

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: 14-0120	Period: From 01/01/2020 To 12/31/2020	Worksheet S Parts I-III Date/Time Prepared: 7/22/2021 2:23 pm
--	-----------------------	---	--

PART I - COST REPORT STATUS

Provider use only	1. ☒ Electronically prepared cost report	Date: 7/22/2021	Time: 2:23 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 PEKIN MEMORIAL HOSPITAL (14-0120) for the cost reporting period beginning 01/01/2020 and ending 12/31/2020 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

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

(Signed)

Officer or Administrator of Provider(s)

Title

Date

Cost Center Description		Title V	Title XVIII		HIT	Title XIX	
			Part A	Part B			
		1.00	2.00	3.00	4.00	5.00	
	PART III - SETTLEMENT SUMMARY						
1.00	Hospital	0	127,693	31,673	0	0	1.00
2.00	Subprovider - IPF	0	0	0		0	2.00
3.00	Subprovider - IRF	0	0	0		0	3.00
5.00	Swing Bed - SNF	0	0	0		0	5.00
6.00	Swing Bed - NF	0				0	6.00
7.00	SKILLED NURSING FACILITY	0	0	0		0	7.00
9.00	HOME HEALTH AGENCY I	0	0	0		0	9.00
200.00	Total	0	127,693	31,673	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: 14-0120		Period: From 01/01/2020 To 12/31/2020		Worksheet S-2 Part I Date/Time Prepared: 7/22/2021 2:23 pm		
1.00		2.00		3.00		4.00					
Hospital and Hospital Health Care Complex Address:											
1.00	Street: 600 SOUTH 13TH STREET			PO Box:				1.00			
2.00	City: PEKIN			State: IL		Zip Code: 61554		County: TAZEWELL			
		Component Name		CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N)			
								V	XVIII	XIX	
		1.00		2.00	3.00	4.00	5.00	6.00	7.00	8.00	
Hospital and Hospital-Based Component Identification:											
3.00	Hospital			PEKIN MEMORIAL HOSPITAL	140120	37900	1	07/01/1966	N	P	N
4.00	Subprovider - IPF										
5.00	Subprovider - IRF										
6.00	Subprovider - (Other)										
7.00	Swing Beds - SNF										
8.00	Swing Beds - NF										
9.00	Hospital-Based SNF										
10.00	Hospital-Based NF										
11.00	Hospital-Based OLTC										
12.00	Hospital-Based HHA										
13.00	Separately Certified ASC										
14.00	Hospital-Based Hospice										
15.00	Hospital-Based Health Clinic - RHC										
16.00	Hospital-Based Health Clinic - FQHC										
17.00	Hospital-Based (CMHC) I										
18.00	Renal Dialysis										
19.00	Other										
							From:	To:			
							1.00	2.00			
20.00	Cost Reporting Period (mm/dd/yyyy)						01/01/2020		12/31/2020		20.00
21.00	Type of Control (see instructions)						2				21.00
							1.00	2.00	3.00		
Inpatient PPS Information											
22.00	Does this facility qualify and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.106(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no.					Y	N				22.00
22.01	Did this hospital receive interim uncompensated care payments for this cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)					Y	Y				22.01
22.02	Is this a newly merged hospital that requires final uncompensated care payments to be determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1.					N	N				22.02
22.03	Did this hospital receive a geographic reclassification from urban to rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no.					N	N		N		22.03
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.					1	N				23.00
				In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of State Medicaid paid days	Out-of State Medicaid eligible unpaid	Medicaid HMO days	Other Medicaid days		
				1.00	2.00	3.00	4.00	5.00	6.00		
24.00	If this provider is an IPPS hospital, enter the in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.			0	125	5	0	726	0		24.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

Provider CCN: 14-0120

Period:
From 01/01/2020
To 12/31/2020Worksheet S-2
Part I
Date/Time Prepared:
7/22/2021 2:23 pm

	In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of State Medicaid paid days	Out-of State Medicaid eligible unpaid	Medicaid HMO days	Other Medicaid days	
	1.00	2.00	3.00	4.00	5.00	6.00	
25.00 If this provider is an IRF, enter the in-state Medicaid paid days in column 1, the in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5.	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	N	45.00
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	46.00
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	47.00
48.00 Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.					N	N	48.00
Teaching Hospitals							
56.00 Is this a hospital involved in training residents in approved GME programs? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", are you impacted by CR 11642 (or subsequent CR), MA GME payment reduction? Enter "Y" for yes or "N" for no in column 2.					N		56.00
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		57.00
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		58.00
59.00 Are costs claimed on line 100 of Worksheet A? If yes, complete Wkst. D-2, Pt. I.					N		59.00
				NAHE 413.85 Y/N	Worksheet A Line #	Pass-Through Qualification Criterion Code	
				1.00	2.00	3.00	
60.00 Are you claiming nursing and allied health education (NAHE) costs for any programs that meet the criteria under 42 CFR 413.85? (see instructions) Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", are you impacted by CR 11642 (or subsequent CR) NAHE MA payment adjustment? Enter "Y" for yes or "N" for no in column 2.					N		60.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

Provider CCN: 14-0120

Period:
From 01/01/2020
To 12/31/2020Worksheet S-2
Part I
Date/Time Prepared:
7/22/2021 2:23 pm

	Y/N	IME	Direct GME	IME	Direct GME	
	1.00	2.00	3.00	4.00	5.00	
61.00 Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions)	N			0.00	0.00	61.00
61.01 Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions)						61.01
61.02 Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions)						61.02
61.03 Enter the base line FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions)						61.03
61.04 Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period.(see instructions).						61.04
61.05 Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions)						61.05
61.06 Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)						61.06
	Program Name		Program Code	Unweighted IME FTE Count	Unweighted Direct GME FTE Count	
	1.00		2.00	3.00	4.00	
61.10 Of the FTEs in line 61.05, specify each new program specialty, if any, and the number of FTE residents for each new program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count.				0.00	0.00	61.10
61.20 Of the FTEs in line 61.05, specify each expanded program specialty, if any, and the number of FTE residents for each expanded program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count.				0.00	0.00	61.20
					1.00	
ACA Provisions Affecting the Health Resources and Services Administration (HRSA)						
62.00 Enter the number of FTE residents that your hospital trained in this cost reporting period for which your hospital received HRSA PCRE funding (see instructions)					0.00	62.00
62.01 Enter the number of FTE residents that rotated from a Teaching Health Center (THC) into your hospital during in this cost reporting period of HRSA THC program. (see instructions)					0.00	62.01
Teaching Hospitals that Claim Residents in Nonprovider Settings						
63.00 Has your facility trained residents in nonprovider settings during this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If yes, complete lines 64 through 67. (see instructions)					N	63.00
	Unweighted FTEs Nonprovider Site		Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))		
	1.00		2.00	3.00		
64.00 Section 5504 of the ACA Base Year FTE Residents in Nonprovider Settings--This base year is your cost reporting period that begins on or after July 1, 2009 and before June 30, 2010. Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)			0.00	0.00	0.000000	64.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

Provider CCN: 14-0120

Period:
From 01/01/2020
To 12/31/2020Worksheet S-2
Part I
Date/Time Prepared:
7/22/2021 2:23 pm

	Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))			
	1.00	2.00	3.00	4.00	5.00			
65.00	Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the program name associated with primary care FTEs for each primary care program in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)		0.00	0.00	0.000000	65.00		
			Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))			
			1.00	2.00	3.00			
Section 5504 of the ACA Current Year FTE Residents in Nonprovider Settings--Effective for cost reporting periods beginning on or after July 1, 2010								
66.00	Enter in column 1 the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)		0.00	0.00	0.000000	66.00		
			Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))			
			1.00	2.00	5.00			
67.00	Enter in column 1, the program name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)		0.00	0.00	0.000000	67.00		
					1.00	2.00	3.00	
Inpatient Psychiatric Facility PPS								
70.00	Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? Enter "Y" for yes or "N" for no.				N		70.00	
71.00	If line 70 is yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost report filed on or before November 15, 2004? Enter "Y" for yes or "N" for no. (see 42 CFR 412.424(d)(1)(iii)(c)) Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)				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)				N	N	0	76.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-0120	Period: From 01/01/2020 To 12/31/2020	Worksheet S-2 Part I Date/Time Prepared: 7/22/2021 2:23 pm	
			1.00		
Long Term Care Hospital PPS					
80.00	Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for no.	N		80.00	
81.00	Is this a LTCH co-located within another hospital for part or all of the cost reporting period? Enter "Y" for yes and "N" for no.	N		81.00	
TEFRA Providers					
85.00	Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no.	N		85.00	
86.00	Did this facility establish a new Other subprovider (excluded unit) under 42 CFR Section §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.			86.00	
87.00	Is this hospital an extended neoplastic disease care hospital classified under section 1886(d)(1)(B)(vi)? Enter "Y" for yes or "N" for no.	N		87.00	
		V	XIX		
		1.00	2.00		
Title V and XIX Services					
90.00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.	N	Y	90.00	
91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.	N	N	91.00	
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.		N	92.00	
93.00	Does this facility operate an ICF/IID facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.	N	N	93.00	
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.	N	N	94.00	
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	95.00	
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.	N	N	96.00	
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	97.00	
98.00	Does title V or XIX follow Medicare (title XVIII) for the interns and residents post stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.00	
98.01	Does title V or XIX follow Medicare (title XVIII) for the reporting of charges on Wkst. C, Pt. I? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.01	
98.02	Does title V or XIX follow Medicare (title XVIII) for the calculation of observation bed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.02	
98.03	Does title V or XIX follow Medicare (title XVIII) for a critical access hospital (CAH) reimbursed 101% of inpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.03	
98.04	Does title V or XIX follow Medicare (title XVIII) for a CAH reimbursed 101% of outpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.04	
98.05	Does title V or XIX follow Medicare (title XVIII) and add back the RCE disallowance on Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.05	
98.06	Does title V or XIX follow Medicare (title XVIII) when cost reimbursed for Wkst. D, Pts. I through IV? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.06	
Rural Providers					
105.00	Does this hospital qualify as a CAH?	N		105.00	
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)	N		106.00	
107.00	Column 1: If line 105 is Y, is this facility eligible for cost reimbursement for I&R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) Column 2: If column 1 is Y and line 70 or line 75 is Y, do you train I&Rs in an approved medical education program in the CAH's excluded IPF and/or IRF unit(s)? Enter "Y" for yes or "N" for no in column 2. (see instructions)	N		107.00	
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	N		108.00	
		Physical	Occupational	Speech	Respiratory
		1.00	2.00	3.00	4.00
109.00	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.	N	N	N	N
					1.00
110.00	Did this hospital participate in the Rural Community Hospital Demonstration project (§410A Demonstration) for the current cost reporting period? Enter "Y" for yes or "N" for no. If yes, complete Worksheet E, Part A, lines 200 through 218, and Worksheet E-2, lines 200 through 215, as applicable.				N

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-0120	Period: From 01/01/2020 To 12/31/2020	Worksheet S-2 Part I Date/Time Prepared: 7/22/2021 2:23 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.	Y		117.00
118.00	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.	1		118.00
		Premiums	Losses	Insurance
		1.00	2.00	3.00
118.01	List amounts of malpractice premiums and paid losses:	879,333	0	60,496 118.01
		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)	Y	HB0721	140.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA				Provider CCN: 14-0120		Period: From 01/01/2020 To 12/31/2020		Worksheet S-2 Part I Date/Time Prepared: 7/22/2021 2:23 pm	
1.00		2.00		3.00					
If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number.									
141.00	Name: PEORIA HOME OFFICE		Contractor's Name: NATIONAL GOVERNMENT SERVICES, INC		Contractor's Number: 00131		141.00		
142.00	Street: 221 NE GLEN OAK		PO Box:				142.00		
143.00	City: PEORIA		State: IL		Zip Code: 61636		143.00		
								1.00	
144.00 Are provider based physicians' costs included in Worksheet A?								Y	
								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.							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	
				1.00		2.00		3.00	
								Title XIX	
				1.00		2.00		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	
156.00	Subprovider - IPF			N		N		N	
157.00	Subprovider - IRF			N		N		N	
158.00	SUBPROVIDER								
159.00	SNF			N		N		N	
160.00	HOME HEALTH AGENCY			N		N		N	
161.00	CMHC			N		N		N	
								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	
				Name		County		State	
				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	
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)							168.00	
168.01	If this provider is a CAH and is not a meaningful user, does this provider qualify for a hardship exception under §413.70(a)(6)(ii)? Enter "Y" for yes or "N" for no. (see instructions)							168.01	
169.00	If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)							0.00	
								Beginning	
								1.00	
								Ending	
								2.00	
170.00	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)							170.00	
								1.00	
								2.00	
171.00	If line 167 is "Y", does this provider have any days for individuals enrolled in section 1876 Medicare cost plans reported on Wkst. S-3, Pt. I, line 2, col. 6? Enter "Y" for yes and "N" for no in column 1. If column 1 is yes, enter the number of section 1876 Medicare days in column 2. (see instructions)							N	
								0	

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 14-0120	Period: From 01/01/2020 To 12/31/2020	Worksheet S-2 Part II Date/Time Prepared: 7/22/2021 2:23 pm
			Y/N 1.00	Date 2.00
General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format.				
COMPLETED BY ALL HOSPITALS				
Provider Organization and Operation				
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)	N		1.00
		Y/N 1.00	Date 2.00	V/I 3.00
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.	N		2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)	N		3.00
		Y/N 1.00	Type 2.00	Date 3.00
Financial Data and Reports				
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	Y	A	4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.	N		5.00
			Y/N 1.00	Legal Oper. 2.00
Approved Educational Activities				
6.00	Column 1: Are costs claimed for nursing school? Column 2: If yes, is the provider is the legal operator of the program?	N		6.00
7.00	Are costs claimed for Allied Health Programs? If "Y" see instructions.	N		7.00
8.00	Were nursing school and/or allied health programs approved and/or renewed during the cost reporting period? If yes, see instructions.	N		8.00
9.00	Are costs claimed for Interns and Residents in an approved graduate medical education program in the current cost report? If yes, see instructions.	N		9.00
10.00	Was an approved Intern and Resident GME program initiated or renewed in the current cost reporting period? If yes, see instructions.	N		10.00
11.00	Are GME cost directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions.	N		11.00
			Y/N 1.00	
Bad Debts				
12.00	Is the provider seeking reimbursement for bad debts? If yes, see instructions.		Y	12.00
13.00	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.		N	13.00
14.00	If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.		N	14.00
Bed Complement				
15.00	Did total beds available change from the prior cost reporting period? If yes, see instructions.		N	15.00
		Part A		Part B
		Y/N 1.00	Date 2.00	Y/N 3.00
				Date 4.00
PS&R Data				
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)	N		N
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	Y	05/11/2021	Y
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N		N
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		N

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE

Provider CCN: 14-0120

Period:
From 01/01/2020
To 12/31/2020Worksheet S-2
Part II
Date/Time Prepared:
7/22/2021 2:23 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		N		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.		N		23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions		N		24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.		N		25.00
26.00	Were assets subject to Sec.2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.		N		26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.		N		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.		N		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		N		29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.		N		30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.		N		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.		N		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.		N		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.		Y		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.		N		35.00
		Y/N	Date		
		1.00	2.00		
Home Office Costs					
36.00	Were home office costs claimed on the cost report?		Y		36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.		Y		37.00
38.00	If line 36 is yes, was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.		N		38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.		N		39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.		Y		40.00
		1.00	2.00		
Cost Report Preparer Contact Information					
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	KEITH	LYONS		41.00
42.00	Enter the employer/company name of the cost report preparer.	UNITY POINT			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	309-712-1132	JONATHAN.LYONS@UNITYPOINT.ORG		43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE

Provider CCN: 14-0120

Period:
From 01/01/2020
To 12/31/2020Worksheet S-2
Part II
Date/Time Prepared:
7/22/2021 2:23 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.	REIMBURSEMENT ANALYST	41.00
42.00	Enter the employer/company name of the cost report preparer.		42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.		43.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 14-0120

Period:
From 01/01/2020
To 12/31/2020Worksheet S-3
Part I
Date/Time Prepared:
7/22/2021 2:23 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	87	31,842	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)		87	31,842	0.00	0	7.00
8.00 INTENSIVE CARE UNIT	31.00	8	2,928	0.00	0	8.00
9.00 CORONARY CARE UNIT						9.00
10.00 BURN INTENSIVE CARE UNIT						10.00
11.00 SURGICAL INTENSIVE CARE UNIT						11.00
12.00 OTHER SPECIAL CARE (SPECIFY)						12.00
13.00 NURSERY	43.00				0	13.00
14.00 Total (see instructions)		95	34,770	0.00	0	14.00
15.00 CAH visits					0	15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY	44.00	0	0		0	19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY	101.00				0	22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
24.10 HOSPICE (non-distinct part)	30.00					24.10
25.00 CMHC - CMHC						25.00
26.00 RURAL HEALTH CLINIC						26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	26.25
27.00 Total (sum of lines 14-26)		95			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: 14-0120

