

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: 14-0206	Period: From 10/01/2019 To 09/30/2020	Worksheet S Parts I-III Date/Time Prepared: 4/26/2021 2:25 pm
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PART I - COST REPORT STATUS

Provider use only	1. ☒ Electronically prepared cost report	Date: 4/26/2021	Time: 2:25 pm
	2. ☐ Manually prepared cost report		
	3. ☐ If this is an amended report enter the number of times the provider resubmitted this cost report		
	4. ☐ Medicare Utilization. Enter "F" for full or "L" for low.		
Contractor use only	5. ☐ Cost Report Status (1) As Submitted (2) Settled without Audit (3) Settled with Audit (4) Reopened (5) Amended	6. Date Received: 7. Contractor No. 8. ☐ Initial Report for this Provider CCN 9. ☐ Final Report for this Provider CCN	10. NPR Date: 11. Contractor's Vendor Code: 4 12. ☐ If line 5, column 1 is 4: Enter number of times reopened = 0-9.

PART II - CERTIFICATION

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

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

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by NORWEGIAN AMERICAN HOSPITAL (14-0206) for the cost reporting period beginning 10/01/2019 and ending 09/30/2020 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

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

(Signed)

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	174,338	-189,112	0	0	1.00
2.00	Subprovider - IPF	0	2,422	0		0	2.00
3.00	Subprovider - IRF	0	0	0		0	3.00
5.00	Swing Bed - SNF	0	0	0		0	5.00
6.00	Swing Bed - NF	0				0	6.00
200.00	Total	0	176,760	-189,112	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: 14-0206		Period: From 10/01/2019 To 09/30/2020		Worksheet S-2 Part I Date/Time Prepared: 4/26/2021 2:25 pm	
1.00		2.00		3.00		4.00				
Hospital and Hospital Health Care Complex Address:										
1.00	Street: 1044 N. FRANSISCO AVENUE			PO Box:				1.00		
2.00	City: CHICAGO			State: IL		Zip Code: 60622		County: COOK		
		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		NORWEGIAN AMERICAN HOSPITAL	140206	16974	1	07/01/1966	N	P	O
4.00	Subprovider - IPF		NORWEGIAN AMERICAN HOSP - PSYCH	14S206	16974	4	10/01/2006	N	P	O
5.00	Subprovider - IRF									
6.00	Subprovider - (Other)									
7.00	Swing Beds - SNF									
8.00	Swing Beds - NF									
9.00	Hospital-Based SNF									
10.00	Hospital-Based NF									
11.00	Hospital-Based OLTC									
12.00	Hospital-Based HHA									
13.00	Separately Certified ASC									
14.00	Hospital-Based Hospice									
15.00	Hospital-Based Health Clinic - RHC									
16.00	Hospital-Based Health Clinic - FQHC									
17.00	Hospital-Based (CMHC) I									
17.10	Hospital-Based (CORF) I									
17.20	Hospital-Based (OPT) I									
17.30	Hospital-Based (OOT) I									
17.40	Hospital-Based (OSP) I									
18.00	Renal Dialysis									
19.00	Other									
							From:	To:		
							1.00	2.00		
20.00	Cost Reporting Period (mm/dd/yyyy)						10/01/2019	09/30/2020		20.00
21.00	Type of Control (see instructions)						2			21.00
							1.00	2.00		3.00
Inpatient PPS Information										
22.00	Does this facility qualify and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.106(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no.					Y	N			22.00
22.01	Did this hospital receive interim uncompensated care payments for this cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)					Y	Y			22.01
22.02	Is this a newly merged hospital that requires final uncompensated care payments to be determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1.					N	N			22.02
22.03	Did this hospital receive a geographic reclassification from urban to rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no.					N	N		N	22.03
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.					1	N			23.00

Worksheet S-2
Part I
Date/Time Prepared:
4/26/2021 2:25 pm

MCRIF32 - 16.9.172.5

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-0206		Period: From 10/01/2019 To 09/30/2020		Worksheet S-2 Part I Date/Time Prepared: 4/26/2021 2:25 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.	N					60.00
		Y/N	IME	Direct GME	IME	Direct GME	
		1.00	2.00	3.00	4.00	5.00	
61.00	Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions)	N			0.00	0.00	61.00
61.01	Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions)						61.01
61.02	Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions)						61.02
61.03	Enter the base line FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions)						61.03
61.04	Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period.(see instructions).						61.04
61.05	Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions)						61.05
61.06	Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)						61.06
		Program Name		Program Code	Unweighted IME FTE Count	Unweighted Direct GME FTE Count	
		1.00		2.00	3.00	4.00	
61.10	Of the FTEs in line 61.05, specify each new program specialty, if any, and the number of FTE residents for each new program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count.				0.00	0.00	61.10
61.20	Of the FTEs in line 61.05, specify each expanded program specialty, if any, and the number of FTE residents for each expanded program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count.				0.00	0.00	61.20
						1.00	
ACA Provisions Affecting the Health Resources and Services Administration (HRSA)							
62.00	Enter the number of FTE residents that your hospital trained in this cost reporting period for which your hospital received HRSA PCRE funding (see instructions)					0.00	62.00
62.01	Enter the number of FTE residents that rotated from a Teaching Health Center (THC) into your hospital during in this cost reporting period of HRSA THC program. (see instructions)					0.00	62.01
Teaching Hospitals that Claim Residents in Nonprovider Settings							
63.00	Has your facility trained residents in nonprovider settings during this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If yes, complete lines 64 through 67. (see instructions)					N	63.00
		Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))			
		1.00	2.00	3.00			
64.00	Section 5504 of the ACA Base Year FTE Residents in Nonprovider Settings--This base year is your cost reporting period that begins on or after July 1, 2009 and before June 30, 2010. Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)	0.00		0.00	0.000000		64.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

Provider CCN: 14-0206

Period:
From 10/01/2019
To 09/30/2020Worksheet S-2
Part I
Date/Time Prepared:
4/26/2021 2:25 pm

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-0206	Period: From 10/01/2019 To 09/30/2020	Worksheet S-2 Part I Date/Time Prepared: 4/26/2021 2:25 pm
			1.00	
Long Term Care Hospital PPS				
80.00	Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for no.	N		80.00
81.00	Is this a LTCH co-located within another hospital for part or all of the cost reporting period? Enter "Y" for yes and "N" for no.	N		81.00
TEFRA Providers				
85.00	Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no.	N		85.00
86.00	Did this facility establish a new Other subprovider (excluded unit) under 42 CFR Section §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.			86.00
87.00	Is this hospital an extended neoplastic disease care hospital classified under section 1886(d)(1)(B)(vi)? Enter "Y" for yes or "N" for no.	N		87.00
		V	XIX	
		1.00	2.00	
Title V and XIX Services				
90.00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.	N	Y	90.00
91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.	N	Y	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.	N	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.	N	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.	N	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.	N	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.	N	Y	98.06
Rural Providers				
105.00	Does this hospital qualify as a CAH?	N		105.00
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)			106.00
107.00	Column 1: If line 105 is Y, is this facility eligible for cost reimbursement for I&R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) Column 2: If column 1 is Y and line 70 or line 75 is Y, do you train I&Rs in an approved medical education program in the CAH's excluded IPF and/or IRF unit(s)? Enter "Y" for yes or "N" for no in column 2. (see instructions)			107.00
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	N		108.00
		Physical	Occupational	Speech
		1.00	2.00	3.00
				Respiratory
				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.			109.00
				1.00
110.00	Did this hospital participate in the Rural Community Hospital Demonstration project (§410A Demonstration) for the current cost reporting period? Enter "Y" for yes or "N" for no. If yes, complete Worksheet E, Part A, lines 200 through 218, and Worksheet E-2, lines 200 through 215, as applicable.		N	110.00

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		1.00	2.00	
111.00	If this facility qualifies as a CAH, did it participate in the Frontier Community Health Integration Project (FCHIP) demonstration for this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If the response to column 1 is Y, enter the integration prong of the FCHIP demo in which this CAH is participating in column 2. Enter all that apply: "A" for Ambulance services; "B" for additional beds; and/or "C" for tele-health services.	N		111.00
		1.00	2.00	3.00
112.00	Did this hospital participate in the Pennsylvania Rural Health Model demonstration for any portion of the current cost reporting period? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2, the date the hospital began participating in the demonstration. In column 3, enter the date the hospital ceased participation in the demonstration, if applicable.	N		112.00
Miscellaneous Cost Reporting Information				
115.00	Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in column 1. If column 1 is yes, enter the method used (A, B, or E only) in column 2. If column 2 is "E", enter in column 3 either "93" percent for short term hospital or "98" percent for long term care (includes psychiatric, rehabilitation and long term hospitals providers) based on the definition in CMS Pub.15-1, chapter 22, §2208.1.	N		0115.00
116.00	Is this facility classified as a referral center? Enter "Y" for yes or "N" for no.	N		116.00
117.00	Is this facility legally required to carry malpractice insurance? Enter "Y" for yes or "N" for no.	N		117.00
118.00	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.	2		118.00
		Premiums	Losses	Insurance
		1.00	2.00	3.00
118.01	List amounts of malpractice premiums and paid losses:	3,384,025	0	0118.01
		1.00	2.00	
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein.	N		118.02
119.00	DO NOT USE THIS LINE			119.00
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 1, "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2, "Y" for yes or "N" for no.	N	N	120.00
121.00	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter "Y" for yes or "N" for no.	Y		121.00
122.00	Does the cost report contain healthcare related taxes as defined in §1903(w)(3) of the Act? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2 the Worksheet A line number where these taxes are included.	N		122.00
Transplant Center Information				
125.00	Does this facility operate a transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.	N		125.00
126.00	If this is a Medicare certified kidney transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			126.00
127.00	If this is a Medicare certified heart transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			127.00
128.00	If this is a Medicare certified liver transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			128.00
129.00	If this is a Medicare certified lung transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			129.00
130.00	If this is a Medicare certified pancreas transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			130.00
131.00	If this is a Medicare certified intestinal transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			131.00
132.00	If this is a Medicare certified islet transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			132.00
133.00	Removed and reserved			133.00
134.00	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.			134.00
All Providers				
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)	N		140.00

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1.00		2.00		3.00						
If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number.										
141.00	Name:	Contractor's Name:		Contractor's Number:				141.00		
142.00	Street:	PO Box:						142.00		
143.00	City:	State:		Zip Code:				143.00		
								1.00		
144.00	Are provider based physicians' costs included in Worksheet A?							Y	144.00	
								1.00	2.00	
145.00	If costs for renal services are claimed on Wkst. A, line 74, are the costs for inpatient services only? Enter "Y" for yes or "N" for no in column 1. If column 1 is no, does the dialysis facility include Medicare utilization for this cost reporting period? Enter "Y" for yes or "N" for no in column 2.				Y				145.00	
146.00	Has the cost allocation methodology changed from the previously filed cost report? Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, chapter 40, §4020) If yes, enter the approval date (mm/dd/yyyy) in column 2.				N				146.00	
								1.00		
147.00	Was there a change in the statistical basis? Enter "Y" for yes or "N" for no.							N	147.00	
148.00	Was there a change in the order of allocation? Enter "Y" for yes or "N" for no.							N	148.00	
149.00	Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no.							N	149.00	
				Part A	Part B	Title V	Title XIX			
				1.00	2.00	3.00	4.00			
Does this facility contain a provider that qualifies for an exemption from the application of the lower of costs or charges? Enter "Y" for yes or "N" for no for each component for Part A and Part B. (See 42 CFR §413.13)										
155.00	Hospital	N		N		N		N		155.00
156.00	Subprovider - IPF	N		N		N		N		156.00
157.00	Subprovider - IRF	N		N		N		N		157.00
158.00	SUBPROVIDER									158.00
159.00	SNF	N		N		N		N		159.00
160.00	HOME HEALTH AGENCY	N		N		N		N		160.00
161.00	CMHC			N		N		N		161.00
161.10	CORF			N		N		N		161.10
161.20	OUTPATIENT PHYSICAL THERAPY			N		N		N		161.20
161.30	OUTPATIENT OCCUPATIONAL THERAPY			N		N		N		161.30
161.40	OUTPATIENT SPEECH PATHOLOGY			N		N		N		161.40
								1.00		
Multicampus										
165.00	Is this hospital part of a Multicampus hospital that has one or more campuses in different CBSAs? Enter "Y" for yes or "N" for no.							N	165.00	
		Name	County	State	Zip Code	CBSA	FTE/Campus			
		0	1.00	2.00	3.00	4.00	5.00			
166.00	If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions)						0.00			166.00
								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	
						Beginning	Ending			
						1.00	2.00			
170.00	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)								170.00	
						1.00	2.00			
171.00	If line 167 is "Y", does this provider have any days for individuals enrolled in section 1876 Medicare cost plans reported on Wkst. S-3, Pt. I, line 2, col. 6? Enter "Y" for yes and "N" for no in column 1. If column 1 is yes, enter the number of section 1876 Medicare days in column 2. (see instructions)					N	0		171.00	

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 14-0206	Period: From 10/01/2019 To 09/30/2020	Worksheet S-2 Part II Date/Time Prepared: 4/26/2021 2:25 pm
			Y/N 1.00	Date 2.00
General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format.				
COMPLETED BY ALL HOSPITALS				
Provider Organization and Operation				
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)	N		1.00
		Y/N 1.00	Date 2.00	V/I 3.00
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.	N		2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)	N		3.00
		Y/N 1.00	Type 2.00	Date 3.00
Financial Data and Reports				
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	Y	A	4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.	N		5.00
			Y/N 1.00	Legal Oper. 2.00
Approved Educational Activities				
6.00	Column 1: Are costs claimed for nursing school? Column 2: If yes, is the provider is the legal operator of the program?	N		6.00
7.00	Are costs claimed for Allied Health Programs? If "Y" see instructions.	N		7.00
8.00	Were nursing school and/or allied health programs approved and/or renewed during the cost reporting period? If yes, see instructions.	N		8.00
9.00	Are costs claimed for Interns and Residents in an approved graduate medical education program in the current cost report? If yes, see instructions.	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
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	02/10/2021	Y 02/10/2021
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N		N
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		N

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE

Provider CCN: 14-0206

Period:
From 10/01/2019
To 09/30/2020Worksheet S-2
Part II
Date/Time Prepared:
4/26/2021 2:25 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?				36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.				37.00
38.00	If line 36 is yes, was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.				38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.				39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.				40.00
		1.00	2.00		
Cost Report Preparer Contact Information					
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	RAJ	SHAH		41.00
42.00	Enter the employer/company name of the cost report preparer.	STRATEGIC REIMBURSEMENT GROUP LLC			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	630 530-7100, X107	RAJ.SHAH@SRGROUPLLC.COM		43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE

Provider CCN: 14-0206

Period:
From 10/01/2019
To 09/30/2020Worksheet S-2
Part II
Date/Time Prepared:
4/26/2021 2:25 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.	MANAGER	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: 14-0206

Period:
From 10/01/2019
To 09/30/2020Worksheet S-3
Part I
Date/Time Prepared:
4/26/2021 2:25 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		30.00	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	161	58,926	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)		161	58,926	0.00	0	7.00
8.00	INTENSIVE CARE UNIT	31.00	12	4,392	0.00	0	8.00
8.01	NICU	31.01	0	0	0.00	0	8.01
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)		173	63,318	0.00	0	14.00
15.00	CAH visits					0	15.00
16.00	SUBPROVIDER - IPF	40.00	12	4,392		0	16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)	30.00					24.10
25.00	CMHC - CMHC						25.00
25.10	CMHC - CORF	99.10				0	25.10
25.20	CMHC - OUTPATIENT PHYSICAL THERAPY	99.20				0	25.20
25.30	CMHC - OUTPATIENT OCCUPATIONAL THERAPY	99.30				0	25.30
25.40	CMHC - OUTPATIENT SPEECH PATHOLOGY	99.40				0	25.40
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)		185				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: 14-0206

Period:
From 10/01/2019
To 09/30/2020Worksheet S-3
Part I
Date/Time Prepared:
4/26/2021 2:25 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)	6,487	2,940	27,056			1.00
2.00	HMO and other (see instructions)	3,287	14,015				2.00
3.00	HMO IPF Subprovider	5	0				3.00
4.00	HMO IRF Subprovider	0	0				4.00
5.00	Hospital Adults & Peds. Swing Bed SNF	0	0	0			5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	0			6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	6,487	2,940	27,056			7.00
8.00	INTENSIVE CARE UNIT	662	310	2,985			8.00
8.01	NICU	0	0	0			8.01
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		196	887			13.00
14.00	Total (see instructions)	7,149	3,446	30,928	21.00	701.33	14.00
15.00	CAH visits	0	0	0			15.00
16.00	SUBPROVIDER - IPF	1,119	216	3,485	0.00	12.28	16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)			14			24.10
25.00	CMHC - CMHC						25.00
25.10	CMHC - CORF	0	0	0	0.00	0.00	25.10
25.20	CMHC - OUTPATIENT PHYSICAL THERAPY	0	0	0	0.00	0.00	25.20
25.30	CMHC - OUTPATIENT OCCUPATIONAL THERAPY	0	0	0	0.00	0.00	25.30
25.40	CMHC - OUTPATIENT SPEECH PATHOLOGY	0	0	0	0.00	0.00	25.40
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)				21.00	713.61	27.00
28.00	Observation Bed Days		63	2,800			28.00
29.00	Ambulance Trips	0					29.00
30.00	Employee discount days (see instruction)			0			30.00
31.00	Employee discount days - IRF			0			31.00
32.00	Labor & delivery days (see instructions)	0	78	108			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: 14-0206

Period:
From 10/01/2019
To 09/30/2020Worksheet S-3
Part I
Date/Time Prepared:
4/26/2021 2:25 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	1,144	663	5,405	1.00
2.00 HMO and other (see instructions)			535	2,761		2.00
3.00 HMO IPF Subprovider				0		3.00
4.00 HMO IRF Subprovider				0		4.00
5.00 Hospital Adults & Peds. Swing Bed SNF						5.00
6.00 Hospital Adults & Peds. Swing Bed NF						6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)						7.00
8.00 INTENSIVE CARE UNIT						8.00
8.01 NICU						8.01
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	1,144	663	5,405	14.00
15.00 CAH visits						15.00
16.00 SUBPROVIDER - IPF	0.00	0	132	29	462	16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY						22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
24.10 HOSPICE (non-distinct part)						24.10
25.00 CMHC - CMHC						25.00
25.10 CMHC - CORF	0.00					25.10
25.20 CMHC - OUTPATIENT PHYSICAL THERAPY	0.00					25.20
25.30 CMHC - OUTPATIENT OCCUPATIONAL THERAPY	0.00					25.30
25.40 CMHC - OUTPATIENT SPEECH PATHOLOGY	0.00					25.40
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: 14-0206

Period:
From 10/01/2019
To 09/30/2020Worksheet S-3
Part II
Date/Time Prepared:
4/26/2021 2:25 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	53,391,653	0	53,391,653	1,484,319.00	35.97
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		882,099	0	882,099	5,965.00	147.88
4.01	Physicians - Part A - Teaching		0	0	0	0.00	0.00
5.00	Physician and Non Physician-Part B		3,077,920	0	3,077,920	30,826.00	99.85
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	164,131	0	164,131	5,954.00	27.57
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)		2,672,042	0	2,672,042	80,965.00	33.00
OTHER WAGES & RELATED COSTS							
11.00	Contract labor: Direct Patient Care		2,610,929	0	2,610,929	35,559.00	73.43
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)		12,430,107	0	12,430,107		
18.00	Wage-related costs (other) (see instructions)						
19.00	Excluded areas		731,289	0	731,289		
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		110,946	0	110,946		
22.01	Physician Part A - Teaching		0	0	0		
23.00	Physician Part B		450,030	0	450,030		
24.00	Wage-related costs (RHC/FQHC)		0	0	0		
25.00	Interns & residents (in an approved program)		51,082	0	51,082		
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: 14-0206

Period:
From 10/01/2019
To 09/30/2020Worksheet S-3
Part II
Date/Time Prepared:
4/26/2021 2:25 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	3,304,646	0	3,304,646	114,272.00	28.92	26.00
27.00	Administrative & General	5.00	11,034,293	0	11,034,293	161,796.00	68.20	27.00
28.00	Administrative & General under contract (see inst.)		722,686	0	722,686	4,661.00	155.05	28.00
29.00	Maintenance & Repairs	6.00	0	0	0	0.00	0.00	29.00
30.00	Operation of Plant	7.00	1,660,539	0	1,660,539	64,181.00	25.87	30.00
31.00	Laundry & Linen Service	8.00	0	0	0	0.00	0.00	31.00
32.00	Housekeeping	9.00	1,305,744	0	1,305,744	78,933.00	16.54	32.00
33.00	Housekeeping under contract (see instructions)		0	0	0	0.00	0.00	33.00
34.00	Dietary	10.00	820,693	-243,667	577,026	34,855.00	16.56	34.00
35.00	Dietary under contract (see instructions)		512,690	0	512,690	11,766.00	43.57	35.00
36.00	Cafeteria	11.00	0	243,667	243,667	14,719.00	16.55	36.00
37.00	Maintenance of Personnel	12.00	0	0	0	0.00	0.00	37.00
38.00	Nursing Administration	13.00	1,344,018	0	1,344,018	24,258.00	55.41	38.00
39.00	Central Services and Supply	14.00	576,813	0	576,813	20,767.00	27.78	39.00
40.00	Pharmacy	15.00	1,577,326	0	1,577,326	48,661.00	32.41	40.00
41.00	Medical Records & Medical Records Library	16.00	374,663	0	374,663	14,604.00	25.65	41.00
42.00	Social Service	17.00	696,157	0	696,157	20,456.00	34.03	42.00
43.00	Other General Service	18.00	0	0	0	0.00	0.00	43.00

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 14-0206

Period:
From 10/01/2019
To 09/30/2020Worksheet S-3
Part III
Date/Time Prepared:
4/26/2021 2:25 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)	51,384,978	0	51,384,978	1,463,966.00	35.10	1.00
2.00	Excluded area salaries (see instructions)	2,672,042	0	2,672,042	80,965.00	33.00	2.00
3.00	Subtotal salaries (line 1 minus line 2)	48,712,936	0	48,712,936	1,383,001.00	35.22	3.00
4.00	Subtotal other wages & related costs (see inst.)	2,610,929	0	2,610,929	35,559.00	73.43	4.00
5.00	Subtotal wage-related costs (see inst.)	12,541,053	0	12,541,053	0.00	25.74	5.00
6.00	Total (sum of lines 3 thru 5)	63,864,918	0	63,864,918	1,418,560.00	45.02	6.00
7.00	Total overhead cost (see instructions)	23,930,268	0	23,930,268	613,929.00	38.98	7.00

HOSPITAL WAGE RELATED COSTS

Provider CCN: 14-0206

Period:
From 10/01/2019
To 09/30/2020Worksheet S-3
Part IV
Date/Time Prepared:
4/26/2021 2:25 pm

		Amount Reported	
		1.00	
PART IV - WAGE RELATED COSTS			
Part A - Core List			
RETIREMENT COST			
1.00	401K Employer Contributions	401,938	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)	3,670,395	4.00
PLAN ADMINISTRATIVE COSTS (Paid to External Organization)			
5.00	401K/TSA Plan Administration fees	0	5.00
6.00	Legal/Accounting/Management Fees-Pension Plan	0	6.00
7.00	Employee Managed Care Program Administration Fees	0	7.00
HEALTH AND INSURANCE COST			
8.00	Health Insurance (Purchased or Self Funded)	0	8.00
8.01	Health Insurance (Self Funded without a Third Party Administrator)	0	8.01
8.02	Health Insurance (Self Funded with a Third Party Administrator)	0	8.02
8.03	Health Insurance (Purchased)	3,823,750	8.03
9.00	Prescription Drug Plan	0	9.00
10.00	Dental, Hearing and Vision Plan	219,480	10.00
11.00	Life Insurance (If employee is owner or beneficiary)	104,037	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)	270,088	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)	0	14.00
15.00	'Workers' Compensation Insurance	1,251,261	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	2,971,680	17.00
18.00	Medicare Taxes - Employers Portion Only	732,938	18.00
19.00	Unemployment Insurance	239,170	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	88,718	23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)	13,773,455	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: 14-0206

 Period:
 From 10/01/2019
 To 09/30/2020

 Worksheet S-3
 Part V
 Date/Time Prepared:
 4/26/2021 2:25 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	2,610,929	13,773,455	1.00
2.00	Hospital	2,610,929	13,773,455	2.00
3.00	Subprovider - IPF	0	0	3.00
4.00	Subprovider - IRF			4.00
5.00	Subprovider - (Other)	0	0	5.00
6.00	Swing Beds - SNF	0	0	6.00
7.00	Swing Beds - NF	0	0	7.00
8.00	Hospital-Based SNF			8.00
9.00	Hospital-Based NF			9.00
10.00	Hospital-Based OLTC			10.00
11.00	Hospital-Based HHA			11.00
12.00	Separately Certified ASC			12.00
13.00	Hospital-Based Hospice			13.00
14.00	Hospital-Based Health Clinic RHC			14.00
15.00	Hospital-Based Health Clinic FQHC			15.00
16.00	Hospital-Based-CMHC			16.00
16.10	Hospital-Based-CMHC 10	0	0	16.10
16.20	Hospital-Based-CMHC 20	0	0	16.20
16.30	Hospital-Based-CMHC 30	0	0	16.30
16.40	Hospital-Based-CMHC 40	0	0	16.40
17.00	Renal Dialysis	0	0	17.00
18.00	Other	0	0	18.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA

Provider CCN: 14-0206

Period:
From 10/01/2019
To 09/30/2020

Worksheet S-10

Date/Time Prepared:
4/26/2021 2:25 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)		0.280252	1.00
Medicaid (see instructions for each line)				
2.00	Net revenue from Medicaid		66,360,560	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		166,653,009	6.00
7.00	Medicaid cost (line 1 times line 6)		46,704,839	7.00
8.00	Difference between net revenue and costs for Medicaid program (line 7 minus sum of lines 2 and 5; if < zero then enter zero)		0	8.00
Children's Health Insurance Program (CHIP) (see instructions for each line)				
9.00	Net revenue from stand-alone CHIP		0	9.00
10.00	Stand-alone CHIP charges		0	10.00
11.00	Stand-alone CHIP cost (line 1 times line 10)		0	11.00
12.00	Difference between net revenue and costs for stand-alone CHIP (line 11 minus line 9; if < zero then enter zero)		0	12.00
Other state or local government indigent care program (see instructions for each line)				
13.00	Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9)		0	13.00
14.00	Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)		0	14.00
15.00	State or local indigent care program cost (line 1 times line 14)		0	15.00
16.00	Difference between net revenue and costs for state or local indigent care program (line 15 minus line 13; if < zero then enter zero)		0	16.00
Grants, donations and total unreimbursed cost for Medicaid, CHIP and state/local indigent care programs (see instructions for each line)				
17.00	Private grants, donations, or endowment income restricted to funding charity care		0	17.00
18.00	Government grants, appropriations or transfers for support of hospital operations		0	18.00
19.00	Total unreimbursed cost for Medicaid, CHIP and state and local indigent care programs (sum of lines 8, 12 and 16)		0	19.00
			Uninsured patients	Insured patients
			1.00	2.00
			Total (col. 1 + col. 2)	3.00
Uncompensated Care (see instructions for each line)				
20.00	Charity care charges and uninsured discounts for the entire facility (see instructions)	15,769,242	946,582	16,715,824
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	4,419,362	946,582	5,365,944
22.00	Payments received from patients for amounts previously written off as charity care	0	0	0
23.00	Cost of charity care (line 21 minus line 22)	4,419,362	946,582	5,365,944
			1.00	
24.00	Does the amount on line 20 column 2, include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?		N	24.00
25.00	If line 24 is yes, enter the charges for patient days beyond the indigent care program's length of stay limit		0	25.00
26.00	Total bad debt expense for the entire hospital complex (see instructions)		2,536,585	26.00
27.00	Medicare reimbursable bad debts for the entire hospital complex (see instructions)		373,989	27.00
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)		575,369	27.01
28.00	Non-Medicare bad debt expense (see instructions)		1,961,216	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)		751,015	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)		6,116,959	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)		6,116,959	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES					Provider CCN: 14-0206	Period: From 10/01/2019 To 09/30/2020	Worksheet A Date/Time Prepared: 4/26/2021 2:25 pm		
Cost Center Description			Salaries	Other	Total (col. 1 + col. 2)	Reclassification ons (See A-6)	Reclassified Trial Balance (col. 3 +- col. 4)		
			1.00	2.00	3.00	4.00	5.00		
	GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT		757,808	757,808	2,875,663	3,633,471	1.00	
2.00	00200	CAP REL COSTS-MVBLE EQUIP		0	0	1,945,128	1,945,128	2.00	
3.00	00300	OTHER CAP REL COSTS		0	0	0	0	3.00	
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	405,548	6,563,875	6,969,423	-289	6,969,134	4.00	
4.01	00401	COMMUNICATIONS	289,705	68,640	358,345	0	358,345	4.01	
4.02	00402	DATA PROCESSING	1,496,382	1,960,896	3,457,278	-304,541	3,152,737	4.02	
4.03	00403	ADMITTING	773,278	233,212	1,006,490	-1,650	1,004,840	4.03	
4.04	00404	CASHIERING	339,733	1,498,661	1,838,394	-2,796	1,835,598	4.04	
5.00	00500	ADMINISTRATIVE & GENERAL	11,034,293	19,182,489	30,216,782	-1,848,731	28,368,051	5.00	
6.00	00600	MAINTENANCE & REPAIRS	0	0	0	0	0	6.00	
7.00	00700	OPERATION OF PLANT	1,660,539	4,125,446	5,785,985	-950,959	4,835,026	7.00	
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0	0	0	8.00	
9.00	00900	HOUSEKEEPING	1,305,744	1,006,382	2,312,126	-8,173	2,303,953	9.00	
10.00	01000	DIETARY	820,693	1,891,989	2,712,682	-819,043	1,893,639	10.00	
11.00	01100	CAFETERIA	0	0	0	799,645	799,645	11.00	
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00	
13.00	01300	NURSING ADMINISTRATION	1,344,018	156,582	1,500,600	-30,601	1,469,999	13.00	
14.00	01400	CENTRAL SERVICES & SUPPLY	576,813	287,566	864,379	-45,237	819,142	14.00	
15.00	01500	PHARMACY	1,577,326	2,900,976	4,478,302	-2,086,678	2,391,624	15.00	
16.00	01600	MEDICAL RECORDS & LIBRARY	374,663	850,267	1,224,930	-4,610	1,220,320	16.00	
17.00	01700	SOCIAL SERVICE	696,157	144,137	840,294	-83	840,211	17.00	
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00	
20.00	02000	NURSING SCHOOL	0	0	0	0	0	20.00	
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	164,131	78,179	242,310	0	242,310	21.00	
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0	22.00	
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	0	0	0	23.00	
	INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	10,808,502	2,747,606	13,556,108	-537,148	13,018,960	30.00	
31.00	03100	INTENSIVE CARE UNIT	1,761,470	1,003,502	2,764,972	-55,106	2,709,866	31.00	
31.01	02060	NICU	0	0	0	0	0	31.01	
40.00	04000	SUBPROVIDER - IPF	1,046,636	656,095	1,702,731	-16,804	1,685,927	40.00	
43.00	04300	NURSERY	927,155	126,609	1,053,764	183,192	1,236,956	43.00	
	ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	1,988,695	3,420,351	5,409,046	-1,390,237	4,018,809	50.00	
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,770,860	802,960	2,573,820	-423,686	2,150,134	52.00	
53.00	05300	ANESTHESIOLOGY	40,392	2,668,852	2,709,244	-22,320	2,686,924	53.00	
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,845,392	2,054,207	3,899,599	-225,342	3,674,257	54.00	
56.01	05601	NUCLEAR MEDICINE	0	0	0	0	0	56.01	
60.00	06000	LABORATORY	3,023	4,458,750	4,461,773	-2,339	4,459,434	60.00	
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30	
65.00	06500	RESPIRATORY THERAPY	717,843	303,419	1,021,262	-20,047	1,001,215	65.00	
66.00	06600	PHYSICAL THERAPY	457,107	65,356	522,463	-16,347	506,116	66.00	
69.00	06900	ELECTROCARDIOLOGY	176,557	79,751	256,308	-40,458	215,850	69.00	
70.00	07000	ELECTROENCEPHALOGRAPHY	55,598	10,052	65,650	-698	64,952	70.00	
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	390,832	390,832	71.00	
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	1,850,336	1,850,336	72.00	
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	1,966,940	1,966,940	73.00	
74.00	07400	RENAL DIALYSIS	0	757,057	757,057	-112	756,945	74.00	
75.01	07501	ACUTE DIALYSIS	0	0	0	0	0	75.01	
75.02	03650	CARD CATH LAB	431,856	1,527,707	1,959,563	-961,755	997,808	75.02	
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97	
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98	
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99	
	OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	3,477,116	1,573,662	5,050,778	-35,039	5,015,739	90.00	
90.01	09001	PH CLINIC	0	0	0	0	0	90.01	
90.02	09002	HEALTHWORKS CLINIC	370,797	82,529	453,326	-920	452,406	90.02	
90.03	09003	DENTAL CLINIC	0	0	0	0	0	90.03	
90.04	09004	WOUND CARE THERAPY	347,622	216,684	564,306	-8,083	556,223	90.04	
90.05	09005	FAMILY PRACTICE CLINIC	0	0	0	0	0	90.05	
91.00	09100	EMERGENCY	2,680,603	2,714,738	5,395,341	-104,943	5,290,398	91.00	
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00	
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0	0	0	0	0	93.99	
	OTHER REIMBURSABLE COST CENTERS								
99.10	09910	CORF	0	0	0	0	0	99.10	
99.20	09920	OUTPATIENT PHYSICAL THERAPY	0	0	0	0	0	99.20	
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY	0	0	0	0	0	99.30	
99.40	09940	OUTPATIENT SPEECH PATHOLOGY	0	0	0	0	0	99.40	
	SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	51,766,247	66,976,992	118,743,239	46,961	118,790,200	118.00	

