

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 07/01/2020 To 12/31/2020	Worksheet S Parts I-III Date/Time Prepared: 7/12/2021 12:41 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.		
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: 07/30/2020 7. Contractor No. 06101 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 CARLE BROMENN MEDICAL CENTER (14-0127) for the cost reporting period beginning 07/01/2020 and ending 12/31/2020 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

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

(Signed) _____
 Officer or Administrator of Provider(s)

 Title

 Date

Cost Center Description		Title V	Title XVIII		HIT	Title XIX	
			Part A	Part B			
		1.00	2.00	3.00	4.00	5.00	
	PART III - SETTLEMENT SUMMARY						
1.00	Hospital	0	554,736	-109,031	0	0	1.00
2.00	Subprovider - IPF	0	0	0		0	2.00
3.00	Subprovider - IRF	0	31,777	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	586,513	-109,031	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 07/01/2020 To 12/31/2020		Worksheet S-2 Part I Date/Time Prepared: 7/12/2021 12:41 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			CARLE BROMENN MEDICAL CENTER	140127	14060	1	07/01/1966	N	P	O
4.00	Subprovider - IPF										
5.00	Subprovider - IRF			CARLE 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)						07/01/2020	12/31/2020		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	Y			22.01	
22.02	Is this a newly merged hospital that requires final uncompensated care payments to be determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1.					N	N			22.02	
22.03	Did this hospital receive a geographic reclassification from urban to rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no.					N	N			Y	
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	

Worksheet S-2
Part I
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MCRIF32 - 16.10.172.2

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-0127		Period: From 07/01/2020 To 12/31/2020		Worksheet S-2 Part I Date/Time Prepared: 7/12/2021 12:41 pm	
		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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

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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	1.37	3.39	0.287815	67.00
67.01		FAMILY MEDICINE & OMT	6400	0.00	0.84	0.000000	67.01
67.02		FAMILY MEDICINE GENERAL	1350	0.00	0.42	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
						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			0
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:			103,738	1,376,899	436,014	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

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		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		140.00	
		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: CARLE HEALTH SYSTEM	Contractor's Name: NGS		Contractor's Number: 06101		141.00	
142.00	Street: 611 W PARK	PO Box:				142.00	
143.00	City: URBANA	State: IL		Zip Code: 61820		143.00	
				1.00			
144.00	Are provider based physicians' costs included in worksheet A?			N		144.00	
		1.00		2.00			
145.00	If costs for renal services are claimed on Wkst. A, line 74, are the costs for inpatient services only? Enter "Y" for yes or "N" for no in column 1. If column 1 is no, does the dialysis facility include Medicare utilization for this cost reporting period? Enter "Y" for yes or "N" for no in column 2.	Y				145.00	
146.00	Has the cost allocation methodology changed from the previously filed cost report? Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, chapter 40, §4020) If yes, enter the approval date (mm/dd/yyyy) in column 2.	N				146.00	
				1.00			
147.00	Was there a change in the statistical basis? Enter "Y" for yes or "N" for no.			N		147.00	
148.00	Was there a change in the order of allocation? Enter "Y" for yes or "N" for no.			N		148.00	
149.00	Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no.			N		149.00	
		Part A		Part B		Title V	
		1.00		2.00		3.00	
						Title XIX	
						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		165.00	
		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		167.00	
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)					168.00	
168.01	If this provider is a CAH and is not a meaningful user, does this provider qualify for a hardship exception under §413.70(a)(6)(ii)? Enter "Y" for yes or "N" for no. (see instructions)					168.01	
169.00	If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)			0.00		169.00	

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-0127	Period: From 07/01/2020 To 12/31/2020	Worksheet S-2 Part I Date/Time Prepared: 7/12/2021 12:41 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)	N		0171.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 14-0127	Period: From 07/01/2020 To 12/31/2020	Worksheet S-2 Part II Date/Time Prepared: 7/12/2021 12:41 pm
			Y/N 1.00	Date 2.00
General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format.				
COMPLETED BY ALL HOSPITALS				
Provider Organization and Operation				
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)	N		1.00
		Y/N 1.00	Date 2.00	V/I 3.00
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.	N		2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)	Y		3.00
		Y/N 1.00	Type 2.00	Date 3.00
Financial Data and Reports				
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	Y	A	03/26/2020 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	04/30/2021	Y 04/30/2021 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 07/01/2020 To 12/31/2020	Worksheet S-2 Part II Date/Time Prepared: 7/12/2021 12:41 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.		N		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.	LUCAS	MORTON		41.00
42.00	Enter the employer/company name of the cost report preparer.	CARLE HEALTH SYSTEM			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	217-902-6326	LUCAS.MORTON@CARLE.COM		43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE

Provider CCN: 14-0127

Period:
From 07/01/2020
To 12/31/2020Worksheet S-2
Part II
Date/Time Prepared:
7/12/2021 12:41 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.	DIRECTOR OF FINANCE		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 07/01/2020
To 12/31/2020Worksheet S-3
Part I
Date/Time Prepared:
7/12/2021 12:41 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	29,072	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	29,072	0.00	0	7.00
8.00 INTENSIVE CARE UNIT	31.00	48	8,832	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	37,904	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	2,760		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 07/01/2020
To 12/31/2020Worksheet S-3
Part I
Date/Time Prepared:
7/12/2021 12:41 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)	4,388	440	13,093			1.00
2.00	HMO and other (see instructions)	2,331	2,897				2.00
3.00	HMO IPF Subprovider	0	0				3.00
4.00	HMO IRF Subprovider	246	108				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)	4,388	440	13,093			7.00
8.00	INTENSIVE CARE UNIT	442	69	1,341			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		291	1,683			13.00
14.00	Total (see instructions)	4,830	800	16,117	6.45	917.30	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	985	9	1,717	0.00	14.25	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)			298			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)				6.45	931.55	27.00
28.00	Observation Bed Days		89	4,702			28.00
29.00	Ambulance Trips	0					29.00
30.00	Employee discount days (see instruction)			414			30.00
31.00	Employee discount days - IRF			0			31.00
32.00	Labor & delivery days (see instructions)	0	71	159			32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)			0			32.01
33.00	LTCH non-covered days	0					33.00
33.01	LTCH site neutral days and discharges	0					33.01

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 14-0127

Period:
From 07/01/2020
To 12/31/2020Worksheet S-3
Part I
Date/Time Prepared:
7/12/2021 12:41 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	1,101	141	7,854	1.00
2.00 HMO and other (see instructions)			439	512		2.00
3.00 HMO IPF Subprovider				0		3.00
4.00 HMO IRF Subprovider				9		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	1,101	141	7,854	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	61	1	222	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 07/01/2020
To 12/31/2020Worksheet S-3
Part II
Date/Time Prepared:
7/12/2021 12:41 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	34,671,607	0	34,671,607	976,176.00	35.52
2.00	Non-physician anesthetist Part A		0	0	0	0.00	0.00
3.00	Non-physician anesthetist Part B		0	0	0	0.00	0.00
4.00	Physician-Part A - Administrative		0	0	0	0.00	0.00
4.01	Physicians - Part A - Teaching		0	0	0	0.00	0.00
5.00	Physician and Non Physician-Part B		0	0	0	0.00	0.00
6.00	Non-physician-Part B for hospital-based RHC and FQHC services		0	0	0	0.00	0.00
7.00	Interns & residents (in an approved program)	21.00	1,038,009	0	1,038,009	23,800.00	43.61
7.01	Contracted interns and residents (in an approved programs)		0	0	0	0.00	0.00
8.00	Home office and/or related organization personnel		0	0	0	0.00	0.00
9.00	SNF	44.00	0	0	0	0.00	0.00
10.00	Excluded area salaries (see instructions)		1,023,174	0	1,023,174	32,198.00	31.78
OTHER WAGES & RELATED COSTS							
11.00	Contract labor: Direct Patient Care		0	0	0	0.00	0.00
12.00	Contract labor: Top level management and other management and administrative services		0	0	0	0.00	0.00
13.00	Contract labor: Physician-Part A - Administrative		0	0	0	0.00	0.00
14.00	Home office and/or related organization salaries and wage-related costs		0	0	0	0.00	0.00
14.01	Home office salaries		0	0	0	0.00	0.00
14.02	Related organization salaries		0	0	0	0.00	0.00
15.00	Home office: Physician Part A - Administrative		0	0	0	0.00	0.00
16.00	Home office and Contract Physicians Part A - Teaching		0	0	0	0.00	0.00
16.01	Home office Physicians Part A - Teaching		0	0	0	0.00	0.00
16.02	Home office contract Physicians Part A - Teaching		0	0	0	0.00	0.00
WAGE-RELATED COSTS							
17.00	Wage-related costs (core) (see instructions)		7,248,076	0	7,248,076		
18.00	Wage-related costs (other) (see instructions)						
19.00	Excluded areas		304,303	0	304,303		
20.00	Non-physician anesthetist Part A		0	0	0		
21.00	Non-physician anesthetist Part B		0	0	0		
22.00	Physician Part A - Administrative		0	0	0		
22.01	Physician Part A - Teaching		0	0	0		
23.00	Physician Part B		0	0	0		
24.00	Wage-related costs (RHC/FQHC)		0	0	0		
25.00	Interns & residents (in an approved program)		258,507	0	258,507		
25.50	Home office wage-related (core)		0	0	0		
25.51	Related organization wage-related (core)		0	0	0		
25.52	Home office: Physician Part A - Administrative - wage-related (core)		0	0	0		

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 14-0127

Period:
From 07/01/2020
To 12/31/2020Worksheet S-3
Part II
Date/Time Prepared:
7/12/2021 12:41 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	216,136	0	216,136	5,270.00	41.01	26.00
27.00	Administrative & General	5.00	6,169,929	0	6,169,929	132,467.00	46.58	27.00
28.00	Administrative & General under contract (see inst.)		162,808	0	162,808	983.00	165.62	28.00
29.00	Maintenance & Repairs	6.00	0	0	0	0.00	0.00	29.00
30.00	Operation of Plant	7.00	1,248,144	0	1,248,144	41,862.00	29.82	30.00
31.00	Laundry & Linen Service	8.00	221,592	0	221,592	12,767.00	17.36	31.00
32.00	Housekeeping	9.00	872,778	0	872,778	47,818.00	18.25	32.00
33.00	Housekeeping under contract (see instructions)		0	0	0	0.00	0.00	33.00
34.00	Dietary	10.00	631,144	-39,167	591,977	31,388.00	18.86	34.00
35.00	Dietary under contract (see instructions)		0	0	0	0.00	0.00	35.00
36.00	Cafeteria	11.00	157,581	39,167	196,748	8,721.00	22.56	36.00
37.00	Maintenance of Personnel	12.00	0	0	0	0.00	0.00	37.00
38.00	Nursing Administration	13.00	1,319,664	0	1,319,664	31,790.00	41.51	38.00
39.00	Central Services and Supply	14.00	401,227	0	401,227	17,828.00	22.51	39.00
40.00	Pharmacy	15.00	1,245,867	0	1,245,867	24,113.00	51.67	40.00
41.00	Medical Records & Medical Records Library	16.00	0	0	0	0.00	0.00	41.00
42.00	Social Service	17.00	241,186	0	241,186	32,677.00	7.38	42.00
43.00	Other General Service	18.00	0	0	0	6,916.00	0.00	43.00

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 14-0127

Period:
From 07/01/2020
To 12/31/2020Worksheet S-3
Part III
Date/Time Prepared:
7/12/2021 12:41 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)	33,796,406	0	33,796,406	953,359.00	35.45	1.00
2.00	Excluded area salaries (see instructions)	1,023,174	0	1,023,174	32,198.00	31.78	2.00
3.00	Subtotal salaries (line 1 minus line 2)	32,773,232	0	32,773,232	921,161.00	35.58	3.00
4.00	Subtotal other wages & related costs (see inst.)	0	0	0	0.00	0.00	4.00
5.00	Subtotal wage-related costs (see inst.)	7,248,076	0	7,248,076	0.00	22.12	5.00
6.00	Total (sum of lines 3 thru 5)	40,021,308	0	40,021,308	921,161.00	43.45	6.00
7.00	Total overhead cost (see instructions)	12,888,056	0	12,888,056	394,600.00	32.66	7.00

HOSPITAL WAGE RELATED COSTS

Provider CCN: 14-0127

Period:
From 07/01/2020
To 12/31/2020Worksheet S-3
Part IV
Date/Time Prepared:
7/12/2021 12:41 pm

		Amount Reported	
		1.00	
PART IV - WAGE RELATED COSTS			
Part A - Core List			
RETIREMENT COST			
1.00	401K Employer Contributions	1,833,559	1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution	0	2.00
3.00	Nonqualified Defined Benefit Plan Cost (see instructions)	0	3.00
4.00	Qualified Defined Benefit Plan Cost (see instructions)	0	4.00
PLAN ADMINISTRATIVE COSTS (Paid to External Organization)			
5.00	401K/TSA Plan Administration fees	0	5.00
6.00	Legal/Accounting/Management Fees-Pension Plan	0	6.00
7.00	Employee Managed Care Program Administration Fees	0	7.00
HEALTH AND INSURANCE COST			
8.00	Health Insurance (Purchased or Self Funded)	0	8.00
8.01	Health Insurance (Self Funded without a Third Party Administrator)	3,246,754	8.01
8.02	Health Insurance (Self Funded with a Third Party Administrator)	0	8.02
8.03	Health Insurance (Purchased)	0	8.03
9.00	Prescription Drug Plan	0	9.00
10.00	Dental, Hearing and Vision Plan	0	10.00
11.00	Life Insurance (If employee is owner or beneficiary)	28,119	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)	126,435	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)	0	14.00
15.00	'Workers' Compensation Insurance	0	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	2,447,046	17.00
18.00	Medicare Taxes - Employers Portion Only	0	18.00
19.00	Unemployment Insurance	0	19.00
20.00	State or Federal Unemployment Taxes	0	20.00
OTHER			
21.00	Executive Deferred Compensation (Other Than Retirement Cost Reported on lines 1 through 4 above. (see instructions))	0	21.00
22.00	Day Care Cost and Allowances	0	22.00
23.00	Tuition Reimbursement	157,373	23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)	7,839,286	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 07/01/2020
To 12/31/2020Worksheet S-3
Part V
Date/Time Prepared:
7/12/2021 12:41 pm

Cost Center Description		Contract Labor	Benefit Cost	
		1.00	2.00	
PART V - Contract Labor and Benefit Cost				
Hospital and Hospital-Based Component Identification:				
1.00	Total facility's contract labor and benefit cost	0	17,893,058	1.00
2.00	Hospital	0	16,723,918	2.00
3.00	Subprovider - IPF	0	0	3.00
4.00	Subprovider - IRF	0	262,030	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	0	0	17.00
18.00	Other	0	907,110	18.00

Health Financial Systems		CARLE BROMENN MEDICAL CENTER		In Lieu of Form CMS-2552-10	
HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA		Provider CCN: 14-0127	Period: From 07/01/2020 To 12/31/2020	Worksheet S-10 Date/Time Prepared: 7/12/2021 12:41 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)			0.336702	1.00
Medicaid (see instructions for each line)					
2.00	Net revenue from Medicaid			1,116,096	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			31,876,788	6.00
7.00	Medicaid cost (line 1 times line 6)			10,732,978	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)			9,616,882	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)			9,616,882	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)	1,086,283	19,208	1,105,491	20.00
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	365,754	19,208	384,962	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)	365,754	19,208	384,962	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)			103,833	26.00
27.00	Medicare reimbursable bad debts for the entire hospital complex (see instructions)			33,312	27.00
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)			51,248	27.01
28.00	Non-Medicare bad debt expense (see instructions)			52,585	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)			35,641	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)			420,603	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)			10,037,485	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-0127

Period:
From 07/01/2020
To 12/31/2020

Worksheet A

Date/Time Prepared:
7/12/2021 12:41 pm

Cost Center Description			Salaries	Other	Total (col. 1 + col. 2)	Reclassificati ons (See A-6)	Reclassified Trial Balance (col. 3 + col. 4)	
			1.00	2.00	3.00	4.00	5.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT		0	0	0	0	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		0	0	0	0	2.00
3.00	00300	OTHER CAP REL COSTS		0	0	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	216,136	88,287	304,423	-4,698	299,725	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	6,169,929	-3,172,099	2,997,830	10,884,499	13,882,329	5.00
7.00	00700	OPERATION OF PLANT	1,248,144	2,690,695	3,938,839	-242,098	3,696,741	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	221,592	206,006	427,598	-64,688	362,910	8.00
9.00	00900	HOUSEKEEPING	872,778	414,399	1,287,177	-104,807	1,182,370	9.00
10.00	01000	DIETARY	631,144	471,651	1,102,795	-114,941	987,854	10.00
11.00	01100	CAFETERIA	157,581	178,260	335,841	88,485	424,326	11.00
13.00	01300	NURSING ADMINISTRATION	1,319,664	336,397	1,656,061	0	1,656,061	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	401,227	493,975	895,202	-551,183	344,019	14.00
15.00	01500	PHARMACY	1,245,867	3,719,093	4,964,960	-3,859,521	1,105,439	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	241,186	46,712	287,898	0	287,898	17.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	1,038,009	0	1,038,009	0	1,038,009	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	566,619	566,619	0	566,619	22.00
23.00	02300	CLINICAL PASTORAL EDUCATION	243,092	55,742	298,834	-1,832	297,002	23.00
23.01	02301	EMS PROGRAM	0	0	0	0	0	23.01
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	8,116,881	3,341,349	11,458,230	-2,504,589	8,953,641	30.00
31.00	03100	INTENSIVE CARE UNIT	1,239,903	726,443	1,966,346	-466,537	1,499,809	31.00
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	0	40.00
41.00	04100	SUBPROVIDER - IRF	583,015	224,705	807,720	-45,918	761,802	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	0	42.00
43.00	04300	NURSERY	0	0	0	1,305,077	1,305,077	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	1,945,703	7,982,510	9,928,213	-6,298,987	3,629,226	50.00
51.00	05100	RECOVERY ROOM	271,301	78,830	350,131	-15,224	334,907	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	178,482	178,482	52.00
53.00	05300	ANESTHESIOLOGY	16,383	1,351,892	1,368,275	-132,234	1,236,041	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,129,516	1,778,128	2,907,644	-1,284,116	1,623,528	54.00
57.00	05700	CT SCAN	379,538	589,684	969,222	-374,570	594,652	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	1,315,352	2,620,358	3,935,710	-1,154,961	2,780,749	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	301,556	301,556	64.00
65.00	06500	RESPIRATORY THERAPY	504,664	221,030	725,694	-89,025	636,669	65.00
66.00	06600	PHYSICAL THERAPY	835,544	210,177	1,045,721	-6,266	1,039,455	66.00
67.00	06700	OCCUPATIONAL THERAPY	113,480	19,469	132,949	-590	132,359	67.00
68.00	06800	SPEECH PATHOLOGY	208,850	53,439	262,289	-1,660	260,629	68.00
69.00	06900	ELECTROCARDIOLOGY	1,317,340	2,768,535	4,085,875	-2,579,933	1,505,942	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	34,884	26,328	61,212	-3,699	57,513	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	1,559,814	1,559,814	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	2,273,076	2,273,076	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	3,771,390	3,771,390	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	155,084	155,084	74.00
76.97	07697	CARDIAC REHABILITATION	173,463	40,602	214,065	-3,984	210,081	76.97
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	243,005	75,115	318,120	-11,365	306,755	90.00
90.01	09001	BASIC DIAGNOSTIC TESTING	0	0	0	0	0	90.01
90.03	09002	PSYCH OUTPATIENT	36,714	10,698	47,412	-112	47,300	90.03
90.04	09003	WOUND CARE CLINIC	284,602	445,001	729,603	-152,008	577,595	90.04
91.00	09100	EMERGENCY	1,718,053	860,625	2,578,678	-444,775	2,133,903	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	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)	34,474,540	29,520,655	63,995,195	3,142	63,998,337	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	87,177	31,542	118,719	-1,482	117,237	190.00
190.01	19001	OTHER NONREIMBURSABLE	109,890	504,055	613,945	-1,660	612,285	190.01
190.13	19007	EUREKA	0	0	0	0	0	190.13
191.00	19100	RESEARCH	0	0	0	0	0	191.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-0127

Period:
From 07/01/2020
To 12/31/2020

Worksheet A

Date/Time Prepared:
7/12/2021 12:41 pm

Cost Center Description			Salaries	Other	Total (col. 1 + col. 2)	Reclassificati ons (See A-6)	Reclassified Trial Balance (col. 3 +- col. 4)	
			1.00	2.00	3.00	4.00	5.00	
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	0	0	0	0	192.00
200.00		TOTAL (SUM OF LINES 118 through 199)	34,671,607	30,056,252	64,727,859	0	64,727,859	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-0127

