

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: 14-0251	Period: From 01/01/2020 To 12/31/2020	Worksheet S Parts I-III Date/Time Prepared: 8/2/2021 11:01 am
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PART I - COST REPORT STATUS

Provider use only	1. ☒ Electronically prepared cost report	Date: 8/2/2021	Time: 11:01 am
	2. ☐ Manually prepared cost report		
	3. ☐ If this is an amended report enter the number of times the provider resubmitted this cost report		
	4. ☒ Medicare Utilization. Enter "F" for full or "L" for low.		
Contractor use only	5. ☒ Cost Report Status (1) As Submitted (2) Settled without Audit (3) Settled with Audit (4) Reopened (5) Amended	6. Date Received: 7. Contractor No. 8. ☒ Initial Report for this Provider CCN 9. ☒ Final Report for this Provider CCN	10. NPR Date: 11. Contractor's Vendor Code: 4 12. ☐ If line 5, column 1 is 4: Enter number of times reopened = 0-9.

PART II - CERTIFICATION

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

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

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by COMMUNITY FIRST MEDICAL CENTER (14-0251) for the cost reporting period beginning 01/01/2020 and ending 12/31/2020 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

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

(Signed)

Officer or Administrator of Provider(s)

Title

Date

Cost Center Description		Title V	Title XVIII		HIT	Title XIX	
			Part A	Part B			
		1.00	2.00	3.00	4.00	5.00	
	PART III - SETTLEMENT SUMMARY						
1.00	Hospital	0	1,351,871	213,964	0	0	1.00
2.00	Subprovider - IPF	0	0	0		0	2.00
3.00	Subprovider - IRF	0	0	0		0	3.00
5.00	Swing Bed - SNF	0	0	0		0	5.00
6.00	Swing Bed - NF	0				0	6.00
7.00	SKILLED NURSING FACILITY	0	0	-89		0	7.00
200.00	Total	0	1,351,871	213,875	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: 14-0251		Period: From 01/01/2020 To 12/31/2020		Worksheet S-2 Part I Date/Time Prepared: 8/2/2021 11:01 am	
1.00		2.00		3.00		4.00			
Hospital and Hospital Health Care Complex Address:									
1.00	Street: 5645 WEST ADDISON ST.			PO Box:				1.00	
2.00	City: CHICAGO			State: IL		Zip Code: 60634		County: COOK	
		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			COMMUNITY FIRST MEDICAL CENTER	140251	16974	1	07/01/1966	N P O
4.00	Subprovider - IPF								
5.00	Subprovider - IRF								
6.00	Subprovider - (Other)								
7.00	Swing Beds - SNF								
8.00	Swing Beds - NF								
9.00	Hospital-Based SNF			CFMC SKILLED NURSING FACILITY	145548	16974		07/01/1985	N P O
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)						01/01/2020	12/31/2020	20.00
21.00	Type of Control (see instructions)						4		21.00
							1.00	2.00	3.00
Inpatient PPS Information									
22.00	Does this facility qualify and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.106(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no.					Y	N		22.00
22.01	Did this hospital receive interim uncompensated care payments for this cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)					Y	Y		22.01
22.02	Is this a newly merged hospital that requires final uncompensated care payments to be determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1.					N	N		22.02
22.03	Did this hospital receive a geographic reclassification from urban to rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no.					N	N	N	22.03
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.					1	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.			1,682	749	0	1	4,591	0

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

Provider CCN: 14-0251

Period:
From 01/01/2020
To 12/31/2020Worksheet S-2
Part I
Date/Time Prepared:
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	In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of State Medicaid paid days	Out-of State Medicaid eligible unpaid	Medicaid HMO days	Other Medicaid days	
	1.00	2.00	3.00	4.00	5.00	6.00	
25.00 If this provider is an IRF, enter the in-state Medicaid paid days in column 1, the in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5.	0	0	0	0	0		25.00
					Urban/Rural S	Date of Geogr	
					1.00	2.00	
26.00 Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter "1" for urban or "2" for rural.					1		26.00
27.00 Enter your standard geographic classification (not wage) status at the end of the cost reporting period. Enter in column 1, "1" for urban or "2" for rural. If applicable, enter the effective date of the geographic reclassification in column 2.					1		27.00
35.00 If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period.					0		35.00
					Beginning:	Ending:	
					1.00	2.00	
36.00 Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.							36.00
37.00 If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status is in effect in the cost reporting period.					0		37.00
37.01 Is this hospital a former MDH that is eligible for the MDH transitional payment in accordance with FY 2016 OPPS final rule? Enter "Y" for yes or "N" for no. (see instructions)							37.01
38.00 If line 37 is 1, enter the beginning and ending dates of MDH status. If line 37 is greater than 1, subscript this line for the number of periods in excess of one and enter subsequent dates.							38.00
					Y/N	Y/N	
					1.00	2.00	
39.00 Does this facility qualify for the inpatient hospital payment adjustment for low volume hospitals in accordance with 42 CFR §412.101(b)(2)(i), (ii), or (iii)? Enter in column 1 "Y" for yes or "N" for no. Does the facility meet the mileage requirements in accordance with 42 CFR §412.101(b)(2)(i), (ii), or (iii)? Enter in column 2 "Y" for yes or "N" for no. (see instructions)					N	N	39.00
40.00 Is this hospital subject to the HAC program reduction adjustment? Enter "Y" for yes or "N" for no in column 1, for discharges prior to October 1. Enter "Y" for yes or "N" for no in column 2, for discharges on or after October 1. (see instructions)					N	N	40.00
					V	XVIII	XIX
					1.00	2.00	3.00
Prospective Payment System (PPS)-Capital							
45.00 Does this facility qualify and receive Capital payment for disproportionate share in accordance with 42 CFR Section §412.320? (see instructions)					N	Y	N
46.00 Is this facility eligible for additional payment exception for extraordinary circumstances pursuant to 42 CFR §412.348(f)? If yes, complete Wkst. L, Pt. III and Wkst. L-1, Pt. I through Pt. III.					N	N	N
47.00 Is this a new hospital under 42 CFR §412.300(b) PPS capital? Enter "Y" for yes or "N" for no.					N	N	N
48.00 Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.					N	N	N
Teaching Hospitals							
56.00 Is this a hospital involved in training residents in approved GME programs? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", are you impacted by CR 11642 (or subsequent CR), MA GME payment reduction? Enter "Y" for yes or "N" for no in column 2.					Y	Y	
57.00 If line 56 is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y" did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If column 2 is "N", complete Wkst. D, Parts III & IV and D-2, Pt. II, if applicable.					N		
58.00 If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, chapter 21, §2148? If yes, complete Wkst. D-5.					N		
59.00 Are costs claimed on line 100 of Worksheet A? If yes, complete Wkst. D-2, Pt. I.					N		
				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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

Provider CCN: 14-0251

Period:
From 01/01/2020
To 12/31/2020Worksheet S-2
Part I
Date/Time Prepared:
8/2/2021 11:01 am

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

Provider CCN: 14-0251

Period:
From 01/01/2020
To 12/31/2020Worksheet S-2
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Date/Time Prepared:
8/2/2021 11:01 am

	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
			Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))	
			1.00	2.00	3.00	
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	
			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.					N
76.00	If line 75 is yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)					0
						75.00
						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	Y	91.00	
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.		N	92.00	
93.00	Does this facility operate an ICF/IID facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.	N	N	93.00	
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.	N	N	94.00	
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	95.00	
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.	N	N	96.00	
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	97.00	
98.00	Does title V or XIX follow Medicare (title XVIII) for the interns and residents post stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	Y	98.00	
98.01	Does title V or XIX follow Medicare (title XVIII) for the reporting of charges on Wkst. C, Pt. I? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	Y	98.01	
98.02	Does title V or XIX follow Medicare (title XVIII) for the calculation of observation bed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	Y	98.02	
98.03	Does title V or XIX follow Medicare (title XVIII) for a critical access hospital (CAH) reimbursed 101% of inpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	Y	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	Y	98.04	
98.05	Does title V or XIX follow Medicare (title XVIII) and add back the RCE disallowance on Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	Y	98.05	
98.06	Does title V or XIX follow Medicare (title XVIII) when cost reimbursed for Wkst. D, Pts. I through IV? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	Y	98.06	
Rural Providers					
105.00	Does this hospital qualify as a CAH?	N		105.00	
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)			106.00	
107.00	Column 1: If line 105 is Y, is this facility eligible for cost reimbursement for I&R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) Column 2: If column 1 is Y and line 70 or line 75 is Y, do you train I&Rs in an approved medical education program in the CAH's excluded IPF and/or IRF unit(s)? Enter "Y" for yes or "N" for no in column 2. (see instructions)			107.00	
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	N		108.00	
		Physical	Occupational	Speech	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.				
		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: 14-0251	Period: From 01/01/2020 To 12/31/2020	Worksheet S-2 Part I Date/Time Prepared: 8/2/2021 11:01 am
		1.00	2.00	
111.00	If this facility qualifies as a CAH, did it participate in the Frontier Community Health Integration Project (FCHIP) demonstration for this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If the response to column 1 is Y, enter the integration prong of the FCHIP demo in which this CAH is participating in column 2. Enter all that apply: "A" for Ambulance services; "B" for additional beds; and/or "C" for tele-health services.	N		111.00
		1.00	2.00	3.00
112.00	Did this hospital participate in the Pennsylvania Rural Health Model demonstration for any portion of the current cost reporting period? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2, the date the hospital began participating in the demonstration. In column 3, enter the date the hospital ceased participation in the demonstration, if applicable.	N		112.00
Miscellaneous Cost Reporting Information				
115.00	Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in column 1. If column 1 is yes, enter the method used (A, B, or E only) in column 2. If column 2 is "E", enter in column 3 either "93" percent for short term hospital or "98" percent for long term care (includes psychiatric, rehabilitation and long term hospitals providers) based on the definition in CMS Pub.15-1, chapter 22, §2208.1.	N		0 115.00
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.	2		118.00
		Premiums	Losses	Insurance
		1.00	2.00	3.00
118.01	List amounts of malpractice premiums and paid losses:	1,494,587	0	0 118.01
		1.00	2.00	
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein.	N		118.02
119.00	DO NOT USE THIS LINE			119.00
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 1, "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2, "Y" for yes or "N" for no.	N	N	120.00
121.00	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter "Y" for yes or "N" for no.	Y		121.00
122.00	Does the cost report contain healthcare related taxes as defined in §1903(w)(3) of the Act? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2 the Worksheet A line number where these taxes are included.	N		122.00
Transplant Center Information				
125.00	Does this facility operate a transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.	N		125.00
126.00	If this is a Medicare certified kidney transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			126.00
127.00	If this is a Medicare certified heart transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			127.00
128.00	If this is a Medicare certified liver transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			128.00
129.00	If this is a Medicare certified lung transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			129.00
130.00	If this is a Medicare certified pancreas transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			130.00
131.00	If this is a Medicare certified intestinal transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			131.00
132.00	If this is a Medicare certified islet transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			132.00
133.00	Removed and reserved			133.00
134.00	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.			134.00
All Providers				
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)	N		140.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

Provider CCN: 14-0251

Period:
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1.00		2.00		3.00			
If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number.							
141.00	Name:	Contractor's Name:		Contractor's Number:		141.00	
142.00	Street:	PO Box:				142.00	
143.00	City:	State:		Zip Code:		143.00	
						1.00	
144.00	Are provider based physicians' costs included in Worksheet A?					Y	144.00
						1.00	
						2.00	
145.00	If costs for renal services are claimed on Wkst. A, line 74, are the costs for inpatient services only? Enter "Y" for yes or "N" for no in column 1. If column 1 is no, does the dialysis facility include Medicare utilization for this cost reporting period? Enter "Y" for yes or "N" for no in column 2.				Y	145.00	
146.00	Has the cost allocation methodology changed from the previously filed cost report? Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, chapter 40, §4020) If yes, enter the approval date (mm/dd/yyyy) in column 2.				N	146.00	
						1.00	
147.00	Was there a change in the statistical basis? Enter "Y" for yes or "N" for no.					N	147.00
148.00	Was there a change in the order of allocation? Enter "Y" for yes or "N" for no.					N	148.00
149.00	Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no.					N	149.00
		Part A	Part B	Title V	Title XIX		
		1.00	2.00	3.00	4.00		
Does this facility contain a provider that qualifies for an exemption from the application of the lower of costs or charges? Enter "Y" for yes or "N" for no for each component for Part A and Part B. (See 42 CFR §413.13)							
155.00	Hospital	N	N	N	N	155.00	
156.00	Subprovider - IPF	N	N	N	N	156.00	
157.00	Subprovider - IRF	N	N	N	N	157.00	
158.00	SUBPROVIDER					158.00	
159.00	SNF	N	N	N	N	159.00	
160.00	HOME HEALTH AGENCY	N	N	N	N	160.00	
161.00	CMHC		N	N	N	161.00	
						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: 14-0251		Period: From 01/01/2020 To 12/31/2020		Worksheet S-2 Part II Date/Time Prepared: 8/2/2021 11:01 am	
				Y/N	Date		
				1.00	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	Date	V/I	
				1.00	2.00	3.00	
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.			N			2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)			N			3.00
				Y/N	Type	Date	
				1.00	2.00	3.00	
Financial Data and Reports							
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.			N			4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.			N			5.00
				Y/N	Legal Oper.		
				1.00	2.00		
Approved Educational Activities							
6.00	Column 1: Are costs claimed for nursing school? Column 2: If yes, is the provider is the legal operator of the program?			N			6.00
7.00	Are costs claimed for Allied Health Programs? If "Y" see instructions.			N			7.00
8.00	Were nursing school and/or allied health programs approved and/or renewed during the cost reporting period? If yes, see instructions.			N			8.00
9.00	Are costs claimed for Interns and Residents in an approved graduate medical education program in the current cost report? If yes, see instructions.			Y			9.00
10.00	Was an approved Intern and Resident GME program initiated or renewed in the current cost reporting period? If yes, see instructions.			N			10.00
11.00	Are GME cost directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions.			N			11.00
				Y/N			
				1.00			
Bad Debts							
12.00	Is the provider seeking reimbursement for bad debts? If yes, see instructions.					Y	12.00
13.00	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.					N	13.00
14.00	If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.					N	14.00
Bed Complement							
15.00	Did total beds available change from the prior cost reporting period? If yes, see instructions.					N	15.00
				Part A		Part B	
				Y/N	Date	Y/N	Date
				1.00	2.00	3.00	4.00
PS&R Data							
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)			N		N	
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)			Y	07/20/2021	Y	07/20/2021
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.			N		N	
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.			N		N	

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE

Provider CCN: 14-0251

Period:
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Date/Time Prepared:
8/2/2021 11:01 am

		Description	Y/N	Y/N	
		0	1.00	3.00	
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:		N	N	20.00
		Y/N	Date	Y/N	Date
		1.00	2.00	3.00	4.00
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		N	21.00
				1.00	
COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)					
Capital Related Cost					
22.00	Have assets been relifed for Medicare purposes? If yes, see instructions				22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.				23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions				24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.				25.00
26.00	Were assets subject to Sec.2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.				26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.				27.00
Interest Expense					
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.				28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions				29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.				30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.				31.00
Purchased Services					
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.				32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.				33.00
Provider-Based Physicians					
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.				34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.				35.00
		Y/N	Date		
		1.00	2.00		
Home Office Costs					
36.00	Were home office costs claimed on the cost report?				36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.				37.00
38.00	If line 36 is yes, was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.				38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.				39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.				40.00
		1.00	2.00		
Cost Report Preparer Contact Information					
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	RAJ	SHAH		41.00
42.00	Enter the employer/company name of the cost report preparer.	STRATEGIC REIMBURSEMENT GROUP, LLC			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	630-530-7100 X 107	RAJ.SHAH@SRGROUPLLC.COM		43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE

Provider CCN: 14-0251

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		3.00		
Cost Report Preparer Contact Information				
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	MANAGER		41.00
42.00	Enter the employer/company name of the cost report preparer.			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.			43.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 14-0251

Period:
From 01/01/2020
To 12/31/2020Worksheet S-3
Part I
Date/Time Prepared:
8/2/2021 11:01 am

Component	Worksheet A Line Number	No. of Beds	Bed Days Available	CAH Hours	I/P Days / O/P Visits / Trips	
					Title V	
	1.00	2.00	3.00	4.00	5.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30.00	193	70,638	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)		193	70,638	0.00	0	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	34.00	20	7,320	0.00	0	11.00
12.00 OTHER SPECIAL CARE (SPECIFY)						12.00
13.00 NURSERY						13.00
14.00 Total (see instructions)		213	77,958	0.00	0	14.00
15.00 CAH visits					0	15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY	44.00	66	24,156		0	19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY						22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
24.10 HOSPICE (non-distinct part)	30.00					24.10
25.00 CMHC - CMHC						25.00
26.00 RURAL HEALTH CLINIC						26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	26.25
27.00 Total (sum of lines 14-26)		279				27.00
28.00 Observation Bed Days					0	28.00
29.00 Ambulance Trips						29.00
30.00 Employee discount days (see instruction)						30.00
31.00 Employee discount days - IRF						31.00
32.00 Labor & delivery days (see instructions)		0	0			32.00
32.01 Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00 LTCH non-covered days						33.00
33.01 LTCH site neutral days and discharges						33.01

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 14-0251

Period:
From 01/01/2020
To 12/31/2020Worksheet S-3
Part I
Date/Time Prepared:
8/2/2021 11:01 am

Component		I/P Days / O/P Visits / Trips			Full Time Equivalents		
		Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
		6.00	7.00	8.00	9.00	10.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	7,874	2,081	23,095			1.00
2.00	HMO and other (see instructions)	4,375	4,591				2.00
3.00	HMO IPF Subprovider	0	0				3.00
4.00	HMO IRF Subprovider	0	0				4.00
5.00	Hospital Adults & Peds. Swing Bed SNF	0	0	0			5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	0			6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	7,874	2,081	23,095			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	1,955	351	3,895			11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY						13.00
14.00	Total (see instructions)	9,829	2,432	26,990	0.93	624.88	14.00
15.00	CAH visits	0	0	0			15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY	7,908	0	10,551	0.00	35.53	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			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)				0.93	660.41	27.00
28.00	Observation Bed Days		49	2,350			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: 14-0251

Period:
From 01/01/2020
To 12/31/2020Worksheet S-3
Part I
Date/Time Prepared:
8/2/2021 11:01 am

Component	Full Time Equivalents	Discharges			Total All Patients	
	Nonpaid Workers	Title V	Title XVIII	Title XIX		
	11.00	12.00	13.00	14.00	15.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)		0	1,494	367	4,078	1.00
2.00 HMO and other (see instructions)			613	675		2.00
3.00 HMO IPF Subprovider				0		3.00
4.00 HMO IRF Subprovider				0		4.00
5.00 Hospital Adults & Peds. Swing Bed SNF						5.00
6.00 Hospital Adults & Peds. Swing Bed NF						6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)						7.00
8.00 INTENSIVE CARE UNIT						8.00
9.00 CORONARY CARE UNIT						9.00
10.00 BURN INTENSIVE CARE UNIT						10.00
11.00 SURGICAL INTENSIVE CARE UNIT						11.00
12.00 OTHER SPECIAL CARE (SPECIFY)						12.00
13.00 NURSERY						13.00
14.00 Total (see instructions)	0.00	0	1,494	367	4,078	14.00
15.00 CAH visits						15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY	0.00					19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY						22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
24.10 HOSPICE (non-distinct part)						24.10
25.00 CMHC - CMHC						25.00
26.00 RURAL HEALTH CLINIC						26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER	0.00					26.25
27.00 Total (sum of lines 14-26)	0.00					27.00
28.00 Observation Bed Days						28.00
29.00 Ambulance Trips						29.00
30.00 Employee discount days (see instruction)						30.00
31.00 Employee discount days - IRF						31.00
32.00 Labor & delivery days (see instructions)						32.00
32.01 Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00 LTCH non-covered days			0			33.00
33.01 LTCH site neutral days and discharges			0			33.01

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 14-0251

Period:
From 01/01/2020
To 12/31/2020Worksheet S-3
Part II
Date/Time Prepared:
8/2/2021 11:01 am

	Wkst. A Line Number	Amount Reported	Reclassificati on of Salaries (from Wkst. A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
	1.00	2.00	3.00	4.00	5.00	6.00	
PART II - WAGE DATA							
SALARIES							
1.00	Total salaries (see instructions)	200.00	43,435,186	0	43,435,186	1,378,941.00	31.50
2.00	Non-physician anesthetist Part A		0	0	0	0.00	0.00
3.00	Non-physician anesthetist Part B		0	0	0	0.00	0.00
4.00	Physician-Part A - Administrative		0	0	0	0.00	0.00
4.01	Physicians - Part A - Teaching		0	0	0	0.00	0.00
5.00	Physician and Non Physician-Part B		1,627,660	0	1,627,660	7,842.00	207.56
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	2,162,315	0	2,162,315	74,196.00	29.14
10.00	Excluded area salaries (see instructions)		689,560	0	689,560	13,433.00	51.33
OTHER WAGES & RELATED COSTS							
11.00	Contract labor: Direct Patient Care		128	0	128	8.00	16.00
12.00	Contract labor: Top level management and other management and administrative services		0	0	0	0.00	0.00
13.00	Contract labor: Physician-Part A - Administrative		0	0	0	0.00	0.00
14.00	Home office and/or related organization salaries and wage-related costs		0	0	0	0.00	0.00
14.01	Home office salaries		0	0	0	0.00	0.00
14.02	Related organization salaries		0	0	0	0.00	0.00
15.00	Home office: Physician Part A - Administrative		0	0	0	0.00	0.00
16.00	Home office and Contract Physicians Part A - Teaching		0	0	0	0.00	0.00
16.01	Home office Physicians Part A - Teaching		0	0	0	0.00	0.00
16.02	Home office contract Physicians Part A - Teaching		0	0	0	0.00	0.00
WAGE-RELATED COSTS							
17.00	Wage-related costs (core) (see instructions)		5,908,480	0	5,908,480		
18.00	Wage-related costs (other) (see instructions)						
19.00	Excluded areas		415,959	0	415,959		
20.00	Non-physician anesthetist Part A		0	0	0		
21.00	Non-physician anesthetist Part B		104,345	0	104,345		
22.00	Physician Part A - Administrative		0	0	0		
22.01	Physician Part A - Teaching		0	0	0		
23.00	Physician Part B		0	0	0		
24.00	Wage-related costs (RHC/FQHC)		0	0	0		
25.00	Interns & residents (in an approved program)		0	0	0		
25.50	Home office wage-related (core)		0	0	0		
25.51	Related organization wage-related (core)		0	0	0		
25.52	Home office: Physician Part A - Administrative - wage-related (core)		0	0	0		

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 14-0251

Period:
From 01/01/2020
To 12/31/2020Worksheet S-3
Part II
Date/Time Prepared:
8/2/2021 11:01 am