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-0206

Period:
From 10/01/2019
To 09/30/2020

Worksheet A

Date/Time Prepared:
4/26/2021 2:25 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	
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	927,628	280,030	1,207,658	-26,953	1,180,705	192.00
192.01	19201	PROHEALTH SERVICES	175	699,106	699,281	-9,330	689,951	192.01
192.02	19202	AUXILIARY	260,114	67,389	327,503	-9,588	317,915	192.02
192.03	19203	GRANT	437,489	84,021	521,510	-1,090	520,420	192.03
200.00		TOTAL (SUM OF LINES 118 through 199)	53,391,653	68,107,538	121,499,191	0	121,499,191	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-0206

Period:
From 10/01/2019
To 09/30/2020

Worksheet A

Date/Time Prepared:
4/26/2021 2:25 pm

Cost Center Description			Adjustments (See A-8)	Net Expenses For Allocation	
			6.00	7.00	
GENERAL SERVICE COST CENTERS					
1.00	00100	CAP REL COSTS-BLDG & FIXT	0	3,633,471	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	0	1,945,128	2.00
3.00	00300	OTHER CAP REL COSTS	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	55	6,969,189	4.00
4.01	00401	COMMUNICATIONS	0	358,345	4.01
4.02	00402	DATA PROCESSING	-12,500	3,140,237	4.02
4.03	00403	ADMITTING	0	1,004,840	4.03
4.04	00404	CASHIERING	0	1,835,598	4.04
5.00	00500	ADMINISTRATIVE & GENERAL	-11,797,008	16,571,043	5.00
6.00	00600	MAINTENANCE & REPAIRS	0	0	6.00
7.00	00700	OPERATION OF PLANT	0	4,835,026	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	8.00
9.00	00900	HOUSEKEEPING	0	2,303,953	9.00
10.00	01000	DIETARY	-13,250	1,880,389	10.00
11.00	01100	CAFETERIA	-219,527	580,118	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	0	1,469,999	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	-47,798	771,344	14.00
15.00	01500	PHARMACY	0	2,391,624	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-481	1,219,839	16.00
17.00	01700	SOCIAL SERVICE	0	840,211	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	19.00
20.00	02000	NURSING SCHOOL	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	-200	242,110	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	-137,960	12,881,000	30.00
31.00	03100	INTENSIVE CARE UNIT	-97,500	2,612,366	31.00
31.01	02060	NICU	0	0	31.01
40.00	04000	SUBPROVIDER - IPF	-503,569	1,182,358	40.00
43.00	04300	NURSERY	0	1,236,956	43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	-389,437	3,629,372	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	2,150,134	52.00
53.00	05300	ANESTHESIOLOGY	-2,555,629	131,295	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-358,539	3,315,718	54.00
56.01	05601	NUCLEAR MEDICINE	0	0	56.01
60.00	06000	LABORATORY	0	4,459,434	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0	1,001,215	65.00
66.00	06600	PHYSICAL THERAPY	0	506,116	66.00
69.00	06900	ELECTROCARDIOLOGY	0	215,850	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	64,952	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	390,832	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	1,850,336	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	1,966,940	73.00
74.00	07400	RENAL DIALYSIS	0	756,945	74.00
75.01	07501	ACUTE DIALYSIS	0	0	75.01
75.02	03650	CARD CATH LAB	-312,621	685,187	75.02
76.97	07697	CARDIAC REHABILITATION	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	76.99
OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	-2,321,875	2,693,864	90.00
90.01	09001	PH CLINIC	0	0	90.01
90.02	09002	HEALTHWORKS CLINIC	-212,873	239,533	90.02
90.03	09003	DENTAL CLINIC	0	0	90.03
90.04	09004	WOUND CARE THERAPY	-106,768	449,455	90.04
90.05	09005	FAMILY PRACTICE CLINIC	0	0	90.05
91.00	09100	EMERGENCY	-1,350,023	3,940,375	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART			92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0	0	93.99
OTHER REIMBURSABLE COST CENTERS					
99.10	09910	CORF	0	0	99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY	0	0	99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY	0	0	99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY	0	0	99.40
SPECIAL PURPOSE COST CENTERS					
118.00	SUBTOTALS (SUM OF LINES 1 through 117)		-20,437,503	98,352,697	118.00
NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	1,180,705	192.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-0206

Period:
From 10/01/2019
To 09/30/2020

Worksheet A

Date/Time Prepared:
4/26/2021 2:25 pm

Cost Center Description			Adjustments (See A-8)	Net Expenses For Allocation	
			6.00	7.00	
192.01	19201	PROHEALTH SERVICES	0	689,951	192.01
192.02	19202	AUXILIARY	0	317,915	192.02
192.03	19203	GRANT	0	520,420	192.03
200.00		TOTAL (SUM OF LINES 118 through 199)	-20,437,503	101,061,688	200.00

RECLASSIFICATIONS

Provider CCN: 14-0206

Period:
From 10/01/2019
To 09/30/2020

Worksheet A-6

Date/Time Prepared:
4/26/2021 2:25 pm

	Increases					
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
	A - PROPERTY INSURANCE					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	95,079		1.00
	0		0	95,079		
	B - EQUIP DEPRECIATION					
1.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	1,276,324		1.00
	0		0	1,276,324		
	C - CHARGEABLE SUPPLIES					
1.00	MEDICAL SUPPLIES CHARGED TO	71.00	0	390,832		1.00
	PATIENT					
2.00	IMPL. DEV. CHARGED TO	72.00	0	1,850,336		2.00
	PATIENTS					
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
	0		0	2,241,168		
	D - SHARED CAFETERIA EXP					
1.00	CAFETERIA	11.00	243,667	555,978		1.00
	0		243,667	555,978		
	F - DEPRECIATION CHARGED TO DEPTS					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	3,100,034		1.00
2.00		0.00	0	0		2.00
3.00		0.00	0	0		3.00
4.00		0.00	0	0		4.00
5.00		0.00	0	0		5.00
6.00		0.00	0	0		6.00
7.00		0.00	0	0		7.00
8.00		0.00	0	0		8.00
9.00		0.00	0	0		9.00
10.00		0.00	0	0		10.00
11.00		0.00	0	0		11.00
12.00		0.00	0	0		12.00
13.00		0.00	0	0		13.00
14.00		0.00	0	0		14.00
15.00		0.00	0	0		15.00
16.00		0.00	0	0		16.00
17.00		0.00	0	0		17.00
18.00		0.00	0	0		18.00
19.00		0.00	0	0		19.00
20.00		0.00	0	0		20.00
21.00		0.00	0	0		21.00
22.00		0.00	0	0		22.00
23.00		0.00	0	0		23.00
24.00		0.00	0	0		24.00
25.00		0.00	0	0		25.00
26.00		0.00	0	0		26.00
27.00		0.00	0	0		27.00
28.00		0.00	0	0		28.00
29.00		0.00	0	0		29.00
30.00		0.00	0	0		30.00
31.00		0.00	0	0		31.00
32.00		0.00	0	0		32.00
33.00		0.00	0	0		33.00
34.00		0.00	0	0		34.00
35.00		0.00	0	0		35.00
	0		0	3,100,034		
	G - INTEREST EXPENSE					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	956,874		1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	668,804		2.00
	0		0	1,625,678		
	J - NURSERY EXP					
1.00	NURSERY	43.00	125,599	68,222		1.00
	0		125,599	68,222		

RECLASSIFICATIONS

Provider CCN: 14-0206

Period:
From 10/01/2019
To 09/30/2020

Worksheet A-6

Date/Time Prepared:
4/26/2021 2:25 pm

	Increases					
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
	K - CHARGEABLE DRUGS					
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	1,966,940		1.00
	0		0	1,966,940		
500.00	Grand Total: Increases		369,266	10,929,423		500.00

RECLASSIFICATIONS

Provider CCN: 14-0206

Period:
From 10/01/2019
To 09/30/2020

Worksheet A-6

Date/Time Prepared:
4/26/2021 2:25 pm

	Decreases					4/26/2021 2:25 pm
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.	
	6.00	7.00	8.00	9.00	10.00	
	A - PROPERTY INSURANCE					
1.00	ADMINISTRATIVE & GENERAL	5.00	0	95,079	12	1.00
	0		0	95,079		
	B - EQUIP DEPRECIATION					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	1,276,324	9	1.00
	0		0	1,276,324		
	C - CHARGEABLE SUPPLIES					
1.00	CENTRAL SERVICES & SUPPLY	14.00	0	249	0	1.00
2.00	ADULTS & PEDIATRICS	30.00	0	60,031	0	2.00
3.00	INTENSIVE CARE UNIT	31.00	0	9,306	0	3.00
4.00	SUBPROVIDER - IPF	40.00	0	8,103	0	4.00
5.00	NURSERY	43.00	0	1,020	0	5.00
6.00	OPERATING ROOM	50.00	0	1,229,852	0	6.00
7.00	DELIVERY ROOM & LABOR ROOM	52.00	0	7,531	0	7.00
8.00	ANESTHESIOLOGY	53.00	0	8,945	0	8.00
9.00	RADIOLOGY-DIAGNOSTIC	54.00	0	9,779	0	9.00
10.00	ELECTROCARDIOLOGY	69.00	0	16	0	10.00
11.00	RENAL DIALYSIS	74.00	0	112	0	11.00
12.00	CARD CATH LAB	75.02	0	854,751	0	12.00
13.00	CLINIC	90.00	0	3,368	0	13.00
14.00	HEALTHWORKS CLINIC	90.02	0	289	0	14.00
15.00	WOUND CARE THERAPY	90.04	0	66	0	15.00
16.00	EMERGENCY	91.00	0	47,750	0	16.00
	0		0	2,241,168		
	D - SHARED CAFETERIA EXP					
1.00	DIETARY	10.00	243,667	555,978	0	1.00
	0		243,667	555,978		
	F - DEPRECIATION CHARGED TO DEPTS					
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	289	9	1.00
2.00	DATA PROCESSING	4.02	0	304,541	0	2.00
3.00	ADMITTING	4.03	0	1,650	0	3.00
4.00	CASHIERING	4.04	0	2,796	0	4.00
5.00	ADMINISTRATIVE & GENERAL	5.00	0	127,974	0	5.00
6.00	OPERATION OF PLANT	7.00	0	950,959	0	6.00
7.00	HOUSEKEEPING	9.00	0	8,173	0	7.00
8.00	DIETARY	10.00	0	19,398	0	8.00
9.00	NURSING ADMINISTRATION	13.00	0	30,601	0	9.00
10.00	CENTRAL SERVICES & SUPPLY	14.00	0	44,988	0	10.00
11.00	PHARMACY	15.00	0	119,738	0	11.00
12.00	MEDICAL RECORDS & LIBRARY	16.00	0	4,610	0	12.00
13.00	SOCIAL SERVICE	17.00	0	83	0	13.00
14.00	ADULTS & PEDIATRICS	30.00	0	283,296	0	14.00
15.00	INTENSIVE CARE UNIT	31.00	0	45,800	0	15.00
16.00	SUBPROVIDER - IPF	40.00	0	8,701	0	16.00
17.00	NURSERY	43.00	0	9,609	0	17.00
18.00	OPERATING ROOM	50.00	0	160,385	0	18.00
19.00	DELIVERY ROOM & LABOR ROOM	52.00	0	416,155	0	19.00
20.00	ANESTHESIOLOGY	53.00	0	13,375	0	20.00
21.00	RADIOLOGY-DIAGNOSTIC	54.00	0	215,563	0	21.00
22.00	LABORATORY	60.00	0	2,339	0	22.00
23.00	RESPIRATORY THERAPY	65.00	0	20,047	0	23.00
24.00	PHYSICAL THERAPY	66.00	0	16,347	0	24.00
25.00	ELECTROCARDIOLOGY	69.00	0	40,442	0	25.00
26.00	ELECTROENCEPHALOGRAPHY	70.00	0	698	0	26.00
27.00	CARD CATH LAB	75.02	0	107,004	0	27.00
28.00	CLINIC	90.00	0	31,671	0	28.00
29.00	HEALTHWORKS CLINIC	90.02	0	631	0	29.00
30.00	WOUND CARE THERAPY	90.04	0	8,017	0	30.00
31.00	EMERGENCY	91.00	0	57,193	0	31.00
32.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	26,953	0	32.00
33.00	PROHEALTH SERVICES	192.01	0	9,330	0	33.00
34.00	AUXILIARY	192.02	0	9,588	0	34.00
35.00	GRANT	192.03	0	1,090	0	35.00
	0		0	3,100,034		
	G - INTEREST EXPENSE					
1.00	ADMINISTRATIVE & GENERAL	5.00	0	1,625,678	11	1.00
2.00		0.00	0	0	11	2.00
	0		0	1,625,678		
	J - NURSERY EXP					
1.00	ADULTS & PEDIATRICS	30.00	125,599	68,222	0	1.00
	0		125,599	68,222		

RECLASSIFICATIONS

Provider CCN: 14-0206

Period:
From 10/01/2019
To 09/30/2020

Worksheet A-6

Date/Time Prepared:
4/26/2021 2:25 pm

	Decreases				Wkst. A-7 Ref.	
	Cost Center	Line #	Salary	Other		
	6.00	7.00	8.00	9.00	10.00	
1.00	K - CHARGEABLE DRUGS					
	PHARMACY	15.00	0	1,966,940	0	1.00
	0		0	1,966,940		
500.00	Grand Total: Decreases		369,266	10,929,423		500.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-0206

Period:
From 10/01/2019
To 09/30/2020Worksheet A-7
Part I
Date/Time Prepared:
4/26/2021 2:25 pm

		Beginning Balances	Acquisitions			Disposals and Retirements		
			Purchases	Donation	Total			
		1.00	2.00	3.00	4.00	5.00		
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES							
1.00	Land	4,840,913	0	0	0	0	1.00	
2.00	Land Improvements	3,689,647	3,125	0	3,125	0	2.00	
3.00	Buildings and Fixtures	53,590,150	526,516	0	526,516	0	3.00	
4.00	Building Improvements	0	0	0	0	0	4.00	
5.00	Fixed Equipment	29,405,775	1,456,811	0	1,456,811	0	5.00	
6.00	Movable Equipment	58,226,267	3,750,713	0	3,750,713	0	6.00	
7.00	HIT designated Assets	0	0	0	0	0	7.00	
8.00	Subtotal (sum of lines 1-7)	149,752,752	5,737,165	0	5,737,165	0	8.00	
9.00	Reconciling Items	0	0	0	0	0	9.00	
10.00	Total (line 8 minus line 9)	149,752,752	5,737,165	0	5,737,165	0	10.00	
		Ending Balance	Fully Depreciated Assets					
		6.00	7.00					
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES							
1.00	Land	4,840,913	0				1.00	
2.00	Land Improvements	3,692,772	0				2.00	
3.00	Buildings and Fixtures	54,116,666	0				3.00	
4.00	Building Improvements	0	0				4.00	
5.00	Fixed Equipment	30,862,586	0				5.00	
6.00	Movable Equipment	61,976,980	0				6.00	
7.00	HIT designated Assets	0	0				7.00	
8.00	Subtotal (sum of lines 1-7)	155,489,917	0				8.00	
9.00	Reconciling Items	0	0				9.00	
10.00	Total (line 8 minus line 9)	155,489,917	0				10.00	

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-0206

Period:
From 10/01/2019
To 09/30/2020Worksheet A-7
Part II
Date/Time Prepared:
4/26/2021 2:25 pm

Cost Center Description		SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	CAP REL COSTS-BLDG & FIXT	757,808	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)	757,808	0	0	0	0	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Other	Total (1) (sum				
		Capital-Related Costs (see instructions)	of cols. 9 through 14)				
		14.00	15.00				
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	CAP REL COSTS-BLDG & FIXT	0	757,808				1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0				2.00
3.00	Total (sum of lines 1-2)	0	757,808				3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-0206

Period:
From 10/01/2019
To 09/30/2020Worksheet A-7
Part III
Date/Time Prepared:
4/26/2021 2:25 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	93,512,937	0	93,512,937	0.601408	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	61,976,981	0	61,976,981	0.398592	0	2.00
3.00	Total (sum of lines 1-2)	155,489,918	0	155,489,918	1.000000	0	3.00
Cost Center Description		ALLOCATION OF OTHER CAPITAL			SUMMARY OF CAPITAL		
		Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	Depreciation	Lease	
		6.00	7.00	8.00	9.00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	2,581,518	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	1,276,324	0	2.00
3.00	Total (sum of lines 1-2)	0	0	0	3,857,842	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	956,874	95,079	0	0	3,633,471	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	668,804	0	0	0	1,945,128	2.00
3.00	Total (sum of lines 1-2)	1,625,678	95,079	0	0	5,578,599	3.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 14-0206

Period:
From 10/01/2019
To 09/30/2020

Worksheet A-8

Date/Time Prepared:
4/26/2021 2:25 pm

Cost Center Description		Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted		Wkst. A-7 Ref.	
				Cost Center	Line #		
		1.00	2.00	3.00	4.00	5.00	
1.00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)			0CAP REL COSTS-BLDG & FIXT	1.00	0	1.00
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)			0CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
3.00	Investment income - other (chapter 2)		0		0.00	0	3.00
4.00	Trade, quantity, and time discounts (chapter 8)		0		0.00	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)		0		0.00	0	5.00
6.00	Rental of provider space by suppliers (chapter 8)		0		0.00	0	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)	A	-71,510	ADMINISTRATIVE & GENERAL	5.00	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	-11,290,791			0	10.00
11.00	Sale of scrap, waste, etc. (chapter 23)		0		0.00	0	11.00
12.00	Related organization transactions (chapter 10)	A-8-1	0			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests	B	-219,527	CAFETERIA	11.00	0	14.00
15.00	Rental of quarters to employee and others		0		0.00	0	15.00
16.00	Sale of medical and surgical supplies to other than patients		0		0.00	0	16.00
17.00	Sale of drugs to other than patients		0		0.00	0	17.00
18.00	Sale of medical records and abstracts	B	-481	MEDICAL RECORDS & LIBRARY	16.00	0	18.00
19.00	Nursing and allied health education (tuition, fees, books, etc.)		0		0.00	0	19.00
20.00	Vending machines		0		0.00	0	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	0	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	RESPIRATORY THERAPY	65.00		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	PHYSICAL THERAPY	66.00		24.00
25.00	Utilization review - physicians' compensation (chapter 21)		0	*** Cost Center Deleted ***	114.00		25.00
26.00	Depreciation - 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	NONPHYSICIAN ANESTHETISTS	19.00		28.00
29.00	Physicians' assistant		0		0.00	0	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	*** Cost Center Deleted ***	67.00		30.00
30.99	Hospice (non-distinct) (see instructions)	B	-7,000	ADULTS & PEDIATRICS	30.00		30.99
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	*** Cost Center Deleted ***	68.00		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest		0		0.00	0	32.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 14-0206

Period:
From 10/01/2019
To 09/30/2020

Worksheet A-8

Date/Time Prepared:
4/26/2021 2:25 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 #		
33.00	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	33.00
33.01	NAH HUMAN RESOURCES MISC REVENUE	B	55	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.01
33.02	NAH INFORMATION SYSTEMS INFO. SYS. U	B	-12,500	DATA PROCESSING	4.02	0	33.02
33.03	NAH FISCAL SERVICES MISC REVENUE	B	-215,757	ADMINISTRATIVE & GENERAL	5.00	0	33.03
33.04	NAH OTHER GENERAL REV MISC REVENUE	B	-177,401	ADMINISTRATIVE & GENERAL	5.00	0	33.04
33.05	NAH RENTAL PROPERTIES MEDICAL OFFICE	B	-25,267	ADMINISTRATIVE & GENERAL	5.00	0	33.05
33.06	NAH ADMIN SUPPORT T-MOBILE LEASE	B	-20,220	ADMINISTRATIVE & GENERAL	5.00	0	33.06
33.07	NAH ADMIN SUPPORT MISC REVENUE	B	-20,064	ADMINISTRATIVE & GENERAL	5.00	0	33.07
33.08	NAH MEDICAL EDUCATION MISC REVENUE	B	-4,592	ADMINISTRATIVE & GENERAL	5.00	0	33.08
33.09	NAH FISCAL SERVICES DISCOUNTS EARNED	B	-1,990	ADMINISTRATIVE & GENERAL	5.00	0	33.09
33.10	NAH CME-CONTNG MED ED MISC REVENUE	B	-500	ADMINISTRATIVE & GENERAL	5.00	0	33.10
33.11	NAH DIETARY MISC REVENUE	B	-13,250	DIETARY	10.00	0	33.11
33.12	NAH MATERIALS MGMT MISC REVENUE	B	-47,798	CENTRAL SERVICES & SUPPLY	14.00	0	33.12
33.13	NAH RADIOLOGY DUPLICATE X-RAY REV	B	-2,946	RADIOLOGY-DIAGNOSTIC	54.00	0	33.13
33.14	NAH OUTPATIENT ADMIN MEDICAL OFFICE	B	-313,159	CLINIC	90.00	0	33.14
33.15	NAH STE 100 WOMENS HLTH MEDICAL OFFI	B	-24,800	CLINIC	90.00	0	33.15
33.16	NAH PAIN/UROL/CC-405 MEDICAL OFFICE	B	-16,364	CLINIC	90.00	0	33.16
33.17	NAH 502 GI/ENT/INF CNTRL MEDICAL OFF	B	-16,220	CLINIC	90.00	0	33.17
33.18	NAH STE 100 WOMENS HLTH MISC REVENUE	B	-600	CLINIC	90.00	0	33.18
33.19	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	33.19
33.20	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	33.20
35.00	NON ALLOW EXP	A	-200	I&R SERVICES-SALARY & FRINGES APPRV	21.00	0	35.00
35.01	NON ALLOW EXP	A	-25,731	ADMINISTRATIVE & GENERAL	5.00	0	35.01
35.02	IL MEDICAID ASSESSMENT	A	-7,710,750	ADMINISTRATIVE & GENERAL	5.00	0	35.02
35.03	DUES - LOBBYING PORTION	A	-8,140	ADMINISTRATIVE & GENERAL	5.00	0	35.03
36.00	LOBBYING FEES	A	-190,000	ADMINISTRATIVE & GENERAL	5.00	0	36.00
38.00	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	38.00
40.00	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	40.00
42.00	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	42.00
43.00	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	43.00
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-20,437,503				50.00

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

(2) Basis for adjustment (see instructions).

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

B. Amount Received - if cost cannot be determined.

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

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

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 14-0206

Period:
From 10/01/2019
To 09/30/2020

Worksheet A-8-2

Date/Time Prepared:
4/26/2021 2:25 pm

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	5.00	AGGREGATE-ADMINISTRATIVE & GENERAL	3,722,935	3,216,738	506,197	197,500	4,190	1.00
2.00	30.00	AGGREGATE-ADULTS & PEDIATRICS	130,960	130,960	0	0	0	2.00
3.00	31.00	AGGREGATE-INTENSIVE CARE UNIT	97,500	97,500	0	0	0	3.00
4.00	40.00	AGGREGATE-SUBPROVIDER - IPF	503,569	503,569	0	0	0	4.00
5.00	50.00	AGGREGATE-OPERATING ROOM	389,437	389,437	0	0	0	5.00
6.00	53.00	AGGREGATE-ANESTHESIOLOGY	2,555,629	2,555,629	0	0	0	6.00
7.00	54.00	AGGREGATE-RADIOLOGY-DIAGNOSTIC	355,593	355,593	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	75.02	AGGREGATE-CARD CATH LAB	312,621	312,621	0	0	0	9.00
10.00	90.00	AGGREGATE-CLINIC	2,075,700	1,769,727	305,973	211,500	1,229	10.00
11.00	90.02	AGGREGATE-HEALTHWORKS CLINIC	212,873	212,873	0	0	0	11.00
12.00	90.04	AGGREGATE-WOUND CARE THERAPY	106,768	106,768	0	0	0	12.00
13.00	91.00	AGGREGATE-EMERGENCY	1,350,023	1,350,023	0	0	0	13.00
200.00			11,813,608	11,001,438	812,170		5,419	200.00
	Wkst. A Line #	Cost Center/Physician Identifier	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	5.00	AGGREGATE-ADMINISTRATIVE & GENERAL	397,849	19,892	0	0	0	1.00
2.00	30.00	AGGREGATE-ADULTS & PEDIATRICS	0	0	0	0	0	2.00
3.00	31.00	AGGREGATE-INTENSIVE CARE UNIT	0	0	0	0	0	3.00
4.00	40.00	AGGREGATE-SUBPROVIDER - IPF	0	0	0	0	0	4.00
5.00	50.00	AGGREGATE-OPERATING ROOM	0	0	0	0	0	5.00
6.00	53.00	AGGREGATE-ANESTHESIOLOGY	0	0	0	0	0	6.00
7.00	54.00	AGGREGATE-RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	75.02	AGGREGATE-CARD CATH LAB	0	0	0	0	0	9.00
10.00	90.00	AGGREGATE-CLINIC	124,968	6,248	0	0	0	10.00
11.00	90.02	AGGREGATE-HEALTHWORKS CLINIC	0	0	0	0	0	11.00
12.00	90.04	AGGREGATE-WOUND CARE THERAPY	0	0	0	0	0	12.00
13.00	91.00	AGGREGATE-EMERGENCY	0	0	0	0	0	13.00
200.00			522,817	26,140	0	0	0	200.00
	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment		
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00	5.00	AGGREGATE-ADMINISTRATIVE & GENERAL	0	397,849	108,348	3,325,086		1.00
2.00	30.00	AGGREGATE-ADULTS & PEDIATRICS	0	0	0	130,960		2.00
3.00	31.00	AGGREGATE-INTENSIVE CARE UNIT	0	0	0	97,500		3.00
4.00	40.00	AGGREGATE-SUBPROVIDER - IPF	0	0	0	503,569		4.00
5.00	50.00	AGGREGATE-OPERATING ROOM	0	0	0	389,437		5.00
6.00	53.00	AGGREGATE-ANESTHESIOLOGY	0	0	0	2,555,629		6.00
7.00	54.00	AGGREGATE-RADIOLOGY-DIAGNOSTIC	0	0	0	355,593		7.00
8.00	0.00		0	0	0	0		8.00
9.00	75.02	AGGREGATE-CARD CATH LAB	0	0	0	312,621		9.00
10.00	90.00	AGGREGATE-CLINIC	0	124,968	181,005	1,950,732		10.00
11.00	90.02	AGGREGATE-HEALTHWORKS CLINIC	0	0	0	212,873		11.00
12.00	90.04	AGGREGATE-WOUND CARE THERAPY	0	0	0	106,768		12.00
13.00	91.00	AGGREGATE-EMERGENCY	0	0	0	1,350,023		13.00
200.00			0	522,817	289,353	11,290,791		200.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0206

Period:
From 10/01/2019
To 09/30/2020Worksheet B
Part I
Date/Time Prepared:
4/26/2021 2:25 pm

Cost Center Description			CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	COMMUNICATIONS	
			Net Expenses for Cost Allocation (from Wkst A col. 7)	BLDG & FIXT	MVBLE EQUIP		
			0	1.00	2.00	4.00	4.01
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT	3,633,471	3,633,471			1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	1,945,128		1,945,128		2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	6,969,189	42,195	181	7,011,565	4.00
4.01	00401	COMMUNICATIONS	358,345	5,631	0	38,336	4.01
4.02	00402	DATA PROCESSING	3,140,237	88,832	191,085	198,013	4.02
4.03	00403	ADMITTING	1,004,840	84,026	1,035	102,326	4.03
4.04	00404	CASHIERING	1,835,598	20,119	1,754	44,956	4.04
5.00	00500	ADMINISTRATIVE & GENERAL	16,571,043	76,886	80,298	1,460,168	5.00
6.00	00600	MAINTENANCE & REPAIRS	0	0	0	0	6.00
7.00	00700	OPERATION OF PLANT	4,835,026	304,737	596,682	219,736	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	51,444	0	0	8.00
9.00	00900	HOUSEKEEPING	2,303,953	49,236	5,128	172,786	9.00
10.00	01000	DIETARY	1,880,389	104,173	8,558	76,357	10.00
11.00	01100	CAFETERIA	580,118	47,196	3,614	32,244	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	1,469,999	33,714	19,201	177,851	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	771,344	154,583	28,228	76,329	14.00
15.00	01500	PHARMACY	2,391,624	67,567	75,130	208,724	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,219,839	69,551	2,893	49,578	16.00
17.00	01700	SOCIAL SERVICE	840,211	2,138	52	92,121	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	19.00
20.00	02000	NURSING SCHOOL	0	0	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	242,110	0	0	21,719	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	1,677	0	0	22.00
23.00	02300	PARAMED ED PRGM- (SPECIFY)	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	12,881,000	583,054	177,755	1,413,647	30.00
31.00	03100	INTENSIVE CARE UNIT	2,612,366	87,952	28,737	233,092	31.00
31.01	02060	NICU	0	0	0	0	31.01
40.00	04000	SUBPROVIDER - IPF	1,182,358	73,952	5,459	138,499	40.00
43.00	04300	NURSERY	1,236,956	54,154	6,029	139,309	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	3,629,372	255,459	100,634	263,160	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	2,150,134	44,682	261,118	234,334	52.00
53.00	05300	ANESTHESIOLOGY	131,295	9,333	8,392	5,345	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,315,718	136,615	135,256	244,197	54.00
56.01	05601	NUCLEAR MEDICINE	0	0	0	0	56.01
60.00	06000	LABORATORY	4,459,434	114,079	1,468	400	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	1,001,215	34,217	12,579	94,991	65.00
66.00	06600	PHYSICAL THERAPY	506,116	36,229	10,257	60,488	66.00
69.00	06900	ELECTROCARDIOLOGY	215,850	44,388	25,375	23,363	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	64,952	6,078	438	7,357	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	390,832	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1,850,336	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,966,940	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	756,945	0	0	0	74.00
75.01	07501	ACUTE DIALYSIS	0	0	0	0	75.01
75.02	03650	CARD CATH LAB	685,187	29,802	67,140	57,147	75.02
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	2,693,864	110,405	19,872	460,120	90.00
90.01	09001	PH CLINIC	0	0	0	0	90.01
90.02	09002	HEALTHWORKS CLINIC	239,533	16,766	396	49,067	90.02
90.03	09003	DENTAL CLINIC	0	0	0	0	90.03
90.04	09004	WOUND CARE THERAPY	449,455	45,185	5,030	46,000	90.04
90.05	09005	FAMILY PRACTICE CLINIC	0	0	0	0	90.05
91.00	09100	EMERGENCY	3,940,375	105,514	35,886	354,719	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0	0	0	0	93.99
OTHER REIMBURSABLE COST CENTERS							
99.10	09910	CORF	0	0	0	0	99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY	0	0	0	0	99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY	0	0	0	0	99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY	0	0	0	0	99.40

