

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: 14-0125	Period: From 01/01/2020 To 12/31/2020	Worksheet S Parts I-III Date/Time Prepared: 7/30/2021 11:17 am
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PART I - COST REPORT STATUS

Provider use only	1. ☒ Electronically prepared cost report	Date: 7/30/2021	Time: 11:17 am
	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 GATEWAY REGIONAL (14-0125) 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) PATRICK GARVEY

Officer or Administrator of Provider(s)

CFO

Title

(Dated when report is electronically signed.)

Date

Cost Center Description		Title V	Title XVIII		HIT	Title XIX	
			Part A	Part B			
		1.00	2.00	3.00	4.00	5.00	
	PART III - SETTLEMENT SUMMARY						
1.00	Hospital	0	633,364	16,505	0	0	1.00
2.00	Subprovider - IPF	0	45,164	1,010		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
200.00	Total	0	678,528	17,515	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: 14-0125

Period:
From 01/01/2020
To 12/31/2020Worksheet S-2
Part I
Date/Time Prepared:
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1.00		2.00		3.00		4.00				
Hospital and Hospital Health Care Complex Address:										
1.00	Street: 2100 MADISON AVE	PO Box:		Zip Code: 62040	County: MADISON					1.00
2.00	City: GRANITE CITY	State: IL								2.00
		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	GATEWAY REGIONAL	140125	41180	1	07/01/1969	N	P	P	3.00
4.00	Subprovider - IPF	PSYCH DPU	14S125	41180	4	01/01/1984	N	P	P	4.00
5.00	Subprovider - IRF									5.00
6.00	Subprovider - (Other)									6.00
7.00	Swing Beds - SNF									7.00
8.00	Swing Beds - NF									8.00
9.00	Hospital-Based SNF									9.00
10.00	Hospital-Based NF									10.00
11.00	Hospital-Based OLTC									11.00
12.00	Hospital-Based HHA									12.00
13.00	Separately Certified ASC									13.00
14.00	Hospital-Based Hospice									14.00
15.00	Hospital-Based Health Clinic - RHC									15.00
16.00	Hospital-Based Health Clinic - FQHC									16.00
17.00	Hospital-Based (CMHC) I									17.00
18.00	Renal Dialysis									18.00
19.00	Other									19.00
						From:	To:			
						1.00	2.00			
20.00	Cost Reporting Period (mm/dd/yyyy)					01/01/2020	12/31/2020		20.00	
21.00	Type of Control (see instructions)					4			21.00	
						1.00	2.00	3.00		
Inpatient PPS Information										
22.00	Does this facility qualify and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.106(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no.				Y	N			22.00	
22.01	Did this hospital receive interim uncompensated care payments for this cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)				Y	Y			22.01	
22.02	Is this a newly merged hospital that requires final uncompensated care payments to be determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1.				N	N			22.02	
22.03	Did this hospital receive a geographic reclassification from urban to rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no.				N	N		N	22.03	
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.				3	N			23.00	
		In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of-State Medicaid paid days	Out-of-State Medicaid eligible unpaid	Medicaid HMO days	Other Medicaid days			
		1.00	2.00	3.00	4.00	5.00	6.00			
24.00	If this provider is an IPPS hospital, enter the in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.	179	2,441	0	467	6,721	11		24.00	

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

Provider CCN: 14-0125

Period:
From 01/01/2020
To 12/31/2020Worksheet S-2
Part I
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		In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of State Medicaid paid days	Out-of State Medicaid eligible unpaid	Medicaid HMO days	Other Medicaid days	
		1.00	2.00	3.00	4.00	5.00	6.00	
25.00	If this provider is an IRF, enter the in-state Medicaid paid days in column 1, the in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5.	0	0	0	0	0		25.00
						Urban/Rural 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)					N	Y	40.00
						V	XVIII	XIX
						1.00	2.00	3.00
Prospective Payment System (PPS)-Capital								
45.00	Does this facility qualify and receive Capital payment for disproportionate share in accordance with 42 CFR Section §412.320? (see instructions)					N	Y	N
46.00	Is this facility eligible for additional payment exception for extraordinary circumstances pursuant to 42 CFR §412.348(f)? If yes, complete Wkst. L, Pt. III and Wkst. L-1, Pt. I through Pt. III.					N	N	N
47.00	Is this a new hospital under 42 CFR §412.300(b) PPS capital? Enter "Y" for yes or "N" for no.					N	N	N
48.00	Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.					N	N	N
Teaching Hospitals								
56.00	Is this a hospital involved in training residents in approved GME programs? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", are you impacted by CR 11642 (or subsequent CR), MA GME payment reduction? Enter "Y" for yes or "N" for no in column 2.					N		
57.00	If line 56 is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y" did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If column 2 is "N", complete Wkst. D, Parts III & IV and D-2, Pt. II, if applicable.							
58.00	If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, chapter 21, §2148? If yes, complete Wkst. D-5.					N		
59.00	Are costs claimed on line 100 of Worksheet A? If yes, complete Wkst. D-2, Pt. I.					N		
				NAHE 413.85 Y/N	Worksheet A Line #	Pass-Through Qualification Criterion Code		
				1.00	2.00	3.00		
60.00	Are you claiming nursing and allied health education (NAHE) costs for any programs that meet the criteria under 42 CFR 413.85? (see instructions) Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", are you impacted by CR 11642 (or subsequent CR) NAHE MA payment adjustment? Enter "Y" for yes or "N" for no in column 2.					N		60.00

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To 12/31/2020Worksheet S-2
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	Y/N	IME	Direct GME	IME	Direct GME	
	1.00	2.00	3.00	4.00	5.00	
61.00 Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions)				0.00	0.00	61.00
61.01 Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions)						61.01
61.02 Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions)						61.02
61.03 Enter the base line FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions)						61.03
61.04 Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period.(see instructions).						61.04
61.05 Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions)						61.05
61.06 Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)						61.06
	Program Name		Program Code	Unweighted IME FTE Count	Unweighted Direct GME FTE Count	
	1.00		2.00	3.00	4.00	
61.10 Of the FTEs in line 61.05, specify each new program specialty, if any, and the number of FTE residents for each new program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count.				0.00	0.00	61.10
61.20 Of the FTEs in line 61.05, specify each expanded program specialty, if any, and the number of FTE residents for each expanded program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count.				0.00	0.00	61.20
					1.00	
ACA Provisions Affecting the Health Resources and Services Administration (HRSA)						
62.00 Enter the number of FTE residents that your hospital trained in this cost reporting period for which your hospital received HRSA PCRE funding (see instructions)					0.00	62.00
62.01 Enter the number of FTE residents that rotated from a Teaching Health Center (THC) into your hospital during in this cost reporting period of HRSA THC program. (see instructions)					0.00	62.01
Teaching Hospitals that Claim Residents in Nonprovider Settings						
63.00 Has your facility trained residents in nonprovider settings during this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If yes, complete lines 64 through 67. (see instructions)					N	63.00
		Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))		
		1.00	2.00	3.00		
64.00 Section 5504 of the ACA Base Year FTE Residents in Nonprovider Settings--This base year is your cost reporting period that begins on or after July 1, 2009 and before June 30, 2010. Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)		0.00	0.00	0.000000		64.00

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	Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))	
	1.00	2.00	3.00	4.00	5.00	
65.00	Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the program name associated with primary care FTEs for each primary care program in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)		0.00	0.00	0.000000	65.00
			Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))	
			1.00	2.00	3.00	
66.00	Section 5504 of the ACA Current Year FTE Residents in Nonprovider Settings--Effective for cost reporting periods beginning on or after July 1, 2010					
	Enter in column 1 the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)		0.00	0.00	0.000000	66.00
	Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))	
	1.00	2.00	3.00	4.00	5.00	
67.00	Enter in column 1, the program name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)		0.00	0.00	0.000000	67.00
			1.00	2.00	3.00	
70.00	Inpatient Psychiatric Facility PPS					
	Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? Enter "Y" for yes or "N" for no.	Y				70.00
71.00	If line 70 is yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost report filed on or before November 15, 2004? Enter "Y" for yes or "N" for no. (see 42 CFR 412.424(d)(1)(iii)(c)) Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)	N	N	0		71.00
	Inpatient Rehabilitation Facility PPS					
75.00	Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF subprovider? Enter "Y" for yes and "N" for no.	N				75.00
76.00	If line 75 is yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)	N	N	0		76.00

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			1.00		
Long Term Care Hospital PPS					
80.00	Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for no.	N		80.00	
81.00	Is this a LTCH co-located within another hospital for part or all of the cost reporting period? Enter "Y" for yes and "N" for no.	N		81.00	
TEFRA Providers					
85.00	Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no.	N		85.00	
86.00	Did this facility establish a new Other subprovider (excluded unit) under 42 CFR Section §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.			86.00	
87.00	Is this hospital an extended neoplastic disease care hospital classified under section 1886(d)(1)(B)(vi)? Enter "Y" for yes or "N" for no.	N		87.00	
		V	XIX		
		1.00	2.00		
Title V and XIX Services					
90.00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.	N	Y	90.00	
91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.	N	N	91.00	
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.		N	92.00	
93.00	Does this facility operate an ICF/IID facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.	N	N	93.00	
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.	N	N	94.00	
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	95.00	
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.	N	N	96.00	
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	97.00	
98.00	Does title V or XIX follow Medicare (title XVIII) for the interns and residents post stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.00	
98.01	Does title V or XIX follow Medicare (title XVIII) for the reporting of charges on Wkst. C, Pt. I? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.01	
98.02	Does title V or XIX follow Medicare (title XVIII) for the calculation of observation bed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.02	
98.03	Does title V or XIX follow Medicare (title XVIII) for a critical access hospital (CAH) reimbursed 101% of inpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.03	
98.04	Does title V or XIX follow Medicare (title XVIII) for a CAH reimbursed 101% of outpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.04	
98.05	Does title V or XIX follow Medicare (title XVIII) and add back the RCE disallowance on Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.05	
98.06	Does title V or XIX follow Medicare (title XVIII) when cost reimbursed for Wkst. D, Pts. I through IV? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.06	
Rural Providers					
105.00	Does this hospital qualify as a CAH?	N		105.00	
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)	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: 14-0125	Period: From 01/01/2020 To 12/31/2020	Worksheet S-2 Part I Date/Time Prepared: 7/30/2021 11:17 am
		1.00	2.00	
111.00	If this facility qualifies as a CAH, did it participate in the Frontier Community Health Integration Project (FCHIP) demonstration for this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If the response to column 1 is Y, enter the integration prong of the FCHIP demo in which this CAH is participating in column 2. Enter all that apply: "A" for Ambulance services; "B" for additional beds; and/or "C" for tele-health services.	N		111.00
		1.00	2.00	3.00
112.00	Did this hospital participate in the Pennsylvania Rural Health Model demonstration for any portion of the current cost reporting period? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2, the date the hospital began participating in the demonstration. In column 3, enter the date the hospital ceased participation in the demonstration, if applicable.	N		112.00
Miscellaneous Cost Reporting Information				
115.00	Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in column 1. If column 1 is yes, enter the method used (A, B, or E only) in column 2. If column 2 is "E", enter in column 3 either "93" percent for short term hospital or "98" percent for long term care (includes psychiatric, rehabilitation and long term hospitals providers) based on the definition in CMS Pub.15-1, chapter 22, §2208.1.	N		0115.00
116.00	Is this facility classified as a referral center? Enter "Y" for yes or "N" for no.	N		116.00
117.00	Is this facility legally required to carry malpractice insurance? Enter "Y" for yes or "N" for no.	N		117.00
118.00	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.	1		118.00
		Premiums	Losses	Insurance
		1.00	2.00	3.00
118.01	List amounts of malpractice premiums and paid losses:	329,997	-18,752	0118.01
		1.00	2.00	
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein.	N		118.02
119.00	DO NOT USE THIS LINE			119.00
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 1, "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2, "Y" for yes or "N" for no.	N	N	120.00
121.00	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter "Y" for yes or "N" for no.	Y		121.00
122.00	Does the cost report contain healthcare related taxes as defined in §1903(w)(3) of the Act? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2 the Worksheet A line number where these taxes are included.	N		122.00
Transplant Center Information				
125.00	Does this facility operate a transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.	N		125.00
126.00	If this is a Medicare certified kidney transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			126.00
127.00	If this is a Medicare certified heart transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			127.00
128.00	If this is a Medicare certified liver transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			128.00
129.00	If this is a Medicare certified lung transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			129.00
130.00	If this is a Medicare certified pancreas transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			130.00
131.00	If this is a Medicare certified intestinal transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			131.00
132.00	If this is a Medicare certified islet transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			132.00
133.00	Removed and reserved			133.00
134.00	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.			134.00
All Providers				
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)	Y	HB0776	140.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA				Provider CCN: 14-0125		Period: From 01/01/2020 To 12/31/2020		Worksheet S-2 Part I Date/Time Prepared: 7/30/2021 11:17 am	
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: QUORUM HEALTH CORPORATION		Contractor's Name: WPS		Contractor's Number: 52280		141.00		
142.00	Street: 1573 MALLORY LANE		PO Box: SUITE 100				142.00		
143.00	City: BRENTWOOD		State: TN		Zip Code: 37027		143.00		
								1.00	
144.00	Are provider based physicians' costs included in Worksheet A?							Y	144.00
								1.00	2.00
145.00	If costs for renal services are claimed on Wkst. A, line 74, are the costs for inpatient services only? Enter "Y" for yes or "N" for no in column 1. If column 1 is no, does the dialysis facility include Medicare utilization for this cost reporting period? Enter "Y" for yes or "N" for no in column 2.					Y		145.00	
146.00	Has the cost allocation methodology changed from the previously filed cost report? Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, chapter 40, §4020) If yes, enter the approval date (mm/dd/yyyy) in column 2.					N		146.00	
								1.00	
147.00	Was there a change in the statistical basis? Enter "Y" for yes or "N" for no.							N	147.00
148.00	Was there a change in the order of allocation? Enter "Y" for yes or "N" for no.							N	148.00
149.00	Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no.							N	149.00
				Part A	Part B	Title V	Title XIX		
				1.00	2.00	3.00	4.00		
Does this facility contain a provider that qualifies for an exemption from the application of the lower of costs or charges? Enter "Y" for yes or "N" for no for each component for Part A and Part B. (See 42 CFR §413.13)									
155.00	Hospital			N	N	N	N		
156.00	Subprovider - IPF			N	N	N	N		
157.00	Subprovider - IRF			N	N	N	N		
158.00	SUBPROVIDER								
159.00	SNF			N	N	N	N		
160.00	HOME HEALTH AGENCY			N	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	165.00
		Name	County	State	Zip Code	CBSA	FTE/Campus		
		0	1.00	2.00	3.00	4.00	5.00		
166.00	If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions)						0.00		
								1.00	
Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act									
167.00	Is this provider a meaningful user under §1886(n)? Enter "Y" for yes or "N" for no.							Y	167.00
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)								168.00
168.01	If this provider is a CAH and is not a meaningful user, does this provider qualify for a hardship exception under §413.70(a)(6)(ii)? Enter "Y" for yes or "N" for no. (see instructions)								168.01
169.00	If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)							9.99	169.00
							Beginning	Ending	
							1.00	2.00	
170.00	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)								170.00
							1.00	2.00	
171.00	If line 167 is "Y", does this provider have any days for individuals enrolled in section 1876 Medicare cost plans reported on Wkst. S-3, Pt. I, line 2, col. 6? Enter "Y" for yes and "N" for no in column 1. If column 1 is yes, enter the number of section 1876 Medicare days in column 2. (see instructions)					N		0	171.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 14-0125	Period: From 01/01/2020 To 12/31/2020	Worksheet S-2 Part II Date/Time Prepared: 7/30/2021 11:17 am	
			Y/N 1.00	Date 2.00	
General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format.					
COMPLETED BY ALL HOSPITALS					
Provider Organization and Operation					
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)	N			1.00
			Y/N 1.00	Date 2.00	V/I 3.00
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.	N			2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)	Y			3.00
			Y/N 1.00	Type 2.00	Date 3.00
Financial Data and Reports					
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	N			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.			Y	15.00
			Part A		Part B
			Y/N 1.00	Date 2.00	Y/N 3.00
				Date 4.00	
PS&R Data					
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)	Y	05/11/2021	Y	05/11/2021
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	N		N	
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N		N	
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		N	

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE

Provider CCN: 14-0125

Period:
From 01/01/2020
To 12/31/2020Worksheet S-2
Part II
Date/Time Prepared:
7/30/2021 11:17 am

		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.		N		40.00
		1.00	2.00		
Cost Report Preparer Contact Information					
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	CLINTON	BALLEW		41.00
42.00	Enter the employer/company name of the cost report preparer.	QHC			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	(615) 221-3869	CBALLEW@QHCUS.COM		43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 14-0125	Period: From 01/01/2020 To 12/31/2020	Worksheet S-2 Part II Date/Time Prepared: 7/30/2021 11:17 am
		3.00		
Cost Report Preparer Contact Information				
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	DIRECTOR OF REIMBURSEMENT		41.00
42.00	Enter the employer/company name of the cost report preparer.			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.			43.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 14-0125

Period:
From 01/01/2020
To 12/31/2020Worksheet S-3
Part I
Date/Time Prepared:
7/30/2021 11:17 am

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	276	101,016	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)		276	101,016	0.00	0	7.00
8.00 INTENSIVE CARE UNIT	31.00	12	4,392	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)		288	105,408	0.00	0	14.00
15.00 CAH visits					0	15.00
16.00 SUBPROVIDER - IPF	40.00	17	6,222		0	16.00
17.00 SUBPROVIDER - IRF	41.00	0	0		0	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						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)		305			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: 14-0125

Period:
From 01/01/2020
To 12/31/2020Worksheet S-3
Part I
Date/Time Prepared:
7/30/2021 11:17 am

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)	2,506	143	17,711			1.00
2.00	HMO and other (see instructions)	1,845	9,640				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)	2,506	143	17,711			7.00
8.00	INTENSIVE CARE UNIT	522	17	1,340			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		19	68			13.00
14.00	Total (see instructions)	3,028	179	19,119	0.00	436.97	14.00
15.00	CAH visits	0	0	0			15.00
16.00	SUBPROVIDER - IPF	1,675	1,304	3,185	0.00	15.96	16.00
17.00	SUBPROVIDER - IRF	0	0	0	0.00	0.00	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						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	452.93	27.00
28.00	Observation Bed Days		0	1,955			28.00
29.00	Ambulance Trips	0					29.00
30.00	Employee discount days (see instruction)			0			30.00
31.00	Employee discount days - IRF			0			31.00
32.00	Labor & delivery days (see instructions)	0	0	15			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: 14-0125

Period:
From 01/01/2020
To 12/31/2020Worksheet S-3
Part I
Date/Time Prepared:
7/30/2021 11:17 am

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	977	508	4,376	1.00
2.00 HMO and other (see instructions)			411	1,453		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	977	508	4,376	14.00
15.00 CAH visits						15.00
16.00 SUBPROVIDER - IPF	0.00	0	204	101	463	16.00
17.00 SUBPROVIDER - IRF	0.00	0	0	0	0	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						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: 14-0125

Period:
From 01/01/2020
To 12/31/2020Worksheet S-3
Part II
Date/Time Prepared:
7/30/2021 11:17 am

	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	30,600,849	0	30,600,849	942,089.00	32.48
2.00	Non-physician anesthetist Part A		0	0	0	0.00	0.00
3.00	Non-physician anesthetist Part B		0	0	0	0.00	0.00
4.00	Physician-Part A - Administrative		0	0	0	0.00	0.00
4.01	Physicians - Part A - Teaching		0	0	0	0.00	0.00
5.00	Physician and Non Physician-Part B		0	0	0	0.00	0.00
6.00	Non-physician-Part B for hospital-based RHC and FQHC services		0	0	0	0.00	0.00
7.00	Interns & residents (in an approved program)	21.00	0	0	0	0.00	0.00
7.01	Contracted interns and residents (in an approved programs)		0	0	0	0.00	0.00
8.00	Home office and/or related organization personnel		0	0	0	0.00	0.00
9.00	SNF	44.00	0	0	0	0.00	0.00
10.00	Excluded area salaries (see instructions)		1,198,275	122,536	1,320,811	37,119.00	35.58
OTHER WAGES & RELATED COSTS							
11.00	Contract labor: Direct Patient Care		2,691,817	0	2,691,817	44,049.00	61.11
12.00	Contract labor: Top level management and other management and administrative services		49,500	0	49,500	440.00	112.50
13.00	Contract labor: Physician-Part A - Administrative		208,804	0	208,804	1,965.00	106.26
14.00	Home office and/or related organization salaries and wage-related costs		0	0	0	0.00	0.00
14.01	Home office salaries		2,168,593	0	2,168,593	33,513.00	64.71
14.02	Related organization salaries		0	0	0	0.00	0.00
15.00	Home office: Physician Part A - Administrative		0	0	0	0.00	0.00
16.00	Home office and Contract Physicians Part A - Teaching		0	0	0	0.00	0.00
16.01	Home office Physicians Part A - Teaching		0	0	0	0.00	0.00
16.02	Home office contract Physicians Part A - Teaching		0	0	0	0.00	0.00
WAGE-RELATED COSTS							
17.00	Wage-related costs (core) (see instructions)		6,838,851	0	6,838,851		
18.00	Wage-related costs (other) (see instructions)						
19.00	Excluded areas		295,963	0	295,963		
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: 14-0125

Period:
From 01/01/2020
To 12/31/2020Worksheet S-3
Part II
Date/Time Prepared:
7/30/2021 11:17 am

		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	289,634	0	289,634	9,820.00	29.49	26.00
27.00	Administrative & General	5.00	3,769,151	373,835	4,142,986	107,778.00	38.44	27.00
28.00	Administrative & General under contract (see inst.)		0	0	0	0.00	0.00	28.00
29.00	Maintenance & Repairs	6.00	0	0	0	0.00	0.00	29.00
30.00	Operation of Plant	7.00	887,637	0	887,637	29,745.00	29.84	30.00
31.00	Laundry & Linen Service	8.00	0	0	0	0.00	0.00	31.00
32.00	Housekeeping	9.00	0	0	0	0.00	0.00	32.00
33.00	Housekeeping under contract (see instructions)		0	0	0	0.00	0.00	33.00
34.00	Dietary	10.00	0	0	0	0.00	0.00	34.00
35.00	Dietary under contract (see instructions)		0	0	0	0.00	0.00	35.00
36.00	Cafeteria	11.00	0	0	0	0.00	0.00	36.00
37.00	Maintenance of Personnel	12.00	0	0	0	0.00	0.00	37.00
38.00	Nursing Administration	13.00	2,198,527	0	2,198,527	58,029.00	37.89	38.00
39.00	Central Services and Supply	14.00	188,264	0	188,264	9,845.00	19.12	39.00
40.00	Pharmacy	15.00	1,316,256	0	1,316,256	34,122.00	38.57	40.00
41.00	Medical Records & Medical Records Library	16.00	56,234	0	56,234	1,417.00	39.69	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: 14-0125