		Wkst. A Line Number	Amount Reported	Reclassificati on of Salaries (from Wkst. A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
25.53	Home office: Physicians Part A - Teaching - wage-related (core)		0	0	0			25.53
OVERHEAD COSTS - DIRECT SALARIES								
26.00	Employee Benefits Department	4.00	441,773	0	441,773	8,925.00	49.50	26.00
27.00	Administrative & General	5.00	4,218,460	0	4,218,460	158,770.00	26.57	27.00
28.00	Administrative & General under contract (see inst.)		490,368	0	490,368	5,377.00	91.20	28.00
29.00	Maintenance & Repairs	6.00	0	0	0	0.00	0.00	29.00
30.00	Operation of Plant	7.00	1,420,370	0	1,420,370	63,260.00	22.45	30.00
31.00	Laundry & Linen Service	8.00	104,051	0	104,051	5,991.00	17.37	31.00
32.00	Housekeeping	9.00	1,410,444	0	1,410,444	82,948.00	17.00	32.00
33.00	Housekeeping under contract (see instructions)		0	0	0	0.00	0.00	33.00
34.00	Dietary	10.00	933,643	-157,358	776,285	44,071.00	17.61	34.00
35.00	Dietary under contract (see instructions)		0	0	0	0.00	0.00	35.00
36.00	Cafeteria	11.00	0	157,358	157,358	8,931.00	17.62	36.00
37.00	Maintenance of Personnel	12.00	0	0	0	0.00	0.00	37.00
38.00	Nursing Administration	13.00	1,064,909	0	1,064,909	32,924.00	32.34	38.00
39.00	Central Services and Supply	14.00	509,349	0	509,349	25,092.00	20.30	39.00
40.00	Pharmacy	15.00	1,560,159	0	1,560,159	42,150.00	37.01	40.00
41.00	Medical Records & Medical Records Library	16.00	2,232,072	0	2,232,072	61,181.00	36.48	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: 14-0251

Period:
From 01/01/2020
To 12/31/2020Worksheet S-3
Part III
Date/Time Prepared:
8/2/2021 11:01 am

	Worksheet A Line Number	Amount Reported	Reclassificati on of Salaries (from Worksheet A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
	1.00	2.00	3.00	4.00	5.00	6.00	
PART III - HOSPITAL WAGE INDEX SUMMARY							
1.00	Net salaries (see instructions)	42,297,894	0	42,297,894	1,376,476.00	30.73	1.00
2.00	Excluded area salaries (see instructions)	2,851,875	0	2,851,875	87,629.00	32.54	2.00
3.00	Subtotal salaries (line 1 minus line 2)	39,446,019	0	39,446,019	1,288,847.00	30.61	3.00
4.00	Subtotal other wages & related costs (see inst.)	128	0	128	8.00	16.00	4.00
5.00	Subtotal wage-related costs (see inst.)	5,908,480	0	5,908,480	0.00	14.98	5.00
6.00	Total (sum of lines 3 thru 5)	45,354,627	0	45,354,627	1,288,855.00	35.19	6.00
7.00	Total overhead cost (see instructions)	14,385,598	0	14,385,598	539,620.00	26.66	7.00

HOSPITAL WAGE RELATED COSTS

Provider CCN: 14-0251

Period:
From 01/01/2020
To 12/31/2020Worksheet S-3
Part IV
Date/Time Prepared:
8/2/2021 11:01 am

		Amount Reported	
		1.00	
PART IV - WAGE RELATED COSTS			
Part A - Core List			
RETIREMENT COST			
1.00	401K Employer Contributions	0	1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution	0	2.00
3.00	Nonqualified Defined Benefit Plan Cost (see instructions)	0	3.00
4.00	Qualified Defined Benefit Plan Cost (see instructions)	0	4.00
PLAN ADMINISTRATIVE COSTS (Paid to External Organization)			
5.00	401K/TSA Plan Administration fees	0	5.00
6.00	Legal/Accounting/Management Fees-Pension Plan	0	6.00
7.00	Employee Managed Care Program Administration Fees	0	7.00
HEALTH AND INSURANCE COST			
8.00	Health Insurance (Purchased or Self Funded)	0	8.00
8.01	Health Insurance (Self Funded without a Third Party Administrator)	0	8.01
8.02	Health Insurance (Self Funded with a Third Party Administrator)	2,321,300	8.02
8.03	Health Insurance (Purchased)	0	8.03
9.00	Prescription Drug Plan	0	9.00
10.00	Dental, Hearing and Vision Plan	0	10.00
11.00	Life Insurance (If employee is owner or beneficiary)	3,108	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)	0	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)	0	14.00
15.00	'Workers' Compensation Insurance	883,353	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	3,184,564	17.00
18.00	Medicare Taxes - Employers Portion Only	0	18.00
19.00	Unemployment Insurance	36,459	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	0	23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)	6,428,784	24.00
Part B - Other than Core Related Cost			
25.00	OTHER WAGE RELATED COSTS (SPECIFY)		25.00

HOSPITAL CONTRACT LABOR AND BENEFIT COST

Provider CCN: 14-0251

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

 Worksheet S-3
 Part V
 Date/Time Prepared:
 8/2/2021 11:01 am

Cost Center Description		Contract Labor	Benefit Cost	
		1.00	2.00	
PART V - Contract Labor and Benefit Cost				
Hospital and Hospital-Based Component Identification:				
1.00	Total facility's contract labor and benefit cost	128	6,428,784	1.00
2.00	Hospital	128	6,428,784	2.00
3.00	Subprovider - IPF			3.00
4.00	Subprovider - IRF			4.00
5.00	Subprovider - (Other)	0	0	5.00
6.00	Swing Beds - SNF	0	0	6.00
7.00	Swing Beds - NF	0	0	7.00
8.00	Hospital-Based SNF	0	0	8.00
9.00	Hospital-Based NF			9.00
10.00	Hospital-Based OLTC			10.00
11.00	Hospital-Based HHA			11.00
12.00	Separately Certified ASC			12.00
13.00	Hospital-Based Hospice			13.00
14.00	Hospital-Based Health Clinic RHC			14.00
15.00	Hospital-Based Health Clinic FQHC			15.00
16.00	Hospital-Based-CMHC			16.00
17.00	Renal Dialysis	0	0	17.00
18.00	Other	0	0	18.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA

Provider CCN: 14-0251

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

Worksheet S-10

Date/Time Prepared:
8/2/2021 11:01 am

			1.00	
Uncompensated and indigent care cost computation				
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided by line 202 column 8)		0.197533	1.00
Medicaid (see instructions for each line)				
2.00	Net revenue from Medicaid		15,325,747	2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?			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		104,152,577	6.00
7.00	Medicaid cost (line 1 times line 6)		20,573,571	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)		5,247,824	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)		5,247,824	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)	19,102,765	72,710	19,175,475
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	3,773,426	72,710	3,846,136
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)	3,773,426	72,710	3,846,136
			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)		20,496,425	26.00
27.00	Medicare reimbursable bad debts for the entire hospital complex (see instructions)		1,427,617	27.00
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)		2,196,333	27.01
28.00	Non-Medicare bad debt expense (see instructions)		18,300,092	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)		4,383,588	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)		8,229,724	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)		13,477,548	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-0251

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

Worksheet A

Date/Time Prepared:
8/2/2021 11:01 am

Cost Center Description			Salaries	Other	Total (col. 1 + col. 2)	Reclassificati ons (See A-6)	Reclassified Trial Balance (col. 3 +- col. 4)	
			1.00	2.00	3.00	4.00	5.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT		1,434,821	1,434,821	601,541	2,036,362	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		0	0	3,455,042	3,455,042	2.00
3.00	00300	OTHER CAP REL COSTS		0	0	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	441,773	2,536,335	2,978,108	0	2,978,108	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	4,218,460	28,403,606	32,622,066	-3,499,862	29,122,204	5.00
6.00	00600	MAINTENANCE & REPAIRS	0	0	0	0	0	6.00
7.00	00700	OPERATION OF PLANT	1,420,370	1,012,615	2,432,985	-52,704	2,380,281	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	104,051	532,379	636,430	0	636,430	8.00
9.00	00900	HOUSEKEEPING	1,410,444	510,219	1,920,663	0	1,920,663	9.00
10.00	01000	DIETARY	933,643	518,946	1,452,589	-245,462	1,207,127	10.00
11.00	01100	CAFETERIA	0	0	0	244,822	244,822	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	1,064,909	-1,368,633	-303,724	0	-303,724	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	509,349	38,109	547,458	-70,944	476,514	14.00
15.00	01500	PHARMACY	1,560,159	3,393,337	4,953,496	-3,205,918	1,747,578	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	2,232,072	643,632	2,875,704	0	2,875,704	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
20.00	02000	NURSING SCHOOL	0	0	0	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	44,560	44,560	0	44,560	22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	7,777,039	3,103,911	10,880,950	-148,020	10,732,930	30.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	2,740,686	2,015,893	4,756,579	-87,358	4,669,221	34.00
44.00	04400	SKILLED NURSING FACILITY	2,162,315	2,405,670	4,567,985	-18,504	4,549,481	44.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	1,985,122	2,412,914	4,398,036	-1,626,008	2,772,028	50.00
51.00	05100	RECOVERY ROOM	424,478	41,242	465,720	-1,602	464,118	51.00
53.00	05300	ANESTHESIOLOGY	101,894	1,099,441	1,201,335	-26,289	1,175,046	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,355,199	184,591	1,539,790	-19,313	1,520,477	54.00
56.00	05600	RADIOISOTOPE	179,961	129,545	309,506	-875	308,631	56.00
57.00	05700	CT SCAN	535,704	152,877	688,581	-110,882	577,699	57.00
58.00	05800	MRI	150,209	44,581	194,790	-4,212	190,578	58.00
59.00	05900	CARDIAC CATHETERIZATION	662,758	1,165,203	1,827,961	-886,962	940,999	59.00
60.00	06000	LABORATORY	1,969,962	3,606,281	5,576,243	-28,155	5,548,088	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	909,302	907,823	1,817,125	-284,852	1,532,273	65.00
66.00	06600	PHYSICAL THERAPY	846,496	170,129	1,016,625	-11,755	1,004,870	66.00
67.00	06700	OCCUPATIONAL THERAPY	397,273	50,099	447,372	-264	447,108	67.00
68.00	06800	SPEECH PATHOLOGY	141,129	10,662	151,791	0	151,791	68.00
69.00	06900	ELECTROCARDIOLOGY	400,973	35,469	436,442	-6,470	429,972	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	41,019	3,077	44,096	0	44,096	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	1,486,758	1,486,758	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	1,535,584	1,535,584	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	3,205,918	3,205,918	73.00
74.00	07400	RENAL DIALYSIS	241,034	23,644	264,678	-2,849	261,829	74.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	683,287	57,569	740,856	-5,720	735,136	90.00
91.00	09100	EMERGENCY	5,144,556	6,626,129	11,770,685	-184,685	11,586,000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0	0	0	0	0	93.99
SPECIAL PURPOSE COST CENTERS								
118.00	SUBTOTALS (SUM OF LINES 1 through 117)		42,745,626	61,946,676	104,692,302	0	104,692,302	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
194.00	07950	ADDISON CENTRAL PHARMACY	689,560	615,114	1,304,674	0	1,304,674	194.00
194.01	07951	PHYSICIAN PRACTICES	0	0	0	0	0	194.01
200.00	TOTAL (SUM OF LINES 118 through 199)		43,435,186	62,561,790	105,996,976	0	105,996,976	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-0251

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

Worksheet A

Date/Time Prepared:
8/2/2021 11:01 am

Cost Center Description			Adjustments (See A-8)	Net Expenses For Allocation	
			6.00	7.00	
GENERAL SERVICE COST CENTERS					
1.00	00100	CAP REL COSTS-BLDG & FIXT	0	2,036,362	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	0	3,455,042	2.00
3.00	00300	OTHER CAP REL COSTS	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	2,978,108	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-7,227,907	21,894,297	5.00
6.00	00600	MAINTENANCE & REPAIRS	0	0	6.00
7.00	00700	OPERATION OF PLANT	-3,581	2,376,700	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	636,430	8.00
9.00	00900	HOUSEKEEPING	0	1,920,663	9.00
10.00	01000	DIETARY	0	1,207,127	10.00
11.00	01100	CAFETERIA	-141,086	103,736	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	0	-303,724	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	476,514	14.00
15.00	01500	PHARMACY	0	1,747,578	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-1,764	2,873,940	16.00
17.00	01700	SOCIAL SERVICE	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	19.00
20.00	02000	NURSING SCHOOL	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	44,560	22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	-1,365,776	9,367,154	30.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	-145,850	4,523,371	34.00
44.00	04400	SKILLED NURSING FACILITY	0	4,549,481	44.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	-388,334	2,383,694	50.00
51.00	05100	RECOVERY ROOM	0	464,118	51.00
53.00	05300	ANESTHESIOLOGY	-1,077,340	97,706	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-3,317	1,517,160	54.00
56.00	05600	RADIOISOTOPE	0	308,631	56.00
57.00	05700	CT SCAN	0	577,699	57.00
58.00	05800	MRI	0	190,578	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	940,999	59.00
60.00	06000	LABORATORY	0	5,548,088	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	-33,390	1,498,883	65.00
66.00	06600	PHYSICAL THERAPY	0	1,004,870	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	447,108	67.00
68.00	06800	SPEECH PATHOLOGY	0	151,791	68.00
69.00	06900	ELECTROCARDIOLOGY	0	429,972	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	44,096	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	1,486,758	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	1,535,584	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	-3,781	3,202,137	73.00
74.00	07400	RENAL DIALYSIS	0	261,829	74.00
76.97	07697	CARDIAC REHABILITATION	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	76.99
OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	0	735,136	90.00
91.00	09100	EMERGENCY	-5,623,425	5,962,575	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART			92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0	0	93.99
SPECIAL PURPOSE COST CENTERS					
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-16,015,551	88,676,751	118.00
NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	0	0	190.00
194.00	07950	ADDISON CENTRAL PHARMACY	0	1,304,674	194.00
194.01	07951	PHYSICIAN PRACTICES	0	0	194.01
200.00		TOTAL (SUM OF LINES 118 through 199)	-16,015,551	89,981,425	200.00

RECLASSIFICATIONS

Provider CCN: 14-0251

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

Worksheet A-6

Date/Time Prepared:
8/2/2021 11:01 am

	Increases					
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
	A - RECLASS CAFETERIA COST					
1.00	CAFETERIA	11.00	157,358	87,464		1.00
	0		157,358	87,464		
	B - RECLASS OTHER CAPITAL COSTS					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	1,357,226		1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	2,823,210		2.00
	0		0	4,180,436		
	C - CHARGEABLE MEDICAL SUPPLIES					
1.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	1,486,758		1.00
2.00	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	1,535,584		2.00
3.00		0.00	0	0		3.00
4.00		0.00	0	0		4.00
5.00		0.00	0	0		5.00
6.00		0.00	0	0		6.00
7.00		0.00	0	0		7.00
8.00		0.00	0	0		8.00
9.00		0.00	0	0		9.00
10.00		0.00	0	0		10.00
11.00		0.00	0	0		11.00
12.00		0.00	0	0		12.00
13.00		0.00	0	0		13.00
14.00		0.00	0	0		14.00
15.00		0.00	0	0		15.00
16.00		0.00	0	0		16.00
17.00		0.00	0	0		17.00
	0		0	3,022,342		
	D - CAPITAL INS					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	293,329		1.00
	0		0	293,329		
	E - CHARGEABLE DRUG COST					
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	3,205,918		1.00
	0		0	3,205,918		
	H - EQUIPMENT LEASE					
1.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	631,832		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
	0		0	631,832		
500.00	Grand Total: Increases		157,358	11,421,321		500.00

RECLASSIFICATIONS

Provider CCN: 14-0251

Period:
From 01/01/2020
To 12/31/2020Worksheet A-6
Date/Time Prepared:
8/2/2021 11:01 am

	Decreases				Wkst. A-7 Ref.		
	Cost Center	Line #	Salary	Other			
	6.00	7.00	8.00	9.00			
	A - RECLASS CAFETERIA COST						
1.00	DIETARY _____	10.00	157,358	87,464	0	1.00	
	0		157,358	87,464			
	B - RECLASS OTHER CAPITAL COSTS						
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	1,049,014	9	1.00	
2.00	ADMINISTRATIVE & GENERAL	5.00	0	3,131,422	9	2.00	
	0		0	4,180,436			
	C - CHARGEABLE MEDICAL SUPPLIES						
1.00	ADULTS & PEDIATRICS	30.00	0	102,174	0	1.00	
2.00	SURGICAL INTENSIVE CARE UNIT	34.00	0	83,746	0	2.00	
3.00	OPERATING ROOM	50.00	0	1,516,993	0	3.00	
4.00	RECOVERY ROOM	51.00	0	1,602	0	4.00	
5.00	ANESTHESIOLOGY	53.00	0	26,289	0	5.00	
6.00	RADIOLOGY-DIAGNOSTIC	54.00	0	18,813	0	6.00	
7.00	RADIOISOTOPE	56.00	0	375	0	7.00	
8.00	CT SCAN	57.00	0	33,853	0	8.00	
9.00	MRI	58.00	0	4,212	0	9.00	
10.00	CARDIAC CATHETERIZATION	59.00	0	886,962	0	10.00	
11.00	RESPIRATORY THERAPY	65.00	0	135,580	0	11.00	
12.00	PHYSICAL THERAPY	66.00	0	11,755	0	12.00	
13.00	OCCUPATIONAL THERAPY	67.00	0	264	0	13.00	
14.00	ELECTROCARDIOLOGY	69.00	0	6,470	0	14.00	
15.00	RENAL DIALYSIS	74.00	0	2,849	0	15.00	
16.00	CLINIC	90.00	0	5,720	0	16.00	
17.00	EMERGENCY _____	91.00	0	184,685	0	17.00	
	0		0	3,022,342			
	D - CAPITAL INS						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	293,329	12	1.00	
	0		0	293,329			
	E - CHARGEABLE DRUG COST						
1.00	PHARMACY _____	15.00	0	3,205,918	0	1.00	
	0		0	3,205,918			
	H - EQUIPMENT LEASE						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	75,111	10	1.00	
2.00	OPERATION OF PLANT	7.00	0	52,704	0	2.00	
3.00	DIETARY	10.00	0	640	0	3.00	
4.00	CENTRAL SERVICES & SUPPLY	14.00	0	70,944	0	4.00	
5.00	ADULTS & PEDIATRICS	30.00	0	45,846	0	5.00	
6.00	SURGICAL INTENSIVE CARE UNIT	34.00	0	3,612	0	6.00	
7.00	SKILLED NURSING FACILITY	44.00	0	18,504	0	7.00	
8.00	OPERATING ROOM	50.00	0	109,015	0	8.00	
9.00	RADIOLOGY-DIAGNOSTIC	54.00	0	500	0	9.00	
10.00	RADIOISOTOPE	56.00	0	500	0	10.00	
11.00	CT SCAN	57.00	0	77,029	0	11.00	
12.00	LABORATORY	60.00	0	28,155	0	12.00	
13.00	RESPIRATORY THERAPY _____	65.00	0	149,272	0	13.00	
	0		0	631,832			
500.00	Grand Total: Decreases		157,358	11,421,321		500.00	

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-0251

Period:
From 01/01/2020
To 12/31/2020Worksheet A-7
Part I
Date/Time Prepared:
8/2/2021 11:01 am

		Beginning Balances	Acquisitions			Disposals and Retirements	
			Purchases	Donation	Total		
			1.00	2.00	3.00		
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES							
1.00	Land	2,492,384	0	0	0	0	1.00
2.00	Land Improvements	0	0	0	0	0	2.00
3.00	Buildings and Fixtures	16,294,082	10,520	0	10,520	0	3.00
4.00	Building Improvements	0	0	0	0	0	4.00
5.00	Fixed Equipment	0	0	0	0	0	5.00
6.00	Movable Equipment	24,469,699	2,348,184	0	2,348,184	0	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	43,256,165	2,358,704	0	2,358,704	0	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	43,256,165	2,358,704	0	2,358,704	0	10.00
		Ending Balance	Fully Depreciated Assets				
		6.00	7.00				
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES							
1.00	Land	2,492,384	0				1.00
2.00	Land Improvements	0	0				2.00
3.00	Buildings and Fixtures	16,304,602	0				3.00
4.00	Building Improvements	0	0				4.00
5.00	Fixed Equipment	0	0				5.00
6.00	Movable Equipment	26,817,883	0				6.00
7.00	HIT designated Assets	0	0				7.00
8.00	Subtotal (sum of lines 1-7)	45,614,869	0				8.00
9.00	Reconciling Items	0	0				9.00
10.00	Total (line 8 minus line 9)	45,614,869	0				10.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-0251

Period:
From 01/01/2020
To 12/31/2020Worksheet A-7
Part II
Date/Time Prepared:
8/2/2021 11:01 am

Cost Center Description		SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	CAP REL COSTS-BLDG & FIXT	1,434,821	0	0	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	1,434,821	0	0	0	0	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Other	Total (1) (sum				
		Capital-Relate	of cols. 9				
		d Costs (see	through 14)				
		instructions)					
		14.00	15.00				
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	CAP REL COSTS-BLDG & FIXT	0	1,434,821				1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0				2.00
3.00	Total (sum of lines 1-2)	0	1,434,821				3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-0251

Period:
From 01/01/2020
To 12/31/2020Worksheet A-7
Part III
Date/Time Prepared:
8/2/2021 11:01 am

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	16,304,602	0	16,304,602	0.378100	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	26,817,883	0	26,817,883	0.621900	0	2.00
3.00	Total (sum of lines 1-2)	43,122,485	0	43,122,485	1.000000	0	3.00
Cost Center Description		ALLOCATION OF OTHER CAPITAL			SUMMARY OF CAPITAL		
		Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	Depreciation	Lease	
		6.00	7.00	8.00	9.00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	1,743,033	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	2,823,210	631,832	2.00
3.00	Total (sum of lines 1-2)	0	0	0	4,566,243	631,832	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0	293,329	0	0	2,036,362	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	0	3,455,042	2.00
3.00	Total (sum of lines 1-2)	0	293,329	0	0	5,491,404	3.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 14-0251

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

Worksheet A-8

Date/Time Prepared:
8/2/2021 11:01 am

Cost Center Description		Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted		Wkst. A-7 Ref.	
				Cost Center	Line #		
		1.00	2.00	3.00	4.00	5.00	
1.00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)			0CAP REL COSTS-BLDG & FIXT	1.00	0	1.00
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)			0CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
3.00	Investment income - other (chapter 2)		0		0.00	0	3.00
4.00	Trade, quantity, and time discounts (chapter 8)		0		0.00	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)		0		0.00	0	5.00
6.00	Rental of provider space by suppliers (chapter 8)		0		0.00	0	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)	A	-12,356	ADMINISTRATIVE & GENERAL	5.00	0	7.00
8.00	Television and radio service (chapter 21)	A	-5,189	ADMINISTRATIVE & GENERAL	5.00	0	8.00
9.00	Parking lot (chapter 21)		0		0.00	0	9.00
10.00	Provider-based physician adjustment	A-8-2	-6,988,719			0	10.00
11.00	Sale of scrap, waste, etc. (chapter 23)		0		0.00	0	11.00
12.00	Related organization transactions (chapter 10)	A-8-1	0			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests	B	-141,086	CAFETERIA	11.00	0	14.00
15.00	Rental of quarters to employee and others		0		0.00	0	15.00
16.00	Sale of medical and surgical supplies to other than patients		0		0.00	0	16.00
17.00	Sale of drugs to other than patients	B	-3,781	DRUGS CHARGED TO PATIENTS	73.00	0	17.00
18.00	Sale of medical records and abstracts	B	-1,764	MEDICAL RECORDS & LIBRARY	16.00	0	18.00
19.00	Nursing and allied health education (tuition, fees, books, etc.)		0		0.00	0	19.00
20.00	Vending machines	B	-3,161	OPERATION OF PLANT	7.00	0	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	0	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	RESPIRATORY THERAPY	65.00		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	PHYSICAL THERAPY	66.00		24.00
25.00	Utilization review - physicians' compensation (chapter 21)		0	*** Cost Center Deleted ***	114.00		25.00
26.00	Depreciation - CAP REL COSTS-BLDG & FIXT		0	CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	27.00
28.00	Non-physician Anesthetist		0	NONPHYSICIAN ANESTHETISTS	19.00		28.00
29.00	Physicians' assistant		0		0.00	0	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	OCCUPATIONAL THERAPY	67.00		30.00
30.99	Hospice (non-distinct) (see instructions)	B	-17,736	ADULTS & PEDIATRICS	30.00		30.99
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	SPEECH PATHOLOGY	68.00		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest		0		0.00	0	32.00
33.00	MISC INCOME	B	-3,317	RADIOLOGY-DIAGNOSTIC	54.00	0	33.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 14-0251

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

Worksheet A-8

Date/Time Prepared:
8/2/2021 11:01 am

Cost Center Description		Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted		Wkst. A-7 Ref.	
				Cost Center	Line #		
		1.00	2.00	3.00	4.00	5.00	
34.00	MISC INCOME	B	-420	OPERATION OF PLANT	7.00	0	34.00
35.00	MISC INCOME	B	-96,072	ADMINISTRATIVE & GENERAL	5.00	0	35.00
36.00	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	36.00
37.00	PART B PROF.	A	-356,560	ADULTS & PEDIATRICS	30.00	0	37.00
38.00	PART B PROF.	A	-1,271,100	EMERGENCY	91.00	0	38.00
39.00	MEDICAID TAX ASSESSMENT	A	-6,994,290	ADMINISTRATIVE & GENERAL	5.00	0	39.00
40.00	NON ALLOW EXP	A	-120,000	ADMINISTRATIVE & GENERAL	5.00	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
45.01	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	45.01
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-16,015,551				50.00

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

(2) Basis for adjustment (see instructions).