Period:
From 07/01/2020
To 12/31/2020

Worksheet A

Date/Time Prepared:
7/12/2021 12:41 pm

Cost Center Description			Adjustments (See A-8) 6.00	Net Expenses For Allocation 7.00	
GENERAL SERVICE COST CENTERS					
1.00	00100	CAP REL COSTS-BLDG & FIXT	4,067,403	4,067,403	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	2,698,780	2,698,780	2.00
3.00	00300	OTHER CAP REL COSTS	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-438,887	-139,162	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	14,497,708	28,380,037	5.00
7.00	00700	OPERATION OF PLANT	-4,239	3,692,502	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	-85,301	277,609	8.00
9.00	00900	HOUSEKEEPING	-18,708	1,163,662	9.00
10.00	01000	DIETARY	-3,099	984,755	10.00
11.00	01100	CAFETERIA	-263,389	160,937	11.00
13.00	01300	NURSING ADMINISTRATION	1,633,731	3,289,792	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	995,291	1,339,310	14.00
15.00	01500	PHARMACY	-20,809	1,084,630	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	440,905	440,905	16.00
17.00	01700	SOCIAL SERVICE	0	287,898	17.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	1,038,009	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	566,619	22.00
23.00	02300	CLINICAL PASTORAL EDUCATION	-7,851	289,151	23.00
23.01	02301	EMS PROGRAM	0	0	23.01
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	-235,050	8,718,591	30.00
31.00	03100	INTENSIVE CARE UNIT	0	1,499,809	31.00
40.00	04000	SUBPROVIDER - IPF	0	0	40.00
41.00	04100	SUBPROVIDER - IRF	0	761,802	41.00
42.00	04200	SUBPROVIDER	0	0	42.00
43.00	04300	NURSERY	0	1,305,077	43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	3,629,226	50.00
51.00	05100	RECOVERY ROOM	0	334,907	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	178,482	52.00
53.00	05300	ANESTHESIOLOGY	0	1,236,041	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	1,623,528	54.00
57.00	05700	CT SCAN	0	594,652	57.00
58.00	05800	MRI	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	59.00
60.00	06000	LABORATORY	-11	2,780,738	60.00
64.00	06400	INTRAVENOUS THERAPY	0	301,556	64.00
65.00	06500	RESPIRATORY THERAPY	0	636,669	65.00
66.00	06600	PHYSICAL THERAPY	-24,799	1,014,656	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	132,359	67.00
68.00	06800	SPEECH PATHOLOGY	0	260,629	68.00
69.00	06900	ELECTROCARDIOLOGY	0	1,505,942	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	57,513	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	1,559,814	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	2,273,076	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	3,771,390	73.00
74.00	07400	RENAL DIALYSIS	0	155,084	74.00
76.97	07697	CARDIAC REHABILITATION	0	210,081	76.97
OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	-160	306,595	90.00
90.01	09001	BASIC DIAGNOSTIC TESTING	0	0	90.01
90.03	09002	PSYCH OUTPATIENT	0	47,300	90.03
90.04	09003	WOUND CARE CLINIC	0	577,595	90.04
91.00	09100	EMERGENCY	0	2,133,903	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	0	0	113.00
116.00	11600	HOSPICE	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	23,231,515	87,229,852	118.00
NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	0	117,237	190.00
190.01	19001	OTHER NONREIMBURSABLE	0	612,285	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)	23,231,515	87,959,374	200.00

RECLASSIFICATIONS

Provider CCN: 14-0127

Period:
From 07/01/2020
To 12/31/2020Worksheet A-6
Date/Time Prepared:
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	Increases					
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
	A - NURSERY EXPENSE					
1.00	NURSERY	43.00	834,413	470,664		1.00
2.00	DELIVERY ROOM & LABOR ROOM	52.00	114,095	64,387		2.00
	TOTALS		948,508	535,051		
	B - CAFETERIA EXPENSE					
1.00	CAFETERIA	11.00	39,167	57,278		1.00
	TOTALS		39,167	57,278		
	C - MEDICAL SUPPLY RECLASS					
1.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	1,559,814		1.00
2.00	ADMINISTRATIVE & GENERAL	5.00	0	12,756,621		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
	TOTALS		0	14,316,435		
	D - DRUG COSTS					
1.00	ADMINISTRATIVE & GENERAL	5.00	0	3,576,528		1.00
2.00	DRUGS CHARGED TO PATIENTS	73.00	0	3,771,390		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
	TOTALS		0	7,347,918		
	E - IMPLANT RECLASS					
1.00	ADMINISTRATIVE & GENERAL	5.00	0	2,155,630		1.00
2.00	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	2,273,076		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
	TOTALS		0	4,428,706		
	F - RENAL DIALYSIS					
1.00	RENAL DIALYSIS	74.00	0	155,084		1.00
2.00		0.00	0	0		2.00
3.00		0.00	0	0		3.00
	TOTALS		0	155,084		
	G - IV THERAPY					
1.00	INTRAVENOUS THERAPY	64.00	246,595	54,961		1.00
2.00		0.00	0	0		2.00
3.00		0.00	0	0		3.00
	TOTALS		246,595	54,961		
500.00	Grand Total: Increases		1,234,270	26,895,433		500.00

RECLASSIFICATIONS

Provider CCN: 14-0127

Period:
From 07/01/2020
To 12/31/2020

Worksheet A-6

Date/Time Prepared:
7/12/2021 12:41 pm

	Decreases						
	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	948,508	535,051	0		1.00
2.00		0.00	0	0	0		2.00
	TOTALS		948,508	535,051			
	B - CAFETERIA EXPENSE						
1.00	DIETARY	10.00	39,167	57,278	0		1.00
	TOTALS		39,167	57,278			
	C - MEDICAL SUPPLY RECLASS						
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	4,698	0		1.00
2.00	OPERATION OF PLANT	7.00	0	242,098	0		2.00
3.00	LAUNDRY & LINEN SERVICE	8.00	0	64,688	0		3.00
4.00	HOUSEKEEPING	9.00	0	104,807	0		4.00
5.00	DIETARY	10.00	0	18,496	0		5.00
6.00	CAFETERIA	11.00	0	7,960	0		6.00
7.00	CENTRAL SERVICES & SUPPLY	14.00	0	551,183	0		7.00
8.00	PHARMACY	15.00	0	361,234	0		8.00
9.00	ADMINISTRATIVE & GENERAL	5.00	0	1,559,814	0		9.00
10.00	CLINICAL PASTORAL EDUCATION	23.00	0	1,832	0		10.00
11.00	ADULTS & PEDIATRICS	30.00	0	662,608	0		11.00
12.00	INTENSIVE CARE UNIT	31.00	0	421,212	0		12.00
13.00	SUBPROVIDER - IRF	41.00	0	42,559	0		13.00
14.00	WOUND CARE CLINIC	90.04	0	149,619	0		14.00
15.00	OPERATING ROOM	50.00	0	4,920,725	0		15.00
16.00	RECOVERY ROOM	51.00	0	15,224	0		16.00
17.00	ANESTHESIOLOGY	53.00	0	132,234	0		17.00
18.00	RADIOLOGY-DIAGNOSTIC	54.00	0	1,277,052	0		18.00
19.00	CT SCAN	57.00	0	374,570	0		19.00
20.00	LABORATORY	60.00	0	1,154,437	0		20.00
21.00	RESPIRATORY THERAPY	65.00	0	89,025	0		21.00
22.00	PHYSICAL THERAPY	66.00	0	5,914	0		22.00
23.00	OCCUPATIONAL THERAPY	67.00	0	590	0		23.00
24.00	SPEECH PATHOLOGY	68.00	0	1,660	0		24.00
25.00	ELECTROCARDIOLOGY	69.00	0	1,740,320	0		25.00
26.00	ELECTROENCEPHALOGRAPHY	70.00	0	3,699	0		26.00
27.00	CARDIAC REHABILITATION	76.97	0	3,984	0		27.00
28.00	CLINIC	90.00	0	6,942	0		28.00
29.00	PSYCH OUTPATIENT	90.03	0	112	0		29.00
30.00	EMERGENCY	91.00	0	394,612	0		30.00
31.00	GIFT FLOWER COFFEE SHOP & CANTEEN	190.00	0	1,482	0		31.00
32.00	OTHER NONREIMBURSABLE	190.01	0	1,045	0		32.00
	TOTALS		0	14,316,435			
	D - DRUG COSTS						
1.00	PHARMACY	15.00	0	3,498,287	0		1.00
2.00	ADULTS & PEDIATRICS	30.00	0	57	0		2.00
3.00	OPERATING ROOM	50.00	0	5,655	0		3.00
4.00	RADIOLOGY-DIAGNOSTIC	54.00	0	4,154	0		4.00
5.00	PHYSICAL THERAPY	66.00	0	352	0		5.00
6.00	ELECTROCARDIOLOGY	69.00	0	60,024	0		6.00
7.00	CLINIC	90.00	0	4,423	0		7.00
8.00	WOUND CARE CLINIC	90.04	0	2,389	0		8.00
9.00	EMERGENCY	91.00	0	572	0		9.00
10.00	OTHER NONREIMBURSABLE	190.01	0	615	0		10.00
11.00	ADMINISTRATIVE & GENERAL	5.00	0	3,771,390	0		11.00
	TOTALS		0	7,347,918			
	E - IMPLANT RECLASS						
1.00	OPERATING ROOM	50.00	0	1,372,607	0		1.00
2.00	RADIOLOGY-DIAGNOSTIC	54.00	0	2,910	0		2.00
3.00	LABORATORY	60.00	0	524	0		3.00
4.00	ELECTROCARDIOLOGY	69.00	0	779,589	0		4.00
5.00	ADMINISTRATIVE & GENERAL	5.00	0	2,273,076	0		5.00
	TOTALS		0	4,428,706			
	F - RENAL DIALYSIS						
1.00	ADULTS & PEDIATRICS	30.00	0	112,461	0		1.00
2.00	INTENSIVE CARE UNIT	31.00	0	39,264	0		2.00
3.00	SUBPROVIDER - IRF	41.00	0	3,359	0		3.00
	TOTALS		0	155,084			
	G - IV THERAPY						
1.00	ADULTS & PEDIATRICS	30.00	200,678	45,226	0		1.00
2.00	INTENSIVE CARE UNIT	31.00	4,930	1,131	0		2.00
3.00	EMERGENCY	91.00	40,987	8,604	0		3.00
	TOTALS		246,595	54,961			
500.00	Grand Total: Decreases		1,234,270	26,895,433			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-0127

Period:
From 07/01/2020
To 12/31/2020Worksheet A-7
Part I
Date/Time Prepared:
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		Beginning Balances	Acquisitions			Disposals and Retirements		
			Purchases	Donation	Total			
		1.00	2.00	3.00	4.00	5.00		
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES							
1.00	Land	7,844,000	0	0	0	0	1.00	
2.00	Land Improvements	10,449,617	0	0	0	0	2.00	
3.00	Buildings and Fixtures	245,489,192	5,899,590	0	5,899,590	3,007	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	84,915,917	2,715,265	0	2,715,265	28,307,849	6.00	
7.00	HIT designated Assets	0	0	0	0	0	7.00	
8.00	Subtotal (sum of lines 1-7)	348,698,726	8,614,855	0	8,614,855	28,310,856	8.00	
9.00	Reconciling Items	0	0	0	0	0	9.00	
10.00	Total (line 8 minus line 9)	348,698,726	8,614,855	0	8,614,855	28,310,856	10.00	
		Ending Balance	Fully Depreciated Assets					
		6.00	7.00					
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES							
1.00	Land	7,844,000	0				1.00	
2.00	Land Improvements	10,449,617	4,727,428				2.00	
3.00	Buildings and Fixtures	251,385,775	127,432,978				3.00	
4.00	Building Improvements	0	0				4.00	
5.00	Fixed Equipment	0	0				5.00	
6.00	Movable Equipment	59,323,333	32,355,206				6.00	
7.00	HIT designated Assets	0	0				7.00	
8.00	Subtotal (sum of lines 1-7)	329,002,725	164,515,612				8.00	
9.00	Reconciling Items	0	0				9.00	
10.00	Total (line 8 minus line 9)	329,002,725	164,515,612				10.00	

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-0127

Period:
From 07/01/2020
To 12/31/2020Worksheet A-7
Part II
Date/Time Prepared:
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Cost Center Description		SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	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	CAP REL COSTS-BLDG & FIXT	0	0				1.00
2.00	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 07/01/2020
To 12/31/2020Worksheet A-7
Part III
Date/Time Prepared:
7/12/2021 12:41 pm

Cost Center Description		COMPUTATION OF RATIOS			ALLOCATION OF OTHER CAPITAL		
		Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	
		1.00	2.00	3.00	4.00	5.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	269,679,392	0	269,679,392	0.819687	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	59,323,332	0	59,323,332	0.180313	0	2.00
3.00	Total (sum of lines 1-2)	329,002,724	0	329,002,724	1.000000	0	3.00
Cost Center Description		ALLOCATION OF OTHER CAPITAL			SUMMARY OF CAPITAL		
		Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	Depreciation	Lease	
		6.00	7.00	8.00	9.00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	4,067,403	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	2,698,780	0	2.00
3.00	Total (sum of lines 1-2)	0	0	0	6,766,183	0	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	0	4,067,403	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	0	2,698,780	2.00
3.00	Total (sum of lines 1-2)	0	0	0	0	6,766,183	3.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 14-0127

Period:
From 07/01/2020
To 12/31/2020

Worksheet A-8

Date/Time Prepared:
7/12/2021 12:41 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				3.00	4.00	5.00	
1.00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)			0CAP REL COSTS-BLDG & FIXT	1.00	0	1.00
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)			0CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
3.00	Investment income - other (chapter 2)		0		0.00	0	3.00
4.00	Trade, quantity, and time discounts (chapter 8)		0		0.00	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)		0		0.00	0	5.00
6.00	Rental of provider space by suppliers (chapter 8)		0		0.00	0	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)		0		0.00	0	7.00
8.00	Television and radio service (chapter 21)		0		0.00	0	8.00
9.00	Parking lot (chapter 21)		0		0.00	0	9.00
10.00	Provider-based physician adjustment	A-8-2	0			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	21,212,952			0	12.00
13.00	Laundry and linen service	B	-85,301	LAUNDRY & LINEN SERVICE	8.00	0	13.00
14.00	Cafeteria-employees and guests	B	-263,389	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	-20,809	PHARMACY	15.00	0	17.00
18.00	Sale of medical records and abstracts		0		0.00	0	18.00
19.00	Nursing and allied health education (tuition, fees, books, etc.)		0		0.00	0	19.00
20.00	Vending machines		0		0.00	0	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	0	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	RESPIRATORY THERAPY	65.00		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	PHYSICAL THERAPY	66.00		24.00
25.00	Utilization review - physicians' compensation (chapter 21)		0	*** Cost Center Deleted ***	114.00		25.00
26.00	Depreciation - CAP REL COSTS-BLDG & FIXT		0	CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	27.00
28.00	Non-physician Anesthetist		0	*** Cost Center Deleted ***	19.00		28.00
29.00	Physicians' assistant		0		0.00	0	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	OCCUPATIONAL THERAPY	67.00		30.00
30.99	Hospice (non-distinct) (see instructions)	B	-235,000	ADULTS & PEDIATRICS	30.00		30.99
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	SPEECH PATHOLOGY	68.00		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest		0		0.00	0	32.00
33.00	MISCELLANEOUS INCOME	B	-3,099	DIETARY	10.00	0	33.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 14-0127

Period:
From 07/01/2020
To 12/31/2020

Worksheet A-8

Date/Time Prepared:
7/12/2021 12:41 pm

Cost Center Description		Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted		Wkst. A-7 Ref.	
				Cost Center	Line #		
		1.00	2.00	3.00	4.00	5.00	
33.03	MISCELLANEOUS INCOME	B	-183,227	ADMINISTRATIVE & GENERAL	5.00	0	33.03
33.04	MISCELLANEOUS INCOME	B	-4,239	OPERATION OF PLANT	7.00	0	33.04
33.08	MISCELLANEOUS INCOME	B	-18,708	HOUSEKEEPING	9.00	0	33.08
33.09	MISCELLANEOUS INCOME	B	-14,459	CENTRAL SERVICES & SUPPLY	14.00	0	33.09
33.10	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	33.10
33.19	MISCELLANEOUS INCOME	B	-7,851	CLINICAL PASTORAL EDUCATION	23.00	0	33.19
33.20	MISCELLANEOUS INCOME	B	-50	ADULTS & PEDIATRICS	30.00	0	33.20
33.21	MISCELLANEOUS INCOME	B	-11	LABORATORY	60.00	0	33.21
33.22	MISCELLANEOUS INCOME	B	-24,799	PHYSICAL THERAPY	66.00	0	33.22
33.24	MISCELLANEOUS INCOME	B	-160	CLINIC	90.00	0	33.24
33.25	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	33.25
33.28	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	33.28
34.00	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	34.00
35.03	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	35.03
35.04	PA ASSESSMENT EXPENSE	A	-3,886,518	ADMINISTRATIVE & GENERAL	5.00	0	35.04
35.05	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	35.05
35.06	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	35.06
35.08	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	35.08
35.09	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	35.09
36.00	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	36.00
36.01	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	36.01
36.02	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	36.02
36.03	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	36.03
36.04	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	36.04
36.05	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	36.05
36.06	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	36.06
36.07	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	36.07
36.09	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	36.09
36.10	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	36.10
36.11	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	36.11
36.13	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	36.13
36.14	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	36.14
36.15	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	36.15
36.16	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	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	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	36.19
37.00	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	37.00
38.00	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	38.00
44.04	ADJ BOOK TO MC DEPR	A	4,067,403	CAP REL COSTS-BLDG & FIXT	1.00	9	44.04
44.05	ADJ BOOK TO MC DEPR	A	2,698,780	CAP REL COSTS-MVBLE EQUIP	2.00	9	44.05

ADJUSTMENTS TO EXPENSES

Provider CCN: 14-0127

Period:
From 07/01/2020
To 12/31/2020

Worksheet A-8

Date/Time Prepared:
7/12/2021 12:41 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	
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		23,231,515				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 07/01/2020
To 12/31/2020

Worksheet A-8-1

Date/Time Prepared:
7/12/2021 12:41 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	0.00			0	0	3.00
3.02	0.00			0	0	3.02
3.03	0.00			0	0	3.03
3.04	0.00			0	0	3.04
3.05	0.00			0	0	3.05
3.06	0.00			0	0	3.06
3.07	0.00			0	0	3.07
3.08	0.00			0	0	3.08
3.09	0.00			0	0	3.09
3.10	0.00			0	0	3.10
3.11	0.00			0	0	3.11
3.12	0.00			0	0	3.12
3.13	13.00	NURSING ADMINISTRATION	PATIENT CARE	1,633,731	0	3.13
3.14	14.00	CENTRAL SERVICES & SUPPLY	CPD	1,009,750	0	3.14
4.00	16.00	MEDICAL RECORDS & LIBRARY	HIM	440,905	0	4.00
4.01	5.00	ADMINISTRATIVE & GENERAL	SUPPLY COST	19,429,180	0	4.01
4.02	4.00	EMPLOYEE BENEFITS DEPARTMENT	HOME OFFICE	-438,887	0	4.02
4.03	5.00	ADMINISTRATIVE & GENERAL	HOME OFFICE	7,425,480	8,287,207	4.03
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.			29,500,159	8,287,207	5.00

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

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

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

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

6.00	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 07/01/2020
To 12/31/2020

Worksheet A-8-1

Date/Time Prepared:
7/12/2021 12:41 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	0	0		3.00
3.02	0	0		3.02
3.03	0	0		3.03
3.04	0	0		3.04
3.05	0	0		3.05
3.06	0	0		3.06
3.07	0	0		3.07
3.08	0	0		3.08
3.09	0	0		3.09
3.10	0	0		3.10
3.11	0	0		3.11
3.12	0	0		3.12
3.13	1,633,731	0		3.13
3.14	1,009,750	0		3.14
4.00	440,905	0		4.00
4.01	19,429,180	0		4.01
4.02	-438,887	0		4.02
4.03	-861,727	0		4.03
5.00	21,212,952			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 07/01/2020
To 12/31/2020

