

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: 14-0217	Period: From 07/01/2019 To 06/30/2020	Worksheet S Parts I-III Date/Time Prepared: 11/28/2020 2:10 pm
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PART I - COST REPORT STATUS			
Provider use only	1. ☒ Electronically prepared cost report 2. ☐ Manually prepared cost report 3. ☐ If this is an amended report enter the number of times the provider resubmitted this cost report 4. ☐ Medicare Utilization. Enter "F" for full or "L" for low.		Date: 11/28/2020 Time: 2:10 pm
Contractor use only	5. ☐ Cost Report Status (1) As Submitted (2) Settled without Audit (3) Settled with Audit (4) Reopened (5) Amended	6. Date Received: 7. Contractor No. 8. ☐ Initial Report for this Provider CCN 9. ☐ Final Report for this Provider CCN	10. NPR Date: 11. Contractor's Vendor Code: 4 12. ☐ If line 5, column 1 is 4: Enter number of times reopened = 0-9.

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

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

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by PRESENCE SAINT JOSEPH HOSPITAL ELGIN (14-0217) for the cost reporting period beginning 07/01/2019 and ending 06/30/2020 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

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

(Signed) KEVIN LARKIN
 Officer or Administrator of Provider(s)

CHIEF FINANCIAL OFFICER
 Title

(Dated when report is electronically signed.)
 Date

Cost Center Description		Title V	Title XVIII		HIT	Title XIX	
			Part A	Part B			
		1.00	2.00	3.00	4.00	5.00	
	PART III - SETTLEMENT SUMMARY						
1.00	Hospital	0	551,025	-62,876	0	0	1.00
2.00	Subprovider - IPF	0	0	0		0	2.00
3.00	Subprovider - IRF	0	78,736	578		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	629,761	-62,298	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: 14-0217		Period: From 07/01/2019 To 06/30/2020		Worksheet S-2 Part I Date/Time Prepared: 11/28/2020 2:10 pm	
1.00		2.00		3.00		4.00			
Hospital and Hospital Health Care Complex Address:									
1.00	Street: 77 NORTH AIRLITE ST.			PO Box:				1.00	
2.00	City: ELGIN			State: IL		Zip Code: 60123		County: KANE	
		Component Name		CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N)	
								V	XVIII
								XIX	
Hospital and Hospital-Based Component Identification:									
3.00	Hospital			PRESENCE SAINT JOSEPH HOSPITAL ELGIN	140217	20994	1	09/01/1966	N P P
4.00	Subprovider - IPF								
5.00	Subprovider - IRF			PRESENCE SAINT JOSEPH REHAB UNIT	14T217	20994	5	09/01/1997	N P N
6.00	Subprovider - (Other)								
7.00	Swing Beds - SNF								
8.00	Swing Beds - NF								
9.00	Hospital-Based SNF								
10.00	Hospital-Based NF								
11.00	Hospital-Based OLTC								
12.00	Hospital-Based HHA								
13.00	Separately Certified ASC								
14.00	Hospital-Based Hospice								
15.00	Hospital-Based Health Clinic - RHC								
16.00	Hospital-Based Health Clinic - FQHC								
17.00	Hospital-Based (CMHC) I								
18.00	Renal Dialysis								
19.00	Other								
							From:	To:	
							1.00	2.00	
20.00	Cost Reporting Period (mm/dd/yyyy)						07/01/2019	06/30/2020	20.00
21.00	Type of Control (see instructions)						1		21.00
							1.00	2.00	3.00
Inpatient PPS Information									
22.00	Does this facility qualify and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.106(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no.					Y	N		22.00
22.01	Did this hospital receive interim uncompensated care payments for this cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)					Y	Y		22.01
22.02	Is this a newly merged hospital that requires final uncompensated care payments to be determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1.					N	N		22.02
22.03	Did this hospital receive a geographic reclassification from urban to rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no.					N	N	N	22.03
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.					3	N		23.00
				In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of-State Medicaid paid days	Out-of-State Medicaid eligible unpaid	Medicaid HMO days	Other Medicaid days
				1.00	2.00	3.00	4.00	5.00	6.00
24.00	If this provider is an IPPS hospital, enter the in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.			1,033	927	0	0	3,545	0

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

Provider CCN: 14-0217

Period:
From 07/01/2019
To 06/30/2020Worksheet S-2
Part I
Date/Time Prepared:
11/28/2020 2:10 pm

		In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of State Medicaid paid days	Out-of State Medicaid eligible unpaid	Medicaid HMO days	Other Medicaid days	
		1.00	2.00	3.00	4.00	5.00	6.00	
25.00	If this provider is an IRF, enter the in-state Medicaid paid days in column 1, the in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5.	0	143	0	0	90		25.00
						Urban/Rural S	Date of Geogr	
						1.00	2.00	
26.00	Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter "1" for urban or "2" for rural.					1		26.00
27.00	Enter your standard geographic classification (not wage) status at the end of the cost reporting period. Enter in column 1, "1" for urban or "2" for rural. If applicable, enter the effective date of the geographic reclassification in column 2.					1		27.00
35.00	If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period.					0		35.00
						Beginning:	Ending:	
						1.00	2.00	
36.00	Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.							36.00
37.00	If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status is in effect in the cost reporting period.					0		37.00
37.01	Is this hospital a former MDH that is eligible for the MDH transitional payment in accordance with FY 2016 OPPS final rule? Enter "Y" for yes or "N" for no. (see instructions)							37.01
38.00	If line 37 is 1, enter the beginning and ending dates of MDH status. If line 37 is greater than 1, subscript this line for the number of periods in excess of one and enter subsequent dates.							38.00
						Y/N	Y/N	
						1.00	2.00	
39.00	Does this facility qualify for the inpatient hospital payment adjustment for low volume hospitals in accordance with 42 CFR §412.101(b)(2)(i), (ii), or (iii)? Enter in column 1 "Y" for yes or "N" for no. Does the facility meet the mileage requirements in accordance with 42 CFR §412.101(b)(2)(i), (ii), or (iii)? Enter in column 2 "Y" for yes or "N" for no. (see instructions)					N	N	39.00
40.00	Is this hospital subject to the HAC program reduction adjustment? Enter "Y" for yes or "N" for no in column 1, for discharges prior to October 1. Enter "Y" for yes or "N" for no in column 2, for discharges on or after October 1. (see instructions)					N	N	40.00
						V	XVIII	XIX
						1.00	2.00	3.00
Prospective Payment System (PPS)-Capital								
45.00	Does this facility qualify and receive Capital payment for disproportionate share in accordance with 42 CFR Section §412.320? (see instructions)					N	Y	N
46.00	Is this facility eligible for additional payment exception for extraordinary circumstances pursuant to 42 CFR §412.348(f)? If yes, complete Wkst. L, Pt. III and Wkst. L-1, Pt. I through Pt. III.					N	N	N
47.00	Is this a new hospital under 42 CFR §412.300(b) PPS capital? Enter "Y" for yes or "N" for no.					N	N	N
48.00	Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.					N	N	N
Teaching Hospitals								
56.00	Is this a hospital involved in training residents in approved GME programs? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", are you impacted by CR 11642 (or subsequent CR), MA GME payment reduction? Enter "Y" for yes or "N" for no in column 2.					N		
57.00	If line 56 is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y" did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If column 2 is "N", complete Wkst. D, Parts III & IV and D-2, Pt. II, if applicable.					N		
58.00	If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, chapter 21, §2148? If yes, complete Wkst. D-5.					N		
59.00	Are costs claimed on line 100 of Worksheet A? If yes, complete Wkst. D-2, Pt. I.					N		
				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
60.01	If line 60 is yes, complete columns 2 and 3 for each program. (see instructions)					0.00	0	60.01

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

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To 06/30/2020Worksheet S-2
Part I
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	Y/N	IME	Direct GME	IME	Direct GME	
	1.00	2.00	3.00	4.00	5.00	
61.00 Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions)	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		
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.						
64.00 Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)		0.00	0.00	0.000000		64.00

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

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			1.00		
Long Term Care Hospital PPS					
80.00	Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for no.	N		80.00	
81.00	Is this a LTCH co-located within another hospital for part or all of the cost reporting period? Enter "Y" for yes and "N" for no.	N		81.00	
TEFRA Providers					
85.00	Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no.	N		85.00	
86.00	Did this facility establish a new Other subprovider (excluded unit) under 42 CFR Section §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.			86.00	
87.00	Is this hospital an extended neoplastic disease care hospital classified under section 1886(d)(1)(B)(vi)? Enter "Y" for yes or "N" for no.	N		87.00	
		V	XIX		
		1.00	2.00		
Title V and XIX Services					
90.00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.	N	Y	90.00	
91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.	N	N	91.00	
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.		N	92.00	
93.00	Does this facility operate an ICF/IID facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.	N	N	93.00	
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.	N	N	94.00	
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	95.00	
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.	N	N	96.00	
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	97.00	
98.00	Does title V or XIX follow Medicare (title XVIII) for the interns and residents post stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.00	
98.01	Does title V or XIX follow Medicare (title XVIII) for the reporting of charges on Wkst. C, Pt. I? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.01	
98.02	Does title V or XIX follow Medicare (title XVIII) for the calculation of observation bed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.02	
98.03	Does title V or XIX follow Medicare (title XVIII) for a critical access hospital (CAH) reimbursed 101% of inpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.03	
98.04	Does title V or XIX follow Medicare (title XVIII) for a CAH reimbursed 101% of outpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.04	
98.05	Does title V or XIX follow Medicare (title XVIII) and add back the RCE disallowance on Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.05	
98.06	Does title V or XIX follow Medicare (title XVIII) when cost reimbursed for Wkst. D, Pts. I through IV? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.06	
Rural Providers					
105.00	Does this hospital qualify as a CAH?	N		105.00	
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)			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	Respiratory
		1.00	2.00	3.00	4.00
109.00	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.	N			
				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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-0217	Period: From 07/01/2019 To 06/30/2020	Worksheet S-2 Part I Date/Time Prepared: 11/28/2020 2:10 pm
		1.00	2.00	
111.00	If this facility qualifies as a CAH, did it participate in the Frontier Community Health Integration Project (FCHIP) demonstration for this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If the response to column 1 is Y, enter the integration prong of the FCHIP demo in which this CAH is participating in column 2. Enter all that apply: "A" for Ambulance services; "B" for additional beds; and/or "C" for tele-health services.	N		111.00
		1.00	2.00	3.00
112.00	Did this hospital participate in the Pennsylvania Rural Health Model demonstration for any portion of the current cost reporting period? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2, the date the hospital began participating in the demonstration. In column 3, enter the date the hospital ceased participation in the demonstration, if applicable.	N		112.00
Miscellaneous Cost Reporting Information				
115.00	Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in column 1. If column 1 is yes, enter the method used (A, B, or E only) in column 2. If column 2 is "E", enter in column 3 either "93" percent for short term hospital or "98" percent for long term care (includes psychiatric, rehabilitation and long term hospitals providers) based on the definition in CMS Pub.15-1, chapter 22, §2208.1.	N		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.	Y		117.00
118.00	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.	1		118.00
		Premiums	Losses	Insurance
		1.00	2.00	3.00
118.01	List amounts of malpractice premiums and paid losses:	1,504,555	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.	Y	5.05	122.00
Transplant Center Information				
125.00	Does this facility operate a transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.	N		125.00
126.00	If this is a Medicare certified kidney transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			126.00
127.00	If this is a Medicare certified heart transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			127.00
128.00	If this is a Medicare certified liver transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			128.00
129.00	If this is a Medicare certified lung transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			129.00
130.00	If this is a Medicare certified pancreas transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			130.00
131.00	If this is a Medicare certified intestinal transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			131.00
132.00	If this is a Medicare certified islet transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			132.00
133.00	Removed and reserved			133.00
134.00	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.			134.00
All Providers				
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)	Y	149013	140.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA				Provider CCN: 14-0217		Period: From 07/01/2019 To 06/30/2020		Worksheet S-2 Part I Date/Time Prepared: 11/28/2020 2:10 pm	
1.00		2.00		3.00					
If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number.									
141.00	Name: ALEXIAN BROTHERS HEALTH SYSTEM	Contractor's Name: WPS		Contractor's Number: 05001				141.00	
142.00	Street: 200 SOUTH WACKER DRIVE	PO Box:						142.00	
143.00	City: CHICAGO	State: IL		Zip Code: 60606				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	N	155.00		
156.00	Subprovider - IPF	N	N	N	N	N	156.00		
157.00	Subprovider - IRF	N	N	N	N	N	157.00		
158.00	SUBPROVIDER						158.00		
159.00	SNF	N	N	N	N	N	159.00		
160.00	HOME HEALTH AGENCY	N	N	N	N	N	160.00		
161.00	CMHC		N	N	N	N	161.00		
								1.00	
Multicampus									
165.00	Is this hospital part of a Multicampus hospital that has one or more campuses in different CBSAs? Enter "Y" for yes or "N" for no.							N	165.00
		Name	County	State	Zip Code	CBSA	FTE/Campus		
		0	1.00	2.00	3.00	4.00	5.00		
166.00	If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions)						0.00		
								1.00	
Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act									
167.00	Is this provider a meaningful user under §1886(n)? Enter "Y" for yes or "N" for no.							Y	167.00
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)								168.00
168.01	If this provider is a CAH and is not a meaningful user, does this provider qualify for a hardship exception under §413.70(a)(6)(ii)? Enter "Y" for yes or "N" for no. (see instructions)								168.01
169.00	If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)							9.99	169.00
						Beginning	Ending		
						1.00	2.00		
170.00	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)								170.00
						1.00	2.00		
171.00	If line 167 is "Y", does this provider have any days for individuals enrolled in section 1876 Medicare cost plans reported on Wkst. S-3, Pt. I, line 2, col. 6? Enter "Y" for yes and "N" for no in column 1. If column 1 is yes, enter the number of section 1876 Medicare days in column 2. (see instructions)							N	0

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 14-0217	Period: From 07/01/2019 To 06/30/2020	Worksheet S-2 Part II Date/Time Prepared: 11/28/2020 2:10 pm
			Y/N 1.00	Date 2.00
General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format.				
COMPLETED BY ALL HOSPITALS				
Provider Organization and Operation				
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)	N		1.00
		Y/N 1.00	Date 2.00	V/I 3.00
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.	N		2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)	Y		3.00
		Y/N 1.00	Type 2.00	Date 3.00
Financial Data and Reports				
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	Y	A	4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.	N		5.00
			Y/N 1.00	Legal Oper. 2.00
Approved Educational Activities				
6.00	Column 1: Are costs claimed for nursing school? Column 2: If yes, is the provider is the legal operator of the program?	N		6.00
7.00	Are costs claimed for Allied Health Programs? If "Y" see instructions.	N		7.00
8.00	Were nursing school and/or allied health programs approved and/or renewed during the cost reporting period? If yes, see instructions.	N		8.00
9.00	Are costs claimed for Interns and Residents in an approved graduate medical education program in the current cost report? If yes, see instructions.	N		9.00
10.00	Was an approved Intern and Resident GME program initiated or renewed in the current cost reporting period? If yes, see instructions.	N		10.00
11.00	Are GME cost directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions.	N		11.00
			Y/N 1.00	
Bad Debts				
12.00	Is the provider seeking reimbursement for bad debts? If yes, see instructions.	Y		12.00
13.00	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.	N		13.00
14.00	If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.	N		14.00
Bed Complement				
15.00	Did total beds available change from the prior cost reporting period? If yes, see instructions.	N		15.00
		Part A		Part B
		Y/N 1.00	Date 2.00	Y/N 3.00
				Date 4.00
PS&R Data				
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)	N		16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	Y	11/12/2020	17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N		18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		19.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 14-0217	Period: From 07/01/2019 To 06/30/2020	Worksheet S-2 Part II Date/Time Prepared: 11/28/2020 2:10 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
		Y/N	Date	Y/N
		1.00	2.00	3.00
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N	N	
				1.00
COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)				
Capital Related Cost				
22.00	Have assets been relifed for Medicare purposes? If yes, see instructions			22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.			23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions			24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.			25.00
26.00	Were assets subject to Sec.2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.			26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.			27.00
Interest Expense				
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.			28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions			29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.			30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.			31.00
Purchased Services				
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.			32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.			33.00
Provider-Based Physicians				
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.			34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.			35.00
		Y/N	Date	
		1.00	2.00	
Home Office Costs				
36.00	Were home office costs claimed on the cost report?	Y		36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.	Y		37.00
38.00	If line 36 is yes, was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.	N		38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.	N		39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.	N		40.00
		1.00	2.00	
Cost Report Preparer Contact Information				
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	ANNE	LITTLE	41.00
42.00	Enter the employer/company name of the cost report preparer.	PRESENCE CARE TRANSFORMATION CORP		42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	(217) 369-5843	ANNE.LITTLE@AMITAHEALTH.ORG	43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE

Provider CCN: 14-0217

Period:
From 07/01/2019
To 06/30/2020Worksheet S-2
Part II
Date/Time Prepared:
11/28/2020 2:10 pm

		3.00	
Cost Report Preparer Contact Information			
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	REIMBURSEMENT DIRECTOR	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: 14-0217

Period:
From 07/01/2019
To 06/30/2020Worksheet S-3
Part I
Date/Time Prepared:
11/28/2020 2:10 pm

Component	Worksheet A Line Number	No. of Beds	Bed Days Available	CAH Hours	I/P Days / O/P Visits / Trips	
					Title V	
	1.00	2.00	3.00	4.00	5.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30.00	129	47,214	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)		129	47,214	0.00	0	7.00
8.00 INTENSIVE CARE UNIT	31.00	15	5,475	0.00	0	8.00
9.00 CORONARY CARE UNIT						9.00
10.00 BURN INTENSIVE CARE UNIT						10.00
11.00 SURGICAL INTENSIVE CARE UNIT						11.00
12.00 OTHER SPECIAL CARE (SPECIFY)						12.00
13.00 NURSERY						13.00
14.00 Total (see instructions)		144	52,689	0.00	0	14.00
15.00 CAH visits					0	15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF	41.00	40	14,600		0	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
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)		184			0	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)		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: 14-0217

Period:
From 07/01/2019
To 06/30/2020Worksheet S-3
Part I
Date/Time Prepared:
11/28/2020 2:10 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)	7,407	1,881	20,928			1.00
2.00	HMO and other (see instructions)	2,351	3,545				2.00
3.00	HMO IPF Subprovider	0	0				3.00
4.00	HMO IRF Subprovider	623	90				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)	7,407	1,881	20,928			7.00
8.00	INTENSIVE CARE UNIT	812	79	1,960			8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY						13.00
14.00	Total (see instructions)	8,219	1,960	22,888	0.00	424.79	14.00
15.00	CAH visits	0	0	0			15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF	5,945	143	7,963	0.00	38.77	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)			280			24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0.00	0.00	26.25
27.00	Total (sum of lines 14-26)				0.00	463.56	27.00
28.00	Observation Bed Days		464	2,363			28.00
29.00	Ambulance Trips	0					29.00
30.00	Employee discount days (see instruction)			0			30.00
31.00	Employee discount days - IRF			0			31.00
32.00	Labor & delivery days (see instructions)	0	0	0			32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)			0			32.01
33.00	LTCH non-covered days	0					33.00
33.01	LTCH site neutral days and discharges	0					33.01

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 14-0217

Period:
From 07/01/2019
To 06/30/2020Worksheet S-3
Part I
Date/Time Prepared:
11/28/2020 2:10 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	1,790	354	5,648	1.00
2.00 HMO and other (see instructions)			520	641		2.00
3.00 HMO IPF Subprovider				0		3.00
4.00 HMO IRF Subprovider				8		4.00
5.00 Hospital Adults & Peds. Swing Bed SNF						5.00
6.00 Hospital Adults & Peds. Swing Bed NF						6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)						7.00
8.00 INTENSIVE CARE UNIT						8.00
9.00 CORONARY CARE UNIT						9.00
10.00 BURN INTENSIVE CARE UNIT						10.00
11.00 SURGICAL INTENSIVE CARE UNIT						11.00
12.00 OTHER SPECIAL CARE (SPECIFY)						12.00
13.00 NURSERY						13.00
14.00 Total (see instructions)	0.00	0	1,790	354	5,648	14.00
15.00 CAH visits						15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF	0.00	0	520	13	892	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
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: 14-0217

Period:
From 07/01/2019
To 06/30/2020Worksheet S-3
Part II
Date/Time Prepared:
11/28/2020 2:10 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	36,310,146	6,904	36,317,050	964,215.02	37.66
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		115,117	0	115,117	942.00	122.20
4.01	Physicians - Part A - Teaching		0	0	0	0.00	0.00
5.00	Physician and Non Physician-Part B		0	0	0	0.00	0.00
6.00	Non-physician-Part B for hospital-based RHC and FQHC services		0	0	0	0.00	0.00
7.00	Interns & residents (in an approved program)	21.00	0	0	0	0.00	0.00
7.01	Contracted interns and residents (in an approved programs)		0	0	0	0.00	0.00
8.00	Home office and/or related organization personnel		0	0	0	0.00	0.00
9.00	SNF	44.00	0	0	0	0.00	0.00
10.00	Excluded area salaries (see instructions)		3,308,525	-207,091	3,101,434	82,853.79	37.43
OTHER WAGES & RELATED COSTS							
11.00	Contract labor: Direct Patient Care		5,451,010	0	5,451,010	125,819.93	43.32
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		576,909	0	576,909	3,949.00	146.09
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		7,010,518	0	7,010,518	147,516.00	47.52
14.02	Related organization salaries		0	0	0	0.00	0.00
15.00	Home office: Physician Part A - Administrative		0	0	0	0.00	0.00
16.00	Home office and Contract Physicians Part A - Teaching		0	0	0	0.00	0.00
16.01	Home office Physicians Part A - Teaching		0	0	0	0.00	0.00
16.02	Home office contract Physicians Part A - Teaching		0	0	0	0.00	0.00
WAGE-RELATED COSTS							
17.00	Wage-related costs (core) (see instructions)		7,669,346	0	7,669,346		
18.00	Wage-related costs (other) (see instructions)						
19.00	Excluded areas		720,208	0	720,208		
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		8,561	0	8,561		
22.01	Physician Part A - Teaching		0	0	0		
23.00	Physician Part B		0	0	0		
24.00	Wage-related costs (RHC/FQHC)		0	0	0		
25.00	Interns & residents (in an approved program)		0	0	0		
25.50	Home office wage-related (core)		1,139,560	0	1,139,560		
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: 14-0217

Period:
From 07/01/2019
To 06/30/2020Worksheet S-3
Part II
Date/Time Prepared:
11/28/2020 2:10 pm

		Wkst. A Line Number	Amount Reported	Reclassificati on of Salaries (from Wkst. A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
25.53	Home office: Physicians Part A - Teaching - wage-related (core)		0	0	0			25.53
OVERHEAD COSTS - DIRECT SALARIES								
26.00	Employee Benefits Department	4.00	216,557	0	216,557	3,441.32	62.93	26.00
27.00	Administrative & General	5.00	2,557,615	0	2,557,615	61,963.00	41.28	27.00
28.00	Administrative & General under contract (see inst.)		344,762	0	344,762	2,372.00	145.35	28.00
29.00	Maintenance & Repairs	6.00	0	0	0	0.00	0.00	29.00
30.00	Operation of Plant	7.00	627,929	0	627,929	30,106.81	20.86	30.00
31.00	Laundry & Linen Service	8.00	0	0	0	0.00	0.00	31.00
32.00	Housekeeping	9.00	0	0	0	0.00	0.00	32.00
33.00	Housekeeping under contract (see instructions)		1,616,838	0	1,616,838	66,348.44	24.37	33.00
34.00	Dietary	10.00	185,227	-99,848	85,379	1,646.63	51.85	34.00
35.00	Dietary under contract (see instructions)		2,076,270	-1,594,743	481,527	17,957.93	26.81	35.00
36.00	Cafeteria	11.00	0	142,269	142,269	2,432.97	58.48	36.00
37.00	Maintenance of Personnel	12.00	0	0	0	0.00	0.00	37.00
38.00	Nursing Administration	13.00	1,491,471	0	1,491,471	39,351.32	37.90	38.00
39.00	Central Services and Supply	14.00	349,743	0	349,743	14,850.38	23.55	39.00
40.00	Pharmacy	15.00	1,625,241	0	1,625,241	33,495.07	48.52	40.00
41.00	Medical Records & Medical Records Library	16.00	0	0	0	0.00	0.00	41.00
42.00	Social Service	17.00	0	0	0	0.00	0.00	42.00
43.00	Other General Service	18.00	0	0	0	0.00	0.00	43.00

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 14-0217

Period:
From 07/01/2019
To 06/30/2020Worksheet S-3
Part III
Date/Time Prepared:
11/28/2020 2:10 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)	40,348,016	-1,587,839	38,760,177	1,050,893.39	36.88	1.00
2.00	Excluded area salaries (see instructions)	3,308,525	-207,091	3,101,434	82,853.79	37.43	2.00
3.00	Subtotal salaries (line 1 minus line 2)	37,039,491	-1,380,748	35,658,743	968,039.60	36.84	3.00
4.00	Subtotal other wages & related costs (see inst.)	13,038,437	0	13,038,437	277,284.93	47.02	4.00
5.00	Subtotal wage-related costs (see inst.)	8,817,467	0	8,817,467	0.00	24.73	5.00
6.00	Total (sum of lines 3 thru 5)	58,895,395	-1,380,748	57,514,647	1,245,324.53	46.18	6.00
7.00	Total overhead cost (see instructions)	11,091,653	-1,552,322	9,539,331	273,965.87	34.82	7.00

HOSPITAL WAGE RELATED COSTS		Provider CCN: 14-0217	Period: From 07/01/2019 To 06/30/2020	Worksheet S-3 Part IV Date/Time Prepared: 11/28/2020 2:10 pm
				Amount Reported
				1.00
PART IV - WAGE RELATED COSTS				
Part A - Core List				
RETIREMENT COST				
1.00	401K Employer Contributions		1,111,461	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)		462,169	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)		4,233,231	8.02
8.03	Health Insurance (Purchased)		0	8.03
9.00	Prescription Drug Plan		0	9.00
10.00	Dental, Hearing and Vision Plan		-42,487	10.00
11.00	Life Insurance (If employee is owner or beneficiary)		-910,265	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)		83,779	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)		0	14.00
15.00	'Workers' Compensation Insurance		642,397	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		2,700,861	17.00
18.00	Medicare Taxes - Employers Portion Only		0	18.00
19.00	Unemployment Insurance		49,594	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		67,376	23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)		8,398,116	24.00
Part B - Other than Core Related Cost				
25.00	EMPLOYEE ACTIVITIES & ASSISTANCE PROG			25.00

HOSPITAL CONTRACT LABOR AND BENEFIT COST

Provider CCN: 14-0217

 Period:
 From 07/01/2019
 To 06/30/2020

 Worksheet S-3
 Part V
 Date/Time Prepared:
 11/28/2020 2:10 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	7,068,348	8,398,116	1.00
2.00	Hospital	7,068,348	8,398,116	2.00
3.00	Subprovider - IPF			3.00
4.00	Subprovider - IRF	0	0	4.00
5.00	Subprovider - (Other)	0	0	5.00
6.00	Swing Beds - SNF	0	0	6.00
7.00	Swing Beds - NF	0	0	7.00
8.00	Hospital-Based SNF			8.00
9.00	Hospital-Based NF			9.00
10.00	Hospital-Based OLTC			10.00
11.00	Hospital-Based HHA			11.00
12.00	Separately Certified ASC			12.00
13.00	Hospital-Based Hospice			13.00
14.00	Hospital-Based Health Clinic RHC			14.00
15.00	Hospital-Based Health Clinic FQHC			15.00
16.00	Hospital-Based-CMHC			16.00
17.00	Renal Dialysis	0	0	17.00
18.00	Other	0	0	18.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA

