

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: 14-0289	Period: From 01/01/2020 To 12/31/2020	Worksheet S Parts I-III Date/Time Prepared: 7/28/2021 3:46 pm
--	-----------------------	---	--

PART I - COST REPORT STATUS

Provider use only	1. ☒ Electronically prepared cost report	Date: 7/28/2021	Time: 3:46 pm
	2. ☐ Manually prepared cost report		
	3. ☐ If this is an amended report enter the number of times the provider resubmitted this cost report		
	4. ☒ Medicare Utilization. Enter "F" for full or "L" for low.		
Contractor use only	5. ☒ Cost Report Status (1) As Submitted (2) Settled without Audit (3) Settled with Audit (4) Reopened (5) Amended	6. Date Received: 7. Contractor No. 8. ☒ Initial Report for this Provider CCN 9. ☒ Final Report for this Provider CCN	10. NPR Date: 11. Contractor's Vendor Code: 4 12. ☐ If line 5, column 1 is 4: Enter number of times reopened = 0-9.

PART II - CERTIFICATION

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

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

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by ANDERSON HOSPITAL (14-0289) 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	357,552	-4,917	0	0	1.00
2.00	Subprovider - IPF	0	0	0		0	2.00
3.00	Subprovider - IRF	0	7,579	0		0	3.00
5.00	Swing Bed - SNF	0	0	0		0	5.00
6.00	Swing Bed - NF	0				0	6.00
9.00	HOME HEALTH AGENCY I	0	0	0		0	9.00
200.00	Total	0	365,131	-4,917	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: 14-0289		Period: From 01/01/2020 To 12/31/2020		Worksheet S-2 Part I Date/Time Prepared: 7/28/2021 3:46 pm		
1.00		2.00		3.00		4.00				
Hospital and Hospital Health Care Complex Address:										
1.00	Street: 6800 STATE ROUTE 162			PO Box:				1.00		
2.00	City: MARYVILLE			State: IL		Zip Code: 62062-1000		County: MADISON 2.00		
		Component Name	CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N)			
							V	XVIII	XIX	
		1.00	2.00	3.00	4.00	5.00	6.00	7.00	8.00	
Hospital and Hospital-Based Component Identification:										
3.00	Hospital		ANDERSON HOSPITAL	140289	41180	1	11/22/1976	N	P	N
4.00	Subprovider - IPF									
5.00	Subprovider - IRF		THE REHABILITATION CENTER	14T289	41180	5	01/01/2005	N	P	N
6.00	Subprovider - (Other)									
7.00	Swing Beds - SNF									
8.00	Swing Beds - NF									
9.00	Hospital-Based SNF									
10.00	Hospital-Based NF									
11.00	Hospital-Based OLTC									
12.00	Hospital-Based HHA		ANDERSON HOME HEALTH	147420	41180		05/30/1985	N	P	N
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)					2			21.00	
						1.00	2.00	3.00		
Inpatient PPS Information										
22.00	Does this facility qualify and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.106(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no.				Y	N			22.00	
22.01	Did this hospital receive interim uncompensated care payments for this cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)				Y	Y			22.01	
22.02	Is this a newly merged hospital that requires final uncompensated care payments to be determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1.				N	N			22.02	
22.03	Did this hospital receive a geographic reclassification from urban to rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no.				N	N	N		22.03	
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.				1	N			23.00	
			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.		811	945	0	0	2,903	246	24.00	

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

Provider CCN: 14-0289

Period:
From 01/01/2020
To 12/31/2020Worksheet S-2
Part I
Date/Time Prepared:
7/28/2021 3:46 pm

		In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of State Medicaid paid days	Out-of State Medicaid eligible unpaid	Medicaid HMO days	Other Medicaid days	
		1.00	2.00	3.00	4.00	5.00	6.00	
25.00	If this provider is an IRF, enter the in-state Medicaid paid days in column 1, the in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5.	12	53	0	0	319		25.00
						Urban/Rural S	Date of Geogr	
						1.00	2.00	
26.00	Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter "1" for urban or "2" for rural.					1		26.00
27.00	Enter your standard geographic classification (not wage) status at the end of the cost reporting period. Enter in column 1, "1" for urban or "2" for rural. If applicable, enter the effective date of the geographic reclassification in column 2.					1		27.00
35.00	If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period.					0		35.00
						Beginning:	Ending:	
						1.00	2.00	
36.00	Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.							36.00
37.00	If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status is in effect in the cost reporting period.					0		37.00
37.01	Is this hospital a former MDH that is eligible for the MDH transitional payment in accordance with FY 2016 OPPS final rule? Enter "Y" for yes or "N" for no. (see instructions)							37.01
38.00	If line 37 is 1, enter the beginning and ending dates of MDH status. If line 37 is greater than 1, subscript this line for the number of periods in excess of one and enter subsequent dates.							38.00
						Y/N	Y/N	
						1.00	2.00	
39.00	Does this facility qualify for the inpatient hospital payment adjustment for low volume hospitals in accordance with 42 CFR §412.101(b)(2)(i), (ii), or (iii)? Enter in column 1 "Y" for yes or "N" for no. Does the facility meet the mileage requirements in accordance with 42 CFR §412.101(b)(2)(i), (ii), or (iii)? Enter in column 2 "Y" for yes or "N" for no. (see instructions)					N	N	39.00
40.00	Is this hospital subject to the HAC program reduction adjustment? Enter "Y" for yes or "N" for no in column 1, for discharges prior to October 1. Enter "Y" for yes or "N" for no in column 2, for discharges on or after October 1. (see instructions)					N	N	40.00
						V	XVIII	XIX
						1.00	2.00	3.00
Prospective Payment System (PPS)-Capital								
45.00	Does this facility qualify and receive Capital payment for disproportionate share in accordance with 42 CFR Section §412.320? (see instructions)					N	Y	N
46.00	Is this facility eligible for additional payment exception for extraordinary circumstances pursuant to 42 CFR §412.348(f)? If yes, complete Wkst. L, Pt. III and Wkst. L-1, Pt. I through Pt. III.					N	N	N
47.00	Is this a new hospital under 42 CFR §412.300(b) PPS capital? Enter "Y" for yes or "N" for no.					N	N	N
48.00	Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.					N	N	N
Teaching Hospitals								
56.00	Is this a hospital involved in training residents in approved GME programs? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", are you impacted by CR 11642 (or subsequent CR), MA GME payment reduction? Enter "Y" for yes or "N" for no in column 2.					N		
57.00	If line 56 is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y" did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If column 2 is "N", complete Wkst. D, Parts III & IV and D-2, Pt. II, if applicable.					N		
58.00	If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, chapter 21, §2148? If yes, complete Wkst. D-5.					N		
59.00	Are costs claimed on line 100 of Worksheet A? If yes, complete Wkst. D-2, Pt. I.					N		
				NAHE 413.85 Y/N	Worksheet A Line #	Pass-Through Qualification Criterion Code		
				1.00	2.00	3.00		
60.00	Are you claiming nursing and allied health education (NAHE) costs for any programs that meet the criteria under 42 CFR 413.85? (see instructions) Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", are you impacted by CR 11642 (or subsequent CR) NAHE MA payment adjustment? Enter "Y" for yes or "N" for no in column 2.			Y	Y			60.00
60.01	If line 60 is yes, complete columns 2 and 3 for each program. (see instructions)					23.00	1	60.01

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

Provider CCN: 14-0289

Period:
From 01/01/2020
To 12/31/2020Worksheet S-2
Part I
Date/Time Prepared:
7/28/2021 3:46 pm

	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: 14-0289

Period:
From 01/01/2020
To 12/31/2020Worksheet S-2
Part I
Date/Time Prepared:
7/28/2021 3:46 pm

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-0289	Period: From 01/01/2020 To 12/31/2020	Worksheet S-2 Part I Date/Time Prepared: 7/28/2021 3:46 pm	
			1.00		
Long Term Care Hospital PPS					
80.00	Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for no.	N		80.00	
81.00	Is this a LTCH co-located within another hospital for part or all of the cost reporting period? Enter "Y" for yes and "N" for no.	N		81.00	
TEFRA Providers					
85.00	Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no.	N		85.00	
86.00	Did this facility establish a new Other subprovider (excluded unit) under 42 CFR Section §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.			86.00	
87.00	Is this hospital an extended neoplastic disease care hospital classified under section 1886(d)(1)(B)(vi)? Enter "Y" for yes or "N" for no.	N		87.00	
		V	XIX		
		1.00	2.00		
Title V and XIX Services					
90.00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.	N	Y	90.00	
91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.	N	N	91.00	
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.		N	92.00	
93.00	Does this facility operate an ICF/IID facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.	N	N	93.00	
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.	N	N	94.00	
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	95.00	
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.	N	N	96.00	
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	97.00	
98.00	Does title V or XIX follow Medicare (title XVIII) for the interns and residents post stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.00	
98.01	Does title V or XIX follow Medicare (title XVIII) for the reporting of charges on Wkst. C, Pt. I? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	Y	98.01	
98.02	Does title V or XIX follow Medicare (title XVIII) for the calculation of observation bed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	Y	98.02	
98.03	Does title V or XIX follow Medicare (title XVIII) for a critical access hospital (CAH) reimbursed 101% of inpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.03	
98.04	Does title V or XIX follow Medicare (title XVIII) for a CAH reimbursed 101% of outpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.04	
98.05	Does title V or XIX follow Medicare (title XVIII) and add back the RCE disallowance on Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N	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	N	98.06	
Rural Providers					
105.00	Does this hospital qualify as a CAH?	N		105.00	
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)			106.00	
107.00	Column 1: If line 105 is Y, is this facility eligible for cost reimbursement for I&R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) Column 2: If column 1 is Y and line 70 or line 75 is Y, do you train I&Rs in an approved medical education program in the CAH's excluded IPF and/or IRF unit(s)? Enter "Y" for yes or "N" for no in column 2. (see instructions)			107.00	
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	N		108.00	
		Physical	Occupational	Speech	Respiratory
		1.00	2.00	3.00	4.00
109.00	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.	N	N	N	N
				1.00	
110.00	Did this hospital participate in the Rural Community Hospital Demonstration project (§410A Demonstration) for the current cost reporting period? Enter "Y" for yes or "N" for no. If yes, complete Worksheet E, Part A, lines 200 through 218, and Worksheet E-2, lines 200 through 215, as applicable.			N	110.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-0289	Period: From 01/01/2020 To 12/31/2020	Worksheet S-2 Part I Date/Time Prepared: 7/28/2021 3:46 pm
		1.00	2.00	
111.00	If this facility qualifies as a CAH, did it participate in the Frontier Community Health Integration Project (FCHIP) demonstration for this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If the response to column 1 is Y, enter the integration prong of the FCHIP demo in which this CAH is participating in column 2. Enter all that apply: "A" for Ambulance services; "B" for additional beds; and/or "C" for tele-health services.	N		111.00
		1.00	2.00	3.00
112.00	Did this hospital participate in the Pennsylvania Rural Health Model demonstration for any portion of the current cost reporting period? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2, the date the hospital began participating in the demonstration. In column 3, enter the date the hospital ceased participation in the demonstration, if applicable.	N		112.00
Miscellaneous Cost Reporting Information				
115.00	Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in column 1. If column 1 is yes, enter the method used (A, B, or E only) in column 2. If column 2 is "E", enter in column 3 either "93" percent for short term hospital or "98" percent for long term care (includes psychiatric, rehabilitation and long term hospitals providers) based on the definition in CMS Pub.15-1, chapter 22, §2208.1.	N		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.	1		118.00
		Premiums	Losses	Insurance
		1.00	2.00	3.00
118.01	List amounts of malpractice premiums and paid losses:	826,877	0	1,600,000 118.01
		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.	N		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)	Y		140.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA				Provider CCN: 14-0289		Period: From 01/01/2020 To 12/31/2020		Worksheet S-2 Part I Date/Time Prepared: 7/28/2021 3:46 pm	
1.00		2.00		3.00					
If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number.									
141.00	Name:	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	N	155.00		
156.00	Subprovider - IPF	N	N	N	N	N	156.00		
157.00	Subprovider - IRF	N	N	N	N	N	157.00		
158.00	SUBPROVIDER						158.00		
159.00	SNF	N	N	N	N	N	159.00		
160.00	HOME HEALTH AGENCY	N	N	N	N	N	160.00		
161.00	CMHC		N	N	N	N	161.00		
								1.00	
Multicampus									
165.00	Is this hospital part of a Multicampus hospital that has one or more campuses in different CBSAs? Enter "Y" for yes or "N" for no.							N	165.00
		Name	County	State	Zip Code	CBSA	FTE/Campus		
		0	1.00	2.00	3.00	4.00	5.00		
166.00	If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions)						0.00		
								1.00	
Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act									
167.00	Is this provider a meaningful user under §1886(n)? Enter "Y" for yes or "N" for no.							Y	167.00
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)								168.00
168.01	If this provider is a CAH and is not a meaningful user, does this provider qualify for a hardship exception under §413.70(a)(6)(ii)? Enter "Y" for yes or "N" for no. (see instructions)								168.01
169.00	If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)							0.00	169.00
						Beginning	Ending		
						1.00	2.00		
170.00	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)								170.00
						1.00	2.00		
171.00	If line 167 is "Y", does this provider have any days for individuals enrolled in section 1876 Medicare cost plans reported on Wkst. S-3, Pt. I, line 2, col. 6? Enter "Y" for yes and "N" for no in column 1. If column 1 is yes, enter the number of section 1876 Medicare days in column 2. (see instructions)							N	0

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 14-0289	Period: From 01/01/2020 To 12/31/2020	Worksheet S-2 Part II Date/Time Prepared: 7/28/2021 3:46 pm
			Y/N 1.00	Date 2.00
General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format.				
COMPLETED BY ALL HOSPITALS				
Provider Organization and Operation				
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)	N		1.00
		Y/N 1.00	Date 2.00	V/I 3.00
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.	N		2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)	N		3.00
		Y/N 1.00	Type 2.00	Date 3.00
Financial Data and Reports				
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	Y	A	4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.	N		5.00
			Y/N 1.00	Legal Oper. 2.00
Approved Educational Activities				
6.00	Column 1: Are costs claimed for nursing school? Column 2: If yes, is the provider is the legal operator of the program?	N		6.00
7.00	Are costs claimed for Allied Health Programs? If "Y" see instructions.	Y		7.00
8.00	Were nursing school and/or allied health programs approved and/or renewed during the cost reporting period? If yes, see instructions.	N		8.00
9.00	Are costs claimed for Interns and Residents in an approved graduate medical education program in the current cost report? If yes, see instructions.	N		9.00
10.00	Was an approved Intern and Resident GME program initiated or renewed in the current cost reporting period? If yes, see instructions.	N		10.00
11.00	Are GME cost directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions.	N		11.00
			Y/N 1.00	
Bad Debts				
12.00	Is the provider seeking reimbursement for bad debts? If yes, see instructions.	Y		12.00
13.00	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.	N		13.00
14.00	If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.	N		14.00
Bed Complement				
15.00	Did total beds available change from the prior cost reporting period? If yes, see instructions.	N		15.00
		Part A		Part B
		Y/N 1.00	Date 2.00	Y/N 3.00 Date 4.00
PS&R Data				
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)	Y	05/23/2021	Y 05/23/2021
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)	N		N
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: 14-0289

Period:
From 01/01/2020
To 12/31/2020Worksheet S-2
Part II
Date/Time Prepared:
7/28/2021 3:46 pm

		Description	Y/N	Y/N	
		0	1.00	3.00	
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:		N	N	20.00
		Y/N	Date	Y/N	Date
		1.00	2.00	3.00	4.00
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		N	21.00
				1.00	
COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)					
Capital Related Cost					
22.00	Have assets been relifed for Medicare purposes? If yes, see instructions		N		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.		N		23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions		N		24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.		N		25.00
26.00	Were assets subject to Sec.2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.		N		26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.		N		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.		N		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		N		29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.		N		30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.		N		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.		N		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.		N		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.		N		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.		N		35.00
		Y/N	Date		
		1.00	2.00		
Home Office Costs					
36.00	Were home office costs claimed on the cost report?		N		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.		N		37.00
38.00	If line 36 is yes, was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.		N		38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.		N		39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.		N		40.00
		1.00	2.00		
Cost Report Preparer Contact Information					
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	PATRICIA		RACHELL	41.00
42.00	Enter the employer/company name of the cost report preparer.	BKD, LLP			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	(314) 231-5544		PRACHELL@BKD.COM	43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE

Provider CCN: 14-0289

Period:
From 01/01/2020
To 12/31/2020Worksheet S-2
Part II
Date/Time Prepared:
7/28/2021 3:46 pm

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 14-0289

Period:
From 01/01/2020
To 12/31/2020Worksheet S-3
Part I
Date/Time Prepared:
7/28/2021 3:46 pm

Component	Worksheet A Line Number	No. of Beds	Bed Days Available	CAH Hours	I/P Days / O/P Visits / Trips	
					Title V	
	1.00	2.00	3.00	4.00	5.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30.00	106	38,796	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)		106	38,796	0.00	0	7.00
8.00 INTENSIVE CARE UNIT	31.00	24	8,784	0.00	0	8.00
9.00 CORONARY CARE UNIT						9.00
10.00 BURN INTENSIVE CARE UNIT						10.00
11.00 SURGICAL INTENSIVE CARE UNIT						11.00
12.00 OTHER SPECIAL CARE (SPECIFY)						12.00
13.00 NURSERY	43.00				0	13.00
14.00 Total (see instructions)		130	47,580	0.00	0	14.00
15.00 CAH visits					0	15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF	41.00	24	8,784		0	17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY	101.00				0	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)		154				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: 14-0289

Period:
From 01/01/2020
To 12/31/2020Worksheet S-3
Part I
Date/Time Prepared:
7/28/2021 3:46 pm

Component		I/P Days / O/P Visits / Trips			Full Time Equivalents		
		Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
		6.00	7.00	8.00	9.00	10.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	6,965	618	18,812			1.00
2.00	HMO and other (see instructions)	4,785	3,849				2.00
3.00	HMO IPF Subprovider	0	0				3.00
4.00	HMO IRF Subprovider	732	372				4.00
5.00	Hospital Adults & Peds. Swing Bed SNF	0	0	0			5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	0			6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	6,965	618	18,812			7.00
8.00	INTENSIVE CARE UNIT	1,219	98	2,843			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		94	2,736			13.00
14.00	Total (see instructions)	8,184	810	24,391	0.00	910.65	14.00
15.00	CAH visits	0	0	0			15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF	2,390	12	4,261	0.00	17.20	17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY	3,524	0	9,223	0.00	19.20	22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)			0			24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0.00	0.00	26.25
27.00	Total (sum of lines 14-26)				0.00	947.05	27.00
28.00	Observation Bed Days		68	3,620			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	246	474			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: 14-0289

Period:
From 01/01/2020
To 12/31/2020Worksheet S-3
Part I
Date/Time Prepared:
7/28/2021 3:46 pm

Component	Full Time Equivalents	Discharges			Total All Patients	
	Nonpaid Workers	Title V	Title XVIII	Title XIX		
	11.00	12.00	13.00	14.00	15.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)		0	1,801	198	6,194	1.00
2.00 HMO and other (see instructions)			1,050	0		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	1,801	198	6,194	14.00
15.00 CAH visits						15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF	0.00	0	197	1	360	17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY	0.00					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: 14-0289

Period:
From 01/01/2020
To 12/31/2020Worksheet S-3
Part II
Date/Time Prepared:
7/28/2021 3:46 pm

	Wkst. A Line Number	Amount Reported	Reclassificati on of Salaries (from Wkst. A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
	1.00	2.00	3.00	4.00	5.00	6.00	
PART II - WAGE DATA							
SALARIES							
1.00	Total salaries (see instructions)	200.00	56,722,626	16,337	56,738,963	1,969,955.47	28.80
2.00	Non-physician anesthetist Part A		0	0	0	0.00	0.00
3.00	Non-physician anesthetist Part B		0	0	0	0.00	0.00
4.00	Physician-Part A - Administrative		0	0	0	0.00	0.00
4.01	Physicians - Part A - Teaching		0	0	0	0.00	0.00
5.00	Physician and Non Physician-Part B		0	0	0	0.00	0.00
6.00	Non-physician-Part B for hospital-based RHC and FQHC services		0	0	0	0.00	0.00
7.00	Interns & residents (in an approved program)	21.00	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		4,426,218	0	4,426,218	171,200.99	25.85
9.00	SNF	44.00	0	0	0	0.00	0.00
10.00	Excluded area salaries (see instructions)		2,583,861	187	2,584,048	81,309.09	31.78
OTHER WAGES & RELATED COSTS							
11.00	Contract labor: Direct Patient Care		683,295	0	683,295	8,589.32	79.55
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		413,534	0	413,534	2,071.00	199.68
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		5,508,782	0	5,508,782	180,321.00	30.55
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)		9,670,671	0	9,670,671		
18.00	Wage-related costs (other) (see instructions)						
19.00	Excluded areas		438,735	0	438,735		
20.00	Non-physician anesthetist Part A		0	0	0		
21.00	Non-physician anesthetist Part B		0	0	0		
22.00	Physician Part A - Administrative		0	0	0		
22.01	Physician Part A - Teaching		0	0	0		
23.00	Physician Part B		0	0	0		
24.00	Wage-related costs (RHC/FQHC)		0	0	0		
25.00	Interns & residents (in an approved program)		0	0	0		
25.50	Home office wage-related (core)		1,137,570	0	1,137,570		
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: 14-0289

Period:
From 01/01/2020
To 12/31/2020Worksheet S-3
Part II
Date/Time Prepared:
7/28/2021 3:46 pm

		Wkst. A Line Number	Amount Reported	Reclassificati on of Salaries (from Wkst. A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
25.53	Home office: Physicians Part A - Teaching - wage-related (core)		0	0	0			25.53
OVERHEAD COSTS - DIRECT SALARIES								
26.00	Employee Benefits Department	4.00	358,225	0	358,225	12,960.55	27.64	26.00
27.00	Administrative & General	5.00	8,972,277	-294,215	8,678,062	318,781.58	27.22	27.00
28.00	Administrative & General under contract (see inst.)		2,480,310	0	2,480,310	36,484.57	67.98	28.00
29.00	Maintenance & Repairs	6.00	1,014,571	0	1,014,571	33,944.18	29.89	29.00
30.00	Operation of Plant	7.00	-16,337	16,337	0	0.00	0.00	30.00
31.00	Laundry & Linen Service	8.00	62,108	0	62,108	4,242.55	14.64	31.00
32.00	Housekeeping	9.00	1,428,943	0	1,428,943	85,943.28	16.63	32.00
33.00	Housekeeping under contract (see instructions)		0	0	0	0.00	0.00	33.00
34.00	Dietary	10.00	854,424	-565,328	289,096	20,331.40	14.22	34.00
35.00	Dietary under contract (see instructions)		0	0	0	0.00	0.00	35.00
36.00	Cafeteria	11.00	0	565,328	565,328	39,757.00	14.22	36.00
37.00	Maintenance of Personnel	12.00	0	0	0	0.00	0.00	37.00
38.00	Nursing Administration	13.00	583,572	0	583,572	12,309.84	47.41	38.00
39.00	Central Services and Supply	14.00	806,916	0	806,916	46,515.19	17.35	39.00
40.00	Pharmacy	15.00	1,865,728	-1,865,728	0	0.00	0.00	40.00
41.00	Medical Records & Medical Records Library	16.00	1,099,112	0	1,099,112	51,927.73	21.17	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: 14-0289

Period:
From 01/01/2020
To 12/31/2020Worksheet S-3
Part III
Date/Time Prepared:
7/28/2021 3:46 pm

	Worksheet A Line Number	Amount Reported	Reclassificati on of Salaries (from Worksheet A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
	1.00	2.00	3.00	4.00	5.00	6.00	
PART III - HOSPITAL WAGE INDEX SUMMARY							
1.00	Net salaries (see instructions)	54,776,718	16,337	54,793,055	1,835,239.05	29.86	1.00
2.00	Excluded area salaries (see instructions)	2,583,861	187	2,584,048	81,309.09	31.78	2.00
3.00	Subtotal salaries (line 1 minus line 2)	52,192,857	16,150	52,209,007	1,753,929.96	29.77	3.00
4.00	Subtotal other wages & related costs (see inst.)	6,605,611	0	6,605,611	190,981.32	34.59	4.00
5.00	Subtotal wage-related costs (see inst.)	10,808,241	0	10,808,241	0.00	20.70	5.00
6.00	Total (sum of lines 3 thru 5)	69,606,709	16,150	69,622,859	1,944,911.28	35.80	6.00
7.00	Total overhead cost (see instructions)	19,509,849	-2,143,606	17,366,243	663,197.87	26.19	7.00

HOSPITAL WAGE RELATED COSTS

Provider CCN: 14-0289

Period:
From 01/01/2020
To 12/31/2020Worksheet S-3
Part IV
Date/Time Prepared:
7/28/2021 3:46 pm

		Amount Reported	
		1.00	
PART IV - WAGE RELATED COSTS			
Part A - Core List			
RETIREMENT COST			
1.00	401K Employer Contributions	1,453,012	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	2,496	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)	5,417,837	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	186,856	10.00
11.00	Life Insurance (If employee is owner or beneficiary)	49,134	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)	73,605	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)	6,712	14.00
15.00	'Workers' Compensation Insurance	361,880	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	4,402,495	17.00
18.00	Medicare Taxes - Employers Portion Only	0	18.00
19.00	Unemployment Insurance	69,855	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))	74,837	21.00
22.00	Day Care Cost and Allowances	0	22.00
23.00	Tuition Reimbursement	172,279	23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)	12,270,998	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: 14-0289

Period:
From 01/01/2020
To 12/31/2020Worksheet S-3
Part V
Date/Time Prepared:
7/28/2021 3:46 pm

Cost Center Description		Contract Labor	Benefit Cost	
		1.00	2.00	
PART V - Contract Labor and Benefit Cost				
Hospital and Hospital-Based Component Identification:				
1.00	Total facility's contract labor and benefit cost	683,295	12,270,998	1.00
2.00	Hospital	683,295	12,270,998	2.00
3.00	Subprovider - IPF			3.00
4.00	Subprovider - IRF	0	0	4.00
5.00	Subprovider - (Other)	0	0	5.00
6.00	Swing Beds - SNF	0	0	6.00
7.00	Swing Beds - NF	0	0	7.00
8.00	Hospital-Based SNF			8.00
9.00	Hospital-Based NF			9.00
10.00	Hospital-Based OLTC			10.00
11.00	Hospital-Based HHA	0	0	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