Worksheet A-8-2

Date/Time Prepared:
7/12/2021 12:41 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	0.00		0	0	0	0	0	1.00
2.00	0.00		0	0	0	0	0	2.00
3.00	0.00		0	0	0	0	0	3.00
4.00	0.00		0	0	0	0	0	4.00
5.00	0.00		0	0	0	0	0	5.00
6.00	0.00		0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			0	0	0	0	0	200.00
	Wkst. A Line #	Cost Center/Physician Identifier	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	0.00		0	0	0	0	0	1.00
2.00	0.00		0	0	0	0	0	2.00
3.00	0.00		0	0	0	0	0	3.00
4.00	0.00		0	0	0	0	0	4.00
5.00	0.00		0	0	0	0	0	5.00
6.00	0.00		0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			0	0	0	0	0	200.00
	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment		
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00	0.00		0	0	0	0		1.00
2.00	0.00		0	0	0	0		2.00
3.00	0.00		0	0	0	0		3.00
4.00	0.00		0	0	0	0		4.00
5.00	0.00		0	0	0	0		5.00
6.00	0.00		0	0	0	0		6.00
7.00	0.00		0	0	0	0		7.00
8.00	0.00		0	0	0	0		8.00
9.00	0.00		0	0	0	0		9.00
10.00	0.00		0	0	0	0		10.00
200.00			0	0	0	0		200.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0127

Period:
From 07/01/2020
To 12/31/2020Worksheet B
Part I
Date/Time Prepared:
7/12/2021 12:41 pm

Cost Center Description			CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
			Net Expenses for Cost Allocation (from Wkst A col. 7)	BLDG & FIXT	MVBLE EQUIP		
			0	1.00	2.00	4.00	4A
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT	4,067,403	4,067,403			1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	2,698,780		2,698,780		2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-139,162	0	1,729	-137,433	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	28,380,037	411,262	131,927	0	5.00
7.00	00700	OPERATION OF PLANT	3,692,502	978,267	64,316	0	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	277,609	82,845	17,033	0	8.00
9.00	00900	HOUSEKEEPING	1,163,662	59,386	15,442	0	9.00
10.00	01000	DIETARY	984,755	30,240	5,746	0	10.00
11.00	01100	CAFETERIA	160,937	49,893	6,783	0	11.00
13.00	01300	NURSING ADMINISTRATION	3,289,792	67,405	1,386	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	1,339,310	47,349	16,071	0	14.00
15.00	01500	PHARMACY	1,084,630	40,930	122,228	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	440,905	46,582	0	0	16.00
17.00	01700	SOCIAL SERVICE	287,898	10,083	0	0	17.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	1,038,009	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	566,619	0	0	0	22.00
23.00	02300	CLINICAL PASTORAL EDUCATION	289,151	13,494	0	0	23.00
23.01	02301	EMS PROGRAM	0	0	0	0	23.01
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	8,718,591	535,442	193,503	0	30.00
31.00	03100	INTENSIVE CARE UNIT	1,499,809	407,724	188,419	0	31.00
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	40.00
41.00	04100	SUBPROVIDER - IRF	761,802	93,518	10,002	0	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	42.00
43.00	04300	NURSERY	1,305,077	43,769	85,613	0	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	3,629,226	249,219	436,119	0	50.00
51.00	05100	RECOVERY ROOM	334,907	21,893	11,902	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	178,482	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	1,236,041	4,380	22,418	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,623,528	127,305	664,711	0	54.00
57.00	05700	CT SCAN	594,652	15,971	231,358	0	57.00
58.00	05800	MRI	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	59.00
60.00	06000	LABORATORY	2,780,738	109,228	83,287	0	60.00
64.00	06400	INTRAVENOUS THERAPY	301,556	82,214	28,420	0	64.00
65.00	06500	RESPIRATORY THERAPY	636,669	40,980	48,267	0	65.00
66.00	06600	PHYSICAL THERAPY	1,014,656	11,700	10,482	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	132,359	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	260,629	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	1,505,942	88,717	178,106	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	57,513	8,196	4,452	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1,559,814	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	2,273,076	0	13,699	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	3,771,390	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	155,084	0	0	0	74.00
76.97	07697	CARDIAC REHABILITATION	210,081	22,786	5,474	0	76.97
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	306,595	0	950	0	90.00
90.01	09001	BASIC DIAGNOSTIC TESTING	0	0	0	0	90.01
90.03	09002	PSYCH OUTPATIENT	47,300	54,357	205	0	90.03
90.04	09003	WOUND CARE CLINIC	577,595	3,016	540	0	90.04
91.00	09100	EMERGENCY	2,133,903	139,687	96,653	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	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)	87,229,852	3,897,838	2,697,241	0	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	117,237	43,145	1,135	0	190.00
190.01	19001	OTHER NONREIMBURSABLE	612,285	126,420	404	0	190.01

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0127

Period:
From 07/01/2020
To 12/31/2020Worksheet B
Part I
Date/Time Prepared:
7/12/2021 12:41 pm

Cost Center Description			Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
				BLDG & FIXT	MVBLE EQUIP			
			0	1.00	2.00	4.00	4A	
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	200.00
201.00		Negative Cost Centers		0	0	-137,433	-137,433	201.00
202.00		TOTAL (sum lines 118 through 201)	87,959,374	4,067,403	2,698,780	-137,433	87,959,374	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0127

Period:
From 07/01/2020
To 12/31/2020Worksheet B
Part I
Date/Time Prepared:
7/12/2021 12:41 pm

Cost Center Description			ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
			5.00	7.00	8.00	9.00	10.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	28,923,226					5.00
7.00	00700	OPERATION OF PLANT	2,314,443	7,049,528				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	184,510	218,091	780,088			8.00
9.00	00900	HOUSEKEEPING	605,357	156,334	77,421	2,077,602		9.00
10.00	01000	DIETARY	498,924	79,608	2,236	1,487	1,602,996	10.00
11.00	01100	CAFETERIA	106,366	131,343	1,070	100,089	0	11.00
13.00	01300	NURSING ADMINISTRATION	1,641,628	177,445	0	0	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	685,635	124,646	0	57,984	0	14.00
15.00	01500	PHARMACY	609,901	107,748	1,035	61,790	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	238,277	122,628	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	145,649	26,544	0	0	0	17.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	507,364	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	276,955	0	0	0	0	22.00
23.00	02300	CLINICAL PASTORAL EDUCATION	147,929	35,524	0	6,780	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	4,617,831	1,409,558	303,658	879,150	1,397,805	30.00
31.00	03100	INTENSIVE CARE UNIT	1,024,472	1,073,338	54,102	35,028	92,313	31.00
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	0	40.00
41.00	04100	SUBPROVIDER - IRF	422,957	246,187	22,165	33,839	112,878	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	0	42.00
43.00	04300	NURSERY	701,143	115,221	3,071	34,493	0	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	2,108,898	656,070	81,093	311,090	0	50.00
51.00	05100	RECOVERY ROOM	180,216	57,633	6,708	33,839	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	87,240	0	0	33,839	0	52.00
53.00	05300	ANESTHESIOLOGY	617,258	11,531	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,180,684	335,131	10,910	67,618	0	54.00
57.00	05700	CT SCAN	411,549	42,044	40,872	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	1,453,284	287,543	202	67,618	0	60.00
64.00	06400	INTRAVENOUS THERAPY	201,473	216,428	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	354,818	107,881	0	6,780	0	65.00
66.00	06600	PHYSICAL THERAPY	506,792	30,801	5,331	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	64,695	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	127,392	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	866,503	233,547	30,686	40,559	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	34,294	21,576	1,028	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	762,415	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1,117,744	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,843,403	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	75,803	0	0	0	0	74.00
76.97	07697	CARDIAC REHABILITATION	116,498	59,983	125	0	0	76.97
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	150,324	0	0	0	0	90.00
90.01	09001	BASIC DIAGNOSTIC TESTING	0	0	0	0	0	90.01
90.03	09002	PSYCH OUTPATIENT	49,789	143,095	0	0	0	90.03
90.04	09003	WOUND CARE CLINIC	284,058	7,939	5,845	35,088	0	90.04
91.00	09100	EMERGENCY	1,158,542	367,728	132,530	270,531	0	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	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)	28,483,013	6,603,145	780,088	2,077,602	1,602,996	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	78,947	113,580	0	0	0	190.00
190.01	19001	OTHER NONREIMBURSABLE	361,266	332,803	0	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
201.00		Negative Cost Centers	0	0	0	0	0	201.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0127

Period:
From 07/01/2020
To 12/31/2020Worksheet 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	
202.00	TOTAL (sum lines 118 through 201)	28,923,226	7,049,528	780,088	2,077,602	1,602,996	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0127

Period:
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Cost Center Description			CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
			11.00	13.00	14.00	15.00	16.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA	556,481					11.00
13.00	01300	NURSING ADMINISTRATION	3,617	5,181,273				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	40,482	0	2,311,477			14.00
15.00	01500	PHARMACY	17,811	0	0	2,046,073		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	2,591	0	0	0	850,983	16.00
17.00	01700	SOCIAL SERVICE	9,131	137,773	0	0	0	17.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0	22.00
23.00	02300	CLINICAL PASTORAL EDUCATION	10,767	162,459	0	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	142,409	2,148,646	0	0	35,815	30.00
31.00	03100	INTENSIVE CARE UNIT	14,986	226,107	0	0	9,591	31.00
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	0	40.00
41.00	04100	SUBPROVIDER - IRF	11,005	0	0	0	4,789	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	0	42.00
43.00	04300	NURSERY	0	0	0	0	9,926	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	58,942	889,319	0	0	119,611	50.00
51.00	05100	RECOVERY ROOM	6,926	104,499	0	0	7,098	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	640	9,664	0	0	13,668	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	30,611	0	0	0	74,485	54.00
57.00	05700	CT SCAN	12,420	0	0	0	82,281	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	41,897	0	0	0	102,007	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	10,294	0	0	0	7,023	65.00
66.00	06600	PHYSICAL THERAPY	22,414	0	0	0	11,933	66.00
67.00	06700	OCCUPATIONAL THERAPY	3,283	0	0	0	2,772	67.00
68.00	06800	SPEECH PATHOLOGY	7,173	0	0	0	778	68.00
69.00	06900	ELECTROCARDIOLOGY	36,726	554,122	0	0	66,661	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	1,102	16,626	0	0	1,634	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	1,975,914	0	32	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	335,563	2,046,073	28	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	105,740	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.97	07697	CARDIAC REHABILITATION	6,328	95,472	0	0	2,044	76.97
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	9,446	142,517	0	0	0	90.00
90.01	09001	BASIC DIAGNOSTIC TESTING	0	0	0	0	0	90.01
90.03	09002	PSYCH OUTPATIENT	2,265	34,174	0	0	0	90.03
90.04	09003	WOUND CARE CLINIC	10,092	152,268	0	0	17,357	90.04
91.00	09100	EMERGENCY	33,645	507,627	0	0	175,710	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	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)	547,003	5,181,273	2,311,477	2,046,073	850,983	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	6,003	0	0	0	0	190.00
190.01	19001	OTHER NONREIMBURSABLE	3,475	0	0	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 - GENERAL SERVICE COSTS

Provider CCN: 14-0127

Period:
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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	
201.00	Negative Cost Centers	0	0	0	0	0	201.00
202.00	TOTAL (sum lines 118 through 201)	556,481	5,181,273	2,311,477	2,046,073	850,983	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

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Cost Center Description			INTERNS & RESIDENTS			CLINICAL PASTORAL EDUCATION	EMS PROGRAM	
			SOCIAL SERVICE	SERVICES-SALAR Y & FRINGES	SERVICES-OTHER PRGM COSTS			
				APPRV	APPRV			
			17.00	21.00	22.00	23.00	23.01	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY						15.00
16.00	01600	MEDICAL RECORDS & LIBRARY						16.00
17.00	01700	SOCIAL SERVICE	617,078					17.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	1,545,373				21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0		843,574			22.00
23.00	02300	CLINICAL PASTORAL EDUCATION	0			666,104		23.00
23.01	02301	EMS PROGRAM	0				0	23.01
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	260,062	1,545,373	843,574	398,834	0	30.00
31.00	03100	INTENSIVE CARE UNIT	117,605	0	0	18,440	0	31.00
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	0	40.00
41.00	04100	SUBPROVIDER - IRF	59,503	0	0	10,567	0	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	0	42.00
43.00	04300	NURSERY	4,900	0	0	0	0	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	0	21,895	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	30,456	0	54.00
57.00	05700	CT SCAN	0	0	0	8,561	0	57.00
58.00	05800	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	8,561	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	2,975	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	21,895	0	90.04
91.00	09100	EMERGENCY	172,033	0	0	134,671	0	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		116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	617,078	1,545,373	843,574	653,880	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	12,224	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

COST ALLOCATION - GENERAL SERVICE COSTS

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Cost Center Description			INTERNS & RESIDENTS				CLINICAL PASTORAL EDUCATION	EMS PROGRAM	
			SOCIAL SERVICE	SERVICES-SALAR	SERVICES-OTHER				
				Y & FRINGES APPRV	PRGM COSTS APPRV				
			17.00	21.00	22.00		23.00	23.01	
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	0	0		0	0	192.00
200.00		Cross Foot Adjustments		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)	617,078	1,545,373	843,574		666,104	0	202.00

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	
GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT				4.00
5.00	00500	ADMINISTRATIVE & GENERAL				5.00
7.00	00700	OPERATION OF PLANT				7.00
8.00	00800	LAUNDRY & LINEN SERVICE				8.00
9.00	00900	HOUSEKEEPING				9.00
10.00	01000	DIETARY				10.00
11.00	01100	CAFETERIA				11.00
13.00	01300	NURSING ADMINISTRATION				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY				14.00
15.00	01500	PHARMACY				15.00
16.00	01600	MEDICAL RECORDS & LIBRARY				16.00
17.00	01700	SOCIAL SERVICE				17.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV				21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV				22.00
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	23,430,251	-2,388,947	21,041,304	30.00
31.00	03100	INTENSIVE CARE UNIT	4,761,934	0	4,761,934	31.00
40.00	04000	SUBPROVIDER - IPF	0	0	0	40.00
41.00	04100	SUBPROVIDER - IRF	1,789,212	0	1,789,212	41.00
42.00	04200	SUBPROVIDER	0	0	0	42.00
43.00	04300	NURSERY	2,303,213	0	2,303,213	43.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	8,561,482	0	8,561,482	50.00
51.00	05100	RECOVERY ROOM	765,621	0	765,621	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	299,561	0	299,561	52.00
53.00	05300	ANESTHESIOLOGY	1,915,600	0	1,915,600	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,145,439	0	4,145,439	54.00
57.00	05700	CT SCAN	1,439,708	0	1,439,708	57.00
58.00	05800	MRI	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	59.00
60.00	06000	LABORATORY	4,925,804	0	4,925,804	60.00
64.00	06400	INTRAVENOUS THERAPY	830,091	0	830,091	64.00
65.00	06500	RESPIRATORY THERAPY	1,212,712	0	1,212,712	65.00
66.00	06600	PHYSICAL THERAPY	1,614,109	0	1,614,109	66.00
67.00	06700	OCCUPATIONAL THERAPY	203,109	0	203,109	67.00
68.00	06800	SPEECH PATHOLOGY	395,972	0	395,972	68.00
69.00	06900	ELECTROCARDIOLOGY	3,610,130	0	3,610,130	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	146,421	0	146,421	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	4,298,175	0	4,298,175	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	5,786,183	0	5,786,183	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	5,720,533	0	5,720,533	73.00
74.00	07400	RENAL DIALYSIS	230,887	0	230,887	74.00
76.97	07697	CARDIAC REHABILITATION	518,791	0	518,791	76.97
OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	612,807	0	612,807	90.00
90.01	09001	BASIC DIAGNOSTIC TESTING	0	0	0	90.01
90.03	09002	PSYCH OUTPATIENT	331,185	0	331,185	90.03
90.04	09003	WOUND CARE CLINIC	1,115,693	0	1,115,693	90.04
91.00	09100	EMERGENCY	5,323,260	0	5,323,260	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)	86,287,883	-2,388,947	83,898,936	118.00
NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	360,047	0	360,047	190.00
190.01	19001	OTHER NONREIMBURSABLE	1,448,877	0	1,448,877	190.01
190.13	19007	EUREKA	0	0	0	190.13
191.00	19100	RESEARCH	0	0	0	191.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0127

Period:
From 07/01/2020
To 12/31/2020Worksheet B
Part I
Date/Time Prepared:
7/12/2021 12:41 pm

Cost Center Description			Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			24.00	25.00	26.00		
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	0	0		192.00
200.00		Cross Foot Adjustments	0	0	0		200.00
201.00		Negative Cost Centers	-137,433	0	-137,433		201.00
202.00		TOTAL (sum lines 118 through 201)	87,959,374	-2,388,947	85,570,427		202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0127

Period:
From 07/01/2020
To 12/31/2020Worksheet B
Part II
Date/Time Prepared:
7/12/2021 12:41 pm

Cost Center Description			CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
			Directly Assigned New Capital Related Costs	BLDG & FIXT	MVBLE EQUIP		
			0	1.00	2.00	2A	4.00
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	0	1,729	1,729	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	17,577	411,262	131,927	560,766	5.00
7.00	00700	OPERATION OF PLANT	1,381	978,267	64,316	1,043,964	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	25,318	82,845	17,033	125,196	8.00
9.00	00900	HOUSEKEEPING	0	59,386	15,442	74,828	9.00
10.00	01000	DIETARY	10,194	30,240	5,746	46,180	10.00
11.00	01100	CAFETERIA	0	49,893	6,783	56,676	11.00
13.00	01300	NURSING ADMINISTRATION	62	67,405	1,386	68,853	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	47,349	16,071	63,420	14.00
15.00	01500	PHARMACY	25	40,930	122,228	163,183	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	90,496	46,582	0	137,078	16.00
17.00	01700	SOCIAL SERVICE	0	10,083	0	10,083	17.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	63,053	0	0	63,053	22.00
23.00	02300	CLINICAL PASTORAL EDUCATION	0	13,494	0	13,494	23.00
23.01	02301	EMS PROGRAM	0	0	0	0	23.01
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	122,898	535,442	193,503	851,843	30.00
31.00	03100	INTENSIVE CARE UNIT	234,628	407,724	188,419	830,771	31.00
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	40.00
41.00	04100	SUBPROVIDER - IRF	30,182	93,518	10,002	133,702	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	42.00
43.00	04300	NURSERY	0	43,769	85,613	129,382	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	215,275	249,219	436,119	900,613	50.00
51.00	05100	RECOVERY ROOM	0	21,893	11,902	33,795	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	4,380	22,418	26,798	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	122,893	127,305	664,711	914,909	54.00
57.00	05700	CT SCAN	20,178	15,971	231,358	267,507	57.00
58.00	05800	MRI	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	59.00
60.00	06000	LABORATORY	56,197	109,228	83,287	248,712	60.00
64.00	06400	INTRAVENOUS THERAPY	0	82,214	28,420	110,634	64.00
65.00	06500	RESPIRATORY THERAPY	8,279	40,980	48,267	97,526	65.00
66.00	06600	PHYSICAL THERAPY	158,718	11,700	10,482	180,900	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	53	88,717	178,106	266,876	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	8,196	4,452	12,648	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	13,699	13,699	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	74.00
76.97	07697	CARDIAC REHABILITATION	0	22,786	5,474	28,260	76.97
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0	0	950	950	90.00
90.01	09001	BASIC DIAGNOSTIC TESTING	0	0	0	0	90.01
90.03	09002	PSYCH OUTPATIENT	0	54,357	205	54,562	90.03
90.04	09003	WOUND CARE CLINIC	0	3,016	540	3,556	90.04
91.00	09100	EMERGENCY	0	139,687	96,653	236,340	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)	1,177,407	3,897,838	2,697,241	7,772,486	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	0	43,145	1,135	44,280	190.00
190.01	19001	OTHER NONREIMBURSABLE	70	126,420	404	126,894	190.01
190.13	19007	EUREKA	0	0	0	0	190.13

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0127

Period:
From 07/01/2020
To 12/31/2020Worksheet B
Part II
Date/Time Prepared:
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Cost Center Description			Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
				BLDG & FIXT	MVBLE EQUIP			
			0	1.00	2.00	2A	4.00	
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		200.00
201.00		Negative Cost Centers		0	0	0	1,729	201.00
202.00		TOTAL (sum lines 118 through 201)	1,177,477	4,067,403	2,698,780	7,943,660	1,729	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0127

Period:
From 07/01/2020
To 12/31/2020Worksheet B
Part II
Date/Time Prepared:
7/12/2021 12:41 pm