Provider CCN: 14-0217

Period:
From 07/01/2019
To 06/30/2020

Worksheet S-10

Date/Time Prepared:
11/28/2020 2:10 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)		0.193281	1.00
Medicaid (see instructions for each line)				
2.00	Net revenue from Medicaid		10,065,736	2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?		N	3.00
4.00	If line 3 is yes, does line 2 include all DSH and/or supplemental payments from Medicaid?			4.00
5.00	If line 4 is no, then enter DSH and/or supplemental payments from Medicaid		0	5.00
6.00	Medicaid charges		125,535,684	6.00
7.00	Medicaid cost (line 1 times line 6)		24,263,663	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)		14,197,927	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)		14,197,927	19.00
		Uninsured patients	Insured patients	Total (col. 1 + col. 2)
		1.00	2.00	3.00
Uncompensated Care (see instructions for each line)				
20.00	Charity care charges and uninsured discounts for the entire facility (see instructions)	29,370,748	1,132,883	30,503,631
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	5,676,808	1,132,883	6,809,691
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)	5,676,808	1,132,883	6,809,691
			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)		4,174,872	26.00
27.00	Medicare reimbursable bad debts for the entire hospital complex (see instructions)		435,179	27.00
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)		669,507	27.01
28.00	Non-Medicare bad debt expense (see instructions)		3,505,365	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)		911,848	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)		7,721,539	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)		21,919,466	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES				Provider CCN: 14-0217		Period: From 07/01/2019 To 06/30/2020		Worksheet A Date/Time Prepared: 11/28/2020 2:10 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		0	0	3,461,164	3,461,164	1.00	
2.00	00200	CAP REL COSTS-MVBLE EQUIP		1,719,379	1,719,379	2,630,964	4,350,343	2.00	
3.00	00300	OTHER CAP REL COSTS		50,243	50,243	-50,243	0	3.00	
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	216,557	5,678,306	5,894,863	0	5,894,863	4.00	
5.01	01160	COMMUNICATIONS	19,525	176,841	196,366	-5,843	190,523	5.01	
5.02	00560	PURCHASING RECEIVING AND STORES	0	12,133	12,133	0	12,133	5.02	
5.03	00570	ADMITTING	0	-271	-271	0	-271	5.03	
5.04	00580	CASHIERING/ACCOUNTS RECEIVABLE	0	0	0	0	0	5.04	
5.05	00590	OTHER ADMIN AND GENERAL	2,538,090	43,668,710	46,206,800	-1,728,783	44,478,017	5.05	
6.00	00600	MAINTENANCE & REPAIRS	0	1,915,150	1,915,150	-26,124	1,889,026	6.00	
7.00	00700	OPERATION OF PLANT	627,929	2,283,939	2,911,868	-137,594	2,774,274	7.00	
8.00	00800	LAUNDRY & LINEN SERVICE	0	355,354	355,354	0	355,354	8.00	
9.00	00900	HOUSEKEEPING	0	2,007,819	2,007,819	-6,295	2,001,524	9.00	
10.00	01000	DIETARY	185,227	3,035,295	3,220,522	-2,429,629	790,893	10.00	
11.00	01100	CAFETERIA	0	0	0	2,468,297	2,468,297	11.00	
13.00	01300	NURSING ADMINISTRATION	1,491,471	742,474	2,233,945	-539,441	1,694,504	13.00	
14.00	01400	CENTRAL SERVICES & SUPPLY	349,743	1,095,750	1,445,493	-584,233	861,260	14.00	
15.00	01500	PHARMACY	1,625,241	7,949,392	9,574,633	-7,774,998	1,799,635	15.00	
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	0	16.00	
23.00	02300	PARAMED ED PRGM-AMBULANCE	213,995	81,685	295,680	-295,680	0	23.00	
INPATIENT ROUTINE SERVICE COST CENTERS									
30.00	03000	ADULTS & PEDIATRICS	9,387,520	1,676,110	11,063,630	-352,292	10,711,338	30.00	
31.00	03100	INTENSIVE CARE UNIT	2,078,075	1,383,705	3,461,780	-270,585	3,191,195	31.00	
41.00	04100	SUBPROVIDER - IRF	3,047,605	1,484,351	4,531,956	-926,045	3,605,911	41.00	
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM	1,340,134	9,403,471	10,743,605	-8,035,074	2,708,531	50.00	
51.00	05100	RECOVERY ROOM	1,769,987	305,515	2,075,502	-120,928	1,954,574	51.00	
53.00	05300	ANESTHESIOLOGY	57,572	2,107,502	2,165,074	-137,878	2,027,196	53.00	
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,874,672	858,909	2,733,581	-255,702	2,477,879	54.00	
54.01	03650	VASCULAR LAB	447,278	213,270	660,548	-134,862	525,686	54.01	
55.00	05500	RADIOLOGY-THERAPEUTIC	838,236	1,677,596	2,515,832	-769,663	1,746,169	55.00	
57.00	05700	CT SCAN	409,724	283,110	692,834	-31,900	660,934	57.00	
58.00	05800	MRI	155,922	181,186	337,108	-42,078	295,030	58.00	
59.00	05900	CARDIAC CATHETERIZATION	1,098,166	3,896,544	4,994,710	-3,429,888	1,564,822	59.00	
60.00	06000	LABORATORY	0	4,607,736	4,607,736	-86,716	4,521,020	60.00	
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	457,392	457,392	0	457,392	62.00	
65.00	06500	RESPIRATORY THERAPY	927,661	274,065	1,201,726	-133,533	1,068,193	65.00	
66.00	06600	PHYSICAL THERAPY	1,286,989	1,275,767	2,562,756	154,342	2,717,098	66.00	
67.00	06700	OCCUPATIONAL THERAPY	174,201	17,843	192,044	422,007	614,051	67.00	
68.00	06800	SPEECH PATHOLOGY	142,720	6,871	149,591	203,101	352,692	68.00	
69.00	06900	ELECTROCARDIOLOGY	531,652	107,295	638,947	-55,455	583,492	69.00	
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	8,744,873	8,744,873	71.00	
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	5,071,434	5,071,434	72.00	
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	7,640,240	7,640,240	73.00	
74.00	07400	RENAL DIALYSIS	0	551,355	551,355	-567	550,788	74.00	
76.00	03950	OTHER ANCILLARY SERVICES COST CENTE	0	0	0	0	0	76.00	
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	337,771	24,217	361,988	0	361,988	76.02	
76.03	03951	OCCUPATIONAL HEALTH	0	0	0	0	0	76.03	
76.97	07697	CARDIAC REHABILITATION	179,654	42,717	222,371	-11,174	211,197	76.97	
76.98	07698	HYPERBARIC OXYGEN THERAPY	87,464	1,054,835	1,142,299	-429,284	713,015	76.98	
OUTPATIENT SERVICE COST CENTERS									
90.01	09001	OUTPATIENT PROCEDURES	0	0	0	0	0	90.01	
91.00	09100	EMERGENCY	2,780,019	2,994,183	5,774,202	-105,341	5,668,861	91.00	
91.01	09101	C'VILLE OUT	0	0	0	0	0	91.01	
91.02	09102	LAKE HILL OUT	0	0	0	0	0	91.02	
91.03	09103	NUTRITION COUNSELING	42,421	3,006	45,427	-45,427	0	91.03	
91.04	09104	HUNTLEY OP	0	0	0	0	0	91.04	
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00	
SPECIAL PURPOSE COST CENTERS									
113.00	11300	INTEREST EXPENSE		1,843,167	1,843,167	-1,843,167	0	113.00	
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	36,263,221	107,503,917	143,767,138	0	143,767,138	118.00	
NONREIMBURSABLE COST CENTERS									
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00	
194.00	07950	MISC NONREIMBURSABLE COST CENTER	-6,904	153,091	146,187	0	146,187	194.00	
194.01	07951	MOB	0	278,228	278,228	0	278,228	194.01	
194.02	07952	COMMUNITY WELLNESS	53,309	4,644	57,953	0	57,953	194.02	
194.03	07953	FUND DEVELOPMENT	0	0	0	0	0	194.03	
194.04	07954	PHYSICIAN PRACTICE MANAGEMENT	520	2	522	0	522	194.04	
200.00		TOTAL (SUM OF LINES 118 through 199)	36,310,146	107,939,882	144,250,028	0	144,250,028	200.00	

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-0217

Period:
From 07/01/2019
To 06/30/2020

Worksheet A

Date/Time Prepared:
11/28/2020 2:10 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	-138,654	3,322,510	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	545,994	4,896,337	2.00
3.00	00300	OTHER CAP REL COSTS	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	309,261	6,204,124	4.00
5.01	01160	COMMUNICATIONS	0	190,523	5.01
5.02	00560	PURCHASING RECEIVING AND STORES	0	12,133	5.02
5.03	00570	ADMITTING	573,643	573,372	5.03
5.04	00580	CASHIERING/ACCOUNTS RECEIVABLE	6,725,381	6,725,381	5.04
5.05	00590	OTHER ADMIN AND GENERAL	1,680,570	46,158,587	5.05
6.00	00600	MAINTENANCE & REPAIRS	215,652	2,104,678	6.00
7.00	00700	OPERATION OF PLANT	0	2,774,274	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	355,354	8.00
9.00	00900	HOUSEKEEPING	0	2,001,524	9.00
10.00	01000	DIETARY	0	790,893	10.00
11.00	01100	CAFETERIA	-386,743	2,081,554	11.00
13.00	01300	NURSING ADMINISTRATION	82,678	1,777,182	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	861,260	14.00
15.00	01500	PHARMACY	172,840	1,972,475	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	44,554	44,554	16.00
23.00	02300	PARAMED ED PRGM-AMBULANCE	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	-55,101	10,656,237	30.00
31.00	03100	INTENSIVE CARE UNIT	-402,340	2,788,855	31.00
41.00	04100	SUBPROVIDER - IRF	0	3,605,911	41.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	2,708,531	50.00
51.00	05100	RECOVERY ROOM	0	1,954,574	51.00
53.00	05300	ANESTHESIOLOGY	-1,950,000	77,196	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-27,296	2,450,583	54.00
54.01	03650	VASCULAR LAB	0	525,686	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	-138,737	1,607,432	55.00
57.00	05700	CT SCAN	-1,181	659,753	57.00
58.00	05800	MRI	0	295,030	58.00
59.00	05900	CARDIAC CATHETERIZATION	-42,830	1,521,992	59.00
60.00	06000	LABORATORY	81,926	4,602,946	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	457,392	62.00
65.00	06500	RESPIRATORY THERAPY	0	1,068,193	65.00
66.00	06600	PHYSICAL THERAPY	0	2,717,098	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	614,051	67.00
68.00	06800	SPEECH PATHOLOGY	0	352,692	68.00
69.00	06900	ELECTROCARDIOLOGY	0	583,492	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	8,744,873	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	5,071,434	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	7,640,240	73.00
74.00	07400	RENAL DIALYSIS	0	550,788	74.00
76.00	03950	OTHER ANCILLARY SERVICES COST CENTE	0	0	76.00
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	361,988	76.02
76.03	03951	OCCUPATIONAL HEALTH	0	0	76.03
76.97	07697	CARDIAC REHABILITATION	0	211,197	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	-3,231	709,784	76.98
OUTPATIENT SERVICE COST CENTERS					
90.01	09001	OUTPATIENT PROCEDURES	0	0	90.01
91.00	09100	EMERGENCY	-2,171,934	3,496,927	91.00
91.01	09101	C'VILLE OUT	0	0	91.01
91.02	09102	LAKE HILL OUT	0	0	91.02
91.03	09103	NUTRITION COUNSELING	0	0	91.03
91.04	09104	HUNTLEY OP	0	0	91.04
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	92.00
SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE	0	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	5,114,452	148,881,590	118.00
NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	190.00
194.00	07950	MISC NONREIMBURSABLE COST CENTER	0	146,187	194.00
194.01	07951	MOB	0	278,228	194.01
194.02	07952	COMMUNITY WELLNESS	0	57,953	194.02
194.03	07953	FUND DEVELOPMENT	0	0	194.03
194.04	07954	PHYSICIAN PRACTICE MANAGEMENT	0	522	194.04
200.00		TOTAL (SUM OF LINES 118 through 199)	5,114,452	149,364,480	200.00

RECLASSIFICATIONS

Provider CCN: 14-0217

Period:
From 07/01/2019
To 06/30/2020Worksheet A-6
Date/Time Prepared:
11/28/2020 2:10 pm

		Increases				
Cost Center		Line #	Salary	Other		
2.00		3.00	4.00	5.00		
A - CAFETERIA						
1.00	CAFETERIA	11.00	142,269	2,326,028		1.00
	0		142,269	2,326,028		
B - EQUIP DEPR						
1.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	3,624,148		1.00
2.00	CAP REL COSTS-BLDG & FIXT	1.00	0	2,293,949		2.00
3.00	SPEECH PATHOLOGY	68.00	0	3,911		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
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
26.00		0.00	0	0		26.00
27.00		0.00	0	0		27.00
28.00		0.00	0	0		28.00
31.00		0.00	0	0		31.00
	0		0	5,922,008		
C - OTHER RECLASSIFICATIONS						
1.00	MISC NONREIMBURSABLE COST CENTER	194.00	6,904	0		1.00
2.00	DIETARY	10.00	42,421	3,006		2.00
	TOTALS		49,325	3,006		
E - REHAB CARE RECLASSIFICATION						
1.00	OCCUPATIONAL THERAPY	67.00	0	100,173		1.00
2.00	SPEECH PATHOLOGY	68.00	0	80,046		2.00
3.00	PHYSICAL THERAPY	66.00	0	361,928		3.00
4.00	OCCUPATIONAL THERAPY	67.00	0	323,844		4.00
5.00	SPEECH PATHOLOGY	68.00	0	119,144		5.00
	TOTALS		0	985,135		
H - INTEREST EXPENSE						
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	1,128,726		1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	714,441		2.00
	0		0	1,843,167		
I - EMS TRAINING COSTS						
1.00	EMERGENCY	91.00	213,995	71,316		1.00
	0		213,995	71,316		
K - DRUG COSTS						
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	7,640,240		1.00
	0		0	7,640,240		
L - IMPLANTS						
1.00	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	5,071,434		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
	0		0	5,071,434		

RECLASSIFICATIONS

Provider CCN: 14-0217

Period:
From 07/01/2019
To 06/30/2020

Worksheet A-6

Date/Time Prepared:
11/28/2020 2:10 pm

	Increases					
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
	M - BILLABLE SUPPLIES					
1.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	9,209,855		1.00
2.00	CENTRAL SERVICES & SUPPLY	14.00	0	19,458		2.00
3.00	OPERATING ROOM	50.00	0	103,812		3.00
4.00	RADIOLOGY-DIAGNOSTIC	54.00	0	1,021		4.00
5.00	CARDIAC CATHETERIZATION	59.00	0	340,691		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
	0		0	9,674,837		
500.00	Grand Total: Increases		405,589	33,537,171		500.00

RECLASSIFICATIONS

Provider CCN: 14-0217

Period:
From 07/01/2019
To 06/30/2020

Worksheet A-6

Date/Time Prepared:
11/28/2020 2:10 pm

	Decreases						
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	A - CAFETERIA						
1.00	DIETARY	10.00	142,269	2,326,028	0		1.00
	0		142,269	2,326,028			
	B - EQUIP DEPR						
1.00	COMMUNICATIONS	5.01	0	5,843	9		1.00
2.00	OTHER ADMIN AND GENERAL	5.05	0	1,728,783	9		2.00
3.00	MAINTENANCE & REPAIRS	6.00	0	26,124	0		3.00
4.00	OPERATION OF PLANT	7.00	0	137,594	0		4.00
5.00	HOUSEKEEPING	9.00	0	6,295	0		5.00
6.00	DIETARY	10.00	0	6,759	0		6.00
7.00	NURSING ADMINISTRATION	13.00	0	539,441	0		7.00
8.00	CENTRAL SERVICES & SUPPLY	14.00	0	98,575	0		8.00
10.00	PARAMED ED PRGM-AMBULANCE	23.00	0	7,564	0		10.00
11.00	ADULTS & PEDIATRICS	30.00	0	17,572	0		11.00
12.00	INTENSIVE CARE UNIT	31.00	0	53,142	0		12.00
13.00	SUBPROVIDER - IRF	41.00	0	6,279	0		13.00
14.00	OPERATING ROOM	50.00	0	332,464	0		14.00
15.00	ANESTHESIOLOGY	53.00	0	23,158	0		15.00
16.00	RADIOLOGY-DIAGNOSTIC	54.00	0	170,206	0		16.00
17.00	VASCULAR LAB	54.01	0	13,735	0		17.00
18.00	RADIOLOGY-THERAPEUTIC	55.00	0	657,096	0		18.00
19.00	CT SCAN	57.00	0	154	0		19.00
20.00	MRI	58.00	0	20,613	0		20.00
21.00	CARDIAC CATHETERIZATION	59.00	0	193,011	0		21.00
22.00	LABORATORY	60.00	0	74,864	0		22.00
23.00	RESPIRATORY THERAPY	65.00	0	9,023	0		23.00
24.00	PHYSICAL THERAPY	66.00	0	9,410	0		24.00
26.00	ELECTROCARDIOLOGY	69.00	0	25,067	0		26.00
27.00	CARDIAC REHABILITATION	76.97	0	9,939	0		27.00
28.00	EMERGENCY	91.00	0	29,918	0		28.00
31.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	1,719,379	9		31.00
	0		0	5,922,008			
	C - OTHER RECLASSIFICATIONS						
1.00	MISC NONREIMBURSABLE COST CENTER	194.00	0	6,904	0		1.00
2.00	NUTRITION COUNSELING	91.03	42,421	3,006	0		2.00
	TOTALS		42,421	9,910			
	E - REHAB CARE RECLASSIFICATION						
1.00	PHYSICAL THERAPY	66.00	0	100,173	0		1.00
2.00	PHYSICAL THERAPY	66.00	0	80,046	0		2.00
3.00	SUBPROVIDER - IRF	41.00	0	361,928	0		3.00
4.00	SUBPROVIDER - IRF	41.00	0	323,844	0		4.00
5.00	SUBPROVIDER - IRF	41.00	0	119,144	0		5.00
	TOTALS		0	985,135			
	H - INTEREST EXPENSE						
1.00	INTEREST EXPENSE	113.00	0	1,843,167	11		1.00
2.00		0.00	0	0	11		2.00
	0		0	1,843,167			
	I - EMS TRAINING COSTS						
1.00	PARAMED ED PRGM-AMBULANCE	23.00	213,995	71,316	0		1.00
	0		213,995	71,316			
	K - DRUG COSTS						
1.00	PHARMACY	15.00	0	7,640,240	0		1.00
	0		0	7,640,240			
	L - IMPLANTS						
1.00	CENTRAL SERVICES & SUPPLY	14.00	0	59,217	0		1.00
2.00	ADULTS & PEDIATRICS	30.00	0	1,064	0		2.00
3.00	INTENSIVE CARE UNIT	31.00	0	6,466	0		3.00
4.00	SUBPROVIDER - IRF	41.00	0	139	0		4.00
5.00	OPERATING ROOM	50.00	0	3,675,375	0		5.00
6.00	RECOVERY ROOM	51.00	0	275	0		6.00
7.00	ANESTHESIOLOGY	53.00	0	382	0		7.00
8.00	RADIOLOGY-DIAGNOSTIC	54.00	0	71	0		8.00
9.00	VASCULAR LAB	54.01	0	242	0		9.00
10.00	RADIOLOGY-THERAPEUTIC	55.00	0	112	0		10.00
11.00	CT SCAN	57.00	0	3,216	0		11.00
12.00	CARDIAC CATHETERIZATION	59.00	0	1,022,276	0		12.00
13.00	PHYSICAL THERAPY	66.00	0	503	0		13.00
14.00	ELECTROCARDIOLOGY	69.00	0	502	0		14.00
15.00	HYPERBARIC OXYGEN THERAPY	76.98	0	288,895	0		15.00
16.00	EMERGENCY	91.00	0	12,699	0		16.00
	0		0	5,071,434			

RECLASSIFICATIONS

Provider CCN: 14-0217

Period:
From 07/01/2019
To 06/30/2020Worksheet A-6
Date/Time Prepared:
11/28/2020 2:10 pm

	Decreases				Wkst. A-7 Ref.		
	Cost Center	Line #	Salary	Other			
	6.00	7.00	8.00	9.00	10.00		
	M - BILLABLE SUPPLIES						
1.00	CENTRAL SERVICES & SUPPLY	14.00	0	445,899	0		1.00
2.00	PHARMACY	15.00	0	134,758	0		2.00
3.00	PARAMED ED PRGM-AMBULANCE	23.00	0	2,805	0		3.00
4.00	ADULTS & PEDIATRICS	30.00	0	333,656	0		4.00
5.00	INTENSIVE CARE UNIT	31.00	0	210,977	0		5.00
6.00	SUBPROVIDER - IRF	41.00	0	114,711	0		6.00
7.00	OPERATING ROOM	50.00	0	4,131,047	0		7.00
8.00	RECOVERY ROOM	51.00	0	120,653	0		8.00
9.00	ANESTHESIOLOGY	53.00	0	114,338	0		9.00
10.00	RADIOLOGY-DIAGNOSTIC	54.00	0	86,446	0		10.00
11.00	VASCULAR LAB	54.01	0	120,885	0		11.00
12.00	RADIOLOGY-THERAPEUTIC	55.00	0	112,455	0		12.00
13.00	CT SCAN	57.00	0	28,530	0		13.00
14.00	MRI	58.00	0	21,465	0		14.00
15.00	CARDIAC CATHETERIZATION	59.00	0	2,555,292	0		15.00
16.00	LABORATORY	60.00	0	11,852	0		16.00
17.00	RESPIRATORY THERAPY	65.00	0	124,510	0		17.00
18.00	PHYSICAL THERAPY	66.00	0	17,454	0		18.00
19.00	OCCUPATIONAL THERAPY	67.00	0	2,010	0		19.00
20.00	ELECTROCARDIOLOGY	69.00	0	29,886	0		20.00
21.00	RENAL DIALYSIS	74.00	0	567	0		21.00
22.00	CARDIAC REHABILITATION	76.97	0	1,235	0		22.00
23.00	HYPERBARIC OXYGEN THERAPY	76.98	0	140,389	0		23.00
24.00	EMERGENCY	91.00	0	348,035	0		24.00
25.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	464,982	0		25.00
	0		0	9,674,837			
500.00	Grand Total: Decreases		398,685	33,544,075			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-0217

Period:
From 07/01/2019
To 06/30/2020Worksheet A-7
Part I
Date/Time Prepared:
11/28/2020 2:10 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	5,020,000	0	0	0	0	1.00	
2.00	Land Improvements	1,271,500	5,994	0	5,994	0	2.00	
3.00	Buildings and Fixtures	47,271,518	2,093,136	0	2,093,136	0	3.00	
4.00	Building Improvements	15,000	0	0	0	0	4.00	
5.00	Fixed Equipment	0	481,182	0	481,182	0	5.00	
6.00	Movable Equipment	87,059	14,902,292	0	14,902,292	0	6.00	
7.00	HIT designated Assets	0	0	0	0	0	7.00	
8.00	Subtotal (sum of lines 1-7)	53,665,077	17,482,604	0	17,482,604	0	8.00	
9.00	Reconciling Items	0	0	0	0	0	9.00	
10.00	Total (line 8 minus line 9)	53,665,077	17,482,604	0	17,482,604	0	10.00	
		Ending Balance	Fully Depreciated Assets					
		6.00	7.00					
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES							
1.00	Land	5,020,000	0				1.00	
2.00	Land Improvements	1,277,494	0				2.00	
3.00	Buildings and Fixtures	49,364,654	0				3.00	
4.00	Building Improvements	15,000	0				4.00	
5.00	Fixed Equipment	481,182	0				5.00	
6.00	Movable Equipment	14,989,351	0				6.00	
7.00	HIT designated Assets	0	0				7.00	
8.00	Subtotal (sum of lines 1-7)	71,147,681	0				8.00	
9.00	Reconciling Items	0	0				9.00	
10.00	Total (line 8 minus line 9)	71,147,681	0				10.00	

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-0217

Period:
From 07/01/2019
To 06/30/2020Worksheet A-7
Part II
Date/Time Prepared:
11/28/2020 2:10 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	0	0	0	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	1,719,379	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	1,719,379	0	0	0	0	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)				
		14.00	15.00				
		PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2					
1.00	CAP REL COSTS-BLDG & FIXT	0	0				1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	1,719,379				2.00
3.00	Total (sum of lines 1-2)	0	1,719,379				3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-0217

Period:
From 07/01/2019
To 06/30/2020Worksheet A-7
Part III
Date/Time Prepared:
11/28/2020 2:10 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	50,657,148	0	50,657,148	0.766051	38,489	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	15,470,533	0	15,470,533	0.233949	11,754	2.00
3.00	Total (sum of lines 1-2)	66,127,681	0	66,127,681	1.000000	50,243	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	38,489	1,829,898	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	11,754	3,964,178	0	2.00
3.00	Total (sum of lines 1-2)	0	0	50,243	5,794,076	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	1,454,123	38,489	0	0	3,322,510	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	920,405	11,754	0	0	4,896,337	2.00
3.00	Total (sum of lines 1-2)	2,374,528	50,243	0	0	8,218,847	3.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 14-0217

Period:
From 07/01/2019
To 06/30/2020

Worksheet A-8

Date/Time Prepared:
11/28/2020 2:10 pm

Cost Center Description		Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted		Wkst. A-7 Ref.	
				Cost Center	Line #		
1.00				3.00	4.00	5.00	
1.00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)			0CAP REL COSTS-BLDG & FIXT	1.00	0	1.00
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)			0CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
3.00	Investment income - other (chapter 2)		0		0.00	0	3.00
4.00	Trade, quantity, and time discounts (chapter 8)		0		0.00	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)		0		0.00	0	5.00
6.00	Rental of provider space by suppliers (chapter 8)		0		0.00	0	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)		0		0.00	0	7.00
8.00	Television and radio service (chapter 21)		0		0.00	0	8.00
9.00	Parking lot (chapter 21)		0		0.00	0	9.00
10.00	Provider-based physician adjustment	A-8-2	-6,282,062			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	12,140,372			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests	B	-386,658	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		0		0.00	0	18.00
19.00	Nursing and allied health education (tuition, fees, books, etc.)		0		0.00	0	19.00
20.00	Vending machines	B	-85	CAFETERIA	11.00	0	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	0	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	RESPIRATORY THERAPY	65.00		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	PHYSICAL THERAPY	66.00		24.00
25.00	Utilization review - physicians' compensation (chapter 21)		0	*** Cost Center Deleted ***	114.00		25.00
26.00	Depreciation - CAP REL COSTS-BLDG & FIXT	A	-464,051	CAP REL COSTS-BLDG & FIXT	1.00	9	26.00
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP	A	340,030	CAP REL COSTS-MVBLE EQUIP	2.00	9	27.00
28.00	Non-physician Anesthetist		0	*** Cost Center Deleted ***	19.00		28.00
29.00	Physicians' assistant		0		0.00	0	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	OCCUPATIONAL THERAPY	67.00		30.00
30.99	Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS	30.00		30.99
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	SPEECH PATHOLOGY	68.00		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest		0		0.00	0	32.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 14-0217

Period:
From 07/01/2019
To 06/30/2020

Worksheet A-8

Date/Time Prepared:
11/28/2020 2:10 pm

Cost Center Description		Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted		Wkst. A-7 Ref.	
				Cost Center	Line #		
		1.00	2.00	3.00	4.00	5.00	
33.00	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	33.00
34.01	MISC REVENUE	B	-58,338	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	34.01
34.02	MISC REVENUE	B	-44,402	OTHER ADMIN AND GENERAL	5.05	0	34.02
34.03	PARAMEDIC PROGRAM	B	-62,496	EMERGENCY	91.00	0	34.03
34.05	MISC REVENUE	B	-32,480	ADULTS & PEDIATRICS	30.00	0	34.05
34.06	MISC REVENUE	B	-148	RADIOLOGY-DIAGNOSTIC	54.00	0	34.06
34.07	CHARITABLE EXPENSE	A	-1,752	OTHER ADMIN AND GENERAL	5.05	0	34.07
34.08	INCOME TAX FEDERAL	A	-18,438	OTHER ADMIN AND GENERAL	5.05	0	34.08
34.10	MARKETING	A	-9,093	OTHER ADMIN AND GENERAL	5.05	0	34.10
35.00	MARKETING	A	-1,053	NURSING ADMINISTRATION	13.00	0	35.00
35.10	PROMOTIONAL ITEMS	A	-3,713	RADIOLOGY-DIAGNOSTIC	54.00	0	35.10
36.00	PROMOTIONAL ITEMS	A	-1,181	CT SCAN	57.00	0	36.00
37.00	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	37.00
38.00	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	38.00
39.00	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	39.00
40.00	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	40.00
41.00	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	41.00
42.00	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	42.00
43.00	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	43.00
44.00	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	44.00
45.00	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	45.00
46.00	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	46.00
47.00	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	47.00
48.00	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	48.00
49.00	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	49.00
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		5,114,452				50.00

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

(2) Basis for adjustment (see instructions).

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

B. Amount Received - if cost cannot be determined.

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

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

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

Provider CCN: 14-0217

Period:
From 07/01/2019
To 06/30/2020

Worksheet A-8-1

Date/Time Prepared:
11/28/2020 2:10 pm

	Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in wks. A, column 5	
	1.00	2.00	3.00	4.00	5.00	
A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:						
1.00		1.00	CAP REL COSTS-BLDG & FIXT	INTEREST EXPENSE	1,086,431	0 1.00
2.00		2.00	CAP REL COSTS-MVBLE EQUIP	INTEREST EXPENSE	687,670	0 2.00
3.00		1.00	CAP REL COSTS-BLDG & FIXT	INTEREST INCOME	-761,034	0 3.00
3.01		2.00	CAP REL COSTS-MVBLE EQUIP	INTERST INCOME	-481,706	0 3.01
3.02		5.05	OTHER ADMIN AND GENERAL	PROJECT SYMPHONY	122,612	21,568,278 3.02
3.03		5.05	OTHER ADMIN AND GENERAL	RESOURCE GROUP	-227,821	0 3.03
3.04		5.05	OTHER ADMIN AND GENERAL	INFO SERVICES	7,362,325	0 3.04
3.05		5.05	OTHER ADMIN AND GENERAL	ACO OPERATIONS	119,067	0 3.05
3.06		5.03	ADMITTING	CALL CENTER AND CENTRAL SCHE	450,151	0 3.06
3.07		5.05	OTHER ADMIN AND GENERAL	CLINICAL INFORMATICS	14,595	0 3.07
3.08		5.05	OTHER ADMIN AND GENERAL	CREDENTIALING	36,104	0 3.08
3.09		5.05	OTHER ADMIN AND GENERAL	QUALITY MANAGEMENT	1,040,878	0 3.09
3.10		5.03	ADMITTING	BEHAVIORAL HEALTH INTAKE	67,415	0 3.10
3.11		15.00	PHARMACY	PHARMACY ADMIN	172,840	0 3.11
3.12		5.04	CASHIERING/ACCOUNTS RECEIVAB	REVENUE CYCLE MGMT	6,725,381	0 3.12
3.13		5.03	ADMITTING	PT ACCESS CONTACT CENTER	56,077	0 3.13
3.14		5.05	OTHER ADMIN AND GENERAL	MEDICAL AFFAIRS ADMIN	163,621	0 3.14
3.15		5.05	OTHER ADMIN AND GENERAL	MANAGED CARE CONTRACTING	103,704	0 3.15
3.16		13.00	NURSING ADMINISTRATION	NURSING ADMINISTRATION	83,731	0 3.16
3.17		6.00	MAINTENANCE & REPAIRS	FACILITIES	215,652	0 3.17
3.18		5.05	OTHER ADMIN AND GENERAL	SERVICE LINES	423,265	0 3.18
4.00		31.00	INTENSIVE CARE UNIT	TELE ICU	430,872	0 4.00
4.01		4.00	EMPLOYEE BENEFITS DEPARTMENT	HUMAN RESOURCES	279,266	0 4.01
4.02		16.00	MEDICAL RECORDS & LIBRARY	HEALTH INFORMATION MGMT	44,554	0 4.02
4.03		5.05	OTHER ADMIN AND GENERAL	CASE MANAGEMENT	172,840	0 4.03
4.04		5.05	OTHER ADMIN AND GENERAL	BIOMED ENG	880,330	0 4.04
4.05		5.05	OTHER ADMIN AND GENERAL	POOLED NON CAPITAL	14,019,151	0 4.05
4.06		4.00	EMPLOYEE BENEFITS DEPARTMENT	WORKERS COMPENSATION IC CO	642,397	554,064 4.06
4.07		5.05	OTHER ADMIN AND GENERAL	INSURANCE	1,562,497	1,347,913 4.07
4.08		0.00			0	0 4.08
4.09		0.00			0	0 4.09
4.10		60.00	LABORATORY	LAB	4,549,791	4,432,029 4.10
5.00			TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.		40,042,656	27,902,284 5.00

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

Symbol (1)	Name	Percentage of Ownership	Related Organization(s) and/or Home Office	
			Name	Percentage of Ownership
1.00	2.00	3.00	4.00	5.00

B. INTERRELATIONSHIP TO RELATED ORGANIZATION(S) AND/OR HOME OFFICE:

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

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

6.00	B	100.00	PRESENCE CARE	100.00	6.00
7.00	C	0.00	ALVERNO LABS	66.67	7.00
8.00		0.00		0.00	8.00
9.00		0.00		0.00	9.00
10.00		0.00		0.00	10.00
100.00	G. Other (financial or non-financial) specify:				100.00

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

Provider CCN: 14-0217

Period:
From 07/01/2019
To 06/30/2020

Worksheet A-8-1

Date/Time Prepared:
11/28/2020 2:10 pm

	Symbol (1)	Name	Percentage of Ownership	Related Organization(s) and/or Home Office	
				Name	Percentage of Ownership
	1.00	2.00	3.00	4.00	5.00

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

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

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

Provider CCN: 14-0217

Period:
From 07/01/2019
To 06/30/2020

Worksheet A-8-1

Date/Time Prepared:
11/28/2020 2:10 pm

	Net Adjustments (col. 4 minus col. 5)*	Wkst. A-7 Ref.		
	6.00	7.00		
A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:				
1.00	1,086,431	11		1.00
2.00	687,670	11		2.00
3.00	-761,034	11		3.00
3.01	-481,706	11		3.01
3.02	-21,445,666	0		3.02
3.03	-227,821	0		3.03
3.04	7,362,325	0		3.04
3.05	119,067	0		3.05
3.06	450,151	0		3.06
3.07	14,595	0		3.07
3.08	36,104	0		3.08
3.09	1,040,878	0		3.09
3.10	67,415	0		3.10
3.11	172,840	0		3.11
3.12	6,725,381	0		3.12
3.13	56,077	0		3.13
3.14	163,621	0		3.14
3.15	103,704	0		3.15
3.16	83,731	0		3.16
3.17	215,652	9		3.17
3.18	423,265	0		3.18
4.00	430,872	0		4.00
4.01	279,266	0		4.01
4.02	44,554	0		4.02
4.03	172,840	0		4.03
4.04	880,330	0		4.04
4.05	14,019,151	9		4.05
4.06	88,333	0		4.06
4.07	214,584	0		4.07
4.08	0	0		4.08
4.09	0	0		4.09
4.10	117,762	0		4.10
5.00	12,140,372			5.00