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0206

Period:
From 10/01/2019
To 09/30/2020Worksheet B
Part I
Date/Time Prepared:
4/26/2021 2:25 pm

Cost Center Description			CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	COMMUNICATIONS	
			Net Expenses for Cost Allocation (from Wkst A col. 7)	BLDG & FIXT	MVBLE EQUIP		
			0	1.00	2.00	4.00	4.01
SPECIAL PURPOSE COST CENTERS							
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	98,352,697	2,991,569	1,915,660	6,796,479	374,757
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	8,760	0	0	1,102
192.00	19200	PHYSICIANS' PRIVATE OFFICES	1,180,705	633,142	16,912	122,751	20,942
192.01	19201	PROHEALTH SERVICES	689,951	0	5,854	23	5,511
192.02	19202	AUXILIARY	317,915	0	6,016	34,420	0
192.03	19203	GRANT	520,420	0	686	57,892	0
200.00		Cross Foot Adjustments					
201.00		Negative Cost Centers		0	0	0	0
202.00		TOTAL (sum lines 118 through 201)	101,061,688	3,633,471	1,945,128	7,011,565	402,312

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0206

Period:
From 10/01/2019
To 09/30/2020Worksheet B
Part I
Date/Time Prepared:
4/26/2021 2:25 pm

Cost Center Description			DATA PROCESSING	ADMITTING	CASHIERING	Subtotal	ADMINISTRATIVE & GENERAL	
			4.02	4.03	4.04	4A.04	5.00	
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
4.01	00401	COMMUNICATIONS						4.01
4.02	00402	DATA PROCESSING	3,623,678					4.02
4.03	00403	ADMITTING	296,483	1,494,221				4.03
4.04	00404	CASHIERING	428,253	0	2,362,645			4.04
5.00	00500	ADMINISTRATIVE & GENERAL	263,540	0	0	18,520,274	18,520,274	5.00
6.00	00600	MAINTENANCE & REPAIRS	0	0	0	0	0	6.00
7.00	00700	OPERATION OF PLANT	32,943	0	0	6,008,964	1,348,267	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0	51,444	11,543	8.00
9.00	00900	HOUSEKEEPING	65,885	0	0	2,596,988	582,702	9.00
10.00	01000	DIETARY	65,885	0	0	2,147,486	481,844	10.00
11.00	01100	CAFETERIA	0	0	0	664,274	149,047	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	0	0	0	1,709,583	383,589	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	197,655	0	0	1,229,241	275,812	14.00
15.00	01500	PHARMACY	230,598	0	0	2,984,665	669,687	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	32,943	0	0	1,399,053	313,914	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	943,340	211,663	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
20.00	02000	NURSING SCHOOL	0	0	0	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	264,931	59,444	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	1,677	376	22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	461,195	579,232	639,953	16,777,721	3,764,479	30.00
31.00	03100	INTENSIVE CARE UNIT	65,885	72,787	75,077	3,175,896	712,595	31.00
31.01	02060	NICU	0	0	0	0	0	31.01
40.00	04000	SUBPROVIDER - IPF	0	44,485	45,885	1,490,638	334,463	40.00
43.00	04300	NURSERY	65,885	19,634	20,251	1,545,525	346,779	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	131,770	61,568	134,722	4,603,138	1,032,834	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	65,885	19,963	25,521	2,803,841	629,115	52.00
53.00	05300	ANESTHESIOLOGY	0	9,939	19,100	186,711	41,893	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	98,828	73,539	206,210	4,232,407	949,651	54.00
56.01	05601	NUCLEAR MEDICINE	0	0	0	0	0	56.01
60.00	06000	LABORATORY	592,965	192,816	351,168	5,738,783	1,287,645	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	65,885	34,779	40,376	1,289,553	289,345	65.00
66.00	06600	PHYSICAL THERAPY	65,885	8,888	21,824	712,994	159,979	66.00
69.00	06900	ELECTROCARDIOLOGY	65,885	18,458	35,874	438,011	98,279	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	65,885	1,126	1,380	147,216	33,032	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	6,568	9,859	407,259	91,379	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	22,297	33,870	1,906,503	427,774	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	191,938	256,037	2,414,915	541,849	73.00
74.00	07400	RENAL DIALYSIS	0	16,217	17,898	791,060	177,495	74.00
75.01	07501	ACUTE DIALYSIS	0	0	0	0	0	75.01
75.02	03650	CARD CATH LAB	0	46,876	68,277	954,429	214,151	75.02
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	197,655	89	11,688	3,501,409	785,632	90.00
90.01	09001	PH CLINIC	0	0	0	0	0	90.01
90.02	09002	HEALTHWORKS CLINIC	0	1	1,916	313,190	70,272	90.02
90.03	09003	DENTAL CLINIC	0	0	0	0	0	90.03
90.04	09004	WOUND CARE THERAPY	0	5,035	44,071	600,287	134,690	90.04
90.05	09005	FAMILY PRACTICE CLINIC	0	0	0	0	0	90.05
91.00	09100	EMERGENCY	65,885	67,986	301,688	4,885,280	1,096,140	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	0	92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0	0	0	0	0	93.99
OTHER REIMBURSABLE COST CENTERS								
99.10	09910	CORF	0	0	0	0	0	99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY	0	0	0	0	0	99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY	0	0	0	0	0	99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY	0	0	0	0	0	99.40
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	3,623,678	1,494,221	2,362,645	97,438,686	17,707,359	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	9,862	2,213	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	1,974,452	443,020	192.00
192.01	19201	PROHEALTH SERVICES	0	0	0	701,339	157,364	192.01

COST ALLOCATION - GENERAL SERVICE COSTS

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Cost Center Description			DATA PROCESSING	ADMITTING	CASHIERING	Subtotal	ADMINISTRATIVE & GENERAL	
			4.02	4.03	4.04	4A.04	5.00	
192.02	19202	AUXILIARY	0	0	0	358,351	80,405	192.02
192.03	19203	GRANT	0	0	0	578,998	129,913	192.03
200.00		Cross Foot Adjustments				0		200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	3,623,678	1,494,221	2,362,645	101,061,688	18,520,274	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0206

Period:
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Cost Center Description			MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
			6.00	7.00	8.00	9.00	10.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
4.01	00401	COMMUNICATIONS						4.01
4.02	00402	DATA PROCESSING						4.02
4.03	00403	ADMITTING						4.03
4.04	00404	CASHIERING						4.04
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS	0					6.00
7.00	00700	OPERATION OF PLANT	0	7,357,231				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	125,699	188,686			8.00
9.00	00900	HOUSEKEEPING	0	120,305	0	3,299,995		9.00
10.00	01000	DIETARY	0	254,538	0	118,119	3,001,987	10.00
11.00	01100	CAFETERIA	0	115,321	0	53,515	0	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	0	82,377	0	38,227	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	377,711	0	175,278	0	14.00
15.00	01500	PHARMACY	0	165,095	0	76,613	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	169,942	0	78,863	0	16.00
17.00	01700	SOCIAL SERVICE	0	5,223	0	2,424	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
20.00	02000	NURSING SCHOOL	0	0	0	0	0	20.00
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	4,097	0	1,901	0	22.00
23.00	02300	PARAMED ED PRGM- (SPECIFY)	0	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	0	1,424,642	60,364	661,111	2,424,716	30.00
31.00	03100	INTENSIVE CARE UNIT	0	214,903	8,048	99,727	266,330	31.00
31.01	02060	NICU	0	0	0	0	0	31.01
40.00	04000	SUBPROVIDER - IPF	0	180,696	0	83,853	310,941	40.00
43.00	04300	NURSERY	0	132,322	10,075	61,404	0	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	624,192	34,170	289,659	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	109,176	28,750	50,663	0	52.00
53.00	05300	ANESTHESIOLOGY	0	22,805	0	10,583	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	333,808	13,583	154,905	0	54.00
56.01	05601	NUCLEAR MEDICINE	0	0	0	0	0	56.01
60.00	06000	LABORATORY	0	278,742	0	129,352	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0	83,606	0	38,798	0	65.00
66.00	06600	PHYSICAL THERAPY	0	88,522	3,491	41,079	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	108,459	0	50,331	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	14,850	0	6,891	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
75.01	07501	ACUTE DIALYSIS	0	0	0	0	0	75.01
75.02	03650	CARD CATH LAB	0	72,818	0	33,791	0	75.02
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	269,764	7,240	125,185	0	90.00
90.01	09001	PH CLINIC	0	0	0	0	0	90.01
90.02	09002	HEALTHWORKS CLINIC	0	40,966	301	19,011	0	90.02
90.03	09003	DENTAL CLINIC	0	0	0	0	0	90.03
90.04	09004	WOUND CARE THERAPY	0	110,405	1,007	51,234	0	90.04
90.05	09005	FAMILY PRACTICE CLINIC	0	0	0	0	0	90.05
91.00	09100	EMERGENCY	0	257,815	21,657	119,640	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0	0	0	0	0	93.99
OTHER REIMBURSABLE COST CENTERS								
99.10	09910	CORF	0	0	0	0	0	99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY	0	0	0	0	0	99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY	0	0	0	0	0	99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY	0	0	0	0	0	99.40
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	5,788,799	188,686	2,572,157	3,001,987	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	21,405	0	9,933	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	1,547,027	0	717,905	0	192.00
192.01	19201	PROHEALTH SERVICES	0	0	0	0	0	192.01

COST ALLOCATION - GENERAL SERVICE COSTS

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Cost Center Description			MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
			6.00	7.00	8.00	9.00	10.00	
192.02	19202	AUXILIARY	0	0	0	0	0	192.02
192.03	19203	GRANT	0	0	0	0	0	192.03
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	0	7,357,231	188,686	3,299,995	3,001,987	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

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Cost Center Description			CAFETERIA	MAINTENANCE OF PERSONNEL	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	
			11.00	12.00	13.00	14.00	15.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
4.01	00401	COMMUNICATIONS						4.01
4.02	00402	DATA PROCESSING						4.02
4.03	00403	ADMITTING						4.03
4.04	00404	CASHIERING						4.04
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA	982,157					11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0				12.00
13.00	01300	NURSING ADMINISTRATION	24,100	0	2,237,876			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	20,627	0	0	2,078,669		14.00
15.00	01500	PHARMACY	48,344	0	0	0	3,944,404	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	14,509	0	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	20,317	0	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
20.00	02000	NURSING SCHOOL	0	0	0	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	5,911	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	PARAMED ED PRGM-(SPECIFY)	0	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	349,509	0	1,203,296	22,334	260,791	30.00
31.00	03100	INTENSIVE CARE UNIT	47,703	0	164,235	5,912	203,546	31.00
31.01	02060	NICU	0	0	0	0	0	31.01
40.00	04000	SUBPROVIDER - IPF	25,381	0	87,383	88	24,238	40.00
43.00	04300	NURSERY	16,122	0	55,504	234	6,746	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	48,902	0	168,362	9,993	225,161	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	41,213	0	141,891	3,801	122,311	52.00
53.00	05300	ANESTHESIOLOGY	2,129	0	7,329	530	5,465	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	50,452	0	0	2,949	441	54.00
56.01	05601	NUCLEAR MEDICINE	0	0	0	0	0	56.01
60.00	06000	LABORATORY	0	0	0	0	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	24,410	0	84,039	25	615	65.00
66.00	06600	PHYSICAL THERAPY	11,533	0	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	5,932	0	20,423	97	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	2,067	0	0	15	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	349,047	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	1,652,511	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	2,663,389	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	108	17,107	74.00
75.01	07501	ACUTE DIALYSIS	0	0	0	0	0	75.01
75.02	03650	CARD CATH LAB	7,668	0	26,400	1,558	28,036	75.02
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	83,316	0	0	995	125,708	90.00
90.01	09001	PH CLINIC	0	0	0	0	0	90.01
90.02	09002	HEALTHWORKS CLINIC	8,991	0	0	171	16,558	90.02
90.03	09003	DENTAL CLINIC	0	0	0	0	0	90.03
90.04	09004	WOUND CARE THERAPY	12,133	0	0	18,606	40,488	90.04
90.05	09005	FAMILY PRACTICE CLINIC	0	0	0	0	0	90.05
91.00	09100	EMERGENCY	81,042	0	279,014	9,305	195,405	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0	0	0	0	0	93.99
OTHER REIMBURSABLE COST CENTERS								
99.10	09910	CORF	0	0	0	0	0	99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY	0	0	0	0	0	99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY	0	0	0	0	0	99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY	0	0	0	0	0	99.40
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	952,311	0	2,237,876	2,078,279	3,936,005	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	21,785	0	0	385	5,178	192.00

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Cost Center Description			CAFETERIA	MAINTENANCE OF PERSONNEL	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	
			11.00	12.00	13.00	14.00	15.00	
192.01	19201	PROHEALTH SERVICES	0	0	0	0	0	192.01
192.02	19202	AUXILIARY	8,061	0	0	5	3,221	192.02
192.03	19203	GRANT	0	0	0	0	0	192.03
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	982,157	0	2,237,876	2,078,669	3,944,404	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

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Cost Center Description			MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	NONPHYSICIAN ANESTHETISTS	NURSING SCHOOL	INTERNS & RESIDENTS SERVICES-SALAR Y & FRINGES APPRV	
			16.00	17.00	19.00	20.00	21.00	
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
4.01	00401	COMMUNICATIONS						4.01
4.02	00402	DATA PROCESSING						4.02
4.03	00403	ADMITTING						4.03
4.04	00404	CASHIERING						4.04
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
12.00	01200	MAINTENANCE OF PERSONNEL						12.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY						15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,976,281					16.00
17.00	01700	SOCIAL SERVICE	0	1,182,967				17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0			19.00
20.00	02000	NURSING SCHOOL	0	0		0		20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0			330,286	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0				22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0				23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	535,410	1,029,181	0	0	297,257	30.00
31.00	03100	INTENSIVE CARE UNIT	62,795	47,319	0	0	0	31.00
31.01	02060	NICU	0	0	0	0	0	31.01
40.00	04000	SUBPROVIDER - IPF	38,378	0	0	0	0	40.00
43.00	04300	NURSERY	16,938	0	0	0	0	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	112,682	35,489	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	21,346	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	15,975	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	172,476	0	0	0	0	54.00
56.01	05601	NUCLEAR MEDICINE	0	0	0	0	0	56.01
60.00	06000	LABORATORY	293,720	0	0	0	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	33,771	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	18,254	0	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	30,005	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	1,155	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	8,246	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	28,329	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	214,151	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	14,970	0	0	0	0	74.00
75.01	07501	ACUTE DIALYSIS	0	0	0	0	0	75.01
75.02	03650	CARD CATH LAB	57,107	0	0	0	0	75.02
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	9,776	0	0	0	33,029	90.00
90.01	09001	PH CLINIC	0	0	0	0	0	90.01
90.02	09002	HEALTHWORKS CLINIC	1,602	0	0	0	0	90.02
90.03	09003	DENTAL CLINIC	0	0	0	0	0	90.03
90.04	09004	WOUND CARE THERAPY	36,861	0	0	0	0	90.04
90.05	09005	FAMILY PRACTICE CLINIC	0	0	0	0	0	90.05
91.00	09100	EMERGENCY	252,334	70,978	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0	0	0	0	0	93.99
OTHER REIMBURSABLE COST CENTERS								
99.10	09910	CORF	0	0	0	0	0	99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY	0	0	0	0	0	99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY	0	0	0	0	0	99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY	0	0	0	0	0	99.40
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	1,976,281	1,182,967	0	0	330,286	118.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0206

Period:
From 10/01/2019
To 09/30/2020Worksheet B
Part I
Date/Time Prepared:
4/26/2021 2:25 pm

Cost Center Description			MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	NONPHYSICIAN ANESTHETISTS	NURSING SCHOOL	INTERNS & RESIDENTS SERVICES-SALAR Y & FRINGES APPRV	
NONREIMBURSABLE COST CENTERS			16.00	17.00	19.00	20.00	21.00	
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
192.01	19201	PROHEALTH SERVICES	0	0	0	0	0	192.01
192.02	19202	AUXILIARY	0	0	0	0	0	192.02
192.03	19203	GRANT	0	0	0	0	0	192.03
200.00		Cross Foot Adjustments			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)	1,976,281	1,182,967	0	0	330,286	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0206

Period:
From 10/01/2019
To 09/30/2020Worksheet B
Part I
Date/Time Prepared:
4/26/2021 2:25 pm

Cost Center Description			INTERNS & RESIDENTS	PARAMED ED PRGM	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			SERVICES-OTHER PRGM COSTS APPRV					
			22.00	23.00	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
4.01	00401	COMMUNICATIONS						4.01
4.02	00402	DATA PROCESSING						4.02
4.03	00403	ADMITTING						4.03
4.04	00404	CASHIERING						4.04
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
12.00	01200	MAINTENANCE OF PERSONNEL						12.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY						15.00
16.00	01600	MEDICAL RECORDS & LIBRARY						16.00
17.00	01700	SOCIAL SERVICE						17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS						19.00
20.00	02000	NURSING SCHOOL						20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV						21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	8,051					22.00
23.00	02300	PARAMED ED PRGM- (SPECIFY)		0				23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	7,246	0	28,818,057	-304,503	28,513,554	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	5,009,009	0	5,009,009	31.00
31.01	02060	NICU	0	0	0	0	0	31.01
40.00	04000	SUBPROVIDER - IPF	0	0	2,576,059	0	2,576,059	40.00
43.00	04300	NURSERY	0	0	2,191,649	0	2,191,649	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	7,184,582	0	7,184,582	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	3,952,107	0	3,952,107	52.00
53.00	05300	ANESTHESIOLOGY	0	0	293,420	0	293,420	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	5,910,672	0	5,910,672	54.00
56.01	05601	NUCLEAR MEDICINE	0	0	0	0	0	56.01
60.00	06000	LABORATORY	0	0	7,728,242	0	7,728,242	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0	0	1,844,162	0	1,844,162	65.00
66.00	06600	PHYSICAL THERAPY	0	0	1,035,852	0	1,035,852	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	751,537	0	751,537	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	205,226	0	205,226	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	855,931	0	855,931	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	4,015,117	0	4,015,117	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	5,834,304	0	5,834,304	73.00
74.00	07400	RENAL DIALYSIS	0	0	1,000,740	0	1,000,740	74.00
75.01	07501	ACUTE DIALYSIS	0	0	0	0	0	75.01
75.02	03650	CARD CATH LAB	0	0	1,395,958	0	1,395,958	75.02
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	805	0	4,942,859	-33,834	4,909,025	90.00
90.01	09001	PH CLINIC	0	0	0	0	0	90.01
90.02	09002	HEALTHWORKS CLINIC	0	0	471,062	0	471,062	90.02
90.03	09003	DENTAL CLINIC	0	0	0	0	0	90.03
90.04	09004	WOUND CARE THERAPY	0	0	1,005,711	0	1,005,711	90.04
90.05	09005	FAMILY PRACTICE CLINIC	0	0	0	0	0	90.05
91.00	09100	EMERGENCY	0	0	7,268,610	0	7,268,610	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				0		92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0	0	0	0	0	93.99
OTHER REIMBURSABLE COST CENTERS								
99.10	09910	CORF	0	0	0	0	0	99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY	0	0	0	0	0	99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY	0	0	0	0	0	99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY	0	0	0	0	0	99.40

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0206

Period:
From 10/01/2019
To 09/30/2020Worksheet B
Part I
Date/Time Prepared:
4/26/2021 2:25 pm

Cost Center Description			INTERNS & RESIDENTS	PARAMED ED PRGM	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			SERVICES-OTHER PRGM COSTS APPRV					
			22.00	23.00	24.00	25.00	26.00	
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	8,051	0	94,290,866	-338,337	93,952,529	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	43,413	0	43,413	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	4,709,752	0	4,709,752	192.00
192.01	19201	PROHEALTH SERVICES	0	0	858,703	0	858,703	192.01
192.02	19202	AUXILIARY	0	0	450,043	0	450,043	192.02
192.03	19203	GRANT	0	0	708,911	0	708,911	192.03
200.00		Cross Foot Adjustments	0	0	0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	8,051	0	101,061,688	-338,337	100,723,351	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0206

Period:
From 10/01/2019
To 09/30/2020Worksheet B
Part II
Date/Time Prepared:
4/26/2021 2:25 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	42,195	181	42,376	42,376 4.00
4.01	00401	COMMUNICATIONS	0	5,631	0	5,631	232 4.01
4.02	00402	DATA PROCESSING	0	88,832	191,085	279,917	1,197 4.02
4.03	00403	ADMITTING	0	84,026	1,035	85,061	619 4.03
4.04	00404	CASHIERING	0	20,119	1,754	21,873	272 4.04
5.00	00500	ADMINISTRATIVE & GENERAL	0	76,886	80,298	157,184	8,817 5.00
6.00	00600	MAINTENANCE & REPAIRS	0	0	0	0	0 6.00
7.00	00700	OPERATION OF PLANT	0	304,737	596,682	901,419	1,328 7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	51,444	0	51,444	0 8.00
9.00	00900	HOUSEKEEPING	0	49,236	5,128	54,364	1,045 9.00
10.00	01000	DIETARY	0	104,173	8,558	112,731	462 10.00
11.00	01100	CAFETERIA	0	47,196	3,614	50,810	195 11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0 12.00
13.00	01300	NURSING ADMINISTRATION	0	33,714	19,201	52,915	1,075 13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	154,583	28,228	182,811	461 14.00
15.00	01500	PHARMACY	0	67,567	75,130	142,697	1,262 15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	69,551	2,893	72,444	300 16.00
17.00	01700	SOCIAL SERVICE	0	2,138	52	2,190	557 17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0 19.00
20.00	02000	NURSING SCHOOL	0	0	0	0	0 20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	131 21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	1,677	0	1,677	0 22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	0	0	0 23.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	0	583,054	177,755	760,809	8,546 30.00
31.00	03100	INTENSIVE CARE UNIT	0	87,952	28,737	116,689	1,409 31.00
31.01	02060	NICU	0	0	0	0	0 31.01
40.00	04000	SUBPROVIDER - IPF	0	73,952	5,459	79,411	837 40.00
43.00	04300	NURSERY	0	54,154	6,029	60,183	842 43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	255,459	100,634	356,093	1,591 50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	44,682	261,118	305,800	1,417 52.00
53.00	05300	ANESTHESIOLOGY	0	9,333	8,392	17,725	32 53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	136,615	135,256	271,871	1,476 54.00
56.01	05601	NUCLEAR MEDICINE	0	0	0	0	0 56.01
60.00	06000	LABORATORY	0	114,079	1,468	115,547	2 60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0 62.30
65.00	06500	RESPIRATORY THERAPY	0	34,217	12,579	46,796	574 65.00
66.00	06600	PHYSICAL THERAPY	0	36,229	10,257	46,486	366 66.00
69.00	06900	ELECTROCARDIOLOGY	0	44,388	25,375	69,763	141 69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	6,078	438	6,516	44 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
75.01	07501	ACUTE DIALYSIS	0	0	0	0	0 75.01
75.02	03650	CARD CATH LAB	0	29,802	67,140	96,942	345 75.02
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0 76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0 76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0 76.99
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0	110,405	19,872	130,277	2,782 90.00
90.01	09001	PH CLINIC	0	0	0	0	0 90.01
90.02	09002	HEALTHWORKS CLINIC	0	16,766	396	17,162	297 90.02
90.03	09003	DENTAL CLINIC	0	0	0	0	0 90.03
90.04	09004	WOUND CARE THERAPY	0	45,185	5,030	50,215	278 90.04
90.05	09005	FAMILY PRACTICE CLINIC	0	0	0	0	0 90.05
91.00	09100	EMERGENCY	0	105,514	35,886	141,400	2,144 91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				0	0 92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0	0	0	0	0 93.99
OTHER REIMBURSABLE COST CENTERS							
99.10	09910	CORF	0	0	0	0	0 99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY	0	0	0	0	0 99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY	0	0	0	0	0 99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY	0	0	0	0	0 99.40
SPECIAL PURPOSE COST CENTERS							
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	2,991,569	1,915,660	4,907,229	41,076 118.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0206

Period:
From 10/01/2019
To 09/30/2020Worksheet B
Part II
Date/Time Prepared:
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Cost Center Description			CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
			Directly Assigned New Capital Related Costs	BLDG & FIXT	MVBLE EQUIP		
			0	1.00	2.00	2A	4.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	8,760	0	8,760	0 190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	633,142	16,912	650,054	742 192.00
192.01	19201	PROHEALTH SERVICES	0	0	5,854	5,854	0 192.01
192.02	19202	AUXILIARY	0	0	6,016	6,016	208 192.02
192.03	19203	GRANT	0	0	686	686	350 192.03
200.00		Cross Foot Adjustments				0	200.00
201.00		Negative Cost Centers		0	0	0	0 201.00
202.00		TOTAL (sum lines 118 through 201)	0	3,633,471	1,945,128	5,578,599	42,376 202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0206

Period:
From 10/01/2019
To 09/30/2020Worksheet B
Part II
Date/Time Prepared:
4/26/2021 2:25 pm

Cost Center Description		COMMUNICATIONS	DATA PROCESSING	ADMITTING	CASHIERING	ADMINISTRATIVE & GENERAL	
		4.01	4.02	4.03	4.04	5.00	
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
4.01	00401	COMMUNICATIONS	5,863				4.01
4.02	00402	DATA PROCESSING	80	281,194			4.02
4.03	00403	ADMITTING	80	23,007	108,767		4.03
4.04	00404	CASHIERING	466	33,232	0	55,843	4.04
5.00	00500	ADMINISTRATIVE & GENERAL	997	20,450	0	0	187,448 5.00
6.00	00600	MAINTENANCE & REPAIRS	0	0	0	0	6.00
7.00	00700	OPERATION OF PLANT	289	2,556	0	0	13,646 7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0	0	117 8.00
9.00	00900	HOUSEKEEPING	0	5,113	0	0	5,898 9.00
10.00	01000	DIETARY	177	5,113	0	0	4,877 10.00
11.00	01100	CAFETERIA	16	0	0	0	1,509 11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0 12.00
13.00	01300	NURSING ADMINISTRATION	129	0	0	0	3,882 13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	16	15,338	0	0	2,792 14.00
15.00	01500	PHARMACY	161	17,894	0	0	6,778 15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	353	2,556	0	0	3,177 16.00
17.00	01700	SOCIAL SERVICE	129	0	0	0	2,142 17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0 19.00
20.00	02000	NURSING SCHOOL	0	0	0	0	0 20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	16	0	0	0	602 21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	4 22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	0	0	0 23.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	610	35,788	42,213	15,023	38,098 30.00
31.00	03100	INTENSIVE CARE UNIT	0	5,113	5,294	1,779	7,212 31.00
31.01	02060	NICU	0	0	0	0	0 31.01
40.00	04000	SUBPROVIDER - IPF	0	0	3,236	1,087	3,385 40.00
43.00	04300	NURSERY	48	5,113	1,428	480	3,510 43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	386	10,225	4,478	3,192	10,454 50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	32	5,113	1,452	605	6,368 52.00
53.00	05300	ANESTHESIOLOGY	48	0	723	453	424 53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	321	7,669	5,349	4,886	9,612 54.00
56.01	05601	NUCLEAR MEDICINE	0	0	0	0	0 56.01
60.00	06000	LABORATORY	386	46,011	14,025	8,321	13,033 60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0 62.30
65.00	06500	RESPIRATORY THERAPY	80	5,113	2,530	957	2,929 65.00
66.00	06600	PHYSICAL THERAPY	48	5,113	646	517	1,619 66.00
69.00	06900	ELECTROCARDIOLOGY	129	5,113	1,343	850	995 69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	5,113	82	33	334 70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	478	234	925 71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	1,622	803	4,330 72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	13,961	6,067	5,484 73.00
74.00	07400	RENAL DIALYSIS	0	0	1,180	424	1,796 74.00
75.01	07501	ACUTE DIALYSIS	0	0	0	0	0 75.01
75.02	03650	CARD CATH LAB	0	0	3,410	1,618	2,168 75.02
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0 76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0 76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0 76.99
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	112	15,338	6	277	7,952 90.00
90.01	09001	PH CLINIC	0	0	0	0	0 90.01
90.02	09002	HEALTHWORKS CLINIC	80	0	0	45	711 90.02
90.03	09003	DENTAL CLINIC	0	0	0	0	0 90.03
90.04	09004	WOUND CARE THERAPY	80	0	366	1,044	1,363 90.04
90.05	09005	FAMILY PRACTICE CLINIC	0	0	0	0	0 90.05
91.00	09100	EMERGENCY	193	5,113	4,945	7,148	11,094 91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0	0	0	0	0 93.99
OTHER REIMBURSABLE COST CENTERS							
99.10	09910	CORF	0	0	0	0	0 99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY	0	0	0	0	0 99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY	0	0	0	0	0 99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY	0	0	0	0	0 99.40
SPECIAL PURPOSE COST CENTERS							
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	5,462	281,194	108,767	55,843	179,220 118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	16	0	0	0	22 190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	305	0	0	0	4,484 192.00
192.01	19201	PROHEALTH SERVICES	80	0	0	0	1,593 192.01

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0206

Period:
From 10/01/2019
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Cost Center Description			COMMUNICATIONS	DATA PROCESSING	ADMITTING	CASHIERING	ADMINISTRATIVE & GENERAL	
			4.01	4.02	4.03	4.04	5.00	
192.02	19202	AUXILIARY	0	0	0	0	814	192.02
192.03	19203	GRANT	0	0	0	0	1,315	192.03
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	5,863	281,194	108,767	55,843	187,448	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0206