Cost Center Description			ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
			5.00	7.00	8.00	9.00	10.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	560,766					5.00
7.00	00700	OPERATION OF PLANT	44,874	1,088,838				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	3,577	33,685	162,458			8.00
9.00	00900	HOUSEKEEPING	11,737	24,147	16,123	126,835		9.00
10.00	01000	DIETARY	9,674	12,296	466	91	68,707	10.00
11.00	01100	CAFETERIA	2,062	20,287	223	6,110	0	11.00
13.00	01300	NURSING ADMINISTRATION	31,829	27,407	0	0	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	13,294	19,252	0	3,540	0	14.00
15.00	01500	PHARMACY	11,825	16,642	216	3,772	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	4,620	18,941	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	2,824	4,100	0	0	0	17.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	9,837	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	5,370	0	0	0	0	22.00
23.00	02300	CLINICAL PASTORAL EDUCATION	2,868	5,487	0	414	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	89,514	217,710	63,238	53,670	59,912	30.00
31.00	03100	INTENSIVE CARE UNIT	19,863	165,783	11,267	2,138	3,957	31.00
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	0	40.00
41.00	04100	SUBPROVIDER - IRF	8,201	38,025	4,616	2,066	4,838	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	0	42.00
43.00	04300	NURSERY	13,594	17,797	640	2,106	0	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	40,889	101,334	16,888	18,992	0	50.00
51.00	05100	RECOVERY ROOM	3,494	8,902	1,397	2,066	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,691	0	0	2,066	0	52.00
53.00	05300	ANESTHESIOLOGY	11,968	1,781	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	22,892	51,763	2,272	4,128	0	54.00
57.00	05700	CT SCAN	7,979	6,494	8,512	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	28,178	44,413	42	4,128	0	60.00
64.00	06400	INTRAVENOUS THERAPY	3,906	33,429	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	6,880	16,663	0	414	0	65.00
66.00	06600	PHYSICAL THERAPY	9,826	4,757	1,110	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	1,254	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	2,470	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	16,800	36,073	6,391	2,476	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	665	3,333	214	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	14,782	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	21,672	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	35,741	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	1,470	0	0	0	0	74.00
76.97	07697	CARDIAC REHABILITATION	2,259	9,265	26	0	0	76.97
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	2,915	0	0	0	0	90.00
90.01	09001	BASIC DIAGNOSTIC TESTING	0	0	0	0	0	90.01
90.03	09002	PSYCH OUTPATIENT	965	22,102	0	0	0	90.03
90.04	09003	WOUND CARE CLINIC	5,508	1,226	1,217	2,142	0	90.04
91.00	09100	EMERGENCY	22,463	56,798	27,600	16,516	0	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	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)	552,230	1,019,892	162,458	126,835	68,707	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	1,531	17,543	0	0	0	190.00
190.01	19001	OTHER NONREIMBURSABLE	7,005	51,403	0	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
201.00		Negative Cost Centers	0	0	0	0	0	201.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0127

Period:
From 07/01/2020
To 12/31/2020Worksheet B
Part II
Date/Time Prepared:
7/12/2021 12:41 pm

Cost Center Description		ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
		5.00	7.00	8.00	9.00	10.00	
202.00	TOTAL (sum lines 118 through 201)	560,766	1,088,838	162,458	126,835	68,707	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0127

Period:
From 07/01/2020
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Part II
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Cost Center Description			CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
			11.00	13.00	14.00	15.00	16.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA	85,358					11.00
13.00	01300	NURSING ADMINISTRATION	555	128,644				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	6,209	0	105,715			14.00
15.00	01500	PHARMACY	2,732	0	0	198,370		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	397	0	0	0	161,036	16.00
17.00	01700	SOCIAL SERVICE	1,401	3,421	0	0	0	17.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0	22.00
23.00	02300	CLINICAL PASTORAL EDUCATION	1,652	4,034	0	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	21,846	53,347	0	0	6,778	30.00
31.00	03100	INTENSIVE CARE UNIT	2,299	5,614	0	0	1,815	31.00
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	0	40.00
41.00	04100	SUBPROVIDER - IRF	1,688	0	0	0	906	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	0	42.00
43.00	04300	NURSERY	0	0	0	0	1,878	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	9,041	22,081	0	0	22,635	50.00
51.00	05100	RECOVERY ROOM	1,062	2,595	0	0	1,343	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	98	240	0	0	2,586	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,695	0	0	0	14,095	54.00
57.00	05700	CT SCAN	1,905	0	0	0	15,571	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	6,426	0	0	0	19,303	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	1,579	0	0	0	1,329	65.00
66.00	06600	PHYSICAL THERAPY	3,438	0	0	0	2,258	66.00
67.00	06700	OCCUPATIONAL THERAPY	503	0	0	0	525	67.00
68.00	06800	SPEECH PATHOLOGY	1,100	0	0	0	147	68.00
69.00	06900	ELECTROCARDIOLOGY	5,633	13,758	0	0	12,615	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	169	413	0	0	309	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	90,369	0	6	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	15,346	198,370	5	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	20,010	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.97	07697	CARDIAC REHABILITATION	971	2,370	0	0	387	76.97
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	1,449	3,538	0	0	0	90.00
90.01	09001	BASIC DIAGNOSTIC TESTING	0	0	0	0	0	90.01
90.03	09002	PSYCH OUTPATIENT	347	848	0	0	0	90.03
90.04	09003	WOUND CARE CLINIC	1,548	3,781	0	0	3,285	90.04
91.00	09100	EMERGENCY	5,161	12,604	0	0	33,250	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)	83,904	128,644	105,715	198,370	161,036	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	921	0	0	0	0	190.00
190.01	19001	OTHER NONREIMBURSABLE	533	0	0	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

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0127

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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	
201.00	Negative Cost Centers	0	0	0	0	0	201.00
202.00	TOTAL (sum lines 118 through 201)	85,358	128,644	105,715	198,370	161,036	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0127

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Cost Center Description			INTERNS & RESIDENTS			CLINICAL PASTORAL EDUCATION	EMS PROGRAM	
			SOCIAL SERVICE	SERVICES-SALAR	SERVICES-OTHER			
				Y & FRINGES APPRV	PRGM COSTS APPRV			
			17.00	21.00	22.00	23.00	23.01	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY						15.00
16.00	01600	MEDICAL RECORDS & LIBRARY						16.00
17.00	01700	SOCIAL SERVICE	21,829					17.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	9,837				21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0		68,423			22.00
23.00	02300	CLINICAL PASTORAL EDUCATION	0			27,949		23.00
23.01	02301	EMS PROGRAM	0				0	23.01
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	9,200					30.00
31.00	03100	INTENSIVE CARE UNIT	4,160					31.00
40.00	04000	SUBPROVIDER - IPF	0					40.00
41.00	04100	SUBPROVIDER - IRF	2,105					41.00
42.00	04200	SUBPROVIDER	0					42.00
43.00	04300	NURSERY	173					43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0					50.00
51.00	05100	RECOVERY ROOM	0					51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0					52.00
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	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 PATIENT	0					71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0					72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0					73.00
74.00	07400	RENAL DIALYSIS	0					74.00
76.97	07697	CARDIAC REHABILITATION	0					76.97
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	105					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	6,086					91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						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						113.00
116.00	11600	HOSPICE	0					116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	21,829	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

ALLOCATION OF CAPITAL RELATED COSTS

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Cost Center Description			INTERNS & RESIDENTS				CLINICAL PASTORAL EDUCATION	EMS PROGRAM	
			SOCIAL SERVICE	SERVICES-SALAR	SERVICES-OTHER				
				Y & FRINGES APPRV	PRGM COSTS APPRV				
			17.00	21.00	22.00		23.00	23.01	
192.00	19200	PHYSICIANS PRIVATE OFFICES	0						192.00
200.00		Cross Foot Adjustments		9,837	68,423		27,949		0 200.00
201.00		Negative Cost Centers	0	0	0		0		0 201.00
202.00		TOTAL (sum lines 118 through 201)	21,829	9,837	68,423		27,949		0 202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0127

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Cost Center Description			Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			24.00	25.00	26.00	
GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT				4.00
5.00	00500	ADMINISTRATIVE & GENERAL				5.00
7.00	00700	OPERATION OF PLANT				7.00
8.00	00800	LAUNDRY & LINEN SERVICE				8.00
9.00	00900	HOUSEKEEPING				9.00
10.00	01000	DIETARY				10.00
11.00	01100	CAFETERIA				11.00
13.00	01300	NURSING ADMINISTRATION				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY				14.00
15.00	01500	PHARMACY				15.00
16.00	01600	MEDICAL RECORDS & LIBRARY				16.00
17.00	01700	SOCIAL SERVICE				17.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV				21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV				22.00
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	1,427,058	0	1,427,058	30.00
31.00	03100	INTENSIVE CARE UNIT	1,047,667	0	1,047,667	31.00
40.00	04000	SUBPROVIDER - IPF	0	0	0	40.00
41.00	04100	SUBPROVIDER - IRF	196,147	0	196,147	41.00
42.00	04200	SUBPROVIDER	0	0	0	42.00
43.00	04300	NURSERY	165,570	0	165,570	43.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,132,473	0	1,132,473	50.00
51.00	05100	RECOVERY ROOM	54,654	0	54,654	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	3,757	0	3,757	52.00
53.00	05300	ANESTHESIOLOGY	43,471	0	43,471	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,014,754	0	1,014,754	54.00
57.00	05700	CT SCAN	307,968	0	307,968	57.00
58.00	05800	MRI	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	59.00
60.00	06000	LABORATORY	351,202	0	351,202	60.00
64.00	06400	INTRAVENOUS THERAPY	147,969	0	147,969	64.00
65.00	06500	RESPIRATORY THERAPY	124,391	0	124,391	65.00
66.00	06600	PHYSICAL THERAPY	202,289	0	202,289	66.00
67.00	06700	OCCUPATIONAL THERAPY	2,282	0	2,282	67.00
68.00	06800	SPEECH PATHOLOGY	3,717	0	3,717	68.00
69.00	06900	ELECTROCARDIOLOGY	360,622	0	360,622	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	17,751	0	17,751	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	105,157	0	105,157	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	249,092	0	249,092	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	55,751	0	55,751	73.00
74.00	07400	RENAL DIALYSIS	1,470	0	1,470	74.00
76.97	07697	CARDIAC REHABILITATION	43,538	0	43,538	76.97
OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	8,957	0	8,957	90.00
90.01	09001	BASIC DIAGNOSTIC TESTING	0	0	0	90.01
90.03	09002	PSYCH OUTPATIENT	78,824	0	78,824	90.03
90.04	09003	WOUND CARE CLINIC	22,263	0	22,263	90.04
91.00	09100	EMERGENCY	416,818	0	416,818	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART		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				113.00
116.00	11600	HOSPICE	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	7,585,612	0	7,585,612	118.00
NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	64,275	0	64,275	190.00
190.01	19001	OTHER NONREIMBURSABLE	185,835	0	185,835	190.01
190.13	19007	EUREKA	0	0	0	190.13
191.00	19100	RESEARCH	0	0	0	191.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0127

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Cost Center Description			Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			24.00	25.00	26.00		
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	0	0		192.00
200.00		Cross Foot Adjustments	106,209	0	106,209		200.00
201.00		Negative Cost Centers	1,729	0	1,729		201.00
202.00		TOTAL (sum lines 118 through 201)	7,943,660	0	7,943,660		202.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0127

Period:
From 07/01/2020
To 12/31/2020

Worksheet B-1

Date/Time Prepared:
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Cost Center Description			CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARY)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
			BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (DOLLAR VALUE)				
			1.00	2.00	4.00	5A	5.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT	482,862					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		4,065,291				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	2,604	61,582,338			4.00
5.00	00500	ADMINISTRATIVE & GENERAL	48,823	198,727	7,776,131	-28,923,226	59,173,581	5.00
7.00	00700	OPERATION OF PLANT	116,135	96,882	1,618,981	0	4,735,085	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	9,835	25,657	405,547	0	377,487	8.00
9.00	00900	HOUSEKEEPING	7,050	23,261	1,368,710	0	1,238,490	9.00
10.00	01000	DIETARY	3,590	8,656	559,388	0	1,020,741	10.00
11.00	01100	CAFETERIA	5,923	10,217	660,092	0	217,613	11.00
13.00	01300	NURSING ADMINISTRATION	8,002	2,088	1,968,483	0	3,358,583	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	5,621	24,209	352,974	0	1,402,730	14.00
15.00	01500	PHARMACY	4,859	184,117	2,378,818	0	1,247,788	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	5,530	0	1,286,486	0	487,487	16.00
17.00	01700	SOCIAL SERVICE	1,197	0	1,376,519	0	297,981	17.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	1,645,253	0	1,038,009	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	566,619	22.00
23.00	02300	CLINICAL PASTORAL EDUCATION	1,602	0	231,075	0	302,645	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	291,482	6,820,974	0	9,447,536	30.00
31.00	03100	INTENSIVE CARE UNIT	48,403	283,824	6,994,117	0	2,095,952	31.00
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	0	40.00
41.00	04100	SUBPROVIDER - IRF	11,102	15,067	922,305	0	865,322	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	0	42.00
43.00	04300	NURSERY	5,196	128,962	2,300,375	0	1,434,459	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	29,586	656,945	4,579,600	0	4,314,564	50.00
51.00	05100	RECOVERY ROOM	2,599	17,928	569,937	0	368,702	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	178,482	52.00
53.00	05300	ANESTHESIOLOGY	520	33,769	29,146	0	1,262,839	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	15,113	1,001,287	2,138,192	0	2,415,544	54.00
57.00	05700	CT SCAN	1,896	348,504	518,861	0	841,981	57.00
58.00	05800	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	125,459	2,270,646	0	2,973,253	60.00
64.00	06400	INTRAVENOUS THERAPY	9,760	42,810	1,588,517	0	412,190	64.00
65.00	06500	RESPIRATORY THERAPY	4,865	72,707	892,853	0	725,916	65.00
66.00	06600	PHYSICAL THERAPY	1,389	15,790	1,566,165	0	1,036,838	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	426,516	0	132,359	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	226,795	0	260,629	68.00
69.00	06900	ELECTROCARDIOLOGY	10,532	268,289	2,318,453	0	1,772,765	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	973	6,706	66,693	0	70,161	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	1,559,814	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	20,635	0	0	2,286,775	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	3,771,390	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	155,084	74.00
76.97	07697	CARDIAC REHABILITATION	2,705	8,246	338,233	0	238,341	76.97
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	1,431	455,265	0	307,545	90.00
90.01	09001	BASIC DIAGNOSTIC TESTING	0	0	0	0	0	90.01
90.03	09002	PSYCH OUTPATIENT	6,453	309	314,806	0	101,862	90.03
90.04	09003	WOUND CARE CLINIC	358	814	542,667	0	581,151	90.04
91.00	09100	EMERGENCY	16,583	145,592	3,102,117	0	2,370,243	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	4,062,974	60,611,690	-28,923,226	58,272,955	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	5,122	1,709	492,277	0	161,517	190.00
190.01	19001	OTHER NONREIMBURSABLE	15,008	608	478,371	0	739,109	190.01

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0127

Period:
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To 12/31/2020

Worksheet B-1

Date/Time Prepared:
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Cost Center Description			CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALA RIE)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
			BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (DOLLAR VALUE)				
			1.00	2.00	4.00	5A	5.00	
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						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	4,067,403	2,698,780	-137,433		28,923,226	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	8.423531	0.663859	0.000000		0.488786	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)			1,729		560,766	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)			0.000028		0.009477	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 07/01/2020
To 12/31/2020

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Date/Time Prepared:
7/12/2021 12:41 pm

Cost Center Description			OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (HOURS OF SERVICE)	DIETARY (MEALS SERVED)	CAFETERIA (FTES)	
			7.00	8.00	9.00	10.00	11.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT	317,904					7.00
8.00	00800	LAUNDRY & LINEN SERVICE	9,835	699,982				8.00
9.00	00900	HOUSEKEEPING	7,050	69,471	34,935			9.00
10.00	01000	DIETARY	3,590	2,006	25	44,975		10.00
11.00	01100	CAFETERIA	5,923	960	1,683	0	382,289	11.00
13.00	01300	NURSING ADMINISTRATION	8,002	0	0	0	2,485	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	5,621	0	975	0	27,810	14.00
15.00	01500	PHARMACY	4,859	929	1,039	0	12,236	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	5,530	0	0	0	1,780	16.00
17.00	01700	SOCIAL SERVICE	1,197	0	0	0	6,273	17.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0	22.00
23.00	02300	CLINICAL PASTORAL EDUCATION	1,602	0	114	0	7,397	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	272,475	14,783	39,218	97,831	30.00
31.00	03100	INTENSIVE CARE UNIT	48,403	48,546	589	2,590	10,295	31.00
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	0	40.00
41.00	04100	SUBPROVIDER - IRF	11,102	19,889	569	3,167	7,560	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	0	42.00
43.00	04300	NURSERY	5,196	2,756	580	0	0	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	29,586	72,766	5,231	0	40,492	50.00
51.00	05100	RECOVERY ROOM	2,599	6,019	569	0	4,758	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	569	0	0	52.00
53.00	05300	ANESTHESIOLOGY	520	0	0	0	440	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	15,113	9,790	1,137	0	21,029	54.00
57.00	05700	CT SCAN	1,896	36,675	0	0	8,532	57.00
58.00	05800	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	181	1,137	0	28,782	60.00
64.00	06400	INTRAVENOUS THERAPY	9,760	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	4,865	0	114	0	7,072	65.00
66.00	06600	PHYSICAL THERAPY	1,389	4,784	0	0	15,398	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	2,255	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	4,928	68.00
69.00	06900	ELECTROCARDIOLOGY	10,532	27,535	682	0	25,230	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	973	922	0	0	757	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.97	07697	CARDIAC REHABILITATION	2,705	112	0	0	4,347	76.97
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0	0	6,489	90.00
90.01	09001	BASIC DIAGNOSTIC TESTING	0	0	0	0	0	90.01
90.03	09002	PSYCH OUTPATIENT	6,453	0	0	0	1,556	90.03
90.04	09003	WOUND CARE CLINIC	358	5,245	590	0	6,933	90.04
91.00	09100	EMERGENCY	16,583	118,921	4,549	0	23,113	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)	297,774	699,982	34,935	44,975	375,778	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	5,122	0	0	0	4,124	190.00
190.01	19001	OTHER NONREIMBURSABLE	15,008	0	0	0	2,387	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

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0127

Period:
From 07/01/2020
To 12/31/2020

Worksheet B-1

Date/Time Prepared:
7/12/2021 12:41 pm

Cost Center Description		OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (HOURS OF SERVICE)	DIETARY (MEALS SERVED)	CAFETERIA (FTES)	
		7.00	8.00	9.00	10.00	11.00	
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)	7,049,528	780,088	2,077,602	1,602,996	556,481	202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	22.175021	1.114440	59.470502	35.641934	1.455655	203.00
204.00	Cost to be allocated (per Wkst. B, Part II)	1,088,838	162,458	126,835	68,707	85,358	204.00
205.00	Unit cost multiplier (Wkst. B, Part II)	3.425053	0.232089	3.630600	1.527671	0.223281	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 07/01/2020
To 12/31/2020

Worksheet B-1

Date/Time Prepared:
7/12/2021 12:41 pm

Cost Center Description			NURSING ADMINISTRATION (NURSING FT ES)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQ UISI)	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	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION	235,911					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	14,848,775				14.00
15.00	01500	PHARMACY	0	0	3,576,528			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	3,774,892		16.00
17.00	01700	SOCIAL SERVICE	6,273	0	0	0	3,526	17.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0	22.00
23.00	02300	CLINICAL PASTORAL EDUCATION	7,397	0	0	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	97,831	0	0	158,874	1,486	30.00
31.00	03100	INTENSIVE CARE UNIT	10,295	0	0	42,547	672	31.00
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	0	40.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	21,243	340	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	0	42.00
43.00	04300	NURSERY	0	0	0	44,031	28	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	40,492	0	0	530,586	0	50.00
51.00	05100	RECOVERY ROOM	4,758	0	0	31,486	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	440	0	0	60,629	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	330,409	0	54.00
57.00	05700	CT SCAN	0	0	0	364,993	0	57.00
58.00	05800	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	452,494	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	31,152	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	52,935	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	12,297	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	3,451	0	68.00
69.00	06900	ELECTROCARDIOLOGY	25,230	0	0	295,704	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	757	0	0	7,247	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	12,693,145	0	143	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	2,155,630	3,576,528	126	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	469,056	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.97	07697	CARDIAC REHABILITATION	4,347	0	0	9,069	0	76.97
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	6,489	0	0	0	17	90.00
90.01	09001	BASIC DIAGNOSTIC TESTING	0	0	0	0	0	90.01
90.03	09002	PSYCH OUTPATIENT	1,556	0	0	0	0	90.03
90.04	09003	WOUND CARE CLINIC	6,933	0	0	76,996	0	90.04
91.00	09100	EMERGENCY	23,113	0	0	779,424	983	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)	235,911	14,848,775	3,576,528	3,774,892	3,526	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	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