Health Financial Systems		ANDERSON HOSPITAL		In Lieu of Form CMS-2552-10		
HOME HEALTH AGENCY STATISTICAL DATA		Provider CCN: 14-0289 Component CCN: 14-7420		Period: From 01/01/2020 To 12/31/2020 Worksheet S-4 Date/Time Prepared: 7/28/2021 3:46 pm		
				Home Health Agency I PPS		
				1.00		
0.00 County				0.00		
		Title V	Title XVIII	Title XIX	Other	Total
		1.00	2.00	3.00	4.00	5.00
HOME HEALTH AGENCY STATISTICAL DATA						
1.00	Home Health Aide Hours	0	590	16	868	1,474
2.00	Unduplicated Census Count (see instructions)	0.00	254.00	8.00	426.00	0.00
				Number of Employees (Full Time Equivalent)		
		Enter the number of hours in your normal work week		Staff	Contract	Total
		0		1.00	2.00	3.00
HOME HEALTH AGENCY - NUMBER OF EMPLOYEES						
3.00	Administrator and Assistant Administrator(s)	0.00		0.00	0.00	0.00
4.00	Director(s) and Assistant Director(s)			0.00	0.00	0.00
5.00	Other Administrative Personnel			3.50	0.00	3.50
6.00	Direct Nursing Service			3.30	0.00	3.30
7.00	Nursing Supervisor			0.00	0.00	0.00
8.00	Physical Therapy Service			3.40	0.00	3.40
9.00	Physical Therapy Supervisor			0.00	0.00	0.00
10.00	Occupational Therapy Service			1.65	0.00	1.65
11.00	Occupational Therapy Supervisor			0.00	0.00	0.00
12.00	Speech Pathology Service			0.00	0.00	0.00
13.00	Speech Pathology Supervisor			0.00	0.00	0.00
14.00	Medical Social Service			0.00	0.00	0.00
15.00	Medical Social Service Supervisor			0.00	0.00	0.00
16.00	Home Health Aide			1.60	0.00	1.60
17.00	Home Health Aide Supervisor			0.00	0.00	0.00
18.00	MANAGER			1.00	0.00	1.00
HOME HEALTH AGENCY CBSA CODES						
19.00	Enter in column 1 the number of CBSAs where you provided services during the cost reporting period.			2		
20.00	List those CBSA code(s) in column 1 serviced during this cost reporting period (line 20 contains the first code).	41180				
20.01		44100				
		Full Episodes		LUPA Episodes	PEP Only Episodes	Total (cols. 1-4)
		Without Outliers	With Outliers			
		1.00	2.00	3.00	4.00	5.00
PPS ACTIVITY DATA						
21.00	Skilled Nursing Visits	1,421	208	64	12	1,705
22.00	Skilled Nursing Visit Charges	259,094	37,742	11,703	2,196	310,735
23.00	Physical Therapy Visits	858	175	14	2	1,049
24.00	Physical Therapy Visit Charges	156,753	32,025	2,562	366	191,706
25.00	Occupational Therapy Visits	387	144	8	0	539
26.00	Occupational Therapy Visit Charges	70,473	26,352	1,464	0	98,289
27.00	Speech Pathology Visits	70	26	0	0	96
28.00	Speech Pathology Visit Charges	12,749	4,758	0	0	17,507
29.00	Medical Social Service Visits	0	0	0	0	0
30.00	Medical Social Service Visit Charges	0	0	0	0	0
31.00	Home Health Aide Visits	73	61	1	0	135
32.00	Home Health Aide Visit Charges	7,073	5,920	97	0	13,090
33.00	Total visits (sum of lines 21, 23, 25, 27, 29, and 31)	2,809	614	87	14	3,524
34.00	Other Charges	0	0	0	0	0
35.00	Total Charges (sum of lines 22, 24, 26, 28, 30, 32, and 34)	506,142	106,797	15,826	2,562	631,327
36.00	Total Number of Episodes (standard/non outlier)	228		62	5	295
37.00	Total Number of Outlier Episodes		12		1	13
38.00	Total Non-Routine Medical Supply Charges	7,931	1,165	323	156	9,575

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA

Provider CCN: 14-0289

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

Worksheet S-10

Date/Time Prepared:
7/28/2021 3:46 pm

				1.00	
	Uncompensated and indigent care cost computation				
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided by line 202 column 8)			0.211505	1.00
	Medicaid (see instructions for each line)				
2.00	Net revenue from Medicaid			17,002,445	2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?			N	3.00
4.00	If line 3 is yes, does line 2 include all DSH and/or supplemental payments from Medicaid?			N	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			90,946,546	6.00
7.00	Medicaid cost (line 1 times line 6)			19,235,649	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)			2,233,204	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)			2,233,204	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)	8,415,067	3,747,168	12,162,235	20.00
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	1,779,829	3,747,168	5,526,997	21.00
22.00	Payments received from patients for amounts previously written off as charity care	0	0	0	22.00
23.00	Cost of charity care (line 21 minus line 22)	1,779,829	3,747,168	5,526,997	23.00
				1.00	
24.00	Does the amount on line 20 column 2, include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?			N	24.00
25.00	If line 24 is yes, enter the charges for patient days beyond the indigent care program's length of stay limit			0	25.00
26.00	Total bad debt expense for the entire hospital complex (see instructions)			9,243,790	26.00
27.00	Medicare reimbursable bad debts for the entire hospital complex (see instructions)			421,548	27.00
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)			648,536	27.01
28.00	Non-Medicare bad debt expense (see instructions)			8,595,254	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)			2,044,927	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)			7,571,924	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)			9,805,128	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-0289

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

Worksheet A

Date/Time Prepared:
7/28/2021 3:46 pm

Cost Center Description			Salaries	Other	Total (col. 1 + col. 2)	Reclassification ons (See A-6)	Reclassified Trial Balance (col. 3 + col. 4)	
			1.00	2.00	3.00	4.00	5.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT		3,239,232	3,239,232	1,340,641	4,579,873	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		4,215,734	4,215,734	437,528	4,653,262	2.00
3.00	00300	OTHER CAP REL COSTS		0	0	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	358,225	11,534,113	11,892,338	2,496	11,894,834	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	8,972,277	31,566,782	40,539,059	-1,061,908	39,477,151	5.00
6.00	00600	MAINTENANCE & REPAIRS	1,014,571	814,607	1,829,178	0	1,829,178	6.00
7.00	00700	OPERATION OF PLANT	-16,337	1,963,457	1,947,120	50,500	1,997,620	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	62,108	503,675	565,783	0	565,783	8.00
9.00	00900	HOUSEKEEPING	1,428,943	292,404	1,721,347	0	1,721,347	9.00
10.00	01000	DIETARY	854,424	1,043,166	1,897,590	-1,255,537	642,053	10.00
11.00	01100	CAFETERIA	0	0	0	1,255,537	1,255,537	11.00
13.00	01300	NURSING ADMINISTRATION	583,572	452,916	1,036,488	-437,186	599,302	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	806,916	629,841	1,436,757	-486,872	949,885	14.00
15.00	01500	PHARMACY	1,865,728	4,779,835	6,645,563	-1,928,173	4,717,390	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,099,112	282,328	1,381,440	0	1,381,440	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
23.00	02300	PARAMEDICAL EDUCATION PRGM	207,256	812	208,068	0	208,068	23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	11,803,083	1,314,639	13,117,722	-2,372,400	10,745,322	30.00
31.00	03100	INTENSIVE CARE UNIT	2,412,411	257,291	2,669,702	-26,768	2,642,934	31.00
41.00	04100	SUBPROVIDER - IRF	1,133,340	720,962	1,854,302	-2,262	1,852,040	41.00
43.00	04300	NURSERY	0	0	0	787,417	787,417	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	5,115,321	8,364,849	13,480,170	-6,409,855	7,070,315	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	1,254,675	1,254,675	52.00
53.00	05300	ANESTHESIOLOGY	0	298,823	298,823	-4,917	293,906	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,304,906	1,464,655	3,769,561	125,384	3,894,945	54.00
56.00	05600	RADIOISOTOPE	156,351	230,264	386,615	-197,751	188,864	56.00
57.00	05700	CT SCAN	493,802	817,071	1,310,873	-150,584	1,160,289	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	183,912	429,940	613,852	-45,491	568,361	58.00
59.00	05900	CARDIAC CATHETERIZATION	925,610	1,797,014	2,722,624	-1,235,739	1,486,885	59.00
60.00	06000	LABORATORY	1,795,632	3,577,164	5,372,796	-7,011	5,365,785	60.00
65.00	06500	RESPIRATORY THERAPY	1,231,108	423,352	1,654,460	-186,241	1,468,219	65.00
66.00	06600	PHYSICAL THERAPY	1,324,596	230,556	1,555,152	-20,001	1,535,151	66.00
67.00	06700	OCCUPATIONAL THERAPY	867,872	13,317	881,189	100,360	981,549	67.00
68.00	06800	SPEECH PATHOLOGY	642,876	10,466	653,342	55,049	708,391	68.00
68.01	03040	AUDIOLOGY	151,740	120,733	272,473	-92,733	179,740	68.01
69.00	06900	ELECTROCARDIOLOGY	517,328	174,558	691,886	-7,655	684,231	69.00
69.01	03160	CARDIOPULMONARY	564,658	63,709	628,367	-26,209	602,158	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	56,074	5,464	61,538	-5,149	56,389	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	9,747,184	9,747,184	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	1,860,108	1,860,108	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	437,186	437,186	74.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	916,791	9,231,320	10,148,111	-113,084	10,035,027	90.00
91.00	09100	EMERGENCY	5,645,155	887,312	6,532,467	-162,070	6,370,397	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
OTHER REIMBURSABLE COST CENTERS								
101.00	10100	HOME HEALTH AGENCY	1,243,265	126,640	1,369,905	-14,948	1,354,957	101.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE		1,203,521	1,203,521	-1,203,521	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	56,722,626	93,082,522	149,805,148	0	149,805,148	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
200.00		TOTAL (SUM OF LINES 118 through 199)	56,722,626	93,082,522	149,805,148	0	149,805,148	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-0289

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

Worksheet A

Date/Time Prepared:
7/28/2021 3:46 pm

Cost Center Description			Adjustments (See A-8)	Net Expenses For Allocation	
			6.00	7.00	
GENERAL SERVICE COST CENTERS					
1.00	00100	CAP REL COSTS-BLDG & FIXT	-863,105	3,716,768	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	-340,416	4,312,846	2.00
3.00	00300	OTHER CAP REL COSTS	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-809,814	11,085,020	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-15,170,132	24,307,019	5.00
6.00	00600	MAINTENANCE & REPAIRS	0	1,829,178	6.00
7.00	00700	OPERATION OF PLANT	155,829	2,153,449	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	565,783	8.00
9.00	00900	HOUSEKEEPING	0	1,721,347	9.00
10.00	01000	DIETARY	0	642,053	10.00
11.00	01100	CAFETERIA	0	1,255,537	11.00
13.00	01300	NURSING ADMINISTRATION	195,193	794,495	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	949,885	14.00
15.00	01500	PHARMACY	0	4,717,390	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	127,245	1,508,685	16.00
17.00	01700	SOCIAL SERVICE	0	0	17.00
23.00	02300	PARAMEDICAL EDUCATION PRGM	0	208,068	23.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	0	10,745,322	30.00
31.00	03100	INTENSIVE CARE UNIT	0	2,642,934	31.00
41.00	04100	SUBPROVIDER - IRF	0	1,852,040	41.00
43.00	04300	NURSERY	0	787,417	43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	7,070,315	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	-90	1,254,585	52.00
53.00	05300	ANESTHESIOLOGY	-72,795	221,111	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-65,583	3,829,362	54.00
56.00	05600	RADIOISOTOPE	0	188,864	56.00
57.00	05700	CT SCAN	0	1,160,289	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	568,361	58.00
59.00	05900	CARDIAC CATHETERIZATION	-15,168	1,471,717	59.00
60.00	06000	LABORATORY	0	5,365,785	60.00
65.00	06500	RESPIRATORY THERAPY	0	1,468,219	65.00
66.00	06600	PHYSICAL THERAPY	0	1,535,151	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	981,549	67.00
68.00	06800	SPEECH PATHOLOGY	0	708,391	68.00
68.01	03040	AUDIOLOGY	-23,617	156,123	68.01
69.00	06900	ELECTROCARDIOLOGY	0	684,231	69.00
69.01	03160	CARDIOPULMONARY	-3,223	598,935	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0	56,389	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	9,747,184	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	1,860,108	73.00
74.00	07400	RENAL DIALYSIS	0	437,186	74.00
OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	-4,450	10,030,577	90.00
91.00	09100	EMERGENCY	-9,000	6,361,397	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)			92.00
OTHER REIMBURSABLE COST CENTERS					
101.00	10100	HOME HEALTH AGENCY	0	1,354,957	101.00
SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE	0	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-16,899,126	132,906,022	118.00
NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	192.00
193.00	19300	NONPAID WORKERS	0	0	193.00
200.00		TOTAL (SUM OF LINES 118 through 199)	-16,899,126	132,906,022	200.00

RECLASSIFICATIONS

Provider CCN: 14-0289

Period:
From 01/01/2020
To 12/31/2020Worksheet A-6
Date/Time Prepared:
7/28/2021 3:46 pm

	Increases				
	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
	A - TO RECLASS INTEREST EXPENSE TO CAPTL				
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	863,105	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	340,416	2.00
			0	1,203,521	
	B - TO RECLASS EXPENSES FOR CAFETERIA				
1.00	CAFETERIA	11.00	565,328	690,209	1.00
			565,328	690,209	
	C - L&D/NURSERY RECLASS				
1.00	NURSERY	43.00	731,715	93,552	1.00
2.00	DELIVERY ROOM & LABOR ROOM	52.00	1,165,949	149,070	2.00
			1,897,664	242,622	
	E - TO RECLASS ELECTRICITY EXP				
1.00	OPERATION OF PLANT	7.00	0	72,935	1.00
2.00		0.00	0	0	2.00
			0	72,935	
	F - TO RECLASS TELEPHONE EXP				
1.00	ADMINISTRATIVE & GENERAL	5.00	0	9,713	1.00
2.00	OPERATION OF PLANT	7.00	0	10,255	2.00
3.00		0.00	0	0	3.00
			0	19,968	
	G - TO RECLASS RENAL DIALYSIS EXP				
1.00	RENAL DIALYSIS	74.00	0	437,186	1.00
			0	437,186	
	H - INSURANCE EXPENSE				
1.00	OTHER CAP REL COSTS	3.00	0	175,812	1.00
			0	175,812	
	J - TO RECLASS MED SUPPLIES				
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	9,747,184	1.00
2.00		0.00	0	0	2.00
3.00		0.00	0	0	3.00
4.00		0.00	0	0	4.00
5.00		0.00	0	0	5.00
6.00		0.00	0	0	6.00
7.00		0.00	0	0	7.00
8.00		0.00	0	0	8.00
9.00		0.00	0	0	9.00
10.00		0.00	0	0	10.00
11.00		0.00	0	0	11.00
12.00		0.00	0	0	12.00
13.00		0.00	0	0	13.00
14.00		0.00	0	0	14.00
15.00		0.00	0	0	15.00
16.00		0.00	0	0	16.00
17.00		0.00	0	0	17.00
18.00		0.00	0	0	18.00
19.00		0.00	0	0	19.00
20.00		0.00	0	0	20.00
21.00		0.00	0	0	21.00
22.00		0.00	0	0	22.00
23.00		0.00	0	0	23.00
24.00		0.00	0	0	24.00
25.00		0.00	0	0	25.00
			0	9,747,184	
	K - TO RECLASS REAL ESTATE TAXES				
1.00	OTHER CAP REL COSTS	3.00	0	161,682	1.00
			0	161,682	
	L - TO RECLASS PHYSICIAN OFFICE LEASE				
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	237,154	1.00
2.00		0.00	0	0	2.00
			0	237,154	
	M - TO RECLASS PROF RENUMERATION				
1.00	RADIOLOGY-DIAGNOSTIC	54.00	0	201,533	1.00
2.00	ANESTHESIOLOGY	53.00	0	175,000	2.00
			0	376,533	
	N - TO RECLASS PENSION AUDIT COSTS				
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	2,496	1.00
			0	2,496	
	O - TO RECLASS REHAB ADMIN EXP				
1.00	SPEECH PATHOLOGY	68.00	51,065	3,984	1.00
2.00	AUDIOLOGY	68.01	12,783	997	2.00
3.00	OCCUPATIONAL THERAPY	67.00	93,586	7,301	3.00
4.00	PHYSICAL THERAPY	66.00	136,781	10,671	4.00
			294,215	22,953	

RECLASSIFICATIONS

Provider CCN: 14-0289

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

Worksheet A-6

Date/Time Prepared:
7/28/2021 3:46 pm

	Increases					
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
	P - TO RECLASS PHARMACISTS SALARIES					
1.00	ADULTS & PEDIATRICS	30.00	4,015	0	1.00	
2.00	INTENSIVE CARE UNIT	31.00	830	0	2.00	
3.00	SUBPROVIDER - IRF	41.00	187	0	3.00	
4.00	NURSERY	43.00	42	0	4.00	
5.00	OPERATING ROOM	50.00	288	0	5.00	
6.00	DELIVERY ROOM & LABOR ROOM	52.00	67	0	6.00	
7.00	DRUGS CHARGED TO PATIENTS	73.00	1,860,108	0	7.00	
8.00	EMERGENCY	91.00	191	0	8.00	
			1,865,728	0		
	Q - TO RECLASS CABLE TB EXPS					
1.00	ADMINISTRATIVE & GENERAL	5.00	0	35,883	1.00	
2.00		0.00	0	0	2.00	
			0	35,883		
	S - PLANT OPERATIONS NEGATIVE SALARIES					
1.00	OPERATION OF PLANT	7.00	16,337	0	1.00	
	TOTALS		16,337	0		
500.00	Grand Total: Increases		4,639,272	13,426,138	500.00	

RECLASSIFICATIONS

Provider CCN: 14-0289

Period:
From 01/01/2020
To 12/31/2020Worksheet A-6
Date/Time Prepared:
7/28/2021 3:46 pm

Decreases						Wkst. A-7 Ref.	
	Cost Center	Line #	Salary	Other			
	6.00	7.00	8.00	9.00	10.00		
A - TO RECLASS INTEREST EXPENSE TO CAPTL							
1.00	INTEREST EXPENSE	113.00	0	1,203,521	11		1.00
2.00		0.00	0	0	11		2.00
	0		0	1,203,521			
B - TO RECLASS EXPENSES FOR CAFETERIA							
1.00	DIETARY	10.00	565,328	690,209	0		1.00
	0		565,328	690,209			
C - L&D/NURSERY RECLASS							
1.00	ADULTS & PEDIATRICS	30.00	1,897,664	242,622	0		1.00
2.00		0.00	0	0	0		2.00
	0		1,897,664	242,622			
E - TO RECLASS ELECTRICITY EXP							
1.00	ADMINISTRATIVE & GENERAL	5.00	0	63	0		1.00
2.00	CLINIC	90.00	0	72,872	0		2.00
	0		0	72,935			
F - TO RECLASS TELEPHONE EXP							
1.00	CLINIC	90.00	0	1,620	0		1.00
2.00	EMERGENCY	91.00	0	18,085	0		2.00
3.00	HOME HEALTH AGENCY	101.00	0	263	0		3.00
	0		0	19,968			
G - TO RECLASS RENAL DIALYSIS EXP							
1.00	NURSING ADMINISTRATION	13.00	0	437,186	0		1.00
	0		0	437,186			
H - INSURANCE EXPENSE							
1.00	ADMINISTRATIVE & GENERAL	5.00	0	175,812	12		1.00
	0		0	175,812			
J - TO RECLASS MED SUPPLIES							
1.00	CENTRAL SERVICES & SUPPLY	14.00	0	486,872	0		1.00
2.00	PHARMACY	15.00	0	62,445	0		2.00
3.00	ADULTS & PEDIATRICS	30.00	0	236,129	0		3.00
4.00	INTENSIVE CARE UNIT	31.00	0	27,598	0		4.00
5.00	SUBPROVIDER - IRF	41.00	0	2,449	0		5.00
6.00	NURSERY	43.00	0	37,892	0		6.00
7.00	OPERATING ROOM	50.00	0	6,410,143	0		7.00
8.00	DELIVERY ROOM & LABOR ROOM	52.00	0	60,411	0		8.00
9.00	ANESTHESIOLOGY	53.00	0	179,917	0		9.00
10.00	RADIOLOGY-DIAGNOSTIC	54.00	0	76,149	0		10.00
11.00	RADIOISOTOPE	56.00	0	197,751	0		11.00
12.00	CT SCAN	57.00	0	150,584	0		12.00
13.00	MAGNETIC RESONANCE IMAGING (MRI)	58.00	0	45,491	0		13.00
14.00	CARDIAC CATHETERIZATION	59.00	0	1,235,739	0		14.00
15.00	LABORATORY	60.00	0	7,011	0		15.00
16.00	RESPIRATORY THERAPY	65.00	0	186,241	0		16.00
17.00	PHYSICAL THERAPY	66.00	0	4,049	0		17.00
18.00	OCCUPATIONAL THERAPY	67.00	0	527	0		18.00
19.00	AUDIOLOGY	68.01	0	106,513	0		19.00
20.00	ELECTROCARDIOLOGY	69.00	0	7,655	0		20.00
21.00	CARDIOPULMONARY	69.01	0	26,209	0		21.00
22.00	ELECTROENCEPHALOGRAPHY	70.00	0	5,149	0		22.00
23.00	CLINIC	90.00	0	35,399	0		23.00
24.00	EMERGENCY	91.00	0	144,176	0		24.00
25.00	HOME HEALTH AGENCY	101.00	0	14,685	0		25.00
	0		0	9,747,184			
K - TO RECLASS REAL ESTATE TAXES							
1.00	ADMINISTRATIVE & GENERAL	5.00	0	161,682	0		1.00
	0		0	161,682			
L - TO RECLASS PHYSICIAN OFFICE LEASE							
1.00	ADMINISTRATIVE & GENERAL	5.00	0	73,750	10		1.00
2.00	PHYSICAL THERAPY	66.00	0	163,404	0		2.00
	0		0	237,154			
M - TO RECLASS PROF RENUMERATION							
1.00	ADMINISTRATIVE & GENERAL	5.00	0	376,533	0		1.00
2.00		0.00	0	0	0		2.00
	0		0	376,533			
N - TO RECLASS PENSION AUDIT COSTS							
1.00	ADMINISTRATIVE & GENERAL	5.00	0	2,496	0		1.00
	0		0	2,496			
O - TO RECLASS REHAB ADMIN EXP							
1.00	ADMINISTRATIVE & GENERAL	5.00	294,215	22,953	0		1.00
2.00		0.00	0	0	0		2.00
3.00		0.00	0	0	0		3.00
4.00		0.00	0	0	0		4.00
	0		294,215	22,953			

RECLASSIFICATIONS

Provider CCN: 14-0289

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

Worksheet A-6

Date/Time Prepared:
7/28/2021 3:46 pm

	Decreases						
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	P - TO RECLASS PHARMACISTS SALARIES						
1.00	PHARMACY	15.00	1,865,728	0	0		1.00
2.00		0.00	0	0	0		2.00
3.00		0.00	0	0	0		3.00
4.00		0.00	0	0	0		4.00
5.00		0.00	0	0	0		5.00
6.00		0.00	0	0	0		6.00
7.00		0.00	0	0	0		7.00
8.00		0.00	0	0	0		8.00
	0		1,865,728	0			
	Q - TO RECLASS CABLE TB EXPS						
1.00	CLINIC	90.00	0	3,193	0		1.00
2.00	OPERATION OF PLANT	7.00	0	32,690	0		2.00
	0		0	35,883			
	S - PLANT OPERATIONS NEGATIVE SALARIES						
1.00	OPERATION OF PLANT	7.00	0	16,337	0		1.00
	TOTALS		0	16,337			
500.00	Grand Total: Decreases		4,622,935	13,442,475			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-0289

Period:
From 01/01/2020
To 12/31/2020Worksheet A-7
Part I
Date/Time Prepared:
7/28/2021 3:46 pm

		Beginning Balances	Acquisitions			Disposals and Retirements		
			Purchases	Donation	Total			
		1.00	2.00	3.00	4.00	5.00		
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES							
1.00	Land	963,454	0	0	0	0	1.00	
2.00	Land Improvements	3,152,271	44,350	0	44,350	984,975	2.00	
3.00	Buildings and Fixtures	110,878,775	459,161	0	459,161	2,253	3.00	
4.00	Building Improvements	24,000	0	0	0	0	4.00	
5.00	Fixed Equipment	5,406,514	110,272	0	110,272	52,940	5.00	
6.00	Movable Equipment	49,345,376	1,614,428	0	1,614,428	2,562,278	6.00	
7.00	HIT designated Assets	0	0	0	0	0	7.00	
8.00	Subtotal (sum of lines 1-7)	169,770,390	2,228,211	0	2,228,211	3,602,446	8.00	
9.00	Reconciling Items	7,680	191,900	0	191,900	0	9.00	
10.00	Total (line 8 minus line 9)	169,762,710	2,036,311	0	2,036,311	3,602,446	10.00	
		Ending Balance	Fully Depreciated Assets					
		6.00	7.00					
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES							
1.00	Land	963,454	0				1.00	
2.00	Land Improvements	2,211,646	0				2.00	
3.00	Buildings and Fixtures	111,335,683	0				3.00	
4.00	Building Improvements	24,000	0				4.00	
5.00	Fixed Equipment	5,463,846	0				5.00	
6.00	Movable Equipment	48,397,526	0				6.00	
7.00	HIT designated Assets	0	0				7.00	
8.00	Subtotal (sum of lines 1-7)	168,396,155	0				8.00	
9.00	Reconciling Items	199,580	0				9.00	
10.00	Total (line 8 minus line 9)	168,196,575	0				10.00	

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-0289

Period:
From 01/01/2020
To 12/31/2020Worksheet A-7
Part II
Date/Time Prepared:
7/28/2021 3:46 pm

Cost Center Description		SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	CAP REL COSTS-BLDG & FIXT	3,239,232	0	0	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	4,132,289	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	7,371,521	0	0	0	0	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Other	Total (1) (sum				
		Capital-Related Costs (see instructions)	of cols. 9 through 14)				
		14.00	15.00				
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	CAP REL COSTS-BLDG & FIXT	0	3,239,232				1.00
2.00	CAP REL COSTS-MVBLE EQUIP	83,445	4,215,734				2.00
3.00	Total (sum of lines 1-2)	83,445	7,454,966				3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-0289

Period:
From 01/01/2020
To 12/31/2020Worksheet A-7
Part III
Date/Time Prepared:
7/28/2021 3:46 pm