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

B. Amount Received - if cost cannot be determined.

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

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

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 14-0251

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

Worksheet A-8-2

Date/Time Prepared:
8/2/2021 11:01 am

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	30.00	AGGREGATE-ADULTS & PEDIATRICS	991,480	991,480	0	0	0	1.00
2.00	34.00	AGGREGATE-SURGICAL INTENSIVE CARE UN	145,850	145,850	0	0	0	2.00
3.00	50.00	AGGREGATE-OPERATING ROOM	388,334	388,334	0	0	0	3.00
4.00	53.00	AGGREGATE-ANESTHESIOLOGY	1,077,340	1,077,340	0	0	0	4.00
5.00	65.00	AGGREGATE-RESPIRATORY THERAPY	33,390	33,390	0	0	0	5.00
6.00	91.00	AGGREGATE-EMERGENCY	4,352,325	4,352,325	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			6,988,719	6,988,719	0	0	0	200.00
	Wkst. A Line #	Cost Center/Physician Identifier	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	30.00	AGGREGATE-ADULTS & PEDIATRICS	0	0	0	0	0	1.00
2.00	34.00	AGGREGATE-SURGICAL INTENSIVE CARE UN	0	0	0	0	0	2.00
3.00	50.00	AGGREGATE-OPERATING ROOM	0	0	0	0	0	3.00
4.00	53.00	AGGREGATE-ANESTHESIOLOGY	0	0	0	0	0	4.00
5.00	65.00	AGGREGATE-RESPIRATORY THERAPY	0	0	0	0	0	5.00
6.00	91.00	AGGREGATE-EMERGENCY	0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			0	0	0	0	0	200.00
	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment		
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00	30.00	AGGREGATE-ADULTS & PEDIATRICS	0	0	0	991,480		1.00
2.00	34.00	AGGREGATE-SURGICAL INTENSIVE CARE UN	0	0	0	145,850		2.00
3.00	50.00	AGGREGATE-OPERATING ROOM	0	0	0	388,334		3.00
4.00	53.00	AGGREGATE-ANESTHESIOLOGY	0	0	0	1,077,340		4.00
5.00	65.00	AGGREGATE-RESPIRATORY THERAPY	0	0	0	33,390		5.00
6.00	91.00	AGGREGATE-EMERGENCY	0	0	0	4,352,325		6.00
7.00	0.00		0	0	0	0		7.00
8.00	0.00		0	0	0	0		8.00
9.00	0.00		0	0	0	0		9.00
10.00	0.00		0	0	0	0		10.00
200.00			0	0	0	6,988,719		200.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0251

Period:
From 01/01/2020
To 12/31/2020Worksheet B
Part I
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Cost Center Description			CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
			Net Expenses for Cost Allocation (from Wkst A col. 7)	BLDG & FIXT	MVBLE EQUIP		
			0	1.00	2.00	4.00	4A
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT	2,036,362	2,036,362			1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	3,455,042		3,455,042		2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	2,978,108	21,671	36,769	3,036,548	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	21,894,297	160,772	272,778	297,941	5.00
6.00	00600	MAINTENANCE & REPAIRS	0	0	0	0	6.00
7.00	00700	OPERATION OF PLANT	2,376,700	235,815	400,101	100,318	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	636,430	0	0	7,349	8.00
9.00	00900	HOUSEKEEPING	1,920,663	48,818	82,828	99,617	9.00
10.00	01000	DIETARY	1,207,127	64,901	110,115	54,827	10.00
11.00	01100	CAFETERIA	103,736	63,658	108,007	11,114	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	-303,724	20,508	34,796	75,212	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	476,514	62,135	105,422	35,974	14.00
15.00	01500	PHARMACY	1,747,578	21,799	36,986	110,191	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	2,873,940	60,299	102,307	157,647	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	19.00
20.00	02000	NURSING SCHOOL	0	0	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	44,560	0	0	0	22.00
23.00	02300	PARAMED ED PRGM- (SPECIFY)	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	9,367,154	439,406	745,531	549,287	30.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	4,523,371	58,671	99,546	193,569	34.00
44.00	04400	SKILLED NURSING FACILITY	4,549,481	159,634	270,846	152,720	44.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	2,383,694	167,916	284,898	140,205	50.00
51.00	05100	RECOVERY ROOM	464,118	11,256	19,098	29,980	51.00
53.00	05300	ANESTHESIOLOGY	97,706	4,931	8,366	7,197	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,517,160	80,631	136,804	95,715	54.00
56.00	05600	RADIOISOTOPE	308,631	4,931	8,366	12,710	56.00
57.00	05700	CT SCAN	577,699	8,963	15,208	37,836	57.00
58.00	05800	MRI	190,578	2,397	4,067	10,609	58.00
59.00	05900	CARDIAC CATHETERIZATION	940,999	49,187	83,453	46,809	59.00
60.00	06000	LABORATORY	5,548,088	77,287	131,131	139,134	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	1,498,883	16,283	27,627	64,222	65.00
66.00	06600	PHYSICAL THERAPY	1,004,870	39,012	66,191	59,786	66.00
67.00	06700	OCCUPATIONAL THERAPY	447,108	9,861	16,732	28,059	67.00
68.00	06800	SPEECH PATHOLOGY	151,791	6,494	11,018	9,968	68.00
69.00	06900	ELECTROCARDIOLOGY	429,972	11,818	20,051	28,320	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	44,096	0	0	2,897	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1,486,758	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1,535,584	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	3,202,137	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	261,829	5,700	9,672	17,024	74.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	735,136	25,688	43,584	48,259	90.00
91.00	09100	EMERGENCY	5,962,575	84,415	143,224	363,350	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0	0	0	0	93.99
SPECIAL PURPOSE COST CENTERS							
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	88,676,751	2,024,857	3,435,522	2,987,846	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	0	11,505	19,520	0	190.00
194.00	07950	ADDISON CENTRAL PHARMACY	1,304,674	0	0	48,702	194.00
194.01	07951	PHYSICIAN PRACTICES	0	0	0	0	194.01
200.00		Cross Foot Adjustments					200.00
201.00		Negative Cost Centers		0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	89,981,425	2,036,362	3,455,042	3,036,548	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0251

Period:
From 01/01/2020
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Cost Center Description			ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
			5.00	6.00	7.00	8.00	9.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	22,625,788					5.00
6.00	00600	MAINTENANCE & REPAIRS	0	0				6.00
7.00	00700	OPERATION OF PLANT	1,043,001	0	4,155,935			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	215,701	0	0	859,480		8.00
9.00	00900	HOUSEKEEPING	721,011	0	125,383	8,913	3,007,233	9.00
10.00	01000	DIETARY	481,463	0	166,690	54	124,369	10.00
11.00	01100	CAFETERIA	95,998	0	163,499	0	121,988	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	0	0	52,674	2,094	39,300	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	227,852	0	159,586	3,009	119,069	14.00
15.00	01500	PHARMACY	642,149	0	55,989	0	41,774	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,070,227	0	154,871	0	115,551	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
20.00	02000	NURSING SCHOOL	0	0	0	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	14,930	0	0	0	0	22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	3,719,539	0	1,128,572	491,487	842,037	30.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	1,633,441	0	150,691	84,683	112,432	34.00
44.00	04400	SKILLED NURSING FACILITY	1,719,725	0	410,003	222,310	305,907	44.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	997,360	0	431,274	36,907	321,778	50.00
51.00	05100	RECOVERY ROOM	175,720	0	28,911	117	21,571	51.00
53.00	05300	ANESTHESIOLOGY	39,603	0	12,664	0	9,449	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	613,253	0	207,091	842	154,513	54.00
56.00	05600	RADIOISOTOPE	112,122	0	12,664	0	9,449	56.00
57.00	05700	CT SCAN	214,336	0	23,022	45	17,177	57.00
58.00	05800	MRI	69,574	0	6,157	0	4,594	58.00
59.00	05900	CARDIAC CATHETERIZATION	375,411	0	126,331	2,229	94,256	59.00
60.00	06000	LABORATORY	1,975,358	0	198,505	306	148,106	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	538,437	0	41,822	0	31,204	65.00
66.00	06600	PHYSICAL THERAPY	391,966	0	100,200	1,968	74,760	66.00
67.00	06700	OCCUPATIONAL THERAPY	168,117	0	25,328	0	18,897	67.00
68.00	06800	SPEECH PATHOLOGY	60,065	0	16,679	0	12,445	68.00
69.00	06900	ELECTROCARDIOLOGY	164,230	0	30,352	403	22,646	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	15,745	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	498,144	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	514,504	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,072,889	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	98,581	0	14,641	3,400	10,924	74.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	285,689	0	65,976	112	49,225	90.00
91.00	09100	EMERGENCY	2,195,798	0	216,811	601	161,765	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0	0	0	0	0	93.99
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	22,161,939	0	4,126,386	859,480	2,985,186	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	10,395	0	29,549	0	22,047	190.00
194.00	07950	ADDISON CENTRAL PHARMACY	453,454	0	0	0	0	194.00
194.01	07951	PHYSICIAN PRACTICES	0	0	0	0	0	194.01
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)	22,625,788	0	4,155,935	859,480	3,007,233	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0251

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Cost Center Description			DIETARY	CAFETERIA	MAINTENANCE OF PERSONNEL	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	
			10.00	11.00	12.00	13.00	14.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
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	2,209,546					10.00
11.00	01100	CAFETERIA	0	668,000				11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0			12.00
13.00	01300	NURSING ADMINISTRATION	0	21,863	0	-57,277		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	16,656	0	0	1,206,217	14.00
15.00	01500	PHARMACY	0	27,981	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	40,618	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
20.00	02000	NURSING SCHOOL	0	0	0	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0	22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	1,359,299	163,345	0	0	0	30.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	229,248	49,499	0	0	0	34.00
44.00	04400	SKILLED NURSING FACILITY	620,999	49,264	0	0	0	44.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	35,177	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0	5,718	0	0	0	51.00
53.00	05300	ANESTHESIOLOGY	0	1,395	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	24,584	0	0	0	54.00
56.00	05600	RADIOISOTOPE	0	2,638	0	0	0	56.00
57.00	05700	CT SCAN	0	13,521	0	0	0	57.00
58.00	05800	MRI	0	2,527	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	9,005	0	0	0	59.00
60.00	06000	LABORATORY	0	46,847	0	0	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0	20,192	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	17,388	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	8,079	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	2,596	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	7,872	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	1,063	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	593,365	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	612,852	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	2,569	0	0	0	74.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	13,355	0	0	0	90.00
91.00	09100	EMERGENCY	0	75,326	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0	0	0	0	0	93.99
SPECIAL PURPOSE COST CENTERS								
118.00	SUBTOTALS (SUM OF LINES 1 through 117)		2,209,546	659,078	0	0	1,206,217	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
194.00	07950	ADDISON CENTRAL PHARMACY	0	0	0	0	0	194.00
194.01	07951	PHYSICIAN PRACTICES	0	8,922	0	0	0	194.01
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	-57,277	0	201.00
202.00		TOTAL (sum lines 118 through 201)	2,209,546	668,000	0	-57,277	1,206,217	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

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Cost Center Description			PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	NONPHYSICIAN ANESTHETISTS	NURSING SCHOOL	
			15.00	16.00	17.00	19.00	20.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
12.00	01200	MAINTENANCE OF PERSONNEL						12.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY	2,684,447					15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	4,575,460				16.00
17.00	01700	SOCIAL SERVICE	0	0	0			17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0		19.00
20.00	02000	NURSING SCHOOL	0	0	0	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0		21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0		22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	0	0		23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	37,321	771,860	0	0	0	30.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	18,807	217,012	0	0	0	34.00
44.00	04400	SKILLED NURSING FACILITY	3,706	138,436	0	0	0	44.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	5,756	155,524	0	0	0	50.00
51.00	05100	RECOVERY ROOM	454	31,680	0	0	0	51.00
53.00	05300	ANESTHESIOLOGY	28	55,516	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	630	175,580	0	0	0	54.00
56.00	05600	RADIOISOTOPE	143	35,880	0	0	0	56.00
57.00	05700	CT SCAN	1,651	348,610	0	0	0	57.00
58.00	05800	MRI	0	39,413	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	93	122,980	0	0	0	59.00
60.00	06000	LABORATORY	0	580,896	0	0	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	1,323	163,762	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	55,669	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	37,039	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	12,304	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	144,183	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	2,128	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	133,569	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	54,024	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,333,743	660,117	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	290	20,538	0	0	0	74.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	294	62,428	0	0	0	90.00
91.00	09100	EMERGENCY	49,222	556,312	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0	0	0	0	0	93.99
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	2,453,461	4,575,460	0	0	0	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
194.00	07950	ADDISON CENTRAL PHARMACY	230,986	0	0	0	0	194.00
194.01	07951	PHYSICIAN PRACTICES	0	0	0	0	0	194.01
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)	2,684,447	4,575,460	0	0	0	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0251

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Cost Center Description			INTERNS & RESIDENTS		PARAMED ED PRGM	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	
			SERVICES-SALARY & FRINGES APPRV	SERVICES-OTHER PRGM COSTS APPRV				
			21.00	22.00	23.00	24.00	25.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
12.00	01200	MAINTENANCE OF PERSONNEL						12.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY						15.00
16.00	01600	MEDICAL RECORDS & LIBRARY						16.00
17.00	01700	SOCIAL SERVICE						17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS						19.00
20.00	02000	NURSING SCHOOL						20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0					21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV		59,490				22.00
23.00	02300	PARAMED ED PRGM- (SPECIFY)			0			23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	0	0	0	19,614,838	0	30.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	0	0	0	7,370,970	0	34.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	8,603,031	0	44.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	0	4,960,489	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	788,623	0	51.00
53.00	05300	ANESTHESIOLOGY	0	0	0	236,855	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	3,006,803	0	54.00
56.00	05600	RADIOISOTOPE	0	0	0	507,534	0	56.00
57.00	05700	CT SCAN	0	0	0	1,258,068	0	57.00
58.00	05800	MRI	0	0	0	329,916	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	1,850,753	0	59.00
60.00	06000	LABORATORY	0	0	0	8,845,658	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0	0	0	2,403,755	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	1,811,810	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	759,220	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	283,360	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	859,847	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	65,929	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	2,711,836	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	2,716,964	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	7,268,886	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	445,168	0	74.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0	1,329,746	0	90.00
91.00	09100	EMERGENCY	0	59,490	0	9,868,889	-59,490	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					0	92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0	0	0	0	0	93.99
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	59,490	0	87,898,948	-59,490	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	0	0	0	93,016	0	190.00
194.00	07950	ADDISON CENTRAL PHARMACY	0	0	0	2,037,816	0	194.00
194.01	07951	PHYSICIAN PRACTICES	0	0	0	8,922	0	194.01
200.00		Cross Foot Adjustments	0	0	0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	-57,277	0	201.00
202.00		TOTAL (sum lines 118 through 201)	0	59,490	0	89,981,425	-59,490	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0251

Period:
From 01/01/2020
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Cost Center Description			Total	
			26.00	
GENERAL SERVICE COST CENTERS				
1.00	00100	CAP REL COSTS-BLDG & FIXT		1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT		4.00
5.00	00500	ADMINISTRATIVE & GENERAL		5.00
6.00	00600	MAINTENANCE & REPAIRS		6.00
7.00	00700	OPERATION OF PLANT		7.00
8.00	00800	LAUNDRY & LINEN SERVICE		8.00
9.00	00900	HOUSEKEEPING		9.00
10.00	01000	DIETARY		10.00
11.00	01100	CAFETERIA		11.00
12.00	01200	MAINTENANCE OF PERSONNEL		12.00
13.00	01300	NURSING ADMINISTRATION		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY		14.00
15.00	01500	PHARMACY		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY		16.00
17.00	01700	SOCIAL SERVICE		17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS		19.00
20.00	02000	NURSING SCHOOL		20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV		21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV		22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)		23.00
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	19,614,838	30.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	7,370,970	34.00
44.00	04400	SKILLED NURSING FACILITY	8,603,031	44.00
ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	4,960,489	50.00
51.00	05100	RECOVERY ROOM	788,623	51.00
53.00	05300	ANESTHESIOLOGY	236,855	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,006,803	54.00
56.00	05600	RADIOISOTOPE	507,534	56.00
57.00	05700	CT SCAN	1,258,068	57.00
58.00	05800	MRI	329,916	58.00
59.00	05900	CARDIAC CATHETERIZATION	1,850,753	59.00
60.00	06000	LABORATORY	8,845,658	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	62.30
65.00	06500	RESPIRATORY THERAPY	2,403,755	65.00
66.00	06600	PHYSICAL THERAPY	1,811,810	66.00
67.00	06700	OCCUPATIONAL THERAPY	759,220	67.00
68.00	06800	SPEECH PATHOLOGY	283,360	68.00
69.00	06900	ELECTROCARDIOLOGY	859,847	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	65,929	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	2,711,836	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	2,716,964	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	7,268,886	73.00
74.00	07400	RENAL DIALYSIS	445,168	74.00
76.97	07697	CARDIAC REHABILITATION	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	76.98
76.99	07699	LITHOTRIPSY	0	76.99
OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	1,329,746	90.00
91.00	09100	EMERGENCY	9,809,399	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART		92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0	93.99
SPECIAL PURPOSE COST CENTERS				
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	87,839,458	118.00
NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	93,016	190.00
194.00	07950	ADDISON CENTRAL PHARMACY	2,037,816	194.00
194.01	07951	PHYSICIAN PRACTICES	8,922	194.01
200.00		Cross Foot Adjustments	0	200.00
201.00		Negative Cost Centers	-57,277	201.00
202.00		TOTAL (sum lines 118 through 201)	89,921,935	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0251

Period:
From 01/01/2020
To 12/31/2020Worksheet B
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Cost Center Description			CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
			Directly Assigned New Capital Related Costs	BLDG & FIXT	MVBLE EQUIP		
			0	1.00	2.00	2A	4.00
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	21,671	36,769	58,440	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	0	160,772	272,778	433,550	5.00
6.00	00600	MAINTENANCE & REPAIRS	0	0	0	0	6.00
7.00	00700	OPERATION OF PLANT	0	235,815	400,101	635,916	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0	141	8.00
9.00	00900	HOUSEKEEPING	0	48,818	82,828	131,646	9.00
10.00	01000	DIETARY	0	64,901	110,115	175,016	10.00
11.00	01100	CAFETERIA	0	63,658	108,007	171,665	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	0	20,508	34,796	55,304	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	62,135	105,422	167,557	14.00
15.00	01500	PHARMACY	0	21,799	36,986	58,785	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	60,299	102,307	162,606	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	19.00
20.00	02000	NURSING SCHOOL	0	0	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	0	439,406	745,531	1,184,937	30.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	0	58,671	99,546	158,217	34.00
44.00	04400	SKILLED NURSING FACILITY	0	159,634	270,846	430,480	44.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	167,916	284,898	452,814	50.00
51.00	05100	RECOVERY ROOM	0	11,256	19,098	30,354	51.00
53.00	05300	ANESTHESIOLOGY	0	4,931	8,366	13,297	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	80,631	136,804	217,435	54.00
56.00	05600	RADIOISOTOPE	0	4,931	8,366	13,297	56.00
57.00	05700	CT SCAN	0	8,963	15,208	24,171	57.00
58.00	05800	MRI	0	2,397	4,067	6,464	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	49,187	83,453	132,640	59.00
60.00	06000	LABORATORY	0	77,287	131,131	208,418	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0	16,283	27,627	43,910	65.00
66.00	06600	PHYSICAL THERAPY	0	39,012	66,191	105,203	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	9,861	16,732	26,593	67.00
68.00	06800	SPEECH PATHOLOGY	0	6,494	11,018	17,512	68.00
69.00	06900	ELECTROCARDIOLOGY	0	11,818	20,051	31,869	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	5,700	9,672	15,372	74.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0	25,688	43,584	69,272	90.00
91.00	09100	EMERGENCY	0	84,415	143,224	227,639	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				0	92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0	0	0	0	93.99
SPECIAL PURPOSE COST CENTERS							
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	2,024,857	3,435,522	5,460,379	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	0	11,505	19,520	31,025	190.00
194.00	07950	ADDISON CENTRAL PHARMACY	0	0	0	937	194.00
194.01	07951	PHYSICIAN PRACTICES	0	0	0	0	194.01
200.00		Cross Foot Adjustments				0	200.00
201.00		Negative Cost Centers				0	201.00
202.00		TOTAL (sum lines 118 through 201)	0	2,036,362	3,455,042	5,491,404	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0251

Period:
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Cost Center Description			ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
			5.00	6.00	7.00	8.00	9.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	439,283					5.00
6.00	00600	MAINTENANCE & REPAIRS	0	0				6.00
7.00	00700	OPERATION OF PLANT	20,250	0	658,096			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	4,188	0	0	4,329		8.00
9.00	00900	HOUSEKEEPING	13,998	0	19,855	45	167,461	9.00
10.00	01000	DIETARY	9,347	0	26,396	0	6,926	10.00
11.00	01100	CAFETERIA	1,864	0	25,890	0	6,793	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	0	0	8,341	11	2,188	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	4,424	0	25,271	15	6,630	14.00
15.00	01500	PHARMACY	12,467	0	8,866	0	2,326	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	20,778	0	24,524	0	6,435	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
20.00	02000	NURSING SCHOOL	0	0	0	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	290	0	0	0	0	22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	72,220	0	178,711	2,474	46,891	30.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	31,713	0	23,862	427	6,261	34.00
44.00	04400	SKILLED NURSING FACILITY	33,388	0	64,924	1,120	17,035	44.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	19,364	0	68,293	186	17,919	50.00
51.00	05100	RECOVERY ROOM	3,412	0	4,578	1	1,201	51.00
53.00	05300	ANESTHESIOLOGY	769	0	2,005	0	526	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	11,906	0	32,793	4	8,604	54.00
56.00	05600	RADIOISOTOPE	2,177	0	2,005	0	526	56.00
57.00	05700	CT SCAN	4,161	0	3,645	0	956	57.00
58.00	05800	MRI	1,351	0	975	0	256	58.00
59.00	05900	CARDIAC CATHETERIZATION	7,289	0	20,005	11	5,249	59.00
60.00	06000	LABORATORY	38,351	0	31,433	2	8,247	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	10,454	0	6,623	0	1,738	65.00
66.00	06600	PHYSICAL THERAPY	7,610	0	15,867	10	4,163	66.00
67.00	06700	OCCUPATIONAL THERAPY	3,264	0	4,011	0	1,052	67.00
68.00	06800	SPEECH PATHOLOGY	1,166	0	2,641	0	693	68.00
69.00	06900	ELECTROCARDIOLOGY	3,188	0	4,806	2	1,261	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	306	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	9,671	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	9,989	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	20,830	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	1,914	0	2,318	17	608	74.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	5,547	0	10,447	1	2,741	90.00
91.00	09100	EMERGENCY	42,631	0	34,332	3	9,008	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0	0	0	0	0	93.99
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	430,277	0	653,417	4,329	166,233	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	202	0	4,679	0	1,228	190.00
194.00	07950	ADDISON CENTRAL PHARMACY	8,804	0	0	0	0	194.00
194.01	07951	PHYSICIAN PRACTICES	0	0	0	0	0	194.01
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)	439,283	0	658,096	4,329	167,461	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0251