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0127

Period:
From 07/01/2020
To 12/31/2020

Worksheet B-1

Date/Time Prepared:
7/12/2021 12:41 pm

Cost Center Description			NURSING ADMINISTRATION (NURSING FT ES)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQ UI SI)	MEDICAL RECORDS & LIBRARY (TIME SPENT)	SOCIAL SERVICE (TIME SPENT)	
			13.00	14.00	15.00	16.00	17.00	
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)	5,181,273	2,311,477	2,046,073	850,983	617,078	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	21.962829	0.155668	0.572084	0.225432	175.007941	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	128,644	105,715	198,370	161,036	21,829	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.545307	0.007119	0.055464	0.042660	6.190868	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 07/01/2020
To 12/31/2020

Worksheet B-1

Date/Time Prepared:
7/12/2021 12:41 pm

Cost Center Description			INTERNS & RESIDENTS		CLINICAL PASTORAL EDUCATION (ASSIGNED TIME)	EMS PROGRAM (ASSIGNED TIME)		
			SERVICES-SALARY & FRINGES APPRV (ASSIGNED TIME)	SERVICES-OTHER PRGM COSTS APPRV (ASSIGNED TIME)				
			21.00	22.00	23.00	23.01		
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY						15.00
16.00	01600	MEDICAL RECORDS & LIBRARY						16.00
17.00	01700	SOCIAL SERVICE						17.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	100					21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV		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
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0		52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	3,675	0		54.00
57.00	05700	CT SCAN	0	0	1,033	0		57.00
58.00	05800	MRI	0	0	0	0		58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0		59.00
60.00	06000	LABORATORY	0	0	0	0		60.00
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 PATIENT	0	0	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0		73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0		74.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0		76.97
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	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						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

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0127

Period:
From 07/01/2020
To 12/31/2020

Worksheet B-1

Date/Time Prepared:
7/12/2021 12:41 pm

Cost Center Description			INTERNS & RESIDENTS		CLINICAL PASTORAL EDUCATION (ASSIGNED TIME)	EMS PROGRAM (ASSIGNED TIME)		
			SERVICES-SALAR Y & FRINGES APPRV (ASSIGNED TIME)	SERVICES-OTHER PRGM COSTS APPRV (ASSIGNED TIME)				
			21.00	22.00	23.00	23.01		
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
202.00		Cost to be allocated (per Wkst. B, Part I)	1,545,373	843,574	666,104	0		202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	15,453.730000	8,435.740000	8.287453	0.000000		203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	9,837	68,423	27,949	0		204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	98.370000	684.230000	0.347733	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 07/01/2020
To 12/31/2020Worksheet C
Part I
Date/Time Prepared:
7/12/2021 12:41 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	21,041,304		21,041,304	0
31.00	03100	INTENSIVE CARE UNIT	4,761,934		4,761,934	0
40.00	04000	SUBPROVIDER - IPF	0		0	0
41.00	04100	SUBPROVIDER - IRF	1,789,212		1,789,212	0
42.00	04200	SUBPROVIDER	0		0	0
43.00	04300	NURSERY	2,303,213		2,303,213	0
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	8,561,482		8,561,482	0
51.00	05100	RECOVERY ROOM	765,621		765,621	0
52.00	05200	DELIVERY ROOM & LABOR ROOM	299,561		299,561	0
53.00	05300	ANESTHESIOLOGY	1,915,600		1,915,600	0
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,145,439		4,145,439	0
57.00	05700	CT SCAN	1,439,708		1,439,708	0
58.00	05800	MRI	0		0	0
59.00	05900	CARDIAC CATHETERIZATION	0		0	0
60.00	06000	LABORATORY	4,925,804		4,925,804	0
64.00	06400	INTRAVENOUS THERAPY	830,091		830,091	0
65.00	06500	RESPIRATORY THERAPY	1,212,712	0	1,212,712	0
66.00	06600	PHYSICAL THERAPY	1,614,109	0	1,614,109	0
67.00	06700	OCCUPATIONAL THERAPY	203,109	0	203,109	0
68.00	06800	SPEECH PATHOLOGY	395,972	0	395,972	0
69.00	06900	ELECTROCARDIOLOGY	3,610,130		3,610,130	0
70.00	07000	ELECTROENCEPHALOGRAPHY	146,421		146,421	0
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	4,298,175		4,298,175	0
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	5,786,183		5,786,183	0
73.00	07300	DRUGS CHARGED TO PATIENTS	5,720,533		5,720,533	0
74.00	07400	RENAL DIALYSIS	230,887		230,887	0
76.97	07697	CARDIAC REHABILITATION	518,791		518,791	0
OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	612,807		612,807	0
90.01	09001	BASIC DIAGNOSTIC TESTING	0		0	0
90.03	09002	PSYCH OUTPATIENT	331,185		331,185	0
90.04	09003	WOUND CARE CLINIC	1,115,693		1,115,693	0
91.00	09100	EMERGENCY	5,323,260		5,323,260	0
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	5,559,786		5,559,786	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)	89,458,722	0	89,458,722	0
201.00		Less Observation Beds	5,559,786		5,559,786	0
202.00		Total (see instructions)	83,898,936	0	83,898,936	0

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0127

Period:
From 07/01/2020
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			Title XVIII		Hospital	PPS	
Cost Center Description			Charges			Cost or Other Ratio	TEFRA Inpatient Ratio
			Inpatient	Outpatient	Total (col. 6 + col. 7)		
			6.00	7.00	8.00		
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	12,497,992		12,497,992		30.00
31.00	03100	INTENSIVE CARE UNIT	12,424,430		12,424,430		31.00
40.00	04000	SUBPROVIDER - IPF	0		0		40.00
41.00	04100	SUBPROVIDER - IRF	1,779,860		1,779,860		41.00
42.00	04200	SUBPROVIDER	0		0		42.00
43.00	04300	NURSERY	4,731,000		4,731,000		43.00
	ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	10,395,368	10,026,703	20,422,071	0.419227	0.000000
51.00	05100	RECOVERY ROOM	753,520	843,677	1,597,197	0.479353	0.000000
52.00	05200	DELIVERY ROOM & LABOR ROOM	643,125	3,775	646,900	0.463072	0.000000
53.00	05300	ANESTHESIOLOGY	1,816,239	1,681,529	3,497,768	0.547664	0.000000
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,102,021	12,886,448	16,988,469	0.244015	0.000000
57.00	05700	CT SCAN	6,373,556	16,647,127	23,020,683	0.062540	0.000000
58.00	05800	MRI	0	0	0	0.000000	0.000000
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0.000000	0.000000
60.00	06000	LABORATORY	11,657,793	17,267,542	28,925,335	0.170294	0.000000
64.00	06400	INTRAVENOUS THERAPY	1,829,783	4,481,501	6,311,284	0.131525	0.000000
65.00	06500	RESPIRATORY THERAPY	1,938,514	155,035	2,093,549	0.579261	0.000000
66.00	06600	PHYSICAL THERAPY	1,849,716	1,850,587	3,700,303	0.436210	0.000000
67.00	06700	OCCUPATIONAL THERAPY	1,319,935	293,498	1,613,433	0.125886	0.000000
68.00	06800	SPEECH PATHOLOGY	433,680	76,109	509,789	0.776737	0.000000
69.00	06900	ELECTROCARDIOLOGY	5,323,297	9,784,222	15,107,519	0.238962	0.000000
70.00	07000	ELECTROENCEPHALOGRAPHY	88,978	165,860	254,838	0.574565	0.000000
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	5,871,598	4,584,765	10,456,363	0.411058	0.000000
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	11,709,998	7,103,126	18,813,124	0.307561	0.000000
73.00	07300	DRUGS CHARGED TO PATIENTS	27,395,518	13,405,731	40,801,249	0.140205	0.000000
74.00	07400	RENAL DIALYSIS	334,810	63,875	398,685	0.579121	0.000000
76.97	07697	CARDIAC REHABILITATION	15,145	271,015	286,160	1.812940	0.000000
	OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	146,575	569,959	716,534	0.855238	0.000000
90.01	09001	BASIC DIAGNOSTIC TESTING	0	0	0	0.000000	0.000000
90.03	09002	PSYCH OUTPATIENT	99,750	111,950	211,700	1.564407	0.000000
90.04	09003	WOUND CARE CLINIC	650	3,036,312	3,036,962	0.367371	0.000000
91.00	09100	EMERGENCY	2,875,414	10,542,953	13,418,367	0.396714	0.000000
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1,092,554	3,824,450	4,917,004	1.130726	0.000000
93.00	04040	OTHER OUTPATIENT SERVICES	0	0	0	0.000000	0.000000
	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)	129,500,819	119,677,749	249,178,568		200.00
201.00		Less Observation Beds					201.00
202.00		Total (see instructions)	129,500,819	119,677,749	249,178,568		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0127

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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	0.419227			50.00
51.00	05100	RECOVERY ROOM	0.479353			51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.463072			52.00
53.00	05300	ANESTHESIOLOGY	0.547664			53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.244015			54.00
57.00	05700	CT SCAN	0.062540			57.00
58.00	05800	MRI	0.000000			58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000			59.00
60.00	06000	LABORATORY	0.170294			60.00
64.00	06400	INTRAVENOUS THERAPY	0.131525			64.00
65.00	06500	RESPIRATORY THERAPY	0.579261			65.00
66.00	06600	PHYSICAL THERAPY	0.436210			66.00
67.00	06700	OCCUPATIONAL THERAPY	0.125886			67.00
68.00	06800	SPEECH PATHOLOGY	0.776737			68.00
69.00	06900	ELECTROCARDIOLOGY	0.238962			69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.574565			70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.411058			71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.307561			72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.140205			73.00
74.00	07400	RENAL DIALYSIS	0.579121			74.00
76.97	07697	CARDIAC REHABILITATION	1.812940			76.97
OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.855238			90.00
90.01	09001	BASIC DIAGNOSTIC TESTING	0.000000			90.01
90.03	09002	PSYCH OUTPATIENT	1.564407			90.03
90.04	09003	WOUND CARE CLINIC	0.367371			90.04
91.00	09100	EMERGENCY	0.396714			91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1.130726			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 07/01/2020
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			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	21,041,304		21,041,304	0
31.00	03100	INTENSIVE CARE UNIT	4,761,934		4,761,934	0
40.00	04000	SUBPROVIDER - IPF	0		0	0
41.00	04100	SUBPROVIDER - IRF	1,789,212		1,789,212	0
42.00	04200	SUBPROVIDER	0		0	0
43.00	04300	NURSERY	2,303,213		2,303,213	0
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	8,561,482		8,561,482	0
51.00	05100	RECOVERY ROOM	765,621		765,621	0
52.00	05200	DELIVERY ROOM & LABOR ROOM	299,561		299,561	0
53.00	05300	ANESTHESIOLOGY	1,915,600		1,915,600	0
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,145,439		4,145,439	0
57.00	05700	CT SCAN	1,439,708		1,439,708	0
58.00	05800	MRI	0		0	0
59.00	05900	CARDIAC CATHETERIZATION	0		0	0
60.00	06000	LABORATORY	4,925,804		4,925,804	0
64.00	06400	INTRAVENOUS THERAPY	830,091		830,091	0
65.00	06500	RESPIRATORY THERAPY	1,212,712	0	1,212,712	0
66.00	06600	PHYSICAL THERAPY	1,614,109	0	1,614,109	0
67.00	06700	OCCUPATIONAL THERAPY	203,109	0	203,109	0
68.00	06800	SPEECH PATHOLOGY	395,972	0	395,972	0
69.00	06900	ELECTROCARDIOLOGY	3,610,130		3,610,130	0
70.00	07000	ELECTROENCEPHALOGRAPHY	146,421		146,421	0
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	4,298,175		4,298,175	0
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	5,786,183		5,786,183	0
73.00	07300	DRUGS CHARGED TO PATIENTS	5,720,533		5,720,533	0
74.00	07400	RENAL DIALYSIS	230,887		230,887	0
76.97	07697	CARDIAC REHABILITATION	518,791		518,791	0
OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	612,807		612,807	0
90.01	09001	BASIC DIAGNOSTIC TESTING	0		0	0
90.03	09002	PSYCH OUTPATIENT	331,185		331,185	0
90.04	09003	WOUND CARE CLINIC	1,115,693		1,115,693	0
91.00	09100	EMERGENCY	5,323,260		5,323,260	0
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	5,559,786		5,559,786	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)	89,458,722	0	89,458,722	0
201.00		Less Observation Beds	5,559,786		5,559,786	0
202.00		Total (see instructions)	83,898,936	0	83,898,936	0

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0127

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7/12/2021 12:41 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	12,497,992		12,497,992			30.00
31.00	03100	INTENSIVE CARE UNIT	12,424,430		12,424,430			31.00
40.00	04000	SUBPROVIDER - IPF	0		0			40.00
41.00	04100	SUBPROVIDER - IRF	1,779,860		1,779,860			41.00
42.00	04200	SUBPROVIDER	0		0			42.00
43.00	04300	NURSERY	4,731,000		4,731,000			43.00
	ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	10,395,368	10,026,703	20,422,071	0.419227	0.000000	50.00
51.00	05100	RECOVERY ROOM	753,520	843,677	1,597,197	0.479353	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	643,125	3,775	646,900	0.463072	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	1,816,239	1,681,529	3,497,768	0.547664	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,102,021	12,886,448	16,988,469	0.244015	0.000000	54.00
57.00	05700	CT SCAN	6,373,556	16,647,127	23,020,683	0.062540	0.000000	57.00
58.00	05800	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	11,657,793	17,267,542	28,925,335	0.170294	0.000000	60.00
64.00	06400	INTRAVENOUS THERAPY	1,829,783	4,481,501	6,311,284	0.131525	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	1,938,514	155,035	2,093,549	0.579261	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	1,849,716	1,850,587	3,700,303	0.436210	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	1,319,935	293,498	1,613,433	0.125886	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	433,680	76,109	509,789	0.776737	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	5,323,297	9,784,222	15,107,519	0.238962	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	88,978	165,860	254,838	0.574565	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	5,871,598	4,584,765	10,456,363	0.411058	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	11,709,998	7,103,126	18,813,124	0.307561	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	27,395,518	13,405,731	40,801,249	0.140205	0.000000	73.00
74.00	07400	RENAL DIALYSIS	334,810	63,875	398,685	0.579121	0.000000	74.00
76.97	07697	CARDIAC REHABILITATION	15,145	271,015	286,160	1.812940	0.000000	76.97
	OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	146,575	569,959	716,534	0.855238	0.000000	90.00
90.01	09001	BASIC DIAGNOSTIC TESTING	0	0	0	0.000000	0.000000	90.01
90.03	09002	PSYCH OUTPATIENT	99,750	111,950	211,700	1.564407	0.000000	90.03
90.04	09003	WOUND CARE CLINIC	650	3,036,312	3,036,962	0.367371	0.000000	90.04
91.00	09100	EMERGENCY	2,875,414	10,542,953	13,418,367	0.396714	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1,092,554	3,824,450	4,917,004	1.130726	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)	129,500,819	119,677,749	249,178,568			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	129,500,819	119,677,749	249,178,568			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0127

Period:
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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
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000			52.00
53.00	05300	ANESTHESIOLOGY	0.000000			53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000			54.00
57.00	05700	CT SCAN	0.000000			57.00
58.00	05800	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 PATIENT	0.000000			71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000			72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000			73.00
74.00	07400	RENAL DIALYSIS	0.000000			74.00
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 07/01/2020
To 12/31/2020Worksheet D
Part I
Date/Time Prepared:
7/12/2021 12:41 pm

			Title XVIII		Hospital	PPS	
Cost Center Description		Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	1,427,058	0	1,427,058	17,795	80.19	30.00
31.00	INTENSIVE CARE UNIT	1,047,667		1,047,667	1,341	781.26	31.00
40.00	SUBPROVIDER - IPF	0	0	0	0	0.00	40.00
41.00	SUBPROVIDER - IRF	196,147	0	196,147	1,717	114.24	41.00
42.00	SUBPROVIDER	0	0	0	0	0.00	42.00
43.00	NURSERY	165,570		165,570	1,683	98.38	43.00
200.00	Total (lines 30 through 199)	2,836,442		2,836,442	22,536		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	4,388	351,874				30.00
31.00	INTENSIVE CARE UNIT	442	345,317				31.00
40.00	SUBPROVIDER - IPF	0	0				40.00
41.00	SUBPROVIDER - IRF	985	112,526				41.00
42.00	SUBPROVIDER	0	0				42.00
43.00	NURSERY	0	0				43.00
200.00	Total (lines 30 through 199)	5,815	809,717				200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 14-0127

Period:
From 07/01/2020
To 12/31/2020Worksheet D
Part II
Date/Time Prepared:
7/12/2021 12:41 pm

Cost Center Description			Title XVIII		Hospital	PPS		
			Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
	ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	1,132,473	20,422,071	0.055453	3,790,978	210,221	50.00
51.00	05100	RECOVERY ROOM	54,654	1,597,197	0.034219	320,285	10,960	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	3,757	646,900	0.005808	0	0	52.00
53.00	05300	ANESTHESIOLOGY	43,471	3,497,768	0.012428	682,050	8,477	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,014,754	16,988,469	0.059732	1,646,227	98,332	54.00
57.00	05700	CT SCAN	307,968	23,020,683	0.013378	2,667,785	35,690	57.00
58.00	05800	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	351,202	28,925,335	0.012142	4,662,203	56,608	60.00
64.00	06400	INTRAVENOUS THERAPY	147,969	6,311,284	0.023445	699,100	16,390	64.00
65.00	06500	RESPIRATORY THERAPY	124,391	2,093,549	0.059416	679,075	40,348	65.00
66.00	06600	PHYSICAL THERAPY	202,289	3,700,303	0.054668	461,225	25,214	66.00
67.00	06700	OCCUPATIONAL THERAPY	2,282	1,613,433	0.001414	186,895	264	67.00
68.00	06800	SPEECH PATHOLOGY	3,717	509,789	0.007291	81,355	593	68.00
69.00	06900	ELECTROCARDIOLOGY	360,622	15,107,519	0.023870	2,625,432	62,669	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	17,751	254,838	0.069656	42,339	2,949	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	105,157	10,456,363	0.010057	1,862,258	18,729	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	249,092	18,813,124	0.013240	4,209,666	55,736	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	55,751	40,801,249	0.001366	10,254,635	14,008	73.00
74.00	07400	RENAL DIALYSIS	1,470	398,685	0.003687	129,775	478	74.00
76.97	07697	CARDIAC REHABILITATION	43,538	286,160	0.152146	5,075	772	76.97
	OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	8,957	716,534	0.012500	75,323	942	90.00
90.01	09001	BASIC DIAGNOSTIC TESTING	0	0	0.000000	0	0	90.01
90.03	09002	PSYCH OUTPATIENT	78,824	211,700	0.372338	3,280	1,221	90.03
90.04	09003	WOUND CARE CLINIC	22,263	3,036,962	0.007331	0	0	90.04
91.00	09100	EMERGENCY	416,818	13,418,367	0.031063	1,173,396	36,449	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	377,076	4,917,004	0.076688	456,752	35,027	92.00
93.00	04040	OTHER OUTPATIENT SERVICES	0	0	0.000000	0	0	93.00
200.00		Total (lines 50 through 199)	5,126,246	217,745,286		36,715,109	732,077	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS					Provider CCN: 14-0127		Period: From 07/01/2020 To 12/31/2020		Worksheet D Part III Date/Time Prepared: 7/12/2021 12:41 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	398,834	0	30.00			
31.00	03100	INTENSIVE CARE UNIT	0	0	0	18,440	0	31.00			
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	0	40.00			
41.00	04100	SUBPROVIDER - IRF	0	0	0	10,567	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	427,841	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	398,834	17,795	22.41	4,388	30.00			
31.00	03100	INTENSIVE CARE UNIT		18,440	1,341	13.75	442	31.00			
40.00	04000	SUBPROVIDER - IPF	0	0	0	0.00	0	40.00			
41.00	04100	SUBPROVIDER - IRF	0	10,567	1,717	6.15	985	41.00			
42.00	04200	SUBPROVIDER	0	0	0	0.00	0	42.00			
43.00	04300	NURSERY		0	1,683	0.00	0	43.00			
200.00		Total (lines 30 through 199)		427,841	22,536		5,815	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	98,335								30.00
31.00	03100	INTENSIVE CARE UNIT	6,078								31.00
40.00	04000	SUBPROVIDER - IPF	0								40.00
41.00	04100	SUBPROVIDER - IRF	6,058								41.00
42.00	04200	SUBPROVIDER	0								42.00
43.00	04300	NURSERY	0								43.00
200.00		Total (lines 30 through 199)	110,471								200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