Period:
From 01/01/2020
To 12/31/2020Worksheet S-3
Part III
Date/Time Prepared:
7/30/2021 11:17 am

	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)	30,600,849	0	30,600,849	942,089.00	32.48	1.00
2.00	Excluded area salaries (see instructions)	1,198,275	122,536	1,320,811	37,119.00	35.58	2.00
3.00	Subtotal salaries (line 1 minus line 2)	29,402,574	-122,536	29,280,038	904,970.00	32.35	3.00
4.00	Subtotal other wages & related costs (see inst.)	5,118,714	0	5,118,714	79,967.00	64.01	4.00
5.00	Subtotal wage-related costs (see inst.)	6,838,851	0	6,838,851	0.00	23.36	5.00
6.00	Total (sum of lines 3 thru 5)	41,360,139	-122,536	41,237,603	984,937.00	41.87	6.00
7.00	Total overhead cost (see instructions)	8,705,703	373,835	9,079,538	250,756.00	36.21	7.00

HOSPITAL WAGE RELATED COSTS		Provider CCN: 14-0125	Period: From 01/01/2020 To 12/31/2020	Worksheet S-3 Part IV Date/Time Prepared: 7/30/2021 11:17 am
				Amount Reported
				1.00
PART IV - WAGE RELATED COSTS				
Part A - Core List				
RETIREMENT COST				
1.00	401K Employer Contributions		500,894	1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution		0	2.00
3.00	Nonqualified Defined Benefit Plan Cost (see instructions)		0	3.00
4.00	Qualified Defined Benefit Plan Cost (see instructions)		0	4.00
PLAN ADMINISTRATIVE COSTS (Paid to External Organization)				
5.00	401K/TSA Plan Administration fees		0	5.00
6.00	Legal/Accounting/Management Fees-Pension Plan		0	6.00
7.00	Employee Managed Care Program Administration Fees		0	7.00
HEALTH AND INSURANCE COST				
8.00	Health Insurance (Purchased or Self Funded)		0	8.00
8.01	Health Insurance (Self Funded without a Third Party Administrator)		0	8.01
8.02	Health Insurance (Self Funded with a Third Party Administrator)		2,993,094	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		18,119	10.00
11.00	Life Insurance (If employee is owner or beneficiary)		20,437	11.00
12.00	Accident Insurance (If employee is owner or beneficiary)		-2,746	12.00
13.00	Disability Insurance (If employee is owner or beneficiary)		24,376	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)		0	14.00
15.00	'Workers' Compensation Insurance		502,690	15.00
16.00	Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. Non cumulative portion)		0	16.00
TAXES				
17.00	FICA-Employers Portion Only		1,861,872	17.00
18.00	Medicare Taxes - Employers Portion Only		435,438	18.00
19.00	Unemployment Insurance		0	19.00
20.00	State or Federal Unemployment Taxes		130,740	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		0	23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)		6,484,914	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: 14-0125

Period:
From 01/01/2020
To 12/31/2020Worksheet S-3
Part V
Date/Time Prepared:
7/30/2021 11:17 am

Cost Center Description		Contract Labor	Benefit Cost	
		1.00	2.00	
PART V - Contract Labor and Benefit Cost				
Hospital and Hospital-Based Component Identification:				
1.00	Total facility's contract labor and benefit cost	2,691,817	6,484,914	1.00
2.00	Hospital	2,691,817	6,484,914	2.00
3.00	Subprovider - IPF	0	0	3.00
4.00	Subprovider - IRF	0	0	4.00
5.00	Subprovider - (Other)	0	0	5.00
6.00	Swing Beds - SNF	0	0	6.00
7.00	Swing Beds - NF	0	0	7.00
8.00	Hospital-Based SNF	0	0	8.00
9.00	Hospital-Based NF			9.00
10.00	Hospital-Based OLTC			10.00
11.00	Hospital-Based HHA			11.00
12.00	Separately Certified ASC			12.00
13.00	Hospital-Based Hospice			13.00
14.00	Hospital-Based Health Clinic RHC			14.00
15.00	Hospital-Based Health Clinic FQHC			15.00
16.00	Hospital-Based-CMHC			16.00
17.00	Renal Dialysis	0	0	17.00
18.00	Other	0	0	18.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA		Provider CCN: 14-0125	Period: From 01/01/2020 To 12/31/2020	Worksheet S-10 Date/Time Prepared: 7/30/2021 11:17 am	
				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)			0.115680	1.00
Medicaid (see instructions for each line)					
2.00	Net revenue from Medicaid			30,717,744	2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?			Y	3.00
4.00	If line 3 is yes, does line 2 include all DSH and/or supplemental payments from Medicaid?			N	4.00
5.00	If line 4 is no, then enter DSH and/or supplemental payments from Medicaid			13,191,457	5.00
6.00	Medicaid charges			223,684,508	6.00
7.00	Medicaid cost (line 1 times line 6)			25,875,824	7.00
8.00	Difference between net revenue and costs for Medicaid program (line 7 minus sum of lines 2 and 5; if < zero then enter zero)			0	8.00
Children's Health Insurance Program (CHIP) (see instructions for each line)					
9.00	Net revenue from stand-alone CHIP			0	9.00
10.00	Stand-alone CHIP charges			0	10.00
11.00	Stand-alone CHIP cost (line 1 times line 10)			0	11.00
12.00	Difference between net revenue and costs for stand-alone CHIP (line 11 minus line 9; if < zero then enter zero)			0	12.00
Other state or local government indigent care program (see instructions for each line)					
13.00	Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9)			0	13.00
14.00	Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)			0	14.00
15.00	State or local indigent care program cost (line 1 times line 14)			0	15.00
16.00	Difference between net revenue and costs for state or local indigent care program (line 15 minus line 13; if < zero then enter zero)			0	16.00
Grants, donations and total unreimbursed cost for Medicaid, CHIP and state/local indigent care programs (see instructions for each line)					
17.00	Private grants, donations, or endowment income restricted to funding charity care			0	17.00
18.00	Government grants, appropriations or transfers for support of hospital operations			0	18.00
19.00	Total unreimbursed cost for Medicaid, CHIP and state and local indigent care programs (sum of lines 8, 12 and 16)			0	19.00
		Uninsured patients	Insured patients	Total (col. 1 + col. 2)	
		1.00	2.00	3.00	
Uncompensated Care (see instructions for each line)					
20.00	Charity care charges and uninsured discounts for the entire facility (see instructions)	17,363,620	4,243	17,367,863	20.00
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	2,008,624	4,243	2,012,867	21.00
22.00	Payments received from patients for amounts previously written off as charity care	0	0	0	22.00
23.00	Cost of charity care (line 21 minus line 22)	2,008,624	4,243	2,012,867	23.00
				1.00	
24.00	Does the amount on line 20 column 2, include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?			N	24.00
25.00	If line 24 is yes, enter the charges for patient days beyond the indigent care program's length of stay limit			0	25.00
26.00	Total bad debt expense for the entire hospital complex (see instructions)			28,455,453	26.00
27.00	Medicare reimbursable bad debts for the entire hospital complex (see instructions)			777,209	27.00
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)			1,195,706	27.01
28.00	Non-Medicare bad debt expense (see instructions)			27,259,747	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)			3,571,905	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)			5,584,772	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)			5,584,772	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-0125

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

Worksheet A

Date/Time Prepared:
7/30/2021 11:17 am

Cost Center Description			Salaries	Other	Total (col. 1 + col. 2)	Reclassification ons (See A-6)	Reclassified Trial Balance (col. 3 + col. 4)	
			1.00	2.00	3.00	4.00	5.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT		1,809,944	1,809,944	1,289,067	3,099,011	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		2,296,680	2,296,680	13,320	2,310,000	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	289,634	45,970	335,604	4,706,927	5,042,531	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	3,769,151	33,050,577	36,819,728	-5,748,370	31,071,358	5.00
7.00	00700	OPERATION OF PLANT	887,637	4,012,531	4,900,168	0	4,900,168	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	246,883	246,883	0	246,883	8.00
9.00	00900	HOUSEKEEPING	0	1,844,489	1,844,489	0	1,844,489	9.00
10.00	01000	DIETARY	0	1,806,507	1,806,507	-945,890	860,617	10.00
11.00	01100	CAFETERIA	0	0	0	945,890	945,890	11.00
13.00	01300	NURSING ADMINISTRATION	2,198,527	992,044	3,190,571	0	3,190,571	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	188,264	59,281	247,545	163,972	411,517	14.00
15.00	01500	PHARMACY	1,316,256	1,371,595	2,687,851	-1,006,848	1,681,003	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	56,234	42,956	99,190	0	99,190	16.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	6,631,707	4,094,984	10,726,691	-48,291	10,678,400	30.00
31.00	03100	INTENSIVE CARE UNIT	1,065,741	1,850,503	2,916,244	0	2,916,244	31.00
40.00	04000	SUBPROVIDER - IPF	1,164,176	349,518	1,513,694	0	1,513,694	40.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
43.00	04300	NURSERY	21,777	561,653	583,430	10,273	593,703	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	1,475,207	4,044,674	5,519,881	-1,590,571	3,929,310	50.00
51.00	05100	RECOVERY ROOM	183,190	71,794	254,984	0	254,984	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	240,845	141,881	382,726	38,018	420,744	52.00
53.00	05300	ANESTHESIOLOGY	0	1,466,074	1,466,074	0	1,466,074	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,878,916	1,300,379	3,179,295	1,208,814	4,388,109	54.00
54.01	05401	ULTRA-SOUND	147,284	39,044	186,328	-186,328	0	54.01
56.00	05600	RADIOISOTOPE	79,108	72,158	151,266	-151,266	0	56.00
57.00	05700	CT SCAN	311,949	341,120	653,069	-653,069	0	57.00
58.00	05800	MRI	129,215	88,936	218,151	-218,151	0	58.00
60.00	06000	LABORATORY	2,692,689	2,326,998	5,019,687	-119	5,019,568	60.00
65.00	06500	RESPIRATORY THERAPY	624,459	267,378	891,837	-77,828	814,009	65.00
66.00	06600	PHYSICAL THERAPY	864,325	191,003	1,055,328	237,432	1,292,760	66.00
67.00	06700	OCCUPATIONAL THERAPY	127,675	10,254	137,929	-137,929	0	67.00
68.00	06800	SPEECH PATHOLOGY	93,525	6,999	100,524	-100,524	0	68.00
69.00	06900	ELECTROCARDIOLOGY	687,348	1,155,719	1,843,067	-217,758	1,625,309	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	390,284	390,284	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	1,332,035	1,332,035	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	1,006,848	1,006,848	73.00
74.00	07400	RENAL DIALYSIS	0	150,431	150,431	0	150,431	74.00
76.00	03020	ACUPUNCTURE	0	0	0	0	0	76.00
76.01	03610	SLEEP LAB	204,573	199,437	404,010	0	404,010	76.01
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	576,344	156,662	733,006	-584,142	148,864	76.02
76.03	03950	WOUND CARE	143,043	45,415	188,458	0	188,458	76.03
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	71,437	116,179	187,616	0	187,616	90.00
91.00	09100	EMERGENCY	2,446,514	4,787,666	7,234,180	-15	7,234,165	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
SPECIAL PURPOSE COST CENTERS								
118.00	SUBTOTALS (SUM OF LINES 1 through 117)		30,566,750	71,416,316	101,983,066	-324,219	101,658,847	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	388,198	388,198	0	388,198	192.00
194.00	07950	OTHER NONREIMB - NONPAID WORKERS	0	0	0	0	0	194.00
194.01	07951	OTHER NONREIMB - MARKETING	0	0	0	318,579	318,579	194.01
194.02	07952	OTHER NONREIMB - SENIOR CIRCLE	34,099	18,272	52,371	5,640	58,011	194.02
194.03	07953	OTHER NONREIMB - INDUSTRIAL MEDICINE	0	0	0	0	0	194.03
200.00	TOTAL (SUM OF LINES 118 through 199)		30,600,849	71,822,786	102,423,635	0	102,423,635	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-0125

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

Worksheet A

Date/Time Prepared:
7/30/2021 11:17 am

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	102,482	3,201,493	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	57,277	2,367,277	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-6,427	5,036,104	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-13,498,561	17,572,797	5.00
7.00	00700	OPERATION OF PLANT	0	4,900,168	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	246,883	8.00
9.00	00900	HOUSEKEEPING	0	1,844,489	9.00
10.00	01000	DIETARY	0	860,617	10.00
11.00	01100	CAFETERIA	-181,184	764,706	11.00
13.00	01300	NURSING ADMINISTRATION	0	3,190,571	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	411,517	14.00
15.00	01500	PHARMACY	0	1,681,003	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-782	98,408	16.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	-2,421,879	8,256,521	30.00
31.00	03100	INTENSIVE CARE UNIT	-1,312,814	1,603,430	31.00
40.00	04000	SUBPROVIDER - IPF	-217,243	1,296,451	40.00
41.00	04100	SUBPROVIDER - IRF	0	0	41.00
43.00	04300	NURSERY	-542,927	50,776	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	44.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	-101,273	3,828,037	50.00
51.00	05100	RECOVERY ROOM	0	254,984	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	420,744	52.00
53.00	05300	ANESTHESIOLOGY	-1,353,901	112,173	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-183,401	4,204,708	54.00
54.01	05401	ULTRA-SOUND	0	0	54.01
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
60.00	06000	LABORATORY	-18,435	5,001,133	60.00
65.00	06500	RESPIRATORY THERAPY	0	814,009	65.00
66.00	06600	PHYSICAL THERAPY	0	1,292,760	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	1,625,309	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	390,284	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	1,332,035	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	1,006,848	73.00
74.00	07400	RENAL DIALYSIS	0	150,431	74.00
76.00	03020	ACUPUNCTURE	0	0	76.00
76.01	03610	SLEEP LAB	0	404,010	76.01
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	-42,109	106,755	76.02
76.03	03950	WOUND CARE	0	188,458	76.03
OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	0	187,616	90.00
91.00	09100	EMERGENCY	-3,058,889	4,175,276	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART			92.00
SPECIAL PURPOSE COST CENTERS					
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-22,780,066	78,878,781	118.00
NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	388,198	192.00
194.00	07950	OTHER NONREIMB - NONPAID WORKERS	0	0	194.00
194.01	07951	OTHER NONREIMB - MARKETING	0	318,579	194.01
194.02	07952	OTHER NONREIMB - SENIOR CIRCLE	0	58,011	194.02
194.03	07953	OTHER NONREIMB - INDUSTRIAL MEDICINE	0	0	194.03
200.00		TOTAL (SUM OF LINES 118 through 199)	-22,780,066	79,643,569	200.00

RECLASSIFICATIONS

Provider CCN: 14-0125

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

Worksheet A-6

Date/Time Prepared:
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	Increases					
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
	A - RECLASS OF EMPLOYEE BENEFITS					
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	4,706,927		1.00
	0		0	4,706,927		
	B - RECLASS OF OXYGEN COSTS					
1.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	78,520		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
	0		0	78,520		
	D - RECLASS OF OTHER CAPITAL COSTS					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	239,999		1.00
2.00	CAP REL COSTS-BLDG & FIXT	1.00	0	1,049,068		2.00
3.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	13,320		3.00
	0		0	1,302,387		
	E - RECLASS OF MARKETING DEPARTMENTS					
1.00	OTHER NONREIMB - MARKETING	194.01	122,536	196,043		1.00
	0		122,536	196,043		
	F - RECLASS OF MEDICAL SUPPLIES					
1.00	CENTRAL SERVICES & SUPPLY	14.00	0	163,972		1.00
2.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	311,764		2.00
3.00	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	1,332,035		3.00
	0		0	1,807,771		
	G - RECLASS OF COST OF DRUGS/IV SOLUTION					
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	1,006,848		1.00
	0		0	1,006,848		
	H - RECLASS OF PT, OT, AND SP COSTS					
1.00	PHYSICAL THERAPY	66.00	221,200	17,253		1.00
2.00		0.00	0	0		2.00
	0		221,200	17,253		
	I - RECLASS OF MISC DEPARTMENTS					
1.00	ADMINISTRATIVE & GENERAL	5.00	496,371	88,792		1.00
2.00	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	76.02	0	1,021		2.00
3.00	OTHER NONREIMB - SENIOR CIRCLE	194.02	0	5,640		3.00
	0		496,371	95,453		
	J - RECLASS OF OTHER RADIOLOGY COSTS					
1.00	RADIOLOGY-DIAGNOSTIC	54.00	667,556	541,258		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
	0		667,556	541,258		
	K - RECLASS OF A PORTION OF DIETARY COST					
1.00	CAFETERIA	11.00	0	945,890		1.00
	0		0	945,890		
	M - OB/GYN COSTS					
1.00	NURSERY	43.00	2,765	7,508		1.00
2.00	DELIVERY ROOM & LABOR ROOM	52.00	22,635	15,383		2.00
	0		25,400	22,891		
500.00	Grand Total: Increases		1,533,063	10,721,241		500.00

RECLASSIFICATIONS

Provider CCN: 14-0125

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

Worksheet A-6

Date/Time Prepared:
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	Decreases						
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	A - RECLASS OF EMPLOYEE BENEFITS						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	4,706,927	0		1.00
	0		0	4,706,927			
	B - RECLASS OF OXYGEN COSTS						
1.00	OPERATING ROOM	50.00	0	558	0		1.00
2.00	LABORATORY	60.00	0	119	0		2.00
3.00	RESPIRATORY THERAPY	65.00	0	77,828	0		3.00
4.00	EMERGENCY	91.00	0	15	0		4.00
	0		0	78,520			
	D - RECLASS OF OTHER CAPITAL COSTS						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	1,302,387	12		1.00
2.00		0.00	0	0	13		2.00
3.00		0.00	0	0	12		3.00
	0		0	1,302,387			
	E - RECLASS OF MARKETING DEPARTMENTS						
1.00	ADMINISTRATIVE & GENERAL	5.00	122,536	196,043	0		1.00
	0		122,536	196,043			
	F - RECLASS OF MEDICAL SUPPLIES						
1.00	OPERATING ROOM	50.00	0	1,590,013	0		1.00
2.00	ELECTROCARDIOLOGY	69.00	0	217,758	0		2.00
3.00		0.00	0	0	0		3.00
	0		0	1,807,771			
	G - RECLASS OF COST OF DRUGS/IV SOLUTION						
1.00	PHARMACY	15.00	0	1,006,848	0		1.00
	0		0	1,006,848			
	H - RECLASS OF PT, OT, AND SP COSTS						
1.00	OCCUPATIONAL THERAPY	67.00	127,675	10,254	0		1.00
2.00	SPEECH PATHOLOGY	68.00	93,525	6,999	0		2.00
	0		221,200	17,253			
	I - RECLASS OF MISC DEPARTMENTS						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	5,640	0		1.00
2.00	PHYSICAL THERAPY	66.00	0	1,021	0		2.00
3.00	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	76.02	496,371	88,792	0		3.00
	0		496,371	95,453			
	J - RECLASS OF OTHER RADIOLOGY COSTS						
1.00	ULTRA-SOUND	54.01	147,284	39,044	0		1.00
2.00	RADIOISOTOPE	56.00	79,108	72,158	0		2.00
3.00	CT SCAN	57.00	311,949	341,120	0		3.00
4.00	MRI	58.00	129,215	88,936	0		4.00
	0		667,556	541,258			
	K - RECLASS OF A PORTION OF DIETARY COST						
1.00	DIETARY	10.00	0	945,890	0		1.00
	0		0	945,890			
	M - OB/GYN COSTS						
1.00	ADULTS & PEDIATRICS	30.00	25,400	22,891	0		1.00
2.00		0.00	0	0	0		2.00
	0		25,400	22,891			
500.00	Grand Total: Decreases		1,533,063	10,721,241			500.00

500.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-0125

Period:
From 01/01/2020
To 12/31/2020Worksheet A-7
Part I
Date/Time Prepared:
7/30/2021 11:17 am

		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	2,950,173	362,212	0	362,212	0	1.00	
2.00	Land Improvements	2,945,972	23,323	0	23,323	0	2.00	
3.00	Buildings and Fixtures	4,086,204	97,111	0	97,111	14,740	3.00	
4.00	Building Improvements	34,298,174	447,528	0	447,528	31,534	4.00	
5.00	Fixed Equipment	8,377,994	731,804	0	731,804	466,890	5.00	
6.00	Movable Equipment	27,014,583	697,079	0	697,079	703,756	6.00	
7.00	HIT designated Assets	6,077,267	308,920	0	308,920	228,635	7.00	
8.00	Subtotal (sum of lines 1-7)	85,750,367	2,667,977	0	2,667,977	1,445,555	8.00	
9.00	Reconciling Items	0	0	0	0	0	9.00	
10.00	Total (line 8 minus line 9)	85,750,367	2,667,977	0	2,667,977	1,445,555	10.00	
		Ending Balance	Fully Depreciated Assets					
		6.00	7.00					
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES								
1.00	Land	3,312,385	0					1.00
2.00	Land Improvements	2,969,295	0					
3.00	Buildings and Fixtures	4,168,575	0					
4.00	Building Improvements	34,714,168	0					4.00
5.00	Fixed Equipment	8,642,908	0					
6.00	Movable Equipment	27,007,906	0					
7.00	HIT designated Assets	6,157,552	0					7.00
8.00	Subtotal (sum of lines 1-7)	86,972,789	0					
9.00	Reconciling Items	0	0					
10.00	Total (line 8 minus line 9)	86,972,789	0					10.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-0125

Period:
From 01/01/2020
To 12/31/2020Worksheet A-7
Part II
Date/Time Prepared:
7/30/2021 11:17 am

Cost Center Description		SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	CAP REL COSTS-BLDG & FIXT	1,809,944	0	0	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2,296,680	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	4,106,624	0	0	0	0	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Other	Total (1) (sum				
		Capital-Related Costs (see instructions)	of cols. 9 through 14)				
		14.00	15.00				
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	CAP REL COSTS-BLDG & FIXT	0	1,809,944				1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	2,296,680				2.00
3.00	Total (sum of lines 1-2)	0	4,106,624				3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-0125

Period:
From 01/01/2020
To 12/31/2020Worksheet A-7
Part III
Date/Time Prepared:
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Cost Center Description		COMPUTATION OF RATIOS			ALLOCATION OF OTHER CAPITAL		
		Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	
		1.00	2.00	3.00	4.00	5.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	45,164,423	0	45,164,423	0.519294	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	41,808,366	0	41,808,366	0.480706	0	2.00
3.00	Total (sum of lines 1-2)	86,972,789	0	86,972,789	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	1,912,426	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	2,353,957	0	2.00
3.00	Total (sum of lines 1-2)	0	0	0	4,266,383	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	0	239,999	1,049,068	0	3,201,493	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	13,320	0	0	2,367,277	2.00
3.00	Total (sum of lines 1-2)	0	253,319	1,049,068	0	5,568,770	3.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 14-0125