Cost Center Description		COMPUTATION OF RATIOS			ALLOCATION OF OTHER CAPITAL		
		Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	
		1.00	2.00	3.00	4.00	5.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	119,799,049	0	119,799,049	0.712256	125,223	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	48,397,526	0	48,397,526	0.287744	50,589	2.00
3.00	Total (sum of lines 1-2)	168,196,575	0	168,196,575	1.000000	175,812	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	115,159	0	240,382	3,239,232	237,154	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	46,523	0	97,112	4,132,289	0	2.00
3.00	Total (sum of lines 1-2)	161,682	0	337,494	7,371,521	237,154	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	125,223	115,159	0	3,716,768	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	50,589	46,523	83,445	4,312,846	2.00
3.00	Total (sum of lines 1-2)	0	175,812	161,682	83,445	8,029,614	3.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 14-0289

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

Worksheet A-8

Date/Time Prepared:
7/28/2021 3:46 pm

Cost Center Description		Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted		Wkst. A-7 Ref.	
				Cost Center	Line #		
1.00				3.00	4.00	5.00	
1.00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)	B	-863,105	CAP REL COSTS-BLDG & FIXT	1.00	11	1.00
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)	B	-340,416	CAP REL COSTS-MVBLE EQUIP	2.00	11	2.00
3.00	Investment income - other (chapter 2)		0		0.00	0	3.00
4.00	Trade, quantity, and time discounts (chapter 8)	B	70	ADMINISTRATIVE & GENERAL	5.00	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	-486	ADMINISTRATIVE & GENERAL	5.00	0	7.00
8.00	Television and radio service (chapter 21)	A	-35,883	OPERATION OF PLANT	7.00	0	8.00
9.00	Parking lot (chapter 21)		0		0.00	0	9.00
10.00	Provider-based physician adjustment	A-8-2	-7,022,363			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	249,047			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests		0		0.00	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	B	-60,410	MEDICAL RECORDS & LIBRARY	16.00	0	16.00
17.00	Sale of drugs to other than patients		0		0.00	0	17.00
18.00	Sale of medical records and abstracts		0		0.00	0	18.00
19.00	Nursing and allied health education (tuition, fees, books, etc.)		0		0.00	0	19.00
20.00	Vending machines		0	ADMINISTRATIVE & GENERAL	5.00	0	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	0	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	RESPIRATORY THERAPY	65.00		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	PHYSICAL THERAPY	66.00		24.00
25.00	Utilization review - physicians' compensation (chapter 21)		0	*** Cost Center Deleted ***	114.00		25.00
26.00	Depreciation - CAP REL COSTS-BLDG & FIXT		0	CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	27.00
28.00	Non-physician Anesthetist		0	*** Cost Center Deleted ***	19.00		28.00
29.00	Physicians' assistant		0		0.00	0	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	OCCUPATIONAL THERAPY	67.00		30.00
30.99	Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS	30.00		30.99
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	SPEECH PATHOLOGY	68.00		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest		0		0.00	0	32.00
33.00	OTHER MISC INCOME	B	-151,886	ADMINISTRATIVE & GENERAL	5.00	0	33.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 14-0289

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

Worksheet A-8

Date/Time Prepared:
7/28/2021 3:46 pm

			Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted			
Cost Center Description	Basis/Code (2)	Amount	Cost Center	Line #	Wkst. A-7 Ref.	
	1.00	2.00	3.00	4.00	5.00	
33.01 OTHER REVENUE CR CARD SHARING REV	B	-43,558	ADMINISTRATIVE & GENERAL	5.00	0	33.01
33.02 MANAGEMENT FEES	B	-468,000	ADMINISTRATIVE & GENERAL	5.00	0	33.02
33.03 OB LACTATION REVENUE	B	-90	DELIVERY ROOM & LABOR ROOM	52.00	0	33.03
33.04 AH OTHER REVENUE HEALTH MGM	B	-3,223	CARDIOPULMONARY	69.01	0	33.04
33.05 SALES TAX REVERSAL	A	-3	ADMINISTRATIVE & GENERAL	5.00	0	33.05
33.06 PHYSICIAN RECRUITMENT	A	-187,518	ADMINISTRATIVE & GENERAL	5.00	0	33.06
33.07 LOBBYING PORTION OF DUES	A	-36,282	ADMINISTRATIVE & GENERAL	5.00	0	33.07
33.08 ALCOHOL EXPENSE	A	-4,030	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.08
33.09 ENTERTAINMENT EXPENSE	A	-5,809	MEDICAL RECORDS & LIBRARY	16.00	0	33.09
33.10 PUBLICITY SALARIES	A	-82,585	ADMINISTRATIVE & GENERAL	5.00	0	33.10
33.11 PUBLICITY EXPENSES	A	-280,324	ADMINISTRATIVE & GENERAL	5.00	0	33.11
33.12 PUBLICITY BENEFITS	A	-16,040	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.12
33.13 DONATION EXPENSE	A	-32,765	ADMINISTRATIVE & GENERAL	5.00	0	33.13
33.14 PROVIDER TAX OFFSET	A	-7,262,220	ADMINISTRATIVE & GENERAL	5.00	0	33.14
33.15 ADVERTISING EXPENSE	A	-223,180	ADMINISTRATIVE & GENERAL	5.00	0	33.15
33.16 ADVERTISING EXPENSE	A	-4,450	CLINIC	90.00	0	33.16
33.17 AUDIOLOGY REVENUE	B	-23,617	AUDIOLOGY	68.01	0	33.17
50.00 TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-16,899,126				50.00

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

(2) Basis for adjustment (see instructions).

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

B. Amount Received - if cost cannot be determined.

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

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

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

Provider CCN: 14-0289

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

Worksheet A-8-1

Date/Time Prepared:
7/28/2021 3:46 pm

	Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in wks. A, column 5	
	1.00	2.00	3.00	4.00	5.00	
	A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:					
1.00	4.00	EMPLOYEE BENEFITS DEPARTMENT	HOME OFFICE EMPLOYEE BENEFIT	945,092	1,734,836	1.00
2.00	5.00	ADMINISTRATIVE & GENERAL	HOME OFFICE A&G	11,690,409	11,231,987	2.00
3.00	7.00	OPERATION OF PLANT	HOME OFFICE PLANT OPERATIONS	191,712	0	3.00
4.00	13.00	NURSING ADMINISTRATION	HOME OFFICE NURSING ADMIN	195,193	0	4.00
4.01	16.00	MEDICAL RECORDS & LIBRARY	HOME OFFICE MEDICAL RECORDS	1,433,072	1,239,608	4.01
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.			14,455,478	14,206,431	5.00

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

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

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

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

6.00	B		0.00	ANDERSON HEALTH	100.00	6.00
7.00			0.00		0.00	7.00
8.00			0.00		0.00	8.00
9.00			0.00		0.00	9.00
10.00			0.00		0.00	10.00
100.00	G. Other (financial or non-financial) specify:					100.00

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

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

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

Provider CCN: 14-0289

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

Worksheet A-8-1

Date/Time Prepared:
7/28/2021 3:46 pm

	Net Adjustments (col. 4 minus col. 5)*	Wkst. A-7 Ref.		
	6.00	7.00		
A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:				
1.00	-789,744	0		1.00
2.00	458,422	0		2.00
3.00	191,712	0		3.00
4.00	195,193	0		4.00
4.01	193,464	0		4.01
5.00	249,047			5.00

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

	Related Organization(s) and/or Home Office		
	Type of Business		
	6.00		
B. INTERRELATIONSHIP TO RELATED ORGANIZATION(S) AND/OR HOME OFFICE:			

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

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

6.00	HEALTH CARE		6.00
7.00			7.00
8.00			8.00
9.00			9.00
10.00			10.00
100.00			100.00

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

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

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 14-0289

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

Worksheet A-8-2

Date/Time Prepared:
7/28/2021 3:46 pm

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	5.00	ADMINISTRATIVE & GENERAL	6,865,918	6,853,918	12,000	211,500	60	1.00
2.00	53.00	ANESTHESIOLOGY	175,000	0	175,000	239,400	888	2.00
3.00	54.00	RADIOLOGY-DIAGNOSTIC	201,533	0	201,533	271,900	1,040	3.00
4.00	59.00	CARDIAC CATHETERIZATION	25,000	0	25,000	246,400	83	4.00
5.00	91.00	EMERGENCY	9,000	9,000	0	211,500	0	5.00
6.00	0.00		0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			7,276,451	6,862,918	413,533		2,071	200.00
	Wkst. A Line #	Cost Center/Physician Identifier	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	5.00	ADMINISTRATIVE & GENERAL	6,101	305	0	0	0	1.00
2.00	53.00	ANESTHESIOLOGY	102,205	5,110	0	0	0	2.00
3.00	54.00	RADIOLOGY-DIAGNOSTIC	135,950	6,798	0	0	0	3.00
4.00	59.00	CARDIAC CATHETERIZATION	9,832	492	0	0	0	4.00
5.00	91.00	EMERGENCY	0	0	0	0	0	5.00
6.00	0.00		0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			254,088	12,705	0	0	0	200.00
	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment		
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00	5.00	ADMINISTRATIVE & GENERAL	0	6,101	5,899	6,859,817		1.00
2.00	53.00	ANESTHESIOLOGY	0	102,205	72,795	72,795		2.00
3.00	54.00	RADIOLOGY-DIAGNOSTIC	0	135,950	65,583	65,583		3.00
4.00	59.00	CARDIAC CATHETERIZATION	0	9,832	15,168	15,168		4.00
5.00	91.00	EMERGENCY	0	0	0	9,000		5.00
6.00	0.00		0	0	0	0		6.00
7.00	0.00		0	0	0	0		7.00
8.00	0.00		0	0	0	0		8.00
9.00	0.00		0	0	0	0		9.00
10.00	0.00		0	0	0	0		10.00
200.00			0	254,088	159,445	7,022,363		200.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0289

Period:
From 01/01/2020
To 12/31/2020Worksheet B
Part I
Date/Time Prepared:
7/28/2021 3:46 pm

Cost Center Description			CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
			Net Expenses for Cost Allocation (from Wkst A col. 7)	BLDG & FIXT	MVBLE EQUIP		
			0	1.00	2.00	4.00	4A
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT	3,716,768	3,716,768			1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	4,312,846		4,312,846		2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	11,085,020	10,234	39,123	11,134,377	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	24,307,019	296,437	972,525	1,699,825	5.00
6.00	00600	MAINTENANCE & REPAIRS	1,829,178	23,741	188,314	200,640	6.00
7.00	00700	OPERATION OF PLANT	2,153,449	296,241	380,398	0	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	565,783	3,510	0	12,282	8.00
9.00	00900	HOUSEKEEPING	1,721,347	24,307	18,638	282,585	9.00
10.00	01000	DIETARY	642,053	89,961	12,608	57,171	10.00
11.00	01100	CAFETERIA	1,255,537	0	24,648	111,798	11.00
13.00	01300	NURSING ADMINISTRATION	794,495	22,765	0	115,406	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	949,885	82,745	43,894	159,574	14.00
15.00	01500	PHARMACY	4,717,390	20,239	71,054	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,508,685	72,412	2,803	217,358	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	17.00
23.00	02300	PARAMEDICAL EDUCATION PRGM	208,068	0	0	41,975	23.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	10,745,322	323,442	164,257	1,959,646	30.00
31.00	03100	INTENSIVE CARE UNIT	2,642,934	75,471	59,982	477,238	31.00
41.00	04100	SUBPROVIDER - IRF	1,852,040	58,102	3,257	224,164	41.00
43.00	04300	NURSERY	787,417	8,381	29,786	144,711	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	7,070,315	257,542	467,645	1,011,653	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,254,585	252,769	47,470	230,589	52.00
53.00	05300	ANESTHESIOLOGY	221,111	0	2,553	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,829,362	17,246	367,267	455,814	54.00
56.00	05600	RADIOISOTOPE	188,864	8,578	109,701	30,920	56.00
57.00	05700	CT SCAN	1,160,289	119,787	372,051	97,653	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	568,361	25,217	40,088	36,370	58.00
59.00	05900	CARDIAC CATHETERIZATION	1,471,717	0	254,551	183,047	59.00
60.00	06000	LABORATORY	5,365,785	74,970	291,496	355,101	60.00
65.00	06500	RESPIRATORY THERAPY	1,468,219	49,286	51,522	243,461	65.00
66.00	06600	PHYSICAL THERAPY	1,535,151	120,533	20,562	272,048	66.00
67.00	06700	OCCUPATIONAL THERAPY	981,549	238,352	4,127	174,157	67.00
68.00	06800	SPEECH PATHOLOGY	708,391	93,094	1,019	145,641	68.00
68.01	03040	AUDIOLOGY	156,123	3,781	256	57,057	68.01
69.00	06900	ELECTROCARDIOLOGY	684,231	0	64,690	102,306	69.00
69.01	03160	CARDIOPULMONARY	598,935	39,716	6,427	111,666	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	56,389	0	8,083	11,089	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	9,747,184	0	0	0	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,860,108	0	0	367,851	73.00
74.00	07400	RENAL DIALYSIS	437,186	0	0	0	74.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	10,030,577	88,723	125,672	181,303	90.00
91.00	09100	EMERGENCY	6,361,397	241,009	66,379	1,116,412	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					92.00
OTHER REIMBURSABLE COST CENTERS							
101.00	10100	HOME HEALTH AGENCY	1,354,957	15,155	0	245,866	101.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	132,906,022	3,053,746	4,312,846	11,134,377	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	17,418	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	395,656	0	0	192.00
193.00	19300	NONPAID WORKERS	0	249,948	0	0	193.00
200.00		Cross Foot Adjustments					200.00
201.00		Negative Cost Centers	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	132,906,022	3,716,768	4,312,846	11,134,377	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0289

Period:
From 01/01/2020
To 12/31/2020Worksheet B
Part I
Date/Time Prepared:
7/28/2021 3:46 pm

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	27,275,806					5.00
6.00	00600	MAINTENANCE & REPAIRS	578,896	2,820,769				6.00
7.00	00700	OPERATION OF PLANT	730,785	246,763	3,807,636			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	150,174	2,924	4,325	738,998		8.00
9.00	00900	HOUSEKEEPING	528,545	20,247	29,951	0	2,625,620	9.00
10.00	01000	DIETARY	207,039	74,936	110,850	0	7,750	10.00
11.00	01100	CAFETERIA	359,438	0	0	0	15,279	11.00
13.00	01300	NURSING ADMINISTRATION	240,833	18,963	28,051	0	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	319,185	68,925	101,958	11,093	8,415	14.00
15.00	01500	PHARMACY	1,241,698	16,859	24,939	0	27,902	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	465,121	60,318	89,226	0	25,466	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
23.00	02300	PARAMEDICAL EDUCATION PRGM	64,566	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	3,406,581	269,421	398,545	258,155	1,007,111	30.00
31.00	03100	INTENSIVE CARE UNIT	840,667	62,866	92,995	43,700	315,331	31.00
41.00	04100	SUBPROVIDER - IRF	551,962	48,398	71,593	0	188,224	41.00
43.00	04300	NURSERY	250,550	6,981	10,327	0	87,248	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	2,274,184	214,527	317,343	103,524	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	461,029	210,552	311,462	82,533	138,843	52.00
53.00	05300	ANESTHESIOLOGY	57,755	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,205,807	14,366	21,250	20,554	51,817	54.00
56.00	05600	RADIOISOTOPE	87,295	7,145	10,570	1,911	4,872	56.00
57.00	05700	CT SCAN	451,828	99,780	147,601	38,043	96,105	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	173,017	21,005	31,072	7,164	18,158	58.00
59.00	05900	CARDIAC CATHETERIZATION	493,023	0	0	7,705	0	59.00
60.00	06000	LABORATORY	1,571,876	62,449	92,378	0	62,668	60.00
65.00	06500	RESPIRATORY THERAPY	468,021	41,054	60,730	0	81,712	65.00
66.00	06600	PHYSICAL THERAPY	503,088	100,402	148,521	2,730	52,481	66.00
67.00	06700	OCCUPATIONAL THERAPY	361,039	198,543	293,697	50,895	5,315	67.00
68.00	06800	SPEECH PATHOLOGY	244,830	77,545	114,710	1,020	2,879	68.00
68.01	03040	AUDIOLOGY	56,090	3,149	4,658	255	664	68.01
69.00	06900	ELECTROCARDIOLOGY	219,804	0	0	4,484	0	69.00
69.01	03160	CARDIOPULMONARY	195,406	33,082	48,938	0	11,958	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	19,511	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	2,516,918	0	0	0	0	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	575,304	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	112,890	0	0	0	0	74.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	2,692,273	73,904	109,324	0	0	90.00
91.00	09100	EMERGENCY	2,010,294	200,756	296,971	105,232	415,422	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
OTHER REIMBURSABLE COST CENTERS								
101.00	10100	HOME HEALTH AGENCY	417,278	12,624	18,674	0	0	101.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	27,104,600	2,268,484	2,990,659	738,998	2,625,620	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	4,498	14,509	21,463	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	102,166	329,574	487,529	0	0	192.00
193.00	19300	NONPAID WORKERS	64,542	208,202	307,985	0	0	193.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	27,275,806	2,820,769	3,807,636	738,998	2,625,620	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0289

Period:
From 01/01/2020
To 12/31/2020Worksheet B
Part I
Date/Time Prepared:
7/28/2021 3:46 pm

Cost Center Description			DIETARY	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	
			10.00	11.00	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	1,202,368					10.00
11.00	01100	CAFETERIA	0	1,766,700				11.00
13.00	01300	NURSING ADMINISTRATION	0	250,398	1,470,911			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	96,764	0	1,842,438		14.00
15.00	01500	PHARMACY	0	66,445	0	5,280	6,191,806	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	104,295	0	18	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
23.00	02300	PARAMEDICAL EDUCATION PRGM	0	25,212	7,886	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	878,695	404,734	481,263	58,839	13,325	30.00
31.00	03100	INTENSIVE CARE UNIT	129,534	76,019	88,654	24,053	2,755	31.00
41.00	04100	SUBPROVIDER - IRF	194,139	94,593	55,916	2,825	620	41.00
43.00	04300	NURSERY	0	22,468	31,065	5,202	139	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	46,914	225,936	71,401	955	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	35,871	49,464	8,293	222	52.00
53.00	05300	ANESTHESIOLOGY	0	31,403	0	9,024	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	36,254	0	1,690	0	54.00
56.00	05600	RADIOISOTOPE	0	3,383	0	168	0	56.00
57.00	05700	CT SCAN	0	67,083	0	16,957	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	12,638	0	268	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	31,662	8,380	0	59.00
60.00	06000	LABORATORY	0	95,232	101,438	238,789	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	37,148	0	10,274	0	65.00
66.00	06600	PHYSICAL THERAPY	0	20,872	69,298	637	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	14,298	47,433	418	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	7,787	25,927	249	0	68.00
68.01	03040	AUDIOLOGY	0	1,979	0	647	0	68.01
69.00	06900	ELECTROCARDIOLOGY	0	36,574	0	1,169	0	69.00
69.01	03160	CARDIOPULMONARY	0	32,042	25,569	1,573	0	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	43	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	1,327,775	0	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	6,173,157	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0	15,012	0	90.00
91.00	09100	EMERGENCY	0	119,295	229,400	32,947	633	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
OTHER REIMBURSABLE COST CENTERS								
101.00	10100	HOME HEALTH AGENCY	0	0	0	507	0	101.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	1,202,368	1,739,701	1,470,911	1,842,438	6,191,806	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	26,999	0	0	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	1,202,368	1,766,700	1,470,911	1,842,438	6,191,806	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0289

Period:
From 01/01/2020
To 12/31/2020Worksheet B
Part I
Date/Time Prepared:
7/28/2021 3:46 pm

Cost Center Description			MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	PARAMEDICAL EDUCATION PRGM	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	
			16.00	17.00	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
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	2,545,702					16.00
17.00	01700	SOCIAL SERVICE	0	0				17.00
23.00	02300	PARAMEDICAL EDUCATION PRGM	0	0	347,707			23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	273,459	0	0	20,642,795	0	30.00
31.00	03100	INTENSIVE CARE UNIT	32,896	0	0	4,965,095	0	31.00
41.00	04100	SUBPROVIDER - IRF	32,258	0	0	3,378,091	0	41.00
43.00	04300	NURSERY	17,943	0	0	1,402,218	0	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	287,039	0	0	12,348,978	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	28,581	0	0	3,112,263	0	52.00
53.00	05300	ANESTHESIOLOGY	48,927	0	0	370,773	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	153,153	0	0	6,174,580	0	54.00
56.00	05600	RADIOISOTOPE	14,217	0	0	467,624	0	56.00
57.00	05700	CT SCAN	283,460	0	0	2,950,637	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	53,388	0	0	986,746	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	45,642	0	0	2,495,727	0	59.00
60.00	06000	LABORATORY	356,166	0	0	8,668,348	0	60.00
65.00	06500	RESPIRATORY THERAPY	59,369	0	0	2,570,796	0	65.00
66.00	06600	PHYSICAL THERAPY	49,123	0	0	2,895,446	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	32,552	0	0	2,402,375	0	67.00
68.00	06800	SPEECH PATHOLOGY	14,021	0	0	1,437,113	0	68.00
68.01	03040	AUDIOLOGY	3,334	0	0	287,993	0	68.01
69.00	06900	ELECTROCARDIOLOGY	68,634	0	0	1,181,892	0	69.00
69.01	03160	CARDIOPULMONARY	5,442	0	0	1,110,754	0	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	8,481	0	0	103,596	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	88,391	0	0	13,680,268	0	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	217,718	0	0	9,194,138	0	73.00
74.00	07400	RENAL DIALYSIS	5,491	0	0	555,567	0	74.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	68,144	0	0	13,384,932	0	90.00
91.00	09100	EMERGENCY	290,912	0	347,707	11,834,766	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					0	92.00
OTHER REIMBURSABLE COST CENTERS								
101.00	10100	HOME HEALTH AGENCY	6,961	0	0	2,072,022	0	101.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	2,545,702	0	347,707	130,675,533	0	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	57,888	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	1,341,924	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	830,677	0	193.00
200.00		Cross Foot Adjustments			0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	2,545,702	0	347,707	132,906,022	0	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0289

Period:
From 01/01/2020
To 12/31/2020Worksheet B
Part I
Date/Time Prepared:
7/28/2021 3:46 pm

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
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
23.00	02300	PARAMEDICAL EDUCATION PRGM	23.00
INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS	30.00
31.00	03100	INTENSIVE CARE UNIT	31.00
41.00	04100	SUBPROVIDER - IRF	41.00
43.00	04300	NURSERY	43.00
ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	52.00
53.00	05300	ANESTHESIOLOGY	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	54.00
56.00	05600	RADIOISOTOPE	56.00
57.00	05700	CT SCAN	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	58.00
59.00	05900	CARDIAC CATHETERIZATION	59.00
60.00	06000	LABORATORY	60.00
65.00	06500	RESPIRATORY THERAPY	65.00
66.00	06600	PHYSICAL THERAPY	66.00
67.00	06700	OCCUPATIONAL THERAPY	67.00
68.00	06800	SPEECH PATHOLOGY	68.00
68.01	03040	AUDIOLOGY	68.01
69.00	06900	ELECTROCARDIOLOGY	69.00
69.01	03160	CARDIOPULMONARY	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	73.00
74.00	07400	RENAL DIALYSIS	74.00
OUTPATIENT SERVICE COST CENTERS			
90.00	09000	CLINIC	90.00
91.00	09100	EMERGENCY	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	92.00
OTHER REIMBURSABLE COST CENTERS			
101.00	10100	HOME HEALTH AGENCY	101.00
SPECIAL PURPOSE COST CENTERS			
113.00	11300	INTEREST EXPENSE	113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	118.00
NONREIMBURSABLE COST CENTERS			
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	192.00
193.00	19300	NONPAID WORKERS	193.00
200.00		Cross Foot Adjustments	200.00
201.00		Negative Cost Centers	201.00
202.00		TOTAL (sum lines 118 through 201)	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0289

Period:
From 01/01/2020
To 12/31/2020Worksheet B
Part II
Date/Time Prepared:
7/28/2021 3:46 pm

Cost Center Description			CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
			Directly Assigned New Capital Related Costs	BLDG & FIXT	MVBLE EQUIP		
			0	1.00	2.00	2A	4.00
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	7,586	10,234	39,123	56,943	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	389,522	296,437	972,525	1,658,484	5.00
6.00	00600	MAINTENANCE & REPAIRS	0	23,741	188,314	212,055	6.00
7.00	00700	OPERATION OF PLANT	0	296,241	380,398	676,639	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	3,510	0	3,510	8.00
9.00	00900	HOUSEKEEPING	0	24,307	18,638	42,945	9.00
10.00	01000	DIETARY	696	89,961	12,608	103,265	10.00
11.00	01100	CAFETERIA	0	0	24,648	24,648	11.00
13.00	01300	NURSING ADMINISTRATION	0	22,765	0	22,765	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	44,447	82,745	43,894	171,086	14.00
15.00	01500	PHARMACY	271,408	20,239	71,054	362,701	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	72,412	2,803	75,215	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	17.00
23.00	02300	PARAMEDICAL EDUCATION PRGM	0	0	0	215	23.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	482	323,442	164,257	488,181	30.00
31.00	03100	INTENSIVE CARE UNIT	0	75,471	59,982	135,453	31.00
41.00	04100	SUBPROVIDER - IRF	132	58,102	3,257	61,491	41.00
43.00	04300	NURSERY	0	8,381	29,786	38,167	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	172,558	257,542	467,645	897,745	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	252,769	47,470	300,239	52.00
53.00	05300	ANESTHESIOLOGY	0	0	2,553	2,553	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	421,032	17,246	367,267	805,545	54.00
56.00	05600	RADIOISOTOPE	8,938	8,578	109,701	127,217	56.00
57.00	05700	CT SCAN	106,501	119,787	372,051	598,339	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	230,554	25,217	40,088	295,859	58.00
59.00	05900	CARDIAC CATHETERIZATION	227,327	0	254,551	481,878	59.00
60.00	06000	LABORATORY	5,345	74,970	291,496	371,811	60.00
65.00	06500	RESPIRATORY THERAPY	96,709	49,286	51,522	197,517	65.00
66.00	06600	PHYSICAL THERAPY	0	120,533	20,562	141,095	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	238,352	4,127	242,479	67.00
68.00	06800	SPEECH PATHOLOGY	0	93,094	1,019	94,113	68.00
68.01	03040	AUDIOLOGY	0	3,781	256	4,037	68.01
69.00	06900	ELECTROCARDIOLOGY	63,023	0	64,690	127,713	69.00
69.01	03160	CARDIOPULMONARY	0	39,716	6,427	46,143	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	8,083	8,083	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	1,881	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	74.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	781,500	88,723	125,672	995,895	90.00
91.00	09100	EMERGENCY	0	241,009	66,379	307,388	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				0	92.00
OTHER REIMBURSABLE COST CENTERS							
101.00	10100	HOME HEALTH AGENCY	0	15,155	0	15,155	101.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	2,827,760	3,053,746	4,312,846	10,194,352	56,943
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	17,418	0	17,418	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	395,656	0	395,656	192.00
193.00	19300	NONPAID WORKERS	0	249,948	0	249,948	193.00
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)	2,827,760	3,716,768	4,312,846	10,857,374	56,943