Period:
From 01/01/2020
To 12/31/2020Worksheet S-3
Part I
Date/Time Prepared:
7/22/2021 2:23 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)	3,223	774	6,295			1.00
2.00	HMO and other (see instructions)	1,927	0				2.00
3.00	HMO IPF Subprovider	0	0				3.00
4.00	HMO IRF Subprovider	0	0				4.00
5.00	Hospital Adults & Peds. Swing Bed SNF	0	0	0			5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	0			6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	3,223	774	6,295			7.00
8.00	INTENSIVE CARE UNIT	257	82	744			8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY		0	0			13.00
14.00	Total (see instructions)	3,480	856	7,039	0.00	245.37	14.00
15.00	CAH visits	0	0	0			15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY	0	0	0	0.00	0.00	19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY	0	0	0	0.00	0.00	22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)			0			24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0.00	0.00	26.25
27.00	Total (sum of lines 14-26)				0.00	245.37	27.00
28.00	Observation Bed Days		407	1,895			28.00
29.00	Ambulance Trips	0					29.00
30.00	Employee discount days (see instruction)			21			30.00
31.00	Employee discount days - IRF			0			31.00
32.00	Labor & delivery days (see instructions)	0	0	0			32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)			0			32.01
33.00	LTCH non-covered days	0					33.00
33.01	LTCH site neutral days and discharges	0					33.01

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 14-0120

Period:
From 01/01/2020
To 12/31/2020Worksheet S-3
Part I
Date/Time Prepared:
7/22/2021 2:23 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	785	172	1,541	1.00
2.00 HMO and other (see instructions)			397	0		2.00
3.00 HMO IPF Subprovider				0		3.00
4.00 HMO IRF Subprovider				0		4.00
5.00 Hospital Adults & Peds. Swing Bed SNF						5.00
6.00 Hospital Adults & Peds. Swing Bed NF						6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)						7.00
8.00 INTENSIVE CARE UNIT						8.00
9.00 CORONARY CARE UNIT						9.00
10.00 BURN INTENSIVE CARE UNIT						10.00
11.00 SURGICAL INTENSIVE CARE UNIT						11.00
12.00 OTHER SPECIAL CARE (SPECIFY)						12.00
13.00 NURSERY						13.00
14.00 Total (see instructions)	0.00	0	785	172	1,541	14.00
15.00 CAH visits						15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY	0.00					19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY	0.00					22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
24.10 HOSPICE (non-distinct part)						24.10
25.00 CMHC - CMHC						25.00
26.00 RURAL HEALTH CLINIC						26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER	0.00					26.25
27.00 Total (sum of lines 14-26)	0.00					27.00
28.00 Observation Bed Days						28.00
29.00 Ambulance Trips						29.00
30.00 Employee discount days (see instruction)						30.00
31.00 Employee discount days - IRF						31.00
32.00 Labor & delivery days (see instructions)						32.00
32.01 Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00 LTCH non-covered days			0			33.00
33.01 LTCH site neutral days and discharges			0			33.01

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 14-0120

Period:
From 01/01/2020
To 12/31/2020Worksheet S-3
Part II
Date/Time Prepared:
7/22/2021 2:23 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	13,430,502	0	13,430,502	496,679.00	27.04 1.00
2.00	Non-physician anesthetist Part A		0	0	0	0.00	0.00 2.00
3.00	Non-physician anesthetist Part B		0	0	0	0.00	0.00 3.00
4.00	Physician-Part A - Administrative		0	0	0	0.00	0.00 4.00
4.01	Physicians - Part A - Teaching		0	0	0	0.00	0.00 4.01
5.00	Physician and Non Physician-Part B		0	0	0	0.00	0.00 5.00
6.00	Non-physician-Part B for hospital-based RHC and FQHC services		0	0	0	0.00	0.00 6.00
7.00	Interns & residents (in an approved program)	21.00	0	0	0	0.00	0.00 7.00
7.01	Contracted interns and residents (in an approved programs)		0	0	0	0.00	0.00 7.01
8.00	Home office and/or related organization personnel		0	0	0	0.00	0.00 8.00
9.00	SNF	44.00	0	0	0	0.00	0.00 9.00
10.00	Excluded area salaries (see instructions)		0	131,831	131,831	8,138.00	16.20 10.00
OTHER WAGES & RELATED COSTS							
11.00	Contract labor: Direct Patient Care		1,145,862	0	1,145,862	20,418.00	56.12 11.00
12.00	Contract labor: Top level management and other management and administrative services		0	0	0	0.00	0.00 12.00
13.00	Contract labor: Physician-Part A - Administrative		0	0	0	0.00	0.00 13.00
14.00	Home office and/or related organization salaries and wage-related costs		0	0	0	0.00	0.00 14.00
14.01	Home office salaries		3,397,671	0	3,397,671	95,772.00	35.48 14.01
14.02	Related organization salaries		0	0	0	0.00	0.00 14.02
15.00	Home office: Physician Part A - Administrative		0	0	0	0.00	0.00 15.00
16.00	Home office and Contract Physicians Part A - Teaching		0	0	0	0.00	0.00 16.00
16.01	Home office Physicians Part A - Teaching		0	0	0	0.00	0.00 16.01
16.02	Home office contract Physicians Part A - Teaching		0	0	0	0.00	0.00 16.02
WAGE-RELATED COSTS							
17.00	Wage-related costs (core) (see instructions)		4,646,459	0	4,646,459		
18.00	Wage-related costs (other) (see instructions)						
19.00	Excluded areas		141	0	141		
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: 14-0120

Period:
From 01/01/2020
To 12/31/2020Worksheet S-3
Part II
Date/Time Prepared:
7/22/2021 2:23 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	200,980	0	200,980	7,432.00	27.04	26.00
27.00	Administrative & General	5.00	236,014	0	236,014	8,145.00	28.98	27.00
28.00	Administrative & General under contract (see inst.)		85,914	0	85,914	320.00	268.48	28.00
29.00	Maintenance & Repairs	6.00	0	0	0	0.00	0.00	29.00
30.00	Operation of Plant	7.00	475,792	0	475,792	19,005.00	25.04	30.00
31.00	Laundry & Linen Service	8.00	28,560	0	28,560	2,138.00	13.36	31.00
32.00	Housekeeping	9.00	545,261	0	545,261	38,149.00	14.29	32.00
33.00	Housekeeping under contract (see instructions)		0	0	0	0.00	0.00	33.00
34.00	Dietary	10.00	625,228	-518,976	106,252	6,560.00	16.20	34.00
35.00	Dietary under contract (see instructions)		0	0	0	0.00	0.00	35.00
36.00	Cafeteria	11.00	0	387,145	387,145	23,900.00	16.20	36.00
37.00	Maintenance of Personnel	12.00	0	0	0	0.00	0.00	37.00
38.00	Nursing Administration	13.00	19,614	0	19,614	685.00	28.63	38.00
39.00	Central Services and Supply	14.00	307,753	0	307,753	17,104.00	17.99	39.00
40.00	Pharmacy	15.00	748,033	0	748,033	17,007.00	43.98	40.00
41.00	Medical Records & Medical Records Library	16.00	0	0	0	0.00	0.00	41.00
42.00	Social Service	17.00	0	0	0	0.00	0.00	42.00
43.00	Other General Service	18.00	0	0	0	0.00	0.00	43.00

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 14-0120

Period:
From 01/01/2020
To 12/31/2020Worksheet S-3
Part III
Date/Time Prepared:
7/22/2021 2:23 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)	13,516,416	0	13,516,416	496,999.00	27.20	1.00
2.00	Excluded area salaries (see instructions)	0	131,831	131,831	8,138.00	16.20	2.00
3.00	Subtotal salaries (line 1 minus line 2)	13,516,416	-131,831	13,384,585	488,861.00	27.38	3.00
4.00	Subtotal other wages & related costs (see inst.)	4,543,533	0	4,543,533	116,190.00	39.10	4.00
5.00	Subtotal wage-related costs (see inst.)	4,646,459	0	4,646,459	0.00	34.72	5.00
6.00	Total (sum of lines 3 thru 5)	22,706,408	-131,831	22,574,577	605,051.00	37.31	6.00
7.00	Total overhead cost (see instructions)	3,273,149	-131,831	3,141,318	140,445.00	22.37	7.00

HOSPITAL WAGE RELATED COSTS

Provider CCN: 14-0120

Period:
From 01/01/2020
To 12/31/2020Worksheet S-3
Part IV
Date/Time Prepared:
7/22/2021 2:23 pm

		Amount Reported	
		1.00	
PART IV - WAGE RELATED COSTS			
Part A - Core List			
RETIREMENT COST			
1.00	401K Employer Contributions	554,881	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)	1,011,012	4.00
PLAN ADMINISTRATIVE COSTS (Paid to External Organization)			
5.00	401K/TSA Plan Administration fees	0	5.00
6.00	Legal/Accounting/Management Fees-Pension Plan	0	6.00
7.00	Employee Managed Care Program Administration Fees	0	7.00
HEALTH AND INSURANCE COST			
8.00	Health Insurance (Purchased or Self Funded)	0	8.00
8.01	Health Insurance (Self Funded without a Third Party Administrator)	0	8.01
8.02	Health Insurance (Self Funded with a Third Party Administrator)	1,752,509	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	40,639	10.00
11.00	Life Insurance (If employee is owner or beneficiary)	7,883	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)	153,695	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)	0	14.00
15.00	'Workers' Compensation Insurance	111,914	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	974,048	17.00
18.00	Medicare Taxes - Employers Portion Only	0	18.00
19.00	Unemployment Insurance	20,591	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	19,429	23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)	4,646,601	24.00
Part B - Other than Core Related Cost			
25.00	OTHER WAGE RELATED COSTS (SPECIFY)		25.00

HOSPITAL CONTRACT LABOR AND BENEFIT COST

Provider CCN: 14-0120

Period:
From 01/01/2020
To 12/31/2020Worksheet S-3
Part V
Date/Time Prepared:
7/22/2021 2:23 pm

Cost Center Description		Contract Labor	Benefit Cost	
		1.00	2.00	
PART V - Contract Labor and Benefit Cost				
Hospital and Hospital-Based Component Identification:				
1.00	Total facility's contract labor and benefit cost	0	0	1.00
2.00	Hospital	0	0	2.00
3.00	Subprovider - IPF			3.00
4.00	Subprovider - IRF			4.00
5.00	Subprovider - (Other)	0	0	5.00
6.00	Swing Beds - SNF	0	0	6.00
7.00	Swing Beds - NF	0	0	7.00
8.00	Hospital-Based SNF	0	0	8.00
9.00	Hospital-Based NF			9.00
10.00	Hospital-Based OLTC			10.00
11.00	Hospital-Based HHA	0	0	11.00
12.00	Separately Certified ASC			12.00
13.00	Hospital-Based Hospice			13.00
14.00	Hospital-Based Health Clinic RHC			14.00
15.00	Hospital-Based Health Clinic FQHC			15.00
16.00	Hospital-Based-CMHC			16.00
17.00	Renal Dialysis	0	0	17.00
18.00	Other	0	0	18.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA

Provider CCN: 14-0120

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

Worksheet S-10

Date/Time Prepared:
7/22/2021 2:23 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)		0.148840	1.00
Medicaid (see instructions for each line)				
2.00	Net revenue from Medicaid		4,688,304	2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?		Y	3.00
4.00	If line 3 is yes, does line 2 include all DSH and/or supplemental payments from Medicaid?			4.00
5.00	If line 4 is no, then enter DSH and/or supplemental payments from Medicaid		1,077,824	5.00
6.00	Medicaid charges		66,463,281	6.00
7.00	Medicaid cost (line 1 times line 6)		9,892,395	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)		4,126,267	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)		4,126,267	19.00
			Uninsured patients	Insured patients
			1.00	2.00
			Total (col. 1 + col. 2)	
			3.00	
Uncompensated Care (see instructions for each line)				
20.00	Charity care charges and uninsured discounts for the entire facility (see instructions)	1,614,965	1,156,310	2,771,275
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	240,371	1,156,310	1,396,681
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)	240,371	1,156,310	1,396,681
			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	
25.00	If line 24 is yes, enter the charges for patient days beyond the indigent care program's length of stay limit		0	
26.00	Total bad debt expense for the entire hospital complex (see instructions)		4,004,822	
27.00	Medicare reimbursable bad debts for the entire hospital complex (see instructions)		141,483	
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)		217,666	
28.00	Non-Medicare bad debt expense (see instructions)		3,787,156	
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)		639,863	
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)		2,036,544	
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)		6,162,811	

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-0120

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

Worksheet A

Date/Time Prepared:
7/22/2021 2:23 pm

Cost Center Description		Salaries	Other	Total (col. 1 + col. 2)	Reclassificati ons (See A-6)	Reclassified Trial Balance (col. 3 + col. 4)	
		1.00	2.00	3.00	4.00	5.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT	-207,693	-207,693	618,848	411,155	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	0	0	62,716	62,716	2.00
3.00	00300	OTHER CAP REL COSTS	0	0	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	200,980	242,089	0	443,069	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	236,014	5,545,792	5,781,806	-82,739	5.00
7.00	00700	OPERATION OF PLANT	475,792	2,316,846	2,792,638	-3	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	28,560	47,772	76,332	0	8.00
9.00	00900	HOUSEKEEPING	545,261	460,171	1,005,432	-2,971	9.00
10.00	01000	DIETARY	625,228	492,137	1,117,365	-930,753	10.00
11.00	01100	CAFETERIA	0	0	691,879	691,879	11.00
13.00	01300	NURSING ADMINISTRATION	19,614	5,789	25,403	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	307,753	453,893	761,646	-35,598	14.00
15.00	01500	PHARMACY	748,033	1,794,579	2,542,612	-1,426,186	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	16.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	2,247,215	1,911,669	4,158,884	-1,151,686	30.00
31.00	03100	INTENSIVE CARE UNIT	636,675	565,616	1,202,291	107,429	31.00
43.00	04300	NURSERY	0	0	0	0	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	44.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	1,889,619	3,767,879	5,657,498	-2,319,269	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	174,166	174,166	-176,253	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,265,044	613,882	1,878,926	170,557	54.00
56.00	05600	RADIOISOTOPE	139,394	294,822	434,216	-433,247	56.00
57.00	05700	CT SCAN	360,457	334,969	695,426	-106,983	57.00
58.00	05800	MRI	136,370	462,460	598,830	-29,715	58.00
59.00	05900	CARDIAC CATHETERIZATION	55,656	264,014	319,670	-214,547	59.00
60.00	06000	LABORATORY	694,172	1,639,523	2,333,695	-206,669	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	160,711	63.00
64.00	06400	INTRAVENOUS THERAPY	105,540	30,079	135,619	1,143,241	64.00
65.00	06500	RESPIRATORY THERAPY	415,389	210,930	626,319	-39,180	65.00
66.00	06600	PHYSICAL THERAPY	0	605,182	605,182	-212,701	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	90,939	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	121,693	68.00
69.00	06900	ELECTROCARDIOLOGY	172,614	97,149	269,763	-17,496	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	22,896	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	2,141,205	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	1,644,490	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	1,642,452	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	74.00
76.00	03610	SLEEP LAB	83,782	131,884	215,666	-215,666	76.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	325,250	182,559	507,809	143,704	90.00
91.00	09100	EMERGENCY	1,716,090	2,291,652	4,007,742	-797,089	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					92.00
OTHER REIMBURSABLE COST CENTERS							
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE		650,383	650,383	-599,608	113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	13,430,502	25,380,193	38,810,695	-235,599	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	1,554	1,554	235,599	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	192.00
194.00	07950	VACANT SPACE	0	0	0	0	194.00
194.01	07951	LEASED SPACE	0	0	0	0	194.01
194.02	07952	FOUNDATION	0	0	0	0	194.02
200.00		TOTAL (SUM OF LINES 118 through 199)	13,430,502	25,381,747	38,812,249	0	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-0120

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

Worksheet A

Date/Time Prepared:
7/22/2021 2:23 pm

Cost Center Description			Adjustments (See A-8)	Net Expenses For Allocation	
			6.00	7.00	
GENERAL SERVICE COST CENTERS					
1.00	00100	CAP REL COSTS-BLDG & FIXT	-30,201	380,954	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	0	62,716	2.00
3.00	00300	OTHER CAP REL COSTS	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-848,401	-405,332	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	4,800,798	10,499,865	5.00
7.00	00700	OPERATION OF PLANT	245,064	3,037,699	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	3,380	79,712	8.00
9.00	00900	HOUSEKEEPING	-19,644	982,817	9.00
10.00	01000	DIETARY	-742	185,870	10.00
11.00	01100	CAFETERIA	-256,889	434,990	11.00
13.00	01300	NURSING ADMINISTRATION	820,656	846,059	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	3,027	729,075	14.00
15.00	01500	PHARMACY	6,507	1,122,933	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	553,968	553,968	16.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	0	3,007,198	30.00
31.00	03100	INTENSIVE CARE UNIT	30,164	1,339,884	31.00
43.00	04300	NURSERY	0	0	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	44.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	26,314	3,364,543	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	52.00
53.00	05300	ANESTHESIOLOGY	2,087	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	103,873	2,153,356	54.00
56.00	05600	RADIOISOTOPE	-969	0	56.00
57.00	05700	CT SCAN	43,298	631,741	57.00
58.00	05800	MRI	-190,882	378,233	58.00
59.00	05900	CARDIAC CATHETERIZATION	40,570	145,693	59.00
60.00	06000	LABORATORY	-66,587	2,060,439	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	160,711	63.00
64.00	06400	INTRAVENOUS THERAPY	0	1,278,860	64.00
65.00	06500	RESPIRATORY THERAPY	609	587,748	65.00
66.00	06600	PHYSICAL THERAPY	-169,300	223,181	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	90,939	67.00
68.00	06800	SPEECH PATHOLOGY	0	121,693	68.00
69.00	06900	ELECTROCARDIOLOGY	3,423	255,690	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	22,896	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	2,141,205	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	1,644,490	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	1,642,452	73.00
74.00	07400	RENAL DIALYSIS	0	0	74.00
76.00	03610	SLEEP LAB	0	0	76.00
OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	-56,275	595,238	90.00
91.00	09100	EMERGENCY	-1,246,784	1,963,869	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART			92.00
OTHER REIMBURSABLE COST CENTERS					
101.00	10100	HOME HEALTH AGENCY	0	0	101.00
SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE	-50,775	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	3,746,289	42,321,385	118.00
NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	237,153	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	192.00
194.00	07950	VACANT SPACE	0	0	194.00
194.01	07951	LEASED SPACE	0	0	194.01
194.02	07952	FOUNDATION	0	0	194.02
200.00		TOTAL (SUM OF LINES 118 through 199)	3,746,289	42,558,538	200.00