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Cost Center Description			DIETARY	CAFETERIA	MAINTENANCE OF PERSONNEL	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	
			10.00	11.00	12.00	13.00	14.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
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	218,740					10.00
11.00	01100	CAFETERIA	0	206,426				11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0			12.00
13.00	01300	NURSING ADMINISTRATION	0	6,756	0	74,047		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	5,147	0	0	209,736	14.00
15.00	01500	PHARMACY	0	8,647	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	12,552	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
20.00	02000	NURSING SCHOOL	0	0	0	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0	22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	134,568	50,476	0	0	0	30.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	22,695	15,296	0	0	0	34.00
44.00	04400	SKILLED NURSING FACILITY	61,477	15,224	0	0	0	44.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	10,870	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0	1,767	0	0	0	51.00
53.00	05300	ANESTHESIOLOGY	0	431	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	7,597	0	0	0	54.00
56.00	05600	RADIOISOTOPE	0	815	0	0	0	56.00
57.00	05700	CT SCAN	0	4,178	0	0	0	57.00
58.00	05800	MRI	0	781	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	2,783	0	0	0	59.00
60.00	06000	LABORATORY	0	14,477	0	0	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0	6,240	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	5,373	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	2,497	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	802	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	2,433	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	329	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	103,174	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	106,562	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	794	0	0	0	74.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	4,127	0	0	0	90.00
91.00	09100	EMERGENCY	0	23,277	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0	0	0	0	0	93.99
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	218,740	203,669	0	0	209,736	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
194.00	07950	ADDISON CENTRAL PHARMACY	0	0	0	0	0	194.00
194.01	07951	PHYSICIAN PRACTICES	0	2,757	0	0	0	194.01
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	74,047	0	201.00
202.00		TOTAL (sum lines 118 through 201)	218,740	206,426	0	74,047	209,736	202.00

ALLOCATION OF CAPITAL RELATED COSTS

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Cost Center Description			PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	NONPHYSICIAN ANESTHETISTS	NURSING SCHOOL	
			15.00	16.00	17.00	19.00	20.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
12.00	01200	MAINTENANCE OF PERSONNEL						12.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY	93,211					15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	229,928				16.00
17.00	01700	SOCIAL SERVICE	0	0	0			17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0		0		19.00
20.00	02000	NURSING SCHOOL	0	0			0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0				21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0				22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0				23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	1,296	38,805		0		30.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	653	10,904		0		34.00
44.00	04400	SKILLED NURSING FACILITY	129	6,956		0		44.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	200	7,815		0		50.00
51.00	05100	RECOVERY ROOM	16	1,592		0		51.00
53.00	05300	ANESTHESIOLOGY	1	2,790		0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	22	8,823		0		54.00
56.00	05600	RADIOISOTOPE	5	1,803		0		56.00
57.00	05700	CT SCAN	57	17,517		0		57.00
58.00	05800	MRI	0	1,980		0		58.00
59.00	05900	CARDIAC CATHETERIZATION	3	6,179		0		59.00
60.00	06000	LABORATORY	0	29,189		0		60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0		0		62.30
65.00	06500	RESPIRATORY THERAPY	46	8,229		0		65.00
66.00	06600	PHYSICAL THERAPY	0	2,797		0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	1,861		0		67.00
68.00	06800	SPEECH PATHOLOGY	0	618		0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	7,245		0		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	107		0		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	6,712		0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	2,715		0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	81,034	33,169		0		73.00
74.00	07400	RENAL DIALYSIS	10	1,032		0		74.00
76.97	07697	CARDIAC REHABILITATION	0	0		0		76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0		0		76.98
76.99	07699	LITHOTRIPSY	0	0		0		76.99
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	10	3,137		0		90.00
91.00	09100	EMERGENCY	1,709	27,953		0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0	0		0		93.99
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	85,191	229,928		0	0	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	0	0		0		190.00
194.00	07950	ADDISON CENTRAL PHARMACY	8,020	0		0		194.00
194.01	07951	PHYSICIAN PRACTICES	0	0		0		194.01
200.00		Cross Foot Adjustments					0	200.00
201.00		Negative Cost Centers	0	0			0	201.00
202.00		TOTAL (sum lines 118 through 201)	93,211	229,928		0	0	202.00

ALLOCATION OF CAPITAL RELATED COSTS

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Cost Center Description			INTERNS & RESIDENTS		PARAMED ED PRGM	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	
			SERVICES-SALAR Y & FRINGES APPRV	SERVICES-OTHER PRGM COSTS APPRV				
			21.00	22.00	23.00	24.00	25.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
12.00	01200	MAINTENANCE OF PERSONNEL						12.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY						15.00
16.00	01600	MEDICAL RECORDS & LIBRARY						16.00
17.00	01700	SOCIAL SERVICE						17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS						19.00
20.00	02000	NURSING SCHOOL						20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0					21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV		290				22.00
23.00	02300	PARAMED ED PRGM- (SPECIFY)			0			23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS				1,720,958	0	30.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT				273,753	0	34.00
44.00	04400	SKILLED NURSING FACILITY				633,672	0	44.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM				580,159	0	50.00
51.00	05100	RECOVERY ROOM				43,498	0	51.00
53.00	05300	ANESTHESIOLOGY				19,957	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC				289,026	0	54.00
56.00	05600	RADIOISOTOPE				20,873	0	56.00
57.00	05700	CT SCAN				55,413	0	57.00
58.00	05800	MRI				12,011	0	58.00
59.00	05900	CARDIAC CATHETERIZATION				175,060	0	59.00
60.00	06000	LABORATORY				332,794	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS				0	0	62.30
65.00	06500	RESPIRATORY THERAPY				78,476	0	65.00
66.00	06600	PHYSICAL THERAPY				142,173	0	66.00
67.00	06700	OCCUPATIONAL THERAPY				39,818	0	67.00
68.00	06800	SPEECH PATHOLOGY				23,624	0	68.00
69.00	06900	ELECTROCARDIOLOGY				51,349	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY				798	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT				119,557	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS				119,266	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS				135,033	0	73.00
74.00	07400	RENAL DIALYSIS				22,393	0	74.00
76.97	07697	CARDIAC REHABILITATION				0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY				0	0	76.98
76.99	07699	LITHOTRIPSY				0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC				96,211	0	90.00
91.00	09100	EMERGENCY				373,543	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					0	92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM				0	0	93.99
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	0	0	5,359,415	0	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN				37,134	0	190.00
194.00	07950	ADDISON CENTRAL PHARMACY				17,761	0	194.00
194.01	07951	PHYSICIAN PRACTICES				2,757	0	194.01
200.00		Cross Foot Adjustments	0	290	0	290	0	200.00
201.00		Negative Cost Centers	0	0	0	74,047	0	201.00
202.00		TOTAL (sum lines 118 through 201)	0	290	0	5,491,404	0	202.00

ALLOCATION OF CAPITAL RELATED COSTS

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Cost Center Description			Total	
			26.00	
GENERAL SERVICE COST CENTERS				
1.00	00100	CAP REL COSTS-BLDG & FIXT		1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT		4.00
5.00	00500	ADMINISTRATIVE & GENERAL		5.00
6.00	00600	MAINTENANCE & REPAIRS		6.00
7.00	00700	OPERATION OF PLANT		7.00
8.00	00800	LAUNDRY & LINEN SERVICE		8.00
9.00	00900	HOUSEKEEPING		9.00
10.00	01000	DIETARY		10.00
11.00	01100	CAFETERIA		11.00
12.00	01200	MAINTENANCE OF PERSONNEL		12.00
13.00	01300	NURSING ADMINISTRATION		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY		14.00
15.00	01500	PHARMACY		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY		16.00
17.00	01700	SOCIAL SERVICE		17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS		19.00
20.00	02000	NURSING SCHOOL		20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV		21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV		22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)		23.00
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	1,720,958	30.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	273,753	34.00
44.00	04400	SKILLED NURSING FACILITY	633,672	44.00
ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	580,159	50.00
51.00	05100	RECOVERY ROOM	43,498	51.00
53.00	05300	ANESTHESIOLOGY	19,957	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	289,026	54.00
56.00	05600	RADIOISOTOPE	20,873	56.00
57.00	05700	CT SCAN	55,413	57.00
58.00	05800	MRI	12,011	58.00
59.00	05900	CARDIAC CATHETERIZATION	175,060	59.00
60.00	06000	LABORATORY	332,794	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	62.30
65.00	06500	RESPIRATORY THERAPY	78,476	65.00
66.00	06600	PHYSICAL THERAPY	142,173	66.00
67.00	06700	OCCUPATIONAL THERAPY	39,818	67.00
68.00	06800	SPEECH PATHOLOGY	23,624	68.00
69.00	06900	ELECTROCARDIOLOGY	51,349	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	798	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	119,557	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	119,266	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	135,033	73.00
74.00	07400	RENAL DIALYSIS	22,393	74.00
76.97	07697	CARDIAC REHABILITATION	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	76.98
76.99	07699	LITHOTRIPSY	0	76.99
OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	96,211	90.00
91.00	09100	EMERGENCY	373,543	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART		92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0	93.99
SPECIAL PURPOSE COST CENTERS				
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	5,359,415	118.00
NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	37,134	190.00
194.00	07950	ADDISON CENTRAL PHARMACY	17,761	194.00
194.01	07951	PHYSICIAN PRACTICES	2,757	194.01
200.00		Cross Foot Adjustments	290	200.00
201.00		Negative Cost Centers	74,047	201.00
202.00		TOTAL (sum lines 118 through 201)	5,491,404	202.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0251

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

Worksheet B-1

Date/Time Prepared:
8/2/2021 11:01 am

Cost Center Description			CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
			BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (SQUARE FEET)				
			1.00	2.00	4.00	5A	5.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT	253,994					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		253,994				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	2,703	2,703	42,993,413			4.00
5.00	00500	ADMINISTRATIVE & GENERAL	20,053	20,053	4,218,460	-22,625,788	67,528,845	5.00
6.00	00600	MAINTENANCE & REPAIRS	0	0	0	0	0	6.00
7.00	00700	OPERATION OF PLANT	29,413	29,413	1,420,370	0	3,112,934	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	104,051	0	643,779	8.00
9.00	00900	HOUSEKEEPING	6,089	6,089	1,410,444	0	2,151,926	9.00
10.00	01000	DIETARY	8,095	8,095	776,285	0	1,436,970	10.00
11.00	01100	CAFETERIA	7,940	7,940	157,358	0	286,515	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	2,558	2,558	1,064,909	173,208	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	7,750	7,750	509,349	0	680,045	14.00
15.00	01500	PHARMACY	2,719	2,719	1,560,159	0	1,916,554	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	7,521	7,521	2,232,072	0	3,194,193	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
20.00	02000	NURSING SCHOOL	0	0	0	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	44,560	22.00
23.00	02300	PARAMED ED PRGM- (SPECIFY)	0	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	54,807	54,807	7,777,039	0	11,101,378	30.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	7,318	7,318	2,740,686	0	4,875,157	34.00
44.00	04400	SKILLED NURSING FACILITY	19,911	19,911	2,162,315	0	5,132,681	44.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	20,944	20,944	1,985,122	0	2,976,713	50.00
51.00	05100	RECOVERY ROOM	1,404	1,404	424,478	0	524,452	51.00
53.00	05300	ANESTHESIOLOGY	615	615	101,894	0	118,200	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	10,057	10,057	1,355,199	0	1,830,310	54.00
56.00	05600	RADIOISOTOPE	615	615	179,961	0	334,638	56.00
57.00	05700	CT SCAN	1,118	1,118	535,704	0	639,706	57.00
58.00	05800	MRI	299	299	150,209	0	207,651	58.00
59.00	05900	CARDIAC CATHETERIZATION	6,135	6,135	662,758	0	1,120,448	59.00
60.00	06000	LABORATORY	9,640	9,640	1,969,962	0	5,895,640	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	2,031	2,031	909,302	0	1,607,015	65.00
66.00	06600	PHYSICAL THERAPY	4,866	4,866	846,496	0	1,169,859	66.00
67.00	06700	OCCUPATIONAL THERAPY	1,230	1,230	397,273	0	501,760	67.00
68.00	06800	SPEECH PATHOLOGY	810	810	141,129	0	179,271	68.00
69.00	06900	ELECTROCARDIOLOGY	1,474	1,474	400,973	0	490,161	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	41,019	0	46,993	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	1,486,758	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	1,535,584	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	3,202,137	73.00
74.00	07400	RENAL DIALYSIS	711	711	241,034	0	294,225	74.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	3,204	3,204	683,287	0	852,667	90.00
91.00	09100	EMERGENCY	10,529	10,529	5,144,556	0	6,553,564	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0	0	0	0	0	93.99
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	252,559	252,559	42,303,853	-22,452,580	66,144,444	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	1,435	1,435	0	0	31,025	190.00
194.00	07950	ADDISON CENTRAL PHARMACY	0	0	689,560	0	1,353,376	194.00
194.01	07951	PHYSICIAN PRACTICES	0	0	0	0	0	194.01
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)	2,036,362	3,455,042	3,036,548		22,625,788	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	8.017363	13.602849	0.070628		0.335054	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)			58,440		439,283	204.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0251

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

Worksheet B-1

Date/Time Prepared:
8/2/2021 11:01 am

Cost Center Description			CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
			BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (SQUARE FEET)				
			1.00	2.00	4.00	5A	5.00	
205.00		Unit cost multiplier (Wkst. B, Part II)			0.001359		0.006505	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: 14-0251

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

Worksheet B-1

Date/Time Prepared:
8/2/2021 11:01 am

Cost Center Description			MAINTENANCE & REPAIRS (SQUARE FEET)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	
			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
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS	0					6.00
7.00	00700	OPERATION OF PLANT	0	201,825				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	573,828			8.00
9.00	00900	HOUSEKEEPING	0	6,089	5,951	195,736		9.00
10.00	01000	DIETARY	0	8,095	36	8,095	112,623	10.00
11.00	01100	CAFETERIA	0	7,940	0	7,940	0	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	0	2,558	1,398	2,558	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	7,750	2,009	7,750	0	14.00
15.00	01500	PHARMACY	0	2,719	0	2,719	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	7,521	0	7,521	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
20.00	02000	NURSING SCHOOL	0	0	0	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0	22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	0	54,807	328,140	54,807	69,285	30.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	0	7,318	56,538	7,318	11,685	34.00
44.00	04400	SKILLED NURSING FACILITY	0	19,911	148,424	19,911	31,653	44.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	20,944	24,641	20,944	0	50.00
51.00	05100	RECOVERY ROOM	0	1,404	78	1,404	0	51.00
53.00	05300	ANESTHESIOLOGY	0	615	0	615	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	10,057	562	10,057	0	54.00
56.00	05600	RADIOISOTOPE	0	615	0	615	0	56.00
57.00	05700	CT SCAN	0	1,118	30	1,118	0	57.00
58.00	05800	MRI	0	299	0	299	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	6,135	1,488	6,135	0	59.00
60.00	06000	LABORATORY	0	9,640	204	9,640	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0	2,031	0	2,031	0	65.00
66.00	06600	PHYSICAL THERAPY	0	4,866	1,314	4,866	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	1,230	0	1,230	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	810	0	810	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	1,474	269	1,474	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	711	2,270	711	0	74.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	3,204	75	3,204	0	90.00
91.00	09100	EMERGENCY	0	10,529	401	10,529	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0	0	0	0	0	93.99
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	200,390	573,828	194,301	112,623	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	0	1,435	0	1,435	0	190.00
194.00	07950	ADDISON CENTRAL PHARMACY	0	0	0	0	0	194.00
194.01	07951	PHYSICIAN PRACTICES	0	0	0	0	0	194.01
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	0	4,155,935	859,480	3,007,233	2,209,546	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.000000	20.591775	1.497801	15.363719	19.618959	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	0	658,096	4,329	167,461	218,740	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.000000	3.260726	0.007544	0.855545	1.942232	205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)						206.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0251

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

Worksheet B-1

Date/Time Prepared:
8/2/2021 11:01 am

Cost Center Description			MAINTENANCE & REPAIRS (SQUARE FEET)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)	6.00	7.00	8.00	9.00	10.00	207.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0251

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

Worksheet B-1

Date/Time Prepared:
8/2/2021 11:01 am

Cost Center Description			CAFETERIA (MEALS SERVED)	MAINTENANCE OF PERSONNEL (NUMBER HOUSED)	NURSING ADMINISTRATION (DIRECT NRSNG HRS)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	
			11.00	12.00	13.00	14.00	15.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA	48,367					11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0				12.00
13.00	01300	NURSING ADMINISTRATION	1,583	0	378,056			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	1,206	0	0	3,022,342		14.00
15.00	01500	PHARMACY	2,026	0	0	0	3,687,689	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	2,941	0	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
20.00	02000	NURSING SCHOOL	0	0	0	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0	22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	11,827	0	163,514	0	51,269	30.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	3,584	0	52,985	0	25,836	34.00
44.00	04400	SKILLED NURSING FACILITY	3,567	0	36,976	0	5,091	44.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	2,547	0	27,101	0	7,907	50.00
51.00	05100	RECOVERY ROOM	414	0	8,603	0	623	51.00
53.00	05300	ANESTHESIOLOGY	101	0	0	0	38	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,780	0	0	0	866	54.00
56.00	05600	RADIOISOTOPE	191	0	0	0	197	56.00
57.00	05700	CT SCAN	979	0	2,115	0	2,268	57.00
58.00	05800	MRI	183	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	652	0	5,659	0	128	59.00
60.00	06000	LABORATORY	3,392	0	0	0	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	1,462	0	0	0	1,817	65.00
66.00	06600	PHYSICAL THERAPY	1,259	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	585	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	188	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	570	0	2,324	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	77	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	1,486,758	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	1,535,584	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	3,205,918	73.00
74.00	07400	RENAL DIALYSIS	186	0	3,866	0	399	74.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	967	0	5,932	0	404	90.00
91.00	09100	EMERGENCY	5,454	0	68,981	0	67,617	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0	0	0	0	0	93.99
SPECIAL PURPOSE COST CENTERS								
118.00	SUBTOTALS (SUM OF LINES 1 through 117)		47,721	0	378,056	3,022,342	3,370,378	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
194.00	07950	ADDISON CENTRAL PHARMACY	0	0	0	0	317,311	194.00
194.01	07951	PHYSICIAN PRACTICES	646	0	0	0	0	194.01
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)	668,000	0	-57,277	1,206,217	2,684,447	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	13.811070	0.000000	0.000000	0.399100	0.727948	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	206,426	0	74,047	209,736	93,211	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	4.267910	0.000000	0.195863	0.069395	0.025276	205.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0251

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

Worksheet B-1

Date/Time Prepared:
8/2/2021 11:01 am

Cost Center Description		CAFETERIA (MEALS SERVED)	MAINTENANCE OF PERSONNEL (NUMBER HOUSED)	NURSING ADMINISTRATION (DIRECT NRSING HRS)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	
		11.00	12.00	13.00	14.00	15.00	
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: 14-0251

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

Worksheet B-1

Date/Time Prepared:
8/2/2021 11:01 am

Cost Center Description			MEDICAL RECORDS & LIBRARY (GROSS CHARGES)	SOCIAL SERVICE (TIME SPENT)	NONPHYSICIAN ANESTHETISTS (ASSIGNED TIME)	NURSING SCHOOL (ASSIGNED TIME)	INTERNS & RESIDENTS SERVICES-SALAR Y & FRINGES APPRV (ASSIGNED TIME)	
			16.00	17.00	19.00	20.00	21.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
12.00	01200	MAINTENANCE OF PERSONNEL						12.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY						15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	444,682,269					16.00
17.00	01700	SOCIAL SERVICE	0	0				17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0			19.00
20.00	02000	NURSING SCHOOL	0	0		0		20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0			100	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0				22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0				23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	75,005,834	0	0	0	0	30.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	21,091,608	0	0	0	0	34.00
44.00	04400	SKILLED NURSING FACILITY	13,454,718	0	0	0	0	44.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	15,115,546	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	3,079,040	0	0	0	0	51.00
53.00	05300	ANESTHESIOLOGY	5,395,651	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	17,064,806	0	0	0	0	54.00
56.00	05600	RADIOISOTOPE	3,487,228	0	0	0	0	56.00
57.00	05700	CT SCAN	33,881,844	0	0	0	0	57.00
58.00	05800	MRI	3,830,638	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	11,952,534	0	0	0	0	59.00
60.00	06000	LABORATORY	56,457,963	0	0	0	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	15,916,212	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	5,410,497	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	3,599,892	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	1,195,868	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	14,013,301	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	206,844	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	12,981,690	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	5,250,684	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	64,157,594	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	1,996,160	0	0	0	0	74.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	6,067,497	0	0	0	0	90.00
91.00	09100	EMERGENCY	54,068,620	0	0	0	100	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0	0	0	0	0	93.99
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	444,682,269	0	0	0	100	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
194.00	07950	ADDISON CENTRAL PHARMACY	0	0	0	0	0	194.00
194.01	07951	PHYSICIAN PRACTICES	0	0	0	0	0	194.01
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	4,575,460	0	0	0	0	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.010289	0.000000	0.000000	0.000000	0.000000	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	229,928	0	0	0	0	204.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0251

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

Worksheet B-1

Date/Time Prepared:
8/2/2021 11:01 am

Cost Center Description			MEDICAL RECORDS & LIBRARY (GROSS CHARGES)	SOCIAL SERVICE (TIME SPENT)	NONPHYSICIAN ANESTHETISTS (ASSIGNED TIME)	NURSING SCHOOL (ASSIGNED TIME)	INTERNS & RESIDENTS SERVICES-SALAR Y & FRINGES APPRV (ASSIGNED TIME)	
			16.00	17.00	19.00	20.00	21.00	
205.00		Unit cost multiplier (Wkst. B, Part II)	0.000517	0.000000	0.000000	0.000000	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

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0251

Period:
From 01/01/2020
To 12/31/2020Worksheet B-1
Date/Time Prepared:
8/2/2021 11:01 am