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

	Related Organization(s) and/or Home Office	
	Type of Business	
	6.00	

B. INTERRELATIONSHIP TO RELATED ORGANIZATION(S) AND/OR HOME OFFICE:

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

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

6.00	HOME OFFICE	6.00
7.00	LABORATORY	7.00
8.00		8.00
9.00		9.00
10.00		10.00
100.00		100.00

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

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

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 14-0217

Period:
From 07/01/2019
To 06/30/2020

Worksheet A-8-2

Date/Time Prepared:
11/28/2020 2:10 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	5.05	OTHER ADMIN AND GENERAL	8,638	0	8,638	211,500	56	1.00
2.00	30.00	ADULTS & PEDIATRICS	54,000	0	54,000	181,300	360	2.00
3.00	31.00	INTENSIVE CARE UNIT	621,622	616,472	5,150	181,300	37	3.00
4.00	41.00	SUBPROVIDER - IRF	73,400	0	73,400	181,300	900	4.00
5.00	5.05	OTHER ADMIN AND GENERAL	1,089,775	1,089,775	0	0	0	5.00
6.00	54.00	RADIOLOGY-DIAGNOSTIC	89,268	0	89,268	271,900	604	6.00
7.00	55.00	RADIOLOGY-THERAPEUTIC	245,013	99,998	145,015	271,900	813	7.00
8.00	59.00	CARDIAC CATHETERIZATION	34,513	0	34,513	271,900	235	8.00
9.00	60.00	LABORATORY	51,000	0	51,000	271,900	116	9.00
10.00	76.98	HYPERBARIC OXYGEN THERAPY	19,500	0	19,500	260,300	130	10.00
11.00	91.00	EMERGENCY	231,918	135,493	96,425	260,300	698	11.00
12.00	31.00	INTENSIVE CARE UNIT	214,815	214,815	0	0	0	12.00
13.00	53.00	ANESTHESIOLOGY	1,950,000	1,950,000	0	0	0	13.00
14.00	54.00	RADIOLOGY-DIAGNOSTIC	12,467	12,467	0	0	0	14.00
15.00	59.00	CARDIAC CATHETERIZATION	33,675	33,675	0	0	0	15.00
16.00	91.00	EMERGENCY	1,964,747	1,964,747	0	0	0	16.00
17.00	5.05	OTHER ADMIN AND GENERAL	93,046	0	93,046	211,500	620	17.00
18.00	54.00	RADIOLOGY-DIAGNOSTIC	5,100	0	5,100	271,900	34	18.00
19.00	59.00	CARDIAC CATHETERIZATION	42,225	0	42,225	271,900	282	19.00
20.00	91.00	EMERGENCY	1,000	0	1,000	260,300	7	20.00
200.00			6,835,722	6,117,442	718,280		4,892	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	5.05	OTHER ADMIN AND GENERAL	5,694	285	0	0	0	1.00
2.00	30.00	ADULTS & PEDIATRICS	31,379	1,569	0	0	0	2.00
3.00	31.00	INTENSIVE CARE UNIT	3,225	161	0	0	0	3.00
4.00	41.00	SUBPROVIDER - IRF	78,447	3,922	0	0	0	4.00
5.00	5.05	OTHER ADMIN AND GENERAL	0	0	0	0	0	5.00
6.00	54.00	RADIOLOGY-DIAGNOSTIC	78,956	3,948	0	0	0	6.00
7.00	55.00	RADIOLOGY-THERAPEUTIC	106,276	5,314	0	0	0	7.00
8.00	59.00	CARDIAC CATHETERIZATION	30,720	1,536	0	0	0	8.00
9.00	60.00	LABORATORY	15,164	758	0	0	0	9.00
10.00	76.98	HYPERBARIC OXYGEN THERAPY	16,269	813	0	0	0	10.00
11.00	91.00	EMERGENCY	87,351	4,368	0	0	0	11.00
12.00	31.00	INTENSIVE CARE UNIT	0	0	0	0	0	12.00
13.00	53.00	ANESTHESIOLOGY	0	0	0	0	0	13.00
14.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	14.00
15.00	59.00	CARDIAC CATHETERIZATION	0	0	0	0	0	15.00
16.00	91.00	EMERGENCY	0	0	0	0	0	16.00
17.00	5.05	OTHER ADMIN AND GENERAL	63,043	3,152	0	0	0	17.00
18.00	54.00	RADIOLOGY-DIAGNOSTIC	4,444	222	0	0	0	18.00
19.00	59.00	CARDIAC CATHETERIZATION	36,863	1,843	0	0	0	19.00
20.00	91.00	EMERGENCY	876	44	0	0	0	20.00
200.00			558,707	27,935	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	5.05	OTHER ADMIN AND GENERAL	0	5,694	2,944	2,944		1.00
2.00	30.00	ADULTS & PEDIATRICS	0	31,379	22,621	22,621		2.00
3.00	31.00	INTENSIVE CARE UNIT	0	3,225	1,925	618,397		3.00
4.00	41.00	SUBPROVIDER - IRF	0	78,447	0	0		4.00
5.00	5.05	OTHER ADMIN AND GENERAL	0	0	0	1,089,775		5.00
6.00	54.00	RADIOLOGY-DIAGNOSTIC	0	78,956	10,312	10,312		6.00
7.00	55.00	RADIOLOGY-THERAPEUTIC	0	106,276	38,739	138,737		7.00
8.00	59.00	CARDIAC CATHETERIZATION	0	30,720	3,793	3,793		8.00
9.00	60.00	LABORATORY	0	15,164	35,836	35,836		9.00
10.00	76.98	HYPERBARIC OXYGEN THERAPY	0	16,269	3,231	3,231		10.00
11.00	91.00	EMERGENCY	0	87,351	9,074	144,567		11.00
12.00	31.00	INTENSIVE CARE UNIT	0	0	0	214,815		12.00
13.00	53.00	ANESTHESIOLOGY	0	0	0	1,950,000		13.00
14.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	12,467		14.00
15.00	59.00	CARDIAC CATHETERIZATION	0	0	0	33,675		15.00
16.00	91.00	EMERGENCY	0	0	0	1,964,747		16.00
17.00	5.05	OTHER ADMIN AND GENERAL	0	63,043	30,003	30,003		17.00
18.00	54.00	RADIOLOGY-DIAGNOSTIC	0	4,444	656	656		18.00
19.00	59.00	CARDIAC CATHETERIZATION	0	36,863	5,362	5,362		19.00
20.00	91.00	EMERGENCY	0	876	124	124		20.00
200.00			0	558,707	164,620	6,282,062		200.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0217

Period:
From 07/01/2019
To 06/30/2020Worksheet B
Part I
Date/Time Prepared:
11/28/2020 2:10 pm

Cost Center Description		Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	COMMUNICATIONS	
			BLDG & FIXT	MVBLE EQUIP			
		0	1.00	2.00	4.00	5.01	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT	3,322,510	3,322,510			1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	4,896,337	4,896,337			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	6,204,124	4,522	6,664	6,215,310	4.00
5.01	01160	COMMUNICATIONS	190,523	27,364	40,326	3,362	261,575
5.02	00560	PURCHASING RECEIVING AND STORES	12,133	25,637	37,781	0	4,094
5.03	00570	ADMITTING	573,372	3,931	5,793	0	7,279
5.04	00580	CASHIERING/ACCOUNTS RECEIVABLE	6,725,381	0	0	0	9,553
5.05	00590	OTHER ADMIN AND GENERAL	46,158,587	165,159	243,392	436,975	40,943
6.00	00600	MAINTENANCE & REPAIRS	2,104,678	345,462	509,102	0	455
7.00	00700	OPERATION OF PLANT	2,774,274	1,175,550	1,732,391	108,109	9,098
8.00	00800	LAUNDRY & LINEN SERVICE	355,354	10,285	15,156	0	455
9.00	00900	HOUSEKEEPING	2,001,524	13,734	20,240	0	910
10.00	01000	DIETARY	790,893	55,781	82,204	14,699	5,914
11.00	01100	CAFETERIA	2,081,554	42,791	63,061	24,494	910
13.00	01300	NURSING ADMINISTRATION	1,777,182	8,210	12,099	256,782	9,553
14.00	01400	CENTRAL SERVICES & SUPPLY	861,260	38,309	56,456	60,214	2,275
15.00	01500	PHARMACY	1,972,475	13,054	19,238	279,813	3,184
16.00	01600	MEDICAL RECORDS & LIBRARY	44,554	34,140	50,311	0	9,098
23.00	02300	PARAMED ED PRGM-AMBULANCE	0	0	0	0	0
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	10,656,237	411,651	606,645	1,616,216	38,668
31.00	03100	INTENSIVE CARE UNIT	2,788,855	60,750	89,526	357,776	3,184
41.00	04100	SUBPROVIDER - IRF	3,605,911	148,327	218,588	524,697	5,914
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	2,708,531	102,617	151,226	230,727	14,102
51.00	05100	RECOVERY ROOM	1,954,574	61,752	91,003	304,733	2,729
53.00	05300	ANESTHESIOLOGY	77,196	1,906	2,809	9,912	1,365
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,450,583	107,844	158,928	322,757	15,922
54.01	03650	VASCULAR LAB	525,686	7,922	11,674	77,007	455
55.00	05500	RADIOLOGY-THERAPEUTIC	1,607,432	153,539	226,268	144,317	14,102
57.00	05700	CT SCAN	659,753	7,996	11,784	70,541	0
58.00	05800	MRI	295,030	9,088	13,393	26,845	0
59.00	05900	CARDIAC CATHETERIZATION	1,521,992	22,118	32,595	189,068	0
60.00	06000	LABORATORY	4,602,946	33,872	49,916	0	9,098
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	457,392	5,470	8,061	0	455
65.00	06500	RESPIRATORY THERAPY	1,068,193	7,852	11,572	159,713	3,184
66.00	06600	PHYSICAL THERAPY	2,717,098	31,881	46,983	221,577	4,094
67.00	06700	OCCUPATIONAL THERAPY	614,051	7,222	10,643	29,992	455
68.00	06800	SPEECH PATHOLOGY	352,692	4,150	6,115	24,572	455
69.00	06900	ELECTROCARDIOLOGY	583,492	38,870	57,282	91,533	3,184
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	8,744,873	0	0	0	0
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	5,071,434	0	0	0	0
73.00	07300	DRUGS CHARGED TO PATIENTS	7,640,240	0	0	0	0
74.00	07400	RENAL DIALYSIS	550,788	3,013	4,440	0	0
76.00	03950	OTHER ANCILLARY SERVICES COST CENTE	0	0	0	0	0
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	361,988	12,940	19,070	58,153	7,734
76.03	03951	OCCUPATIONAL HEALTH	0	0	0	0	0
76.97	07697	CARDIAC REHABILITATION	211,197	3,837	5,654	30,930	0
76.98	07698	HYPERBARIC OXYGEN THERAPY	709,784	0	0	15,058	0
OUTPATIENT SERVICE COST CENTERS							
90.01	09001	OUTPATIENT PROCEDURES	0	0	0	0	0
91.00	09100	EMERGENCY	3,496,927	103,605	152,682	515,470	16,832
91.01	09101	C'VILLE OUT	0	0	0	0	0
91.02	09102	LAKE HILL OUT	0	0	0	0	0
91.03	09103	NUTRITION COUNSELING	0	0	0	0	0
91.04	09104	HUNTLEY OP	0	0	0	0	0
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	0
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE	0	0	0	0	0
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	148,881,590	3,312,151	4,881,071	6,206,042	245,653
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	7,510	11,067	0	910
194.00	07950	MISC NONREIMBURSABLE COST CENTER	146,187	0	0	0	0
194.01	07951	MOB	278,228	0	0	0	13,192
194.02	07952	COMMUNITY WELLNESS	57,953	0	0	9,178	0
194.03	07953	FUND DEVELOPMENT	0	2,849	4,199	0	1,820
194.04	07954	PHYSICIAN PRACTICE MANAGEMENT	522	0	0	90	0
200.00		Cross Foot Adjustments	0	0	0	0	0

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0217

Period:
From 07/01/2019
To 06/30/2020Worksheet B
Part I
Date/Time Prepared:
11/28/2020 2:10 pm

Cost Center Description			Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	COMMUNICATIONS	
				BLDG & FIXT	MVBLE EQUIP			
			0	1.00	2.00	4.00	5.01	
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	149,364,480	3,322,510	4,896,337	6,215,310	261,575	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0217

Period:
From 07/01/2019
To 06/30/2020Worksheet B
Part I
Date/Time Prepared:
11/28/2020 2:10 pm

Cost Center Description			PURCHASING RECEIVING AND STORES	ADMITTING	CASHIERING/ACC OUNTS RECEIVABLE	Subtotal	OTHER ADMIN AND GENERAL	
			5.02	5.03	5.04	5A.04	5.05	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	01160	COMMUNICATIONS						5.01
5.02	00560	PURCHASING RECEIVING AND STORES	79,645					5.02
5.03	00570	ADMITTING	3	590,378				5.03
5.04	00580	CASHIERING/ACCOUNTS RECEIVABLE	0	0	6,734,934			5.04
5.05	00590	OTHER ADMIN AND GENERAL	2,603	0	0	47,047,659	47,047,659	5.05
6.00	00600	MAINTENANCE & REPAIRS	0	0	0	2,959,697	1,360,937	6.00
7.00	00700	OPERATION OF PLANT	291	0	0	5,799,713	2,666,841	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0	381,250	175,308	8.00
9.00	00900	HOUSEKEEPING	0	0	0	2,036,408	936,387	9.00
10.00	01000	DIETARY	10	0	0	949,501	436,602	10.00
11.00	01100	CAFETERIA	0	0	0	2,212,810	1,017,501	11.00
13.00	01300	NURSING ADMINISTRATION	41	0	0	2,063,867	949,014	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	1,301	0	0	1,019,815	468,934	14.00
15.00	01500	PHARMACY	333	0	0	2,288,097	1,052,120	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	138,103	63,503	16.00
23.00	02300	PARAMED ED PRGM-AMBULANCE	0	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	497	78,598	899,713	14,308,225	6,579,285	30.00
31.00	03100	INTENSIVE CARE UNIT	145	16,630	189,614	3,506,480	1,612,360	31.00
41.00	04100	SUBPROVIDER - IRF	180	22,265	253,858	4,779,740	2,197,834	41.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	1,469	60,645	691,460	3,960,777	1,821,256	50.00
51.00	05100	RECOVERY ROOM	94	26,596	303,240	2,744,721	1,262,086	51.00
53.00	05300	ANESTHESIOLOGY	6	12,035	137,224	242,453	111,485	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	344	22,879	260,868	3,340,125	1,535,866	54.00
54.01	03650	VASCULAR LAB	19	8,952	102,066	733,781	337,409	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	91	15,887	181,142	2,342,778	1,077,263	55.00
57.00	05700	CT SCAN	34	39,368	448,869	1,238,345	569,420	57.00
58.00	05800	MRI	1	8,476	96,640	449,473	206,678	58.00
59.00	05900	CARDIAC CATHETERIZATION	57	31,771	362,250	2,159,851	993,149	59.00
60.00	06000	LABORATORY	96	43,534	496,371	5,235,833	2,407,556	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	2,296	1,074	12,244	486,992	223,930	62.00
65.00	06500	RESPIRATORY THERAPY	34	8,213	93,641	1,352,402	621,866	65.00
66.00	06600	PHYSICAL THERAPY	29	19,730	224,958	3,266,350	1,501,943	66.00
67.00	06700	OCCUPATIONAL THERAPY	3	4,698	53,567	720,631	331,363	67.00
68.00	06800	SPEECH PATHOLOGY	0	1,317	15,013	404,314	185,913	68.00
69.00	06900	ELECTROCARDIOLOGY	25	17,113	195,122	986,621	453,671	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	43,901	21,579	246,036	9,056,389	4,164,336	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	25,459	35,032	399,426	5,531,351	2,543,442	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	33,323	379,938	8,053,501	3,703,185	73.00
74.00	07400	RENAL DIALYSIS	0	2,151	24,531	584,923	268,961	74.00
76.00	03950	OTHER ANCILLARY SERVICES COST CENTE	0	0	0	0	0	76.00
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	4,069	46,393	510,347	234,669	76.02
76.03	03951	OCCUPATIONAL HEALTH	0	0	0	0	0	76.03
76.97	07697	CARDIAC REHABILITATION	8	1,171	13,352	266,149	122,381	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	22	4,052	46,205	775,121	356,418	76.98
OUTPATIENT SERVICE COST CENTERS								
90.01	09001	OUTPATIENT PROCEDURES	0	0	0	0	0	90.01
91.00	09100	EMERGENCY	209	49,220	561,193	4,896,138	2,251,357	91.00
91.01	09101	C'VILLE OUT	0	0	0	0	0	91.01
91.02	09102	LAKE HILL OUT	0	0	0	0	0	91.02
91.03	09103	NUTRITION COUNSELING	0	0	0	0	0	91.03
91.04	09104	HUNTLEY OP	0	0	0	0	0	91.04
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				0		92.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	79,601	590,378	6,734,934	148,830,731	46,802,229	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	19,487	8,961	190.00
194.00	07950	MISC NONREIMBURSABLE COST CENTER	44	0	0	146,231	67,240	194.00
194.01	07951	MOB	0	0	0	291,420	134,002	194.01
194.02	07952	COMMUNITY WELLNESS	0	0	0	67,131	30,868	194.02
194.03	07953	FUND DEVELOPMENT	0	0	0	8,868	4,078	194.03
194.04	07954	PHYSICIAN PRACTICE MANAGEMENT	0	0	0	612	281	194.04
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)	79,645	590,378	6,734,934	149,364,480	47,047,659	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0217

Period:
From 07/01/2019
To 06/30/2020Worksheet B
Part I
Date/Time Prepared:
11/28/2020 2:10 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
5.01	01160	COMMUNICATIONS						5.01
5.02	00560	PURCHASING RECEIVING AND STORES						5.02
5.03	00570	ADMITTING						5.03
5.04	00580	CASHIERING/ACCOUNTS RECEIVABLE						5.04
5.05	00590	OTHER ADMIN AND GENERAL						5.05
6.00	00600	MAINTENANCE & REPAIRS	4,320,634					6.00
7.00	00700	OPERATION OF PLANT	1,846,660	10,313,214				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	16,156	67,349	640,063			8.00
9.00	00900	HOUSEKEEPING	21,575	89,940	0	3,084,310		9.00
10.00	01000	DIETARY	87,626	365,284	0	110,935	1,949,948	10.00
11.00	01100	CAFETERIA	67,220	280,220	0	85,102	0	11.00
13.00	01300	NURSING ADMINISTRATION	12,897	53,762	0	16,327	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	60,179	250,869	0	76,188	0	14.00
15.00	01500	PHARMACY	20,507	85,486	0	25,962	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	53,630	223,565	0	67,896	0	16.00
23.00	02300	PARAMED ED PRGM-AMBULANCE	0	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	646,659	2,695,715	434,191	818,676	1,322,762	30.00
31.00	03100	INTENSIVE CARE UNIT	95,431	397,821	40,664	120,816	123,882	31.00
41.00	04100	SUBPROVIDER - IRF	233,006	971,328	165,208	294,988	503,304	41.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	161,201	671,995	0	204,082	0	50.00
51.00	05100	RECOVERY ROOM	97,006	404,387	0	122,811	0	51.00
53.00	05300	ANESTHESIOLOGY	2,994	12,482	0	3,791	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	169,411	706,222	0	214,477	0	54.00
54.01	03650	VASCULAR LAB	12,444	51,877	0	15,755	0	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	241,193	1,005,458	0	305,353	0	55.00
57.00	05700	CT SCAN	12,561	52,365	0	15,903	0	57.00
58.00	05800	MRI	14,277	59,516	0	18,075	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	34,745	144,839	0	43,987	0	59.00
60.00	06000	LABORATORY	53,209	221,810	0	67,363	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	8,593	35,820	0	10,878	0	62.00
65.00	06500	RESPIRATORY THERAPY	12,335	51,422	0	15,617	0	65.00
66.00	06600	PHYSICAL THERAPY	50,082	208,776	0	63,404	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	11,345	47,294	0	14,363	0	67.00
68.00	06800	SPEECH PATHOLOGY	6,519	27,174	0	8,253	0	68.00
69.00	06900	ELECTROCARDIOLOGY	61,060	254,542	0	77,303	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	4,733	19,730	0	5,992	0	74.00
76.00	03950	OTHER ANCILLARY SERVICES COST CENTE	0	0	0	0	0	76.00
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	20,327	84,739	0	25,735	0	76.02
76.03	03951	OCCUPATIONAL HEALTH	0	0	0	0	0	76.03
76.97	07697	CARDIAC REHABILITATION	6,027	25,126	0	7,631	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
OUTPATIENT SERVICE COST CENTERS								
90.01	09001	OUTPATIENT PROCEDURES	0	0	0	0	0	90.01
91.00	09100	EMERGENCY	162,753	678,464	0	206,046	0	91.00
91.01	09101	C'VILLE OUT	0	0	0	0	0	91.01
91.02	09102	LAKE HILL OUT	0	0	0	0	0	91.02
91.03	09103	NUTRITION COUNSELING	0	0	0	0	0	91.03
91.04	09104	HUNTLEY OP	0	0	0	0	0	91.04
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	4,304,361	10,245,377	640,063	3,063,709	1,949,948	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	11,797	49,179	0	14,935	0	190.00
194.00	07950	MISC NONREIMBURSABLE COST CENTER	0	0	0	0	0	194.00
194.01	07951	MOB	0	0	0	0	0	194.01
194.02	07952	COMMUNITY WELLNESS	0	0	0	0	0	194.02
194.03	07953	FUND DEVELOPMENT	4,476	18,658	0	5,666	0	194.03
194.04	07954	PHYSICIAN PRACTICE MANAGEMENT	0	0	0	0	0	194.04
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)	4,320,634	10,313,214	640,063	3,084,310	1,949,948	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0217

Period:
From 07/01/2019
To 06/30/2020Worksheet B
Part I
Date/Time Prepared:
11/28/2020 2:10 pm

Cost Center Description			CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
			11.00	13.00	14.00	15.00	16.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	01160	COMMUNICATIONS						5.01
5.02	00560	PURCHASING RECEIVING AND STORES						5.02
5.03	00570	ADMITTING						5.03
5.04	00580	CASHIERING/ACCOUNTS RECEIVABLE						5.04
5.05	00590	OTHER ADMIN AND GENERAL						5.05
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	3,662,853					11.00
13.00	01300	NURSING ADMINISTRATION	166,705	3,262,572				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	62,910	0	1,938,895			14.00
15.00	01500	PHARMACY	141,897	0	0	3,614,069		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	546,697	16.00
23.00	02300	PARAMED ED PRGM-AMBULANCE	0	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	1,125,642	1,173,997	12,844	9,540	72,852	30.00
31.00	03100	INTENSIVE CARE UNIT	210,318	219,354	3,738	3,439	15,397	31.00
41.00	04100	SUBPROVIDER - IRF	341,612	356,287	4,656	799	20,614	41.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	145,375	151,620	37,954	11,172	56,150	50.00
51.00	05100	RECOVERY ROOM	202,790	211,502	2,429	9,262	24,624	51.00
53.00	05300	ANESTHESIOLOGY	6,092	6,354	164	4,705	11,143	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	218,469	227,855	8,884	18,351	21,184	54.00
54.01	03650	VASCULAR LAB	39,974	41,692	502	2,640	8,288	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	91,344	95,269	2,339	2,725	14,710	55.00
57.00	05700	CT SCAN	50,036	52,185	887	30,245	36,450	57.00
58.00	05800	MRI	15,442	16,105	34	1,898	7,848	58.00
59.00	05900	CARDIAC CATHETERIZATION	93,208	97,213	1,466	54,565	29,416	59.00
60.00	06000	LABORATORY	0	0	2,484	0	40,308	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	59,309	0	994	62.00
65.00	06500	RESPIRATORY THERAPY	105,121	109,637	884	310	7,604	65.00
66.00	06600	PHYSICAL THERAPY	142,033	148,134	754	0	18,268	66.00
67.00	06700	OCCUPATIONAL THERAPY	18,949	19,763	81	0	4,350	67.00
68.00	06800	SPEECH PATHOLOGY	12,429	12,963	1	306	1,219	68.00
69.00	06900	ELECTROCARDIOLOGY	65,850	68,679	659	0	15,845	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	1,133,923	0	19,979	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	657,598	0	32,435	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	3,448,792	30,853	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	354	1,992	74.00
76.00	03950	OTHER ANCILLARY SERVICES COST CENTE	0	0	0	0	0	76.00
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	43,410	45,275	0	0	3,767	76.02
76.03	03951	OCCUPATIONAL HEALTH	0	0	0	0	0	76.03
76.97	07697	CARDIAC REHABILITATION	20,224	21,093	208	0	1,084	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	8,367	8,726	557	113	3,752	76.98
OUTPATIENT SERVICE COST CENTERS								
90.01	09001	OUTPATIENT PROCEDURES	0	0	0	0	0	90.01
91.00	09100	EMERGENCY	325,268	178,745	5,399	14,853	45,571	91.00
91.01	09101	C'VILLE OUT	0	0	0	0	0	91.01
91.02	09102	LAKE HILL OUT	0	0	0	0	0	91.02
91.03	09103	NUTRITION COUNSELING	0	0	0	0	0	91.03
91.04	09104	HUNTLEY OP	0	0	0	0	0	91.04
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	3,653,465	3,262,448	1,937,754	3,614,069	546,697	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
194.00	07950	MISC NONREIMBURSABLE COST CENTER	3,686	0	1,130	0	0	194.00
194.01	07951	MOB	0	0	0	0	0	194.01
194.02	07952	COMMUNITY WELLNESS	5,702	124	11	0	0	194.02
194.03	07953	FUND DEVELOPMENT	0	0	0	0	0	194.03
194.04	07954	PHYSICIAN PRACTICE MANAGEMENT	0	0	0	0	0	194.04
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)	3,662,853	3,262,572	1,938,895	3,614,069	546,697	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0217

Period:
From 07/01/2019
To 06/30/2020Worksheet B
Part I
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Cost Center Description			PARAMED ED PRGM-AMBULANCE	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			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
5.01	01160	COMMUNICATIONS					5.01
5.02	00560	PURCHASING RECEIVING AND STORES					5.02
5.03	00570	ADMITTING					5.03
5.04	00580	CASHIERING/ACCOUNTS RECEIVABLE					5.04
5.05	00590	OTHER ADMIN AND GENERAL					5.05
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
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
23.00	02300	PARAMED ED PRGM-AMBULANCE	0				23.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	0	29,200,388	0	29,200,388	30.00
31.00	03100	INTENSIVE CARE UNIT	0	6,349,700	0	6,349,700	31.00
41.00	04100	SUBPROVIDER - IRF	0	9,869,376	0	9,869,376	41.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	7,221,582	0	7,221,582	50.00
51.00	05100	RECOVERY ROOM	0	5,081,618	0	5,081,618	51.00
53.00	05300	ANESTHESIOLOGY	0	401,663	0	401,663	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	6,460,844	0	6,460,844	54.00
54.01	03650	VASCULAR LAB	0	1,244,362	0	1,244,362	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	0	5,178,432	0	5,178,432	55.00
57.00	05700	CT SCAN	0	2,058,397	0	2,058,397	57.00
58.00	05800	MRI	0	789,346	0	789,346	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	3,652,439	0	3,652,439	59.00
60.00	06000	LABORATORY	0	8,028,563	0	8,028,563	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	826,516	0	826,516	62.00
65.00	06500	RESPIRATORY THERAPY	0	2,277,198	0	2,277,198	65.00
66.00	06600	PHYSICAL THERAPY	0	5,399,744	0	5,399,744	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	1,168,139	0	1,168,139	67.00
68.00	06800	SPEECH PATHOLOGY	0	659,091	0	659,091	68.00
69.00	06900	ELECTROCARDIOLOGY	0	1,984,230	0	1,984,230	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	14,374,627	0	14,374,627	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	8,764,826	0	8,764,826	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	15,236,331	0	15,236,331	73.00
74.00	07400	RENAL DIALYSIS	0	886,685	0	886,685	74.00
76.00	03950	OTHER ANCILLARY SERVICES COST CENTE	0	0	0	0	76.00
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	968,269	0	968,269	76.02
76.03	03951	OCCUPATIONAL HEALTH	0	0	0	0	76.03
76.97	07697	CARDIAC REHABILITATION	0	469,923	0	469,923	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	1,153,054	0	1,153,054	76.98
OUTPATIENT SERVICE COST CENTERS							
90.01	09001	OUTPATIENT PROCEDURES	0	0	0	0	90.01
91.00	09100	EMERGENCY	0	8,764,594	0	8,764,594	91.00
91.01	09101	C'VILLE OUT	0	0	0	0	91.01
91.02	09102	LAKE HILL OUT	0	0	0	0	91.02
91.03	09103	NUTRITION COUNSELING	0	0	0	0	91.03
91.04	09104	HUNTLEY OP	0	0	0	0	91.04
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	92.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE	0	0	0	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	148,469,937	0	148,469,937	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	104,359	0	104,359	190.00
194.00	07950	MISC NONREIMBURSABLE COST CENTER	0	218,287	0	218,287	194.00
194.01	07951	MOB	0	425,422	0	425,422	194.01
194.02	07952	COMMUNITY WELLNESS	0	103,836	0	103,836	194.02
194.03	07953	FUND DEVELOPMENT	0	41,746	0	41,746	194.03
194.04	07954	PHYSICIAN PRACTICE MANAGEMENT	0	893	0	893	194.04
200.00		Cross Foot Adjustments	0	0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	0	149,364,480	0	149,364,480	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0217