RECLASSIFICATIONS

Provider CCN: 14-0120

Period:
From 01/01/2020
To 12/31/2020Worksheet A-6
Date/Time Prepared:
7/22/2021 2:23 pm

		Increases				
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
	A - TO RECLASS CAFETERIA COSTS					
1.00	CAFETERIA	11.00	387,145	304,734		1.00
2.00	GIFT, FLOWER, COFFEE SHOP & CANTEEN	190.00	131,831	103,768		2.00
			518,976	408,502		
	E - TO RECLASS SUPPLY COSTS					
1.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	2,141,205		1.00
2.00		0.00	0	0		2.00
3.00		0.00	0	0		3.00
4.00		0.00	0	0		4.00
5.00		0.00	0	0		5.00
6.00		0.00	0	0		6.00
7.00		0.00	0	0		7.00
8.00		0.00	0	0		8.00
9.00		0.00	0	0		9.00
10.00		0.00	0	0		10.00
11.00		0.00	0	0		11.00
12.00		0.00	0	0		12.00
13.00		0.00	0	0		13.00
14.00		0.00	0	0		14.00
15.00		0.00	0	0		15.00
16.00		0.00	0	0		16.00
17.00		0.00	0	0		17.00
18.00		0.00	0	0		18.00
19.00		0.00	0	0		19.00
20.00		0.00	0	0		20.00
21.00		0.00	0	0		21.00
22.00		0.00	0	0		22.00
			0	2,141,205		
	F - TO RECLASS BILLABLE DRUGS					
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	1,642,452		1.00
2.00	LABORATORY	60.00	0	765		2.00
3.00		0.00	0	0		3.00
4.00		0.00	0	0		4.00
5.00		0.00	0	0		5.00
6.00		0.00	0	0		6.00
7.00		0.00	0	0		7.00
8.00		0.00	0	0		8.00
9.00		0.00	0	0		9.00
10.00		0.00	0	0		10.00
11.00		0.00	0	0		11.00
12.00		0.00	0	0		12.00
13.00		0.00	0	0		13.00
14.00		0.00	0	0		14.00
15.00		0.00	0	0		15.00
16.00		0.00	0	0		16.00
17.00		0.00	0	0		17.00
18.00		0.00	0	0		18.00
			0	1,643,217		
	G - IMPLANTIBLES					
1.00	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	1,644,490		1.00
2.00	HOUSEKEEPING	9.00	0	48		2.00
3.00		0.00	0	0		3.00
4.00		0.00	0	0		4.00
5.00		0.00	0	0		5.00
6.00		0.00	0	0		6.00
7.00		0.00	0	0		7.00
8.00		0.00	0	0		8.00
9.00		0.00	0	0		9.00
10.00		0.00	0	0		10.00
11.00		0.00	0	0		11.00
12.00		0.00	0	0		12.00
13.00		0.00	0	0		13.00
14.00		0.00	0	0		14.00
			0	1,644,538		
	H - BLOOD					
1.00	BLOOD STORING, PROCESSING & TRANS.	63.00	0	160,711		1.00
			0	160,711		

RECLASSIFICATIONS

Provider CCN: 14-0120

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

Worksheet A-6

Date/Time Prepared:
7/22/2021 2:23 pm

Increases					
Cost Center		Line #	Salary	Other	
2.00		3.00	4.00	5.00	
I - TO RECLASS INTEREST EXPENSE					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	599,608	1.00
	0		0	599,608	
J - TO RECLASS PROPERTY INSURANCE					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	19,240	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	62,716	2.00
	0		0	81,956	
K - COST CENTER MAPPING					
1.00	INTENSIVE CARE UNIT	31.00	119,049	72,092	1.00
2.00	OPERATING ROOM	50.00	100,487	98,722	2.00
3.00	ANESTHESIOLOGY	53.00	1,128	3,770	3.00
4.00	RADIOLOGY-DIAGNOSTIC	54.00	149,773	204,597	4.00
5.00	CT SCAN	57.00	3,746	1,557	5.00
6.00	LABORATORY	60.00	4,644	1,323	6.00
7.00	INTRAVENOUS THERAPY	64.00	619,540	534,091	7.00
8.00	RESPIRATORY THERAPY	65.00	23,858	21,137	8.00
9.00	OCCUPATIONAL THERAPY	67.00	0	90,939	9.00
10.00	SPEECH PATHOLOGY	68.00	0	121,693	10.00
11.00	ELECTROENCEPHALOGRAPHY	70.00	3,833	19,063	11.00
12.00	CLINIC	90.00	117,348	51,576	12.00
13.00	EMERGENCY	91.00	1,577	1,246	13.00
	0		1,144,983	1,221,806	
N - TO RECLASS ANESTHESIOLOGY EXPENSE					
1.00	OPERATING ROOM	50.00	0	106,306	1.00
	0		0	106,306	
500.00	Grand Total: Increases		1,663,959	8,007,849	500.00

RECLASSIFICATIONS

Provider CCN: 14-0120

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

Worksheet A-6

Date/Time Prepared:
7/22/2021 2:23 pm

	Decreases						
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	A - TO RECLASS CAFETERIA COSTS						
1.00	DIETARY	10.00	518,976	408,502	0		1.00
2.00		0.00	0	0	0		2.00
	0		518,976	408,502			
	E - TO RECLASS SUPPLY COSTS						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	753	0		1.00
2.00	OPERATION OF PLANT	7.00	0	3	0		2.00
3.00	HOUSEKEEPING	9.00	0	3,019	0		3.00
4.00	DIETARY	10.00	0	2,602	0		4.00
5.00	CENTRAL SERVICES & SUPPLY	14.00	0	33,106	0		5.00
6.00	PHARMACY	15.00	0	12,122	0		6.00
7.00	ADULTS & PEDIATRICS	30.00	0	279,331	0		7.00
8.00	INTENSIVE CARE UNIT	31.00	0	1,438	0		8.00
9.00	OPERATING ROOM	50.00	0	1,079,218	0		9.00
10.00	ANESTHESIOLOGY	53.00	0	59,676	0		10.00
11.00	RADIOLOGY-DIAGNOSTIC	54.00	0	58,535	0		11.00
12.00	RADIOISOTOPE	56.00	0	123,790	0		12.00
13.00	CT SCAN	57.00	0	91,592	0		13.00
14.00	MRI	58.00	0	5,662	0		14.00
15.00	CARDIAC CATHETERIZATION	59.00	0	23,851	0		15.00
16.00	LABORATORY	60.00	0	52,690	0		16.00
17.00	RESPIRATORY THERAPY	65.00	0	74,536	0		17.00
18.00	PHYSICAL THERAPY	66.00	0	68	0		18.00
19.00	ELECTROCARDIOLOGY	69.00	0	10,651	0		19.00
20.00	SLEEP LAB	76.00	0	32,586	0		20.00
21.00	CLINIC	90.00	0	10,217	0		21.00
22.00	EMERGENCY	91.00	0	185,759	0		22.00
	0		0	2,141,205			
	F - TO RECLASS BILLABLE DRUGS						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	30	0		1.00
2.00	DIETARY	10.00	0	673	0		2.00
3.00	CENTRAL SERVICES & SUPPLY	14.00	0	368	0		3.00
4.00	PHARMACY	15.00	0	1,414,064	0		4.00
5.00	ADULTS & PEDIATRICS	30.00	0	48,646	0		5.00
6.00	INTENSIVE CARE UNIT	31.00	0	3	0		6.00
7.00	OPERATING ROOM	50.00	0	35,071	0		7.00
8.00	ANESTHESIOLOGY	53.00	0	14,330	0		8.00
9.00	RADIOLOGY-DIAGNOSTIC	54.00	0	668	0		9.00
10.00	RADIOISOTOPE	56.00	0	875	0		10.00
11.00	CT SCAN	57.00	0	17,438	0		11.00
12.00	MRI	58.00	0	22,217	0		12.00
13.00	CARDIAC CATHETERIZATION	59.00	0	8,827	0		13.00
14.00	RESPIRATORY THERAPY	65.00	0	4,054	0		14.00
15.00	ELECTROCARDIOLOGY	69.00	0	528	0		15.00
16.00	SLEEP LAB	76.00	0	1,503	0		16.00
17.00	CLINIC	90.00	0	89	0		17.00
18.00	EMERGENCY	91.00	0	73,833	0		18.00
	0		0	1,643,217			
	G - IMPLANTIBLES						
1.00	CENTRAL SERVICES & SUPPLY	14.00	0	2,124	0		1.00
2.00	ADULTS & PEDIATRICS	30.00	0	10,636	0		2.00
3.00	INTENSIVE CARE UNIT	31.00	0	99	0		3.00
4.00	OPERATING ROOM	50.00	0	1,492,828	0		4.00
5.00	ANESTHESIOLOGY	53.00	0	839	0		5.00
6.00	RADIOLOGY-DIAGNOSTIC	54.00	0	72	0		6.00
7.00	RADIOISOTOPE	56.00	0	1,095	0		7.00
8.00	CT SCAN	57.00	0	3,256	0		8.00
9.00	MRI	58.00	0	1,836	0		9.00
10.00	CARDIAC CATHETERIZATION	59.00	0	44,948	0		10.00
11.00	RESPIRATORY THERAPY	65.00	0	71	0		11.00
12.00	ELECTROCARDIOLOGY	69.00	0	595	0		12.00
13.00	SLEEP LAB	76.00	0	50,220	0		13.00
14.00	EMERGENCY	91.00	0	35,919	0		14.00
	0		0	1,644,538			
	H - BLOOD						
1.00	LABORATORY	60.00	0	160,711	0		1.00
	0		0	160,711			
	I - TO RECLASS INTEREST EXPENSE						
1.00	INTEREST EXPENSE	113.00	0	599,608	11		1.00
	0		0	599,608			
	J - TO RECLASS PROPERTY INSURANCE						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	81,956	12		1.00
2.00		0.00	0	0	12		2.00
	0		0	81,956			

RECLASSIFICATIONS

Provider CCN: 14-0120

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

Worksheet A-6

Date/Time Prepared:
7/22/2021 2:23 pm

	Decreases						
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	K - COST CENTER MAPPING						
1.00	ADULTS & PEDIATRICS	30.00	489,261	323,812	0		1.00
2.00	INTENSIVE CARE UNIT	31.00	43,570	38,602	0		2.00
3.00	OPERATING ROOM	50.00	9,314	8,353	0		3.00
4.00	RADIOLOGY-DIAGNOSTIC	54.00	90,280	34,258	0		4.00
5.00	RADIOISOTOPE	56.00	138,976	168,511	0		5.00
6.00	CARDIAC CATHETERIZATION	59.00	31,533	105,388	0		6.00
7.00	INTRAVENOUS THERAPY	64.00	8,086	2,304	0		7.00
8.00	RESPIRATORY THERAPY	65.00	4,183	1,331	0		8.00
9.00	PHYSICAL THERAPY	66.00	0	212,633	0		9.00
10.00	ELECTROCARDIOLOGY	69.00	3,833	1,889	0		10.00
11.00	SLEEP LAB	76.00	83,782	47,575	0		11.00
12.00	CLINIC	90.00	8,333	6,581	0		12.00
13.00	EMERGENCY	91.00	233,832	270,569	0		13.00
	0		1,144,983	1,221,806			
	N - TO RECLASS ANESTHESIOLOGY EXPENSE						
1.00	ANESTHESIOLOGY	53.00	0	106,306	0		1.00
	0		0	106,306			
500.00	Grand Total: Decreases		1,663,959	8,007,849			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-0120

Period:
From 01/01/2020
To 12/31/2020Worksheet A-7
Part I
Date/Time Prepared:
7/22/2021 2:23 pm

		Beginning Balances	Acquisitions			Disposals and Retirements		
			Purchases	Donation	Total			
		1.00	2.00	3.00	4.00	5.00		
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES							
1.00	Land	2,250,000	0	0	0	0	1.00	
2.00	Land Improvements	1,956,871	0	0	0	0	2.00	
3.00	Buildings and Fixtures	11,585,946	0	0	0	0	3.00	
4.00	Building Improvements	24,268,734	1,134,285	0	1,134,285	0	4.00	
5.00	Fixed Equipment	20,119,739	0	0	0	0	5.00	
6.00	Movable Equipment	34,730,485	5,109,401	0	5,109,401	2,077,820	6.00	
7.00	HIT designated Assets	0	0	0	0	0	7.00	
8.00	Subtotal (sum of lines 1-7)	94,911,775	6,243,686	0	6,243,686	2,077,820	8.00	
9.00	Reconciling Items	0	0	0	0	0	9.00	
10.00	Total (line 8 minus line 9)	94,911,775	6,243,686	0	6,243,686	2,077,820	10.00	
		Ending Balance	Fully Depreciated Assets					
		6.00	7.00					
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES							
1.00	Land	2,250,000	0				1.00	
2.00	Land Improvements	1,956,871	0				2.00	
3.00	Buildings and Fixtures	11,585,946	0				3.00	
4.00	Building Improvements	25,403,019	0				4.00	
5.00	Fixed Equipment	20,119,739	0				5.00	
6.00	Movable Equipment	37,762,066	0				6.00	
7.00	HIT designated Assets	0	0				7.00	
8.00	Subtotal (sum of lines 1-7)	99,077,641	0				8.00	
9.00	Reconciling Items	0	0				9.00	
10.00	Total (line 8 minus line 9)	99,077,641	0				10.00	

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-0120

Period:
From 01/01/2020
To 12/31/2020Worksheet A-7
Part II
Date/Time Prepared:
7/22/2021 2:23 pm

Cost Center Description		SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	CAP REL COSTS-BLDG & FIXT	-207,693	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)	-207,693	0	0	0	0	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Other	Total (1) (sum				
		Capital-Related Costs (see instructions)	of cols. 9 through 14)				
		14.00	15.00				
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	CAP REL COSTS-BLDG & FIXT	0	-207,693				1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0				2.00
3.00	Total (sum of lines 1-2)	0	-207,693				3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-0120

Period:
From 01/01/2020
To 12/31/2020Worksheet A-7
Part III
Date/Time Prepared:
7/22/2021 2:23 pm

Cost Center Description		COMPUTATION OF RATIOS			ALLOCATION OF OTHER CAPITAL		
		Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	
		1.00	2.00	3.00	4.00	5.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	61,315,575	0	61,315,575	0.618864	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	37,762,066	0	37,762,066	0.381136	0	2.00
3.00	Total (sum of lines 1-2)	99,077,641	0	99,077,641	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	-207,693	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)	0	0	0	-207,693	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	569,407	19,240	0	0	380,954	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	62,716	0	0	62,716	2.00
3.00	Total (sum of lines 1-2)	569,407	81,956	0	0	443,670	3.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 14-0120

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

Worksheet A-8

Date/Time Prepared:
7/22/2021 2:23 pm

Cost Center Description		Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted		Wkst. A-7 Ref.	
				Cost Center	Line #		
		1.00	2.00	3.00	4.00	5.00	
1.00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)			0CAP REL COSTS-BLDG & FIXT	1.00	0	1.00
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)			0CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
3.00	Investment income - other (chapter 2)		0		0.00	0	3.00
4.00	Trade, quantity, and time discounts (chapter 8)		0		0.00	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)		0		0.00	0	5.00
6.00	Rental of provider space by suppliers (chapter 8)		0		0.00	0	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)		0		0.00	0	7.00
8.00	Television and radio service (chapter 21)		0		0.00	0	8.00
9.00	Parking lot (chapter 21)		0		0.00	0	9.00
10.00	Provider-based physician adjustment	A-8-2	-1,550,123			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	6,565,513			0	12.00
13.00	Laundry and linen service	B		0HOUSEKEEPING	9.00	0	13.00
14.00	Cafeteria-employees and guests	B		0CAFETERIA	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		0MEDICAL RECORDS & LIBRARY	16.00	0	18.00
19.00	Nursing and allied health education (tuition, fees, books, etc.)		0		0.00	0	19.00
20.00	Vending machines		0		0.00	0	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	0	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3		0RESPIRATORY THERAPY	65.00		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3		0PHYSICAL THERAPY	66.00		24.00
25.00	Utilization review - physicians' compensation (chapter 21)			0*** Cost Center Deleted ***	114.00		25.00
26.00	Depreciation - CAP REL COSTS-BLDG & FIXT			0CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP			0CAP REL COSTS-MVBLE EQUIP	2.00	0	27.00
28.00	Non-physician Anesthetist			0*** Cost Center Deleted ***	19.00		28.00
29.00	Physicians' assistant			0	0.00	0	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3		0OCCUPATIONAL THERAPY	67.00		30.00
30.99	Hospice (non-distinct) (see instructions)			0ADULTS & PEDIATRICS	30.00		30.99
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3		0SPEECH PATHOLOGY	68.00		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest			0	0.00	0	32.00
33.00	MOW & CATERING	B	-256,889	CAFETERIA	11.00	0	33.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 14-0120

