

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: 14-0292	Period: From 01/01/2020 To 12/31/2020	Worksheet S Parts I-III Date/Time Prepared: 7/28/2021 9:55 am
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PART I - COST REPORT STATUS

Provider use only	1. ☒ Electronically prepared cost report	Date: 7/28/2021	Time: 9:55 am
	2. ☐ Manually prepared cost report		
	3. ☐ If this is an amended report enter the number of times the provider resubmitted this cost report		
	4. ☐ Medicare Utilization. Enter "F" for full or "L" for low.		
Contractor use only	5. ☐ Cost Report Status (1) As Submitted (2) Settled without Audit (3) Settled with Audit (4) Reopened (5) Amended	6. Date Received: 7. Contractor No. 8. ☐ Initial Report for this Provider CCN 9. ☐ Final Report for this Provider CCN	10. NPR Date: 11. Contractor's Vendor Code: 4 12. ☐ If line 5, column 1 is 4: Enter number of times reopened = 0-9.

PART II - CERTIFICATION

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

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

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by ADVENTIST GLENOAKS HOSPITAL (14-0292) 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) JARED BROWN

Officer or Administrator of Provider(s)

CFO

Title

(Dated when report is electronically signed.)

Date

Cost Center Description		Title V	Title XVIII		HIT	Title XIX	
			Part A	Part B			
		1.00	2.00	3.00	4.00	5.00	
	PART III - SETTLEMENT SUMMARY						
1.00	Hospital	0	-138,682	-17,748	0	0	1.00
2.00	Subprovider - IPF	0	-14,312	0		0	2.00
3.00	Subprovider - IRF	0	0	0		0	3.00
5.00	Swing Bed - SNF	0	0	0		0	5.00
6.00	Swing Bed - NF	0				0	6.00
200.00	Total	0	-152,994	-17,748	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: 14-0292		Period: From 01/01/2020 To 12/31/2020		Worksheet S-2 Part I Date/Time Prepared: 7/28/2021 9:55 am		
1.00		2.00		3.00		4.00					
Hospital and Hospital Health Care Complex Address:											
1.00	Street: 701 WINTHROP AVENUE			PO Box:				1.00			
2.00	City: GLENDALE HEIGHTS			State: IL		Zip Code: 60139-		County: DUPAGE			
		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			ADVENTIST GLENOAKS HOSPITAL	140292	16974	1	11/23/1982	N	P	O
4.00	Subprovider - IPF			GLEN OAKS MED CTR PSYCH UNIT	14S292	16974	4	01/01/1984	N	P	T
5.00	Subprovider - IRF										
6.00	Subprovider - (Other)										
7.00	Swing Beds - SNF										
8.00	Swing Beds - NF										
9.00	Hospital-Based SNF										
10.00	Hospital-Based NF										
11.00	Hospital-Based OLTC										
12.00	Hospital-Based HHA										
13.00	Separately Certified ASC										
14.00	Hospital-Based Hospice										
15.00	Hospital-Based Health Clinic - RHC										
16.00	Hospital-Based Health Clinic - FQHC										
17.00	Hospital-Based (CMHC) I										
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)						1				21.00
							1.00	2.00		3.00	
Inpatient PPS Information											
22.00	Does this facility qualify and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.106(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no.					Y	N				22.00
22.01	Did this hospital receive interim uncompensated care payments for this cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)					Y	Y				22.01
22.02	Is this a newly merged hospital that requires final uncompensated care payments to be determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1.					N	N				22.02
22.03	Did this hospital receive a geographic reclassification from urban to rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no.					N	N		Y		22.03
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.					3	N				23.00
				In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of-State Medicaid paid days	Out-of-State Medicaid eligible unpaid	Medicaid HMO days	Other Medicaid days		
				1.00	2.00	3.00	4.00	5.00	6.00		
24.00	If this provider is an IPPS hospital, enter the in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.			598	1,060	0	13	5,685	47		24.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

Provider CCN: 14-0292

Period:
From 01/01/2020
To 12/31/2020Worksheet S-2
Part I
Date/Time Prepared:
7/28/2021 9:55 am

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

Provider CCN: 14-0292

Period:
From 01/01/2020
To 12/31/2020Worksheet S-2
Part I
Date/Time Prepared:
7/28/2021 9:55 am