Provider CCN: 14-0127

Period:
From 07/01/2020
To 12/31/2020Worksheet D
Part IV
Date/Time Prepared:
7/12/2021 12:41 pm

Cost Center Description			Title XVIII		Hospital		PPS	
			Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health	
			1.00	2A	2.00	3A	3.00	
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	0	0	21,895	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	30,456	54.00
57.00	05700	CT SCAN	0	0	0	0	8,561	57.00
58.00	05800	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	8,561	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	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	21,895	90.04
91.00	09100	EMERGENCY	0	0	0	0	134,671	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	105,386	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	331,425	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

Provider CCN: 14-0127

Period:
From 07/01/2020
To 12/31/2020Worksheet D
Part IV
Date/Time Prepared:
7/12/2021 12:41 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	21,895	21,895	20,422,071	0.001072	50.00
51.00	05100	RECOVERY ROOM	0	0	0	1,597,197	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	646,900	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	3,497,768	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	30,456	30,456	16,988,469	0.001793	54.00
57.00	05700	CT SCAN	0	8,561	8,561	23,020,683	0.000372	57.00
58.00	05800	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	28,925,335	0.000000	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	6,311,284	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	2,093,549	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	3,700,303	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	1,613,433	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	509,789	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	8,561	8,561	15,107,519	0.000567	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	254,838	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	10,456,363	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	18,813,124	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	40,801,249	0.000000	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	398,685	0.000000	74.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	286,160	0.000000	76.97
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0	716,534	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	211,700	0.000000	90.03
90.04	09003	WOUND CARE CLINIC	0	21,895	21,895	3,036,962	0.007210	90.04
91.00	09100	EMERGENCY	0	134,671	134,671	13,418,367	0.010036	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	105,386	105,386	4,917,004	0.021433	92.00
93.00	04040	OTHER OUTPATIENT SERVICES	0	0	0	0	0.000000	93.00
200.00		Total (lines 50 through 199)	0	331,425	331,425	217,745,286		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-0127

Period:
From 07/01/2020
To 12/31/2020Worksheet D
Part IV
Date/Time Prepared:
7/12/2021 12:41 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	0.001072	3,790,978	4,064	1,667,976	1,788	50.00
51.00	05100	RECOVERY ROOM	0.000000	320,285	0	464,230	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	682,050	0	333,489	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.001793	1,646,227	2,952	2,476,070	4,440	54.00
57.00	05700	CT SCAN	0.000372	2,667,785	992	3,313,091	1,232	57.00
58.00	05800	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	4,662,203	0	2,109,789	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0.000000	699,100	0	882,611	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.000000	679,075	0	15,570	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	461,225	0	9,645	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	186,895	0	2,715	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	81,355	0	5,260	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000567	2,625,432	1,489	3,642,518	2,065	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	42,339	0	25,382	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	1,862,258	0	991,569	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	4,209,666	0	1,812,881	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	10,254,635	0	2,082,514	0	73.00
74.00	07400	RENAL DIALYSIS	0.000000	129,775	0	8,730	0	74.00
76.97	07697	CARDIAC REHABILITATION	0.000000	5,075	0	118,870	0	76.97
	OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0.000000	75,323	0	58,747	0	90.00
90.01	09001	BASIC DIAGNOSTIC TESTING	0.000000	0	0	0	0	90.01
90.03	09002	PSYCH OUTPATIENT	0.000000	3,280	0	9,630	0	90.03
90.04	09003	WOUND CARE CLINIC	0.007210	0	0	930,708	6,710	90.04
91.00	09100	EMERGENCY	0.010036	1,173,396	11,776	1,386,294	13,913	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.021433	456,752	9,790	991,874	21,259	92.00
93.00	04040	OTHER OUTPATIENT SERVICES	0.000000	0	0	0	0	93.00
200.00		Total (lines 50 through 199)		36,715,109	31,063	23,340,163	51,407	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-0127

Period:
From 07/01/2020
To 12/31/2020Worksheet D
Part V
Date/Time Prepared:
7/12/2021 12:41 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	0.419227	1,667,976		0	699,261	50.00	
51.00	05100	RECOVERY ROOM	0.479353	464,230		0	222,530	51.00	
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.463072	0		0	0	52.00	
53.00	05300	ANESTHESIOLOGY	0.547664	333,489		0	182,640	53.00	
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.244015	2,476,070		0	604,198	54.00	
57.00	05700	CT SCAN	0.062540	3,313,091		0	207,201	57.00	
58.00	05800	MRI	0.000000	0		0	0	58.00	
59.00	05900	CARDIAC CATHETERIZATION	0.000000	0		0	0	59.00	
60.00	06000	LABORATORY	0.170294	2,109,789		0	359,284	60.00	
64.00	06400	INTRAVENOUS THERAPY	0.131525	882,611		0	116,085	64.00	
65.00	06500	RESPIRATORY THERAPY	0.579261	15,570		0	9,019	65.00	
66.00	06600	PHYSICAL THERAPY	0.436210	9,645		0	4,207	66.00	
67.00	06700	OCCUPATIONAL THERAPY	0.125886	2,715		0	342	67.00	
68.00	06800	SPEECH PATHOLOGY	0.776737	5,260		0	4,086	68.00	
69.00	06900	ELECTROCARDIOLOGY	0.238962	3,642,518		0	870,423	69.00	
70.00	07000	ELECTROENCEPHALOGRAPHY	0.574565	25,382		0	14,584	70.00	
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.411058	991,569		0	407,592	71.00	
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.307561	1,812,881		0	557,571	72.00	
73.00	07300	DRUGS CHARGED TO PATIENTS	0.140205	2,082,514		0	24,290	73.00	
74.00	07400	RENAL DIALYSIS	0.579121	8,730		0	5,056	74.00	
76.97	07697	CARDIAC REHABILITATION	1.812940	118,870		0	215,504	76.97	
	OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0.855238	58,747		0	50,243	90.00	
90.01	09001	BASIC DIAGNOSTIC TESTING	0.000000	0		0	0	90.01	
90.03	09002	PSYCH OUTPATIENT	1.564407	9,630		0	15,065	90.03	
90.04	09003	WOUND CARE CLINIC	0.367371	930,708		0	341,915	90.04	
91.00	09100	EMERGENCY	0.396714	1,386,294		0	549,962	91.00	
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1.130726	991,874		0	1,121,538	92.00	
93.00	04040	OTHER OUTPATIENT SERVICES	0.000000	0		0	0	93.00	
200.00		Subtotal (see instructions)		23,340,163		0	24,290	200.00	
201.00		Less PBP Clinic Lab. Services-Program Only Charges				0	0	201.00	
202.00		Net Charges (line 200 - line 201)		23,340,163		0	24,290	202.00	

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-0127

Period:
From 07/01/2020
To 12/31/2020Worksheet D
Part V
Date/Time Prepared:
7/12/2021 12:41 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				
51.00	05100	RECOVERY ROOM	0	0				
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0				
53.00	05300	ANESTHESIOLOGY	0	0				
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0				
57.00	05700	CT SCAN	0	0				
58.00	05800	MRI	0	0				
59.00	05900	CARDIAC CATHETERIZATION	0	0				
60.00	06000	LABORATORY	0	0				
64.00	06400	INTRAVENOUS THERAPY	0	0				
65.00	06500	RESPIRATORY THERAPY	0	0				
66.00	06600	PHYSICAL THERAPY	0	0				
67.00	06700	OCCUPATIONAL THERAPY	0	0				
68.00	06800	SPEECH PATHOLOGY	0	0				
69.00	06900	ELECTROCARDIOLOGY	0	0				
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0				
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0				
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0				
73.00	07300	DRUGS CHARGED TO PATIENTS	0	3,406				
74.00	07400	RENAL DIALYSIS	0	0				
76.97	07697	CARDIAC REHABILITATION	0	0				
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0				
90.01	09001	BASIC DIAGNOSTIC TESTING	0	0				
90.03	09002	PSYCH OUTPATIENT	0	0				
90.04	09003	WOUND CARE CLINIC	0	0				
91.00	09100	EMERGENCY	0	0				
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0				
93.00	04040	OTHER OUTPATIENT SERVICES	0	0				
200.00		Subtotal (see instructions)	0	3,406				
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0					
202.00		Net Charges (line 200 - line 201)	0	3,406				

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 14-0127

Period:

Worksheet D

Component CCN: 14-T127

From 07/01/2020
To 12/31/2020Part II
Date/Time Prepared:
7/12/2021 12:41 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	1,132,473	20,422,071	0.055453	6,863	381	50.00
51.00	05100	RECOVERY ROOM	54,654	1,597,197	0.034219	750	26	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	3,757	646,900	0.005808	0	0	52.00
53.00	05300	ANESTHESIOLOGY	43,471	3,497,768	0.012428	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,014,754	16,988,469	0.059732	120,008	7,168	54.00
57.00	05700	CT SCAN	307,968	23,020,683	0.013378	67,153	898	57.00
58.00	05800	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	351,202	28,925,335	0.012142	238,831	2,900	60.00
64.00	06400	INTRAVENOUS THERAPY	147,969	6,311,284	0.023445	3,152	74	64.00
65.00	06500	RESPIRATORY THERAPY	124,391	2,093,549	0.059416	51,645	3,069	65.00
66.00	06600	PHYSICAL THERAPY	202,289	3,700,303	0.054668	821,703	44,921	66.00
67.00	06700	OCCUPATIONAL THERAPY	2,282	1,613,433	0.001414	862,950	1,220	67.00
68.00	06800	SPEECH PATHOLOGY	3,717	509,789	0.007291	233,384	1,702	68.00
69.00	06900	ELECTROCARDIOLOGY	360,622	15,107,519	0.023870	9,921	237	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	17,751	254,838	0.069656	4,313	300	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	105,157	10,456,363	0.010057	48,278	486	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	249,092	18,813,124	0.013240	851	11	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	55,751	40,801,249	0.001366	1,011,902	1,382	73.00
74.00	07400	RENAL DIALYSIS	1,470	398,685	0.003687	21,825	80	74.00
76.97	07697	CARDIAC REHABILITATION	43,538	286,160	0.152146	0	0	76.97
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	8,957	716,534	0.012500	16,110	201	90.00
90.01	09001	BASIC DIAGNOSTIC TESTING	0	0	0.000000	0	0	90.01
90.03	09002	PSYCH OUTPATIENT	78,824	211,700	0.372338	0	0	90.03
90.04	09003	WOUND CARE CLINIC	22,263	3,036,962	0.007331	0	0	90.04
91.00	09100	EMERGENCY	416,818	13,418,367	0.031063	1,062	33	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	4,917,004	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)	4,749,170	217,745,286		3,520,701	65,089	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

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

Period:
From 07/01/2020
To 12/31/2020

Worksheet D
Part IV
Date/Time Prepared:
7/12/2021 12:41 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	21,895	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	30,456	54.00
57.00	05700	CT SCAN	0	0	0	0	8,561	57.00
58.00	05800	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	8,561	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	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	21,895	90.04
91.00	09100	EMERGENCY	0	0	0	0	134,671	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	226,039	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

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

Period:
From 07/01/2020
To 12/31/2020

Worksheet D
Part IV
Date/Time Prepared:
7/12/2021 12:41 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	21,895	21,895	20,422,071	0.001072	50.00
51.00	05100	RECOVERY ROOM	0	0	0	1,597,197	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	646,900	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	3,497,768	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	30,456	30,456	16,988,469	0.001793	54.00
57.00	05700	CT SCAN	0	8,561	8,561	23,020,683	0.000372	57.00
58.00	05800	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	28,925,335	0.000000	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	6,311,284	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	2,093,549	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	3,700,303	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	1,613,433	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	509,789	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	8,561	8,561	15,107,519	0.000567	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	254,838	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	10,456,363	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	18,813,124	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	40,801,249	0.000000	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	398,685	0.000000	74.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	286,160	0.000000	76.97
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0	716,534	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	211,700	0.000000	90.03
90.04	09003	WOUND CARE CLINIC	0	21,895	21,895	3,036,962	0.007210	90.04
91.00	09100	EMERGENCY	0	134,671	134,671	13,418,367	0.010036	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	4,917,004	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	226,039	226,039	217,745,286		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS				Provider CCN: 14-0127 Component CCN: 14-T127		Period: From 07/01/2020 To 12/31/2020		Worksheet D Part IV Date/Time Prepared: 7/12/2021 12:41 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		0.001072	6,863		7	0	50.00
51.00	05100	RECOVERY ROOM		0.000000	750		0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM		0.000000	0		0	0	52.00
53.00	05300	ANESTHESIOLOGY		0.000000	0		0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC		0.001793	120,008	215	0	0	54.00
57.00	05700	CT SCAN		0.000372	67,153	25	0	0	57.00
58.00	05800	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	238,831	0	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY		0.000000	3,152	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY		0.000000	51,645	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY		0.000000	821,703	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY		0.000000	862,950	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY		0.000000	233,384	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY		0.000567	9,921	6	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY		0.000000	4,313	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT		0.000000	48,278	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS		0.000000	851	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS		0.000000	1,011,902	0	0	0	73.00
74.00	07400	RENAL DIALYSIS		0.000000	21,825	0	0	0	74.00
76.97	07697	CARDIAC REHABILITATION		0.000000	0	0	0	0	76.97
OUTPATIENT SERVICE COST CENTERS									
90.00	09000	CLINIC		0.000000	16,110	0	0	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	0	0	90.03
90.04	09003	WOUND CARE CLINIC		0.007210	0	0	0	0	90.04
91.00	09100	EMERGENCY		0.010036	1,062	11	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART		0.000000	0	0	0	0	92.00
93.00	04040	OTHER OUTPATIENT SERVICES		0.000000	0	0	0	0	93.00
200.00		Total (lines 50 through 199)			3,520,701	264	0	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-0127

Period:
From 07/01/2020
To 12/31/2020Worksheet D
Part V
Date/Time Prepared:
7/12/2021 12:41 pm

			Title XIX		Hospital		Cost	
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	0.419227	0	408,244	0	0	50.00
51.00	05100	RECOVERY ROOM	0.479353	0	61,470	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.463072	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.547664	0	83,600	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.244015	0	670,263	0	0	54.00
57.00	05700	CT SCAN	0.062540	0	710,975	0	0	57.00
58.00	05800	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	0.170294	0	807,438	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0.131525	0	185,745	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.579261	0	22,354	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.436210	0	61,628	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.125886	0	7,470	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.776737	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.238962	0	194,816	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.574565	0	5,740	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.411058	0	55,408	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.307561	0	19,243	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.140205	0	528,267	0	0	73.00
74.00	07400	RENAL DIALYSIS	0.579121	0	0	0	0	74.00
76.97	07697	CARDIAC REHABILITATION	1.812940	0	9,540	0	0	76.97
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0.855238	0	13,306	0	0	90.00
90.01	09001	BASIC DIAGNOSTIC TESTING	0.000000	0	0	0	0	90.01
90.03	09002	PSYCH OUTPATIENT	1.564407	0	4,540	0	0	90.03
90.04	09003	WOUND CARE CLINIC	0.367371	0	12,450	0	0	90.04
91.00	09100	EMERGENCY	0.396714	0	1,763,437	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1.130726	0	143,271	0	0	92.00
93.00	04040	OTHER OUTPATIENT SERVICES	0.000000	0	0	0	0	93.00
200.00		Subtotal (see instructions)		0	5,769,205	0	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 - line 201)		0	5,769,205	0	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-0127

Period:
From 07/01/2020
To 12/31/2020Worksheet D
Part V
Date/Time Prepared:
7/12/2021 12:41 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	171,147	0	50.00	
51.00	05100	RECOVERY ROOM	29,466	0	51.00	
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	52.00	
53.00	05300	ANESTHESIOLOGY	45,785	0	53.00	
54.00	05400	RADIOLOGY-DIAGNOSTIC	163,554	0	54.00	
57.00	05700	CT SCAN	44,464	0	57.00	
58.00	05800	MRI	0	0	58.00	
59.00	05900	CARDIAC CATHETERIZATION	0	0	59.00	
60.00	06000	LABORATORY	137,502	0	60.00	
64.00	06400	INTRAVENOUS THERAPY	24,430	0	64.00	
65.00	06500	RESPIRATORY THERAPY	12,949	0	65.00	
66.00	06600	PHYSICAL THERAPY	26,883	0	66.00	
67.00	06700	OCCUPATIONAL THERAPY	940	0	67.00	
68.00	06800	SPEECH PATHOLOGY	0	0	68.00	
69.00	06900	ELECTROCARDIOLOGY	46,554	0	69.00	
70.00	07000	ELECTROENCEPHALOGRAPHY	3,298	0	70.00	
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	22,776	0	71.00	
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	5,918	0	72.00	
73.00	07300	DRUGS CHARGED TO PATIENTS	74,066	0	73.00	
74.00	07400	RENAL DIALYSIS	0	0	74.00	
76.97	07697	CARDIAC REHABILITATION	17,295	0	76.97	
OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	11,380	0	90.00	
90.01	09001	BASIC DIAGNOSTIC TESTING	0	0	90.01	
90.03	09002	PSYCH OUTPATIENT	7,102	0	90.03	
90.04	09003	WOUND CARE CLINIC	4,574	0	90.04	
91.00	09100	EMERGENCY	699,580	0	91.00	
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	162,000	0	92.00	
93.00	04040	OTHER OUTPATIENT SERVICES	0	0	93.00	
200.00		Subtotal (see instructions)	1,711,663	0	200.00	
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0		201.00	
202.00		Net Charges (line 200 - line 201)	1,711,663	0	202.00	

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-0127

Period:
From 07/01/2020
To 12/31/2020

Worksheet D-1

Date/Time Prepared:
7/12/2021 12:41 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)	17,795	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	17,795	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)	13,093	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)	4,388	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)	21,041,304	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)	21,041,304	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)	21,041,304	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)	1,182.43	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	5,188,503	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)	5,188,503	41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-0127

Period:
From 07/01/2020
To 12/31/2020

Worksheet D-1

Date/Time Prepared:
7/12/2021 12:41 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	4,761,934	1,341	3,551.03	442	1,569,555	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)					9,537,607	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					16,295,665	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)					801,604	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					763,140	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)					1,564,744	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					14,730,921	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)					4,702	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					1,182.43	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)					5,559,786	89.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-0127

Period:
From 07/01/2020
To 12/31/2020

Worksheet D-1

Date/Time Prepared:
7/12/2021 12:41 pm

		Title XVIII		Hospital	PPS	
Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
	1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00 Capital-related cost	1,427,058	21,041,304	0.067822	5,559,786	377,076	90.00
91.00 Nursing School cost	0	21,041,304	0.000000	5,559,786	0	91.00
92.00 Allied health cost	398,834	21,041,304	0.018955	5,559,786	105,386	92.00
93.00 All other Medical Education	0	21,041,304	0.000000	5,559,786	0	93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-0127 Component CCN: 14-T127	Period: From 07/01/2020 To 12/31/2020	Worksheet D-1 Date/Time Prepared: 7/12/2021 12:41 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)		1,717	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		1,717	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)		1,717	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)		985	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)		1,789,212	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)		1,789,212	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)		1,789,212	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)		1,042.06	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		1,026,429	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)		1,026,429	41.00

COMPUTATION OF INPATIENT OPERATING COST				Provider CCN: 14-0127 Component CCN: 14-T127	Period: From 07/01/2020 To 12/31/2020	Worksheet D-1 Date/Time Prepared: 7/12/2021 12:41 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	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)					949,737	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					1,976,166	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)					118,584	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					65,353	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)					183,937	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					1,792,229	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 07/01/2020 To 12/31/2020		Worksheet D-1 Date/Time Prepared: 7/12/2021 12:41 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	196,147	1,789,212	0.109628	0	0	90.00		
91.00	Nursing School cost	0	1,789,212	0.000000	0	0	91.00		
92.00	Allied health cost	10,567	1,789,212	0.005906	0	0	92.00		
93.00	All other Medical Education	0	1,789,212	0.000000	0	0	93.00		