Cost Center Description			INTERNS & RESIDENTS	PARAMED ED PRGM (ASSIGNED TIME)	
			SERVICES-OTHER		
			PRGM COSTS APPRV (ASSIGNED TIME)		
			22.00		
GENERAL SERVICE COST CENTERS					
1.00	00100	CAP REL COSTS-BLDG & FIXT			1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT			4.00
5.00	00500	ADMINISTRATIVE & GENERAL			5.00
6.00	00600	MAINTENANCE & REPAIRS			6.00
7.00	00700	OPERATION OF PLANT			7.00
8.00	00800	LAUNDRY & LINEN SERVICE			8.00
9.00	00900	HOUSEKEEPING			9.00
10.00	01000	DIETARY			10.00
11.00	01100	CAFETERIA			11.00
12.00	01200	MAINTENANCE OF PERSONNEL			12.00
13.00	01300	NURSING ADMINISTRATION			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY			14.00
15.00	01500	PHARMACY			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY			16.00
17.00	01700	SOCIAL SERVICE			17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS			19.00
20.00	02000	NURSING SCHOOL			20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV			21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	100		22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)		0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	0	0	30.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	0	0	34.00
44.00	04400	SKILLED NURSING FACILITY	0	0	44.00
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
56.00	05600	RADIOISOTOPE	0	0	56.00
57.00	05700	CT SCAN	0	0	57.00
58.00	05800	MRI	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	59.00
60.00	06000	LABORATORY	0	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	74.00
76.97	07697	CARDIAC REHABILITATION	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	76.99
OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	0	0	90.00
91.00	09100	EMERGENCY	100	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART			92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0	0	93.99
SPECIAL PURPOSE COST CENTERS					
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	100	0	118.00
NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	0	0	190.00
194.00	07950	ADDISON CENTRAL PHARMACY	0	0	194.00
194.01	07951	PHYSICIAN PRACTICES	0	0	194.01
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)	59,490	0	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	594.900000	0.000000	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	290	0	204.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0251

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

Worksheet B-1

Date/Time Prepared:
8/2/2021 11:01 am

Cost Center Description			INTERNS & RESIDENTS	PARAMED ED PRGM (ASSIGNED TIME)	
			SERVICES-OTHER PRGM COSTS APPRV (ASSIGNED TIME)		
			22.00		
205.00		Unit cost multiplier (Wkst. B, Part II)	2.900000	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: 14-0251

Period:
From 01/01/2020
To 12/31/2020Worksheet C
Part I
Date/Time Prepared:
8/2/2021 11:01 am

			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	19,614,838		19,614,838	0	19,614,838	30.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	7,370,970		7,370,970	0	7,370,970	34.00
44.00	04400	SKILLED NURSING FACILITY	8,603,031		8,603,031	0	8,603,031	44.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	4,960,489		4,960,489	0	4,960,489	50.00
51.00	05100	RECOVERY ROOM	788,623		788,623	0	788,623	51.00
53.00	05300	ANESTHESIOLOGY	236,855		236,855	0	236,855	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,006,803		3,006,803	0	3,006,803	54.00
56.00	05600	RADIOISOTOPE	507,534		507,534	0	507,534	56.00
57.00	05700	CT SCAN	1,258,068		1,258,068	0	1,258,068	57.00
58.00	05800	MRI	329,916		329,916	0	329,916	58.00
59.00	05900	CARDIAC CATHETERIZATION	1,850,753		1,850,753	0	1,850,753	59.00
60.00	06000	LABORATORY	8,845,658		8,845,658	0	8,845,658	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0		0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	2,403,755	0	2,403,755	0	2,403,755	65.00
66.00	06600	PHYSICAL THERAPY	1,811,810	0	1,811,810	0	1,811,810	66.00
67.00	06700	OCCUPATIONAL THERAPY	759,220	0	759,220	0	759,220	67.00
68.00	06800	SPEECH PATHOLOGY	283,360	0	283,360	0	283,360	68.00
69.00	06900	ELECTROCARDIOLOGY	859,847		859,847	0	859,847	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	65,929		65,929	0	65,929	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	2,711,836		2,711,836	0	2,711,836	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	2,716,964		2,716,964	0	2,716,964	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	7,268,886		7,268,886	0	7,268,886	73.00
74.00	07400	RENAL DIALYSIS	445,168		445,168	0	445,168	74.00
76.97	07697	CARDIAC REHABILITATION	0		0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0		0	0	0	76.98
76.99	07699	LITHOTRIPSY	0		0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	1,329,746		1,329,746	0	1,329,746	90.00
91.00	09100	EMERGENCY	9,809,399		9,809,399	0	9,809,399	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1,811,545		1,811,545	0	1,811,545	92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0		0	0	0	93.99
200.00		Subtotal (see instructions)	89,651,003	0	89,651,003	0	89,651,003	200.00
201.00		Less Observation Beds	1,811,545		1,811,545	0	1,811,545	201.00
202.00		Total (see instructions)	87,839,458	0	87,839,458	0	87,839,458	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES				Provider CCN: 14-0251		Period: From 01/01/2020 To 12/31/2020		Worksheet C Part I Date/Time Prepared: 8/2/2021 11:01 am		
				Title XVIII			Hospital		PPS	
Cost Center Description			Charges			Cost or Other Ratio	TEFRA Inpatient Ratio			
			Inpatient	Outpatient	Total (col. 6 + col. 7)					
			6.00	7.00	8.00					
9.00			10.00							
INPATIENT ROUTINE SERVICE COST CENTERS										
30.00	03000	ADULTS & PEDIATRICS	68,206,212		68,206,212					30.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	21,091,608		21,091,608					34.00
44.00	04400	SKILLED NURSING FACILITY	13,454,718		13,454,718					44.00
ANCILLARY SERVICE COST CENTERS										
50.00	05000	OPERATING ROOM	8,031,078	7,084,468	15,115,546	0.328171	0.000000			50.00
51.00	05100	RECOVERY ROOM	1,700,656	1,378,384	3,079,040	0.256126	0.000000			51.00
53.00	05300	ANESTHESIOLOGY	2,425,919	2,969,732	5,395,651	0.043897	0.000000			53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	7,598,547	9,466,259	17,064,806	0.176199	0.000000			54.00
56.00	05600	RADIOISOTOPE	1,260,474	2,226,754	3,487,228	0.145541	0.000000			56.00
57.00	05700	CT SCAN	12,979,220	20,902,624	33,881,844	0.037131	0.000000			57.00
58.00	05800	MRI	1,640,081	2,190,557	3,830,638	0.086126	0.000000			58.00
59.00	05900	CARDIAC CATHETERIZATION	8,696,407	3,256,127	11,952,534	0.154842	0.000000			59.00
60.00	06000	LABORATORY	39,837,345	16,620,618	56,457,963	0.156677	0.000000			60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0.000000	0.000000			62.30
65.00	06500	RESPIRATORY THERAPY	15,332,386	583,826	15,916,212	0.151026	0.000000			65.00
66.00	06600	PHYSICAL THERAPY	4,630,607	779,890	5,410,497	0.334869	0.000000			66.00
67.00	06700	OCCUPATIONAL THERAPY	3,349,015	250,877	3,599,892	0.210901	0.000000			67.00
68.00	06800	SPEECH PATHOLOGY	1,133,045	62,823	1,195,868	0.236949	0.000000			68.00
69.00	06900	ELECTROCARDIOLOGY	8,354,859	5,658,442	14,013,301	0.061359	0.000000			69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	157,568	49,276	206,844	0.318738	0.000000			70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	10,406,056	2,575,634	12,981,690	0.208897	0.000000			71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	3,372,576	1,878,108	5,250,684	0.517450	0.000000			72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	56,451,077	7,706,517	64,157,594	0.113297	0.000000			73.00
74.00	07400	RENAL DIALYSIS	1,886,842	109,318	1,996,160	0.223012	0.000000			74.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0.000000	0.000000			76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0.000000	0.000000			76.98
76.99	07699	LITHOTRIPSY	0	0	0	0.000000	0.000000			76.99
OUTPATIENT SERVICE COST CENTERS										
90.00	09000	CLINIC	1,218,911	4,848,586	6,067,497	0.219159	0.000000			90.00
91.00	09100	EMERGENCY	21,583,580	32,485,040	54,068,620	0.181425	0.000000			91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1,313,524	5,486,098	6,799,622	0.266418	0.000000			92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0	0	0	0.000000	0.000000			93.99
200.00		Subtotal (see instructions)	316,112,311	128,569,958	444,682,269					200.00
201.00		Less Observation Beds								201.00
202.00		Total (see instructions)	316,112,311	128,569,958	444,682,269					202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0251

Period:
From 01/01/2020
To 12/31/2020Worksheet C
Part I
Date/Time Prepared:
8/2/2021 11:01 am

Cost Center Description			PPS Inpatient Ratio	Title XVIII	Hospital	PPS
			11.00			
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS				30.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT				34.00
44.00	04400	SKILLED NURSING FACILITY				44.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.328171			50.00
51.00	05100	RECOVERY ROOM	0.256126			51.00
53.00	05300	ANESTHESIOLOGY	0.043897			53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.176199			54.00
56.00	05600	RADIOISOTOPE	0.145541			56.00
57.00	05700	CT SCAN	0.037131			57.00
58.00	05800	MRI	0.086126			58.00
59.00	05900	CARDIAC CATHETERIZATION	0.154842			59.00
60.00	06000	LABORATORY	0.156677			60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0.000000			62.30
65.00	06500	RESPIRATORY THERAPY	0.151026			65.00
66.00	06600	PHYSICAL THERAPY	0.334869			66.00
67.00	06700	OCCUPATIONAL THERAPY	0.210901			67.00
68.00	06800	SPEECH PATHOLOGY	0.236949			68.00
69.00	06900	ELECTROCARDIOLOGY	0.061359			69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.318738			70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.208897			71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.517450			72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.113297			73.00
74.00	07400	RENAL DIALYSIS	0.223012			74.00
76.97	07697	CARDIAC REHABILITATION	0.000000			76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0.000000			76.98
76.99	07699	LITHOTRIPSY	0.000000			76.99
OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.219159			90.00
91.00	09100	EMERGENCY	0.181425			91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.266418			92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0.000000			93.99
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: 14-0251

Period:
From 01/01/2020
To 12/31/2020Worksheet C
Part I
Date/Time Prepared:
8/2/2021 11:01 am

			Title XIX		Hospital		Cost	
Cost Center Description			Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs			
					Total Costs	RCE Disallowance		Total Costs
			1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	19,614,838		19,614,838	0	19,614,838	30.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	7,370,970		7,370,970	0	7,370,970	34.00
44.00	04400	SKILLED NURSING FACILITY	8,603,031		8,603,031	0	8,603,031	44.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	4,960,489		4,960,489	0	4,960,489	50.00
51.00	05100	RECOVERY ROOM	788,623		788,623	0	788,623	51.00
53.00	05300	ANESTHESIOLOGY	236,855		236,855	0	236,855	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,006,803		3,006,803	0	3,006,803	54.00
56.00	05600	RADIOISOTOPE	507,534		507,534	0	507,534	56.00
57.00	05700	CT SCAN	1,258,068		1,258,068	0	1,258,068	57.00
58.00	05800	MRI	329,916		329,916	0	329,916	58.00
59.00	05900	CARDIAC CATHETERIZATION	1,850,753		1,850,753	0	1,850,753	59.00
60.00	06000	LABORATORY	8,845,658		8,845,658	0	8,845,658	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0		0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	2,403,755	0	2,403,755	0	2,403,755	65.00
66.00	06600	PHYSICAL THERAPY	1,811,810	0	1,811,810	0	1,811,810	66.00
67.00	06700	OCCUPATIONAL THERAPY	759,220	0	759,220	0	759,220	67.00
68.00	06800	SPEECH PATHOLOGY	283,360	0	283,360	0	283,360	68.00
69.00	06900	ELECTROCARDIOLOGY	859,847		859,847	0	859,847	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	65,929		65,929	0	65,929	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	2,711,836		2,711,836	0	2,711,836	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	2,716,964		2,716,964	0	2,716,964	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	7,268,886		7,268,886	0	7,268,886	73.00
74.00	07400	RENAL DIALYSIS	445,168		445,168	0	445,168	74.00
76.97	07697	CARDIAC REHABILITATION	0		0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0		0	0	0	76.98
76.99	07699	LITHOTRIPSY	0		0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	1,329,746		1,329,746	0	1,329,746	90.00
91.00	09100	EMERGENCY	9,809,399		9,809,399	0	9,809,399	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1,811,545		1,811,545	0	1,811,545	92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0		0	0	0	93.99
200.00		Subtotal (see instructions)	89,651,003	0	89,651,003	0	89,651,003	200.00
201.00		Less Observation Beds	1,811,545		1,811,545	0	1,811,545	201.00
202.00		Total (see instructions)	87,839,458	0	87,839,458	0	87,839,458	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0251

Period:
From 01/01/2020
To 12/31/2020Worksheet C
Part I
Date/Time Prepared:
8/2/2021 11:01 am

			Title XIX		Hospital	Cost	
Cost Center Description			Charges			Cost or Other Ratio	TEFRA Inpatient Ratio
			Inpatient	Outpatient	Total (col. 6 + col. 7)		
			6.00	7.00	8.00	9.00	10.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	68,206,212		68,206,212		30.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	21,091,608		21,091,608		34.00
44.00	04400	SKILLED NURSING FACILITY	13,454,718		13,454,718		44.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	8,031,078	7,084,468	15,115,546	0.328171	50.00
51.00	05100	RECOVERY ROOM	1,700,656	1,378,384	3,079,040	0.256126	51.00
53.00	05300	ANESTHESIOLOGY	2,425,919	2,969,732	5,395,651	0.043897	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	7,598,547	9,466,259	17,064,806	0.176199	54.00
56.00	05600	RADIOISOTOPE	1,260,474	2,226,754	3,487,228	0.145541	56.00
57.00	05700	CT SCAN	12,979,220	20,902,624	33,881,844	0.037131	57.00
58.00	05800	MRI	1,640,081	2,199,557	3,839,638	0.086126	58.00
59.00	05900	CARDIAC CATHETERIZATION	8,696,407	3,256,127	11,952,534	0.154842	59.00
60.00	06000	LABORATORY	39,837,345	16,620,618	56,457,963	0.156677	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0.000000	62.30
65.00	06500	RESPIRATORY THERAPY	15,332,386	583,826	15,916,212	0.151026	65.00
66.00	06600	PHYSICAL THERAPY	4,630,607	779,890	5,410,497	0.334869	66.00
67.00	06700	OCCUPATIONAL THERAPY	3,349,015	250,877	3,599,892	0.210901	67.00
68.00	06800	SPEECH PATHOLOGY	1,133,045	62,823	1,195,868	0.236949	68.00
69.00	06900	ELECTROCARDIOLOGY	8,354,859	5,658,442	14,013,301	0.061359	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	157,568	49,276	206,844	0.318738	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	10,406,056	2,575,634	12,981,690	0.208897	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	3,372,576	1,878,108	5,250,684	0.517450	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	56,451,077	7,706,517	64,157,594	0.113297	73.00
74.00	07400	RENAL DIALYSIS	1,886,842	109,318	1,996,160	0.223012	74.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0.000000	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0.000000	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0.000000	76.99
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	1,218,911	4,848,586	6,067,497	0.219159	90.00
91.00	09100	EMERGENCY	21,583,580	32,485,040	54,068,620	0.181425	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1,313,524	5,486,098	6,799,622	0.266418	92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0	0	0	0.000000	93.99
200.00		Subtotal (see instructions)	316,112,311	128,569,958	444,682,269		200.00
201.00		Less Observation Beds					201.00
202.00		Total (see instructions)	316,112,311	128,569,958	444,682,269		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0251

Period:
From 01/01/2020
To 12/31/2020Worksheet C
Part I
Date/Time Prepared:
8/2/2021 11:01 am

Cost Center Description			PPS Inpatient Ratio	Title XIX	Hospital	Cost
			11.00			
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS				30.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT				34.00
44.00	04400	SKILLED NURSING FACILITY				44.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.000000			50.00
51.00	05100	RECOVERY ROOM	0.000000			51.00
53.00	05300	ANESTHESIOLOGY	0.000000			53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000			54.00
56.00	05600	RADIOISOTOPE	0.000000			56.00
57.00	05700	CT SCAN	0.000000			57.00
58.00	05800	MRI	0.000000			58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000			59.00
60.00	06000	LABORATORY	0.000000			60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0.000000			62.30
65.00	06500	RESPIRATORY THERAPY	0.000000			65.00
66.00	06600	PHYSICAL THERAPY	0.000000			66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000			67.00
68.00	06800	SPEECH PATHOLOGY	0.000000			68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000			69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000			70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000			71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000			72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000			73.00
74.00	07400	RENAL DIALYSIS	0.000000			74.00
76.97	07697	CARDIAC REHABILITATION	0.000000			76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0.000000			76.98
76.99	07699	LITHOTRIPSY	0.000000			76.99
OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.000000			90.00
91.00	09100	EMERGENCY	0.000000			91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000			92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0.000000			93.99
200.00		Subtotal (see instructions)				200.00
201.00		Less Observation Beds				201.00
202.00		Total (see instructions)				202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

Provider CCN: 14-0251

Period:
From 01/01/2020
To 12/31/2020Worksheet D
Part I
Date/Time Prepared:
8/2/2021 11:01 am

			Title XVIII		Hospital	PPS	
Cost Center Description		Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	1,720,958	0	1,720,958	25,445	67.63	30.00
34.00	SURGICAL INTENSIVE CARE UNIT	273,753		273,753	3,895	70.28	34.00
44.00	SKILLED NURSING FACILITY	633,672		633,672	10,551	60.06	44.00
200.00	Total (lines 30 through 199)	2,628,383		2,628,383	39,891		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	7,874	532,519				30.00
34.00	SURGICAL INTENSIVE CARE UNIT	1,955	137,397				34.00
44.00	SKILLED NURSING FACILITY	7,908	474,954				44.00
200.00	Total (lines 30 through 199)	17,737	1,144,870				200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 14-0251

Period:
From 01/01/2020
To 12/31/2020Worksheet D
Part II
Date/Time Prepared:
8/2/2021 11:01 am

			Title XVIII		Hospital	PPS		
Cost Center Description			Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
	ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	580,159	15,115,546	0.038382	2,974,676	114,174	50.00
51.00	05100	RECOVERY ROOM	43,498	3,079,040	0.014127	583,400	8,242	51.00
53.00	05300	ANESTHESIOLOGY	19,957	5,395,651	0.003699	903,562	3,342	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	289,026	17,064,806	0.016937	2,655,578	44,978	54.00
56.00	05600	RADIOISOTOPE	20,873	3,487,228	0.005986	505,244	3,024	56.00
57.00	05700	CT SCAN	55,413	33,881,844	0.001635	4,930,297	8,061	57.00
58.00	05800	MRI	12,011	3,830,638	0.003136	622,442	1,952	58.00
59.00	05900	CARDIAC CATHETERIZATION	175,060	11,952,534	0.014646	2,330,418	34,131	59.00
60.00	06000	LABORATORY	332,794	56,457,963	0.005895	13,279,138	78,281	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0.000000	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	78,476	15,916,212	0.004931	5,165,930	25,473	65.00
66.00	06600	PHYSICAL THERAPY	142,173	5,410,497	0.026277	391,975	10,300	66.00
67.00	06700	OCCUPATIONAL THERAPY	39,818	3,599,892	0.011061	301,502	3,335	67.00
68.00	06800	SPEECH PATHOLOGY	23,624	1,195,868	0.019755	326,548	6,451	68.00
69.00	06900	ELECTROCARDIOLOGY	51,349	14,013,301	0.003664	3,743,357	13,716	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	798	206,844	0.003858	68,466	264	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	119,557	12,981,690	0.009210	3,479,859	32,050	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	119,266	5,250,684	0.022714	1,407,828	31,977	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	135,033	64,157,594	0.002105	16,768,300	35,297	73.00
74.00	07400	RENAL DIALYSIS	22,393	1,996,160	0.011218	982,078	11,017	74.00
76.97	07697	CARDIAC REHABILITATION	0	0	0.000000	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0.000000	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0.000000	0	0	76.99
	OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	96,211	6,067,497	0.015857	533,791	8,464	90.00
91.00	09100	EMERGENCY	373,543	54,068,620	0.006909	5,773,510	39,889	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	158,941	6,799,622	0.023375	510,160	11,925	92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0	0	0.000000	0	0	93.99
200.00		Total (lines 50 through 199)	2,889,973	341,929,731		68,238,059	526,343	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS						Provider CCN: 14-0251		Period: From 01/01/2020 To 12/31/2020		Worksheet D Part III Date/Time Prepared: 8/2/2021 11:01 am		
						Title XVIII		Hospital		PPS		
Cost Center Description						Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health Cost	All Other Medical Education Cost		
						1A	1.00	2A	2.00	3.00		
INPATIENT ROUTINE SERVICE COST CENTERS												
30.00	03000	ADULTS & PEDIATRICS		0	0		0		0		30.00	
34.00	03400	SURGICAL INTENSIVE CARE UNIT		0	0		0		0		34.00	
44.00	04400	SKILLED NURSING FACILITY		0	0		0		0		44.00	
200.00		Total (lines 30 through 199)		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		25,445		0.00	7,874	30.00	
34.00	03400	SURGICAL INTENSIVE CARE UNIT			0		3,895		0.00	1,955	34.00	
44.00	04400	SKILLED NURSING FACILITY			0		10,551		0.00	7,908	44.00	
200.00		Total (lines 30 through 199)			0		39,891			17,737	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	
34.00	03400	SURGICAL INTENSIVE CARE UNIT		0							34.00	
44.00	04400	SKILLED NURSING FACILITY		0							44.00	
200.00		Total (lines 30 through 199)		0							200.00	

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

Provider CCN: 14-0251

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

Worksheet D
Part IV
Date/Time Prepared:
8/2/2021 11:01 am

Cost Center Description		Title XVIII			Hospital		PPS	
		Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health		
		1.00	2A	2.00	3A	3.00		
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	0	0	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
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
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
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	0	92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0	0	0	0	0	93.99
200.00		Total (lines 50 through 199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

Provider CCN: 14-0251

Period:
From 01/01/2020
To 12/31/2020Worksheet D
Part IV
Date/Time Prepared:
8/2/2021 11:01 am

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	15,115,546	0.000000	50.00
51.00	05100	RECOVERY ROOM	0	0	0	3,079,040	0.000000	51.00
53.00	05300	ANESTHESIOLOGY	0	0	0	5,395,651	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	17,064,806	0.000000	54.00
56.00	05600	RADIOISOTOPE	0	0	0	3,487,228	0.000000	56.00
57.00	05700	CT SCAN	0	0	0	33,881,844	0.000000	57.00
58.00	05800	MRI	0	0	0	3,830,638	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	11,952,534	0.000000	59.00
60.00	06000	LABORATORY	0	0	0	56,457,963	0.000000	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0.000000	62.30
65.00	06500	RESPIRATORY THERAPY	0	0	0	15,916,212	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	5,410,497	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	3,599,892	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	1,195,868	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	14,013,301	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	206,844	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	12,981,690	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	5,250,684	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	64,157,594	0.000000	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	1,996,160	0.000000	74.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0.000000	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0.000000	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0.000000	76.99
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0	6,067,497	0.000000	90.00
91.00	09100	EMERGENCY	0	0	0	54,068,620	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	6,799,622	0.000000	92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0	0	0	0	0.000000	93.99
200.00		Total (lines 50 through 199)	0	0	0	341,929,731		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-0251

Period:
From 01/01/2020
To 12/31/2020Worksheet D
Part IV
Date/Time Prepared:
8/2/2021 11:01 am