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

Worksheet A-8

Date/Time Prepared:
7/30/2021 11:17 am

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)	B	-342,310	CAP REL COSTS-BLDG & FIXT	1.00	9	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)	A	-48,783	ADMINISTRATIVE & GENERAL	5.00	0	7.00
8.00	Television and radio service (chapter 21)	A	0	ADMINISTRATIVE & GENERAL	5.00	0	8.00
9.00	Parking lot (chapter 21)		0		0.00	0	9.00
10.00	Provider-based physician adjustment	A-8-2	-9,263,245			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	-2,010,800			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests	B	-181,184	CAFETERIA	11.00	0	14.00
15.00	Rental of quarters to employee and others		0		0.00	0	15.00
16.00	Sale of medical and surgical supplies to other than patients		0		0.00	0	16.00
17.00	Sale of drugs to other than patients	B	0	DRUGS CHARGED TO PATIENTS	73.00	0	17.00
18.00	Sale of medical records and abstracts	B	-782	MEDICAL RECORDS & LIBRARY	16.00	0	18.00
19.00	Nursing and allied health education (tuition, fees, books, etc.)		0		0.00	0	19.00
20.00	Vending machines	B	-3,947	ADMINISTRATIVE & GENERAL	5.00	0	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	0	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	RESPIRATORY THERAPY	65.00		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	PHYSICAL THERAPY	66.00		24.00
25.00	Utilization review - physicians' compensation (chapter 21)		0	*** Cost Center Deleted ***	114.00		25.00
26.00	Depreciation - CAP REL COSTS-BLDG & FIXT	A	59,547	CAP REL COSTS-BLDG & FIXT	1.00	9	26.00
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP	A	32,192	CAP REL COSTS-MVBLE EQUIP	2.00	9	27.00
28.00	Non-physician Anesthetist		0	*** Cost Center Deleted ***	19.00		28.00
29.00	Physicians' assistant		0		0.00	0	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	OCCUPATIONAL THERAPY	67.00		30.00
30.99	Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS	30.00		30.99
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	SPEECH PATHOLOGY	68.00		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest		0		0.00	0	32.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 14-0125

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

Worksheet A-8

Date/Time Prepared:
7/30/2021 11:17 am

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	
33.00	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	33.00
33.01	PATIENT TRANSPORTATION	A	-1,596	ADMINISTRATIVE & GENERAL	5.00	0	33.01
33.02	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	33.02
33.03	OTHER MISC REVENUE	B	-30,946	ADMINISTRATIVE & GENERAL	5.00	0	33.03
33.05	PATIENT PHONES WAGE COST	A	-27,565	ADMINISTRATIVE & GENERAL	5.00	0	33.05
33.06	PATIENT PHONES BENEFIT COST	A	-6,427	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.06
33.07	PATIENT PHONES DEPRECIATION EXPENSE	A	-5,846	CAP REL COSTS-MVBLE EQUIP	2.00	9	33.07
33.08	PATIENT TV DEPRECIATION	A	-20,695	CAP REL COSTS-MVBLE EQUIP	2.00	9	33.08
33.09	MARKETING EXPENSE	A	-199,426	ADMINISTRATIVE & GENERAL	5.00	0	33.09
33.11	PHYSICIAN RECRUITING	A	-235,558	ADMINISTRATIVE & GENERAL	5.00	0	33.11
33.12	LOBBYING EXPENSES	A	-34,831	ADMINISTRATIVE & GENERAL	5.00	0	33.12
33.13	CHARITABLE CONTRIBUTIONS	A	-100	ADMINISTRATIVE & GENERAL	5.00	0	33.13
33.14	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	33.14
33.15	ILLINOIS PROVIDER TAX	A	-10,457,080	ADMINISTRATIVE & GENERAL	5.00	0	33.15
33.17	NON ALLOWABLE LEGAL FEES	A	-684	ADMINISTRATIVE & GENERAL	5.00	0	33.17
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-22,780,066				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: 14-0125

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

Worksheet A-8-1

Date/Time Prepared:
7/30/2021 11:17 am

	Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in wks. A, column 5	
	1.00	2.00	3.00	4.00	5.00	
A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:						
1.00		5.00	ADMINISTRATIVE & GENERAL	DIRECT ALLOCATION - QHR COST	11,965	0 1.00
2.00		5.00	ADMINISTRATIVE & GENERAL	POOLED ALLOCATION OF NON-CAP	790,852	0 2.00
3.00		1.00	CAP REL COSTS-BLDG & FIXT	NEW CAPITAL - BUILDING & FIX	385,245	0 3.00
4.00		2.00	CAP REL COSTS-MVBLE EQUIP	NEW CAPITAL - MOVABLE EQUIPM	51,626	0 4.00
4.01		5.00	ADMINISTRATIVE & GENERAL	NON-CAPITAL FUNCTIONAL ALLOC	2,770,099	0 4.01
4.02		5.00	ADMINISTRATIVE & GENERAL	MALPRACTICE COSTS	159,433	1,943,452 4.02
4.03		5.00	ADMINISTRATIVE & GENERAL	MANAGEMENT FEES	0	4,236,568 4.03
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.				4,169,220	6,180,020 5.00

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

	Symbol (1)	Name	Percentage of Ownership	Related Organization(s) and/or Home Office		
	1.00	2.00	3.00	Name	Percentage of Ownership	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	QHC, INC.	100.00	QHC, INC.	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: 14-0125

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

Worksheet A-8-1

Date/Time Prepared:
7/30/2021 11:17 am

	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	11,965	0		1.00
2.00	790,852	0		2.00
3.00	385,245	9		3.00
4.00	51,626	9		4.00
4.01	2,770,099	0		4.01
4.02	-1,784,019	0		4.02
4.03	-4,236,568	0		4.03
5.00	-2,010,800			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	HOSPITAL MANAGEMENT		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: 14-0125

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

Worksheet A-8-2

Date/Time Prepared:
7/30/2021 11:17 am

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	5.00	ADMINISTRATIVE & GENERAL	10,374	10,374	0	0	0	1.00
2.00	30.00	ADULTS & PEDIATRICS	2,421,879	2,421,879	0	0	0	2.00
3.00	31.00	INTENSIVE CARE UNIT	1,312,814	1,312,814	0	0	0	3.00
4.00	40.00	SUBPROVIDER - IPF	217,243	217,243	0	0	0	4.00
5.00	43.00	NURSERY	542,927	542,927	0	0	0	5.00
6.00	50.00	OPERATING ROOM	101,273	101,273	0	0	0	6.00
7.00	53.00	ANESTHESIOLOGY	1,353,901	1,353,901	0	0	0	7.00
8.00	54.00	RADIOLOGY-DIAGNOSTIC	183,401	183,401	0	0	0	8.00
9.00	60.00	LABORATORY	18,435	18,435	0	0	0	9.00
10.00	76.02	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	42,109	42,109	0	0	0	10.00
11.00	91.00	EMERGENCY	3,058,889	3,058,889	0	0	0	11.00
200.00			9,263,245	9,263,245	0	0	0	200.00
	Wkst. A Line #	Cost Center/Physician Identifier	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	5.00	ADMINISTRATIVE & GENERAL	0	0	0	0	0	1.00
2.00	30.00	ADULTS & PEDIATRICS	0	0	0	0	0	2.00
3.00	31.00	INTENSIVE CARE UNIT	0	0	0	0	0	3.00
4.00	40.00	SUBPROVIDER - IPF	0	0	0	0	0	4.00
5.00	43.00	NURSERY	0	0	0	0	0	5.00
6.00	50.00	OPERATING ROOM	0	0	0	0	0	6.00
7.00	53.00	ANESTHESIOLOGY	0	0	0	0	0	7.00
8.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	8.00
9.00	60.00	LABORATORY	0	0	0	0	0	9.00
10.00	76.02	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0	0	0	0	10.00
11.00	91.00	EMERGENCY	0	0	0	0	0	11.00
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	5.00	ADMINISTRATIVE & GENERAL	0	0	0	10,374		1.00
2.00	30.00	ADULTS & PEDIATRICS	0	0	0	2,421,879		2.00
3.00	31.00	INTENSIVE CARE UNIT	0	0	0	1,312,814		3.00
4.00	40.00	SUBPROVIDER - IPF	0	0	0	217,243		4.00
5.00	43.00	NURSERY	0	0	0	542,927		5.00
6.00	50.00	OPERATING ROOM	0	0	0	101,273		6.00
7.00	53.00	ANESTHESIOLOGY	0	0	0	1,353,901		7.00
8.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	183,401		8.00
9.00	60.00	LABORATORY	0	0	0	18,435		9.00
10.00	76.02	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0	0	42,109		10.00
11.00	91.00	EMERGENCY	0	0	0	3,058,889		11.00
200.00			0	0	0	9,263,245		200.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0125

Period:
From 01/01/2020
To 12/31/2020Worksheet B
Part I
Date/Time Prepared:
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Cost Center Description			CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
			Net Expenses for Cost Allocation (from Wkst A col. 7)	BLDG & FIXT	MVBLE EQUIP		
			0	1.00	2.00	4.00	4A
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT	3,201,493	3,201,493			1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	2,367,277		2,367,277		2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	5,036,104	11,980	10,256	5,058,340	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	17,572,797	356,362	305,086	691,382	5.00
7.00	00700	OPERATION OF PLANT	4,900,168	815,220	697,922	148,129	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	246,883	19,771	16,926	0	8.00
9.00	00900	HOUSEKEEPING	1,844,489	29,523	25,275	0	9.00
10.00	01000	DIETARY	860,617	43,831	37,524	0	10.00
11.00	01100	CAFETERIA	764,706	32,454	27,784	0	11.00
13.00	01300	NURSING ADMINISTRATION	3,190,571	1,190	1,019	366,890	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	411,517	35,956	30,782	31,417	14.00
15.00	01500	PHARMACY	1,681,003	25,638	21,949	219,657	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	98,408	102,473	87,729	9,384	16.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	8,256,521	373,113	319,427	1,102,464	30.00
31.00	03100	INTENSIVE CARE UNIT	1,603,430	113,357	97,047	177,851	31.00
40.00	04000	SUBPROVIDER - IPF	1,296,451	58,952	50,469	194,278	40.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	41.00
43.00	04300	NURSERY	50,776	4,677	4,004	4,096	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	44.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	3,828,037	187,938	160,896	246,183	50.00
51.00	05100	RECOVERY ROOM	254,984	8,111	6,944	30,571	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	420,744	32,276	27,631	43,970	52.00
53.00	05300	ANESTHESIOLOGY	112,173	2,580	2,208	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,204,708	134,539	115,181	424,955	54.00
54.01	05401	ULTRA-SOUND	0	0	0	0	54.01
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
60.00	06000	LABORATORY	5,001,133	45,729	39,149	449,356	60.00
65.00	06500	RESPIRATORY THERAPY	814,009	37,429	32,044	104,210	65.00
66.00	06600	PHYSICAL THERAPY	1,292,760	88,301	75,596	181,152	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	1,625,309	25,806	22,093	114,705	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	390,284	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1,332,035	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,006,848	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	150,431	0	0	0	74.00
76.00	03020	ACUPUNCTURE	0	0	0	0	76.00
76.01	03610	SLEEP LAB	404,010	35,201	30,136	34,139	76.01
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	106,755	18,193	15,575	13,346	76.02
76.03	03950	WOUND CARE	188,458	14,297	12,240	23,871	76.03
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	187,616	44,014	37,681	11,921	90.00
91.00	09100	EMERGENCY	4,175,276	52,833	45,231	408,274	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					92.00
SPECIAL PURPOSE COST CENTERS							
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	78,878,781	2,751,744	2,355,804	5,032,201	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	3,586	3,070	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	388,198	436,348	0	0	192.00
194.00	07950	OTHER NONREIMB - NONPAID WORKERS	0	0	0	0	194.00
194.01	07951	OTHER NONREIMB - MARKETING	318,579	9,815	8,403	20,449	194.01
194.02	07952	OTHER NONREIMB - SENIOR CIRCLE	58,011	0	0	5,690	194.02
194.03	07953	OTHER NONREIMB - INDUSTRIAL MEDICINE	0	0	0	0	194.03
200.00		Cross Foot Adjustments					200.00
201.00		Negative Cost Centers					201.00
202.00		TOTAL (sum lines 118 through 201)	79,643,569	3,201,493	2,367,277	5,058,340	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0125

Period:
From 01/01/2020
To 12/31/2020Worksheet B
Part I
Date/Time Prepared:
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Cost Center Description			ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
			5.00	7.00	8.00	9.00	10.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	18,925,627					5.00
7.00	00700	OPERATION OF PLANT	2,045,181	8,606,620				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	88,391	107,590	479,561			8.00
9.00	00900	HOUSEKEEPING	592,002	160,657	0	2,651,946		9.00
10.00	01000	DIETARY	293,610	238,518	0	59,045	1,533,145	10.00
11.00	01100	CAFETERIA	257,133	176,606	0	43,718	0	11.00
13.00	01300	NURSING ADMINISTRATION	1,109,538	6,477	0	1,603	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	158,863	195,665	0	48,436	0	14.00
15.00	01500	PHARMACY	607,263	139,516	0	34,537	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	92,884	557,636	0	138,041	0	16.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	3,133,056	2,030,397	321,409	502,620	983,932	30.00
31.00	03100	INTENSIVE CARE UNIT	620,802	616,866	20,407	152,704	52,176	31.00
40.00	04000	SUBPROVIDER - IPF	498,762	320,801	51,017	79,413	162,744	40.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
43.00	04300	NURSERY	19,809	25,450	0	6,300	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	1,378,653	1,022,717	35,711	253,171	0	50.00
51.00	05100	RECOVERY ROOM	93,699	44,137	0	10,926	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	163,523	175,636	0	43,478	4,314	52.00
53.00	05300	ANESTHESIOLOGY	36,456	14,037	0	3,475	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,520,889	732,130	0	181,237	0	54.00
54.01	05401	ULTRA-SOUND	0	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
60.00	06000	LABORATORY	1,725,357	248,846	0	61,601	0	60.00
65.00	06500	RESPIRATORY THERAPY	307,861	203,682	0	50,421	0	65.00
66.00	06600	PHYSICAL THERAPY	510,500	480,517	0	118,951	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	557,287	140,429	0	34,763	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	121,650	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	415,191	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	313,832	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	46,889	0	0	0	0	74.00
76.00	03020	ACUPUNCTURE	0	0	0	0	0	76.00
76.01	03610	SLEEP LAB	156,935	191,556	0	47,419	0	76.01
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	47,961	99,002	0	24,508	0	76.02
76.03	03950	WOUND CARE	74,454	77,804	0	19,260	0	76.03
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	87,659	239,517	0	59,292	0	90.00
91.00	09100	EMERGENCY	1,459,245	287,506	51,017	71,171	19,334	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	18,535,335	8,533,695	479,561	2,046,090	1,222,500	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	2,075	19,515	0	4,831	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	257,009	0	0	587,804	212,307	192.00
194.00	07950	OTHER NONREIMB - NONPAID WORKERS	0	0	0	0	0	194.00
194.01	07951	OTHER NONREIMB - MARKETING	111,353	53,410	0	13,221	0	194.01
194.02	07952	OTHER NONREIMB - SENIOR CIRCLE	19,855	0	0	0	0	194.02
194.03	07953	OTHER NONREIMB - INDUSTRIAL MEDICINE	0	0	0	0	98,338	194.03
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	18,925,627	8,606,620	479,561	2,651,946	1,533,145	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0125

Period:
From 01/01/2020
To 12/31/2020Worksheet B
Part I
Date/Time Prepared:
7/30/2021 11:17 am

Cost Center Description			CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
			11.00	13.00	14.00	15.00	16.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA	1,302,401					11.00
13.00	01300	NURSING ADMINISTRATION	95,103	4,772,391				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	16,123	0	928,759			14.00
15.00	01500	PHARMACY	55,903	412,380	22,026	3,219,872		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	2,318	0	3,953	0	1,092,826	16.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	358,256	2,069,741	41,245	0	192,415	30.00
31.00	03100	INTENSIVE CARE UNIT	44,041	333,895	24,261	0	22,186	31.00
40.00	04000	SUBPROVIDER - IPF	54,403	364,734	2,763	0	30,367	40.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
43.00	04300	NURSERY	989	7,689	211	0	317	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	70,219	462,179	275,050	0	106,847	50.00
51.00	05100	RECOVERY ROOM	7,090	57,393	2,237	0	15,351	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	29,076	82,547	82	0	882	52.00
53.00	05300	ANESTHESIOLOGY	0	0	13,201	0	21,158	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	139,825	0	24,084	0	89,233	54.00
54.01	05401	ULTRA-SOUND	0	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
60.00	06000	LABORATORY	162,152	0	115,053	0	228,101	60.00
65.00	06500	RESPIRATORY THERAPY	34,530	0	19,953	0	29,437	65.00
66.00	06600	PHYSICAL THERAPY	53,176	0	1,185	0	21,256	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	30,338	215,345	53,205	0	60,560	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	12,739	0	7,551	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	200,845	0	14,310	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	3,219,872	32,109	73.00
74.00	07400	RENAL DIALYSIS	0	0	10	0	4,675	74.00
76.00	03020	ACUPUNCTURE	0	0	0	0	0	76.00
76.01	03610	SLEEP LAB	10,294	0	5,691	0	2,385	76.01
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	7,056	0	439	0	3,834	76.02
76.03	03950	WOUND CARE	8,965	0	5,772	0	1,568	76.03
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	3,886	0	0	0	8,415	90.00
91.00	09100	EMERGENCY	112,215	766,488	101,108	0	199,869	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	1,295,958	4,772,391	925,113	3,219,872	1,092,826	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07950	OTHER NONREIMB - NONPAID WORKERS	0	0	0	0	0	194.00
194.01	07951	OTHER NONREIMB - MARKETING	4,261	0	0	0	0	194.01
194.02	07952	OTHER NONREIMB - SENIOR CIRCLE	2,182	0	3,646	0	0	194.02
194.03	07953	OTHER NONREIMB - INDUSTRIAL MEDICINE	0	0	0	0	0	194.03
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	1,302,401	4,772,391	928,759	3,219,872	1,092,826	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0125

Period:
From 01/01/2020
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Cost Center Description			Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			24.00	25.00	26.00	
GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT				4.00
5.00	00500	ADMINISTRATIVE & GENERAL				5.00
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	19,684,596	0	19,684,596	30.00
31.00	03100	INTENSIVE CARE UNIT	3,879,023	0	3,879,023	31.00
40.00	04000	SUBPROVIDER - IPF	3,165,154	0	3,165,154	40.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	41.00
43.00	04300	NURSERY	124,318	0	124,318	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	44.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	8,027,601	0	8,027,601	50.00
51.00	05100	RECOVERY ROOM	531,443	0	531,443	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,024,159	0	1,024,159	52.00
53.00	05300	ANESTHESIOLOGY	205,288	0	205,288	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	7,566,781	0	7,566,781	54.00
54.01	05401	ULTRA-SOUND	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	57.00
58.00	05800	MRI	0	0	0	58.00
60.00	06000	LABORATORY	8,076,477	0	8,076,477	60.00
65.00	06500	RESPIRATORY THERAPY	1,633,576	0	1,633,576	65.00
66.00	06600	PHYSICAL THERAPY	2,823,394	0	2,823,394	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	2,879,840	0	2,879,840	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	532,224	0	532,224	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1,962,381	0	1,962,381	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	4,572,661	0	4,572,661	73.00
74.00	07400	RENAL DIALYSIS	202,005	0	202,005	74.00
76.00	03020	ACUPUNCTURE	0	0	0	76.00
76.01	03610	SLEEP LAB	917,766	0	917,766	76.01
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	336,669	0	336,669	76.02
76.03	03950	WOUND CARE	426,689	0	426,689	76.03
OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	680,001	0	680,001	90.00
91.00	09100	EMERGENCY	7,749,567	0	7,749,567	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART		0		92.00
SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	77,001,613	0	77,001,613	118.00
NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	33,077	0	33,077	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	1,881,666	0	1,881,666	192.00
194.00	07950	OTHER NONREIMB - NONPAID WORKERS	0	0	0	194.00
194.01	07951	OTHER NONREIMB - MARKETING	539,491	0	539,491	194.01
194.02	07952	OTHER NONREIMB - SENIOR CIRCLE	89,384	0	89,384	194.02
194.03	07953	OTHER NONREIMB - INDUSTRIAL MEDICINE	98,338	0	98,338	194.03
200.00		Cross Foot Adjustments	0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	79,643,569	0	79,643,569	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0125

Period:
From 01/01/2020
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Cost Center Description		Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
			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	11,980	10,256	22,236	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	0	356,362	305,086	661,448	5.00
7.00	00700	OPERATION OF PLANT	0	815,220	697,922	1,513,142	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	19,771	16,926	36,697	8.00
9.00	00900	HOUSEKEEPING	0	29,523	25,275	54,798	9.00
10.00	01000	DIETARY	0	43,831	37,524	81,355	10.00
11.00	01100	CAFETERIA	0	32,454	27,784	60,238	11.00
13.00	01300	NURSING ADMINISTRATION	0	1,190	1,019	2,209	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	35,956	30,782	66,738	14.00
15.00	01500	PHARMACY	0	25,638	21,949	47,587	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	102,473	87,729	190,202	16.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	0	373,113	319,427	692,540	30.00
31.00	03100	INTENSIVE CARE UNIT	0	113,357	97,047	210,404	31.00
40.00	04000	SUBPROVIDER - IPF	0	58,952	50,469	109,421	40.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	41.00
43.00	04300	NURSERY	0	4,677	4,004	8,681	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	44.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	187,938	160,896	348,834	50.00
51.00	05100	RECOVERY ROOM	0	8,111	6,944	15,055	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	32,276	27,631	59,907	52.00
53.00	05300	ANESTHESIOLOGY	0	2,580	2,208	4,788	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	134,539	115,181	249,720	54.00
54.01	05401	ULTRA-SOUND	0	0	0	0	54.01
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
60.00	06000	LABORATORY	0	45,729	39,149	84,878	60.00
65.00	06500	RESPIRATORY THERAPY	0	37,429	32,044	69,473	65.00
66.00	06600	PHYSICAL THERAPY	0	88,301	75,596	163,897	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	25,806	22,093	47,899	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	74.00
76.00	03020	ACUPUNCTURE	0	0	0	0	76.00
76.01	03610	SLEEP LAB	0	35,201	30,136	65,337	76.01
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	18,193	15,575	33,768	76.02
76.03	03950	WOUND CARE	0	14,297	12,240	26,537	76.03
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0	44,014	37,681	81,695	90.00
91.00	09100	EMERGENCY	0	52,833	45,231	98,064	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				0	92.00
SPECIAL PURPOSE COST CENTERS							
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	2,751,744	2,355,804	5,107,548	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	3,586	3,070	6,656	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	436,348	0	436,348	192.00
194.00	07950	OTHER NONREIMB - NONPAID WORKERS	0	0	0	0	194.00
194.01	07951	OTHER NONREIMB - MARKETING	0	9,815	8,403	18,218	194.01
194.02	07952	OTHER NONREIMB - SENIOR CIRCLE	0	0	0	0	194.02
194.03	07953	OTHER NONREIMB - INDUSTRIAL MEDICINE	0	0	0	0	194.03
200.00		Cross Foot Adjustments				0	200.00
201.00		Negative Cost Centers				0	201.00
202.00		TOTAL (sum lines 118 through 201)	0	3,201,493	2,367,277	5,568,770	202.00