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT			Provider CCN: 14-0127	Period: From 07/01/2020 To 12/31/2020	Worksheet D-3 Date/Time Prepared: 7/12/2021 12:41 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		6,975,010		30.00
31.00	03100	INTENSIVE CARE UNIT		1,270,750		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	0.419227	3,790,978	1,589,280	50.00
51.00	05100	RECOVERY ROOM	0.479353	320,285	153,530	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.463072	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.547664	682,050	373,534	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.244015	1,646,227	401,704	54.00
57.00	05700	CT SCAN	0.062540	2,667,785	166,843	57.00
58.00	05800	MRI	0.000000	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	0	0	59.00
60.00	06000	LABORATORY	0.170294	4,662,203	793,945	60.00
64.00	06400	INTRAVENOUS THERAPY	0.131525	699,100	91,949	64.00
65.00	06500	RESPIRATORY THERAPY	0.579261	679,075	393,362	65.00
66.00	06600	PHYSICAL THERAPY	0.436210	461,225	201,191	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.125886	186,895	23,527	67.00
68.00	06800	SPEECH PATHOLOGY	0.776737	81,355	63,191	68.00
69.00	06900	ELECTROCARDIOLOGY	0.238962	2,625,432	627,378	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.574565	42,339	24,327	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.411058	1,862,258	765,496	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.307561	4,209,666	1,294,729	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.140205	10,254,635	1,437,751	73.00
74.00	07400	RENAL DIALYSIS	0.579121	129,775	75,155	74.00
76.97	07697	CARDIAC REHABILITATION	1.812940	5,075	9,201	76.97
OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.855238	75,323	64,419	90.00
90.01	09001	BASIC DIAGNOSTIC TESTING	0.000000	0	0	90.01
90.03	09002	PSYCH OUTPATIENT	1.564407	3,280	5,131	90.03
90.04	09003	WOUND CARE CLINIC	0.367371	0	0	90.04
91.00	09100	EMERGENCY	0.396714	1,173,396	465,503	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1.130726	456,752	516,461	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)		36,715,109	9,537,607	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)		36,715,109		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 14-0127 Component CCN: 14-T127	Period: From 07/01/2020 To 12/31/2020	Worksheet D-3 Date/Time Prepared: 7/12/2021 12:41 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		1,645,250		41.00
42.00	04200 SUBPROVIDER		0		42.00
43.00	04300 NURSERY				43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.419227	6,863	2,877	50.00
51.00	05100 RECOVERY ROOM	0.479353	750	360	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.463072	0	0	52.00
53.00	05300 ANESTHESIOLOGY	0.547664	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.244015	120,008	29,284	54.00
57.00	05700 CT SCAN	0.062540	67,153	4,200	57.00
58.00	05800 MRI	0.000000	0	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	0.000000	0	0	59.00
60.00	06000 LABORATORY	0.170294	238,831	40,671	60.00
64.00	06400 INTRAVENOUS THERAPY	0.131525	3,152	415	64.00
65.00	06500 RESPIRATORY THERAPY	0.579261	51,645	29,916	65.00
66.00	06600 PHYSICAL THERAPY	0.436210	821,703	358,435	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.125886	862,950	108,633	67.00
68.00	06800 SPEECH PATHOLOGY	0.776737	233,384	181,278	68.00
69.00	06900 ELECTROCARDIOLOGY	0.238962	9,921	2,371	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0.574565	4,313	2,478	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.411058	48,278	19,845	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.307561	851	262	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.140205	1,011,902	141,874	73.00
74.00	07400 RENAL DIALYSIS	0.579121	21,825	12,639	74.00
76.97	07697 CARDIAC REHABILITATION	1.812940	0	0	76.97
OUTPATIENT SERVICE COST CENTERS					
90.00	09000 CLINIC	0.855238	16,110	13,778	90.00
90.01	09001 BASIC DIAGNOSTIC TESTING	0.000000	0	0	90.01
90.03	09002 PSYCH OUTPATIENT	1.564407	0	0	90.03
90.04	09003 WOUND CARE CLINIC	0.367371	0	0	90.04
91.00	09100 EMERGENCY	0.396714	1,062	421	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	1.130726	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)		3,520,701	949,737	200.00
201.00	Less PBP Clinic Laboratory Services-Program only charges (line 61)		0	0	201.00
202.00	Net charges (line 200 minus line 201)		3,520,701		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT			Provider CCN: 14-0127	Period: From 07/01/2020 To 12/31/2020	Worksheet D-3 Date/Time Prepared: 7/12/2021 12:41 pm	
Cost Center Description			Title XIX	Hospital	Cost	
			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		0		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	0.419227	0	0	50.00
51.00	05100	RECOVERY ROOM	0.479353	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.463072	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.547664	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.244015	0	0	54.00
57.00	05700	CT SCAN	0.062540	0	0	57.00
58.00	05800	MRI	0.000000	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	0	0	59.00
60.00	06000	LABORATORY	0.170294	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0.131525	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.579261	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.436210	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.125886	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.776737	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.238962	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.574565	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.411058	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.307561	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.140205	0	0	73.00
74.00	07400	RENAL DIALYSIS	0.579121	0	0	74.00
76.97	07697	CARDIAC REHABILITATION	1.812940	0	0	76.97
OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.855238	0	0	90.00
90.01	09001	BASIC DIAGNOSTIC TESTING	0.000000	0	0	90.01
90.03	09002	PSYCH OUTPATIENT	1.564407	0	0	90.03
90.04	09003	WOUND CARE CLINIC	0.367371	0	0	90.04
91.00	09100	EMERGENCY	0.396714	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1.130726	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)		0	0	200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0	0	201.00
202.00		Net charges (line 200 minus line 201)		0	0	202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 14-0127 Component CCN: 14-T127	Period: From 07/01/2020 To 12/31/2020	Worksheet D-3 Date/Time Prepared: 7/12/2021 12:41 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		0		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	0.419227	0	0	50.00
51.00	05100 RECOVERY ROOM	0.479353	0	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.463072	0	0	52.00
53.00	05300 ANESTHESIOLOGY	0.547664	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.244015	0	0	54.00
57.00	05700 CT SCAN	0.062540	0	0	57.00
58.00	05800 MRI	0.000000	0	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	0.000000	0	0	59.00
60.00	06000 LABORATORY	0.170294	0	0	60.00
64.00	06400 INTRAVENOUS THERAPY	0.131525	0	0	64.00
65.00	06500 RESPIRATORY THERAPY	0.579261	0	0	65.00
66.00	06600 PHYSICAL THERAPY	0.436210	0	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.125886	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0.776737	0	0	68.00
69.00	06900 ELECTROCARDIOLOGY	0.238962	0	0	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0.574565	0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.411058	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.307561	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.140205	0	0	73.00
74.00	07400 RENAL DIALYSIS	0.579121	0	0	74.00
76.97	07697 CARDIAC REHABILITATION	1.812940	0	0	76.97
OUTPATIENT SERVICE COST CENTERS					
90.00	09000 CLINIC	0.855238	0	0	90.00
90.01	09001 BASIC DIAGNOSTIC TESTING	0.000000	0	0	90.01
90.03	09002 PSYCH OUTPATIENT	1.564407	0	0	90.03
90.04	09003 WOUND CARE CLINIC	0.367371	0	0	90.04
91.00	09100 EMERGENCY	0.396714	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	1.130726	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)		0	0	200.00
201.00	Less PBP Clinic Laboratory Services-Program only charges (line 61)		0	0	201.00
202.00	Net charges (line 200 minus line 201)		0	0	202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0127	Period: From 07/01/2020 To 12/31/2020	Worksheet E Part A Date/Time Prepared: 7/12/2021 12:41 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)		5,066,321	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1 (see instructions)		6,143,465	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)		82,166	2.03
2.04	Outlier payments for discharges occurring on or after October 1 (see instructions)		99,653	2.04
3.00	Managed Care Simulated Payments		4,714,166	3.00
4.00	Bed days available divided by number of days in the cost reporting period (see instructions)		178.83	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		12.80	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).		0.070290	19.00
20.00	Prior year resident to bed ratio (see instructions)		0.065570	20.00
21.00	Enter the lesser of lines 19 or 20 (see instructions)		0.065570	21.00
22.00	IME payment adjustment (see instructions)		394,293	22.00
22.01	IME payment adjustment - Managed Care (see instructions)		165,816	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)		0.23	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)		394,293	29.00
29.01	Total IME payment - Managed Care (sum of lines 22.01 and 28.01)		165,816	29.01
Disproportionate Share Adjustment				
30.00	Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)		5.32	30.00
31.00	Percentage of Medicaid patient days (see instructions)		23.34	31.00
32.00	Sum of lines 30 and 31		28.66	32.00
33.00	Allowable disproportionate share percentage (see instructions)		13.92	33.00
34.00	Disproportionate share adjustment (see instructions)		390,101	34.00

CALCULATION OF REIMBURSEMENT SETTLEMENT

Provider CCN: 14-0127

Period:
From 07/01/2020
To 12/31/2020Worksheet E
Part A
Date/Time Prepared:
7/12/2021 12:41 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)		8,272,872,447	8,350,599,096	35.00
35.01	Factor 3 (see instructions)		0.000301311	0.000146526	35.01
35.02	Hospital uncompensated care payment (If line 34 is zero, enter zero on this line) (see instructions)		2,492,708	1,223,578	35.02
35.03	Pro rata share of the hospital uncompensated care payment amount (see instructions)		626,582	308,409	35.03
36.00	Total uncompensated care (sum of columns 1 and 2 on line 35.03)		934,991		36.00
Additional payment for high percentage of ESRD beneficiary discharges (lines 40 through 46)					
40.00	Total Medicare discharges, excluding MS-DRGs 652, 682, 683, 684 and 685. (see instructions)		0		40.00
41.00	Total ESRD Medicare discharges excluding MS-DRGs 652, 682, 683, 684 an 685. (see instructions)		0		41.00
41.01	Total ESRD Medicare covered and paid discharges excluding MS-DRGs 652, 682, 683, 684 an 685. (see instructions)		0		41.01
42.00	Divide line 41 by line 40 (if less than 10%, you do not qualify for adjustment)		0.00		42.00
43.00	Total Medicare ESRD inpatient days excluding MS-DRGs 652, 682, 683, 684 an 685. (see instructions)		0		43.00
44.00	Ratio of average length of stay to one week (line 43 divided by line 41 divided by 7 days)		0.000000		44.00
45.00	Average weekly cost for dialysis treatments (see instructions)		0.00		45.00
46.00	Total additional payment (line 45 times line 44 times line 41.01)		0		46.00
47.00	Subtotal (see instructions)		13,110,990		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)			13,276,806	49.00
50.00	Payment for inpatient program capital (from Wkst. L, Pt. I and Pt. II, as applicable)			964,379	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).			249,873	52.00
53.00	Nursing and Allied Health Managed Care payment			59,212	53.00
54.00	Special add-on payments for new technologies			155,053	54.00
54.01	Islet isolation add-on payment			0	54.01
55.00	Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line 69)			0	55.00
56.00	Cost of physicians' services in a teaching hospital (see intructions)			0	56.00
57.00	Routine service other pass through costs (from Wkst. D, Pt. III, column 9, lines 30 through 35).			104,413	57.00
58.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 11 line 200)			31,063	58.00
59.00	Total (sum of amounts on lines 49 through 58)			14,840,799	59.00
60.00	Primary payer payments			3,592	60.00
61.00	Total amount payable for program beneficiaries (line 59 minus line 60)			14,837,207	61.00
62.00	Deductibles billed to program beneficiaries			1,234,601	62.00
63.00	Coinsurance billed to program beneficiaries			9,856	63.00
64.00	Allowable bad debts (see instructions)			39,424	64.00
65.00	Adjusted reimbursable bad debts (see instructions)			25,626	65.00
66.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			35,200	66.00
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)			13,618,376	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			0	70.00
70.50	Rural Community Hospital Demonstration Project (\$410A Demonstration) adjustment (see instructions)			0	70.50
70.87	Demonstration payment adjustment amount before sequestration			0	70.87
70.88	SCH or MDH volume decrease adjustment (contractor use only)			0	70.88
70.89	Pioneer ACO demonstration payment adjustment amount (see instructions)			0	70.89
70.90	HSP bonus payment HVBP adjustment amount (see instructions)			0	70.90
70.91	HSP bonus payment HRR adjustment amount (see instructions)			0	70.91
70.92	Bundled Model 1 discount amount (see instructions)			0	70.92
70.93	HVBP payment adjustment amount (see instructions)			52,818	70.93
70.94	HRR adjustment amount (see instructions)			-34,929	70.94
70.95	Recovery of accelerated depreciation			0	70.95

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0127	Period: From 07/01/2020 To 12/31/2020	Worksheet E Part A Date/Time Prepared: 7/12/2021 12:41 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)		13,636,265	71.00	
71.01	Sequestration adjustment (see instructions)		0	71.01	
71.02	Demonstration payment adjustment amount after sequestration		0	71.02	
71.03	Sequestration adjustment-PARHM pass-throughs		0	71.03	
72.00	Interim payments		13,081,529	72.00	
72.01	Interim payments-PARHM		0	72.01	
73.00	Tentative settlement (for contractor use only)		0	73.00	
73.01	Tentative settlement-PARHM (for contractor use only)		0	73.01	
74.00	Balance due provider/program (line 71 minus lines 71.01, 71.02, 72, and 73)		554,736	74.00	
74.01	Balance due provider/program-PARHM (see instructions)		0	74.01	
75.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		350,266	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)		407,611	90.00	
91.00	Capital outlier from Wkst. L, Pt. I, line 2		42,993	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
HVPB Adjustment for HSP Bonus Payment					
101.00	HVPB adjustment factor (see instructions)		0.0000000000	0.0000000000	101.00
102.00	HVPB 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

LOW VOLUME CALCULATION EXHIBIT 4

Provider CCN: 14-0127

Period:
From 07/01/2020
To 12/31/2020Worksheet E
Part A Exhibit 4
Date/Time Prepared:
7/12/2021 12:41 pm

					Title XVIII		Hospital	7/12/2021 12:41 pm PPS	
		W/S E, Part A	Amounts (from	Pre/Post	Period Prior	Period	Total (Col 2		
		line	E, Part A)	Entitlement	to 10/01	On/After 10/01	through 4)		
		0	1.00	2.00	3.00	4.00	5.00		
1.00	DRG amounts other than outlier payments	1.00	0	0	0	0	0	1.00	
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1	1.01	5,066,321	0	5,066,321		5,066,321	1.01	
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	6,143,465	0		6,143,465	6,143,465	1.02	
1.03	DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October 1	1.03	0	0	0		0	1.03	
1.04	DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1	1.04	0	0		0	0	1.04	
2.00	Outlier payments for discharges (see instructions)	2.00						2.00	
2.01	Outlier payments for discharges for Model 4 BPCI	2.02	0	0	0	0	0	2.01	
2.02	Outlier payments for discharges occurring prior to October 1 (see instructions)	2.03	82,166	0	82,166		82,166	2.02	
2.03	Outlier payments for discharges occurring on or after October 1 (see instructions)	2.04	99,653	0		99,653	99,653	2.03	
3.00	Operating outlier reconciliation	2.01	0	0	0	0	0	3.00	
4.00	Managed care simulated payments	3.00	4,714,166	0	2,150,133	2,564,033	4,714,166	4.00	
Indirect Medical Education Adjustment									
5.00	Amount from Worksheet E, Part A, line 21 (see instructions)	21.00	0.065570	0.065570	0.065570	0.065570		5.00	
6.00	IME payment adjustment (see instructions)	22.00	394,293	0	178,203	216,090	394,293	6.00	
6.01	IME payment adjustment for managed care (see instructions)	22.01	165,816	0	75,629	90,187	165,816	6.01	
Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA									
7.00	IME payment adjustment factor (see instructions)	27.00	0.000000	0.000000	0.000000	0.000000		7.00	
8.00	IME adjustment (see instructions)	28.00	0	0	0	0	0	8.00	
8.01	IME payment adjustment add on for managed care (see instructions)	28.01	0	0	0	0	0	8.01	
9.00	Total IME payment (sum of lines 6 and 8)	29.00	394,293	0	178,203	216,090	394,293	9.00	
9.01	Total IME payment for managed care (sum of lines 6.01 and 8.01)	29.01	165,816	0	75,629	90,187	165,816	9.01	
Disproportionate Share Adjustment									
10.00	Allowable disproportionate share percentage (see instructions)	33.00	0.1392	0.1392	0.1392	0.1392		10.00	
11.00	Disproportionate share adjustment (see instructions)	34.00	390,101	0	176,308	213,793	390,101	11.00	
11.01	Uncompensated care payments	36.00	934,991	0	626,582	308,409	934,991	11.01	
Additional payment for high percentage of ESRD beneficiary discharges									
12.00	Total ESRD additional payment (see instructions)	46.00	0	0	0	0	0	12.00	
13.00	Subtotal (see instructions)	47.00	13,110,990	0	6,129,580	6,981,410	13,110,990	13.00	
14.00	Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see instructions)	48.00	0	0	0	0	0	14.00	
15.00	Total payment for inpatient operating costs (see instructions)	49.00	13,276,806	0	6,205,209	7,071,597	13,276,806	15.00	
16.00	Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable)	50.00	964,379	0	449,763	514,616	964,379	16.00	

LOW VOLUME CALCULATION EXHIBIT 4

Provider CCN: 14-0127

Period:
From 07/01/2020
To 12/31/2020Worksheet E
Part A Exhibit 4
Date/Time Prepared:
7/12/2021 12:41 pm

				Title XVIII		Hospital	PPS	
		W/S E, Part A line	Amounts (from E, Part A)	Pre/Post Entitlement	Period Prior to 10/01	Period On/After 10/01	Total (Col 2 through 4)	
		0	1.00	2.00	3.00	4.00	5.00	
17.00	Special add-on payments for new technologies	54.00	155,053	0	0	155,053	155,053	17.00
17.01	Net organ aquisition cost							17.01
17.02	Credits received from manufacturers for replaced devices for applicable MS-DRGs	68.00	0	0	0	0	0	17.02
18.00	Capital outlier reconciliation adjustment amount (see instructions)	93.00	0	0	0	0	0	18.00
19.00	SUBTOTAL			0	6,654,972	7,741,266	14,396,238	19.00
		W/S L, line	(Amounts from L)					
		0	1.00	2.00	3.00	4.00	5.00	
20.00	Capital DRG other than outlier	1.00	857,631	0	400,404	457,227	857,631	20.00
20.01	Model 4 BPCI Capital DRG other than outlier	1.01	0	0	0	0	0	20.01
21.00	Capital DRG outlier payments	2.00	17,382	0	7,637	9,745	17,382	21.00
21.01	Model 4 BPCI Capital DRG outlier payments	2.01	0	0	0	0	0	21.01
22.00	Indirect medical education percentage (see instructions)	5.00	0.0445	0.0445	0.0445	0.0445		22.00
23.00	Indirect medical education adjustment (see instructions)	6.00	38,165	0	17,818	20,347	38,165	23.00
24.00	Allowable disproportionate share percentage (see instructions)	10.00	0.0597	0.0597	0.0597	0.0597		24.00
25.00	Disproportionate share adjustment (see instructions)	11.00	51,201	0	23,904	27,297	51,201	25.00
26.00	Total prospective capital payments (see instructions)	12.00	964,379	0	449,763	514,616	964,379	26.00
		W/S E, Part A line	(Amounts to E, Part A)					
		0	1.00	2.00	3.00	4.00	5.00	
27.00	Low volume adjustment factor				0.000000	0.000000		27.00
28.00	Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)	70.96			0		0	28.00
29.00	Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)	70.97				0	0	29.00
100.00	Transfer low volume adjustments to Wkst. E, Pt. A.		Y					100.00

HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULATION EXHIBIT 5

Provider CCN: 14-0127

Period:
From 07/01/2020
To 12/31/2020Worksheet E
Part A Exhibit 5
Date/Time Prepared:
7/12/2021 12:41 pm