Period:
From 07/01/2019
To 06/30/2020Worksheet B
Part II
Date/Time Prepared:
11/28/2020 2:10 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	4,522	6,664	11,186	4.00
5.01	01160	COMMUNICATIONS	0	27,364	40,326	67,690	5.01
5.02	00560	PURCHASING RECEIVING AND STORES	0	25,637	37,781	63,418	5.02
5.03	00570	ADMITTING	0	3,931	5,793	9,724	5.03
5.04	00580	CASHIERING/ACCOUNTS RECEIVABLE	0	0	0	0	5.04
5.05	00590	OTHER ADMIN AND GENERAL	0	165,159	243,392	408,551	5.05
6.00	00600	MAINTENANCE & REPAIRS	0	345,462	509,102	854,564	6.00
7.00	00700	OPERATION OF PLANT	0	1,175,550	1,732,391	2,907,941	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	10,285	15,156	25,441	8.00
9.00	00900	HOUSEKEEPING	0	13,734	20,240	33,974	9.00
10.00	01000	DIETARY	0	55,781	82,204	137,985	10.00
11.00	01100	CAFETERIA	0	42,791	63,061	105,852	11.00
13.00	01300	NURSING ADMINISTRATION	0	8,210	12,099	20,309	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	38,309	56,456	94,765	14.00
15.00	01500	PHARMACY	0	13,054	19,238	32,292	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	34,140	50,311	84,451	16.00
23.00	02300	PARAMED ED PRGM-AMBULANCE	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	0	411,651	606,645	1,018,296	30.00
31.00	03100	INTENSIVE CARE UNIT	0	60,750	89,526	150,276	31.00
41.00	04100	SUBPROVIDER - IRF	0	148,327	218,588	366,915	41.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	102,617	151,226	253,843	50.00
51.00	05100	RECOVERY ROOM	0	61,752	91,003	152,755	51.00
53.00	05300	ANESTHESIOLOGY	0	1,906	2,809	4,715	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	107,844	158,928	266,772	54.00
54.01	03650	VASCULAR LAB	0	7,922	11,674	19,596	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	0	153,539	226,268	379,807	55.00
57.00	05700	CT SCAN	0	7,996	11,784	19,780	57.00
58.00	05800	MRI	0	9,088	13,393	22,481	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	22,118	32,595	54,713	59.00
60.00	06000	LABORATORY	0	33,872	49,916	83,788	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	5,470	8,061	13,531	62.00
65.00	06500	RESPIRATORY THERAPY	0	7,852	11,572	19,424	65.00
66.00	06600	PHYSICAL THERAPY	0	31,881	46,983	78,864	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	7,222	10,643	17,865	67.00
68.00	06800	SPEECH PATHOLOGY	0	4,150	6,115	10,265	68.00
69.00	06900	ELECTROCARDIOLOGY	0	38,870	57,282	96,152	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	3,013	4,440	7,453	74.00
76.00	03950	OTHER ANCILLARY SERVICES COST CENTE	0	0	0	0	76.00
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	12,940	19,070	32,010	76.02
76.03	03951	OCCUPATIONAL HEALTH	0	0	0	0	76.03
76.97	07697	CARDIAC REHABILITATION	0	3,837	5,654	9,491	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	76.98
OUTPATIENT SERVICE COST CENTERS							
90.01	09001	OUTPATIENT PROCEDURES	0	0	0	0	90.01
91.00	09100	EMERGENCY	0	103,605	152,682	256,287	91.00
91.01	09101	C'VILLE OUT	0	0	0	0	91.01
91.02	09102	LAKE HILL OUT	0	0	0	0	91.02
91.03	09103	NUTRITION COUNSELING	0	0	0	0	91.03
91.04	09104	HUNTLEY OP	0	0	0	0	91.04
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	92.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE	0	0	0	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	3,312,151	4,881,071	8,193,222	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	7,510	11,067	18,577	190.00
194.00	07950	MISC NONREIMBURSABLE COST CENTER	0	0	0	0	194.00
194.01	07951	MOB	2,797	0	0	2,797	194.01
194.02	07952	COMMUNITY WELLNESS	1,021	0	0	1,021	194.02
194.03	07953	FUND DEVELOPMENT	0	2,849	4,199	7,048	194.03
194.04	07954	PHYSICIAN PRACTICE MANAGEMENT	0	0	0	0	194.04
200.00		Cross Foot Adjustments				0	200.00
201.00		Negative Cost Centers		0	0	0	201.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0217

Period:
From 07/01/2019
To 06/30/2020Worksheet B
Part II
Date/Time Prepared:
11/28/2020 2:10 pm

Cost Center Description		Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
			BLDG & FIXT	MVBLE EQUIP			
		0	1.00	2.00	2A	4.00	
202.00	TOTAL (sum lines 118 through 201)	3,818	3,322,510	4,896,337	8,222,665	11,186	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0217

Period:
From 07/01/2019
To 06/30/2020Worksheet B
Part II
Date/Time Prepared:
11/28/2020 2:10 pm

Cost Center Description			COMMUNICATIONS	PURCHASING RECEIVING AND STORES	ADMITTING	CASHIERING/ACC OUNTS RECEIVABLE	OTHER ADMIN AND GENERAL	
			5.01	5.02	5.03	5.04	5.05	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	01160	COMMUNICATIONS	67,696					5.01
5.02	00560	PURCHASING RECEIVING AND STORES	1,060	64,478				5.02
5.03	00570	ADMITTING	1,884	2	11,610			5.03
5.04	00580	CASHIERING/ACCOUNTS RECEIVABLE	2,472	0	0	2,472		5.04
5.05	00590	OTHER ADMIN AND GENERAL	10,594	2,107	0	0	422,039	5.05
6.00	00600	MAINTENANCE & REPAIRS	118	0	0	0	12,209	6.00
7.00	00700	OPERATION OF PLANT	2,355	236	0	0	23,924	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	118	0	0	0	1,573	8.00
9.00	00900	HOUSEKEEPING	235	0	0	0	8,400	9.00
10.00	01000	DIETARY	1,531	8	0	0	3,917	10.00
11.00	01100	CAFETERIA	235	0	0	0	9,128	11.00
13.00	01300	NURSING ADMINISTRATION	2,472	33	0	0	8,513	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	589	1,054	0	0	4,207	14.00
15.00	01500	PHARMACY	824	270	0	0	9,438	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	2,355	0	0	0	570	16.00
23.00	02300	PARAMED ED PRGM-AMBULANCE	0	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	10,007	403	1,627	474	59,001	30.00
31.00	03100	INTENSIVE CARE UNIT	824	117	324	65	14,464	31.00
41.00	04100	SUBPROVIDER - IRF	1,531	146	434	87	19,716	41.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	3,650	1,190	1,183	237	16,338	50.00
51.00	05100	RECOVERY ROOM	706	76	519	104	11,322	51.00
53.00	05300	ANESTHESIOLOGY	353	5	235	47	1,000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,121	278	446	89	13,778	54.00
54.01	03650	VASCULAR LAB	118	16	175	35	3,027	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	3,650	73	310	62	9,664	55.00
57.00	05700	CT SCAN	0	28	768	154	5,108	57.00
58.00	05800	MRI	0	1	165	33	1,854	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	46	620	124	8,909	59.00
60.00	06000	LABORATORY	2,355	78	849	170	21,598	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	118	1,859	21	4	2,009	62.00
65.00	06500	RESPIRATORY THERAPY	824	28	160	32	5,579	65.00
66.00	06600	PHYSICAL THERAPY	1,060	24	385	77	13,474	66.00
67.00	06700	OCCUPATIONAL THERAPY	118	3	92	18	2,973	67.00
68.00	06800	SPEECH PATHOLOGY	118	0	26	5	1,668	68.00
69.00	06900	ELECTROCARDIOLOGY	824	21	334	67	4,070	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	35,538	421	84	37,358	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	20,610	683	137	22,817	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	650	130	33,221	73.00
74.00	07400	RENAL DIALYSIS	0	0	42	8	2,413	74.00
76.00	03950	OTHER ANCILLARY SERVICES COST CENTE	0	0	0	0	0	76.00
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	2,001	0	79	16	2,105	76.02
76.03	03951	OCCUPATIONAL HEALTH	0	0	0	0	0	76.03
76.97	07697	CARDIAC REHABILITATION	0	7	23	5	1,098	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	17	79	16	3,197	76.98
OUTPATIENT SERVICE COST CENTERS								
90.01	09001	OUTPATIENT PROCEDURES	0	0	0	0	0	90.01
91.00	09100	EMERGENCY	4,356	169	960	192	20,197	91.00
91.01	09101	C'VILLE OUT	0	0	0	0	0	91.01
91.02	09102	LAKE HILL OUT	0	0	0	0	0	91.02
91.03	09103	NUTRITION COUNSELING	0	0	0	0	0	91.03
91.04	09104	HUNTLEY OP	0	0	0	0	0	91.04
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	63,576	64,443	11,610	2,472	419,837	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	235	0	0	0	80	190.00
194.00	07950	MISC NONREIMBURSABLE COST CENTER	0	35	0	0	603	194.00
194.01	07951	MOB	3,414	0	0	0	1,202	194.01
194.02	07952	COMMUNITY WELLNESS	0	0	0	0	277	194.02
194.03	07953	FUND DEVELOPMENT	471	0	0	0	37	194.03
194.04	07954	PHYSICIAN PRACTICE MANAGEMENT	0	0	0	0	3	194.04
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)	67,696	64,478	11,610	2,472	422,039	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0217

Period:
From 07/01/2019
To 06/30/2020Worksheet B
Part II
Date/Time Prepared:
11/28/2020 2:10 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
5.01	01160	COMMUNICATIONS						5.01
5.02	00560	PURCHASING RECEIVING AND STORES						5.02
5.03	00570	ADMITTING						5.03
5.04	00580	CASHIERING/ACCOUNTS RECEIVABLE						5.04
5.05	00590	OTHER ADMIN AND GENERAL						5.05
6.00	00600	MAINTENANCE & REPAIRS	866,891					6.00
7.00	00700	OPERATION OF PLANT	370,514	3,305,165				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	3,242	21,584	51,958			8.00
9.00	00900	HOUSEKEEPING	4,329	28,824	0	75,762		9.00
10.00	01000	DIETARY	17,581	117,066	0	2,725	280,839	10.00
11.00	01100	CAFETERIA	13,487	89,805	0	2,090	0	11.00
13.00	01300	NURSING ADMINISTRATION	2,588	17,230	0	401	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	12,074	80,398	0	1,871	0	14.00
15.00	01500	PHARMACY	4,114	27,397	0	638	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	10,760	71,648	0	1,668	0	16.00
23.00	02300	PARAMED ED PRGM-AMBULANCE	0	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	129,746	863,920	35,246	20,110	190,509	30.00
31.00	03100	INTENSIVE CARE UNIT	19,147	127,493	3,301	2,968	17,842	31.00
41.00	04100	SUBPROVIDER - IRF	46,750	311,290	13,411	7,246	72,488	41.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	32,343	215,360	0	5,013	0	50.00
51.00	05100	RECOVERY ROOM	19,463	129,597	0	3,017	0	51.00
53.00	05300	ANESTHESIOLOGY	601	4,000	0	93	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	33,991	226,329	0	5,268	0	54.00
54.01	03650	VASCULAR LAB	2,497	16,625	0	387	0	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	48,393	322,228	0	7,501	0	55.00
57.00	05700	CT SCAN	2,520	16,782	0	391	0	57.00
58.00	05800	MRI	2,864	19,073	0	444	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	6,971	46,418	0	1,080	0	59.00
60.00	06000	LABORATORY	10,676	71,085	0	1,655	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	1,724	11,479	0	267	0	62.00
65.00	06500	RESPIRATORY THERAPY	2,475	16,480	0	384	0	65.00
66.00	06600	PHYSICAL THERAPY	10,048	66,908	0	1,557	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	2,276	15,157	0	353	0	67.00
68.00	06800	SPEECH PATHOLOGY	1,308	8,709	0	203	0	68.00
69.00	06900	ELECTROCARDIOLOGY	12,251	81,575	0	1,899	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	950	6,323	0	147	0	74.00
76.00	03950	OTHER ANCILLARY SERVICES COST CENTE	0	0	0	0	0	76.00
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	4,079	27,157	0	632	0	76.02
76.03	03951	OCCUPATIONAL HEALTH	0	0	0	0	0	76.03
76.97	07697	CARDIAC REHABILITATION	1,209	8,052	0	187	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
OUTPATIENT SERVICE COST CENTERS								
90.01	09001	OUTPATIENT PROCEDURES	0	0	0	0	0	90.01
91.00	09100	EMERGENCY	32,655	217,433	0	5,061	0	91.00
91.01	09101	C'VILLE OUT	0	0	0	0	0	91.01
91.02	09102	LAKE HILL OUT	0	0	0	0	0	91.02
91.03	09103	NUTRITION COUNSELING	0	0	0	0	0	91.03
91.04	09104	HUNTLEY OP	0	0	0	0	0	91.04
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	0	92.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	863,626	3,283,425	51,958	75,256	280,839	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	2,367	15,761	0	367	0	190.00
194.00	07950	MISC NONREIMBURSABLE COST CENTER	0	0	0	0	0	194.00
194.01	07951	MOB	0	0	0	0	0	194.01
194.02	07952	COMMUNITY WELLNESS	0	0	0	0	0	194.02
194.03	07953	FUND DEVELOPMENT	898	5,979	0	139	0	194.03
194.04	07954	PHYSICIAN PRACTICE MANAGEMENT	0	0	0	0	0	194.04
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)	866,891	3,305,165	51,958	75,762	280,839	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0217

Period:
From 07/01/2019
To 06/30/2020Worksheet B
Part II
Date/Time Prepared:
11/28/2020 2:10 pm

Cost Center Description			CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
			11.00	13.00	14.00	15.00	16.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	01160	COMMUNICATIONS						5.01
5.02	00560	PURCHASING RECEIVING AND STORES						5.02
5.03	00570	ADMITTING						5.03
5.04	00580	CASHIERING/ACCOUNTS RECEIVABLE						5.04
5.05	00590	OTHER ADMIN AND GENERAL						5.05
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	220,641					11.00
13.00	01300	NURSING ADMINISTRATION	10,042	62,050				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	3,790	0	198,856			14.00
15.00	01500	PHARMACY	8,548	0	0	84,025		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	171,452	16.00
23.00	02300	PARAMED ED PRGM-AMBULANCE	0	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	67,805	22,326	1,317	222	23,043	30.00
31.00	03100	INTENSIVE CARE UNIT	12,669	4,172	383	80	4,823	31.00
41.00	04100	SUBPROVIDER - IRF	20,578	6,776	478	19	6,456	41.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	8,757	2,884	3,893	260	17,586	50.00
51.00	05100	RECOVERY ROOM	12,216	4,023	249	215	7,712	51.00
53.00	05300	ANESTHESIOLOGY	367	121	17	109	3,490	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	13,160	4,334	911	427	6,635	54.00
54.01	03650	VASCULAR LAB	2,408	793	52	61	2,596	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	5,502	1,812	240	63	4,607	55.00
57.00	05700	CT SCAN	3,014	993	91	703	11,416	57.00
58.00	05800	MRI	930	306	4	44	2,458	58.00
59.00	05900	CARDIAC CATHETERIZATION	5,615	1,849	150	1,269	9,213	59.00
60.00	06000	LABORATORY	0	0	255	0	12,624	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	6,083	0	311	62.00
65.00	06500	RESPIRATORY THERAPY	6,332	2,085	91	7	2,382	65.00
66.00	06600	PHYSICAL THERAPY	8,556	2,817	77	0	5,721	66.00
67.00	06700	OCCUPATIONAL THERAPY	1,141	376	8	0	1,362	67.00
68.00	06800	SPEECH PATHOLOGY	749	247	0	7	382	68.00
69.00	06900	ELECTROCARDIOLOGY	3,967	1,306	68	0	4,963	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	116,295	0	6,258	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	67,445	0	10,159	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	80,183	9,663	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	8	624	74.00
76.00	03950	OTHER ANCILLARY SERVICES COST CENTE	0	0	0	0	0	76.00
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	2,615	861	0	0	1,180	76.02
76.03	03951	OCCUPATIONAL HEALTH	0	0	0	0	0	76.03
76.97	07697	CARDIAC REHABILITATION	1,218	401	21	0	340	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	504	166	57	3	1,175	76.98
OUTPATIENT SERVICE COST CENTERS								
90.01	09001	OUTPATIENT PROCEDURES	0	0	0	0	0	90.01
91.00	09100	EMERGENCY	19,593	3,400	554	345	14,273	91.00
91.01	09101	C'VILLE OUT	0	0	0	0	0	91.01
91.02	09102	LAKE HILL OUT	0	0	0	0	0	91.02
91.03	09103	NUTRITION COUNSELING	0	0	0	0	0	91.03
91.04	09104	HUNTLEY OP	0	0	0	0	0	91.04
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	220,076	62,048	198,739	84,025	171,452	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
194.00	07950	MISC NONREIMBURSABLE COST CENTER	222	0	116	0	0	194.00
194.01	07951	MOB	0	0	0	0	0	194.01
194.02	07952	COMMUNITY WELLNESS	343	2	1	0	0	194.02
194.03	07953	FUND DEVELOPMENT	0	0	0	0	0	194.03
194.04	07954	PHYSICIAN PRACTICE MANAGEMENT	0	0	0	0	0	194.04
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)	220,641	62,050	198,856	84,025	171,452	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0217

Period:
From 07/01/2019
To 06/30/2020Worksheet B
Part II
Date/Time Prepared:
11/28/2020 2:10 pm

Cost Center Description			PARAMED ED PRGM-AMBULANCE	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			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
5.01	01160	COMMUNICATIONS					5.01
5.02	00560	PURCHASING RECEIVING AND STORES					5.02
5.03	00570	ADMITTING					5.03
5.04	00580	CASHIERING/ACCOUNTS RECEIVABLE					5.04
5.05	00590	OTHER ADMIN AND GENERAL					5.05
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
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
23.00	02300	PARAMED ED PRGM-AMBULANCE	0				23.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS		2,446,957	0	2,446,957	30.00
31.00	03100	INTENSIVE CARE UNIT		359,592	0	359,592	31.00
41.00	04100	SUBPROVIDER - IRF		875,266	0	875,266	41.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM		562,952	0	562,952	50.00
51.00	05100	RECOVERY ROOM		342,523	0	342,523	51.00
53.00	05300	ANESTHESIOLOGY		15,171	0	15,171	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC		577,120	0	577,120	54.00
54.01	03650	VASCULAR LAB		48,525	0	48,525	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC		784,172	0	784,172	55.00
57.00	05700	CT SCAN		61,875	0	61,875	57.00
58.00	05800	MRI		50,705	0	50,705	58.00
59.00	05900	CARDIAC CATHETERIZATION		137,317	0	137,317	59.00
60.00	06000	LABORATORY		205,133	0	205,133	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL		37,406	0	37,406	62.00
65.00	06500	RESPIRATORY THERAPY		56,571	0	56,571	65.00
66.00	06600	PHYSICAL THERAPY		189,967	0	189,967	66.00
67.00	06700	OCCUPATIONAL THERAPY		41,796	0	41,796	67.00
68.00	06800	SPEECH PATHOLOGY		23,731	0	23,731	68.00
69.00	06900	ELECTROCARDIOLOGY		207,662	0	207,662	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT		195,954	0	195,954	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS		121,851	0	121,851	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS		123,847	0	123,847	73.00
74.00	07400	RENAL DIALYSIS		17,968	0	17,968	74.00
76.00	03950	OTHER ANCILLARY SERVICES COST CENTE		0	0	0	76.00
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES		72,840	0	72,840	76.02
76.03	03951	OCCUPATIONAL HEALTH		0	0	0	76.03
76.97	07697	CARDIAC REHABILITATION		22,108	0	22,108	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY		5,241	0	5,241	76.98
OUTPATIENT SERVICE COST CENTERS							
90.01	09001	OUTPATIENT PROCEDURES		0	0	0	90.01
91.00	09100	EMERGENCY		576,403	0	576,403	91.00
91.01	09101	C'VILLE OUT		0	0	0	91.01
91.02	09102	LAKE HILL OUT		0	0	0	91.02
91.03	09103	NUTRITION COUNSELING		0	0	0	91.03
91.04	09104	HUNTLEY OP		0	0	0	91.04
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART		0	0	0	92.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE		0	0	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	8,160,653	0	8,160,653	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN		37,387	0	37,387	190.00
194.00	07950	MISC NONREIMBURSABLE COST CENTER		976	0	976	194.00
194.01	07951	MOB		7,413	0	7,413	194.01
194.02	07952	COMMUNITY WELLNESS		1,661	0	1,661	194.02
194.03	07953	FUND DEVELOPMENT		14,572	0	14,572	194.03
194.04	07954	PHYSICIAN PRACTICE MANAGEMENT		3	0	3	194.04
200.00		Cross Foot Adjustments	0	0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	0	8,222,665	0	8,222,665	202.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0217

Period:
From 07/01/2019
To 06/30/2020

Worksheet B-1

Date/Time Prepared:
11/28/2020 2:10 pm

Cost Center Description		CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	COMMUNICATIONS (NUMBER PHO NES)	PURCHASING RECEIVING AND STORES (PURCH REQU IS \$)	
		BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (SQUARE FEET)				
		1.00	2.00	4.00	5.01	5.02	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT	669,375				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		669,375			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	911	911	36,100,493		4.00
5.01	01160	COMMUNICATIONS	5,513	5,513	19,525	575	5.01
5.02	00560	PURCHASING RECEIVING AND STORES	5,165	5,165	0	9	15,865,891
5.03	00570	ADMITTING	792	792	0	16	534
5.04	00580	CASHIERING/ACCOUNTS RECEIVABLE	0	0	0	21	0
5.05	00590	OTHER ADMIN AND GENERAL	33,274	33,274	2,538,090	90	518,566
6.00	00600	MAINTENANCE & REPAIRS	69,599	69,599	0	1	0
7.00	00700	OPERATION OF PLANT	236,834	236,834	627,929	20	58,022
8.00	00800	LAUNDRY & LINEN SERVICE	2,072	2,072	0	1	0
9.00	00900	HOUSEKEEPING	2,767	2,767	0	2	0
10.00	01000	DIETARY	11,238	11,238	85,379	13	2,067
11.00	01100	CAFETERIA	8,621	8,621	142,269	2	0
13.00	01300	NURSING ADMINISTRATION	1,654	1,654	1,491,471	21	8,238
14.00	01400	CENTRAL SERVICES & SUPPLY	7,718	7,718	349,743	5	259,257
15.00	01500	PHARMACY	2,630	2,630	1,625,241	7	66,334
16.00	01600	MEDICAL RECORDS & LIBRARY	6,878	6,878	0	20	0
23.00	02300	PARAMED ED PRGM-AMBULANCE	0	0	0	0	0
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	82,934	82,934	9,387,520	85	99,055
31.00	03100	INTENSIVE CARE UNIT	12,239	12,239	2,078,075	7	28,827
41.00	04100	SUBPROVIDER - IRF	29,883	29,883	3,047,605	13	35,911
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	20,674	20,674	1,340,134	31	292,702
51.00	05100	RECOVERY ROOM	12,441	12,441	1,769,987	6	18,729
53.00	05300	ANESTHESIOLOGY	384	384	57,572	3	1,267
54.00	05400	RADIOLOGY-DIAGNOSTIC	21,727	21,727	1,874,672	35	68,515
54.01	03650	VASCULAR LAB	1,596	1,596	447,278	1	3,875
55.00	05500	RADIOLOGY-THERAPEUTIC	30,933	30,933	838,236	31	18,040
57.00	05700	CT SCAN	1,611	1,611	409,724	0	6,840
58.00	05800	MRI	1,831	1,831	155,922	0	266
59.00	05900	CARDIAC CATHETERIZATION	4,456	4,456	1,098,166	0	11,309
60.00	06000	LABORATORY	6,824	6,824	0	20	19,153
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	1,102	1,102	0	1	457,392
65.00	06500	RESPIRATORY THERAPY	1,582	1,582	927,661	7	6,814
66.00	06600	PHYSICAL THERAPY	6,423	6,423	1,286,989	9	5,813
67.00	06700	OCCUPATIONAL THERAPY	1,455	1,455	174,201	1	627
68.00	06800	SPEECH PATHOLOGY	836	836	142,720	1	9
69.00	06900	ELECTROCARDIOLOGY	7,831	7,831	531,652	7	5,079
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	8,744,873
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	5,071,434
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0
74.00	07400	RENAL DIALYSIS	607	607	0	0	0
76.00	03950	OTHER ANCILLARY SERVICES COST CENTE	0	0	0	0	0
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	2,607	2,607	337,771	17	0
76.03	03951	OCCUPATIONAL HEALTH	0	0	0	0	0
76.97	07697	CARDIAC REHABILITATION	773	773	179,654	0	1,604
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	87,464	0	4,294
OUTPATIENT SERVICE COST CENTERS							
90.01	09001	OUTPATIENT PROCEDURES	0	0	0	0	0
91.00	09100	EMERGENCY	20,873	20,873	2,994,014	37	41,639
91.01	09101	C'VILLE OUT	0	0	0	0	0
91.02	09102	LAKE HILL OUT	0	0	0	0	0
91.03	09103	NUTRITION COUNSELING	0	0	0	0	0
91.04	09104	HUNTLEY OP	0	0	0	0	0
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	0
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	667,288	667,288	36,046,664	540	15,857,085
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	1,513	1,513	0	2	0
194.00	07950	MISC NONREIMBURSABLE COST CENTER	0	0	0	0	8,718
194.01	07951	MOB	0	0	0	29	0
194.02	07952	COMMUNITY WELLNESS	0	0	53,309	0	88
194.03	07953	FUND DEVELOPMENT	574	574	0	4	0
194.04	07954	PHYSICIAN PRACTICE MANAGEMENT	0	0	520	0	0
200.00		Cross Foot Adjustments					

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0217

Period:
From 07/01/2019
To 06/30/2020

Worksheet B-1

Date/Time Prepared:
11/28/2020 2:10 pm

Cost Center Description		CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	COMMUNICATIONS (NUMBER PHO NES)	PURCHASING RECEIVING AND STORES (PURCH REQU IS \$)	
		BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (SQUARE FEET)				
		1.00	2.00	4.00	5.01	5.02	
201.00	Negative Cost Centers						201.00
202.00	Cost to be allocated (per Wkst. B, Part I)	3,322,510	4,896,337	6,215,310	261,575	79,645	202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	4.963600	7.314789	0.172167	454.913043	0.005020	203.00
204.00	Cost to be allocated (per Wkst. B, Part II)			11,186	67,696	64,478	204.00
205.00	Unit cost multiplier (Wkst. B, Part II)			0.000310	117.732174	0.004064	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: 14-0217

Period:
From 07/01/2019
To 06/30/2020

Worksheet B-1

Date/Time Prepared:
11/28/2020 2:10 pm

Cost Center Description			ADMITTING (GROSS CHARGES)	CASHIERING/ACC OUNTS RECEIVABLE (GROSS CHARGES)	Reconciliation	OTHER ADMIN AND GENERAL (ACCUM COST)	MAINTENANCE & REPAIRS (SQUARE FEET)	
			5.03	5.04	5A.05	5.05	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
5.01	01160	COMMUNICATIONS						5.01
5.02	00560	PURCHASING RECEIVING AND STORES						5.02
5.03	00570	ADMITTING	768,154,886					5.03
5.04	00580	CASHIERING/ACCOUNTS RECEIVABLE	0	768,154,886				5.04
5.05	00590	OTHER ADMIN AND GENERAL	0	0	-47,047,659	102,316,821		5.05
6.00	00600	MAINTENANCE & REPAIRS	0	0	0	2,959,697	554,121	6.00
7.00	00700	OPERATION OF PLANT	0	0	0	5,799,713	236,834	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0	381,250	2,072	8.00
9.00	00900	HOUSEKEEPING	0	0	0	2,036,408	2,767	9.00
10.00	01000	DIETARY	0	0	0	949,501	11,238	10.00
11.00	01100	CAFETERIA	0	0	0	2,212,810	8,621	11.00
13.00	01300	NURSING ADMINISTRATION	0	0	0	2,063,867	1,654	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	1,019,815	7,718	14.00
15.00	01500	PHARMACY	0	0	0	2,288,097	2,630	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	138,103	6,878	16.00
23.00	02300	PARAMED ED PRGM-AMBULANCE	0	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	102,641,883	102,641,883	0	14,308,225	82,934	30.00
31.00	03100	INTENSIVE CARE UNIT	21,625,684	21,625,684	0	3,506,480	12,239	31.00
41.00	04100	SUBPROVIDER - IRF	28,952,737	28,952,737	0	4,779,740	29,883	41.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	78,861,752	78,861,752	0	3,960,777	20,674	50.00
51.00	05100	RECOVERY ROOM	34,584,861	34,584,861	0	2,744,721	12,441	51.00
53.00	05300	ANESTHESIOLOGY	15,650,556	15,650,556	0	242,453	384	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	29,752,264	29,752,264	0	3,340,125	21,727	54.00
54.01	03650	VASCULAR LAB	11,640,694	11,640,694	0	733,781	1,596	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	20,659,454	20,659,454	0	2,342,778	30,933	55.00
57.00	05700	CT SCAN	51,193,968	51,193,968	0	1,238,345	1,611	57.00
58.00	05800	MRI	11,021,861	11,021,861	0	449,473	1,831	58.00
59.00	05900	CARDIAC CATHETERIZATION	41,314,981	41,314,981	0	2,159,851	4,456	59.00
60.00	06000	LABORATORY	56,611,687	56,611,687	0	5,235,833	6,824	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	1,396,421	1,396,421	0	486,992	1,102	62.00
65.00	06500	RESPIRATORY THERAPY	10,679,874	10,679,874	0	1,352,402	1,582	65.00
66.00	06600	PHYSICAL THERAPY	25,656,746	25,656,746	0	3,266,350	6,423	66.00
67.00	06700	OCCUPATIONAL THERAPY	6,109,383	6,109,383	0	720,631	1,455	67.00
68.00	06800	SPEECH PATHOLOGY	1,712,261	1,712,261	0	404,314	836	68.00
69.00	06900	ELECTROCARDIOLOGY	22,253,849	22,253,849	0	986,621	7,831	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	28,060,660	28,060,660	0	9,056,389	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	45,554,925	45,554,925	0	5,531,351	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	43,332,310	43,332,310	0	8,053,501	0	73.00
74.00	07400	RENAL DIALYSIS	2,797,773	2,797,773	0	584,923	607	74.00
76.00	03950	OTHER ANCILLARY SERVICES COST CENTE	0	0	0	0	0	76.00
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	5,291,187	5,291,187	0	510,347	2,607	76.02
76.03	03951	OCCUPATIONAL HEALTH	0	0	0	0	0	76.03
76.97	07697	CARDIAC REHABILITATION	1,522,773	1,522,773	0	266,149	773	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	5,269,701	5,269,701	0	775,121	0	76.98
OUTPATIENT SERVICE COST CENTERS								
90.01	09001	OUTPATIENT PROCEDURES	0	0	0	0	0	90.01
91.00	09100	EMERGENCY	64,004,641	64,004,641	0	4,896,138	20,873	91.00
91.01	09101	C'VILLE OUT	0	0	0	0	0	91.01
91.02	09102	LAKE HILL OUT	0	0	0	0	0	91.02
91.03	09103	NUTRITION COUNSELING	0	0	0	0	0	91.03
91.04	09104	HUNTLEY OP	0	0	0	0	0	91.04
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	0	92.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	768,154,886	768,154,886	-47,047,659	101,783,072	552,034	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	19,487	1,513	190.00
194.00	07950	MISC NONREIMBURSABLE COST CENTER	0	0	0	146,231	0	194.00
194.01	07951	MOB	0	0	0	291,420	0	194.01
194.02	07952	COMMUNITY WELLNESS	0	0	0	67,131	0	194.02
194.03	07953	FUND DEVELOPMENT	0	0	0	8,868	574	194.03
194.04	07954	PHYSICIAN PRACTICE MANAGEMENT	0	0	0	612	0	194.04
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0217

Period:
From 07/01/2019
To 06/30/2020

Worksheet B-1

Date/Time Prepared:
11/28/2020 2:10 pm

Cost Center Description		ADMITTING (GROSS CHARGES)	CASHIERING/ACC OUNTS RECEIVABLE (GROSS CHARGES)	Reconciliation	OTHER ADMIN AND GENERAL (ACCUM COST)	MAINTENANCE & REPAIRS (SQUARE FEET)	
		5.03	5.04	5A.05	5.05	6.00	
202.00	Cost to be allocated (per Wkst. B, Part I)	590,378	6,734,934		47,047,659	4,320,634	202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	0.000769	0.008768		0.459823	7.797275	203.00
204.00	Cost to be allocated (per Wkst. B, Part II)	11,610	2,472		422,039	866,891	204.00
205.00	Unit cost multiplier (Wkst. B, Part II)	0.000015	0.000003		0.004125	1.564444	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: 14-0217

