

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: 14-0127	Period: From 01/01/2020 To 06/30/2020	Worksheet S Parts I-III Date/Time Prepared: 11/24/2020 1:07 pm
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PART I - COST REPORT STATUS			
Provider use only	1. ☒ Electronically prepared cost report 2. ☐ Manually prepared cost report 3. ☐ If this is an amended report enter the number of times the provider resubmitted this cost report 4. ☐ Medicare Utilization. Enter "F" for full or "L" for low.		Date: 11/24/2020 Time: 1:07 pm
Contractor use only	5. ☐ Cost Report Status (1) As Submitted (2) Settled without Audit (3) Settled with Audit (4) Reopened (5) Amended	6. Date Received: 7. Contractor No. 8. ☐ Initial Report for this Provider CCN 9. ☐ Final Report for this Provider CCN	10. NPR Date: 11. Contractor's Vendor Code: 4 12. ☐ If line 5, column 1 is 4: Enter number of times reopened = 0-9.

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

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

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by ADVOCATE BROMENN MEDICAL CENTER (14-0127) for the cost reporting period beginning 01/01/2020 and ending 06/30/2020 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) MICHAEL VOLANTE
 Officer or Administrator of Provider(s)

VP REIMBURSEMENT
 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	192,286	16,293	0	0	1.00
2.00	Subprovider - IPF	0	0	0		0	2.00
3.00	Subprovider - IRF	0	12,226	0		0	3.00
4.00	SUBPROVIDER I						4.00
5.00	Swing Bed - SNF	0	0	0		0	5.00
6.00	Swing Bed - NF	0				0	6.00
9.00	HOME HEALTH AGENCY I	0	0	0		0	9.00
200.00	Total	0	204,512	16,293	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: 14-0127		Period: From 01/01/2020 To 06/30/2020		Worksheet S-2 Part I Date/Time Prepared: 11/24/2020 1:07 pm		
1.00		2.00		3.00		4.00					
Hospital and Hospital Health Care Complex Address:											
1.00	Street: 1304 VIRGINIA			PO Box:				1.00			
2.00	City: NORMAL			State: IL		Zip Code: 61761-		County: MCLEAN			
		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			ADVOCATE BROMENN MEDICAL CENTER	140127	14060	1	07/01/1966	N	P	O
4.00	Subprovider - IPF										
5.00	Subprovider - IRF			ADVOCATE BROMENN REHABILITATION	14T127	14060	5	07/01/1990	N	P	O
6.00	Subprovider - (Other)										
7.00	Swing Beds - SNF										
8.00	Swing Beds - NF										
9.00	Hospital-Based SNF										
10.00	Hospital-Based NF										
11.00	Hospital-Based OLTC										
12.00	Hospital-Based HHA										
13.00	Separately Certified ASC										
14.00	Hospital-Based Hospice										
15.00	Hospital-Based Health Clinic - RHC										
16.00	Hospital-Based Health Clinic - FQHC										
17.00	Hospital-Based (CMHC) I										
17.10	Hospital-Based (CORF) I										
18.00	Renal Dialysis										
19.00	Other										
							From:	To:			
							1.00	2.00			
20.00	Cost Reporting Period (mm/dd/yyyy)						01/01/2020	06/30/2020		20.00	
21.00	Type of Control (see instructions)						1			21.00	
							1.00	2.00	3.00		
Inpatient PPS Information											
22.00	Does this facility qualify and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.106(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no.					Y	N			22.00	
22.01	Did this hospital receive interim uncompensated care payments for this cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)					Y	N			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	Y		22.03	
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.					1	N			23.00	

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

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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	
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.	4	1,275	0	0	1,931	63	24.00
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	25	0	0	85		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	N	40.00
					V	XVIII	XIX
					1.00	2.00	3.00
Prospective Payment System (PPS)-Capital							
45.00 Does this facility qualify and receive Capital payment for disproportionate share in accordance with 42 CFR Section §412.320? (see instructions)					N	Y	N
46.00 Is this facility eligible for additional payment exception for extraordinary circumstances pursuant to 42 CFR §412.348(f)? If yes, complete Wkst. L, Pt. III and Wkst. L-1, Pt. I through Pt. III.					N	N	N
47.00 Is this a new hospital under 42 CFR §412.300(b) PPS capital? Enter "Y" for yes or "N" for no.					N	N	N
48.00 Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.					N	N	N
Teaching Hospitals							
56.00 Is this a hospital involved in training residents in approved GME programs? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", are you impacted by CR 11642 (or subsequent CR), MA GME payment reduction? Enter "Y" for yes or "N" for no in column 2.					Y	Y	
57.00 If line 56 is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y" did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If column 2 is "N", complete Wkst. D, Parts III & IV and D-2, Pt. II, if applicable.					N		
58.00 If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, chapter 21, §2148? If yes, complete Wkst. D-5.					N		
59.00 Are costs claimed on line 100 of Worksheet A? If yes, complete Wkst. D-2, Pt. I.					N		

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		NAHE 413.85 Y/N	Worksheet A Line #	Pass-Through Qualification Criterion Code			
		1.00	2.00	3.00			
60.00	Are you claiming nursing and allied health education (NAHE) costs for any programs that meet the criteria under 42 CFR 413.85? (see instructions) Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", are you impacted by CR 11642 (or subsequent CR) NAHE MA payment adjustment? Enter "Y" for yes or "N" for no in column 2.	Y	Y			60.00	
60.01	If line 60 is yes, complete columns 2 and 3 for each program. (see instructions)		23.00	1		60.01	
		Y/N	IME	Direct GME	IME	Direct GME	
		1.00	2.00	3.00	4.00	5.00	
61.00	Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions)	N			0.00	0.00	61.00
61.01	Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions)						61.01
61.02	Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions)						61.02
61.03	Enter the base line FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions)						61.03
61.04	Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period.(see instructions).						61.04
61.05	Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions)						61.05
61.06	Enter the amount of ACA \$5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)						61.06
		Program Name	Program Code	Unweighted IME FTE Count	Unweighted Direct GME FTE Count		
		1.00	2.00	3.00	4.00		
61.10	Of the FTEs in line 61.05, specify each new program specialty, if any, and the number of FTE residents for each new program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count.			0.00	0.00	61.10	
61.20	Of the FTEs in line 61.05, specify each expanded program specialty, if any, and the number of FTE residents for each expanded program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count.			0.00	0.00	61.20	
						1.00	
<u>ACA Provisions Affecting the Health Resources and Services Administration (HRSA)</u>							
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
<u>Teaching Hospitals that Claim Residents in Nonprovider Settings</u>							
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)					Y	63.00

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			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)					64.00	
		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	
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)	FAMILY PRACTICE - OSTEOPATHIC	3630	1.50	6.64	0.184275	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)					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)	FAMILY MEDICINE & OSTEOPATHIC MANIPU	3630	1.38	3.29	0.295503	67.00
67.01		FAMILY MEDICINE & OMT	6400	0.00	1.00	0.000000	67.01
67.02		FAMILY MEDICINE GENERAL	1350	0.00	0.83	0.000000	67.02

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			1.00	2.00	3.00
Inpatient Psychiatric Facility PPS					
70.00	Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? Enter "Y" for yes or "N" for no.	N			70.00
71.00	If line 70 is yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost report filed on or before November 15, 2004? Enter "Y" for yes or "N" for no. (see 42 CFR 412.424(d)(1)(iii)(c)) Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)			0	71.00
Inpatient Rehabilitation Facility PPS					
75.00	Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF subprovider? Enter "Y" for yes and "N" for no.	Y			75.00
76.00	If line 75 is yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)	N	N	0	76.00
			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.	Y	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

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				V	XIX		
				1.00	2.00		
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	109.00	
				1.00			
110.00	Did this hospital participate in the Rural Community Hospital Demonstration project (§410A Demonstration) for the current cost reporting period? Enter "Y" for yes or "N" for no. If yes, complete Worksheet E, Part A, lines 200 through 218, and Worksheet E-2, lines 200 through 215, as applicable.	N				110.00	
				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:	117,624	725,000	2,891,887		118.01	
				1.00	2.00		
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein.	N				118.02	
119.00	DO NOT USE THIS LINE					119.00	
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 1, "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2, "Y" for yes or "N" for no.	N		N		120.00	
121.00	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter "Y" for yes or "N" for no.	Y				121.00	
122.00	Does the cost report contain healthcare related taxes as defined in §1903(w)(3) of the Act? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2 the Worksheet A line number where these taxes are included.	N				122.00	
Transplant Center Information							
125.00	Does this facility operate a transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.	N				125.00	
126.00	If this is a Medicare certified kidney transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					126.00	
127.00	If this is a Medicare certified heart transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					127.00	
128.00	If this is a Medicare certified liver transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					128.00	
129.00	If this is a Medicare certified lung transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					129.00	
130.00	If this is a Medicare certified pancreas transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					130.00	

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA			Provider CCN: 14-0127		Period: From 01/01/2020 To 06/30/2020		Worksheet S-2 Part I Date/Time Prepared: 11/24/2020 1:07 pm	
			1.00		2.00			
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		14H036	
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: ADVOCATE AURORA HEALTHCARE		Contractor's Name: NGS		Contractor's Number: 06101			
142.00	Street: 3075 HIGHLAND PKWY		PO Box: SUITE 600					
143.00	City: DOWNERS GROVE		State: IL		Zip Code: 60515			
			1.00					
144.00	Are provider based physicians' costs included in worksheet A?						Y	
			1.00			2.00		
145.00	If costs for renal services are claimed on Wkst. A, line 74, are the costs for inpatient services only? Enter "Y" for yes or "N" for no in column 1. If column 1 is no, does the dialysis facility include Medicare utilization for this cost reporting period? Enter "Y" for yes or "N" for no in column 2.							145.00
146.00	Has the cost allocation methodology changed from the previously filed cost report? Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, chapter 40, §4020) If yes, enter the approval date (mm/dd/yyyy) in column 2.						N	146.00
			1.00					
147.00	Was there a change in the statistical basis? Enter "Y" for yes or "N" for no.						N	147.00
148.00	Was there a change in the order of allocation? Enter "Y" for yes or "N" for no.						N	148.00
149.00	Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no.						N	149.00
			Part A		Part B		Title V	
			1.00		2.00		3.00	
			4.00					
Does this facility contain a provider that qualifies for an exemption from the application of the lower of costs or charges? Enter "Y" for yes or "N" for no for each component for Part A and Part B. (See 42 CFR §413.13)								
155.00	Hospital		N		N		N	
156.00	Subprovider - IPF		N		N		N	
157.00	Subprovider - IRF		N		N		N	
158.00	SUBPROVIDER							
159.00	SNF		N		N		N	
160.00	HOME HEALTH AGENCY		N		N		N	
161.00	CMHC				N		N	
161.10	CORF				N		N	
			1.00					
Multicampus								
165.00	Is this hospital part of a Multicampus hospital that has one or more campuses in different CBSAs? Enter "Y" for yes or "N" for no.						N	
			Name		County		State	
			0		1.00		2.00	
							3.00	
							4.00	
							5.00	
166.00	If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions)						0.00	
			1.00					
Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act								
167.00	Is this provider a meaningful user under §1886(n)? Enter "Y" for yes or "N" for no.						Y	
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)							
168.01	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)							
169.00	If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)						0.00	

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-0127	Period: From 01/01/2020 To 06/30/2020	Worksheet S-2 Part I Date/Time Prepared: 11/24/2020 1:07 pm
			Beginning 1.00	Ending 2.00
170.00	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)			170.00
			1.00	2.00
171.00	If line 167 is "Y", does this provider have any days for individuals enrolled in section 1876 Medicare cost plans reported on Wkst. S-3, Pt. I, line 2, col. 6? Enter "Y" for yes and "N" for no in column 1. If column 1 is yes, enter the number of section 1876 Medicare days in column 2. (see instructions)	Y	2,132	171.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 14-0127	Period: From 01/01/2020 To 06/30/2020	Worksheet S-2 Part II Date/Time Prepared: 11/24/2020 1:07 pm
			Y/N 1.00	Date 2.00
General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format.				
COMPLETED BY ALL HOSPITALS				
Provider Organization and Operation				
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)	N		1.00
		Y/N 1.00	Date 2.00	V/I 3.00
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.	N		2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)	Y		3.00
		Y/N 1.00	Type 2.00	Date 3.00
Financial Data and Reports				
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	N		06/30/2020 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.	Y		7.00
8.00	Were nursing school and/or allied health programs approved and/or renewed during the cost reporting period? If yes, see instructions.	N		8.00
9.00	Are costs claimed for Interns and Residents in an approved graduate medical education program in the current cost report? If yes, see instructions.	Y		9.00
10.00	Was an approved Intern and Resident GME program initiated or renewed in the current cost reporting period? If yes, see instructions.	N		10.00
11.00	Are GME cost directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions.	N		11.00
			Y/N 1.00	
Bad Debts				
12.00	Is the provider seeking reimbursement for bad debts? If yes, see instructions.		Y	12.00
13.00	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.		N	13.00
14.00	If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.		N	14.00
Bed Complement				
15.00	Did total beds available change from the prior cost reporting period? If yes, see instructions.		N	15.00
		Part A		Part B
		Y/N 1.00	Date 2.00	Y/N 3.00 Date 4.00
PS&R Data				
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)	N		N 16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	Y	10/08/2020	Y 10/08/2020 17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N		N 18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		N 19.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE
Provider CCN: 14-0127
Period: From 01/01/2020 To 06/30/2020
Worksheet S-2 Part II Date/Time Prepared: 11/24/2020 1:07 pm

		Description	Y/N	Y/N	
		0	1.00	3.00	
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:		N	N	20.00
		Y/N	Date	Y/N	Date
		1.00	2.00	3.00	4.00
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		N	21.00
					1.00
COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)					
Capital Related Cost					
22.00	Have assets been relifed for Medicare purposes? If yes, see instructions				22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.				23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions				24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.				25.00
26.00	Were assets subject to Sec.2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.				26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.				27.00
Interest Expense					
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.				28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions				29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.				30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.				31.00
Purchased Services					
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.				32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.				33.00
Provider-Based Physicians					
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.				34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.				35.00
		Y/N	Date		
		1.00	2.00		
Home Office Costs					
36.00	Were home office costs claimed on the cost report?		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.		Y	12/31/2020	38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.		Y		39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.		N		40.00
		1.00	2.00		
Cost Report Preparer Contact Information					
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	PAMELA	DYE		41.00
42.00	Enter the employer/company name of the cost report preparer.	ADVOCATE HEALTHCARE			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	630-929-5760	PAMELA.DYE@ADVOCATEHEALTH.CO M		43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 14-0127	Period: From 01/01/2020 To 06/30/2020	Worksheet S-2 Part II Date/Time Prepared: 11/24/2020 1:07 pm
		3.00		
Cost Report Preparer Contact Information				
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	SENIOR REIMBURSEMENT SPECIALIST		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: 14-0127

Period:
From 01/01/2020
To 06/30/2020Worksheet S-3
Part I
Date/Time Prepared:
11/24/2020 1:07 pm

Component	Worksheet A Line Number	No. of Beds	Bed Days Available	CAH Hours	I/P Days / O/P Visits / Trips	
					Title V	
	1.00	2.00	3.00	4.00	5.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30.00	158	28,756	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)		158	28,756	0.00	0	7.00
8.00 INTENSIVE CARE UNIT	31.00	48	8,736	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)		206	37,492	0.00	0	14.00
15.00 CAH visits					0	15.00
16.00 SUBPROVIDER - IPF	40.00	0	0		0	16.00
17.00 SUBPROVIDER - IRF	41.00	15	2,730		0	17.00
18.00 SUBPROVIDER	42.00	0	0		0	18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY	101.00				0	22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE	116.00	0	0			24.00
24.10 HOSPICE (non-distinct part)	30.00					24.10
25.00 CMHC - CMHC						25.00
25.10 CMHC - CORF	99.10				0	25.10
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)		221				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: 14-0127

Period:
From 01/01/2020
To 06/30/2020Worksheet S-3
Part I
Date/Time Prepared:
11/24/2020 1:07 pm

Component		I/P Days / O/P Visits / Trips			Full Time Equivalents		
		Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
		6.00	7.00	8.00	9.00	10.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	1,255	513	5,658			1.00
2.00	HMO and other (see instructions)	2,132	1,931				2.00
3.00	HMO IPF Subprovider	0	0				3.00
4.00	HMO IRF Subprovider	156	85				4.00
5.00	Hospital Adults & Peds. Swing Bed SNF	0	0	0			5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	0			6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	1,255	513	5,658			7.00
8.00	INTENSIVE CARE UNIT	2,817	257	6,290			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		505	1,666			13.00
14.00	Total (see instructions)	4,072	1,275	13,614	12.92	873.42	14.00
15.00	CAH visits	0	0	0			15.00
16.00	SUBPROVIDER - IPF	0	0	0	0.00	0.00	16.00
17.00	SUBPROVIDER - IRF	583	25	1,287	0.00	14.12	17.00
18.00	SUBPROVIDER		0	0	0.00	0.00	18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY	0	0	0	0.00	0.00	22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE	0	0	0	0.00	0.00	24.00
24.10	HOSPICE (non-distinct part)			259			24.10
25.00	CMHC - CMHC						25.00
25.10	CMHC - CORF	0	0	0	0.00	0.00	25.10
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)				12.92	887.54	27.00
28.00	Observation Bed Days		32	1,813			28.00
29.00	Ambulance Trips	0					29.00
30.00	Employee discount days (see instruction)			146			30.00
31.00	Employee discount days - IRF			0			31.00
32.00	Labor & delivery days (see instructions)	0	67	176			32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)			25			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: 14-0127

Period:
From 01/01/2020
To 06/30/2020Worksheet S-3
Part I
Date/Time Prepared:
11/24/2020 1:07 pm

Component	Full Time Equivalents	Discharges			Total All Patients	
	Nonpaid Workers	Title V	Title XVIII	Title XIX		
	11.00	12.00	13.00	14.00	15.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)		0	988	133	3,480	1.00
2.00 HMO and other (see instructions)			490	538		2.00
3.00 HMO IPF Subprovider				0		3.00
4.00 HMO IRF Subprovider				8		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	988	133	3,480	14.00
15.00 CAH visits						15.00
16.00 SUBPROVIDER - IPF	0.00	0	0	0	0	16.00
17.00 SUBPROVIDER - IRF	0.00	0	50	3	109	17.00
18.00 SUBPROVIDER	0.00	0		0	0	18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY	0.00					22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE	0.00					24.00
24.10 HOSPICE (non-distinct part)						24.10
25.00 CMHC - CMHC						25.00
25.10 CMHC - CORF	0.00					25.10
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: 14-0127

Period:
From 01/01/2020
To 06/30/2020Worksheet S-3
Part II
Date/Time Prepared:
11/24/2020 1:07 pm

	Wkst. A Line Number	Amount Reported	Reclassificati on of Salaries (from Wkst. A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
	1.00	2.00	3.00	4.00	5.00	6.00	
PART II - WAGE DATA							
SALARIES							
1.00	Total salaries (see instructions)	200.00	31,127,405	0	31,127,405	923,042.00	33.72 1.00
2.00	Non-physician anesthetist Part A		0	0	0	0.00	0.00 2.00
3.00	Non-physician anesthetist Part B		0	0	0	0.00	0.00 3.00
4.00	Physician-Part A - Administrative		236,093	0	236,093	1,656.00	142.57 4.00
4.01	Physicians - Part A - Teaching		0	0	0	0.00	0.00 4.01
5.00	Physician and Non Physician-Part B		14,580	0	14,580	69.00	211.30 5.00
6.00	Non-physician-Part B for hospital-based RHC and FQHC services		0	0	0	0.00	0.00 6.00
7.00	Interns & residents (in an approved program)	21.00	836,938	0	836,938	25,854.00	32.37 7.00
7.01	Contracted interns and residents (in an approved programs)		0	0	0	0.00	0.00 7.01
8.00	Home office and/or related organization personnel		0	0	0	0.00	0.00 8.00
9.00	SNF	44.00	0	0	0	0.00	0.00 9.00
10.00	Excluded area salaries (see instructions)		1,086,462	41,397	1,127,859	42,160.00	26.75 10.00
OTHER WAGES & RELATED COSTS							
11.00	Contract labor: Direct Patient Care		596,502	0	596,502	8,174.00	72.98 11.00
12.00	Contract labor: Top level management and other management and administrative services		0	0	0	0.00	0.00 12.00
13.00	Contract labor: Physician-Part A - Administrative		0	0	0	0.00	0.00 13.00
14.00	Home office and/or related organization salaries and wage-related costs		0	0	0	0.00	0.00 14.00
14.01	Home office salaries		3,831,380	0	3,831,380	53,772.00	71.25 14.01
14.02	Related organization salaries		0	0	0	0.00	0.00 14.02
15.00	Home office: Physician Part A - Administrative		0	0	0	0.00	0.00 15.00
16.00	Home office and Contract Physicians Part A - Teaching		0	0	0	0.00	0.00 16.00
16.01	Home office Physicians Part A - Teaching		0	0	0	0.00	0.00 16.01
16.02	Home office contract Physicians Part A - Teaching		0	0	0	0.00	0.00 16.02
WAGE-RELATED COSTS							
17.00	Wage-related costs (core) (see instructions)		8,884,770	0	8,884,770		
18.00	Wage-related costs (other) (see instructions)						
19.00	Excluded areas		352,513	0	352,513		
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		54,781	0	54,781		
22.01	Physician Part A - Teaching		0	0	0		
23.00	Physician Part B		4,475	0	4,475		
24.00	Wage-related costs (RHC/FQHC)		0	0	0		
25.00	Interns & residents (in an approved program)		256,867	0	256,867		
25.50	Home office wage-related (core)		577,701	0	577,701		
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: 14-0127

Period:
From 01/01/2020
To 06/30/2020Worksheet S-3
Part II
Date/Time Prepared:
11/24/2020 1:07 pm

		Wkst. A Line Number	Amount Reported	Reclassificati on of Salaries (from Wkst. A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
25.53	Home office: Physicians Part A - Teaching - wage-related (core)		0	0	0			25.53
OVERHEAD COSTS - DIRECT SALARIES								
26.00	Employee Benefits Department	4.00	416,263	-271,470	144,793	4,447.00	32.56	26.00
27.00	Administrative & General	5.00	4,763,931	-1,101,085	3,662,846	59,293.00	61.78	27.00
28.00	Administrative & General under contract (see inst.)		342,169	0	342,169	2,276.00	150.34	28.00
29.00	Maintenance & Repairs	6.00	0	0	0	0.00	0.00	29.00
30.00	Operation of Plant	7.00	983,268	-6,171	977,097	35,825.00	27.27	30.00
31.00	Laundry & Linen Service	8.00	200,250	9,117	209,367	12,708.00	16.48	31.00
32.00	Housekeeping	9.00	748,622	381	749,003	45,141.00	16.59	32.00
33.00	Housekeeping under contract (see instructions)		0	0	0	0.00	0.00	33.00
34.00	Dietary	10.00	594,245	-209,551	384,694	20,412.00	18.85	34.00
35.00	Dietary under contract (see instructions)		0	0	0	0.00	0.00	35.00
36.00	Cafeteria	11.00	0	252,561	252,561	13,134.00	19.23	36.00
37.00	Maintenance of Personnel	12.00	0	0	0	0.00	0.00	37.00
38.00	Nursing Administration	13.00	1,005,177	97,836	1,103,013	26,117.00	42.23	38.00
39.00	Central Services and Supply	14.00	160,455	0	160,455	7,426.00	21.61	39.00
40.00	Pharmacy	15.00	1,156,560	-5,778	1,150,782	23,705.00	48.55	40.00
41.00	Medical Records & Medical Records Library	16.00	621,667	24,884	646,551	22,007.00	29.38	41.00
42.00	Social Service	17.00	717,958	18,810	736,768	16,989.00	43.37	42.00
43.00	Other General Service	18.00	0	0	0	0.00	0.00	43.00

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 14-0127

Period:
From 01/01/2020
To 06/30/2020Worksheet S-3
Part III
Date/Time Prepared:
11/24/2020 1:07 pm

	Worksheet A Line Number	Amount Reported	Reclassificati on of Salaries (from Worksheet A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
	1.00	2.00	3.00	4.00	5.00	6.00	
PART III - HOSPITAL WAGE INDEX SUMMARY							
1.00	Net salaries (see instructions)	30,618,056	0	30,618,056	899,395.00	34.04	1.00
2.00	Excluded area salaries (see instructions)	1,086,462	41,397	1,127,859	42,160.00	26.75	2.00
3.00	Subtotal salaries (line 1 minus line 2)	29,531,594	-41,397	29,490,197	857,235.00	34.40	3.00
4.00	Subtotal other wages & related costs (see inst.)	4,427,882	0	4,427,882	61,946.00	71.48	4.00
5.00	Subtotal wage-related costs (see inst.)	9,517,252	0	9,517,252	0.00	32.27	5.00
6.00	Total (sum of lines 3 thru 5)	43,476,728	-41,397	43,435,331	919,181.00	47.25	6.00
7.00	Total overhead cost (see instructions)	11,710,565	-1,190,466	10,520,099	289,480.00	36.34	7.00

HOSPITAL WAGE RELATED COSTS		Provider CCN: 14-0127	Period: From 01/01/2020 To 06/30/2020	Worksheet S-3 Part IV Date/Time Prepared: 11/24/2020 1:07 pm
				Amount Reported
				1.00
PART IV - WAGE RELATED COSTS				
Part A - Core List				
RETIREMENT COST				
1.00	401K Employer Contributions		1,831,771	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)		210,650	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		52,200	6.00
7.00	Employee Managed Care Program Administration Fees		360,810	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)		2,465,902	8.02
8.03	Health Insurance (Purchased)		0	8.03
9.00	Prescription Drug Plan		982,352	9.00
10.00	Dental, Hearing and Vision Plan		8,434	10.00
11.00	Life Insurance (If employee is owner or beneficiary)		29,400	11.00
12.00	Accident Insurance (If employee is owner or beneficiary)		0	12.00
13.00	Disability Insurance (If employee is owner or beneficiary)		364,688	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)		0	14.00
15.00	'Workers' Compensation Insurance		636,172	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		2,330,888	17.00
18.00	Medicare Taxes - Employers Portion Only		0	18.00
19.00	Unemployment Insurance		16,800	19.00
20.00	State or Federal Unemployment Taxes		0	20.00
OTHER				
21.00	Executive Deferred Compensation (Other Than Retirement Cost Reported on lines 1 through 4 above. (see instructions))		76,579	21.00
22.00	Day Care Cost and Allowances		0	22.00
23.00	Tuition Reimbursement		186,760	23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)		9,553,406	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: 14-0127