		Title XVIII		Hospital		PPS	
		Wkst. E, Pt. A, line	Amt. from Wkst. E, Pt. A	Period to 10/01	Period on after 10/01	Total (cols. 2 and 3)	
		0	1.00	2.00	3.00	4.00	
1.00	DRG amounts other than outlier payments	1.00					1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1	1.01	5,066,321	5,066,321		5,066,321	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	6,143,465		6,143,465	6,143,465	1.02
1.03	DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October 1	1.03	0	0		0	1.03
1.04	DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1	1.04	0		0	0	1.04
2.00	Outlier payments for discharges (see instructions)	2.00					2.00
2.01	Outlier payments for discharges for Model 4 BPCI	2.02	0	0	0	0	2.01
2.02	Outlier payments for discharges occurring prior to October 1 (see instructions)	2.03	82,166	82,166		82,166	2.02
2.03	Outlier payments for discharges occurring on or after October 1 (see instructions)	2.04	99,653		99,653	99,653	2.03
3.00	Operating outlier reconciliation	2.01	0	0	0	0	3.00
4.00	Managed care simulated payments	3.00	4,714,166	2,150,133	2,564,033	4,714,166	4.00
Indirect Medical Education Adjustment							
5.00	Amount from Worksheet E, Part A, line 21 (see instructions)	21.00	0.065570	0.065570	0.065570		5.00
6.00	IME payment adjustment (see instructions)	22.00	394,293	178,203	216,090	394,293	6.00
6.01	IME payment adjustment for managed care (see instructions)	22.01	165,816	75,629	90,187	165,816	6.01
Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA							
7.00	IME payment adjustment factor (see instructions)	27.00	0.000000	0.000000	0.000000		7.00
8.00	IME adjustment (see instructions)	28.00	0	0	0	0	8.00
8.01	IME payment adjustment add on for managed care (see instructions)	28.01	0	0	0	0	8.01
9.00	Total IME payment (sum of lines 6 and 8)	29.00	394,293	178,203	216,090	394,293	9.00
9.01	Total IME payment for managed care (sum of lines 6.01 and 8.01)	29.01	165,816	75,629	90,187	165,816	9.01
Disproportionate Share Adjustment							
10.00	Allowable disproportionate share percentage (see instructions)	33.00	0.1392	0.1392	0.1392		10.00
11.00	Disproportionate share adjustment (see instructions)	34.00	390,101	176,308	213,793	390,101	11.00
11.01	Uncompensated care payments	36.00	934,991	626,582	308,409	934,991	11.01
Additional payment for high percentage of ESRD beneficiary discharges							
12.00	Total ESRD additional payment (see instructions)	46.00	0	0	0	0	12.00
13.00	Subtotal (see instructions)	47.00	13,110,990	6,129,580	6,981,410	13,110,990	13.00
14.00	Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see instructions)	48.00	0	0	0	0	14.00
15.00	Total payment for inpatient operating costs (see instructions)	49.00	13,276,806	6,205,209	7,071,597	13,276,806	15.00
16.00	Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable)	50.00	964,379	449,763	514,616	964,379	16.00
17.00	Special add-on payments for new technologies	54.00	155,053	0	155,053	155,053	17.00
17.01	Net organ acquisition cost						17.01
17.02	Credits received from manufacturers for replaced devices for applicable MS-DRGs	68.00	0	0	0	0	17.02
18.00	Capital outlier reconciliation adjustment amount (see instructions)	93.00	0	0	0	0	18.00
19.00	SUBTOTAL			6,654,972	7,741,266	14,396,238	19.00

HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULATION EXHIBIT 5

Provider CCN: 14-0127

Period:
From 07/01/2020
To 12/31/2020Worksheet E
Part A Exhibit 5
Date/Time Prepared:
7/12/2021 12:41 pm

		Title XVIII		Hospital		PPS	
		Wkst. L, line	(Amt. from Wkst. L)				
		0	1.00	2.00	3.00	4.00	
20.00	Capital DRG other than outlier	1.00	857,631	400,404	457,227	857,631	20.00
20.01	Model 4 BPCI Capital DRG other than outlier	1.01	0	0	0	0	20.01
21.00	Capital DRG outlier payments	2.00	17,382	7,637	9,745	17,382	21.00
21.01	Model 4 BPCI Capital DRG outlier payments	2.01	0	0	0	0	21.01
22.00	Indirect medical education percentage (see instructions)	5.00	0.0445	0.0445	0.0445		22.00
23.00	Indirect medical education adjustment (see instructions)	6.00	38,165	17,818	20,347	38,165	23.00
24.00	Allowable disproportionate share percentage (see instructions)	10.00	0.0597	0.0597	0.0597		24.00
25.00	Disproportionate share adjustment (see instructions)	11.00	51,201	23,904	27,297	51,201	25.00
26.00	Total prospective capital payments (see instructions)	12.00	964,379	449,763	514,616	964,379	26.00
		Wkst. E, Pt. A, line	(Amt. from Wkst. E, Pt. A)				
		0	1.00	2.00	3.00	4.00	
27.00							27.00
28.00	Low volume adjustment prior to October 1	70.96	0	0		0	28.00
29.00	Low volume adjustment on or after October 1	70.97	0		0	0	29.00
30.00	HVBP payment adjustment (see instructions)	70.93	52,818	30,291	22,527	52,818	30.00
30.01	HVBP payment adjustment for HSP bonus payment (see instructions)	70.90	0	0	0	0	30.01
31.00	HRR adjustment (see instructions)	70.94	-34,929	-6,586	-28,343	-34,929	31.00
31.01	HRR adjustment for HSP bonus payment (see instructions)	70.91	0	0	0	0	31.01
						(Amt. to Wkst. E, Pt. A)	
		0	1.00	2.00	3.00	4.00	
32.00	HAC Reduction Program adjustment (see instructions)	70.99		0	0	0	32.00
100.00	Transfer HAC Reduction Program adjustment to Wkst. E, Pt. A.		N				100.00

Health Financial Systems		CARLE BROMENN MEDICAL CENTER		In Lieu of Form CMS-2552-10	
CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0127	Period: From 07/01/2020 To 12/31/2020	Worksheet E Part B Date/Time Prepared: 7/12/2021 12:41 pm	
		Title XVIII	Hospital	PPS	
				1.00	
PART B - MEDICAL AND OTHER HEALTH SERVICES					
1.00	Medical and other services (see instructions)		3,406	1.00	
2.00	Medical and other services reimbursed under OPPS (see instructions)		6,798,878	2.00	
3.00	OPPS payments		4,728,695	3.00	
4.00	Outlier payment (see instructions)		29,702	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		5,146,751	6.00	
7.00	Sum of lines 3, 4, and 4.01, divided by line 6		92.45	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		51,407	9.00	
10.00	Organ acquisitions		0	10.00	
11.00	Total cost (sum of lines 1 and 10) (see instructions)		3,406	11.00	
COMPUTATION OF LESSER OF COST OR CHARGES					
Reasonable charges					
12.00	Ancillary service charges		24,290	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)		24,290	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)		24,290	18.00	
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)		20,884	19.00	
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)		0	20.00	
21.00	Lesser of cost or charges (see instructions)		3,406	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)		4,809,804	24.00	
COMPUTATION OF REIMBURSEMENT SETTLEMENT					
25.00	Deductibles and coinsurance amounts (for CAH, see instructions)		0	25.00	
26.00	Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)		798,833	26.00	
27.00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions)		4,014,377	27.00	
28.00	Direct graduate medical education payments (from Wkst. E-4, line 50)		93,705	28.00	
29.00	ESRD direct medical education costs (from Wkst. E-4, line 36)		0	29.00	
30.00	Subtotal (sum of lines 27 through 29)		4,108,082	30.00	
31.00	Primary payer payments		2,948	31.00	
32.00	Subtotal (line 30 minus line 31)		4,105,134	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)		10,149	34.00	
35.00	Adjusted reimbursable bad debts (see instructions)		6,597	35.00	
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		10,149	36.00	
37.00	Subtotal (see instructions)		4,111,731	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)			39.50	
39.97	Demonstration payment adjustment amount before sequestration		0	39.97	
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)		0	39.98	
39.99	RECOVERY OF ACCELERATED DEPRECIATION		0	39.99	
40.00	Subtotal (see instructions)		4,111,731	40.00	
40.01	Sequestration adjustment (see instructions)		0	40.01	
40.02	Demonstration payment adjustment amount after sequestration		0	40.02	
40.03	Sequestration adjustment-PARHM pass-throughs			40.03	
41.00	Interim payments		4,220,762	41.00	
41.01	Interim payments-PARHM			41.01	
42.00	Tentative settlement (for contractors use only)		0	42.00	
42.01	Tentative settlement-PARHM (for contractor use only)			42.01	
43.00	Balance due provider/program (see instructions)		-109,031	43.00	
43.01	Balance due provider/program-PARHM (see instructions)			43.01	
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		0	44.00	
TO BE COMPLETED BY CONTRACTOR					
90.00	Original outlier amount (see instructions)		45,117	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 07/01/2020
To 12/31/2020Worksheet E-1
Part I
Date/Time Prepared:
7/12/2021 12:41 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		13,081,529		4,165,418	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	09/09/2020	55,344	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		55,344	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)		13,081,529		4,220,762	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		554,736		0	6.01	
6.02	SETTLEMENT TO PROGRAM		0		109,031	6.02	
7.00	Total Medicare program liability (see instructions)		13,636,265		4,111,731	7.00	
				Contractor Number	NPR Date (Mo/Day/Yr)		
		0		1.00	2.00		
8.00	Name of Contractor	NATIONAL GOVERNMENT SERVICES INC.		06101		8.00	

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

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

 Period:
 From 07/01/2020
 To 12/31/2020

 Worksheet E-1
 Part I
 Date/Time Prepared:
 7/12/2021 12:41 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				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		1,414,794		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	09/09/2020	8,824		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)		8,824		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		1,423,618		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		31,777		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		1,455,395		0	7.00
				Contractor Number	NPR Date (Mo/Day/Yr)	
				1.00	2.00	
8.00	Name of Contractor	0		06101		8.00
		NATIONAL GOVERNMENT SERVICES INC.				

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT

Provider CCN: 14-0127

Period:
From 07/01/2020
To 12/31/2020Worksheet E-1
Part II
Date/Time Prepared:
7/12/2021 12:41 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 07/01/2020 To 12/31/2020	Worksheet E-3 Part III Date/Time Prepared: 7/12/2021 12:41 pm
		Title XVIII	Subprovider - IRF	PPS
				1.00
PART III - MEDICARE PART A SERVICES - IRF PPS				
1.00	Net Federal PPS Payment (see instructions)		1,285,479	1.00
2.00	Medicare SSI ratio (IRF PPS only) (see instructions)		0.0107	2.00
3.00	Inpatient Rehabilitation LIP Payments (see instructions)		65,174	3.00
4.00	Outlier Payments		102,963	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)		9.331522	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)		1,453,616	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)			15.00
16.00	Cost of physicians' services in a teaching hospital (see instructions)		0	16.00
17.00	Subtotal (see instructions)		1,453,616	17.00
18.00	Primary payer payments		0	18.00
19.00	Subtotal (line 17 less line 18).		1,453,616	19.00
20.00	Deductibles		5,632	20.00
21.00	Subtotal (line 19 minus line 20)		1,447,984	21.00
22.00	Coinsurance		0	22.00
23.00	Subtotal (line 21 minus line 22)		1,447,984	23.00
24.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)		1,675	24.00
25.00	Adjusted reimbursable bad debts (see instructions)		1,089	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)		1,449,073	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)		6,322	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)		1,455,395	32.00
32.01	Sequestration adjustment (see instructions)		0	32.01
32.02	Demonstration payment adjustment amount after sequestration		0	32.02
33.00	Interim payments		1,423,618	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)		31,777	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		102,963	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 07/01/2020 To 12/31/2020	Worksheet E-4 Date/Time Prepared: 7/12/2021 12:41 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)			6.35	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.	3.27	3.08	6.35	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.	3.22	3.03	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	3.22	3.03		11.00
12.00	Total weighted resident FTE count for the prior cost reporting year (see instructions)	3.20	3.19		12.00
13.00	Total weighted resident FTE count for the penultimate cost reporting year (see instructions)	2.93	3.76		13.00
14.00	Rolling average FTE count (sum of lines 11 through 13 divided by 3).	3.12	3.33		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	3.12	3.33		17.00
18.00	Per resident amount	105,801.54	105,801.54		18.00
19.00	Approved amount for resident costs	330,101	352,319	682,420	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)			0.10	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)			682,420	25.00
		Inpatient Part	Managed Care	Total	
		A			
		1.00	2.00	3.00	
COMPUTATION OF PROGRAM PATIENT LOAD					
26.00	Inpatient Days (see instructions) (Title XIX - see S-2 Part IX, line 3.02, column 2)	5,815	2,577		26.00
27.00	Total Inpatient Days (see instructions)	16,310	16,310		27.00
28.00	Ratio of inpatient days to total inpatient days	0.356530	0.158001		28.00
29.00	Program direct GME amount	243,303	107,823	351,126	29.00
29.01	Percent reduction for MA DGME		7.00		29.01
30.00	Reduction for direct GME payments for Medicare Advantage		7,548	7,548	30.00
31.00	Net Program direct GME amount			343,578	31.00

DIRECT GRADUATE MEDICAL EDUCATION (GME) & ESRD OUTPATIENT DIRECT MEDICAL EDUCATION COSTS		Provider CCN: 14-0127	Period: From 07/01/2020 To 12/31/2020	Worksheet E-4 Date/Time Prepared: 7/12/2021 12:41 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)			398,685	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)			18,271,831	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)			3,592	40.00
41.00	Total Part A reasonable cost (sum of lines 37 through 39 minus line 40)			18,268,239	41.00
Part B Reasonable Cost					
42.00	Reasonable cost (see instructions)			6,853,691	42.00
43.00	Primary payer payments (see instructions)			2,948	43.00
44.00	Total Part B reasonable cost (line 42 minus line 43)			6,850,743	44.00
45.00	Total reasonable cost (sum of lines 41 and 44)			25,118,982	45.00
46.00	Ratio of Part A reasonable cost to total reasonable cost (line 41 ÷ line 45)			0.727268	46.00
47.00	Ratio of Part B reasonable cost to total reasonable cost (line 44 ÷ line 45)			0.272732	47.00
ALLOCATION OF MEDICARE DIRECT GME COSTS BETWEEN PART A AND PART B					
48.00	Total program GME payment (line 31)			343,578	48.00
49.00	Part A Medicare GME payment (line 46 x 48) (title XVIII only) (see instructions)			249,873	49.00
50.00	Part B Medicare GME payment (line 47 x 48) (title XVIII only) (see instructions)			93,705	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 07/01/2020
To 12/31/2020

Worksheet G

Date/Time Prepared:
7/12/2021 12:41 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	449,712,000	0	0	0	1.00
2.00 Temporary investments	106,529,000	0	0	0	2.00
3.00 Notes receivable	0	0	0	0	3.00
4.00 Accounts receivable	1,620,938,000	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	637,826,000	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)	2,815,005,000	0	0	0	11.00
FIXED ASSETS					
12.00 Land	497,363,000	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	7,875,340,000	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	2,496,988,000	0	0	0	23.00
24.00 Accumulated depreciation	-4,967,768,000	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)	5,901,923,000	0	0	0	30.00
OTHER ASSETS					
31.00 Investments	9,140,565,000	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	1,075,876,000	0	0	0	34.00
35.00 Total other assets (sum of lines 31-34)	10,216,441,000	0	0	0	35.00
36.00 Total assets (sum of lines 11, 30, and 35)	18,933,369,000	0	0	0	36.00
CURRENT LIABILITIES					
37.00 Accounts payable	1,863,035,000	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)	77,957,000	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	767,958,000	0	0	0	44.00
45.00 Total current liabilities (sum of lines 37 thru 44)	2,708,950,000	0	0	0	45.00
LONG TERM LIABILITIES					
46.00 Mortgage payable	2,729,366,000	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	1,796,389,000	0	0	0	49.00
50.00 Total long term liabilities (sum of lines 46 thru 49)	4,525,755,000	0	0	0	50.00
51.00 Total liabilities (sum of lines 45 and 50)	7,234,705,000	0	0	0	51.00
CAPITAL ACCOUNTS					
52.00 General fund balance	11,698,664,000	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)	11,698,664,000	0	0	0	59.00
60.00 Total liabilities and fund balances (sum of lines 51 and 59)	18,933,369,000	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 14-0127

Period:
From 07/01/2020
To 12/31/2020

Worksheet G-1

Date/Time Prepared:
7/12/2021 12:41 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		10,242,997,000		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		114,820,092				2.00
3.00	Total (sum of line 1 and line 2)		10,357,817,092		0		3.00
4.00	Additions (credit adjustments) (specify)	0		0		0	4.00
5.00	ADJ TO AHC FUND BALANCE	1,453,204,431		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)		1,453,204,431		0		10.00
11.00	Subtotal (line 3 plus line 10)		11,811,021,523		0		11.00
12.00	RECONCILING ITEM	0		0		0	12.00
13.00		0		0		0	13.00
14.00		0		0		0	14.00
15.00		0		0		0	15.00
16.00		0		0		0	16.00
17.00		0		0		0	17.00
18.00	Total deductions (sum of lines 12-17)		0		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		11,811,021,523		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	ADJ TO AHC FUND BALANCE		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			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 07/01/2020
To 12/31/2020Worksheet G-2
Parts I & II
Date/Time Prepared:
7/12/2021 12:41 pm

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
PART I - PATIENT REVENUES					
General Inpatient Routine Services					
1.00	Hospital	42,295,032		42,295,032	1.00
2.00	SUBPROVIDER - IPF	0		0	2.00
3.00	SUBPROVIDER - IRF	2,719,340		2,719,340	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)	45,014,372		45,014,372	10.00
Intensive Care Type Inpatient Hospital Services					
11.00	INTENSIVE CARE UNIT	23,068,351		23,068,351	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)	23,068,351		23,068,351	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	68,082,723		68,082,723	17.00
18.00	Ancillary services	177,469,011	199,955,074	377,424,085	18.00
19.00	Outpatient services	11,449,157	44,619,951	56,069,108	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)	257,000,891	244,575,025	501,575,916	28.00
PART II - OPERATING EXPENSES					
29.00	Operating expenses (per Wkst. A, column 3, line 200)		64,727,859		29.00
30.00	ADD (SPECIFY)	0			30.00
31.00	IMMATERIAL VARIANCE	73			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)		73		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)		64,727,932		43.00

STATEMENT OF REVENUES AND EXPENSES

Provider CCN: 14-0127

Period:
From 07/01/2020
To 12/31/2020

Worksheet G-3

Date/Time Prepared:
7/12/2021 12:41 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	501,575,916	1.00
2.00	Less contractual allowances and discounts on patients' accounts	327,030,103	2.00
3.00	Net patient revenues (line 1 minus line 2)	174,545,813	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	64,727,932	4.00
5.00	Net income from service to patients (line 3 minus line 4)	109,817,881	5.00
OTHER INCOME			
6.00	Contributions, donations, bequests, etc	1,199,640	6.00
7.00	Income from investments	5,993	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	230,259	13.00
14.00	Revenue from meals sold to employees and guests	240,394	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	1,329,514	17.00
18.00	Revenue from sale of medical records and abstracts	682	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	81,757	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	990,809	20.00
21.00	Rental of vending machines	0	21.00
22.00	Rental of hospital space	12,000	22.00
23.00	Governmental appropriations	0	23.00
24.00	OTHER	911,163	24.00
24.50	COVID-19 PHE Funding	0	24.50
25.00	Total other income (sum of lines 6-24)	5,002,211	25.00
26.00	Total (line 5 plus line 25)	114,820,092	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)	114,820,092	29.00

CALCULATION OF CAPITAL PAYMENT		Provider CCN: 14-0127	Period: From 07/01/2020 To 12/31/2020	Worksheet L Parts I-III Date/Time Prepared: 7/12/2021 12:41 pm
		Title XVIII	Hospital	PPS
		1.00		
PART I - FULLY PROSPECTIVE METHOD				
CAPITAL FEDERAL AMOUNT				
1.00	Capital DRG other than outlier		857,631	1.00
1.01	Model 4 BPCI Capital DRG other than outlier		0	1.01
2.00	Capital DRG outlier payments		17,382	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)		81.56	3.00
4.00	Number of interns & residents (see instructions)		12.57	4.00
5.00	Indirect medical education percentage (see instructions)		4.45	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)		38,165	6.00
7.00	Percentage of SSI recipient patient days to Medicare Part A patient days (Worksheet E, part A line 30) (see instructions)		5.32	7.00
8.00	Percentage of Medicaid patient days to total days (see instructions)		23.34	8.00
9.00	Sum of lines 7 and 8		28.66	9.00
10.00	Allowable disproportionate share percentage (see instructions)		5.97	10.00
11.00	Disproportionate share adjustment (see instructions)		51,201	11.00
12.00	Total prospective capital payments (see instructions)		964,379	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