Period:
From 07/01/2019
To 06/30/2020

Worksheet B-1

Date/Time Prepared:
11/28/2020 2:10 pm

Cost Center Description			OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (TOTAL PATIENT DAYS)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	CAFETERIA (HOURS)	
			7.00	8.00	9.00	10.00	11.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	01160	COMMUNICATIONS						5.01
5.02	00560	PURCHASING RECEIVING AND STORES						5.02
5.03	00570	ADMITTING						5.03
5.04	00580	CASHIERING/ACCOUNTS RECEIVABLE						5.04
5.05	00590	OTHER ADMIN AND GENERAL						5.05
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT	317,287					7.00
8.00	00800	LAUNDRY & LINEN SERVICE	2,072	30,851				8.00
9.00	00900	HOUSEKEEPING	2,767	0	312,448			9.00
10.00	01000	DIETARY	11,238	0	11,238	30,851		10.00
11.00	01100	CAFETERIA	8,621	0	8,621	0	864,622	11.00
13.00	01300	NURSING ADMINISTRATION	1,654	0	1,654	0	39,351	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	7,718	0	7,718	0	14,850	14.00
15.00	01500	PHARMACY	2,630	0	2,630	0	33,495	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	6,878	0	6,878	0	0	16.00
23.00	02300	PARAMED ED PRGM-AMBULANCE	0	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	82,934	20,928	82,934	20,928	265,709	30.00
31.00	03100	INTENSIVE CARE UNIT	12,239	1,960	12,239	1,960	49,646	31.00
41.00	04100	SUBPROVIDER - IRF	29,883	7,963	29,883	7,963	80,638	41.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	20,674	0	20,674	0	34,316	50.00
51.00	05100	RECOVERY ROOM	12,441	0	12,441	0	47,869	51.00
53.00	05300	ANESTHESIOLOGY	384	0	384	0	1,438	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	21,727	0	21,727	0	51,570	54.00
54.01	03650	VASCULAR LAB	1,596	0	1,596	0	9,436	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	30,933	0	30,933	0	21,562	55.00
57.00	05700	CT SCAN	1,611	0	1,611	0	11,811	57.00
58.00	05800	MRI	1,831	0	1,831	0	3,645	58.00
59.00	05900	CARDIAC CATHETERIZATION	4,456	0	4,456	0	22,002	59.00
60.00	06000	LABORATORY	6,824	0	6,824	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	1,102	0	1,102	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	1,582	0	1,582	0	24,814	65.00
66.00	06600	PHYSICAL THERAPY	6,423	0	6,423	0	33,527	66.00
67.00	06700	OCCUPATIONAL THERAPY	1,455	0	1,455	0	4,473	67.00
68.00	06800	SPEECH PATHOLOGY	836	0	836	0	2,934	68.00
69.00	06900	ELECTROCARDIOLOGY	7,831	0	7,831	0	15,544	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	607	0	607	0	0	74.00
76.00	03950	OTHER ANCILLARY SERVICES COST CENTE	0	0	0	0	0	76.00
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	2,607	0	2,607	0	10,247	76.02
76.03	03951	OCCUPATIONAL HEALTH	0	0	0	0	0	76.03
76.97	07697	CARDIAC REHABILITATION	773	0	773	0	4,774	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	1,975	76.98
OUTPATIENT SERVICE COST CENTERS								
90.01	09001	OUTPATIENT PROCEDURES	0	0	0	0	0	90.01
91.00	09100	EMERGENCY	20,873	0	20,873	0	76,780	91.00
91.01	09101	C'VILLE OUT	0	0	0	0	0	91.01
91.02	09102	LAKE HILL OUT	0	0	0	0	0	91.02
91.03	09103	NUTRITION COUNSELING	0	0	0	0	0	91.03
91.04	09104	HUNTLEY OP	0	0	0	0	0	91.04
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	0	92.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	315,200	30,851	310,361	30,851	862,406	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	1,513	0	1,513	0	0	190.00
194.00	07950	MISC NONREIMBURSABLE COST CENTER	0	0	0	0	870	194.00
194.01	07951	MOB	0	0	0	0	0	194.01
194.02	07952	COMMUNITY WELLNESS	0	0	0	0	1,346	194.02
194.03	07953	FUND DEVELOPMENT	574	0	574	0	0	194.03
194.04	07954	PHYSICIAN PRACTICE MANAGEMENT	0	0	0	0	0	194.04
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)	10,313,214	640,063	3,084,310	1,949,948	3,662,853	202.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0217

Period:
From 07/01/2019
To 06/30/2020

Worksheet B-1

Date/Time Prepared:
11/28/2020 2:10 pm

Cost Center Description		OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (TOTAL PATIENT DAYS)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	CAFETERIA (HOURS)	
		7.00	8.00	9.00	10.00	11.00	
203.00	Unit cost multiplier (Wkst. B, Part I)	32.504370	20.746913	9.871435	63.205342	4.236363	203.00
204.00	Cost to be allocated (per Wkst. B, Part II)	3,305,165	51,958	75,762	280,839	220,641	204.00
205.00	Unit cost multiplier (Wkst. B, Part II)	10.416957	1.684159	0.242479	9.103076	0.255188	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: 14-0217

Period:
From 07/01/2019
To 06/30/2020

Worksheet B-1

Date/Time Prepared:
11/28/2020 2:10 pm

Cost Center Description			NURSING ADMINISTRATION (DIRECT NRSNG HRS)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)	PARAMED ED PRGM-AMBULANCE (ASSIGNED TIME)	
			13.00	14.00	15.00	16.00	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
5.01	01160	COMMUNICATIONS						5.01
5.02	00560	PURCHASING RECEIVING AND STORES						5.02
5.03	00570	ADMITTING						5.03
5.04	00580	CASHIERING/ACCOUNTS RECEIVABLE						5.04
5.05	00590	OTHER ADMIN AND GENERAL						5.05
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
13.00	01300	NURSING ADMINISTRATION	738,413					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	14,952,873				14.00
15.00	01500	PHARMACY	0	0	7,647,763			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	768,154,886		16.00
23.00	02300	PARAMED ED PRGM-AMBULANCE	0	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	265,709	99,055	20,187	102,641,883	0	30.00
31.00	03100	INTENSIVE CARE UNIT	49,646	28,827	7,278	21,625,684	0	31.00
41.00	04100	SUBPROVIDER - IRF	80,638	35,911	1,691	28,952,737	0	41.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	34,316	292,702	23,641	78,861,752	0	50.00
51.00	05100	RECOVERY ROOM	47,869	18,729	19,600	34,584,861	0	51.00
53.00	05300	ANESTHESIOLOGY	1,438	1,267	9,957	15,650,556	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	51,570	68,515	38,832	29,752,264	0	54.00
54.01	03650	VASCULAR LAB	9,436	3,875	5,586	11,640,694	0	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	21,562	18,040	5,766	20,659,454	0	55.00
57.00	05700	CT SCAN	11,811	6,840	64,001	51,193,968	0	57.00
58.00	05800	MRI	3,645	266	4,016	11,021,861	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	22,002	11,309	115,465	41,314,981	0	59.00
60.00	06000	LABORATORY	0	19,153	0	56,611,687	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	457,392	0	1,396,421	0	62.00
65.00	06500	RESPIRATORY THERAPY	24,814	6,814	656	10,679,874	0	65.00
66.00	06600	PHYSICAL THERAPY	33,527	5,813	0	25,656,746	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	4,473	627	0	6,109,383	0	67.00
68.00	06800	SPEECH PATHOLOGY	2,934	9	648	1,712,261	0	68.00
69.00	06900	ELECTROCARDIOLOGY	15,544	5,079	0	22,253,849	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	8,744,873	0	28,060,660	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	5,071,434	0	45,554,925	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	7,298,019	43,332,310	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	750	2,797,773	0	74.00
76.00	03950	OTHER ANCILLARY SERVICES COST CENTE	0	0	0	0	0	76.00
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	10,247	0	0	5,291,187	0	76.02
76.03	03951	OCCUPATIONAL HEALTH	0	0	0	0	0	76.03
76.97	07697	CARDIAC REHABILITATION	4,774	1,604	0	1,522,773	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	1,975	4,294	240	5,269,701	0	76.98
OUTPATIENT SERVICE COST CENTERS								
90.01	09001	OUTPATIENT PROCEDURES	0	0	0	0	0	90.01
91.00	09100	EMERGENCY	40,455	41,639	31,430	64,004,641	0	91.00
91.01	09101	C'VILLE OUT	0	0	0	0	0	91.01
91.02	09102	LAKE HILL OUT	0	0	0	0	0	91.02
91.03	09103	NUTRITION COUNSELING	0	0	0	0	0	91.03
91.04	09104	HUNTLEY OP	0	0	0	0	0	91.04
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	0	92.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	738,385	14,944,067	7,647,763	768,154,886	0	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
194.00	07950	MISC NONREIMBURSABLE COST CENTER	0	8,718	0	0	0	194.00
194.01	07951	MOB	0	0	0	0	0	194.01
194.02	07952	COMMUNITY WELLNESS	28	88	0	0	0	194.02
194.03	07953	FUND DEVELOPMENT	0	0	0	0	0	194.03
194.04	07954	PHYSICIAN PRACTICE MANAGEMENT	0	0	0	0	0	194.04
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0217

Period:
From 07/01/2019
To 06/30/2020

Worksheet B-1

Date/Time Prepared:
11/28/2020 2:10 pm

Cost Center Description		NURSING ADMINISTRATION (DIRECT NRSING HRS)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)	PARAMED ED PRGM-AMBULANCE (ASSIGNED TIME)	
		13.00	14.00	15.00	16.00	23.00	
202.00	Cost to be allocated (per Wkst. B, Part I)	3,262,572	1,938,895	3,614,069	546,697	0	202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	4.418357	0.129667	0.472566	0.000712	0.000000	203.00
204.00	Cost to be allocated (per Wkst. B, Part II)	62,050	198,856	84,025	171,452	0	204.00
205.00	Unit cost multiplier (Wkst. B, Part II)	0.084032	0.013299	0.010987	0.000223	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: 14-0217

Period:
From 07/01/2019
To 06/30/2020Worksheet C
Part I
Date/Time Prepared:
11/28/2020 2:10 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	29,200,388		29,200,388	22,621	29,223,009	30.00
31.00	03100	INTENSIVE CARE UNIT	6,349,700		6,349,700	1,925	6,351,625	31.00
41.00	04100	SUBPROVIDER - IRF	9,869,376		9,869,376	0	9,869,376	41.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	7,221,582		7,221,582	0	7,221,582	50.00
51.00	05100	RECOVERY ROOM	5,081,618		5,081,618	0	5,081,618	51.00
53.00	05300	ANESTHESIOLOGY	401,663		401,663	0	401,663	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	6,460,844		6,460,844	10,968	6,471,812	54.00
54.01	03650	VASCULAR LAB	1,244,362		1,244,362	0	1,244,362	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	5,178,432		5,178,432	38,739	5,217,171	55.00
57.00	05700	CT SCAN	2,058,397		2,058,397	0	2,058,397	57.00
58.00	05800	MRI	789,346		789,346	0	789,346	58.00
59.00	05900	CARDIAC CATHETERIZATION	3,652,439		3,652,439	9,155	3,661,594	59.00
60.00	06000	LABORATORY	8,028,563		8,028,563	35,836	8,064,399	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	826,516		826,516	0	826,516	62.00
65.00	06500	RESPIRATORY THERAPY	2,277,198	0	2,277,198	0	2,277,198	65.00
66.00	06600	PHYSICAL THERAPY	5,399,744	0	5,399,744	0	5,399,744	66.00
67.00	06700	OCCUPATIONAL THERAPY	1,168,139	0	1,168,139	0	1,168,139	67.00
68.00	06800	SPEECH PATHOLOGY	659,091	0	659,091	0	659,091	68.00
69.00	06900	ELECTROCARDIOLOGY	1,984,230		1,984,230	0	1,984,230	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	14,374,627		14,374,627	0	14,374,627	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	8,764,826		8,764,826	0	8,764,826	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	15,236,331		15,236,331	0	15,236,331	73.00
74.00	07400	RENAL DIALYSIS	886,685		886,685	0	886,685	74.00
76.00	03950	OTHER ANCILLARY SERVICES COST CENTE	0		0	0	0	76.00
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	968,269		968,269	0	968,269	76.02
76.03	03951	OCCUPATIONAL HEALTH	0		0	0	0	76.03
76.97	07697	CARDIAC REHABILITATION	469,923		469,923	0	469,923	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	1,153,054		1,153,054	3,231	1,156,285	76.98
OUTPATIENT SERVICE COST CENTERS								
90.01	09001	OUTPATIENT PROCEDURES	0		0	0	0	90.01
91.00	09100	EMERGENCY	8,764,594		8,764,594	9,198	8,773,792	91.00
91.01	09101	C'VILLE OUT	0		0	0	0	91.01
91.02	09102	LAKE HILL OUT	0		0	0	0	91.02
91.03	09103	NUTRITION COUNSELING	0		0	0	0	91.03
91.04	09104	HUNTLEY OP	0		0	0	0	91.04
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	2,964,832		2,964,832		2,964,832	92.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	151,434,769	0	151,434,769	131,673	151,566,442	200.00
201.00		Less Observation Beds	2,964,832		2,964,832		2,964,832	201.00
202.00		Total (see instructions)	148,469,937	0	148,469,937	131,673	148,601,610	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0217

Period:
From 07/01/2019
To 06/30/2020Worksheet C
Part I
Date/Time Prepared:
11/28/2020 2:10 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	88,630,514		88,630,514		30.00
31.00	03100	INTENSIVE CARE UNIT	21,625,684		21,625,684		31.00
41.00	04100	SUBPROVIDER - IRF	28,952,737		28,952,737		41.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	35,265,357	43,596,395	78,861,752	0.091573	50.00
51.00	05100	RECOVERY ROOM	13,397,368	21,187,493	34,584,861	0.146932	51.00
53.00	05300	ANESTHESIOLOGY	6,085,759	9,564,797	15,650,556	0.025664	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	7,873,269	21,878,995	29,752,264	0.217155	54.00
54.01	03650	VASCULAR LAB	3,162,828	8,477,866	11,640,694	0.106898	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	1,121,006	19,538,448	20,659,454	0.250657	55.00
57.00	05700	CT SCAN	14,056,940	37,137,028	51,193,968	0.040208	57.00
58.00	05800	MRI	2,914,503	8,107,358	11,021,861	0.071616	58.00
59.00	05900	CARDIAC CATHETERIZATION	14,113,584	27,201,397	41,314,981	0.088405	59.00
60.00	06000	LABORATORY	28,480,700	28,130,987	56,611,687	0.141818	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	780,143	616,278	1,396,421	0.591882	62.00
65.00	06500	RESPIRATORY THERAPY	9,629,798	1,050,076	10,679,874	0.213223	65.00
66.00	06600	PHYSICAL THERAPY	15,797,683	9,859,063	25,656,746	0.210461	66.00
67.00	06700	OCCUPATIONAL THERAPY	6,007,563	101,820	6,109,383	0.191204	67.00
68.00	06800	SPEECH PATHOLOGY	1,648,351	63,910	1,712,261	0.384924	68.00
69.00	06900	ELECTROCARDIOLOGY	8,409,026	13,844,823	22,253,849	0.089163	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	8,289,010	19,771,650	28,060,660	0.512270	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	24,837,635	20,717,290	45,554,925	0.192401	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	17,488,043	25,844,267	43,332,310	0.351616	73.00
74.00	07400	RENAL DIALYSIS	2,679,999	117,774	2,797,773	0.316925	74.00
76.00	03950	OTHER ANCILLARY SERVICES COST CENTE	0	0	0	0.000000	76.00
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	3,360,969	1,930,218	5,291,187	0.182997	76.02
76.03	03951	OCCUPATIONAL HEALTH	0	0	0	0.000000	76.03
76.97	07697	CARDIAC REHABILITATION	2,643	1,520,130	1,522,773	0.308597	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	19,794	5,249,907	5,269,701	0.218808	76.98
OUTPATIENT SERVICE COST CENTERS							
90.01	09001	OUTPATIENT PROCEDURES	0	0	0	0.000000	90.01
91.00	09100	EMERGENCY	23,005,458	40,999,183	64,004,641	0.136937	91.00
91.01	09101	C'VILLE OUT	0	0	0	0.000000	91.01
91.02	09102	LAKE HILL OUT	0	0	0	0.000000	91.02
91.03	09103	NUTRITION COUNSELING	0	0	0	0.000000	91.03
91.04	09104	HUNTLEY OP	0	0	0	0.000000	91.04
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	4,033,379	9,977,990	14,011,369	0.211602	92.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
200.00		Subtotal (see instructions)	391,669,743	376,485,143	768,154,886		200.00
201.00		Less Observation Beds					201.00
202.00		Total (see instructions)	391,669,743	376,485,143	768,154,886		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0217

Period:
From 07/01/2019
To 06/30/2020Worksheet C
Part I
Date/Time Prepared:
11/28/2020 2:10 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
41.00	04100	SUBPROVIDER - IRF				41.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.091573			50.00
51.00	05100	RECOVERY ROOM	0.146932			51.00
53.00	05300	ANESTHESIOLOGY	0.025664			53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.217523			54.00
54.01	03650	VASCULAR LAB	0.106898			54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	0.252532			55.00
57.00	05700	CT SCAN	0.040208			57.00
58.00	05800	MRI	0.071616			58.00
59.00	05900	CARDIAC CATHETERIZATION	0.088626			59.00
60.00	06000	LABORATORY	0.142451			60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0.591882			62.00
65.00	06500	RESPIRATORY THERAPY	0.213223			65.00
66.00	06600	PHYSICAL THERAPY	0.210461			66.00
67.00	06700	OCCUPATIONAL THERAPY	0.191204			67.00
68.00	06800	SPEECH PATHOLOGY	0.384924			68.00
69.00	06900	ELECTROCARDIOLOGY	0.089163			69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.512270			71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.192401			72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.351616			73.00
74.00	07400	RENAL DIALYSIS	0.316925			74.00
76.00	03950	OTHER ANCILLARY SERVICES COST CENTE	0.000000			76.00
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0.182997			76.02
76.03	03951	OCCUPATIONAL HEALTH	0.000000			76.03
76.97	07697	CARDIAC REHABILITATION	0.308597			76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0.219421			76.98
OUTPATIENT SERVICE COST CENTERS						
90.01	09001	OUTPATIENT PROCEDURES	0.000000			90.01
91.00	09100	EMERGENCY	0.137081			91.00
91.01	09101	C'VILLE OUT	0.000000			91.01
91.02	09102	LAKE HILL OUT	0.000000			91.02
91.03	09103	NUTRITION COUNSELING	0.000000			91.03
91.04	09104	HUNTLEY OP	0.000000			91.04
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.211602			92.00
SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE				113.00
200.00		Subtotal (see instructions)				200.00
201.00		Less Observation Beds				201.00
202.00		Total (see instructions)				202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0217

Period:
From 07/01/2019
To 06/30/2020Worksheet C
Part I
Date/Time Prepared:
11/28/2020 2:10 pm

				Title XIX		Hospital		PPS	
Cost Center Description			Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs				
					Total Costs	RCE Disallowance	Total Costs		
			1.00	2.00	3.00	4.00	5.00		
INPATIENT ROUTINE SERVICE COST CENTERS									
30.00	03000	ADULTS & PEDIATRICS	29,200,388		29,200,388	22,621	29,223,009	30.00	
31.00	03100	INTENSIVE CARE UNIT	6,349,700		6,349,700	1,925	6,351,625	31.00	
41.00	04100	SUBPROVIDER - IRF	9,869,376		9,869,376	0	9,869,376	41.00	
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM	7,221,582		7,221,582	0	7,221,582	50.00	
51.00	05100	RECOVERY ROOM	5,081,618		5,081,618	0	5,081,618	51.00	
53.00	05300	ANESTHESIOLOGY	401,663		401,663	0	401,663	53.00	
54.00	05400	RADIOLOGY-DIAGNOSTIC	6,460,844		6,460,844	10,968	6,471,812	54.00	
54.01	03650	VASCULAR LAB	1,244,362		1,244,362	0	1,244,362	54.01	
55.00	05500	RADIOLOGY-THERAPEUTIC	5,178,432		5,178,432	38,739	5,217,171	55.00	
57.00	05700	CT SCAN	2,058,397		2,058,397	0	2,058,397	57.00	
58.00	05800	MRI	789,346		789,346	0	789,346	58.00	
59.00	05900	CARDIAC CATHETERIZATION	3,652,439		3,652,439	9,155	3,661,594	59.00	
60.00	06000	LABORATORY	8,028,563		8,028,563	35,836	8,064,399	60.00	
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	826,516		826,516	0	826,516	62.00	
65.00	06500	RESPIRATORY THERAPY	2,277,198	0	2,277,198	0	2,277,198	65.00	
66.00	06600	PHYSICAL THERAPY	5,399,744	0	5,399,744	0	5,399,744	66.00	
67.00	06700	OCCUPATIONAL THERAPY	1,168,139	0	1,168,139	0	1,168,139	67.00	
68.00	06800	SPEECH PATHOLOGY	659,091	0	659,091	0	659,091	68.00	
69.00	06900	ELECTROCARDIOLOGY	1,984,230		1,984,230	0	1,984,230	69.00	
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	14,374,627		14,374,627	0	14,374,627	71.00	
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	8,764,826		8,764,826	0	8,764,826	72.00	
73.00	07300	DRUGS CHARGED TO PATIENTS	15,236,331		15,236,331	0	15,236,331	73.00	
74.00	07400	RENAL DIALYSIS	886,685		886,685	0	886,685	74.00	
76.00	03950	OTHER ANCILLARY SERVICES COST CENTE	0		0	0	0	76.00	
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	968,269		968,269	0	968,269	76.02	
76.03	03951	OCCUPATIONAL HEALTH	0		0	0	0	76.03	
76.97	07697	CARDIAC REHABILITATION	469,923		469,923	0	469,923	76.97	
76.98	07698	HYPERBARIC OXYGEN THERAPY	1,153,054		1,153,054	3,231	1,156,285	76.98	
OUTPATIENT SERVICE COST CENTERS									
90.01	09001	OUTPATIENT PROCEDURES	0		0	0	0	90.01	
91.00	09100	EMERGENCY	8,764,594		8,764,594	9,198	8,773,792	91.00	
91.01	09101	C'VILLE OUT	0		0	0	0	91.01	
91.02	09102	LAKE HILL OUT	0		0	0	0	91.02	
91.03	09103	NUTRITION COUNSELING	0		0	0	0	91.03	
91.04	09104	HUNTLEY OP	0		0	0	0	91.04	
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	2,964,832		2,964,832		2,964,832	92.00	
SPECIAL PURPOSE COST CENTERS									
113.00	11300	INTEREST EXPENSE						113.00	
200.00		Subtotal (see instructions)	151,434,769	0	151,434,769	131,673	151,566,442	200.00	
201.00		Less Observation Beds	2,964,832		2,964,832		2,964,832	201.00	
202.00		Total (see instructions)	148,469,937	0	148,469,937	131,673	148,601,610	202.00	

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0217

Period:
From 07/01/2019
To 06/30/2020Worksheet C
Part I
Date/Time Prepared:
11/28/2020 2:10 pm

			Title XIX		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	88,630,514		88,630,514		30.00
31.00	03100	INTENSIVE CARE UNIT	21,625,684		21,625,684		31.00
41.00	04100	SUBPROVIDER - IRF	28,952,737		28,952,737		41.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	35,265,357	43,596,395	78,861,752	0.091573	50.00
51.00	05100	RECOVERY ROOM	13,397,368	21,187,493	34,584,861	0.146932	51.00
53.00	05300	ANESTHESIOLOGY	6,085,759	9,564,797	15,650,556	0.025664	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	7,873,269	21,878,995	29,752,264	0.217155	54.00
54.01	03650	VASCULAR LAB	3,162,828	8,477,866	11,640,694	0.106898	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	1,121,006	19,538,448	20,659,454	0.250657	55.00
57.00	05700	CT SCAN	14,056,940	37,137,028	51,193,968	0.040208	57.00
58.00	05800	MRI	2,914,503	8,107,358	11,021,861	0.071616	58.00
59.00	05900	CARDIAC CATHETERIZATION	14,113,584	27,201,397	41,314,981	0.088405	59.00
60.00	06000	LABORATORY	28,480,700	28,130,987	56,611,687	0.141818	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	780,143	616,278	1,396,421	0.591882	62.00
65.00	06500	RESPIRATORY THERAPY	9,629,798	1,050,076	10,679,874	0.213223	65.00
66.00	06600	PHYSICAL THERAPY	15,797,683	9,859,063	25,656,746	0.210461	66.00
67.00	06700	OCCUPATIONAL THERAPY	6,007,563	101,820	6,109,383	0.191204	67.00
68.00	06800	SPEECH PATHOLOGY	1,648,351	63,910	1,712,261	0.384924	68.00
69.00	06900	ELECTROCARDIOLOGY	8,409,026	13,844,823	22,253,849	0.089163	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	8,289,010	19,771,650	28,060,660	0.512270	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	24,837,635	20,717,290	45,554,925	0.192401	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	17,488,043	25,844,267	43,332,310	0.351616	73.00
74.00	07400	RENAL DIALYSIS	2,679,999	117,774	2,797,773	0.316925	74.00
76.00	03950	OTHER ANCILLARY SERVICES COST CENTE	0	0	0	0.000000	76.00
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	3,360,969	1,930,218	5,291,187	0.182997	76.02
76.03	03951	OCCUPATIONAL HEALTH	0	0	0	0.000000	76.03
76.97	07697	CARDIAC REHABILITATION	2,643	1,520,130	1,522,773	0.308597	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	19,794	5,249,907	5,269,701	0.218808	76.98
OUTPATIENT SERVICE COST CENTERS							
90.01	09001	OUTPATIENT PROCEDURES	0	0	0	0.000000	90.01
91.00	09100	EMERGENCY	23,005,458	40,999,183	64,004,641	0.136937	91.00
91.01	09101	C'VILLE OUT	0	0	0	0.000000	91.01
91.02	09102	LAKE HILL OUT	0	0	0	0.000000	91.02
91.03	09103	NUTRITION COUNSELING	0	0	0	0.000000	91.03
91.04	09104	HUNTLEY OP	0	0	0	0.000000	91.04
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	4,033,379	9,977,990	14,011,369	0.211602	92.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
200.00		Subtotal (see instructions)	391,669,743	376,485,143	768,154,886		200.00
201.00		Less Observation Beds					201.00
202.00		Total (see instructions)	391,669,743	376,485,143	768,154,886		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0217

Period:
From 07/01/2019
To 06/30/2020Worksheet C
Part I
Date/Time Prepared:
11/28/2020 2:10 pm

Cost Center Description			PPS Inpatient Ratio	Title XIX	Hospital	PPS
			11.00			
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS				30.00
31.00	03100	INTENSIVE CARE UNIT				31.00
41.00	04100	SUBPROVIDER - IRF				41.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.091573			50.00
51.00	05100	RECOVERY ROOM	0.146932			51.00
53.00	05300	ANESTHESIOLOGY	0.025664			53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.217523			54.00
54.01	03650	VASCULAR LAB	0.106898			54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	0.252532			55.00
57.00	05700	CT SCAN	0.040208			57.00
58.00	05800	MRI	0.071616			58.00
59.00	05900	CARDIAC CATHETERIZATION	0.088626			59.00
60.00	06000	LABORATORY	0.142451			60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0.591882			62.00
65.00	06500	RESPIRATORY THERAPY	0.213223			65.00
66.00	06600	PHYSICAL THERAPY	0.210461			66.00
67.00	06700	OCCUPATIONAL THERAPY	0.191204			67.00
68.00	06800	SPEECH PATHOLOGY	0.384924			68.00
69.00	06900	ELECTROCARDIOLOGY	0.089163			69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.512270			71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.192401			72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.351616			73.00
74.00	07400	RENAL DIALYSIS	0.316925			74.00
76.00	03950	OTHER ANCILLARY SERVICES COST CENTE	0.000000			76.00
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0.182997			76.02
76.03	03951	OCCUPATIONAL HEALTH	0.000000			76.03
76.97	07697	CARDIAC REHABILITATION	0.308597			76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0.219421			76.98
OUTPATIENT SERVICE COST CENTERS						
90.01	09001	OUTPATIENT PROCEDURES	0.000000			90.01
91.00	09100	EMERGENCY	0.137081			91.00
91.01	09101	C'VILLE OUT	0.000000			91.01
91.02	09102	LAKE HILL OUT	0.000000			91.02
91.03	09103	NUTRITION COUNSELING	0.000000			91.03
91.04	09104	HUNTLEY OP	0.000000			91.04
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.211602			92.00
SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE				113.00
200.00		Subtotal (see instructions)				200.00
201.00		Less Observation Beds				201.00
202.00		Total (see instructions)				202.00

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

Provider CCN: 14-0217

Period:
From 07/01/2019
To 06/30/2020Worksheet C
Part II
Date/Time Prepared:
11/28/2020 2:10 pm

Cost Center Description			Title XIX			Hospital	PPS	
			Total Cost (Wkst. B, Part I, col. 26)	Capital Cost (Wkst. B, Part II col. 26)	Operating Cost Net of Capital Cost (col. 1 - col. 2)	Capital Reduction	Operating Cost Reduction Amount	
			1.00	2.00	3.00	4.00	5.00	
	ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	7,221,582	562,952	6,658,630	0	0	50.00
51.00	05100	RECOVERY ROOM	5,081,618	342,523	4,739,095	0	0	51.00
53.00	05300	ANESTHESIOLOGY	401,663	15,171	386,492	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	6,460,844	577,120	5,883,724	0	0	54.00
54.01	03650	VASCULAR LAB	1,244,362	48,525	1,195,837	0	0	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	5,178,432	784,172	4,394,260	0	0	55.00
57.00	05700	CT SCAN	2,058,397	61,875	1,996,522	0	0	57.00
58.00	05800	MRI	789,346	50,705	738,641	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	3,652,439	137,317	3,515,122	0	0	59.00
60.00	06000	LABORATORY	8,028,563	205,133	7,823,430	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	826,516	37,406	789,110	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	2,277,198	56,571	2,220,627	0	0	65.00
66.00	06600	PHYSICAL THERAPY	5,399,744	189,967	5,209,777	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	1,168,139	41,796	1,126,343	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	659,091	23,731	635,360	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	1,984,230	207,662	1,776,568	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	14,374,627	195,954	14,178,673	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	8,764,826	121,851	8,642,975	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	15,236,331	123,847	15,112,484	0	0	73.00
74.00	07400	RENAL DIALYSIS	886,685	17,968	868,717	0	0	74.00
76.00	03950	OTHER ANCILLARY SERVICES COST CENTE	0	0	0	0	0	76.00
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	968,269	72,840	895,429	0	0	76.02
76.03	03951	OCCUPATIONAL HEALTH	0	0	0	0	0	76.03
76.97	07697	CARDIAC REHABILITATION	469,923	22,108	447,815	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	1,153,054	5,241	1,147,813	0	0	76.98
	OUTPATIENT SERVICE COST CENTERS							
90.01	09001	OUTPATIENT PROCEDURES	0	0	0	0	0	90.01
91.00	09100	EMERGENCY	8,764,594	576,403	8,188,191	0	0	91.00
91.01	09101	C'VILLE OUT	0	0	0	0	0	91.01
91.02	09102	LAKE HILL OUT	0	0	0	0	0	91.02
91.03	09103	NUTRITION COUNSELING	0	0	0	0	0	91.03
91.04	09104	HUNTLEY OP	0	0	0	0	0	91.04
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	2,964,832	248,257	2,716,575	0	0	92.00
	SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (sum of lines 50 thru 199)	106,015,305	4,727,095	101,288,210	0	0	200.00
201.00		Less Observation Beds	2,964,832	248,257	2,716,575	0	0	201.00
202.00		Total (line 200 minus line 201)	103,050,473	4,478,838	98,571,635	0	0	202.00

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

Provider CCN: 14-0217

Period:
From 07/01/2019
To 06/30/2020Worksheet C
Part II
Date/Time Prepared:
11/28/2020 2:10 pm