Period:
From 10/01/2019
To 09/30/2020Worksheet B
Part II
Date/Time Prepared:
4/26/2021 2:25 pm

Cost Center Description			MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
			6.00	7.00	8.00	9.00	10.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
4.01	00401	COMMUNICATIONS						4.01
4.02	00402	DATA PROCESSING						4.02
4.03	00403	ADMITTING						4.03
4.04	00404	CASHIERING						4.04
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS	0					6.00
7.00	00700	OPERATION OF PLANT	0	919,238				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	15,705	67,266			8.00
9.00	00900	HOUSEKEEPING	0	15,031	0	81,451		9.00
10.00	01000	DIETARY	0	31,803	0	2,915	158,078	10.00
11.00	01100	CAFETERIA	0	14,409	0	1,321	0	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	0	10,292	0	944	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	47,192	0	4,326	0	14.00
15.00	01500	PHARMACY	0	20,628	0	1,891	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	21,233	0	1,946	0	16.00
17.00	01700	SOCIAL SERVICE	0	653	0	60	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
20.00	02000	NURSING SCHOOL	0	0	0	0	0	20.00
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	512	0	47	0	22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	0	178,000	21,519	16,318	127,681	30.00
31.00	03100	INTENSIVE CARE UNIT	0	26,851	2,869	2,461	14,024	31.00
31.01	02060	NICU	0	0	0	0	0	31.01
40.00	04000	SUBPROVIDER - IPF	0	22,577	0	2,070	16,373	40.00
43.00	04300	NURSERY	0	16,533	3,592	1,516	0	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	77,989	12,182	7,149	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	13,641	10,249	1,250	0	52.00
53.00	05300	ANESTHESIOLOGY	0	2,849	0	261	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	41,707	4,842	3,823	0	54.00
56.01	05601	NUCLEAR MEDICINE	0	0	0	0	0	56.01
60.00	06000	LABORATORY	0	34,827	0	3,193	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0	10,446	0	958	0	65.00
66.00	06600	PHYSICAL THERAPY	0	11,060	1,245	1,014	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	13,551	0	1,242	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	1,855	0	170	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
75.01	07501	ACUTE DIALYSIS	0	0	0	0	0	75.01
75.02	03650	CARD CATH LAB	0	9,098	0	834	0	75.02
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	33,705	2,581	3,090	0	90.00
90.01	09001	PH CLINIC	0	0	0	0	0	90.01
90.02	09002	HEALTHWORKS CLINIC	0	5,118	107	469	0	90.02
90.03	09003	DENTAL CLINIC	0	0	0	0	0	90.03
90.04	09004	WOUND CARE THERAPY	0	13,794	359	1,265	0	90.04
90.05	09005	FAMILY PRACTICE CLINIC	0	0	0	0	0	90.05
91.00	09100	EMERGENCY	0	32,212	7,721	2,953	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0	0	0	0	0	93.99
OTHER REIMBURSABLE COST CENTERS								
99.10	09910	CORF	0	0	0	0	0	99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY	0	0	0	0	0	99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY	0	0	0	0	0	99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY	0	0	0	0	0	99.40
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	723,271	67,266	63,486	158,078	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	2,674	0	245	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	193,293	0	17,720	0	192.00
192.01	19201	PROHEALTH SERVICES	0	0	0	0	0	192.01

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0206

Period:
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Cost Center Description			MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
			6.00	7.00	8.00	9.00	10.00	
192.02	19202	AUXILIARY	0	0	0	0	0	192.02
192.03	19203	GRANT	0	0	0	0	0	192.03
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	0	919,238	67,266	81,451	158,078	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0206

Period:
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Cost Center Description			CAFETERIA	MAINTENANCE OF PERSONNEL	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	
			11.00	12.00	13.00	14.00	15.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
4.01	00401	COMMUNICATIONS						4.01
4.02	00402	DATA PROCESSING						4.02
4.03	00403	ADMITTING						4.03
4.04	00404	CASHIERING						4.04
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA	68,260					11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0				12.00
13.00	01300	NURSING ADMINISTRATION	1,675	0	70,912			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	1,434	0	0	254,370		14.00
15.00	01500	PHARMACY	3,360	0	0	0	194,671	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,008	0	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	1,412	0	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
20.00	02000	NURSING SCHOOL	0	0	0	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	411	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	PARAMED ED PRGM-(SPECIFY)	0	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	24,293	0	38,129	2,733	12,871	30.00
31.00	03100	INTENSIVE CARE UNIT	3,315	0	5,204	723	10,046	31.00
31.01	02060	NICU	0	0	0	0	0	31.01
40.00	04000	SUBPROVIDER - IPF	1,764	0	2,769	11	1,196	40.00
43.00	04300	NURSERY	1,120	0	1,759	29	333	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	3,399	0	5,335	1,223	11,113	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	2,864	0	4,496	465	6,037	52.00
53.00	05300	ANESTHESIOLOGY	148	0	232	65	270	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,506	0	0	361	22	54.00
56.01	05601	NUCLEAR MEDICINE	0	0	0	0	0	56.01
60.00	06000	LABORATORY	0	0	0	0	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	1,696	0	2,663	3	30	65.00
66.00	06600	PHYSICAL THERAPY	802	0	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	412	0	647	12	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	144	0	0	2	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	42,713	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	202,219	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	131,447	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	13	844	74.00
75.01	07501	ACUTE DIALYSIS	0	0	0	0	0	75.01
75.02	03650	CARD CATH LAB	533	0	837	191	1,384	75.02
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	5,790	0	0	122	6,204	90.00
90.01	09001	PH CLINIC	0	0	0	0	0	90.01
90.02	09002	HEALTHWORKS CLINIC	625	0	0	21	817	90.02
90.03	09003	DENTAL CLINIC	0	0	0	0	0	90.03
90.04	09004	WOUND CARE THERAPY	843	0	0	2,277	1,998	90.04
90.05	09005	FAMILY PRACTICE CLINIC	0	0	0	0	0	90.05
91.00	09100	EMERGENCY	5,632	0	8,841	1,139	9,644	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0	0	0	0	0	93.99
OTHER REIMBURSABLE COST CENTERS								
99.10	09910	CORF	0	0	0	0	0	99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY	0	0	0	0	0	99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY	0	0	0	0	0	99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY	0	0	0	0	0	99.40
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	66,186	0	70,912	254,322	194,256	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	1,514	0	0	47	256	192.00

ALLOCATION OF CAPITAL RELATED COSTS

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Cost Center Description			CAFETERIA	MAINTENANCE OF PERSONNEL	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	
			11.00	12.00	13.00	14.00	15.00	
192.01	19201	PROHEALTH SERVICES	0	0	0	0	0	192.01
192.02	19202	AUXILIARY	560	0	0	1	159	192.02
192.03	19203	GRANT	0	0	0	0	0	192.03
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	68,260	0	70,912	254,370	194,671	202.00

ALLOCATION OF CAPITAL RELATED COSTS

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Cost Center Description			MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	NONPHYSICIAN ANESTHETISTS	NURSING SCHOOL	INTERNS & RESIDENTS SERVICES-SALAR Y & FRINGES APPRV	
			16.00	17.00	19.00	20.00	21.00	
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
4.01	00401	COMMUNICATIONS						4.01
4.02	00402	DATA PROCESSING						4.02
4.03	00403	ADMITTING						4.03
4.04	00404	CASHIERING						4.04
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
12.00	01200	MAINTENANCE OF PERSONNEL						12.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY						15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	103,017					16.00
17.00	01700	SOCIAL SERVICE	0	7,143				17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0			19.00
20.00	02000	NURSING SCHOOL	0	0		0		20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0			1,160	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0				22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0				23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	27,979	6,214				30.00
31.00	03100	INTENSIVE CARE UNIT	3,270	286				31.00
31.01	02060	NICU	0	0				31.01
40.00	04000	SUBPROVIDER - IPF	1,999	0				40.00
43.00	04300	NURSERY	882	0				43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	5,868	214				50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,112	0				52.00
53.00	05300	ANESTHESIOLOGY	832	0				53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	8,982	0				54.00
56.01	05601	NUCLEAR MEDICINE	0	0				56.01
60.00	06000	LABORATORY	15,296	0				60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0				62.30
65.00	06500	RESPIRATORY THERAPY	1,759	0				65.00
66.00	06600	PHYSICAL THERAPY	951	0				66.00
69.00	06900	ELECTROCARDIOLOGY	1,563	0				69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	60	0				70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	429	0				71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1,475	0				72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	11,153	0				73.00
74.00	07400	RENAL DIALYSIS	780	0				74.00
75.01	07501	ACUTE DIALYSIS	0	0				75.01
75.02	03650	CARD CATH LAB	2,974	0				75.02
76.97	07697	CARDIAC REHABILITATION	0	0				76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0				76.98
76.99	07699	LITHOTRIPSY	0	0				76.99
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	509	0				90.00
90.01	09001	PH CLINIC	0	0				90.01
90.02	09002	HEALTHWORKS CLINIC	83	0				90.02
90.03	09003	DENTAL CLINIC	0	0				90.03
90.04	09004	WOUND CARE THERAPY	1,920	0				90.04
90.05	09005	FAMILY PRACTICE CLINIC	0	0				90.05
91.00	09100	EMERGENCY	13,141	429				91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0	0				93.99
OTHER REIMBURSABLE COST CENTERS								
99.10	09910	CORF	0	0				99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY	0	0				99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY	0	0				99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY	0	0				99.40
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	103,017	7,143	0	0	0	118.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0206

Period:
From 10/01/2019
To 09/30/2020Worksheet B
Part II
Date/Time Prepared:
4/26/2021 2:25 pm

Cost Center Description			MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	NONPHYSICIAN ANESTHETISTS	NURSING SCHOOL	INTERNS & RESIDENTS	SERVICES-SALAR Y & FRINGES APPRV	
			16.00	17.00	19.00	20.00	21.00		
NONREIMBURSABLE COST CENTERS									
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0					190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0					192.00
192.01	19201	PROHEALTH SERVICES	0	0					192.01
192.02	19202	AUXILIARY	0	0					192.02
192.03	19203	GRANT	0	0					192.03
200.00		Cross Foot Adjustments			0	0		1,160	200.00
201.00		Negative Cost Centers	0	0	0	0		0	201.00
202.00		TOTAL (sum lines 118 through 201)	103,017	7,143	0	0		1,160	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0206

Period:
From 10/01/2019
To 09/30/2020Worksheet B
Part II
Date/Time Prepared:
4/26/2021 2:25 pm

Cost Center Description			INTERNS & RESIDENTS	PARAMED ED PRGM	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			SERVICES-OTHER PRGM COSTS APPRV					
			22.00	23.00	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
4.01	00401	COMMUNICATIONS						4.01
4.02	00402	DATA PROCESSING						4.02
4.03	00403	ADMITTING						4.03
4.04	00404	CASHIERING						4.04
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
12.00	01200	MAINTENANCE OF PERSONNEL						12.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY						15.00
16.00	01600	MEDICAL RECORDS & LIBRARY						16.00
17.00	01700	SOCIAL SERVICE						17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS						19.00
20.00	02000	NURSING SCHOOL						20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV						21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	2,240					22.00
23.00	02300	PARAMED ED PRGM- (SPECIFY)		0				23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS			1,356,824	0	1,356,824	30.00
31.00	03100	INTENSIVE CARE UNIT			206,545	0	206,545	31.00
31.01	02060	NICU			0	0	0	31.01
40.00	04000	SUBPROVIDER - IPF			136,715	0	136,715	40.00
43.00	04300	NURSERY			97,368	0	97,368	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM			510,891	0	510,891	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM			360,901	0	360,901	52.00
53.00	05300	ANESTHESIOLOGY			24,062	0	24,062	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC			364,427	0	364,427	54.00
56.01	05601	NUCLEAR MEDICINE			0	0	0	56.01
60.00	06000	LABORATORY			250,641	0	250,641	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS			0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY			76,534	0	76,534	65.00
66.00	06600	PHYSICAL THERAPY			69,867	0	69,867	66.00
69.00	06900	ELECTROCARDIOLOGY			95,761	0	95,761	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY			14,353	0	14,353	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT			44,779	0	44,779	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS			210,449	0	210,449	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS			168,112	0	168,112	73.00
74.00	07400	RENAL DIALYSIS			5,037	0	5,037	74.00
75.01	07501	ACUTE DIALYSIS			0	0	0	75.01
75.02	03650	CARD CATH LAB			120,334	0	120,334	75.02
76.97	07697	CARDIAC REHABILITATION			0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY			0	0	0	76.98
76.99	07699	LITHOTRIPSY			0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC			208,745	0	208,745	90.00
90.01	09001	PH CLINIC			0	0	0	90.01
90.02	09002	HEALTHWORKS CLINIC			25,535	0	25,535	90.02
90.03	09003	DENTAL CLINIC			0	0	0	90.03
90.04	09004	WOUND CARE THERAPY			75,802	0	75,802	90.04
90.05	09005	FAMILY PRACTICE CLINIC			0	0	0	90.05
91.00	09100	EMERGENCY			253,749	0	253,749	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				0		92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM			0	0	0	93.99
OTHER REIMBURSABLE COST CENTERS								
99.10	09910	CORF			0	0	0	99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY			0	0	0	99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY			0	0	0	99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY			0	0	0	99.40

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0206

Period:
From 10/01/2019
To 09/30/2020Worksheet B
Part II
Date/Time Prepared:
4/26/2021 2:25 pm

Cost Center Description		INTERNS & RESIDENTS	PARAMED ED PRGM	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
		SERVICES-OTHER PRGM COSTS APPRV					
		22.00	23.00	24.00	25.00	26.00	
SPECIAL PURPOSE COST CENTERS							
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	0	0	4,677,431	0	4,677,431	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN			11,717	0	11,717	190.00
192.00	19200 PHYSICIANS' PRIVATE OFFICES			868,415	0	868,415	192.00
192.01	19201 PROHEALTH SERVICES			7,527	0	7,527	192.01
192.02	19202 AUXILIARY			7,758	0	7,758	192.02
192.03	19203 GRANT			2,351	0	2,351	192.03
200.00	Cross Foot Adjustments	2,240	0	3,400	0	3,400	200.00
201.00	Negative Cost Centers	0	0	0	0	0	201.00
202.00	TOTAL (sum lines 118 through 201)	2,240	0	5,578,599	0	5,578,599	202.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0206

Period:
From 10/01/2019
To 09/30/2020

Worksheet B-1

Date/Time Prepared:
4/26/2021 2:25 pm

Cost Center Description			CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	COMMUNICATIONS ((NUMBER OF PHONES))	DATA PROCESSING ((MACHINE TIME))	
			BLDG & FIXT ((SQUARE FEET))	MVBLE EQUIP ((DOLLAR VALUE))				
			1.00	2.00	4.00	4.01	4.02	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT	260,059					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		3,100,037				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	3,020	289	52,986,105			4.00
4.01	00401	COMMUNICATIONS	403	0	289,705	365		4.01
4.02	00402	DATA PROCESSING	6,358	304,541	1,496,382	5	110	4.02
4.03	00403	ADMITTING	6,014	1,650	773,278	5	9	4.03
4.04	00404	CASHIERING	1,440	2,796	339,733	29	13	4.04
5.00	00500	ADMINISTRATIVE & GENERAL	5,503	127,974	11,034,293	62	8	5.00
6.00	00600	MAINTENANCE & REPAIRS	0	0	0	0	0	6.00
7.00	00700	OPERATION OF PLANT	21,811	950,959	1,660,539	18	1	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	3,682	0	0	0	0	8.00
9.00	00900	HOUSEKEEPING	3,524	8,173	1,305,744	0	2	9.00
10.00	01000	DIETARY	7,456	13,639	577,026	11	2	10.00
11.00	01100	CAFETERIA	3,378	5,759	243,667	1	0	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	2,413	30,601	1,344,018	8	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	11,064	44,988	576,813	1	6	14.00
15.00	01500	PHARMACY	4,836	119,738	1,577,326	10	7	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	4,978	4,610	374,663	22	1	16.00
17.00	01700	SOCIAL SERVICE	153	83	696,157	8	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
20.00	02000	NURSING SCHOOL	0	0	0	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	164,131	1	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	120	0	0	0	0	22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	41,731	283,296	10,682,903	38	14	30.00
31.00	03100	INTENSIVE CARE UNIT	6,295	45,800	1,761,470	0	2	31.00
31.01	02060	NICU	0	0	0	0	0	31.01
40.00	04000	SUBPROVIDER - IPF	5,293	8,701	1,046,636	0	0	40.00
43.00	04300	NURSERY	3,876	9,609	1,052,754	3	2	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	18,284	160,385	1,988,695	24	4	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	3,198	416,155	1,770,860	2	2	52.00
53.00	05300	ANESTHESIOLOGY	668	13,375	40,392	3	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	9,778	215,563	1,845,392	20	3	54.00
56.01	05601	NUCLEAR MEDICINE	0	0	0	0	0	56.01
60.00	06000	LABORATORY	8,165	2,339	3,023	24	18	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	2,449	20,047	717,843	5	2	65.00
66.00	06600	PHYSICAL THERAPY	2,593	16,347	457,107	3	2	66.00
69.00	06900	ELECTROCARDIOLOGY	3,177	40,442	176,557	8	2	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	435	698	55,598	0	2	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
75.01	07501	ACUTE DIALYSIS	0	0	0	0	0	75.01
75.02	03650	CARD CATH LAB	2,133	107,004	431,856	0	0	75.02
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	7,902	31,671	3,477,116	7	6	90.00
90.01	09001	PH CLINIC	0	0	0	0	0	90.01
90.02	09002	HEALTHWORKS CLINIC	1,200	631	370,797	5	0	90.02
90.03	09003	DENTAL CLINIC	0	0	0	0	0	90.03
90.04	09004	WOUND CARE THERAPY	3,234	8,017	347,622	5	0	90.04
90.05	09005	FAMILY PRACTICE CLINIC	0	0	0	0	0	90.05
91.00	09100	EMERGENCY	7,552	57,193	2,680,603	12	2	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0	0	0	0	0	93.99
OTHER REIMBURSABLE COST CENTERS								
99.10	09910	CORF	0	0	0	0	0	99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY	0	0	0	0	0	99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY	0	0	0	0	0	99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY	0	0	0	0	0	99.40

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0206

Period:
From 10/01/2019
To 09/30/2020

Worksheet B-1

Date/Time Prepared:
4/26/2021 2:25 pm

Cost Center Description			CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	COMMUNICATIONS ((NUMBER OF PHONES))	DATA PROCESSING ((MACHINE TIME))	
			BLDG & FIXT ((SQUARE FEET))	MVBLE EQUIP ((DOLLAR VALUE))				
			1.00	2.00				
	SPECIAL PURPOSE COST CENTERS							
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	214,116	3,053,073	51,360,699	340	110	118.00
	NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	627	0	0	1	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	45,316	26,953	927,628	19	0	192.00
192.01	19201	PROHEALTH SERVICES	0	9,330	175	5	0	192.01
192.02	19202	AUXILIARY	0	9,588	260,114	0	0	192.02
192.03	19203	GRANT	0	1,093	437,489	0	0	192.03
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	3,633,471	1,945,128	7,011,565	402,312	3,623,678	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	13.971718	0.627453	0.132328	1,102.224658	32,942.527273	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)			42,376	5,863	281,194	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)			0.000800	16.063014	2,556.309091	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: 14-0206

Period:
From 10/01/2019
To 09/30/2020

Worksheet B-1

Date/Time Prepared:
4/26/2021 2:25 pm

Cost Center Description		ADMITTING (INPATIENT REVENUE)	CASHIERING (GROSS REVENUE)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM COST)	MAINTENANCE & REPAIRS ((SQUARE FEET))	
		4.03	4.04	5A	5.00	6.00	
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
4.01	00401	COMMUNICATIONS					4.01
4.02	00402	DATA PROCESSING					4.02
4.03	00403	ADMITTING	218,680,540				4.03
4.04	00404	CASHIERING	0	335,242,530			4.04
5.00	00500	ADMINISTRATIVE & GENERAL	0	-18,520,274	82,541,414		5.00
6.00	00600	MAINTENANCE & REPAIRS	0	0	0	0	6.00
7.00	00700	OPERATION OF PLANT	0	0	6,008,964	0	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	51,444	0	8.00
9.00	00900	HOUSEKEEPING	0	0	2,596,988	0	9.00
10.00	01000	DIETARY	0	0	2,147,486	0	10.00
11.00	01100	CAFETERIA	0	0	664,274	0	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	0	0	1,709,583	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	1,229,241	0	14.00
15.00	01500	PHARMACY	0	0	2,984,665	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	1,399,053	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	943,340	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	19.00
20.00	02000	NURSING SCHOOL	0	0	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	264,931	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	1,677	0	22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	84,773,696	90,819,795	0	16,777,721	30.00
31.00	03100	INTENSIVE CARE UNIT	10,652,287	10,652,287	0	3,175,896	31.00
31.01	02060	NICU	0	0	0	0	31.01
40.00	04000	SUBPROVIDER - IPF	6,510,300	6,510,300	0	1,490,638	40.00
43.00	04300	NURSERY	2,873,347	2,873,347	0	1,545,525	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	9,010,408	19,114,886	0	4,603,138	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	2,921,592	3,620,984	0	2,803,841	52.00
53.00	05300	ANESTHESIOLOGY	1,454,512	2,709,918	0	186,711	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	10,762,280	29,257,954	0	4,232,407	54.00
56.01	05601	NUCLEAR MEDICINE	0	0	0	0	56.01
60.00	06000	LABORATORY	28,218,358	49,825,261	0	5,738,783	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	5,089,884	5,728,720	0	1,289,553	65.00
66.00	06600	PHYSICAL THERAPY	1,300,682	3,096,470	0	712,994	66.00
69.00	06900	ELECTROCARDIOLOGY	2,701,236	5,089,944	0	438,011	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	164,730	195,855	0	147,216	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	961,240	1,398,826	0	407,259	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	3,263,069	4,805,607	0	1,906,503	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	28,089,814	36,327,573	0	2,414,915	73.00
74.00	07400	RENAL DIALYSIS	2,373,302	2,539,502	0	791,060	74.00
75.01	07501	ACUTE DIALYSIS	0	0	0	0	75.01
75.02	03650	CARD CATH LAB	6,860,175	9,687,385	0	954,429	75.02
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	13,051	1,658,326	0	3,501,409	90.00
90.01	09001	PH CLINIC	0	0	0	0	90.01
90.02	09002	HEALTHWORKS CLINIC	78	271,795	0	313,190	90.02
90.03	09003	DENTAL CLINIC	0	0	0	0	90.03
90.04	09004	WOUND CARE THERAPY	736,801	6,252,965	0	600,287	90.04
90.05	09005	FAMILY PRACTICE CLINIC	0	0	0	0	90.05
91.00	09100	EMERGENCY	9,949,698	42,804,830	0	4,885,280	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0	0	0	0	93.99
OTHER REIMBURSABLE COST CENTERS							
99.10	09910	CORF	0	0	0	0	99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY	0	0	0	0	99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY	0	0	0	0	99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY	0	0	0	0	99.40
SPECIAL PURPOSE COST CENTERS							
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	218,680,540	335,242,530	-18,520,274	78,918,412	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEN	0	0	0	9,862	190.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0206

Period:
From 10/01/2019
To 09/30/2020

Worksheet B-1

Date/Time Prepared:
4/26/2021 2:25 pm

Cost Center Description			ADMITTING (INPATIENT REVENUE)	CASHIERING (GROSS REVENUE)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM COST)	MAINTENANCE & REPAIRS ((SQUARE FEET))	
			4.03	4.04	5A	5.00	6.00	
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	1,974,452	0	192.00
192.01	19201	PROHEALTH SERVICES	0	0	0	701,339	0	192.01
192.02	19202	AUXILIARY	0	0	0	358,351	0	192.02
192.03	19203	GRANT	0	0	0	578,998	0	192.03
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	1,494,221	2,362,645		18,520,274	0	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.006833	0.007048		0.224376	0.000000	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	108,767	55,843		187,448	0	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.000497	0.000167		0.002271	0.000000	205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)						206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0206

Period:
From 10/01/2019
To 09/30/2020

Worksheet B-1

Date/Time Prepared:
4/26/2021 2:25 pm

Cost Center Description		OPERATION OF PLANT ((SQUARE FEET))	LAUNDRY & LINEN SERVICE ((POUNDS OF LAUNDRY))	HOUSEKEEPING ((SQUARE FEET))	DIETARY ((MEALS SERVED))	CAFETERIA ((MEALS SERVED))	
		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
4.01	00401	COMMUNICATIONS					4.01
4.02	00402	DATA PROCESSING					4.02
4.03	00403	ADMITTING					4.03
4.04	00404	CASHIERING					4.04
5.00	00500	ADMINISTRATIVE & GENERAL					5.00
6.00	00600	MAINTENANCE & REPAIRS					6.00
7.00	00700	OPERATION OF PLANT	215,510				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	3,682	309,685			8.00
9.00	00900	HOUSEKEEPING	3,524	0	208,304		9.00
10.00	01000	DIETARY	7,456	0	7,456	100,938	10.00
11.00	01100	CAFETERIA	3,378	0	3,378	0	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	47,519	12.00
13.00	01300	NURSING ADMINISTRATION	2,413	0	2,413	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	11,064	0	11,064	0	14.00
15.00	01500	PHARMACY	4,836	0	4,836	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	4,978	0	4,978	0	16.00
17.00	01700	SOCIAL SERVICE	153	0	153	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	19.00
20.00	02000	NURSING SCHOOL	0	0	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	286	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	120	0	120	0	22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	41,731	99,074	41,731	81,528	30.00
31.00	03100	INTENSIVE CARE UNIT	6,295	13,209	6,295	8,955	31.00
31.01	02060	NICU	0	0	0	0	31.01
40.00	04000	SUBPROVIDER - IPF	5,293	0	5,293	10,455	40.00
43.00	04300	NURSERY	3,876	16,535	3,876	0	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	18,284	56,083	18,284	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	3,198	47,186	3,198	0	52.00
53.00	05300	ANESTHESIOLOGY	668	0	668	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	9,778	22,294	9,778	0	54.00
56.01	05601	NUCLEAR MEDICINE	0	0	0	0	56.01
60.00	06000	LABORATORY	8,165	0	8,165	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	2,449	0	2,449	0	65.00
66.00	06600	PHYSICAL THERAPY	2,593	5,730	2,593	0	66.00
69.00	06900	ELECTROCARDIOLOGY	3,177	0	3,177	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	435	0	435	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
75.01	07501	ACUTE DIALYSIS	0	0	0	0	75.01
75.02	03650	CARD CATH LAB	2,133	0	2,133	0	75.02
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	7,902	11,883	7,902	0	90.00
90.01	09001	PH CLINIC	0	0	0	0	90.01
90.02	09002	HEALTHWORKS CLINIC	1,200	494	1,200	0	90.02
90.03	09003	DENTAL CLINIC	0	0	0	0	90.03
90.04	09004	WOUND CARE THERAPY	3,234	1,652	3,234	0	90.04
90.05	09005	FAMILY PRACTICE CLINIC	0	0	0	0	90.05
91.00	09100	EMERGENCY	7,552	35,545	7,552	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0	0	0	0	93.99
OTHER REIMBURSABLE COST CENTERS							
99.10	09910	CORF	0	0	0	0	99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY	0	0	0	0	99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY	0	0	0	0	99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY	0	0	0	0	99.40
SPECIAL PURPOSE COST CENTERS							
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	169,567	309,685	162,361	100,938	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	627	0	627	0	190.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0206

Period:
From 10/01/2019
To 09/30/2020

Worksheet B-1

Date/Time Prepared:
4/26/2021 2:25 pm

Cost Center Description			OPERATION OF PLANT ((SQUARE FEET))	LAUNDRY & LINEN SERVICE ((POUNDS OF LAUNDRY))	HOUSEKEEPING ((SQUARE FEET))	DIETARY ((MEALS SERVED))	CAFETERIA ((MEALS SERVED))	
			7.00	8.00	9.00	10.00	11.00	
192.00	19200	PHYSICIANS' PRIVATE OFFICES	45,316	0	45,316	0	1,054	192.00
192.01	19201	PROHEALTH SERVICES	0	0	0	0	0	192.01
192.02	19202	AUXILIARY	0	0	0	0	390	192.02
192.03	19203	GRANT	0	0	0	0	0	192.03
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	7,357,231	188,686	3,299,995	3,001,987	982,157	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	34.138699	0.609284	15.842207	29.740900	20.668722	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	919,238	67,266	81,451	158,078	68,260	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	4.265408	0.217208	0.391020	1.566090	1.436478	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: 14-0206

Period:
From 10/01/2019
To 09/30/2020

Worksheet B-1

Date/Time Prepared:
4/26/2021 2:25 pm

Cost Center Description			MAINTENANCE OF PERSONNEL (NUMBER HOUSED)	NURSING ADMINISTRATION ((DIRECT NRSG HRS))	CENTRAL SERVICES & SUPPLY ((COSTED REQUIS))	PHARMACY ((COSTED REQUIS))	MEDICAL RECORDS & LIBRARY (GROSS REVENUE)	
			12.00	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
4.01	00401	COMMUNICATIONS						4.01
4.02	00402	DATA PROCESSING						4.02
4.03	00403	ADMITTING						4.03
4.04	00404	CASHIERING						4.04
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0					12.00
13.00	01300	NURSING ADMINISTRATION	0	31,449				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	2,327,511			14.00
15.00	01500	PHARMACY	0	0	0	2,912,985		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	335,242,530	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
20.00	02000	NURSING SCHOOL	0	0	0	0	0	20.00
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	PARAMED ED PRGM-(SPECIFY)	0	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	0	16,910	25,008	192,597	90,819,795	30.00
31.00	03100	INTENSIVE CARE UNIT	0	2,308	6,620	150,321	10,652,287	31.00
31.01	02060	NICU	0	0	0	0	0	31.01
40.00	04000	SUBPROVIDER - IPF	0	1,228	99	17,900	6,510,300	40.00
43.00	04300	NURSERY	0	780	262	4,982	2,873,347	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	2,366	11,189	166,284	19,114,886	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	1,994	4,256	90,328	3,620,984	52.00
53.00	05300	ANESTHESIOLOGY	0	103	593	4,036	2,709,918	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	3,302	326	29,257,954	54.00
56.01	05601	NUCLEAR MEDICINE	0	0	0	0	0	56.01
60.00	06000	LABORATORY	0	0	0	0	49,825,261	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0	1,181	28	454	5,728,720	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	3,096,470	66.00
69.00	06900	ELECTROCARDIOLOGY	0	287	109	0	5,089,944	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	17	0	195,855	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	390,832	0	1,398,826	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	1,850,336	0	4,805,607	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	1,966,940	36,327,573	73.00
74.00	07400	RENAL DIALYSIS	0	0	121	12,634	2,539,502	74.00
75.01	07501	ACUTE DIALYSIS	0	0	0	0	0	75.01
75.02	03650	CARD CATH LAB	0	371	1,745	20,705	9,687,385	75.02
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	1,114	92,837	1,658,326	90.00
90.01	09001	PH CLINIC	0	0	0	0	0	90.01
90.02	09002	HEALTHWORKS CLINIC	0	0	191	12,228	271,795	90.02
90.03	09003	DENTAL CLINIC	0	0	0	0	0	90.03
90.04	09004	WOUND CARE THERAPY	0	0	20,833	29,901	6,252,965	90.04
90.05	09005	FAMILY PRACTICE CLINIC	0	0	0	0	0	90.05
91.00	09100	EMERGENCY	0	3,921	10,419	144,309	42,804,830	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0	0	0	0	0	93.99
OTHER REIMBURSABLE COST CENTERS								
99.10	09910	CORF	0	0	0	0	0	99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY	0	0	0	0	0	99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY	0	0	0	0	0	99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY	0	0	0	0	0	99.40
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	31,449	2,327,074	2,906,782	335,242,530	118.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0206