Period:
From 01/01/2020
To 06/30/2020Worksheet S-3
Part V
Date/Time Prepared:
11/24/2020 1:07 pm

Cost Center Description		Contract Labor	Benefit Cost	
		1.00	2.00	
PART V - Contract Labor and Benefit Cost				
Hospital and Hospital-Based Component Identification:				
1.00	Total facility's contract labor and benefit cost	596,502	9,553,406	1.00
2.00	Hospital	596,502	8,884,770	2.00
3.00	Subprovider - IPF	0	0	3.00
4.00	Subprovider - IRF	0	144,391	4.00
5.00	Subprovider - (Other)	0	0	5.00
6.00	Swing Beds - SNF	0	0	6.00
7.00	Swing Beds - NF	0	0	7.00
8.00	Hospital-Based SNF			8.00
9.00	Hospital-Based NF			9.00
10.00	Hospital-Based OLTC			10.00
11.00	Hospital-Based HHA	0	0	11.00
12.00	Separately Certified ASC			12.00
13.00	Hospital-Based Hospice	0	0	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
16.10	Hospital-Based-CMHC 10	0	0	16.10
17.00	Renal Dialysis			17.00
18.00	Other	0	524,245	18.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA		Provider CCN: 14-0127	Period: From 01/01/2020 To 06/30/2020	Worksheet S-10 Date/Time Prepared: 11/24/2020 1:07 pm	
				1.00	
Uncompensated and indigent care cost computation					
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided by line 202 column 8)			0.337007	1.00
Medicaid (see instructions for each line)					
2.00	Net revenue from Medicaid			6,105,341	2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?			Y	3.00
4.00	If line 3 is yes, does line 2 include all DSH and/or supplemental payments from Medicaid?			Y	4.00
5.00	If line 4 is no, then enter DSH and/or supplemental payments from Medicaid			0	5.00
6.00	Medicaid charges			36,311,579	6.00
7.00	Medicaid cost (line 1 times line 6)			12,237,256	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)			6,131,915	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)			6,131,915	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)	3,167,326	286,049	3,453,375	20.00
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	1,067,411	286,049	1,353,460	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)	1,067,411	286,049	1,353,460	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)			3,832,659	26.00
27.00	Medicare reimbursable bad debts for the entire hospital complex (see instructions)			231,980	27.00
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)			356,892	27.01
28.00	Non-Medicare bad debt expense (see instructions)			3,475,767	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)			1,296,270	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)			2,649,730	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)			8,781,645	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-0127

Period:
From 01/01/2020
To 06/30/2020

Worksheet A

Date/Time Prepared:
11/24/2020 1:07 pm

	Cost Center Description	Salaries	Other	Total (col. 1 + col. 2)	Reclassification ons (See A-6)	Reclassified Trial Balance (col. 3 +- col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT		0	0	0	1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP		0	0	0	2.00
3.00	00300	OTHER CAPITAL RELATED COSTS		0	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	416,263	6,960,093	7,376,356	-339,456	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	4,763,931	19,173,641	23,937,572	-1,040,770	5.00
7.00	00700	OPERATION OF PLANT	983,268	1,939,331	2,922,599	-26,072	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	200,250	12,187	212,437	6,509	8.00
9.00	00900	HOUSEKEEPING	748,622	234,778	983,400	-4,915	9.00
10.00	01000	DIETARY	594,245	249,011	843,256	-544,725	10.00
11.00	01100	CAFETERIA	0	0	0	586,129	11.00
13.00	01300	NURSING ADMINISTRATION	1,005,177	100,940	1,106,117	97,074	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	160,455	441,212	601,667	-282,283	14.00
15.00	01500	PHARMACY	1,156,560	3,271,742	4,428,302	-67,867	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	621,667	215,311	836,978	24,876	16.00
17.00	01700	SOCIAL SERVICE	717,958	52,767	770,725	18,810	17.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	836,938	0	836,938	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	0	333,250	333,250	-71	22.00
23.00	02300	CLINICAL PASTORAL EDUCATION	212,375	38,378	250,753	-95,132	23.00
23.01	02301	EMS PROGRAM	0	0	0	0	23.01
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	5,446,732	1,546,248	6,992,980	-3,041,635	30.00
31.00	03100	INTENSIVE CARE UNIT	2,909,479	945,405	3,854,884	332,448	31.00
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	40.00
41.00	04100	SUBPROVIDER - IRF	474,979	73,924	548,903	28,526	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	42.00
43.00	04300	NURSERY	0	0	0	1,533,088	43.00
	ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,863,925	6,171,005	8,034,930	-4,505,579	50.00
51.00	05100	RECOVERY ROOM	234,668	25,187	259,855	22,575	51.00
53.00	05300	ANESTHESIOLOGY	14,051	1,146,235	1,160,286	-98,123	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,041,753	554,168	1,595,921	-138,787	54.00
57.00	05700	CT SCAN	312,648	173,978	486,626	-106,942	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	59.00
60.00	06000	LABORATORY	1,124,087	1,756,421	2,880,508	-1,010,756	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	762,755	64.00
65.00	06500	RESPIRATORY THERAPY	457,665	142,105	599,770	-80,660	65.00
66.00	06600	PHYSICAL THERAPY	631,372	140,965	772,337	102,441	66.00
67.00	06700	OCCUPATIONAL THERAPY	203,439	18,336	221,775	19,599	67.00
68.00	06800	SPEECH PATHOLOGY	118,655	12,413	131,068	6,165	68.00
69.00	06900	ELECTROCARDIOLOGY	1,079,789	2,019,925	3,099,714	-1,681,082	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	30,668	14,341	45,009	29,172	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	5,846,059	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	3,886,185	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	1,512	73.00
76.97	07697	CARDIAC REHABILITATION	123,487	46,986	170,473	32,942	76.97
	OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	212,224	43,906	256,130	2,639	90.00
90.01	09001	BASIC DIAGNOSTIC TESTING	223,700	34,194	257,894	-257,895	90.01
90.03	09002	PSYCH OUTPATIENT	0	0	0	158,783	90.03
90.04	09003	WOUND CARE CLINIC	243,748	318,721	562,469	-129,931	90.04
91.00	09100	EMERGENCY	1,563,519	636,506	2,200,025	-120,039	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					92.00
93.00	04040	OTHER OUTPATIENT SERVICES	0	0	0	0	93.00
	OTHER REIMBURSABLE COST CENTERS						
99.10	09910	CORF	0	0	0	0	99.10
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	101.00
	SPECIAL PURPOSE COST CENTERS						
109.00	10900	PANCREAS ACQUISITION	0	0	0	0	109.00
110.00	11000	INTESTINAL ACQUISITION	0	0	0	0	110.00
111.00	11100	ISLET ACQUISITION	0	0	0	0	111.00
113.00	11300	INTEREST EXPENSE		805,330	805,330	0	113.00
116.00	11600	HOSPICE	0	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	30,728,297	49,648,940	80,377,237	-74,433	118.00
	NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	223,094	152,500	375,594	-49	190.00
190.01	19001	OTHER NONREIMBURSABLE	176,014	552,405	728,419	74,482	190.01
190.13	19007	EUREKA	0	0	0	0	190.13
191.00	19100	RESEARCH	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	192.00
200.00		TOTAL (SUM OF LINES 118 through 199)	31,127,405	50,353,845	81,481,250	0	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-0127

Period:
From 01/01/2020
To 06/30/2020

Worksheet A

Date/Time Prepared:
11/24/2020 1:07 pm

Cost Center Description			Adjustments (See A-8)	Net Expenses For Allocation	
			6.00	7.00	
GENERAL SERVICE COST CENTERS					
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT	3,032,125	3,032,125	1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP	2,375,004	2,375,004	2.00
3.00	00300	OTHER CAPITAL RELATED COSTS	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	169,540	7,206,440	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-8,171,456	14,725,346	5.00
7.00	00700	OPERATION OF PLANT	78,397	2,974,924	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	-106,261	112,685	8.00
9.00	00900	HOUSEKEEPING	-19,127	959,358	9.00
10.00	01000	DIETARY	-250	298,281	10.00
11.00	01100	CAFETERIA	-57,077	529,052	11.00
13.00	01300	NURSING ADMINISTRATION	-13,884	1,189,307	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	319,384	14.00
15.00	01500	PHARMACY	-26,105	4,334,330	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-562	861,292	16.00
17.00	01700	SOCIAL SERVICE	0	789,535	17.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	836,938	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	10,001	343,180	22.00
23.00	02300	CLINICAL PASTORAL EDUCATION	-4,479	151,142	23.00
23.01	02301	EMS PROGRAM	0	0	23.01
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	-559,593	3,391,752	30.00
31.00	03100	INTENSIVE CARE UNIT	-76,827	4,110,505	31.00
40.00	04000	SUBPROVIDER - IPF	0	0	40.00
41.00	04100	SUBPROVIDER - IRF	0	577,429	41.00
42.00	04200	SUBPROVIDER	0	0	42.00
43.00	04300	NURSERY	-1,050	1,532,038	43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	-789,148	2,740,203	50.00
51.00	05100	RECOVERY ROOM	0	282,430	51.00
53.00	05300	ANESTHESIOLOGY	-1,028,656	33,507	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-41,282	1,415,852	54.00
57.00	05700	CT SCAN	3,405	383,089	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	59.00
60.00	06000	LABORATORY	-131,437	1,738,315	60.00
64.00	06400	INTRAVENOUS THERAPY	0	762,755	64.00
65.00	06500	RESPIRATORY THERAPY	0	519,110	65.00
66.00	06600	PHYSICAL THERAPY	-80,427	794,351	66.00
67.00	06700	OCCUPATIONAL THERAPY	7,577	248,951	67.00
68.00	06800	SPEECH PATHOLOGY	5,814	143,047	68.00
69.00	06900	ELECTROCARDIOLOGY	0	1,418,632	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	74,181	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	5,846,059	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	3,886,185	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	1,512	73.00
76.97	07697	CARDIAC REHABILITATION	0	203,415	76.97
OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	26,363	285,132	90.00
90.01	09001	BASIC DIAGNOSTIC TESTING	0	-1	90.01
90.03	09002	PSYCH OUTPATIENT	0	158,783	90.03
90.04	09003	WOUND CARE CLINIC	19,807	452,345	90.04
91.00	09100	EMERGENCY	-6,200	2,073,786	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	92.00
93.00	04040	OTHER OUTPATIENT SERVICES	0	0	93.00
OTHER REIMBURSABLE COST CENTERS					
99.10	09910	CORF	0	0	99.10
101.00	10100	HOME HEALTH AGENCY	0	0	101.00
SPECIAL PURPOSE COST CENTERS					
109.00	10900	PANCREAS ACQUISITION	0	0	109.00
110.00	11000	INTESTINAL ACQUISITION	0	0	110.00
111.00	11100	ISLET ACQUISITION	0	0	111.00
113.00	11300	INTEREST EXPENSE	-805,330	0	113.00
116.00	11600	HOSPICE	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-6,191,118	74,111,686	118.00
NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	375,545	190.00
190.01	19001	OTHER NONREIMBURSABLE	109,514	912,415	190.01
190.13	19007	EUREKA	0	0	190.13
191.00	19100	RESEARCH	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	192.00
200.00		TOTAL (SUM OF LINES 118 through 199)	-6,081,604	75,399,646	200.00

RECLASSIFICATIONS

Provider CCN: 14-0127

Period:
From 01/01/2020
To 06/30/2020

Worksheet A-6

Date/Time Prepared:
11/24/2020 1:07 pm

	Increases					
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
	A - NURSERY EXPENSE					
1.00	NURSERY	43.00	1,278,725	357,103	1.00	
	TOTALS		1,278,725	357,103		
	B - CAFETERIA EXPENSE					
1.00	CAFETERIA	11.00	252,561	333,568	1.00	
	TOTALS		252,561	333,568		
	C - MEDICAL SUPPLY RECLASS					
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	9,713,748	1.00	
2.00		0.00	0	0	2.00	
3.00		0.00	0	0	3.00	
4.00		0.00	0	0	4.00	
5.00		0.00	0	0	5.00	
6.00		0.00	0	0	6.00	
7.00		0.00	0	0	7.00	
8.00		0.00	0	0	8.00	
9.00		0.00	0	0	9.00	
10.00		0.00	0	0	10.00	
11.00		0.00	0	0	11.00	
12.00		0.00	0	0	12.00	
13.00		0.00	0	0	13.00	
14.00		0.00	0	0	14.00	
15.00		0.00	0	0	15.00	
16.00		0.00	0	0	16.00	
17.00		0.00	0	0	17.00	
18.00		0.00	0	0	18.00	
19.00		0.00	0	0	19.00	
20.00		0.00	0	0	20.00	
21.00		0.00	0	0	21.00	
22.00		0.00	0	0	22.00	
23.00		0.00	0	0	23.00	
24.00		0.00	0	0	24.00	
25.00		0.00	0	0	25.00	
26.00		0.00	0	0	26.00	
27.00		0.00	0	0	27.00	
28.00		0.00	0	0	28.00	
29.00		0.00	0	0	29.00	
30.00		0.00	0	0	30.00	
31.00		0.00	0	0	31.00	
32.00		0.00	0	0	32.00	
33.00		0.00	0	0	33.00	
34.00		0.00	0	0	34.00	
	TOTALS		0	9,713,748		
	D - MANAGEMENT COMPENSATION RECLASS					
1.00	ADMINISTRATIVE & GENERAL	5.00	276,995	0	1.00	
	TOTALS		276,995	0		
	E - IMPLANT RECLASS					
1.00	IMPL. DEV. CHARGED TO PATIENT	72.00	0	3,886,185	1.00	
	TOTALS		0	3,886,185		
	F - EQUIP DEPR EXPENSE					
1.00		0.00	0	0	1.00	
	TOTALS		0	0		
	G - BASIC DIAGNOSTIC TESTING					
1.00	OPERATING ROOM	50.00	244,185	22,828	1.00	
2.00	RADIOLOGY-DIAGNOSTIC	54.00	2,598	243	2.00	
3.00	LABORATORY	60.00	7,793	729	3.00	
4.00	ELECTROCARDIOLOGY	69.00	5,195	486	4.00	
	TOTALS		259,771	24,286		
	H - RECLASS EUREKA ALLOCATED COSTS					
1.00	ADMINISTRATIVE & GENERAL	5.00	69,531	68,155	1.00	
2.00		0.00	0	0	2.00	
3.00		0.00	0	0	3.00	
4.00		0.00	0	0	4.00	
5.00		0.00	0	0	5.00	
6.00		0.00	0	0	6.00	
7.00		0.00	0	0	7.00	
	TOTALS		69,531	68,155		
	I - A&G RELATED CPE COSTS					
1.00	ADMINISTRATIVE & GENERAL	5.00	87,328	14,431	1.00	
	TOTALS		87,328	14,431		

RECLASSIFICATIONS

Provider CCN: 14-0127

Period:
From 01/01/2020
To 06/30/2020

Worksheet A-6

Date/Time Prepared:
11/24/2020 1:07 pm

	Increases					
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
	J - RECLASS MD CONTRACT EXPENSES					
1.00	ADULTS & PEDIATRICS	30.00	12,500	0	1.00	
2.00	SUBPROVIDER - IRF	41.00	29,000	0	2.00	
3.00	WOUND CARE CLINIC	90.04	4,000	0	3.00	
	TOTALS		45,500	0		
	K - ASSOCIATE BONUS					
1.00		0.00	0	0	1.00	
	TOTALS		0	0		
	L - INFUSION THERAPY					
1.00	INTRAVENOUS THERAPY	64.00	603,405	159,350	1.00	
2.00		0.00	0	0	2.00	
	TOTALS		603,405	159,350		
	M - OP BEHAVIORAL HEALTH					
1.00	PSYCH OUTPATIENT	90.03	147,613	11,170	1.00	
	TOTALS		147,613	11,170		
	N - ICU RECLASS					
1.00	INTENSIVE CARE UNIT	31.00	643,251	73,474	1.00	
	TOTALS		643,251	73,474		
	O - COVID SALARY RECLASS					
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	5,525	0	1.00	
2.00	ADMINISTRATIVE & GENERAL	5.00	88,273	0	2.00	
3.00	OPERATION OF PLANT	7.00	2,873	0	3.00	
4.00	LAUNDRY & LINEN SERVICE	8.00	19,111	0	4.00	
5.00	HOUSEKEEPING	9.00	381	0	5.00	
6.00	DIETARY	10.00	43,010	0	6.00	
7.00	NURSING ADMINISTRATION	13.00	97,836	0	7.00	
8.00	MEDICAL RECORDS & LIBRARY	16.00	24,884	0	8.00	
9.00	SOCIAL SERVICE	17.00	18,810	0	9.00	
10.00	CLINICAL PASTORAL EDUCATION	23.00	6,627	0	10.00	
11.00	ADULTS & PEDIATRICS	30.00	279,777	0	11.00	
12.00	INTENSIVE CARE UNIT	31.00	118,629	0	12.00	
13.00	SUBPROVIDER - IRF	41.00	18,115	0	13.00	
14.00	OPERATING ROOM	50.00	212,220	0	14.00	
15.00	RECOVERY ROOM	51.00	29,220	0	15.00	
16.00	ANESTHESIOLOGY	53.00	1,882	0	16.00	
17.00	RADIOLOGY-DIAGNOSTIC	54.00	49,005	0	17.00	
18.00	CT SCAN	57.00	3,541	0	18.00	
19.00	LABORATORY	60.00	64,480	0	19.00	
20.00	RESPIRATORY THERAPY	65.00	378	0	20.00	
21.00	PHYSICAL THERAPY	66.00	111,462	0	21.00	
22.00	OCCUPATIONAL THERAPY	67.00	22,011	0	22.00	
23.00	SPEECH PATHOLOGY	68.00	6,618	0	23.00	
24.00	ELECTROCARDIOLOGY	69.00	83,658	0	24.00	
25.00	ELECTROENCEPHALOGRAPHY	70.00	30,819	0	25.00	
26.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	18,496	0	26.00	
27.00	DRUGS CHARGED TO PATIENTS	73.00	1,512	0	27.00	
28.00	CARDIAC REHABILITATION	76.97	34,617	0	28.00	
29.00	CLINIC	90.00	9,874	0	29.00	
30.00	BASIC DIAGNOSTIC TESTING	90.01	36,071	0	30.00	
31.00	WOUND CARE CLINIC	90.04	16,813	0	31.00	
32.00	EMERGENCY	91.00	46,201	0	32.00	
33.00	OTHER NONREIMBURSABLE	190.01	74,983	0	33.00	
	TOTALS		1,577,712	0		
500.00	Grand Total: Increases		5,242,392	14,641,470	500.00	

RECLASSIFICATIONS

Provider CCN: 14-0127

Period:
From 01/01/2020
To 06/30/2020

Worksheet A-6

Date/Time Prepared:
11/24/2020 1:07 pm

	Decreases							11/24/2020 1:07 pm
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.			
	6.00	7.00	8.00	9.00	10.00			
	A - NURSERY EXPENSE							
1.00	ADULTS & PEDIATRICS	30.00	1,278,725	357,103	0			1.00
	TOTALS		1,278,725	357,103				
	B - CAFETERIA EXPENSE							
1.00	DIETARY	10.00	252,561	333,568	0			1.00
	TOTALS		252,561	333,568				
	C - MEDICAL SUPPLY RECLASS							
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	2,703	0			1.00
2.00	OPERATION OF PLANT	7.00	0	17,637	0			2.00
3.00	LAUNDRY & LINEN SERVICE	8.00	0	2,000	0			3.00
4.00	HOUSEKEEPING	9.00	0	5,296	0			4.00
5.00	DIETARY	10.00	0	1,606	0			5.00
6.00	NURSING ADMINISTRATION	13.00	0	762	0			6.00
7.00	CENTRAL SERVICES & SUPPLY	14.00	0	282,283	0			7.00
8.00	PHARMACY	15.00	0	62,089	0			8.00
9.00	MEDICAL RECORDS & LIBRARY	16.00	0	8	0			9.00
10.00	I&R SERVICES-OTHER PRGM	22.00	0	71	0			10.00
	COSTS APPRVD							
11.00	ADULTS & PEDIATRICS	30.00	0	299,315	0			11.00
12.00	INTENSIVE CARE UNIT	31.00	0	235,166	0			12.00
13.00	SUBPROVIDER - IRF	41.00	0	18,589	0			13.00
14.00	NURSERY	43.00	0	102,740	0			14.00
15.00	OPERATING ROOM	50.00	0	4,977,355	0			15.00
16.00	RECOVERY ROOM	51.00	0	6,645	0			16.00
17.00	ANESTHESIOLOGY	53.00	0	100,005	0			17.00
18.00	RADIOLOGY-DIAGNOSTIC	54.00	0	190,633	0			18.00
19.00	CT SCAN	57.00	0	110,483	0			19.00
20.00	LABORATORY	60.00	0	1,074,746	0			20.00
21.00	RESPIRATORY THERAPY	65.00	0	81,038	0			21.00
22.00	PHYSICAL THERAPY	66.00	0	9,021	0			22.00
23.00	OCCUPATIONAL THERAPY	67.00	0	2,412	0			23.00
24.00	SPEECH PATHOLOGY	68.00	0	453	0			24.00
25.00	ELECTROCARDIOLOGY	69.00	0	1,770,421	0			25.00
26.00	ELECTROENCEPHALOGRAPHY	70.00	0	1,647	0			26.00
27.00	CARDIAC REHABILITATION	76.97	0	1,675	0			27.00
28.00	CLINIC	90.00	0	7,235	0			28.00
29.00	WOUND CARE CLINIC	90.04	0	150,744	0			29.00
30.00	EMERGENCY	91.00	0	166,240	0			30.00
31.00	GIFT, FLOWER, COFFEE SHOP & CANTEEN	190.00	0	49	0			31.00
32.00	BASIC DIAGNOSTIC TESTING	90.01	0	9,909	0			32.00
33.00	OTHER NONREIMBURSABLE	190.01	0	501	0			33.00
34.00	ADMINISTRATIVE & GENERAL	5.00	0	22,271	0			34.00
	TOTALS		0	9,713,748				
	D - MANAGEMENT COMPENSATION RECLASS							
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	276,995	0	0			1.00
	TOTALS		276,995	0				
	E - IMPLANT RECLASS							
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	3,886,185	0			1.00
	TOTALS		0	3,886,185				
	F - EQUIP DEPR EXPENSE							
1.00		0.00	0	0	0			1.00
	TOTALS		0	0				
	G - BASIC DIAGNOSTIC TESTING							
1.00	BASIC DIAGNOSTIC TESTING	90.01	259,771	24,286	0			1.00
2.00		0.00	0	0	0			2.00
3.00		0.00	0	0	0			3.00
4.00		0.00	0	0	0			4.00
	TOTALS		259,771	24,286				
	H - RECLASS EUREKA ALLOCATED COSTS							
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	65,283	0			1.00
2.00	OPERATION OF PLANT	7.00	9,044	2,264	9			2.00
3.00	LAUNDRY & LINEN SERVICE	8.00	9,994	608	0			3.00
4.00	PHARMACY	15.00	5,778	0	0			4.00
5.00	LABORATORY	60.00	9,012	0	0			5.00
6.00	ADULTS & PEDIATRICS	30.00	28,246	0	0			6.00
7.00	OPERATING ROOM	50.00	7,457	0	0			7.00
	TOTALS		69,531	68,155				
	I - A&G RELATED CPE COSTS							
1.00	CLINICAL PASTORAL EDUCATION	23.00	87,328	14,431	0			1.00
	TOTALS		87,328	14,431				

RECLASSIFICATIONS

Provider CCN: 14-0127

Period:
From 01/01/2020
To 06/30/2020

Worksheet A-6

Date/Time Prepared:
11/24/2020 1:07 pm

	Decreases						
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	J - RECLASS MD CONTRACT EXPENSES						
1.00	ADMINISTRATIVE & GENERAL	5.00	45,500	0	0		1.00
2.00		0.00	0	0	0		2.00
3.00		0.00	0	0	0		3.00
	TOTALS		45,500	0			
	K - ASSOCIATE BONUS						
1.00		0.00	0	0	0		1.00
	TOTALS		0	0			
	L - INFUSION THERAPY						
1.00	ADULTS & PEDIATRICS	30.00	386,533	108,482	0		1.00
2.00	INTENSIVE CARE UNIT	31.00	216,872	50,868	0		2.00
	TOTALS		603,405	159,350			
	M - OP BEHAVIORAL HEALTH						
1.00	ADULTS & PEDIATRICS	30.00	147,613	11,170	0		1.00
	TOTALS		147,613	11,170			
	N - ICU RECLASS						
1.00	ADULTS & PEDIATRICS	30.00	643,251	73,474	0		1.00
	TOTALS		643,251	73,474			
	O - COVID SALARY RECLASS						
1.00	ADMINISTRATIVE & GENERAL	5.00	1,577,712	0	0		1.00
2.00		0.00	0	0	0		2.00
3.00		0.00	0	0	0		3.00
4.00		0.00	0	0	0		4.00
5.00		0.00	0	0	0		5.00
6.00		0.00	0	0	0		6.00
7.00		0.00	0	0	0		7.00
8.00		0.00	0	0	0		8.00
9.00		0.00	0	0	0		9.00
10.00		0.00	0	0	0		10.00
11.00		0.00	0	0	0		11.00
12.00		0.00	0	0	0		12.00
13.00		0.00	0	0	0		13.00
14.00		0.00	0	0	0		14.00
15.00		0.00	0	0	0		15.00
16.00		0.00	0	0	0		16.00
17.00		0.00	0	0	0		17.00
18.00		0.00	0	0	0		18.00
19.00		0.00	0	0	0		19.00
20.00		0.00	0	0	0		20.00
21.00		0.00	0	0	0		21.00
22.00		0.00	0	0	0		22.00
23.00		0.00	0	0	0		23.00
24.00		0.00	0	0	0		24.00
25.00		0.00	0	0	0		25.00
26.00		0.00	0	0	0		26.00
27.00		0.00	0	0	0		27.00
28.00		0.00	0	0	0		28.00
29.00		0.00	0	0	0		29.00
30.00		0.00	0	0	0		30.00
31.00		0.00	0	0	0		31.00
32.00		0.00	0	0	0		32.00
33.00		0.00	0	0	0		33.00
	TOTALS		1,577,712	0			
500.00	Grand Total: Decreases		5,242,392	14,641,470			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-0127