Cost Center Description				Title XIX		Hospital	PPS
				Cost Net of Capital and Operating Cost Reduction	Total Charges (Worksheet C, Part I, column 8)	Outpatient Cost to Charge Ratio (col. 6 / col. 7)	
				6.00	7.00	8.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM		7,221,582	78,861,752	0.091573	50.00
51.00	05100	RECOVERY ROOM		5,081,618	34,584,861	0.146932	51.00
53.00	05300	ANESTHESIOLOGY		401,663	15,650,556	0.025664	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC		6,460,844	29,752,264	0.217155	54.00
54.01	03650	VASCULAR LAB		1,244,362	11,640,694	0.106898	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC		5,178,432	20,659,454	0.250657	55.00
57.00	05700	CT SCAN		2,058,397	51,193,968	0.040208	57.00
58.00	05800	MRI		789,346	11,021,861	0.071616	58.00
59.00	05900	CARDIAC CATHETERIZATION		3,652,439	41,314,981	0.088405	59.00
60.00	06000	LABORATORY		8,028,563	56,611,687	0.141818	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL		826,516	1,396,421	0.591882	62.00
65.00	06500	RESPIRATORY THERAPY		2,277,198	10,679,874	0.213223	65.00
66.00	06600	PHYSICAL THERAPY		5,399,744	25,656,746	0.210461	66.00
67.00	06700	OCCUPATIONAL THERAPY		1,168,139	6,109,383	0.191204	67.00
68.00	06800	SPEECH PATHOLOGY		659,091	1,712,261	0.384924	68.00
69.00	06900	ELECTROCARDIOLOGY		1,984,230	22,253,849	0.089163	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT		14,374,627	28,060,660	0.512270	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS		8,764,826	45,554,925	0.192401	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS		15,236,331	43,332,310	0.351616	73.00
74.00	07400	RENAL DIALYSIS		886,685	2,797,773	0.316925	74.00
76.00	03950	OTHER ANCILLARY SERVICES COST CENTE		0	0	0.000000	76.00
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES		968,269	5,291,187	0.182997	76.02
76.03	03951	OCCUPATIONAL HEALTH		0	0	0.000000	76.03
76.97	07697	CARDIAC REHABILITATION		469,923	1,522,773	0.308597	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY		1,153,054	5,269,701	0.218808	76.98
OUTPATIENT SERVICE COST CENTERS							
90.01	09001	OUTPATIENT PROCEDURES		0	0	0.000000	90.01
91.00	09100	EMERGENCY		8,764,594	64,004,641	0.136937	91.00
91.01	09101	C'VILLE OUT		0	0	0.000000	91.01
91.02	09102	LAKE HILL OUT		0	0	0.000000	91.02
91.03	09103	NUTRITION COUNSELING		0	0	0.000000	91.03
91.04	09104	HUNTLEY OP		0	0	0.000000	91.04
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART		2,964,832	14,011,369	0.211602	92.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
200.00		Subtotal (sum of lines 50 thru 199)		106,015,305	628,945,951		200.00
201.00		Less Observation Beds		2,964,832	0		201.00
202.00		Total (line 200 minus line 201)		103,050,473	628,945,951		202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

Provider CCN: 14-0217

Period:
From 07/01/2019
To 06/30/2020Worksheet D
Part I
Date/Time Prepared:
11/28/2020 2:10 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	2,446,957	0	2,446,957	23,291	105.06	30.00
31.00	INTENSIVE CARE UNIT	359,592		359,592	1,960	183.47	31.00
41.00	SUBPROVIDER - IRF	875,266	0	875,266	7,963	109.92	41.00
200.00	Total (lines 30 through 199)	3,681,815		3,681,815	33,214		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	7,407	778,179				30.00
31.00	INTENSIVE CARE UNIT	812	148,978				31.00
41.00	SUBPROVIDER - IRF	5,945	653,474				41.00
200.00	Total (lines 30 through 199)	14,164	1,580,631				200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 14-0217

Period:
From 07/01/2019
To 06/30/2020Worksheet D
Part II
Date/Time Prepared:
11/28/2020 2:10 pm

Cost Center Description		Title XVIII		Hospital		PPS	
		Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
		1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	562,952	78,861,752	0.007138	16,862,942	120,368 50.00
51.00	05100	RECOVERY ROOM	342,523	34,584,861	0.009904	5,770,514	57,151 51.00
53.00	05300	ANESTHESIOLOGY	15,171	15,650,556	0.000969	2,721,617	2,637 53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	577,120	29,752,264	0.019398	3,449,303	66,910 54.00
54.01	03650	VASCULAR LAB	48,525	11,640,694	0.004169	1,227,600	5,118 54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	784,172	20,659,454	0.037957	334,012	12,678 55.00
57.00	05700	CT SCAN	61,875	51,193,968	0.001209	5,976,877	7,226 57.00
58.00	05800	MRI	50,705	11,021,861	0.004600	1,275,174	5,866 58.00
59.00	05900	CARDIAC CATHETERIZATION	137,317	41,314,981	0.003324	6,031,124	20,047 59.00
60.00	06000	LABORATORY	205,133	56,611,687	0.003624	10,445,174	37,853 60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	37,406	1,396,421	0.026787	464,798	12,451 62.00
65.00	06500	RESPIRATORY THERAPY	56,571	10,679,874	0.005297	3,690,606	19,549 65.00
66.00	06600	PHYSICAL THERAPY	189,967	25,656,746	0.007404	2,180,223	16,142 66.00
67.00	06700	OCCUPATIONAL THERAPY	41,796	6,109,383	0.006841	1,035,016	7,081 67.00
68.00	06800	SPEECH PATHOLOGY	23,731	1,712,261	0.013859	539,717	7,480 68.00
69.00	06900	ELECTROCARDIOLOGY	207,662	22,253,849	0.009332	3,728,836	34,797 69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	195,954	28,060,660	0.006983	3,843,748	26,841 71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	121,851	45,554,925	0.002675	12,821,324	34,297 72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	123,847	43,332,310	0.002858	6,200,818	17,722 73.00
74.00	07400	RENAL DIALYSIS	17,968	2,797,773	0.006422	813,720	5,226 74.00
76.00	03950	OTHER ANCILLARY SERVICES COST CENTE	0	0	0.000000	0	0 76.00
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	72,840	5,291,187	0.013766	381,192	5,247 76.02
76.03	03951	OCCUPATIONAL HEALTH	0	0	0.000000	0	0 76.03
76.97	07697	CARDIAC REHABILITATION	22,108	1,522,773	0.014518	1,925	28 76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	5,241	5,269,701	0.000995	9,975	10 76.98
OUTPATIENT SERVICE COST CENTERS							
90.01	09001	OUTPATIENT PROCEDURES	0	0	0.000000	0	0 90.01
91.00	09100	EMERGENCY	576,403	64,004,641	0.009006	8,207,263	73,915 91.00
91.01	09101	C'VILLE OUT	0	0	0.000000	0	0 91.01
91.02	09102	LAKE HILL OUT	0	0	0.000000	0	0 91.02
91.03	09103	NUTRITION COUNSELING	0	0	0.000000	0	0 91.03
91.04	09104	HUNTLEY OP	0	0	0.000000	0	0 91.04
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	248,257	14,011,369	0.017718	1,722,372	30,517 92.00
200.00		Total (lines 50 through 199)	4,727,095	628,945,951		99,735,870	627,157 200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS					Provider CCN: 14-0217		Period: From 07/01/2019 To 06/30/2020		Worksheet D Part III Date/Time Prepared: 11/28/2020 2:10 pm		
					Title XVIII		Hospital		PPS		
Cost Center Description					Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health Cost	All Other Medical Education Cost		
					1A	1.00	2A	2.00	3.00		
INPATIENT ROUTINE SERVICE COST CENTERS											
30.00	03000	ADULTS & PEDIATRICS		0	0	0	0	0	0	30.00	
31.00	03100	INTENSIVE CARE UNIT		0	0	0	0	0	0	31.00	
41.00	04100	SUBPROVIDER - IRF		0	0	0	0	0	0	41.00	
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	23,291	0.00	7,407		30.00	
31.00	03100	INTENSIVE CARE UNIT			0	1,960	0.00	812		31.00	
41.00	04100	SUBPROVIDER - IRF		0	0	7,963	0.00	5,945		41.00	
200.00		Total (lines 30 through 199)			0	33,214		14,164		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	
41.00	04100	SUBPROVIDER - IRF		0						41.00	
200.00		Total (lines 30 through 199)		0						200.00	

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

Provider CCN: 14-0217

Period:
From 07/01/2019
To 06/30/2020

Worksheet D
Part IV
Date/Time Prepared:
11/28/2020 2:10 pm

Cost Center Description		Title XVIII		Hospital		PPS	
		Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health	
		1.00	2A	2.00	3A	3.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	51.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	54.00
54.01	03650	VASCULAR LAB	0	0	0	0	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	55.00
57.00	05700	CT SCAN	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	59.00
60.00	06000	LABORATORY	0	0	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	74.00
76.00	03950	OTHER ANCILLARY SERVICES COST CENTE	0	0	0	0	76.00
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0	0	0	76.02
76.03	03951	OCCUPATIONAL HEALTH	0	0	0	0	76.03
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	76.98
OUTPATIENT SERVICE COST CENTERS							
90.01	09001	OUTPATIENT PROCEDURES	0	0	0	0	90.01
91.00	09100	EMERGENCY	0	0	0	0	91.00
91.01	09101	C'VILLE OUT	0	0	0	0	91.01
91.02	09102	LAKE HILL OUT	0	0	0	0	91.02
91.03	09103	NUTRITION COUNSELING	0	0	0	0	91.03
91.04	09104	HUNTLEY OP	0	0	0	0	91.04
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	92.00
200.00		Total (lines 50 through 199)	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

Provider CCN: 14-0217

Period:
From 07/01/2019
To 06/30/2020Worksheet D
Part IV
Date/Time Prepared:
11/28/2020 2:10 pm

Cost Center Description			Title XVIII		Hospital		PPS
			All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7) (see instructions)
			4.00	5.00	6.00	7.00	8.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	0	0	78,861,752	0.000000
51.00	05100	RECOVERY ROOM	0	0	0	34,584,861	0.000000
53.00	05300	ANESTHESIOLOGY	0	0	0	15,650,556	0.000000
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	29,752,264	0.000000
54.01	03650	VASCULAR LAB	0	0	0	11,640,694	0.000000
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	20,659,454	0.000000
57.00	05700	CT SCAN	0	0	0	51,193,968	0.000000
58.00	05800	MRI	0	0	0	11,021,861	0.000000
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	41,314,981	0.000000
60.00	06000	LABORATORY	0	0	0	56,611,687	0.000000
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0	1,396,421	0.000000
65.00	06500	RESPIRATORY THERAPY	0	0	0	10,679,874	0.000000
66.00	06600	PHYSICAL THERAPY	0	0	0	25,656,746	0.000000
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	6,109,383	0.000000
68.00	06800	SPEECH PATHOLOGY	0	0	0	1,712,261	0.000000
69.00	06900	ELECTROCARDIOLOGY	0	0	0	22,253,849	0.000000
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	28,060,660	0.000000
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	45,554,925	0.000000
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	43,332,310	0.000000
74.00	07400	RENAL DIALYSIS	0	0	0	2,797,773	0.000000
76.00	03950	OTHER ANCILLARY SERVICES COST CENTE	0	0	0	0	0.000000
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0	0	5,291,187	0.000000
76.03	03951	OCCUPATIONAL HEALTH	0	0	0	0	0.000000
76.97	07697	CARDIAC REHABILITATION	0	0	0	1,522,773	0.000000
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	5,269,701	0.000000
OUTPATIENT SERVICE COST CENTERS							
90.01	09001	OUTPATIENT PROCEDURES	0	0	0	0	0.000000
91.00	09100	EMERGENCY	0	0	0	64,004,641	0.000000
91.01	09101	C'VILLE OUT	0	0	0	0	0.000000
91.02	09102	LAKE HILL OUT	0	0	0	0	0.000000
91.03	09103	NUTRITION COUNSELING	0	0	0	0	0.000000
91.04	09104	HUNTLEY OP	0	0	0	0	0.000000
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	14,011,369	0.000000
200.00		Total (lines 50 through 199)	0	0	0	628,945,951	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-0217

Period:
From 07/01/2019
To 06/30/2020Worksheet D
Part IV
Date/Time Prepared:
11/28/2020 2:10 pm

Cost Center Description			Title XVIII		Hospital		PPS
			Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)
			9.00	10.00	11.00	12.00	13.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0.000000	16,862,942	0	17,258,567	0
51.00	05100	RECOVERY ROOM	0.000000	5,770,514	0	7,601,916	0
53.00	05300	ANESTHESIOLOGY	0.000000	2,721,617	0	3,413,051	0
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	3,449,303	0	5,969,322	0
54.01	03650	VASCULAR LAB	0.000000	1,227,600	0	1,969,603	0
55.00	05500	RADIOLOGY-THERAPEUTIC	0.000000	334,012	0	7,498,482	0
57.00	05700	CT SCAN	0.000000	5,976,877	0	8,561,673	0
58.00	05800	MRI	0.000000	1,275,174	0	2,919,542	0
59.00	05900	CARDIAC CATHETERIZATION	0.000000	6,031,124	0	13,782,105	0
60.00	06000	LABORATORY	0.000000	10,445,174	0	4,777,186	0
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0.000000	464,798	0	187,052	0
65.00	06500	RESPIRATORY THERAPY	0.000000	3,690,606	0	313,194	0
66.00	06600	PHYSICAL THERAPY	0.000000	2,180,223	0	335,617	0
67.00	06700	OCCUPATIONAL THERAPY	0.000000	1,035,016	0	6,356	0
68.00	06800	SPEECH PATHOLOGY	0.000000	539,717	0	2,032	0
69.00	06900	ELECTROCARDIOLOGY	0.000000	3,728,836	0	4,737,737	0
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	3,843,748	0	10,264,662	0
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	12,821,324	0	11,643,503	0
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	6,200,818	0	8,970,398	0
74.00	07400	RENAL DIALYSIS	0.000000	813,720	0	27,380	0
76.00	03950	OTHER ANCILLARY SERVICES COST CENTE	0.000000	0	0	0	0
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0.000000	381,192	0	0	0
76.03	03951	OCCUPATIONAL HEALTH	0.000000	0	0	0	0
76.97	07697	CARDIAC REHABILITATION	0.000000	1,925	0	632,323	0
76.98	07698	HYPERBARIC OXYGEN THERAPY	0.000000	9,975	0	1,912,489	0
OUTPATIENT SERVICE COST CENTERS							
90.01	09001	OUTPATIENT PROCEDURES	0.000000	0	0	0	0
91.00	09100	EMERGENCY	0.000000	8,207,263	0	6,236,350	0
91.01	09101	C'VILLE OUT	0.000000	0	0	0	0
91.02	09102	LAKE HILL OUT	0.000000	0	0	0	0
91.03	09103	NUTRITION COUNSELING	0.000000	0	0	0	0
91.04	09104	HUNTLEY OP	0.000000	0	0	0	0
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	1,722,372	0	2,660,530	0
200.00		Total (lines 50 through 199)		99,735,870	0	121,681,070	0

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-0217

Period:
From 07/01/2019
To 06/30/2020Worksheet D
Part V
Date/Time Prepared:
11/28/2020 2:10 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	0.091573	17,258,567	0	0	1,580,419	50.00	
51.00	05100	RECOVERY ROOM	0.146932	7,601,916	0	0	1,116,965	51.00	
53.00	05300	ANESTHESIOLOGY	0.025664	3,413,051	0	0	87,593	53.00	
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.217155	5,969,322	0	0	1,296,268	54.00	
54.01	03650	VASCULAR LAB	0.106898	1,969,603	0	0	210,547	54.01	
55.00	05500	RADIOLOGY-THERAPEUTIC	0.250657	7,498,482	0	0	1,879,547	55.00	
57.00	05700	CT SCAN	0.040208	8,561,673	0	0	344,248	57.00	
58.00	05800	MRI	0.071616	2,919,542	0	0	209,086	58.00	
59.00	05900	CARDIAC CATHETERIZATION	0.088405	13,782,105	0	0	1,218,407	59.00	
60.00	06000	LABORATORY	0.141818	4,777,186	0	0	677,491	60.00	
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0.591882	187,052	0	0	110,713	62.00	
65.00	06500	RESPIRATORY THERAPY	0.213223	313,194	0	0	66,780	65.00	
66.00	06600	PHYSICAL THERAPY	0.210461	335,617	0	0	70,634	66.00	
67.00	06700	OCCUPATIONAL THERAPY	0.191204	6,356	0	0	1,215	67.00	
68.00	06800	SPEECH PATHOLOGY	0.384924	2,032	0	0	782	68.00	
69.00	06900	ELECTROCARDIOLOGY	0.089163	4,737,737	0	0	422,431	69.00	
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.512270	10,264,662	0	0	5,258,278	71.00	
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.192401	11,643,503	0	0	2,240,222	72.00	
73.00	07300	DRUGS CHARGED TO PATIENTS	0.351616	8,970,398	0	28,850	3,154,135	73.00	
74.00	07400	RENAL DIALYSIS	0.316925	27,380	0	0	8,677	74.00	
76.00	03950	OTHER ANCILLARY SERVICES COST CENTE	0.000000	0	0	0	0	76.00	
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0.182997	0	0	0	0	76.02	
76.03	03951	OCCUPATIONAL HEALTH	0.000000	0	0	0	0	76.03	
76.97	07697	CARDIAC REHABILITATION	0.308597	632,323	0	0	195,133	76.97	
76.98	07698	HYPERBARIC OXYGEN THERAPY	0.218808	1,912,489	0	0	418,468	76.98	
OUTPATIENT SERVICE COST CENTERS									
90.01	09001	OUTPATIENT PROCEDURES	0.000000	0	0	0	0	90.01	
91.00	09100	EMERGENCY	0.136937	6,236,350	0	0	853,987	91.00	
91.01	09101	C'VILLE OUT	0.000000	0	0	0	0	91.01	
91.02	09102	LAKE HILL OUT	0.000000	0	0	0	0	91.02	
91.03	09103	NUTRITION COUNSELING	0.000000	0	0	0	0	91.03	
91.04	09104	HUNTLEY OP	0.000000	0	0	0	0	91.04	
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.211602	2,660,530	0	0	562,973	92.00	
200.00		Subtotal (see instructions)		121,681,070	0	28,850	21,984,999	200.00	
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00	
202.00		Net Charges (line 200 - line 201)		121,681,070	0	28,850	21,984,999	202.00	

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-0217

Period:
From 07/01/2019
To 06/30/2020Worksheet D
Part V
Date/Time Prepared:
11/28/2020 2:10 pm

			Title XVIII		Hospital	PPS
	Cost Center Description	Costs				
		Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)			
		6.00	7.00			
	ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	0		50.00
51.00	05100	RECOVERY ROOM	0	0		51.00
53.00	05300	ANESTHESIOLOGY	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0		54.00
54.01	03650	VASCULAR LAB	0	0		54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0		55.00
57.00	05700	CT SCAN	0	0		57.00
58.00	05800	MRI	0	0		58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0		59.00
60.00	06000	LABORATORY	0	0		60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0		62.00
65.00	06500	RESPIRATORY THERAPY	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	10,144		73.00
74.00	07400	RENAL DIALYSIS	0	0		74.00
76.00	03950	OTHER ANCILLARY SERVICES COST CENTE	0	0		76.00
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0		76.02
76.03	03951	OCCUPATIONAL HEALTH	0	0		76.03
76.97	07697	CARDIAC REHABILITATION	0	0		76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0		76.98
	OUTPATIENT SERVICE COST CENTERS					
90.01	09001	OUTPATIENT PROCEDURES	0	0		90.01
91.00	09100	EMERGENCY	0	0		91.00
91.01	09101	C'VILLE OUT	0	0		91.01
91.02	09102	LAKE HILL OUT	0	0		91.02
91.03	09103	NUTRITION COUNSELING	0	0		91.03
91.04	09104	HUNTLEY OP	0	0		91.04
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0		92.00
200.00		Subtotal (see instructions)	0	10,144		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	0	10,144		202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 14-0217

Period:

Worksheet D

Component CCN: 14-T217

From 07/01/2019
To 06/30/2020Part II
Date/Time Prepared:
11/28/2020 2:10 pm

Title XVIII

Subprovider -
IRF

PPS

Cost Center Description			Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	562,952	78,861,752	0.007138	61,091	436	50.00
51.00	05100	RECOVERY ROOM	342,523	34,584,861	0.009904	26,925	267	51.00
53.00	05300	ANESTHESIOLOGY	15,171	15,650,556	0.000969	10,626	10	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	577,120	29,752,264	0.019398	244,268	4,738	54.00
54.01	03650	VASCULAR LAB	48,525	11,640,694	0.004169	128,114	534	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	784,172	20,659,454	0.037957	47,989	1,822	55.00
57.00	05700	CT SCAN	61,875	51,193,968	0.001209	241,237	292	57.00
58.00	05800	MRI	50,705	11,021,861	0.004600	65,408	301	58.00
59.00	05900	CARDIAC CATHETERIZATION	137,317	41,314,981	0.003324	27,023	90	59.00
60.00	06000	LABORATORY	205,133	56,611,687	0.003624	1,715,117	6,216	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	37,406	1,396,421	0.026787	10,441	280	62.00
65.00	06500	RESPIRATORY THERAPY	56,571	10,679,874	0.005297	1,145,003	6,065	65.00
66.00	06600	PHYSICAL THERAPY	189,967	25,656,746	0.007404	6,077,049	44,994	66.00
67.00	06700	OCCUPATIONAL THERAPY	41,796	6,109,383	0.006841	4,972,547	34,017	67.00
68.00	06800	SPEECH PATHOLOGY	23,731	1,712,261	0.013859	990,850	13,732	68.00
69.00	06900	ELECTROCARDIOLOGY	207,662	22,253,849	0.009332	88,942	830	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	195,954	28,060,660	0.006983	17,315	121	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	121,851	45,554,925	0.002675	27,628	74	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	123,847	43,332,310	0.002858	1,628,552	4,654	73.00
74.00	07400	RENAL DIALYSIS	17,968	2,797,773	0.006422	389,523	2,502	74.00
76.00	03950	OTHER ANCILLARY SERVICES COST CENTE	0	0	0.000000	0	0	76.00
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	72,840	5,291,187	0.013766	0	0	76.02
76.03	03951	OCCUPATIONAL HEALTH	0	0	0.000000	0	0	76.03
76.97	07697	CARDIAC REHABILITATION	22,108	1,522,773	0.014518	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	5,241	5,269,701	0.000995	0	0	76.98
OUTPATIENT SERVICE COST CENTERS								
90.01	09001	OUTPATIENT PROCEDURES	0	0	0.000000	0	0	90.01
91.00	09100	EMERGENCY	576,403	64,004,641	0.009006	13,827	125	91.00
91.01	09101	C'VILLE OUT	0	0	0.000000	0	0	91.01
91.02	09102	LAKE HILL OUT	0	0	0.000000	0	0	91.02
91.03	09103	NUTRITION COUNSELING	0	0	0.000000	0	0	91.03
91.04	09104	HUNTLEY OP	0	0	0.000000	0	0	91.04
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	14,011,369	0.000000	0	0	92.00
200.00		Total (lines 50 through 199)	4,478,838	628,945,951		17,929,475	122,100	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS				Provider CCN: 14-0217 Component CCN: 14-T217		Period: From 07/01/2019 To 06/30/2020		Worksheet D Part IV Date/Time Prepared: 11/28/2020 2:10 pm	
				Title XVIII		Subprovider - IRF		PPS	
Cost Center Description				Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health	
				1.00	2A	2.00	3A	3.00	
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM		0	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM		0	0	0	0	0	51.00
53.00	05300	ANESTHESIOLOGY		0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC		0	0	0	0	0	54.00
54.01	03650	VASCULAR LAB		0	0	0	0	0	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC		0	0	0	0	0	55.00
57.00	05700	CT SCAN		0	0	0	0	0	57.00
58.00	05800	MRI		0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION		0	0	0	0	0	59.00
60.00	06000	LABORATORY		0	0	0	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL		0	0	0	0	0	62.00
65.00	06500	RESPIRATORY THERAPY		0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY		0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY		0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY		0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY		0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT		0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS		0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS		0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS		0	0	0	0	0	74.00
76.00	03950	OTHER ANCILLARY SERVICES COST CENTE		0	0	0	0	0	76.00
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES		0	0	0	0	0	76.02
76.03	03951	OCCUPATIONAL HEALTH		0	0	0	0	0	76.03
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
OUTPATIENT SERVICE COST CENTERS									
90.01	09001	OUTPATIENT PROCEDURES		0	0	0	0	0	90.01
91.00	09100	EMERGENCY		0	0	0	0	0	91.00
91.01	09101	C'VILLE OUT		0	0	0	0	0	91.01
91.02	09102	LAKE HILL OUT		0	0	0	0	0	91.02
91.03	09103	NUTRITION COUNSELING		0	0	0	0	0	91.03
91.04	09104	HUNTLEY OP		0	0	0	0	0	91.04
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART		0	0	0	0	0	92.00
200.00		Total (lines 50 through 199)		0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS				Provider CCN: 14-0217 Component CCN: 14-T217		Period: From 07/01/2019 To 06/30/2020		Worksheet D Part IV Date/Time Prepared: 11/28/2020 2:10 pm	
				Title XVIII		Subprovider - IRF		PPS	
Cost Center Description				All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7) (see instructions)	
				4.00	5.00	6.00	7.00	8.00	
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM		0	0	0	78,861,752	0.000000	50.00
51.00	05100	RECOVERY ROOM		0	0	0	34,584,861	0.000000	51.00
53.00	05300	ANESTHESIOLOGY		0	0	0	15,650,556	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC		0	0	0	29,752,264	0.000000	54.00
54.01	03650	VASCULAR LAB		0	0	0	11,640,694	0.000000	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC		0	0	0	20,659,454	0.000000	55.00
57.00	05700	CT SCAN		0	0	0	51,193,968	0.000000	57.00
58.00	05800	MRI		0	0	0	11,021,861	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION		0	0	0	41,314,981	0.000000	59.00
60.00	06000	LABORATORY		0	0	0	56,611,687	0.000000	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL		0	0	0	1,396,421	0.000000	62.00
65.00	06500	RESPIRATORY THERAPY		0	0	0	10,679,874	0.000000	65.00
66.00	06600	PHYSICAL THERAPY		0	0	0	25,656,746	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY		0	0	0	6,109,383	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY		0	0	0	1,712,261	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY		0	0	0	22,253,849	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT		0	0	0	28,060,660	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS		0	0	0	45,554,925	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS		0	0	0	43,332,310	0.000000	73.00
74.00	07400	RENAL DIALYSIS		0	0	0	2,797,773	0.000000	74.00
76.00	03950	OTHER ANCILLARY SERVICES COST CENTE		0	0	0	0	0.000000	76.00
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES		0	0	0	5,291,187	0.000000	76.02
76.03	03951	OCCUPATIONAL HEALTH		0	0	0	0	0.000000	76.03
76.97	07697	CARDIAC REHABILITATION		0	0	0	1,522,773	0.000000	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY		0	0	0	5,269,701	0.000000	76.98
OUTPATIENT SERVICE COST CENTERS									
90.01	09001	OUTPATIENT PROCEDURES		0	0	0	0	0.000000	90.01
91.00	09100	EMERGENCY		0	0	0	64,004,641	0.000000	91.00
91.01	09101	C'VILLE OUT		0	0	0	0	0.000000	91.01
91.02	09102	LAKE HILL OUT		0	0	0	0	0.000000	91.02
91.03	09103	NUTRITION COUNSELING		0	0	0	0	0.000000	91.03
91.04	09104	HUNTLEY OP		0	0	0	0	0.000000	91.04
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART		0	0	0	14,011,369	0.000000	92.00
200.00		Total (lines 50 through 199)		0	0	0	628,945,951		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS				Provider CCN: 14-0217 Component CCN: 14-T217		Period: From 07/01/2019 To 06/30/2020		Worksheet D Part IV Date/Time Prepared: 11/28/2020 2:10 pm	
				Title XVIII		Subprovider - IRF		PPS	
Cost Center Description				Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
				9.00	10.00	11.00	12.00	13.00	
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM		0.000000	61,091	0	0	0	50.00
51.00	05100	RECOVERY ROOM		0.000000	26,925	0	0	0	51.00
53.00	05300	ANESTHESIOLOGY		0.000000	10,626	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC		0.000000	244,268	0	0	0	54.00
54.01	03650	VASCULAR LAB		0.000000	128,114	0	0	0	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC		0.000000	47,989	0	0	0	55.00
57.00	05700	CT SCAN		0.000000	241,237	0	0	0	57.00
58.00	05800	MRI		0.000000	65,408	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION		0.000000	27,023	0	0	0	59.00
60.00	06000	LABORATORY		0.000000	1,715,117	0	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL		0.000000	10,441	0	0	0	62.00
65.00	06500	RESPIRATORY THERAPY		0.000000	1,145,003	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY		0.000000	6,077,049	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY		0.000000	4,972,547	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY		0.000000	990,850	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY		0.000000	88,942	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT		0.000000	17,315	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS		0.000000	27,628	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS		0.000000	1,628,552	0	0	0	73.00
74.00	07400	RENAL DIALYSIS		0.000000	389,523	0	0	0	74.00
76.00	03950	OTHER ANCILLARY SERVICES COST CENTE		0.000000	0	0	0	0	76.00
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES		0.000000	0	0	0	0	76.02
76.03	03951	OCCUPATIONAL HEALTH		0.000000	0	0	0	0	76.03
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
OUTPATIENT SERVICE COST CENTERS									
90.01	09001	OUTPATIENT PROCEDURES		0.000000	0	0	0	0	90.01
91.00	09100	EMERGENCY		0.000000	13,827	0	3,295	0	91.00
91.01	09101	C'VILLE OUT		0.000000	0	0	0	0	91.01
91.02	09102	LAKE HILL OUT		0.000000	0	0	0	0	91.02
91.03	09103	NUTRITION COUNSELING		0.000000	0	0	0	0	91.03
91.04	09104	HUNTLEY OP		0.000000	0	0	0	0	91.04
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART		0.000000	0	0	0	0	92.00
200.00		Total (lines 50 through 199)			17,929,475	0	3,295	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-0217

Period:

Worksheet D

Component CCN: 14-T217

From 07/01/2019
To 06/30/2020Part V
Date/Time Prepared:
11/28/2020 2:10 pm

Title XVIII

Subprovider -
IRF

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	0.091573	0	0	0	0 50.00
51.00	05100 RECOVERY ROOM	0.146932	0	0	0	0 51.00
53.00	05300 ANESTHESIOLOGY	0.025664	0	0	0	0 53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.217155	0	0	0	0 54.00
54.01	03650 VASCULAR LAB	0.106898	0	0	0	0 54.01
55.00	05500 RADIOLOGY-THERAPEUTIC	0.250657	0	0	0	0 55.00
57.00	05700 CT SCAN	0.040208	0	0	0	0 57.00
58.00	05800 MRI	0.071616	0	0	0	0 58.00
59.00	05900 CARDIAC CATHETERIZATION	0.088405	0	0	0	0 59.00
60.00	06000 LABORATORY	0.141818	0	0	0	0 60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0.591882	0	0	0	0 62.00
65.00	06500 RESPIRATORY THERAPY	0.213223	0	0	0	0 65.00
66.00	06600 PHYSICAL THERAPY	0.210461	0	0	0	0 66.00
67.00	06700 OCCUPATIONAL THERAPY	0.191204	0	0	0	0 67.00
68.00	06800 SPEECH PATHOLOGY	0.384924	0	0	0	0 68.00
69.00	06900 ELECTROCARDIOLOGY	0.089163	0	0	0	0 69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.512270	0	0	0	0 71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.192401	0	0	0	0 72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.351616	0	0	6,478	0 73.00
74.00	07400 RENAL DIALYSIS	0.316925	0	0	0	0 74.00
76.00	03950 OTHER ANCILLARY SERVICES COST CENTE	0.000000	0	0	0	0 76.00
76.02	03550 PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0.182997	0	0	0	0 76.02
76.03	03951 OCCUPATIONAL HEALTH	0.000000	0	0	0	0 76.03
76.97	07697 CARDIAC REHABILITATION	0.308597	0	0	0	0 76.97
76.98	07698 HYPERBARIC OXYGEN THERAPY	0.218808	0	0	0	0 76.98
OUTPATIENT SERVICE COST CENTERS						
90.01	09001 OUTPATIENT PROCEDURES	0.000000	0	0	0	0 90.01
91.00	09100 EMERGENCY	0.136937	3,295	0	0	451 91.00
91.01	09101 C'VILLE OUT	0.000000	0	0	0	0 91.01
91.02	09102 LAKE HILL OUT	0.000000	0	0	0	0 91.02
91.03	09103 NUTRITION COUNSELING	0.000000	0	0	0	0 91.03
91.04	09104 HUNTLEY OP	0.000000	0	0	0	0 91.04
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0.211602	0	0	0	0 92.00
200.00	Subtotal (see instructions)		3,295	0	6,478	451 200.00
201.00	Less PBP Clinic Lab. Services-Program Only Charges			0	0	0 201.00
202.00	Net Charges (line 200 - line 201)		3,295	0	6,478	451 202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-0217