Period:
From 10/01/2019
To 09/30/2020

Worksheet B-1

Date/Time Prepared:
4/26/2021 2:25 pm

Cost Center Description			MAINTENANCE OF PERSONNEL (NUMBER HOUSED)	NURSING ADMINISTRATION ((DIRECT NRSG HRS))	CENTRAL SERVICES & SUPPLY ((COSTED REQUIS))	PHARMACY ((COSTED REQUIS))	MEDICAL RECORDS & LIBRARY (GROSS REVENUE)	
			12.00	13.00	14.00	15.00	16.00	
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	431	3,824	0	192.00
192.01	19201	PROHEALTH SERVICES	0	0	0	0	0	192.01
192.02	19202	AUXILIARY	0	0	6	2,379	0	192.02
192.03	19203	GRANT	0	0	0	0	0	192.03
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	0	2,237,876	2,078,669	3,944,404	1,976,281	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.000000	71.158892	0.893087	1.354076	0.005895	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	0	70,912	254,370	194,671	103,017	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.000000	2.254825	0.109288	0.066829	0.000307	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: 14-0206

Period:
From 10/01/2019
To 09/30/2020

Worksheet B-1

Date/Time Prepared:
4/26/2021 2:25 pm

Cost Center Description			INTERNS & RESIDENTS			
			SOCIAL SERVICE ((TIME SPENT))	NONPHYSICIAN ANESTHETISTS (ASSIGNED TIME)	NURSING SCHOOL (ASSIGNED TIME)	SERVICES-SALAR Y & FRINGES APPRV ((ASSIGNED TIME))
			17.00	19.00	20.00	21.00
GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT				
2.00	00200	CAP REL COSTS-MVBLE EQUIP				
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT				
4.01	00401	COMMUNICATIONS				
4.02	00402	DATA PROCESSING				
4.03	00403	ADMITTING				
4.04	00404	CASHIERING				
5.00	00500	ADMINISTRATIVE & GENERAL				
6.00	00600	MAINTENANCE & REPAIRS				
7.00	00700	OPERATION OF PLANT				
8.00	00800	LAUNDRY & LINEN SERVICE				
9.00	00900	HOUSEKEEPING				
10.00	01000	DIETARY				
11.00	01100	CAFETERIA				
12.00	01200	MAINTENANCE OF PERSONNEL				
13.00	01300	NURSING ADMINISTRATION				
14.00	01400	CENTRAL SERVICES & SUPPLY				
15.00	01500	PHARMACY				
16.00	01600	MEDICAL RECORDS & LIBRARY				
17.00	01700	SOCIAL SERVICE	100			
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0		
20.00	02000	NURSING SCHOOL	0		0	
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0			100
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0			
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0			100
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	87	0	0	90
31.00	03100	INTENSIVE CARE UNIT	4	0	0	0
31.01	02060	NICU	0	0	0	0
40.00	04000	SUBPROVIDER - IPF	0	0	0	0
43.00	04300	NURSERY	0	0	0	0
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	3	0	0	0
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0
53.00	05300	ANESTHESIOLOGY	0	0	0	0
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0
56.01	05601	NUCLEAR MEDICINE	0	0	0	0
60.00	06000	LABORATORY	0	0	0	0
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0
65.00	06500	RESPIRATORY THERAPY	0	0	0	0
66.00	06600	PHYSICAL THERAPY	0	0	0	0
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0
74.00	07400	RENAL DIALYSIS	0	0	0	0
75.01	07501	ACUTE DIALYSIS	0	0	0	0
75.02	03650	CARD CATH LAB	0	0	0	0
76.97	07697	CARDIAC REHABILITATION	0	0	0	0
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0
76.99	07699	LITHOTRIPSY	0	0	0	0
OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	10
90.01	09001	PH CLINIC	0	0	0	0
90.02	09002	HEALTHWORKS CLINIC	0	0	0	0
90.03	09003	DENTAL CLINIC	0	0	0	0
90.04	09004	WOUND CARE THERAPY	0	0	0	0
90.05	09005	FAMILY PRACTICE CLINIC	0	0	0	0
91.00	09100	EMERGENCY	6	0	0	0
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0	0	0	0
OTHER REIMBURSABLE COST CENTERS						
99.10	09910	CORF	0	0	0	0
99.20	09920	OUTPATIENT PHYSICAL THERAPY	0	0	0	0
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY	0	0	0	0
99.40	09940	OUTPATIENT SPEECH PATHOLOGY	0	0	0	0

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0206

Period:
From 10/01/2019
To 09/30/2020

Worksheet B-1

Date/Time Prepared:
4/26/2021 2:25 pm

Cost Center Description			SOCIAL SERVICE ((TIME SPENT))	NONPHYSICIAN ANESTHETISTS (ASSIGNED TIME)	NURSING SCHOOL (ASSIGNED TIME)	INTERNS & RESIDENTS		
						SERVICES-SALAR Y & FRINGES APPRV ((ASSIGNED TIME))	SERVICES-OTHER PRGM COSTS APPRV ((ASSIGNED TIME))	
						17.00	19.00	
SPECIAL PURPOSE COST CENTERS								
118.00	SUBTOTALS (SUM OF LINES 1 through 117)		100	0	0	100	100	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
192.01	19201	PROHEALTH SERVICES	0	0	0	0	0	192.01
192.02	19202	AUXILIARY	0	0	0	0	0	192.02
192.03	19203	GRANT	0	0	0	0	0	192.03
200.00	Cross Foot Adjustments							200.00
201.00	Negative Cost Centers							201.00
202.00	Cost to be allocated (per Wkst. B, Part I)		1,182,967	0	0	330,286	8,051	202.00
203.00	Unit cost multiplier (Wkst. B, Part I)		11,829.670000	0.000000	0.000000	3,302.860000	80.510000	203.00
204.00	Cost to be allocated (per Wkst. B, Part II)		7,143	0	0	1,160	2,240	204.00
205.00	Unit cost multiplier (Wkst. B, Part II)		71.430000	0.000000	0.000000	11.600000	22.400000	205.00
206.00	NAHE adjustment amount to be allocated (per Wkst. B-2)				0			206.00
207.00	NAHE unit cost multiplier (Wkst. D, Parts III and IV)				0.000000			207.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0206

Period:
From 10/01/2019
To 09/30/2020

Worksheet B-1

Date/Time Prepared:
4/26/2021 2:25 pm

Cost Center Description		PARAMED ED PRGM (ASSIGNED TIME)	
		23.00	
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
4.01	00401	COMMUNICATIONS	4.01
4.02	00402	DATA PROCESSING	4.02
4.03	00403	ADMITTING	4.03
4.04	00404	CASHIERING	4.04
5.00	00500	ADMINISTRATIVE & GENERAL	5.00
6.00	00600	MAINTENANCE & REPAIRS	6.00
7.00	00700	OPERATION OF PLANT	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	8.00
9.00	00900	HOUSEKEEPING	9.00
10.00	01000	DIETARY	10.00
11.00	01100	CAFETERIA	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	12.00
13.00	01300	NURSING ADMINISTRATION	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	14.00
15.00	01500	PHARMACY	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	16.00
17.00	01700	SOCIAL SERVICE	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	19.00
20.00	02000	NURSING SCHOOL	20.00
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	PARAMED ED PRGM-(SPECIFY)	23.00
INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS	30.00
31.00	03100	INTENSIVE CARE UNIT	31.00
31.01	02060	NICU	31.01
40.00	04000	SUBPROVIDER - IPF	40.00
43.00	04300	NURSERY	43.00
ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	52.00
53.00	05300	ANESTHESIOLOGY	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	54.00
56.01	05601	NUCLEAR MEDICINE	56.01
60.00	06000	LABORATORY	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	62.30
65.00	06500	RESPIRATORY THERAPY	65.00
66.00	06600	PHYSICAL THERAPY	66.00
69.00	06900	ELECTROCARDIOLOGY	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	73.00
74.00	07400	RENAL DIALYSIS	74.00
75.01	07501	ACUTE DIALYSIS	75.01
75.02	03650	CARD CATH LAB	75.02
76.97	07697	CARDIAC REHABILITATION	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	76.98
76.99	07699	LITHOTRIPSY	76.99
OUTPATIENT SERVICE COST CENTERS			
90.00	09000	CLINIC	90.00
90.01	09001	PH CLINIC	90.01
90.02	09002	HEALTHWORKS CLINIC	90.02
90.03	09003	DENTAL CLINIC	90.03
90.04	09004	WOUND CARE THERAPY	90.04
90.05	09005	FAMILY PRACTICE CLINIC	90.05
91.00	09100	EMERGENCY	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	93.99
OTHER REIMBURSABLE COST CENTERS			
99.10	09910	CORF	99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY	99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY	99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY	99.40
SPECIAL PURPOSE COST CENTERS			
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	118.00
NONREIMBURSABLE COST CENTERS			
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	190.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0206

Period:
From 10/01/2019
To 09/30/2020Worksheet B-1
Date/Time Prepared:
4/26/2021 2:25 pm

Cost Center Description			PARAMED ED PRGM (ASSIGNED TIME)	
			23.00	
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	192.00
192.01	19201	PROHEALTH SERVICES	0	192.01
192.02	19202	AUXILIARY	0	192.02
192.03	19203	GRANT	0	192.03
200.00		Cross Foot Adjustments		200.00
201.00		Negative Cost Centers		201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	0	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.000000	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	0	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.000000	205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)	0	206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)	0.000000	207.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0206

Period:
From 10/01/2019
To 09/30/2020Worksheet C
Part I
Date/Time Prepared:
4/26/2021 2:25 pm

				Title XVIII	Hospital	PPS		
	Cost Center Description		Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs			
					Total Costs	RCE Disallowance		Total Costs
			1.00	2.00	3.00	4.00	5.00	
	INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	28,513,554		28,513,554	0	28,513,554	30.00
31.00	03100	INTENSIVE CARE UNIT	5,009,009		5,009,009	0	5,009,009	31.00
31.01	02060	NICU	0		0	0	0	31.01
40.00	04000	SUBPROVIDER - IPF	2,576,059		2,576,059	0	2,576,059	40.00
43.00	04300	NURSERY	2,191,649		2,191,649	0	2,191,649	43.00
	ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	7,184,582		7,184,582	0	7,184,582	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	3,952,107		3,952,107	0	3,952,107	52.00
53.00	05300	ANESTHESIOLOGY	293,420		293,420	0	293,420	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	5,910,672		5,910,672	0	5,910,672	54.00
56.01	05601	NUCLEAR MEDICINE	0		0	0	0	56.01
60.00	06000	LABORATORY	7,728,242		7,728,242	0	7,728,242	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0		0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	1,844,162	0	1,844,162	0	1,844,162	65.00
66.00	06600	PHYSICAL THERAPY	1,035,852	0	1,035,852	0	1,035,852	66.00
69.00	06900	ELECTROCARDIOLOGY	751,537		751,537	0	751,537	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	205,226		205,226	0	205,226	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	855,931		855,931	0	855,931	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	4,015,117		4,015,117	0	4,015,117	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	5,834,304		5,834,304	0	5,834,304	73.00
74.00	07400	RENAL DIALYSIS	1,000,740		1,000,740	0	1,000,740	74.00
75.01	07501	ACUTE DIALYSIS	0		0	0	0	75.01
75.02	03650	CARD CATH LAB	1,395,958		1,395,958	0	1,395,958	75.02
76.97	07697	CARDIAC REHABILITATION	0		0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0		0	0	0	76.98
76.99	07699	LITHOTRIPSY	0		0	0	0	76.99
	OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	4,909,025		4,909,025	181,005	5,090,030	90.00
90.01	09001	PH CLINIC	0		0	0	0	90.01
90.02	09002	HEALTHWORKS CLINIC	471,062		471,062	0	471,062	90.02
90.03	09003	DENTAL CLINIC	0		0	0	0	90.03
90.04	09004	WOUND CARE THERAPY	1,005,711		1,005,711	0	1,005,711	90.04
90.05	09005	FAMILY PRACTICE CLINIC	0		0	0	0	90.05
91.00	09100	EMERGENCY	7,268,610		7,268,610	0	7,268,610	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	2,674,112		2,674,112		2,674,112	92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0		0	0	0	93.99
	OTHER REIMBURSABLE COST CENTERS							
99.10	09910	CORF	0		0		0	99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY	0		0		0	99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY	0		0		0	99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY	0		0		0	99.40
200.00		Subtotal (see instructions)	96,626,641	0	96,626,641	181,005	96,807,646	200.00
201.00		Less Observation Beds	2,674,112		2,674,112		2,674,112	201.00
202.00		Total (see instructions)	93,952,529	0	93,952,529	181,005	94,133,534	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0206

Period:
From 10/01/2019
To 09/30/2020Worksheet C
Part I
Date/Time Prepared:
4/26/2021 2:25 pm

			Title XVIII		Hospital	PPS	
Cost Center Description			Charges			Cost or Other Ratio	TEFRA Inpatient Ratio
			Inpatient	Outpatient	Total (col. 6 + col. 7)		
			6.00	7.00	8.00		
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	83,404,320		83,404,320		30.00
31.00	03100	INTENSIVE CARE UNIT	10,652,287		10,652,287		31.00
31.01	02060	NICU	0		0		31.01
40.00	04000	SUBPROVIDER - IPF	6,510,300		6,510,300		40.00
43.00	04300	NURSERY	2,873,347		2,873,347		43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	9,010,408	10,104,478	19,114,886	0.375863	0.000000
52.00	05200	DELIVERY ROOM & LABOR ROOM	2,921,592	699,392	3,620,984	1.091446	0.000000
53.00	05300	ANESTHESIOLOGY	1,454,512	1,255,406	2,709,918	0.108276	0.000000
54.00	05400	RADIOLOGY-DIAGNOSTIC	10,762,280	18,495,674	29,257,954	0.202019	0.000000
56.01	05601	NUCLEAR MEDICINE	0	0	0	0.000000	0.000000
60.00	06000	LABORATORY	28,218,358	21,606,903	49,825,261	0.155107	0.000000
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0.000000	0.000000
65.00	06500	RESPIRATORY THERAPY	5,089,884	638,836	5,728,720	0.321915	0.000000
66.00	06600	PHYSICAL THERAPY	1,300,682	1,795,788	3,096,470	0.334527	0.000000
69.00	06900	ELECTROCARDIOLOGY	2,701,236	2,388,708	5,089,944	0.147651	0.000000
70.00	07000	ELECTROENCEPHALOGRAPHY	164,730	31,125	195,855	1.047847	0.000000
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	961,240	437,586	1,398,826	0.611892	0.000000
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	3,263,069	1,542,538	4,805,607	0.835507	0.000000
73.00	07300	DRUGS CHARGED TO PATIENTS	28,089,814	8,237,759	36,327,573	0.160603	0.000000
74.00	07400	RENAL DIALYSIS	2,373,302	166,200	2,539,502	0.394069	0.000000
75.01	07501	ACUTE DIALYSIS	0	0	0	0.000000	0.000000
75.02	03650	CARD CATH LAB	6,860,175	2,827,210	9,687,385	0.144101	0.000000
76.97	07697	CARDIAC REHABILITATION	0	0	0	0.000000	0.000000
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0.000000	0.000000
76.99	07699	LITHOTRIPSY	0	0	0	0.000000	0.000000
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	13,051	1,645,275	1,658,326	2.960229	0.000000
90.01	09001	PH CLINIC	0	0	0	0.000000	0.000000
90.02	09002	HEALTHWORKS CLINIC	78	271,717	271,795	1.733152	0.000000
90.03	09003	DENTAL CLINIC	0	0	0	0.000000	0.000000
90.04	09004	WOUND CARE THERAPY	736,801	5,516,164	6,252,965	0.160837	0.000000
90.05	09005	FAMILY PRACTICE CLINIC	0	0	0	0.000000	0.000000
91.00	09100	EMERGENCY	9,949,698	32,855,132	42,804,830	0.169808	0.000000
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1,369,376	6,046,099	7,415,475	0.360612	0.000000
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0	0	0	0.000000	0.000000
OTHER REIMBURSABLE COST CENTERS							
99.10	09910	CORF	0	0	0		99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY	0	0	0		99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY	0	0	0		99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY	0	0	0		99.40
200.00		Subtotal (see instructions)	218,680,540	116,561,990	335,242,530		200.00
201.00		Less Observation Beds					201.00
202.00		Total (see instructions)	218,680,540	116,561,990	335,242,530		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0206

Period:
From 10/01/2019
To 09/30/2020Worksheet C
Part I
Date/Time Prepared:
4/26/2021 2:25 pm

Cost Center Description		PPS Inpatient Ratio	Title XVIII	Hospital	PPS
		11.00			
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS			30.00
31.00	03100	INTENSIVE CARE UNIT			31.00
31.01	02060	NICU			31.01
40.00	04000	SUBPROVIDER - IPF			40.00
43.00	04300	NURSERY			43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0.375863		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1.091446		52.00
53.00	05300	ANESTHESIOLOGY	0.108276		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.202019		54.00
56.01	05601	NUCLEAR MEDICINE	0.000000		56.01
60.00	06000	LABORATORY	0.155107		60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0.000000		62.30
65.00	06500	RESPIRATORY THERAPY	0.321915		65.00
66.00	06600	PHYSICAL THERAPY	0.334527		66.00
69.00	06900	ELECTROCARDIOLOGY	0.147651		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	1.047847		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.611892		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.835507		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.160603		73.00
74.00	07400	RENAL DIALYSIS	0.394069		74.00
75.01	07501	ACUTE DIALYSIS	0.000000		75.01
75.02	03650	CARD CATH LAB	0.144101		75.02
76.97	07697	CARDIAC REHABILITATION	0.000000		76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0.000000		76.98
76.99	07699	LITHOTRIPSY	0.000000		76.99
OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	3.069378		90.00
90.01	09001	PH CLINIC	0.000000		90.01
90.02	09002	HEALTHWORKS CLINIC	1.733152		90.02
90.03	09003	DENTAL CLINIC	0.000000		90.03
90.04	09004	WOUND CARE THERAPY	0.160837		90.04
90.05	09005	FAMILY PRACTICE CLINIC	0.000000		90.05
91.00	09100	EMERGENCY	0.169808		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.360612		92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0.000000		93.99
OTHER REIMBURSABLE COST CENTERS					
99.10	09910	CORF			99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY			99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY			99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY			99.40
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: 14-0206

Period:
From 10/01/2019
To 09/30/2020Worksheet C
Part I
Date/Time Prepared:
4/26/2021 2:25 pm

				Title XIX		Hospital		Cost	
Cost Center Description			Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Total Costs	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	28,513,554		28,513,554	0	28,513,554	30.00	
31.00	03100	INTENSIVE CARE UNIT	5,009,009		5,009,009	0	5,009,009	31.00	
31.01	02060	NICU	0		0	0	0	31.01	
40.00	04000	SUBPROVIDER - IPF	2,576,059		2,576,059	0	2,576,059	40.00	
43.00	04300	NURSERY	2,191,649		2,191,649	0	2,191,649	43.00	
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM	7,184,582		7,184,582	0	7,184,582	50.00	
52.00	05200	DELIVERY ROOM & LABOR ROOM	3,952,107		3,952,107	0	3,952,107	52.00	
53.00	05300	ANESTHESIOLOGY	293,420		293,420	0	293,420	53.00	
54.00	05400	RADIOLOGY-DIAGNOSTIC	5,910,672		5,910,672	0	5,910,672	54.00	
56.01	05601	NUCLEAR MEDICINE	0		0	0	0	56.01	
60.00	06000	LABORATORY	7,728,242		7,728,242	0	7,728,242	60.00	
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0		0	0	0	62.30	
65.00	06500	RESPIRATORY THERAPY	1,844,162	0	1,844,162	0	1,844,162	65.00	
66.00	06600	PHYSICAL THERAPY	1,035,852	0	1,035,852	0	1,035,852	66.00	
69.00	06900	ELECTROCARDIOLOGY	751,537		751,537	0	751,537	69.00	
70.00	07000	ELECTROENCEPHALOGRAPHY	205,226		205,226	0	205,226	70.00	
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	855,931		855,931	0	855,931	71.00	
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	4,015,117		4,015,117	0	4,015,117	72.00	
73.00	07300	DRUGS CHARGED TO PATIENTS	5,834,304		5,834,304	0	5,834,304	73.00	
74.00	07400	RENAL DIALYSIS	1,000,740		1,000,740	0	1,000,740	74.00	
75.01	07501	ACUTE DIALYSIS	0		0	0	0	75.01	
75.02	03650	CARD CATH LAB	1,395,958		1,395,958	0	1,395,958	75.02	
76.97	07697	CARDIAC REHABILITATION	0		0	0	0	76.97	
76.98	07698	HYPERBARIC OXYGEN THERAPY	0		0	0	0	76.98	
76.99	07699	LITHOTRIPSY	0		0	0	0	76.99	
OUTPATIENT SERVICE COST CENTERS									
90.00	09000	CLINIC	4,909,025		4,909,025	181,005	5,090,030	90.00	
90.01	09001	PH CLINIC	0		0	0	0	90.01	
90.02	09002	HEALTHWORKS CLINIC	471,062		471,062	0	471,062	90.02	
90.03	09003	DENTAL CLINIC	0		0	0	0	90.03	
90.04	09004	WOUND CARE THERAPY	1,005,711		1,005,711	0	1,005,711	90.04	
90.05	09005	FAMILY PRACTICE CLINIC	0		0	0	0	90.05	
91.00	09100	EMERGENCY	7,268,610		7,268,610	0	7,268,610	91.00	
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	2,674,112		2,674,112	0	2,674,112	92.00	
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0		0	0	0	93.99	
OTHER REIMBURSABLE COST CENTERS									
99.10	09910	CORF	0		0		0	99.10	
99.20	09920	OUTPATIENT PHYSICAL THERAPY	0		0		0	99.20	
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY	0		0		0	99.30	
99.40	09940	OUTPATIENT SPEECH PATHOLOGY	0		0		0	99.40	
200.00		Subtotal (see instructions)	96,626,641	0	96,626,641	181,005	96,807,646	200.00	
201.00		Less Observation Beds	2,674,112		2,674,112		2,674,112	201.00	
202.00		Total (see instructions)	93,952,529	0	93,952,529	181,005	94,133,534	202.00	

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0206

Period:
From 10/01/2019
To 09/30/2020Worksheet C
Part I
Date/Time Prepared:
4/26/2021 2:25 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	83,404,320		83,404,320		30.00
31.00	03100	INTENSIVE CARE UNIT	10,652,287		10,652,287		31.00
31.01	02060	NICU	0		0		31.01
40.00	04000	SUBPROVIDER - IPF	6,510,300		6,510,300		40.00
43.00	04300	NURSERY	2,873,347		2,873,347		43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	9,010,408	10,104,478	19,114,886	0.375863	0.000000
52.00	05200	DELIVERY ROOM & LABOR ROOM	2,921,592	699,392	3,620,984	1.091446	0.000000
53.00	05300	ANESTHESIOLOGY	1,454,512	1,255,406	2,709,918	0.108276	0.000000
54.00	05400	RADIOLOGY-DIAGNOSTIC	10,762,280	18,495,674	29,257,954	0.202019	0.000000
56.01	05601	NUCLEAR MEDICINE	0	0	0	0.000000	0.000000
60.00	06000	LABORATORY	28,218,358	21,606,903	49,825,261	0.155107	0.000000
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0.000000	0.000000
65.00	06500	RESPIRATORY THERAPY	5,089,884	638,836	5,728,720	0.321915	0.000000
66.00	06600	PHYSICAL THERAPY	1,300,682	1,795,788	3,096,470	0.334527	0.000000
69.00	06900	ELECTROCARDIOLOGY	2,701,236	2,388,708	5,089,944	0.147651	0.000000
70.00	07000	ELECTROENCEPHALOGRAPHY	164,730	31,125	195,855	1.047847	0.000000
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	961,240	437,586	1,398,826	0.611892	0.000000
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	3,263,069	1,542,538	4,805,607	0.835507	0.000000
73.00	07300	DRUGS CHARGED TO PATIENTS	28,089,814	8,237,759	36,327,573	0.160603	0.000000
74.00	07400	RENAL DIALYSIS	2,373,302	166,200	2,539,502	0.394069	0.000000
75.01	07501	ACUTE DIALYSIS	0	0	0	0.000000	0.000000
75.02	03650	CARD CATH LAB	6,860,175	2,827,210	9,687,385	0.144101	0.000000
76.97	07697	CARDIAC REHABILITATION	0	0	0	0.000000	0.000000
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0.000000	0.000000
76.99	07699	LITHOTRIPSY	0	0	0	0.000000	0.000000
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	13,051	1,645,275	1,658,326	2.960229	0.000000
90.01	09001	PH CLINIC	0	0	0	0.000000	0.000000
90.02	09002	HEALTHWORKS CLINIC	78	271,717	271,795	1.733152	0.000000
90.03	09003	DENTAL CLINIC	0	0	0	0.000000	0.000000
90.04	09004	WOUND CARE THERAPY	736,801	5,516,164	6,252,965	0.160837	0.000000
90.05	09005	FAMILY PRACTICE CLINIC	0	0	0	0.000000	0.000000
91.00	09100	EMERGENCY	9,949,698	32,855,132	42,804,830	0.169808	0.000000
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1,369,376	6,046,099	7,415,475	0.360612	0.000000
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0	0	0	0.000000	0.000000
OTHER REIMBURSABLE COST CENTERS							
99.10	09910	CORF	0	0	0		99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY	0	0	0		99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY	0	0	0		99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY	0	0	0		99.40
200.00		Subtotal (see instructions)	218,680,540	116,561,990	335,242,530		200.00
201.00		Less Observation Beds					201.00
202.00		Total (see instructions)	218,680,540	116,561,990	335,242,530		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0206

Period:
From 10/01/2019
To 09/30/2020Worksheet C
Part I
Date/Time Prepared:
4/26/2021 2:25 pm

Cost Center Description			PPS Inpatient Ratio	Title XIX	Hospital	Cost
			11.00			
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS				30.00
31.00	03100	INTENSIVE CARE UNIT				31.00
31.01	02060	NICU				31.01
40.00	04000	SUBPROVIDER - IPF				40.00
43.00	04300	NURSERY				43.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.000000			50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000			52.00
53.00	05300	ANESTHESIOLOGY	0.000000			53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000			54.00
56.01	05601	NUCLEAR MEDICINE	0.000000			56.01
60.00	06000	LABORATORY	0.000000			60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0.000000			62.30
65.00	06500	RESPIRATORY THERAPY	0.000000			65.00
66.00	06600	PHYSICAL THERAPY	0.000000			66.00
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
75.01	07501	ACUTE DIALYSIS	0.000000			75.01
75.02	03650	CARD CATH LAB	0.000000			75.02
76.97	07697	CARDIAC REHABILITATION	0.000000			76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0.000000			76.98
76.99	07699	LITHOTRIPSY	0.000000			76.99
OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.000000			90.00
90.01	09001	PH CLINIC	0.000000			90.01
90.02	09002	HEALTHWORKS CLINIC	0.000000			90.02
90.03	09003	DENTAL CLINIC	0.000000			90.03
90.04	09004	WOUND CARE THERAPY	0.000000			90.04
90.05	09005	FAMILY PRACTICE CLINIC	0.000000			90.05
91.00	09100	EMERGENCY	0.000000			91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000			92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0.000000			93.99
OTHER REIMBURSABLE COST CENTERS						
99.10	09910	CORF				99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY				99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY				99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY				99.40
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: 14-0206

Period:
From 10/01/2019
To 09/30/2020Worksheet D
Part I
Date/Time Prepared:
4/26/2021 2:25 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	1,356,824	0	1,356,824	29,856	45.45	30.00
31.00	INTENSIVE CARE UNIT	206,545		206,545	2,985	69.19	31.00
31.01	NICU	0		0	0	0.00	31.01
40.00	SUBPROVIDER - IPF	136,715	0	136,715	3,485	39.23	40.00
43.00	NURSERY	97,368		97,368	887	109.77	43.00
200.00	Total (lines 30 through 199)	1,797,452		1,797,452	37,213		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	6,487	294,834				
31.00	INTENSIVE CARE UNIT	662	45,804				
31.01	NICU	0	0				
40.00	SUBPROVIDER - IPF	1,119	43,898				
43.00	NURSERY	0	0				
200.00	Total (lines 30 through 199)	8,268	384,536				

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 14-0206

Period:
From 10/01/2019
To 09/30/2020Worksheet D
Part II
Date/Time Prepared:
4/26/2021 2:25 pm