ALLOCATION OF CAPITAL RELATED COSTS

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Cost Center Description			ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
			5.00	7.00	8.00	9.00	10.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	664,489					5.00
7.00	00700	OPERATION OF PLANT	71,808	1,585,602				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	3,103	19,821	59,621			8.00
9.00	00900	HOUSEKEEPING	20,786	29,598	0	105,182		9.00
10.00	01000	DIETARY	10,309	43,942	0	2,342	137,948	10.00
11.00	01100	CAFETERIA	9,028	32,536	0	1,734	0	11.00
13.00	01300	NURSING ADMINISTRATION	38,957	1,193	0	64	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	5,578	36,047	0	1,921	0	14.00
15.00	01500	PHARMACY	21,322	25,703	0	1,370	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	3,261	102,734	0	5,475	0	16.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	109,996	374,064	39,958	19,935	88,531	30.00
31.00	03100	INTENSIVE CARE UNIT	21,797	113,645	2,537	6,057	4,695	31.00
40.00	04000	SUBPROVIDER - IPF	17,512	59,101	6,343	3,150	14,643	40.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
43.00	04300	NURSERY	696	4,689	0	250	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	48,406	188,416	4,440	10,041	0	50.00
51.00	05100	RECOVERY ROOM	3,290	8,131	0	433	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	5,741	32,358	0	1,724	388	52.00
53.00	05300	ANESTHESIOLOGY	1,280	2,586	0	138	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	53,400	134,881	0	7,188	0	54.00
54.01	05401	ULTRA-SOUND	0	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
60.00	06000	LABORATORY	60,579	45,845	0	2,443	0	60.00
65.00	06500	RESPIRATORY THERAPY	10,809	37,524	0	2,000	0	65.00
66.00	06600	PHYSICAL THERAPY	17,924	88,526	0	4,718	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	19,567	25,871	0	1,379	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	4,271	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	14,578	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	11,019	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	1,646	0	0	0	0	74.00
76.00	03020	ACUPUNCTURE	0	0	0	0	0	76.00
76.01	03610	SLEEP LAB	5,510	35,290	0	1,881	0	76.01
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	1,684	18,239	0	972	0	76.02
76.03	03950	WOUND CARE	2,614	14,334	0	764	0	76.03
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	3,078	44,126	0	2,352	0	90.00
91.00	09100	EMERGENCY	51,236	52,967	6,343	2,823	1,740	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	650,785	1,572,167	59,621	81,154	109,997	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	73	3,595	0	192	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	9,024	0	0	23,312	19,103	192.00
194.00	07950	OTHER NONREIMB - NONPAID WORKERS	0	0	0	0	0	194.00
194.01	07951	OTHER NONREIMB - MARKETING	3,910	9,840	0	524	0	194.01
194.02	07952	OTHER NONREIMB - SENIOR CIRCLE	697	0	0	0	0	194.02
194.03	07953	OTHER NONREIMB - INDUSTRIAL MEDICINE	0	0	0	0	8,848	194.03
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)	664,489	1,585,602	59,621	105,182	137,948	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0125

Period:
From 01/01/2020
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Cost Center Description			CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
			11.00	13.00	14.00	15.00	16.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA	103,536					11.00
13.00	01300	NURSING ADMINISTRATION	7,560	51,597				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	1,282	0	111,704			14.00
15.00	01500	PHARMACY	4,444	4,458	2,649	108,499		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	184	0	475	0	302,372	16.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	28,479	22,380	4,961	0	53,201	30.00
31.00	03100	INTENSIVE CARE UNIT	3,501	3,610	2,918	0	6,134	31.00
40.00	04000	SUBPROVIDER - IPF	4,325	3,943	332	0	8,396	40.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
43.00	04300	NURSERY	79	83	25	0	88	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	5,582	4,997	33,079	0	29,542	50.00
51.00	05100	RECOVERY ROOM	564	620	269	0	4,245	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	2,311	892	10	0	244	52.00
53.00	05300	ANESTHESIOLOGY	0	0	1,588	0	5,850	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	11,116	0	2,897	0	24,672	54.00
54.01	05401	ULTRA-SOUND	0	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
60.00	06000	LABORATORY	12,891	0	13,838	0	63,281	60.00
65.00	06500	RESPIRATORY THERAPY	2,745	0	2,400	0	8,139	65.00
66.00	06600	PHYSICAL THERAPY	4,227	0	143	0	5,877	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	2,412	2,328	6,399	0	16,744	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	1,532	0	2,088	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	24,156	0	3,957	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	108,499	8,878	73.00
74.00	07400	RENAL DIALYSIS	0	0	1	0	1,293	74.00
76.00	03020	ACUPUNCTURE	0	0	0	0	0	76.00
76.01	03610	SLEEP LAB	818	0	685	0	660	76.01
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	561	0	53	0	1,060	76.02
76.03	03950	WOUND CARE	713	0	694	0	434	76.03
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	309	0	0	0	2,327	90.00
91.00	09100	EMERGENCY	8,921	8,286	12,161	0	55,262	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	103,024	51,597	111,265	108,499	302,372	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07950	OTHER NONREIMB - NONPAID WORKERS	0	0	0	0	0	194.00
194.01	07951	OTHER NONREIMB - MARKETING	339	0	0	0	0	194.01
194.02	07952	OTHER NONREIMB - SENIOR CIRCLE	173	0	439	0	0	194.02
194.03	07953	OTHER NONREIMB - INDUSTRIAL MEDICINE	0	0	0	0	0	194.03
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	103,536	51,597	111,704	108,499	302,372	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0125

Period:
From 01/01/2020
To 12/31/2020Worksheet B
Part II
Date/Time Prepared:
7/30/2021 11:17 am

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	1,438,882	0	1,438,882	30.00
31.00	03100	INTENSIVE CARE UNIT	376,080	0	376,080	31.00
40.00	04000	SUBPROVIDER - IPF	228,021	0	228,021	40.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	41.00
43.00	04300	NURSERY	14,609	0	14,609	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	44.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	674,420	0	674,420	50.00
51.00	05100	RECOVERY ROOM	32,741	0	32,741	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	103,768	0	103,768	52.00
53.00	05300	ANESTHESIOLOGY	16,230	0	16,230	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	485,743	0	485,743	54.00
54.01	05401	ULTRA-SOUND	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	57.00
58.00	05800	MRI	0	0	0	58.00
60.00	06000	LABORATORY	285,731	0	285,731	60.00
65.00	06500	RESPIRATORY THERAPY	133,548	0	133,548	65.00
66.00	06600	PHYSICAL THERAPY	286,109	0	286,109	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	123,104	0	123,104	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	7,891	0	7,891	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	42,691	0	42,691	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	128,396	0	128,396	73.00
74.00	07400	RENAL DIALYSIS	2,940	0	2,940	74.00
76.00	03020	ACUPUNCTURE	0	0	0	76.00
76.01	03610	SLEEP LAB	110,331	0	110,331	76.01
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	56,396	0	56,396	76.02
76.03	03950	WOUND CARE	46,195	0	46,195	76.03
OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	133,939	0	133,939	90.00
91.00	09100	EMERGENCY	299,599	0	299,599	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART		0		92.00
SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	5,027,364	0	5,027,364	118.00
NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	10,516	0	10,516	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	487,787	0	487,787	192.00
194.00	07950	OTHER NONREIMB - NONPAID WORKERS	0	0	0	194.00
194.01	07951	OTHER NONREIMB - MARKETING	32,921	0	32,921	194.01
194.02	07952	OTHER NONREIMB - SENIOR CIRCLE	1,334	0	1,334	194.02
194.03	07953	OTHER NONREIMB - INDUSTRIAL MEDICINE	8,848	0	8,848	194.03
200.00		Cross Foot Adjustments	0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	5,568,770	0	5,568,770	202.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0125

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

Worksheet B-1

Date/Time Prepared:
7/30/2021 11:17 am

Cost Center Description			CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
			BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (SQUARE FEET)				
			1.00	2.00	4.00	5A	5.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT	610,630					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		527,404				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	2,285	2,285	30,311,215			4.00
5.00	00500	ADMINISTRATIVE & GENERAL	67,970	67,970	4,142,986	-18,925,627	60,717,942	5.00
7.00	00700	OPERATION OF PLANT	155,489	155,489	887,637	0	6,561,439	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	3,771	3,771	0	0	283,580	8.00
9.00	00900	HOUSEKEEPING	5,631	5,631	0	0	1,899,287	9.00
10.00	01000	DIETARY	8,360	8,360	0	0	941,972	10.00
11.00	01100	CAFETERIA	6,190	6,190	0	0	824,944	11.00
13.00	01300	NURSING ADMINISTRATION	227	227	2,198,527	0	3,559,670	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	6,858	6,858	188,264	0	509,672	14.00
15.00	01500	PHARMACY	4,890	4,890	1,316,256	0	1,948,247	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	19,545	19,545	56,234	0	297,994	16.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	71,165	71,165	6,606,307	0	10,051,525	30.00
31.00	03100	INTENSIVE CARE UNIT	21,621	21,621	1,065,741	0	1,991,685	31.00
40.00	04000	SUBPROVIDER - IPF	11,244	11,244	1,164,176	0	1,600,150	40.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
43.00	04300	NURSERY	892	892	24,542	0	63,553	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	35,846	35,846	1,475,207	0	4,423,054	50.00
51.00	05100	RECOVERY ROOM	1,547	1,547	183,190	0	300,610	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	6,156	6,156	263,480	0	524,621	52.00
53.00	05300	ANESTHESIOLOGY	492	492	0	0	116,961	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	25,661	25,661	2,546,472	0	4,879,383	54.00
54.01	05401	ULTRA-SOUND	0	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
60.00	06000	LABORATORY	8,722	8,722	2,692,689	0	5,535,367	60.00
65.00	06500	RESPIRATORY THERAPY	7,139	7,139	624,459	0	987,692	65.00
66.00	06600	PHYSICAL THERAPY	16,842	16,842	1,085,525	0	1,637,809	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	4,922	4,922	687,348	0	1,787,913	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	390,284	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	1,332,035	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	1,006,848	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	150,431	74.00
76.00	03020	ACUPUNCTURE	0	0	0	0	0	76.00
76.01	03610	SLEEP LAB	6,714	6,714	204,573	0	503,486	76.01
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	3,470	3,470	79,973	0	153,869	76.02
76.03	03950	WOUND CARE	2,727	2,727	143,043	0	238,866	76.03
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	8,395	8,395	71,437	0	281,232	90.00
91.00	09100	EMERGENCY	10,077	10,077	2,446,514	0	4,681,614	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	524,848	524,848	30,154,580	-18,925,627	59,465,793	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	684	684	0	0	6,656	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	83,226	0	0	0	824,546	192.00
194.00	07950	OTHER NONREIMB - NONPAID WORKERS	0	0	0	0	0	194.00
194.01	07951	OTHER NONREIMB - MARKETING	1,872	1,872	122,536	0	357,246	194.01
194.02	07952	OTHER NONREIMB - SENIOR CIRCLE	0	0	34,099	0	63,701	194.02
194.03	07953	OTHER NONREIMB - INDUSTRIAL MEDICINE	0	0	0	0	0	194.03
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	3,201,493	2,367,277	5,058,340		18,925,627	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	5.242934	4.488546	0.166880		0.311697	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)			22,236		664,489	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)			0.000734		0.010944	205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)						206.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0125

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

Worksheet B-1

Date/Time Prepared:
7/30/2021 11:17 am

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

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0125

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

Worksheet B-1

Date/Time Prepared:
7/30/2021 11:17 am

Cost Center Description			OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS)	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	301,660					7.00
8.00	00800	LAUNDRY & LINEN SERVICE	3,771	341,306				8.00
9.00	00900	HOUSEKEEPING	5,631	0	375,484			9.00
10.00	01000	DIETARY	8,360	0	8,360	137,899		10.00
11.00	01100	CAFETERIA	6,190	0	6,190	0	38,208	11.00
13.00	01300	NURSING ADMINISTRATION	227	0	227	0	2,790	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	6,858	0	6,858	0	473	14.00
15.00	01500	PHARMACY	4,890	0	4,890	0	1,640	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	19,545	0	19,545	0	68	16.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	71,165	228,748	71,165	88,500	10,510	30.00
31.00	03100	INTENSIVE CARE UNIT	21,621	14,524	21,621	4,693	1,292	31.00
40.00	04000	SUBPROVIDER - IPF	11,244	36,309	11,244	14,638	1,596	40.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
43.00	04300	NURSERY	892	0	892	0	29	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	35,846	25,416	35,846	0	2,060	50.00
51.00	05100	RECOVERY ROOM	1,547	0	1,547	0	208	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	6,156	0	6,156	388	853	52.00
53.00	05300	ANESTHESIOLOGY	492	0	492	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	25,661	0	25,661	0	4,102	54.00
54.01	05401	ULTRA-SOUND	0	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
60.00	06000	LABORATORY	8,722	0	8,722	0	4,757	60.00
65.00	06500	RESPIRATORY THERAPY	7,139	0	7,139	0	1,013	65.00
66.00	06600	PHYSICAL THERAPY	16,842	0	16,842	0	1,560	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	4,922	0	4,922	0	890	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.00	03020	ACUPUNCTURE	0	0	0	0	0	76.00
76.01	03610	SLEEP LAB	6,714	0	6,714	0	302	76.01
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	3,470	0	3,470	0	207	76.02
76.03	03950	WOUND CARE	2,727	0	2,727	0	263	76.03
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	8,395	0	8,395	0	114	90.00
91.00	09100	EMERGENCY	10,077	36,309	10,077	1,739	3,292	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	299,104	341,306	289,702	109,958	38,019	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	684	0	684	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	83,226	19,096	0	192.00
194.00	07950	OTHER NONREIMB - NONPAID WORKERS	0	0	0	0	0	194.00
194.01	07951	OTHER NONREIMB - MARKETING	1,872	0	1,872	0	125	194.01
194.02	07952	OTHER NONREIMB - SENIOR CIRCLE	0	0	0	0	64	194.02
194.03	07953	OTHER NONREIMB - INDUSTRIAL MEDICINE	0	0	0	8,845	0	194.03
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	8,606,620	479,561	2,651,946	1,533,145	1,302,401	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	28.530863	1.405076	7.062740	11.117883	34.087128	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	1,585,602	59,621	105,182	137,948	103,536	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	5.256255	0.174685	0.280124	1.000355	2.709799	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: 14-0125

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

Worksheet B-1

Date/Time Prepared:
7/30/2021 11:17 am

Cost Center Description			NURSING ADMINISTRATION (NURSING SALARIE)	CENTRAL SERVICES & SUPPLY (COSTED REQ S)	PHARMACY (COSTED REQ S)	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)	
			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	15,232,760				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	4,511,683			14.00
15.00	01500	PHARMACY	1,316,256	106,999	1,006,848		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	19,205	0	665,643,041	16.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	6,606,307	200,357	0	117,183,467	30.00
31.00	03100	INTENSIVE CARE UNIT	1,065,741	117,854	0	13,511,677	31.00
40.00	04000	SUBPROVIDER - IPF	1,164,176	13,420	0	18,494,161	40.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	41.00
43.00	04300	NURSERY	24,542	1,023	0	192,770	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	44.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	1,475,207	1,336,118	0	65,071,178	50.00
51.00	05100	RECOVERY ROOM	183,190	10,869	0	9,349,208	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	263,479	396	0	537,430	52.00
53.00	05300	ANESTHESIOLOGY	0	64,129	0	12,885,753	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	116,992	0	54,343,831	54.00
54.01	05401	ULTRA-SOUND	0	0	0	0	54.01
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
60.00	06000	LABORATORY	0	558,900	0	139,012,968	60.00
65.00	06500	RESPIRATORY THERAPY	0	96,929	0	17,927,399	65.00
66.00	06600	PHYSICAL THERAPY	0	5,757	0	12,945,168	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	687,348	258,459	0	36,881,915	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	61,883	0	4,598,596	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	975,658	0	8,715,110	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	1,006,848	19,554,745	73.00
74.00	07400	RENAL DIALYSIS	0	48	0	2,847,389	74.00
76.00	03020	ACUPUNCTURE	0	0	0	0	76.00
76.01	03610	SLEEP LAB	0	27,647	0	1,452,683	76.01
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	2,131	0	2,334,956	76.02
76.03	03950	WOUND CARE	0	28,038	0	954,929	76.03
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0	0	0	5,124,730	90.00
91.00	09100	EMERGENCY	2,446,514	491,158	0	121,722,978	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					92.00
SPECIAL PURPOSE COST CENTERS							
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	15,232,760	4,493,970	1,006,848	665,643,041	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	OTHER NONREIMB - NONPAID WORKERS	0	0	0	0	194.00
194.01	07951	OTHER NONREIMB - MARKETING	0	0	0	0	194.01
194.02	07952	OTHER NONREIMB - SENIOR CIRCLE	0	17,713	0	0	194.02
194.03	07953	OTHER NONREIMB - INDUSTRIAL MEDICINE	0	0	0	0	194.03
200.00		Cross Foot Adjustments					200.00
201.00		Negative Cost Centers					201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	4,772,391	928,759	3,219,872	1,092,826	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.313298	0.205856	3.197972	0.001642	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	51,597	111,704	108,499	302,372	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.003387	0.024759	0.107761	0.000454	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: 14-0125

Period:
From 01/01/2020
To 12/31/2020Worksheet C
Part I
Date/Time Prepared:
7/30/2021 11:17 am

				Title XVIII		Hospital		PPS	
Cost Center Description			Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs				
					Total Costs	RCE		Total Costs	
						Disallowance			
			1.00	2.00	3.00	4.00	5.00		
INPATIENT ROUTINE SERVICE COST CENTERS									
30.00	03000	ADULTS & PEDIATRICS	19,684,596		19,684,596	0	19,684,596	30.00	
31.00	03100	INTENSIVE CARE UNIT	3,879,023		3,879,023	0	3,879,023	31.00	
40.00	04000	SUBPROVIDER - IPF	3,165,154		3,165,154	0	3,165,154	40.00	
41.00	04100	SUBPROVIDER - IRF	0		0	0	0	41.00	
43.00	04300	NURSERY	124,318		124,318	0	124,318	43.00	
44.00	04400	SKILLED NURSING FACILITY	0		0	0	0	44.00	
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM	8,027,601		8,027,601	0	8,027,601	50.00	
51.00	05100	RECOVERY ROOM	531,443		531,443	0	531,443	51.00	
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,024,159		1,024,159	0	1,024,159	52.00	
53.00	05300	ANESTHESIOLOGY	205,288		205,288	0	205,288	53.00	
54.00	05400	RADIOLOGY-DIAGNOSTIC	7,566,781		7,566,781	0	7,566,781	54.00	
54.01	05401	ULTRA-SOUND	0		0	0	0	54.01	
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	
60.00	06000	LABORATORY	8,076,477		8,076,477	0	8,076,477	60.00	
65.00	06500	RESPIRATORY THERAPY	1,633,576	0	1,633,576	0	1,633,576	65.00	
66.00	06600	PHYSICAL THERAPY	2,823,394	0	2,823,394	0	2,823,394	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	2,879,840		2,879,840	0	2,879,840	69.00	
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	532,224		532,224	0	532,224	71.00	
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1,962,381		1,962,381	0	1,962,381	72.00	
73.00	07300	DRUGS CHARGED TO PATIENTS	4,572,661		4,572,661	0	4,572,661	73.00	
74.00	07400	RENAL DIALYSIS	202,005		202,005	0	202,005	74.00	
76.00	03020	ACUPUNCTURE	0		0	0	0	76.00	
76.01	03610	SLEEP LAB	917,766		917,766	0	917,766	76.01	
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	336,669		336,669	0	336,669	76.02	
76.03	03950	WOUND CARE	426,689		426,689	0	426,689	76.03	
OUTPATIENT SERVICE COST CENTERS									
90.00	09000	CLINIC	680,001		680,001	0	680,001	90.00	
91.00	09100	EMERGENCY	7,749,567		7,749,567	0	7,749,567	91.00	
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1,956,857		1,956,857	0	1,956,857	92.00	
200.00		Subtotal (see instructions)	78,958,470	0	78,958,470	0	78,958,470	200.00	
201.00		Less Observation Beds	1,956,857		1,956,857	0	1,956,857	201.00	
202.00		Total (see instructions)	77,001,613	0	77,001,613	0	77,001,613	202.00	

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0125

Period:
From 01/01/2020
To 12/31/2020Worksheet C
Part I
Date/Time Prepared:
7/30/2021 11:17 am

			Title XVIII		Hospital		7/30/2021 11:17 am 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	108,654,956		108,654,956			30.00
31.00	03100	INTENSIVE CARE UNIT	13,511,677		13,511,677			31.00
40.00	04000	SUBPROVIDER - IPF	18,494,161		18,494,161			40.00
41.00	04100	SUBPROVIDER - IRF	0		0			41.00
43.00	04300	NURSERY	192,770		192,770			43.00
44.00	04400	SKILLED NURSING FACILITY	0		0			44.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	15,390,303	49,680,875	65,071,178	0.123366	0.000000	50.00
51.00	05100	RECOVERY ROOM	2,109,589	7,239,619	9,349,208	0.056844	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	534,506	2,924	537,430	1.905660	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	3,342,143	9,543,610	12,885,753	0.015931	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	9,372,771	44,971,060	54,343,831	0.139239	0.000000	54.00
54.01	05401	ULTRA-SOUND	0	0	0	0.000000	0.000000	54.01
56.00	05600	RADIOISOTOPE	0	0	0	0.000000	0.000000	56.00
57.00	05700	CT SCAN	0	0	0	0.000000	0.000000	57.00
58.00	05800	MRI	0	0	0	0.000000	0.000000	58.00
60.00	06000	LABORATORY	40,206,467	98,806,501	139,012,968	0.058099	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	15,177,752	2,749,647	17,927,399	0.091122	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	2,219,130	10,726,038	12,945,168	0.218104	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0.000000	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0.000000	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	16,247,633	20,634,282	36,881,915	0.078083	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	4,150,725	447,871	4,598,596	0.115736	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	3,602,551	5,112,559	8,715,110	0.225170	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	13,167,186	6,387,559	19,554,745	0.233839	0.000000	73.00
74.00	07400	RENAL DIALYSIS	2,698,284	149,105	2,847,389	0.070944	0.000000	74.00
76.00	03020	ACUPUNCTURE	0	0	0	0.000000	0.000000	76.00
76.01	03610	SLEEP LAB	0	1,452,683	1,452,683	0.631773	0.000000	76.01
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	2,210,957	123,999	2,334,956	0.144186	0.000000	76.02
76.03	03950	WOUND CARE	987	953,942	954,929	0.446828	0.000000	76.03
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	5,917	5,118,813	5,124,730	0.132690	0.000000	90.00
91.00	09100	EMERGENCY	28,842,079	92,880,899	121,722,978	0.063666	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	2,603,065	5,925,446	8,528,511	0.229449	0.000000	92.00
200.00		Subtotal (see instructions)	302,735,609	362,907,432	665,643,041			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	302,735,609	362,907,432	665,643,041			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES			Provider CCN: 14-0125	Period: From 01/01/2020 To 12/31/2020	Worksheet C Part I Date/Time Prepared: 7/30/2021 11:17 am
			Title XVIII	Hospital	PPS
Cost Center Description			PPS Inpatient Ratio		
			11.00		
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS			30.00
31.00	03100	INTENSIVE CARE UNIT			31.00
40.00	04000	SUBPROVIDER - IPF			40.00
41.00	04100	SUBPROVIDER - IRF			41.00
43.00	04300	NURSERY			43.00
44.00	04400	SKILLED NURSING FACILITY			44.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0.123366		50.00
51.00	05100	RECOVERY ROOM	0.056844		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1.905660		52.00
53.00	05300	ANESTHESIOLOGY	0.015931		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.139239		54.00
54.01	05401	ULTRA-SOUND	0.000000		54.01
56.00	05600	RADIOISOTOPE	0.000000		56.00
57.00	05700	CT SCAN	0.000000		57.00
58.00	05800	MRI	0.000000		58.00
60.00	06000	LABORATORY	0.058099		60.00
65.00	06500	RESPIRATORY THERAPY	0.091122		65.00
66.00	06600	PHYSICAL THERAPY	0.218104		66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000		67.00
68.00	06800	SPEECH PATHOLOGY	0.000000		68.00
69.00	06900	ELECTROCARDIOLOGY	0.078083		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.115736		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.225170		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.233839		73.00
74.00	07400	RENAL DIALYSIS	0.070944		74.00
76.00	03020	ACUPUNCTURE	0.000000		76.00
76.01	03610	SLEEP LAB	0.631773		76.01
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0.144186		76.02
76.03	03950	WOUND CARE	0.446828		76.03
OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	0.132690		90.00
91.00	09100	EMERGENCY	0.063666		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.229449		92.00
200.00		Subtotal (see instructions)			200.00
201.00		Less Observation Beds			201.00
202.00		Total (see instructions)			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0125