Period:
From 01/01/2020
To 06/30/2020Worksheet A-7
Part I
Date/Time Prepared:
11/24/2020 1:07 pm

		Beginning Balances	Acquisitions			Disposals and Retirements		
			Purchases	Donation	Total			
		1.00	2.00	3.00	4.00	5.00		
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES							
1.00	Land	7,844,000	0	0	0	414,500	1.00	
2.00	Land Improvements	10,449,617	0	0	0	0	2.00	
3.00	Buildings and Fixtures	251,385,775	1,430,445	0	1,430,445	0	3.00	
4.00	Building Improvements	0	0	0	0	0	4.00	
5.00	Fixed Equipment	0	0	0	0	0	5.00	
6.00	Movable Equipment	59,323,333	2,692,723	0	2,692,723	731,961	6.00	
7.00	HIT designated Assets	0	0	0	0	0	7.00	
8.00	Subtotal (sum of lines 1-7)	329,002,725	4,123,168	0	4,123,168	1,146,461	8.00	
9.00	Reconciling Items	0	0	0	0	0	9.00	
10.00	Total (line 8 minus line 9)	329,002,725	4,123,168	0	4,123,168	1,146,461	10.00	
		Ending Balance	Fully Depreciated Assets					
		6.00	7.00					
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES							
1.00	Land	7,429,500	0					1.00
2.00	Land Improvements	10,449,617	4,786,794					2.00
3.00	Buildings and Fixtures	252,816,220	128,980,637					3.00
4.00	Building Improvements	0	0					4.00
5.00	Fixed Equipment	0	0					5.00
6.00	Movable Equipment	61,284,095	33,066,637					6.00
7.00	HIT designated Assets	0	0					7.00
8.00	Subtotal (sum of lines 1-7)	331,979,432	166,834,068					8.00
9.00	Reconciling Items	0	0					9.00
10.00	Total (line 8 minus line 9)	331,979,432	166,834,068					10.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-0127

Period:
From 01/01/2020
To 06/30/2020Worksheet A-7
Part II
Date/Time Prepared:
11/24/2020 1:07 pm

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

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-0127

Period:
From 01/01/2020
To 06/30/2020Worksheet A-7
Part III
Date/Time Prepared:
11/24/2020 1:07 pm

Cost Center Description		COMPUTATION OF RATIOS			ALLOCATION OF OTHER CAPITAL		
		Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	
		1.00	2.00	3.00	4.00	5.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	NEW CAP REL COSTS-BLDG & FIXT	270,695,337	0	270,695,337	0.815398	0	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	61,284,094	0	61,284,094	0.184602	0	2.00
3.00	Total (sum of lines 1-2)	331,979,431	0	331,979,431	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	NEW CAP REL COSTS-BLDG & FIXT	0	0	0	3,032,125	0	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0	0	2,375,004	0	2.00
3.00	Total (sum of lines 1-2)	0	0	0	5,407,129	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	NEW CAP REL COSTS-BLDG & FIXT	0	0	0	0	3,032,125	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0	0	0	2,375,004	2.00
3.00	Total (sum of lines 1-2)	0	0	0	0	5,407,129	3.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 14-0127

Period:
From 01/01/2020
To 06/30/2020

Worksheet A-8

Date/Time Prepared:
11/24/2020 1:07 pm

Cost Center Description		Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted		Wkst. A-7 Ref.	
				Cost Center	Line #		
		1.00	2.00	3.00	4.00	5.00	
1.00	Investment income - NEW CAP REL COSTS-BLDG & FIXT (chapter 2)			0 NEW CAP REL COSTS-BLDG & FIXT	1.00	0	1.00
2.00	Investment income - NEW CAP REL COSTS-MVBLE EQUIP (chapter 2)			0 NEW CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
3.00	Investment income - other (chapter 2)		0		0.00	0	3.00
4.00	Trade, quantity, and time discounts (chapter 8)		0		0.00	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)		0		0.00	0	5.00
6.00	Rental of provider space by suppliers (chapter 8)		0		0.00	0	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)		0		0.00	0	7.00
8.00	Television and radio service (chapter 21)		0		0.00	0	8.00
9.00	Parking lot (chapter 21)		0		0.00	0	9.00
10.00	Provider-based physician adjustment	A-8-2	-2,503,162			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	-181,187			0	12.00
13.00	Laundry and linen service	B	-106,261	LAUNDRY & LINEN SERVICE	8.00	0	13.00
14.00	Cafeteria-employees and guests	B	-59,243	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	-26,105	PHARMACY	15.00	0	17.00
18.00	Sale of medical records and abstracts	B	-562	MEDICAL RECORDS & LIBRARY	16.00	0	18.00
19.00	Nursing and allied health education (tuition, fees, books, etc.)		0		0.00	0	19.00
20.00	Vending machines		0		0.00	0	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	0	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3		0 RESPIRATORY THERAPY	65.00		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3		0 PHYSICAL THERAPY	66.00		24.00
25.00	Utilization review - physicians' compensation (chapter 21)			0 *** Cost Center Deleted ***	114.00		25.00
26.00	Depreciation - NEW CAP REL COSTS-BLDG & FIXT			0 NEW CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
27.00	Depreciation - NEW CAP REL COSTS-MVBLE EQUIP			0 NEW CAP REL COSTS-MVBLE EQUIP	2.00	0	27.00
28.00	Non-physician Anesthetist			0 *** Cost Center Deleted ***	19.00		28.00
29.00	Physicians' assistant			0	0.00	0	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3		0 OCCUPATIONAL THERAPY	67.00		30.00
30.99	Hospice (non-distinct) (see instructions)	B	-129,500	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

ADJUSTMENTS TO EXPENSES

Provider CCN: 14-0127

Period:
From 01/01/2020
To 06/30/2020

Worksheet A-8

Date/Time Prepared:
11/24/2020 1:07 pm

Cost Center Description		Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted		Wkst. A-7 Ref.	
				Cost Center	Line #		
		1.00	2.00	3.00	4.00	5.00	
32.00	CAH HIT Adjustment for Depreciation and Interest		0		0.00	0	32.00
33.00	MISCELLANEOUS INCOME	B	9,098	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.00
33.03	MISCELLANEOUS INCOME	B	-77,827	ADMINISTRATIVE & GENERAL	5.00	0	33.03
33.04	MISCELLANEOUS INCOME	B	-10,598	OPERATION OF PLANT	7.00	0	33.04
33.08	MISCELLANEOUS INCOME	B	-21,024	HOUSEKEEPING	9.00	0	33.08
33.09	MISCELLANEOUS INCOME	B	-13,884	NURSING ADMINISTRATION	13.00	0	33.09
33.10	MISCELLANEOUS INCOME	B	-6,475	I&R SERVICES-OTHER PRGM	22.00	0	33.10
33.19	MISCELLANEOUS INCOME	B	-2,490	COSTS APPRVD			
33.19	MISCELLANEOUS INCOME	B	-2,490	CLINICAL PASTORAL EDUCATION	23.00	0	33.19
33.20	MISCELLANEOUS INCOME	B	-1,050	NURSERY	43.00	0	33.20
33.21	MISCELLANEOUS INCOME	B	-116,137	LABORATORY	60.00	0	33.21
33.22	MISCELLANEOUS INCOME	B	-47,775	PHYSICAL THERAPY	66.00	0	33.22
33.24	NON ALLOWABLE EXPENSES	A	142	I&R SERVICES-OTHER PRGM	22.00	0	33.24
33.25	NON ALLOWABLE EXPENSES	A	-1,989	COSTS APPRVD			
33.25	NON ALLOWABLE EXPENSES	A	-1,989	CLINICAL PASTORAL EDUCATION	23.00	0	33.25
33.28	NON ALLOWABLE EXPENSES	A	-8,545	ADULTS & PEDIATRICS	30.00	0	33.28
34.00	NON ALLOWABLE EXPENSES	A	-700	OPERATING ROOM	50.00	0	34.00
35.00	NON ALLOWABLE EXPENSES	A	-4,327	INTENSIVE CARE UNIT	31.00	0	35.00
35.01	CHANGE IN EXP AFTER 6.30.20	A	-1,113,638	ADMINISTRATIVE & GENERAL	5.00	0	35.01
35.02	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	35.02
35.03	INTEREST EXPENSE	A	-805,330	INTEREST EXPENSE	113.00	11	35.03
35.04	PA ASSESSMENT EXPENSE	A	-3,460,356	ADMINISTRATIVE & GENERAL	5.00	0	35.04
35.05	ADVANCED MRI RENTAL COSTS	A	-31,250	RADIOLOGY-DIAGNOSTIC	54.00	0	35.05
35.06	SELF INSURANCE EXPENSE	A	-1,139,400	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	35.06
35.07	NON ALLOWABLE EXPENSES	A	-6,200	EMERGENCY	91.00	0	35.07
35.08	NON ALLOWABLE EXPENSES	A	-1,121,667	ADMINISTRATIVE & GENERAL	5.00	0	35.08
35.09	NON ALLOWABLE EXPENSES	A	-344	OPERATION OF PLANT	7.00	0	35.09
36.00	NON ALLOWABLE EXPENSES	A	-250	DIETARY	10.00	0	36.00
36.15	MARKETING OFFSET	A	-46,600	ADMINISTRATIVE & GENERAL	5.00	0	36.15
36.16	EUREKA OVERALLOCATION	A	88,005	ADMINISTRATIVE & GENERAL	5.00	0	36.16
36.17	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	36.17
36.18	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	36.18
36.19	NON ALLOWABLE EXPENSES		0		0.00	0	36.19
44.04	ADJ BOOK TO MC DEPR	A	2,991,904	NEW CAP REL COSTS-BLDG & FIXT	1.00	9	44.04
44.05	ADJ BOOK TO MC DEPR	A	1,873,123	NEW CAP REL COSTS-MVBLE EQUIP	2.00	9	44.05
45.00	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	45.00
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-6,081,604				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: 14-0127

Period:
From 01/01/2020
To 06/30/2020

Worksheet A-8-1

Date/Time Prepared:
11/24/2020 1:07 pm

	Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in wks. A, column 5	
	1.00	2.00	3.00	4.00	5.00	
A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:						
1.00	0.00			0	0	1.00
2.00	0.00			0	0	2.00
3.00	4.00	EMPLOYEE BENEFITS DEPARTMENT	BUILDING RENTAL	21,593	0	3.00
3.01	5.00	ADMINISTRATIVE & GENERAL	BUILDING RENTAL	23,135	0	3.01
3.02	11.00	CAFETERIA	BUILDING RENTAL	2,166	0	3.02
3.03	22.00	I&R SERVICES-OTHER PRGM COST	BUILDING RENTAL	16,334	0	3.03
3.04	54.00	RADIOLOGY-DIAGNOSTIC	BUILDING RENTAL	16,649	26,681	3.04
3.05	57.00	CT SCAN	BUILDING RENTAL	17,355	10,190	3.05
3.06	60.00	LABORATORY	BUILDING RENTAL	6,970	22,270	3.06
3.07	66.00	PHYSICAL THERAPY	BUILDING RENTAL	43,333	75,985	3.07
3.08	67.00	OCCUPATIONAL THERAPY	BUILDING RENTAL	7,577	0	3.08
3.09	68.00	SPEECH PATHOLOGY	BUILDING RENTAL	5,814	0	3.09
3.10	90.00	CLINIC	BUILDING RENTAL	26,363	0	3.10
3.11	90.04	WOUND CARE CLINIC	BUILDING RENTAL	19,807	0	3.11
3.12	190.01	OTHER NONREIMBURSABLE	BUILDING RENTAL	109,514	0	3.12
3.13	7.00	OPERATION OF PLANT	BUILDING RENTAL	89,339	0	3.13
3.14	9.00	HOUSEKEEPING	BUILDING RENTAL	1,897	0	3.14
3.15	0.00			0	0	3.15
4.00	1.00	NEW CAP REL COSTS-BLDG & FIX	HOME OFFICE	40,221	0	4.00
4.01	2.00	NEW CAP REL COSTS-MVBLE EQUI	HOME OFFICE	501,881	0	4.01
4.02	4.00	EMPLOYEE BENEFITS DEPARTMENT	HOME OFFICE	1,278,249	0	4.02
4.03	5.00	ADMINISTRATIVE & GENERAL	HOME OFFICE	4,917,050	7,191,308	4.03
4.04	0.00			0	0	4.04
4.05	0.00			0	0	4.05
5.00	0		0	7,145,247	7,326,434	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	4.00	5.00
B. INTERRELATIONSHIP TO RELATED ORGANIZATION(S) AND/OR HOME OFFICE:					

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

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

6.00	C		0.00	ADVANCED MRI	42.80	6.00
7.00	B		0.00	ADVOCATE HEALTH	100.00	7.00
8.00			0.00		0.00	8.00
9.00	B		0.00	ADVOCATE HEALTH CARE	100.00	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: 14-0127

Period:
From 01/01/2020
To 06/30/2020

Worksheet A-8-1

Date/Time Prepared:
11/24/2020 1:07 pm

	Net Adjustments (col. 4 minus col. 5)*	Wkst. A-7 Ref.		
	6.00	7.00		
A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:				
1.00	0	0		1.00
2.00	0	0		2.00
3.00	21,593	0		3.00
3.01	23,135	0		3.01
3.02	2,166	0		3.02
3.03	16,334	0		3.03
3.04	-10,032	0		3.04
3.05	7,165	0		3.05
3.06	-15,300	0		3.06
3.07	-32,652	0		3.07
3.08	7,577	0		3.08
3.09	5,814	0		3.09
3.10	26,363	0		3.10
3.11	19,807	0		3.11
3.12	109,514	0		3.12
3.13	89,339	0		3.13
3.14	1,897	0		3.14
3.15	0	0		3.15
4.00	40,221	9		4.00
4.01	501,881	9		4.01
4.02	1,278,249	0		4.02
4.03	-2,274,258	0		4.03
4.04	0	0		4.04
4.05	0	0		4.05
5.00	-181,187			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	MRI SERVICES		6.00
7.00	SAME PARENT CO		7.00
8.00			8.00
9.00	HOME OFFICE		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: 14-0127

Period:
From 01/01/2020
To 06/30/2020

Worksheet A-8-2

Date/Time Prepared:
11/24/2020 1:07 pm

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	5.00	ADMINISTRATIVE & GENERAL	188,250	188,250	0	171,400	0	1.00
2.00	30.00	ADULTS & PEDIATRICS	421,548	421,548	0	171,400	0	2.00
3.00	31.00	INTENSIVE CARE UNIT	72,500	72,500	0	171,400	0	3.00
4.00	50.00	OPERATING ROOM	788,448	788,448	0	171,400	0	4.00
5.00	53.00	ANESTHESIOLOGY	1,028,656	1,028,656	0	171,400	0	5.00
6.00	57.00	CT SCAN	3,760	3,760	0	171,400	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			2,503,162	2,503,162	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	50.00	OPERATING ROOM	0	0	0	0	0	4.00
5.00	53.00	ANESTHESIOLOGY	0	0	0	0	0	5.00
6.00	57.00	CT SCAN	0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			0	0	0	0	0	200.00
	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment		
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00	5.00	ADMINISTRATIVE & GENERAL	0	0	0	188,250		1.00
2.00	30.00	ADULTS & PEDIATRICS	0	0	0	421,548		2.00
3.00	31.00	INTENSIVE CARE UNIT	0	0	0	72,500		3.00
4.00	50.00	OPERATING ROOM	0	0	0	788,448		4.00
5.00	53.00	ANESTHESIOLOGY	0	0	0	1,028,656		5.00
6.00	57.00	CT SCAN	0	0	0	3,760		6.00
7.00	0.00		0	0	0	0		7.00
8.00	0.00		0	0	0	0		8.00
9.00	0.00		0	0	0	0		9.00
10.00	0.00		0	0	0	0		10.00
200.00			0	0	0	2,503,162		200.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0127

Period:
From 01/01/2020
To 06/30/2020Worksheet B
Part I
Date/Time Prepared:
11/24/2020 1:07 pm

Cost Center Description			CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
			Net Expenses for Cost Allocation (from Wkst A col. 7)	NEW BLDG & FIXT	NEW MVBLE EQUIP		
			0	1.00	2.00	4.00	4A
GENERAL SERVICE COST CENTERS							
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT	3,032,125	3,032,125			1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP	2,375,004		2,375,004		2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	7,206,440	0	1,651	7,208,091	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	14,725,346	306,583	114,610	862,732	5.00
7.00	00700	OPERATION OF PLANT	2,974,924	729,266	67,194	227,322	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	112,685	61,759	22,847	48,709	8.00
9.00	00900	HOUSEKEEPING	959,358	44,270	15,069	174,256	9.00
10.00	01000	DIETARY	298,281	22,543	6,054	89,499	10.00
11.00	01100	CAFETERIA	529,052	37,193	3,975	58,758	11.00
13.00	01300	NURSING ADMINISTRATION	1,189,307	50,248	1,324	256,616	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	319,384	35,297	27,840	41,633	14.00
15.00	01500	PHARMACY	4,334,330	30,512	116,725	268,081	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	861,292	34,726	0	150,420	16.00
17.00	01700	SOCIAL SERVICE	789,535	7,517	0	171,409	17.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	836,938	0	0	194,714	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	343,180	0	0	0	22.00
23.00	02300	CLINICAL PASTORAL EDUCATION	151,142	10,060	0	30,634	23.00
23.01	02301	EMS PROGRAM	0	0	0	0	23.01
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	3,391,752	399,156	155,780	758,505	30.00
31.00	03100	INTENSIVE CARE UNIT	4,110,505	303,946	127,296	803,686	31.00
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	40.00
41.00	04100	SUBPROVIDER - IRF	577,429	69,715	10,013	114,718	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	42.00
43.00	04300	NURSERY	1,532,038	32,628	61,931	293,624	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	2,740,203	185,785	527,733	538,090	50.00
51.00	05100	RECOVERY ROOM	282,430	16,320	11,171	61,394	51.00
53.00	05300	ANESTHESIOLOGY	33,507	3,265	0	3,707	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,415,852	94,902	520,286	254,369	54.00
57.00	05700	CT SCAN	383,089	11,906	209,695	73,561	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	59.00
60.00	06000	LABORATORY	1,738,315	81,426	92,649	276,237	60.00
64.00	06400	INTRAVENOUS THERAPY	762,755	61,288	19,643	140,033	64.00
65.00	06500	RESPIRATORY THERAPY	519,110	30,550	27,562	106,564	65.00
66.00	06600	PHYSICAL THERAPY	794,351	8,722	9,177	172,820	66.00
67.00	06700	OCCUPATIONAL THERAPY	248,951	0	0	52,451	67.00
68.00	06800	SPEECH PATHOLOGY	143,047	0	0	29,145	68.00
69.00	06900	ELECTROCARDIOLOGY	1,418,632	66,136	131,294	271,885	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	74,181	6,110	4,251	14,305	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	5,846,059	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	3,886,185	0	18,568	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,512	0	0	0	73.00
76.97	07697	CARDIAC REHABILITATION	203,415	16,986	3,232	36,783	76.97
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	285,132	0	908	51,671	90.00
90.01	09001	BASIC DIAGNOSTIC TESTING	-1	0	0	0	90.01
90.03	09002	PSYCH OUTPATIENT	158,783	40,522	266	34,342	90.03
90.04	09003	WOUND CARE CLINIC	452,345	2,248	516	60,620	90.04
91.00	09100	EMERGENCY	2,073,786	104,133	64,276	374,501	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	92.00
93.00	04040	OTHER OUTPATIENT SERVICES	0	0	0	0	93.00
OTHER REIMBURSABLE COST CENTERS							
99.10	09910	CORF	0	0	0	0	99.10
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS							
109.00	10900	PANCREAS ACQUISITION	0	0	0	0	109.00
110.00	11000	INTESTINAL ACQUISITION	0	0	0	0	110.00
111.00	11100	ISLET ACQUISITION	0	0	0	0	111.00
113.00	11300	INTEREST EXPENSE	0	0	0	0	113.00
116.00	11600	HOSPICE	0	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	74,111,686	2,905,718	2,373,536	7,097,794	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	375,545	32,164	1,083	51,903	190.00
190.01	19001	OTHER NONREIMBURSABLE	912,415	94,243	385	58,394	190.01
190.13	19007	EUREKA	0	0	0	0	190.13
191.00	19100	RESEARCH	0	0	0	0	191.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0127

Period:
From 01/01/2020
To 06/30/2020Worksheet B
Part I
Date/Time Prepared:
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Cost Center Description			Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
				NEW BLDG & FIXT	NEW MVBLE EQUIP			
			0	1.00	2.00	4.00	4A	
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
200.00		Cross Foot Adjustments						0 200.00
201.00		Negative Cost Centers		0	0	0	0	0 201.00
202.00		TOTAL (sum lines 118 through 201)	75,399,646	3,032,125	2,375,004	7,208,091	75,399,646	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0127

Period:
From 01/01/2020
To 06/30/2020Worksheet B
Part I
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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	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	16,009,271					5.00
7.00	00700	OPERATION OF PLANT	1,077,891	5,076,597				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	66,312	157,055	469,367			8.00
9.00	00900	HOUSEKEEPING	321,572	112,581	41,106	1,668,212		9.00
10.00	01000	DIETARY	112,239	57,329	1,470	1,238	588,653	10.00
11.00	01100	CAFETERIA	169,547	94,584	965	47,277	0	11.00
13.00	01300	NURSING ADMINISTRATION	403,665	127,784	0	0	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	114,335	89,762	0	45,247	0	14.00
15.00	01500	PHARMACY	1,280,315	77,593	0	46,188	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	282,078	88,308	0	1,782	0	16.00
17.00	01700	SOCIAL SERVICE	261,058	19,115	0	5,297	0	17.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	278,092	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	92,508	0	0	7,970	0	22.00
23.00	02300	CLINICAL PASTORAL EDUCATION	51,711	25,582	0	3,168	0	23.00
23.01	02301	EMS PROGRAM	0	0	0	0	0	23.01
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	1,268,332	1,015,066	114,893	565,791	251,663	30.00
31.00	03100	INTENSIVE CARE UNIT	1,440,915	772,946	83,293	25,346	279,772	31.00
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	0	40.00
41.00	04100	SUBPROVIDER - IRF	208,067	177,287	10,701	26,386	57,218	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	0	42.00
43.00	04300	NURSERY	517,615	82,975	2,031	26,931	0	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	1,076,033	472,458	59,586	242,920	0	50.00
51.00	05100	RECOVERY ROOM	100,092	41,503	4,038	26,386	0	51.00
53.00	05300	ANESTHESIOLOGY	10,912	8,304	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	616,055	241,339	20,018	52,822	0	54.00
57.00	05700	CT SCAN	182,829	30,277	11,067	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	589,966	207,070	227	52,822	0	60.00
64.00	06400	INTRAVENOUS THERAPY	265,171	155,857	1,305	149,009	0	64.00
65.00	06500	RESPIRATORY THERAPY	184,321	77,689	0	5,297	0	65.00
66.00	06600	PHYSICAL THERAPY	265,535	22,181	2,015	10,297	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	81,246	0	0	1,733	0	67.00
68.00	06800	SPEECH PATHOLOGY	46,416	0	0	644	0	68.00
69.00	06900	ELECTROCARDIOLOGY	508,915	168,185	18,278	31,683	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	26,645	15,538	680	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,575,864	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	1,052,565	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	408	0	0	0	0	73.00
76.97	07697	CARDIAC REHABILITATION	70,198	43,196	98	0	0	76.97
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	91,033	0	88	11,089	0	90.00
90.01	09001	BASIC DIAGNOSTIC TESTING	0	0	0	0	0	90.01
90.03	09002	PSYCH OUTPATIENT	63,054	103,048	0	0	0	90.03
90.04	09003	WOUND CARE CLINIC	139,020	5,717	3,463	36,782	0	90.04
91.00	09100	EMERGENCY	705,357	264,813	94,045	211,187	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
93.00	04040	OTHER OUTPATIENT SERVICES	0	0	0	0	0	93.00
OTHER REIMBURSABLE COST CENTERS								
99.10	09910	CORF	0	0	0	0	0	99.10
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS								
109.00	10900	PANCREAS ACQUISITION	0	0	0	0	0	109.00
110.00	11000	INTESTINAL ACQUISITION	0	0	0	0	0	110.00
111.00	11100	ISLET ACQUISITION	0	0	0	0	0	111.00
113.00	11300	INTEREST EXPENSE	0	0	0	0	0	113.00
116.00	11600	HOSPICE	0	0	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	15,597,887	4,755,142	469,367	1,635,292	588,653	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	124,185	81,793	0	30,841	0	190.00
190.01	19001	OTHER NONREIMBURSABLE	287,199	239,662	0	2,079	0	190.01
190.13	19007	EUREKA	0	0	0	0	0	190.13
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
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)	16,009,271	5,076,597	469,367	1,668,212	588,653	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0127