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0289

Period:
From 01/01/2020
To 12/31/2020Worksheet B
Part II
Date/Time Prepared:
7/28/2021 3:46 pm

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	1,667,174					5.00
6.00	00600	MAINTENANCE & REPAIRS	35,383	248,464				6.00
7.00	00700	OPERATION OF PLANT	44,667	21,736	743,042			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	9,179	258	844	13,854		8.00
9.00	00900	HOUSEKEEPING	32,306	1,783	5,845	0	84,324	9.00
10.00	01000	DIETARY	12,655	6,601	21,632	0	249	10.00
11.00	01100	CAFETERIA	21,970	0	0	0	491	11.00
13.00	01300	NURSING ADMINISTRATION	14,720	1,670	5,474	0	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	19,509	6,071	19,897	208	270	14.00
15.00	01500	PHARMACY	75,895	1,485	4,867	0	896	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	28,429	5,313	17,412	0	818	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
23.00	02300	PARAMEDICAL EDUCATION PRGM	3,946	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	208,231	23,732	77,774	4,841	32,346	30.00
31.00	03100	INTENSIVE CARE UNIT	51,384	5,537	18,148	819	10,127	31.00
41.00	04100	SUBPROVIDER - IRF	33,737	4,263	13,971	0	6,045	41.00
43.00	04300	NURSERY	15,314	615	2,015	0	2,802	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	139,003	18,896	61,928	1,941	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	28,179	18,546	60,780	1,547	4,459	52.00
53.00	05300	ANESTHESIOLOGY	3,530	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	73,702	1,265	4,147	385	1,664	54.00
56.00	05600	RADIOISOTOPE	5,336	629	2,063	36	156	56.00
57.00	05700	CT SCAN	27,617	8,789	28,804	713	3,086	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	10,575	1,850	6,064	134	583	58.00
59.00	05900	CARDIAC CATHETERIZATION	30,135	0	0	144	0	59.00
60.00	06000	LABORATORY	96,077	5,501	18,027	0	2,013	60.00
65.00	06500	RESPIRATORY THERAPY	28,606	3,616	11,851	0	2,624	65.00
66.00	06600	PHYSICAL THERAPY	30,750	8,844	28,983	51	1,685	66.00
67.00	06700	OCCUPATIONAL THERAPY	22,068	17,488	57,314	954	171	67.00
68.00	06800	SPEECH PATHOLOGY	14,965	6,830	22,385	19	92	68.00
68.01	03040	AUDIOLOGY	3,428	277	909	5	21	68.01
69.00	06900	ELECTROCARDIOLOGY	13,435	0	0	84	0	69.00
69.01	03160	CARDIOPULMONARY	11,944	2,914	9,550	0	384	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	1,193	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	153,840	0	0	0	0	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	35,164	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	6,900	0	0	0	0	74.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	164,558	6,510	21,334	0	0	90.00
91.00	09100	EMERGENCY	122,874	17,683	57,953	1,973	13,342	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
OTHER REIMBURSABLE COST CENTERS								
101.00	10100	HOME HEALTH AGENCY	25,505	1,112	3,644	0	0	101.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	1,656,709	199,814	583,615	13,854	84,324	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	275	1,278	4,188	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	6,245	29,033	95,137	0	0	192.00
193.00	19300	NONPAID WORKERS	3,945	18,339	60,102	0	0	193.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	1,667,174	248,464	743,042	13,854	84,324	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0289

Period:
From 01/01/2020
To 12/31/2020Worksheet B
Part II
Date/Time Prepared:
7/28/2021 3:46 pm

Cost Center Description			DIETARY	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	
			10.00	11.00	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	144,694					10.00
11.00	01100	CAFETERIA	0	47,681				11.00
13.00	01300	NURSING ADMINISTRATION	0	6,758	51,977			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	2,612	0	220,469		14.00
15.00	01500	PHARMACY	0	1,793	0	632	448,269	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	2,815	0	2	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
23.00	02300	PARAMEDICAL EDUCATION PRGM	0	680	279	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	105,743	10,924	17,005	7,041	965	30.00
31.00	03100	INTENSIVE CARE UNIT	15,588	2,052	3,133	2,878	199	31.00
41.00	04100	SUBPROVIDER - IRF	23,363	2,553	1,976	338	45	41.00
43.00	04300	NURSERY	0	606	1,098	622	10	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	1,266	7,984	8,544	69	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	968	1,748	992	16	52.00
53.00	05300	ANESTHESIOLOGY	0	848	0	1,080	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	978	0	202	0	54.00
56.00	05600	RADIOISOTOPE	0	91	0	20	0	56.00
57.00	05700	CT SCAN	0	1,810	0	2,029	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	341	0	32	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	1,119	1,003	0	59.00
60.00	06000	LABORATORY	0	2,570	3,584	28,573	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	1,003	0	1,229	0	65.00
66.00	06600	PHYSICAL THERAPY	0	563	2,449	76	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	386	1,676	50	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	210	916	30	0	68.00
68.01	03040	AUDIOLOGY	0	53	0	77	0	68.01
69.00	06900	ELECTROCARDIOLOGY	0	987	0	140	0	69.00
69.01	03160	CARDIOPULMONARY	0	865	904	188	0	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	5	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	158,887	0	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	446,919	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0	1,796	0	90.00
91.00	09100	EMERGENCY	0	3,220	8,106	3,942	46	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
OTHER REIMBURSABLE COST CENTERS								
101.00	10100	HOME HEALTH AGENCY	0	0	0	61	0	101.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	144,694	46,952	51,977	220,469	448,269	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	729	0	0	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	144,694	47,681	51,977	220,469	448,269	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0289

Period:
From 01/01/2020
To 12/31/2020Worksheet B
Part II
Date/Time Prepared:
7/28/2021 3:46 pm

Cost Center Description			MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	PARAMEDICAL EDUCATION PRGM	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	
			16.00	17.00	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
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	131,115					16.00
17.00	01700	SOCIAL SERVICE	0	0				17.00
23.00	02300	PARAMEDICAL EDUCATION PRGM	0	0	5,120			23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	14,084	0		1,000,903	0	30.00
31.00	03100	INTENSIVE CARE UNIT	1,694	0		249,452	0	31.00
41.00	04100	SUBPROVIDER - IRF	1,661	0		150,589	0	41.00
43.00	04300	NURSERY	924	0		62,913	0	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	14,784	0		1,157,332	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,472	0		420,125	0	52.00
53.00	05300	ANESTHESIOLOGY	2,520	0		10,531	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	7,888	0		898,106	0	54.00
56.00	05600	RADIOISOTOPE	732	0		136,438	0	56.00
57.00	05700	CT SCAN	14,599	0		686,285	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	2,750	0		318,374	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	2,351	0		517,566	0	59.00
60.00	06000	LABORATORY	18,344	0		548,315	0	60.00
65.00	06500	RESPIRATORY THERAPY	3,058	0		250,749	0	65.00
66.00	06600	PHYSICAL THERAPY	2,530	0		218,417	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	1,677	0		345,153	0	67.00
68.00	06800	SPEECH PATHOLOGY	722	0		141,027	0	68.00
68.01	03040	AUDIOLOGY	172	0		9,271	0	68.01
69.00	06900	ELECTROCARDIOLOGY	3,535	0		146,417	0	69.00
69.01	03160	CARDIOPULMONARY	280	0		73,743	0	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	437	0		9,775	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	4,553	0		317,280	0	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	0		0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	11,213	0		495,177	0	73.00
74.00	07400	RENAL DIALYSIS	283	0		7,183	0	74.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	3,510	0		1,194,530	0	90.00
91.00	09100	EMERGENCY	14,983	0		557,217	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					0	92.00
OTHER REIMBURSABLE COST CENTERS								
101.00	10100	HOME HEALTH AGENCY	359	0		47,093	0	101.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	131,115	0	0	9,969,961	0	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		23,159	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0		526,800	0	192.00
193.00	19300	NONPAID WORKERS	0	0		332,334	0	193.00
200.00		Cross Foot Adjustments			5,120	5,120	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	131,115	0	5,120	10,857,374	0	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0289

Period:
From 01/01/2020
To 12/31/2020Worksheet B
Part II
Date/Time Prepared:
7/28/2021 3:46 pm

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
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
23.00	02300	PARAMEDICAL EDUCATION PRGM	23.00
INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS	30.00
31.00	03100	INTENSIVE CARE UNIT	31.00
41.00	04100	SUBPROVIDER - IRF	41.00
43.00	04300	NURSERY	43.00
ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	52.00
53.00	05300	ANESTHESIOLOGY	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	54.00
56.00	05600	RADIOISOTOPE	56.00
57.00	05700	CT SCAN	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	58.00
59.00	05900	CARDIAC CATHETERIZATION	59.00
60.00	06000	LABORATORY	60.00
65.00	06500	RESPIRATORY THERAPY	65.00
66.00	06600	PHYSICAL THERAPY	66.00
67.00	06700	OCCUPATIONAL THERAPY	67.00
68.00	06800	SPEECH PATHOLOGY	68.00
68.01	03040	AUDIOLOGY	68.01
69.00	06900	ELECTROCARDIOLOGY	69.00
69.01	03160	CARDIOPULMONARY	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	73.00
74.00	07400	RENAL DIALYSIS	74.00
OUTPATIENT SERVICE COST CENTERS			
90.00	09000	CLINIC	90.00
91.00	09100	EMERGENCY	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	92.00
OTHER REIMBURSABLE COST CENTERS			
101.00	10100	HOME HEALTH AGENCY	101.00
SPECIAL PURPOSE COST CENTERS			
113.00	11300	INTEREST EXPENSE	113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	118.00
NONREIMBURSABLE COST CENTERS			
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	192.00
193.00	19300	NONPAID WORKERS	193.00
200.00		Cross Foot Adjustments	200.00
201.00		Negative Cost Centers	201.00
202.00		TOTAL (sum lines 118 through 201)	202.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0289

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

Worksheet B-1

Date/Time Prepared:
7/28/2021 3:46 pm

Cost Center Description		CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
		BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (DOLLAR VALUE)				
		1.00	2.00	4.00	5A	5.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT	453,228				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		2,763,230			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	1,248	25,066	56,303,153		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	36,148	623,094	8,595,478	-27,275,806	5.00
6.00	00600	MAINTENANCE & REPAIRS	2,895	120,652	1,014,571	0	6.00
7.00	00700	OPERATION OF PLANT	36,124	243,720	0	0	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	428	0	62,108	0	8.00
9.00	00900	HOUSEKEEPING	2,964	11,941	1,428,943	0	9.00
10.00	01000	DIETARY	10,970	8,078	289,096	0	10.00
11.00	01100	CAFETERIA	0	15,792	565,328	0	11.00
13.00	01300	NURSING ADMINISTRATION	2,776	0	583,572	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	10,090	28,123	806,916	0	14.00
15.00	01500	PHARMACY	2,468	45,524	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	8,830	1,796	1,099,112	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	17.00
23.00	02300	PARAMEDICAL EDUCATION PRGM	0	0	212,256	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	39,441	105,239	9,909,434	0	30.00
31.00	03100	INTENSIVE CARE UNIT	9,203	38,430	2,413,241	0	31.00
41.00	04100	SUBPROVIDER - IRF	7,085	2,087	1,133,527	0	41.00
43.00	04300	NURSERY	1,022	19,084	731,757	0	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	31,405	299,619	5,115,609	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	30,823	30,414	1,166,016	0	52.00
53.00	05300	ANESTHESIOLOGY	0	1,636	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,103	235,307	2,304,906	0	54.00
56.00	05600	RADIOISOTOPE	1,046	70,285	156,351	0	56.00
57.00	05700	CT SCAN	14,607	238,372	493,802	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	3,075	25,684	183,912	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	163,090	925,610	0	59.00
60.00	06000	LABORATORY	9,142	186,761	1,795,632	0	60.00
65.00	06500	RESPIRATORY THERAPY	6,010	33,010	1,231,108	0	65.00
66.00	06600	PHYSICAL THERAPY	14,698	13,174	1,375,661	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	29,065	2,644	880,655	0	67.00
68.00	06800	SPEECH PATHOLOGY	11,352	653	736,462	0	68.00
68.01	03040	AUDIOLOGY	461	164	288,520	0	68.01
69.00	06900	ELECTROCARDIOLOGY	0	41,447	517,328	0	69.00
69.01	03160	CARDIOPULMONARY	4,843	4,118	564,658	0	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0	5,179	56,074	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	1,860,108	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	74.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	10,819	80,518	916,791	0	90.00
91.00	09100	EMERGENCY	29,389	42,529	5,645,346	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				0	92.00
OTHER REIMBURSABLE COST CENTERS							
101.00	10100	HOME HEALTH AGENCY	1,848	0	1,243,265	0	101.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	372,378	2,763,230	56,303,153	-27,275,806	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	2,124	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	48,247	0	0	0	192.00
193.00	19300	NONPAID WORKERS	30,479	0	0	0	193.00
200.00		Cross Foot Adjustments					200.00
201.00		Negative Cost Centers					201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	3,716,768	4,312,846	11,134,377	27,275,806	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	8.200658	1.560799	0.197758	0.258220	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)			56,943	1,667,174	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)			0.001011	0.015783	205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)					206.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0289

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

Worksheet B-1

Date/Time Prepared:
7/28/2021 3:46 pm

Cost Center Description			CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
			BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (DOLLAR VALUE)				
			1.00	2.00	4.00	5A	5.00	
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0289

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

Worksheet B-1

Date/Time Prepared:
7/28/2021 3:46 pm

Cost Center Description			MAINTENANCE & REPAIRS (SQUARE FEET)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (HOURS OF SERVICE)	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	412,937					6.00
7.00	00700	OPERATION OF PLANT	36,124	376,813				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	428	428	1,104,630			8.00
9.00	00900	HOUSEKEEPING	2,964	2,964	0	11,857		9.00
10.00	01000	DIETARY	10,970	10,970	0	35	96,331	10.00
11.00	01100	CAFETERIA	0	0	0	69	0	11.00
13.00	01300	NURSING ADMINISTRATION	2,776	2,776	0	0	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	10,090	10,090	16,581	38	0	14.00
15.00	01500	PHARMACY	2,468	2,468	0	126	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	8,830	8,830	0	115	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
23.00	02300	PARAMEDICAL EDUCATION PRGM	0	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	39,441	39,441	385,885	4,548	70,399	30.00
31.00	03100	INTENSIVE CARE UNIT	9,203	9,203	65,321	1,424	10,378	31.00
41.00	04100	SUBPROVIDER - IRF	7,085	7,085	0	850	15,554	41.00
43.00	04300	NURSERY	1,022	1,022	0	394	0	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	31,405	31,405	154,744	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	30,823	30,823	123,367	627	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,103	2,103	30,723	234	0	54.00
56.00	05600	RADIOISOTOPE	1,046	1,046	2,856	22	0	56.00
57.00	05700	CT SCAN	14,607	14,607	56,866	434	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	3,075	3,075	10,709	82	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	11,517	0	0	59.00
60.00	06000	LABORATORY	9,142	9,142	0	283	0	60.00
65.00	06500	RESPIRATORY THERAPY	6,010	6,010	0	369	0	65.00
66.00	06600	PHYSICAL THERAPY	14,698	14,698	4,081	237	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	29,065	29,065	76,076	24	0	67.00
68.00	06800	SPEECH PATHOLOGY	11,352	11,352	1,524	13	0	68.00
68.01	03040	AUDIOLOGY	461	461	381	3	0	68.01
69.00	06900	ELECTROCARDIOLOGY	0	0	6,702	0	0	69.00
69.01	03160	CARDIOPULMONARY	4,843	4,843	0	54	0	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPLANTABLE DEVICES 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
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	10,819	10,819	0	0	0	90.00
91.00	09100	EMERGENCY	29,389	29,389	157,297	1,876	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
OTHER REIMBURSABLE COST CENTERS								
101.00	10100	HOME HEALTH AGENCY	1,848	1,848	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	332,087	295,963	1,104,630	11,857	96,331	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	2,124	2,124	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	48,247	48,247	0	0	0	192.00
193.00	19300	NONPAID WORKERS	30,479	30,479	0	0	0	193.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	2,820,769	3,807,636	738,998	2,625,620	1,202,368	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	6.830991	10.104842	0.669000	221.440499	12.481631	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	248,464	743,042	13,854	84,324	144,694	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.601700	1.971912	0.012542	7.111748	1.502050	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: 14-0289

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

Worksheet B-1

Date/Time Prepared:
7/28/2021 3:46 pm

Cost Center Description			CAFETERIA (MEALS SERVED)	NURSING ADMINISTRATION (DIRECT NURS. HRS.)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (TIME SPENT)	
			11.00	13.00	14.00	15.00	16.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
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	27,679					11.00
13.00	01300	NURSING ADMINISTRATION	3,923	12,311				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	1,516	0	13,525,301			14.00
15.00	01500	PHARMACY	1,041	0	38,759	3,597,953		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,634	0	131	0	51,927	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
23.00	02300	PARAMEDICAL EDUCATION PRGM	395	66	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	6,341	4,028	431,938	7,743	5,578	30.00
31.00	03100	INTENSIVE CARE UNIT	1,191	742	176,574	1,601	671	31.00
41.00	04100	SUBPROVIDER - IRF	1,482	468	20,740	360	658	41.00
43.00	04300	NURSERY	352	260	38,188	81	366	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	735	1,891	524,153	555	5,855	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	562	414	60,882	129	583	52.00
53.00	05300	ANESTHESIOLOGY	492	0	66,244	0	998	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	568	0	12,407	0	3,124	54.00
56.00	05600	RADIOISOTOPE	53	0	1,234	0	290	56.00
57.00	05700	CT SCAN	1,051	0	124,478	0	5,782	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	198	0	1,967	0	1,089	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	265	61,518	0	931	59.00
60.00	06000	LABORATORY	1,492	849	1,752,942	0	7,265	60.00
65.00	06500	RESPIRATORY THERAPY	582	0	75,422	0	1,211	65.00
66.00	06600	PHYSICAL THERAPY	327	580	4,674	0	1,002	66.00
67.00	06700	OCCUPATIONAL THERAPY	224	397	3,065	0	664	67.00
68.00	06800	SPEECH PATHOLOGY	122	217	1,828	0	286	68.00
68.01	03040	AUDIOLOGY	31	0	4,751	0	68	68.01
69.00	06900	ELECTROCARDIOLOGY	573	0	8,579	0	1,400	69.00
69.01	03160	CARDIOPULMONARY	502	214	11,546	0	111	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	315	0	173	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	9,747,184	0	1,803	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	3,587,116	4,441	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	112	74.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	110,203	0	1,390	90.00
91.00	09100	EMERGENCY	1,869	1,920	241,859	368	5,934	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
OTHER REIMBURSABLE COST CENTERS								
101.00	10100	HOME HEALTH AGENCY	0	0	3,720	0	142	101.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	27,256	12,311	13,525,301	3,597,953	51,927	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	423	0	0	0	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	1,766,700	1,470,911	1,842,438	6,191,806	2,545,702	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	63.828173	119.479409	0.136222	1.720925	49.024631	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	47,681	51,977	220,469	448,269	131,115	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	1.722642	4.221997	0.016300	0.124590	2.524987	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: 14-0289

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

Worksheet B-1

Date/Time Prepared:
7/28/2021 3:46 pm

Cost Center Description			SOCIAL SERVICE (TIME SPENT)	PARAMEDICAL EDUCATION PRGM (ASSIGNED TIME)	
			17.00	23.00	
GENERAL SERVICE COST CENTERS					
1.00	00100	CAP REL COSTS-BLDG & FIXT			1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT			4.00
5.00	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
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	0		17.00
23.00	02300	PARAMEDICAL EDUCATION PRGM	0	100	23.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	31.00
41.00	04100	SUBPROVIDER - IRF	0	0	41.00
43.00	04300	NURSERY	0	0	43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	54.00
56.00	05600	RADIOISOTOPE	0	0	56.00
57.00	05700	CT SCAN	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	59.00
60.00	06000	LABORATORY	0	0	60.00
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
68.01	03040	AUDIOLOGY	0	0	68.01
69.00	06900	ELECTROCARDIOLOGY	0	0	69.00
69.01	03160	CARDIOPULMONARY	0	0	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	71.00
72.00	07200	IMPLANTABLE DEVICES 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
OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	0	0	90.00
91.00	09100	EMERGENCY	0	100	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)			92.00
OTHER REIMBURSABLE COST CENTERS					
101.00	10100	HOME HEALTH AGENCY	0	0	101.00
SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE			113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	100	118.00
NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	192.00
193.00	19300	NONPAID WORKERS	0	0	193.00
200.00		Cross Foot Adjustments			200.00
201.00		Negative Cost Centers			201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	0	347,707	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.000000	3,477.070000	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	0	5,120	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.000000	51.200000	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

Worksheet C
Part I
Date/Time Prepared:
7/28/2021 3:46 pm

MCRIF32 - 16.10.172.3

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0289

Period:
From 01/01/2020
To 12/31/2020Worksheet C
Part I
Date/Time Prepared:
7/28/2021 3:46 pm

			Title XVIII			Hospital		PPS	
Cost Center Description			Charges			Cost or Other Ratio	TEFRA Inpatient Ratio		
			Inpatient	Outpatient	Total (col. 6 + col. 7)				
			6.00	7.00	8.00				
	INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	43,417,480		43,417,480			30.00	
31.00	03100	INTENSIVE CARE UNIT	7,986,353		7,986,353			31.00	
41.00	04100	SUBPROVIDER - IRF	7,823,755		7,823,755			41.00	
43.00	04300	NURSERY	4,353,872		4,353,872			43.00	
	ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	15,695,786	53,967,504	69,663,290	0.177267	0.000000	50.00	
52.00	05200	DELIVERY ROOM & LABOR ROOM	6,893,526	44,134	6,937,660	0.448604	0.000000	52.00	
53.00	05300	ANESTHESIOLOGY	2,365,730	9,513,838	11,879,568	0.031211	0.000000	53.00	
54.00	05400	RADIOLOGY-DIAGNOSTIC	8,561,156	28,607,465	37,168,621	0.166123	0.000000	54.00	
56.00	05600	RADIOISOTOPE	558,533	2,897,275	3,455,808	0.135315	0.000000	56.00	
57.00	05700	CT SCAN	14,541,680	54,254,875	68,796,555	0.042889	0.000000	57.00	
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	2,188,622	10,767,223	12,955,845	0.076162	0.000000	58.00	
59.00	05900	CARDIAC CATHETERIZATION	6,480,141	4,599,580	11,079,721	0.225252	0.000000	59.00	
60.00	06000	LABORATORY	35,518,551	50,923,576	86,442,127	0.100279	0.000000	60.00	
65.00	06500	RESPIRATORY THERAPY	10,810,665	3,592,620	14,403,285	0.178487	0.000000	65.00	
66.00	06600	PHYSICAL THERAPY	5,737,862	6,183,261	11,921,123	0.242884	0.000000	66.00	
67.00	06700	OCCUPATIONAL THERAPY	4,928,193	2,967,104	7,895,297	0.304279	0.000000	67.00	
68.00	06800	SPEECH PATHOLOGY	1,126,148	2,270,917	3,397,065	0.423045	0.000000	68.00	
68.01	03040	AUDIOLOGY	0	810,174	810,174	0.355471	0.000000	68.01	
69.00	06900	ELECTROCARDIOLOGY	6,275,966	10,384,100	16,660,066	0.070942	0.000000	69.00	
69.01	03160	CARDIOPULMONARY	207	1,317,787	1,317,994	0.842761	0.000000	69.01	
70.00	07000	ELECTROENCEPHALOGRAPHY	84,394	1,969,076	2,053,470	0.050449	0.000000	70.00	
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	8,701,687	12,749,258	21,450,945	0.637747	0.000000	71.00	
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	0	0	0.000000	0.000000	72.00	
73.00	07300	DRUGS CHARGED TO PATIENTS	16,064,909	36,779,841	52,844,750	0.173984	0.000000	73.00	
74.00	07400	RENAL DIALYSIS	1,273,377	60,056	1,333,433	0.416644	0.000000	74.00	
	OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	40,249	16,498,277	16,538,526	0.809318	0.000000	90.00	
91.00	09100	EMERGENCY	14,573,615	56,034,498	70,608,113	0.167612	0.000000	91.00	
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	8,395,725	14,559,029	22,954,754	0.145123	0.000000	92.00	
	OTHER REIMBURSABLE COST CENTERS								
101.00	10100	HOME HEALTH AGENCY	0	1,686,003	1,686,003			101.00	
	SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00	
200.00		Subtotal (see instructions)	234,398,182	383,437,471	617,835,653			200.00	
201.00		Less Observation Beds						201.00	
202.00		Total (see instructions)	234,398,182	383,437,471	617,835,653			202.00	

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0289

Period:
From 01/01/2020
To 12/31/2020Worksheet C
Part I
Date/Time Prepared:
7/28/2021 3:46 pm

Cost Center Description			PPS Inpatient Ratio	Title XVIII	Hospital	PPS
			11.00			
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS				30.00
31.00	03100	INTENSIVE CARE UNIT				31.00
41.00	04100	SUBPROVIDER - IRF				41.00
43.00	04300	NURSERY				43.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.177267			50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.448604			52.00
53.00	05300	ANESTHESIOLOGY	0.037339			53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.167888			54.00
56.00	05600	RADIOISOTOPE	0.135315			56.00
57.00	05700	CT SCAN	0.042889			57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.076162			58.00
59.00	05900	CARDIAC CATHETERIZATION	0.226621			59.00
60.00	06000	LABORATORY	0.100279			60.00
65.00	06500	RESPIRATORY THERAPY	0.178487			65.00
66.00	06600	PHYSICAL THERAPY	0.242884			66.00
67.00	06700	OCCUPATIONAL THERAPY	0.304279			67.00
68.00	06800	SPEECH PATHOLOGY	0.423045			68.00
68.01	03040	AUDIOLOGY	0.355471			68.01
69.00	06900	ELECTROCARDIOLOGY	0.070942			69.00
69.01	03160	CARDIOPULMONARY	0.842761			69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0.050449			70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.637747			71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0.000000			72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.173984			73.00
74.00	07400	RENAL DIALYSIS	0.416644			74.00
OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.809318			90.00
91.00	09100	EMERGENCY	0.167612			91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.145123			92.00
OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY				101.00
SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE				113.00
200.00		Subtotal (see instructions)				200.00
201.00		Less Observation Beds				201.00
202.00		Total (see instructions)				202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

Provider CCN: 14-0289

Period:
From 01/01/2020
To 12/31/2020Worksheet D
Part I
Date/Time Prepared:
7/28/2021 3:46 pm