Period:
From 01/01/2020
To 12/31/2020Worksheet C
Part I
Date/Time Prepared:
7/30/2021 11:17 am

				Title XIX		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	19,684,596		19,684,596	0	19,684,596	30.00	
31.00	03100	INTENSIVE CARE UNIT	3,879,023		3,879,023	0	3,879,023	31.00	
40.00	04000	SUBPROVIDER - IPF	3,165,154		3,165,154	0	3,165,154	40.00	
41.00	04100	SUBPROVIDER - IRF	0		0	0	0	41.00	
43.00	04300	NURSERY	124,318		124,318	0	124,318	43.00	
44.00	04400	SKILLED NURSING FACILITY	0		0	0	0	44.00	
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM	8,027,601		8,027,601	0	8,027,601	50.00	
51.00	05100	RECOVERY ROOM	531,443		531,443	0	531,443	51.00	
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,024,159		1,024,159	0	1,024,159	52.00	
53.00	05300	ANESTHESIOLOGY	205,288		205,288	0	205,288	53.00	
54.00	05400	RADIOLOGY-DIAGNOSTIC	7,566,781		7,566,781	0	7,566,781	54.00	
54.01	05401	ULTRA-SOUND	0		0	0	0	54.01	
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	
60.00	06000	LABORATORY	8,076,477		8,076,477	0	8,076,477	60.00	
65.00	06500	RESPIRATORY THERAPY	1,633,576	0	1,633,576	0	1,633,576	65.00	
66.00	06600	PHYSICAL THERAPY	2,823,394	0	2,823,394	0	2,823,394	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	2,879,840		2,879,840	0	2,879,840	69.00	
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	532,224		532,224	0	532,224	71.00	
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1,962,381		1,962,381	0	1,962,381	72.00	
73.00	07300	DRUGS CHARGED TO PATIENTS	4,572,661		4,572,661	0	4,572,661	73.00	
74.00	07400	RENAL DIALYSIS	202,005		202,005	0	202,005	74.00	
76.00	03020	ACUPUNCTURE	0		0	0	0	76.00	
76.01	03610	SLEEP LAB	917,766		917,766	0	917,766	76.01	
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	336,669		336,669	0	336,669	76.02	
76.03	03950	WOUND CARE	426,689		426,689	0	426,689	76.03	
OUTPATIENT SERVICE COST CENTERS									
90.00	09000	CLINIC	680,001		680,001	0	680,001	90.00	
91.00	09100	EMERGENCY	7,749,567		7,749,567	0	7,749,567	91.00	
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1,956,857		1,956,857	0	1,956,857	92.00	
200.00		Subtotal (see instructions)	78,958,470	0	78,958,470	0	78,958,470	200.00	
201.00		Less Observation Beds	1,956,857		1,956,857	0	1,956,857	201.00	
202.00		Total (see instructions)	77,001,613	0	77,001,613	0	77,001,613	202.00	

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0125

Period:
From 01/01/2020
To 12/31/2020Worksheet C
Part I
Date/Time Prepared:
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			Title XIX		Hospital		7/30/2021 11:17 am 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	108,654,956		108,654,956			30.00
31.00	03100	INTENSIVE CARE UNIT	13,511,677		13,511,677			31.00
40.00	04000	SUBPROVIDER - IPF	18,494,161		18,494,161			40.00
41.00	04100	SUBPROVIDER - IRF	0		0			41.00
43.00	04300	NURSERY	192,770		192,770			43.00
44.00	04400	SKILLED NURSING FACILITY	0		0			44.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	15,390,303	49,680,875	65,071,178	0.123366	0.000000	50.00
51.00	05100	RECOVERY ROOM	2,109,589	7,239,619	9,349,208	0.056844	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	534,506	2,924	537,430	1.905660	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	3,342,143	9,543,610	12,885,753	0.015931	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	9,372,771	44,971,060	54,343,831	0.139239	0.000000	54.00
54.01	05401	ULTRA-SOUND	0	0	0	0.000000	0.000000	54.01
56.00	05600	RADIOISOTOPE	0	0	0	0.000000	0.000000	56.00
57.00	05700	CT SCAN	0	0	0	0.000000	0.000000	57.00
58.00	05800	MRI	0	0	0	0.000000	0.000000	58.00
60.00	06000	LABORATORY	40,206,467	98,806,501	139,012,968	0.058099	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	15,177,752	2,749,647	17,927,399	0.091122	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	2,219,130	10,726,038	12,945,168	0.218104	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0.000000	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0.000000	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	16,247,633	20,634,282	36,881,915	0.078083	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	4,150,725	447,871	4,598,596	0.115736	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	3,602,551	5,112,559	8,715,110	0.225170	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	13,167,186	6,387,559	19,554,745	0.233839	0.000000	73.00
74.00	07400	RENAL DIALYSIS	2,698,284	149,105	2,847,389	0.070944	0.000000	74.00
76.00	03020	ACUPUNCTURE	0	0	0	0.000000	0.000000	76.00
76.01	03610	SLEEP LAB	0	1,452,683	1,452,683	0.631773	0.000000	76.01
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	2,210,957	123,999	2,334,956	0.144186	0.000000	76.02
76.03	03950	WOUND CARE	987	953,942	954,929	0.446828	0.000000	76.03
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	5,917	5,118,813	5,124,730	0.132690	0.000000	90.00
91.00	09100	EMERGENCY	28,842,079	92,880,899	121,722,978	0.063666	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	2,603,065	5,925,446	8,528,511	0.229449	0.000000	92.00
200.00		Subtotal (see instructions)	302,735,609	362,907,432	665,643,041			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	302,735,609	362,907,432	665,643,041			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES			Provider CCN: 14-0125	Period: From 01/01/2020 To 12/31/2020	Worksheet C Part I Date/Time Prepared: 7/30/2021 11:17 am
			Title XIX	Hospital	PPS
Cost Center Description			PPS Inpatient Ratio		
			11.00		
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS			30.00
31.00	03100	INTENSIVE CARE UNIT			31.00
40.00	04000	SUBPROVIDER - IPF			40.00
41.00	04100	SUBPROVIDER - IRF			41.00
43.00	04300	NURSERY			43.00
44.00	04400	SKILLED NURSING FACILITY			44.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0.123366		50.00
51.00	05100	RECOVERY ROOM	0.056844		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1.905660		52.00
53.00	05300	ANESTHESIOLOGY	0.015931		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.139239		54.00
54.01	05401	ULTRA-SOUND	0.000000		54.01
56.00	05600	RADIOISOTOPE	0.000000		56.00
57.00	05700	CT SCAN	0.000000		57.00
58.00	05800	MRI	0.000000		58.00
60.00	06000	LABORATORY	0.058099		60.00
65.00	06500	RESPIRATORY THERAPY	0.091122		65.00
66.00	06600	PHYSICAL THERAPY	0.218104		66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000		67.00
68.00	06800	SPEECH PATHOLOGY	0.000000		68.00
69.00	06900	ELECTROCARDIOLOGY	0.078083		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.115736		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.225170		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.233839		73.00
74.00	07400	RENAL DIALYSIS	0.070944		74.00
76.00	03020	ACUPUNCTURE	0.000000		76.00
76.01	03610	SLEEP LAB	0.631773		76.01
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0.144186		76.02
76.03	03950	WOUND CARE	0.446828		76.03
OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	0.132690		90.00
91.00	09100	EMERGENCY	0.063666		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.229449		92.00
200.00		Subtotal (see instructions)			200.00
201.00		Less Observation Beds			201.00
202.00		Total (see instructions)			202.00

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

Provider CCN: 14-0125

Period:
From 01/01/2020
To 12/31/2020Worksheet C
Part II
Date/Time Prepared:
7/30/2021 11:17 am

Cost Center Description			Title XIX		Hospital	PPS	
			Total Cost (Wkst. B, Part I, col. 26)	Capital Cost (Wkst. B, Part II col. 26)	Operating Cost Net of Capital Cost (col. 1 - col. 2)	Capital Reduction	Operating Cost Reduction Amount
			1.00	2.00	3.00	4.00	5.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	8,027,601	674,420	7,353,181	0	0
51.00	05100	RECOVERY ROOM	531,443	32,741	498,702	0	0
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,024,159	103,768	920,391	0	0
53.00	05300	ANESTHESIOLOGY	205,288	16,230	189,058	0	0
54.00	05400	RADIOLOGY-DIAGNOSTIC	7,566,781	485,743	7,081,038	0	0
54.01	05401	ULTRA-SOUND	0	0	0	0	0
56.00	05600	RADIOISOTOPE	0	0	0	0	0
57.00	05700	CT SCAN	0	0	0	0	0
58.00	05800	MRI	0	0	0	0	0
60.00	06000	LABORATORY	8,076,477	285,731	7,790,746	0	0
65.00	06500	RESPIRATORY THERAPY	1,633,576	133,548	1,500,028	0	0
66.00	06600	PHYSICAL THERAPY	2,823,394	286,109	2,537,285	0	0
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0
69.00	06900	ELECTROCARDIOLOGY	2,879,840	123,104	2,756,736	0	0
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	532,224	7,891	524,333	0	0
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1,962,381	42,691	1,919,690	0	0
73.00	07300	DRUGS CHARGED TO PATIENTS	4,572,661	128,396	4,444,265	0	0
74.00	07400	RENAL DIALYSIS	202,005	2,940	199,065	0	0
76.00	03020	ACUPUNCTURE	0	0	0	0	0
76.01	03610	SLEEP LAB	917,766	110,331	807,435	0	0
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	336,669	56,396	280,273	0	0
76.03	03950	WOUND CARE	426,689	46,195	380,494	0	0
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	680,001	133,939	546,062	0	0
91.00	09100	EMERGENCY	7,749,567	299,599	7,449,968	0	0
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1,956,857	143,040	1,813,817	0	0
200.00		Subtotal (sum of lines 50 thru 199)	52,105,379	3,112,812	48,992,567	0	0
201.00		Less Observation Beds	1,956,857	143,040	1,813,817	0	0
202.00		Total (line 200 minus line 201)	50,148,522	2,969,772	47,178,750	0	0

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

Provider CCN: 14-0125

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

Worksheet C
Part II
Date/Time Prepared:
7/30/2021 11:17 am

Cost Center Description			Title XIX		Hospital	PPS
			Cost Net of Capital and Operating Cost Reduction	Total Charges (Worksheet C, Part I, column 8)	Outpatient Cost to Charge Ratio (col. 6 / col. 7)	
			6.00	7.00	8.00	
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	8,027,601	65,071,178	0.123366	50.00
51.00	05100	RECOVERY ROOM	531,443	9,349,208	0.056844	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,024,159	537,430	1.905660	52.00
53.00	05300	ANESTHESIOLOGY	205,288	12,885,753	0.015931	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	7,566,781	54,343,831	0.139239	54.00
54.01	05401	ULTRA-SOUND	0	0	0.000000	54.01
56.00	05600	RADIOISOTOPE	0	0	0.000000	56.00
57.00	05700	CT SCAN	0	0	0.000000	57.00
58.00	05800	MRI	0	0	0.000000	58.00
60.00	06000	LABORATORY	8,076,477	139,012,968	0.058099	60.00
65.00	06500	RESPIRATORY THERAPY	1,633,576	17,927,399	0.091122	65.00
66.00	06600	PHYSICAL THERAPY	2,823,394	12,945,168	0.218104	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	2,879,840	36,881,915	0.078083	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	532,224	4,598,596	0.115736	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1,962,381	8,715,110	0.225170	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	4,572,661	19,554,745	0.233839	73.00
74.00	07400	RENAL DIALYSIS	202,005	2,847,389	0.070944	74.00
76.00	03020	ACUPUNCTURE	0	0	0.000000	76.00
76.01	03610	SLEEP LAB	917,766	1,452,683	0.631773	76.01
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	336,669	2,334,956	0.144186	76.02
76.03	03950	WOUND CARE	426,689	954,929	0.446828	76.03
OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	680,001	5,124,730	0.132690	90.00
91.00	09100	EMERGENCY	7,749,567	121,722,978	0.063666	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1,956,857	8,528,511	0.229449	92.00
200.00		Subtotal (sum of lines 50 thru 199)	52,105,379	524,789,477		200.00
201.00		Less Observation Beds	1,956,857	0		201.00
202.00		Total (line 200 minus line 201)	50,148,522	524,789,477		202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

Provider CCN: 14-0125

Period:
From 01/01/2020
To 12/31/2020Worksheet D
Part I
Date/Time Prepared:
7/30/2021 11:17 am

			Title XVIII		Hospital	PPS	
Cost Center Description		Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	1,438,882	0	1,438,882	19,666	73.17	30.00
31.00	INTENSIVE CARE UNIT	376,080		376,080	1,340	280.66	31.00
40.00	SUBPROVIDER - IPF	228,021	0	228,021	3,185	71.59	40.00
41.00	SUBPROVIDER - IRF	0	0	0	0	0.00	41.00
43.00	NURSERY	14,609		14,609	68	214.84	43.00
44.00	SKILLED NURSING FACILITY	0		0	0	0.00	44.00
200.00	Total (lines 30 through 199)	2,057,592		2,057,592	24,259		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	2,506	183,364				30.00
31.00	INTENSIVE CARE UNIT	522	146,505				31.00
40.00	SUBPROVIDER - IPF	1,675	119,913				40.00
41.00	SUBPROVIDER - IRF	0	0				41.00
43.00	NURSERY	0	0				43.00
44.00	SKILLED NURSING FACILITY	0	0				44.00
200.00	Total (lines 30 through 199)	4,703	449,782				200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS				Provider CCN: 14-0125	Period: From 01/01/2020 To 12/31/2020	Worksheet D Part II Date/Time Prepared: 7/30/2021 11:17 am			
				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	674,420	65,071,178	0.010364	5,910,719	61,259	50.00	
51.00	05100	RECOVERY ROOM	32,741	9,349,208	0.003502	707,191	2,477	51.00	
52.00	05200	DELIVERY ROOM & LABOR ROOM	103,768	537,430	0.193082	0	0	52.00	
53.00	05300	ANESTHESIOLOGY	16,230	12,885,753	0.001260	1,359,100	1,712	53.00	
54.00	05400	RADIOLOGY-DIAGNOSTIC	485,743	54,343,831	0.008938	3,849,716	34,409	54.00	
54.01	05401	ULTRA-SOUND	0	0	0.000000	0	0	54.01	
56.00	05600	RADIOISOTOPE	0	0	0.000000	0	0	56.00	
57.00	05700	CT SCAN	0	0	0.000000	0	0	57.00	
58.00	05800	MRI	0	0	0.000000	0	0	58.00	
60.00	06000	LABORATORY	285,731	139,012,968	0.002055	13,667,506	28,087	60.00	
65.00	06500	RESPIRATORY THERAPY	133,548	17,927,399	0.007449	6,881,070	51,257	65.00	
66.00	06600	PHYSICAL THERAPY	286,109	12,945,168	0.022102	1,076,061	23,783	66.00	
67.00	06700	OCCUPATIONAL THERAPY	0	0	0.000000	0	0	67.00	
68.00	06800	SPEECH PATHOLOGY	0	0	0.000000	0	0	68.00	
69.00	06900	ELECTROCARDIOLOGY	123,104	36,881,915	0.003338	6,430,037	21,463	69.00	
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	7,891	4,598,596	0.001716	2,019,145	3,465	71.00	
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	42,691	8,715,110	0.004899	1,209,383	5,925	72.00	
73.00	07300	DRUGS CHARGED TO PATIENTS	128,396	19,554,745	0.006566	3,987,766	26,184	73.00	
74.00	07400	RENAL DIALYSIS	2,940	2,847,389	0.001033	1,673,804	1,729	74.00	
76.00	03020	ACUPUNCTURE	0	0	0.000000	0	0	76.00	
76.01	03610	SLEEP LAB	110,331	1,452,683	0.075950	0	0	76.01	
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	56,396	2,334,956	0.024153	202,331	4,887	76.02	
76.03	03950	WOUND CARE	46,195	954,929	0.048375	987	48	76.03	
	OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	133,939	5,124,730	0.026136	1,157	30	90.00	
91.00	09100	EMERGENCY	299,599	121,722,978	0.002461	8,403,596	20,681	91.00	
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	143,040	8,528,511	0.016772	1,132,884	19,001	92.00	
200.00		Total (lines 50 through 199)	3,112,812	524,789,477		58,512,453	306,397	200.00	

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS					Provider CCN: 14-0125		Period: From 01/01/2020 To 12/31/2020		Worksheet D Part III Date/Time Prepared: 7/30/2021 11:17 am		
					Title XVIII		Hospital		PPS		
Cost Center Description			Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health Cost	All Other Medical Education Cost				
			1A	1.00	2A	2.00	3.00				
INPATIENT ROUTINE SERVICE COST CENTERS											
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	0	0	30.00		
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	0	31.00		
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	0	0	40.00		
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	0	41.00		
43.00	04300	NURSERY	0	0	0	0	0	0	43.00		
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	19,666	0.00	2,506		30.00		
31.00	03100	INTENSIVE CARE UNIT	0	0	1,340	0.00	522		31.00		
40.00	04000	SUBPROVIDER - IPF	0	0	3,185	0.00	1,675		40.00		
41.00	04100	SUBPROVIDER - IRF	0	0	0	0.00	0		41.00		
43.00	04300	NURSERY	0	0	68	0.00	0		43.00		
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0.00	0		44.00		
200.00		Total (lines 30 through 199)	0	0	24,259		4,703		200.00		
Cost Center Description			Inpatient Program Pass-Through Cost (col. 7 x col. 8)								
			9.00								
INPATIENT ROUTINE SERVICE COST CENTERS											
30.00	03000	ADULTS & PEDIATRICS	0								30.00
31.00	03100	INTENSIVE CARE UNIT	0								31.00
40.00	04000	SUBPROVIDER - IPF	0								40.00
41.00	04100	SUBPROVIDER - IRF	0								41.00
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: 14-0125

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

Worksheet D
Part IV
Date/Time Prepared:
7/30/2021 11:17 am

Cost Center Description		Title XVIII		Hospital		PPS	
		Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health	
		1.00	2A	2.00	3A	3.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	54.00
54.01	05401	ULTRA-SOUND	0	0	0	0	54.01
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
60.00	06000	LABORATORY	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	66.00
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
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	03020	ACUPUNCTURE	0	0	0	0	76.00
76.01	03610	SLEEP LAB	0	0	0	0	76.01
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0	0	0	76.02
76.03	03950	WOUND CARE	0	0	0	0	76.03
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: 14-0125		Period: From 01/01/2020 To 12/31/2020		Worksheet D Part IV Date/Time Prepared: 7/30/2021 11:17 am	
			Title XVIII		Hospital		PPS	
Cost Center Description			All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7) (see instructions)	
			4.00	5.00	6.00	7.00	8.00	
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	0	65,071,178	0.000000	50.00
51.00	05100	RECOVERY ROOM	0	0	0	9,349,208	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	537,430	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	12,885,753	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	54,343,831	0.000000	54.00
54.01	05401	ULTRA-SOUND	0	0	0	0	0.000000	54.01
56.00	05600	RADIOISOTOPE	0	0	0	0	0.000000	56.00
57.00	05700	CT SCAN	0	0	0	0	0.000000	57.00
58.00	05800	MRI	0	0	0	0	0.000000	58.00
60.00	06000	LABORATORY	0	0	0	139,012,968	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	17,927,399	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	12,945,168	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	36,881,915	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	4,598,596	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	8,715,110	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	19,554,745	0.000000	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	2,847,389	0.000000	74.00
76.00	03020	ACUPUNCTURE	0	0	0	0	0.000000	76.00
76.01	03610	SLEEP LAB	0	0	0	1,452,683	0.000000	76.01
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0	0	2,334,956	0.000000	76.02
76.03	03950	WOUND CARE	0	0	0	954,929	0.000000	76.03
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0	5,124,730	0.000000	90.00
91.00	09100	EMERGENCY	0	0	0	121,722,978	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	8,528,511	0.000000	92.00
200.00		Total (lines 50 through 199)	0	0	0	524,789,477		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS				Provider CCN: 14-0125		Period: From 01/01/2020 To 12/31/2020		Worksheet D Part IV Date/Time Prepared: 7/30/2021 11:17 am	
				Title XVIII		Hospital		PPS	
Cost Center Description				Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
				9.00	10.00	11.00	12.00	13.00	
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM		0.000000	5,910,719	0	7,573,068	0	50.00
51.00	05100	RECOVERY ROOM		0.000000	707,191	0	963,036	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM		0.000000	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY		0.000000	1,359,100	0	1,628,437	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC		0.000000	3,849,716	0	7,728,962	0	54.00
54.01	05401	ULTRA-SOUND		0.000000	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE		0.000000	0	0	0	0	56.00
57.00	05700	CT SCAN		0.000000	0	0	0	0	57.00
58.00	05800	MRI		0.000000	0	0	0	0	58.00
60.00	06000	LABORATORY		0.000000	13,667,506	0	6,242,478	0	60.00
65.00	06500	RESPIRATORY THERAPY		0.000000	6,881,070	0	606,033	0	65.00
66.00	06600	PHYSICAL THERAPY		0.000000	1,076,061	0	67,799	0	66.00
67.00	06700	OCCUPATIONAL THERAPY		0.000000	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY		0.000000	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY		0.000000	6,430,037	0	3,945,584	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT		0.000000	2,019,145	0	195,526	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS		0.000000	1,209,383	0	1,375,739	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS		0.000000	3,987,766	0	888,891	0	73.00
74.00	07400	RENAL DIALYSIS		0.000000	1,673,804	0	86,576	0	74.00
76.00	03020	ACUPUNCTURE		0.000000	0	0	0	0	76.00
76.01	03610	SLEEP LAB		0.000000	0	0	263,328	0	76.01
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES		0.000000	202,331	0	0	0	76.02
76.03	03950	WOUND CARE		0.000000	987	0	206,345	0	76.03
OUTPATIENT SERVICE COST CENTERS									
90.00	09000	CLINIC		0.000000	1,157	0	148,268	0	90.00
91.00	09100	EMERGENCY		0.000000	8,403,596	0	11,645,339	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART		0.000000	1,132,884	0	1,179,810	0	92.00
200.00		Total (lines 50 through 199)			58,512,453	0	44,745,219	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-0125