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

Worksheet A-8

Date/Time Prepared:
7/22/2021 2:23 pm

Cost Center Description		Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted		Wkst. A-7 Ref.	
				Cost Center	Line #		
		1.00	2.00	3.00	4.00	5.00	
33.01	MISCELLANEOUS REVENUE	B	-19,644	HOUSEKEEPING	9.00	0	33.01
33.02	MISCELLANEOUS REVENUE	B	-624	RADIOLOGY-DIAGNOSTIC	54.00	0	33.02
33.03	MISCELLANEOUS REVENUE	B	-193	CT SCAN	57.00	0	33.03
33.04	MISCELLANEOUS REVENUE	B	-169,300	PHYSICAL THERAPY	66.00	0	33.04
33.05	MISCELLANEOUS REVENUE	B	-500	EMERGENCY	91.00	0	33.05
33.06	OTHER ADJUSTMENTS (SPECIFY) (3)	B	0		0.00	0	33.06
33.07	OTHER ADJUSTMENTS (SPECIFY) (3)	B	0		0.00	0	33.07
33.08	OTHER ADJUSTMENTS (SPECIFY) (3)	B	0		0.00	0	33.08
33.09	OTHER ADJUSTMENTS (SPECIFY) (3)	B	0		0.00	0	33.09
33.10	OTHER ADJUSTMENTS (SPECIFY) (3)	B	0		0.00	0	33.10
33.11	OTHER ADJUSTMENTS (SPECIFY) (3)	A	0		0.00	0	33.11
33.12	OTHER ADJUSTMENTS (SPECIFY) (3)	A	0		0.00	0	33.12
33.13	OTHER ADJUSTMENTS (SPECIFY) (3)	A	0		0.00	0	33.13
33.14	CRNA - PURCHASED SERVICES	A	-5,352	ANESTHESIOLOGY	53.00	0	33.14
33.15	SELF INSURANCE EXPENSE	A	-1,086,013	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.15
33.16	REMOVE NON-ALLOWABLE INTEREST	A	-136,076	INTEREST EXPENSE	113.00	13	33.16
33.17	DEPRECIATION TO AHA	A	-30,201	CAP REL COSTS-BLDG & FIXT	1.00	11	33.17
33.18	DEPRECIATION TO AHA	A	177,886	OPERATION OF PLANT	7.00	0	33.18
33.19	DEPRECIATION TO AHA	A	3,380	LAUNDRY & LINEN SERVICE	8.00	0	33.19
33.20	DEPRECIATION TO AHA	A	-742	DIETARY	10.00	0	33.20
33.21	DEPRECIATION TO AHA	A	3,027	CENTRAL SERVICES & SUPPLY	14.00	0	33.21
33.22	DEPRECIATION TO AHA	A	6,507	PHARMACY	15.00	0	33.22
33.23	DEPRECIATION TO AHA	A	30,164	INTENSIVE CARE UNIT	31.00	0	33.23
33.24	DEPRECIATION TO AHA	A	163,189	OPERATING ROOM	50.00	0	33.24
33.25	DEPRECIATION TO AHA	A	7,439	ANESTHESIOLOGY	53.00	0	33.25
33.26	DEPRECIATION TO AHA	A	104,497	RADIOLOGY-DIAGNOSTIC	54.00	0	33.26
33.27	DEPRECIATION TO AHA	A	-969	RADIOISOTOPE	56.00	0	33.27
33.28	DEPRECIATION TO AHA	A	43,491	CT SCAN	57.00	0	33.28
33.29	DEPRECIATION TO AHA	A	-190,882	MRI	58.00	0	33.29
33.30	DEPRECIATION TO AHA	A	40,570	CARDIAC CATHETERIZATION	59.00	0	33.30
33.31	DEPRECIATION TO AHA	A	913	LABORATORY	60.00	0	33.31
33.32	DEPRECIATION TO AHA	A	609	RESPIRATORY THERAPY	65.00	0	33.32
33.33	DEPRECIATION TO AHA	A	3,423	ELECTROCARDIOLOGY	69.00	0	33.33
33.34	DEPRECIATION TO AHA	A	-231	CLINIC	90.00	0	33.34
33.35	DEPRECIATION TO AHA	A	43,420	EMERGENCY	91.00	0	33.35
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		3,746,289				50.00

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

(2) Basis for adjustment (see instructions).

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

B. Amount Received - if cost cannot be determined.

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

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

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

Provider CCN: 14-0120

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

Worksheet A-8-1

Date/Time Prepared:
7/22/2021 2:23 pm

	Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in wks. A, column 5	
	1.00	2.00	3.00	4.00	5.00	
A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:						
1.00	4.00	EMPLOYEE BENEFITS DEPARTMENT	PEORIA HOME OFFICE	237,612	0	1.00
2.00	16.00	MEDICAL RECORDS & LIBRARY	PEORIA HOME OFFICE	553,968	0	2.00
3.00	13.00	NURSING ADMINISTRATION	PEORIA HOME OFFICE	820,656	0	3.00
4.00	7.00	OPERATION OF PLANT	PEORIA HOME OFFICE	67,178	0	4.00
4.01	5.00	ADMINISTRATIVE & GENERAL	PEORIA HOME OFFICE	4,800,798	0	4.01
4.02	113.00	INTEREST EXPENSE	PEORIA HOME OFFICE	725,554	640,253	4.02
5.00	TOTALS (sum of lines 1-4).			7,205,766	640,253	5.00
	Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.					

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

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

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

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

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

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

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

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

Provider CCN: 14-0120

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

Worksheet A-8-1

Date/Time Prepared:
7/22/2021 2:23 pm

	Net Adjustments (col. 4 minus col. 5)*	Wkst. A-7 Ref.		
	6.00	7.00		
A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:				
1.00	237,612	9		1.00
2.00	553,968	0		2.00
3.00	820,656	0		3.00
4.00	67,178	0		4.00
4.01	4,800,798	0		4.01
4.02	85,301	0		4.02
5.00	6,565,513			5.00

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

	Related Organization(s) and/or Home Office		
	Type of Business		
	6.00		
B. INTERRELATIONSHIP TO RELATED ORGANIZATION(S) AND/OR HOME OFFICE:			

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

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

6.00	HEALTH SYSTEM		6.00
7.00			7.00
8.00			8.00
9.00			9.00
10.00			10.00
100.00			100.00

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

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

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 14-0120

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

Worksheet A-8-2

Date/Time Prepared:
7/22/2021 2:23 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	50.00	OPERATING ROOM	136,875	136,875	0	246,400	0	1.00
2.00	60.00	LABORATORY	67,500	67,500	0	260,300	0	2.00
3.00	90.00	CLINIC	56,044	56,044	0	211,500	0	3.00
4.00	91.00	EMERGENCY	1,289,704	1,289,704	0	211,500	0	4.00
5.00	0.00		0	0	0	0	0	5.00
6.00	0.00		0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			1,550,123	1,550,123	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	50.00	OPERATING ROOM	0	0	0	0	0	1.00
2.00	60.00	LABORATORY	0	0	0	0	0	2.00
3.00	90.00	CLINIC	0	0	0	0	0	3.00
4.00	91.00	EMERGENCY	0	0	0	0	0	4.00
5.00	0.00		0	0	0	0	0	5.00
6.00	0.00		0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			0	0	0	0	0	200.00
	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment		
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00	50.00	OPERATING ROOM	0	0	0	136,875		1.00
2.00	60.00	LABORATORY	0	0	0	67,500		2.00
3.00	90.00	CLINIC	0	0	0	56,044		3.00
4.00	91.00	EMERGENCY	0	0	0	1,289,704		4.00
5.00	0.00		0	0	0	0		5.00
6.00	0.00		0	0	0	0		6.00
7.00	0.00		0	0	0	0		7.00
8.00	0.00		0	0	0	0		8.00
9.00	0.00		0	0	0	0		9.00
10.00	0.00		0	0	0	0		10.00
200.00			0	0	0	1,550,123		200.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0120

Period:
From 01/01/2020
To 12/31/2020Worksheet B
Part I
Date/Time Prepared:
7/22/2021 2:23 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	380,954	380,954			1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	62,716		62,716		2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-405,332	11,028	208	-394,096	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	10,499,865	0	0	10,499,865	5.00
7.00	00700	OPERATION OF PLANT	3,037,699	88,645	21,988	3,148,332	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	79,712	7,293	349	87,354	8.00
9.00	00900	HOUSEKEEPING	982,817	10,657	119	993,593	9.00
10.00	01000	DIETARY	185,870	0	0	185,870	10.00
11.00	01100	CAFETERIA	434,990	0	0	434,990	11.00
13.00	01300	NURSING ADMINISTRATION	846,059	0	0	846,059	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	729,075	20,225	744	750,044	14.00
15.00	01500	PHARMACY	1,122,933	8,691	2,693	1,134,317	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	553,968	0	0	553,968	16.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	3,007,198	54,522	1,702	3,063,422	30.00
31.00	03100	INTENSIVE CARE UNIT	1,339,884	8,075	1,071	1,349,030	31.00
43.00	04300	NURSERY	0	0	0	0	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	44.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	3,364,543	52,317	14,317	3,431,177	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,153,356	29,567	7,826	2,190,749	54.00
56.00	05600	RADIOISOTOPE	0	0	0	0	56.00
57.00	05700	CT SCAN	631,741	5,547	3,389	640,677	57.00
58.00	05800	MRI	378,233	4,767	453	383,453	58.00
59.00	05900	CARDIAC CATHETERIZATION	145,693	0	1,812	147,505	59.00
60.00	06000	LABORATORY	2,060,439	11,767	526	2,072,732	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	160,711	587	0	161,298	63.00
64.00	06400	INTRAVENOUS THERAPY	1,278,860	14,794	633	1,294,287	64.00
65.00	06500	RESPIRATORY THERAPY	587,748	2,082	541	590,371	65.00
66.00	06600	PHYSICAL THERAPY	223,181	603	18	223,802	66.00
67.00	06700	OCCUPATIONAL THERAPY	90,939	282	8	91,229	67.00
68.00	06800	SPEECH PATHOLOGY	121,693	154	4	121,851	68.00
69.00	06900	ELECTROCARDIOLOGY	255,690	5,518	806	262,014	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	22,896	126	384	23,406	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	2,141,205	0	0	2,141,205	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1,644,490	0	0	1,644,490	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,642,452	0	0	1,642,452	73.00
74.00	07400	RENAL DIALYSIS	0	647	0	647	74.00
76.00	03610	SLEEP LAB	0	0	0	0	76.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	595,238	17,557	658	613,453	90.00
91.00	09100	EMERGENCY	1,963,869	18,887	2,467	1,985,223	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				0	92.00
OTHER REIMBURSABLE COST CENTERS							
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	42,321,385	374,338	62,716	42,708,865	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	237,153	6,616	0	243,769	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	192.00
194.00	07950	VACANT SPACE	0	0	0	0	194.00
194.01	07951	LEASED SPACE	0	0	0	0	194.01
194.02	07952	FOUNDATION	0	0	0	0	194.02
200.00		Cross Foot Adjustments					200.00
201.00		Negative Cost Centers		0	0	-394,096	201.00
202.00		TOTAL (sum lines 118 through 201)	42,558,538	380,954	62,716	-394,096	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0120

Period:
From 01/01/2020
To 12/31/2020Worksheet B
Part I
Date/Time Prepared:
7/22/2021 2:23 pm

Cost Center Description			ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
			5.00	7.00	8.00	9.00	10.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	10,499,865					5.00
7.00	00700	OPERATION OF PLANT	1,018,621	4,166,953				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	28,263	108,039	223,656			8.00
9.00	00900	HOUSEKEEPING	321,470	157,880	0	1,472,943		9.00
10.00	01000	DIETARY	60,137	0	0	0	246,007	10.00
11.00	01100	CAFETERIA	140,738	0	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	273,736	0	0	0	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	242,671	299,624	1,140	113,131	0	14.00
15.00	01500	PHARMACY	367,000	128,750	1,625	48,613	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	179,232	0	0	0	0	16.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	991,149	807,702	53,932	304,970	220,005	30.00
31.00	03100	INTENSIVE CARE UNIT	436,469	119,630	4,583	45,170	26,002	31.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	1,110,132	775,034	54,256	292,635	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	708,802	438,013	38,202	165,384	0	54.00
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	207,287	82,173	0	31,027	0	57.00
58.00	05800	MRI	124,064	70,613	3,845	26,662	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	47,724	0	0	0	0	59.00
60.00	06000	LABORATORY	670,618	174,321	84	65,820	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	52,187	8,693	0	3,282	0	63.00
64.00	06400	INTRAVENOUS THERAPY	418,757	219,159	18,223	82,750	0	64.00
65.00	06500	RESPIRATORY THERAPY	191,010	30,838	39	11,644	0	65.00
66.00	06600	PHYSICAL THERAPY	72,410	8,937	2,300	3,374	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	29,517	4,179	1,080	1,578	0	67.00
68.00	06800	SPEECH PATHOLOGY	39,424	2,288	590	864	0	68.00
69.00	06900	ELECTROCARDIOLOGY	84,773	81,746	0	30,866	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	7,573	1,861	0	703	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	692,772	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	532,063	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	531,404	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	209	9,578	0	3,616	0	74.00
76.00	03610	SLEEP LAB	0	0	0	0	0	76.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	198,478	260,093	126	98,205	0	90.00
91.00	09100	EMERGENCY	642,305	279,798	43,631	105,645	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
OTHER REIMBURSABLE COST CENTERS								
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	10,420,995	4,068,949	223,656	1,435,939	246,007	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	78,870	98,004	0	37,004	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07950	VACANT SPACE	0	0	0	0	0	194.00
194.01	07951	LEASED SPACE	0	0	0	0	0	194.01
194.02	07952	FOUNDATION	0	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)	10,499,865	4,166,953	223,656	1,472,943	246,007	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0120

Period:
From 01/01/2020
To 12/31/2020Worksheet B
Part I
Date/Time Prepared:
7/22/2021 2:23 pm

Cost Center Description			CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
			11.00	13.00	14.00	15.00	16.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA	575,728					11.00
13.00	01300	NURSING ADMINISTRATION	767	1,120,562				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	21,615	0	1,428,225			14.00
15.00	01500	PHARMACY	21,668	0	4,700	1,706,673		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	733,200	16.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	93,313	1,002,122	112,427	0	117,459	30.00
31.00	03100	INTENSIVE CARE UNIT	35,611	118,440	596	0	22,614	31.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	87,228	0	804,299	0	300,412	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	55,956	0	70,902	0	0	54.00
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	14,922	0	36,775	0	0	57.00
58.00	05800	MRI	5,635	0	2,907	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	900	0	19,600	0	0	59.00
60.00	06000	LABORATORY	34,844	0	20,429	0	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	33,098	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	19,578	0	17,970	0	45,530	65.00
66.00	06600	PHYSICAL THERAPY	0	0	26	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	7,831	0	4,361	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	1,323	0	32,106	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	77,514	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	133,702	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	1,706,673	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.00	03610	SLEEP LAB	0	0	0	0	0	76.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	70,852	0	3,961	0	0	90.00
91.00	09100	EMERGENCY	57,623	0	85,950	0	247,185	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
OTHER REIMBURSABLE COST CENTERS								
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	562,764	1,120,562	1,428,225	1,706,673	733,200	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	12,964	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07950	VACANT SPACE	0	0	0	0	0	194.00
194.01	07951	LEASED SPACE	0	0	0	0	0	194.01
194.02	07952	FOUNDATION	0	0	0	0	0	194.02
200.00		Cross Foot Adjustments	0	0	0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	575,728	1,120,562	1,428,225	1,706,673	733,200	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0120