Period:
From 01/01/2020
To 06/30/2020Worksheet B
Part I
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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	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	NEW 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	941,351					11.00
13.00	01300	NURSING ADMINISTRATION	33,483	2,062,427				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	10,961	0	684,459			14.00
15.00	01500	PHARMACY	30,510	0	30,127	6,214,381		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	28,216	11,279	2,701	0	1,460,802	16.00
17.00	01700	SOCIAL SERVICE	21,789	73,227	0	0	0	17.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	33,150	0	0	0	0	22.00
23.00	02300	CLINICAL PASTORAL EDUCATION	9,094	0	2,837	18	0	23.00
23.01	02301	EMS PROGRAM	0	0	0	0	0	23.01
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	136,281	452,585	72,801	2,714	61,195	30.00
31.00	03100	INTENSIVE CARE UNIT	135,441	494,905	55,423	3,888	16,388	31.00
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	0	40.00
41.00	04100	SUBPROVIDER - IRF	19,669	66,077	5,827	44	8,182	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	0	42.00
43.00	04300	NURSERY	41,311	161,932	56,353	1,569	16,960	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	73,888	248,607	41,009	80,172	204,372	50.00
51.00	05100	RECOVERY ROOM	7,974	31,771	176	1,785	12,128	51.00
53.00	05300	ANESTHESIOLOGY	1,027	3,350	429	27,086	23,353	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	38,724	320	15,056	2,126	127,267	54.00
57.00	05700	CT SCAN	11,268	0	717	21,530	140,588	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	60,540	957	39,502	221	174,292	60.00
64.00	06400	INTRAVENOUS THERAPY	26,176	91,587	12,290	843	6,785	64.00
65.00	06500	RESPIRATORY THERAPY	17,962	140	28,642	4,894	11,999	65.00
66.00	06600	PHYSICAL THERAPY	23,109	3,006	1,474	63	20,390	66.00
67.00	06700	OCCUPATIONAL THERAPY	7,961	0	0	0	4,737	67.00
68.00	06800	SPEECH PATHOLOGY	3,707	0	409	0	1,329	68.00
69.00	06900	ELECTROCARDIOLOGY	38,457	131,183	18,722	113,164	113,900	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	2,160	0	13	0	2,791	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	8,398	0	0	55	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	49	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	4,921,607	180,671	73.00
76.97	07697	CARDIAC REHABILITATION	7,481	0	1,240	2	3,493	76.97
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	9,841	7,679	12,494	6,361	0	90.00
90.01	09001	BASIC DIAGNOSTIC TESTING	0	0	0	0	0	90.01
90.03	09002	PSYCH OUTPATIENT	4,894	0	726	0	0	90.03
90.04	09003	WOUND CARE CLINIC	9,428	10,264	4,737	2,408	29,657	90.04
91.00	09100	EMERGENCY	67,900	259,442	77,217	120,333	300,221	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
93.00	04040	OTHER OUTPATIENT SERVICES	0	0	0	0	0	93.00
OTHER REIMBURSABLE COST CENTERS								
99.10	09910	CORF	0	0	0	0	0	99.10
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS								
109.00	10900	PANCREAS ACQUISITION	0	0	0	0	0	109.00
110.00	11000	INTESTINAL ACQUISITION	0	0	0	0	0	110.00
111.00	11100	ISLET ACQUISITION	0	0	0	0	0	111.00
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	0	0	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	912,402	2,056,709	480,922	5,310,828	1,460,802	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	16,348	0	198,334	0	0	190.00
190.01	19001	OTHER NONREIMBURSABLE	12,601	5,718	5,203	903,553	0	190.01
190.13	19007	EUREKA	0	0	0	0	0	190.13
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
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)	941,351	2,062,427	684,459	6,214,381	1,460,802	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0127

Period:
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Cost Center Description			INTERNS & RESIDENTS			CLINICAL PASTORAL EDUCATION	EMS PROGRAM	
			SOCIAL SERVICE	SERVICES-SALAR Y & FRINGES	SERVICES-OTHER PRGM COSTS			
			17.00	21.00	22.00	23.00	23.01	
GENERAL SERVICE COST CENTERS								
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY						15.00
16.00	01600	MEDICAL RECORDS & LIBRARY						16.00
17.00	01700	SOCIAL SERVICE	1,348,947					17.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	1,309,744				21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	0		476,808			22.00
23.00	02300	CLINICAL PASTORAL EDUCATION	0			284,246		23.00
23.01	02301	EMS PROGRAM	0				0	23.01
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	568,501	1,309,744	476,808	170,195	0	30.00
31.00	03100	INTENSIVE CARE UNIT	257,088	0	0	7,869	0	31.00
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	0	40.00
41.00	04100	SUBPROVIDER - IRF	130,074	0	0	4,509	0	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	0	42.00
43.00	04300	NURSERY	10,712	0	0	0	0	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	0	9,343	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	12,997	0	54.00
57.00	05700	CT SCAN	0	0	0	3,653	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
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	3,653	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	6,504	0	0	0	0	90.00
90.01	09001	BASIC DIAGNOSTIC TESTING	0	0	0	0	0	90.01
90.03	09002	PSYCH OUTPATIENT	0	0	0	0	0	90.03
90.04	09003	WOUND CARE CLINIC	0	0	0	9,343	0	90.04
91.00	09100	EMERGENCY	376,068	0	0	57,468	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
93.00	04040	OTHER OUTPATIENT SERVICES	0	0	0	0	0	93.00
OTHER REIMBURSABLE COST CENTERS								
99.10	09910	CORF	0	0	0	0	0	99.10
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS								
109.00	10900	PANCREAS ACQUISITION	0	0	0	0	0	109.00
110.00	11000	INTESTINAL ACQUISITION	0	0	0	0	0	110.00
111.00	11100	ISLET ACQUISITION	0	0	0	0	0	111.00
113.00	11300	INTEREST EXPENSE	0	0	0	0	0	113.00
116.00	11600	HOSPICE	0	0	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	1,348,947	1,309,744	476,808	279,030	0	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
190.01	19001	OTHER NONREIMBURSABLE	0	0	0	5,216	0	190.01
190.13	19007	EUREKA	0	0	0	0	0	190.13
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
200.00		Cross Foot Adjustments	0	0	0	0	0	200.00

COST ALLOCATION - GENERAL SERVICE COSTS

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Period:
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Cost Center Description			INTERNS & RESIDENTS			CLINICAL PASTORAL EDUCATION	EMS PROGRAM	
			SOCIAL SERVICE	SERVICES-SALAR Y & FRINGES	SERVICES-OTHER PRGM COSTS			
201.00		Negative Cost Centers	17.00	21.00	22.00	23.00	23.01	
			0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	1,348,947	1,309,744	476,808	284,246		0 202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0127

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	NEW CAP REL COSTS-BLDG & FIXT				1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT				4.00
5.00	00500	ADMINISTRATIVE & GENERAL				5.00
7.00	00700	OPERATION OF PLANT				7.00
8.00	00800	LAUNDRY & LINEN SERVICE				8.00
9.00	00900	HOUSEKEEPING				9.00
10.00	01000	DIETARY				10.00
11.00	01100	CAFETERIA				11.00
13.00	01300	NURSING ADMINISTRATION				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY				14.00
15.00	01500	PHARMACY				15.00
16.00	01600	MEDICAL RECORDS & LIBRARY				16.00
17.00	01700	SOCIAL SERVICE				17.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD				21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD				22.00
23.00	02300	CLINICAL PASTORAL EDUCATION				23.00
23.01	02301	EMS PROGRAM				23.01
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	11,171,762	-1,786,552	9,385,210	30.00
31.00	03100	INTENSIVE CARE UNIT	8,918,707	0	8,918,707	31.00
40.00	04000	SUBPROVIDER - IPF	0	0	0	40.00
41.00	04100	SUBPROVIDER - IRF	1,485,916	0	1,485,916	41.00
42.00	04200	SUBPROVIDER	0	0	0	42.00
43.00	04300	NURSERY	2,838,610	0	2,838,610	43.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	6,500,199	0	6,500,199	50.00
51.00	05100	RECOVERY ROOM	597,168	0	597,168	51.00
53.00	05300	ANESTHESIOLOGY	114,940	0	114,940	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,412,133	0	3,412,133	54.00
57.00	05700	CT SCAN	1,080,180	0	1,080,180	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	59.00
60.00	06000	LABORATORY	3,314,224	0	3,314,224	60.00
64.00	06400	INTRAVENOUS THERAPY	1,692,742	0	1,692,742	64.00
65.00	06500	RESPIRATORY THERAPY	1,014,730	0	1,014,730	65.00
66.00	06600	PHYSICAL THERAPY	1,333,140	0	1,333,140	66.00
67.00	06700	OCCUPATIONAL THERAPY	397,079	0	397,079	67.00
68.00	06800	SPEECH PATHOLOGY	224,697	0	224,697	68.00
69.00	06900	ELECTROCARDIOLOGY	3,034,087	0	3,034,087	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	146,674	0	146,674	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	7,430,376	0	7,430,376	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	4,957,367	0	4,957,367	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	5,104,198	0	5,104,198	73.00
76.97	07697	CARDIAC REHABILITATION	386,124	0	386,124	76.97
OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	482,800	0	482,800	90.00
90.01	09001	BASIC DIAGNOSTIC TESTING	-1	0	-1	90.01
90.03	09002	PSYCH OUTPATIENT	405,635	0	405,635	90.03
90.04	09003	WOUND CARE CLINIC	766,548	0	766,548	90.04
91.00	09100	EMERGENCY	5,150,747	0	5,150,747	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	92.00
93.00	04040	OTHER OUTPATIENT SERVICES	0	0	0	93.00
OTHER REIMBURSABLE COST CENTERS						
99.10	09910	CORF	0	0	0	99.10
101.00	10100	HOME HEALTH AGENCY	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS						
109.00	10900	PANCREAS ACQUISITION	0	0	0	109.00
110.00	11000	INTESTINAL ACQUISITION	0	0	0	110.00
111.00	11100	ISLET ACQUISITION	0	0	0	111.00
113.00	11300	INTEREST EXPENSE	0	0	0	113.00
116.00	11600	HOSPICE	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	71,960,782	-1,786,552	70,174,230	118.00
NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	912,196	0	912,196	190.00
190.01	19001	OTHER NONREIMBURSABLE	2,526,668	0	2,526,668	190.01
190.13	19007	EUREKA	0	0	0	190.13
191.00	19100	RESEARCH	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	192.00
200.00		Cross Foot Adjustments	0	0	0	200.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0127

Period:
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Cost Center Description		Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
		24.00	25.00	26.00		
201.00	Negative Cost Centers	0	0	0		201.00
202.00	TOTAL (sum lines 118 through 201)	75,399,646	-1,786,552	73,613,094		202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0127

Period:
From 01/01/2020
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Cost Center Description			CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
			Directly Assigned New Capital Related Costs	NEW BLDG & FIXT	NEW MVBLE EQUIP		
			0	1.00	2.00	2A	4.00
GENERAL SERVICE COST CENTERS							
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	0	1,651	1,651	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	139,583	306,583	114,610	560,776	5.00
7.00	00700	OPERATION OF PLANT	150	729,266	67,194	796,610	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	8,688	61,759	22,847	93,294	8.00
9.00	00900	HOUSEKEEPING	0	44,270	15,069	59,339	9.00
10.00	01000	DIETARY	10,754	22,543	6,054	39,351	10.00
11.00	01100	CAFETERIA	0	37,193	3,975	41,168	11.00
13.00	01300	NURSING ADMINISTRATION	0	50,248	1,324	51,572	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	35,297	27,840	63,137	14.00
15.00	01500	PHARMACY	0	30,512	116,725	147,237	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	17,790	34,726	0	52,516	16.00
17.00	01700	SOCIAL SERVICE	0	7,517	0	7,517	17.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	34,419	0	0	34,419	22.00
23.00	02300	CLINICAL PASTORAL EDUCATION	0	10,060	0	10,060	23.00
23.01	02301	EMS PROGRAM	0	0	0	0	23.01
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	55,922	399,156	155,780	610,858	30.00
31.00	03100	INTENSIVE CARE UNIT	88,294	303,946	127,296	519,536	31.00
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	40.00
41.00	04100	SUBPROVIDER - IRF	10,486	69,715	10,013	90,214	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	42.00
43.00	04300	NURSERY	0	32,628	61,931	94,559	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	1,780	185,785	527,733	715,298	50.00
51.00	05100	RECOVERY ROOM	0	16,320	11,171	27,491	51.00
53.00	05300	ANESTHESIOLOGY	0	3,265	0	3,265	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	57,931	94,902	520,286	673,119	54.00
57.00	05700	CT SCAN	10,190	11,906	209,695	231,791	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	59.00
60.00	06000	LABORATORY	29,709	81,426	92,649	203,784	60.00
64.00	06400	INTRAVENOUS THERAPY	0	61,288	19,643	80,931	64.00
65.00	06500	RESPIRATORY THERAPY	0	30,550	27,562	58,112	65.00
66.00	06600	PHYSICAL THERAPY	76,673	8,722	9,177	94,572	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	66,136	131,294	197,430	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	6,110	4,251	10,361	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	18,568	18,568	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
76.97	07697	CARDIAC REHABILITATION	0	16,986	3,232	20,218	76.97
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0	0	908	908	90.00
90.01	09001	BASIC DIAGNOSTIC TESTING	0	0	0	0	90.01
90.03	09002	PSYCH OUTPATIENT	0	40,522	266	40,788	90.03
90.04	09003	WOUND CARE CLINIC	0	2,248	516	2,764	90.04
91.00	09100	EMERGENCY	0	104,133	64,276	168,409	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	92.00
93.00	04040	OTHER OUTPATIENT SERVICES	0	0	0	0	93.00
OTHER REIMBURSABLE COST CENTERS							
99.10	09910	CORF	0	0	0	0	99.10
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS							
109.00	10900	PANCREAS ACQUISITION	0	0	0	0	109.00
110.00	11000	INTESTINAL ACQUISITION	0	0	0	0	110.00
111.00	11100	ISLET ACQUISITION	0	0	0	0	111.00
113.00	11300	INTEREST EXPENSE	0	0	0	0	113.00
116.00	11600	HOSPICE	0	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	542,369	2,905,718	2,373,536	5,821,623	1,626
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	32,164	1,083	33,247	190.00
190.01	19001	OTHER NONREIMBURSABLE	0	94,243	385	94,628	190.01
190.13	19007	EUREKA	0	0	0	0	190.13
191.00	19100	RESEARCH	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	192.00

ALLOCATION OF CAPITAL RELATED COSTS

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Cost Center Description		Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
			NEW BLDG & FIXT	NEW MVBLE EQUIP			
		0	1.00	2.00	2A	4.00	
200.00	Cross Foot Adjustments				0		200.00
201.00	Negative Cost Centers		0	0	0	0	201.00
202.00	TOTAL (sum lines 118 through 201)	542,369	3,032,125	2,375,004	5,949,498	1,651	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	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	560,983					5.00
7.00	00700	OPERATION OF PLANT	37,772	834,434				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	2,324	25,815	121,444			8.00
9.00	00900	HOUSEKEEPING	11,269	18,505	10,636	99,789		9.00
10.00	01000	DIETARY	3,933	9,423	380	74	53,181	10.00
11.00	01100	CAFETERIA	5,941	15,547	250	2,828	0	11.00
13.00	01300	NURSING ADMINISTRATION	14,145	21,004	0	0	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	4,007	14,754	0	2,707	0	14.00
15.00	01500	PHARMACY	44,865	12,754	0	2,763	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	9,885	14,515	0	107	0	16.00
17.00	01700	SOCIAL SERVICE	9,148	3,142	0	317	0	17.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	9,745	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	3,242	0	0	477	0	22.00
23.00	02300	CLINICAL PASTORAL EDUCATION	1,812	4,205	0	190	0	23.00
23.01	02301	EMS PROGRAM	0	0	0	0	0	23.01
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	44,445	166,843	29,727	33,844	22,736	30.00
31.00	03100	INTENSIVE CARE UNIT	50,493	127,048	21,551	1,516	25,276	31.00
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	0	40.00
41.00	04100	SUBPROVIDER - IRF	7,291	29,141	2,769	1,578	5,169	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	0	42.00
43.00	04300	NURSERY	18,138	13,638	526	1,611	0	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	37,707	77,657	15,417	14,531	0	50.00
51.00	05100	RECOVERY ROOM	3,507	6,822	1,045	1,578	0	51.00
53.00	05300	ANESTHESIOLOGY	382	1,365	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	21,588	39,669	5,180	3,160	0	54.00
57.00	05700	CT SCAN	6,407	4,977	2,863	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	20,674	34,036	59	3,160	0	60.00
64.00	06400	INTRAVENOUS THERAPY	9,292	25,618	338	8,913	0	64.00
65.00	06500	RESPIRATORY THERAPY	6,459	12,770	0	317	0	65.00
66.00	06600	PHYSICAL THERAPY	9,305	3,646	521	616	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	2,847	0	0	104	0	67.00
68.00	06800	SPEECH PATHOLOGY	1,627	0	0	38	0	68.00
69.00	06900	ELECTROCARDIOLOGY	17,834	27,644	4,729	1,895	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	934	2,554	176	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	55,202	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	36,884	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	14	0	0	0	0	73.00
76.97	07697	CARDIAC REHABILITATION	2,460	7,100	25	0	0	76.97
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	3,190	0	23	663	0	90.00
90.01	09001	BASIC DIAGNOSTIC TESTING	0	0	0	0	0	90.01
90.03	09002	PSYCH OUTPATIENT	2,210	16,938	0	0	0	90.03
90.04	09003	WOUND CARE CLINIC	4,872	940	896	2,200	0	90.04
91.00	09100	EMERGENCY	24,717	43,527	24,333	12,633	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
93.00	04040	OTHER OUTPATIENT SERVICES	0	0	0	0	0	93.00
OTHER REIMBURSABLE COST CENTERS								
99.10	09910	CORF	0	0	0	0	0	99.10
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS								
109.00	10900	PANCREAS ACQUISITION	0	0	0	0	0	109.00
110.00	11000	INTESTINAL ACQUISITION	0	0	0	0	0	110.00
111.00	11100	ISLET ACQUISITION	0	0	0	0	0	111.00
113.00	11300	INTEREST EXPENSE	0	0	0	0	0	113.00
116.00	11600	HOSPICE	0	0	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	546,567	781,597	121,444	97,820	53,181	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	4,352	13,444	0	1,845	0	190.00
190.01	19001	OTHER NONREIMBURSABLE	10,064	39,393	0	124	0	190.01
190.13	19007	EUREKA	0	0	0	0	0	190.13
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
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)	560,983	834,434	121,444	99,789	53,181	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0127

Period:
From 01/01/2020
To 06/30/2020Worksheet B
Part II
Date/Time Prepared:
11/24/2020 1:07 pm

Cost Center Description			CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
			11.00	13.00	14.00	15.00	16.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	NEW 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	65,747					11.00
13.00	01300	NURSING ADMINISTRATION	2,339	89,118				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	766	0	85,380			14.00
15.00	01500	PHARMACY	2,131	0	3,758	213,569		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,971	487	337	0	79,852	16.00
17.00	01700	SOCIAL SERVICE	1,522	3,164	0	0	0	17.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	2,315	0	0	0	0	22.00
23.00	02300	CLINICAL PASTORAL EDUCATION	635	0	354	1	0	23.00
23.01	02301	EMS PROGRAM	0	0	0	0	0	23.01
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	9,517	19,556	9,081	93	3,345	30.00
31.00	03100	INTENSIVE CARE UNIT	9,460	21,386	6,913	134	896	31.00
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	0	40.00
41.00	04100	SUBPROVIDER - IRF	1,374	2,855	727	2	447	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	0	42.00
43.00	04300	NURSERY	2,885	6,997	7,029	54	927	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	5,161	10,742	5,115	2,755	11,171	50.00
51.00	05100	RECOVERY ROOM	557	1,373	22	61	663	51.00
53.00	05300	ANESTHESIOLOGY	72	145	54	931	1,277	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,705	14	1,878	73	6,957	54.00
57.00	05700	CT SCAN	787	0	89	740	7,685	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	4,228	41	4,928	8	9,527	60.00
64.00	06400	INTRAVENOUS THERAPY	1,828	3,957	1,533	29	371	64.00
65.00	06500	RESPIRATORY THERAPY	1,255	6	3,573	168	656	65.00
66.00	06600	PHYSICAL THERAPY	1,614	130	184	2	1,115	66.00
67.00	06700	OCCUPATIONAL THERAPY	556	0	0	0	259	67.00
68.00	06800	SPEECH PATHOLOGY	259	0	51	0	73	68.00
69.00	06900	ELECTROCARDIOLOGY	2,686	5,668	2,335	3,889	6,226	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	151	0	2	0	153	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	363	0	0	3	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	3	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	169,140	9,876	73.00
76.97	07697	CARDIAC REHABILITATION	522	0	155	0	191	76.97
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	687	332	1,558	219	0	90.00
90.01	09001	BASIC DIAGNOSTIC TESTING	0	0	0	0	0	90.01
90.03	09002	PSYCH OUTPATIENT	342	0	91	0	0	90.03
90.04	09003	WOUND CARE CLINIC	658	444	591	83	1,621	90.04
91.00	09100	EMERGENCY	4,742	11,211	9,632	4,135	16,410	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
93.00	04040	OTHER OUTPATIENT SERVICES	0	0	0	0	0	93.00
OTHER REIMBURSABLE COST CENTERS								
99.10	09910	CORF	0	0	0	0	0	99.10
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS								
109.00	10900	PANCREAS ACQUISITION	0	0	0	0	0	109.00
110.00	11000	INTESTINAL ACQUISITION	0	0	0	0	0	110.00
111.00	11100	ISLET ACQUISITION	0	0	0	0	0	111.00
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	0	0	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	63,725	88,871	59,990	182,517	79,852	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	1,142	0	24,741	0	0	190.00
190.01	19001	OTHER NONREIMBURSABLE	880	247	649	31,052	0	190.01
190.13	19007	EUREKA	0	0	0	0	0	190.13
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
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)	65,747	89,118	85,380	213,569	79,852	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0127

Period:
From 01/01/2020
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Cost Center Description			INTERNS & RESIDENTS			CLINICAL PASTORAL EDUCATION	EMS PROGRAM	
			SOCIAL SERVICE	SERVICES-SALAR Y & FRINGES	SERVICES-OTHER PRGM COSTS			
			17.00	21.00	22.00	23.00	23.01	
GENERAL SERVICE COST CENTERS								
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY						15.00
16.00	01600	MEDICAL RECORDS & LIBRARY						16.00
17.00	01700	SOCIAL SERVICE	24,849					17.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	9,789				21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	0		40,453			22.00
23.00	02300	CLINICAL PASTORAL EDUCATION	0			17,264		23.00
23.01	02301	EMS PROGRAM	0				0	23.01
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	10,472					30.00
31.00	03100	INTENSIVE CARE UNIT	4,736					31.00
40.00	04000	SUBPROVIDER - IPF	0					40.00
41.00	04100	SUBPROVIDER - IRF	2,396					41.00
42.00	04200	SUBPROVIDER	0					42.00
43.00	04300	NURSERY	197					43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0					50.00
51.00	05100	RECOVERY ROOM	0					51.00
53.00	05300	ANESTHESIOLOGY	0					53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0					54.00
57.00	05700	CT SCAN	0					57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0					58.00
59.00	05900	CARDIAC CATHETERIZATION	0					59.00
60.00	06000	LABORATORY	0					60.00
64.00	06400	INTRAVENOUS THERAPY	0					64.00
65.00	06500	RESPIRATORY THERAPY	0					65.00
66.00	06600	PHYSICAL THERAPY	0					66.00
67.00	06700	OCCUPATIONAL THERAPY	0					67.00
68.00	06800	SPEECH PATHOLOGY	0					68.00
69.00	06900	ELECTROCARDIOLOGY	0					69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0					70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0					71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0					72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0					73.00
76.97	07697	CARDIAC REHABILITATION	0					76.97
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	120					90.00
90.01	09001	BASIC DIAGNOSTIC TESTING	0					90.01
90.03	09002	PSYCH OUTPATIENT	0					90.03
90.04	09003	WOUND CARE CLINIC	0					90.04
91.00	09100	EMERGENCY	6,928					91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0					92.00
93.00	04040	OTHER OUTPATIENT SERVICES	0					93.00
OTHER REIMBURSABLE COST CENTERS								
99.10	09910	CORF	0					99.10
101.00	10100	HOME HEALTH AGENCY	0					101.00
SPECIAL PURPOSE COST CENTERS								
109.00	10900	PANCREAS ACQUISITION	0					109.00
110.00	11000	INTESTINAL ACQUISITION	0					110.00
111.00	11100	ISLET ACQUISITION	0					111.00
113.00	11300	INTEREST EXPENSE	0					113.00
116.00	11600	HOSPICE	0					116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	24,849	0	0	0	0	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0					190.00
190.01	19001	OTHER NONREIMBURSABLE	0					190.01
190.13	19007	EUREKA	0					190.13
191.00	19100	RESEARCH	0					191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0					192.00
200.00		Cross Foot Adjustments		9,789	40,453	17,264	0	200.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0127

 Period:
 From 01/01/2020
 To 06/30/2020

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Cost Center Description			INTERNS & RESIDENTS			CLINICAL PASTORAL EDUCATION	EMS PROGRAM	
			SOCIAL SERVICE	SERVICES-SALAR	SERVICES-OTHER			
				Y & FRINGES	PRGM COSTS			
			17.00	21.00	22.00	23.00	23.01	
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	24,849	9,789	40,453	17,264	0	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0127

Period:
From 01/01/2020
To 06/30/2020Worksheet B
Part II
Date/Time Prepared:
11/24/2020 1:07 pm

Cost Center Description			Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			24.00	25.00	26.00	
GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT				1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT				4.00
5.00	00500	ADMINISTRATIVE & GENERAL				5.00
7.00	00700	OPERATION OF PLANT				7.00
8.00	00800	LAUNDRY & LINEN SERVICE				8.00
9.00	00900	HOUSEKEEPING				9.00
10.00	01000	DIETARY				10.00
11.00	01100	CAFETERIA				11.00
13.00	01300	NURSING ADMINISTRATION				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY				14.00
15.00	01500	PHARMACY				15.00
16.00	01600	MEDICAL RECORDS & LIBRARY				16.00
17.00	01700	SOCIAL SERVICE				17.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD				21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD				22.00
23.00	02300	CLINICAL PASTORAL EDUCATION				23.00
23.01	02301	EMS PROGRAM				23.01
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	960,690	0	960,690	30.00
31.00	03100	INTENSIVE CARE UNIT	789,128	0	789,128	31.00
40.00	04000	SUBPROVIDER - IPF	0	0	0	40.00
41.00	04100	SUBPROVIDER - IRF	143,989	0	143,989	41.00
42.00	04200	SUBPROVIDER	0	0	0	42.00
43.00	04300	NURSERY	146,628	0	146,628	43.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	895,677	0	895,677	50.00
51.00	05100	RECOVERY ROOM	43,133	0	43,133	51.00
53.00	05300	ANESTHESIOLOGY	7,492	0	7,492	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	754,401	0	754,401	54.00
57.00	05700	CT SCAN	255,356	0	255,356	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	59.00
60.00	06000	LABORATORY	280,508	0	280,508	60.00
64.00	06400	INTRAVENOUS THERAPY	132,842	0	132,842	64.00
65.00	06500	RESPIRATORY THERAPY	83,340	0	83,340	65.00
66.00	06600	PHYSICAL THERAPY	111,744	0	111,744	66.00
67.00	06700	OCCUPATIONAL THERAPY	3,778	0	3,778	67.00
68.00	06800	SPEECH PATHOLOGY	2,055	0	2,055	68.00
69.00	06900	ELECTROCARDIOLOGY	270,398	0	270,398	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	14,334	0	14,334	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	55,568	0	55,568	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	55,455	0	55,455	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	179,030	0	179,030	73.00
76.97	07697	CARDIAC REHABILITATION	30,679	0	30,679	76.97
OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	7,712	0	7,712	90.00
90.01	09001	BASIC DIAGNOSTIC TESTING	0	0	0	90.01
90.03	09002	PSYCH OUTPATIENT	60,377	0	60,377	90.03
90.04	09003	WOUND CARE CLINIC	15,083	0	15,083	90.04
91.00	09100	EMERGENCY	326,762	0	326,762	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	92.00
93.00	04040	OTHER OUTPATIENT SERVICES	0	0	0	93.00
OTHER REIMBURSABLE COST CENTERS						
99.10	09910	CORF	0	0	0	99.10
101.00	10100	HOME HEALTH AGENCY	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS						
109.00	10900	PANCREAS ACQUISITION	0	0	0	109.00
110.00	11000	INTESTINAL ACQUISITION	0	0	0	110.00
111.00	11100	ISLET ACQUISITION	0	0	0	111.00
113.00	11300	INTEREST EXPENSE	0	0	0	113.00
116.00	11600	HOSPICE	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	5,626,159	0	5,626,159	118.00
NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	78,783	0	78,783	190.00
190.01	19001	OTHER NONREIMBURSABLE	177,050	0	177,050	190.01
190.13	19007	EUREKA	0	0	0	190.13
191.00	19100	RESEARCH	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	192.00
200.00		Cross Foot Adjustments	67,506	0	67,506	200.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0127