			Title XVIII		Hospital	PPS	
Cost Center Description		Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	1,000,903	0	1,000,903	22,432	44.62	30.00
31.00	INTENSIVE CARE UNIT	249,452		249,452	2,843	87.74	31.00
41.00	SUBPROVIDER - IRF	150,589	0	150,589	4,261	35.34	41.00
43.00	NURSERY	62,913		62,913	2,736	22.99	43.00
200.00	Total (lines 30 through 199)	1,463,857		1,463,857	32,272		200.00
Cost Center Description		Inpatient Program days	Inpatient Program Capital Cost (col. 5 x col. 6)				
		6.00	7.00				
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	6,965	310,778				
31.00	INTENSIVE CARE UNIT	1,219	106,955				
41.00	SUBPROVIDER - IRF	2,390	84,463				
43.00	NURSERY	0	0				
200.00	Total (lines 30 through 199)	10,574	502,196				

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 14-0289

Period:
From 01/01/2020
To 12/31/2020Worksheet D
Part II
Date/Time Prepared:
7/28/2021 3:46 pm

Cost Center Description			Title XVIII		Hospital	PPS		
			Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
	ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	1,157,332	69,663,290	0.016613	3,410,720	56,662	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	420,125	6,937,660	0.060557	15,410	933	52.00
53.00	05300	ANESTHESIOLOGY	10,531	11,879,568	0.000886	567,366	503	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	898,106	37,168,621	0.024163	3,403,145	82,230	54.00
56.00	05600	RADIOISOTOPE	136,438	3,455,808	0.039481	230,057	9,083	56.00
57.00	05700	CT SCAN	686,285	68,796,555	0.009976	5,682,988	56,693	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	318,374	12,955,845	0.024574	786,295	19,322	58.00
59.00	05900	CARDIAC CATHETERIZATION	517,566	11,079,721	0.046713	1,821,620	85,093	59.00
60.00	06000	LABORATORY	548,315	86,442,127	0.006343	12,676,074	80,404	60.00
65.00	06500	RESPIRATORY THERAPY	250,749	14,403,285	0.017409	4,654,866	81,037	65.00
66.00	06600	PHYSICAL THERAPY	218,417	11,921,123	0.018322	1,322,453	24,230	66.00
67.00	06700	OCCUPATIONAL THERAPY	345,153	7,895,297	0.043716	982,978	42,972	67.00
68.00	06800	SPEECH PATHOLOGY	141,027	3,397,065	0.041514	232,229	9,641	68.00
68.01	03040	AUDIOLOGY	9,271	810,174	0.011443	0	0	68.01
69.00	06900	ELECTROCARDIOLOGY	146,417	16,660,066	0.008789	2,583,469	22,706	69.00
69.01	03160	CARDIOPULMONARY	73,743	1,317,994	0.055951	0	0	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	9,775	2,053,470	0.004760	39,112	186	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	317,280	21,450,945	0.014791	2,906,910	42,996	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	0	0.000000	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	495,177	52,844,750	0.009370	5,538,523	51,896	73.00
74.00	07400	RENAL DIALYSIS	7,183	1,333,433	0.005387	694,905	3,743	74.00
	OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	1,194,530	16,538,526	0.072227	1,557	112	90.00
91.00	09100	EMERGENCY	557,217	70,608,113	0.007892	5,244,094	41,386	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	161,523	22,954,754	0.007037	2,842,536	20,003	92.00
200.00		Total (lines 50 through 199)	8,620,534	552,568,190		55,637,307	731,831	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS					Provider CCN: 14-0289		Period: From 01/01/2020 To 12/31/2020		Worksheet D Part III Date/Time Prepared: 7/28/2021 3:46 pm		
					Title XVIII		Hospital		PPS		
Cost Center Description					Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health Cost	All Other Medical Education Cost		
					1A	1.00	2A	2.00	3.00		
INPATIENT ROUTINE SERVICE COST CENTERS											
30.00	03000	ADULTS & PEDIATRICS		0	0	0	0	0	0	30.00	
31.00	03100	INTENSIVE CARE UNIT		0	0	0	0	0	0	31.00	
41.00	04100	SUBPROVIDER - IRF		0	0	0	0	0	0	41.00	
43.00	04300	NURSERY		0	0	0	0	0	0	43.00	
200.00		Total (lines 30 through 199)		0	0	0	0	0	0	200.00	
Cost Center Description					Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days		
					4.00	5.00	6.00	7.00	8.00		
INPATIENT ROUTINE SERVICE COST CENTERS											
30.00	03000	ADULTS & PEDIATRICS		0	0	22,432	0.00	6,965	30.00		
31.00	03100	INTENSIVE CARE UNIT		0	0	2,843	0.00	1,219	31.00		
41.00	04100	SUBPROVIDER - IRF		0	0	4,261	0.00	2,390	41.00		
43.00	04300	NURSERY		0	0	2,736	0.00	0	43.00		
200.00		Total (lines 30 through 199)		0	0	32,272		10,574	200.00		
Cost Center Description					Inpatient Program Pass-Through Cost (col. 7 x col. 8)						
					9.00						
INPATIENT ROUTINE SERVICE COST CENTERS											
30.00	03000	ADULTS & PEDIATRICS		0						30.00	
31.00	03100	INTENSIVE CARE UNIT		0						31.00	
41.00	04100	SUBPROVIDER - IRF		0						41.00	
43.00	04300	NURSERY		0						43.00	
200.00		Total (lines 30 through 199)		0						200.00	

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

Provider CCN: 14-0289

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

Worksheet D
Part IV
Date/Time Prepared:
7/28/2021 3:46 pm

Cost Center Description		Title XVIII		Hospital		PPS	
		Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health	
		1.00	2A	2.00	3A	3.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	54.00
56.00	05600	RADIOISOTOPE	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	59.00
60.00	06000	LABORATORY	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	68.00
68.01	03040	AUDIOLOGY	0	0	0	0	68.01
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	69.00
69.01	03160	CARDIOPULMONARY	0	0	0	0	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	74.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	0	347,707	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	92.00
200.00		Total (lines 50 through 199)	0	0	0	347,707	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

Provider CCN: 14-0289

Period:
From 01/01/2020
To 12/31/2020Worksheet D
Part IV
Date/Time Prepared:
7/28/2021 3:46 pm

			Title XVIII		Hospital	PPS		
Cost Center Description			All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7) (see instructions)	
			4.00	5.00	6.00	7.00	8.00	
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	0	69,663,290	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	6,937,660	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	11,879,568	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	37,168,621	0.000000	54.00
56.00	05600	RADIOISOTOPE	0	0	0	3,455,808	0.000000	56.00
57.00	05700	CT SCAN	0	0	0	68,796,555	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	12,955,845	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	11,079,721	0.000000	59.00
60.00	06000	LABORATORY	0	0	0	86,442,127	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	14,403,285	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	11,921,123	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	7,895,297	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	3,397,065	0.000000	68.00
68.01	03040	AUDIOLOGY	0	0	0	810,174	0.000000	68.01
69.00	06900	ELECTROCARDIOLOGY	0	0	0	16,660,066	0.000000	69.00
69.01	03160	CARDIOPULMONARY	0	0	0	1,317,994	0.000000	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	2,053,470	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	21,450,945	0.000000	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	0	0	0	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	52,844,750	0.000000	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	1,333,433	0.000000	74.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0	16,538,526	0.000000	90.00
91.00	09100	EMERGENCY	0	347,707	347,707	70,608,113	0.004924	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	22,954,754	0.000000	92.00
200.00		Total (lines 50 through 199)	0	347,707	347,707	552,568,190		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-0289

Period:
From 01/01/2020
To 12/31/2020Worksheet D
Part IV
Date/Time Prepared:
7/28/2021 3:46 pm

Cost Center Description		Title XVIII			Hospital		PPS
		Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
		9.00	10.00	11.00	12.00	13.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0.000000	3,410,720	0	11,199,588	0 50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	15,410	0	0	0 52.00
53.00	05300	ANESTHESIOLOGY	0.000000	567,366	0	1,835,211	0 53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	3,403,145	0	4,465,730	0 54.00
56.00	05600	RADIOISOTOPE	0.000000	230,057	0	808,489	0 56.00
57.00	05700	CT SCAN	0.000000	5,682,988	0	13,234,420	0 57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000	786,295	0	2,548,290	0 58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	1,821,620	0	1,321,416	0 59.00
60.00	06000	LABORATORY	0.000000	12,676,074	0	6,644,572	0 60.00
65.00	06500	RESPIRATORY THERAPY	0.000000	4,654,866	0	809,786	0 65.00
66.00	06600	PHYSICAL THERAPY	0.000000	1,322,453	0	76,499	0 66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	982,978	0	18,034	0 67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	232,229	0	7,736	0 68.00
68.01	03040	AUDIOLOGY	0.000000	0	0	63,584	0 68.01
69.00	06900	ELECTROCARDIOLOGY	0.000000	2,583,469	0	2,640,188	0 69.00
69.01	03160	CARDIOPULMONARY	0.000000	0	0	445,091	0 69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	39,112	0	380,826	0 70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	2,906,910	0	3,561,843	0 71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0.000000	0	0	0	0 72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	5,538,523	0	15,009,929	0 73.00
74.00	07400	RENAL DIALYSIS	0.000000	694,905	0	36,908	0 74.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0.000000	1,557	0	7,354,609	0 90.00
91.00	09100	EMERGENCY	0.004924	5,244,094	25,822	9,746,933	47,994 91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	2,842,536	0	2,993,441	0 92.00
200.00		Total (lines 50 through 199)		55,637,307	25,822	85,203,123	47,994 200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-0289

Period:
From 01/01/2020
To 12/31/2020Worksheet D
Part V
Date/Time Prepared:
7/28/2021 3:46 pm

			Title XVIII		Hospital		PPS		
	Cost Center Description		Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges		Costs			
				PPS Reimbursed Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	PPS Services (see inst.)		
			1.00	2.00	3.00	4.00	5.00		
	ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0.177267	11,199,588		0	1,985,317	50.00	
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.448604	0		0	0	52.00	
53.00	05300	ANESTHESIOLOGY	0.031211	1,835,211		0	57,279	53.00	
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.166123	4,465,730		0	741,860	54.00	
56.00	05600	RADIOISOTOPE	0.135315	808,489		0	109,401	56.00	
57.00	05700	CT SCAN	0.042889	13,234,420		0	567,611	57.00	
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.076162	2,548,290		0	194,083	58.00	
59.00	05900	CARDIAC CATHETERIZATION	0.225252	1,321,416		0	297,652	59.00	
60.00	06000	LABORATORY	0.100279	6,644,572		0	666,311	60.00	
65.00	06500	RESPIRATORY THERAPY	0.178487	809,786		0	144,536	65.00	
66.00	06600	PHYSICAL THERAPY	0.242884	76,499		0	18,580	66.00	
67.00	06700	OCCUPATIONAL THERAPY	0.304279	18,034		0	5,487	67.00	
68.00	06800	SPEECH PATHOLOGY	0.423045	7,736		0	3,273	68.00	
68.01	03040	AUDIOLOGY	0.355471	63,584		0	22,602	68.01	
69.00	06900	ELECTROCARDIOLOGY	0.070942	2,640,188		0	187,300	69.00	
69.01	03160	CARDIOPULMONARY	0.842761	445,091		0	375,105	69.01	
70.00	07000	ELECTROENCEPHALOGRAPHY	0.050449	380,826		0	19,212	70.00	
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.637747	3,561,843		0	2,271,555	71.00	
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0.000000	0		0	0	72.00	
73.00	07300	DRUGS CHARGED TO PATIENTS	0.173984	15,009,929		0	13,460	73.00	
74.00	07400	RENAL DIALYSIS	0.416644	36,908		0	0	74.00	
	OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0.809318	7,354,609		0	5,952,217	90.00	
91.00	09100	EMERGENCY	0.167612	9,746,933		0	123	91.00	
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.145123	2,993,441		0	0	92.00	
200.00		Subtotal (see instructions)		85,203,123		0	13,583	200.00	
201.00		Less PBP Clinic Lab. Services-Program Only Charges				0	0	201.00	
202.00		Net Charges (line 200 - line 201)		85,203,123		0	13,583	202.00	

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-0289

Period:
From 01/01/2020
To 12/31/2020Worksheet D
Part V
Date/Time Prepared:
7/28/2021 3:46 pm

			Title XVIII		Hospital	PPS
Cost Center Description			Costs			
			Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
	ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	0		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0		52.00
53.00	05300	ANESTHESIOLOGY	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0		54.00
56.00	05600	RADIOISOTOPE	0	0		56.00
57.00	05700	CT SCAN	0	0		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0		58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0		59.00
60.00	06000	LABORATORY	0	0		60.00
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
68.01	03040	AUDIOLOGY	0	0		68.01
69.00	06900	ELECTROCARDIOLOGY	0	0		69.00
69.01	03160	CARDIOPULMONARY	0	0		69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	2,342		73.00
74.00	07400	RENAL DIALYSIS	0	0		74.00
	OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	0	0		90.00
91.00	09100	EMERGENCY	0	21		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0		92.00
200.00		Subtotal (see instructions)	0	2,363		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	0	2,363		202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS					Provider CCN: 14-0289	Period: From 01/01/2020 To 12/31/2020	Worksheet D Part II Date/Time Prepared: 7/28/2021 3:46 pm	
					Component CCN: 14-T289			
					Title XVIII		Subprovider - IRF	PPS
Cost Center Description			Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
	ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	1,157,332	69,663,290	0.016613	19,942	331	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	420,125	6,937,660	0.006557	0	0	52.00
53.00	05300	ANESTHESIOLOGY	10,531	11,879,568	0.000886	3,549	3	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	898,106	37,168,621	0.024163	132,259	3,196	54.00
56.00	05600	RADIOISOTOPE	136,438	3,455,808	0.039481	9,325	368	56.00
57.00	05700	CT SCAN	686,285	68,796,555	0.009976	93,575	934	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	318,374	12,955,845	0.024574	16,466	405	58.00
59.00	05900	CARDIAC CATHETERIZATION	517,566	11,079,721	0.046713	9,452	442	59.00
60.00	06000	LABORATORY	548,315	86,442,127	0.006343	424,902	2,695	60.00
65.00	06500	RESPIRATORY THERAPY	250,749	14,403,285	0.017409	197,491	3,438	65.00
66.00	06600	PHYSICAL THERAPY	218,417	11,921,123	0.018322	1,692,947	31,018	66.00
67.00	06700	OCCUPATIONAL THERAPY	345,153	7,895,297	0.043716	1,633,129	71,394	67.00
68.00	06800	SPEECH PATHOLOGY	141,027	3,397,065	0.041514	349,032	14,490	68.00
68.01	03040	AUDIOLOGY	9,271	810,174	0.011443	0	0	68.01
69.00	06900	ELECTROCARDIOLOGY	146,417	16,660,066	0.008789	25,786	227	69.00
69.01	03160	CARDIOPULMONARY	73,743	1,317,994	0.055951	0	0	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	9,775	2,053,470	0.004760	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	317,280	21,450,945	0.014791	76,169	1,127	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	0	0.000000	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	495,177	52,844,750	0.009370	447,683	4,195	73.00
74.00	07400	RENAL DIALYSIS	7,183	1,333,433	0.005387	59,933	323	74.00
	OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	1,194,530	16,538,526	0.072227	0	0	90.00
91.00	09100	EMERGENCY	557,217	70,608,113	0.007892	4,011	32	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	22,954,754	0.000000	0	0	92.00
200.00		Total (lines 50 through 199)	8,459,011	552,568,190		5,195,651	134,618	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS				Provider CCN: 14-0289 Component CCN: 14-T289		Period: From 01/01/2020 To 12/31/2020		Worksheet D Part IV Date/Time Prepared: 7/28/2021 3:46 pm	
				Title XVIII		Subprovider - IRF		PPS	
Cost Center Description				Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health	
				1.00	2A	2.00	3A	3.00	
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM		0	0	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM		0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY		0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC		0	0	0	0	0	54.00
56.00	05600	RADIOISOTOPE		0	0	0	0	0	56.00
57.00	05700	CT SCAN		0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)		0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION		0	0	0	0	0	59.00
60.00	06000	LABORATORY		0	0	0	0	0	60.00
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
68.01	03040	AUDIOLOGY		0	0	0	0	0	68.01
69.00	06900	ELECTROCARDIOLOGY		0	0	0	0	0	69.00
69.01	03160	CARDIOPULMONARY		0	0	0	0	0	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY		0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS		0	0	0	0	0	71.00
72.00	07200	IMPLANTABLE DEVICES 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
OUTPATIENT SERVICE COST CENTERS									
90.00	09000	CLINIC		0	0	0	0	0	90.00
91.00	09100	EMERGENCY		0	0	0	0	347,707	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)		0	0	0	0	0	92.00
200.00		Total (lines 50 through 199)		0	0	0	0	347,707	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS			Provider CCN: 14-0289 Component CCN: 14-T289		Period: From 01/01/2020 To 12/31/2020		Worksheet D Part IV Date/Time Prepared: 7/28/2021 3:46 pm	
			Title XVIII		Subprovider - IRF		PPS	
Cost Center Description			All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7) (see instructions)	
			4.00	5.00	6.00	7.00	8.00	
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	0	69,663,290	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	6,937,660	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	11,879,568	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	37,168,621	0.000000	54.00
56.00	05600	RADIOISOTOPE	0	0	0	3,455,808	0.000000	56.00
57.00	05700	CT SCAN	0	0	0	68,796,555	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	12,955,845	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	11,079,721	0.000000	59.00
60.00	06000	LABORATORY	0	0	0	86,442,127	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	14,403,285	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	11,921,123	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	7,895,297	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	3,397,065	0.000000	68.00
68.01	03040	AUDIOLOGY	0	0	0	810,174	0.000000	68.01
69.00	06900	ELECTROCARDIOLOGY	0	0	0	16,660,066	0.000000	69.00
69.01	03160	CARDIOPULMONARY	0	0	0	1,317,994	0.000000	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	2,053,470	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	21,450,945	0.000000	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	0	0	0	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	52,844,750	0.000000	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	1,333,433	0.000000	74.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0	16,538,526	0.000000	90.00
91.00	09100	EMERGENCY	0	347,707	347,707	70,608,113	0.004924	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	22,954,754	0.000000	92.00
200.00		Total (lines 50 through 199)	0	347,707	347,707	552,568,190		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS				Provider CCN: 14-0289 Component CCN: 14-T289		Period: From 01/01/2020 To 12/31/2020		Worksheet D Part IV Date/Time Prepared: 7/28/2021 3:46 pm	
				Title XVIII		Subprovider - IRF		PPS	
Cost Center Description				Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
				9.00	10.00	11.00	12.00	13.00	
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM		0.000000	19,942	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM		0.000000	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY		0.000000	3,549	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC		0.000000	132,259	0	0	0	54.00
56.00	05600	RADIOISOTOPE		0.000000	9,325	0	0	0	56.00
57.00	05700	CT SCAN		0.000000	93,575	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)		0.000000	16,466	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION		0.000000	9,452	0	0	0	59.00
60.00	06000	LABORATORY		0.000000	424,902	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY		0.000000	197,491	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY		0.000000	1,692,947	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY		0.000000	1,633,129	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY		0.000000	349,032	0	0	0	68.00
68.01	03040	AUDIOLOGY		0.000000	0	0	0	0	68.01
69.00	06900	ELECTROCARDIOLOGY		0.000000	25,786	0	0	0	69.00
69.01	03160	CARDIOPULMONARY		0.000000	0	0	0	0	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY		0.000000	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS		0.000000	76,169	0	0	0	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS		0.000000	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS		0.000000	447,683	0	0	0	73.00
74.00	07400	RENAL DIALYSIS		0.000000	59,933	0	0	0	74.00
OUTPATIENT SERVICE COST CENTERS									
90.00	09000	CLINIC		0.000000	0	0	0	0	90.00
91.00	09100	EMERGENCY		0.004924	4,011	20	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)		0.000000	0	0	0	0	92.00
200.00		Total (lines 50 through 199)			5,195,651	20	0	0	200.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-0289	Period: From 01/01/2020 To 12/31/2020	Worksheet D-1 Date/Time Prepared: 7/28/2021 3:46 pm	
		Title XVIII	Hospital	PPS	
Cost Center Description				1.00	
	PART I - ALL PROVIDER COMPONENTS				
	INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		22,432	1.00	
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		22,432	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)		18,812	4.00	
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		0	5.00	
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	6.00	
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		0	7.00	
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	8.00	
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions)		6,965	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)		20,642,795	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)		20,642,795	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)		20,642,795	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)		920.24	38.00	
39.00	Program general inpatient routine service cost (line 9 x line 38)		6,409,472	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)		6,409,472	41.00	

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-0289

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

Worksheet D-1

Date/Time Prepared:
7/28/2021 3:46 pm

		Title XVIII		Hospital	PPS	
Cost Center Description		Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)
		1.00	2.00	3.00	4.00	5.00
42.00	NURSERY (title V & XIX only)	0	0	0.00	0	0
Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	4,965,095	2,843	1,746.43	1,219	2,128,898
44.00	CORONARY CARE UNIT					
45.00	BURN INTENSIVE CARE UNIT					
46.00	SURGICAL INTENSIVE CARE UNIT					
47.00	OTHER SPECIAL CARE (SPECIFY)					
Cost Center Description						
						1.00
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					9,357,161
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					17,895,531
PASS THROUGH COST ADJUSTMENTS						
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)					417,733
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					757,653
52.00	Total Program excludable cost (sum of lines 50 and 51)					1,175,386
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					16,720,145
TARGET AMOUNT AND LIMIT COMPUTATION						
54.00	Program discharges					0
55.00	Target amount per discharge					0.00
56.00	Target amount (line 54 x line 55)					0
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)					0
58.00	Bonus payment (see instructions)					0
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket					0.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket					0.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)					0
62.00	Relief payment (see instructions)					0
63.00	Allowable Inpatient cost plus incentive payment (see instructions)					0
PROGRAM INPATIENT ROUTINE SWING BED COST						
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)					0
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					0
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)					0
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)					0
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)					0
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)					0
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY						
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)					70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)					71.00
72.00	Program routine service cost (line 9 x line 71)					72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)					73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)					74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)					75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)					76.00
77.00	Program capital-related costs (line 9 x line 76)					77.00
78.00	Inpatient routine service cost (line 74 minus line 77)					78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)					79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)					80.00
81.00	Inpatient routine service cost per diem limitation					81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)					82.00
83.00	Reasonable inpatient routine service costs (see instructions)					83.00
84.00	Program inpatient ancillary services (see instructions)					84.00
85.00	Utilization review - physician compensation (see instructions)					85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)					86.00
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
87.00	Total observation bed days (see instructions)					3,620
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					920.24
89.00	Observation bed cost (line 87 x line 88) (see instructions)					3,331,269

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-0289

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

Worksheet D-1

Date/Time Prepared:
7/28/2021 3:46 pm

		Title XVIII		Hospital	PPS	
Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
	1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00 Capital-related cost	1,000,903	20,642,795	0.048487	3,331,269	161,523	90.00
91.00 Nursing School cost	0	20,642,795	0.000000	3,331,269	0	91.00
92.00 Allied health cost	0	20,642,795	0.000000	3,331,269	0	92.00
93.00 All other Medical Education	0	20,642,795	0.000000	3,331,269	0	93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-0289 Component CCN: 14-T289	Period: From 01/01/2020 To 12/31/2020	Worksheet D-1 Date/Time Prepared: 7/28/2021 3:46 pm
		Title XVIII	Subprovider - IRF	PPS
Cost Center Description			1.00	
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		4,261	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		4,261	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)		4,261	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)		2,390	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)		3,378,091	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)		3,378,091	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)		3,378,091	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)		792.79	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		1,894,768	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)		1,894,768	41.00

COMPUTATION OF INPATIENT OPERATING COST			Provider CCN: 14-0289 Component CCN: 14-T289	Period: From 01/01/2020 To 12/31/2020	Worksheet D-1 Date/Time Prepared: 7/28/2021 3:46 pm
			Title XVIII	Subprovider - IRF	PPS
Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)
	1.00	2.00	3.00	4.00	5.00
42.00 NURSERY (title V & XIX only)	0	0	0.00	0	0
Intensive Care Type Inpatient Hospital Units					
43.00 INTENSIVE CARE UNIT	0	0	0.00	0	0
44.00 CORONARY CARE UNIT					
45.00 BURN INTENSIVE CARE UNIT					
46.00 SURGICAL INTENSIVE CARE UNIT					
47.00 OTHER SPECIAL CARE (SPECIFY)					
Cost Center Description					1.00
48.00 Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					1,322,115
49.00 Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					3,216,883
PASS THROUGH COST ADJUSTMENTS					
50.00 Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)					84,463
51.00 Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					134,638
52.00 Total Program excludable cost (sum of lines 50 and 51)					219,101
53.00 Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					2,997,782
TARGET AMOUNT AND LIMIT COMPUTATION					
54.00 Program discharges					0
55.00 Target amount per discharge					0.00
56.00 Target amount (line 54 x line 55)					0
57.00 Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)					0
58.00 Bonus payment (see instructions)					0
59.00 Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket					0.00
60.00 Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket					0.00
61.00 If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)					0
62.00 Relief payment (see instructions)					0
63.00 Allowable Inpatient cost plus incentive payment (see instructions)					0
PROGRAM INPATIENT ROUTINE SWING BED COST					
64.00 Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)					0
65.00 Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					0
66.00 Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)					0
67.00 Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)					0
68.00 Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)					0
69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)					0
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY					
70.00 Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)					70.00
71.00 Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)					71.00
72.00 Program routine service cost (line 9 x line 71)					72.00
73.00 Medically necessary private room cost applicable to Program (line 14 x line 35)					73.00
74.00 Total Program general inpatient routine service costs (line 72 + line 73)					74.00
75.00 Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)					75.00
76.00 Per diem capital-related costs (line 75 ÷ line 2)					76.00
77.00 Program capital-related costs (line 9 x line 76)					77.00
78.00 Inpatient routine service cost (line 74 minus line 77)					78.00
79.00 Aggregate charges to beneficiaries for excess costs (from provider records)					79.00
80.00 Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)					80.00
81.00 Inpatient routine service cost per diem limitation					81.00
82.00 Inpatient routine service cost limitation (line 9 x line 81)					82.00
83.00 Reasonable inpatient routine service costs (see instructions)					83.00
84.00 Program inpatient ancillary services (see instructions)					84.00
85.00 Utilization review - physician compensation (see instructions)					85.00
86.00 Total Program inpatient operating costs (sum of lines 83 through 85)					86.00
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST					
87.00 Total observation bed days (see instructions)					0
88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					0.00
89.00 Observation bed cost (line 87 x line 88) (see instructions)					0