Period:

Worksheet D

Component CCN: 14-T217

From 07/01/2019
To 06/30/2020Part V
Date/Time Prepared:
11/28/2020 2:10 pm

Title XVIII

Subprovider -
IRF

PPS

Cost Center Description		Costs			
		Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
		6.00	7.00		
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	51.00
53.00	05300	ANESTHESIOLOGY	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	54.00
54.01	03650	VASCULAR LAB	0	0	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	55.00
57.00	05700	CT SCAN	0	0	57.00
58.00	05800	MRI	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	59.00
60.00	06000	LABORATORY	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	2,278	73.00
74.00	07400	RENAL DIALYSIS	0	0	74.00
76.00	03950	OTHER ANCILLARY SERVICES COST CENTE	0	0	76.00
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0	76.02
76.03	03951	OCCUPATIONAL HEALTH	0	0	76.03
76.97	07697	CARDIAC REHABILITATION	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	76.98
OUTPATIENT SERVICE COST CENTERS					
90.01	09001	OUTPATIENT PROCEDURES	0	0	90.01
91.00	09100	EMERGENCY	0	0	91.00
91.01	09101	C'VILLE OUT	0	0	91.01
91.02	09102	LAKE HILL OUT	0	0	91.02
91.03	09103	NUTRITION COUNSELING	0	0	91.03
91.04	09104	HUNTLEY OP	0	0	91.04
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	92.00
200.00		Subtotal (see instructions)	0	2,278	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0		201.00
202.00		Net Charges (line 200 - line 201)	0	2,278	202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

Provider CCN: 14-0217

Period:
From 07/01/2019
To 06/30/2020Worksheet D
Part I
Date/Time Prepared:
11/28/2020 2:10 pm

			Title XIX		Hospital	PPS	
Cost Center Description		Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	2,446,957	0	2,446,957	23,291	105.06	30.00
31.00	INTENSIVE CARE UNIT	359,592		359,592	1,960	183.47	31.00
41.00	SUBPROVIDER - IRF	875,266	0	875,266	7,963	109.92	41.00
200.00	Total (lines 30 through 199)	3,681,815		3,681,815	33,214		200.00
Cost Center Description		Inpatient Program days	Inpatient Program Capital Cost (col. 5 x col. 6)				
		6.00	7.00				
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	1,881	197,618				30.00
31.00	INTENSIVE CARE UNIT	79	14,494				31.00
41.00	SUBPROVIDER - IRF	143	15,719				41.00
200.00	Total (lines 30 through 199)	2,103	227,831				200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 14-0217

Period:
From 07/01/2019
To 06/30/2020Worksheet D
Part II
Date/Time Prepared:
11/28/2020 2:10 pm

Cost Center Description		Title XIX		Hospital		PPS	
		Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
		1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	562,952	78,861,752	0.007138	0	0 50.00
51.00	05100	RECOVERY ROOM	342,523	34,584,861	0.009904	0	0 51.00
53.00	05300	ANESTHESIOLOGY	15,171	15,650,556	0.000969	0	0 53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	577,120	29,752,264	0.019398	0	0 54.00
54.01	03650	VASCULAR LAB	48,525	11,640,694	0.004169	0	0 54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	784,172	20,659,454	0.037957	0	0 55.00
57.00	05700	CT SCAN	61,875	51,193,968	0.001209	0	0 57.00
58.00	05800	MRI	50,705	11,021,861	0.004600	0	0 58.00
59.00	05900	CARDIAC CATHETERIZATION	137,317	41,314,981	0.003324	0	0 59.00
60.00	06000	LABORATORY	205,133	56,611,687	0.003624	0	0 60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	37,406	1,396,421	0.026787	0	0 62.00
65.00	06500	RESPIRATORY THERAPY	56,571	10,679,874	0.005297	0	0 65.00
66.00	06600	PHYSICAL THERAPY	189,967	25,656,746	0.007404	0	0 66.00
67.00	06700	OCCUPATIONAL THERAPY	41,796	6,109,383	0.006841	0	0 67.00
68.00	06800	SPEECH PATHOLOGY	23,731	1,712,261	0.013859	0	0 68.00
69.00	06900	ELECTROCARDIOLOGY	207,662	22,253,849	0.009332	0	0 69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	195,954	28,060,660	0.006983	0	0 71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	121,851	45,554,925	0.002675	0	0 72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	123,847	43,332,310	0.002858	0	0 73.00
74.00	07400	RENAL DIALYSIS	17,968	2,797,773	0.006422	0	0 74.00
76.00	03950	OTHER ANCILLARY SERVICES COST CENTE	0	0	0.000000	0	0 76.00
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	72,840	5,291,187	0.013766	0	0 76.02
76.03	03951	OCCUPATIONAL HEALTH	0	0	0.000000	0	0 76.03
76.97	07697	CARDIAC REHABILITATION	22,108	1,522,773	0.014518	0	0 76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	5,241	5,269,701	0.000995	0	0 76.98
OUTPATIENT SERVICE COST CENTERS							
90.01	09001	OUTPATIENT PROCEDURES	0	0	0.000000	0	0 90.01
91.00	09100	EMERGENCY	576,403	64,004,641	0.009006	0	0 91.00
91.01	09101	C'VILLE OUT	0	0	0.000000	0	0 91.01
91.02	09102	LAKE HILL OUT	0	0	0.000000	0	0 91.02
91.03	09103	NUTRITION COUNSELING	0	0	0.000000	0	0 91.03
91.04	09104	HUNTLEY OP	0	0	0.000000	0	0 91.04
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	248,257	14,011,369	0.017718	0	0 92.00
200.00		Total (lines 50 through 199)	4,727,095	628,945,951		0	0 200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS					Provider CCN: 14-0217		Period: From 07/01/2019 To 06/30/2020		Worksheet D Part III Date/Time Prepared: 11/28/2020 2:10 pm		
					Title XIX		Hospital		PPS		
Cost Center Description					Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health Cost	All Other Medical Education Cost		
					1A	1.00	2A	2.00	3.00		
INPATIENT ROUTINE SERVICE COST CENTERS											
30.00	03000	ADULTS & PEDIATRICS		0	0	0	0	0	0	30.00	
31.00	03100	INTENSIVE CARE UNIT		0	0	0	0	0	0	31.00	
41.00	04100	SUBPROVIDER - IRF		0	0	0	0	0	0	41.00	
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	23,291	0.00		1,881	30.00	
31.00	03100	INTENSIVE CARE UNIT			0	1,960	0.00		79	31.00	
41.00	04100	SUBPROVIDER - IRF		0	0	7,963	0.00		143	41.00	
200.00		Total (lines 30 through 199)			0	33,214			2,103	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	
41.00	04100	SUBPROVIDER - IRF		0						41.00	
200.00		Total (lines 30 through 199)		0						200.00	

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS			Provider CCN: 14-0217		Period: From 07/01/2019 To 06/30/2020		Worksheet D Part IV Date/Time Prepared: 11/28/2020 2:10 pm	
			Title XIX		Hospital		PPS	
Cost Center Description			Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health	
			1.00	2A	2.00	3A	3.00	
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
54.01	03650	VASCULAR LAB	0	0	0	0	0	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	0	55.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.00	03950	OTHER ANCILLARY SERVICES COST CENTE	0	0	0	0	0	76.00
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0	0	0	0	76.02
76.03	03951	OCCUPATIONAL HEALTH	0	0	0	0	0	76.03
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
OUTPATIENT SERVICE COST CENTERS								
90.01	09001	OUTPATIENT PROCEDURES	0	0	0	0	0	90.01
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
91.01	09101	C'VILLE OUT	0	0	0	0	0	91.01
91.02	09102	LAKE HILL OUT	0	0	0	0	0	91.02
91.03	09103	NUTRITION COUNSELING	0	0	0	0	0	91.03
91.04	09104	HUNTLEY OP	0	0	0	0	0	91.04
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	0	92.00
200.00		Total (lines 50 through 199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS			Provider CCN: 14-0217		Period: From 07/01/2019 To 06/30/2020		Worksheet D Part IV Date/Time Prepared: 11/28/2020 2:10 pm	
			Title XIX		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	78,861,752	0.000000	50.00
51.00	05100	RECOVERY ROOM	0	0	0	34,584,861	0.000000	51.00
53.00	05300	ANESTHESIOLOGY	0	0	0	15,650,556	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	29,752,264	0.000000	54.00
54.01	03650	VASCULAR LAB	0	0	0	11,640,694	0.000000	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	20,659,454	0.000000	55.00
57.00	05700	CT SCAN	0	0	0	51,193,968	0.000000	57.00
58.00	05800	MRI	0	0	0	11,021,861	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	41,314,981	0.000000	59.00
60.00	06000	LABORATORY	0	0	0	56,611,687	0.000000	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0	1,396,421	0.000000	62.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	10,679,874	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	25,656,746	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	6,109,383	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	1,712,261	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	22,253,849	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	28,060,660	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	45,554,925	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	43,332,310	0.000000	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	2,797,773	0.000000	74.00
76.00	03950	OTHER ANCILLARY SERVICES COST CENTE	0	0	0	0	0.000000	76.00
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0	0	5,291,187	0.000000	76.02
76.03	03951	OCCUPATIONAL HEALTH	0	0	0	0	0.000000	76.03
76.97	07697	CARDIAC REHABILITATION	0	0	0	1,522,773	0.000000	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	5,269,701	0.000000	76.98
OUTPATIENT SERVICE COST CENTERS								
90.01	09001	OUTPATIENT PROCEDURES	0	0	0	0	0.000000	90.01
91.00	09100	EMERGENCY	0	0	0	64,004,641	0.000000	91.00
91.01	09101	C'VILLE OUT	0	0	0	0	0.000000	91.01
91.02	09102	LAKE HILL OUT	0	0	0	0	0.000000	91.02
91.03	09103	NUTRITION COUNSELING	0	0	0	0	0.000000	91.03
91.04	09104	HUNTLEY OP	0	0	0	0	0.000000	91.04
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	14,011,369	0.000000	92.00
200.00		Total (lines 50 through 199)	0	0	0	628,945,951		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-0217

Period:
From 07/01/2019
To 06/30/2020Worksheet D
Part IV
Date/Time Prepared:
11/28/2020 2:10 pm

Cost Center Description			Title XIX		Hospital		PPS
			Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)
			9.00	10.00	11.00	12.00	13.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0.000000	0	0	0	0
51.00	05100	RECOVERY ROOM	0.000000	0	0	0	0
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	0	0
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	0	0	0	0
54.01	03650	VASCULAR LAB	0.000000	0	0	0	0
55.00	05500	RADIOLOGY-THERAPEUTIC	0.000000	0	0	0	0
57.00	05700	CT SCAN	0.000000	0	0	0	0
58.00	05800	MRI	0.000000	0	0	0	0
59.00	05900	CARDIAC CATHETERIZATION	0.000000	0	0	0	0
60.00	06000	LABORATORY	0.000000	0	0	0	0
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0.000000	0	0	0	0
65.00	06500	RESPIRATORY THERAPY	0.000000	0	0	0	0
66.00	06600	PHYSICAL THERAPY	0.000000	0	0	0	0
67.00	06700	OCCUPATIONAL THERAPY	0.000000	0	0	0	0
68.00	06800	SPEECH PATHOLOGY	0.000000	0	0	0	0
69.00	06900	ELECTROCARDIOLOGY	0.000000	0	0	0	0
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	0	0	0	0
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	0	0	0
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	0	0	0	0
74.00	07400	RENAL DIALYSIS	0.000000	0	0	0	0
76.00	03950	OTHER ANCILLARY SERVICES COST CENTE	0.000000	0	0	0	0
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0.000000	0	0	0	0
76.03	03951	OCCUPATIONAL HEALTH	0.000000	0	0	0	0
76.97	07697	CARDIAC REHABILITATION	0.000000	0	0	0	0
76.98	07698	HYPERBARIC OXYGEN THERAPY	0.000000	0	0	0	0
OUTPATIENT SERVICE COST CENTERS							
90.01	09001	OUTPATIENT PROCEDURES	0.000000	0	0	0	0
91.00	09100	EMERGENCY	0.000000	0	0	0	0
91.01	09101	C'VILLE OUT	0.000000	0	0	0	0
91.02	09102	LAKE HILL OUT	0.000000	0	0	0	0
91.03	09103	NUTRITION COUNSELING	0.000000	0	0	0	0
91.04	09104	HUNTLEY OP	0.000000	0	0	0	0
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	0	0	0	0
200.00		Total (lines 50 through 199)		0	0	0	0

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-0217	Period: From 07/01/2019 To 06/30/2020	Worksheet D-1 Date/Time Prepared: 11/28/2020 2:10 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)		23,291	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		23,291	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)		20,928	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)		7,407	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)		29,223,009	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)		29,223,009	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)		29,223,009	37.00
PART II - HOSPITAL AND SUBPROVIDERS ONLY				
PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS				
38.00	Adjusted general inpatient routine service cost per diem (see instructions)		1,254.69	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		9,293,489	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)		9,293,489	41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-0217

Period:
From 07/01/2019
To 06/30/2020

Worksheet D-1

Date/Time Prepared:
11/28/2020 2:10 pm

		Title XVIII		Hospital	PPS	
Cost Center Description		Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)
		1.00	2.00	3.00	4.00	5.00
42.00	NURSERY (title V & XIX only)					42.00
Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	6,351,625	1,960	3,240.63	812	2,631,392
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)					16,476,999
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					28,401,880
PASS THROUGH COST ADJUSTMENTS						
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)					927,157
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					627,157
52.00	Total Program excludable cost (sum of lines 50 and 51)					1,554,314
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					26,847,566
TARGET AMOUNT AND LIMIT COMPUTATION						
54.00	Program discharges					0
55.00	Target amount per discharge					0.00
56.00	Target amount (line 54 x line 55)					0
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)					0
58.00	Bonus payment (see instructions)					0
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket					0.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket					0.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)					0
62.00	Relief payment (see instructions)					0
63.00	Allowable Inpatient cost plus incentive payment (see instructions)					0
PROGRAM INPATIENT ROUTINE SWING BED COST						
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)					0
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					0
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)					0
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)					0
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)					0
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)					0
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY						
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)					70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)					71.00
72.00	Program routine service cost (line 9 x line 71)					72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)					73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)					74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)					75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)					76.00
77.00	Program capital-related costs (line 9 x line 76)					77.00
78.00	Inpatient routine service cost (line 74 minus line 77)					78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)					79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)					80.00
81.00	Inpatient routine service cost per diem limitation					81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)					82.00
83.00	Reasonable inpatient routine service costs (see instructions)					83.00
84.00	Program inpatient ancillary services (see instructions)					84.00
85.00	Utilization review - physician compensation (see instructions)					85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)					86.00
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
87.00	Total observation bed days (see instructions)					2,363
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					1,254.69
89.00	Observation bed cost (line 87 x line 88) (see instructions)					2,964,832

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-0217

Period:
From 07/01/2019
To 06/30/2020

Worksheet D-1

Date/Time Prepared:
11/28/2020 2:10 pm

		Title XVIII		Hospital	PPS	
Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
	1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00 Capital-related cost	2,446,957	29,223,009	0.083734	2,964,832	248,257	90.00
91.00 Nursing School cost	0	29,223,009	0.000000	2,964,832	0	91.00
92.00 Allied health cost	0	29,223,009	0.000000	2,964,832	0	92.00
93.00 All other Medical Education	0	29,223,009	0.000000	2,964,832	0	93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-0217 Component CCN: 14-T217	Period: From 07/01/2019 To 06/30/2020	Worksheet D-1 Date/Time Prepared: 11/28/2020 2:10 pm
		Title XVIII	Subprovider - IRF	PPS
Cost Center Description			1.00	
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		7,963	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		7,963	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)		7,963	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)		5,945	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)		0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period		0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)		0	14.00
15.00	Total nursery days (title V or XIX only)		0	15.00
16.00	Nursery days (title V or XIX only)		0	16.00
SWING BED ADJUSTMENT				
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period		0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)		9,869,376	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)		0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)		0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)		0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)		0	25.00
26.00	Total swing-bed cost (see instructions)		0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)		9,869,376	27.00
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)		0	28.00
29.00	Private room charges (excluding swing-bed charges)		0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)		0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)		0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)		0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)		0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)		0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)		0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)		9,869,376	37.00
PART II - HOSPITAL AND SUBPROVIDERS ONLY				
PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS				
38.00	Adjusted general inpatient routine service cost per diem (see instructions)		1,239.40	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		7,368,233	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)		7,368,233	41.00

COMPUTATION OF INPATIENT OPERATING COST				Provider CCN: 14-0217 Component CCN: 14-T217	Period: From 07/01/2019 To 06/30/2020	Worksheet D-1 Date/Time Prepared: 11/28/2020 2:10 pm	
				Title XVIII	Subprovider - IRF	PPS	
Cost Center Description		Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)						42.00
Intensive Care Type Inpatient Hospital Units							
43.00	INTENSIVE CARE UNIT	0	0	0.00	0	0	43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00
Cost Center Description							
						1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					3,931,432	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					11,299,665	49.00
PASS THROUGH COST ADJUSTMENTS							
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)					653,474	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					122,100	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)					775,574	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					10,524,091	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: 14-0217 Component CCN: 14-T217		Period: From 07/01/2019 To 06/30/2020		Worksheet D-1 Date/Time Prepared: 11/28/2020 2:10 pm	
		Title XVIII		Subprovider - IRF		PPS	
Cost Center Description		Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00	Capital-related cost	875,266	9,869,376	0.088685	0	0	90.00
91.00	Nursing School cost	0	9,869,376	0.000000	0	0	91.00
92.00	Allied health cost	0	9,869,376	0.000000	0	0	92.00
93.00	All other Medical Education	0	9,869,376	0.000000	0	0	93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-0217	Period: From 07/01/2019 To 06/30/2020	Worksheet D-1 Date/Time Prepared: 11/28/2020 2:10 pm	
Cost Center Description		Title XIX	Hospital	PPS	
				1.00	
PART I - ALL PROVIDER COMPONENTS					
INPATIENT DAYS					
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)			23,291	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)			23,291	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)			20,928	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)			1,881	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)			29,223,009	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)			29,223,009	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)			29,223,009	37.00
PART II - HOSPITAL AND SUBPROVIDERS ONLY					
PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS					
38.00	Adjusted general inpatient routine service cost per diem (see instructions)			1,254.69	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)			2,360,072	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)			2,360,072	41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-0217

Period:
From 07/01/2019
To 06/30/2020

Worksheet D-1

Date/Time Prepared:
11/28/2020 2:10 pm

Cost Center Description		Title XIX		Hospital		PPS
		Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)
		1.00	2.00	3.00	4.00	5.00
42.00	NURSERY (title V & XIX only)					42.00
	Intensive Care Type Inpatient Hospital Units					
43.00	INTENSIVE CARE UNIT	6,351,625	1,960	3,240.63	79	256,010
44.00	CORONARY CARE UNIT					
45.00	BURN INTENSIVE CARE UNIT					
46.00	SURGICAL INTENSIVE CARE UNIT					
47.00	OTHER SPECIAL CARE (SPECIFY)					
	Cost Center Description					
						1.00
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					0
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					2,616,082
	PASS THROUGH COST ADJUSTMENTS					
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)					212,112
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					0
52.00	Total Program excludable cost (sum of lines 50 and 51)					212,112
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					2,403,970
	TARGET AMOUNT AND LIMIT COMPUTATION					
54.00	Program discharges					0
55.00	Target amount per discharge					0.00
56.00	Target amount (line 54 x line 55)					0
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)					0
58.00	Bonus payment (see instructions)					0
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket					0.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket					0.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)					0
62.00	Relief payment (see instructions)					0
63.00	Allowable Inpatient cost plus incentive payment (see instructions)					0
	PROGRAM INPATIENT ROUTINE SWING BED COST					
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)					0
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					0
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)					0
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)					0
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)					0
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)					0
	PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY					
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)					70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)					71.00
72.00	Program routine service cost (line 9 x line 71)					72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)					73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)					74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)					75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)					76.00
77.00	Program capital-related costs (line 9 x line 76)					77.00
78.00	Inpatient routine service cost (line 74 minus line 77)					78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)					79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)					80.00
81.00	Inpatient routine service cost per diem limitation					81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)					82.00
83.00	Reasonable inpatient routine service costs (see instructions)					83.00
84.00	Program inpatient ancillary services (see instructions)					84.00
85.00	Utilization review - physician compensation (see instructions)					85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)					86.00
	PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST					
87.00	Total observation bed days (see instructions)					2,363
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					1,254.69
89.00	Observation bed cost (line 87 x line 88) (see instructions)					2,964,832

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-0217

Period:
From 07/01/2019
To 06/30/2020

Worksheet D-1

Date/Time Prepared:
11/28/2020 2:10 pm

Cost Center Description		Title XIX		Hospital	PPS	
		Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00
COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	2,446,957	29,223,009	0.083734	2,964,832	248,257
91.00	Nursing School cost	0	29,223,009	0.000000	2,964,832	0
92.00	Allied health cost	0	29,223,009	0.000000	2,964,832	0
93.00	All other Medical Education	0	29,223,009	0.000000	2,964,832	0

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 14-0217	Period: From 07/01/2019 To 06/30/2020	Worksheet D-3 Date/Time Prepared: 11/28/2020 2:10 pm	
Cost Center Description		Title XVIII	Hospital	PPS	
		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS		32,508,768	30.00
31.00	03100	INTENSIVE CARE UNIT		7,645,295	31.00
41.00	04100	SUBPROVIDER - IRF		0	41.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0.091573	16,862,942	50.00
51.00	05100	RECOVERY ROOM	0.146932	5,770,514	51.00
53.00	05300	ANESTHESIOLOGY	0.025664	2,721,617	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.217523	3,449,303	54.00
54.01	03650	VASCULAR LAB	0.106898	1,227,600	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	0.252532	334,012	55.00
57.00	05700	CT SCAN	0.040208	5,976,877	57.00
58.00	05800	MRI	0.071616	1,275,174	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.088626	6,031,124	59.00
60.00	06000	LABORATORY	0.142451	10,445,174	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0.591882	464,798	62.00
65.00	06500	RESPIRATORY THERAPY	0.213223	3,690,606	65.00
66.00	06600	PHYSICAL THERAPY	0.210461	2,180,223	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.191204	1,035,016	67.00
68.00	06800	SPEECH PATHOLOGY	0.384924	539,717	68.00
69.00	06900	ELECTROCARDIOLOGY	0.089163	3,728,836	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.512270	3,843,748	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.192401	12,821,324	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.351616	6,200,818	73.00
74.00	07400	RENAL DIALYSIS	0.316925	813,720	74.00
76.00	03950	OTHER ANCILLARY SERVICES COST CENTE	0.000000	0	76.00
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0.182997	381,192	76.02
76.03	03951	OCCUPATIONAL HEALTH	0.000000	0	76.03
76.97	07697	CARDIAC REHABILITATION	0.308597	1,925	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0.219421	9,975	76.98
OUTPATIENT SERVICE COST CENTERS					
90.01	09001	OUTPATIENT PROCEDURES	0.000000	0	90.01
91.00	09100	EMERGENCY	0.137081	8,207,263	91.00
91.01	09101	C'VILLE OUT	0.000000	0	91.01
91.02	09102	LAKE HILL OUT	0.000000	0	91.02
91.03	09103	NUTRITION COUNSELING	0.000000	0	91.03
91.04	09104	HUNTLEY OP	0.000000	0	91.04
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.211602	1,722,372	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		99,735,870	200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0	201.00
202.00		Net charges (line 200 minus line 201)		99,735,870	202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 14-0217 Component CCN: 14-T217	Period: From 07/01/2019 To 06/30/2020	Worksheet D-3 Date/Time Prepared: 11/28/2020 2:10 pm	
		Title XVIII	Subprovider - IRF	PPS	
Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDIATRICS		0		30.00
31.00	03100 INTENSIVE CARE UNIT		0		31.00
41.00	04100 SUBPROVIDER - IRF		21,829,810		41.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.091573	61,091	5,594	50.00
51.00	05100 RECOVERY ROOM	0.146932	26,925	3,956	51.00
53.00	05300 ANESTHESIOLOGY	0.025664	10,626	273	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.217523	244,268	53,134	54.00
54.01	03650 VASCULAR LAB	0.106898	128,114	13,695	54.01
55.00	05500 RADIOLOGY-THERAPEUTIC	0.252532	47,989	12,119	55.00
57.00	05700 CT SCAN	0.040208	241,237	9,700	57.00
58.00	05800 MRI	0.071616	65,408	4,684	58.00
59.00	05900 CARDIAC CATHETERIZATION	0.088626	27,023	2,395	59.00
60.00	06000 LABORATORY	0.142451	1,715,117	244,320	60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0.591882	10,441	6,180	62.00
65.00	06500 RESPIRATORY THERAPY	0.213223	1,145,003	244,141	65.00
66.00	06600 PHYSICAL THERAPY	0.210461	6,077,049	1,278,982	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.191204	4,972,547	950,771	67.00
68.00	06800 SPEECH PATHOLOGY	0.384924	990,850	381,402	68.00
69.00	06900 ELECTROCARDIOLOGY	0.089163	88,942	7,930	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.512270	17,315	8,870	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.192401	27,628	5,316	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.351616	1,628,552	572,625	73.00
74.00	07400 RENAL DIALYSIS	0.316925	389,523	123,450	74.00
76.00	03950 OTHER ANCILLARY SERVICES COST CENTE	0.000000	0	0	76.00
76.02	03550 PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0.182997	0	0	76.02
76.03	03951 OCCUPATIONAL HEALTH	0.000000	0	0	76.03
76.97	07697 CARDIAC REHABILITATION	0.308597	0	0	76.97
76.98	07698 HYPERBARIC OXYGEN THERAPY	0.219421	0	0	76.98
OUTPATIENT SERVICE COST CENTERS					
90.01	09001 OUTPATIENT PROCEDURES	0.000000	0	0	90.01
91.00	09100 EMERGENCY	0.137081	13,827	1,895	91.00
91.01	09101 C'VILLE OUT	0.000000	0	0	91.01
91.02	09102 LAKE HILL OUT	0.000000	0	0	91.02
91.03	09103 NUTRITION COUNSELING	0.000000	0	0	91.03
91.04	09104 HUNTLEY OP	0.000000	0	0	91.04
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0.211602	0	0	92.00
200.00	Total (sum of lines 50 through 94 and 96 through 98)		17,929,475	3,931,432	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)		17,929,475	0	202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0217	Period: From 07/01/2019 To 06/30/2020	Worksheet E Part A Date/Time Prepared: 11/28/2020 2:10 pm
		Title XVIII	Hospital	PPS
				1.00
PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS				
1.00	DRG Amounts Other than Outlier Payments		0	1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1 (see instructions)		5,855,210	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1 (see instructions)		12,550,022	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)		49,746	2.03
2.04	Outlier payments for discharges occurring on or after October 1 (see instructions)		53,234	2.04
3.00	Managed Care Simulated Payments		0	3.00
4.00	Bed days available divided by number of days in the cost reporting period (see instructions)		136.74	4.00
Indirect Medical Education Adjustment				
5.00	FTE count for allopathic and osteopathic programs for the most recent cost reporting period ending on or before 12/31/1996.(see instructions)		0.00	5.00
6.00	FTE count for allopathic and osteopathic programs that meet the criteria for an add-on to the cap for new programs in accordance with 42 CFR 413.79(e)		0.00	6.00
7.00	MMA Section 422 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(1)		0.00	7.00
7.01	ACA § 5503 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(2) If the cost report straddles July 1, 2011 then see instructions.		0.00	7.01
8.00	Adjustment (increase or decrease) to the FTE count for allopathic and osteopathic programs for affiliated programs in accordance with 42 CFR 413.75(b), 413.79(c)(2)(iv), 64 FR 26340 (May 12, 1998), and 67 FR 50069 (August 1, 2002).		0.00	8.00
8.01	The amount of increase if the hospital was awarded FTE cap slots under § 5503 of the ACA. If the cost report straddles July 1, 2011, see instructions.		0.00	8.01
8.02	The amount of increase if the hospital was awarded FTE cap slots from a closed teaching hospital under § 5506 of ACA. (see instructions)		0.00	8.02
9.00	Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus lines (8, 8.01 and 8.02) (see instructions)		0.00	9.00
10.00	FTE count for allopathic and osteopathic programs in the current year from your records		0.00	10.00
11.00	FTE count for residents in dental and podiatric programs.		0.00	11.00
12.00	Current year allowable FTE (see instructions)		0.00	12.00
13.00	Total allowable FTE count for the prior year.		0.00	13.00
14.00	Total allowable FTE count for the penultimate year if that year ended on or after September 30, 1997, otherwise enter zero.		0.00	14.00
15.00	Sum of lines 12 through 14 divided by 3.		0.00	15.00
16.00	Adjustment for residents in initial years of the program		0.00	16.00
17.00	Adjustment for residents displaced by program or hospital closure		0.00	17.00
18.00	Adjusted rolling average FTE count		0.00	18.00
19.00	Current year resident to bed ratio (line 18 divided by line 4).		0.000000	19.00
20.00	Prior year resident to bed ratio (see instructions)		0.000000	20.00
21.00	Enter the lesser of lines 19 or 20 (see instructions)		0.000000	21.00
22.00	IME payment adjustment (see instructions)		0	22.00
22.01	IME payment adjustment - Managed Care (see instructions)		0	22.01
Indirect Medical Education Adjustment for the Add-on for § 422 of the MMA				
23.00	Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 CFR 412.105 (f)(1)(iv)(C).		0.00	23.00
24.00	IME FTE Resident Count Over Cap (see instructions)		0.00	24.00
25.00	If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see instructions)		0.00	25.00
26.00	Resident to bed ratio (divide line 25 by line 4)		0.000000	26.00
27.00	IME payments adjustment factor. (see instructions)		0.000000	27.00
28.00	IME add-on adjustment amount (see instructions)		0	28.00
28.01	IME add-on adjustment amount - Managed Care (see instructions)		0	28.01
29.00	Total IME payment (sum of lines 22 and 28)		0	29.00
29.01	Total IME payment - Managed Care (sum of lines 22.01 and 28.01)		0	29.01
Disproportionate Share Adjustment				
30.00	Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)		4.38	30.00
31.00	Percentage of Medicaid patient days (see instructions)		24.05	31.00
32.00	Sum of lines 30 and 31		28.43	32.00
33.00	Allowable disproportionate share percentage (see instructions)		12.67	33.00
34.00	Disproportionate share adjustment (see instructions)		582,986	34.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0217	Period: From 07/01/2019 To 06/30/2020	Worksheet E Part A Date/Time Prepared: 11/28/2020 2:10 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)	1,502,568	1,847,374	35.02
35.03	Pro rata share of the hospital uncompensated care payment amount (see instructions)	378,730	1,383,007	35.03
36.00	Total uncompensated care (sum of columns 1 and 2 on line 35.03)	1,761,737		36.00
Additional payment for high percentage of ESRD beneficiary discharges (lines 40 through 46)				
40.00	Total Medicare discharges on Worksheet S-3, Part I excluding discharges for MS-DRGs 652, 682, 683, 684 and 685 (see instructions)		0	40.00
			Before 1/1	On/After 1/1
			1.00	1.01
41.00	Total ESRD Medicare discharges excluding MS-DRGs 652, 682, 683, 684 an 685. (see instructions)		0	0 41.00
41.01	Total ESRD Medicare covered and paid discharges excluding MS-DRGs 652, 682, 683, 684 an 685. (see instructions)		0	0 41.01
42.00	Divide line 41 by line 40 (if less than 10%, you do not qualify for adjustment)	0.00		42.00
43.00	Total Medicare ESRD inpatient days excluding MS-DRGs 652, 682, 683, 684 an 685. (see instructions)	0		43.00
44.00	Ratio of average length of stay to one week (line 43 divided by line 41 divided by 7 days)	0.000000		44.00
45.00	Average weekly cost for dialysis treatments (see instructions)	0.00	0.00	45.00
46.00	Total additional payment (line 45 times line 44 times line 41.01)	0		46.00
47.00	Subtotal (see instructions)	20,852,935		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)		20,852,935	49.00
50.00	Payment for inpatient program capital (from Wkst. L, Pt. I and Pt. II, as applicable)		1,558,804	50.00
51.00	Exception payment for inpatient program capital (Wkst. L, Pt. III, see instructions)		0	51.00
52.00	Direct graduate medical education payment (from Wkst. E-4, line 49 see instructions).		0	52.00
53.00	Nursing and Allied Health Managed Care payment		0	53.00
54.00	Special add-on payments for new technologies		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 intructions)		0	56.00
57.00	Routine service other pass through costs (from Wkst. D, Pt. III, column 9, lines 30 through 35).		0	57.00
58.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 11 line 200)		0	58.00
59.00	Total (sum of amounts on lines 49 through 58)		22,411,739	59.00
60.00	Primary payer payments		22,245	60.00
61.00	Total amount payable for program beneficiaries (line 59 minus line 60)		22,389,494	61.00
62.00	Deductibles billed to program beneficiaries		1,761,320	62.00
63.00	Coinsurance billed to program beneficiaries		70,015	63.00
64.00	Allowable bad debts (see instructions)		400,353	64.00
65.00	Adjusted reimbursable bad debts (see instructions)		260,229	65.00
66.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		259,429	66.00
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)		20,818,388	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)		-55,224	70.93
70.94	HRR adjustment amount (see instructions)		-5,020	70.94
70.95	Recovery of accelerated depreciation		0	70.95