Period:
From 01/01/2020
To 12/31/2020Worksheet D
Part V
Date/Time Prepared:
7/30/2021 11:17 am

			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	0.123366	7,573,068	0	0	934,259	50.00
51.00	05100	RECOVERY ROOM	0.056844	963,036	0	0	54,743	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1.905660	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.015931	1,628,437	0	0	25,943	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.139239	7,728,962	0	0	1,076,173	54.00
54.01	05401	ULTRA-SOUND	0.000000	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0.000000	0	0	0	0	56.00
57.00	05700	CT SCAN	0.000000	0	0	0	0	57.00
58.00	05800	MRI	0.000000	0	0	0	0	58.00
60.00	06000	LABORATORY	0.058099	6,242,478	0	1,002	362,682	60.00
65.00	06500	RESPIRATORY THERAPY	0.091122	606,033	0	0	55,223	65.00
66.00	06600	PHYSICAL THERAPY	0.218104	67,799	0	0	14,787	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.078083	3,945,584	0	0	308,083	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.115736	195,526	0	0	22,629	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.225170	1,375,739	0	0	309,775	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.233839	888,891	20,017	0	207,857	73.00
74.00	07400	RENAL DIALYSIS	0.070944	86,576	0	0	6,142	74.00
76.00	03020	ACUPUNCTURE	0.000000	0	0	0	0	76.00
76.01	03610	SLEEP LAB	0.631773	263,328	0	0	166,364	76.01
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0.144186	0	0	0	0	76.02
76.03	03950	WOUND CARE	0.446828	206,345	0	0	92,201	76.03
	OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0.132690	148,268	0	0	19,674	90.00
91.00	09100	EMERGENCY	0.063666	11,645,339	0	0	741,412	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.229449	1,179,810	0	0	270,706	92.00
200.00		Subtotal (see instructions)		44,745,219	20,017	1,002	4,668,653	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 - line 201)		44,745,219	20,017	1,002	4,668,653	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST			Provider CCN: 14-0125		Period: From 01/01/2020 To 12/31/2020		Worksheet D Part V Date/Time Prepared: 7/30/2021 11:17 am	
			Title XVIII		Hospital		PPS	
Cost Center Description			Costs					
			Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)				
			6.00	7.00				
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	50.00			
51.00	05100	RECOVERY ROOM	0	0	51.00			
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	52.00			
53.00	05300	ANESTHESIOLOGY	0	0	53.00			
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	54.00			
54.01	05401	ULTRA-SOUND	0	0	54.01			
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			
60.00	06000	LABORATORY	0	58	60.00			
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			
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	4,681	0	73.00			
74.00	07400	RENAL DIALYSIS	0	0	74.00			
76.00	03020	ACUPUNCTURE	0	0	76.00			
76.01	03610	SLEEP LAB	0	0	76.01			
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0	76.02			
76.03	03950	WOUND CARE	0	0	76.03			
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	90.00			
91.00	09100	EMERGENCY	0	0	91.00			
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	92.00			
200.00		Subtotal (see instructions)	4,681	58	200.00			
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0		201.00			
202.00		Net Charges (line 200 - line 201)	4,681	58	202.00			

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 14-0125

Period:

Worksheet D

Component CCN: 14-S125

From 01/01/2020
To 12/31/2020Part II
Date/Time Prepared:
7/30/2021 11:17 am

Title XVIII

Subprovider -
IPF

PPS

Cost Center Description		Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
		1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	674,420	65,071,178	0.010364	0	50.00
51.00	05100	RECOVERY ROOM	32,741	9,349,208	0.003502	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	103,768	537,430	0.193082	0	52.00
53.00	05300	ANESTHESIOLOGY	16,230	12,885,753	0.001260	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	485,743	54,343,831	0.008938	119,497	54.00
54.01	05401	ULTRA-SOUND	0	0	0.000000	0	54.01
56.00	05600	RADIOISOTOPE	0	0	0.000000	0	56.00
57.00	05700	CT SCAN	0	0	0.000000	0	57.00
58.00	05800	MRI	0	0	0.000000	0	58.00
60.00	06000	LABORATORY	285,731	139,012,968	0.002055	1,321,113	60.00
65.00	06500	RESPIRATORY THERAPY	133,548	17,927,399	0.007449	13,270	65.00
66.00	06600	PHYSICAL THERAPY	286,109	12,945,168	0.022102	72,869	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0.000000	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0.000000	0	68.00
69.00	06900	ELECTROCARDIOLOGY	123,104	36,881,915	0.003338	47,257	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	7,891	4,598,596	0.001716	7,838	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	42,691	8,715,110	0.004899	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	128,396	19,554,745	0.006566	618,919	73.00
74.00	07400	RENAL DIALYSIS	2,940	2,847,389	0.001033	0	74.00
76.00	03020	ACUPUNCTURE	0	0	0.000000	0	76.00
76.01	03610	SLEEP LAB	110,331	1,452,683	0.075950	0	76.01
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	56,396	2,334,956	0.024153	157,394	76.02
76.03	03950	WOUND CARE	46,195	954,929	0.048375	0	76.03
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	133,939	5,124,730	0.026136	0	90.00
91.00	09100	EMERGENCY	299,599	121,722,978	0.002461	1,025,280	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	8,528,511	0.000000	0	92.00
200.00		Total (lines 50 through 199)	2,969,772	524,789,477		3,383,437	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS				Provider CCN: 14-0125 Component CCN: 14-S125		Period: From 01/01/2020 To 12/31/2020		Worksheet D Part IV Date/Time Prepared: 7/30/2021 11:17 am	
				Title XVIII		Subprovider - IPF		PPS	
Cost Center Description				Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health	
				1.00	2A	2.00	3A	3.00	
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM		0	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM		0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM		0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY		0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC		0	0	0	0	0	54.00
54.01	05401	ULTRA-SOUND		0	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE		0	0	0	0	0	56.00
57.00	05700	CT SCAN		0	0	0	0	0	57.00
58.00	05800	MRI		0	0	0	0	0	58.00
60.00	06000	LABORATORY		0	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY		0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY		0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY		0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY		0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY		0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT		0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS		0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS		0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS		0	0	0	0	0	74.00
76.00	03020	ACUPUNCTURE		0	0	0	0	0	76.00
76.01	03610	SLEEP LAB		0	0	0	0	0	76.01
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES		0	0	0	0	0	76.02
76.03	03950	WOUND CARE		0	0	0	0	0	76.03
OUTPATIENT SERVICE COST CENTERS									
90.00	09000	CLINIC		0	0	0	0	0	90.00
91.00	09100	EMERGENCY		0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART		0	0	0	0	0	92.00
200.00		Total (lines 50 through 199)		0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS			Provider CCN: 14-0125 Component CCN: 14-S125		Period: From 01/01/2020 To 12/31/2020		Worksheet D Part IV Date/Time Prepared: 7/30/2021 11:17 am	
			Title XVIII		Subprovider - IPF		PPS	
Cost Center Description			All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7) (see instructions)	
			4.00	5.00	6.00	7.00	8.00	
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	0	65,071,178	0.000000	50.00
51.00	05100	RECOVERY ROOM	0	0	0	9,349,208	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	537,430	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	12,885,753	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	54,343,831	0.000000	54.00
54.01	05401	ULTRA-SOUND	0	0	0	0	0.000000	54.01
56.00	05600	RADIOISOTOPE	0	0	0	0	0.000000	56.00
57.00	05700	CT SCAN	0	0	0	0	0.000000	57.00
58.00	05800	MRI	0	0	0	0	0.000000	58.00
60.00	06000	LABORATORY	0	0	0	139,012,968	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	17,927,399	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	12,945,168	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	36,881,915	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	4,598,596	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	8,715,110	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	19,554,745	0.000000	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	2,847,389	0.000000	74.00
76.00	03020	ACUPUNCTURE	0	0	0	0	0.000000	76.00
76.01	03610	SLEEP LAB	0	0	0	1,452,683	0.000000	76.01
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0	0	2,334,956	0.000000	76.02
76.03	03950	WOUND CARE	0	0	0	954,929	0.000000	76.03
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0	5,124,730	0.000000	90.00
91.00	09100	EMERGENCY	0	0	0	121,722,978	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	8,528,511	0.000000	92.00
200.00		Total (lines 50 through 199)	0	0	0	524,789,477		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS			Provider CCN: 14-0125 Component CCN: 14-S125		Period: From 01/01/2020 To 12/31/2020		Worksheet D Part IV Date/Time Prepared: 7/30/2021 11:17 am	
			Title XVIII		Subprovider - IPF		PPS	
Cost Center Description			Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
			9.00	10.00	11.00	12.00	13.00	
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0.000000	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0.000000	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	119,497	0	1,782	0	54.00
54.01	05401	ULTRA-SOUND	0.000000	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0.000000	0	0	0	0	56.00
57.00	05700	CT SCAN	0.000000	0	0	0	0	57.00
58.00	05800	MRI	0.000000	0	0	0	0	58.00
60.00	06000	LABORATORY	0.000000	1,321,113	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.000000	13,270	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	72,869	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	47,257	0	694	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	7,838	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	618,919	0	131	0	73.00
74.00	07400	RENAL DIALYSIS	0.000000	0	0	0	0	74.00
76.00	03020	ACUPUNCTURE	0.000000	0	0	0	0	76.00
76.01	03610	SLEEP LAB	0.000000	0	0	0	0	76.01
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0.000000	157,394	0	0	0	76.02
76.03	03950	WOUND CARE	0.000000	0	0	0	0	76.03
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0.000000	0	0	0	0	90.00
91.00	09100	EMERGENCY	0.000000	1,025,280	0	20,139	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	0	0	0	0	92.00
200.00		Total (lines 50 through 199)		3,383,437	0	22,746	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-0125

Period:

Worksheet D

Component CCN: 14-S125

From 01/01/2020
To 12/31/2020Part V
Date/Time Prepared:
7/30/2021 11:17 am

Title XVIII

Subprovider -
IPF

PPS

Cost Center Description		Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges		Costs		
			PPS Reimbursed Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	PPS Services (see inst.)	
		1.00	2.00	3.00	4.00	5.00	
	ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.123366	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0.056844	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1.905660	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.015931	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.139239	1,782	0	248	54.00
54.01	05401	ULTRA-SOUND	0.000000	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0.000000	0	0	0	56.00
57.00	05700	CT SCAN	0.000000	0	0	0	57.00
58.00	05800	MRI	0.000000	0	0	0	58.00
60.00	06000	LABORATORY	0.058099	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.091122	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.218104	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.078083	694	0	54	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.115736	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.225170	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.233839	131	0	4,349	73.00
74.00	07400	RENAL DIALYSIS	0.070944	0	0	0	74.00
76.00	03020	ACUPUNCTURE	0.000000	0	0	0	76.00
76.01	03610	SLEEP LAB	0.631773	0	0	0	76.01
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0.144186	0	0	0	76.02
76.03	03950	WOUND CARE	0.446828	0	0	0	76.03
	OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.132690	0	0	0	90.00
91.00	09100	EMERGENCY	0.063666	20,139	0	1,282	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.229449	0	0	0	92.00
200.00		Subtotal (see instructions)		22,746	0	4,349	200.00
201.00		Less PBP Clinic Lab. Services-Program			0	0	201.00
		Only Charges					
202.00		Net Charges (line 200 - line 201)		22,746	0	4,349	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST			Provider CCN: 14-0125	Period: From 01/01/2020 To 12/31/2020	Worksheet D Part V Date/Time Prepared: 7/30/2021 11:17 am	
			Component CCN: 14-S125			
			Title XVIII	Subprovider - IPF	PPS	
Cost Center Description			Costs			
			Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
	ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	0	50.00	
51.00	05100	RECOVERY ROOM	0	0	51.00	
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	52.00	
53.00	05300	ANESTHESIOLOGY	0	0	53.00	
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	54.00	
54.01	05401	ULTRA-SOUND	0	0	54.01	
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	
60.00	06000	LABORATORY	0	0	60.00	
65.00	06500	RESPIRATORY THERAPY	0	0	65.00	
66.00	06600	PHYSICAL THERAPY	0	0	66.00	
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	
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	1,017	73.00	
74.00	07400	RENAL DIALYSIS	0	0	74.00	
76.00	03020	ACUPUNCTURE	0	0	76.00	
76.01	03610	SLEEP LAB	0	0	76.01	
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0	76.02	
76.03	03950	WOUND CARE	0	0	76.03	
	OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	0	0	90.00	
91.00	09100	EMERGENCY	0	0	91.00	
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	92.00	
200.00		Subtotal (see instructions)	0	1,017	200.00	
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0		201.00	
202.00		Net Charges (line 200 - line 201)	0	1,017	202.00	

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

Provider CCN: 14-0125

Period:
From 01/01/2020
To 12/31/2020Worksheet D
Part I
Date/Time Prepared:
7/30/2021 11:17 am

			Title XIX		Hospital	PPS	
Cost Center Description		Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	1,438,882	0	1,438,882	19,666	73.17	30.00
31.00	INTENSIVE CARE UNIT	376,080		376,080	1,340	280.66	31.00
40.00	SUBPROVIDER - IPF	228,021	0	228,021	3,185	71.59	40.00
41.00	SUBPROVIDER - IRF	0	0	0	0	0.00	41.00
43.00	NURSERY	14,609		14,609	68	214.84	43.00
44.00	SKILLED NURSING FACILITY	0		0	0	0.00	44.00
200.00	Total (lines 30 through 199)	2,057,592		2,057,592	24,259		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	143	10,463				30.00
31.00	INTENSIVE CARE UNIT	17	4,771				31.00
40.00	SUBPROVIDER - IPF	1,304	93,353				40.00
41.00	SUBPROVIDER - IRF	0	0				41.00
43.00	NURSERY	19	4,082				43.00
44.00	SKILLED NURSING FACILITY	0	0				44.00
200.00	Total (lines 30 through 199)	1,483	112,669				200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS				Provider CCN: 14-0125	Period: From 01/01/2020 To 12/31/2020	Worksheet D Part II Date/Time Prepared: 7/30/2021 11:17 am	
				Title XIX		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	674,420	65,071,178	0.010364	0	50.00
51.00	05100	RECOVERY ROOM	32,741	9,349,208	0.003502	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	103,768	537,430	0.193082	0	52.00
53.00	05300	ANESTHESIOLOGY	16,230	12,885,753	0.001260	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	485,743	54,343,831	0.008938	0	54.00
54.01	05401	ULTRA-SOUND	0	0	0.000000	0	54.01
56.00	05600	RADIOISOTOPE	0	0	0.000000	0	56.00
57.00	05700	CT SCAN	0	0	0.000000	0	57.00
58.00	05800	MRI	0	0	0.000000	0	58.00
60.00	06000	LABORATORY	285,731	139,012,968	0.002055	0	60.00
65.00	06500	RESPIRATORY THERAPY	133,548	17,927,399	0.007449	0	65.00
66.00	06600	PHYSICAL THERAPY	286,109	12,945,168	0.022102	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0.000000	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0.000000	0	68.00
69.00	06900	ELECTROCARDIOLOGY	123,104	36,881,915	0.003338	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	7,891	4,598,596	0.001716	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	42,691	8,715,110	0.004899	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	128,396	19,554,745	0.006566	0	73.00
74.00	07400	RENAL DIALYSIS	2,940	2,847,389	0.001033	0	74.00
76.00	03020	ACUPUNCTURE	0	0	0.000000	0	76.00
76.01	03610	SLEEP LAB	110,331	1,452,683	0.075950	0	76.01
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	56,396	2,334,956	0.024153	0	76.02
76.03	03950	WOUND CARE	46,195	954,929	0.048375	0	76.03
	OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	133,939	5,124,730	0.026136	0	90.00
91.00	09100	EMERGENCY	299,599	121,722,978	0.002461	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	143,040	8,528,511	0.016772	0	92.00
200.00		Total (lines 50 through 199)	3,112,812	524,789,477		0	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS					Provider CCN: 14-0125		Period: From 01/01/2020 To 12/31/2020		Worksheet D Part III Date/Time Prepared: 7/30/2021 11:17 am		
					Title XIX		Hospital		PPS		
Cost Center Description			Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health Cost	All Other Medical Education Cost				
			1A	1.00	2A	2.00	3.00				
INPATIENT ROUTINE SERVICE COST CENTERS											
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	0	0	30.00		
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	0	31.00		
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	0	0	40.00		
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	0	41.00		
43.00	04300	NURSERY	0	0	0	0	0	0	43.00		
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	19,666	0.00	143	30.00			
31.00	03100	INTENSIVE CARE UNIT	0	0	1,340	0.00	17	31.00			
40.00	04000	SUBPROVIDER - IPF	0	0	3,185	0.00	1,304	40.00			
41.00	04100	SUBPROVIDER - IRF	0	0	0	0.00	0	41.00			
43.00	04300	NURSERY	0	0	68	0.00	19	43.00			
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0.00	0	44.00			
200.00		Total (lines 30 through 199)	0	0	24,259		1,483	200.00			
Cost Center Description			Inpatient Program Pass-Through Cost (col. 7 x col. 8)								
			9.00								
INPATIENT ROUTINE SERVICE COST CENTERS											
30.00	03000	ADULTS & PEDIATRICS	0								30.00
31.00	03100	INTENSIVE CARE UNIT	0								31.00
40.00	04000	SUBPROVIDER - IPF	0								40.00
41.00	04100	SUBPROVIDER - IRF	0								41.00
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: 14-0125		Period: From 01/01/2020 To 12/31/2020		Worksheet D Part IV Date/Time Prepared: 7/30/2021 11:17 am	
			Title XIX		Hospital		PPS	
Cost Center Description			Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health	
			1.00	2A	2.00	3A	3.00	
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
54.01	05401	ULTRA-SOUND	0	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.00	03020	ACUPUNCTURE	0	0	0	0	0	76.00
76.01	03610	SLEEP LAB	0	0	0	0	0	76.01
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0	0	0	0	76.02
76.03	03950	WOUND CARE	0	0	0	0	0	76.03
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	0	92.00
200.00		Total (lines 50 through 199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS				Provider CCN: 14-0125		Period: From 01/01/2020 To 12/31/2020	Worksheet D Part IV Date/Time Prepared: 7/30/2021 11:17 am	
Cost Center Description				Title XIX		Hospital	PPS	
				All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7) (see instructions)
				4.00	5.00	6.00	7.00	8.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM		0	0	0	65,071,178	0.000000
51.00	05100	RECOVERY ROOM		0	0	0	9,349,208	0.000000
52.00	05200	DELIVERY ROOM & LABOR ROOM		0	0	0	537,430	0.000000
53.00	05300	ANESTHESIOLOGY		0	0	0	12,885,753	0.000000
54.00	05400	RADIOLOGY-DIAGNOSTIC		0	0	0	54,343,831	0.000000
54.01	05401	ULTRA-SOUND		0	0	0	0	0.000000
56.00	05600	RADIOISOTOPE		0	0	0	0	0.000000
57.00	05700	CT SCAN		0	0	0	0	0.000000
58.00	05800	MRI		0	0	0	0	0.000000
60.00	06000	LABORATORY		0	0	0	139,012,968	0.000000
65.00	06500	RESPIRATORY THERAPY		0	0	0	17,927,399	0.000000
66.00	06600	PHYSICAL THERAPY		0	0	0	12,945,168	0.000000
67.00	06700	OCCUPATIONAL THERAPY		0	0	0	0	0.000000
68.00	06800	SPEECH PATHOLOGY		0	0	0	0	0.000000
69.00	06900	ELECTROCARDIOLOGY		0	0	0	36,881,915	0.000000
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT		0	0	0	4,598,596	0.000000
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS		0	0	0	8,715,110	0.000000
73.00	07300	DRUGS CHARGED TO PATIENTS		0	0	0	19,554,745	0.000000
74.00	07400	RENAL DIALYSIS		0	0	0	2,847,389	0.000000
76.00	03020	ACUPUNCTURE		0	0	0	0	0.000000
76.01	03610	SLEEP LAB		0	0	0	1,452,683	0.000000
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES		0	0	0	2,334,956	0.000000
76.03	03950	WOUND CARE		0	0	0	954,929	0.000000
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC		0	0	0	5,124,730	0.000000
91.00	09100	EMERGENCY		0	0	0	121,722,978	0.000000
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART		0	0	0	8,528,511	0.000000
200.00		Total (lines 50 through 199)		0	0	0	524,789,477	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-0125

Period:
From 01/01/2020
To 12/31/2020Worksheet D
Part IV
Date/Time Prepared:
7/30/2021 11:17 am