COMPUTATION OF INPATIENT OPERATING COST			Provider CCN: 14-0289 Component CCN: 14-T289		Period: From 01/01/2020 To 12/31/2020		Worksheet D-1 Date/Time Prepared: 7/28/2021 3:46 pm
			Title XVIII		Subprovider - IRF		PPS
Cost Center Description		Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00	Capital-related cost	150,589	3,378,091	0.044578	0	0	90.00
91.00	Nursing School cost	0	3,378,091	0.000000	0	0	91.00
92.00	Allied health cost	0	3,378,091	0.000000	0	0	92.00
93.00	All other Medical Education	0	3,378,091	0.000000	0	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT			Provider CCN: 14-0289	Period: From 01/01/2020 To 12/31/2020	Worksheet D-3 Date/Time Prepared: 7/28/2021 3:46 pm	
			Title XVIII	Hospital	PPS	
Cost Center Description			Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS		13,015,641		30.00
31.00	03100	INTENSIVE CARE UNIT		3,275,979		31.00
41.00	04100	SUBPROVIDER - IRF		0		41.00
43.00	04300	NURSERY				43.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.177267	3,410,720	604,608	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.448604	15,410	6,913	52.00
53.00	05300	ANESTHESIOLOGY	0.037339	567,366	21,185	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.167888	3,403,145	571,347	54.00
56.00	05600	RADIOISOTOPE	0.135315	230,057	31,130	56.00
57.00	05700	CT SCAN	0.042889	5,682,988	243,738	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.076162	786,295	59,886	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.226621	1,821,620	412,817	59.00
60.00	06000	LABORATORY	0.100279	12,676,074	1,271,144	60.00
65.00	06500	RESPIRATORY THERAPY	0.178487	4,654,866	830,833	65.00
66.00	06600	PHYSICAL THERAPY	0.242884	1,322,453	321,203	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.304279	982,978	299,100	67.00
68.00	06800	SPEECH PATHOLOGY	0.423045	232,229	98,243	68.00
68.01	03040	AUDIOLOGY	0.355471	0	0	68.01
69.00	06900	ELECTROCARDIOLOGY	0.070942	2,583,469	183,276	69.00
69.01	03160	CARDIOPULMONARY	0.842761	0	0	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0.050449	39,112	1,973	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.637747	2,906,910	1,853,873	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0.000000	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.173984	5,538,523	963,614	73.00
74.00	07400	RENAL DIALYSIS	0.416644	694,905	289,528	74.00
OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.809318	1,557	1,260	90.00
91.00	09100	EMERGENCY	0.167612	5,244,094	878,973	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.145123	2,842,536	412,517	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		55,637,307	9,357,161	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)		55,637,307		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 14-0289 Component CCN: 14-T289	Period: From 01/01/2020 To 12/31/2020	Worksheet D-3 Date/Time Prepared: 7/28/2021 3:46 pm	
		Title XVIII	Subprovider - IRF	PPS	
Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDIATRICS		0		30.00
31.00	03100 INTENSIVE CARE UNIT		0		31.00
41.00	04100 SUBPROVIDER - IRF		4,416,995		41.00
43.00	04300 NURSERY				43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.177267	19,942	3,535	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.448604	0	0	52.00
53.00	05300 ANESTHESIOLOGY	0.037339	3,549	133	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.167888	132,259	22,205	54.00
56.00	05600 RADIOISOTOPE	0.135315	9,325	1,262	56.00
57.00	05700 CT SCAN	0.042889	93,575	4,013	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0.076162	16,466	1,254	58.00
59.00	05900 CARDIAC CATHETERIZATION	0.226621	9,452	2,142	59.00
60.00	06000 LABORATORY	0.100279	424,902	42,609	60.00
65.00	06500 RESPIRATORY THERAPY	0.178487	197,491	35,250	65.00
66.00	06600 PHYSICAL THERAPY	0.242884	1,692,947	411,190	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.304279	1,633,129	496,927	67.00
68.00	06800 SPEECH PATHOLOGY	0.423045	349,032	147,656	68.00
68.01	03040 AUDIOLOGY	0.355471	0	0	68.01
69.00	06900 ELECTROCARDIOLOGY	0.070942	25,786	1,829	69.00
69.01	03160 CARDIOPULMONARY	0.842761	0	0	69.01
70.00	07000 ELECTROENCEPHALOGRAPHY	0.050449	0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.637747	76,169	48,577	71.00
72.00	07200 IMPLANTABLE DEVICES CHARGED TO PATIENTS	0.000000	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.173984	447,683	77,890	73.00
74.00	07400 RENAL DIALYSIS	0.416644	59,933	24,971	74.00
OUTPATIENT SERVICE COST CENTERS					
90.00	09000 CLINIC	0.809318	0	0	90.00
91.00	09100 EMERGENCY	0.167612	4,011	672	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.145123	0	0	92.00
200.00	Total (sum of lines 50 through 94 and 96 through 98)		5,195,651	1,322,115	200.00
201.00	Less PBP Clinic Laboratory Services-Program only charges (line 61)		0	0	201.00
202.00	Net charges (line 200 minus line 201)		5,195,651		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT

Provider CCN: 14-0289

Period:
From 01/01/2020
To 12/31/2020Worksheet E
Part A
Date/Time Prepared:
7/28/2021 3:46 pm

		Title XVIII	Hospital	PPS	
				1.00	
PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS					
1.00	DRG Amounts Other than Outlier Payments			0	1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1 (see instructions)			0	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1 (see instructions)			15,461,896	1.02
1.03	DRG for federal specific operating payment for Model 4 BPCI for discharges occurring prior to October 1 (see instructions)			0	1.03
1.04	DRG for federal specific operating payment for Model 4 BPCI for discharges occurring on or after October 1 (see instructions)			0	1.04
2.00	Outlier payments for discharges. (see instructions)				2.00
2.01	Outlier reconciliation amount			0	2.01
2.02	Outlier payment for discharges for Model 4 BPCI (see instructions)			0	2.02
2.03	Outlier payments for discharges occurring prior to October 1 (see instructions)			0	2.03
2.04	Outlier payments for discharges occurring on or after October 1 (see instructions)			103,635	2.04
3.00	Managed Care Simulated Payments			0	3.00
4.00	Bed days available divided by number of days in the cost reporting period (see instructions)			120.11	4.00
Indirect Medical Education Adjustment					
5.00	FTE count for allopathic and osteopathic programs for the most recent cost reporting period ending on or before 12/31/1996.(see instructions)			0.00	5.00
6.00	FTE count for allopathic and osteopathic programs that meet the criteria for an add-on to the cap for new programs in accordance with 42 CFR 413.79(e)			0.00	6.00
7.00	MMA Section 422 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(1)			0.00	7.00
7.01	ACA § 5503 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(2) If the cost report straddles July 1, 2011 then see instructions.			0.00	7.01
8.00	Adjustment (increase or decrease) to the FTE count for allopathic and osteopathic programs for affiliated programs in accordance with 42 CFR 413.75(b), 413.79(c)(2)(iv), 64 FR 26340 (May 12, 1998), and 67 FR 50069 (August 1, 2002).			0.00	8.00
8.01	The amount of increase if the hospital was awarded FTE cap slots under § 5503 of the ACA. If the cost report straddles July 1, 2011, see instructions.			0.00	8.01
8.02	The amount of increase if the hospital was awarded FTE cap slots from a closed teaching hospital under § 5506 of ACA. (see instructions)			0.00	8.02
9.00	Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus lines (8, 8.01 and 8.02) (see instructions)			0.00	9.00
10.00	FTE count for allopathic and osteopathic programs in the current year from your records			0.00	10.00
11.00	FTE count for residents in dental and podiatric programs.			0.00	11.00
12.00	Current year allowable FTE (see instructions)			0.00	12.00
13.00	Total allowable FTE count for the prior year.			0.00	13.00
14.00	Total allowable FTE count for the penultimate year if that year ended on or after September 30, 1997, otherwise enter zero.			0.00	14.00
15.00	Sum of lines 12 through 14 divided by 3.			0.00	15.00
16.00	Adjustment for residents in initial years of the program			0.00	16.00
17.00	Adjustment for residents displaced by program or hospital closure			0.00	17.00
18.00	Adjusted rolling average FTE count			0.00	18.00
19.00	Current year resident to bed ratio (line 18 divided by line 4).			0.000000	19.00
20.00	Prior year resident to bed ratio (see instructions)			0.000000	20.00
21.00	Enter the lesser of lines 19 or 20 (see instructions)			0.000000	21.00
22.00	IME payment adjustment (see instructions)			0	22.00
22.01	IME payment adjustment - Managed Care (see instructions)			0	22.01
Indirect Medical Education Adjustment for the Add-on for § 422 of the MMA					
23.00	Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 CFR 412.105 (f)(1)(iv)(C) .			0.00	23.00
24.00	IME FTE Resident Count Over Cap (see instructions)			0.00	24.00
25.00	If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see instructions)			0.00	25.00
26.00	Resident to bed ratio (divide line 25 by line 4)			0.000000	26.00
27.00	IME payments adjustment factor. (see instructions)			0.000000	27.00
28.00	IME add-on adjustment amount (see instructions)			0	28.00
28.01	IME add-on adjustment amount - Managed Care (see instructions)			0	28.01
29.00	Total IME payment (sum of lines 22 and 28)			0	29.00
29.01	Total IME payment - Managed Care (sum of lines 22.01 and 28.01)			0	29.01
Disproportionate Share Adjustment					
30.00	Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)			3.25	30.00
31.00	Percentage of Medicaid patient days (see instructions)			19.73	31.00
32.00	Sum of lines 30 and 31			22.98	32.00
33.00	Allowable disproportionate share percentage (see instructions)			8.17	33.00
34.00	Disproportionate share adjustment (see instructions)			315,809	34.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0289	Period: From 01/01/2020 To 12/31/2020	Worksheet E Part A Date/Time Prepared: 7/28/2021 3:46 pm	
		Title XVIII	Hospital	PPS	
			Prior to 10/1	On/After 10/1	
			1.00	2.00	
Uncompensated Care Adjustment					
35.00	Total uncompensated care amount (see instructions)		0	0	35.00
35.01	Factor 3 (see instructions)	0.000000000	0.000000000		35.01
35.02	Hospital uncompensated care payment (If line 34 is zero, enter zero on this line) (see instructions)	1,046,940	1,526,092		35.02
35.03	Pro rata share of the hospital uncompensated care payment amount (see instructions)	783,775	384,659		35.03
36.00	Total uncompensated care (sum of columns 1 and 2 on line 35.03)	1,168,434			36.00
Additional payment for high percentage of ESRD beneficiary discharges (lines 40 through 46)					
40.00	Total Medicare discharges, excluding MS-DRGs 652, 682, 683, 684 and 685. (see instructions)		0		40.00
41.00	Total ESRD Medicare discharges excluding MS-DRGs 652, 682, 683, 684 and 685. (see instructions)		0		41.00
41.01	Total ESRD Medicare covered and paid discharges excluding MS-DRGs 652, 682, 683, 684 and 685. (see instructions)		0		41.01
42.00	Divide line 41 by line 40 (if less than 10%, you do not qualify for adjustment)	0.00			42.00
43.00	Total Medicare ESRD inpatient days excluding MS-DRGs 652, 682, 683, 684 and 685. (see instructions)		0		43.00
44.00	Ratio of average length of stay to one week (line 43 divided by line 41 divided by 7 days)	0.000000			44.00
45.00	Average weekly cost for dialysis treatments (see instructions)	0.00			45.00
46.00	Total additional payment (line 45 times line 44 times line 41.01)		0		46.00
47.00	Subtotal (see instructions)	17,049,774			47.00
48.00	Hospital specific payments (to be completed by SCH and MDH, small rural hospitals only. (see instructions)		0		48.00
				Amount	
				1.00	
49.00	Total payment for inpatient operating costs (see instructions)		17,049,774		49.00
50.00	Payment for inpatient program capital (from Wkst. L, Pt. I and Pt. II, as applicable)		1,250,016		50.00
51.00	Exception payment for inpatient program capital (Wkst. L, Pt. III, see instructions)		0		51.00
52.00	Direct graduate medical education payment (from Wkst. E-4, line 49 see instructions).		0		52.00
53.00	Nursing and Allied Health Managed Care payment		20,198		53.00
54.00	Special add-on payments for new technologies		51,627		54.00
54.01	Islet isolation add-on payment		0		54.01
55.00	Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line 69)		0		55.00
56.00	Cost of physicians' services in a teaching hospital (see instructions)		0		56.00
57.00	Routine service other pass through costs (from Wkst. D, Pt. III, column 9, lines 30 through 35).		0		57.00
58.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 11 line 200)		25,822		58.00
59.00	Total (sum of amounts on lines 49 through 58)		18,397,437		59.00
60.00	Primary payer payments		47,686		60.00
61.00	Total amount payable for program beneficiaries (line 59 minus line 60)		18,349,751		61.00
62.00	Deductibles billed to program beneficiaries		1,803,032		62.00
63.00	Coinurance billed to program beneficiaries		54,890		63.00
64.00	Allowable bad debts (see instructions)		412,154		64.00
65.00	Adjusted reimbursable bad debts (see instructions)		267,900		65.00
66.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		375,916		66.00
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)		16,759,729		67.00
68.00	Credits received from manufacturers for replaced devices for applicable to MS-DRGs (see instructions)		0		68.00
69.00	Outlier payments reconciliation (sum of lines 93, 95 and 96). (For SCH see instructions)		0		69.00
70.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0		70.00
70.50	Rural Community Hospital Demonstration Project (\$410A Demonstration) adjustment (see instructions)		0		70.50
70.87	Demonstration payment adjustment amount before sequestration		0		70.87
70.88	SCH or MDH volume decrease adjustment (contractor use only)		0		70.88
70.89	Pioneer ACO demonstration payment adjustment amount (see instructions)		0		70.89
70.90	HSP bonus payment HVBP adjustment amount (see instructions)		0		70.90
70.91	HSP bonus payment HRR adjustment amount (see instructions)		0		70.91
70.92	Bundled Model 1 discount amount (see instructions)		0		70.92
70.93	HVBP payment adjustment amount (see instructions)		84,988		70.93
70.94	HRR adjustment amount (see instructions)		-51,649		70.94
70.95	Recovery of accelerated depreciation		0		70.95

CALCULATION OF REIMBURSEMENT SETTLEMENT

Provider CCN: 14-0289

Period:
From 01/01/2020
To 12/31/2020Worksheet E
Part A
Date/Time Prepared:
7/28/2021 3:46 pm

		Title XVIII	Hospital	PPS	
		FFY (yyyy)	Amount		
		0	1.00		
70.96	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period prior to 10/1)	0	0	70.96	
70.97	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period ending on or after 10/1)	0	0	70.97	
70.98	Low Volume Payment-3		0	70.98	
70.99	HAC adjustment amount (see instructions)		0	70.99	
71.00	Amount due provider (line 67 minus lines 68 plus/minus lines 69 & 70)		16,793,068	71.00	
71.01	Sequestration adjustment (see instructions)		110,834	71.01	
71.02	Demonstration payment adjustment amount after sequestration		0	71.02	
71.03	Sequestration adjustment-PARHM pass-throughs			71.03	
72.00	Interim payments		16,324,682	72.00	
72.01	Interim payments-PARHM			72.01	
73.00	Tentative settlement (for contractor use only)		0	73.00	
73.01	Tentative settlement-PARHM (for contractor use only)			73.01	
74.00	Balance due provider/program (line 71 minus lines 71.01, 71.02, 72, and 73)		357,552	74.00	
74.01	Balance due provider/program-PARHM (see instructions)			74.01	
75.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		431,996	75.00	
TO BE COMPLETED BY CONTRACTOR (lines 90 through 96)					
90.00	Operating outlier amount from Wkst. E, Pt. A, line 2, or sum of 2.03 plus 2.04 (see instructions)			0	90.00
91.00	Capital outlier from Wkst. L, Pt. I, line 2			0	91.00
92.00	Operating outlier reconciliation adjustment amount (see instructions)			0	92.00
93.00	Capital outlier reconciliation adjustment amount (see instructions)			0	93.00
94.00	The rate used to calculate the time value of money (see instructions)		0.00	94.00	
95.00	Time value of money for operating expenses (see instructions)			0	95.00
96.00	Time value of money for capital related expenses (see instructions)			0	96.00
			Prior to 10/1	On/After 10/1	
			1.00	2.00	
HSP Bonus Payment Amount					
100.00	HSP bonus amount (see instructions)		0	0	100.00
HVB Adjustment for HSP Bonus Payment					
101.00	HVB adjustment factor (see instructions)	0.0000000000	0.0000000000	101.00	
102.00	HVB adjustment amount for HSP bonus payment (see instructions)	0	0	102.00	
HRR Adjustment for HSP Bonus Payment					
103.00	HRR adjustment factor (see instructions)	0.0000	0.0000	103.00	
104.00	HRR adjustment amount for HSP bonus payment (see instructions)	0	0	104.00	
Rural Community Hospital Demonstration Project (\$410A Demonstration) Adjustment					
200.00	Is this the first year of the current 5-year demonstration period under the 21st Century Cures Act? Enter "Y" for yes or "N" for no.				200.00
Cost Reimbursement					
201.00	Medicare inpatient service costs (from Wkst. D-1, Pt. II, line 49)				201.00
202.00	Medicare discharges (see instructions)				202.00
203.00	Case-mix adjustment factor (see instructions)				203.00
Computation of Demonstration Target Amount Limitation (N/A in first year of the current 5-year demonstration period)					
204.00	Medicare target amount				204.00
205.00	Case-mix adjusted target amount (line 203 times line 204)				205.00
206.00	Medicare inpatient routine cost cap (line 202 times line 205)				206.00
Adjustment to Medicare Part A Inpatient Reimbursement					
207.00	Program reimbursement under the \$410A Demonstration (see instructions)				207.00
208.00	Medicare Part A inpatient service costs (from Wkst. E, Pt. A, line 59)				208.00
209.00	Adjustment to Medicare IPPS payments (see instructions)				209.00
210.00	Reserved for future use				210.00
211.00	Total adjustment to Medicare IPPS payments (see instructions)				211.00
Comparison of PPS versus Cost Reimbursement					
212.00	Total adjustment to Medicare Part A IPPS payments (from line 211)				212.00
213.00	Low-volume adjustment (see instructions)				213.00
218.00	Net Medicare Part A IPPS adjustment (difference between PPS and cost reimbursement) (line 212 minus line 213) (see instructions)				218.00

LOW VOLUME CALCULATION EXHIBIT 4

Provider CCN: 14-0289

Period:
From 01/01/2020
To 12/31/2020Worksheet E
Part A Exhibit 4
Date/Time Prepared:
7/28/2021 3:46 pm

		Title XVIII		Hospital		PPS	
		W/S E, Part A line	Amounts (from E, Part A)	Pre/Post Entitlement	Period Prior to 10/01	Period On/After 10/01	Total (Col 2 through 4)
		0	1.00	2.00	3.00	4.00	5.00
1.00	DRG amounts other than outlier payments	1.00	0	0	0	0	0
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1	1.01	0	0	0	0	0
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	15,461,896	0	0	15,461,896	15,461,896
1.03	DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October 1	1.03	0	0	0	0	0
1.04	DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1	1.04	0	0	0	0	0
2.00	Outlier payments for discharges (see instructions)	2.00					
2.01	Outlier payments for discharges for Model 4 BPCI	2.02	0	0	0	0	0
2.02	Outlier payments for discharges occurring prior to October 1 (see instructions)	2.03	0	0	0	0	0
2.03	Outlier payments for discharges occurring on or after October 1 (see instructions)	2.04	103,635	0	0	103,635	103,635
3.00	Operating outlier reconciliation	2.01	0	0	0	0	0
4.00	Managed care simulated payments	3.00	0	0	0	0	0
Indirect Medical Education Adjustment							
5.00	Amount from Worksheet E, Part A, line 21 (see instructions)	21.00	0.000000	0.000000	0.000000	0.000000	0
6.00	IME payment adjustment (see instructions)	22.00	0	0	0	0	0
6.01	IME payment adjustment for managed care (see instructions)	22.01	0	0	0	0	0
Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA							
7.00	IME payment adjustment factor (see instructions)	27.00	0.000000	0.000000	0.000000	0.000000	0
8.00	IME adjustment (see instructions)	28.00	0	0	0	0	0
8.01	IME payment adjustment add on for managed care (see instructions)	28.01	0	0	0	0	0
9.00	Total IME payment (sum of lines 6 and 8)	29.00	0	0	0	0	0
9.01	Total IME payment for managed care (sum of lines 6.01 and 8.01)	29.01	0	0	0	0	0
Disproportionate Share Adjustment							
10.00	Allowable disproportionate share percentage (see instructions)	33.00	0.0817	0.0817	0.0817	0.0817	0
11.00	Disproportionate share adjustment (see instructions)	34.00	315,809	0	0	315,809	315,809
11.01	Uncompensated care payments	36.00	1,168,434	0	769,190	263,166	1,032,356
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	17,049,774	0	769,190	16,280,584	17,049,774
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	17,049,774	0	769,190	16,280,584	17,049,774
16.00	Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable)	50.00	1,250,016	0	0	1,250,016	1,250,016

LOW VOLUME CALCULATION EXHIBIT 4

Provider CCN: 14-0289

Period:
From 01/01/2020
To 12/31/2020Worksheet E
Part A Exhibit 4
Date/Time Prepared:
7/28/2021 3:46 pm

				Title XVIII		Hospital	PPS	
		W/S E, Part A line	Amounts (from E, Part A)	Pre/Post Entitlement	Period Prior to 10/01	Period On/After 10/01	Total (Col 2 through 4)	
		0	1.00	2.00	3.00	4.00	5.00	
17.00	Special add-on payments for new technologies	54.00	51,627	0	0	51,627	51,627	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	769,190	17,582,227	18,351,417	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	1,188,838	0	0	1,188,838	1,188,838	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	4,589	0	0	4,589	4,589	21.00
21.01	Model 4 BPCI Capital DRG outlier payments	2.01	0	0	0	0	0	21.01
22.00	Indirect medical education percentage (see instructions)	5.00	0.0000	0.0000	0.0000	0.0000		22.00
23.00	Indirect medical education adjustment (see instructions)	6.00	0	0	0	0	0	23.00
24.00	Allowable disproportionate share percentage (see instructions)	10.00	0.0476	0.0476	0.0476	0.0476		24.00
25.00	Disproportionate share adjustment (see instructions)	11.00	56,589	0	0	56,589	56,589	25.00
26.00	Total prospective capital payments (see instructions)	12.00	1,250,016	0	0	1,250,016	1,250,016	26.00
		W/S E, Part A line	(Amounts to E, Part A)					
		0	1.00	2.00	3.00	4.00	5.00	
27.00	Low volume adjustment factor				0.000000	0.000000		27.00
28.00	Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)	70.96			0		0	28.00
29.00	Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)	70.97				0	0	29.00
100.00	Transfer low volume adjustments to Wkst. E, Pt. A.		Y					100.00

HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULATION EXHIBIT 5

Provider CCN: 14-0289

Period:
From 01/01/2020
To 12/31/2020Worksheet E
Part A Exhibit 5
Date/Time Prepared:
7/28/2021 3:46 pm

		Title XVIII		Hospital		PPS	
		Wkst. E, Pt. A, line	Amt. from Wkst. E, Pt. A	Period to 10/01	Period on after 10/01	Total (cols. 2 and 3)	
		0	1.00	2.00	3.00	4.00	
1.00	DRG amounts other than outlier payments	1.00					1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1	1.01	0	0		0	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	15,461,896		15,461,896	15,461,896	1.02
1.03	DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October 1	1.03	0	0		0	1.03
1.04	DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1	1.04	0		0	0	1.04
2.00	Outlier payments for discharges (see instructions)	2.00					2.00
2.01	Outlier payments for discharges for Model 4 BPCI	2.02	0	0	0	0	2.01
2.02	Outlier payments for discharges occurring prior to October 1 (see instructions)	2.03	0	0		0	2.02
2.03	Outlier payments for discharges occurring on or after October 1 (see instructions)	2.04	103,635		103,635	103,635	2.03
3.00	Operating outlier reconciliation	2.01	0	0	0	0	3.00
4.00	Managed care simulated payments	3.00	0	0	0	0	4.00
Indirect Medical Education Adjustment							
5.00	Amount from Worksheet E, Part A, line 21 (see instructions)	21.00	0.000000	0.000000	0.000000		5.00
6.00	IME payment adjustment (see instructions)	22.00	0	0	0	0	6.00
6.01	IME payment adjustment for managed care (see instructions)	22.01	0	0	0	0	6.01
Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA							
7.00	IME payment adjustment factor (see instructions)	27.00	0.000000	0.000000	0.000000		7.00
8.00	IME adjustment (see instructions)	28.00	0	0	0	0	8.00
8.01	IME payment adjustment add on for managed care (see instructions)	28.01	0	0	0	0	8.01
9.00	Total IME payment (sum of lines 6 and 8)	29.00	0	0	0	0	9.00
9.01	Total IME payment for managed care (sum of lines 6.01 and 8.01)	29.01	0	0	0	0	9.01
Disproportionate Share Adjustment							
10.00	Allowable disproportionate share percentage (see instructions)	33.00	0.0817	0.0817	0.0817		10.00
11.00	Disproportionate share adjustment (see instructions)	34.00	315,809	0	315,809	315,809	11.00
11.01	Uncompensated care payments	36.00	1,168,434	769,190	263,166	1,032,356	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	17,049,774	769,190	16,280,584	17,049,774	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	17,049,774	769,190	16,280,584	17,049,774	15.00
16.00	Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable)	50.00	1,250,016	0	1,250,016	1,250,016	16.00
17.00	Special add-on payments for new technologies	54.00	51,627	0	51,627	51,627	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			769,190	17,582,227	18,351,417	19.00

HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULATION EXHIBIT 5

Provider CCN: 14-0289

Period:
From 01/01/2020
To 12/31/2020Worksheet E
Part A Exhibit 5
Date/Time Prepared:
7/28/2021 3:46 pm