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0217	Period: From 07/01/2019 To 06/30/2020	Worksheet E Part A Date/Time Prepared: 11/28/2020 2:10 pm
		Title XVIII	Hospital	PPS
		FFY (yyyy)	Amount	
		0	1.00	
70.96	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period prior to 10/1)	0	0	70.96
70.97	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period ending on or after 10/1)	0	0	70.97
70.98	Low Volume Payment-3		0	70.98
70.99	HAC adjustment amount (see instructions)		0	70.99
71.00	Amount due provider (line 67 minus lines 68 plus/minus lines 69 & 70)		20,758,144	71.00
71.01	Sequestration adjustment (see instructions)		346,661	71.01
71.02	Demonstration payment adjustment amount after sequestration		0	71.02
71.03	Sequestration adjustment-PARHM pass-throughs		0	71.03
72.00	Interim payments		19,860,458	72.00
72.01	Interim payments-PARHM		0	72.01
73.00	Tentative settlement (for contractor use only)		0	73.00
73.01	Tentative settlement-PARHM (for contractor use only)		0	73.01
74.00	Balance due provider/program (line 71 minus lines 71.01, 71.02, 72, and 73)		551,025	74.00
74.01	Balance due provider/program-PARHM (see instructions)		0	74.01
75.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		613,635	75.00
TO BE COMPLETED BY CONTRACTOR (lines 90 through 96)				
90.00	Operating outlier amount from Wkst. E, Pt. A, line 2, or sum of 2.03 plus 2.04 (see instructions)		0	90.00
91.00	Capital outlier from Wkst. L, Pt. I, line 2		0	91.00
92.00	Operating outlier reconciliation adjustment amount (see instructions)		0	92.00
93.00	Capital outlier reconciliation adjustment amount (see instructions)		0	93.00
94.00	The rate used to calculate the time value of money (see instructions)		0.00	94.00
95.00	Time value of money for operating expenses (see instructions)		0	95.00
96.00	Time value of money for capital related expenses (see instructions)		0	96.00
			Prior to 10/1	On/After 10/1
			1.00	2.00
HSP Bonus Payment Amount				
100.00	HSP bonus amount (see instructions)		0	100.00
HVBP Adjustment for HSP Bonus Payment				
101.00	HVBP adjustment factor (see instructions)		0.0000000000	101.00
102.00	HVBP adjustment amount for HSP bonus payment (see instructions)		0	102.00
HRR Adjustment for HSP Bonus Payment				
103.00	HRR adjustment factor (see instructions)		0.0000	103.00
104.00	HRR adjustment amount for HSP bonus payment (see instructions)		0	104.00
Rural Community Hospital Demonstration Project (\$410A Demonstration) Adjustment				
200.00	Is this the first year of the current 5-year demonstration period under the 21st Century Cures Act? Enter "Y" for yes or "N" for no.			200.00
Cost Reimbursement				
201.00	Medicare inpatient service costs (from Wkst. D-1, Pt. II, line 49)			201.00
202.00	Medicare discharges (see instructions)			202.00
203.00	Case-mix adjustment factor (see instructions)			203.00
Computation of Demonstration Target Amount Limitation (N/A in first year of the current 5-year demonstration period)				
204.00	Medicare target amount			204.00
205.00	Case-mix adjusted target amount (line 203 times line 204)			205.00
206.00	Medicare inpatient routine cost cap (line 202 times line 205)			206.00
Adjustment to Medicare Part A Inpatient Reimbursement				
207.00	Program reimbursement under the \$410A Demonstration (see instructions)			207.00
208.00	Medicare Part A inpatient service costs (from Wkst. E, Pt. A, line 59)			208.00
209.00	Adjustment to Medicare IPPS payments (see instructions)			209.00
210.00	Reserved for future use			210.00
211.00	Total adjustment to Medicare IPPS payments (see instructions)			211.00
Comparison of PPS versus Cost Reimbursement				
212.00	Total adjustment to Medicare Part A IPPS payments (from line 211)			212.00
213.00	Low-volume adjustment (see instructions)			213.00
218.00	Net Medicare Part A IPPS adjustment (difference between PPS and cost reimbursement) (line 212 minus line 213) (see instructions)			218.00

LOW VOLUME CALCULATION EXHIBIT 4

Provider CCN: 14-0217

Period:
From 07/01/2019
To 06/30/2020Worksheet E
Part A Exhibit 4
Date/Time Prepared:
11/28/2020 2:10 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	5,855,210	0	5,855,210		5,855,210
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	12,550,022	0		12,550,022	12,550,022
1.03	DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October 1	1.03	0	0	0		0
1.04	DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1	1.04	0	0		0	0
2.00	Outlier payments for discharges (see instructions)	2.00					
2.01	Outlier payments for discharges for Model 4 BPCI	2.02	0	0	0	0	0
2.02	Outlier payments for discharges occurring prior to October 1 (see instructions)	2.03	49,746	0	49,746		49,746
2.03	Outlier payments for discharges occurring on or after October 1 (see instructions)	2.04	53,234	0		53,234	53,234
3.00	Operating outlier reconciliation	2.01	0	0	0	0	0
4.00	Managed care simulated payments	3.00	0	0	0	0	0
Indirect Medical Education Adjustment							
5.00	Amount from Worksheet E, Part A, line 21 (see instructions)	21.00	0.000000	0.000000	0.000000	0.000000	
6.00	IME payment adjustment (see instructions)	22.00	0	0	0	0	0
6.01	IME payment adjustment for managed care (see instructions)	22.01	0	0	0	0	0
Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA							
7.00	IME payment adjustment factor (see instructions)	27.00	0.000000	0.000000	0.000000	0.000000	
8.00	IME adjustment (see instructions)	28.00	0	0	0	0	0
8.01	IME payment adjustment add on for managed care (see instructions)	28.01	0	0	0	0	0
9.00	Total IME payment (sum of lines 6 and 8)	29.00	0	0	0	0	0
9.01	Total IME payment for managed care (sum of lines 6.01 and 8.01)	29.01	0	0	0	0	0
Disproportionate Share Adjustment							
10.00	Allowable disproportionate share percentage (see instructions)	33.00	0.1267	0.1267	0.1267	0.1267	
11.00	Disproportionate share adjustment (see instructions)	34.00	582,986	0	185,464	397,522	582,986
11.01	Uncompensated care payments	36.00	1,761,737	0	719,336	207,352	926,688
Additional payment for high percentage of ESRD beneficiary discharges							
12.00	Total ESRD additional payment (see instructions)	46.00	0	0	0	0	0
13.00	Subtotal (see instructions)	47.00	20,852,935	0	6,809,756	14,043,179	20,852,935
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	20,852,935	0	6,809,756	14,043,179	20,852,935
16.00	Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable)	50.00	1,558,804	0	506,195	1,052,609	1,558,804

LOW VOLUME CALCULATION EXHIBIT 4

Provider CCN: 14-0217

Period:
From 07/01/2019
To 06/30/2020Worksheet E
Part A Exhibit 4
Date/Time Prepared:
11/28/2020 2:10 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	7,315,951	15,095,788	22,411,739	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	1,469,071	0	476,314	992,757	1,469,071	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	2,617	0	1,636	981	2,617	21.00
21.01	Model 4 BPCI Capital DRG outlier payments	2.01	0	0	0	0	0	21.01
22.00	Indirect medical education percentage (see instructions)	5.00	0.0000	0.0000	0.0000	0.0000		22.00
23.00	Indirect medical education adjustment (see instructions)	6.00	0	0	0	0	0	23.00
24.00	Allowable disproportionate share percentage (see instructions)	10.00	0.0593	0.0593	0.0593	0.0593		24.00
25.00	Disproportionate share adjustment (see instructions)	11.00	87,116	0	28,245	58,871	87,116	25.00
26.00	Total prospective capital payments (see instructions)	12.00	1,558,804	0	506,195	1,052,609	1,558,804	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: 14-0217

Period:
From 07/01/2019
To 06/30/2020Worksheet E
Part A Exhibit 5
Date/Time Prepared:
11/28/2020 2:10 pm

		Title XVIII		Hospital		PPS	
		Wkst. E, Pt. A, line	Amt. from Wkst. E, Pt. A)	Period to 10/01	Period on after 10/01	Total (cols. 2 and 3)	
		0	1.00	2.00	3.00	4.00	
1.00	DRG amounts other than outlier payments	1.00					1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1	1.01	5,855,210	5,855,210		5,855,210	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	12,550,022		12,550,022	12,550,022	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	49,746	49,746		49,746	2.02
2.03	Outlier payments for discharges occurring on or after October 1 (see instructions)	2.04	53,234		53,234	53,234	2.03
3.00	Operating outlier reconciliation	2.01	0	0	0	0	3.00
4.00	Managed care simulated payments	3.00	0	0	0	0	4.00
Indirect Medical Education Adjustment							
5.00	Amount from Worksheet E, Part A, line 21 (see instructions)	21.00	0.000000	0.000000	0.000000		5.00
6.00	IME payment adjustment (see instructions)	22.00	0	0	0	0	6.00
6.01	IME payment adjustment for managed care (see instructions)	22.01	0	0	0	0	6.01
Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA							
7.00	IME payment adjustment factor (see instructions)	27.00	0.000000	0.000000	0.000000		7.00
8.00	IME adjustment (see instructions)	28.00	0	0	0	0	8.00
8.01	IME payment adjustment add on for managed care (see instructions)	28.01	0	0	0	0	8.01
9.00	Total IME payment (sum of lines 6 and 8)	29.00	0	0	0	0	9.00
9.01	Total IME payment for managed care (sum of lines 6.01 and 8.01)	29.01	0	0	0	0	9.01
Disproportionate Share Adjustment							
10.00	Allowable disproportionate share percentage (see instructions)	33.00	0.1267	0.1267	0.1267		10.00
11.00	Disproportionate share adjustment (see instructions)	34.00	582,986	185,464	397,522	582,986	11.00
11.01	Uncompensated care payments	36.00	1,761,737	234,918	1,123,838	1,358,756	11.01
Additional payment for high percentage of ESRD beneficiary discharges							
12.00	Total ESRD additional payment (see instructions)	46.00	0	0	0	0	12.00
13.00	Subtotal (see instructions)	47.00	20,852,935	6,325,338	14,527,597	20,852,935	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	20,852,935	6,325,338	14,527,597	20,852,935	15.00
16.00	Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable)	50.00	1,558,804	506,195	1,052,609	1,558,804	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			6,831,533	15,580,206	22,411,739	19.00

HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULATION EXHIBIT 5

Provider CCN: 14-0217

Period:
From 07/01/2019
To 06/30/2020Worksheet E
Part A Exhibit 5
Date/Time Prepared:
11/28/2020 2:10 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	1,469,071	476,314	992,757	1,469,071	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	2,617	1,636	981	2,617	21.00
21.01	Model 4 BPCI Capital DRG outlier payments	2.01	0	0	0	0	21.01
22.00	Indirect medical education percentage (see instructions)	5.00	0.0000	0.0000	0.0000		22.00
23.00	Indirect medical education adjustment (see instructions)	6.00	0	0	0	0	23.00
24.00	Allowable disproportionate share percentage (see instructions)	10.00	0.0593	0.0593	0.0593		24.00
25.00	Disproportionate share adjustment (see instructions)	11.00	87,116	28,245	58,871	87,116	25.00
26.00	Total prospective capital payments (see instructions)	12.00	1,558,804	506,195	1,052,609	1,558,804	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	-55,224	-7,189	-48,035	-55,224	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	-5,020	0	-5,020	-5,020	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: 14-0217	Period: From 07/01/2019 To 06/30/2020	Worksheet E Part B Date/Time Prepared: 11/28/2020 2:10 pm
		Title XVIII	Hospital	PPS
				1.00
PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)		10,144	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)		21,984,999	2.00
3.00	OPPS payments		14,578,774	3.00
4.00	Outlier payment (see instructions)		95,616	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)		10,144	11.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
12.00	Ancillary service charges		28,850	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)		28,850	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)		28,850	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)		18,706	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)		10,144	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)		14,674,390	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)		2,293,728	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)		12,390,806	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)		12,390,806	30.00
31.00	Primary payer payments		330	31.00
32.00	Subtotal (line 30 minus line 31)		12,390,476	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)		256,462	34.00
35.00	Adjusted reimbursable bad debts (see instructions)		166,700	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		148,555	36.00
37.00	Subtotal (see instructions)		12,557,176	37.00
38.00	MSP-LCC reconciliation amount from PS&R		145	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)		12,557,031	40.00
40.01	Sequestration adjustment (see instructions)		209,702	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		12,410,205	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)		-62,876	43.00
43.01	Balance due provider/program-PARHM (see instructions)		0	43.01
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		0	44.00
TO BE COMPLETED BY CONTRACTOR				
90.00	Original outlier amount (see instructions)		0	90.00
91.00	Outlier reconciliation adjustment amount (see instructions)		0	91.00
92.00	The rate used to calculate the Time Value of Money		0.00	92.00
93.00	Time Value of Money (see instructions)		0	93.00
94.00	Total (sum of lines 91 and 93)		0	94.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0217 Component CCN: 14-T217	Period: From 07/01/2019 To 06/30/2020	Worksheet E Part B Date/Time Prepared: 11/28/2020 2:10 pm
		Title XVIII	Subprovider - IRF	PPS
			1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES			
1.00	Medical and other services (see instructions)		2,278	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)		451	2.00
3.00	OPPS payments		1,181	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)		2,278	11.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
12.00	Ancillary service charges		6,478	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)		6,478	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)		6,478	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)		4,200	19.00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)		0	20.00
21.00	Lesser of cost or charges (see instructions)		2,278	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)		1,181	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)		3,459	27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 50)		0	28.00
29.00	ESRD direct medical education costs (from Wkst. E-4, line 36)		0	29.00
30.00	Subtotal (sum of lines 27 through 29)		3,459	30.00
31.00	Primary payer payments		0	31.00
32.00	Subtotal (line 30 minus line 31)		3,459	32.00
ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)				
33.00	Composite rate ESRD (from Wkst. I-5, line 11)		0	33.00
34.00	Allowable bad debts (see instructions)		0	34.00
35.00	Adjusted reimbursable bad debts (see instructions)		0	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		0	36.00
37.00	Subtotal (see instructions)		3,459	37.00
38.00	MSP-LCC reconciliation amount from PS&R		0	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	39.00
39.50	Pioneer ACO demonstration payment adjustment (see instructions)		39.50	
39.97	Demonstration payment adjustment amount before sequestration		0	39.97
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)		0	39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION		0	39.99
40.00	Subtotal (see instructions)		3,459	40.00
40.01	Sequestration adjustment (see instructions)		58	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		2,823	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)		578	43.00
43.01	Balance due provider/program-PARHM (see instructions)		0	43.01
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		0	44.00
TO BE COMPLETED BY CONTRACTOR				
90.00	Original outlier amount (see instructions)		0	90.00
91.00	Outlier reconciliation adjustment amount (see instructions)		0	91.00
92.00	The rate used to calculate the Time Value of Money		0.00	92.00
93.00	Time Value of Money (see instructions)		0	93.00
94.00	Total (sum of lines 91 and 93)		0	94.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 14-0217

Period:
From 07/01/2019
To 06/30/2020Worksheet E-1
Part I
Date/Time Prepared:
11/28/2020 2:10 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		19,543,325		12,184,271	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		292,918		193,520	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	02/17/2020	24,215	02/17/2020	48,977	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	09/24/2019	16,563	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)		24,215		32,414	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)		19,860,458		12,410,205	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		551,025		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		62,876	6.02
7.00	Total Medicare program liability (see instructions)		20,411,483		12,347,329	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: 14-0217
 Component CCN: 14-T217

 Period:
 From 07/01/2019
 To 06/30/2020

 Worksheet E-1
 Part I
 Date/Time Prepared:
 11/28/2020 2:10 pm

Title XVIII

Subprovider -
IRF

PPS

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider					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		10,739,843		2,823	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)		0		0	3.00
Program to Provider						
3.01	ADJUSTMENTS TO PROVIDER	02/17/2020	18,437		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)		18,437		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)		10,758,280		2,823	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		78,736		578	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		10,837,016		3,401	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: 14-0217

Period:
From 07/01/2019
To 06/30/2020Worksheet E-1
Part II
Date/Time Prepared:
11/28/2020 2:10 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: 14-0217 Component CCN: 14-T217	Period: From 07/01/2019 To 06/30/2020	Worksheet E-3 Part III Date/Time Prepared: 11/28/2020 2:10 pm
		Title XVIII	Subprovider - IRF	PPS
				1.00
1.00	PART III - MEDICARE PART A SERVICES - IRF PPS			
1.00	Net Federal PPS Payment (see instructions)			11,017,264 1.00
2.00	Medicare SSI ratio (IRF PPS only) (see instructions)			0.0124 2.00
3.00	Inpatient Rehabilitation LIP Payments (see instructions)			144,326 3.00
4.00	Outlier Payments			34,202 4.00
5.00	Unweighted intern and resident FTE count in the most recent cost reporting period ending on or prior to November 15, 2004 (see instructions)			0.00 5.00
5.01	Cap increases for the unweighted intern and resident FTE count for residents that were displaced by program or hospital closure, that would not be counted without a temporary cap adjustment under 42 CFR §412.424(d)(1)(iii)(F)(1) or (2) (see instructions)			0.00 5.01
6.00	New Teaching program adjustment. (see instructions)			0.00 6.00
7.00	Current year's unweighted FTE count of I&R excluding FTEs in the new program growth period of a "new teaching program" (see instructions)			0.00 7.00
8.00	Current year's unweighted I&R FTE count for residents within the new program growth period of a "new teaching program" (see instructions)			0.00 8.00
9.00	Intern and resident count for IRF PPS medical education adjustment (see instructions)			0.00 9.00
10.00	Average Daily Census (see instructions)			21.756831 10.00
11.00	Teaching Adjustment Factor (see instructions)			0.000000 11.00
12.00	Teaching Adjustment (see instructions)			0 12.00
13.00	Total PPS Payment (see instructions)			11,195,792 13.00
14.00	Nursing and Allied Health Managed Care payments (see instruction)			0 14.00
15.00	Organ acquisition (DO NOT USE THIS LINE)			0 15.00
16.00	Cost of physicians' services in a teaching hospital (see instructions)			0 16.00
17.00	Subtotal (see instructions)			11,195,792 17.00
18.00	Primary payer payments			0 18.00
19.00	Subtotal (line 17 less line 18).			11,195,792 19.00
20.00	Deductibles			129,316 20.00
21.00	Subtotal (line 19 minus line 20)			11,066,476 21.00
22.00	Coinsurance			53,658 22.00
23.00	Subtotal (line 21 minus line 22)			11,012,818 23.00
24.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)			12,692 24.00
25.00	Adjusted reimbursable bad debts (see instructions)			8,250 25.00
26.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			0 26.00
27.00	Subtotal (sum of lines 23 and 25)			11,021,068 27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 49)			0 28.00
29.00	Other pass through costs (see instructions)			0 29.00
30.00	Outlier payments reconciliation			0 30.00
31.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0 31.00
31.50	Pioneer ACO demonstration payment adjustment (see instructions)			0 31.50
31.99	Demonstration payment adjustment amount before sequestration			0 31.99
32.00	Total amount payable to the provider (see instructions)			11,021,068 32.00
32.01	Sequestration adjustment (see instructions)			184,052 32.01
32.02	Demonstration payment adjustment amount after sequestration			0 32.02
33.00	Interim payments			10,758,280 33.00
34.00	Tentative settlement (for contractor use only)			0 34.00
35.00	Balance due provider/program (line 32 minus lines 32.01, 32.02, 33, and 34)			78,736 35.00
36.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2			0 36.00
TO BE COMPLETED BY CONTRACTOR				
50.00	Original outlier amount from Wkst. E-3, Pt. III, line 4			34,202 50.00
51.00	Outlier reconciliation adjustment amount (see instructions)			0 51.00
52.00	The rate used to calculate the Time Value of Money			0.00 52.00
53.00	Time Value of Money (see instructions)			0 53.00

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

Provider CCN: 14-0217

Period:
From 07/01/2019
To 06/30/2020

Worksheet G

Date/Time Prepared:
11/28/2020 2:10 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	2,150	0	0	0	1.00
2.00	Temporary investments	0	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	15,466,236	0	0	0	4.00
5.00	Other receivable	86,652	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	0	0	0	0	6.00
7.00	Inventory	2,754,354	0	0	0	7.00
8.00	Prepaid expenses	0	0	0	0	8.00
9.00	Other current assets	342,640	0	0	0	9.00
10.00	Due from other funds	10,552,116	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	29,204,148	0	0	0	11.00
FIXED ASSETS						
12.00	Land	5,020,000	0	0	0	12.00
13.00	Land improvements	1,277,494	0	0	0	13.00
14.00	Accumulated depreciation	-280,192	0	0	0	14.00
15.00	Buildings	50,015,450	0	0	0	15.00
16.00	Accumulated depreciation	-4,293,750	0	0	0	16.00
17.00	Leasehold improvements	0	0	0	0	17.00
18.00	Accumulated depreciation	0	0	0	0	18.00
19.00	Fixed equipment	0	0	0	0	19.00
20.00	Accumulated depreciation	0	0	0	0	20.00
21.00	Automobiles and trucks	0	0	0	0	21.00
22.00	Accumulated depreciation	0	0	0	0	22.00
23.00	Major movable equipment	14,984,044	0	0	0	23.00
24.00	Accumulated depreciation	-5,299,307	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	5,251,749	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	66,675,488	0	0	0	30.00
OTHER ASSETS						
31.00	Investments	0	0	0	0	31.00
32.00	Deposits on leases	0	0	0	0	32.00
33.00	Due from owners/officers	0	0	0	0	33.00
34.00	Other assets	2,795,244	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	2,795,244	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	98,674,880	0	0	0	36.00
CURRENT LIABILITIES						
37.00	Accounts payable	6,897,526	0	0	0	37.00
38.00	Salaries, wages, and fees payable	0	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	0	0	0	0	40.00
41.00	Deferred income	0	0	0	0	41.00
42.00	Accelerated payments	0	0	0	0	42.00
43.00	Due to other funds	55,995,991	0	0	0	43.00
44.00	Other current liabilities	0	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	62,893,517	0	0	0	45.00
LONG TERM LIABILITIES						
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	0	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	3,114,826	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	3,114,826	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	66,008,343	0	0	0	51.00
CAPITAL ACCOUNTS						
52.00	General fund balance	32,666,537				52.00
53.00	Specific purpose fund		0			53.00
54.00	Donor created - endowment fund balance - restricted			0		54.00
55.00	Donor created - endowment fund balance - unrestricted			0		55.00
56.00	Governing body created - endowment fund balance			0		56.00
57.00	Plant fund balance - invested in plant				0	57.00
58.00	Plant fund balance - reserve for plant improvement, replacement, and expansion				0	58.00
59.00	Total fund balances (sum of lines 52 thru 58)	32,666,537	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	98,674,880	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 14-0217

Period:
From 07/01/2019
To 06/30/2020

Worksheet G-1

Date/Time Prepared:
11/28/2020 2:10 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		72,388,125		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		-16,091,447				2.00
3.00	Total (sum of line 1 and line 2)		56,296,678		0		3.00
4.00	TRANSFERS RESTRICTED CONTRIBUTIONS	179,227		0		0	4.00
5.00	OTHER	125,607		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)		304,834		0		10.00
11.00	Subtotal (line 3 plus line 10)		56,601,512		0		11.00
12.00	TRANSFER FROM AFFILIATES	96		0		0	12.00
13.00	NET ASSET TRANS FROM ALPHA	23,934,879		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)		23,934,975		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		32,666,537		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	TRANSFERS RESTRICTED CONTRIBUTIONS		0				4.00
5.00	OTHER		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	TRANSFER FROM AFFILIATES		0				12.00
13.00	NET ASSET TRANS FROM ALPHA		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: 14-0217

Period:
From 07/01/2019
To 06/30/2020Worksheet G-2
Parts I & II
Date/Time Prepared:
11/28/2020 2:10 pm

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
PART I - PATIENT REVENUES					
General Inpatient Routine Services					
1.00	Hospital	88,630,514		88,630,514	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF	28,952,737		28,952,737	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)	117,583,251		117,583,251	10.00
Intensive Care Type Inpatient Hospital Services					
11.00	INTENSIVE CARE UNIT	21,625,684		21,625,684	11.00
12.00	CORONARY CARE UNIT				12.00
13.00	BURN INTENSIVE CARE UNIT				13.00
14.00	SURGICAL INTENSIVE CARE UNIT				14.00
15.00	OTHER SPECIAL CARE (SPECIFY)				15.00
16.00	Total intensive care type inpatient hospital services (sum of lines 11-15)	21,625,684		21,625,684	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	139,208,935		139,208,935	17.00
18.00	Ancillary services	201,846,119	325,507,969	527,354,088	18.00
19.00	Outpatient services	50,614,688	50,977,174	101,591,862	19.00
20.00	RURAL HEALTH CLINIC	0	0	0	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY				22.00
23.00	AMBULANCE SERVICES				23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	NRCC MISCELLANEOUS INCOME	0	21,196	21,196	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	391,669,742	376,506,339	768,176,081	28.00
PART II - OPERATING EXPENSES					
29.00	Operating expenses (per Wkst. A, column 3, line 200)		144,250,028		29.00
30.00	BALANCING AMOUNT	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	BALANCING AMOUNT	1,371			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)		1,371		42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer to Wkst. G-3, line 4)		144,248,657		43.00

STATEMENT OF REVENUES AND EXPENSES

Provider CCN: 14-0217

Period:
From 07/01/2019
To 06/30/2020

Worksheet G-3

Date/Time Prepared:
11/28/2020 2:10 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	768,176,081	1.00
2.00	Less contractual allowances and discounts on patients' accounts	650,571,984	2.00
3.00	Net patient revenues (line 1 minus line 2)	117,604,097	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	144,248,657	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-26,644,560	5.00
OTHER INCOME			
6.00	Contributions, donations, bequests, etc	145,445	6.00
7.00	Income from investments	0	7.00
8.00	Revenues from telephone and other miscellaneous communication services	0	8.00
9.00	Revenue from television and radio service	0	9.00
10.00	Purchase discounts	0	10.00
11.00	Rebates and refunds of expenses	0	11.00
12.00	Parking lot receipts	0	12.00
13.00	Revenue from laundry and linen service	0	13.00
14.00	Revenue from meals sold to employees and guests	386,658	14.00
15.00	Revenue from rental of living quarters	0	15.00
16.00	Revenue from sale of medical and surgical supplies to other than patients	0	16.00
17.00	Revenue from sale of drugs to other than patients	0	17.00
18.00	Revenue from sale of medical records and abstracts	0	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	0	20.00
21.00	Rental of vending machines	0	21.00
22.00	Rental of hospital space	198,775	22.00
23.00	Governmental appropriations	9,213,670	23.00
24.00	OTHER INCOME	608,565	24.00
24.50	COVID-19 PHE Funding	0	24.50
25.00	Total other income (sum of lines 6-24)	10,553,113	25.00
26.00	Total (line 5 plus line 25)	-16,091,447	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)	-16,091,447	29.00

CALCULATION OF CAPITAL PAYMENT		Provider CCN: 14-0217	Period: From 07/01/2019 To 06/30/2020	Worksheet L Parts I-III Date/Time Prepared: 11/28/2020 2:10 pm
		Title XVIII	Hospital	PPS
		1.00		
PART I - FULLY PROSPECTIVE METHOD				
CAPITAL FEDERAL AMOUNT				
1.00	Capital DRG other than outlier		1,469,071	1.00
1.01	Model 4 BPCI Capital DRG other than outlier		0	1.01
2.00	Capital DRG outlier payments		2,617	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)		62.54	3.00
4.00	Number of interns & residents (see instructions)		0.00	4.00
5.00	Indirect medical education percentage (see instructions)		0.00	5.00
6.00	Indirect medical education adjustment (multiply line 5 by the sum of lines 1 and 1.01, columns 1 and 1.01)(see instructions)		0	6.00
7.00	Percentage of SSI recipient patient days to Medicare Part A patient days (Worksheet E, part A line 30) (see instructions)		4.38	7.00
8.00	Percentage of Medicaid patient days to total days (see instructions)		24.05	8.00
9.00	Sum of lines 7 and 8		28.43	9.00
10.00	Allowable disproportionate share percentage (see instructions)		5.93	10.00
11.00	Disproportionate share adjustment (see instructions)		87,116	11.00
12.00	Total prospective capital payments (see instructions)		1,558,804	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