			Title XVIII		Hospital	PPS		
Cost Center Description			Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	510,891	19,114,886	0.026727	2,124,303	56,776	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	360,901	3,620,984	0.099669	13,432	1,339	52.00
53.00	05300	ANESTHESIOLOGY	24,062	2,709,918	0.008879	347,994	3,090	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	364,427	29,257,954	0.012456	2,972,863	37,030	54.00
56.01	05601	NUCLEAR MEDICINE	0	0	0.000000	0	0	56.01
60.00	06000	LABORATORY	250,641	49,825,261	0.005030	7,033,814	35,380	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0.000000	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	76,534	5,728,720	0.013360	1,157,134	15,459	65.00
66.00	06600	PHYSICAL THERAPY	69,867	3,096,470	0.022563	446,719	10,079	66.00
69.00	06900	ELECTROCARDIOLOGY	95,761	5,089,944	0.018814	729,503	13,725	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	14,353	195,855	0.073284	47,720	3,497	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	44,779	1,398,826	0.032012	217,161	6,952	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	210,449	4,805,607	0.043792	951,949	41,688	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	168,112	36,327,573	0.004628	7,172,322	33,194	73.00
74.00	07400	RENAL DIALYSIS	5,037	2,539,502	0.001983	1,042,020	2,066	74.00
75.01	07501	ACUTE DIALYSIS	0	0	0.000000	0	0	75.01
75.02	03650	CARD CATH LAB	120,334	9,687,385	0.012422	1,995,013	24,782	75.02
76.97	07697	CARDIAC REHABILITATION	0	0	0.000000	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0.000000	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0.000000	0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	208,745	1,658,326	0.125877	3,748	472	90.00
90.01	09001	PH CLINIC	0	0	0.000000	0	0	90.01
90.02	09002	HEALTHWORKS CLINIC	25,535	271,795	0.093949	0	0	90.02
90.03	09003	DENTAL CLINIC	0	0	0.000000	0	0	90.03
90.04	09004	WOUND CARE THERAPY	75,802	6,252,965	0.012123	272,096	3,299	90.04
90.05	09005	FAMILY PRACTICE CLINIC	0	0	0.000000	0	0	90.05
91.00	09100	EMERGENCY	253,749	42,804,830	0.005928	2,441,675	14,474	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	127,248	7,415,475	0.017160	421,527	7,233	92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0	0	0.000000	0	0	93.99
200.00		Total (lines 50 through 199)	3,007,227	231,802,276		29,390,993	310,535	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS					Provider CCN: 14-0206		Period: From 10/01/2019 To 09/30/2020		Worksheet D Part III Date/Time Prepared: 4/26/2021 2:25 pm		
					Title XVIII		Hospital		PPS		
Cost Center Description					Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health Cost	All Other Medical Education Cost		
					1A	1.00	2A	2.00	3.00		
INPATIENT ROUTINE SERVICE COST CENTERS											
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	0	0	0	30.00	
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	0	0	31.00	
31.01	02060	NICU	0	0	0	0	0	0	0	31.01	
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	0	0	0	40.00	
43.00	04300	NURSERY	0	0	0	0	0	0	0	43.00	
200.00	Total (lines 30 through 199)		0	0	0	0	0	0	0	200.00	
Cost Center Description					Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days		
					4.00	5.00	6.00	7.00	8.00		
INPATIENT ROUTINE SERVICE COST CENTERS											
30.00	03000	ADULTS & PEDIATRICS	0	0	29,856	0.00	6,487	30.00			
31.00	03100	INTENSIVE CARE UNIT	0	0	2,985	0.00	662	31.00			
31.01	02060	NICU	0	0	0	0.00	0	31.01			
40.00	04000	SUBPROVIDER - IPF	0	0	3,485	0.00	1,119	40.00			
43.00	04300	NURSERY	0	0	887	0.00	0	43.00			
200.00	Total (lines 30 through 199)		0	0	37,213		8,268	200.00			
Cost Center Description					Inpatient Program Pass-Through Cost (col. 7 x col. 8)						
					9.00						
INPATIENT ROUTINE SERVICE COST CENTERS											
30.00	03000	ADULTS & PEDIATRICS	0								30.00
31.00	03100	INTENSIVE CARE UNIT	0								31.00
31.01	02060	NICU	0								31.01
40.00	04000	SUBPROVIDER - IPF	0								40.00
43.00	04300	NURSERY	0								43.00
200.00	Total (lines 30 through 199)		0								200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS			Provider CCN: 14-0206		Period: From 10/01/2019 To 09/30/2020		Worksheet D Part IV Date/Time Prepared: 4/26/2021 2:25 pm	
			Title XVIII		Hospital		PPS	
Cost Center Description			Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health	
			1.00	2A	2.00	3A	3.00	
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
56.01	05601	NUCLEAR MEDICINE	0	0	0	0	0	56.01
60.00	06000	LABORATORY	0	0	0	0	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
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
75.01	07501	ACUTE DIALYSIS	0	0	0	0	0	75.01
75.02	03650	CARD CATH LAB	0	0	0	0	0	75.02
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	PH CLINIC	0	0	0	0	0	90.01
90.02	09002	HEALTHWORKS CLINIC	0	0	0	0	0	90.02
90.03	09003	DENTAL CLINIC	0	0	0	0	0	90.03
90.04	09004	WOUND CARE THERAPY	0	0	0	0	0	90.04
90.05	09005	FAMILY PRACTICE CLINIC	0	0	0	0	0	90.05
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	0	92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0	0	0	0	0	93.99
200.00		Total (lines 50 through 199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

Provider CCN: 14-0206

Period:
From 10/01/2019
To 09/30/2020

Worksheet D
Part IV
Date/Time Prepared:
4/26/2021 2:25 pm

			Title XVIII		Hospital	PPS		
Cost Center Description			All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7) (see instructions)	
			4.00	5.00	6.00	7.00	8.00	
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	0	19,114,886	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	3,620,984	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	2,709,918	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	29,257,954	0.000000	54.00
56.01	05601	NUCLEAR MEDICINE	0	0	0	0	0.000000	56.01
60.00	06000	LABORATORY	0	0	0	49,825,261	0.000000	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0.000000	62.30
65.00	06500	RESPIRATORY THERAPY	0	0	0	5,728,720	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	3,096,470	0.000000	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	5,089,944	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	195,855	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	1,398,826	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	4,805,607	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	36,327,573	0.000000	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	2,539,502	0.000000	74.00
75.01	07501	ACUTE DIALYSIS	0	0	0	0	0.000000	75.01
75.02	03650	CARD CATH LAB	0	0	0	9,687,385	0.000000	75.02
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0.000000	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0.000000	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0.000000	76.99
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0	1,658,326	0.000000	90.00
90.01	09001	PH CLINIC	0	0	0	0	0.000000	90.01
90.02	09002	HEALTHWORKS CLINIC	0	0	0	271,795	0.000000	90.02
90.03	09003	DENTAL CLINIC	0	0	0	0	0.000000	90.03
90.04	09004	WOUND CARE THERAPY	0	0	0	6,252,965	0.000000	90.04
90.05	09005	FAMILY PRACTICE CLINIC	0	0	0	0	0.000000	90.05
91.00	09100	EMERGENCY	0	0	0	42,804,830	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	7,415,475	0.000000	92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0	0	0	0	0.000000	93.99
200.00		Total (lines 50 through 199)	0	0	0	231,802,276		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-0206

Period:
From 10/01/2019
To 09/30/2020Worksheet D
Part IV
Date/Time Prepared:
4/26/2021 2:25 pm

Cost Center Description			Title XVIII			Hospital		PPS	
			Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)		
									9.00
	ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0.000000	2,124,303	0	1,564,223	0	50.00	
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	13,432	0	978	0	52.00	
53.00	05300	ANESTHESIOLOGY	0.000000	347,994	0	164,622	0	53.00	
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	2,972,863	0	2,078,576	0	54.00	
56.01	05601	NUCLEAR MEDICINE	0.000000	0	0	0	0	56.01	
60.00	06000	LABORATORY	0.000000	7,033,814	0	1,405,751	0	60.00	
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0.000000	0	0	0	0	62.30	
65.00	06500	RESPIRATORY THERAPY	0.000000	1,157,134	0	82,288	0	65.00	
66.00	06600	PHYSICAL THERAPY	0.000000	446,719	0	1,904	0	66.00	
69.00	06900	ELECTROCARDIOLOGY	0.000000	729,503	0	471,710	0	69.00	
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	47,720	0	6,590	0	70.00	
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	217,161	0	220,844	0	71.00	
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	951,949	0	580,006	0	72.00	
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	7,172,322	0	1,741,716	0	73.00	
74.00	07400	RENAL DIALYSIS	0.000000	1,042,020	0	68,250	0	74.00	
75.01	07501	ACUTE DIALYSIS	0.000000	0	0	0	0	75.01	
75.02	03650	CARD CATH LAB	0.000000	1,995,013	0	1,423,777	0	75.02	
76.97	07697	CARDIAC REHABILITATION	0.000000	0	0	0	0	76.97	
76.98	07698	HYPERBARIC OXYGEN THERAPY	0.000000	0	0	0	0	76.98	
76.99	07699	LITHOTRIPSY	0.000000	0	0	0	0	76.99	
	OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0.000000	3,748	0	404,912	0	90.00	
90.01	09001	PH CLINIC	0.000000	0	0	0	0	90.01	
90.02	09002	HEALTHWORKS CLINIC	0.000000	0	0	29	0	90.02	
90.03	09003	DENTAL CLINIC	0.000000	0	0	0	0	90.03	
90.04	09004	WOUND CARE THERAPY	0.000000	272,096	0	1,243,836	0	90.04	
90.05	09005	FAMILY PRACTICE CLINIC	0.000000	0	0	0	0	90.05	
91.00	09100	EMERGENCY	0.000000	2,441,675	0	2,851,891	0	91.00	
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	421,527	0	828,884	0	92.00	
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0.000000	0	0	0	0	93.99	
200.00		Total (lines 50 through 199)		29,390,993	0	15,140,787	0	200.00	

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-0206

Period:
From 10/01/2019
To 09/30/2020Worksheet D
Part V
Date/Time Prepared:
4/26/2021 2:25 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	0.375863	1,564,223	0	0	587,934	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1.091446	978	0	0	1,067	52.00
53.00	05300	ANESTHESIOLOGY	0.108276	164,622	0	0	17,825	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.202019	2,078,576	0	0	419,912	54.00
56.01	05601	NUCLEAR MEDICINE	0.000000	0	0	0	0	56.01
60.00	06000	LABORATORY	0.155107	1,405,751	0	0	218,042	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0.000000	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0.321915	82,288	0	0	26,490	65.00
66.00	06600	PHYSICAL THERAPY	0.334527	1,904	0	0	637	66.00
69.00	06900	ELECTROCARDIOLOGY	0.147651	471,710	0	0	69,648	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	1.047847	6,590	0	0	6,905	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.611892	220,844	0	0	135,133	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.835507	580,006	0	0	484,599	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.160603	1,741,716	0	2,454	279,725	73.00
74.00	07400	RENAL DIALYSIS	0.394069	68,250	0	0	26,895	74.00
75.01	07501	ACUTE DIALYSIS	0.000000	0	0	0	0	75.01
75.02	03650	CARD CATH LAB	0.144101	1,423,777	0	0	205,168	75.02
76.97	07697	CARDIAC REHABILITATION	0.000000	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0.000000	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0.000000	0	0	0	0	76.99
	OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	2.960229	404,912	0	0	1,198,632	90.00
90.01	09001	PH CLINIC	0.000000	0	0	0	0	90.01
90.02	09002	HEALTHWORKS CLINIC	1.733152	29	0	0	50	90.02
90.03	09003	DENTAL CLINIC	0.000000	0	0	0	0	90.03
90.04	09004	WOUND CARE THERAPY	0.160837	1,243,836	0	0	200,055	90.04
90.05	09005	FAMILY PRACTICE CLINIC	0.000000	0	0	0	0	90.05
91.00	09100	EMERGENCY	0.169808	2,851,891	0	0	484,274	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.360612	828,884	0	0	298,906	92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0.000000	0	0	0	0	93.99
200.00		Subtotal (see instructions)		15,140,787	0	2,454	4,661,897	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 - line 201)		15,140,787	0	2,454	4,661,897	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-0206

Period:
From 10/01/2019
To 09/30/2020Worksheet D
Part V
Date/Time Prepared:
4/26/2021 2:25 pm

			Title XVIII		Hospital	PPS
	Cost Center Description		Costs			
			Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
	ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	0		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0		52.00
53.00	05300	ANESTHESIOLOGY	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0		54.00
56.01	05601	NUCLEAR MEDICINE	0	0		56.01
60.00	06000	LABORATORY	0	0		60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0		62.30
65.00	06500	RESPIRATORY THERAPY	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0		66.00
69.00	06900	ELECTROCARDIOLOGY	0	0		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	394		73.00
74.00	07400	RENAL DIALYSIS	0	0		74.00
75.01	07501	ACUTE DIALYSIS	0	0		75.01
75.02	03650	CARD CATH LAB	0	0		75.02
76.97	07697	CARDIAC REHABILITATION	0	0		76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0		76.98
76.99	07699	LITHOTRIPSY	0	0		76.99
	OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	0	0		90.00
90.01	09001	PH CLINIC	0	0		90.01
90.02	09002	HEALTHWORKS CLINIC	0	0		90.02
90.03	09003	DENTAL CLINIC	0	0		90.03
90.04	09004	WOUND CARE THERAPY	0	0		90.04
90.05	09005	FAMILY PRACTICE CLINIC	0	0		90.05
91.00	09100	EMERGENCY	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0		92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0	0		93.99
200.00		Subtotal (see instructions)	0	394		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	0	394		202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 14-0206

Period:

Worksheet D

Component CCN: 14-S206

From 10/01/2019
To 09/30/2020Part II
Date/Time Prepared:
4/26/2021 2:25 pm

Cost Center Description			Title XVIII		Subprovider - IPF	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	510,891	19,114,886	0.026727	0	0 50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	360,901	3,620,984	0.099669	0	0 52.00
53.00	05300	ANESTHESIOLOGY	24,062	2,709,918	0.008879	0	0 53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	364,427	29,257,954	0.012456	36,900	460 54.00
56.01	05601	NUCLEAR MEDICINE	0	0	0.000000	0	0 56.01
60.00	06000	LABORATORY	250,641	49,825,261	0.005030	249,016	1,253 60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0.000000	0	0 62.30
65.00	06500	RESPIRATORY THERAPY	76,534	5,728,720	0.013360	0	0 65.00
66.00	06600	PHYSICAL THERAPY	69,867	3,096,470	0.022563	6,455	146 66.00
69.00	06900	ELECTROCARDIOLOGY	95,761	5,089,944	0.018814	12,249	230 69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	14,353	195,855	0.073284	655	48 70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	44,779	1,398,826	0.032012	1,188	38 71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	210,449	4,805,607	0.043792	0	0 72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	168,112	36,327,573	0.004628	333,408	1,543 73.00
74.00	07400	RENAL DIALYSIS	5,037	2,539,502	0.001983	0	0 74.00
75.01	07501	ACUTE DIALYSIS	0	0	0.000000	0	0 75.01
75.02	03650	CARD CATH LAB	120,334	9,687,385	0.012422	0	0 75.02
76.97	07697	CARDIAC REHABILITATION	0	0	0.000000	0	0 76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0.000000	0	0 76.98
76.99	07699	LITHOTRIPSY	0	0	0.000000	0	0 76.99
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	208,745	1,658,326	0.125877	0	0 90.00
90.01	09001	PH CLINIC	0	0	0.000000	0	0 90.01
90.02	09002	HEALTHWORKS CLINIC	25,535	271,795	0.093949	0	0 90.02
90.03	09003	DENTAL CLINIC	0	0	0.000000	0	0 90.03
90.04	09004	WOUND CARE THERAPY	75,802	6,252,965	0.012123	2,985	36 90.04
90.05	09005	FAMILY PRACTICE CLINIC	0	0	0.000000	0	0 90.05
91.00	09100	EMERGENCY	253,749	42,804,830	0.005928	110,665	656 91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	7,415,475	0.000000	0	0 92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0	0	0.000000	0	0 93.99
200.00		Total (lines 50 through 199)	2,879,979	231,802,276		753,521	4,410 200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS			Provider CCN: 14-0206 Component CCN: 14-S206		Period: From 10/01/2019 To 09/30/2020		Worksheet D Part IV Date/Time Prepared: 4/26/2021 2:25 pm	
			Title XVIII		Subprovider - IPF		PPS	
Cost Center Description			Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health	
			1.00	2A	2.00	3A	3.00	
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
56.01	05601	NUCLEAR MEDICINE	0	0	0	0	0	56.01
60.00	06000	LABORATORY	0	0	0	0	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
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
75.01	07501	ACUTE DIALYSIS	0	0	0	0	0	75.01
75.02	03650	CARD CATH LAB	0	0	0	0	0	75.02
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	PH CLINIC	0	0	0	0	0	90.01
90.02	09002	HEALTHWORKS CLINIC	0	0	0	0	0	90.02
90.03	09003	DENTAL CLINIC	0	0	0	0	0	90.03
90.04	09004	WOUND CARE THERAPY	0	0	0	0	0	90.04
90.05	09005	FAMILY PRACTICE CLINIC	0	0	0	0	0	90.05
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	0	92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0	0	0	0	0	93.99
200.00		Total (lines 50 through 199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS			Provider CCN: 14-0206 Component CCN: 14-S206		Period: From 10/01/2019 To 09/30/2020		Worksheet D Part IV Date/Time Prepared: 4/26/2021 2:25 pm	
			Title XVIII		Subprovider - IPF		PPS	
Cost Center Description			All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7) (see instructions)	
			4.00	5.00	6.00	7.00	8.00	
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	0	19,114,886	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	3,620,984	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	2,709,918	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	29,257,954	0.000000	54.00
56.01	05601	NUCLEAR MEDICINE	0	0	0	0	0.000000	56.01
60.00	06000	LABORATORY	0	0	0	49,825,261	0.000000	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0.000000	62.30
65.00	06500	RESPIRATORY THERAPY	0	0	0	5,728,720	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	3,096,470	0.000000	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	5,089,944	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	195,855	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	1,398,826	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	4,805,607	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	36,327,573	0.000000	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	2,539,502	0.000000	74.00
75.01	07501	ACUTE DIALYSIS	0	0	0	0	0.000000	75.01
75.02	03650	CARD CATH LAB	0	0	0	9,687,385	0.000000	75.02
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0.000000	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0.000000	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0.000000	76.99
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0	1,658,326	0.000000	90.00
90.01	09001	PH CLINIC	0	0	0	0	0.000000	90.01
90.02	09002	HEALTHWORKS CLINIC	0	0	0	271,795	0.000000	90.02
90.03	09003	DENTAL CLINIC	0	0	0	0	0.000000	90.03
90.04	09004	WOUND CARE THERAPY	0	0	0	6,252,965	0.000000	90.04
90.05	09005	FAMILY PRACTICE CLINIC	0	0	0	0	0.000000	90.05
91.00	09100	EMERGENCY	0	0	0	42,804,830	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	7,415,475	0.000000	92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0	0	0	0	0.000000	93.99
200.00		Total (lines 50 through 199)	0	0	0	231,802,276		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS				Provider CCN: 14-0206 Component CCN: 14-S206		Period: From 10/01/2019 To 09/30/2020		Worksheet D Part IV Date/Time Prepared: 4/26/2021 2:25 pm	
				Title XVIII		Subprovider - IPF		PPS	
Cost Center Description				Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
				9.00	10.00	11.00	12.00	13.00	
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM	0.000000	0	0	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	36,900	0	0	0	0	54.00
56.01	05601	NUCLEAR MEDICINE	0.000000	0	0	0	0	0	56.01
60.00	06000	LABORATORY	0.000000	249,016	0	0	0	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0.000000	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0.000000	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	6,455	0	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	12,249	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	655	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	1,188	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	333,408	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0.000000	0	0	0	0	0	74.00
75.01	07501	ACUTE DIALYSIS	0.000000	0	0	0	0	0	75.01
75.02	03650	CARD CATH LAB	0.000000	0	0	0	0	0	75.02
76.97	07697	CARDIAC REHABILITATION	0.000000	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0.000000	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0.000000	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS									
90.00	09000	CLINIC	0.000000	0	0	0	0	0	90.00
90.01	09001	PH CLINIC	0.000000	0	0	0	0	0	90.01
90.02	09002	HEALTHWORKS CLINIC	0.000000	0	0	0	0	0	90.02
90.03	09003	DENTAL CLINIC	0.000000	0	0	0	0	0	90.03
90.04	09004	WOUND CARE THERAPY	0.000000	2,985	0	0	0	0	90.04
90.05	09005	FAMILY PRACTICE CLINIC	0.000000	0	0	0	0	0	90.05
91.00	09100	EMERGENCY	0.000000	110,665	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	0	0	0	0	0	92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0.000000	0	0	0	0	0	93.99
200.00		Total (lines 50 through 199)			753,521	0	0	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST				Provider CCN: 14-0206 Component CCN: 14-S206		Period: From 10/01/2019 To 09/30/2020		Worksheet D Part V Date/Time Prepared: 4/26/2021 2:25 pm	
				Title XVIII		Subprovider - IPF		PPS	
Cost Center Description			Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges			Costs		
				PPS Reimbursed Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	PPS Services (see inst.)		
			1.00	2.00	3.00	4.00	5.00		
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM	0.375863	0	0	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1.091446	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.108276	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.202019	0	0	0	0	0	54.00
56.01	05601	NUCLEAR MEDICINE	0.000000	0	0	0	0	0	56.01
60.00	06000	LABORATORY	0.155107	0	0	0	0	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0.000000	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0.321915	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.334527	0	0	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0.147651	0	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	1.047847	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.611892	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.835507	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.160603	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0.394069	0	0	0	0	0	74.00
75.01	07501	ACUTE DIALYSIS	0.000000	0	0	0	0	0	75.01
75.02	03650	CARD CATH LAB	0.144101	0	0	0	0	0	75.02
76.97	07697	CARDIAC REHABILITATION	0.000000	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0.000000	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0.000000	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS									
90.00	09000	CLINIC	2.960229	0	0	0	0	0	90.00
90.01	09001	PH CLINIC	0.000000	0	0	0	0	0	90.01
90.02	09002	HEALTHWORKS CLINIC	1.733152	0	0	0	0	0	90.02
90.03	09003	DENTAL CLINIC	0.000000	0	0	0	0	0	90.03
90.04	09004	WOUND CARE THERAPY	0.160837	0	0	0	0	0	90.04
90.05	09005	FAMILY PRACTICE CLINIC	0.000000	0	0	0	0	0	90.05
91.00	09100	EMERGENCY	0.169808	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.360612	0	0	0	0	0	92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0.000000	0	0	0	0	0	93.99
200.00		Subtotal (see instructions)		0	0	0	0	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0	0		201.00
202.00		Net Charges (line 200 - line 201)		0	0	0	0	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-0206

Period:

Worksheet D

Component CCN: 14-S206

From 10/01/2019
To 09/30/2020Part V
Date/Time Prepared:
4/26/2021 2:25 pm

Title XVIII

Subprovider -
IPF

PPS

Cost Center Description			Costs			
			Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0		52.00
53.00	05300	ANESTHESIOLOGY	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0		54.00
56.01	05601	NUCLEAR MEDICINE	0	0		56.01
60.00	06000	LABORATORY	0	0		60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0		62.30
65.00	06500	RESPIRATORY THERAPY	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0		66.00
69.00	06900	ELECTROCARDIOLOGY	0	0		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0		73.00
74.00	07400	RENAL DIALYSIS	0	0		74.00
75.01	07501	ACUTE DIALYSIS	0	0		75.01
75.02	03650	CARD CATH LAB	0	0		75.02
76.97	07697	CARDIAC REHABILITATION	0	0		76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0		76.98
76.99	07699	LITHOTRIPSY	0	0		76.99
OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0		90.00
90.01	09001	PH CLINIC	0	0		90.01
90.02	09002	HEALTHWORKS CLINIC	0	0		90.02
90.03	09003	DENTAL CLINIC	0	0		90.03
90.04	09004	WOUND CARE THERAPY	0	0		90.04
90.05	09005	FAMILY PRACTICE CLINIC	0	0		90.05
91.00	09100	EMERGENCY	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0		92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0	0		93.99
200.00		Subtotal (see instructions)	0	0		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	0	0		202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS					Provider CCN: 14-0206		Period: From 10/01/2019 To 09/30/2020		Worksheet D Part III Date/Time Prepared: 4/26/2021 2:25 pm		
					Title XIX		Hospital		Cost		
Cost Center Description			Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health Cost	All Other Medical Education Cost				
			1A	1.00	2A	2.00	3.00				
INPATIENT ROUTINE SERVICE COST CENTERS											
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	0	0	30.00		
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	0	31.00		
31.01	02060	NICU	0	0	0	0	0	0	31.01		
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	0	0	40.00		
43.00	04300	NURSERY	0	0	0	0	0	0	43.00		
200.00	Total (lines 30 through 199)		0	0	0	0	0	0	200.00		
Cost Center Description			Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	Total Patient Days	Per Diem (col. 5 ÷ col. 6)		Inpatient Program Days			
			4.00	5.00	6.00	7.00		8.00			
INPATIENT ROUTINE SERVICE COST CENTERS											
30.00	03000	ADULTS & PEDIATRICS	0	0	29,856	0.00	2,940		30.00		
31.00	03100	INTENSIVE CARE UNIT	0	0	2,985	0.00	310		31.00		
31.01	02060	NICU	0	0	0	0.00	0		31.01		
40.00	04000	SUBPROVIDER - IPF	0	0	3,485	0.00	216		40.00		
43.00	04300	NURSERY	0	0	887	0.00	196		43.00		
200.00	Total (lines 30 through 199)		0	0	37,213		3,662		200.00		
Cost Center Description			Inpatient Program Pass-Through Cost (col. 7 x col. 8)								
			9.00								
INPATIENT ROUTINE SERVICE COST CENTERS											
30.00	03000	ADULTS & PEDIATRICS	0								30.00
31.00	03100	INTENSIVE CARE UNIT	0								31.00
31.01	02060	NICU	0								31.01
40.00	04000	SUBPROVIDER - IPF	0								40.00
43.00	04300	NURSERY	0								43.00
200.00	Total (lines 30 through 199)		0								200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

Provider CCN: 14-0206

Period:
From 10/01/2019
To 09/30/2020Worksheet D
Part IV
Date/Time Prepared:
4/26/2021 2:25 pm

Cost Center Description			Title XIX		Hospital		Cost	
			Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health	
			1.00	2A	2.00	3A	3.00	
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
56.01	05601	NUCLEAR MEDICINE	0	0	0	0	0	56.01
60.00	06000	LABORATORY	0	0	0	0	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
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
75.01	07501	ACUTE DIALYSIS	0	0	0	0	0	75.01
75.02	03650	CARD CATH LAB	0	0	0	0	0	75.02
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	PH CLINIC	0	0	0	0	0	90.01
90.02	09002	HEALTHWORKS CLINIC	0	0	0	0	0	90.02
90.03	09003	DENTAL CLINIC	0	0	0	0	0	90.03
90.04	09004	WOUND CARE THERAPY	0	0	0	0	0	90.04
90.05	09005	FAMILY PRACTICE CLINIC	0	0	0	0	0	90.05
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	0	92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0	0	0	0	0	93.99
200.00		Total (lines 50 through 199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

Provider CCN: 14-0206

Period:
From 10/01/2019
To 09/30/2020

Worksheet D
Part IV
Date/Time Prepared:
4/26/2021 2:25 pm

Cost Center Description			Title XIX		Hospital		Cost	
			All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7) (see instructions)	
			4.00	5.00	6.00	7.00	8.00	
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	0	19,114,886	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	3,620,984	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	2,709,918	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	29,257,954	0.000000	54.00
56.01	05601	NUCLEAR MEDICINE	0	0	0	0	0.000000	56.01
60.00	06000	LABORATORY	0	0	0	49,825,261	0.000000	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0.000000	62.30
65.00	06500	RESPIRATORY THERAPY	0	0	0	5,728,720	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	3,096,470	0.000000	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	5,089,944	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	195,855	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	1,398,826	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	4,805,607	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	36,327,573	0.000000	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	2,539,502	0.000000	74.00
75.01	07501	ACUTE DIALYSIS	0	0	0	0	0.000000	75.01
75.02	03650	CARD CATH LAB	0	0	0	9,687,385	0.000000	75.02
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0.000000	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0.000000	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0.000000	76.99
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0	1,658,326	0.000000	90.00
90.01	09001	PH CLINIC	0	0	0	0	0.000000	90.01
90.02	09002	HEALTHWORKS CLINIC	0	0	0	271,795	0.000000	90.02
90.03	09003	DENTAL CLINIC	0	0	0	0	0.000000	90.03
90.04	09004	WOUND CARE THERAPY	0	0	0	6,252,965	0.000000	90.04
90.05	09005	FAMILY PRACTICE CLINIC	0	0	0	0	0.000000	90.05
91.00	09100	EMERGENCY	0	0	0	42,804,830	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	7,415,475	0.000000	92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0	0	0	0	0.000000	93.99
200.00		Total (lines 50 through 199)	0	0	0	231,802,276		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-0206

Period:
From 10/01/2019
To 09/30/2020Worksheet D
Part IV
Date/Time Prepared:
4/26/2021 2:25 pm

Cost Center Description		Title XIX			Hospital		Cost	
		Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)		
		9.00	10.00	11.00	12.00	13.00		
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0.000000	713,423	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	140,947	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	102,690	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	890,502	0	0	0	54.00
56.01	05601	NUCLEAR MEDICINE	0.000000	0	0	0	0	56.01
60.00	06000	LABORATORY	0.000000	2,499,237	0	0	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0.000000	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0.000000	424,078	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	79,351	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	190,283	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	15,365	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	269,324	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	331,315	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	2,285,234	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0.000000	97,650	0	0	0	74.00
75.01	07501	ACUTE DIALYSIS	0.000000	0	0	0	0	75.01
75.02	03650	CARD CATH LAB	0.000000	620,442	0	0	0	75.02
76.97	07697	CARDIAC REHABILITATION	0.000000	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0.000000	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0.000000	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0.000000	0	0	0	0	90.00
90.01	09001	PH CLINIC	0.000000	0	0	0	0	90.01
90.02	09002	HEALTHWORKS CLINIC	0.000000	0	0	0	0	90.02
90.03	09003	DENTAL CLINIC	0.000000	0	0	0	0	90.03
90.04	09004	WOUND CARE THERAPY	0.000000	33,839	0	0	0	90.04
90.05	09005	FAMILY PRACTICE CLINIC	0.000000	0	0	0	0	90.05
91.00	09100	EMERGENCY	0.000000	918,711	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	83,396	0	0	0	92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0.000000	0	0	0	0	93.99
200.00		Total (lines 50 through 199)		9,695,787	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

Provider CCN: 14-0206

Period:
From 10/01/2019
To 09/30/2020

Worksheet D
Part IV
Date/Time Prepared:
4/26/2021 2:25 pm

Component CCN: 14-S206

			Title XIX		Subprovider - IPF		Cost	
Cost Center Description			Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health	
			1.00	2A	2.00	3A	3.00	
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
56.01	05601	NUCLEAR MEDICINE	0	0	0	0	0	56.01
60.00	06000	LABORATORY	0	0	0	0	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
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
75.01	07501	ACUTE DIALYSIS	0	0	0	0	0	75.01
75.02	03650	CARD CATH LAB	0	0	0	0	0	75.02
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	PH CLINIC	0	0	0	0	0	90.01
90.02	09002	HEALTHWORKS CLINIC	0	0	0	0	0	90.02
90.03	09003	DENTAL CLINIC	0	0	0	0	0	90.03
90.04	09004	WOUND CARE THERAPY	0	0	0	0	0	90.04
90.05	09005	FAMILY PRACTICE CLINIC	0	0	0	0	0	90.05
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	0	92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0	0	0	0	0	93.99
200.00		Total (lines 50 through 199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS			Provider CCN: 14-0206 Component CCN: 14-S206		Period: From 10/01/2019 To 09/30/2020		Worksheet D Part IV Date/Time Prepared: 4/26/2021 2:25 pm	
			Title XIX		Subprovider - IPF		Cost	
Cost Center Description			All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7) (see instructions)	
			4.00	5.00	6.00	7.00	8.00	
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	0	19,114,886	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	3,620,984	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	2,709,918	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	29,257,954	0.000000	54.00
56.01	05601	NUCLEAR MEDICINE	0	0	0	0	0.000000	56.01
60.00	06000	LABORATORY	0	0	0	49,825,261	0.000000	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0.000000	62.30
65.00	06500	RESPIRATORY THERAPY	0	0	0	5,728,720	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	3,096,470	0.000000	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	5,089,944	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	195,855	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	1,398,826	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	4,805,607	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	36,327,573	0.000000	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	2,539,502	0.000000	74.00
75.01	07501	ACUTE DIALYSIS	0	0	0	0	0.000000	75.01
75.02	03650	CARD CATH LAB	0	0	0	9,687,385	0.000000	75.02
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0.000000	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0.000000	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0.000000	76.99
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0	1,658,326	0.000000	90.00
90.01	09001	PH CLINIC	0	0	0	0	0.000000	90.01
90.02	09002	HEALTHWORKS CLINIC	0	0	0	271,795	0.000000	90.02
90.03	09003	DENTAL CLINIC	0	0	0	0	0.000000	90.03
90.04	09004	WOUND CARE THERAPY	0	0	0	6,252,965	0.000000	90.04
90.05	09005	FAMILY PRACTICE CLINIC	0	0	0	0	0.000000	90.05
91.00	09100	EMERGENCY	0	0	0	42,804,830	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	7,415,475	0.000000	92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0	0	0	0	0.000000	93.99
200.00		Total (lines 50 through 199)	0	0	0	231,802,276		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS				Provider CCN: 14-0206 Component CCN: 14-S206		Period: From 10/01/2019 To 09/30/2020		Worksheet D Part IV Date/Time Prepared: 4/26/2021 2:25 pm	
				Title XIX		Subprovider - IPF		Cost	
Cost Center Description				Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
				9.00	10.00	11.00	12.00	13.00	
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM		0.000000	0	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM		0.000000	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY		0.000000	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC		0.000000	0	0	0	0	54.00
56.01	05601	NUCLEAR MEDICINE		0.000000	0	0	0	0	56.01
60.00	06000	LABORATORY		0.000000	0	0	0	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS		0.000000	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY		0.000000	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY		0.000000	0	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY		0.000000	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY		0.000000	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT		0.000000	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS		0.000000	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS		0.000000	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS		0.000000	0	0	0	0	74.00
75.01	07501	ACUTE DIALYSIS		0.000000	0	0	0	0	75.01
75.02	03650	CARD CATH LAB		0.000000	0	0	0	0	75.02
76.97	07697	CARDIAC REHABILITATION		0.000000	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY		0.000000	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY		0.000000	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS									
90.00	09000	CLINIC		0.000000	0	0	0	0	90.00
90.01	09001	PH CLINIC		0.000000	0	0	0	0	90.01
90.02	09002	HEALTHWORKS CLINIC		0.000000	0	0	0	0	90.02
90.03	09003	DENTAL CLINIC		0.000000	0	0	0	0	90.03
90.04	09004	WOUND CARE THERAPY		0.000000	0	0	0	0	90.04
90.05	09005	FAMILY PRACTICE CLINIC		0.000000	0	0	0	0	90.05
91.00	09100	EMERGENCY		0.000000	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART		0.000000	0	0	0	0	92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM		0.000000	0	0	0	0	93.99
200.00		Total (lines 50 through 199)			0	0	0	0	200.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-0206	Period: From 10/01/2019 To 09/30/2020	Worksheet D-1 Date/Time Prepared: 4/26/2021 2:25 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)		29,856	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		29,856	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)		27,056	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)		6,487	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)		28,513,554	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)		28,513,554	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)		28,513,554	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)		955.04	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		6,195,344	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)		6,195,344	41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-0206