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	2,974,676	0	2,095,580	0 50.00
51.00	05100	RECOVERY ROOM	0.000000	583,400	0	376,963	0 51.00
53.00	05300	ANESTHESIOLOGY	0.000000	903,562	0	780,787	0 53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	2,655,578	0	1,370,832	0 54.00
56.00	05600	RADIOISOTOPE	0.000000	505,244	0	646,110	0 56.00
57.00	05700	CT SCAN	0.000000	4,930,297	0	4,167,446	0 57.00
58.00	05800	MRI	0.000000	622,442	0	674,536	0 58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	2,330,418	0	803,960	0 59.00
60.00	06000	LABORATORY	0.000000	13,279,138	0	2,253,663	0 60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0.000000	0	0	0	0 62.30
65.00	06500	RESPIRATORY THERAPY	0.000000	5,165,930	0	134,903	0 65.00
66.00	06600	PHYSICAL THERAPY	0.000000	391,975	0	1,350	0 66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	301,502	0	833	0 67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	326,548	0	11,567	0 68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	3,743,357	0	1,824,428	0 69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	68,466	0	15,422	0 70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	3,479,859	0	702,037	0 71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	1,407,828	0	812,511	0 72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	16,768,300	0	1,975,418	0 73.00
74.00	07400	RENAL DIALYSIS	0.000000	982,078	0	27,016	0 74.00
76.97	07697	CARDIAC REHABILITATION	0.000000	0	0	0	0 76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0.000000	0	0	0	0 76.98
76.99	07699	LITHOTRIPSY	0.000000	0	0	0	0 76.99
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0.000000	533,791	0	1,099,356	0 90.00
91.00	09100	EMERGENCY	0.000000	5,773,510	0	4,693,846	0 91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	510,160	0	1,054,741	0 92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0.000000	0	0	0	0 93.99
200.00		Total (lines 50 through 199)		68,238,059	0	25,523,305	0 200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-0251

Period:
From 01/01/2020
To 12/31/2020Worksheet D
Part V
Date/Time Prepared:
8/2/2021 11:01 am

			Title XVIII		Hospital		PPS	
	Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges		Costs			
			PPS Reimbursed Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	PPS Services (see inst.)		
		1.00	2.00	3.00	4.00	5.00		
	ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0.328171	2,095,580	0	0	687,709	50.00
51.00	05100	RECOVERY ROOM	0.256126	376,963	0	0	96,550	51.00
53.00	05300	ANESTHESIOLOGY	0.043897	780,787	0	0	34,274	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.176199	1,370,832	0	0	241,539	54.00
56.00	05600	RADIOISOTOPE	0.145541	646,110	0	0	94,035	56.00
57.00	05700	CT SCAN	0.037131	4,167,446	0	0	154,741	57.00
58.00	05800	MRI	0.086126	674,536	0	0	58,095	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.154842	803,960	0	0	124,487	59.00
60.00	06000	LABORATORY	0.156677	2,253,663	0	0	353,097	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0.000000	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0.151026	134,903	0	0	20,374	65.00
66.00	06600	PHYSICAL THERAPY	0.334869	1,350	0	0	452	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.210901	833	0	0	176	67.00
68.00	06800	SPEECH PATHOLOGY	0.236949	11,567	0	0	2,741	68.00
69.00	06900	ELECTROCARDIOLOGY	0.061359	1,824,428	0	0	111,945	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.318738	15,422	0	0	4,916	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.208897	702,037	0	0	146,653	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.517450	812,511	0	0	420,434	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.113297	1,975,418	0	3,443	223,809	73.00
74.00	07400	RENAL DIALYSIS	0.223012	27,016	0	0	6,025	74.00
76.97	07697	CARDIAC REHABILITATION	0.000000	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0.000000	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0.000000	0	0	0	0	76.99
	OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0.219159	1,099,356	0	0	240,934	90.00
91.00	09100	EMERGENCY	0.181425	4,693,846	0	0	851,581	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.266418	1,054,741	0	0	281,002	92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0.000000	0	0	0	0	93.99
200.00		Subtotal (see instructions)		25,523,305	0	3,443	4,155,569	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 - line 201)		25,523,305	0	3,443	4,155,569	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-0251

Period:
From 01/01/2020
To 12/31/2020Worksheet D
Part V
Date/Time Prepared:
8/2/2021 11:01 am

			Title XVIII		Hospital	PPS
	Cost Center Description	Costs				
		Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)			
		6.00	7.00			
	ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	0		50.00
51.00	05100	RECOVERY ROOM	0	0		51.00
53.00	05300	ANESTHESIOLOGY	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0		54.00
56.00	05600	RADIOISOTOPE	0	0		56.00
57.00	05700	CT SCAN	0	0		57.00
58.00	05800	MRI	0	0		58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0		59.00
60.00	06000	LABORATORY	0	0		60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0		62.30
65.00	06500	RESPIRATORY THERAPY	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO 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	390		73.00
74.00	07400	RENAL DIALYSIS	0	0		74.00
76.97	07697	CARDIAC REHABILITATION	0	0		76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0		76.98
76.99	07699	LITHOTRIPSY	0	0		76.99
	OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	0	0		90.00
91.00	09100	EMERGENCY	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0		92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0	0		93.99
200.00		Subtotal (see instructions)	0	390		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	0	390		202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-0251

Period:

Worksheet D

Component CCN: 14-5548

From 01/01/2020
To 12/31/2020Part V
Date/Time Prepared:
8/2/2021 11:01 am

Title XVIII

Skilled Nursing
Facility

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	0.328171	0	0	0	0 50.00
51.00	05100 RECOVERY ROOM	0.256126	0	0	0	0 51.00
53.00	05300 ANESTHESIOLOGY	0.043897	0	0	0	0 53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.176199	0	0	0	0 54.00
56.00	05600 RADIOISOTOPE	0.145541	0	0	0	0 56.00
57.00	05700 CT SCAN	0.037131	0	0	0	0 57.00
58.00	05800 MRI	0.086126	0	0	0	0 58.00
59.00	05900 CARDIAC CATHETERIZATION	0.154842	0	0	0	0 59.00
60.00	06000 LABORATORY	0.156677	0	0	0	0 60.00
62.30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0.000000	0	0	0	0 62.30
65.00	06500 RESPIRATORY THERAPY	0.151026	0	0	0	0 65.00
66.00	06600 PHYSICAL THERAPY	0.334869	0	0	0	0 66.00
67.00	06700 OCCUPATIONAL THERAPY	0.210901	0	0	0	0 67.00
68.00	06800 SPEECH PATHOLOGY	0.236949	0	0	0	0 68.00
69.00	06900 ELECTROCARDIOLOGY	0.061359	0	0	0	0 69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0.318738	0	0	0	0 70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.208897	0	0	0	0 71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.517450	0	0	0	0 72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.113297	0	0	5,513	0 73.00
74.00	07400 RENAL DIALYSIS	0.223012	0	0	0	0 74.00
76.97	07697 CARDIAC REHABILITATION	0.000000	0	0	0	0 76.97
76.98	07698 HYPERBARIC OXYGEN THERAPY	0.000000	0	0	0	0 76.98
76.99	07699 LITHOTRIPSY	0.000000	0	0	0	0 76.99
OUTPATIENT SERVICE COST CENTERS						
90.00	09000 CLINIC	0.219159	0	0	0	0 90.00
91.00	09100 EMERGENCY	0.181425	0	0	0	0 91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0.266418	0	0	0	0 92.00
93.99	09399 PARTIAL HOSPITALIZATION PROGRAM	0.000000	0	0	0	0 93.99
200.00	Subtotal (see instructions)		0	0	5,513	0 200.00
201.00	Less PBP Clinic Lab. Services-Program Only Charges			0	0	201.00
202.00	Net Charges (line 200 - line 201)		0	0	5,513	0 202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-0251

Period:

Worksheet D

Component CCN: 14-5548

From 01/01/2020
To 12/31/2020Part V
Date/Time Prepared:
8/2/2021 11:01 am

Title XVIII

Skilled Nursing
Facility

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
56.00	05600	RADIOISOTOPE	0	0	56.00
57.00	05700	CT SCAN	0	0	57.00
58.00	05800	MRI	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	59.00
60.00	06000	LABORATORY	0	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO 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	625	73.00
74.00	07400	RENAL DIALYSIS	0	0	74.00
76.97	07697	CARDIAC REHABILITATION	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	76.99
	OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0	0	90.00
91.00	09100	EMERGENCY	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0	0	93.99
200.00		Subtotal (see instructions)	0	625	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0		201.00
202.00		Net Charges (line 200 - line 201)	0	625	202.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-0251	Period: From 01/01/2020 To 12/31/2020	Worksheet D-1 Date/Time Prepared: 8/2/2021 11:01 am
Cost Center Description		Title XVIII	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)		25,445	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		25,445	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)		23,095	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)		7,874	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)		0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period		0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)		0	14.00
15.00	Total nursery days (title V or XIX only)		0	15.00
16.00	Nursery days (title V or XIX only)		0	16.00
SWING BED ADJUSTMENT				
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period		0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)		19,614,838	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)		0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)		0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)		0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)		0	25.00
26.00	Total swing-bed cost (see instructions)		0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)		19,614,838	27.00
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)		0	28.00
29.00	Private room charges (excluding swing-bed charges)		0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)		0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)		0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)		0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)		0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)		0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)		0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)		19,614,838	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)		770.87	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		6,069,830	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)		0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)		6,069,830	41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-0251

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

Worksheet D-1

Date/Time Prepared:
8/2/2021 11:01 am

Cost Center Description		Title XVIII		Hospital		PPS	
		Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)						42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT						43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT	7,370,970	3,895	1,892.42	1,955	3,699,681	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)					10,563,302	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					20,332,813	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)					669,916	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					526,343	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)					1,196,259	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					19,136,554	53.00
	TARGET AMOUNT AND LIMIT COMPUTATION						
54.00	Program discharges					0	54.00
55.00	Target amount per discharge					0.00	55.00
56.00	Target amount (line 54 x line 55)					0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)					0	57.00
58.00	Bonus payment (see instructions)					0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket					0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket					0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)					0	61.00
62.00	Relief payment (see instructions)					0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)					0	63.00
	PROGRAM INPATIENT ROUTINE SWING BED COST						
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)					0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)					0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)					0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)					0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)					0	69.00
	PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY						
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)						70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)						71.00
72.00	Program routine service cost (line 9 x line 71)						72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)						73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)						74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)						75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)						76.00
77.00	Program capital-related costs (line 9 x line 76)						77.00
78.00	Inpatient routine service cost (line 74 minus line 77)						78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)						79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)						80.00
81.00	Inpatient routine service cost per diem limitation						81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)						82.00
83.00	Reasonable inpatient routine service costs (see instructions)						83.00
84.00	Program inpatient ancillary services (see instructions)						84.00
85.00	Utilization review - physician compensation (see instructions)						85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)						86.00
	PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
87.00	Total observation bed days (see instructions)					2,350	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					770.87	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)					1,811,545	89.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-0251

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

Worksheet D-1

Date/Time Prepared:
8/2/2021 11:01 am

Cost Center Description		Title XVIII		Hospital	PPS	
		Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00
COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	1,720,958	19,614,838	0.087738	1,811,545	158,941
91.00	Nursing School cost	0	19,614,838	0.000000	1,811,545	0
92.00	Allied health cost	0	19,614,838	0.000000	1,811,545	0
93.00	All other Medical Education	0	19,614,838	0.000000	1,811,545	0

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-0251 Component CCN: 14-5548	Period: From 01/01/2020 To 12/31/2020	Worksheet D-1 Date/Time Prepared: 8/2/2021 11:01 am
		Title XVIII	Skilled Nursing Facility	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)		10,551	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		10,551	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)		10,551	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)		7,908	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)		8,603,031	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)		8,603,031	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)		8,603,031	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)			38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)			39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)			40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)			41.00

COMPUTATION OF INPATIENT OPERATING COST			Provider CCN: 14-0251 Component CCN: 14-5548	Period: From 01/01/2020 To 12/31/2020	Worksheet D-1 Date/Time Prepared: 8/2/2021 11:01 am
			Title XVIII	Skilled Nursing Facility	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					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)					48.00
49.00 Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					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)					50.00
51.00 Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					51.00
52.00 Total Program excludable cost (sum of lines 50 and 51)					52.00
53.00 Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					53.00
TARGET AMOUNT AND LIMIT COMPUTATION					
54.00 Program discharges					54.00
55.00 Target amount per discharge					55.00
56.00 Target amount (line 54 x line 55)					56.00
57.00 Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)					57.00
58.00 Bonus payment (see instructions)					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					59.00
60.00 Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket					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)					61.00
62.00 Relief payment (see instructions)					62.00
63.00 Allowable Inpatient cost plus incentive payment (see instructions)					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)					64.00
65.00 Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					65.00
66.00 Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)					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)					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)					68.00
69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)					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)				8,603,031	70.00
71.00 Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)				815.38	71.00
72.00 Program routine service cost (line 9 x line 71)				6,448,025	72.00
73.00 Medically necessary private room cost applicable to Program (line 14 x line 35)				0	73.00
74.00 Total Program general inpatient routine service costs (line 72 + line 73)				6,448,025	74.00
75.00 Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)				0	75.00
76.00 Per diem capital-related costs (line 75 ÷ line 2)				0.00	76.00
77.00 Program capital-related costs (line 9 x line 76)				0	77.00
78.00 Inpatient routine service cost (line 74 minus line 77)				0	78.00
79.00 Aggregate charges to beneficiaries for excess costs (from provider records)				0	79.00
80.00 Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)				0	80.00
81.00 Inpatient routine service cost per diem limitation				0.00	81.00
82.00 Inpatient routine service cost limitation (line 9 x line 81)				0	82.00
83.00 Reasonable inpatient routine service costs (see instructions)				6,448,025	83.00
84.00 Program inpatient ancillary services (see instructions)				2,624,795	84.00
85.00 Utilization review - physician compensation (see instructions)				0	85.00
86.00 Total Program inpatient operating costs (sum of lines 83 through 85)				9,072,820	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: 14-0251 Component CCN: 14-5548		Period: From 01/01/2020 To 12/31/2020		Worksheet D-1 Date/Time Prepared: 8/2/2021 11:01 am
			Title XVIII		Skilled Nursing Facility		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	0	0	0.000000	0	0	90.00
91.00	Nursing School cost	0	0	0.000000	0	0	91.00
92.00	Allied health cost	0	0	0.000000	0	0	92.00
93.00	All other Medical Education	0	0	0.000000	0	0	93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-0251	Period: From 01/01/2020 To 12/31/2020	Worksheet D-1 Date/Time Prepared: 8/2/2021 11:01 am
Cost Center Description		Title XIX	Hospital	Cost
				1.00
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		25,445	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		25,445	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)		23,095	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions)		2,081	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)		0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period		0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)		0	14.00
15.00	Total nursery days (title V or XIX only)		0	15.00
16.00	Nursery days (title V or XIX only)		0	16.00
SWING BED ADJUSTMENT				
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period		0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)		19,614,838	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)		0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)		0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)		0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)		0	25.00
26.00	Total swing-bed cost (see instructions)		0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)		19,614,838	27.00
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)		0	28.00
29.00	Private room charges (excluding swing-bed charges)		0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)		0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)		0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)		0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)		0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)		0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)		0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)		19,614,838	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)		770.87	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		1,604,180	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)		0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)		1,604,180	41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-0251

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

Worksheet D-1

Date/Time Prepared:
8/2/2021 11:01 am

		Title XIX		Hospital		Cost	
Cost Center Description		Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)						42.00
Intensive Care Type Inpatient Hospital Units							
43.00	INTENSIVE CARE UNIT						43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT	7,370,970	3,895	1,892.42	351	664,239	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)					1,429,073	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					3,697,492	49.00
PASS THROUGH COST ADJUSTMENTS							
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)					0	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					0	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)					0	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					0	53.00
TARGET AMOUNT AND LIMIT COMPUTATION							
54.00	Program discharges					0	54.00
55.00	Target amount per discharge					0.00	55.00
56.00	Target amount (line 54 x line 55)					0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)					0	57.00
58.00	Bonus payment (see instructions)					0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket					0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket					0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)					0	61.00
62.00	Relief payment (see instructions)					0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)					0	63.00
PROGRAM INPATIENT ROUTINE SWING BED COST							
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)					0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)					0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)					0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)					0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)					0	69.00
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY							
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)						70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)						71.00
72.00	Program routine service cost (line 9 x line 71)						72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)						73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)						74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)						75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)						76.00
77.00	Program capital-related costs (line 9 x line 76)						77.00
78.00	Inpatient routine service cost (line 74 minus line 77)						78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)						79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)						80.00
81.00	Inpatient routine service cost per diem limitation						81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)						82.00
83.00	Reasonable inpatient routine service costs (see instructions)						83.00
84.00	Program inpatient ancillary services (see instructions)						84.00
85.00	Utilization review - physician compensation (see instructions)						85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)						86.00
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
87.00	Total observation bed days (see instructions)					2,350	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					770.87	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)					1,811,545	89.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-0251

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

Worksheet D-1

Date/Time Prepared:
8/2/2021 11:01 am

Cost Center Description		Title XIX		Hospital		Cost	
		Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)		
		1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00	Capital-related cost	1,720,958	19,614,838	0.087738	1,811,545	158,941	90.00
91.00	Nursing School cost	0	19,614,838	0.000000	1,811,545	0	91.00
92.00	Allied health cost	0	19,614,838	0.000000	1,811,545	0	92.00
93.00	All other Medical Education	0	19,614,838	0.000000	1,811,545	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT			Provider CCN: 14-0251	Period: From 01/01/2020 To 12/31/2020	Worksheet D-3 Date/Time Prepared: 8/2/2021 11:01 am
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		23,731,445	30.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT		7,965,752	34.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0.328171	2,974,676	50.00
51.00	05100	RECOVERY ROOM	0.256126	583,400	51.00
53.00	05300	ANESTHESIOLOGY	0.043897	903,562	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.176199	2,655,578	54.00
56.00	05600	RADIOISOTOPE	0.145541	505,244	56.00
57.00	05700	CT SCAN	0.037131	4,930,297	57.00
58.00	05800	MRI	0.086126	622,442	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.154842	2,330,418	59.00
60.00	06000	LABORATORY	0.156677	13,279,138	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0.000000	0	62.30
65.00	06500	RESPIRATORY THERAPY	0.151026	5,165,930	65.00
66.00	06600	PHYSICAL THERAPY	0.334869	391,975	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.210901	301,502	67.00
68.00	06800	SPEECH PATHOLOGY	0.236949	326,548	68.00
69.00	06900	ELECTROCARDIOLOGY	0.061359	3,743,357	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.318738	68,466	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.208897	3,479,859	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.517450	1,407,828	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.113297	16,768,300	73.00
74.00	07400	RENAL DIALYSIS	0.223012	982,078	74.00
76.97	07697	CARDIAC REHABILITATION	0.000000	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0.000000	0	76.98
76.99	07699	LITHOTRIPSY	0.000000	0	76.99
OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	0.219159	533,791	90.00
91.00	09100	EMERGENCY	0.181425	5,773,510	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.266418	510,160	92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0.000000	0	93.99
200.00		Total (sum of lines 50 through 94 and 96 through 98)		68,238,059	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)		68,238,059	202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 14-0251 Component CCN: 14-5548	Period: From 01/01/2020 To 12/31/2020	Worksheet D-3 Date/Time Prepared: 8/2/2021 11:01 am	
		Title XVIII	Skilled Nursing Facility	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
34.00	03400 SURGICAL INTENSIVE CARE UNIT		0		34.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.328171	737	242	50.00
51.00	05100 RECOVERY ROOM	0.256126	2,034	521	51.00
53.00	05300 ANESTHESIOLOGY	0.043897	2,936	129	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.176199	175,088	30,850	54.00
56.00	05600 RADIOISOTOPE	0.145541	2,320	338	56.00
57.00	05700 CT SCAN	0.037131	3,312	123	57.00
58.00	05800 MRI	0.086126	67	6	58.00
59.00	05900 CARDIAC CATHETERIZATION	0.154842	19,310	2,990	59.00
60.00	06000 LABORATORY	0.156677	2,543,088	398,443	60.00
62.30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0.000000	0	0	62.30
65.00	06500 RESPIRATORY THERAPY	0.151026	752,081	113,584	65.00
66.00	06600 PHYSICAL THERAPY	0.334869	2,740,750	917,792	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.210901	1,954,997	412,311	67.00
68.00	06800 SPEECH PATHOLOGY	0.236949	275,797	65,350	68.00
69.00	06900 ELECTROCARDIOLOGY	0.061359	41,372	2,539	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0.318738	1,842	587	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.208897	641,347	133,975	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.517450	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.113297	4,793,285	543,065	73.00
74.00	07400 RENAL DIALYSIS	0.223012	0	0	74.00
76.97	07697 CARDIAC REHABILITATION	0.000000	0	0	76.97
76.98	07698 HYPERBARIC OXYGEN THERAPY	0.000000	0	0	76.98
76.99	07699 LITHOTRIPSY	0.000000	0	0	76.99
OUTPATIENT SERVICE COST CENTERS					
90.00	09000 CLINIC	0.219159	3,153	691	90.00
91.00	09100 EMERGENCY	0.181425	6,942	1,259	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0.266418	0	0	92.00
93.99	09399 PARTIAL HOSPITALIZATION PROGRAM	0.000000	0	0	93.99
200.00	Total (sum of lines 50 through 94 and 96 through 98)		13,960,458	2,624,795	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)		13,960,458		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT			Provider CCN: 14-0251	Period: From 01/01/2020 To 12/31/2020	Worksheet D-3 Date/Time Prepared: 8/2/2021 11:01 am
			Title XIX	Hospital	Cost
Cost Center Description			Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)
			1.00	2.00	3.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS		1,953,499	30.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT		1,568,309	34.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0.328171	630,953	50.00
51.00	05100	RECOVERY ROOM	0.256126	146,882	51.00
53.00	05300	ANESTHESIOLOGY	0.043897	175,652	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.176199	418,318	54.00
56.00	05600	RADIOISOTOPE	0.145541	35,842	56.00
57.00	05700	CT SCAN	0.037131	786,350	57.00
58.00	05800	MRI	0.086126	89,373	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.154842	287,347	59.00
60.00	06000	LABORATORY	0.156677	1,718,435	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0.000000	0	62.30
65.00	06500	RESPIRATORY THERAPY	0.151026	208,613	65.00
66.00	06600	PHYSICAL THERAPY	0.334869	81,462	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.210901	38,525	67.00
68.00	06800	SPEECH PATHOLOGY	0.236949	32,703	68.00
69.00	06900	ELECTROCARDIOLOGY	0.061359	409,646	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.318738	4,298	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.208897	657,608	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.517450	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.113297	2,901,684	73.00
74.00	07400	RENAL DIALYSIS	0.223012	14,160	74.00
76.97	07697	CARDIAC REHABILITATION	0.000000	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0.000000	0	76.98
76.99	07699	LITHOTRIPSY	0.000000	0	76.99
OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	0.219159	40,591	90.00
91.00	09100	EMERGENCY	0.181425	870,527	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.266418	36,991	92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0.000000	0	93.99
200.00		Total (sum of lines 50 through 94 and 96 through 98)		9,585,960	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)		9,585,960	202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0251	Period: From 01/01/2020 To 12/31/2020	Worksheet E Part A Date/Time Prepared: 8/2/2021 11:01 am	
		Title XVIII	Hospital	PPS	
				1.00	
PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS					
1.00	DRG Amounts Other than Outlier Payments			0	1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1 (see instructions)			11,911,999	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1 (see instructions)			4,407,729	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)			78,023	2.03
2.04	Outlier payments for discharges occurring on or after October 1 (see instructions)			36,803	2.04
3.00	Managed Care Simulated Payments			6,797,836	3.00
4.00	Bed days available divided by number of days in the cost reporting period (see instructions)			206.51	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)			1.56	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.			0.11	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).			1.50	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)			2.95	9.00
10.00	FTE count for allopathic and osteopathic programs in the current year from your records			0.93	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)			0.93	12.00
13.00	Total allowable FTE count for the prior year.			1.27	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.			2.95	14.00
15.00	Sum of lines 12 through 14 divided by 3.			1.72	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			1.72	18.00
19.00	Current year resident to bed ratio (line 18 divided by line 4).			0.008329	19.00
20.00	Prior year resident to bed ratio (see instructions)			0.006280	20.00
21.00	Enter the lesser of lines 19 or 20 (see instructions)			0.006280	21.00
22.00	IME payment adjustment (see instructions)			55,944	22.00
22.01	IME payment adjustment - Managed Care (see instructions)			23,303	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)			-2.02	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)			55,944	29.00
29.01	Total IME payment - Managed Care (sum of lines 22.01 and 28.01)			23,303	29.01
Disproportionate Share Adjustment					
30.00	Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)			7.83	30.00
31.00	Percentage of Medicaid patient days (see instructions)			26.02	31.00
32.00	Sum of lines 30 and 31			33.85	32.00
33.00	Allowable disproportionate share percentage (see instructions)			17.14	33.00
34.00	Disproportionate share adjustment (see instructions)			699,300	34.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0251	Period: From 01/01/2020 To 12/31/2020	Worksheet E Part A Date/Time Prepared: 8/2/2021 11:01 am
		Title XVIII	Hospital	PPS
			Prior to 10/1	On/After 10/1
			1.00	2.00
Uncompensated Care Adjustment				
35.00	Total uncompensated care amount (see instructions)		0	0
35.01	Factor 3 (see instructions)	0.000000000	0.000000000	
35.02	Hospital uncompensated care payment (If line 34 is zero, enter zero on this line) (see instructions)	2,110,260	1,388,329	
35.03	Pro rata share of the hospital uncompensated care payment amount (see instructions)	1,579,812	349,935	
36.00	Total uncompensated care (sum of columns 1 and 2 on line 35.03)	1,929,747		
Additional payment for high percentage of ESRD beneficiary discharges (lines 40 through 46)				
40.00	Total Medicare discharges, excluding MS-DRGs 652, 682, 683, 684 and 685. (see instructions)		0	
41.00	Total ESRD Medicare discharges excluding MS-DRGs 652, 682, 683, 684 and 685. (see instructions)		0	
41.01	Total ESRD Medicare covered and paid discharges excluding MS-DRGs 652, 682, 683, 684 and 685. (see instructions)		0	
42.00	Divide line 41 by line 40 (if less than 10%, you do not qualify for adjustment)	0.00		
43.00	Total Medicare ESRD inpatient days excluding MS-DRGs 652, 682, 683, 684 and 685. (see instructions)		0	
44.00	Ratio of average length of stay to one week (line 43 divided by line 41 divided by 7 days)	0.000000		
45.00	Average weekly cost for dialysis treatments (see instructions)	0.00		
46.00	Total additional payment (line 45 times line 44 times line 41.01)	0		
47.00	Subtotal (see instructions)	19,119,545		
48.00	Hospital specific payments (to be completed by SCH and MDH, small rural hospitals only. (see instructions)	0		
			Amount	
			1.00	
49.00	Total payment for inpatient operating costs (see instructions)		19,142,848	
50.00	Payment for inpatient program capital (from Wkst. L, Pt. I and Pt. II, as applicable)		1,357,602	
51.00	Exception payment for inpatient program capital (Wkst. L, Pt. III, see instructions)		0	
52.00	Direct graduate medical education payment (from Wkst. E-4, line 49 see instructions).		67,671	
53.00	Nursing and Allied Health Managed Care payment		0	
54.00	Special add-on payments for new technologies		46,171	
54.01	Islet isolation add-on payment		0	
55.00	Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line 69)		0	
56.00	Cost of physicians' services in a teaching hospital (see instructions)		0	
57.00	Routine service other pass through costs (from Wkst. D, Pt. III, column 9, lines 30 through 35).		0	
58.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 11 line 200)		0	
59.00	Total (sum of amounts on lines 49 through 58)		20,614,292	
60.00	Primary payer payments		412	
61.00	Total amount payable for program beneficiaries (line 59 minus line 60)		20,613,880	
62.00	Deductibles billed to program beneficiaries		1,463,264	
63.00	Coinurance billed to program beneficiaries		74,976	
64.00	Allowable bad debts (see instructions)		1,522,824	
65.00	Adjusted reimbursable bad debts (see instructions)		989,836	
66.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		1,167,251	
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)		20,065,476	
68.00	Credits received from manufacturers for replaced devices for applicable to MS-DRGs (see instructions)		0	
69.00	Outlier payments reconciliation (sum of lines 93, 95 and 96). (For SCH see instructions)		0	
70.00	SUMMARY PSR - OTHER ADJ		-3,164	
70.50	Rural Community Hospital Demonstration Project (\$410A Demonstration) adjustment (see instructions)		0	
70.87	Demonstration payment adjustment amount before sequestration		0	
70.88	SCH or MDH volume decrease adjustment (contractor use only)		0	
70.89	Pioneer ACO demonstration payment adjustment amount (see instructions)		0	
70.90	HSP bonus payment HVBP adjustment amount (see instructions)		0	
70.91	HSP bonus payment HRR adjustment amount (see instructions)		0	
70.92	Bundled Model 1 discount amount (see instructions)		0	
70.93	HVBP payment adjustment amount (see instructions)		47,803	
70.94	HRR adjustment amount (see instructions)		-67,991	
70.95	Recovery of accelerated depreciation		0	