Period:
From 01/01/2020
To 12/31/2020Worksheet B
Part I
Date/Time Prepared:
7/22/2021 2:23 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
7.00	00700	OPERATION OF PLANT				7.00
8.00	00800	LAUNDRY & LINEN SERVICE				8.00
9.00	00900	HOUSEKEEPING				9.00
10.00	01000	DIETARY				10.00
11.00	01100	CAFETERIA				11.00
13.00	01300	NURSING ADMINISTRATION				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY				14.00
15.00	01500	PHARMACY				15.00
16.00	01600	MEDICAL RECORDS & LIBRARY				16.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	6,766,501	0	6,766,501	30.00
31.00	03100	INTENSIVE CARE UNIT	2,158,145	0	2,158,145	31.00
43.00	04300	NURSERY	0	0	0	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	44.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	6,855,173	0	6,855,173	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,668,008	0	3,668,008	54.00
56.00	05600	RADIOISOTOPE	0	0	0	56.00
57.00	05700	CT SCAN	1,012,861	0	1,012,861	57.00
58.00	05800	MRI	617,179	0	617,179	58.00
59.00	05900	CARDIAC CATHETERIZATION	215,729	0	215,729	59.00
60.00	06000	LABORATORY	3,038,848	0	3,038,848	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	225,460	0	225,460	63.00
64.00	06400	INTRAVENOUS THERAPY	2,066,274	0	2,066,274	64.00
65.00	06500	RESPIRATORY THERAPY	906,980	0	906,980	65.00
66.00	06600	PHYSICAL THERAPY	310,849	0	310,849	66.00
67.00	06700	OCCUPATIONAL THERAPY	127,583	0	127,583	67.00
68.00	06800	SPEECH PATHOLOGY	165,017	0	165,017	68.00
69.00	06900	ELECTROCARDIOLOGY	471,591	0	471,591	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	66,972	0	66,972	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	2,911,491	0	2,911,491	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	2,310,255	0	2,310,255	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	3,880,529	0	3,880,529	73.00
74.00	07400	RENAL DIALYSIS	14,050	0	14,050	74.00
76.00	03610	SLEEP LAB	0	0	0	76.00
OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	1,245,168	0	1,245,168	90.00
91.00	09100	EMERGENCY	3,447,360	0	3,447,360	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART		0		92.00
OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE				113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	42,482,023	0	42,482,023	118.00
NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	470,611	0	470,611	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	192.00
194.00	07950	VACANT SPACE	0	0	0	194.00
194.01	07951	LEASED SPACE	0	0	0	194.01
194.02	07952	FOUNDATION	0	0	0	194.02
200.00		Cross Foot Adjustments	0	0	0	200.00
201.00		Negative Cost Centers	-394,096	0	-394,096	201.00
202.00		TOTAL (sum lines 118 through 201)	42,558,538	0	42,558,538	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0120

Period:
From 01/01/2020
To 12/31/2020Worksheet B
Part II
Date/Time Prepared:
7/22/2021 2:23 pm

Cost Center Description			CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
			Directly Assigned New Capital Related Costs	BLDG & FIXT	MVBLE EQUIP		
			0	1.00	2.00	2A	4.00
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	11,028	208	11,236	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	10,260	0	0	10,260	5.00
7.00	00700	OPERATION OF PLANT	1,086,018	88,645	21,988	1,196,651	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	17,247	7,293	349	24,889	8.00
9.00	00900	HOUSEKEEPING	5,872	10,657	119	16,648	9.00
10.00	01000	DIETARY	0	0	0	0	10.00
11.00	01100	CAFETERIA	0	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	0	0	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	74,381	20,225	744	95,350	14.00
15.00	01500	PHARMACY	133,019	8,691	2,693	144,403	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	16.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	84,070	54,522	1,702	140,294	30.00
31.00	03100	INTENSIVE CARE UNIT	52,891	8,075	1,071	62,037	31.00
43.00	04300	NURSERY	0	0	0	0	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	44.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	707,175	52,317	14,317	773,809	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	386,284	29,567	7,826	423,677	54.00
56.00	05600	RADIOISOTOPE	286	0	0	286	56.00
57.00	05700	CT SCAN	167,381	5,547	3,389	176,317	57.00
58.00	05800	MRI	174,942	4,767	453	180,162	58.00
59.00	05900	CARDIAC CATHETERIZATION	89,496	0	1,812	91,308	59.00
60.00	06000	LABORATORY	25,958	11,767	526	38,251	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	587	0	587	63.00
64.00	06400	INTRAVENOUS THERAPY	31,276	14,794	633	46,703	64.00
65.00	06500	RESPIRATORY THERAPY	26,704	2,082	541	29,327	65.00
66.00	06600	PHYSICAL THERAPY	865	603	18	1,486	66.00
67.00	06700	OCCUPATIONAL THERAPY	406	282	8	696	67.00
68.00	06800	SPEECH PATHOLOGY	222	154	4	380	68.00
69.00	06900	ELECTROCARDIOLOGY	39,814	5,518	806	46,138	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	18,078	126	384	18,588	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	647	0	647	74.00
76.00	03610	SLEEP LAB	908	0	0	908	76.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	32,516	17,557	658	50,731	90.00
91.00	09100	EMERGENCY	121,848	18,887	2,467	143,202	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				0	92.00
OTHER REIMBURSABLE COST CENTERS							
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	3,287,917	374,338	62,716	3,724,971	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	6,616	0	6,616	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	192.00
194.00	07950	VACANT SPACE	0	0	0	0	194.00
194.01	07951	LEASED SPACE	0	0	0	0	194.01
194.02	07952	FOUNDATION	0	0	0	0	194.02
200.00		Cross Foot Adjustments				0	200.00
201.00		Negative Cost Centers		0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	3,287,917	380,954	62,716	3,731,587	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0120

Period:
From 01/01/2020
To 12/31/2020Worksheet B
Part II
Date/Time Prepared:
7/22/2021 2:23 pm

Cost Center Description			ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
			5.00	7.00	8.00	9.00	10.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	10,260					5.00
7.00	00700	OPERATION OF PLANT	995	1,197,646				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	28	31,052	55,969			8.00
9.00	00900	HOUSEKEEPING	314	45,377	0	62,339		9.00
10.00	01000	DIETARY	59	0	0	0	59	10.00
11.00	01100	CAFETERIA	137	0	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	267	0	0	0	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	237	86,117	285	4,788	0	14.00
15.00	01500	PHARMACY	358	37,005	407	2,057	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	175	0	0	0	0	16.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	968	232,144	13,496	12,907	53	30.00
31.00	03100	INTENSIVE CARE UNIT	426	34,384	1,147	1,912	6	31.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	1,089	222,756	13,578	12,385	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	692	125,892	9,560	7,000	0	54.00
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	202	23,618	0	1,313	0	57.00
58.00	05800	MRI	121	20,295	962	1,128	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	47	0	0	0	0	59.00
60.00	06000	LABORATORY	655	50,102	21	2,786	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	51	2,499	0	139	0	63.00
64.00	06400	INTRAVENOUS THERAPY	409	62,990	4,560	3,502	0	64.00
65.00	06500	RESPIRATORY THERAPY	187	8,863	10	493	0	65.00
66.00	06600	PHYSICAL THERAPY	71	2,569	576	143	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	29	1,201	270	67	0	67.00
68.00	06800	SPEECH PATHOLOGY	39	658	148	37	0	68.00
69.00	06900	ELECTROCARDIOLOGY	83	23,495	0	1,306	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	7	535	0	30	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	677	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	520	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	519	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	2,753	0	153	0	74.00
76.00	03610	SLEEP LAB	0	0	0	0	0	76.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	194	74,755	31	4,156	0	90.00
91.00	09100	EMERGENCY	627	80,418	10,918	4,471	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
OTHER REIMBURSABLE COST CENTERS								
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	10,183	1,169,478	55,969	60,773	59	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	77	28,168	0	1,566	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07950	VACANT SPACE	0	0	0	0	0	194.00
194.01	07951	LEASED SPACE	0	0	0	0	0	194.01
194.02	07952	FOUNDATION	0	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)	10,260	1,197,646	55,969	62,339	59	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0120

Period:
From 01/01/2020
To 12/31/2020Worksheet B
Part II
Date/Time Prepared:
7/22/2021 2:23 pm

Cost Center Description			CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
			11.00	13.00	14.00	15.00	16.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA	137					11.00
13.00	01300	NURSING ADMINISTRATION	0	267				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	5	0	186,782			14.00
15.00	01500	PHARMACY	5	0	615	184,850		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	175	16.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	23	239	14,703	0	28	30.00
31.00	03100	INTENSIVE CARE UNIT	8	28	78	0	5	31.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	21	0	105,188	0	72	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	13	0	9,272	0	0	54.00
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	4	0	4,809	0	0	57.00
58.00	05800	MRI	1	0	380	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	2,563	0	0	59.00
60.00	06000	LABORATORY	8	0	2,672	0	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	8	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	5	0	2,350	0	11	65.00
66.00	06600	PHYSICAL THERAPY	0	0	3	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	2	0	570	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	4,199	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	10,137	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	17,485	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	184,850	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.00	03610	SLEEP LAB	0	0	0	0	0	76.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	17	0	518	0	0	90.00
91.00	09100	EMERGENCY	14	0	11,240	0	59	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
OTHER REIMBURSABLE COST CENTERS								
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	134	267	186,782	184,850	175	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	3	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07950	VACANT SPACE	0	0	0	0	0	194.00
194.01	07951	LEASED SPACE	0	0	0	0	0	194.01
194.02	07952	FOUNDATION	0	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)	137	267	186,782	184,850	175	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0120

Period:
From 01/01/2020
To 12/31/2020Worksheet B
Part II
Date/Time Prepared:
7/22/2021 2:23 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
7.00	00700	OPERATION OF PLANT				7.00
8.00	00800	LAUNDRY & LINEN SERVICE				8.00
9.00	00900	HOUSEKEEPING				9.00
10.00	01000	DIETARY				10.00
11.00	01100	CAFETERIA				11.00
13.00	01300	NURSING ADMINISTRATION				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY				14.00
15.00	01500	PHARMACY				15.00
16.00	01600	MEDICAL RECORDS & LIBRARY				16.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	414,855	0	414,855	30.00
31.00	03100	INTENSIVE CARE UNIT	100,031	0	100,031	31.00
43.00	04300	NURSERY	0	0	0	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	44.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,128,898	0	1,128,898	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	576,106	0	576,106	54.00
56.00	05600	RADIOISOTOPE	286	0	286	56.00
57.00	05700	CT SCAN	206,263	0	206,263	57.00
58.00	05800	MRI	203,049	0	203,049	58.00
59.00	05900	CARDIAC CATHETERIZATION	93,918	0	93,918	59.00
60.00	06000	LABORATORY	94,495	0	94,495	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	3,276	0	3,276	63.00
64.00	06400	INTRAVENOUS THERAPY	118,172	0	118,172	64.00
65.00	06500	RESPIRATORY THERAPY	41,246	0	41,246	65.00
66.00	06600	PHYSICAL THERAPY	4,848	0	4,848	66.00
67.00	06700	OCCUPATIONAL THERAPY	2,263	0	2,263	67.00
68.00	06800	SPEECH PATHOLOGY	1,262	0	1,262	68.00
69.00	06900	ELECTROCARDIOLOGY	71,594	0	71,594	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	23,359	0	23,359	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	10,814	0	10,814	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	18,005	0	18,005	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	185,369	0	185,369	73.00
74.00	07400	RENAL DIALYSIS	3,553	0	3,553	74.00
76.00	03610	SLEEP LAB	908	0	908	76.00
OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	130,402	0	130,402	90.00
91.00	09100	EMERGENCY	250,949	0	250,949	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART		0		92.00
OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE				113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	3,683,921	0	3,683,921	118.00
NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	36,430	0	36,430	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	192.00
194.00	07950	VACANT SPACE	0	0	0	194.00
194.01	07951	LEASED SPACE	0	0	0	194.01
194.02	07952	FOUNDATION	0	0	0	194.02
200.00		Cross Foot Adjustments	0	0	0	200.00
201.00		Negative Cost Centers	11,236	0	11,236	201.00
202.00		TOTAL (sum lines 118 through 201)	3,731,587	0	3,731,587	202.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0120

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

Worksheet B-1

Date/Time Prepared:
7/22/2021 2:23 pm

Cost Center Description			CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
			BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (DOLLAR VALUE)				
			1.00	2.00	4.00	5A	5.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT	185,020					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		3,097,679				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	5,356	10,260	13,229,522			4.00
5.00	00500	ADMINISTRATIVE & GENERAL	0	0	236,014	-10,499,865	32,452,769	5.00
7.00	00700	OPERATION OF PLANT	43,053	1,086,018	475,792	0	3,148,332	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	3,542	17,247	28,560	0	87,354	8.00
9.00	00900	HOUSEKEEPING	5,176	5,872	545,261	0	993,593	9.00
10.00	01000	DIETARY	0	0	106,253	0	185,870	10.00
11.00	01100	CAFETERIA	0	0	387,145	0	434,990	11.00
13.00	01300	NURSING ADMINISTRATION	0	0	19,614	0	846,059	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	9,823	36,735	307,753	0	750,044	14.00
15.00	01500	PHARMACY	4,221	133,019	748,033	0	1,134,317	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	553,968	16.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	26,480	84,070	1,757,953	0	3,063,422	30.00
31.00	03100	INTENSIVE CARE UNIT	3,922	52,891	712,154	0	1,349,030	31.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	25,409	707,175	1,981,921	0	3,431,177	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	14,360	386,570	1,324,955	0	2,190,749	54.00
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	2,694	167,381	364,203	0	640,677	57.00
58.00	05800	MRI	2,315	22,375	136,370	0	383,453	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	89,496	24,123	0	147,505	59.00
60.00	06000	LABORATORY	5,715	25,958	698,816	0	2,072,732	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	285	0	0	0	161,298	63.00
64.00	06400	INTRAVENOUS THERAPY	7,185	31,276	716,994	0	1,294,287	64.00
65.00	06500	RESPIRATORY THERAPY	1,011	26,704	435,064	0	590,371	65.00
66.00	06600	PHYSICAL THERAPY	293	865	0	0	223,802	66.00
67.00	06700	OCCUPATIONAL THERAPY	137	406	0	0	91,229	67.00
68.00	06800	SPEECH PATHOLOGY	75	222	0	0	121,851	68.00
69.00	06900	ELECTROCARDIOLOGY	2,680	39,814	168,781	0	262,014	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	61	18,986	26,538	0	23,406	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	2,141,205	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	1,644,490	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	1,642,452	73.00
74.00	07400	RENAL DIALYSIS	314	0	0	0	647	74.00
76.00	03610	SLEEP LAB	0	0	0	0	0	76.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	8,527	32,491	411,559	0	613,453	90.00
91.00	09100	EMERGENCY	9,173	121,848	1,483,835	0	1,985,223	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
OTHER REIMBURSABLE COST CENTERS								
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	181,807	3,097,679	13,097,691	-10,499,865	32,209,000	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	3,213	0	131,831	0	243,769	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07950	VACANT SPACE	0	0	0	0	0	194.00
194.01	07951	LEASED SPACE	0	0	0	0	0	194.01
194.02	07952	FOUNDATION	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)	380,954	62,716	-394,096		10,499,865	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	2.058988	0.020246	0.000000		0.323543	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)			11,236		10,260	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)			0.000849		0.000316	205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)						206.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0120

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

Worksheet B-1

Date/Time Prepared:
7/22/2021 2:23 pm

Cost Center Description			CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
			BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (DOLLAR VALUE)				
			1.00	2.00	4.00	5A	5.00	
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0120

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

Worksheet B-1

Date/Time Prepared:
7/22/2021 2:23 pm

Cost Center Description		OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	CAFETERIA (FTE'S)	
		7.00	8.00	9.00	10.00	11.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500	ADMINISTRATIVE & GENERAL					5.00
7.00	00700	OPERATION OF PLANT	136,611				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	3,542	279,213			8.00
9.00	00900	HOUSEKEEPING	5,176	0	127,893		9.00
10.00	01000	DIETARY	0	0	0	21,117	10.00
11.00	01100	CAFETERIA	0	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	0	0	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	9,823	1,423	9,823	0	14.00
15.00	01500	PHARMACY	4,221	2,029	4,221	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	16.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	26,480	67,329	26,480	18,885	30.00
31.00	03100	INTENSIVE CARE UNIT	3,922	5,721	3,922	2,232	31.00
43.00	04300	NURSERY	0	0	0	0	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	44.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	25,409	67,735	25,409	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	14,360	47,691	14,360	0	54.00
56.00	05600	RADIOISOTOPE	0	0	0	0	56.00
57.00	05700	CT SCAN	2,694	0	2,694	0	57.00
58.00	05800	MRI	2,315	4,800	2,315	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	59.00
60.00	06000	LABORATORY	5,715	105	5,715	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	285	0	285	0	63.00
64.00	06400	INTRAVENOUS THERAPY	7,185	22,750	7,185	0	64.00
65.00	06500	RESPIRATORY THERAPY	1,011	49	1,011	0	65.00
66.00	06600	PHYSICAL THERAPY	293	2,871	293	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	137	1,348	137	0	67.00
68.00	06800	SPEECH PATHOLOGY	75	736	75	0	68.00
69.00	06900	ELECTROCARDIOLOGY	2,680	0	2,680	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	61	0	61	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	314	0	314	0	74.00
76.00	03610	SLEEP LAB	0	0	0	0	76.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	8,527	157	8,527	0	90.00
91.00	09100	EMERGENCY	9,173	54,469	9,173	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					92.00
OTHER REIMBURSABLE COST CENTERS							
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	133,398	279,213	124,680	21,117	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	3,213	0	3,213	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	192.00
194.00	07950	VACANT SPACE	0	0	0	0	194.00
194.01	07951	LEASED SPACE	0	0	0	0	194.01
194.02	07952	FOUNDATION	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)	4,166,953	223,656	1,472,943	246,007	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	30.502324	0.801023	11.516995	11.649714	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	1,197,646	55,969	62,339	59	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	8.766834	0.200453	0.487431	0.002794	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: 14-0120