Period:
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To 06/30/2020Worksheet B
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Date/Time Prepared:
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Cost Center Description		Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
		24.00	25.00	26.00		
201.00	Negative Cost Centers	0	0	0		201.00
202.00	TOTAL (sum lines 118 through 201)	5,949,498	0	5,949,498		202.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0127

Period:
From 01/01/2020
To 06/30/2020

Worksheet B-1

Date/Time Prepared:
11/24/2020 1:07 pm

Cost Center Description			CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
			NEW BLDG & FIXT (SQUARE FEET)	NEW MVBLE EQUIP (DOLLAR VALUE)				
			1.00	2.00	4.00	5A	5.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT	482,862					1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP		1,873,123				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	1,302	30,982,612			4.00
5.00	00500	ADMINISTRATIVE & GENERAL	48,823	90,391	3,708,346	-16,009,271	59,390,376	5.00
7.00	00700	OPERATION OF PLANT	116,135	52,995	977,097	0	3,998,706	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	9,835	18,019	209,367	0	246,000	8.00
9.00	00900	HOUSEKEEPING	7,050	11,885	749,003	0	1,192,953	9.00
10.00	01000	DIETARY	3,590	4,775	384,694	0	416,377	10.00
11.00	01100	CAFETERIA	5,923	3,135	252,561	0	628,978	11.00
13.00	01300	NURSING ADMINISTRATION	8,002	1,044	1,103,013	0	1,497,495	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	5,621	21,957	178,951	0	424,154	14.00
15.00	01500	PHARMACY	4,859	92,059	1,152,294	0	4,749,648	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	5,530	0	646,551	0	1,046,438	16.00
17.00	01700	SOCIAL SERVICE	1,197	0	736,768	0	968,461	17.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	0	836,938	0	1,031,652	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	0	0	0	0	343,180	22.00
23.00	02300	CLINICAL PASTORAL EDUCATION	1,602	0	131,674	0	191,836	23.00
23.01	02301	EMS PROGRAM	0	0	0	0	0	23.01
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	63,565	122,861	3,260,283	0	4,705,193	30.00
31.00	03100	INTENSIVE CARE UNIT	48,403	100,396	3,454,486	0	5,345,433	31.00
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	0	40.00
41.00	04100	SUBPROVIDER - IRF	11,102	7,897	493,094	0	771,875	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	0	42.00
43.00	04300	NURSERY	5,196	48,844	1,262,084	0	1,920,221	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	29,586	416,212	2,312,874	0	3,991,811	50.00
51.00	05100	RECOVERY ROOM	2,599	8,810	263,888	0	371,315	51.00
53.00	05300	ANESTHESIOLOGY	520	0	15,933	0	40,479	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	15,113	410,340	1,093,356	0	2,285,409	54.00
57.00	05700	CT SCAN	1,896	165,383	316,189	0	678,251	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	12,967	73,071	1,187,348	0	2,188,627	60.00
64.00	06400	INTRAVENOUS THERAPY	9,760	15,492	601,904	0	983,719	64.00
65.00	06500	RESPIRATORY THERAPY	4,865	21,738	458,043	0	683,786	65.00
66.00	06600	PHYSICAL THERAPY	1,389	7,238	742,834	0	985,070	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	225,450	0	301,402	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	125,273	0	172,192	68.00
69.00	06900	ELECTROCARDIOLOGY	10,532	103,549	1,168,642	0	1,887,947	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	973	3,353	61,487	0	98,847	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	5,846,059	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	14,644	0	0	3,904,753	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	1,512	73.00
76.97	07697	CARDIAC REHABILITATION	2,705	2,549	158,104	0	260,416	76.97
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	716	222,098	0	337,711	90.00
90.01	09001	BASIC DIAGNOSTIC TESTING	0	0	0	1	0	90.01
90.03	09002	PSYCH OUTPATIENT	6,453	210	147,613	0	233,913	90.03
90.04	09003	WOUND CARE CLINIC	358	407	260,561	0	515,729	90.04
91.00	09100	EMERGENCY	16,583	50,693	1,609,720	0	2,616,696	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
93.00	04040	OTHER OUTPATIENT SERVICES	0	0	0	0	0	93.00
OTHER REIMBURSABLE COST CENTERS								
99.10	09910	CORF	0	0	0	0	0	99.10
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS								
109.00	10900	PANCREAS ACQUISITION	0	0	0	0	0	109.00
110.00	11000	INTESTINAL ACQUISITION	0	0	0	0	0	110.00
111.00	11100	ISLET ACQUISITION	0	0	0	0	0	111.00
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	0	0	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	462,732	1,871,965	30,508,521	-16,009,270	57,864,244	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	5,122	854	223,094	0	460,695	190.00
190.01	19001	OTHER NONREIMBURSABLE	15,008	304	250,997	0	1,065,437	190.01
190.13	19007	EUREKA	0	0	0	0	0	190.13
191.00	19100	RESEARCH	0	0	0	0	0	191.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0127

Period:
From 01/01/2020
To 06/30/2020

Worksheet B-1

Date/Time Prepared:
11/24/2020 1:07 pm

Cost Center Description			CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
			NEW BLDG & FIXT (SQUARE FEET)	NEW MVBLE EQUIP (DOLLAR VALUE)				
			1.00	2.00	4.00	5A	5.00	
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
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)	3,032,125	2,375,004	7,208,091		16,009,271	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	6.279486	1.267938	0.232650		0.269560	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)			1,651		560,983	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)			0.000053		0.009446	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: 14-0127

Period:
From 01/01/2020
To 06/30/2020

Worksheet B-1

Date/Time Prepared:
11/24/2020 1:07 pm

Cost Center Description		OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (HOURS OF SERVICE)	DIETARY (MEALS SERVED)	CAFETERIA (FTE'S)	
		7.00	8.00	9.00	10.00	11.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	NEW 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	317,904				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	9,835	424,459			8.00
9.00	00900	HOUSEKEEPING	7,050	37,173	33,698		9.00
10.00	01000	DIETARY	3,590	1,329	25	14,722	10.00
11.00	01100	CAFETERIA	5,923	873	955	0	11.00
13.00	01300	NURSING ADMINISTRATION	8,002	0	0	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	5,621	0	914	0	14.00
15.00	01500	PHARMACY	4,859	0	933	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	5,530	0	36	0	16.00
17.00	01700	SOCIAL SERVICE	1,197	0	107	0	17.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	0	0	161	0	22.00
23.00	02300	CLINICAL PASTORAL EDUCATION	1,602	0	64	0	23.00
23.01	02301	EMS PROGRAM	0	0	0	0	23.01
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	63,565	103,899	11,429	6,294	30.00
31.00	03100	INTENSIVE CARE UNIT	48,403	75,324	512	6,997	31.00
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	40.00
41.00	04100	SUBPROVIDER - IRF	11,102	9,677	533	1,431	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	42.00
43.00	04300	NURSERY	5,196	1,837	544	0	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	29,586	53,885	4,907	0	50.00
51.00	05100	RECOVERY ROOM	2,599	3,652	533	0	51.00
53.00	05300	ANESTHESIOLOGY	520	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	15,113	18,103	1,067	0	54.00
57.00	05700	CT SCAN	1,896	10,008	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	59.00
60.00	06000	LABORATORY	12,967	205	1,067	0	60.00
64.00	06400	INTRAVENOUS THERAPY	9,760	1,180	3,010	0	64.00
65.00	06500	RESPIRATORY THERAPY	4,865	0	107	0	65.00
66.00	06600	PHYSICAL THERAPY	1,389	1,822	208	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	35	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	13	0	68.00
69.00	06900	ELECTROCARDIOLOGY	10,532	16,529	640	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	973	615	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
76.97	07697	CARDIAC REHABILITATION	2,705	89	0	0	76.97
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0	80	224	0	90.00
90.01	09001	BASIC DIAGNOSTIC TESTING	0	0	0	0	90.01
90.03	09002	PSYCH OUTPATIENT	6,453	0	0	0	90.03
90.04	09003	WOUND CARE CLINIC	358	3,132	743	0	90.04
91.00	09100	EMERGENCY	16,583	85,047	4,266	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					92.00
93.00	04040	OTHER OUTPATIENT SERVICES	0	0	0	0	93.00
OTHER REIMBURSABLE COST CENTERS							
99.10	09910	CORF	0	0	0	0	99.10
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS							
109.00	10900	PANCREAS ACQUISITION	0	0	0	0	109.00
110.00	11000	INTESTINAL ACQUISITION	0	0	0	0	110.00
111.00	11100	ISLET ACQUISITION	0	0	0	0	111.00
113.00	11300	INTEREST EXPENSE					113.00
116.00	11600	HOSPICE	0	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	297,774	424,459	33,033	14,722	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	5,122	0	623	0	190.00
190.01	19001	OTHER NONREIMBURSABLE	15,008	0	42	0	190.01
190.13	19007	EUREKA	0	0	0	0	190.13
191.00	19100	RESEARCH	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	192.00
200.00		Cross Foot Adjustments					200.00
201.00		Negative Cost Centers					201.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0127

Period:
From 01/01/2020
To 06/30/2020

Worksheet B-1

Date/Time Prepared:
11/24/2020 1:07 pm

Cost Center Description			OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (HOURS OF SERVICE)	DIETARY (MEALS SERVED)	CAFETERIA (FTE'S)	
			7.00	8.00	9.00	10.00	11.00	
202.00		Cost to be allocated (per Wkst. B, Part I)	5,076,597	469,367	1,668,212	588,653	941,351	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	15.968962	1.105801	49.504778	39.984581	13.334717	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	834,434	121,444	99,789	53,181	65,747	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	2.624799	0.286115	2.961274	3.612349	0.931340	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: 14-0127

Period:
From 01/01/2020
To 06/30/2020

Worksheet B-1

Date/Time Prepared:
11/24/2020 1:07 pm

Cost Center Description			NURSING ADMINISTRATION (NURSING FTE'S)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUISITIO)	MEDICAL RECORDS & LIBRARY (TIME SPENT)	SOCIAL SERVICE (TIME SPENT)	
			13.00	14.00	15.00	16.00	17.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	NEW 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	916,088					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	430,599				14.00
15.00	01500	PHARMACY	0	18,953	3,540,413			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	5,010	1,699	0	3,792,506		16.00
17.00	01700	SOCIAL SERVICE	32,526	0	0	0	3,526	17.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	0	0	0	0	0	22.00
23.00	02300	CLINICAL PASTORAL EDUCATION	0	1,785	10	0	0	23.00
23.01	02301	EMS PROGRAM	0	0	0	0	0	23.01
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	201,029	45,800	1,546	158,874	1,486	30.00
31.00	03100	INTENSIVE CARE UNIT	219,827	34,867	2,215	42,547	672	31.00
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	0	40.00
41.00	04100	SUBPROVIDER - IRF	29,350	3,666	25	21,243	340	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	0	42.00
43.00	04300	NURSERY	71,927	35,452	894	44,031	28	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	110,426	25,799	45,675	530,586	0	50.00
51.00	05100	RECOVERY ROOM	14,112	111	1,017	31,486	0	51.00
53.00	05300	ANESTHESIOLOGY	1,488	270	15,431	60,629	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	142	9,472	1,211	330,409	0	54.00
57.00	05700	CT SCAN	0	451	12,266	364,993	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	425	24,851	126	452,494	0	60.00
64.00	06400	INTRAVENOUS THERAPY	40,681	7,732	480	17,614	0	64.00
65.00	06500	RESPIRATORY THERAPY	62	18,019	2,788	31,152	0	65.00
66.00	06600	PHYSICAL THERAPY	1,335	927	36	52,935	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	12,297	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	257	0	3,451	0	68.00
69.00	06900	ELECTROCARDIOLOGY	58,269	11,778	64,471	295,704	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	8	0	7,247	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	3,730	0	0	143	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	126	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	2,803,904	469,056	0	73.00
76.97	07697	CARDIAC REHABILITATION	0	780	1	9,069	0	76.97
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	3,411	7,860	3,624	0	17	90.00
90.01	09001	BASIC DIAGNOSTIC TESTING	0	0	0	0	0	90.01
90.03	09002	PSYCH OUTPATIENT	0	457	0	0	0	90.03
90.04	09003	WOUND CARE CLINIC	4,559	2,980	1,372	76,996	0	90.04
91.00	09100	EMERGENCY	115,239	48,578	68,555	779,424	983	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
93.00	04040	OTHER OUTPATIENT SERVICES	0	0	0	0	0	93.00
OTHER REIMBURSABLE COST CENTERS								
99.10	09910	CORF	0	0	0	0	0	99.10
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS								
109.00	10900	PANCREAS ACQUISITION	0	0	0	0	0	109.00
110.00	11000	INTESTINAL ACQUISITION	0	0	0	0	0	110.00
111.00	11100	ISLET ACQUISITION	0	0	0	0	0	111.00
113.00	11300	INTEREST EXPENSE	0	0	0	0	0	113.00
116.00	11600	HOSPICE	0	0	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	913,548	302,552	3,025,647	3,792,506	3,526	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	124,774	0	0	0	190.00
190.01	19001	OTHER NONREIMBURSABLE	2,540	3,273	514,766	0	0	190.01
190.13	19007	EUREKA	0	0	0	0	0	190.13
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
200.00		Cross Foot Adjustments						200.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0127

Period:
From 01/01/2020
To 06/30/2020

Worksheet B-1

Date/Time Prepared:
11/24/2020 1:07 pm

Cost Center Description		NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY (COSTED REQUISITIO)	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	
		(NURSING FTE'S)	(COSTED REQUIS.)		(TIME SPENT)	(TIME SPENT)	
201.00	Negative Cost Centers	13.00	14.00	15.00	16.00	17.00	201.00
202.00	Cost to be allocated (per Wkst. B, Part I)	2,062,427	684,459	6,214,381	1,460,802	1,348,947	202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	2.251342	1.589551	1.755270	0.385181	382.571469	203.00
204.00	Cost to be allocated (per Wkst. B, Part II)	89,118	85,380	213,569	79,852	24,849	204.00
205.00	Unit cost multiplier (Wkst. B, Part II)	0.097281	0.198282	0.060323	0.021055	7.047362	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: 14-0127

Period:
From 01/01/2020
To 06/30/2020

Worksheet B-1

Date/Time Prepared:
11/24/2020 1:07 pm

Cost Center Description			INTERNS & RESIDENTS		CLINICAL PASTORAL EDUCATION (ASSIGNED TIME)	EMS PROGRAM (ASSIGNED TIME)		
			SERVICES-SALARY & FRINGES (ASSIGNED TIME)	SERVICES-OTHER PRGM COSTS (ASSIGNED TIME)				
			21.00	22.00				
GENERAL SERVICE COST CENTERS								
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY						15.00
16.00	01600	MEDICAL RECORDS & LIBRARY						16.00
17.00	01700	SOCIAL SERVICE						17.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	100					21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD		100				22.00
23.00	02300	CLINICAL PASTORAL EDUCATION			80,375			23.00
23.01	02301	EMS PROGRAM				0		23.01
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	100	100	48,125	0		30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	2,225	0		31.00
40.00	04000	SUBPROVIDER - IPF	0	0	0	0		40.00
41.00	04100	SUBPROVIDER - IRF	0	0	1,275	0		41.00
42.00	04200	SUBPROVIDER	0	0	0	0		42.00
43.00	04300	NURSERY	0	0	0	0		43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	2,642	0		50.00
51.00	05100	RECOVERY ROOM	0	0	0	0		51.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	3,675	0		54.00
57.00	05700	CT SCAN	0	0	1,033	0		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0		58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0		59.00
60.00	06000	LABORATORY	0	0	0	0		60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0		64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	1,033	0		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0		73.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0		76.97
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0	0		90.00
90.01	09001	BASIC DIAGNOSTIC TESTING	0	0	0	0		90.01
90.03	09002	PSYCH OUTPATIENT	0	0	0	0		90.03
90.04	09003	WOUND CARE CLINIC	0	0	2,642	0		90.04
91.00	09100	EMERGENCY	0	0	16,250	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0		92.00
93.00	04040	OTHER OUTPATIENT SERVICES	0	0	0	0		93.00
OTHER REIMBURSABLE COST CENTERS								
99.10	09910	CORF	0	0	0	0		99.10
101.00	10100	HOME HEALTH AGENCY	0	0	0	0		101.00
SPECIAL PURPOSE COST CENTERS								
109.00	10900	PANCREAS ACQUISITION	0	0	0	0		109.00
110.00	11000	INTESTINAL ACQUISITION	0	0	0	0		110.00
111.00	11100	ISLET ACQUISITION	0	0	0	0		111.00
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE			0	0		116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	100	100	78,900	0		118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0		190.00
190.01	19001	OTHER NONREIMBURSABLE	0	0	1,475	0		190.01
190.13	19007	EUREKA	0	0	0	0		190.13
191.00	19100	RESEARCH	0	0	0	0		191.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0127

Period:
From 01/01/2020
To 06/30/2020

Worksheet B-1

Date/Time Prepared:
11/24/2020 1:07 pm

Cost Center Description			INTERNS & RESIDENTS		CLINICAL PASTORAL EDUCATION (ASSIGNED TIME)	EMS PROGRAM (ASSIGNED TIME)		
			SERVICES-SALAR Y & FRINGES (ASSIGNED TIME)	SERVICES-OTHER PRGM COSTS (ASSIGNED TIME)				
			21.00	22.00	23.00	23.01		
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0		192.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	1,309,744	476,808	284,246	0		202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	13,097.440000	4,768.080000	3.536498	0.000000		203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	9,789	40,453	17,264	0		204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	97.890000	404.530000	0.214793	0.000000		205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)			0	0		206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)			0.000000	0.000000		207.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0127

Period:
From 01/01/2020
To 06/30/2020Worksheet C
Part I
Date/Time Prepared:
11/24/2020 1:07 pm

			Title XVIII		Hospital		PPS	
Cost Center Description			Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs		Total Costs	
					Total Costs	RCE Disallowance		
			1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	9,385,210		9,385,210	0	9,385,210	30.00
31.00	03100	INTENSIVE CARE UNIT	8,918,707		8,918,707	0	8,918,707	31.00
40.00	04000	SUBPROVIDER - IPF	0		0	0	0	40.00
41.00	04100	SUBPROVIDER - IRF	1,485,916		1,485,916	0	1,485,916	41.00
42.00	04200	SUBPROVIDER	0		0	0	0	42.00
43.00	04300	NURSERY	2,838,610		2,838,610	0	2,838,610	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	6,500,199		6,500,199	0	6,500,199	50.00
51.00	05100	RECOVERY ROOM	597,168		597,168	0	597,168	51.00
53.00	05300	ANESTHESIOLOGY	114,940		114,940	0	114,940	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,412,133		3,412,133	0	3,412,133	54.00
57.00	05700	CT SCAN	1,080,180		1,080,180	0	1,080,180	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0		0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0		0	0	0	59.00
60.00	06000	LABORATORY	3,314,224		3,314,224	0	3,314,224	60.00
64.00	06400	INTRAVENOUS THERAPY	1,692,742		1,692,742	0	1,692,742	64.00
65.00	06500	RESPIRATORY THERAPY	1,014,730	0	1,014,730	0	1,014,730	65.00
66.00	06600	PHYSICAL THERAPY	1,333,140	0	1,333,140	0	1,333,140	66.00
67.00	06700	OCCUPATIONAL THERAPY	397,079	0	397,079	0	397,079	67.00
68.00	06800	SPEECH PATHOLOGY	224,697	0	224,697	0	224,697	68.00
69.00	06900	ELECTROCARDIOLOGY	3,034,087		3,034,087	0	3,034,087	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	146,674		146,674	0	146,674	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	7,430,376		7,430,376	0	7,430,376	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	4,957,367		4,957,367	0	4,957,367	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	5,104,198		5,104,198	0	5,104,198	73.00
76.97	07697	CARDIAC REHABILITATION	386,124		386,124	0	386,124	76.97
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	482,800		482,800	0	482,800	90.00
90.01	09001	BASIC DIAGNOSTIC TESTING	0		0	0	0	90.01
90.03	09002	PSYCH OUTPATIENT	405,635		405,635	0	405,635	90.03
90.04	09003	WOUND CARE CLINIC	766,548		766,548	0	766,548	90.04
91.00	09100	EMERGENCY	5,150,747		5,150,747	0	5,150,747	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	2,277,527		2,277,527	0	2,277,527	92.00
93.00	04040	OTHER OUTPATIENT SERVICES	0		0	0	0	93.00
OTHER REIMBURSABLE COST CENTERS								
99.10	09910	CORF	0		0		0	99.10
101.00	10100	HOME HEALTH AGENCY	0		0		0	101.00
SPECIAL PURPOSE COST CENTERS								
109.00	10900	PANCREAS ACQUISITION	0		0		0	109.00
110.00	11000	INTESTINAL ACQUISITION	0		0		0	110.00
111.00	11100	ISLET ACQUISITION	0		0		0	111.00
113.00	11300	INTEREST EXPENSE	0		0		0	113.00
116.00	11600	HOSPICE	0		0		0	116.00
200.00		Subtotal (see instructions)	72,451,758	0	72,451,758	0	72,451,758	200.00
201.00		Less Observation Beds	2,277,527		2,277,527		2,277,527	201.00
202.00		Total (see instructions)	70,174,231	0	70,174,231	0	70,174,231	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0127

Period:
From 01/01/2020
To 06/30/2020Worksheet C
Part I
Date/Time Prepared:
11/24/2020 1:07 pm

			Title XVIII			Hospital	PPS		
Cost Center Description			Charges			Cost or Other Ratio	TEFRA Inpatient Ratio		
			Inpatient	Outpatient	Total (col. 6 + col. 7)				
			6.00	7.00	8.00	9.00	10.00		
	INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	10,537,372		10,537,372			30.00	
31.00	03100	INTENSIVE CARE UNIT	12,665,921		12,665,921			31.00	
40.00	04000	SUBPROVIDER - IPF	0		0			40.00	
41.00	04100	SUBPROVIDER - IRF	1,350,115		1,350,115			41.00	
42.00	04200	SUBPROVIDER	0		0			42.00	
43.00	04300	NURSERY	7,525,500		7,525,500			43.00	
	ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	8,793,031	8,168,819	16,961,850	0.383225	0.000000	50.00	
51.00	05100	RECOVERY ROOM	620,210	778,829	1,399,039	0.426842	0.000000	51.00	
53.00	05300	ANESTHESIOLOGY	1,578,387	1,475,562	3,053,949	0.037637	0.000000	53.00	
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,763,833	11,585,094	15,348,927	0.222304	0.000000	54.00	
57.00	05700	CT SCAN	5,524,501	11,191,331	16,715,832	0.064620	0.000000	57.00	
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0.000000	0.000000	58.00	
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0.000000	0.000000	59.00	
60.00	06000	LABORATORY	10,116,745	12,693,301	22,810,046	0.145297	0.000000	60.00	
64.00	06400	INTRAVENOUS THERAPY	759,487	2,850,382	3,609,869	0.468921	0.000000	64.00	
65.00	06500	RESPIRATORY THERAPY	2,001,510	208,265	2,209,775	0.459201	0.000000	65.00	
66.00	06600	PHYSICAL THERAPY	1,477,910	1,104,101	2,582,011	0.516318	0.000000	66.00	
67.00	06700	OCCUPATIONAL THERAPY	1,265,220	186,047	1,451,267	0.273609	0.000000	67.00	
68.00	06800	SPEECH PATHOLOGY	384,224	85,145	469,369	0.478721	0.000000	68.00	
69.00	06900	ELECTROCARDIOLOGY	6,707,140	8,861,495	15,568,635	0.194885	0.000000	69.00	
70.00	07000	ELECTROENCEPHALOGRAPHY	91,805	198,347	290,152	0.505507	0.000000	70.00	
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	3,904,510	2,636,061	6,540,571	1.136044	0.000000	71.00	
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	7,309,581	3,530,610	10,840,191	0.457314	0.000000	72.00	
73.00	07300	DRUGS CHARGED TO PATIENTS	20,160,243	12,373,552	32,533,795	0.156889	0.000000	73.00	
76.97	07697	CARDIAC REHABILITATION	11,060	204,526	215,586	1.791044	0.000000	76.97	
	OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	460,499	460,499	1.048428	0.000000	90.00	
90.01	09001	BASIC DIAGNOSTIC TESTING	0	0	0	0.000000	0.000000	90.01	
90.03	09002	PSYCH OUTPATIENT	0	218,000	218,000	1.860711	0.000000	90.03	
90.04	09003	WOUND CARE CLINIC	189,600	2,353,662	2,543,262	0.301403	0.000000	90.04	
91.00	09100	EMERGENCY	4,288,820	12,683,332	16,972,152	0.303482	0.000000	91.00	
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	731,500	2,622,612	3,354,112	0.679025	0.000000	92.00	
93.00	04040	OTHER OUTPATIENT SERVICES	0	0	0	0.000000	0.000000	93.00	
	OTHER REIMBURSABLE COST CENTERS								
99.10	09910	CORF	0	0	0			99.10	
101.00	10100	HOME HEALTH AGENCY	0	0	0			101.00	
	SPECIAL PURPOSE COST CENTERS								
109.00	10900	PANCREAS ACQUISITION	0	0	0			109.00	
110.00	11000	INTESTINAL ACQUISITION	0	0	0			110.00	
111.00	11100	ISLET ACQUISITION	0	0	0			111.00	
113.00	11300	INTEREST EXPENSE						113.00	
116.00	11600	HOSPICE	0	0	0			116.00	
200.00		Subtotal (see instructions)	111,758,225	96,469,572	208,227,797			200.00	
201.00		Less Observation Beds						201.00	
202.00		Total (see instructions)	111,758,225	96,469,572	208,227,797			202.00	