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0251	Period: From 01/01/2020 To 12/31/2020	Worksheet E Part A Date/Time Prepared: 8/2/2021 11:01 am
		Title XVIII	Hospital	PPS
		FFY (yyyy)	Amount	
		0	1.00	
70.96	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period prior to 10/1)	0	0	70.96
70.97	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period ending on or after 10/1)	0	0	70.97
70.98	Low Volume Payment-3		0	70.98
70.99	HAC adjustment amount (see instructions)		0	70.99
71.00	Amount due provider (line 67 minus lines 68 plus/minus lines 69 & 70)		20,042,124	71.00
71.01	Sequestration adjustment (see instructions)		132,278	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		18,557,975	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)		1,351,871	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		493,753	75.00
TO BE COMPLETED BY CONTRACTOR (lines 90 through 96)				
90.00	Operating outlier amount from Wkst. E, Pt. A, line 2, or sum of 2.03 plus 2.04 (see instructions)		0	90.00
91.00	Capital outlier from Wkst. L, Pt. I, line 2		0	91.00
92.00	Operating outlier reconciliation adjustment amount (see instructions)		0	92.00
93.00	Capital outlier reconciliation adjustment amount (see instructions)		0	93.00
94.00	The rate used to calculate the time value of money (see instructions)		0.00	94.00
95.00	Time value of money for operating expenses (see instructions)		0	95.00
96.00	Time value of money for capital related expenses (see instructions)		0	96.00
		Prior to 10/1	On/After 10/1	
		1.00	2.00	
HSP Bonus Payment Amount				
100.00	HSP bonus amount (see instructions)		0	100.00
HVBP Adjustment for HSP Bonus Payment				
101.00	HVBP adjustment factor (see instructions)	0.0000000000	0.0000000000	101.00
102.00	HVBP adjustment amount for HSP bonus payment (see instructions)		0	102.00
HRR Adjustment for HSP Bonus Payment				
103.00	HRR adjustment factor (see instructions)	0.0000	0.0000	103.00
104.00	HRR adjustment amount for HSP bonus payment (see instructions)		0	104.00
Rural Community Hospital Demonstration Project (§410A Demonstration) Adjustment				
200.00	Is this the first year of the current 5-year demonstration period under the 21st Century Cures Act? Enter "Y" for yes or "N" for no.			200.00
Cost Reimbursement				
201.00	Medicare inpatient service costs (from Wkst. D-1, Pt. II, line 49)			201.00
202.00	Medicare discharges (see instructions)			202.00
203.00	Case-mix adjustment factor (see instructions)			203.00
Computation of Demonstration Target Amount Limitation (N/A in first year of the current 5-year demonstration period)				
204.00	Medicare target amount			204.00
205.00	Case-mix adjusted target amount (line 203 times line 204)			205.00
206.00	Medicare inpatient routine cost cap (line 202 times line 205)			206.00
Adjustment to Medicare Part A Inpatient Reimbursement				
207.00	Program reimbursement under the §410A Demonstration (see instructions)			207.00
208.00	Medicare Part A inpatient service costs (from Wkst. E, Pt. A, line 59)			208.00
209.00	Adjustment to Medicare IPPS payments (see instructions)			209.00
210.00	Reserved for future use			210.00
211.00	Total adjustment to Medicare IPPS payments (see instructions)			211.00
Comparison of PPS versus Cost Reimbursement				
212.00	Total adjustment to Medicare Part A IPPS payments (from line 211)			212.00
213.00	Low-volume adjustment (see instructions)			213.00
218.00	Net Medicare Part A IPPS adjustment (difference between PPS and cost reimbursement) (line 212 minus line 213) (see instructions)			218.00

LOW VOLUME CALCULATION EXHIBIT 4

Provider CCN: 14-0251

Period:
From 01/01/2020
To 12/31/2020Worksheet E
Part A Exhibit 4
Date/Time Prepared:
8/2/2021 11:01 am

		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	11,911,999	0	11,911,999		11,911,999
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	4,407,729	0		4,407,729	4,407,729
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	78,023	0	78,023		78,023
2.03	Outlier payments for discharges occurring on or after October 1 (see instructions)	2.04	36,803	0		36,803	36,803
3.00	Operating outlier reconciliation	2.01	0	0	0	0	0
4.00	Managed care simulated payments	3.00	6,797,836	0	4,666,364	2,131,472	6,797,836
Indirect Medical Education Adjustment							
5.00	Amount from Worksheet E, Part A, line 21 (see instructions)	21.00	0.006280	0.006280	0.006280	0.006280	
6.00	IME payment adjustment (see instructions)	22.00	55,944	0	40,834	15,110	55,944
6.01	IME payment adjustment for managed care (see instructions)	22.01	23,303	0	15,996	7,307	23,303
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	55,944	0	40,834	15,110	55,944
9.01	Total IME payment for managed care (sum of lines 6.01 and 8.01)	29.01	23,303	0	15,996	7,307	23,303
Disproportionate Share Adjustment							
10.00	Allowable disproportionate share percentage (see instructions)	33.00	0.1714	0.1714	0.1714	0.1714	
11.00	Disproportionate share adjustment (see instructions)	34.00	699,300	0	510,429	188,871	699,300
11.01	Uncompensated care payments	36.00	1,929,747	0	1,579,812	349,935	1,929,747
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	19,119,545	0	14,121,097	4,998,448	19,119,545
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	19,142,848	0	14,137,093	5,005,755	19,142,848
16.00	Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable)	50.00	1,357,602	0	1,001,404	356,198	1,357,602

LOW VOLUME CALCULATION EXHIBIT 4

Provider CCN: 14-0251

Period:
From 01/01/2020
To 12/31/2020Worksheet E
Part A Exhibit 4
Date/Time Prepared:
8/2/2021 11:01 am

				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	46,171	0	0	46,171	46,171	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	15,138,497	5,408,124	20,546,621	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	1,253,289	0	924,859	328,430	1,253,289	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	7,183	0	4,869	2,314	7,183	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	0.0066	0.0066	0.0066	0.0066		22.00
23.00	Indirect medical education adjustment (see instructions)	6.00	8,272	0	6,104	2,168	8,272	23.00
24.00	Allowable disproportionate share percentage (see instructions)	10.00	0.0709	0.0709	0.0709	0.0709		24.00
25.00	Disproportionate share adjustment (see instructions)	11.00	88,858	0	65,572	23,286	88,858	25.00
26.00	Total prospective capital payments (see instructions)	12.00	1,357,602	0	1,001,404	356,198	1,357,602	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.		N					100.00

HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULATION EXHIBIT 5

Provider CCN: 14-0251

Period:
From 01/01/2020
To 12/31/2020Worksheet E
Part A Exhibit 5
Date/Time Prepared:
8/2/2021 11:01 am

		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	11,911,999	11,911,999		11,911,999	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	4,407,729		4,407,729	4,407,729	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	78,023	78,023		78,023	2.02
2.03	Outlier payments for discharges occurring on or after October 1 (see instructions)	2.04	36,803		36,803	36,803	2.03
3.00	Operating outlier reconciliation	2.01	0	0	0	0	3.00
4.00	Managed care simulated payments	3.00	6,797,836	4,666,364	2,131,472	6,797,836	4.00
Indirect Medical Education Adjustment							
5.00	Amount from Worksheet E, Part A, line 21 (see instructions)	21.00	0.006280	0.006280	0.006280		5.00
6.00	IME payment adjustment (see instructions)	22.00	55,944	40,834	15,110	55,944	6.00
6.01	IME payment adjustment for managed care (see instructions)	22.01	23,303	15,996	7,307	23,303	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	55,944	40,834	15,110	55,944	9.00
9.01	Total IME payment for managed care (sum of lines 6.01 and 8.01)	29.01	23,303	15,996	7,307	23,303	9.01
Disproportionate Share Adjustment							
10.00	Allowable disproportionate share percentage (see instructions)	33.00	0.1714	0.1714	0.1714		10.00
11.00	Disproportionate share adjustment (see instructions)	34.00	699,300	510,429	188,871	699,300	11.00
11.01	Uncompensated care payments	36.00	1,929,747	1,579,812	349,935	1,929,747	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	19,119,545	14,121,097	4,998,448	19,119,545	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	19,142,848	14,137,093	5,005,755	19,142,848	15.00
16.00	Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable)	50.00	1,357,602	1,001,404	356,198	1,357,602	16.00
17.00	Special add-on payments for new technologies	54.00	46,171	0	46,171	46,171	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			15,138,497	5,408,124	20,546,621	19.00

HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULATION EXHIBIT 5

Provider CCN: 14-0251

Period:
From 01/01/2020
To 12/31/2020Worksheet E
Part A Exhibit 5
Date/Time Prepared:
8/2/2021 11:01 am

		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	1,253,289	924,859	328,430	1,253,289	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	7,183	4,869	2,314	7,183	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	0.0066	0.0066	0.0066		22.00
23.00	Indirect medical education adjustment (see instructions)	6.00	8,272	6,104	2,168	8,272	23.00
24.00	Allowable disproportionate share percentage (see instructions)	10.00	0.0709	0.0709	0.0709		24.00
25.00	Disproportionate share adjustment (see instructions)	11.00	88,858	65,572	23,286	88,858	25.00
26.00	Total prospective capital payments (see instructions)	12.00	1,357,602	1,001,404	356,198	1,357,602	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	47,803	47,803	0	47,803	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	-67,991	-48,839	-19,152	-67,991	31.00
31.01	HRR adjustment for HSP bonus payment (see instructions)	70.91	0	0	0	0	31.01
						(Amt. to Wkst. E, Pt. A)	
		0	1.00	2.00	3.00	4.00	
32.00	HAC Reduction Program adjustment (see instructions)	70.99		0	0	0	32.00
100.00	Transfer HAC Reduction Program adjustment to Wkst. E, Pt. A.		N				100.00

Health Financial Systems		COMMUNITY FIRST MEDICAL CENTER		In Lieu of Form CMS-2552-10	
CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0251	Period: From 01/01/2020 To 12/31/2020	Worksheet E Part B Date/Time Prepared: 8/2/2021 11:01 am	
		Title XVIII	Hospital	PPS	
					1.00
PART B - MEDICAL AND OTHER HEALTH SERVICES					
1.00	Medical and other services (see instructions)			390	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)			4,155,569	2.00
3.00	OPPS payments			3,491,245	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)			390	11.00
COMPUTATION OF LESSER OF COST OR CHARGES					
Reasonable charges					
12.00	Ancillary service charges			3,443	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)			3,443	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)			3,443	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)			3,053	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)			390	21.00
22.00	Interns and residents (see instructions)			0	22.00
23.00	Cost of physicians' services in a teaching hospital (see instructions)			0	23.00
24.00	Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)			3,491,245	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)			709,221	26.00
27.00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions)			2,782,414	27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 50)			8,819	28.00
29.00	ESRD direct medical education costs (from Wkst. E-4, line 36)			0	29.00
30.00	Subtotal (sum of lines 27 through 29)			2,791,233	30.00
31.00	Primary payer payments			0	31.00
32.00	Subtotal (line 30 minus line 31)			2,791,233	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)			673,509	34.00
35.00	Adjusted reimbursable bad debts (see instructions)			437,781	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			481,548	36.00
37.00	Subtotal (see instructions)			3,229,014	37.00
38.00	MSP-LCC reconciliation amount from PS&R			0	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	39.00
39.50	Pioneer ACO demonstration payment adjustment (see instructions)			0	39.50
39.97	Demonstration payment adjustment amount before sequestration			0	39.97
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)			0	39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION			0	39.99
40.00	Subtotal (see instructions)			3,229,014	40.00
40.01	Sequestration adjustment (see instructions)			21,311	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			2,993,739	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)			213,964	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: 14-0251 Component CCN: 14-5548	Period: From 01/01/2020 To 12/31/2020	Worksheet E Part B Date/Time Prepared: 8/2/2021 11:01 am
		Title XVIII	Skilled Nursing Facility	PPS
			1.00	
PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)		625	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)		0	2.00
3.00	OPPS payments			3.00
4.00	Outlier payment (see instructions)			4.00
4.01	Outlier reconciliation amount (see instructions)			4.01
5.00	Enter the hospital specific payment to cost ratio (see instructions)			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)		625	11.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
12.00	Ancillary service charges		5,513	12.00
13.00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, line 69)			13.00
14.00	Total reasonable charges (sum of lines 12 and 13)		5,513	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 charge basis 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)		5,513	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)		4,888	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)		625	21.00
22.00	Interns and residents (see instructions)		0	22.00
23.00	Cost of physicians' services in a teaching hospital (see instructions)		0	23.00
24.00	Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)		0	24.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25.00	Deductibles and coinsurance amounts (for CAH, see instructions)		0	25.00
26.00	Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)			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)		625	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)		625	30.00
31.00	Primary payer payments		0	31.00
32.00	Subtotal (line 30 minus line 31)		625	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)		625	37.00
38.00	MSP-LCC reconciliation amount from PS&R			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)		625	40.00
40.01	Sequestration adjustment (see instructions)		4	40.01
40.02	Demonstration payment adjustment amount after sequestration		0	40.02
40.03	Sequestration adjustment-PARHM pass-throughs			40.03
41.00	Interim payments		710	41.00
41.01	Interim payments-PARHM			41.01
42.00	Tentative settlement (for contractors use only)		0	42.00
42.01	Tentative settlement-PARHM (for contractor use only)			42.01
43.00	Balance due provider/program (see instructions)		-89	43.00
43.01	Balance due provider/program-PARHM (see instructions)			43.01
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		0	44.00
TO BE COMPLETED BY CONTRACTOR				
90.00	Original outlier amount (see instructions)			90.00
91.00	Outlier reconciliation adjustment amount (see instructions)			91.00
92.00	The rate used to calculate the Time Value of Money			92.00
93.00	Time Value of Money (see instructions)			93.00
94.00	Total (sum of lines 91 and 93)			94.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 14-0251

Period:
From 01/01/2020
To 12/31/2020Worksheet E-1
Part I
Date/Time Prepared:
8/2/2021 11:01 am

		Title XVIII		Hospital		PPS	
		Inpatient Part A		Part B			
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount		
		1.00	2.00	3.00	4.00		
1.00	Total interim payments paid to provider		18,726,815		3,120,068	1.00	
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00	
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00	
Program to Provider							
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01	
3.02			0		0	3.02	
3.03			0		0	3.03	
3.04			0		0	3.04	
3.05			0		0	3.05	
Provider to Program							
3.50	ADJUSTMENTS TO PROGRAM	12/23/2020	168,840	12/23/2020	126,329	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)		-168,840		-126,329	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)		18,557,975		2,993,739	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		1,351,871		213,964	6.01	
6.02	SETTLEMENT TO PROGRAM		0		0	6.02	
7.00	Total Medicare program liability (see instructions)		19,909,846		3,207,703	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: 14-0251
 Component CCN: 14-5548

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

 Worksheet E-1
 Part I
 Date/Time Prepared:
 8/2/2021 11:01 am

		Title XVIII		Skilled Nursing Facility	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				
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		4,704,843		710
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
Program to Provider					
3.01	ADJUSTMENTS TO PROVIDER		0		0
3.02			0		0
3.03			0		0
3.04			0		0
3.05			0		0
Provider to Program					
3.50	ADJUSTMENTS TO PROGRAM		0		0
3.51			0		0
3.52			0		0
3.53			0		0
3.54			0		0
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0
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)		4,704,843		710
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)				
Program to Provider					
5.01	TENTATIVE TO PROVIDER		0		0
5.02			0		0
5.03			0		0
Provider to Program					
5.50	TENTATIVE TO PROGRAM		0		0
5.51			0		0
5.52			0		0
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0
6.00	Determined net settlement amount (balance due) based on the cost report. (1)				
6.01	SETTLEMENT TO PROVIDER		0		0
6.02	SETTLEMENT TO PROGRAM		0		89
7.00	Total Medicare program liability (see instructions)		4,704,843		621
				Contractor Number	NPR Date (Mo/Day/Yr)
				1.00	2.00
8.00	Name of Contractor	0			

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT

Provider CCN: 14-0251

Period:
From 01/01/2020
To 12/31/2020Worksheet E-1
Part II
Date/Time Prepared:
8/2/2021 11:01 am