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

Worksheet B-1

Date/Time Prepared:
7/22/2021 2:23 pm

Cost Center Description		NURSING ADMINISTRATION (DIRECT NURS. HRS.)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (TIME SPENT)		
		13.00	14.00	15.00	16.00		
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500	ADMINISTRATIVE & GENERAL					5.00
7.00	00700	OPERATION OF PLANT					7.00
8.00	00800	LAUNDRY & LINEN SERVICE					8.00
9.00	00900	HOUSEKEEPING					9.00
10.00	01000	DIETARY					10.00
11.00	01100	CAFETERIA					11.00
13.00	01300	NURSING ADMINISTRATION	7,039				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	3,683,621			14.00
15.00	01500	PHARMACY	0	12,122	1,642,452		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	29,051	16.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	6,295	289,967	0	4,654	30.00
31.00	03100	INTENSIVE CARE UNIT	744	1,537	0	896	31.00
43.00	04300	NURSERY	0	0	0	0	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	44.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	2,074,419	0	11,903	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	182,867	0	0	54.00
56.00	05600	RADIOISOTOPE	0	0	0	0	56.00
57.00	05700	CT SCAN	0	94,848	0	0	57.00
58.00	05800	MRI	0	7,498	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	50,551	0	0	59.00
60.00	06000	LABORATORY	0	52,690	0	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	46,348	0	1,804	65.00
66.00	06600	PHYSICAL THERAPY	0	68	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	11,247	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	82,806	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	199,920	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	344,838	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	1,642,452	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	74.00
76.00	03610	SLEEP LAB	0	0	0	0	76.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0	10,217	0	0	90.00
91.00	09100	EMERGENCY	0	221,678	0	9,794	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					92.00
OTHER REIMBURSABLE COST CENTERS							
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	7,039	3,683,621	1,642,452	29,051	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	192.00
194.00	07950	VACANT SPACE	0	0	0	0	194.00
194.01	07951	LEASED SPACE	0	0	0	0	194.01
194.02	07952	FOUNDATION	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)	1,120,562	1,428,225	1,706,673	733,200	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	159.193351	0.387723	1.039101	25.238374	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	267	186,782	184,850	175	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.037932	0.050706	0.112545	0.006024	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: 14-0120

Period:
From 01/01/2020
To 12/31/2020Worksheet C
Part I
Date/Time Prepared:
7/22/2021 2:23 pm

			Title XVIII		Hospital		PPS	
Cost Center Description			Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs			
					Total Costs	RCE Disallowance		Total Costs
			1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	6,766,501		6,766,501	0	6,766,501	30.00
31.00	03100	INTENSIVE CARE UNIT	2,158,145		2,158,145	0	2,158,145	31.00
43.00	04300	NURSERY	0		0	0	0	43.00
44.00	04400	SKILLED NURSING FACILITY	0		0	0	0	44.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	6,855,173		6,855,173	0	6,855,173	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0		0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0		0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,668,008		3,668,008	0	3,668,008	54.00
56.00	05600	RADIOISOTOPE	0		0	0	0	56.00
57.00	05700	CT SCAN	1,012,861		1,012,861	0	1,012,861	57.00
58.00	05800	MRI	617,179		617,179	0	617,179	58.00
59.00	05900	CARDIAC CATHETERIZATION	215,729		215,729	0	215,729	59.00
60.00	06000	LABORATORY	3,038,848		3,038,848	0	3,038,848	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	225,460		225,460	0	225,460	63.00
64.00	06400	INTRAVENOUS THERAPY	2,066,274		2,066,274	0	2,066,274	64.00
65.00	06500	RESPIRATORY THERAPY	906,980	0	906,980	0	906,980	65.00
66.00	06600	PHYSICAL THERAPY	310,849	0	310,849	0	310,849	66.00
67.00	06700	OCCUPATIONAL THERAPY	127,583	0	127,583	0	127,583	67.00
68.00	06800	SPEECH PATHOLOGY	165,017	0	165,017	0	165,017	68.00
69.00	06900	ELECTROCARDIOLOGY	471,591		471,591	0	471,591	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	66,972		66,972	0	66,972	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	2,911,491		2,911,491	0	2,911,491	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	2,310,255		2,310,255	0	2,310,255	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	3,880,529		3,880,529	0	3,880,529	73.00
74.00	07400	RENAL DIALYSIS	14,050		14,050	0	14,050	74.00
76.00	03610	SLEEP LAB	0		0	0	0	76.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	1,245,168		1,245,168	0	1,245,168	90.00
91.00	09100	EMERGENCY	3,447,360		3,447,360	0	3,447,360	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1,565,630		1,565,630		1,565,630	92.00
OTHER REIMBURSABLE COST CENTERS								
101.00	10100	HOME HEALTH AGENCY	0		0		0	101.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	44,047,653	0	44,047,653	0	44,047,653	200.00
201.00		Less Observation Beds	1,565,630		1,565,630		1,565,630	201.00
202.00		Total (see instructions)	42,482,023	0	42,482,023	0	42,482,023	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0120

Period:
From 01/01/2020
To 12/31/2020Worksheet C
Part I
Date/Time Prepared:
7/22/2021 2:23 pm

			Title XVIII		Hospital	PPS		
Cost Center Description			Charges			Cost or Other Ratio	TEFRA Inpatient Ratio	
			Inpatient	Outpatient	Total (col. 6 + col. 7)			
			6.00	7.00	8.00			
	INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	14,256,861		14,256,861			30.00
31.00	03100	INTENSIVE CARE UNIT	5,146,693		5,146,693			31.00
43.00	04300	NURSERY	0		0			43.00
44.00	04400	SKILLED NURSING FACILITY	0		0			44.00
	ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	7,834,594	49,626,118	57,460,712	0.119302	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0.000000	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0.000000	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,298,506	19,196,100	21,494,606	0.170648	0.000000	54.00
56.00	05600	RADIOISOTOPE	0	0	0	0.000000	0.000000	56.00
57.00	05700	CT SCAN	5,288,068	32,768,993	38,057,061	0.026614	0.000000	57.00
58.00	05800	MRI	776,713	9,741,099	10,517,812	0.058679	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	1,533	247,241	248,774	0.0867169	0.000000	59.00
60.00	06000	LABORATORY	10,452,049	21,257,060	31,709,109	0.095835	0.000000	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	640,039	520,869	1,160,908	0.194210	0.000000	63.00
64.00	06400	INTRAVENOUS THERAPY	1,627,306	9,182,591	10,809,897	0.191147	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	3,972,163	1,788,404	5,760,567	0.157446	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	704,067	1,074,005	1,778,072	0.174824	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	348,262	145,337	493,599	0.258475	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	216,328	333,322	549,650	0.300222	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	1,885,128	4,935,515	6,820,643	0.069142	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	25,550	86,154	111,704	0.599549	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	3,666,552	3,698,679	7,365,231	0.395302	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	3,555,237	4,635,087	8,190,324	0.282071	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	6,295,927	8,387,186	14,683,113	0.264285	0.000000	73.00
74.00	07400	RENAL DIALYSIS	0	23,845	23,845	0.589222	0.000000	74.00
76.00	03610	SLEEP LAB	0	0	0	0.000000	0.000000	76.00
	OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	1,168,410	4,464,118	5,632,528	0.221067	0.000000	90.00
91.00	09100	EMERGENCY	5,407,884	34,538,391	39,946,275	0.086300	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	320,158	2,883,372	3,203,530	0.488720	0.000000	92.00
	OTHER REIMBURSABLE COST CENTERS							
101.00	10100	HOME HEALTH AGENCY	0	0	0			101.00
	SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	75,888,028	209,533,486	285,421,514			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	75,888,028	209,533,486	285,421,514			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0120

Period:
From 01/01/2020
To 12/31/2020Worksheet C
Part I
Date/Time Prepared:
7/22/2021 2:23 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
43.00	04300	NURSERY				43.00
44.00	04400	SKILLED NURSING FACILITY				44.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.119302			50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000			52.00
53.00	05300	ANESTHESIOLOGY	0.000000			53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.170648			54.00
56.00	05600	RADIOISOTOPE	0.000000			56.00
57.00	05700	CT SCAN	0.026614			57.00
58.00	05800	MRI	0.058679			58.00
59.00	05900	CARDIAC CATHETERIZATION	0.867169			59.00
60.00	06000	LABORATORY	0.095835			60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.194210			63.00
64.00	06400	INTRAVENOUS THERAPY	0.191147			64.00
65.00	06500	RESPIRATORY THERAPY	0.157446			65.00
66.00	06600	PHYSICAL THERAPY	0.174824			66.00
67.00	06700	OCCUPATIONAL THERAPY	0.258475			67.00
68.00	06800	SPEECH PATHOLOGY	0.300222			68.00
69.00	06900	ELECTROCARDIOLOGY	0.069142			69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.599549			70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.395302			71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.282071			72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.264285			73.00
74.00	07400	RENAL DIALYSIS	0.589222			74.00
76.00	03610	SLEEP LAB	0.000000			76.00
OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.221067			90.00
91.00	09100	EMERGENCY	0.086300			91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.488720			92.00
OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY				101.00
SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE				113.00
200.00		Subtotal (see instructions)				200.00
201.00		Less Observation Beds				201.00
202.00		Total (see instructions)				202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS				Provider CCN: 14-0120		Period: From 01/01/2020 To 12/31/2020		Worksheet D Part I Date/Time Prepared: 7/22/2021 2:23 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			414,855	0	414,855	8,190	50.65	30.00
31.00	INTENSIVE CARE UNIT			100,031		100,031	744	134.45	31.00
43.00	NURSERY			0		0	0	0.00	43.00
44.00	SKILLED NURSING FACILITY			0		0	0	0.00	44.00
200.00	Total (lines 30 through 199)			514,886		514,886	8,934		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			3,223	163,245				
31.00	INTENSIVE CARE UNIT			257	34,554				
43.00	NURSERY			0	0				
44.00	SKILLED NURSING FACILITY			0	0				
200.00	Total (lines 30 through 199)			3,480	197,799				

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 14-0120

Period:
From 01/01/2020
To 12/31/2020Worksheet D
Part II
Date/Time Prepared:
7/22/2021 2:23 pm

				Title XVIII		Hospital	PPS	
Cost Center Description			Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
	ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	1,128,898	57,460,712	0.019646	3,146,681	61,820	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0.000000	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0.000000	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	576,106	21,494,606	0.026802	1,122,597	30,088	54.00
56.00	05600	RADIOISOTOPE	286	0	0.000000	0	0	56.00
57.00	05700	CT SCAN	206,263	38,057,061	0.005420	2,598,920	14,086	57.00
58.00	05800	MRI	203,049	10,517,812	0.019305	338,469	6,534	58.00
59.00	05900	CARDIAC CATHETERIZATION	93,918	248,774	0.377523	1,533	579	59.00
60.00	06000	LABORATORY	94,495	31,709,109	0.002980	4,985,341	14,856	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	3,276	1,160,908	0.002822	285,797	807	63.00
64.00	06400	INTRAVENOUS THERAPY	118,172	10,809,897	0.010932	738,613	8,075	64.00
65.00	06500	RESPIRATORY THERAPY	41,246	5,760,567	0.007160	1,781,110	12,753	65.00
66.00	06600	PHYSICAL THERAPY	4,848	1,778,072	0.002727	385,108	1,050	66.00
67.00	06700	OCCUPATIONAL THERAPY	2,263	493,599	0.004585	160,026	734	67.00
68.00	06800	SPEECH PATHOLOGY	1,262	549,650	0.002296	121,265	278	68.00
69.00	06900	ELECTROCARDIOLOGY	71,594	6,820,643	0.010497	1,290,385	13,545	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	23,359	111,704	0.209115	14,526	3,038	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	10,814	7,365,231	0.001468	1,719,706	2,525	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	18,005	8,190,324	0.002198	1,420,430	3,122	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	185,369	14,683,113	0.012625	2,785,915	35,172	73.00
74.00	07400	RENAL DIALYSIS	3,553	23,845	0.149004	0	0	74.00
76.00	03610	SLEEP LAB	908	0	0.000000	0	0	76.00
	OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	130,402	5,632,528	0.023152	512,828	11,873	90.00
91.00	09100	EMERGENCY	250,949	39,946,275	0.006282	2,432,611	15,282	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	95,989	3,203,530	0.029964	160,160	4,799	92.00
200.00		Total (lines 50 through 199)	3,265,024	266,017,960		26,002,021	241,016	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS					Provider CCN: 14-0120		Period: From 01/01/2020 To 12/31/2020		Worksheet D Part III Date/Time Prepared: 7/22/2021 2:23 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
43.00	04300	NURSERY		0	0	0	0	0	0	43.00
44.00	04400	SKILLED NURSING FACILITY		0	0	0	0	0	0	44.00
200.00		Total (lines 30 through 199)		0	0	0	0	0	0	200.00
Cost Center Description					Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days	
					4.00	5.00	6.00	7.00	8.00	
INPATIENT ROUTINE SERVICE COST CENTERS										
30.00	03000	ADULTS & PEDIATRICS		0	0	8,190	0.00	3,223	30.00	
31.00	03100	INTENSIVE CARE UNIT			0	744	0.00	257	31.00	
43.00	04300	NURSERY			0	0	0.00	0	43.00	
44.00	04400	SKILLED NURSING FACILITY			0	0	0.00	0	44.00	
200.00		Total (lines 30 through 199)			0	8,934		3,480	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
43.00	04300	NURSERY		0						43.00
44.00	04400	SKILLED NURSING FACILITY		0						44.00
200.00		Total (lines 30 through 199)		0						200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

Provider CCN: 14-0120

Period:
From 01/01/2020
To 12/31/2020Worksheet D
Part IV
Date/Time Prepared:
7/22/2021 2:23 pm

Cost Center Description		Title XVIII		Hospital		PPS	
		Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health	
		1.00	2A	2.00	3A	3.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	54.00
56.00	05600	RADIOISOTOPE	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	59.00
60.00	06000	LABORATORY	0	0	0	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	74.00
76.00	03610	SLEEP LAB	0	0	0	0	76.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	92.00
200.00		Total (lines 50 through 199)	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS			Provider CCN: 14-0120		Period: From 01/01/2020 To 12/31/2020		Worksheet D Part IV Date/Time Prepared: 7/22/2021 2:23 pm	
			Title XVIII		Hospital		PPS	
Cost Center Description			All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7) (see instructions)	
			4.00	5.00	6.00	7.00	8.00	
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	0	57,460,712	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	21,494,606	0.000000	54.00
56.00	05600	RADIOISOTOPE	0	0	0	0	0.000000	56.00
57.00	05700	CT SCAN	0	0	0	38,057,061	0.000000	57.00
58.00	05800	MRI	0	0	0	10,517,812	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	248,774	0.000000	59.00
60.00	06000	LABORATORY	0	0	0	31,709,109	0.000000	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	1,160,908	0.000000	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	10,809,897	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	5,760,567	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	1,778,072	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	493,599	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	549,650	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	6,820,643	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	111,704	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	7,365,231	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	8,190,324	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	14,683,113	0.000000	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	23,845	0.000000	74.00
76.00	03610	SLEEP LAB	0	0	0	0	0.000000	76.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0	5,632,528	0.000000	90.00
91.00	09100	EMERGENCY	0	0	0	39,946,275	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	3,203,530	0.000000	92.00
200.00		Total (lines 50 through 199)	0	0	0	266,017,960		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