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0127

Period:
From 01/01/2020
To 06/30/2020Worksheet C
Part I
Date/Time Prepared:
11/24/2020 1:07 pm

Cost Center Description		PPS Inpatient Ratio	Title XVIII	Hospital	PPS
		11.00			
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS			30.00
31.00	03100	INTENSIVE CARE UNIT			31.00
40.00	04000	SUBPROVIDER - IPF			40.00
41.00	04100	SUBPROVIDER - IRF			41.00
42.00	04200	SUBPROVIDER			42.00
43.00	04300	NURSERY			43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0.383225		50.00
51.00	05100	RECOVERY ROOM	0.426842		51.00
53.00	05300	ANESTHESIOLOGY	0.037637		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.222304		54.00
57.00	05700	CT SCAN	0.064620		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000		58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000		59.00
60.00	06000	LABORATORY	0.145297		60.00
64.00	06400	INTRAVENOUS THERAPY	0.468921		64.00
65.00	06500	RESPIRATORY THERAPY	0.459201		65.00
66.00	06600	PHYSICAL THERAPY	0.516318		66.00
67.00	06700	OCCUPATIONAL THERAPY	0.273609		67.00
68.00	06800	SPEECH PATHOLOGY	0.478721		68.00
69.00	06900	ELECTROCARDIOLOGY	0.194885		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.505507		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1.136044		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.457314		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.156889		73.00
76.97	07697	CARDIAC REHABILITATION	1.791044		76.97
OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	1.048428		90.00
90.01	09001	BASIC DIAGNOSTIC TESTING	0.000000		90.01
90.03	09002	PSYCH OUTPATIENT	1.860711		90.03
90.04	09003	WOUND CARE CLINIC	0.301403		90.04
91.00	09100	EMERGENCY	0.303482		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.679025		92.00
93.00	04040	OTHER OUTPATIENT SERVICES	0.000000		93.00
OTHER REIMBURSABLE COST CENTERS					
99.10	09910	CORF			99.10
101.00	10100	HOME HEALTH AGENCY			101.00
SPECIAL PURPOSE COST CENTERS					
109.00	10900	PANCREAS ACQUISITION			109.00
110.00	11000	INTESTINAL ACQUISITION			110.00
111.00	11100	ISLET ACQUISITION			111.00
113.00	11300	INTEREST EXPENSE			113.00
116.00	11600	HOSPICE			116.00
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: 14-0127

Period:
From 01/01/2020
To 06/30/2020Worksheet C
Part I
Date/Time Prepared:
11/24/2020 1:07 pm

			Title XIX	Hospital	Cost	
Cost Center Description			Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Total Costs	Total Costs
			1.00	2.00	3.00	4.00
						5.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	9,385,210		9,385,210	0
31.00	03100	INTENSIVE CARE UNIT	8,918,707		8,918,707	0
40.00	04000	SUBPROVIDER - IPF	0		0	0
41.00	04100	SUBPROVIDER - IRF	1,485,916		1,485,916	0
42.00	04200	SUBPROVIDER	0		0	0
43.00	04300	NURSERY	2,838,610		2,838,610	0
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	6,500,199		6,500,199	0
51.00	05100	RECOVERY ROOM	597,168		597,168	0
53.00	05300	ANESTHESIOLOGY	114,940		114,940	0
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,412,133		3,412,133	0
57.00	05700	CT SCAN	1,080,180		1,080,180	0
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0		0	0
59.00	05900	CARDIAC CATHETERIZATION	0		0	0
60.00	06000	LABORATORY	3,314,224		3,314,224	0
64.00	06400	INTRAVENOUS THERAPY	1,692,742		1,692,742	0
65.00	06500	RESPIRATORY THERAPY	1,014,730	0	1,014,730	0
66.00	06600	PHYSICAL THERAPY	1,333,140	0	1,333,140	0
67.00	06700	OCCUPATIONAL THERAPY	397,079	0	397,079	0
68.00	06800	SPEECH PATHOLOGY	224,697	0	224,697	0
69.00	06900	ELECTROCARDIOLOGY	3,034,087		3,034,087	0
70.00	07000	ELECTROENCEPHALOGRAPHY	146,674		146,674	0
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	7,430,376		7,430,376	0
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	4,957,367		4,957,367	0
73.00	07300	DRUGS CHARGED TO PATIENTS	5,104,198		5,104,198	0
76.97	07697	CARDIAC REHABILITATION	386,124		386,124	0
OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	482,800		482,800	0
90.01	09001	BASIC DIAGNOSTIC TESTING	0		0	0
90.03	09002	PSYCH OUTPATIENT	405,635		405,635	0
90.04	09003	WOUND CARE CLINIC	766,548		766,548	0
91.00	09100	EMERGENCY	5,150,747		5,150,747	0
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	2,277,527		2,277,527	0
93.00	04040	OTHER OUTPATIENT SERVICES	0		0	0
OTHER REIMBURSABLE COST CENTERS						
99.10	09910	CORF	0		0	0
101.00	10100	HOME HEALTH AGENCY	0		0	0
SPECIAL PURPOSE COST CENTERS						
109.00	10900	PANCREAS ACQUISITION	0		0	0
110.00	11000	INTESTINAL ACQUISITION	0		0	0
111.00	11100	ISLET ACQUISITION	0		0	0
113.00	11300	INTEREST EXPENSE	0		0	0
116.00	11600	HOSPICE	0		0	0
200.00		Subtotal (see instructions)	72,451,758	0	72,451,758	0
201.00		Less Observation Beds	2,277,527		2,277,527	0
202.00		Total (see instructions)	70,174,231	0	70,174,231	0

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0127

Period:
From 01/01/2020
To 06/30/2020Worksheet C
Part I
Date/Time Prepared:
11/24/2020 1:07 pm

			Title XIX			Hospital	Cost	
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	10,537,372		10,537,372			30.00
31.00	03100	INTENSIVE CARE UNIT	12,665,921		12,665,921			31.00
40.00	04000	SUBPROVIDER - IPF	0		0			40.00
41.00	04100	SUBPROVIDER - IRF	1,350,115		1,350,115			41.00
42.00	04200	SUBPROVIDER	0		0			42.00
43.00	04300	NURSERY	7,525,500		7,525,500			43.00
	ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	8,793,031	8,168,819	16,961,850	0.383225	0.000000	50.00
51.00	05100	RECOVERY ROOM	620,210	778,829	1,399,039	0.426842	0.000000	51.00
53.00	05300	ANESTHESIOLOGY	1,578,387	1,475,562	3,053,949	0.037637	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,763,833	11,585,094	15,348,927	0.222304	0.000000	54.00
57.00	05700	CT SCAN	5,524,501	11,191,331	16,715,832	0.064620	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0.000000	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0.000000	0.000000	59.00
60.00	06000	LABORATORY	10,116,745	12,693,301	22,810,046	0.145297	0.000000	60.00
64.00	06400	INTRAVENOUS THERAPY	759,487	2,850,382	3,609,869	0.468921	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	2,001,510	208,265	2,209,775	0.459201	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	1,477,910	1,104,101	2,582,011	0.516318	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	1,265,220	186,047	1,451,267	0.273609	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	384,224	85,145	469,369	0.478721	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	6,707,140	8,861,495	15,568,635	0.194885	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	91,805	198,347	290,152	0.505507	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	3,904,510	2,636,061	6,540,571	1.136044	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	7,309,581	3,530,610	10,840,191	0.457314	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	20,160,243	12,373,552	32,533,795	0.156889	0.000000	73.00
76.97	07697	CARDIAC REHABILITATION	11,060	204,526	215,586	1.791044	0.000000	76.97
	OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0	460,499	460,499	1.048428	0.000000	90.00
90.01	09001	BASIC DIAGNOSTIC TESTING	0	0	0	0.000000	0.000000	90.01
90.03	09002	PSYCH OUTPATIENT	0	218,000	218,000	1.860711	0.000000	90.03
90.04	09003	WOUND CARE CLINIC	189,600	2,353,662	2,543,262	0.301403	0.000000	90.04
91.00	09100	EMERGENCY	4,288,820	12,683,332	16,972,152	0.303482	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	731,500	2,622,612	3,354,112	0.679025	0.000000	92.00
93.00	04040	OTHER OUTPATIENT SERVICES	0	0	0	0.000000	0.000000	93.00
	OTHER REIMBURSABLE COST CENTERS							
99.10	09910	CORF	0	0	0			99.10
101.00	10100	HOME HEALTH AGENCY	0	0	0			101.00
	SPECIAL PURPOSE COST CENTERS							
109.00	10900	PANCREAS ACQUISITION	0	0	0			109.00
110.00	11000	INTESTINAL ACQUISITION	0	0	0			110.00
111.00	11100	ISLET ACQUISITION	0	0	0			111.00
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	0	0	0			116.00
200.00		Subtotal (see instructions)	111,758,225	96,469,572	208,227,797			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	111,758,225	96,469,572	208,227,797			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0127

Period:
From 01/01/2020
To 06/30/2020Worksheet C
Part I
Date/Time Prepared:
11/24/2020 1:07 pm

Cost Center Description			PPS Inpatient Ratio	Title XIX	Hospital	Cost
			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
42.00	04200	SUBPROVIDER				42.00
43.00	04300	NURSERY				43.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.000000			50.00
51.00	05100	RECOVERY ROOM	0.000000			51.00
53.00	05300	ANESTHESIOLOGY	0.000000			53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000			54.00
57.00	05700	CT SCAN	0.000000			57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000			58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000			59.00
60.00	06000	LABORATORY	0.000000			60.00
64.00	06400	INTRAVENOUS THERAPY	0.000000			64.00
65.00	06500	RESPIRATORY THERAPY	0.000000			65.00
66.00	06600	PHYSICAL THERAPY	0.000000			66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000			67.00
68.00	06800	SPEECH PATHOLOGY	0.000000			68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000			69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000			70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000			71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.000000			72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000			73.00
76.97	07697	CARDIAC REHABILITATION	0.000000			76.97
OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.000000			90.00
90.01	09001	BASIC DIAGNOSTIC TESTING	0.000000			90.01
90.03	09002	PSYCH OUTPATIENT	0.000000			90.03
90.04	09003	WOUND CARE CLINIC	0.000000			90.04
91.00	09100	EMERGENCY	0.000000			91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000			92.00
93.00	04040	OTHER OUTPATIENT SERVICES	0.000000			93.00
OTHER REIMBURSABLE COST CENTERS						
99.10	09910	CORF				99.10
101.00	10100	HOME HEALTH AGENCY				101.00
SPECIAL PURPOSE COST CENTERS						
109.00	10900	PANCREAS ACQUISITION				109.00
110.00	11000	INTESTINAL ACQUISITION				110.00
111.00	11100	ISLET ACQUISITION				111.00
113.00	11300	INTEREST EXPENSE				113.00
116.00	11600	HOSPICE				116.00
200.00		Subtotal (see instructions)				200.00
201.00		Less Observation Beds				201.00
202.00		Total (see instructions)				202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

Provider CCN: 14-0127

Period:
From 01/01/2020
To 06/30/2020Worksheet D
Part I
Date/Time Prepared:
11/24/2020 1:07 pm

			Title XVIII		Hospital	PPS	
Cost Center Description		Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	960,690	0	960,690	7,471	128.59	30.00
31.00	INTENSIVE CARE UNIT	789,128		789,128	6,290	125.46	31.00
40.00	SUBPROVIDER - IPF	0	0	0	0	0.00	40.00
41.00	SUBPROVIDER - IRF	143,989	0	143,989	1,287	111.88	41.00
42.00	SUBPROVIDER	0	0	0	0	0.00	42.00
43.00	NURSERY	146,628		146,628	1,666	88.01	43.00
200.00	Total (lines 30 through 199)	2,040,435		2,040,435	16,714		200.00
Cost Center Description		Inpatient Program days	Inpatient Program Capital Cost (col. 5 x col. 6)				
		6.00	7.00				
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	1,255	161,380				30.00
31.00	INTENSIVE CARE UNIT	2,817	353,421				31.00
40.00	SUBPROVIDER - IPF	0	0				40.00
41.00	SUBPROVIDER - IRF	583	65,226				41.00
42.00	SUBPROVIDER	0	0				42.00
43.00	NURSERY	0	0				43.00
200.00	Total (lines 30 through 199)	4,655	580,027				200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 14-0127

Period:
From 01/01/2020
To 06/30/2020Worksheet D
Part II
Date/Time Prepared:
11/24/2020 1:07 pm

			Title XVIII		Hospital	PPS		
Cost Center Description			Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	895,677	16,961,850	0.052805	3,312,751	174,930	50.00
51.00	05100	RECOVERY ROOM	43,133	1,399,039	0.030830	251,037	7,739	51.00
53.00	05300	ANESTHESIOLOGY	7,492	3,053,949	0.002453	558,212	1,369	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	754,401	15,348,927	0.049150	1,542,111	75,795	54.00
57.00	05700	CT SCAN	255,356	16,715,832	0.015276	2,330,975	35,608	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0.000000	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0.000000	0	0	59.00
60.00	06000	LABORATORY	280,508	22,810,046	0.012298	3,717,539	45,718	60.00
64.00	06400	INTRAVENOUS THERAPY	132,842	3,609,869	0.036800	275,824	10,150	64.00
65.00	06500	RESPIRATORY THERAPY	83,340	2,209,775	0.037714	771,255	29,087	65.00
66.00	06600	PHYSICAL THERAPY	111,744	2,582,011	0.043278	422,820	18,299	66.00
67.00	06700	OCCUPATIONAL THERAPY	3,778	1,451,267	0.002603	286,575	746	67.00
68.00	06800	SPEECH PATHOLOGY	2,055	469,369	0.004378	77,480	339	68.00
69.00	06900	ELECTROCARDIOLOGY	270,398	15,568,635	0.017368	2,958,175	51,378	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	14,334	290,152	0.049402	32,985	1,630	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	55,568	6,540,571	0.008496	1,652,188	14,037	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	55,455	10,840,191	0.005116	3,520,691	18,012	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	179,030	32,533,795	0.005503	6,902,449	37,984	73.00
76.97	07697	CARDIAC REHABILITATION	30,679	215,586	0.142305	3,607	513	76.97
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	7,712	460,499	0.016747	0	0	90.00
90.01	09001	BASIC DIAGNOSTIC TESTING	0	0	0.000000	0	0	90.01
90.03	09002	PSYCH OUTPATIENT	60,377	218,000	0.276959	0	0	90.03
90.04	09003	WOUND CARE CLINIC	15,083	2,543,262	0.005931	77,678	461	90.04
91.00	09100	EMERGENCY	326,762	16,972,152	0.019253	1,566,565	30,161	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	233,132	3,354,112	0.069506	293,049	20,369	92.00
93.00	04040	OTHER OUTPATIENT SERVICES	0	0	0.000000	0	0	93.00
200.00		Total (lines 50 through 199)	3,818,856	176,148,889		30,553,966	574,325	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS					Provider CCN: 14-0127		Period: From 01/01/2020 To 06/30/2020		Worksheet D Part III Date/Time Prepared: 11/24/2020 1:07 pm		
					Title XVIII		Hospital		PPS		
Cost Center Description			Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health Cost	All Other Medical Education Cost				
			1A	1.00	2A	2.00	3.00				
INPATIENT ROUTINE SERVICE COST CENTERS											
30.00	03000	ADULTS & PEDIATRICS	0	0	0	170,195	0	30.00			
31.00	03100	INTENSIVE CARE UNIT	0	0	0	7,869	0	31.00			
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	0	40.00			
41.00	04100	SUBPROVIDER - IRF	0	0	0	4,509	0	41.00			
42.00	04200	SUBPROVIDER	0	0	0	0	0	42.00			
43.00	04300	NURSERY	0	0	0	0	0	43.00			
200.00		Total (lines 30 through 199)	0	0	0	182,573	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	170,195	7,471	22.78	1,255	30.00			
31.00	03100	INTENSIVE CARE UNIT		7,869	6,290	1.25	2,817	31.00			
40.00	04000	SUBPROVIDER - IPF	0	0	0	0.00	0	40.00			
41.00	04100	SUBPROVIDER - IRF	0	4,509	1,287	3.50	583	41.00			
42.00	04200	SUBPROVIDER	0	0	0	0.00	0	42.00			
43.00	04300	NURSERY		0	1,666	0.00	0	43.00			
200.00		Total (lines 30 through 199)		182,573	16,714		4,655	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	28,589								30.00
31.00	03100	INTENSIVE CARE UNIT	3,521								31.00
40.00	04000	SUBPROVIDER - IPF	0								40.00
41.00	04100	SUBPROVIDER - IRF	2,041								41.00
42.00	04200	SUBPROVIDER	0								42.00
43.00	04300	NURSERY	0								43.00
200.00		Total (lines 30 through 199)	34,151								200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS			Provider CCN: 14-0127		Period: From 01/01/2020 To 06/30/2020		Worksheet D Part IV Date/Time Prepared: 11/24/2020 1:07 pm	
			Title XVIII		Hospital		PPS	
Cost Center Description			Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health	
			1.00	2A	2.00	3A	3.00	
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	0	0	9,343	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	12,997	54.00
57.00	05700	CT SCAN	0	0	0	0	3,653	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
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	3,653	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	BASIC DIAGNOSTIC TESTING	0	0	0	0	0	90.01
90.03	09002	PSYCH OUTPATIENT	0	0	0	0	0	90.03
90.04	09003	WOUND CARE CLINIC	0	0	0	0	9,343	90.04
91.00	09100	EMERGENCY	0	0	0	0	57,468	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	41,301	92.00
93.00	04040	OTHER OUTPATIENT SERVICES	0	0	0	0	0	93.00
200.00		Total (lines 50 through 199)	0	0	0	0	137,758	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

Provider CCN: 14-0127

Period:
From 01/01/2020
To 06/30/2020

Worksheet D
Part IV
Date/Time Prepared:
11/24/2020 1:07 pm

			Title XVIII		Hospital	PPS		
Cost Center Description			All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7) (see instructions)	
			4.00	5.00	6.00	7.00	8.00	
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	9,343	9,343	16,961,850	0.000551	50.00
51.00	05100	RECOVERY ROOM	0	0	0	1,399,039	0.000000	51.00
53.00	05300	ANESTHESIOLOGY	0	0	0	3,053,949	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	12,997	12,997	15,348,927	0.000847	54.00
57.00	05700	CT SCAN	0	3,653	3,653	16,715,832	0.000219	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0.000000	59.00
60.00	06000	LABORATORY	0	0	0	22,810,046	0.000000	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	3,609,869	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	2,209,775	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	2,582,011	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	1,451,267	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	469,369	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	3,653	3,653	15,568,635	0.000235	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	290,152	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	6,540,571	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	10,840,191	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	32,533,795	0.000000	73.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	215,586	0.000000	76.97
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0	460,499	0.000000	90.00
90.01	09001	BASIC DIAGNOSTIC TESTING	0	0	0	0	0.000000	90.01
90.03	09002	PSYCH OUTPATIENT	0	0	0	218,000	0.000000	90.03
90.04	09003	WOUND CARE CLINIC	0	9,343	9,343	2,543,262	0.003674	90.04
91.00	09100	EMERGENCY	0	57,468	57,468	16,972,152	0.003386	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	41,301	41,301	3,354,112	0.012314	92.00
93.00	04040	OTHER OUTPATIENT SERVICES	0	0	0	0	0.000000	93.00
200.00	Total (lines 50 through 199)		0	137,758	137,758	176,148,889		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

Provider CCN: 14-0127

Period:
From 01/01/2020
To 06/30/2020

Worksheet D
Part IV
Date/Time Prepared:
11/24/2020 1:07 pm

			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	0.000551	3,312,751	1,825	1,773,307	977	50.00
51.00	05100	RECOVERY ROOM	0.000000	251,037	0	130,438	0	51.00
53.00	05300	ANESTHESIOLOGY	0.000000	558,212	0	286,844	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000847	1,542,111	1,306	2,737,921	2,319	54.00
57.00	05700	CT SCAN	0.000219	2,330,975	510	2,317,637	508	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	0	0	0	0	59.00
60.00	06000	LABORATORY	0.000000	3,717,539	0	1,820,243	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0.000000	275,824	0	576,030	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.000000	771,255	0	37,845	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	422,820	0	8,785	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	286,575	0	1,480	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	77,480	0	3,365	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000235	2,958,175	695	2,866,412	674	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	32,985	0	29,077	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	1,652,188	0	715,944	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.000000	3,520,691	0	1,011,871	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	6,902,449	0	1,955,777	0	73.00
76.97	07697	CARDIAC REHABILITATION	0.000000	3,607	0	86,755	0	76.97
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0.000000	0	0	4,122	0	90.00
90.01	09001	BASIC DIAGNOSTIC TESTING	0.000000	0	0	0	0	90.01
90.03	09002	PSYCH OUTPATIENT	0.000000	0	0	3,024	0	90.03
90.04	09003	WOUND CARE CLINIC	0.003674	77,678	285	1,095,465	4,025	90.04
91.00	09100	EMERGENCY	0.003386	1,566,565	5,304	1,554,648	5,264	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.012314	293,049	3,609	640,746	7,890	92.00
93.00	04040	OTHER OUTPATIENT SERVICES	0.000000	0	0	0	0	93.00
200.00		Total (lines 50 through 199)		30,553,966	13,534	19,657,736	21,657	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST				Provider CCN: 14-0127		Period: From 01/01/2020 To 06/30/2020		Worksheet D Part V Date/Time Prepared: 11/24/2020 1:07 pm	
				Title XVIII		Hospital		PPS	
Cost Center Description				Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges		Costs		
					PPS Reimbursed Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	PPS Services (see inst.)	
				1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM		0.383225	1,773,307	0	0	679,576	50.00
51.00	05100	RECOVERY ROOM		0.426842	130,438	0	0	55,676	51.00
53.00	05300	ANESTHESIOLOGY		0.037637	286,844	0	0	10,796	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC		0.222304	2,737,921	0	0	608,651	54.00
57.00	05700	CT SCAN		0.064620	2,317,637	0	0	149,766	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)		0.000000	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION		0.000000	0	0	0	0	59.00
60.00	06000	LABORATORY		0.145297	1,820,243	0	0	264,476	60.00
64.00	06400	INTRAVENOUS THERAPY		0.468921	576,030	0	0	270,113	64.00
65.00	06500	RESPIRATORY THERAPY		0.459201	37,845	0	0	17,378	65.00
66.00	06600	PHYSICAL THERAPY		0.516318	8,785	0	0	4,536	66.00
67.00	06700	OCCUPATIONAL THERAPY		0.273609	1,480	0	0	405	67.00
68.00	06800	SPEECH PATHOLOGY		0.478721	3,365	0	0	1,611	68.00
69.00	06900	ELECTROCARDIOLOGY		0.194885	2,866,412	0	0	558,621	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY		0.505507	29,077	0	0	14,699	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS		1.136044	715,944	0	0	813,344	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT		0.457314	1,011,871	0	0	462,743	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS		0.156889	1,955,777	0	13,889	306,840	73.00
76.97	07697	CARDIAC REHABILITATION		1.791044	86,755	0	0	155,382	76.97
OUTPATIENT SERVICE COST CENTERS									
90.00	09000	CLINIC		1.048428	4,122	0	0	4,322	90.00
90.01	09001	BASIC DIAGNOSTIC TESTING		0.000000	0	0	0	0	90.01
90.03	09002	PSYCH OUTPATIENT		1.860711	3,024	0	0	5,627	90.03
90.04	09003	WOUND CARE CLINIC		0.301403	1,095,465	0	0	330,176	90.04
91.00	09100	EMERGENCY		0.303482	1,554,648	0	0	471,808	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)		0.679025	640,746	0	0	435,083	92.00
93.00	04040	OTHER OUTPATIENT SERVICES		0.000000	0	0	0	0	93.00
200.00		Subtotal (see instructions)			19,657,736	0	13,889	5,621,629	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges				0	0		201.00
202.00		Net Charges (line 200 - line 201)			19,657,736	0	13,889	5,621,629	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST			Provider CCN: 14-0127		Period: From 01/01/2020 To 06/30/2020	Worksheet D Part V Date/Time Prepared: 11/24/2020 1:07 pm
			Title XVIII		Hospital	PPS
Cost Center Description			Costs			
			Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0		50.00
51.00	05100	RECOVERY ROOM	0	0		51.00
53.00	05300	ANESTHESIOLOGY	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0		54.00
57.00	05700	CT SCAN	0	0		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0		58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0		59.00
60.00	06000	LABORATORY	0	0		60.00
64.00	06400	INTRAVENOUS THERAPY	0	0		64.00
65.00	06500	RESPIRATORY THERAPY	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	2,179		73.00
76.97	07697	CARDIAC REHABILITATION	0	0		76.97
OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0		90.00
90.01	09001	BASIC DIAGNOSTIC TESTING	0	0		90.01
90.03	09002	PSYCH OUTPATIENT	0	0		90.03
90.04	09003	WOUND CARE CLINIC	0	0		90.04
91.00	09100	EMERGENCY	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0		92.00
93.00	04040	OTHER OUTPATIENT SERVICES	0	0		93.00
200.00		Subtotal (see instructions)	0	2,179		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	0	2,179		202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS				Provider CCN: 14-0127 Component CCN: 14-T127		Period: From 01/01/2020 To 06/30/2020		Worksheet D Part II Date/Time Prepared: 11/24/2020 1:07 pm	
				Title XVIII		Subprovider - IRF		PPS	
Cost Center Description			Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)		
			1.00	2.00	3.00	4.00	5.00		
	ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	895,677	16,961,850	0.052805	4,017	212	50.00	
51.00	05100	RECOVERY ROOM	43,133	1,399,039	0.030830	0	0	51.00	
53.00	05300	ANESTHESIOLOGY	7,492	3,053,949	0.002453	240	1	53.00	
54.00	05400	RADIOLOGY-DIAGNOSTIC	754,401	15,348,927	0.049150	37,311	1,834	54.00	
57.00	05700	CT SCAN	255,356	16,715,832	0.015276	47,534	726	57.00	
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0.000000	0	0	58.00	
59.00	05900	CARDIAC CATHETERIZATION	0	0	0.000000	0	0	59.00	
60.00	06000	LABORATORY	280,508	22,810,046	0.012298	102,388	1,259	60.00	
64.00	06400	INTRAVENOUS THERAPY	132,842	3,609,869	0.036800	0	0	64.00	
65.00	06500	RESPIRATORY THERAPY	83,340	2,209,775	0.037714	28,578	1,078	65.00	
66.00	06600	PHYSICAL THERAPY	111,744	2,582,011	0.043278	298,985	12,939	66.00	
67.00	06700	OCCUPATIONAL THERAPY	3,778	1,451,267	0.002603	326,475	850	67.00	
68.00	06800	SPEECH PATHOLOGY	2,055	469,369	0.004378	91,854	402	68.00	
69.00	06900	ELECTROCARDIOLOGY	270,398	15,568,635	0.017368	5,240	91	69.00	
70.00	07000	ELECTROENCEPHALOGRAPHY	14,334	290,152	0.049402	2,121	105	70.00	
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	55,568	6,540,571	0.008496	19,741	168	71.00	
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	55,455	10,840,191	0.005116	851	4	72.00	
73.00	07300	DRUGS CHARGED TO PATIENTS	179,030	32,533,795	0.005503	346,368	1,906	73.00	
76.97	07697	CARDIAC REHABILITATION	30,679	215,586	0.142305	0	0	76.97	
	OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	7,712	460,499	0.016747	0	0	90.00	
90.01	09001	BASIC DIAGNOSTIC TESTING	0	0	0.000000	0	0	90.01	
90.03	09002	PSYCH OUTPATIENT	60,377	218,000	0.276959	0	0	90.03	
90.04	09003	WOUND CARE CLINIC	15,083	2,543,262	0.005931	14,780	88	90.04	
91.00	09100	EMERGENCY	326,762	16,972,152	0.019253	0	0	91.00	
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	3,354,112	0.000000	0	0	92.00	
93.00	04040	OTHER OUTPATIENT SERVICES	0	0	0.000000	0	0	93.00	
200.00		Total (lines 50 through 199)	3,585,724	176,148,889		1,326,483	21,663	200.00	