Period:
From 10/01/2019
To 09/30/2020

Worksheet D-1

Date/Time Prepared:
4/26/2021 2:25 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	5,009,009	2,985	1,678.06	662	1,110,876		43.00
43.01	NICU	0	0	0.00	0	0		43.01
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)					6,622,146		48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					13,928,366		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)					340,638		50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					310,535		51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)					651,173		52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					13,277,193		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)					2,800		87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					955.04		88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)					2,674,112		89.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-0206

Period:
From 10/01/2019
To 09/30/2020

Worksheet D-1

Date/Time Prepared:
4/26/2021 2:25 pm

Cost Center Description		Title XVIII		Hospital		PPS	
		Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)		
		1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00	Capital-related cost	1,356,824	28,513,554	0.047585	2,674,112	127,248	90.00
91.00	Nursing School cost	0	28,513,554	0.000000	2,674,112	0	91.00
92.00	Allied health cost	0	28,513,554	0.000000	2,674,112	0	92.00
93.00	All other Medical Education	0	28,513,554	0.000000	2,674,112	0	93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-0206 Component CCN: 14-S206	Period: From 10/01/2019 To 09/30/2020	Worksheet D-1 Date/Time Prepared: 4/26/2021 2:25 pm
		Title XVIII	Subprovider - IPF	PPS
Cost Center Description			1.00	
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		3,485	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		3,485	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.		0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)		3,485	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions)		1,119	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)		2,576,059	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)		2,576,059	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)		2,576,059	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)		739.18	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		827,142	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)		827,142	41.00

COMPUTATION OF INPATIENT OPERATING COST				Provider CCN: 14-0206	Period: From 10/01/2019 To 09/30/2020	Worksheet D-1	
				Component CCN: 14-S206		Date/Time Prepared: 4/26/2021 2:25 pm	
				Title XVIII	Subprovider - IPF	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
43.01	NICU	0	0	0.00	0	0	43.01
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)					124,278	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					951,420	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)					43,898	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					4,410	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)					48,308	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					903,112	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: 14-0206 Component CCN: 14-S206		Period: From 10/01/2019 To 09/30/2020		Worksheet D-1 Date/Time Prepared: 4/26/2021 2:25 pm
			Title XVIII		Subprovider - IPF		PPS
Cost Center Description		Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00	Capital-related cost	136,715	2,576,059	0.053071	0	0	90.00
91.00	Nursing School cost	0	2,576,059	0.000000	0	0	91.00
92.00	Allied health cost	0	2,576,059	0.000000	0	0	92.00
93.00	All other Medical Education	0	2,576,059	0.000000	0	0	93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-0206	Period: From 10/01/2019 To 09/30/2020	Worksheet D-1 Date/Time Prepared: 4/26/2021 2:25 pm
		Title XIX	Hospital	Cost
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)	29,856	1.00	
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	29,856	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)	27,056	4.00	
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	0	5.00	
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	6.00	
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	0	7.00	
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	8.00	
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions)	2,940	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)	887	15.00	
16.00	Nursery days (title V or XIX only)	196	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)	28,513,554	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)	28,513,554	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)	28,513,554	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)	955.04	38.00	
39.00	Program general inpatient routine service cost (line 9 x line 38)	2,807,818	39.00	
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)	0	40.00	
41.00	Total Program general inpatient routine service cost (line 39 + line 40)	2,807,818	41.00	

COMPUTATION OF INPATIENT OPERATING COST				Provider CCN: 14-0206	Period: From 10/01/2019 To 09/30/2020	Worksheet D-1 Date/Time Prepared: 4/26/2021 2:25 pm	
				Title XIX		Hospital	Cost
Cost Center Description		Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)	2,191,649	887	2,470.86	196	484,289	42.00
Intensive Care Type Inpatient Hospital Units							
43.00	INTENSIVE CARE UNIT	5,009,009	2,985	1,678.06	310	520,199	43.00
43.01	NICU	0	0	0.00	0	0	43.01
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)					2,335,944	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					6,148,250	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)					0	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					0	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)					0	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					0	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)					2,800	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					955.04	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)					2,674,112	89.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-0206

Period:
From 10/01/2019
To 09/30/2020

Worksheet D-1

Date/Time Prepared:
4/26/2021 2:25 pm

Cost Center Description		Title XIX		Hospital		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	1,356,824	28,513,554	0.047585	2,674,112	127,248	90.00
91.00	Nursing School cost	0	28,513,554	0.000000	2,674,112	0	91.00
92.00	Allied health cost	0	28,513,554	0.000000	2,674,112	0	92.00
93.00	All other Medical Education	0	28,513,554	0.000000	2,674,112	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 14-0206	Period: From 10/01/2019 To 09/30/2020	Worksheet D-3 Date/Time Prepared: 4/26/2021 2:25 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		20,335,892		30.00
31.00	03100 INTENSIVE CARE UNIT		2,433,907		31.00
31.01	02060 NICU		0		31.01
40.00	04000 SUBPROVIDER - IPF		0		40.00
43.00	04300 NURSERY				43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.375863	2,124,303	798,447	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	1.091446	13,432	14,660	52.00
53.00	05300 ANESTHESIOLOGY	0.108276	347,994	37,679	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.202019	2,972,863	600,575	54.00
56.01	05601 NUCLEAR MEDICINE	0.000000	0	0	56.01
60.00	06000 LABORATORY	0.155107	7,033,814	1,090,994	60.00
62.30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0.000000	0	0	62.30
65.00	06500 RESPIRATORY THERAPY	0.321915	1,157,134	372,499	65.00
66.00	06600 PHYSICAL THERAPY	0.334527	446,719	149,440	66.00
69.00	06900 ELECTROCARDIOLOGY	0.147651	729,503	107,712	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	1.047847	47,720	50,003	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.611892	217,161	132,879	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.835507	951,949	795,360	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.160603	7,172,322	1,151,896	73.00
74.00	07400 RENAL DIALYSIS	0.394069	1,042,020	410,628	74.00
75.01	07501 ACUTE DIALYSIS	0.000000	0	0	75.01
75.02	03650 CARD CATH LAB	0.144101	1,995,013	287,483	75.02
76.97	07697 CARDIAC REHABILITATION	0.000000	0	0	76.97
76.98	07698 HYPERBARIC OXYGEN THERAPY	0.000000	0	0	76.98
76.99	07699 LITHOTRIPSY	0.000000	0	0	76.99
OUTPATIENT SERVICE COST CENTERS					
90.00	09000 CLINIC	3.069378	3,748	11,504	90.00
90.01	09001 PH CLINIC	0.000000	0	0	90.01
90.02	09002 HEALTHWORKS CLINIC	1.733152	0	0	90.02
90.03	09003 DENTAL CLINIC	0.000000	0	0	90.03
90.04	09004 WOUND CARE THERAPY	0.160837	272,096	43,763	90.04
90.05	09005 FAMILY PRACTICE CLINIC	0.000000	0	0	90.05
91.00	09100 EMERGENCY	0.169808	2,441,675	414,616	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0.360612	421,527	152,008	92.00
93.99	09399 PARTIAL HOSPITALIZATION PROGRAM	0.000000	0	0	93.99
200.00	Total (sum of lines 50 through 94 and 96 through 98)		29,390,993	6,622,146	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)		29,390,993		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 14-0206 Component CCN: 14-S206	Period: From 10/01/2019 To 09/30/2020	Worksheet D-3 Date/Time Prepared: 4/26/2021 2:25 pm	
		Title XVIII	Subprovider - IPF	PPS	
Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDIATRICS		0		30.00
31.00	03100 INTENSIVE CARE UNIT		0		31.00
31.01	02060 NICU		0		31.01
40.00	04000 SUBPROVIDER - IPF		2,070,344		40.00
43.00	04300 NURSERY				43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.375863	0	0	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	1.091446	0	0	52.00
53.00	05300 ANESTHESIOLOGY	0.108276	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.202019	36,900	7,455	54.00
56.01	05601 NUCLEAR MEDICINE	0.000000	0	0	56.01
60.00	06000 LABORATORY	0.155107	249,016	38,624	60.00
62.30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0.000000	0	0	62.30
65.00	06500 RESPIRATORY THERAPY	0.321915	0	0	65.00
66.00	06600 PHYSICAL THERAPY	0.334527	6,455	2,159	66.00
69.00	06900 ELECTROCARDIOLOGY	0.147651	12,249	1,809	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	1.047847	655	686	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.611892	1,188	727	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.835507	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.160603	333,408	53,546	73.00
74.00	07400 RENAL DIALYSIS	0.394069	0	0	74.00
75.01	07501 ACUTE DIALYSIS	0.000000	0	0	75.01
75.02	03650 CARD CATH LAB	0.144101	0	0	75.02
76.97	07697 CARDIAC REHABILITATION	0.000000	0	0	76.97
76.98	07698 HYPERBARIC OXYGEN THERAPY	0.000000	0	0	76.98
76.99	07699 LITHOTRIPSY	0.000000	0	0	76.99
OUTPATIENT SERVICE COST CENTERS					
90.00	09000 CLINIC	3.069378	0	0	90.00
90.01	09001 PH CLINIC	0.000000	0	0	90.01
90.02	09002 HEALTHWORKS CLINIC	1.733152	0	0	90.02
90.03	09003 DENTAL CLINIC	0.000000	0	0	90.03
90.04	09004 WOUND CARE THERAPY	0.160837	2,985	480	90.04
90.05	09005 FAMILY PRACTICE CLINIC	0.000000	0	0	90.05
91.00	09100 EMERGENCY	0.169808	110,665	18,792	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0.360612	0	0	92.00
93.99	09399 PARTIAL HOSPITALIZATION PROGRAM	0.000000	0	0	93.99
200.00	Total (sum of lines 50 through 94 and 96 through 98)		753,521	124,278	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)		753,521		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 14-0206	Period: From 10/01/2019 To 09/30/2020	Worksheet D-3 Date/Time Prepared: 4/26/2021 2:25 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		6,971,030		30.00
31.00	03100 INTENSIVE CARE UNIT		1,078,781		31.00
31.01	02060 NICU		0		31.01
40.00	04000 SUBPROVIDER - IPF		124,652		40.00
43.00	04300 NURSERY		271,049		43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.375863	713,423	268,149	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	1.091446	140,947	153,836	52.00
53.00	05300 ANESTHESIOLOGY	0.108276	102,690	11,119	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.202019	890,502	179,898	54.00
56.01	05601 NUCLEAR MEDICINE	0.000000	0	0	56.01
60.00	06000 LABORATORY	0.155107	2,499,237	387,649	60.00
62.30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0.000000	0	0	62.30
65.00	06500 RESPIRATORY THERAPY	0.321915	424,078	136,517	65.00
66.00	06600 PHYSICAL THERAPY	0.334527	79,351	26,545	66.00
69.00	06900 ELECTROCARDIOLOGY	0.147651	190,283	28,095	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	1.047847	15,365	16,100	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.611892	269,324	164,797	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.835507	331,315	276,816	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.160603	2,285,234	367,015	73.00
74.00	07400 RENAL DIALYSIS	0.394069	97,650	38,481	74.00
75.01	07501 ACUTE DIALYSIS	0.000000	0	0	75.01
75.02	03650 CARD CATH LAB	0.144101	620,442	89,406	75.02
76.97	07697 CARDIAC REHABILITATION	0.000000	0	0	76.97
76.98	07698 HYPERBARIC OXYGEN THERAPY	0.000000	0	0	76.98
76.99	07699 LITHOTRIPSY	0.000000	0	0	76.99
OUTPATIENT SERVICE COST CENTERS					
90.00	09000 CLINIC	2.960229	0	0	90.00
90.01	09001 PH CLINIC	0.000000	0	0	90.01
90.02	09002 HEALTHWORKS CLINIC	1.733152	0	0	90.02
90.03	09003 DENTAL CLINIC	0.000000	0	0	90.03
90.04	09004 WOUND CARE THERAPY	0.160837	33,839	5,443	90.04
90.05	09005 FAMILY PRACTICE CLINIC	0.000000	0	0	90.05
91.00	09100 EMERGENCY	0.169808	918,711	156,004	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0.360612	83,396	30,074	92.00
93.99	09399 PARTIAL HOSPITALIZATION PROGRAM	0.000000	0	0	93.99
200.00	Total (sum of lines 50 through 94 and 96 through 98)		9,695,787	2,335,944	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)		9,695,787		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT

Provider CCN: 14-0206

Period:
From 10/01/2019
To 09/30/2020Worksheet E
Part A
Date/Time Prepared:
4/26/2021 2:25 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)			0	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1 (see instructions)			10,284,381	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)			0	2.03
2.04	Outlier payments for discharges occurring on or after October 1 (see instructions)			586,560	2.04
3.00	Managed Care Simulated Payments			4,536,113	3.00
4.00	Bed days available divided by number of days in the cost reporting period (see instructions)			165.31	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)			2.68	5.00
6.00	FTE count for allopathic and osteopathic programs that meet the criteria for an add-on to the cap for new programs in accordance with 42 CFR 413.79(e)			0.00	6.00
7.00	MMA Section 422 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(1)			0.00	7.00
7.01	ACA § 5503 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(2) If the cost report straddles July 1, 2011 then see instructions.			1.74	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)			12.44	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)			13.38	9.00
10.00	FTE count for allopathic and osteopathic programs in the current year from your records			18.00	10.00
11.00	FTE count for residents in dental and podiatric programs.			3.00	11.00
12.00	Current year allowable FTE (see instructions)			16.38	12.00
13.00	Total allowable FTE count for the prior year.			15.56	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.			10.26	14.00
15.00	Sum of lines 12 through 14 divided by 3.			14.07	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			14.07	18.00
19.00	Current year resident to bed ratio (line 18 divided by line 4).			0.085113	19.00
20.00	Prior year resident to bed ratio (see instructions)			0.095361	20.00
21.00	Enter the lesser of lines 19 or 20 (see instructions)			0.085113	21.00
22.00	IME payment adjustment (see instructions)			466,983	22.00
22.01	IME payment adjustment - Managed Care (see instructions)			205,971	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)			4.62	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)			466,983	29.00
29.01	Total IME payment - Managed Care (sum of lines 22.01 and 28.01)			205,971	29.01
Disproportionate Share Adjustment					
30.00	Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)			22.70	30.00
31.00	Percentage of Medicaid patient days (see instructions)			56.51	31.00
32.00	Sum of lines 30 and 31			79.21	32.00
33.00	Allowable disproportionate share percentage (see instructions)			54.56	33.00
34.00	Disproportionate share adjustment (see instructions)			1,402,790	34.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0206	Period: From 10/01/2019 To 09/30/2020	Worksheet E Part A Date/Time Prepared: 4/26/2021 2:25 pm	
		Title XVIII	Hospital	PPS	
			Prior to 10/1	On/After 10/1	
			1.00	2.00	
Uncompensated Care Adjustment					
35.00	Total uncompensated care amount (see instructions)		0	0	35.00
35.01	Factor 3 (see instructions)	0.000000000	0.000000000		35.01
35.02	Hospital uncompensated care payment (If line 34 is zero, enter zero on this line) (see instructions)		0	1,556,234	35.02
35.03	Pro rata share of the hospital uncompensated care payment amount (see instructions)		0	1,556,234	35.03
36.00	Total uncompensated care (sum of columns 1 and 2 on line 35.03)		1,556,234		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)		1,633		40.00
			Before 1/1	On/After 1/1	
			1.00	1.01	
41.00	Total ESRD Medicare discharges excluding MS-DRGs 652, 682, 683, 684 and 685. (see instructions)		167	26	41.00
41.01	Total ESRD Medicare covered and paid discharges excluding MS-DRGs 652, 682, 683, 684 and 685. (see instructions)		167	26	41.01
42.00	Divide line 41 by line 40 (if less than 10%, you do not qualify for adjustment)		11.82		42.00
43.00	Total Medicare ESRD inpatient days excluding MS-DRGs 652, 682, 683, 684 and 685. (see instructions)		1,020		43.00
44.00	Ratio of average length of stay to one week (line 43 divided by line 41 divided by 7 days)		0.754996		44.00
45.00	Average weekly cost for dialysis treatments (see instructions)		705.81	717.99	45.00
46.00	Total additional payment (line 45 times line 44 times line 41.01)		103,085		46.00
47.00	Subtotal (see instructions)		14,400,033		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)			14,606,004	49.00
50.00	Payment for inpatient program capital (from Wkst. L, Pt. I and Pt. II, as applicable)			1,001,966	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).			366,541	52.00
53.00	Nursing and Allied Health Managed Care payment			0	53.00
54.00	Special add-on payments for new technologies			0	54.00
54.01	Islet isolation add-on payment			0	54.01
55.00	Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line 69)			0	55.00
56.00	Cost of physicians' services in a teaching hospital (see instructions)			0	56.00
57.00	Routine service other pass through costs (from Wkst. D, Pt. III, column 9, lines 30 through 35).			0	57.00
58.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 11 line 200)			0	58.00
59.00	Total (sum of amounts on lines 49 through 58)			15,974,511	59.00
60.00	Primary payer payments			0	60.00
61.00	Total amount payable for program beneficiaries (line 59 minus line 60)			15,974,511	61.00
62.00	Deductibles billed to program beneficiaries			869,264	62.00
63.00	Coinsurance billed to program beneficiaries			176,561	63.00
64.00	Allowable bad debts (see instructions)			425,214	64.00
65.00	Adjusted reimbursable bad debts (see instructions)			276,389	65.00
66.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			235,657	66.00
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)			15,205,075	67.00
68.00	Credits received from manufacturers for replaced devices for applicable to MS-DRGs (see instructions)			0	68.00
69.00	Outlier payments reconciliation (sum of lines 93, 95 and 96). (For SCH see instructions)			0	69.00
70.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	70.00
70.50	Rural Community Hospital Demonstration Project (\$410A Demonstration) adjustment (see instructions)			0	70.50
70.87	Demonstration payment adjustment amount before sequestration			0	70.87
70.88	SCH or MDH volume decrease adjustment (contractor use only)			0	70.88
70.89	Pioneer ACO demonstration payment adjustment amount (see instructions)				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)			-5,425	70.93
70.94	HRR adjustment amount (see instructions)			-62,735	70.94
70.95	Recovery of accelerated depreciation			0	70.95

CALCULATION OF REIMBURSEMENT SETTLEMENT

Provider CCN: 14-0206

Period:
From 10/01/2019
To 09/30/2020Worksheet E
Part A
Date/Time Prepared:
4/26/2021 2:25 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	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	0	70.97
70.98	Low Volume Payment-3		0	0	70.98
70.99	HAC adjustment amount (see instructions)		0	0	70.99
71.00	Amount due provider (line 67 minus lines 68 plus/minus lines 69 & 70)		15,136,915	71.00	71.00
71.01	Sequestration adjustment (see instructions)		175,588	71.01	71.01
71.02	Demonstration payment adjustment amount after sequestration		0	71.02	71.02
71.03	Sequestration adjustment-PARHM pass-throughs		0	71.03	71.03
72.00	Interim payments		14,786,989	72.00	72.00
72.01	Interim payments-PARHM		0	72.01	72.01
73.00	Tentative settlement (for contractor use only)		0	73.00	73.00
73.01	Tentative settlement-PARHM (for contractor use only)		0	73.01	73.01
74.00	Balance due provider/program (line 71 minus lines 71.01, 71.02, 72, and 73)		174,338	74.00	74.00
74.01	Balance due provider/program-PARHM (see instructions)		0	74.01	74.01
75.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		533,957	75.00	75.00
TO BE COMPLETED BY CONTRACTOR (lines 90 through 96)					
90.00	Operating outlier amount from Wkst. E, Pt. A, line 2, or sum of 2.03 plus 2.04 (see instructions)		0	90.00	90.00
91.00	Capital outlier from Wkst. L, Pt. I, line 2		0	91.00	91.00
92.00	Operating outlier reconciliation adjustment amount (see instructions)		0	92.00	92.00
93.00	Capital outlier reconciliation adjustment amount (see instructions)		0	93.00	93.00
94.00	The rate used to calculate the time value of money (see instructions)		0.00	94.00	94.00
95.00	Time value of money for operating expenses (see instructions)		0	95.00	95.00
96.00	Time value of money for capital related expenses (see instructions)		0	96.00	96.00
			Prior to 10/1	On/After 10/1	
			1.00	2.00	
HSP Bonus Payment Amount					
100.00	HSP bonus amount (see instructions)			0	100.00
HVBP Adjustment for HSP Bonus Payment					
101.00	HVBP adjustment factor (see instructions)		0.0000000000	101.00	101.00
102.00	HVBP adjustment amount for HSP bonus payment (see instructions)		0	102.00	102.00
HRR Adjustment for HSP Bonus Payment					
103.00	HRR adjustment factor (see instructions)		0.0000	103.00	103.00
104.00	HRR adjustment amount for HSP bonus payment (see instructions)		0	104.00	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	200.00
Cost Reimbursement					
201.00	Medicare inpatient service costs (from Wkst. D-1, Pt. II, line 49)			201.00	201.00
202.00	Medicare discharges (see instructions)			202.00	202.00
203.00	Case-mix adjustment factor (see instructions)			203.00	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	204.00
205.00	Case-mix adjusted target amount (line 203 times line 204)			205.00	205.00
206.00	Medicare inpatient routine cost cap (line 202 times line 205)			206.00	206.00
Adjustment to Medicare Part A Inpatient Reimbursement					
207.00	Program reimbursement under the \$410A Demonstration (see instructions)			207.00	207.00
208.00	Medicare Part A inpatient service costs (from Wkst. E, Pt. A, line 59)			208.00	208.00
209.00	Adjustment to Medicare IPPS payments (see instructions)			209.00	209.00
210.00	Reserved for future use			210.00	210.00
211.00	Total adjustment to Medicare IPPS payments (see instructions)			211.00	211.00
Comparison of PPS versus Cost Reimbursement					
212.00	Total adjustment to Medicare Part A IPPS payments (from line 211)			212.00	212.00
213.00	Low-volume adjustment (see instructions)			213.00	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	218.00

LOW VOLUME CALCULATION EXHIBIT 4

Provider CCN: 14-0206

Period:
From 10/01/2019
To 09/30/2020Worksheet E
Part A Exhibit 4
Date/Time Prepared:
4/26/2021 2:25 pm

		Title XVIII		Hospital		PPS	
		W/S E, Part A line	Amounts (from E, Part A)	Pre/Post Entitlement	Period Prior to 10/01	Period On/After 10/01	Total (Col 2 through 4)
		0	1.00	2.00	3.00	4.00	5.00
1.00	DRG amounts other than outlier payments	1.00	0	0	0	0	0
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1	1.01	0	0	0	0	0
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	10,284,381	0	0	10,284,381	10,284,381
1.03	DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October 1	1.03	0	0	0	0	0
1.04	DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1	1.04	0	0	0	0	0
2.00	Outlier payments for discharges (see instructions)	2.00					
2.01	Outlier payments for discharges for Model 4 BPCI	2.02	0	0	0	0	0
2.02	Outlier payments for discharges occurring prior to October 1 (see instructions)	2.03	0	0	0	0	0
2.03	Outlier payments for discharges occurring on or after October 1 (see instructions)	2.04	586,560	0	0	586,560	586,560
3.00	Operating outlier reconciliation	2.01	0	0	0	0	0
4.00	Managed care simulated payments	3.00	4,536,113	0	0	4,536,113	4,536,113
Indirect Medical Education Adjustment							
5.00	Amount from Worksheet E, Part A, line 21 (see instructions)	21.00	0.085113	0.085113	0.085113	0.085113	0.085113
6.00	IME payment adjustment (see instructions)	22.00	466,983	0	0	466,983	466,983
6.01	IME payment adjustment for managed care (see instructions)	22.01	205,971	0	0	205,971	205,971
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	0.000000
8.00	IME adjustment (see instructions)	28.00	0	0	0	0	0
8.01	IME payment adjustment add on for managed care (see instructions)	28.01	0	0	0	0	0
9.00	Total IME payment (sum of lines 6 and 8)	29.00	466,983	0	0	466,983	466,983
9.01	Total IME payment for managed care (sum of lines 6.01 and 8.01)	29.01	205,971	0	0	205,971	205,971
Disproportionate Share Adjustment							
10.00	Allowable disproportionate share percentage (see instructions)	33.00	0.5456	0.5456	0.5456	0.5456	0.5456
11.00	Disproportionate share adjustment (see instructions)	34.00	1,402,790	0	0	1,402,790	1,402,790
11.01	Uncompensated care payments	36.00	1,556,234	0	0	1,556,234	1,556,234
Additional payment for high percentage of ESRD beneficiary discharges							
12.00	Total ESRD additional payment (see instructions)	46.00	103,085	0	0	103,085	103,085
13.00	Subtotal (see instructions)	47.00	14,400,033	0	0	14,400,033	14,400,033
14.00	Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see instructions)	48.00	0	0	0	0	0
15.00	Total payment for inpatient operating costs (see instructions)	49.00	14,606,004	0	0	14,606,004	14,606,004
16.00	Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable)	50.00	1,001,966	0	0	1,001,966	1,001,966

LOW VOLUME CALCULATION EXHIBIT 4

Provider CCN: 14-0206

Period:
From 10/01/2019
To 09/30/2020Worksheet E
Part A Exhibit 4
Date/Time Prepared:
4/26/2021 2:25 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	0	0	0	0	0	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	0	15,607,970	15,607,970	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	805,774	0	0	805,774	805,774	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	16,182	0	0	16,182	16,182	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	0.0494	0.0494	0.0494	0.0494		22.00
23.00	Indirect medical education adjustment (see instructions)	6.00	39,805	0	0	39,805	39,805	23.00
24.00	Allowable disproportionate share percentage (see instructions)	10.00	0.1740	0.1740	0.1740	0.1740		24.00
25.00	Disproportionate share adjustment (see instructions)	11.00	140,205	0	0	140,205	140,205	25.00
26.00	Total prospective capital payments (see instructions)	12.00	1,001,966	0	0	1,001,966	1,001,966	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: 14-0206

Period:
From 10/01/2019
To 09/30/2020Worksheet E
Part A Exhibit 5
Date/Time Prepared:
4/26/2021 2:25 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	0	0		0	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	10,284,381		10,284,381	10,284,381	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	0	0		0	2.02
2.03	Outlier payments for discharges occurring on or after October 1 (see instructions)	2.04	586,560		586,560	586,560	2.03
3.00	Operating outlier reconciliation	2.01	0	0	0	0	3.00
4.00	Managed care simulated payments	3.00	4,536,113	0	4,536,113	4,536,113	4.00
Indirect Medical Education Adjustment							
5.00	Amount from Worksheet E, Part A, line 21 (see instructions)	21.00	0.085113	0.085113	0.085113		5.00
6.00	IME payment adjustment (see instructions)	22.00	466,983	0	466,983	466,983	6.00
6.01	IME payment adjustment for managed care (see instructions)	22.01	205,971	0	205,971	205,971	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	466,983	0	466,983	466,983	9.00
9.01	Total IME payment for managed care (sum of lines 6.01 and 8.01)	29.01	205,971	0	205,971	205,971	9.01
Disproportionate Share Adjustment							
10.00	Allowable disproportionate share percentage (see instructions)	33.00	0.5456	0.5456	0.5456		10.00
11.00	Disproportionate share adjustment (see instructions)	34.00	1,402,790	0	1,402,790	1,402,790	11.00
11.01	Uncompensated care payments	36.00	1,556,234	0	1,556,234	1,556,234	11.01
Additional payment for high percentage of ESRD beneficiary discharges							
12.00	Total ESRD additional payment (see instructions)	46.00	103,085	0	103,085	103,085	12.00
13.00	Subtotal (see instructions)	47.00	14,400,033	0	14,400,033	14,400,033	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	14,606,004	0	14,606,004	14,606,004	15.00
16.00	Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable)	50.00	1,001,966	0	1,001,966	1,001,966	16.00
17.00	Special add-on payments for new technologies	54.00	0	0	0	0	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			0	15,607,970	15,607,970	19.00

HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULATION EXHIBIT 5

Provider CCN: 14-0206

Period:
From 10/01/2019
To 09/30/2020Worksheet E
Part A Exhibit 5
Date/Time Prepared:
4/26/2021 2:25 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	805,774	0	805,774	805,774	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	16,182	0	16,182	16,182	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	0.0494	0.0494	0.0494		22.00
23.00	Indirect medical education adjustment (see instructions)	6.00	39,805	0	39,805	39,805	23.00
24.00	Allowable disproportionate share percentage (see instructions)	10.00	0.1740	0.1740	0.1740		24.00
25.00	Disproportionate share adjustment (see instructions)	11.00	140,205	0	140,205	140,205	25.00
26.00	Total prospective capital payments (see instructions)	12.00	1,001,966	0	1,001,966	1,001,966	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	-5,425	0	-5,425	-5,425	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	-62,735	0	-62,735	-62,735	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