Cost Center Description		Title XIX			Hospital		PPS	
		Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)		
		9.00	10.00	11.00	12.00	13.00		
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0.000000	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0.000000	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	0	0	0	0	54.00
54.01	05401	ULTRA-SOUND	0.000000	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0.000000	0	0	0	0	56.00
57.00	05700	CT SCAN	0.000000	0	0	0	0	57.00
58.00	05800	MRI	0.000000	0	0	0	0	58.00
60.00	06000	LABORATORY	0.000000	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.000000	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0.000000	0	0	0	0	74.00
76.00	03020	ACUPUNCTURE	0.000000	0	0	0	0	76.00
76.01	03610	SLEEP LAB	0.000000	0	0	0	0	76.01
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0.000000	0	0	0	0	76.02
76.03	03950	WOUND CARE	0.000000	0	0	0	0	76.03
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0.000000	0	0	0	0	90.00
91.00	09100	EMERGENCY	0.000000	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	0	0	0	0	92.00
200.00		Total (lines 50 through 199)		0	0	0	0	200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS				Provider CCN: 14-0125 Component CCN: 14-S125		Period: From 01/01/2020 To 12/31/2020		Worksheet D Part II Date/Time Prepared: 7/30/2021 11:17 am	
				Title XIX		Subprovider - IPF		PPS	
Cost Center Description				Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
				1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM		674,420	65,071,178	0.010364	0	0	50.00
51.00	05100	RECOVERY ROOM		32,741	9,349,208	0.003502	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM		103,768	537,430	0.193082	0	0	52.00
53.00	05300	ANESTHESIOLOGY		16,230	12,885,753	0.001260	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC		485,743	54,343,831	0.008938	0	0	54.00
54.01	05401	ULTRA-SOUND		0	0	0.000000	0	0	54.01
56.00	05600	RADIOISOTOPE		0	0	0.000000	0	0	56.00
57.00	05700	CT SCAN		0	0	0.000000	0	0	57.00
58.00	05800	MRI		0	0	0.000000	0	0	58.00
60.00	06000	LABORATORY		285,731	139,012,968	0.002055	0	0	60.00
65.00	06500	RESPIRATORY THERAPY		133,548	17,927,399	0.007449	0	0	65.00
66.00	06600	PHYSICAL THERAPY		286,109	12,945,168	0.022102	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY		0	0	0.000000	0	0	67.00
68.00	06800	SPEECH PATHOLOGY		0	0	0.000000	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY		123,104	36,881,915	0.003338	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT		7,891	4,598,596	0.001716	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS		42,691	8,715,110	0.004899	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS		128,396	19,554,745	0.006566	0	0	73.00
74.00	07400	RENAL DIALYSIS		2,940	2,847,389	0.001033	0	0	74.00
76.00	03020	ACUPUNCTURE		0	0	0.000000	0	0	76.00
76.01	03610	SLEEP LAB		110,331	1,452,683	0.075950	0	0	76.01
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES		56,396	2,334,956	0.024153	0	0	76.02
76.03	03950	WOUND CARE		46,195	954,929	0.048375	0	0	76.03
OUTPATIENT SERVICE COST CENTERS									
90.00	09000	CLINIC		133,939	5,124,730	0.026136	0	0	90.00
91.00	09100	EMERGENCY		299,599	121,722,978	0.002461	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART		0	8,528,511	0.000000	0	0	92.00
200.00		Total (lines 50 through 199)		2,969,772	524,789,477		0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS			Provider CCN: 14-0125 Component CCN: 14-S125		Period: From 01/01/2020 To 12/31/2020		Worksheet D Part IV Date/Time Prepared: 7/30/2021 11:17 am	
			Title XIX		Subprovider - IPF		PPS	
Cost Center Description			Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health	
			1.00	2A	2.00	3A	3.00	
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
54.01	05401	ULTRA-SOUND	0	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.00	03020	ACUPUNCTURE	0	0	0	0	0	76.00
76.01	03610	SLEEP LAB	0	0	0	0	0	76.01
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0	0	0	0	76.02
76.03	03950	WOUND CARE	0	0	0	0	0	76.03
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	0	92.00
200.00		Total (lines 50 through 199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS			Provider CCN: 14-0125 Component CCN: 14-S125		Period: From 01/01/2020 To 12/31/2020		Worksheet D Part IV Date/Time Prepared: 7/30/2021 11:17 am	
			Title XIX		Subprovider - IPF		PPS	
Cost Center Description			All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7) (see instructions)	
			4.00	5.00	6.00	7.00	8.00	
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	0	65,071,178	0.000000	50.00
51.00	05100	RECOVERY ROOM	0	0	0	9,349,208	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	537,430	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	12,885,753	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	54,343,831	0.000000	54.00
54.01	05401	ULTRA-SOUND	0	0	0	0	0.000000	54.01
56.00	05600	RADIOISOTOPE	0	0	0	0	0.000000	56.00
57.00	05700	CT SCAN	0	0	0	0	0.000000	57.00
58.00	05800	MRI	0	0	0	0	0.000000	58.00
60.00	06000	LABORATORY	0	0	0	139,012,968	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	17,927,399	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	12,945,168	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	36,881,915	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	4,598,596	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	8,715,110	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	19,554,745	0.000000	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	2,847,389	0.000000	74.00
76.00	03020	ACUPUNCTURE	0	0	0	0	0.000000	76.00
76.01	03610	SLEEP LAB	0	0	0	1,452,683	0.000000	76.01
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0	0	2,334,956	0.000000	76.02
76.03	03950	WOUND CARE	0	0	0	954,929	0.000000	76.03
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0	5,124,730	0.000000	90.00
91.00	09100	EMERGENCY	0	0	0	121,722,978	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	8,528,511	0.000000	92.00
200.00		Total (lines 50 through 199)	0	0	0	524,789,477		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS				Provider CCN: 14-0125 Component CCN: 14-S125		Period: From 01/01/2020 To 12/31/2020		Worksheet D Part IV Date/Time Prepared: 7/30/2021 11:17 am	
				Title XIX		Subprovider - IPF		PPS	
Cost Center Description				Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
				9.00	10.00	11.00	12.00	13.00	
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM		0.000000	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM		0.000000	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM		0.000000	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY		0.000000	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC		0.000000	0	0	0	0	54.00
54.01	05401	ULTRA-SOUND		0.000000	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE		0.000000	0	0	0	0	56.00
57.00	05700	CT SCAN		0.000000	0	0	0	0	57.00
58.00	05800	MRI		0.000000	0	0	0	0	58.00
60.00	06000	LABORATORY		0.000000	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY		0.000000	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY		0.000000	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY		0.000000	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY		0.000000	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY		0.000000	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT		0.000000	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS		0.000000	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS		0.000000	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS		0.000000	0	0	0	0	74.00
76.00	03020	ACUPUNCTURE		0.000000	0	0	0	0	76.00
76.01	03610	SLEEP LAB		0.000000	0	0	0	0	76.01
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES		0.000000	0	0	0	0	76.02
76.03	03950	WOUND CARE		0.000000	0	0	0	0	76.03
OUTPATIENT SERVICE COST CENTERS									
90.00	09000	CLINIC		0.000000	0	0	0	0	90.00
91.00	09100	EMERGENCY		0.000000	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART		0.000000	0	0	0	0	92.00
200.00		Total (lines 50 through 199)			0	0	0	0	200.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-0125	Period: From 01/01/2020 To 12/31/2020	Worksheet D-1 Date/Time Prepared: 7/30/2021 11:17 am	
		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)			19,666	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)			19,666	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)			17,711	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)			2,506	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)			0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)			0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period			0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)			0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)			0	14.00
15.00	Total nursery days (title V or XIX only)			0	15.00
16.00	Nursery days (title V or XIX only)			0	16.00
	SWING BED ADJUSTMENT				
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period			0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period			0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period			0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period			0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)			19,684,596	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)			0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)			0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)			0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)			0	25.00
26.00	Total swing-bed cost (see instructions)			0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)			19,684,596	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)			0	28.00
29.00	Private room charges (excluding swing-bed charges)			0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)			0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)			0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)			0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)			0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)			0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)			0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)			0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)			19,684,596	37.00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY				
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS				
38.00	Adjusted general inpatient routine service cost per diem (see instructions)			1,000.95	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)			2,508,381	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)			2,508,381	41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-0125

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

Worksheet D-1

Date/Time Prepared:
7/30/2021 11:17 am

		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	3,879,023	1,340	2,894.79	522	1,511,080
44.00	CORONARY CARE UNIT					
45.00	BURN INTENSIVE CARE UNIT					
46.00	SURGICAL INTENSIVE CARE UNIT					
47.00	OTHER SPECIAL CARE (SPECIFY)					
	Cost Center Description					1.00
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					5,866,896
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					9,886,357
	PASS THROUGH COST ADJUSTMENTS					
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)					329,869
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					306,397
52.00	Total Program excludable cost (sum of lines 50 and 51)					636,266
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					9,250,091
	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)					1,955
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					1,000.95
89.00	Observation bed cost (line 87 x line 88) (see instructions)					1,956,857

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-0125

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

Worksheet D-1

Date/Time Prepared:
7/30/2021 11:17 am

		Title XVIII		Hospital	PPS	
Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
	1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00 Capital-related cost	1,438,882	19,684,596	0.073097	1,956,857	143,040	90.00
91.00 Nursing School cost	0	19,684,596	0.000000	1,956,857	0	91.00
92.00 Allied health cost	0	19,684,596	0.000000	1,956,857	0	92.00
93.00 All other Medical Education	0	19,684,596	0.000000	1,956,857	0	93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-0125 Component CCN: 14-S125	Period: From 01/01/2020 To 12/31/2020	Worksheet D-1 Date/Time Prepared: 7/30/2021 11:17 am
		Title XVIII	Subprovider - IPF	PPS
Cost Center Description			1.00	
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		3,185	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		3,185	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)		3,185	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions)		1,675	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)		3,165,154	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)		3,165,154	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)		3,165,154	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)		993.77	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		1,664,565	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)		0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)		1,664,565	41.00

COMPUTATION OF INPATIENT OPERATING COST				Provider CCN: 14-0125 Component CCN: 14-S125	Period: From 01/01/2020 To 12/31/2020	Worksheet D-1 Date/Time Prepared: 7/30/2021 11:17 am	
				Title XVIII		Subprovider - IPF	PPS
Cost Center Description		Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)	0	0	0.00	0		42.00
Intensive Care Type Inpatient Hospital Units							
43.00	INTENSIVE CARE UNIT	0	0	0.00	0	0	43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00
Cost Center Description							
							1.00
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					347,789	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					2,012,354	49.00
PASS THROUGH COST ADJUSTMENTS							
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)					119,913	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					16,053	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)					135,966	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					1,876,388	53.00
TARGET AMOUNT AND LIMIT COMPUTATION							
54.00	Program discharges					0	54.00
55.00	Target amount per discharge					0.00	55.00
56.00	Target amount (line 54 x line 55)					0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)					0	57.00
58.00	Bonus payment (see instructions)					0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket					0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket					0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)					0	61.00
62.00	Relief payment (see instructions)					0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)					0	63.00
PROGRAM INPATIENT ROUTINE SWING BED COST							
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)					0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)					0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)					0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)					0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)					0	69.00
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY							
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)						70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)						71.00
72.00	Program routine service cost (line 9 x line 71)						72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)						73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)						74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)						75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)						76.00
77.00	Program capital-related costs (line 9 x line 76)						77.00
78.00	Inpatient routine service cost (line 74 minus line 77)						78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)						79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)						80.00
81.00	Inpatient routine service cost per diem limitation						81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)						82.00
83.00	Reasonable inpatient routine service costs (see instructions)						83.00
84.00	Program inpatient ancillary services (see instructions)						84.00
85.00	Utilization review - physician compensation (see instructions)						85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)						86.00
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
87.00	Total observation bed days (see instructions)					0	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					0.00	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)					0	89.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-0125 Component CCN: 14-S125		Period: From 01/01/2020 To 12/31/2020		Worksheet D-1 Date/Time Prepared: 7/30/2021 11:17 am	
		Title XVIII		Subprovider - IPF		PPS	
Cost Center Description		Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00	Capital-related cost	228,021	3,165,154	0.072041	0	0	90.00
91.00	Nursing School cost	0	3,165,154	0.000000	0	0	91.00
92.00	Allied health cost	0	3,165,154	0.000000	0	0	92.00
93.00	All other Medical Education	0	3,165,154	0.000000	0	0	93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-0125	Period: From 01/01/2020 To 12/31/2020	Worksheet D-1 Date/Time Prepared: 7/30/2021 11:17 am	
		Title XIX	Hospital	PPS	
Cost Center Description				1.00	
PART I - ALL PROVIDER COMPONENTS					
INPATIENT DAYS					
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)			19,666	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)			19,666	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)			17,711	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)			143	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)			68	15.00
16.00	Nursery days (title V or XIX only)			19	16.00
SWING BED ADJUSTMENT					
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period			0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period			0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period			0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period			0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)			19,684,596	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)			0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)			0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)			0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)			0	25.00
26.00	Total swing-bed cost (see instructions)			0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)			19,684,596	27.00
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT					
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)			0	28.00
29.00	Private room charges (excluding swing-bed charges)			0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)			0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)			0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)			0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)			0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)			0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)			0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)			0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)			19,684,596	37.00
PART II - HOSPITAL AND SUBPROVIDERS ONLY					
PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS					
38.00	Adjusted general inpatient routine service cost per diem (see instructions)			1,000.95	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)			143,136	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)			143,136	41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-0125

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

Worksheet D-1

Date/Time Prepared:
7/30/2021 11:17 am

Cost Center Description		Title XIX		Hospital		PPS	
		Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)	124,318	68	1,828.21	19	34,736	42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	3,879,023	1,340	2,894.79	17	49,211	43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00
	Cost Center Description						
						1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)						0 48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)						227,083 49.00
	PASS THROUGH COST ADJUSTMENTS						
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)						19,316 50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)						0 51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)						19,316 52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)						207,767 53.00
	TARGET AMOUNT AND LIMIT COMPUTATION						
54.00	Program discharges						0 54.00
55.00	Target amount per discharge						0.00 55.00
56.00	Target amount (line 54 x line 55)						0 56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)						0 57.00
58.00	Bonus payment (see instructions)						0 58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket						0.00 59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket						0.00 60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)						0 61.00
62.00	Relief payment (see instructions)						0 62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)						0 63.00
	PROGRAM INPATIENT ROUTINE SWING BED COST						
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)						0 64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)						0 65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)						0 66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)						0 67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)						0 68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)						0 69.00
	PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY						
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)						70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)						71.00
72.00	Program routine service cost (line 9 x line 71)						72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)						73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)						74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)						75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)						76.00
77.00	Program capital-related costs (line 9 x line 76)						77.00
78.00	Inpatient routine service cost (line 74 minus line 77)						78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)						79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)						80.00
81.00	Inpatient routine service cost per diem limitation						81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)						82.00
83.00	Reasonable inpatient routine service costs (see instructions)						83.00
84.00	Program inpatient ancillary services (see instructions)						84.00
85.00	Utilization review - physician compensation (see instructions)						85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)						86.00
	PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
87.00	Total observation bed days (see instructions)						1,955 87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)						1,000.95 88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)						1,956,857 89.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-0125

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

Worksheet D-1

Date/Time Prepared:
7/30/2021 11:17 am

Cost Center Description		Title XIX		Hospital	PPS	
		Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00
COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	1,438,882	19,684,596	0.073097	1,956,857	143,040
91.00	Nursing School cost	0	19,684,596	0.000000	1,956,857	0
92.00	Allied health cost	0	19,684,596	0.000000	1,956,857	0
93.00	All other Medical Education	0	19,684,596	0.000000	1,956,857	0

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-0125 Component CCN: 14-S125	Period: From 01/01/2020 To 12/31/2020	Worksheet D-1 Date/Time Prepared: 7/30/2021 11:17 am
		Title XIX	Subprovider - IPF	PPS
Cost Center Description			1.00	
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		3,185	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		3,185	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)		3,185	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions)		1,304	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)		68	15.00
16.00	Nursery days (title V or XIX only)		19	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)		3,165,154	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)		3,165,154	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)		3,165,154	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)		993.77	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		1,295,876	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)		0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)		1,295,876	41.00

COMPUTATION OF INPATIENT OPERATING COST				Provider CCN: 14-0125 Component CCN: 14-S125	Period: From 01/01/2020 To 12/31/2020	Worksheet D-1 Date/Time Prepared: 7/30/2021 11:17 am	
				Title XIX		Subprovider - IPF	PPS
Cost Center Description		Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)	0	0	0.00	0		42.00
Intensive Care Type Inpatient Hospital Units							
43.00	INTENSIVE CARE UNIT	0	0	0.00	0	0	43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00
Cost Center Description							
							1.00
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					0	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					1,295,876	49.00
PASS THROUGH COST ADJUSTMENTS							
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)					93,353	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					0	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)					93,353	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					1,202,523	53.00
TARGET AMOUNT AND LIMIT COMPUTATION							
54.00	Program discharges					0	54.00
55.00	Target amount per discharge					0.00	55.00
56.00	Target amount (line 54 x line 55)					0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)					0	57.00
58.00	Bonus payment (see instructions)					0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket					0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket					0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)					0	61.00
62.00	Relief payment (see instructions)					0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)					0	63.00
PROGRAM INPATIENT ROUTINE SWING BED COST							
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)					0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)					0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)					0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)					0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)					0	69.00
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY							
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)						70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)						71.00
72.00	Program routine service cost (line 9 x line 71)						72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)						73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)						74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)						75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)						76.00
77.00	Program capital-related costs (line 9 x line 76)						77.00
78.00	Inpatient routine service cost (line 74 minus line 77)						78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)						79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)						80.00
81.00	Inpatient routine service cost per diem limitation						81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)						82.00
83.00	Reasonable inpatient routine service costs (see instructions)						83.00
84.00	Program inpatient ancillary services (see instructions)						84.00
85.00	Utilization review - physician compensation (see instructions)						85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)						86.00
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
87.00	Total observation bed days (see instructions)					0	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					0.00	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)					0	89.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-0125 Component CCN: 14-S125		Period: From 01/01/2020 To 12/31/2020		Worksheet D-1 Date/Time Prepared: 7/30/2021 11:17 am	
		Title XIX		Subprovider - IPF		PPS	
Cost Center Description		Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00	Capital-related cost	228,021	3,165,154	0.072041	0	0	90.00
91.00	Nursing School cost	0	3,165,154	0.000000	0	0	91.00
92.00	Allied health cost	0	3,165,154	0.000000	0	0	92.00
93.00	All other Medical Education	0	3,165,154	0.000000	0	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT			Provider CCN: 14-0125	Period: From 01/01/2020 To 12/31/2020	Worksheet D-3 Date/Time Prepared: 7/30/2021 11:17 am	
			Title XVIII	Hospital	PPS	
Cost Center Description			Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS		15,704,570		30.00
31.00	03100	INTENSIVE CARE UNIT		5,616,510		31.00
40.00	04000	SUBPROVIDER - IPF		8,198,557		40.00
41.00	04100	SUBPROVIDER - IRF		0		41.00
43.00	04300	NURSERY				43.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.123366	5,910,719	729,182	50.00
51.00	05100	RECOVERY ROOM	0.056844	707,191	40,200	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1.905660	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.015931	1,359,100	21,652	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.139239	3,849,716	536,031	54.00
54.01	05401	ULTRA-SOUND	0.000000	0	0	54.01
56.00	05600	RADIOISOTOPE	0.000000	0	0	56.00
57.00	05700	CT SCAN	0.000000	0	0	57.00
58.00	05800	MRI	0.000000	0	0	58.00
60.00	06000	LABORATORY	0.058099	13,667,506	794,068	60.00
65.00	06500	RESPIRATORY THERAPY	0.091122	6,881,070	627,017	65.00
66.00	06600	PHYSICAL THERAPY	0.218104	1,076,061	234,693	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.078083	6,430,037	502,077	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.115736	2,019,145	233,688	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.225170	1,209,383	272,317	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.233839	3,987,766	932,495	73.00
74.00	07400	RENAL DIALYSIS	0.070944	1,673,804	118,746	74.00
76.00	03020	ACUPUNCTURE	0.000000	0	0	76.00
76.01	03610	SLEEP LAB	0.631773	0	0	76.01
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0.144186	202,331	29,173	76.02
76.03	03950	WOUND CARE	0.446828	987	441	76.03
OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.132690	1,157	154	90.00
91.00	09100	EMERGENCY	0.063666	8,403,596	535,023	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.229449	1,132,884	259,939	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		58,512,453	5,866,896	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)		58,512,453		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 14-0125 Component CCN: 14-S125	Period: From 01/01/2020 To 12/31/2020	Worksheet D-3 Date/Time Prepared: 7/30/2021 11:17 am	
		Title XVIII	Subprovider - IPF	PPS	
Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDIATRICS		0		30.00
31.00	03100 INTENSIVE CARE UNIT		0		31.00
40.00	04000 SUBPROVIDER - IPF		9,721,700		40.00
41.00	04100 SUBPROVIDER - IRF		0		41.00
43.00	04300 NURSERY				43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.123366	0	0	50.00
51.00	05100 RECOVERY ROOM	0.056844	0	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	1.905660	0	0	52.00
53.00	05300 ANESTHESIOLOGY	0.015931	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.139239	119,497	16,639	54.00
54.01	05401 ULTRA-SOUND	0.000000	0	0	54.01
56.00	05600 RADIOISOTOPE	0.000000	0	0	56.00
57.00	05700 CT SCAN	0.000000	0	0	57.00
58.00	05800 MRI	0.000000	0	0	58.00
60.00	06000 LABORATORY	0.058099	1,321,113	76,755	60.00
65.00	06500 RESPIRATORY THERAPY	0.091122	13,270	1,209	65.00
66.00	06600 PHYSICAL THERAPY	0.218104	72,869	15,893	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.000000	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0.000000	0	0	68.00
69.00	06900 ELECTROCARDIOLOGY	0.078083	47,257	3,690	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.115736	7,838	907	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.225170	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.233839	618,919	144,727	73.00
74.00	07400 RENAL DIALYSIS	0.070944	0	0	74.00
76.00	03020 ACUPUNCTURE	0.000000	0	0	76.00
76.01	03610 SLEEP LAB	0.631773	0	0	76.01
76.02	03550 PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0.144186	157,394	22,694	76.02
76.03	03950 WOUND CARE	0.446828	0	0	76.03
OUTPATIENT SERVICE COST CENTERS					
90.00	09000 CLINIC	0.132690	0	0	90.00
91.00	09100 EMERGENCY	0.063666	1,025,280	65,275	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0.229449	0	0	92.00
200.00	Total (sum of lines 50 through 94 and 96 through 98)		3,383,437	347,789	200.00
201.00	Less PBP Clinic Laboratory Services-Program only charges (line 61)		0	0	201.00
202.00	Net charges (line 200 minus line 201)		3,383,437		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0125	Period: From 01/01/2020 To 12/31/2020	Worksheet E Part A Date/Time Prepared: 7/30/2021 11:17 am
		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)		5,354,886	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1 (see instructions)		2,353,486	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)		100,944	2.03
2.04	Outlier payments for discharges occurring on or after October 1 (see instructions)		0	2.04
3.00	Managed Care Simulated Payments		0	3.00
4.00	Bed days available divided by number of days in the cost reporting period (see instructions)		282.66	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)		15.01	30.00
31.00	Percentage of Medicaid patient days (see instructions)		51.32	31.00
32.00	Sum of lines 30 and 31		66.33	32.00
33.00	Allowable disproportionate share percentage (see instructions)		54.43	33.00
34.00	Disproportionate share adjustment (see instructions)		1,048,917	34.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0125	Period: From 01/01/2020 To 12/31/2020	Worksheet E Part A Date/Time Prepared: 7/30/2021 11:17 am	
		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)	1,240,127	788,718		35.02
35.03	Pro rata share of the hospital uncompensated care payment amount (see instructions)	928,401	198,800		35.03
36.00	Total uncompensated care (sum of columns 1 and 2 on line 35.03)	1,127,201			36.00
Additional payment for high percentage of ESRD beneficiary discharges (lines 40 through 46)					
40.00	Total Medicare discharges, excluding MS-DRGs 652, 682, 683, 684 and 685. (see instructions)		0		40.00
41.00	Total ESRD Medicare discharges excluding MS-DRGs 652, 682, 683, 684 and 685. (see instructions)		0		41.00
41.01	Total ESRD Medicare covered and paid discharges excluding MS-DRGs 652, 682, 683, 684 and 685. (see instructions)		0		41.01
42.00	Divide line 41 by line 40 (if less than 10%, you do not qualify for adjustment)	0.00			42.00
43.00	Total Medicare ESRD inpatient days excluding MS-DRGs 652, 682, 683, 684 and 685. (see instructions)		0		43.00
44.00	Ratio of average length of stay to one week (line 43 divided by line 41 divided by 7 days)	0.000000			44.00
45.00	Average weekly cost for dialysis treatments (see instructions)	0.00			45.00
46.00	Total additional payment (line 45 times line 44 times line 41.01)		0		46.00
47.00	Subtotal (see instructions)	9,985,434			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)		9,985,434		49.00
50.00	Payment for inpatient program capital (from Wkst. L, Pt. I and Pt. II, as applicable)		694,527		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		20,780		54.00
54.01	Islet isolation add-on payment		0		54.01
55.00	Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line 69)		0		55.00
56.00	Cost of physicians' services in a teaching hospital (see instructions)		0		56.00
57.00	Routine service other pass through costs (from Wkst. D, Pt. III, column 9, lines 30 through 35).		0		57.00
58.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 11 line 200)		0		58.00
59.00	Total (sum of amounts on lines 49 through 58)		10,700,741		59.00
60.00	Primary payer payments		0		60.00
61.00	Total amount payable for program beneficiaries (line 59 minus line 60)		10,700,741		61.00
62.00	Deductibles billed to program beneficiaries		865,612		62.00
63.00	Coinurance billed to program beneficiaries		92,928		63.00
64.00	Allowable bad debts (see instructions)		729,590		64.00
65.00	Adjusted reimbursable bad debts (see instructions)		474,234		65.00
66.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		437,640		66.00
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)		10,216,435		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)		-69,437		70.93
70.94	HRR adjustment amount (see instructions)		-80,747		70.94
70.95	Recovery of accelerated depreciation		0		70.95