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

Provider CCN: 14-0127
Component CCN: 14-T127

Period:
From 01/01/2020
To 06/30/2020

Worksheet D
Part IV
Date/Time Prepared:
11/24/2020 1:07 pm

			Title XVIII		Subprovider - IRF		PPS	
Cost Center Description			Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health	
			1.00	2A	2.00	3A	3.00	
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	0	0	9,343	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	12,997	54.00
57.00	05700	CT SCAN	0	0	0	0	3,653	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
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	3,653	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	BASIC DIAGNOSTIC TESTING	0	0	0	0	0	90.01
90.03	09002	PSYCH OUTPATIENT	0	0	0	0	0	90.03
90.04	09003	WOUND CARE CLINIC	0	0	0	0	9,343	90.04
91.00	09100	EMERGENCY	0	0	0	0	57,468	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
93.00	04040	OTHER OUTPATIENT SERVICES	0	0	0	0	0	93.00
200.00		Total (lines 50 through 199)	0	0	0	0	96,457	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS				Provider CCN: 14-0127 Component CCN: 14-T127		Period: From 01/01/2020 To 06/30/2020		Worksheet D Part IV Date/Time Prepared: 11/24/2020 1:07 pm	
				Title XVIII		Subprovider - IRF		PPS	
Cost Center Description				All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7) (see instructions)	
				4.00	5.00	6.00	7.00	8.00	
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM	0		9,343	9,343	16,961,850	0.000551	50.00
51.00	05100	RECOVERY ROOM	0		0	0	1,399,039	0.000000	51.00
53.00	05300	ANESTHESIOLOGY	0		0	0	3,053,949	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0		12,997	12,997	15,348,927	0.000847	54.00
57.00	05700	CT SCAN	0		3,653	3,653	16,715,832	0.000219	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0		0	0	0	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	0		0	0	0	0.000000	59.00
60.00	06000	LABORATORY	0		0	0	22,810,046	0.000000	60.00
64.00	06400	INTRAVENOUS THERAPY	0		0	0	3,609,869	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	0		0	0	2,209,775	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0		0	0	2,582,011	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0		0	0	1,451,267	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0		0	0	469,369	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0		3,653	3,653	15,568,635	0.000235	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0		0	0	290,152	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0		0	0	6,540,571	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0		0	0	10,840,191	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0		0	0	32,533,795	0.000000	73.00
76.97	07697	CARDIAC REHABILITATION	0		0	0	215,586	0.000000	76.97
OUTPATIENT SERVICE COST CENTERS									
90.00	09000	CLINIC	0		0	0	460,499	0.000000	90.00
90.01	09001	BASIC DIAGNOSTIC TESTING	0		0	0	0	0.000000	90.01
90.03	09002	PSYCH OUTPATIENT	0		0	0	218,000	0.000000	90.03
90.04	09003	WOUND CARE CLINIC	0		9,343	9,343	2,543,262	0.003674	90.04
91.00	09100	EMERGENCY	0		57,468	57,468	16,972,152	0.003386	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0		0	0	3,354,112	0.000000	92.00
93.00	04040	OTHER OUTPATIENT SERVICES	0		0	0	0	0.000000	93.00
200.00		Total (lines 50 through 199)	0		96,457	96,457	176,148,889		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS				Provider CCN: 14-0127 Component CCN: 14-T127		Period: From 01/01/2020 To 06/30/2020		Worksheet D Part IV Date/Time Prepared: 11/24/2020 1:07 pm	
				Title XVIII		Subprovider - IRF		PPS	
Cost Center Description				Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
				9.00	10.00	11.00	12.00	13.00	
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM	0.000551		4,017		2	0	50.00
51.00	05100	RECOVERY ROOM	0.000000		0		0	0	51.00
53.00	05300	ANESTHESIOLOGY	0.000000		240		0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000847		37,311		32	0	54.00
57.00	05700	CT SCAN	0.000219		47,534		10	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000		0		0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000		0		0	0	59.00
60.00	06000	LABORATORY	0.000000		102,388		0	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0.000000		0		0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.000000		28,578		0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000		298,985		0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000		326,475		0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000		91,854		0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000235		5,240		1	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000		2,121		0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000		19,741		0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.000000		851		0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000		346,368		0	0	73.00
76.97	07697	CARDIAC REHABILITATION	0.000000		0		0	0	76.97
OUTPATIENT SERVICE COST CENTERS									
90.00	09000	CLINIC	0.000000		0		0	0	90.00
90.01	09001	BASIC DIAGNOSTIC TESTING	0.000000		0		0	0	90.01
90.03	09002	PSYCH OUTPATIENT	0.000000		0		0	0	90.03
90.04	09003	WOUND CARE CLINIC	0.003674		14,780		54	0	90.04
91.00	09100	EMERGENCY	0.003386		0		0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000		0		0	0	92.00
93.00	04040	OTHER OUTPATIENT SERVICES	0.000000		0		0	0	93.00
200.00		Total (lines 50 through 199)			1,326,483		99	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST				Provider CCN: 14-0127		Period: From 01/01/2020 To 06/30/2020		Worksheet D Part V Date/Time Prepared: 11/24/2020 1:07 pm	
				Title XIX		Hospital		Cost	
Cost Center Description				Cost to Charge Ratio From Worksheet C, Part I, col. 9	PPS Reimbursed Services (see inst.)	Charges		Costs	
						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		0.383225	0	122,632	0	0	50.00
51.00	05100	RECOVERY ROOM		0.426842	0	13,870	0	0	51.00
53.00	05300	ANESTHESIOLOGY		0.037637	0	25,623	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC		0.222304	0	188,428	0	0	54.00
57.00	05700	CT SCAN		0.064620	0	235,713	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)		0.000000	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION		0.000000	0	0	0	0	59.00
60.00	06000	LABORATORY		0.145297	0	280,959	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY		0.468921	0	60,245	0	0	64.00
65.00	06500	RESPIRATORY THERAPY		0.459201	0	3,871	0	0	65.00
66.00	06600	PHYSICAL THERAPY		0.516318	0	44,961	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY		0.273609	0	5,535	0	0	67.00
68.00	06800	SPEECH PATHOLOGY		0.478721	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY		0.194885	0	68,519	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY		0.505507	0	3,288	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS		1.136044	0	21,802	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT		0.457314	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS		0.156889	0	182,894	0	0	73.00
76.97	07697	CARDIAC REHABILITATION		1.791044	0	290	0	0	76.97
OUTPATIENT SERVICE COST CENTERS									
90.00	09000	CLINIC		1.048428	0	9,868	0	0	90.00
90.01	09001	BASIC DIAGNOSTIC TESTING		0.000000	0	0	0	0	90.01
90.03	09002	PSYCH OUTPATIENT		1.860711	0	0	0	0	90.03
90.04	09003	WOUND CARE CLINIC		0.301403	0	6,785	0	0	90.04
91.00	09100	EMERGENCY		0.303482	0	549,591	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)		0.679025	0	36,327	0	0	92.00
93.00	04040	OTHER OUTPATIENT SERVICES		0.000000	0	0	0	0	93.00
200.00		Subtotal (see instructions)			0	1,861,201	0	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges				0	0	0	201.00
202.00		Net Charges (line 200 - line 201)			0	1,861,201	0	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST			Provider CCN: 14-0127		Period: From 01/01/2020 To 06/30/2020	Worksheet D Part V Date/Time Prepared: 11/24/2020 1:07 pm
			Title XIX		Hospital	Cost
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	46,996	0		50.00
51.00	05100	RECOVERY ROOM	5,920	0		51.00
53.00	05300	ANESTHESIOLOGY	964	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	41,888	0		54.00
57.00	05700	CT SCAN	15,232	0		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0		58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0		59.00
60.00	06000	LABORATORY	40,822	0		60.00
64.00	06400	INTRAVENOUS THERAPY	28,250	0		64.00
65.00	06500	RESPIRATORY THERAPY	1,778	0		65.00
66.00	06600	PHYSICAL THERAPY	23,214	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	1,514	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	13,353	0		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	1,662	0		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	24,768	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	28,694	0		73.00
76.97	07697	CARDIAC REHABILITATION	519	0		76.97
OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	10,346	0		90.00
90.01	09001	BASIC DIAGNOSTIC TESTING	0	0		90.01
90.03	09002	PSYCH OUTPATIENT	0	0		90.03
90.04	09003	WOUND CARE CLINIC	2,045	0		90.04
91.00	09100	EMERGENCY	166,791	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	24,667	0		92.00
93.00	04040	OTHER OUTPATIENT SERVICES	0	0		93.00
200.00		Subtotal (see instructions)	479,423	0		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	479,423	0		202.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-0127	Period: From 01/01/2020 To 06/30/2020	Worksheet D-1 Date/Time Prepared: 11/24/2020 1:07 pm
		Title XVIII	Hospital	PPS
Cost Center Description				1.00
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		7,471	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		7,471	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)		5,658	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)		1,255	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)		9,385,210	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)		9,385,210	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)		9,385,210	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)		1,256.22	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		1,576,556	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)		1,576,556	41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-0127

Period:
From 01/01/2020
To 06/30/2020

Worksheet D-1

Date/Time Prepared:
11/24/2020 1:07 pm

Cost Center Description		Title XVIII		Hospital		PPS	
		Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)	0	0	0.00	0	0	42.00
Intensive Care Type Inpatient Hospital Units							
43.00	INTENSIVE CARE UNIT	8,918,707	6,290	1,417.92	2,817	3,994,281	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)					9,115,993	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					14,686,830	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)					546,911	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					587,859	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)					1,134,770	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					13,552,060	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)					1,813	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					1,256.22	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)					2,277,527	89.00

COMPUTATION OF INPATIENT OPERATING COST				Provider CCN: 14-0127		Period: From 01/01/2020 To 06/30/2020		Worksheet D-1 Date/Time Prepared: 11/24/2020 1:07 pm	
				Title XVIII		Hospital		PPS	
Cost Center Description		Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)			
							1.00	2.00	3.00
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST								
90.00	Capital-related cost	960,690	9,385,210	0.102362	2,277,527	233,132	90.00		
91.00	Nursing School cost	0	9,385,210	0.000000	2,277,527	0	91.00		
92.00	Allied health cost	170,195	9,385,210	0.018134	2,277,527	41,301	92.00		
93.00	All other Medical Education	0	9,385,210	0.000000	2,277,527	0	93.00		

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-0127 Component CCN: 14-T127	Period: From 01/01/2020 To 06/30/2020	Worksheet D-1 Date/Time Prepared: 11/24/2020 1:07 pm
		Title XVIII	Subprovider - IRF	PPS
Cost Center Description			1.00	
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		1,287	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		1,287	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)		1,287	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)		583	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)		1,485,916	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)		1,485,916	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)		1,485,916	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)		1,154.56	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		673,108	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)		673,108	41.00

COMPUTATION OF INPATIENT OPERATING COST				Provider CCN: 14-0127 Component CCN: 14-T127	Period: From 01/01/2020 To 06/30/2020	Worksheet D-1 Date/Time Prepared: 11/24/2020 1:07 pm	
				Title XVIII		Subprovider - IRF	PPS
Cost Center Description		Total	Total	Average Per	Program Days	Program Cost (col. 3 x col. 4)	
		Inpatient Cost	Inpatient Days	Diem (col. 1 ÷ col. 2)			
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)	0	0	0.00	0		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)					412,288	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					1,085,396	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)					67,267	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					21,762	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)					89,029	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					996,367	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: 14-0127 Component CCN: 14-T127		Period: From 01/01/2020 To 06/30/2020	Worksheet D-1 Date/Time Prepared: 11/24/2020 1:07 pm	
		Title XVIII		Subprovider - IRF	PPS	
Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
	1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00 Capital-related cost	143,989	1,485,916	0.096903	0	0	90.00
91.00 Nursing School cost	0	1,485,916	0.000000	0	0	91.00
92.00 Allied health cost	4,509	1,485,916	0.003034	0	0	92.00
93.00 All other Medical Education	0	1,485,916	0.000000	0	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT			Provider CCN: 14-0127	Period: From 01/01/2020 To 06/30/2020	Worksheet D-3 Date/Time Prepared: 11/24/2020 1:07 pm	
			Title XVIII	Hospital	PPS	
Cost Center Description			Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS		1,596,117		30.00
31.00	03100	INTENSIVE CARE UNIT		5,649,183		31.00
40.00	04000	SUBPROVIDER - IPF		0		40.00
41.00	04100	SUBPROVIDER - IRF		0		41.00
42.00	04200	SUBPROVIDER		0		42.00
43.00	04300	NURSERY				43.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.383225	3,312,751	1,269,529	50.00
51.00	05100	RECOVERY ROOM	0.426842	251,037	107,153	51.00
53.00	05300	ANESTHESIOLOGY	0.037637	558,212	21,009	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.222304	1,542,111	342,817	54.00
57.00	05700	CT SCAN	0.064620	2,330,975	150,628	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	0	0	59.00
60.00	06000	LABORATORY	0.145297	3,717,539	540,147	60.00
64.00	06400	INTRAVENOUS THERAPY	0.468921	275,824	129,340	64.00
65.00	06500	RESPIRATORY THERAPY	0.459201	771,255	354,161	65.00
66.00	06600	PHYSICAL THERAPY	0.516318	422,820	218,310	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.273609	286,575	78,409	67.00
68.00	06800	SPEECH PATHOLOGY	0.478721	77,480	37,091	68.00
69.00	06900	ELECTROCARDIOLOGY	0.194885	2,958,175	576,504	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.505507	32,985	16,674	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1.136044	1,652,188	1,876,958	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.457314	3,520,691	1,610,061	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.156889	6,902,449	1,082,918	73.00
76.97	07697	CARDIAC REHABILITATION	1.791044	3,607	6,460	76.97
OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	1.048428	0	0	90.00
90.01	09001	BASIC DIAGNOSTIC TESTING	0.000000	0	0	90.01
90.03	09002	PSYCH OUTPATIENT	1.860711	0	0	90.03
90.04	09003	WOUND CARE CLINIC	0.301403	77,678	23,412	90.04
91.00	09100	EMERGENCY	0.303482	1,566,565	475,424	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.679025	293,049	198,988	92.00
93.00	04040	OTHER OUTPATIENT SERVICES	0.000000	0	0	93.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		30,553,966	9,115,993	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)		30,553,966		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 14-0127 Component CCN: 14-T127	Period: From 01/01/2020 To 06/30/2020	Worksheet D-3 Date/Time Prepared: 11/24/2020 1:07 pm	
		Title XVIII	Subprovider - IRF	PPS	
Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDIATRICS		0		30.00
31.00	03100 INTENSIVE CARE UNIT		0		31.00
40.00	04000 SUBPROVIDER - IPF		0		40.00
41.00	04100 SUBPROVIDER - IRF		619,415		41.00
42.00	04200 SUBPROVIDER		0		42.00
43.00	04300 NURSERY				43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.383225	4,017	1,539	50.00
51.00	05100 RECOVERY ROOM	0.426842	0	0	51.00
53.00	05300 ANESTHESIOLOGY	0.037637	240	9	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.222304	37,311	8,294	54.00
57.00	05700 CT SCAN	0.064620	47,534	3,072	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0.000000	0	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	0.000000	0	0	59.00
60.00	06000 LABORATORY	0.145297	102,388	14,877	60.00
64.00	06400 INTRAVENOUS THERAPY	0.468921	0	0	64.00
65.00	06500 RESPIRATORY THERAPY	0.459201	28,578	13,123	65.00
66.00	06600 PHYSICAL THERAPY	0.516318	298,985	154,371	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.273609	326,475	89,326	67.00
68.00	06800 SPEECH PATHOLOGY	0.478721	91,854	43,972	68.00
69.00	06900 ELECTROCARDIOLOGY	0.194885	5,240	1,021	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0.505507	2,121	1,072	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	1.136044	19,741	22,427	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	0.457314	851	389	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.156889	346,368	54,341	73.00
76.97	07697 CARDIAC REHABILITATION	1.791044	0	0	76.97
OUTPATIENT SERVICE COST CENTERS					
90.00	09000 CLINIC	1.048428	0	0	90.00
90.01	09001 BASIC DIAGNOSTIC TESTING	0.000000	0	0	90.01
90.03	09002 PSYCH OUTPATIENT	1.860711	0	0	90.03
90.04	09003 WOUND CARE CLINIC	0.301403	14,780	4,455	90.04
91.00	09100 EMERGENCY	0.303482	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.679025	0	0	92.00
93.00	04040 OTHER OUTPATIENT SERVICES	0.000000	0	0	93.00
200.00	Total (sum of lines 50 through 94 and 96 through 98)		1,326,483	412,288	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)		1,326,483		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT			Provider CCN: 14-0127	Period: From 01/01/2020 To 06/30/2020	Worksheet D-3 Date/Time Prepared: 11/24/2020 1:07 pm	
			Title XIX	Hospital	Cost	
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		751,765		30.00
31.00	03100	INTENSIVE CARE UNIT		319,771		31.00
40.00	04000	SUBPROVIDER - IPF		0		40.00
41.00	04100	SUBPROVIDER - IRF		0		41.00
42.00	04200	SUBPROVIDER		0		42.00
43.00	04300	NURSERY		1,309,500		43.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.383225	218,326	83,668	50.00
51.00	05100	RECOVERY ROOM	0.426842	10,175	4,343	51.00
53.00	05300	ANESTHESIOLOGY	0.037637	41,290	1,554	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.222304	110,859	24,644	54.00
57.00	05700	CT SCAN	0.064620	198,288	12,813	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	0	0	59.00
60.00	06000	LABORATORY	0.145297	434,466	63,127	60.00
64.00	06400	INTRAVENOUS THERAPY	0.468921	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.459201	86,784	39,851	65.00
66.00	06600	PHYSICAL THERAPY	0.516318	14,865	7,675	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.273609	11,115	3,041	67.00
68.00	06800	SPEECH PATHOLOGY	0.478721	8,475	4,057	68.00
69.00	06900	ELECTROCARDIOLOGY	0.194885	142,942	27,857	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.505507	2,121	1,072	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1.136044	123,294	140,067	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.457314	80,924	37,008	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.156889	785,531	123,241	73.00
76.97	07697	CARDIAC REHABILITATION	1.791044	640	1,146	76.97
OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	1.048428	0	0	90.00
90.01	09001	BASIC DIAGNOSTIC TESTING	0.000000	0	0	90.01
90.03	09002	PSYCH OUTPATIENT	1.860711	0	0	90.03
90.04	09003	WOUND CARE CLINIC	0.301403	2,615	788	90.04
91.00	09100	EMERGENCY	0.303482	181,578	55,106	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.679025	25,677	17,435	92.00
93.00	04040	OTHER OUTPATIENT SERVICES	0.000000	0	0	93.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		2,479,965	648,493	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)		2,479,965	0	202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 14-0127 Component CCN: 14-T127	Period: From 01/01/2020 To 06/30/2020	Worksheet D-3 Date/Time Prepared: 11/24/2020 1:07 pm	
		Title XIX	Subprovider - IRF	Cost	
Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDIATRICS		0		30.00
31.00	03100 INTENSIVE CARE UNIT		0		31.00
40.00	04000 SUBPROVIDER - IPF		0		40.00
41.00	04100 SUBPROVIDER - IRF		31,200		41.00
42.00	04200 SUBPROVIDER		0		42.00
43.00	04300 NURSERY		0		43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.383225	0	0	50.00
51.00	05100 RECOVERY ROOM	0.426842	0	0	51.00
53.00	05300 ANESTHESIOLOGY	0.037637	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.222304	1,205	268	54.00
57.00	05700 CT SCAN	0.064620	3,290	213	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0.000000	0	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	0.000000	0	0	59.00
60.00	06000 LABORATORY	0.145297	9,365	1,361	60.00
64.00	06400 INTRAVENOUS THERAPY	0.468921	0	0	64.00
65.00	06500 RESPIRATORY THERAPY	0.459201	0	0	65.00
66.00	06600 PHYSICAL THERAPY	0.516318	16,665	8,604	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.273609	18,390	5,032	67.00
68.00	06800 SPEECH PATHOLOGY	0.478721	3,430	1,642	68.00
69.00	06900 ELECTROCARDIOLOGY	0.194885	1,702	332	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0.505507	0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	1.136044	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	0.457314	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.156889	21,822	3,424	73.00
76.97	07697 CARDIAC REHABILITATION	1.791044	0	0	76.97
OUTPATIENT SERVICE COST CENTERS					
90.00	09000 CLINIC	1.048428	0	0	90.00
90.01	09001 BASIC DIAGNOSTIC TESTING	0.000000	0	0	90.01
90.03	09002 PSYCH OUTPATIENT	1.860711	0	0	90.03
90.04	09003 WOUND CARE CLINIC	0.301403	1,100	332	90.04
91.00	09100 EMERGENCY	0.303482	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.679025	0	0	92.00
93.00	04040 OTHER OUTPATIENT SERVICES	0.000000	0	0	93.00
200.00	Total (sum of lines 50 through 94 and 96 through 98)		76,969	21,208	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)		76,969		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0127	Period: From 01/01/2020 To 06/30/2020	Worksheet E Part A Date/Time Prepared: 11/24/2020 1:07 pm
		Title XVIII	Hospital	PPS
		1.00		
PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS				
1.00	DRG Amounts Other than Outlier Payments		0	1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1 (see instructions)		9,725,382	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1 (see instructions)		0	1.02
1.03	DRG for federal specific operating payment for Model 4 BPCI for discharges occurring prior to October 1 (see instructions)		0	1.03
1.04	DRG for federal specific operating payment for Model 4 BPCI for discharges occurring on or after October 1 (see instructions)		0	1.04
2.00	Outlier payments for discharges. (see instructions)			2.00
2.01	Outlier reconciliation amount		0	2.01
2.02	Outlier payment for discharges for Model 4 BPCI (see instructions)		0	2.02
2.03	Outlier payments for discharges occurring prior to October 1 (see instructions)		147,191	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		4,765,374	3.00
4.00	Bed days available divided by number of days in the cost reporting period (see instructions)		194.48	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)		13.60	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.		1.03	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)		12.57	9.00
10.00	FTE count for allopathic and osteopathic programs in the current year from your records		12.92	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)		12.57	12.00
13.00	Total allowable FTE count for the prior year.		12.57	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.		12.57	14.00
15.00	Sum of lines 12 through 14 divided by 3.		12.57	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		12.57	18.00
19.00	Current year resident to bed ratio (line 18 divided by line 4).		0.064634	19.00
20.00	Prior year resident to bed ratio (see instructions)		0.065568	20.00
21.00	Enter the lesser of lines 19 or 20 (see instructions)		0.064634	21.00
22.00	IME payment adjustment (see instructions)		337,296	22.00
22.01	IME payment adjustment - Managed Care (see instructions)		165,273	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)		0.35	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)		337,296	29.00
29.01	Total IME payment - Managed Care (sum of lines 22.01 and 28.01)		165,273	29.01
Disproportionate Share Adjustment				
30.00	Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)		4.54	30.00
31.00	Percentage of Medicaid patient days (see instructions)		23.49	31.00
32.00	Sum of lines 30 and 31		28.03	32.00
33.00	Allowable disproportionate share percentage (see instructions)		12.34	33.00
34.00	Disproportionate share adjustment (see instructions)		300,028	34.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0127	Period: From 01/01/2020 To 06/30/2020	Worksheet E Part A Date/Time Prepared: 11/24/2020 1:07 pm	
		Title XVIII	Hospital	PPS	
			Prior to 10/1	On/After 10/1	
			1.00	2.00	
Uncompensated Care Adjustment					
35.00	Total uncompensated care amount (see instructions)		8,350,599,096	0	35.00
35.01	Factor 3 (see instructions)		0.000146526	0.000000000	35.01
35.02	Hospital uncompensated care payment (If line 34 is zero, enter zero on this line) (see instructions)		1,223,578	0	35.02
35.03	Pro rata share of the hospital uncompensated care payment amount (see instructions)		608,446	0	35.03
36.00	Total uncompensated care (sum of columns 1 and 2 on line 35.03)		608,446		36.00
Additional payment for high percentage of ESRD beneficiary discharges (lines 40 through 46)					
40.00	Total Medicare discharges on Worksheet S-3, Part I excluding discharges for 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)		11,118,343		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)			11,283,616	49.00
50.00	Payment for inpatient program capital (from Wkst. L, Pt. I and Pt. II, as applicable)			869,813	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).			252,406	52.00
53.00	Nursing and Allied Health Managed Care payment			60,767	53.00
54.00	Special add-on payments for new technologies			0	54.00
54.01	Islet isolation add-on payment			0	54.01
55.00	Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line 69)			0	55.00
56.00	Cost of physicians' services in a teaching hospital (see instructions)			0	56.00
57.00	Routine service other pass through costs (from Wkst. D, Pt. III, column 9, lines 30 through 35).			32,110	57.00
58.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 11 line 200)			13,534	58.00
59.00	Total (sum of amounts on lines 49 through 58)			12,512,246	59.00
60.00	Primary payer payments			12,061	60.00
61.00	Total amount payable for program beneficiaries (line 59 minus line 60)			12,500,185	61.00
62.00	Deductibles billed to program beneficiaries			1,039,368	62.00
63.00	Coinurance billed to program beneficiaries			20,042	63.00
64.00	Allowable bad debts (see instructions)			235,653	64.00
65.00	Adjusted reimbursable bad debts (see instructions)			153,174	65.00
66.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			163,391	66.00
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)			11,593,949	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 PER PS&R			-2,687	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)			58,148	70.93
70.94	HRR adjustment amount (see instructions)			-12,643	70.94
70.95	Recovery of accelerated depreciation			0	70.95