Provider CCN: 14-0120

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

Worksheet D
Part IV
Date/Time Prepared:
7/22/2021 2:23 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	3,146,681	0	14,206,437	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	1,122,597	0	4,187,133	0	54.00
56.00	05600	RADIOISOTOPE	0.000000	0	0	0	0	56.00
57.00	05700	CT SCAN	0.000000	2,598,920	0	9,142,202	0	57.00
58.00	05800	MRI	0.000000	338,469	0	2,532,165	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	1,533	0	14,125	0	59.00
60.00	06000	LABORATORY	0.000000	4,985,341	0	3,164,299	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.000000	285,797	0	184,759	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0.000000	738,613	0	2,044,070	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.000000	1,781,110	0	472,440	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	385,108	0	56,928	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	160,026	0	20,648	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	121,265	0	6,555	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	1,290,385	0	2,005,380	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	14,526	0	11,928	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	1,719,706	0	1,185,338	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	1,420,430	0	1,704,120	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	2,785,915	0	2,291,993	0	73.00
74.00	07400	RENAL DIALYSIS	0.000000	0	0	12,660	0	74.00
76.00	03610	SLEEP LAB	0.000000	0	0	0	0	76.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0.000000	512,828	0	1,452,896	0	90.00
91.00	09100	EMERGENCY	0.000000	2,432,611	0	6,017,237	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	160,160	0	538,198	0	92.00
200.00		Total (lines 50 through 199)		26,002,021	0	51,251,511	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST				Provider CCN: 14-0120		Period: From 01/01/2020 To 12/31/2020		Worksheet D Part V Date/Time Prepared: 7/22/2021 2:23 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		0.119302	14,206,437	0	0	1,694,856	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		0.170648	4,187,133	0	0	714,526	54.00
56.00	05600	RADIOISOTOPE		0.000000	0	0	0	0	56.00
57.00	05700	CT SCAN		0.026614	9,142,202	0	0	243,311	57.00
58.00	05800	MRI		0.058679	2,532,165	0	0	148,585	58.00
59.00	05900	CARDIAC CATHETERIZATION		0.867169	14,125	0	0	12,249	59.00
60.00	06000	LABORATORY		0.095835	3,164,299	0	0	303,251	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.		0.194210	184,759	0	0	35,882	63.00
64.00	06400	INTRAVENOUS THERAPY		0.191147	2,044,070	0	0	390,718	64.00
65.00	06500	RESPIRATORY THERAPY		0.157446	472,440	0	0	74,384	65.00
66.00	06600	PHYSICAL THERAPY		0.174824	56,928	0	0	9,952	66.00
67.00	06700	OCCUPATIONAL THERAPY		0.258475	20,648	0	0	5,337	67.00
68.00	06800	SPEECH PATHOLOGY		0.300222	6,555	0	0	1,968	68.00
69.00	06900	ELECTROCARDIOLOGY		0.069142	2,005,380	0	0	138,656	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY		0.599549	11,928	0	0	7,151	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT		0.395302	1,185,338	0	0	468,566	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS		0.282071	1,704,120	0	0	480,683	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS		0.264285	2,291,993	0	11,531	605,739	73.00
74.00	07400	RENAL DIALYSIS		0.589222	12,660	0	0	7,460	74.00
76.00	03610	SLEEP LAB		0.000000	0	0	0	0	76.00
OUTPATIENT SERVICE COST CENTERS									
90.00	09000	CLINIC		0.221067	1,452,896	0	255	321,187	90.00
91.00	09100	EMERGENCY		0.086300	6,017,237	0	0	519,288	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART		0.488720	538,198	0	0	263,028	92.00
200.00		Subtotal (see instructions)			51,251,511	0	11,786	6,446,777	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges				0	0		201.00
202.00		Net Charges (line 200 - line 201)			51,251,511	0	11,786	6,446,777	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST				Provider CCN: 14-0120		Period: From 01/01/2020 To 12/31/2020		Worksheet D Part V Date/Time Prepared: 7/22/2021 2:23 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
56.00	05600	RADIOISOTOPE	0	0					56.00
57.00	05700	CT SCAN	0	0					57.00
58.00	05800	MRI	0	0					58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0					59.00
60.00	06000	LABORATORY	0	0					60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0					63.00
64.00	06400	INTRAVENOUS THERAPY	0	0					64.00
65.00	06500	RESPIRATORY THERAPY	0	0					65.00
66.00	06600	PHYSICAL THERAPY	0	0					66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0					67.00
68.00	06800	SPEECH PATHOLOGY	0	0					68.00
69.00	06900	ELECTROCARDIOLOGY	0	0					69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0					70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0					71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0					72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	3,047					73.00
74.00	07400	RENAL DIALYSIS	0	0					74.00
76.00	03610	SLEEP LAB	0	0					76.00
OUTPATIENT SERVICE COST CENTERS									
90.00	09000	CLINIC	0	56					90.00
91.00	09100	EMERGENCY	0	0					91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0					92.00
200.00		Subtotal (see instructions)	0	3,103					200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0						201.00
202.00		Net Charges (line 200 - line 201)	0	3,103					202.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-0120

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

Worksheet D-1

Date/Time Prepared:
7/22/2021 2:23 pm

Title XVIII		Hospital	PPS
Cost Center Description			1.00
PART I - ALL PROVIDER COMPONENTS			
INPATIENT DAYS			
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	8,190	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	8,190	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.	0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)	6,295	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)	3,223	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)	6,766,501	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)	6,766,501	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)	6,766,501	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)	826.19	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	2,662,810	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)	2,662,810	41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-0120

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

Worksheet D-1

Date/Time Prepared:
7/22/2021 2:23 pm

		Title XVIII		Hospital	PPS	
Cost Center Description		Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)
		1.00	2.00	3.00	4.00	5.00
42.00	NURSERY (title V & XIX only)	0	0	0.00	0	0
Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	2,158,145	744	2,900.73	257	745,488
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)					4,073,561
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					7,481,859
PASS THROUGH COST ADJUSTMENTS						
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)					197,799
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					241,016
52.00	Total Program excludable cost (sum of lines 50 and 51)					438,815
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					7,043,044
TARGET AMOUNT AND LIMIT COMPUTATION						
54.00	Program discharges					0
55.00	Target amount per discharge					0.00
56.00	Target amount (line 54 x line 55)					0
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)					0
58.00	Bonus payment (see instructions)					0
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket					0.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket					0.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)					0
62.00	Relief payment (see instructions)					0
63.00	Allowable Inpatient cost plus incentive payment (see instructions)					0
PROGRAM INPATIENT ROUTINE SWING BED COST						
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)					0
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					0
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)					0
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)					0
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)					0
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)					0
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY						
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)					70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)					71.00
72.00	Program routine service cost (line 9 x line 71)					72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)					73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)					74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)					75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)					76.00
77.00	Program capital-related costs (line 9 x line 76)					77.00
78.00	Inpatient routine service cost (line 74 minus line 77)					78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)					79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)					80.00
81.00	Inpatient routine service cost per diem limitation					81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)					82.00
83.00	Reasonable inpatient routine service costs (see instructions)					83.00
84.00	Program inpatient ancillary services (see instructions)					84.00
85.00	Utilization review - physician compensation (see instructions)					85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)					86.00
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
87.00	Total observation bed days (see instructions)					1,895
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					826.19
89.00	Observation bed cost (line 87 x line 88) (see instructions)					1,565,630

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-0120

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

Worksheet D-1

Date/Time Prepared:
7/22/2021 2:23 pm

Cost Center Description		Title XVIII		Hospital		PPS	
		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	414,855	6,766,501	0.061310	1,565,630	95,989	90.00
91.00	Nursing School cost	0	6,766,501	0.000000	1,565,630	0	91.00
92.00	Allied health cost	0	6,766,501	0.000000	1,565,630	0	92.00
93.00	All other Medical Education	0	6,766,501	0.000000	1,565,630	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT			Provider CCN: 14-0120	Period: From 01/01/2020 To 12/31/2020	Worksheet D-3 Date/Time Prepared: 7/22/2021 2:23 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		7,312,553		30.00
31.00	03100	INTENSIVE CARE UNIT		1,955,558		31.00
43.00	04300	NURSERY				43.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.119302	3,146,681	375,405	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.170648	1,122,597	191,569	54.00
56.00	05600	RADIOISOTOPE	0.000000	0	0	56.00
57.00	05700	CT SCAN	0.026614	2,598,920	69,168	57.00
58.00	05800	MRI	0.058679	338,469	19,861	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.867169	1,533	1,329	59.00
60.00	06000	LABORATORY	0.095835	4,985,341	477,770	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.194210	285,797	55,505	63.00
64.00	06400	INTRAVENOUS THERAPY	0.191147	738,613	141,184	64.00
65.00	06500	RESPIRATORY THERAPY	0.157446	1,781,110	280,429	65.00
66.00	06600	PHYSICAL THERAPY	0.174824	385,108	67,326	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.258475	160,026	41,363	67.00
68.00	06800	SPEECH PATHOLOGY	0.300222	121,265	36,406	68.00
69.00	06900	ELECTROCARDIOLOGY	0.069142	1,290,385	89,220	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.599549	14,526	8,709	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.395302	1,719,706	679,803	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.282071	1,420,430	400,662	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.264285	2,785,915	736,276	73.00
74.00	07400	RENAL DIALYSIS	0.589222	0	0	74.00
76.00	03610	SLEEP LAB	0.000000	0	0	76.00
OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.221067	512,828	113,369	90.00
91.00	09100	EMERGENCY	0.086300	2,432,611	209,934	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.488720	160,160	78,273	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		26,002,021	4,073,561	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)		26,002,021		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT

Provider CCN: 14-0120

Period:
From 01/01/2020
To 12/31/2020Worksheet E
Part A
Date/Time Prepared:
7/22/2021 2:23 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)			4,072,390	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1 (see instructions)			1,947,199	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)			69,485	2.03
2.04	Outlier payments for discharges occurring on or after October 1 (see instructions)			34,324	2.04
3.00	Managed Care Simulated Payments			0	3.00
4.00	Bed days available divided by number of days in the cost reporting period (see instructions)			89.82	4.00
Indirect Medical Education Adjustment					
5.00	FTE count for allopathic and osteopathic programs for the most recent cost reporting period ending on or before 12/31/1996.(see instructions)			0.00	5.00
6.00	FTE count for allopathic and osteopathic programs that meet the criteria for an add-on to the cap for new programs in accordance with 42 CFR 413.79(e)			0.00	6.00
7.00	MMA Section 422 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(1)			0.00	7.00
7.01	ACA § 5503 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(2) If the cost report straddles July 1, 2011 then see instructions.			0.00	7.01
8.00	Adjustment (increase or decrease) to the FTE count for allopathic and osteopathic programs for affiliated programs in accordance with 42 CFR 413.75(b), 413.79(c)(2)(iv), 64 FR 26340 (May 12, 1998), and 67 FR 50069 (August 1, 2002).			0.00	8.00
8.01	The amount of increase if the hospital was awarded FTE cap slots under § 5503 of the ACA. If the cost report straddles July 1, 2011, see instructions.			0.00	8.01
8.02	The amount of increase if the hospital was awarded FTE cap slots from a closed teaching hospital under § 5506 of ACA. (see instructions)			0.00	8.02
9.00	Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus lines (8, 8.01 and 8.02) (see instructions)			0.00	9.00
10.00	FTE count for allopathic and osteopathic programs in the current year from your records			0.00	10.00
11.00	FTE count for residents in dental and podiatric programs.			0.00	11.00
12.00	Current year allowable FTE (see instructions)			0.00	12.00
13.00	Total allowable FTE count for the prior year.			0.00	13.00
14.00	Total allowable FTE count for the penultimate year if that year ended on or after September 30, 1997, otherwise enter zero.			0.00	14.00
15.00	Sum of lines 12 through 14 divided by 3.			0.00	15.00
16.00	Adjustment for residents in initial years of the program			0.00	16.00
17.00	Adjustment for residents displaced by program or hospital closure			0.00	17.00
18.00	Adjusted rolling average FTE count			0.00	18.00
19.00	Current year resident to bed ratio (line 18 divided by line 4).			0.000000	19.00
20.00	Prior year resident to bed ratio (see instructions)			0.000000	20.00
21.00	Enter the lesser of lines 19 or 20 (see instructions)			0.000000	21.00
22.00	IME payment adjustment (see instructions)			0	22.00
22.01	IME payment adjustment - Managed Care (see instructions)			0	22.01
Indirect Medical Education Adjustment for the Add-on for § 422 of the MMA					
23.00	Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 CFR 412.105 (f)(1)(iv)(C).			0.00	23.00
24.00	IME FTE Resident Count Over Cap (see instructions)			0.00	24.00
25.00	If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see instructions)			0.00	25.00
26.00	Resident to bed ratio (divide line 25 by line 4)			0.000000	26.00
27.00	IME payments adjustment factor. (see instructions)			0.000000	27.00
28.00	IME add-on adjustment amount (see instructions)			0	28.00
28.01	IME add-on adjustment amount - Managed Care (see instructions)			0	28.01
29.00	Total IME payment (sum of lines 22 and 28)			0	29.00
29.01	Total IME payment - Managed Care (sum of lines 22.01 and 28.01)			0	29.01
Disproportionate Share Adjustment					
30.00	Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)			4.41	30.00
31.00	Percentage of Medicaid patient days (see instructions)			12.12	31.00
32.00	Sum of lines 30 and 31			16.53	32.00
33.00	Allowable disproportionate share percentage (see instructions)			3.64	33.00
34.00	Disproportionate share adjustment (see instructions)			54,779	34.00

CALCULATION OF REIMBURSEMENT SETTLEMENT

Provider CCN: 14-0120

Period:
From 01/01/2020
To 12/31/2020Worksheet E
Part A
Date/Time Prepared:
7/22/2021 2:23 pm

		Title XVIII	Hospital	PPS	
			Prior to 10/1	On/After 10/1	
			1.00	2.00	
	Uncompensated Care Adjustment				
35.00	Total uncompensated care amount (see instructions)		0	0	35.00
35.01	Factor 3 (see instructions)		0.000000000	0.000000000	35.01
35.02	Hospital uncompensated care payment (If line 34 is zero, enter zero on this line) (see instructions)		517,364	554,247	35.02
35.03	Pro rata share of the hospital uncompensated care payment amount (see instructions)		387,316	139,701	35.03
36.00	Total uncompensated care (sum of columns 1 and 2 on line 35.03)		527,017		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 an 685. (see instructions)		0		41.00
41.01	Total ESRD Medicare covered and paid discharges excluding MS-DRGs 652, 682, 683, 684 an 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 an 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)		6,705,194		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)			6,705,194	49.00
50.00	Payment for inpatient program capital (from Wkst. L, Pt. I and Pt. II, as applicable)			472,188	50.00
51.00	Exception payment for inpatient program capital (Wkst. L, Pt. III, see instructions)			0	51.00
52.00	Direct graduate medical education payment (from Wkst. E-4, line 49 see instructions).			0	52.00
53.00	Nursing and Allied Health Managed Care payment			0	53.00
54.00	Special add-on payments for new technologies			14,151	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 intructions)			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)			7,191,533	59.00
60.00	Primary payer payments			0	60.00
61.00	Total amount payable for program beneficiaries (line 59 minus line 60)			7,191,533	61.00
62.00	Deductibles billed to program beneficiaries			803,616	62.00
63.00	Coinurance billed to program beneficiaries			5,940	63.00
64.00	Allowable bad debts (see instructions)			84,505	64.00
65.00	Adjusted reimbursable bad debts (see instructions)			54,928	65.00
66.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			81,777	66.00
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)			6,436,905	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)			18,621	70.93
70.94	HRR adjustment amount (see instructions)			-124,944	70.94
70.95	Recovery of accelerated depreciation			0	70.95

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0120	Period: From 01/01/2020 To 12/31/2020	Worksheet E Part A Date/Time Prepared: 7/22/2021 2:23 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)		47,089	70.99
71.00	Amount due provider (line 67 minus lines 68 plus/minus lines 69 & 70)		6,283,493	71.00
71.01	Sequestration adjustment (see instructions)		41,471	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		6,114,329	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)		127,693	74.00
74.01	Balance due provider/program-PARHM (see instructions)		0	74.01
75.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		0	75.00
TO BE COMPLETED BY CONTRACTOR (lines 90 through 96)				
90.00	Operating outlier amount from Wkst. E, Pt. A, line 2, or sum of 2.03 plus 2.04 (see instructions)		0	90.00
91.00	Capital outlier from Wkst. L, Pt. I, line 2		0	91.00
92.00	Operating outlier reconciliation adjustment amount (see instructions)		0	92.00
93.00	Capital outlier reconciliation adjustment amount (see instructions)		0	93.00
94.00	The rate used to calculate the time value of money (see instructions)		0.00	94.00
95.00	Time value of money for operating expenses (see instructions)		0	95.00
96.00	Time value of money for capital related expenses (see instructions)		0	96.00
		Prior to 10/1	On/After 10/1	
		1.00	2.00	
HSP Bonus Payment Amount				
100.00	HSP bonus amount (see instructions)		0	100.00
HVBP Adjustment for HSP Bonus Payment				
101.00	HVBP adjustment factor (see instructions)	0.0000000000	0.0000000000	101.00
102.00	HVBP adjustment amount for HSP bonus payment (see instructions)		0	102.00
HRR Adjustment for HSP Bonus Payment				
103.00	HRR adjustment factor (see instructions)	0.0000	0.0000	103.00
104.00	HRR adjustment amount for HSP bonus payment (see instructions)		0	104.00
Rural Community Hospital Demonstration Project (\$410A Demonstration) Adjustment				
200.00	Is this the first year of the current 5-year demonstration period under the 21st Century Cures Act? Enter "Y" for yes or "N" for no.			200.00
Cost Reimbursement				
201.00	Medicare inpatient service costs (from Wkst. D-1, Pt. II, line 49)			201.00
202.00	Medicare discharges (see instructions)			202.00
203.00	Case-mix adjustment factor (see instructions)			203.00
Computation of Demonstration Target Amount Limitation (N/A in first year of the current 5-year demonstration period)				
204.00	Medicare target amount			204.00
205.00	Case-mix adjusted target amount (line 203 times line 204)			205.00
206.00	Medicare inpatient routine cost cap (line 202 times line 205)			206.00
Adjustment to Medicare Part A Inpatient Reimbursement				
207.00	Program reimbursement under the \$410A Demonstration (see instructions)			207.00
208.00	Medicare Part A inpatient service costs (from Wkst. E, Pt. A, line 59)			208.00
209.00	Adjustment to Medicare IPPS payments (see instructions)			209.00
210.00	Reserved for future use			210.00
211.00	Total adjustment to Medicare IPPS payments (see instructions)			211.00
Comparison of PPS versus Cost Reimbursement				
212.00	Total adjustment to Medicare Part A IPPS payments (from line 211)			212.00
213.00	Low-volume adjustment (see instructions)			213.00
218.00	Net Medicare Part A IPPS adjustment (difference between PPS and cost reimbursement) (line 212 minus line 213) (see instructions)			218.00