		Title XVIII		Hospital		PPS	
		Wkst. L, line	(Amt. from Wkst. L)				
		0	1.00	2.00	3.00	4.00	
20.00	Capital DRG other than outlier	1.00	1,188,838	0	1,188,838	1,188,838	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	4,589	0	4,589	4,589	21.00
21.01	Model 4 BPCI Capital DRG outlier payments	2.01	0	0	0	0	21.01
22.00	Indirect medical education percentage (see instructions)	5.00	0.0000	0.0000	0.0000		22.00
23.00	Indirect medical education adjustment (see instructions)	6.00	0	0	0	0	23.00
24.00	Allowable disproportionate share percentage (see instructions)	10.00	0.0476	0.0476	0.0476		24.00
25.00	Disproportionate share adjustment (see instructions)	11.00	56,589	0	56,589	56,589	25.00
26.00	Total prospective capital payments (see instructions)	12.00	1,250,016	0	1,250,016	1,250,016	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	84,988	0	84,988	84,988	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	-51,649	0	-51,649	-51,649	31.00
31.01	HRR adjustment for HSP bonus payment (see instructions)	70.91	0	0	0	0	31.01
						(Amt. to Wkst. E, Pt. A)	
		0	1.00	2.00	3.00	4.00	
32.00	HAC Reduction Program adjustment (see instructions)	70.99		0	0	0	32.00
100.00	Transfer HAC Reduction Program adjustment to Wkst. E, Pt. A.		N				100.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0289	Period: From 01/01/2020 To 12/31/2020	Worksheet E Part B Date/Time Prepared: 7/28/2021 3:46 pm
		Title XVIII	Hospital	PPS
				1.00
PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)		2,363	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)		18,266,371	2.00
3.00	OPPS payments		14,172,731	3.00
4.00	Outlier payment (see instructions)		36,068	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		47,994	9.00
10.00	Organ acquisitions		0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)		2,363	11.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
12.00	Ancillary service charges		13,583	12.00
13.00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, line 69)		0	13.00
14.00	Total reasonable charges (sum of lines 12 and 13)		13,583	14.00
Customary charges				
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis		0	15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a chargebasis had such payment been made in accordance with 42 CFR §413.13(e)		0	16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)		0.000000	17.00
18.00	Total customary charges (see instructions)		13,583	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)		11,220	19.00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)		0	20.00
21.00	Lesser of cost or charges (see instructions)		2,363	21.00
22.00	Interns and residents (see instructions)		0	22.00
23.00	Cost of physicians' services in a teaching hospital (see instructions)		0	23.00
24.00	Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)		14,256,793	24.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25.00	Deductibles and coinsurance amounts (for CAH, see instructions)		0	25.00
26.00	Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)		2,589,409	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)		11,669,747	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)		11,669,747	30.00
31.00	Primary payer payments		1,317	31.00
32.00	Subtotal (line 30 minus line 31)		11,668,430	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)		233,883	34.00
35.00	Adjusted reimbursable bad debts (see instructions)		152,024	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		180,366	36.00
37.00	Subtotal (see instructions)		11,820,454	37.00
38.00	MSP-LCC reconciliation amount from PS&R		-35	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)		11,820,489	40.00
40.01	Sequestration adjustment (see instructions)		78,015	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		11,747,391	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)		-4,917	43.00
43.01	Balance due provider/program-PARHM (see instructions)		0	43.01
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		0	44.00
TO BE COMPLETED BY CONTRACTOR				
90.00	Original outlier amount (see instructions)		0	90.00
91.00	Outlier reconciliation adjustment amount (see instructions)		0	91.00
92.00	The rate used to calculate the Time Value of Money		0.00	92.00
93.00	Time Value of Money (see instructions)		0	93.00
94.00	Total (sum of lines 91 and 93)		0	94.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 14-0289

Period:
From 01/01/2020
To 12/31/2020Worksheet E-1
Part I
Date/Time Prepared:
7/28/2021 3:46 pm

		Title XVIII		Hospital		PPS	
		Inpatient Part A		Part B			
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount		
		1.00	2.00	3.00	4.00		
1.00	Total interim payments paid to provider		16,365,007		11,791,720	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	12/09/2020	40,325	12/09/2020	44,329	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)		-40,325		-44,329	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)		16,324,682		11,747,391	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		357,552		0	6.01	
6.02	SETTLEMENT TO PROGRAM		0		4,917	6.02	
7.00	Total Medicare program liability (see instructions)		16,682,234		11,742,474	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: 14-0289
 Component CCN: 14-T289

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

 Worksheet E-1
 Part I
 Date/Time Prepared:
 7/28/2021 3:46 pm

		Title XVIII		Subprovider - IRF		PPS	
		Inpatient Part A		Part B			
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount		
		1.00	2.00	3.00	4.00		
1.00	Total interim payments paid to provider					0	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		4,144,296			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	12/09/2020	14,378			0	3.50
3.51			0			0	3.51
3.52			0			0	3.52
3.53			0			0	3.53
3.54			0			0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		-14,378			0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		4,129,918			0	4.00
TO BE COMPLETED BY CONTRACTOR							
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)						5.00
Program to Provider							
5.01	TENTATIVE TO PROVIDER		0			0	5.01
5.02			0			0	5.02
5.03			0			0	5.03
Provider to Program							
5.50	TENTATIVE TO PROGRAM		0			0	5.50
5.51			0			0	5.51
5.52			0			0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0			0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)						6.00
6.01	SETTLEMENT TO PROVIDER		7,579			0	6.01
6.02	SETTLEMENT TO PROGRAM		0			0	6.02
7.00	Total Medicare program liability (see instructions)		4,137,497			0	7.00
				Contractor Number	NPR Date (Mo/Day/Yr)		
		0		1.00	2.00		
8.00	Name of Contractor						8.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT

Provider CCN: 14-0289

Period:
From 01/01/2020
To 12/31/2020Worksheet E-1
Part II
Date/Time Prepared:
7/28/2021 3:46 pm

Title XVIII

Hospital

PPS

1.00

TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS

HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION

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

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0289 Component CCN: 14-T289	Period: From 01/01/2020 To 12/31/2020	Worksheet E-3 Part III Date/Time Prepared: 7/28/2021 3:46 pm
		Title XVIII	Subprovider - IRF	PPS
				1.00
PART III - MEDICARE PART A SERVICES - IRF PPS				
1.00	Net Federal PPS Payment (see instructions)			4,036,638 1.00
2.00	Medicare SSI ratio (IRF PPS only) (see instructions)			0.0419 2.00
3.00	Inpatient Rehabilitation LIP Payments (see instructions)			162,273 3.00
4.00	Outlier Payments			2,403 4.00
5.00	Unweighted intern and resident FTE count in the most recent cost reporting period ending on or prior to November 15, 2004 (see instructions)			0.00 5.00
5.01	Cap increases for the unweighted intern and resident FTE count for residents that were displaced by program or hospital closure, that would not be counted without a temporary cap adjustment under 42 CFR §412.424(d)(1)(iii)(F)(1) or (2) (see instructions)			0.00 5.01
6.00	New Teaching program adjustment. (see instructions)			0.00 6.00
7.00	Current year's unweighted FTE count of I&R excluding FTEs in the new program growth period of a "new teaching program" (see instructions)			0.00 7.00
8.00	Current year's unweighted I&R FTE count for residents within the new program growth period of a "new teaching program" (see instructions)			0.00 8.00
9.00	Intern and resident count for IRF PPS medical education adjustment (see instructions)			0.00 9.00
10.00	Average Daily Census (see instructions)			11.642077 10.00
11.00	Teaching Adjustment Factor (see instructions)			0.000000 11.00
12.00	Teaching Adjustment (see instructions)			0 12.00
13.00	Total PPS Payment (see instructions)			4,201,314 13.00
14.00	Nursing and Allied Health Managed Care payments (see instruction)			0 14.00
15.00	Organ acquisition (DO NOT USE THIS LINE)			0 15.00
16.00	Cost of physicians' services in a teaching hospital (see instructions)			0 16.00
17.00	Subtotal (see instructions)			4,201,314 17.00
18.00	Primary payer payments			0 18.00
19.00	Subtotal (line 17 less line 18).			4,201,314 19.00
20.00	Deductibles			29,524 20.00
21.00	Subtotal (line 19 minus line 20)			4,171,790 21.00
22.00	Coinsurance			8,448 22.00
23.00	Subtotal (line 21 minus line 22)			4,163,342 23.00
24.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)			2,499 24.00
25.00	Adjusted reimbursable bad debts (see instructions)			1,624 25.00
26.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			2,499 26.00
27.00	Subtotal (sum of lines 23 and 25)			4,164,966 27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 49)			0 28.00
29.00	Other pass through costs (see instructions)			20 29.00
30.00	Outlier payments reconciliation			0 30.00
31.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0 31.00
31.50	Pioneer ACO demonstration payment adjustment (see instructions)			0 31.50
31.99	Demonstration payment adjustment amount before sequestration			0 31.99
32.00	Total amount payable to the provider (see instructions)			4,164,986 32.00
32.01	Sequestration adjustment (see instructions)			27,489 32.01
32.02	Demonstration payment adjustment amount after sequestration			0 32.02
33.00	Interim payments			4,129,918 33.00
34.00	Tentative settlement (for contractor use only)			0 34.00
35.00	Balance due provider/program (line 32 minus lines 32.01, 32.02, 33, and 34)			7,579 35.00
36.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2			0 36.00
TO BE COMPLETED BY CONTRACTOR				
50.00	Original outlier amount from Wkst. E-3, Pt. III, line 4			2,403 50.00
51.00	Outlier reconciliation adjustment amount (see instructions)			0 51.00
52.00	The rate used to calculate the Time Value of Money			0.00 52.00
53.00	Time Value of Money (see instructions)			0 53.00

DIRECT GRADUATE MEDICAL EDUCATION (GME) & ESRD OUTPATIENT DIRECT MEDICAL EDUCATION COSTS		Provider CCN: 14-0289	Period: From 01/01/2020 To 12/31/2020	Worksheet E-4 Date/Time Prepared: 7/28/2021 3:46 pm	
		Title XVIII	Hospital	PPS	
				1.00	
COMPUTATION OF TOTAL DIRECT GME AMOUNT					
1.00	Unweighted resident FTE count for allopathic and osteopathic programs for cost reporting periods ending on or before December 31, 1996.			0.00	1.00
2.00	Unweighted FTE resident cap add-on for new programs per 42 CFR 413.79(e)(1) (see instructions)			0.00	2.00
3.00	Amount of reduction to Direct GME cap under section 422 of MMA			0.00	3.00
3.01	Direct GME cap reduction amount under ACA §5503 in accordance with 42 CFR §413.79 (m). (see instructions for cost reporting periods straddling 7/1/2011)			0.00	3.01
4.00	Adjustment (plus or minus) to the FTE cap for allopathic and osteopathic programs due to a Medicare GME affiliation agreement (42 CFR §413.75(b) and § 413.79 (f))			0.00	4.00
4.01	ACA Section 5503 increase to the Direct GME FTE Cap (see instructions for cost reporting periods straddling 7/1/2011)			0.00	4.01
4.02	ACA Section 5506 number of additional direct GME FTE cap slots (see instructions for cost reporting periods straddling 7/1/2011)			0.00	4.02
5.00	FTE adjusted cap (line 1 plus line 2 minus line 3 and 3.01 plus or minus line 4 plus lines 4.01 and 4.02 plus applicable subscripts)			0.00	5.00
6.00	Unweighted resident FTE count for allopathic and osteopathic programs for the current year from your records (see instructions)			0.00	6.00
7.00	Enter the lesser of line 5 or line 6			0.00	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	0.00	0.00	8.00
9.00	If line 6 is less than 5 enter the amount from line 8, otherwise multiply line 8 times the result of line 5 divided by the amount on line 6.	0.00	0.00	0.00	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	0.00		11.00
12.00	Total weighted resident FTE count for the prior cost reporting year (see instructions)	0.00	0.00		12.00
13.00	Total weighted resident FTE count for the penultimate cost reporting year (see instructions)	0.00	0.00		13.00
14.00	Rolling average FTE count (sum of lines 11 through 13 divided by 3).	0.00	0.00		14.00
15.00	Adjustment for residents in initial years of new programs	0.00	0.00		15.00
15.01	Unweighted adjustment for residents in initial years of new programs	0.00	0.00		15.01
16.00	Adjustment for residents displaced by program or hospital closure	0.00	0.00		16.00
16.01	Unweighted adjustment for residents displaced by program or hospital closure	0.00	0.00		16.01
17.00	Adjusted rolling average FTE count	0.00	0.00		17.00
18.00	Per resident amount	0.00	0.00		18.00
19.00	Approved amount for resident costs	0	0	0	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)			0	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)	10,574	5,517		26.00
27.00	Total Inpatient Days (see instructions)	26,390	26,390		27.00
28.00	Ratio of inpatient days to total inpatient days	0.400682	0.209056		28.00
29.00	Program direct GME amount	0	0	0	29.00
29.01	Percent reduction for MA DGME				29.01
30.00	Reduction for direct GME payments for Medicare Advantage		0	0	30.00
31.00	Net Program direct GME amount			0	31.00

DIRECT GRADUATE MEDICAL EDUCATION (GME) & ESRD OUTPATIENT DIRECT MEDICAL EDUCATION COSTS		Provider CCN: 14-0289	Period: From 01/01/2020 To 12/31/2020	Worksheet E-4 Date/Time Prepared: 7/28/2021 3:46 pm	
		Title XVIII	Hospital	PPS	
				1.00	
	DIRECT MEDICAL EDUCATION COSTS FOR ESRD COMPOSITE RATE - TITLE XVIII ONLY (NURSING SCHOOL AND PARAMEDICAL EDUCATION COSTS)				
32.00	Renal dialysis direct medical education costs (from Wkst. B, Pt. I, sum of col. 20 and 23, lines 74 and 94)			0	32.00
33.00	Renal dialysis and home dialysis total charges (Wkst. C, Pt. I, col. 8, sum of lines 74 and 94)			1,333,433	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)			21,112,414	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)			47,686	40.00
41.00	Total Part A reasonable cost (sum of lines 37 through 39 minus line 40)			21,064,728	41.00
Part B Reasonable Cost					
42.00	Reasonable cost (see instructions)			18,316,728	42.00
43.00	Primary payer payments (see instructions)			1,317	43.00
44.00	Total Part B reasonable cost (line 42 minus line 43)			18,315,411	44.00
45.00	Total reasonable cost (sum of lines 41 and 44)			39,380,139	45.00
46.00	Ratio of Part A reasonable cost to total reasonable cost (line 41 ÷ line 45)			0.534907	46.00
47.00	Ratio of Part B reasonable cost to total reasonable cost (line 44 ÷ line 45)			0.465093	47.00
ALLOCATION OF MEDICARE DIRECT GME COSTS BETWEEN PART A AND PART B					
48.00	Total program GME payment (line 31)			0	48.00
49.00	Part A Medicare GME payment (line 46 x 48) (title XVIII only) (see instructions)			0	49.00
50.00	Part B Medicare GME payment (line 47 x 48) (title XVIII only) (see instructions)			0	50.00

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

Provider CCN: 14-0289

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

Worksheet G

Date/Time Prepared:
7/28/2021 3:46 pm

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
CURRENT ASSETS						
1.00	Cash on hand in banks	3,620,152	0	0	0	1.00
2.00	Temporary investments	108,437,035	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	99,534,723	0	0	0	4.00
5.00	Other receivable	2,189,011	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-79,305,724	0	0	0	6.00
7.00	Inventory	2,866,641	0	0	0	7.00
8.00	Prepaid expenses	1,280,221	0	0	0	8.00
9.00	Other current assets	7,500	0	0	0	9.00
10.00	Due from other funds	292,525	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	138,922,084	0	0	0	11.00
FIXED ASSETS						
12.00	Land	963,454	0	0	0	12.00
13.00	Land improvements	2,211,646	0	0	0	13.00
14.00	Accumulated depreciation	-1,701,059	0	0	0	14.00
15.00	Buildings	111,136,104	0	0	0	15.00
16.00	Accumulated depreciation	-48,269,468	0	0	0	16.00
17.00	Leasehold improvements	24,000	0	0	0	17.00
18.00	Accumulated depreciation	-24,000	0	0	0	18.00
19.00	Fixed equipment	5,463,846	0	0	0	19.00
20.00	Accumulated depreciation	-4,237,795	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	48,314,341	0	0	0	23.00
24.00	Accumulated depreciation	-28,323,353	0	0	0	24.00
25.00	Minor equipment depreciable	83,185	0	0	0	25.00
26.00	Accumulated depreciation	-83,185	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	199,580	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	85,757,296	0	0	0	30.00
OTHER ASSETS						
31.00	Investments	46,620,415	0	0	0	31.00
32.00	Deposits on leases	0	0	0	0	32.00
33.00	Due from owners/officers	0	0	0	0	33.00
34.00	Other assets	2,211,907	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	48,832,322	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	273,511,702	0	0	0	36.00
CURRENT LIABILITIES						
37.00	Accounts payable	4,819,869	0	0	0	37.00
38.00	Salaries, wages, and fees payable	6,131,534	0	0	0	38.00
39.00	Payroll taxes payable	146,458	0	0	0	39.00
40.00	Notes and loans payable (short term)	4,116,531	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	2,802,549	0	0	0	43.00
44.00	Other current liabilities	25,552,167	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	43,569,108	0	0	0	45.00
LONG TERM LIABILITIES						
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	38,708,499	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	20,990,000	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	59,698,499	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	103,267,607	0	0	0	51.00
CAPITAL ACCOUNTS						
52.00	General fund balance	170,244,095				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)	170,244,095	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	273,511,702	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 14-0289

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

Worksheet G-1

Date/Time Prepared:
7/28/2021 3:46 pm

		General Fund		Special Purpose Fund		Endowment Fund	
		1.00	2.00	3.00	4.00	5.00	
1.00	Fund balances at beginning of period		169,743,629		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		22,362,775				2.00
3.00	Total (sum of line 1 and line 2)		192,106,404		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)		192,106,404		0		11.00
12.00	TRANSFERS	21,862,309		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)		21,862,309		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		170,244,095		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	TRANSFERS		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: 14-0289

Period:
From 01/01/2020
To 12/31/2020Worksheet G-2
Parts I & II
Date/Time Prepared:
7/28/2021 3:46 pm

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
PART I - PATIENT REVENUES					
General Inpatient Routine Services					
1.00	Hospital	47,771,352		47,771,352	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF	7,823,755		7,823,755	3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	0		0	5.00
6.00	Swing bed - NF	0		0	6.00
7.00	SKILLED NURSING FACILITY				7.00
8.00	NURSING FACILITY				8.00
9.00	OTHER LONG TERM CARE				9.00
10.00	Total general inpatient care services (sum of lines 1-9)	55,595,107		55,595,107	10.00
Intensive Care Type Inpatient Hospital Services					
11.00	INTENSIVE CARE UNIT	7,986,353		7,986,353	11.00
12.00	CORONARY CARE UNIT				12.00
13.00	BURN INTENSIVE CARE UNIT				13.00
14.00	SURGICAL INTENSIVE CARE UNIT				14.00
15.00	OTHER SPECIAL CARE (SPECIFY)				15.00
16.00	Total intensive care type inpatient hospital services (sum of lines 11-15)	7,986,353		7,986,353	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	63,581,460		63,581,460	17.00
18.00	Ancillary services	147,807,133	294,659,664	442,466,797	18.00
19.00	Outpatient services	23,009,589	87,091,804	110,101,393	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		1,686,003	1,686,003	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)	234,398,182	383,437,471	617,835,653	28.00
PART II - OPERATING EXPENSES					
29.00	Operating expenses (per Wkst. A, column 3, line 200)		149,805,148		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)		149,805,148		43.00

STATEMENT OF REVENUES AND EXPENSES

Provider CCN: 14-0289

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

Worksheet G-3

Date/Time Prepared:
7/28/2021 3:46 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	617,835,653	1.00
2.00	Less contractual allowances and discounts on patients' accounts	466,034,328	2.00
3.00	Net patient revenues (line 1 minus line 2)	151,801,325	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	149,805,148	4.00
5.00	Net income from service to patients (line 3 minus line 4)	1,996,177	5.00
OTHER INCOME			
6.00	Contributions, donations, bequests, etc	0	6.00
7.00	Income from investments	12,518,008	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	-70	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	0	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	60,410	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	1,103,155	22.00
23.00	Governmental appropriations	0	23.00
24.00	MANAGEMENT FEES	468,000	24.00
24.01	AUDIOLOGY INCOME	23,617	24.01
24.02	MISC INCOME	198,757	24.02
24.50	COVID-19 PHE Funding	6,076,357	24.50
25.00	Total other income (sum of lines 6-24)	20,448,234	25.00
26.00	Total (line 5 plus line 25)	22,444,411	26.00
27.00	LOSS ON DISPOSAL OF INCOME	81,636	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	81,636	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	22,362,775	29.00

ANALYSIS OF HOSPITAL-BASED HOME HEALTH AGENCY COSTS

Provider CCN: 14-0289

Period:

Worksheet H

HHA CCN: 14-7420

From 01/01/2020
To 12/31/2020Date/Time Prepared:
7/28/2021 3:46 pm

					Home Health Agency I	PPS
	Salaries	Employee Benefits	Transportation (see instructions)	Contracted/Purchased Services	Other Costs	Total (sum of cols. 1 thru 5)
	1.00	2.00	3.00	4.00	5.00	6.00
GENERAL SERVICE COST CENTERS						
1.00 Capital Related - Bldg. & Fixtures			0		0	0
2.00 Capital Related - Movable Equipment			0		0	0
3.00 Plant Operation & Maintenance	0	0	0	0	0	0
4.00 Transportation	0	0	0	0	0	0
5.00 Administrative and General	193,926	0	0	0	11,147	205,073
HHA REIMBURSABLE SERVICES						
6.00 Skilled Nursing Care	619,050	0	23,577	0	0	642,627
7.00 Physical Therapy	267,945	0	15,861	46,972	0	330,778
8.00 Occupational Therapy	141,782	0	7,705	0	0	149,487
9.00 Speech Pathology	0	0	1,223	0	0	1,223
10.00 Medical Social Services	0	0	0	0	0	0
11.00 Home Health Aide	20,562	0	1,750	0	0	22,312
12.00 Supplies (see instructions)	0	0	0	0	18,405	18,405
13.00 Drugs	0	0	0	0	0	0
14.00 DME	0	0	0	0	0	0
HHA NONREIMBURSABLE SERVICES						
15.00 Home Dialysis Aide Services	0	0	0	0	0	0
16.00 Respiratory Therapy	0	0	0	0	0	0
17.00 Private Duty Nursing	0	0	0	0	0	0
18.00 Clinic	0	0	0	0	0	0
19.00 Health Promotion Activities	0	0	0	0	0	0
20.00 Day Care Program	0	0	0	0	0	0
21.00 Home Delivered Meals Program	0	0	0	0	0	0
22.00 Homemaker Service	0	0	0	0	0	0
23.00 All Others (specify)	0	0	0	0	0	0
23.50 Telemedicine	0	0	0	0	0	0
24.00 Total (sum of lines 1-23)	1,243,265	0	50,116	46,972	29,552	1,369,905
	Reclassification	Reclassified Trial Balance (col. 6 + col.7)	Adjustments	Net Expenses for Allocation (col. 8 + col. 9)		
	7.00	8.00	9.00	10.00		
GENERAL SERVICE COST CENTERS						
1.00 Capital Related - Bldg. & Fixtures	0	0	0	0		1.00
2.00 Capital Related - Movable Equipment	0	0	0	0		2.00
3.00 Plant Operation & Maintenance	0	0	0	0		3.00
4.00 Transportation	0	0	0	0		4.00
5.00 Administrative and General	-263	204,810	0	204,810		5.00
HHA REIMBURSABLE SERVICES						
6.00 Skilled Nursing Care	0	642,627	0	642,627		6.00
7.00 Physical Therapy	0	330,778	0	330,778		7.00
8.00 Occupational Therapy	0	149,487	0	149,487		8.00
9.00 Speech Pathology	0	1,223	0	1,223		9.00
10.00 Medical Social Services	0	0	0	0		10.00
11.00 Home Health Aide	0	22,312	0	22,312		11.00
12.00 Supplies (see instructions)	-14,685	3,720	0	3,720		12.00
13.00 Drugs	0	0	0	0		13.00
14.00 DME	0	0	0	0		14.00
HHA NONREIMBURSABLE SERVICES						
15.00 Home Dialysis Aide Services	0	0	0	0		15.00
16.00 Respiratory Therapy	0	0	0	0		16.00
17.00 Private Duty Nursing	0	0	0	0		17.00
18.00 Clinic	0	0	0	0		18.00
19.00 Health Promotion Activities	0	0	0	0		19.00
20.00 Day Care Program	0	0	0	0		20.00
21.00 Home Delivered Meals Program	0	0	0	0		21.00
22.00 Homemaker Service	0	0	0	0		22.00
23.00 All Others (specify)	0	0	0	0		23.00
23.50 Telemedicine	0	0	0	0		23.50
24.00 Total (sum of lines 1-23)	-14,948	1,354,957	0	1,354,957		24.00

Column, 6 line 24 should agree with the Worksheet A, column 3, line 101, or subscript as applicable.