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0127	Period: From 01/01/2020 To 06/30/2020	Worksheet E Part A Date/Time Prepared: 11/24/2020 1:07 pm	
		Title XVIII	Hospital	PPS	
		FFY (yyyy)	Amount		
		0	1.00		
70.96	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period prior to 10/1)	0	0	70.96	
70.97	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period ending on or after 10/1)	0	0	70.97	
70.98	Low Volume Payment-3		0	70.98	
70.99	HAC adjustment amount (see instructions)		0	70.99	
71.00	Amount due provider (line 67 minus lines 68 plus/minus lines 69 & 70)		11,636,767	71.00	
71.01	Sequestration adjustment (see instructions)		154,769	71.01	
71.02	Demonstration payment adjustment amount after sequestration		0	71.02	
71.03	Sequestration adjustment-PARHM pass-throughs			71.03	
72.00	Interim payments		11,289,712	72.00	
72.01	Interim payments-PARHM			72.01	
73.00	Tentative settlement (for contractor use only)		0	73.00	
73.01	Tentative settlement-PARHM (for contractor use only)			73.01	
74.00	Balance due provider/program (line 71 minus lines 71.01, 71.02, 72, and 73)		192,286	74.00	
74.01	Balance due provider/program-PARHM (see instructions)			74.01	
75.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		198,589	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	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	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	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: 14-0127	Period: From 01/01/2020 To 06/30/2020	Worksheet E Part B Date/Time Prepared: 11/24/2020 1:07 pm
		Title XVIII	Hospital	PPS
				1.00
PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)		2,179	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)		5,599,972	2.00
3.00	OPPS payments		3,868,685	3.00
4.00	Outlier payment (see instructions)		19,257	4.00
4.01	Outlier reconciliation amount (see instructions)		0	4.01
5.00	Enter the hospital specific payment to cost ratio (see instructions)		0.757	5.00
6.00	Line 2 times line 5		4,239,179	6.00
7.00	Sum of lines 3, 4, and 4.01, divided by line 6		91.71	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		21,657	9.00
10.00	Organ acquisitions		0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)		2,179	11.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
12.00	Ancillary service charges		13,889	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)		13,889	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)		13,889	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)		11,710	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)		2,179	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)		3,909,599	24.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25.00	Deductibles and coinsurance amounts (for CAH, see instructions)		714,830	25.00
26.00	Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)		0	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)		3,196,948	27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 50)		90,063	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)		3,287,011	30.00
31.00	Primary payer payments		324	31.00
32.00	Subtotal (line 30 minus line 31)		3,286,687	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)		119,875	34.00
35.00	Adjusted reimbursable bad debts (see instructions)		77,919	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		73,962	36.00
37.00	Subtotal (see instructions)		3,364,606	37.00
38.00	MSP-LCC reconciliation amount from PS&R		0	38.00
39.00	OTHER ADJUSTMENTS PER PS&R		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)		3,364,606	40.00
40.01	Sequestration adjustment (see instructions)		44,749	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		3,303,564	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)		16,293	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: 14-0127

Period:
From 01/01/2020
To 06/30/2020Worksheet E-1
Part I
Date/Time Prepared:
11/24/2020 1:07 pm

		Title XVIII		Hospital		PPS	
		Inpatient Part A		Part B			
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount		
		1.00	2.00	3.00	4.00		
1.00	Total interim payments paid to provider		11,289,712		3,303,564	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)		11,289,712		3,303,564	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		192,286		16,293	6.01	
6.02	SETTLEMENT TO PROGRAM		0		0	6.02	
7.00	Total Medicare program liability (see instructions)		11,481,998		3,319,857	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: 14-0127
 Component CCN: 14-T127

 Period:
 From 01/01/2020
 To 06/30/2020

 Worksheet E-1
 Part I
 Date/Time Prepared:
 11/24/2020 1:07 pm

		Title XVIII		Subprovider - IRF		PPS
		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		995,058		0	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		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)		995,058		0	4.00
TO BE COMPLETED BY CONTRACTOR						
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
Program to Provider						
5.01	TENTATIVE TO PROVIDER		0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
Provider to Program						
5.50	TENTATIVE TO PROGRAM		0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		12,226		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		1,007,284		0	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: 14-0127

Period:
From 01/01/2020
To 06/30/2020Worksheet E-1
Part II
Date/Time Prepared:
11/24/2020 1:07 pm

Title XVIII

Hospital

PPS

1.00

TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS

HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION

1.00	Total hospital discharges as defined in AARA §4102 from Wkst. S-3, Pt. I col. 15 line 14	1.00
2.00	Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, 8-12	2.00
3.00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2	3.00
4.00	Total inpatient days from S-3, Pt. I col. 8 sum of lines 1, 8-12	4.00
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200	5.00
6.00	Total hospital charity care charges from Wkst. S-10, col. 3 line 20	6.00
7.00	CAH only - The reasonable cost incurred for the purchase of certified HIT technology Wkst. S-2, Pt. I line 168	7.00
8.00	Calculation of the HIT incentive payment (see instructions)	8.00
9.00	Sequestration adjustment amount (see instructions)	9.00
10.00	Calculation of the HIT incentive payment after sequestration (see instructions)	10.00
INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH		
30.00	Initial/interim HIT payment adjustment (see instructions)	30.00
31.00	Other Adjustment (specify)	31.00
32.00	Balance due provider (line 8 (or line 10) minus line 30 and line 31) (see instructions)	32.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0127 Component CCN: 14-T127	Period: From 01/01/2020 To 06/30/2020	Worksheet E-3 Part III Date/Time Prepared: 11/24/2020 1:07 pm
		Title XVIII	Subprovider - IRF	PPS
				1.00
PART III - MEDICARE PART A SERVICES - IRF PPS				
1.00	Net Federal PPS Payment (see instructions)			988,148 1.00
2.00	Medicare SSI ratio (IRF PPS only) (see instructions)			0.0138 2.00
3.00	Inpatient Rehabilitation LIP Payments (see instructions)			30,139 3.00
4.00	Outlier Payments			2,363 4.00
5.00	Unweighted intern and resident FTE count in the most recent cost reporting period ending on or prior to November 15, 2004 (see instructions)			0.00 5.00
5.01	Cap increases for the unweighted intern and resident FTE count for residents that were displaced by program or hospital closure, that would not be counted without a temporary cap adjustment under 42 CFR §412.424(d)(1)(iii)(F)(1) or (2) (see instructions)			0.00 5.01
6.00	New Teaching program adjustment. (see instructions)			0.00 6.00
7.00	Current year's unweighted FTE count of I&R excluding FTEs in the new program growth period of a "new teaching program" (see instructions)			0.00 7.00
8.00	Current year's unweighted I&R FTE count for residents within the new program growth period of a "new teaching program" (see instructions)			0.00 8.00
9.00	Intern and resident count for IRF PPS medical education adjustment (see instructions)			0.00 9.00
10.00	Average Daily Census (see instructions)			7.071429 10.00
11.00	Teaching Adjustment Factor (see instructions)			0.000000 11.00
12.00	Teaching Adjustment (see instructions)			0 12.00
13.00	Total PPS Payment (see instructions)			1,020,650 13.00
14.00	Nursing and Allied Health Managed Care payments (see instruction)			0 14.00
15.00	Organ acquisition (DO NOT USE THIS LINE)			0 15.00
16.00	Cost of physicians' services in a teaching hospital (see instructions)			0 16.00
17.00	Subtotal (see instructions)			1,020,650 17.00
18.00	Primary payer payments			0 18.00
19.00	Subtotal (line 17 less line 18).			1,020,650 19.00
20.00	Deductibles			2,816 20.00
21.00	Subtotal (line 19 minus line 20)			1,017,834 21.00
22.00	Coinsurance			0 22.00
23.00	Subtotal (line 21 minus line 22)			1,017,834 23.00
24.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)			1,364 24.00
25.00	Adjusted reimbursable bad debts (see instructions)			887 25.00
26.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			0 26.00
27.00	Subtotal (sum of lines 23 and 25)			1,018,721 27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 49)			0 28.00
29.00	Other pass through costs (see instructions)			2,140 29.00
30.00	Outlier payments reconciliation			0 30.00
31.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0 31.00
31.50	Pioneer ACO demonstration payment adjustment (see instructions)			0 31.50
31.99	Demonstration payment adjustment amount before sequestration			0 31.99
32.00	Total amount payable to the provider (see instructions)			1,020,861 32.00
32.01	Sequestration adjustment (see instructions)			13,577 32.01
32.02	Demonstration payment adjustment amount after sequestration			0 32.02
33.00	Interim payments			995,058 33.00
34.00	Tentative settlement (for contractor use only)			0 34.00
35.00	Balance due provider/program (line 32 minus lines 32.01, 32.02, 33, and 34)			12,226 35.00
36.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2			8,647 36.00
TO BE COMPLETED BY CONTRACTOR				
50.00	Original outlier amount from Wkst. E-3, Pt. III, line 4			2,363 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

DIRECT GRADUATE MEDICAL EDUCATION (GME) & ESRD OUTPATIENT DIRECT MEDICAL EDUCATION COSTS		Provider CCN: 14-0127	Period: From 01/01/2020 To 06/30/2020	Worksheet E-4 Date/Time Prepared: 11/24/2020 1:07 pm	
		Title XVIII	Hospital	PPS	
				1.00	
COMPUTATION OF TOTAL DIRECT GME AMOUNT					
1.00	Unweighted resident FTE count for allopathic and osteopathic programs for cost reporting periods ending on or before December 31, 1996.			6.76	1.00
2.00	Unweighted FTE resident cap add-on for new programs per 42 CFR 413.79(e)(1) (see instructions)			0.00	2.00
3.00	Amount of reduction to Direct GME cap under section 422 of MMA			0.00	3.00
3.01	Direct GME cap reduction amount under ACA §5503 in accordance with 42 CFR §413.79 (m). (see instructions for cost reporting periods straddling 7/1/2011)			0.51	3.01
4.00	Adjustment (plus or minus) to the FTE cap for allopathic and osteopathic programs due to a Medicare GME affiliation agreement (42 CFR §413.75(b) and § 413.79 (f))			0.00	4.00
4.01	ACA Section 5503 increase to the Direct GME FTE Cap (see instructions for cost reporting periods straddling 7/1/2011)			0.00	4.01
4.02	ACA Section 5506 number of additional direct GME FTE cap slots (see instructions for cost reporting periods straddling 7/1/2011)			0.00	4.02
5.00	FTE adjusted cap (line 1 plus line 2 minus line 3 and 3.01 plus or minus line 4 plus lines 4.01 and 4.02 plus applicable subscripts)			6.25	5.00
6.00	Unweighted resident FTE count for allopathic and osteopathic programs for the current year from your records (see instructions)			6.42	6.00
7.00	Enter the lesser of line 5 or line 6			6.25	7.00
		Primary Care	Other	Total	
		1.00	2.00	3.00	
8.00	Weighted FTE count for physicians in an allopathic and osteopathic program for the current year.	3.23	3.19	6.42	8.00
9.00	If line 6 is less than 5 enter the amount from line 8, otherwise multiply line 8 times the result of line 5 divided by the amount on line 6.	3.14	3.11	6.25	9.00
10.00	Weighted dental and podiatric resident FTE count for the current year		0.00		10.00
10.01	Unweighted dental and podiatric resident FTE count for the current year		0.00		10.01
11.00	Total weighted FTE count	3.14	3.11		11.00
12.00	Total weighted resident FTE count for the prior cost reporting year (see instructions)	2.93	3.76		12.00
13.00	Total weighted resident FTE count for the penultimate cost reporting year (see instructions)	2.65	3.60		13.00
14.00	Rolling average FTE count (sum of lines 11 through 13 divided by 3).	2.91	3.49		14.00
15.00	Adjustment for residents in initial years of new programs	0.00	0.00		15.00
15.01	Unweighted adjustment for residents in initial years of new programs	0.00	0.00		15.01
16.00	Adjustment for residents displaced by program or hospital closure	0.00	0.00		16.00
16.01	Unweighted adjustment for residents displaced by program or hospital closure	0.00	0.00		16.01
17.00	Adjusted rolling average FTE count	2.91	3.49		17.00
18.00	Per resident amount	105,801.54	105,801.54		18.00
19.00	Approved amount for resident costs	307,882	369,247	677,129	19.00
				1.00	
20.00	Additional unweighted allopathic and osteopathic direct GME FTE resident cap slots received under 42 Sec. 413.79(c)(4)			0.00	20.00
21.00	Direct GME FTE unweighted resident count over cap (see instructions)			0.17	21.00
22.00	Allowable additional direct GME FTE Resident Count (see instructions)			0.00	22.00
23.00	Enter the locality adjustment national average per resident amount (see instructions)			0.00	23.00
24.00	Multiply line 22 time line 23			0	24.00
25.00	Total direct GME amount (sum of lines 19 and 24)			677,129	25.00
		Inpatient Part	Managed Care	Total	
		A			
		1.00	2.00	3.00	
COMPUTATION OF PROGRAM PATIENT LOAD					
26.00	Inpatient Days (see instructions)	4,655	2,288		26.00
27.00	Total Inpatient Days (see instructions)	13,411	13,411		27.00
28.00	Ratio of inpatient days to total inpatient days	0.347103	0.170606		28.00
29.00	Program direct GME amount	235,034	115,522	350,556	29.00
29.01	Percent reduction for MA DGME		7.00		29.01
30.00	Reduction for direct GME payments for Medicare Advantage		8,087	8,087	30.00
31.00	Net Program direct GME amount			342,469	31.00

DIRECT GRADUATE MEDICAL EDUCATION (GME) & ESRD OUTPATIENT DIRECT MEDICAL EDUCATION COSTS		Provider CCN: 14-0127	Period: From 01/01/2020 To 06/30/2020	Worksheet E-4 Date/Time Prepared: 11/24/2020 1:07 pm	
		Title XVIII	Hospital	PPS	
				1.00	
	DIRECT MEDICAL EDUCATION COSTS FOR ESRD COMPOSITE RATE - TITLE XVIII ONLY (NURSING SCHOOL AND PARAMEDICAL EDUCATION COSTS)				
32.00	Renal dialysis direct medical education costs (from Wkst. B, Pt. I, sum of col. 20 and 23, lines 74 and 94)			0	32.00
33.00	Renal dialysis and home dialysis total charges (Wkst. C, Pt. I, col. 8, sum of lines 74 and 94)			0	33.00
34.00	Ratio of direct medical education costs to total charges (line 32 ÷ line 33)			0.000000	34.00
35.00	Medicare outpatient ESRD charges (see instructions)			0	35.00
36.00	Medicare outpatient ESRD direct medical education costs (line 34 x line 35)			0	36.00
APPORTIONMENT BASED ON MEDICARE REASONABLE COST - TITLE XVIII ONLY					
Part A Reasonable Cost					
37.00	Reasonable cost (see instructions)			15,772,226	37.00
38.00	Organ acquisition costs (Wkst. D-4, Pt. III, col. 1, line 69)			0	38.00
39.00	Cost of physicians' services in a teaching hospital (see instructions)			0	39.00
40.00	Primary payer payments (see instructions)			12,061	40.00
41.00	Total Part A reasonable cost (sum of lines 37 through 39 minus line 40)			15,760,165	41.00
Part B Reasonable Cost					
42.00	Reasonable cost (see instructions)			5,623,808	42.00
43.00	Primary payer payments (see instructions)			324	43.00
44.00	Total Part B reasonable cost (line 42 minus line 43)			5,623,484	44.00
45.00	Total reasonable cost (sum of lines 41 and 44)			21,383,649	45.00
46.00	Ratio of Part A reasonable cost to total reasonable cost (line 41 ÷ line 45)			0.737019	46.00
47.00	Ratio of Part B reasonable cost to total reasonable cost (line 44 ÷ line 45)			0.262981	47.00
ALLOCATION OF MEDICARE DIRECT GME COSTS BETWEEN PART A AND PART B					
48.00	Total program GME payment (line 31)			342,469	48.00
49.00	Part A Medicare GME payment (line 46 x 48) (title XVIII only) (see instructions)			252,406	49.00
50.00	Part B Medicare GME payment (line 47 x 48) (title XVIII only) (see instructions)			90,063	50.00

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

Provider CCN: 14-0127

Period:
From 01/01/2020
To 06/30/2020

Worksheet G

Date/Time Prepared:
11/24/2020 1:07 pm

	General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
	1.00	2.00	3.00	4.00	
CURRENT ASSETS					
1.00 Cash on hand in banks	1,488,595,000	0	0	0	1.00
2.00 Temporary investments	106,249,000	0	0	0	2.00
3.00 Notes receivable	0	0	0	0	3.00
4.00 Accounts receivable	1,399,405,000	0	0	0	4.00
5.00 Other receivable	0	0	0	0	5.00
6.00 Allowances for uncollectible notes and accounts receivable	0	0	0	0	6.00
7.00 Inventory	0	0	0	0	7.00
8.00 Prepaid expenses	0	0	0	0	8.00
9.00 Other current assets	625,902,000	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)	3,620,151,000	0	0	0	11.00
FIXED ASSETS					
12.00 Land	478,956,000	0	0	0	12.00
13.00 Land improvements	0	0	0	0	13.00
14.00 Accumulated depreciation	0	0	0	0	14.00
15.00 Buildings	7,865,296,000	0	0	0	15.00
16.00 Accumulated depreciation	0	0	0	0	16.00
17.00 Leasehold improvements	0	0	0	0	17.00
18.00 Accumulated depreciation	0	0	0	0	18.00
19.00 Fixed equipment	0	0	0	0	19.00
20.00 Accumulated depreciation	0	0	0	0	20.00
21.00 Automobiles and trucks	0	0	0	0	21.00
22.00 Accumulated depreciation	0	0	0	0	22.00
23.00 Major movable equipment	2,542,542,000	0	0	0	23.00
24.00 Accumulated depreciation	-5,121,020,000	0	0	0	24.00
25.00 Minor equipment depreciable	0	0	0	0	25.00
26.00 Accumulated depreciation	0	0	0	0	26.00
27.00 HIT designated Assets	0	0	0	0	27.00
28.00 Accumulated depreciation	0	0	0	0	28.00
29.00 Minor equipment-nondepreciable	0	0	0	0	29.00
30.00 Total fixed assets (sum of lines 12-29)	5,765,774,000	0	0	0	30.00
OTHER ASSETS					
31.00 Investments	8,472,465,000	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	1,207,166,000	0	0	0	34.00
35.00 Total other assets (sum of lines 31-34)	9,679,631,000	0	0	0	35.00
36.00 Total assets (sum of lines 11, 30, and 35)	19,065,556,000	0	0	0	36.00
CURRENT LIABILITIES					
37.00 Accounts payable	1,671,691,000	0	0	0	37.00
38.00 Salaries, wages, and fees payable	0	0	0	0	38.00
39.00 Payroll taxes payable	0	0	0	0	39.00
40.00 Notes and loans payable (short term)	77,503,000	0	0	0	40.00
41.00 Deferred income	0	0	0	0	41.00
42.00 Accelerated payments	0	0	0	0	42.00
43.00 Due to other funds	0	0	0	0	43.00
44.00 Other current liabilities	1,304,996,000	0	0	0	44.00
45.00 Total current liabilities (sum of lines 37 thru 44)	3,054,190,000	0	0	0	45.00
LONG TERM LIABILITIES					
46.00 Mortgage payable	3,385,449,000	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	1,872,076,000	0	0	0	49.00
50.00 Total long term liabilities (sum of lines 46 thru 49)	5,257,525,000	0	0	0	50.00
51.00 Total liabilities (sum of lines 45 and 50)	8,311,715,000	0	0	0	51.00
CAPITAL ACCOUNTS					
52.00 General fund balance	10,753,841,000	0	0	0	52.00
53.00 Specific purpose fund	0	0	0	0	53.00
54.00 Donor created - endowment fund balance - restricted	0	0	0	0	54.00
55.00 Donor created - endowment fund balance - unrestricted	0	0	0	0	55.00
56.00 Governing body created - endowment fund balance	0	0	0	0	56.00
57.00 Plant fund balance - invested in plant	0	0	0	0	57.00
58.00 Plant fund balance - reserve for plant improvement, replacement, and expansion	0	0	0	0	58.00
59.00 Total fund balances (sum of lines 52 thru 58)	10,753,841,000	0	0	0	59.00
60.00 Total liabilities and fund balances (sum of lines 51 and 59)	19,065,556,000	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 14-0127

Period:
From 01/01/2020
To 06/30/2020

Worksheet G-1

Date/Time Prepared:
11/24/2020 1:07 pm

		General Fund		Special Purpose Fund		Endowment Fund	
		1.00	2.00	3.00	4.00	5.00	
1.00	Fund balances at beginning of period		11,698,664,000		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		-2,514,684				2.00
3.00	Total (sum of line 1 and line 2)		11,696,149,316		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)		11,696,149,316		0		11.00
12.00	RECONCILING ITEM	0		0		0	12.00
13.00	ADJ TO AHC FUND BALANCE	942,308,316		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)		942,308,316		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		10,753,841,000		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	RECONCILING ITEM		0				12.00
13.00	ADJ TO AHC FUND BALANCE		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: 14-0127

Period:
From 01/01/2020
To 06/30/2020Worksheet G-2
Parts I & II
Date/Time Prepared:
11/24/2020 1:07 pm

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
PART I - PATIENT REVENUES					
General Inpatient Routine Services					
1.00	Hospital	18,028,169		18,028,169	1.00
2.00	SUBPROVIDER - IPF	0		0	2.00
3.00	SUBPROVIDER - IRF	1,350,115		1,350,115	3.00
4.00	SUBPROVIDER	0		0	4.00
5.00	Swing bed - SNF	0		0	5.00
6.00	Swing bed - NF	0		0	6.00
7.00	SKILLED NURSING FACILITY				7.00
8.00	NURSING FACILITY				8.00
9.00	OTHER LONG TERM CARE				9.00
10.00	Total general inpatient care services (sum of lines 1-9)	19,378,284		19,378,284	10.00
Intensive Care Type Inpatient Hospital Services					
11.00	INTENSIVE CARE UNIT	12,547,075		12,547,075	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)	12,547,075		12,547,075	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	31,925,359		31,925,359	17.00
18.00	Ancillary services	76,822,695	81,104,729	157,927,424	18.00
19.00	Outpatient services	5,209,920	18,120,105	23,330,025	19.00
20.00	RURAL HEALTH CLINIC	0	0	0	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY		0	0	22.00
23.00	AMBULANCE SERVICES				23.00
24.00	CMHC				24.00
24.10	CORF	0	0	0	24.10
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE	0	0	0	26.00
27.00	OTHER (SPECIFY)	0	0	0	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	113,957,974	99,224,834	213,182,808	28.00
PART II - OPERATING EXPENSES					
29.00	Operating expenses (per Wkst. A, column 3, line 200)		81,481,250		29.00
30.00	ADD (SPECIFY)	0			30.00
31.00	IMMATERIAL VARIANCE	1			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)		1		36.00
37.00	RECONCILING AMOUNT	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)		81,481,251		43.00

STATEMENT OF REVENUES AND EXPENSES

Provider CCN: 14-0127

Period:
From 01/01/2020
To 06/30/2020

Worksheet G-3

Date/Time Prepared:
11/24/2020 1:07 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	213,182,808	1.00
2.00	Less contractual allowances and discounts on patients' accounts	142,845,433	2.00
3.00	Net patient revenues (line 1 minus line 2)	70,337,375	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	81,481,251	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-11,143,876	5.00
OTHER INCOME			
6.00	Contributions, donations, bequests, etc	653,634	6.00
7.00	Income from investments	1,071	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	106,261	13.00
14.00	Revenue from meals sold to employees and guests	60,107	14.00
15.00	Revenue from rental of living quarters	0	15.00
16.00	Revenue from sale of medical and surgical supplies to other than patients	0	16.00
17.00	Revenue from sale of drugs to other than patients	644,564	17.00
18.00	Revenue from sale of medical records and abstracts	562	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	22,496	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	335,849	20.00
21.00	Rental of vending machines	0	21.00
22.00	Rental of hospital space	4,500	22.00
23.00	Governmental appropriations	6,339,218	23.00
24.00	OTHER	460,930	24.00
24.50	COVID-19 PHE Funding	0	24.50
25.00	Total other income (sum of lines 6-24)	8,629,192	25.00
26.00	Total (line 5 plus line 25)	-2,514,684	26.00
27.00	OTHER EXPENSES (SPECIFY)	0	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	0	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	-2,514,684	29.00

CALCULATION OF CAPITAL PAYMENT		Provider CCN: 14-0127	Period: From 01/01/2020 To 06/30/2020	Worksheet L Parts I-III Date/Time Prepared: 11/24/2020 1:07 pm
		Title XVIII	Hospital	PPS
		1.00		
PART I - FULLY PROSPECTIVE METHOD				
CAPITAL FEDERAL AMOUNT				
1.00	Capital DRG other than outlier		768,789	1.00
1.01	Model 4 BPCI Capital DRG other than outlier		0	1.01
2.00	Capital DRG outlier payments		14,612	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)		67.42	3.00
4.00	Number of interns & residents (see instructions)		12.57	4.00
5.00	Indirect medical education percentage (see instructions)		5.40	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)		41,515	6.00
7.00	Percentage of SSI recipient patient days to Medicare Part A patient days (Worksheet E, part A line 30) (see instructions)		4.54	7.00
8.00	Percentage of Medicaid patient days to total days (see instructions)		23.49	8.00
9.00	Sum of lines 7 and 8		28.03	9.00
10.00	Allowable disproportionate share percentage (see instructions)		5.84	10.00
11.00	Disproportionate share adjustment (see instructions)		44,897	11.00
12.00	Total prospective capital payments (see instructions)		869,813	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