LOW VOLUME CALCULATION EXHIBIT 4

Provider CCN: 14-0120

Period:
From 01/01/2020
To 12/31/2020Worksheet E
Part A Exhibit 4
Date/Time Prepared:
7/22/2021 2:23 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	4,072,390	0	4,072,390		4,072,390
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	1,947,199	0		1,947,199	1,947,199
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	69,485	0	69,485		69,485
2.03	Outlier payments for discharges occurring on or after October 1 (see instructions)	2.04	34,324	0		34,324	34,324
3.00	Operating outlier reconciliation	2.01	0	0	0	0	0
4.00	Managed care simulated payments	3.00	0	0	0	0	0
Indirect Medical Education Adjustment							
5.00	Amount from Worksheet E, Part A, line 21 (see instructions)	21.00	0.000000	0.000000	0.000000	0.000000	
6.00	IME payment adjustment (see instructions)	22.00	0	0	0	0	0
6.01	IME payment adjustment for managed care (see instructions)	22.01	0	0	0	0	0
Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA							
7.00	IME payment adjustment factor (see instructions)	27.00	0.000000	0.000000	0.000000	0.000000	
8.00	IME adjustment (see instructions)	28.00	0	0	0	0	0
8.01	IME payment adjustment add on for managed care (see instructions)	28.01	0	0	0	0	0
9.00	Total IME payment (sum of lines 6 and 8)	29.00	0	0	0	0	0
9.01	Total IME payment for managed care (sum of lines 6.01 and 8.01)	29.01	0	0	0	0	0
Disproportionate Share Adjustment							
10.00	Allowable disproportionate share percentage (see instructions)	33.00	0.0364	0.0364	0.0364	0.0364	
11.00	Disproportionate share adjustment (see instructions)	34.00	54,779	0	37,059	17,720	54,779
11.01	Uncompensated care payments	36.00	527,017	0	387,316	139,701	527,017
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	6,705,194	0	4,566,250	2,138,944	6,705,194
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	6,705,194	0	4,566,250	2,138,944	6,705,194
16.00	Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable)	50.00	472,188	0	324,858	147,330	472,188

LOW VOLUME CALCULATION EXHIBIT 4

Provider CCN: 14-0120

Period:
From 01/01/2020
To 12/31/2020Worksheet E
Part A Exhibit 4
Date/Time Prepared:
7/22/2021 2:23 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	14,151	0	0	14,151	14,151	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	4,891,108	2,300,425	7,191,533	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	465,633	0	320,496	145,137	465,633	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	6,555	0	4,362	2,193	6,555	21.00
21.01	Model 4 BPCI Capital DRG outlier payments	2.01	0	0	0	0	0	21.01
22.00	Indirect medical education percentage (see instructions)	5.00	0.0000	0.0000	0.0000	0.0000		22.00
23.00	Indirect medical education adjustment (see instructions)	6.00	0	0	0	0	0	23.00
24.00	Allowable disproportionate share percentage (see instructions)	10.00	0.0000	0.0000	0.0000	0.0000		24.00
25.00	Disproportionate share adjustment (see instructions)	11.00	0	0	0	0	0	25.00
26.00	Total prospective capital payments (see instructions)	12.00	472,188	0	324,858	147,330	472,188	26.00
		W/S E, Part A line	(Amounts to E, Part A)					
		0	1.00	2.00	3.00	4.00	5.00	
27.00	Low volume adjustment factor				0.000000	0.000000		27.00
28.00	Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)	70.96			0		0	28.00
29.00	Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)	70.97				0	0	29.00
100.00	Transfer low volume adjustments to Wkst. E, Pt. A.		Y					100.00

HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULATION EXHIBIT 5

Provider CCN: 14-0120

Period:
From 01/01/2020
To 12/31/2020Worksheet E
Part A Exhibit 5
Date/Time Prepared:
7/22/2021 2:23 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	4,072,390	4,072,390		4,072,390	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	1,947,199		1,947,199	1,947,199	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	69,485	69,485		69,485	2.02
2.03	Outlier payments for discharges occurring on or after October 1 (see instructions)	2.04	34,324		34,324	34,324	2.03
3.00	Operating outlier reconciliation	2.01	0	0	0	0	3.00
4.00	Managed care simulated payments	3.00	0	0	0	0	4.00
Indirect Medical Education Adjustment							
5.00	Amount from Worksheet E, Part A, line 21 (see instructions)	21.00	0.000000	0.000000	0.000000		5.00
6.00	IME payment adjustment (see instructions)	22.00	0	0	0	0	6.00
6.01	IME payment adjustment for managed care (see instructions)	22.01	0	0	0	0	6.01
Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA							
7.00	IME payment adjustment factor (see instructions)	27.00	0.000000	0.000000	0.000000		7.00
8.00	IME adjustment (see instructions)	28.00	0	0	0	0	8.00
8.01	IME payment adjustment add on for managed care (see instructions)	28.01	0	0	0	0	8.01
9.00	Total IME payment (sum of lines 6 and 8)	29.00	0	0	0	0	9.00
9.01	Total IME payment for managed care (sum of lines 6.01 and 8.01)	29.01	0	0	0	0	9.01
Disproportionate Share Adjustment							
10.00	Allowable disproportionate share percentage (see instructions)	33.00	0.0364	0.0364	0.0364		10.00
11.00	Disproportionate share adjustment (see instructions)	34.00	54,779	37,059	17,720	54,779	11.00
11.01	Uncompensated care payments	36.00	527,017	387,316	139,701	527,017	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	6,705,194	4,566,250	2,138,944	6,705,194	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	6,705,194	4,566,250	2,138,944	6,705,194	15.00
16.00	Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable)	50.00	472,188	324,858	147,330	472,188	16.00
17.00	Special add-on payments for new technologies	54.00	14,151	0	14,151	14,151	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			4,891,108	2,300,425	7,191,533	19.00

HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULATION EXHIBIT 5

Provider CCN: 14-0120

Period:
From 01/01/2020
To 12/31/2020Worksheet E
Part A Exhibit 5
Date/Time Prepared:
7/22/2021 2:23 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	465,633	320,496	145,137	465,633	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	6,555	4,362	2,193	6,555	21.00
21.01	Model 4 BPCI Capital DRG outlier payments	2.01	0	0	0	0	21.01
22.00	Indirect medical education percentage (see instructions)	5.00	0.0000	0.0000	0.0000		22.00
23.00	Indirect medical education adjustment (see instructions)	6.00	0	0	0	0	23.00
24.00	Allowable disproportionate share percentage (see instructions)	10.00	0.0000	0.0000	0.0000		24.00
25.00	Disproportionate share adjustment (see instructions)	11.00	0	0	0	0	25.00
26.00	Total prospective capital payments (see instructions)	12.00	472,188	324,858	147,330	472,188	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	18,621	2,903	15,718	18,621	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	-124,944	-80,226	-44,718	-124,944	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		48,138	22,714	70,852	32.00
100.00	Transfer HAC Reduction Program adjustment to Wkst. E, Pt. A.		N				100.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0120	Period: From 01/01/2020 To 12/31/2020	Worksheet E Part B Date/Time Prepared: 7/22/2021 2:23 pm
		Title XVIII	Hospital	PPS
				1.00
PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)		3,103	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)		6,446,777	2.00
3.00	OPPS payments		5,280,576	3.00
4.00	Outlier payment (see instructions)		4,538	4.00
4.01	Outlier reconciliation amount (see instructions)		0	4.01
5.00	Enter the hospital specific payment to cost ratio (see instructions)		0.000	5.00
6.00	Line 2 times line 5		0	6.00
7.00	Sum of lines 3, 4, and 4.01, divided by line 6		0.00	7.00
8.00	Transitional corridor payment (see instructions)		0	8.00
9.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200		0	9.00
10.00	Organ acquisitions		0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)		3,103	11.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
12.00	Ancillary service charges		11,786	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)		11,786	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)		11,786	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)		8,683	19.00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)		0	20.00
21.00	Lesser of cost or charges (see instructions)		3,103	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)		5,285,114	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)		991,121	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)		4,297,096	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)		4,297,096	30.00
31.00	Primary payer payments		240	31.00
32.00	Subtotal (line 30 minus line 31)		4,296,856	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)		133,161	34.00
35.00	Adjusted reimbursable bad debts (see instructions)		86,555	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		131,939	36.00
37.00	Subtotal (see instructions)		4,383,411	37.00
38.00	MSP-LCC reconciliation amount from PS&R		7	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)		4,383,404	40.00
40.01	Sequestration adjustment (see instructions)		28,930	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		4,322,801	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)		31,673	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: 14-0120

Period:
From 01/01/2020
To 12/31/2020Worksheet E-1
Part I
Date/Time Prepared:
7/22/2021 2:23 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		6,114,329		4,322,801	1.00	
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00	
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00	
Program to Provider							
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01	
3.02			0		0	3.02	
3.03			0		0	3.03	
3.04			0		0	3.04	
3.05			0		0	3.05	
Provider to Program							
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50	
3.51			0		0	3.51	
3.52			0		0	3.52	
3.53			0		0	3.53	
3.54			0		0	3.54	
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99	
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		6,114,329		4,322,801	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		127,693		31,673	6.01	
6.02	SETTLEMENT TO PROGRAM		0		0	6.02	
7.00	Total Medicare program liability (see instructions)		6,242,022		4,354,474	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: 14-0120	Period: From 01/01/2020 To 12/31/2020	Worksheet E-1 Part II Date/Time Prepared: 7/22/2021 2:23 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

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

Provider CCN: 14-0120

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

Worksheet G

Date/Time Prepared:
7/22/2021 2:23 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	6,462,772	0	0	0	1.00
2.00	Temporary investments	1,767,411	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	5,060,766	0	0	0	4.00
5.00	Other receivable	2,434,967	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	0	0	0	0	6.00
7.00	Inventory	1,360,853	0	0	0	7.00
8.00	Prepaid expenses	443,330	0	0	0	8.00
9.00	Other current assets	0	0	0	0	9.00
10.00	Due from other funds	7,336,651	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	24,866,750	0	0	0	11.00
FIXED ASSETS						
12.00	Land	2,430,968	0	0	0	12.00
13.00	Land improvements	11,944,507	0	0	0	13.00
14.00	Accumulated depreciation	-1,378,127	0	0	0	14.00
15.00	Buildings	2,501,107	0	0	0	15.00
16.00	Accumulated depreciation	0	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	6,427,467	0	0	0	19.00
20.00	Accumulated depreciation	-2,112,513	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	8,265,051	0	0	0	23.00
24.00	Accumulated depreciation	-1,600,511	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)	26,477,949	0	0	0	30.00
OTHER ASSETS						
31.00	Investments	9,529,225	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	0	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	9,529,225	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	60,873,924	0	0	0	36.00
CURRENT LIABILITIES						
37.00	Accounts payable	2,078,447	0	0	0	37.00
38.00	Salaries, wages, and fees payable	963,366	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	0	0	0	0	40.00
41.00	Deferred income	0	0	0	0	41.00
42.00	Accelerated payments	0	0	0	0	42.00
43.00	Due to other funds	9,156,796	0	0	0	43.00
44.00	Other current liabilities	2,331,297	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	14,529,906	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	23,128,486	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	23,128,486	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	37,658,392	0	0	0	51.00
CAPITAL ACCOUNTS						
52.00	General fund balance	23,215,532				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)	23,215,532	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	60,873,924	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 14-0120

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

Worksheet G-1

Date/Time Prepared:
7/22/2021 2:23 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		23,075,001		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		-57,009				2.00
3.00	Total (sum of line 1 and line 2)		23,017,992		0		3.00
4.00	Additions (credit adjustments) (specify)	0		0		0	4.00
5.00	CHANGE IN TEMP OR PERM REST	197,541		0		0	5.00
6.00		0		0		0	6.00
7.00		0		0		0	7.00
8.00		0		0		0	8.00
9.00		0		0		0	9.00
10.00	Total additions (sum of line 4-9)		197,541		0		10.00
11.00	Subtotal (line 3 plus line 10)		23,215,533		0		11.00
12.00	Deductions (debit adjustments) (specify)	0		0		0	12.00
13.00		0		0		0	13.00
14.00		0		0		0	14.00
15.00		0		0		0	15.00
16.00		0		0		0	16.00
17.00		0		0		0	17.00
18.00	Total deductions (sum of lines 12-17)		0		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		23,215,533		0		19.00
		Endowment Fund		Plant Fund			
		6.00	7.00	8.00			
1.00	Fund balances at beginning of period	0		0			1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)						2.00
3.00	Total (sum of line 1 and line 2)	0		0			3.00
4.00	Additions (credit adjustments) (specify)		0				4.00
5.00	CHANGE IN TEMP OR PERM REST		0				5.00
6.00			0				6.00
7.00			0				7.00
8.00			0				8.00
9.00			0				9.00
10.00	Total additions (sum of line 4-9)	0		0			10.00
11.00	Subtotal (line 3 plus line 10)	0		0			11.00
12.00	Deductions (debit adjustments) (specify)		0				12.00
13.00			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: 14-0120

Period:
From 01/01/2020
To 12/31/2020Worksheet G-2
Parts I & II
Date/Time Prepared:
7/22/2021 2:23 pm

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
PART I - PATIENT REVENUES					
General Inpatient Routine Services					
1.00	Hospital	15,837,829		15,837,829	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	0		0	5.00
6.00	Swing bed - NF	0		0	6.00
7.00	SKILLED NURSING FACILITY	0		0	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)	15,837,829		15,837,829	10.00
Intensive Care Type Inpatient Hospital Services					
11.00	INTENSIVE CARE UNIT	4,241,074		4,241,074	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)	4,241,074		4,241,074	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	20,078,903		20,078,903	17.00
18.00	Ancillary services	55,651,673	0	55,651,673	18.00
19.00	Outpatient services	0	213,095,345	213,095,345	19.00
20.00	RURAL HEALTH CLINIC	0	0	0	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY		0	0	22.00
23.00	AMBULANCE SERVICES				23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	OTHER (SPECIFY)	0	0	0	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	75,730,576	213,095,345	288,825,921	28.00
PART II - OPERATING EXPENSES					
29.00	Operating expenses (per Wkst. A, column 3, line 200)		38,812,249		29.00
30.00	ADD (SPECIFY)	0			30.00
31.00		0			31.00
32.00		0			32.00
33.00		0			33.00
34.00		0			34.00
35.00		0			35.00
36.00	Total additions (sum of lines 30-35)		0		36.00
37.00	DEDUCT (SPECIFY)	0			37.00
38.00		0			38.00
39.00		0			39.00
40.00		0			40.00
41.00		0			41.00
42.00	Total deductions (sum of lines 37-41)		0		42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer to Wkst. G-3, line 4)		38,812,249		43.00

STATEMENT OF REVENUES AND EXPENSES

Provider CCN: 14-0120

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

Worksheet G-3

Date/Time Prepared:
7/22/2021 2:23 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	288,825,921	1.00
2.00	Less contractual allowances and discounts on patients' accounts	242,138,642	2.00
3.00	Net patient revenues (line 1 minus line 2)	46,687,279	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	38,812,249	4.00
5.00	Net income from service to patients (line 3 minus line 4)	7,875,030	5.00
OTHER INCOME			
6.00	Contributions, donations, bequests, etc	0	6.00
7.00	Income from investments	48,092	7.00
8.00	Revenues from telephone and other miscellaneous communication services	0	8.00
9.00	Revenue from television and radio service	0	9.00
10.00	Purchase discounts	0	10.00
11.00	Rebates and refunds of expenses	0	11.00
12.00	Parking lot receipts	0	12.00
13.00	Revenue from laundry and linen service	0	13.00
14.00	Revenue from meals sold to employees and guests	218,337	14.00
15.00	Revenue from rental of living quarters	0	15.00
16.00	Revenue from sale of medical and surgical supplies to other than patients	0	16.00
17.00	Revenue from sale of drugs to other than patients	0	17.00
18.00	Revenue from sale of medical records and abstracts	0	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	0	20.00
21.00	Rental of vending machines	0	21.00
22.00	Rental of hospital space	0	22.00
23.00	Governmental appropriations	0	23.00
24.00	MISC INCOME	327,553	24.00
24.50	COVID-19 PHE Funding	1,208,031	24.50
25.00	Total other income (sum of lines 6-24)	1,802,013	25.00
26.00	Total (line 5 plus line 25)	9,677,043	26.00
27.00	PEORIA HOME OFFICE EXPENSES	9,734,052	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	9,734,052	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	-57,009	29.00

CALCULATION OF CAPITAL PAYMENT		Provider CCN: 14-0120	Period: From 01/01/2020 To 12/31/2020	Worksheet L Parts I-III Date/Time Prepared: 7/22/2021 2:23 pm
		Title XVIII	Hospital	PPS
		1.00		
PART I - FULLY PROSPECTIVE METHOD				
CAPITAL FEDERAL AMOUNT				
1.00	Capital DRG other than outlier		465,633	1.00
1.01	Model 4 BPCI Capital DRG other than outlier		0	1.01
2.00	Capital DRG outlier payments		6,555	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)		19.29	3.00
4.00	Number of interns & residents (see instructions)		0.00	4.00
5.00	Indirect medical education percentage (see instructions)		0.00	5.00
6.00	Indirect medical education adjustment (multiply line 5 by the sum of lines 1 and 1.01, columns 1 and 1.01)(see instructions)		0	6.00
7.00	Percentage of SSI recipient patient days to Medicare Part A patient days (Worksheet E, part A line 30) (see instructions)		0.00	7.00
8.00	Percentage of Medicaid patient days to total days (see instructions)		0.00	8.00
9.00	Sum of lines 7 and 8		0.00	9.00
10.00	Allowable disproportionate share percentage (see instructions)		0.00	10.00
11.00	Disproportionate share adjustment (see instructions)		0	11.00
12.00	Total prospective capital payments (see instructions)		472,188	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