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0125	Period: From 01/01/2020 To 12/31/2020	Worksheet E Part A Date/Time Prepared: 7/30/2021 11:17 am
		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)		29,325	70.99
71.00	Amount due provider (line 67 minus lines 68 plus/minus lines 69 & 70)		10,036,926	71.00
71.01	Sequestration adjustment (see instructions)		66,244	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		9,337,318	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)		633,364	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		1,843,371	75.00
TO BE COMPLETED BY CONTRACTOR (lines 90 through 96)				
90.00	Operating outlier amount from Wkst. E, Pt. A, line 2, or sum of 2.03 plus 2.04 (see instructions)		0	90.00
91.00	Capital outlier from Wkst. L, Pt. I, line 2		0	91.00
92.00	Operating outlier reconciliation adjustment amount (see instructions)		0	92.00
93.00	Capital outlier reconciliation adjustment amount (see instructions)		0	93.00
94.00	The rate used to calculate the time value of money (see instructions)		0.00	94.00
95.00	Time value of money for operating expenses (see instructions)		0	95.00
96.00	Time value of money for capital related expenses (see instructions)		0	96.00
		Prior to 10/1	On/After 10/1	
		1.00	2.00	
HSP Bonus Payment Amount				
100.00	HSP bonus amount (see instructions)		0	100.00
HVBP Adjustment for HSP Bonus Payment				
101.00	HVBP adjustment factor (see instructions)	0.0000000000	0.0000000000	101.00
102.00	HVBP adjustment amount for HSP bonus payment (see instructions)		0	102.00
HRR Adjustment for HSP Bonus Payment				
103.00	HRR adjustment factor (see instructions)	0.0000	0.0000	103.00
104.00	HRR adjustment amount for HSP bonus payment (see instructions)		0	104.00
Rural Community Hospital Demonstration Project (\$410A Demonstration) Adjustment				
200.00	Is this the first year of the current 5-year demonstration period under the 21st Century Cures Act? Enter "Y" for yes or "N" for no.			200.00
Cost Reimbursement				
201.00	Medicare inpatient service costs (from Wkst. D-1, Pt. II, line 49)			201.00
202.00	Medicare discharges (see instructions)			202.00
203.00	Case-mix adjustment factor (see instructions)			203.00
Computation of Demonstration Target Amount Limitation (N/A in first year of the current 5-year demonstration period)				
204.00	Medicare target amount			204.00
205.00	Case-mix adjusted target amount (line 203 times line 204)			205.00
206.00	Medicare inpatient routine cost cap (line 202 times line 205)			206.00
Adjustment to Medicare Part A Inpatient Reimbursement				
207.00	Program reimbursement under the \$410A Demonstration (see instructions)			207.00
208.00	Medicare Part A inpatient service costs (from Wkst. E, Pt. A, line 59)			208.00
209.00	Adjustment to Medicare IPPS payments (see instructions)			209.00
210.00	Reserved for future use			210.00
211.00	Total adjustment to Medicare IPPS payments (see instructions)			211.00
Comparison of PPS versus Cost Reimbursement				
212.00	Total adjustment to Medicare Part A IPPS payments (from line 211)			212.00
213.00	Low-volume adjustment (see instructions)			213.00
218.00	Net Medicare Part A IPPS adjustment (difference between PPS and cost reimbursement) (line 212 minus line 213) (see instructions)			218.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0125	Period: From 01/01/2020 To 12/31/2020	Worksheet E Part B Date/Time Prepared: 7/30/2021 11:17 am
		Title XVIII	Hospital	PPS
				1.00
PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)		4,739	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)		4,668,653	2.00
3.00	OPPS payments		3,166,653	3.00
4.00	Outlier payment (see instructions)		4,550	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)		4,739	11.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
12.00	Ancillary service charges		21,019	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)		21,019	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)		21,019	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)		16,280	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)		4,739	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)		3,171,203	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)		589,632	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)		2,586,310	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)		2,586,310	30.00
31.00	Primary payer payments		1,248	31.00
32.00	Subtotal (line 30 minus line 31)		2,585,062	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)		282,854	34.00
35.00	Adjusted reimbursable bad debts (see instructions)		183,855	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		105,892	36.00
37.00	Subtotal (see instructions)		2,768,917	37.00
38.00	MSP-LCC reconciliation amount from PS&R		-6	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	39.00
39.50	Pioneer ACO demonstration payment adjustment (see instructions)		0	39.50
39.97	Demonstration payment adjustment amount before sequestration		0	39.97
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)		0	39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION		0	39.99
40.00	Subtotal (see instructions)		2,768,923	40.00
40.01	Sequestration adjustment (see instructions)		18,275	40.01
40.02	Demonstration payment adjustment amount after sequestration		0	40.02
40.03	Sequestration adjustment-PARHM pass-throughs		0	40.03
41.00	Interim payments		2,734,143	41.00
41.01	Interim payments-PARHM		0	41.01
42.00	Tentative settlement (for contractors use only)		0	42.00
42.01	Tentative settlement-PARHM (for contractor use only)		0	42.01
43.00	Balance due provider/program (see instructions)		16,505	43.00
43.01	Balance due provider/program-PARHM (see instructions)		0	43.01
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		0	44.00
TO BE COMPLETED BY CONTRACTOR				
90.00	Original outlier amount (see instructions)		0	90.00
91.00	Outlier reconciliation adjustment amount (see instructions)		0	91.00
92.00	The rate used to calculate the Time Value of Money		0.00	92.00
93.00	Time Value of Money (see instructions)		0	93.00
94.00	Total (sum of lines 91 and 93)		0	94.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0125 Component CCN: 14-S125	Period: From 01/01/2020 To 12/31/2020	Worksheet E Part B Date/Time Prepared: 7/30/2021 11:17 am
		Title XVIII	Subprovider - IPF	PPS
			1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES			
1.00	Medical and other services (see instructions)		1,017	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)		1,615	2.00
3.00	OPPS payments		2,627	3.00
4.00	Outlier payment (see instructions)		0	4.00
4.01	Outlier reconciliation amount (see instructions)		0	4.01
5.00	Enter the hospital specific payment to cost ratio (see instructions)		0.000	5.00
6.00	Line 2 times line 5		0	6.00
7.00	Sum of lines 3, 4, and 4.01, divided by line 6		0.00	7.00
8.00	Transitional corridor payment (see instructions)		0	8.00
9.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200		0	9.00
10.00	Organ acquisitions		0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)		1,017	11.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
12.00	Ancillary service charges		4,349	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)		4,349	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)		4,349	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)		3,332	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)		1,017	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)		2,627	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)		264	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)		3,380	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)		3,380	30.00
31.00	Primary payer payments		0	31.00
32.00	Subtotal (line 30 minus line 31)		3,380	32.00
ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)				
33.00	Composite rate ESRD (from Wkst. I-5, line 11)		0	33.00
34.00	Allowable bad debts (see instructions)		0	34.00
35.00	Adjusted reimbursable bad debts (see instructions)		0	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		0	36.00
37.00	Subtotal (see instructions)		3,380	37.00
38.00	MSP-LCC reconciliation amount from PS&R		0	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	39.00
39.50	Pioneer ACO demonstration payment adjustment (see instructions)		39.50	
39.97	Demonstration payment adjustment amount before sequestration		0	39.97
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)		0	39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION		0	39.99
40.00	Subtotal (see instructions)		3,380	40.00
40.01	Sequestration adjustment (see instructions)		22	40.01
40.02	Demonstration payment adjustment amount after sequestration		0	40.02
40.03	Sequestration adjustment-PARHM pass-throughs		0	40.03
41.00	Interim payments		2,348	41.00
41.01	Interim payments-PARHM		0	41.01
42.00	Tentative settlement (for contractors use only)		0	42.00
42.01	Tentative settlement-PARHM (for contractor use only)		0	42.01
43.00	Balance due provider/program (see instructions)		1,010	43.00
43.01	Balance due provider/program-PARHM (see instructions)		0	43.01
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		0	44.00
TO BE COMPLETED BY CONTRACTOR				
90.00	Original outlier amount (see instructions)		0	90.00
91.00	Outlier reconciliation adjustment amount (see instructions)		0	91.00
92.00	The rate used to calculate the Time Value of Money		0.00	92.00
93.00	Time Value of Money (see instructions)		0	93.00
94.00	Total (sum of lines 91 and 93)		0	94.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 14-0125

Period:
From 01/01/2020
To 12/31/2020Worksheet E-1
Part I
Date/Time Prepared:
7/30/2021 11:17 am

		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		9,337,318		2,734,143	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)		9,337,318		2,734,143	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		633,364		16,505	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		9,970,682		2,750,648	7.00
				Contractor Number	NPR Date (Mo/Day/Yr)	
		0		1.00	2.00	
8.00	Name of Contractor					8.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED		Provider CCN: 14-0125 Component CCN: 14-S125		Period: From 01/01/2020 To 12/31/2020		Worksheet E-1 Part I Date/Time Prepared: 7/30/2021 11:17 am	
		Title XVIII		Subprovider - IPF		PPS	
		Inpatient Part A		Part B			
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount		
		1.00	2.00	3.00	4.00		
1.00	Total interim payments paid to provider					1.00	
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		1,369,687		2,348	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)		1,369,687		2,348	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		45,164		1,010	6.01	
6.02	SETTLEMENT TO PROGRAM		0		0	6.02	
7.00	Total Medicare program liability (see instructions)		1,414,851		3,358	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: 14-0125	Period: From 01/01/2020 To 12/31/2020	Worksheet E-1 Part II Date/Time Prepared: 7/30/2021 11:17 am
		Title XVIII	Hospital	PPS
				1.00
TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS				
HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION				
1.00	Total hospital discharges as defined in AARA §4102 from Wkst. S-3, Pt. I col. 15 line 14			1.00
2.00	Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, 8-12			2.00
3.00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2			3.00
4.00	Total inpatient days from S-3, Pt. I col. 8 sum of lines 1, 8-12			4.00
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200			5.00
6.00	Total hospital charity care charges from Wkst. S-10, col. 3 line 20			6.00
7.00	CAH only - The reasonable cost incurred for the purchase of certified HIT technology Wkst. S-2, Pt. I line 168			7.00
8.00	Calculation of the HIT incentive payment (see instructions)			8.00
9.00	Sequestration adjustment amount (see instructions)			9.00
10.00	Calculation of the HIT incentive payment after sequestration (see instructions)			10.00
INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH				
30.00	Initial/interim HIT payment adjustment (see instructions)			30.00
31.00	Other Adjustment (specify)			31.00
32.00	Balance due provider (line 8 (or line 10) minus line 30 and line 31) (see instructions)			32.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0125 Component CCN: 14-S125	Period: From 01/01/2020 To 12/31/2020	Worksheet E-3 Part II Date/Time Prepared: 7/30/2021 11:17 am
		Title XVIII	Subprovider - IPF	PPS
				1.00
PART II - MEDICARE PART A SERVICES - IPF PPS				
1.00	Net Federal IPF PPS Payments (excluding outlier, ECT, and medical education payments)			1,560,000 1.00
2.00	Net IPF PPS Outlier Payments			0 2.00
3.00	Net IPF PPS ECT Payments			0 3.00
4.00	Unweighted intern and resident FTE count in the most recent cost report filed on or before November 15, 2004. (see instructions)			0.00 4.00
4.01	Cap increases for the unweighted intern and resident FTE count for residents that were displaced by program or hospital closure, that would not be counted without a temporary cap adjustment under 42 CFR §412.424(d)(1)(iii)(F)(1) or (2) (see instructions)			0.00 4.01
5.00	New Teaching program adjustment. (see instructions)			0.00 5.00
6.00	Current year's unweighted FTE count of I&R excluding FTEs in the new program growth period of a "new teaching program" (see instructions)			0.00 6.00
7.00	Current year's unweighted I&R FTE count for residents within the new program growth period of a "new teaching program" (see instructions)			0.00 7.00
8.00	Intern and resident count for IPF PPS medical education adjustment (see instructions)			0.00 8.00
9.00	Average Daily Census (see instructions)			8.702186 9.00
10.00	Teaching Adjustment Factor $\{((1 + (\text{line 8/line 9})) \text{ raised to the power of } .5150 - 1)\}$.			0.000000 10.00
11.00	Teaching Adjustment (line 1 multiplied by line 10).			0 11.00
12.00	Adjusted Net IPF PPS Payments (sum of lines 1, 2, 3 and 11)			1,560,000 12.00
13.00	Nursing and Allied Health Managed Care payment (see instruction)			0 13.00
14.00	Organ acquisition (DO NOT USE THIS LINE)			0 14.00
15.00	Cost of physicians' services in a teaching hospital (see instructions)			0 15.00
16.00	Subtotal (see instructions)			1,560,000 16.00
17.00	Primary payer payments			0 17.00
18.00	Subtotal (line 16 less line 17).			1,560,000 18.00
19.00	Deductibles			181,510 19.00
20.00	Subtotal (line 18 minus line 19)			1,378,490 20.00
21.00	Coinurance			73,359 21.00
22.00	Subtotal (line 20 minus line 21)			1,305,131 22.00
23.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)			183,262 23.00
24.00	Adjusted reimbursable bad debts (see instructions)			119,120 24.00
25.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			79,484 25.00
26.00	Subtotal (sum of lines 22 and 24)			1,424,251 26.00
27.00	Direct graduate medical education payments (see instructions)			0 27.00
28.00	Other pass through costs (see instructions)			0 28.00
29.00	Outlier payments reconciliation			0 29.00
30.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0 30.00
30.50	Pioneer ACO demonstration payment adjustment (see instructions)			0 30.50
30.99	Demonstration payment adjustment amount before sequestration			0 30.99
31.00	Total amount payable to the provider (see instructions)			1,424,251 31.00
31.01	Sequestration adjustment (see instructions)			9,400 31.01
31.02	Demonstration payment adjustment amount after sequestration			0 31.02
32.00	Interim payments			1,369,687 32.00
33.00	Tentative settlement (for contractor use only)			0 33.00
34.00	Balance due provider/program (line 31 minus lines 31.01, 31.02, 32 and 33)			45,164 34.00
35.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2			0 35.00
TO BE COMPLETED BY CONTRACTOR				
50.00	Original outlier amount from Worksheet E-3, Part II, line 2			0 50.00
51.00	Outlier reconciliation adjustment amount (see instructions)			0 51.00
52.00	The rate used to calculate the Time Value of Money			0.00 52.00
53.00	Time Value of Money (see instructions)			0 53.00

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

Provider CCN: 14-0125

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

Worksheet G

Date/Time Prepared:
7/30/2021 11:17 am

		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	-1,285,999	0	0	0	1.00
2.00	Temporary investments	0	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	25,156,956	0	0	0	4.00
5.00	Other receivable	0	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-12,737,725	0	0	0	6.00
7.00	Inventory	2,426,390	0	0	0	7.00
8.00	Prepaid expenses	1,526,156	0	0	0	8.00
9.00	Other current assets	227,701	0	0	0	9.00
10.00	Due from other funds	0	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	15,313,479	0	0	0	11.00
FIXED ASSETS						
12.00	Land	3,137,151	0	0	0	12.00
13.00	Land improvements	262,723	0	0	0	13.00
14.00	Accumulated depreciation	-16,343	0	0	0	14.00
15.00	Buildings	20,418,274	0	0	0	15.00
16.00	Accumulated depreciation	-455,578	0	0	0	16.00
17.00	Leasehold improvements	1,009,516	0	0	0	17.00
18.00	Accumulated depreciation	-45,279	0	0	0	18.00
19.00	Fixed equipment	744,844	0	0	0	19.00
20.00	Accumulated depreciation	-77,230	0	0	0	20.00
21.00	Automobiles and trucks	4,232	0	0	0	21.00
22.00	Accumulated depreciation	-1,058	0	0	0	22.00
23.00	Major movable equipment	3,497,252	0	0	0	23.00
24.00	Accumulated depreciation	-553,448	0	0	0	24.00
25.00	Minor equipment depreciable	1,146,941	0	0	0	25.00
26.00	Accumulated depreciation	-171,172	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)	28,900,825	0	0	0	30.00
OTHER ASSETS						
31.00	Investments	0	0	0	0	31.00
32.00	Deposits on leases	0	0	0	0	32.00
33.00	Due from owners/officers	0	0	0	0	33.00
34.00	Other assets	2,103,134	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	2,103,134	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	46,317,438	0	0	0	36.00
CURRENT LIABILITIES						
37.00	Accounts payable	8,995,715	0	0	0	37.00
38.00	Salaries, wages, and fees payable	2,855,875	0	0	0	38.00
39.00	Payroll taxes payable	1,263,419	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	15,796,119	0	0	0	43.00
44.00	Other current liabilities	2,116,166	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	31,027,294	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	0	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	0	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	31,027,294	0	0	0	51.00
CAPITAL ACCOUNTS						
52.00	General fund balance	15,290,144				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)	15,290,144	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	46,317,438	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 14-0125

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

Worksheet G-1

Date/Time Prepared:
7/30/2021 11:17 am

		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		73,155,908		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		9,593,343				2.00
3.00	Total (sum of line 1 and line 2)		82,749,251		0		3.00
4.00	Additions (credit adjustments) (specify)	0		0		0	4.00
5.00		0		0		0	5.00
6.00		0		0		0	6.00
7.00		0		0		0	7.00
8.00		0		0		0	8.00
9.00		0		0		0	9.00
10.00	Total additions (sum of line 4-9)		0		0		10.00
11.00	Subtotal (line 3 plus line 10)		82,749,251		0		11.00
12.00	REORGANIZATION ADJUSTMENTS TO RE.	67,459,105		0		0	12.00
13.00	ROUNDING	2		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)		67,459,107		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		15,290,144		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			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	REORGANIZATION ADJUSTMENTS TO RE.		0				12.00
13.00	ROUNDING		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: 14-0125

Period:
From 01/01/2020
To 12/31/2020Worksheet G-2
Parts I & II
Date/Time Prepared:
7/30/2021 11:17 am

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
PART I - PATIENT REVENUES					
General Inpatient Routine Services					
1.00	Hospital	108,847,726		108,847,726	1.00
2.00	SUBPROVIDER - IPF	18,494,161		18,494,161	2.00
3.00	SUBPROVIDER - IRF	0		0	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)	127,341,887		127,341,887	10.00
Intensive Care Type Inpatient Hospital Services					
11.00	INTENSIVE CARE UNIT	13,511,677		13,511,677	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)	13,511,677		13,511,677	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	140,853,564		140,853,564	17.00
18.00	Ancillary services	130,429,997	258,983,261	389,413,258	18.00
19.00	Outpatient services	31,451,061	103,925,158	135,376,219	19.00
20.00	RURAL HEALTH CLINIC	0	0	0	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY				22.00
23.00	AMBULANCE SERVICES				23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	PHYSICIAN AND INDUSTRIAL MEDICINE	0	5,602,039	5,602,039	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	302,734,622	368,510,458	671,245,080	28.00
PART II - OPERATING EXPENSES					
29.00	Operating expenses (per Wkst. A, column 3, line 200)		102,423,635		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)		102,423,635		43.00

STATEMENT OF REVENUES AND EXPENSES

Provider CCN: 14-0125

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

Worksheet G-3

Date/Time Prepared:
7/30/2021 11:17 am

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	671,245,080	1.00
2.00	Less contractual allowances and discounts on patients' accounts	581,112,752	2.00
3.00	Net patient revenues (line 1 minus line 2)	90,132,328	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	102,423,635	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-12,291,307	5.00
OTHER INCOME			
6.00	Contributions, donations, bequests, etc	0	6.00
7.00	Income from investments	0	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	0	14.00
15.00	Revenue from rental of living quarters	342,310	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	782	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	3,947	21.00
22.00	Rental of hospital space	0	22.00
23.00	Governmental appropriations	0	23.00
24.00	OTHER INCOME	233,127	24.00
24.50	COVID-19 PHE Funding	21,387,192	24.50
25.00	Total other income (sum of lines 6-24)	21,967,358	25.00
26.00	Total (line 5 plus line 25)	9,676,051	26.00
27.00	GAIN/LOSS DISPOSAL	82,708	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	82,708	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	9,593,343	29.00

CALCULATION OF CAPITAL PAYMENT

Provider CCN: 14-0125

Period:
From 01/01/2020
To 12/31/2020Worksheet L
Parts I-III
Date/Time Prepared:
7/30/2021 11:17 am

		Title XVIII	Hospital	PPS
				1.00
PART I - FULLY PROSPECTIVE METHOD				
CAPITAL FEDERAL AMOUNT				
1.00	Capital DRG other than outlier		595,926	1.00
1.01	Model 4 BPCI Capital DRG other than outlier		0	1.01
2.00	Capital DRG outlier payments		12,966	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)		52.09	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)		15.01	7.00
8.00	Percentage of Medicaid patient days to total days (see instructions)		51.32	8.00
9.00	Sum of lines 7 and 8		66.33	9.00
10.00	Allowable disproportionate share percentage (see instructions)		14.37	10.00
11.00	Disproportionate share adjustment (see instructions)		85,635	11.00
12.00	Total prospective capital payments (see instructions)		694,527	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