.00 Total current liabilities (sum of lines 37 thru 44)	27,299,192	0	0	0	45.00
LONG TERM LIABILITIES					
46.00 Mortgage payable	0	0	0	0	46.00
47.00 Notes payable	0	0	0	0	47.00
48.00 Unsecured loans	0	0	0	0	48.00
49.00 Other long term liabilities	12,543,859	0	0	0	49.00
50.00 Total long term liabilities (sum of lines 46 thru 49)	12,543,859	0	0	0	50.00
51.00 Total liabilities (sum of lines 45 and 50)	39,843,051	0	0	0	51.00
CAPITAL ACCOUNTS					
52.00 General fund balance	73,540,197				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)	73,540,197	0	0	0	59.00
60.00 Total liabilities and fund balances (sum of lines 51 and 59)	113,383,248	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 14-0103

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

Worksheet G-1

Date/Time Prepared:
7/19/2021 1:49 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		55,295,124		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		15,341,295				2.00
3.00	Total (sum of line 1 and line 2)		70,636,419		0		3.00
4.00	RECONCILING ITEM	0		0		0	4.00
5.00	GAINS ON INVESTMENTS	0		0		0	5.00
6.00	TEMPORARILY RESTRICTED	0		0		0	6.00
7.00	CONTRIBUTIONS	0		0		0	7.00
8.00	TRANSFERS	0		0		0	8.00
9.00	ASSETS RELEASED	2,903,778		0		0	9.00
10.00	Total additions (sum of line 4-9)		2,903,778		0		10.00
11.00	Subtotal (line 3 plus line 10)		73,540,197		0		11.00
12.00	TRANSFERS	0		0		0	12.00
13.00	RECONCILIING ITEM	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)		0		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		73,540,197		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	RECONCILING ITEM		0				4.00
5.00	GAINS ON INVESTMENTS		0				5.00
6.00	TEMPORARILY RESTRICTED		0				6.00
7.00	CONTRIBUTIONS		0				7.00
8.00	TRANSFERS		0				8.00
9.00	ASSETS RELEASED		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	TRANSFERS		0				12.00
13.00	RECONCILIING ITEM		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: 14-0103

Period:
From 01/01/2020
To 12/31/2020Worksheet G-2
Parts I & II
Date/Time Prepared:
7/19/2021 1:49 pm

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
PART I - PATIENT REVENUES					
General Inpatient Routine Services					
1.00	Hospital	15,938,314		15,938,314	1.00
2.00	SUBPROVIDER - IPF	13,574,225		13,574,225	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)	29,512,539		29,512,539	10.00
Intensive Care Type Inpatient Hospital Services					
11.00	INTENSIVE CARE UNIT	7,508,728		7,508,728	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)	7,508,728		7,508,728	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	37,021,267		37,021,267	17.00
18.00	Ancillary services	51,703,378		51,703,378	18.00
19.00	Outpatient services	0	63,685,679	63,685,679	19.00
20.00	RURAL HEALTH CLINIC	0	0	0	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY				22.00
23.00	AMBULANCE SERVICES				23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	OP PHARMACY & OTHER	170,094	1,666,570	1,836,664	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	88,894,739	65,352,249	154,246,988	28.00
PART II - OPERATING EXPENSES					
29.00	Operating expenses (per Wkst. A, column 3, line 200)		104,435,784		29.00
30.00	ADD (SPECIFY)	0			30.00
31.00	BAD DEBTS	0			31.00
32.00	BP	0			32.00
33.00		0			33.00
34.00		0			34.00
35.00	ROUNDING	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)		104,435,784		43.00

STATEMENT OF REVENUES AND EXPENSES

Provider CCN: 14-0103

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

Worksheet G-3

Date/Time Prepared:
7/19/2021 1:49 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	154,246,988	1.00
2.00	Less contractual allowances and discounts on patients' accounts	68,812,495	2.00
3.00	Net patient revenues (line 1 minus line 2)	85,434,493	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	104,435,784	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-19,001,291	5.00
OTHER INCOME			
6.00	Contributions, donations, bequests, etc	0	6.00
7.00	Income from investments	96,968	7.00
8.00	Revenues from telephone and other miscellaneous communication services	105	8.00
9.00	Revenue from television and radio service	0	9.00
10.00	Purchase discounts	0	10.00
11.00	Rebates and refunds of expenses	0	11.00
12.00	Parking lot receipts	0	12.00
13.00	Revenue from laundry and linen service	0	13.00
14.00	Revenue from meals sold to employees and guests	382,714	14.00
15.00	Revenue from rental of living quarters	0	15.00
16.00	Revenue from sale of medical and surgical supplies to other than patients	0	16.00
17.00	Revenue from sale of drugs to other than patients	0	17.00
18.00	Revenue from sale of medical records and abstracts	24,752	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	20,501	21.00
22.00	Rental of hospital space	0	22.00
23.00	Governmental appropriations	0	23.00
24.00	MISCELLANEOUS INCOME	53,298	24.00
24.01	ER PRO FEE INCOME	1,811,456	24.01
24.02	ANEST PRO FEE INCOME	213,755	24.02
24.03	SISTERS MAINTENANCE	0	24.03
24.04	OTHER RENTAL INCOME	285,097	24.04
24.05	OTHER	0	24.05
24.06	PARTNERS IN HEALTH	147,772	24.06
24.07	OTHER PRO FEE	1,918,326	24.07
24.08	CLINIC REVENUE	751,783	24.08
24.09	GAIN FROM DISPOSAL	0	24.09
24.10	NET ASSETS RELEASED	4,235,454	24.10
24.11	CAPITAL GAINS	40,048	24.11
24.50	COVID-19 PHE Funding	24,360,556	24.50
25.00	Total other income (sum of lines 6-24)	34,342,585	25.00
26.00	Total (line 5 plus line 25)	15,341,294	26.00
27.00	RECONCILING ITEM	-1	27.00
27.01	OTHER EXPENSES (SPECIFY)	0	27.01
28.00	Total other expenses (sum of line 27 and subscripts)	-1	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	15,341,295	29.00

CALCULATION OF CAPITAL PAYMENT

Provider CCN: 14-0103

Period:
From 01/01/2020
To 12/31/2020Worksheet L
Parts I-III
Date/Time Prepared:
7/19/2021 1:49 pm

Title XVIII		Hospital	PPS
			1.00
PART I - FULLY PROSPECTIVE METHOD			
CAPITAL FEDERAL AMOUNT			
1.00	Capital DRG other than outlier	407,765	1.00
1.01	Model 4 BPCI Capital DRG other than outlier	0	1.01
2.00	Capital DRG outlier payments	8,333	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)	42.34	3.00
4.00	Number of interns & residents (see instructions)	3.03	4.00
5.00	Indirect medical education percentage (see instructions)	2.04	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)	8,318	6.00
7.00	Percentage of SSI recipient patient days to Medicare Part A patient days (Worksheet E, part A line 30) (see instructions)	25.49	7.00
8.00	Percentage of Medicaid patient days to total days (see instructions)	54.68	8.00
9.00	Sum of lines 7 and 8	80.17	9.00
10.00	Allowable disproportionate share percentage (see instructions)	17.62	10.00
11.00	Disproportionate share adjustment (see instructions)	71,848	11.00
12.00	Total prospective capital payments (see instructions)	496,264	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