COST ALLOCATION - HHA GENERAL SERVICE COST

Provider CCN: 14-0289

Period:

Worksheet H-1

HHA CCN: 14-7420

From 01/01/2020
To 12/31/2020Part I
Date/Time Prepared:
7/28/2021 3:46 pmHome Health
Agency I

PPS

		Net Expenses for Cost Allocation (from Wkst. H, col. 10)	Capital Related Costs		Plant Operation & Maintenance	Transportation	Subtotal (cols. 0-4)	
			Bldgs & Fixtures	Movable Equipment				
			0	1.00	2.00	3.00	4.00	
	GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. & Fixtures	0	0				0	1.00
2.00	Capital Related - Movable Equipment	0		0			0	2.00
3.00	Plant Operation & Maintenance	0	0	0	0		0	3.00
4.00	Transportation	0	0	0	0	0	0	4.00
5.00	Administrative and General	204,810	0	0	0	0	204,810	5.00
	HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	642,627	0	0	0	0	642,627	6.00
7.00	Physical Therapy	330,778	0	0	0	0	330,778	7.00
8.00	Occupational Therapy	149,487	0	0	0	0	149,487	8.00
9.00	Speech Pathology	1,223	0	0	0	0	1,223	9.00
10.00	Medical Social Services	0	0	0	0	0	0	10.00
11.00	Home Health Aide	22,312	0	0	0	0	22,312	11.00
12.00	Supplies (see instructions)	3,720	0	0	0	0	3,720	12.00
13.00	Drugs	0	0	0	0	0	0	13.00
14.00	DME	0	0	0	0	0	0	14.00
	HHA NONREIMBURSABLE SERVICES							
15.00	Home Dialysis Aide Services	0	0	0	0	0	0	15.00
16.00	Respiratory Therapy	0	0	0	0	0	0	16.00
17.00	Private Duty Nursing	0	0	0	0	0	0	17.00
18.00	Clinic	0	0	0	0	0	0	18.00
19.00	Health Promotion Activities	0	0	0	0	0	0	19.00
20.00	Day Care Program	0	0	0	0	0	0	20.00
21.00	Home Delivered Meals Program	0	0	0	0	0	0	21.00
22.00	Homemaker Service	0	0	0	0	0	0	22.00
23.00	All Others (specify)	0	0	0	0	0	0	23.00
23.50	Telemedicine	0	0	0	0	0	0	23.50
24.00	Total (sum of lines 1-23)	1,354,957	0	0	0	0	1,354,957	24.00
		Administrative & General	Total (cols. 4A + 5)					
		5.00	6.00					
	GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. & Fixtures							1.00
2.00	Capital Related - Movable Equipment							2.00
3.00	Plant Operation & Maintenance							3.00
4.00	Transportation							4.00
5.00	Administrative and General	204,810						5.00
	HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	114,434	757,061					6.00
7.00	Physical Therapy	58,903	389,681					7.00
8.00	Occupational Therapy	26,620	176,107					8.00
9.00	Speech Pathology	218	1,441					9.00
10.00	Medical Social Services	0	0					10.00
11.00	Home Health Aide	3,973	26,285					11.00
12.00	Supplies (see instructions)	662	4,382					12.00
13.00	Drugs	0	0					13.00
14.00	DME	0	0					14.00
	HHA NONREIMBURSABLE SERVICES							
15.00	Home Dialysis Aide Services	0	0					15.00
16.00	Respiratory Therapy	0	0					16.00
17.00	Private Duty Nursing	0	0					17.00
18.00	Clinic	0	0					18.00
19.00	Health Promotion Activities	0	0					19.00
20.00	Day Care Program	0	0					20.00
21.00	Home Delivered Meals Program	0	0					21.00
22.00	Homemaker Service	0	0					22.00
23.00	All Others (specify)	0	0					23.00
23.50	Telemedicine	0	0					23.50
24.00	Total (sum of lines 1-23)		1,354,957					24.00

COST ALLOCATION - HHA STATISTICAL BASIS

Provider CCN: 14-0289

Period:

Worksheet H-1

HHA CCN: 14-7420

From 01/01/2020
To 12/31/2020Part II
Date/Time Prepared:
7/28/2021 3:46 pmHome Health
Agency I

PPS

	Capital Related Costs		Plant Operation & Maintenance (SQUARE FEET)	Transportation (MILEAGE)	Reconciliation	Administrative & General (ACCUM. COST)	
	Bldgs & Fixtures (SQUARE FEET)	Movable Equipment (DOLLAR VALUE)					
	1.00	2.00	3.00	4.00	5A.00	5.00	
GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. & Fixtures	0			0		1.00
2.00	Capital Related - Movable Equipment		0		0		2.00
3.00	Plant Operation & Maintenance	0	0	0	0		3.00
4.00	Transportation (see instructions)	0	0	0	0		4.00
5.00	Administrative and General	0	0	0	0	-204,810	5.00
	1,150,147						
HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	0	0	0	0	642,627	6.00
7.00	Physical Therapy	0	0	0	0	330,778	7.00
8.00	Occupational Therapy	0	0	0	0	149,487	8.00
9.00	Speech Pathology	0	0	0	0	1,223	9.00
10.00	Medical Social Services	0	0	0	0	0	10.00
11.00	Home Health Aide	0	0	0	0	22,312	11.00
12.00	Supplies (see instructions)	0	0	0	0	3,720	12.00
13.00	Drugs	0	0	0	0	0	13.00
14.00	DME	0	0	0	0	0	14.00
HHA NONREIMBURSABLE SERVICES							
15.00	Home Dialysis Aide Services	0	0	0	0	0	15.00
16.00	Respiratory Therapy	0	0	0	0	0	16.00
17.00	Private Duty Nursing	0	0	0	0	0	17.00
18.00	Clinic	0	0	0	0	0	18.00
19.00	Health Promotion Activities	0	0	0	0	0	19.00
20.00	Day Care Program	0	0	0	0	0	20.00
21.00	Home Delivered Meals Program	0	0	0	0	0	21.00
22.00	Homemaker Service	0	0	0	0	0	22.00
23.00	All Others (specify)	0	0	0	0	0	23.00
23.50	Telemedicine	0	0	0	0	0	23.50
24.00	Total (sum of lines 1-23)	0	0	0	0	-204,810	24.00
25.00	Cost To Be Allocated (per Worksheet H-1, Part I)	0	0	0	0	204,810	25.00
26.00	Unit Cost Multiplier	0.000000	0.000000	0.000000	0.000000	0.178073	26.00

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

Provider CCN: 14-0289

Period:

Worksheet H-2

HHA CCN: 14-7420

From 01/01/2020
To 12/31/2020Part I
Date/Time Prepared:
7/28/2021 3:46 pmHome Health
Agency I

PPS

Cost Center Description		HHA Trial Balance (1)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	Subtotal	ADMINISTRATIVE & GENERAL	
			BLDG & FIXT	MVBLE EQUIP				
		0	1.00	2.00	4.00	4A	5.00	
1.00	Administrative and General	0	15,155	0	38,350	53,505	13,816	1.00
2.00	Skilled Nursing Care	757,061	0	0	122,423	879,484	227,100	2.00
3.00	Physical Therapy	389,681	0	0	52,988	442,669	114,306	3.00
4.00	Occupational Therapy	176,107	0	0	28,039	204,146	52,715	4.00
5.00	Speech Pathology	1,441	0	0	0	1,441	372	5.00
6.00	Medical Social Services	0	0	0	0	0	0	6.00
7.00	Home Health Aide	26,285	0	0	4,066	30,351	7,837	7.00
8.00	Supplies (see instructions)	4,382	0	0	0	4,382	1,132	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
19.50	Telemedicine	0	0	0	0	0	0	19.50
20.00	Total (sum of lines 1-19) (2)	1,354,957	15,155	0	245,866	1,615,978	417,278	20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.					0.000000		21.00
Cost Center Description		MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	
		6.00	7.00	8.00	9.00	10.00	11.00	
1.00	Administrative and General	12,624	18,674	0	0	0	0	1.00
2.00	Skilled Nursing Care	0	0	0	0	0	0	2.00
3.00	Physical Therapy	0	0	0	0	0	0	3.00
4.00	Occupational Therapy	0	0	0	0	0	0	4.00
5.00	Speech Pathology	0	0	0	0	0	0	5.00
6.00	Medical Social Services	0	0	0	0	0	0	6.00
7.00	Home Health Aide	0	0	0	0	0	0	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
19.50	Telemedicine	0	0	0	0	0	0	19.50
20.00	Total (sum of lines 1-19) (2)	12,624	18,674	0	0	0	0	20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.							21.00

(1) Column 0, line 20 must agree with Wkst. A, column 7, line 101.

(2) Columns 0 through 26, line 20 must agree with the corresponding columns of Wkst. B, Part I, line 101.

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

Provider CCN: 14-0289

Period:

Worksheet H-2

HHA CCN: 14-7420

From 01/01/2020

Part I

To 12/31/2020

Date/Time Prepared:

7/28/2021 3:46 pm

Cost Center Description		NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE Agency I	PARAMEDICAL EDUCATION PRGM	
		13.00	14.00	15.00	16.00	17.00	23.00	
1.00	Administrative and General	0	507	0	6,961	0	0	1.00
2.00	Skilled Nursing Care	0	0	0	0	0	0	2.00
3.00	Physical Therapy	0	0	0	0	0	0	3.00
4.00	Occupational Therapy	0	0	0	0	0	0	4.00
5.00	Speech Pathology	0	0	0	0	0	0	5.00
6.00	Medical Social Services	0	0	0	0	0	0	6.00
7.00	Home Health Aide	0	0	0	0	0	0	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
19.50	Telemedicine	0	0	0	0	0	0	19.50
20.00	Total (sum of lines 1-19) (2)	0	507	0	6,961	0	0	20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.							21.00
Cost Center Description		Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Subtotal	Allocated HHA A&G (see Part II)	Total HHA Costs		
		24.00	25.00	26.00	27.00	28.00		
1.00	Administrative and General	106,087	0	106,087				1.00
2.00	Skilled Nursing Care	1,106,584	0	1,106,584	59,713	1,166,297		2.00
3.00	Physical Therapy	556,975	0	556,975	30,056	587,031		3.00
4.00	Occupational Therapy	256,861	0	256,861	13,861	270,722		4.00
5.00	Speech Pathology	1,813	0	1,813	98	1,911		5.00
6.00	Medical Social Services	0	0	0	0	0		6.00
7.00	Home Health Aide	38,188	0	38,188	2,061	40,249		7.00
8.00	Supplies (see instructions)	5,514	0	5,514	298	5,812		8.00
9.00	Drugs	0	0	0	0	0		9.00
10.00	DME	0	0	0	0	0		10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0		11.00
12.00	Respiratory Therapy	0	0	0	0	0		12.00
13.00	Private Duty Nursing	0	0	0	0	0		13.00
14.00	Clinic	0	0	0	0	0		14.00
15.00	Health Promotion Activities	0	0	0	0	0		15.00
16.00	Day Care Program	0	0	0	0	0		16.00
17.00	Home Delivered Meals Program	0	0	0	0	0		17.00
18.00	Homemaker Service	0	0	0	0	0		18.00
19.00	All Others (specify)	0	0	0	0	0		19.00
19.50	Telemedicine	0	0	0	0	0		19.50
20.00	Total (sum of lines 1-19) (2)	2,072,022	0	2,072,022	106,087	2,072,022		20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.				0.053963			21.00

(1) Column 0, line 20 must agree with Wkst. A, column 7, line 101.

(2) Columns 0 through 26, line 20 must agree with the corresponding columns of Wkst. B, Part I, line 101.

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS

Provider CCN: 14-0289
HHA CCN: 14-7420Period:
From 01/01/2020
To 12/31/2020Worksheet H-2
Part II
Date/Time Prepared:
7/28/2021 3:46 pm

						Home Health Agency I	PPS	
Cost Center Description		CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	MAINTENANCE & REPAIRS (SQUARE FEET)	
		BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (DOLLAR VALUE)					
		1.00	2.00				4.00	
1.00	Administrative and General	1,848	0	193,926	0	53,505	1,848	1.00
2.00	Skilled Nursing Care	0	0	619,050	0	879,484	0	2.00
3.00	Physical Therapy	0	0	267,945	0	442,669	0	3.00
4.00	Occupational Therapy	0	0	141,782	0	204,146	0	4.00
5.00	Speech Pathology	0	0	0	0	1,441	0	5.00
6.00	Medical Social Services	0	0	0	0	0	0	6.00
7.00	Home Health Aide	0	0	20,562	0	30,351	0	7.00
8.00	Supplies (see instructions)	0	0	0	0	4,382	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
19.50	Telemedicine	0	0	0	0	0	0	19.50
20.00	Total (sum of lines 1-19)	1,848	0	1,243,265		1,615,978	1,848	20.00
21.00	Total cost to be allocated	15,155	0	245,866		417,278	12,624	21.00
22.00	Unit cost multiplier	8.200758	0.000000	0.197758		0.258220	6.831169	22.00
Cost Center Description		OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (HOURS OF SERVICE)	DIETARY (MEALS SERVED)	CAFETERIA (MEALS SERVED)	NURSING ADMINISTRATION (DIRECT NURS. HRS.)	
		7.00	8.00	9.00	10.00	11.00	13.00	
1.00	Administrative and General	1,848	0	0	0	0	0	1.00
2.00	Skilled Nursing Care	0	0	0	0	0	0	2.00
3.00	Physical Therapy	0	0	0	0	0	0	3.00
4.00	Occupational Therapy	0	0	0	0	0	0	4.00
5.00	Speech Pathology	0	0	0	0	0	0	5.00
6.00	Medical Social Services	0	0	0	0	0	0	6.00
7.00	Home Health Aide	0	0	0	0	0	0	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
19.50	Telemedicine	0	0	0	0	0	0	19.50
20.00	Total (sum of lines 1-19)	1,848	0	0	0	0	0	20.00
21.00	Total cost to be allocated	18,674	0	0	0	0	0	21.00
22.00	Unit cost multiplier	10.104978	0.000000	0.000000	0.000000	0.000000	0.000000	22.00

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS

Provider CCN: 14-0289

Period:

Worksheet H-2

HHA CCN: 14-7420

From 01/01/2020
To 12/31/2020Part II
Date/Time Prepared:
7/28/2021 3:46 pmHome Health
Agency I

PPS

Cost Center Description		CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (TIME SPENT)	SOCIAL SERVICE (TIME SPENT)	PARAMEDICAL EDUCATION PRGM (ASSIGNED TIME)		
		14.00	15.00	16.00	17.00	23.00		
1.00	Administrative and General	3,720	0	142	0	0		1.00
2.00	Skilled Nursing Care	0	0	0	0	0		2.00
3.00	Physical Therapy	0	0	0	0	0		3.00
4.00	Occupational Therapy	0	0	0	0	0		4.00
5.00	Speech Pathology	0	0	0	0	0		5.00
6.00	Medical Social Services	0	0	0	0	0		6.00
7.00	Home Health Aide	0	0	0	0	0		7.00
8.00	Supplies (see instructions)	0	0	0	0	0		8.00
9.00	Drugs	0	0	0	0	0		9.00
10.00	DME	0	0	0	0	0		10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0		11.00
12.00	Respiratory Therapy	0	0	0	0	0		12.00
13.00	Private Duty Nursing	0	0	0	0	0		13.00
14.00	Clinic	0	0	0	0	0		14.00
15.00	Health Promotion Activities	0	0	0	0	0		15.00
16.00	Day Care Program	0	0	0	0	0		16.00
17.00	Home Delivered Meals Program	0	0	0	0	0		17.00
18.00	Homemaker Service	0	0	0	0	0		18.00
19.00	All Others (specify)	0	0	0	0	0		19.00
19.50	Telemedicine	0	0	0	0	0		19.50
20.00	Total (sum of lines 1-19)	3,720	0	142	0	0		20.00
21.00	Total cost to be allocated	507	0	6,961	0	0		21.00
22.00	Unit cost multiplier	0.136290	0.000000	49.021127	0.000000	0.000000		22.00

APPORTIONMENT OF PATIENT SERVICE COSTS

Provider CCN: 14-0289

Period:

Worksheet H-3

HHA CCN: 14-7420

From 01/01/2020
To 12/31/2020Part I
Date/Time Prepared:
7/28/2021 3:46 pm

				Title XVIII		Home Health Agency I	PPS	
Cost Center Description		From, Wkst. H-2, Part I, col. 28, line	Facility Costs (from Wkst. H-2, Part I)	Shared Ancillary Costs (from Part II)	Total HHA Costs (cols. 1 + 2)	Total Visits	Average Cost Per Visit (col. 3 ÷ col. 4)	
		0	1.00	2.00	3.00	4.00	5.00	
PART I - COMPUTATION OF LESSER OF AGGREGATE PROGRAM COST, AGGREGATE OF THE PROGRAM LIMITATION COST, OR BENEFICIARY COST LIMITATION								
Cost Per Visit Computation								
1.00	Skilled Nursing Care	2.00	1,166,297		1,166,297	4,339	268.79	1.00
2.00	Physical Therapy	3.00	587,031	0	587,031	2,919	201.11	2.00
3.00	Occupational Therapy	4.00	270,722	0	270,722	1,418	190.92	3.00
4.00	Speech Pathology	5.00	1,911	0	1,911	225	8.49	4.00
5.00	Medical Social Services	6.00	0		0	0	0.00	5.00
6.00	Home Health Aide	7.00	40,249		40,249	322	125.00	6.00
7.00	Total (sum of lines 1-6)		2,066,210	0	2,066,210	9,223		7.00
Cost Center Description		Cost Limits	CBSA No. (1)	Part A	Program Visits			
					Part B			
						Not Subject to Deductibles & Coinsurance	Subject to Deductibles	
		0	1.00	2.00	3.00	4.00	5.00	
Limitation Cost Computation								
8.00	Skilled Nursing Care		41180	0	1,701			8.00
8.01	Skilled Nursing Care		44100	0	4			8.01
9.00	Physical Therapy		41180	0	1,046			9.00
9.01	Physical Therapy		44100	0	3			9.01
10.00	Occupational Therapy		41180	0	537			10.00
10.01	Occupational Therapy		44100	0	2			10.01
11.00	Speech Pathology		41180	0	96			11.00
11.01	Speech Pathology		44100	0	0			11.01
12.00	Medical Social Services		41180	0	0			12.00
12.01	Medical Social Services		44100	0	0			12.01
13.00	Home Health Aide		41180	0	135			13.00
13.01	Home Health Aide		44100	0	0			13.01
14.00	Total (sum of lines 8-13)			0	3,524			14.00
Cost Center Description		From Wkst. H-2 Part I, col. 28, line	Facility Costs (from Wkst. H-2, Part I)	Shared Ancillary Costs (from Part II)	Total HHA Costs (cols. 1 + 2)	Total Charges (from HHA Records)	Ratio (col. 3 ÷ col. 4)	
		0	1.00	2.00	3.00	4.00	5.00	
Supplies and Drugs Cost Computations								
15.00	Cost of Medical Supplies	8.00	5,812	0	5,812	9,575	0.606997	15.00
16.00	Cost of Drugs	9.00	0	0	0	0	0.000000	16.00
Cost Center Description		Program Visits			Cost of Services			
		Part B						
		Part A	Not Subject to Deductibles & Coinsurance		Part A	Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance	
			6.00					7.00
PART I - COMPUTATION OF LESSER OF AGGREGATE PROGRAM COST, AGGREGATE OF THE PROGRAM LIMITATION COST, OR BENEFICIARY COST LIMITATION								
Cost Per Visit Computation								
1.00	Skilled Nursing Care	0	1,705		0	458,287		1.00
2.00	Physical Therapy	0	1,049		0	210,964		2.00
3.00	Occupational Therapy	0	539		0	102,906		3.00
4.00	Speech Pathology	0	96		0	815		4.00
5.00	Medical Social Services	0	0		0	0		5.00
6.00	Home Health Aide	0	135		0	16,875		6.00
7.00	Total (sum of lines 1-6)	0	3,524		0	789,847		7.00

APPORTIONMENT OF PATIENT SERVICE COSTS

Provider CCN: 14-0289

Period:

Worksheet H-3

HHA CCN: 14-7420

From 01/01/2020
To 12/31/2020Part I
Date/Time Prepared:
7/28/2021 3:46 pm

Title XVIII

Home Health
Agency I

PPS

Cost Center Description		Agency 1		Agency 2		Agency 3		Agency 4		
		6.00	7.00	8.00	9.00	10.00	11.00			
Limitation Cost Computation										
8.00	Skilled Nursing Care							8.00		
8.01	Skilled Nursing Care							8.01		
9.00	Physical Therapy							9.00		
9.01	Physical Therapy							9.01		
10.00	Occupational Therapy							10.00		
10.01	Occupational Therapy							10.01		
11.00	Speech Pathology							11.00		
11.01	Speech Pathology							11.01		
12.00	Medical Social Services							12.00		
12.01	Medical Social Services							12.01		
13.00	Home Health Aide							13.00		
13.01	Home Health Aide							13.01		
14.00	Total (sum of lines 8-13)							14.00		
Cost Center Description		Program Covered Charges			Cost of Services					
		Part A	Part B		Part A	Part B				
			Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance		Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance			
			6.00	7.00	8.00	9.00	10.00	11.00		
Supplies and Drugs Cost Computations										
15.00	Cost of Medical Supplies	0	16,662	0	0	10,114	0	15.00		
16.00	Cost of Drugs		0	0		0	0	16.00		
Cost Center Description		Total Program Cost (sum of cols. 9-10)								
		12.00								
PART I - COMPUTATION OF LESSER OF AGGREGATE PROGRAM COST, AGGREGATE OF THE PROGRAM LIMITATION COST, OR BENEFICIARY COST LIMITATION										
Cost Per Visit Computation										
1.00	Skilled Nursing Care	458,287							1.00	
2.00	Physical Therapy	210,964							2.00	
3.00	Occupational Therapy	102,906							3.00	
4.00	Speech Pathology	815							4.00	
5.00	Medical Social Services	0							5.00	
6.00	Home Health Aide	16,875							6.00	
7.00	Total (sum of lines 1-6)	789,847							7.00	
Cost Center Description										
		12.00								
Limitation Cost Computation										
8.00	Skilled Nursing Care								8.00	
8.01	Skilled Nursing Care								8.01	
9.00	Physical Therapy								9.00	
9.01	Physical Therapy								9.01	
10.00	Occupational Therapy								10.00	
10.01	Occupational Therapy								10.01	
11.00	Speech Pathology								11.00	
11.01	Speech Pathology								11.01	
12.00	Medical Social Services								12.00	
12.01	Medical Social Services								12.01	
13.00	Home Health Aide								13.00	
13.01	Home Health Aide								13.01	
14.00	Total (sum of lines 8-13)								14.00	

APPORTIONMENT OF PATIENT SERVICE COSTS

Provider CCN: 14-0289

Period:

Worksheet H-3

HHA CCN: 14-7420

From 01/01/2020
To 12/31/2020Part II
Date/Time Prepared:
7/28/2021 3:46 pm

Title XVIII

Home Health
Agency I

PPS

Cost Center Description	From Wkst. C, Part I, col. 9, line	Cost to Charge Ratio	Total HHA Charge (from provider records)	HHA Shared Ancillary Costs (col. 1 x col. 2)	Transfer to Part I as Indicated		
	0	1.00	2.00	3.00	4.00		
PART II - APPORTIONMENT OF COST OF HHA SERVICES FURNISHED BY SHARED HOSPITAL DEPARTMENTS							
1.00 Physical Therapy	66.00	0.242884	0	0	col. 2, line 2.00		1.00
2.00 Occupational Therapy	67.00	0.304279	0	0	col. 2, line 3.00		2.00
3.00 Speech Pathology	68.00	0.423045	0	0	col. 2, line 4.00		3.00
3.01 Speech Pathology 1	68.01	0.355471	0	0	col. 2, line 4.01		3.01
4.00 Cost of Medical Supplies	71.00	0.637747	0	0	col. 2, line 15.00		4.00
5.00 Cost of Drugs	73.00	0.173984	0	0	col. 2, line 16.00		5.00

CALCULATION OF HHA REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0289 HHA CCN: 14-7420	Period: From 01/01/2020 To 12/31/2020	Worksheet H-4 Part I-II Date/Time Prepared: 7/28/2021 3:46 pm
		Title XVIII	Home Health Agency I	PPS
		Part A	Part B	
			Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance
		1.00	2.00	3.00
PART I - COMPUTATION OF THE LESSER OF REASONABLE COST OR CUSTOMARY CHARGES				
Reasonable Cost of Part A & Part B Services				
1.00	Reasonable cost of services (see instructions)	0	0	0
2.00	Total charges	0	0	0
Customary Charges				
3.00	Amount actually collected from patients liable for payment for services on a charge basis (from your records)	0	0	0
4.00	Amount 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(b)	0	0	0
5.00	Ratio of line 3 to line 4 (not to exceed 1.000000)	0.000000	0.000000	0.000000
6.00	Total customary charges (see instructions)	0	0	0
7.00	Excess of total customary charges over total reasonable cost (complete only if line 6 exceeds line 1)	0	0	0
8.00	Excess of reasonable cost over customary charges (complete only if line 1 exceeds line 6)	0	0	0
9.00	Primary payer amounts	0	0	0
			Part A Services	Part B Services
			1.00	2.00
PART II - COMPUTATION OF HHA REIMBURSEMENT SETTLEMENT				
10.00	Total reasonable cost (see instructions)		0	0
11.00	Total PPS Reimbursement - Full Episodes without Outliers		0	650,839
12.00	Total PPS Reimbursement - Full Episodes with Outliers		0	61,567
13.00	Total PPS Reimbursement - LUPA Episodes		0	15,413
14.00	Total PPS Reimbursement - PEP Episodes		0	1,928
15.00	Total PPS Outlier Reimbursement - Full Episodes with Outliers		0	19,538
16.00	Total PPS Outlier Reimbursement - PEP Episodes		0	0
17.00	Total Other Payments		0	0
18.00	DME Payments		0	0
19.00	Oxygen Payments		0	0
20.00	Prosthetic and Orthotic Payments		0	0
21.00	Part B deductibles billed to Medicare patients (exclude coinsurance)		0	0
22.00	Subtotal (sum of lines 10 thru 20 minus line 21)		0	749,285
23.00	Excess reasonable cost (from line 8)		0	0
24.00	Subtotal (line 22 minus line 23)		0	749,285
25.00	Coinsurance billed to program patients (from your records)		0	0
26.00	Net cost (line 24 minus line 25)		0	749,285
27.00	Reimbursable bad debts (from your records)			0
28.00	Reimbursable bad debts for dual eligible beneficiaries (see instructions)			0
29.00	Total costs - current cost reporting period (line 26 plus line 27)		0	749,285
30.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	0
30.50	Pioneer ACO demonstration payment adjustment (see instructions)		0	0
30.99	Demonstration payment adjustment amount before sequestration		0	0
31.00	Subtotal (see instructions)		0	749,285
31.01	Sequestration adjustment (see instructions)		0	4,564
31.02	Demonstration payment adjustment amount after sequestration		0	0
32.00	Interim payments (see instructions)		0	744,721
33.00	Tentative settlement (for contractor use only)		0	0
34.00	Balance due provider/program (line 31 minus lines 31.01, 32, and 33)		0	0
35.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		0	0

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED HHAS FOR SERVICES RENDERED
TO PROGRAM BENEFICIARIESProvider CCN: 14-0289
HHA CCN: 14-7420Period:
From 01/01/2020
To 12/31/2020Worksheet H-5
Date/Time Prepared:
7/28/2021 3:46 pm

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		0		744,721	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			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			0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. H-4, Part II, column as appropriate, line 32)		0		744,721	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			0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
Provider to Program						
5.50			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		0		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		0		744,721	7.00
				Contractor Number	NPR Date (Mo/Day/Yr)	
		0		1.00	2.00	
8.00	Name of Contractor					8.00

CALCULATION OF CAPITAL PAYMENT		Provider CCN: 14-0289	Period: From 01/01/2020 To 12/31/2020	Worksheet L Parts I-III Date/Time Prepared: 7/28/2021 3:46 pm
		Title XVIII	Hospital	PPS
		1.00		
PART I - FULLY PROSPECTIVE METHOD				
CAPITAL FEDERAL AMOUNT				
1.00	Capital DRG other than outlier		1,188,838	1.00
1.01	Model 4 BPCI Capital DRG other than outlier		0	1.01
2.00	Capital DRG outlier payments		4,589	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)		60.46	3.00
4.00	Number of interns & residents (see instructions)		0.00	4.00
5.00	Indirect medical education percentage (see instructions)		0.00	5.00
6.00	Indirect medical education adjustment (multiply line 5 by the sum of lines 1 and 1.01, columns 1 and 1.01)(see instructions)		0	6.00
7.00	Percentage of SSI recipient patient days to Medicare Part A patient days (Worksheet E, part A line 30) (see instructions)		3.25	7.00
8.00	Percentage of Medicaid patient days to total days (see instructions)		19.73	8.00
9.00	Sum of lines 7 and 8		22.98	9.00
10.00	Allowable disproportionate share percentage (see instructions)		4.76	10.00
11.00	Disproportionate share adjustment (see instructions)		56,589	11.00
12.00	Total prospective capital payments (see instructions)		1,250,016	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