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0206	Period: From 10/01/2019 To 09/30/2020	Worksheet E Part B Date/Time Prepared: 4/26/2021 2:25 pm
		Title XVIII	Hospital	PPS
				1.00
PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)		394	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)		4,661,897	2.00
3.00	OPPS payments		2,831,681	3.00
4.00	Outlier payment (see instructions)		56,568	4.00
4.01	Outlier reconciliation amount (see instructions)		0	4.01
5.00	Enter the hospital specific payment to cost ratio (see instructions)		0.000	5.00
6.00	Line 2 times line 5		0	6.00
7.00	Sum of lines 3, 4, and 4.01, divided by line 6		0.00	7.00
8.00	Transitional corridor payment (see instructions)		0	8.00
9.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200		0	9.00
10.00	Organ acquisitions		0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)		394	11.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
12.00	Ancillary service charges		2,454	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)		2,454	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)		2,454	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)		2,060	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)		394	21.00
22.00	Interns and residents (see instructions)		0	22.00
23.00	Cost of physicians' services in a teaching hospital (see instructions)		0	23.00
24.00	Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)		2,888,249	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)		531,507	26.00
27.00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions)		2,357,136	27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 50)		114,846	28.00
29.00	ESRD direct medical education costs (from Wkst. E-4, line 36)		0	29.00
30.00	Subtotal (sum of lines 27 through 29)		2,471,982	30.00
31.00	Primary payer payments		86	31.00
32.00	Subtotal (line 30 minus line 31)		2,471,896	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)		147,879	34.00
35.00	Adjusted reimbursable bad debts (see instructions)		96,121	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		64,774	36.00
37.00	Subtotal (see instructions)		2,568,017	37.00
38.00	MSP-LCC reconciliation amount from PS&R		0	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	39.00
39.50	Pioneer ACO demonstration payment adjustment (see instructions)		0	39.50
39.97	Demonstration payment adjustment amount before sequestration		0	39.97
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)		0	39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION		0	39.99
40.00	Subtotal (see instructions)		2,568,017	40.00
40.01	Sequestration adjustment (see instructions)		29,789	40.01
40.02	Demonstration payment adjustment amount after sequestration		0	40.02
40.03	Sequestration adjustment-PARHM pass-throughs		0	40.03
41.00	Interim payments		2,727,340	41.00
41.01	Interim payments-PARHM		0	41.01
42.00	Tentative settlement (for contractors use only)		0	42.00
42.01	Tentative settlement-PARHM (for contractor use only)		0	42.01
43.00	Balance due provider/program (see instructions)		-189,112	43.00
43.01	Balance due provider/program-PARHM (see instructions)		0	43.01
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		0	44.00
TO BE COMPLETED BY CONTRACTOR				
90.00	Original outlier amount (see instructions)		0	90.00
91.00	Outlier reconciliation adjustment amount (see instructions)		0	91.00
92.00	The rate used to calculate the Time Value of Money		0.00	92.00
93.00	Time Value of Money (see instructions)		0	93.00
94.00	Total (sum of lines 91 and 93)		0	94.00

Health Financial Systems		NORWEGIAN AMERICAN HOSPITAL		In Lieu of Form CMS-2552-10	
CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0206	Period: From 10/01/2019	Worksheet E	
		Component CCN: 14-S206	To 09/30/2020	Part B	
		Title XVIII	Subprovider - IPF	Date/Time Prepared: 4/26/2021 2:25 pm	
				PPS	
				1.00	
PART B - MEDICAL AND OTHER HEALTH SERVICES					
1.00	Medical and other services (see instructions)			0	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)			0	2.00
3.00	OPPS payments			0	3.00
4.00	Outlier payment (see instructions)			0	4.00
4.01	Outlier reconciliation amount (see instructions)			0	4.01
5.00	Enter the hospital specific payment to cost ratio (see instructions)			0.000	5.00
6.00	Line 2 times line 5			0	6.00
7.00	Sum of lines 3, 4, and 4.01, divided by line 6			0.00	7.00
8.00	Transitional corridor payment (see instructions)			0	8.00
9.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200			0	9.00
10.00	Organ acquisitions			0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)			0	11.00
COMPUTATION OF LESSER OF COST OR CHARGES					
Reasonable charges					
12.00	Ancillary service charges			0	12.00
13.00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, line 69)			0	13.00
14.00	Total reasonable charges (sum of lines 12 and 13)			0	14.00
Customary charges					
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis			0	15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a chargebasis had such payment been made in accordance with 42 CFR §413.13(e)			0	16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)			0.000000	17.00
18.00	Total customary charges (see instructions)			0	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)			0	19.00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)			0	20.00
21.00	Lesser of cost or charges (see instructions)			0	21.00
22.00	Interns and residents (see instructions)			0	22.00
23.00	Cost of physicians' services in a teaching hospital (see instructions)			0	23.00
24.00	Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)			0	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)			0	26.00
27.00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions)			0	27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 50)			0	28.00
29.00	ESRD direct medical education costs (from Wkst. E-4, line 36)			0	29.00
30.00	Subtotal (sum of lines 27 through 29)			0	30.00
31.00	Primary payer payments			0	31.00
32.00	Subtotal (line 30 minus line 31)			0	32.00
ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)					
33.00	Composite rate ESRD (from Wkst. I-5, line 11)			0	33.00
34.00	Allowable bad debts (see instructions)			0	34.00
35.00	Adjusted reimbursable bad debts (see instructions)			0	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			0	36.00
37.00	Subtotal (see instructions)			0	37.00
38.00	MSP-LCC reconciliation amount from PS&R			0	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	39.00
39.50	Pioneer ACO demonstration payment adjustment (see instructions)				39.50
39.97	Demonstration payment adjustment amount before sequestration			0	39.97
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)			0	39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION			0	39.99
40.00	Subtotal (see instructions)			0	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			0	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)			0	43.00
43.01	Balance due provider/program-PARHM (see instructions)				43.01
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2			0	44.00
TO BE COMPLETED BY CONTRACTOR					
90.00	Original outlier amount (see instructions)			0	90.00
91.00	Outlier reconciliation adjustment amount (see instructions)			0	91.00
92.00	The rate used to calculate the Time Value of Money			0.00	92.00
93.00	Time Value of Money (see instructions)			0	93.00
94.00	Total (sum of lines 91 and 93)			0	94.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 14-0206

Period:
From 10/01/2019
To 09/30/2020Worksheet E-1
Part I
Date/Time Prepared:
4/26/2021 2:25 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		14,751,736		2,722,726	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	02/10/2020	35,253	02/10/2020	4,614	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)		35,253		4,614	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)		14,786,989		2,727,340	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		174,338		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		189,112	6.02
7.00	Total Medicare program liability (see instructions)		14,961,327		2,538,228	7.00
				Contractor Number	NPR Date (Mo/Day/Yr)	
		0		1.00	2.00	
8.00	Name of Contractor					8.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED		Provider CCN: 14-0206 Component CCN: 14-S206		Period: From 10/01/2019 To 09/30/2020		Worksheet E-1 Part I Date/Time Prepared: 4/26/2021 2:25 pm	
		Title XVIII		Subprovider - IPF		PPS	
		Inpatient Part A		Part B			
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount		
		1.00	2.00	3.00	4.00		
1.00	Total interim payments paid to provider		945,443		0	1.00	
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00	
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00	
Program to Provider							
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01	
3.02			0		0	3.02	
3.03			0		0	3.03	
3.04			0		0	3.04	
3.05			0		0	3.05	
Provider to Program							
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50	
3.51			0		0	3.51	
3.52			0		0	3.52	
3.53			0		0	3.53	
3.54			0		0	3.54	
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99	
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		945,443		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		2,422		0	6.01	
6.02	SETTLEMENT TO PROGRAM		0		0	6.02	
7.00	Total Medicare program liability (see instructions)		947,865		0	7.00	
				Contractor Number	NPR Date (Mo/Day/Yr)		
		0		1.00	2.00		
8.00	Name of Contractor					8.00	

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT		Provider CCN: 14-0206	Period: From 10/01/2019 To 09/30/2020	Worksheet E-1 Part II Date/Time Prepared: 4/26/2021 2:25 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: 14-0206 Component CCN: 14-S206	Period: From 10/01/2019 To 09/30/2020	Worksheet E-3 Part II Date/Time Prepared: 4/26/2021 2:25 pm
		Title XVIII	Subprovider - IPF	PPS
				1.00
	PART II - MEDICARE PART A SERVICES - IPF PPS			
1.00	Net Federal IPF PPS Payments (excluding outlier, ECT, and medical education payments)			1,071,800 1.00
2.00	Net IPF PPS Outlier Payments			0 2.00
3.00	Net IPF PPS ECT Payments			0 3.00
4.00	Unweighted intern and resident FTE count in the most recent cost report filed on or before November 15, 2004. (see instructions)			0.00 4.00
4.01	Cap increases for the unweighted intern and resident FTE count for residents that were displaced by program or hospital closure, that would not be counted without a temporary cap adjustment under 42 CFR §412.424(d)(1)(iii)(F)(1) or (2) (see instructions)			0.00 4.01
5.00	New Teaching program adjustment. (see instructions)			0.00 5.00
6.00	Current year's unweighted FTE count of I&R excluding FTEs in the new program growth period of a "new teaching program" (see instructions)			0.00 6.00
7.00	Current year's unweighted I&R FTE count for residents within the new program growth period of a "new teaching program" (see instructions)			0.00 7.00
8.00	Intern and resident count for IPF PPS medical education adjustment (see instructions)			0.00 8.00
9.00	Average Daily Census (see instructions)			9.521858 9.00
10.00	Teaching Adjustment Factor {(1 + (line 8/line 9)) raised to the power of .5150 -1}.			0.000000 10.00
11.00	Teaching Adjustment (line 1 multiplied by line 10).			0 11.00
12.00	Adjusted Net IPF PPS Payments (sum of lines 1, 2, 3 and 11)			1,071,800 12.00
13.00	Nursing and Allied Health Managed Care payment (see instruction)			0 13.00
14.00	Organ acquisition (DO NOT USE THIS LINE)			0 14.00
15.00	Cost of physicians' services in a teaching hospital (see instructions)			0 15.00
16.00	Subtotal (see instructions)			1,071,800 16.00
17.00	Primary payer payments			0 17.00
18.00	Subtotal (line 16 less line 17).			1,071,800 18.00
19.00	Deductibles			85,096 19.00
20.00	Subtotal (line 18 minus line 19)			986,704 20.00
21.00	Coinsurance			29,194 21.00
22.00	Subtotal (line 20 minus line 21)			957,510 22.00
23.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)			2,276 23.00
24.00	Adjusted reimbursable bad debts (see instructions)			1,479 24.00
25.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			230 25.00
26.00	Subtotal (sum of lines 22 and 24)			958,989 26.00
27.00	Direct graduate medical education payments (see instructions)			0 27.00
28.00	Other pass through costs (see instructions)			0 28.00
29.00	Outlier payments reconciliation			0 29.00
30.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0 30.00
30.50	Pioneer ACO demonstration payment adjustment (see instructions)			0 30.50
30.99	Demonstration payment adjustment amount before sequestration			0 30.99
31.00	Total amount payable to the provider (see instructions)			958,989 31.00
31.01	Sequestration adjustment (see instructions)			11,124 31.01
31.02	Demonstration payment adjustment amount after sequestration			0 31.02
32.00	Interim payments			945,443 32.00
33.00	Tentative settlement (for contractor use only)			0 33.00
34.00	Balance due provider/program (line 31 minus lines 31.01, 31.02, 32 and 33)			2,422 34.00
35.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2			0 35.00
TO BE COMPLETED BY CONTRACTOR				
50.00	Original outlier amount from Worksheet E-3, Part II, line 2			0 50.00
51.00	Outlier reconciliation adjustment amount (see instructions)			0 51.00
52.00	The rate used to calculate the Time Value of Money			0.00 52.00
53.00	Time Value of Money (see instructions)			0 53.00

CALCULATION OF REIMBURSEMENT SETTLEMENT

Provider CCN: 14-0206

Period:
From 10/01/2019
To 09/30/2020Worksheet E-3
Part VII
Date/Time Prepared:
4/26/2021 2:25 pm

		Title XIX	Hospital	Cost	
			Inpatient	Outpatient	
			1.00	2.00	
PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR XIX SERVICES					
COMPUTATION OF NET COST OF COVERED SERVICES					
1.00	Inpatient hospital/SNF/NF services		6,148,250		1.00
2.00	Medical and other services			0	2.00
3.00	Organ acquisition (certified transplant centers only)		0		3.00
4.00	Subtotal (sum of lines 1, 2 and 3)		6,148,250	0	4.00
5.00	Inpatient primary payer payments		0		5.00
6.00	Outpatient primary payer payments			0	6.00
7.00	Subtotal (line 4 less sum of lines 5 and 6)		6,148,250	0	7.00
COMPUTATION OF LESSER OF COST OR CHARGES					
Reasonable Charges					
8.00	Routine service charges		8,445,512		8.00
9.00	Ancillary service charges		9,695,787	0	9.00
10.00	Organ acquisition charges, net of revenue		0		10.00
11.00	Incentive from target amount computation		0		11.00
12.00	Total reasonable charges (sum of lines 8 through 11)		18,141,299	0	12.00
CUSTOMARY CHARGES					
13.00	Amount actually collected from patients liable for payment for services on a charge basis		0	0	13.00
14.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)		0	0	14.00
15.00	Ratio of line 13 to line 14 (not to exceed 1.000000)		0.000000	0.000000	15.00
16.00	Total customary charges (see instructions)		18,141,299	0	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)		11,993,049	0	17.00
18.00	Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 16) (see instructions)		0	0	18.00
19.00	Interns and Residents (see instructions)		0	0	19.00
20.00	Cost of physicians' services in a teaching hospital (see instructions)		0	0	20.00
21.00	Cost of covered services (enter the lesser of line 4 or line 16)		6,148,250	0	21.00
PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be completed for PPS providers.					
22.00	Other than outlier payments		0	0	22.00
23.00	Outlier payments		0	0	23.00
24.00	Program capital payments		0	0	24.00
25.00	Capital exception payments (see instructions)		0	0	25.00
26.00	Routine and Ancillary service other pass through costs		0	0	26.00
27.00	Subtotal (sum of lines 22 through 26)		0	0	27.00
28.00	Customary charges (title V or XIX PPS covered services only)		0	0	28.00
29.00	Titles V or XIX (sum of lines 21 and 27)		6,148,250	0	29.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT					
30.00	Excess of reasonable cost (from line 18)		0	0	30.00
31.00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)		6,148,250	0	31.00
32.00	Deductibles		0	0	32.00
33.00	Coinurance		0	0	33.00
34.00	Allowable bad debts (see instructions)		0	0	34.00
35.00	Utilization review		0	0	35.00
36.00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)		6,148,250	0	36.00
37.00	INTERIM PAYMENT RECONCILIATION		-1,768,335	0	37.00
38.00	Subtotal (line 36 ± line 37)		4,379,915	0	38.00
39.00	Direct graduate medical education payments (from Wkst. E-4)		0	0	39.00
40.00	Total amount payable to the provider (sum of lines 38 and 39)		4,379,915	0	40.00
41.00	Interim payments		4,379,915	0	41.00
42.00	Balance due provider/program (line 40 minus line 41)		0	0	42.00
43.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, chapter 1, §115.2		0	0	43.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0206 Component CCN: 14-S206	Period: From 10/01/2019 To 09/30/2020	Worksheet E-3 Part VII Date/Time Prepared: 4/26/2021 2:25 pm
		Title XIX	Subprovider - IPF	Cost
		Inpatient 1.00	Outpatient 2.00	
PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR XIX SERVICES				
COMPUTATION OF NET COST OF COVERED SERVICES				
1.00	Inpatient hospital/SNF/NF services	0		1.00
2.00	Medical and other services		0	2.00
3.00	Organ acquisition (certified transplant centers only)	0		3.00
4.00	Subtotal (sum of lines 1, 2 and 3)	0	0	4.00
5.00	Inpatient primary payer payments	0		5.00
6.00	Outpatient primary payer payments		0	6.00
7.00	Subtotal (line 4 less sum of lines 5 and 6)	0	0	7.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable Charges				
8.00	Routine service charges	0		8.00
9.00	Ancillary service charges	0	0	9.00
10.00	Organ acquisition charges, net of revenue	0		10.00
11.00	Incentive from target amount computation	0		11.00
12.00	Total reasonable charges (sum of lines 8 through 11)	0	0	12.00
CUSTOMARY CHARGES				
13.00	Amount actually collected from patients liable for payment for services on a charge basis	0	0	13.00
14.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)	0	0	14.00
15.00	Ratio of line 13 to line 14 (not to exceed 1.000000)	0.000000	0.000000	15.00
16.00	Total customary charges (see instructions)	0	0	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)	0	0	17.00
18.00	Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 16) (see instructions)	0	0	18.00
19.00	Interns and Residents (see instructions)	0	0	19.00
20.00	Cost of physicians' services in a teaching hospital (see instructions)	0	0	20.00
21.00	Cost of covered services (enter the lesser of line 4 or line 16)	0	0	21.00
PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be completed for PPS providers.				
22.00	Other than outlier payments	0	0	22.00
23.00	Outlier payments	0	0	23.00
24.00	Program capital payments	0	0	24.00
25.00	Capital exception payments (see instructions)	0	0	25.00
26.00	Routine and Ancillary service other pass through costs	0	0	26.00
27.00	Subtotal (sum of lines 22 through 26)	0	0	27.00
28.00	Customary charges (title V or XIX PPS covered services only)	0	0	28.00
29.00	Titles V or XIX (sum of lines 21 and 27)	0	0	29.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT				
30.00	Excess of reasonable cost (from line 18)	0	0	30.00
31.00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)	0	0	31.00
32.00	Deductibles	0	0	32.00
33.00	Coinurance	0	0	33.00
34.00	Allowable bad debts (see instructions)	0	0	34.00
35.00	Utilization review	0	0	35.00
36.00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)	0	0	36.00
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	37.00
38.00	Subtotal (line 36 ± line 37)	0	0	38.00
39.00	Direct graduate medical education payments (from Wkst. E-4)	0	0	39.00
40.00	Total amount payable to the provider (sum of lines 38 and 39)	0	0	40.00
41.00	Interim payments	0	0	41.00
42.00	Balance due provider/program (line 40 minus line 41)	0	0	42.00
43.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, chapter 1, §115.2	0	0	43.00

DIRECT GRADUATE MEDICAL EDUCATION (GME) & ESRD OUTPATIENT DIRECT MEDICAL EDUCATION COSTS		Provider CCN: 14-0206		Period: From 10/01/2019 To 09/30/2020		Worksheet E-4 Date/Time Prepared: 4/26/2021 2:25 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.					1.98	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)					1.29	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)					12.44	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)					13.13	5.00
6.00	Unweighted resident FTE count for allopathic and osteopathic programs for the current year from your records (see instructions)					18.00	6.00
7.00	Enter the lesser of line 5 or line 6					13.13	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.	18.00	0.00	18.00		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.	13.13	0.00	13.13		9.00	
10.00	Weighted dental and podiatric resident FTE count for the current year		3.00			10.00	
10.01	Unweighted dental and podiatric resident FTE count for the current year		3.00			10.01	
11.00	Total weighted FTE count	13.13	3.00			11.00	
12.00	Total weighted resident FTE count for the prior cost reporting year (see instructions)	12.56	3.00			12.00	
13.00	Total weighted resident FTE count for the penultimate cost reporting year (see instructions)	7.26	3.00			13.00	
14.00	Rolling average FTE count (sum of lines 11 through 13 divided by 3).	10.98	3.00			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	10.98	3.00			17.00	
18.00	Per resident amount	102,223.91	102,223.91			18.00	
19.00	Approved amount for resident costs	1,122,419	306,672	1,429,091		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)			4.87		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)			1,429,091		25.00	
		Inpatient Part A	Managed Care Prior to 1/1	Managed Care On or after 1/1	Total		
		1.00	2.00	2.01	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)	8,268	1,646	1,646			26.00
27.00	Total Inpatient Days (see instructions)	33,634	33,634	33,634			27.00
28.00	Ratio of inpatient days to total inpatient days	0.245823	0.048939	0.048939			28.00
29.00	Program direct GME amount	351,303	69,938	69,938	491,179	29.00	
29.01	Percent reduction for MA DGME		7.00	7.00			29.01
30.00	Reduction for direct GME payments for Medicare Advantage		4,896	4,896	9,792	30.00	
31.00	Net Program direct GME amount				481,387	31.00	

DIRECT GRADUATE MEDICAL EDUCATION (GME) & ESRD OUTPATIENT DIRECT MEDICAL EDUCATION COSTS		Provider CCN: 14-0206	Period: From 10/01/2019 To 09/30/2020	Worksheet E-4 Date/Time Prepared: 4/26/2021 2:25 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)		2,539,502		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)		14,879,786		37.00
38.00	Organ acquisition costs (Wkst. D-4, Pt. III, col. 1, line 69)		0		38.00
39.00	Cost of physicians' services in a teaching hospital (see instructions)		0		39.00
40.00	Primary payer payments (see instructions)		0		40.00
41.00	Total Part A reasonable cost (sum of lines 37 through 39 minus line 40)		14,879,786		41.00
Part B Reasonable Cost					
42.00	Reasonable cost (see instructions)		4,662,291		42.00
43.00	Primary payer payments (see instructions)		86		43.00
44.00	Total Part B reasonable cost (line 42 minus line 43)		4,662,205		44.00
45.00	Total reasonable cost (sum of lines 41 and 44)		19,541,991		45.00
46.00	Ratio of Part A reasonable cost to total reasonable cost (line 41 ÷ line 45)		0.761426		46.00
47.00	Ratio of Part B reasonable cost to total reasonable cost (line 44 ÷ line 45)		0.238574		47.00
ALLOCATION OF MEDICARE DIRECT GME COSTS BETWEEN PART A AND PART B					
48.00	Total program GME payment (line 31)		481,387		48.00
49.00	Part A Medicare GME payment (line 46 x 48) (title XVIII only) (see instructions)		366,541		49.00
50.00	Part B Medicare GME payment (line 47 x 48) (title XVIII only) (see instructions)		114,846		50.00

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

Provider CCN: 14-0206

Period:
From 10/01/2019
To 09/30/2020

Worksheet G

Date/Time Prepared:
4/26/2021 2:25 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	52,946,340	0	0	0	1.00
2.00 Temporary investments	24,615,687	0	0	0	2.00
3.00 Notes receivable	0	0	0	0	3.00
4.00 Accounts receivable	36,340,289	0	0	0	4.00
5.00 Other receivable	3,069,664	0	0	0	5.00
6.00 Allowances for uncollectible notes and accounts receivable	-27,189,616	0	0	0	6.00
7.00 Inventory	1,900,332	0	0	0	7.00
8.00 Prepaid expenses	862,982	0	0	0	8.00
9.00 Other current assets	2,514,986	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)	95,060,664	0	0	0	11.00
FIXED ASSETS					
12.00 Land	4,840,913	0	0	0	12.00
13.00 Land improvements	3,689,647	0	0	0	13.00
14.00 Accumulated depreciation	47,977,632	0	0	0	14.00
15.00 Buildings	2,828,573	0	0	0	15.00
16.00 Accumulated depreciation	-41,166,747	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	30,862,586	0	0	0	19.00
20.00 Accumulated depreciation	-20,878,178	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	61,976,981	0	0	0	23.00
24.00 Accumulated depreciation	-52,182,988	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)	37,948,419	0	0	0	30.00
OTHER ASSETS					
31.00 Investments	5,044,962	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	6,158,366	0	0	0	34.00
35.00 Total other assets (sum of lines 31-34)	11,203,328	0	0	0	35.00
36.00 Total assets (sum of lines 11, 30, and 35)	144,212,411	0	0	0	36.00
CURRENT LIABILITIES					
37.00 Accounts payable	12,773,400	0	0	0	37.00
38.00 Salaries, wages, and fees payable	5,812,071	0	0	0	38.00
39.00 Payroll taxes payable	1,210,561	0	0	0	39.00
40.00 Notes and loans payable (short term)	3,373,123	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	45,360,892	0	0	0	44.00
45.00 Total current liabilities (sum of lines 37 thru 44)	68,530,047	0	0	0	45.00
LONG TERM LIABILITIES					
46.00 Mortgage payable	0	0	0	0	46.00
47.00 Notes payable	25,999,246	0	0	0	47.00
48.00 Unsecured loans	0	0	0	0	48.00
49.00 Other long term liabilities	14,930,690	0	0	0	49.00
50.00 Total long term liabilities (sum of lines 46 thru 49)	40,929,936	0	0	0	50.00
51.00 Total liabilities (sum of lines 45 and 50)	109,459,983	0	0	0	51.00
CAPITAL ACCOUNTS					
52.00 General fund balance	34,752,428	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)	34,752,428	0	0	0	59.00
60.00 Total liabilities and fund balances (sum of lines 51 and 59)	144,212,411	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 14-0206

Period:
From 10/01/2019
To 09/30/2020

Worksheet G-1

Date/Time Prepared:
4/26/2021 2:25 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		32,100,174		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		2,652,255				2.00
3.00	Total (sum of line 1 and line 2)		34,752,429		0		3.00
4.00	Additions (credit adjustments) (specify)	0		0		0	4.00
5.00		0		0		0	5.00
6.00		0		0		0	6.00
7.00		0		0		0	7.00
8.00		0		0		0	8.00
9.00		0		0		0	9.00
10.00	Total additions (sum of line 4-9)		0		0		10.00
11.00	Subtotal (line 3 plus line 10)		34,752,429		0		11.00
12.00	Deductions (debit adjustments) (specify)	0		0		0	12.00
13.00		0		0		0	13.00
14.00		0		0		0	14.00
15.00		0		0		0	15.00
16.00		0		0		0	16.00
17.00		0		0		0	17.00
18.00	Total deductions (sum of lines 12-17)		0		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		34,752,429		0		19.00
		Endowment Fund		Plant Fund			
		6.00	7.00	8.00			
1.00	Fund balances at beginning of period	0		0			1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)						2.00
3.00	Total (sum of line 1 and line 2)	0		0			3.00
4.00	Additions (credit adjustments) (specify)		0				4.00
5.00			0				5.00
6.00			0				6.00
7.00			0				7.00
8.00			0				8.00
9.00			0				9.00
10.00	Total additions (sum of line 4-9)	0		0			10.00
11.00	Subtotal (line 3 plus line 10)	0		0			11.00
12.00	Deductions (debit adjustments) (specify)		0				12.00
13.00			0				13.00
14.00			0				14.00
15.00			0				15.00
16.00			0				16.00
17.00			0				17.00
18.00	Total deductions (sum of lines 12-17)	0		0			18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)	0		0			19.00

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES

Provider CCN: 14-0206

Period:
From 10/01/2019
To 09/30/2020Worksheet G-2
Parts I & II
Date/Time Prepared:
4/26/2021 2:25 pm

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
PART I - PATIENT REVENUES					
General Inpatient Routine Services					
1.00	Hospital	84,036,217		84,036,217	1.00
2.00	SUBPROVIDER - IPF	6,510,300		6,510,300	2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	0		0	5.00
6.00	Swing bed - NF	0		0	6.00
7.00	SKILLED NURSING FACILITY				7.00
8.00	NURSING FACILITY				8.00
9.00	OTHER LONG TERM CARE				9.00
10.00	Total general inpatient care services (sum of lines 1-9)	90,546,517		90,546,517	10.00
Intensive Care Type Inpatient Hospital Services					
11.00	INTENSIVE CARE UNIT	10,946,948		10,946,948	11.00
11.01	NICU	0		0	11.01
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)	10,946,948		10,946,948	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	101,493,465		101,493,465	17.00
18.00	Ancillary services	116,402,625	129,613,931	246,016,556	18.00
19.00	Outpatient services	0	0	0	19.00
20.00	RURAL HEALTH CLINIC	0	0	0	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY				22.00
23.00	AMBULANCE SERVICES				23.00
24.00	CMHC				24.00
24.10	CORF	0	0	0	24.10
24.20	OUTPATIENT PHYSICAL THERAPY	0	0	0	24.20
24.30	OUTPATIENT OCCUPATIONAL THERAPY	0	0	0	24.30
24.40	OUTPATIENT SPEECH PATHOLOGY	0	0	0	24.40
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	OTHER (SPECIFY)	0	0	0	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	217,896,090	129,613,931	347,510,021	28.00
PART II - OPERATING EXPENSES					
29.00	Operating expenses (per Wkst. A, column 3, line 200)		121,499,191		29.00
30.00	ADD (SPECIFY)	0			30.00
31.00		0			31.00
32.00		0			32.00
33.00		0			33.00
34.00		0			34.00
35.00		0			35.00
36.00	Total additions (sum of lines 30-35)		0		36.00
37.00	NAH OTHER GENERAL REV ILL MEDICAID T	7,710,750			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)		7,710,750		42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer to Wkst. G-3, line 4)		113,788,441		43.00

STATEMENT OF REVENUES AND EXPENSES

Provider CCN: 14-0206

Period:
From 10/01/2019
To 09/30/2020

Worksheet G-3

Date/Time Prepared:
4/26/2021 2:25 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	347,510,021	1.00
2.00	Less contractual allowances and discounts on patients' accounts	245,752,523	2.00
3.00	Net patient revenues (line 1 minus line 2)	101,757,498	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	113,788,441	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-12,030,943	5.00
OTHER INCOME			
6.00	Contributions, donations, bequests, etc	672,300	6.00
7.00	Income from investments	131,529	7.00
8.00	Revenues from telephone and other miscellaneous communication services	0	8.00
9.00	Revenue from television and radio service	0	9.00
10.00	Purchase discounts	0	10.00
11.00	Rebates and refunds of expenses	0	11.00
12.00	Parking lot receipts	0	12.00
13.00	Revenue from laundry and linen service	0	13.00
14.00	Revenue from meals sold to employees and guests	219,527	14.00
15.00	Revenue from rental of living quarters	0	15.00
16.00	Revenue from sale of medical and surgical supplies to other than patients	0	16.00
17.00	Revenue from sale of drugs to other than patients	0	17.00
18.00	Revenue from sale of medical records and abstracts	481	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	0	20.00
21.00	Rental of vending machines	0	21.00
22.00	Rental of hospital space	429,609	22.00
23.00	Governmental appropriations	0	23.00
24.00	OTHER (SPECIFY)	0	24.00
24.01	NAH CLIN INTEGRTN:MEDICA MEDICAL EDU	1,545,325	24.01
24.02	4010-MISC REV	686,394	24.02
24.03	GRANT ETC	1,924,688	24.03
24.04	OTHER MISC REV	114,079	24.04
24.50	COVID-19 PHE Funding	8,959,266	24.50
25.00	Total other income (sum of lines 6-24)	14,683,198	25.00
26.00	Total (line 5 plus line 25)	2,652,255	26.00
27.00	OTHER EXPENSES (SPECIFY)	0	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	0	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	2,652,255	29.00

CALCULATION OF CAPITAL PAYMENT		Provider CCN: 14-0206	Period: From 10/01/2019 To 09/30/2020	Worksheet L Parts I-III Date/Time Prepared: 4/26/2021 2:25 pm
		Title XVIII	Hospital	PPS
		1.00		
PART I - FULLY PROSPECTIVE METHOD				
CAPITAL FEDERAL AMOUNT				
1.00	Capital DRG other than outlier		805,774	1.00
1.01	Model 4 BPCI Capital DRG other than outlier		0	1.01
2.00	Capital DRG outlier payments		16,182	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)		82.37	3.00
4.00	Number of interns & residents (see instructions)		14.07	4.00
5.00	Indirect medical education percentage (see instructions)		4.94	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)		39,805	6.00
7.00	Percentage of SSI recipient patient days to Medicare Part A patient days (Worksheet E, part A line 30) (see instructions)		22.70	7.00
8.00	Percentage of Medicaid patient days to total days (see instructions)		56.51	8.00
9.00	Sum of lines 7 and 8		79.21	9.00
10.00	Allowable disproportionate share percentage (see instructions)		17.40	10.00
11.00	Disproportionate share adjustment (see instructions)		140,205	11.00
12.00	Total prospective capital payments (see instructions)		1,001,966	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