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

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0251 Component CCN: 14-5548	Period: From 01/01/2020 To 12/31/2020	Worksheet E-3 Part VI Date/Time Prepared: 8/2/2021 11:01 am
		Title XVIII	Skilled Nursing Facility	PPS
				1.00
PART VI - CALCULATION OF REIMBURSEMENT SETTLEMENT - ALL OTHER HEALTH SERVICES FOR TITLE XVIII PART A PPS SNF SERVICES				
PROSPECTIVE PAYMENT AMOUNT (SEE INSTRUCTIONS)				
1.00	Resource Utilization Group Payment (RUGS)			5,112,818 1.00
2.00	Routine service other pass through costs			0 2.00
3.00	Ancillary service other pass through costs			0 3.00
4.00	Subtotal (sum of lines 1 through 3)			5,112,818 4.00
COMPUTATION OF NET COST OF COVERED SERVICES				
5.00	Medical and other services (Do not use this line as vaccine costs are included in line 1 of W/S E, Part B. This line is now shaded.)			5.00
6.00	Deductible			0 6.00
7.00	Coinsurance			373,676 7.00
8.00	Allowable bad debts (see instructions)			0 8.00
9.00	Reimbursable bad debts for dual eligible beneficiaries (see instructions)			0 9.00
10.00	Adjusted reimbursable bad debts (see instructions)			0 10.00
11.00	Utilization review			0 11.00
12.00	Subtotal (sum of lines 4, 5 minus lines 6 and 7, plus lines 10 and 11)(see instructions)			4,739,142 12.00
13.00	Inpatient primary payer payments			0 13.00
14.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0 14.00
14.50	Pioneer ACO demonstration payment adjustment (see instructions)			0 14.50
14.99	Demonstration payment adjustment amount before sequestration			0 14.99
15.00	Subtotal (see instructions)			4,739,142 15.00
15.01	Sequestration adjustment (see instructions)			34,299 15.01
15.02	Demonstration payment adjustment amount after sequestration			0 15.02
15.75	Sequestration for non-claims based amounts (see instructions)			0 15.75
16.00	Interim payments			4,704,843 16.00
17.00	Tentative settlement (for contractor use only)			0 17.00
18.00	Balance due provider/program (line 15 minus lines 15.01, 15.02, 15.75, 16, and 17)			0 18.00
19.00	Protested amounts (nonallowable cost report items) in accordance with CMS 19 Pub. 15-2, chapter 1, §115.2			0 19.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0251	Period: From 01/01/2020 To 12/31/2020	Worksheet E-3 Part VII Date/Time Prepared: 8/2/2021 11:01 am
		Title XIX	Hospital	Cost
			Inpatient	Outpatient
			1.00	2.00
PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR XIX SERVICES				
COMPUTATION OF NET COST OF COVERED SERVICES				
1.00	Inpatient hospital/SNF/NF services	3,697,492		1.00
2.00	Medical and other services		0	2.00
3.00	Organ acquisition (certified transplant centers only)	3,521,808		3.00
4.00	Subtotal (sum of lines 1, 2 and 3)	7,291,493	0	4.00
5.00	Inpatient primary payer payments	0		5.00
6.00	Outpatient primary payer payments		0	6.00
7.00	Subtotal (line 4 less sum of lines 5 and 6)	7,291,493	0	7.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable Charges				
8.00	Routine service charges	0		8.00
9.00	Ancillary service charges	9,585,960	0	9.00
10.00	Organ acquisition charges, net of revenue	3,521,808		10.00
11.00	Incentive from target amount computation	0		11.00
12.00	Total reasonable charges (sum of lines 8 through 11)	13,107,768	0	12.00
CUSTOMARY CHARGES				
13.00	Amount actually collected from patients liable for payment for services on a charge basis	0	0	13.00
14.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)	0	0	14.00
15.00	Ratio of line 13 to line 14 (not to exceed 1.000000)	0.000000	0.000000	15.00
16.00	Total customary charges (see instructions)	13,107,768	0	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)	5,816,275	0	17.00
18.00	Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 16) (see instructions)	0	0	18.00
19.00	Interns and Residents (see instructions)	0	0	19.00
20.00	Cost of physicians' services in a teaching hospital (see instructions)	0	0	20.00
21.00	Cost of covered services (enter the lesser of line 4 or line 16)	7,291,493	0	21.00
PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be completed for PPS providers.				
22.00	Other than outlier payments	0	0	22.00
23.00	Outlier payments	0	0	23.00
24.00	Program capital payments	0		24.00
25.00	Capital exception payments (see instructions)	0		25.00
26.00	Routine and Ancillary service other pass through costs	0	0	26.00
27.00	Subtotal (sum of lines 22 through 26)	0	0	27.00
28.00	Customary charges (title V or XIX PPS covered services only)	0		28.00
29.00	Titles V or XIX (sum of lines 21 and 27)	7,291,493	0	29.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT				
30.00	Excess of reasonable cost (from line 18)	0	0	30.00
31.00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)	7,291,493	0	31.00
32.00	Deductibles	0	0	32.00
33.00	Coinurance	0	0	33.00
34.00	Allowable bad debts (see instructions)	0	0	34.00
35.00	Utilization review	0		35.00
36.00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)	7,291,493	0	36.00
37.00	INTERIM PAYMENT RECONCILIATION	-5,531,120	0	37.00
38.00	Subtotal (line 36 ± line 37)	1,760,373	0	38.00
39.00	Direct graduate medical education payments (from Wkst. E-4)	0		39.00
40.00	Total amount payable to the provider (sum of lines 38 and 39)	1,760,373	0	40.00
41.00	Interim payments	1,760,373	0	41.00
42.00	Balance due provider/program (line 40 minus line 41)	0		42.00
43.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, chapter 1, §115.2	0	0	43.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0251 Component CCN: 14-5548	Period: From 01/01/2020 To 12/31/2020	Worksheet E-3 Part VII Date/Time Prepared: 8/2/2021 11:01 am
		Title XIX	Skilled Nursing Facility	Cost
		Inpatient	Outpatient	
		1.00	2.00	
PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR XIX SERVICES				
COMPUTATION OF NET COST OF COVERED SERVICES				
1.00	Inpatient hospital/SNF/NF services	0		1.00
2.00	Medical and other services		0	2.00
3.00	Organ acquisition (certified transplant centers only)	0		3.00
4.00	Subtotal (sum of lines 1, 2 and 3)	0	0	4.00
5.00	Inpatient primary payer payments	0		5.00
6.00	Outpatient primary payer payments		0	6.00
7.00	Subtotal (line 4 less sum of lines 5 and 6)	0	0	7.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable Charges				
8.00	Routine service charges	0		8.00
9.00	Ancillary service charges	0	0	9.00
10.00	Organ acquisition charges, net of revenue	0		10.00
11.00	Incentive from target amount computation	0		11.00
12.00	Total reasonable charges (sum of lines 8 through 11)	0	0	12.00
CUSTOMARY CHARGES				
13.00	Amount actually collected from patients liable for payment for services on a charge basis	0	0	13.00
14.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)	0	0	14.00
15.00	Ratio of line 13 to line 14 (not to exceed 1.000000)	0.000000	0.000000	15.00
16.00	Total customary charges (see instructions)	0	0	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)	0	0	17.00
18.00	Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 16) (see instructions)	0	0	18.00
19.00	Interns and Residents (see instructions)	0	0	19.00
20.00	Cost of physicians' services in a teaching hospital (see instructions)	0	0	20.00
21.00	Cost of covered services (enter the lesser of line 4 or line 16)	0	0	21.00
PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be completed for PPS providers.				
22.00	Other than outlier payments	0	0	22.00
23.00	Outlier payments	0	0	23.00
24.00	Program capital payments	0	0	24.00
25.00	Capital exception payments (see instructions)	0	0	25.00
26.00	Routine and Ancillary service other pass through costs	0	0	26.00
27.00	Subtotal (sum of lines 22 through 26)	0	0	27.00
28.00	Customary charges (title V or XIX PPS covered services only)	0	0	28.00
29.00	Titles V or XIX (sum of lines 21 and 27)	0	0	29.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT				
30.00	Excess of reasonable cost (from line 18)	0	0	30.00
31.00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)	0	0	31.00
32.00	Deductibles	0	0	32.00
33.00	Coinsurance	0	0	33.00
34.00	Allowable bad debts (see instructions)	0	0	34.00
35.00	Utilization review	0	0	35.00
36.00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)	0	0	36.00
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	37.00
38.00	Subtotal (line 36 ± line 37)	0	0	38.00
39.00	Direct graduate medical education payments (from Wkst. E-4)	0	0	39.00
40.00	Total amount payable to the provider (sum of lines 38 and 39)	0	0	40.00
41.00	Interim payments	0	0	41.00
42.00	Balance due provider/program (line 40 minus line 41)	0	0	42.00
43.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, chapter 1, §115.2	0	0	43.00

DIRECT GRADUATE MEDICAL EDUCATION (GME) & ESRD OUTPATIENT DIRECT MEDICAL EDUCATION COSTS		Provider CCN: 14-0251	Period: From 01/01/2020 To 12/31/2020	Worksheet E-4 Date/Time Prepared: 8/2/2021 11:01 am	
		Title XVIII	Hospital	PPS	
				1.00	
COMPUTATION OF TOTAL DIRECT GME AMOUNT					
1.00	Unweighted resident FTE count for allopathic and osteopathic programs for cost reporting periods ending on or before December 31, 1996.			0.00	1.00
2.00	Unweighted FTE resident cap add-on for new programs per 42 CFR 413.79(e)(1) (see instructions)			1.56	2.00
3.00	Amount of reduction to Direct GME cap under section 422 of MMA			0.00	3.00
3.01	Direct GME cap reduction amount under ACA §5503 in accordance with 42 CFR §413.79 (m). (see instructions for cost reporting periods straddling 7/1/2011)			0.13	3.01
4.00	Adjustment (plus or minus) to the FTE cap for allopathic and osteopathic programs due to a Medicare GME affiliation agreement (42 CFR §413.75(b) and § 413.79 (f))			1.25	4.00
4.01	ACA Section 5503 increase to the Direct GME FTE Cap (see instructions for cost reporting periods straddling 7/1/2011)			0.00	4.01
4.02	ACA Section 5506 number of additional direct GME FTE cap slots (see instructions for cost reporting periods straddling 7/1/2011)			0.00	4.02
5.00	FTE adjusted cap (line 1 plus line 2 minus line 3 and 3.01 plus or minus line 4 plus lines 4.01 and 4.02 plus applicable subscripts)			2.68	5.00
6.00	Unweighted resident FTE count for allopathic and osteopathic programs for the current year from your records (see instructions)			0.93	6.00
7.00	Enter the lesser of line 5 or line 6			0.93	7.00
		Primary Care	Other	Total	
		1.00	2.00	3.00	
8.00	Weighted FTE count for physicians in an allopathic and osteopathic program for the current year.	0.00	0.93	0.93	8.00
9.00	If line 6 is less than 5 enter the amount from line 8, otherwise multiply line 8 times the result of line 5 divided by the amount on line 6.	0.00	0.93	0.93	9.00
10.00	Weighted dental and podiatric resident FTE count for the current year		0.00		10.00
10.01	Unweighted dental and podiatric resident FTE count for the current year		0.00		10.01
11.00	Total weighted FTE count	0.00	0.93		11.00
12.00	Total weighted resident FTE count for the prior cost reporting year (see instructions)	0.00	1.27		12.00
13.00	Total weighted resident FTE count for the penultimate cost reporting year (see instructions)	0.00	2.22		13.00
14.00	Rolling average FTE count (sum of lines 11 through 13 divided by 3).	0.00	1.47		14.00
15.00	Adjustment for residents in initial years of new programs	0.00	0.00		15.00
15.01	Unweighted adjustment for residents in initial years of new programs	0.00	0.00		15.01
16.00	Adjustment for residents displaced by program or hospital closure	0.00	0.00		16.00
16.01	Unweighted adjustment for residents displaced by program or hospital closure	0.00	0.00		16.01
17.00	Adjusted rolling average FTE count	0.00	1.47		17.00
18.00	Per resident amount	104,024.20	101,053.25		18.00
19.00	Approved amount for resident costs	0	148,548	148,548	19.00
				1.00	
20.00	Additional unweighted allopathic and osteopathic direct GME FTE resident cap slots received under 42 Sec. 413.79(c)(4)			0.00	20.00
21.00	Direct GME FTE unweighted resident count over cap (see instructions)			0.00	21.00
22.00	Allowable additional direct GME FTE Resident Count (see instructions)			0.00	22.00
23.00	Enter the locality adjustment national average per resident amount (see instructions)			0.00	23.00
24.00	Multiply line 22 time line 23			0	24.00
25.00	Total direct GME amount (sum of lines 19 and 24)			148,548	25.00
		Inpatient Part	Managed Care	Total	
		A			
		1.00	2.00	3.00	
COMPUTATION OF PROGRAM PATIENT LOAD					
26.00	Inpatient Days (see instructions) (Title XIX - see S-2 Part IX, line 3.02, column 2)	9,829	4,375		26.00
27.00	Total Inpatient Days (see instructions)	26,990	26,990		27.00
28.00	Ratio of inpatient days to total inpatient days	0.364172	0.162097		28.00
29.00	Program direct GME amount	54,097	24,079	78,176	29.00
29.01	Percent reduction for MA DGME		7.00		29.01
30.00	Reduction for direct GME payments for Medicare Advantage		1,686	1,686	30.00
31.00	Net Program direct GME amount			76,490	31.00

DIRECT GRADUATE MEDICAL EDUCATION (GME) & ESRD OUTPATIENT DIRECT MEDICAL EDUCATION COSTS		Provider CCN: 14-0251	Period: From 01/01/2020 To 12/31/2020	Worksheet E-4 Date/Time Prepared: 8/2/2021 11:01 am	
		Title XVIII	Hospital	PPS	
				1.00	
	DIRECT MEDICAL EDUCATION COSTS FOR ESRD COMPOSITE RATE - TITLE XVIII ONLY (NURSING SCHOOL AND PARAMEDICAL EDUCATION COSTS)				
32.00	Renal dialysis direct medical education costs (from Wkst. B, Pt. I, sum of col. 20 and 23, lines 74 and 94)			0	32.00
33.00	Renal dialysis and home dialysis total charges (Wkst. C, Pt. I, col. 8, sum of lines 74 and 94)			1,996,160	33.00
34.00	Ratio of direct medical education costs to total charges (line 32 ÷ line 33)			0.000000	34.00
35.00	Medicare outpatient ESRD charges (see instructions)			0	35.00
36.00	Medicare outpatient ESRD direct medical education costs (line 34 x line 35)			0	36.00
APPORTIONMENT BASED ON MEDICARE REASONABLE COST - TITLE XVIII ONLY					
Part A Reasonable Cost					
37.00	Reasonable cost (see instructions)			31,893,656	37.00
38.00	Organ acquisition costs (Wkst. D-4, Pt. III, col. 1, line 69)			0	38.00
39.00	Cost of physicians' services in a teaching hospital (see instructions)			0	39.00
40.00	Primary payer payments (see instructions)			412	40.00
41.00	Total Part A reasonable cost (sum of lines 37 through 39 minus line 40)			31,893,244	41.00
Part B Reasonable Cost					
42.00	Reasonable cost (see instructions)			4,156,584	42.00
43.00	Primary payer payments (see instructions)			0	43.00
44.00	Total Part B reasonable cost (line 42 minus line 43)			4,156,584	44.00
45.00	Total reasonable cost (sum of lines 41 and 44)			36,049,828	45.00
46.00	Ratio of Part A reasonable cost to total reasonable cost (line 41 ÷ line 45)			0.884699	46.00
47.00	Ratio of Part B reasonable cost to total reasonable cost (line 44 ÷ line 45)			0.115301	47.00
ALLOCATION OF MEDICARE DIRECT GME COSTS BETWEEN PART A AND PART B					
48.00	Total program GME payment (line 31)			76,490	48.00
49.00	Part A Medicare GME payment (line 46 x 48) (title XVIII only) (see instructions)			67,671	49.00
50.00	Part B Medicare GME payment (line 47 x 48) (title XVIII only) (see instructions)			8,819	50.00

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

Provider CCN: 14-0251

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

Worksheet G

Date/Time Prepared:
8/2/2021 11:01 am

	General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
	1.00	2.00	3.00	4.00	
CURRENT ASSETS					
1.00 Cash on hand in banks	15,228,810	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	162,037,543	0	0	0	4.00
5.00 Other receivable	3,435,270	0	0	0	5.00
6.00 Allowances for uncollectible notes and accounts receivable	-94,810,408	0	0	0	6.00
7.00 Inventory	10,432,313	0	0	0	7.00
8.00 Prepaid expenses	562,776	0	0	0	8.00
9.00 Other current assets	1,133,151	0	0	0	9.00
10.00 Due from other funds	0	0	0	0	10.00
11.00 Total current assets (sum of lines 1-10)	98,019,455	0	0	0	11.00
FIXED ASSETS					
12.00 Land	2,492,384	0	0	0	12.00
13.00 Land improvements	0	0	0	0	13.00
14.00 Accumulated depreciation	0	0	0	0	14.00
15.00 Buildings	16,304,602	0	0	0	15.00
16.00 Accumulated depreciation	-2,358,577	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	26,817,883	0	0	0	23.00
24.00 Accumulated depreciation	-4,340,229	0	0	0	24.00
25.00 Minor equipment depreciable	0	0	0	0	25.00
26.00 Accumulated depreciation	0	0	0	0	26.00
27.00 HIT designated Assets	0	0	0	0	27.00
28.00 Accumulated depreciation	0	0	0	0	28.00
29.00 Minor equipment-nondepreciable	0	0	0	0	29.00
30.00 Total fixed assets (sum of lines 12-29)	38,916,063	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	0	0	0	0	34.00
35.00 Total other assets (sum of lines 31-34)	0	0	0	0	35.00
36.00 Total assets (sum of lines 11, 30, and 35)	136,935,518	0	0	0	36.00
CURRENT LIABILITIES					
37.00 Accounts payable	54,480,399	0	0	0	37.00
38.00 Salaries, wages, and fees payable	5,456,623	0	0	0	38.00
39.00 Payroll taxes payable	0	0	0	0	39.00
40.00 Notes and loans payable (short term)	302,406	0	0	0	40.00
41.00 Deferred income	0	0	0	0	41.00
42.00 Accelerated payments	0	0	0	0	42.00
43.00 Due to other funds	0	0	0	0	43.00
44.00 Other current liabilities	26,216,795	0	0	0	44.00
45.00 Total current liabilities (sum of lines 37 thru 44)	86,456,223	0	0	0	45.00
LONG TERM LIABILITIES					
46.00 Mortgage payable	0	0	0	0	46.00
47.00 Notes payable	29,053,904	0	0	0	47.00
48.00 Unsecured loans	0	0	0	0	48.00
49.00 Other long term liabilities	8,944,853	0	0	0	49.00
50.00 Total long term liabilities (sum of lines 46 thru 49)	37,998,757	0	0	0	50.00
51.00 Total liabilities (sum of lines 45 and 50)	124,454,980	0	0	0	51.00
CAPITAL ACCOUNTS					
52.00 General fund balance	12,480,538				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)	12,480,538	0	0	0	59.00
60.00 Total liabilities and fund balances (sum of lines 51 and 59)	136,935,518	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 14-0251

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

Worksheet G-1

Date/Time Prepared:
8/2/2021 11:01 am

		General Fund		Special Purpose Fund		Endowment Fund	
		1.00	2.00	3.00	4.00	5.00	
1.00	Fund balances at beginning of period		15,087,127		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		-2,606,589				2.00
3.00	Total (sum of line 1 and line 2)		12,480,538		0		3.00
4.00	Additions (credit adjustments) (specify)	0		0		0	4.00
5.00		0		0		0	5.00
6.00		0		0		0	6.00
7.00		0		0		0	7.00
8.00		0		0		0	8.00
9.00		0		0		0	9.00
10.00	Total additions (sum of line 4-9)		0		0		10.00
11.00	Subtotal (line 3 plus line 10)		12,480,538		0		11.00
12.00	Deductions (debit adjustments) (specify)	0		0		0	12.00
13.00		0		0		0	13.00
14.00		0		0		0	14.00
15.00		0		0		0	15.00
16.00		0		0		0	16.00
17.00		0		0		0	17.00
18.00	Total deductions (sum of lines 12-17)		0		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		12,480,538		0		19.00
		Endowment Fund		Plant Fund			
		6.00	7.00	8.00			
1.00	Fund balances at beginning of period	0		0			1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)						2.00
3.00	Total (sum of line 1 and line 2)	0		0			3.00
4.00	Additions (credit adjustments) (specify)		0				4.00
5.00			0				5.00
6.00			0				6.00
7.00			0				7.00
8.00			0				8.00
9.00			0				9.00
10.00	Total additions (sum of line 4-9)	0		0			10.00
11.00	Subtotal (line 3 plus line 10)	0		0			11.00
12.00	Deductions (debit adjustments) (specify)		0				12.00
13.00			0				13.00
14.00			0				14.00
15.00			0				15.00
16.00			0				16.00
17.00			0				17.00
18.00	Total deductions (sum of lines 12-17)	0		0			18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)	0		0			19.00

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES

Provider CCN: 14-0251

Period:
From 01/01/2020
To 12/31/2020Worksheet G-2
Parts I & II
Date/Time Prepared:
8/2/2021 11:01 am

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
PART I - PATIENT REVENUES					
General Inpatient Routine Services					
1.00	Hospital	63,477,987		63,477,987	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	0		0	5.00
6.00	Swing bed - NF	0		0	6.00
7.00	SKILLED NURSING FACILITY	13,804,035		13,804,035	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)	77,282,022		77,282,022	10.00
Intensive Care Type Inpatient Hospital Services					
11.00	INTENSIVE CARE UNIT				11.00
12.00	CORONARY CARE UNIT				12.00
13.00	BURN INTENSIVE CARE UNIT				13.00
14.00	SURGICAL INTENSIVE CARE UNIT	21,627,702		21,627,702	14.00
15.00	OTHER SPECIAL CARE (SPECIFY)				15.00
16.00	Total intensive care type inpatient hospital services (sum of lines 11-15)	21,627,702		21,627,702	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	98,909,724		98,909,724	17.00
18.00	Ancillary services	210,381,984		210,381,984	18.00
19.00	Outpatient services	0	135,390,673	135,390,673	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	OTHER (SPECIFY)	0	0	0	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	309,291,708	135,390,673	444,682,381	28.00
PART II - OPERATING EXPENSES					
29.00	Operating expenses (per Wkst. A, column 3, line 200)		105,996,976		29.00
30.00	ADD (SPECIFY)	0			30.00
31.00		0			31.00
32.00		0			32.00
33.00		0			33.00
34.00		0			34.00
35.00		0			35.00
36.00	Total additions (sum of lines 30-35)		0		36.00
37.00	DEDUCT (SPECIFY)	0			37.00
38.00		0			38.00
39.00		0			39.00
40.00		0			40.00
41.00		0			41.00
42.00	Total deductions (sum of lines 37-41)		0		42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer to Wkst. G-3, line 4)		105,996,976		43.00

STATEMENT OF REVENUES AND EXPENSES

Provider CCN: 14-0251

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

Worksheet G-3

Date/Time Prepared:
8/2/2021 11:01 am

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	444,682,381	1.00
2.00	Less contractual allowances and discounts on patients' accounts	370,157,615	2.00
3.00	Net patient revenues (line 1 minus line 2)	74,524,766	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	105,996,976	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-31,472,210	5.00
OTHER INCOME			
6.00	Contributions, donations, bequests, etc	0	6.00
7.00	Income from investments	0	7.00
8.00	Revenues from telephone and other miscellaneous communication services	0	8.00
9.00	Revenue from television and radio service	0	9.00
10.00	Purchase discounts	0	10.00
11.00	Rebates and refunds of expenses	0	11.00
12.00	Parking lot receipts	0	12.00
13.00	Revenue from laundry and linen service	0	13.00
14.00	Revenue from meals sold to employees and guests	141,086	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	1,587	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	0	22.00
23.00	Governmental appropriations	0	23.00
24.00	OTHER (SPECIFY)	0	24.00
24.01	GAIN/LOSS ON SALE FIXED ASSETS	2,647,282	24.01
24.02	ADDISON CENTRAL PHARMACY	424,382	24.02
24.03	OTHER INCOME	214,989	24.03
24.04	OTHER (SPECIFY)	0	24.04
24.05	OTHER (SPECIFY)	0	24.05
24.50	COVID-19 PHE Funding	25,436,295	24.50
25.00	Total other income (sum of lines 6-24)	28,865,621	25.00
26.00	Total (line 5 plus line 25)	-2,606,589	26.00
27.00	OTHER EXPENSES (SPECIFY)	0	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	0	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	-2,606,589	29.00

CALCULATION OF CAPITAL PAYMENT		Provider CCN: 14-0251	Period: From 01/01/2020 To 12/31/2020	Worksheet L Parts I-III Date/Time Prepared: 8/2/2021 11:01 am
		Title XVIII	Hospital	PPS
		1.00		
PART I - FULLY PROSPECTIVE METHOD				
CAPITAL FEDERAL AMOUNT				
1.00	Capital DRG other than outlier		1,253,289	1.00
1.01	Model 4 BPCI Capital DRG other than outlier		0	1.01
2.00	Capital DRG outlier payments		7,183	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)		73.74	3.00
4.00	Number of interns & residents (see instructions)		1.72	4.00
5.00	Indirect medical education percentage (see instructions)		0.66	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)		8,272	6.00
7.00	Percentage of SSI recipient patient days to Medicare Part A patient days (Worksheet E, part A line 30) (see instructions)		7.83	7.00
8.00	Percentage of Medicaid patient days to total days (see instructions)		26.02	8.00
9.00	Sum of lines 7 and 8		33.85	9.00
10.00	Allowable disproportionate share percentage (see instructions)		7.09	10.00
11.00	Disproportionate share adjustment (see instructions)		88,858	11.00
12.00	Total prospective capital payments (see instructions)		1,357,602	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