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

Provider CCN: 14-0292

Period:
From 01/01/2020
To 12/31/2020Worksheet S-2
Part I
Date/Time Prepared:
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	Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))	
	1.00	2.00	3.00	4.00	5.00	
65.00	Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the program name associated with primary care FTEs for each primary care program in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)		0.00	0.00	0.000000	65.00
			Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))	
			1.00	2.00	3.00	
66.00	Section 5504 of the ACA Current Year FTE Residents in Nonprovider Settings--Effective for cost reporting periods beginning on or after July 1, 2010					
	Enter in column 1 the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)		0.00	0.00	0.000000	66.00
			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	
70.00	Inpatient Psychiatric Facility PPS Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? Enter "Y" for yes or "N" for no.				Y	70.00
71.00	If line 70 is yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost report filed on or before November 15, 2004? Enter "Y" for yes or "N" for no. (see 42 CFR 412.424(d)(1)(iii)(c)) Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)				N N 0	71.00
75.00	Inpatient Rehabilitation Facility PPS Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF subprovider? Enter "Y" for yes and "N" for no.				N	75.00
76.00	If line 75 is yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)				0	76.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-0292	Period: From 01/01/2020 To 12/31/2020	Worksheet S-2 Part I Date/Time Prepared: 7/28/2021 9:55 am	
			1.00		
Long Term Care Hospital PPS					
80.00	Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for no.	N		80.00	
81.00	Is this a LTCH co-located within another hospital for part or all of the cost reporting period? Enter "Y" for yes and "N" for no.	N		81.00	
TEFRA Providers					
85.00	Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no.	N		85.00	
86.00	Did this facility establish a new Other subprovider (excluded unit) under 42 CFR Section §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.			86.00	
87.00	Is this hospital an extended neoplastic disease care hospital classified under section 1886(d)(1)(B)(vi)? Enter "Y" for yes or "N" for no.	N		87.00	
		V	XIX		
		1.00	2.00		
Title V and XIX Services					
90.00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.	N	Y	90.00	
91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.	N	N	91.00	
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.		N	92.00	
93.00	Does this facility operate an ICF/IID facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.	N	N	93.00	
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.	N	N	94.00	
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	95.00	
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.	N	N	96.00	
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	97.00	
98.00	Does title V or XIX follow Medicare (title XVIII) for the interns and residents post stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.00	
98.01	Does title V or XIX follow Medicare (title XVIII) for the reporting of charges on Wkst. C, Pt. I? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.01	
98.02	Does title V or XIX follow Medicare (title XVIII) for the calculation of observation bed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.02	
98.03	Does title V or XIX follow Medicare (title XVIII) for a critical access hospital (CAH) reimbursed 101% of inpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.03	
98.04	Does title V or XIX follow Medicare (title XVIII) for a CAH reimbursed 101% of outpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.04	
98.05	Does title V or XIX follow Medicare (title XVIII) and add back the RCE disallowance on Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.05	
98.06	Does title V or XIX follow Medicare (title XVIII) when cost reimbursed for Wkst. D, Pts. I through IV? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.06	
Rural Providers					
105.00	Does this hospital qualify as a CAH?	N		105.00	
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)			106.00	
107.00	Column 1: If line 105 is Y, is this facility eligible for cost reimbursement for I&R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) Column 2: If column 1 is Y and line 70 or line 75 is Y, do you train I&Rs in an approved medical education program in the CAH's excluded IPF and/or IRF unit(s)? Enter "Y" for yes or "N" for no in column 2. (see instructions)			107.00	
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	N		108.00	
		Physical	Occupational	Speech	Respiratory
		1.00	2.00	3.00	4.00
109.00	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.	N	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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-0292	Period: From 01/01/2020 To 12/31/2020	Worksheet S-2 Part I Date/Time Prepared: 7/28/2021 9:55 am
		1.00	2.00	
111.00	If this facility qualifies as a CAH, did it participate in the Frontier Community Health Integration Project (FCHIP) demonstration for this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If the response to column 1 is Y, enter the integration prong of the FCHIP demo in which this CAH is participating in column 2. Enter all that apply: "A" for Ambulance services; "B" for additional beds; and/or "C" for tele-health services.	N		111.00
		1.00	2.00	3.00
112.00	Did this hospital participate in the Pennsylvania Rural Health Model demonstration for any portion of the current cost reporting period? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2, the date the hospital began participating in the demonstration. In column 3, enter the date the hospital ceased participation in the demonstration, if applicable.	N		112.00
Miscellaneous Cost Reporting Information				
115.00	Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in column 1. If column 1 is yes, enter the method used (A, B, or E only) in column 2. If column 2 is "E", enter in column 3 either "93" percent for short term hospital or "98" percent for long term care (includes psychiatric, rehabilitation and long term hospitals providers) based on the definition in CMS Pub.15-1, chapter 22, §2208.1.	N		0 115.00
116.00	Is this facility classified as a referral center? Enter "Y" for yes or "N" for no.	N		116.00
117.00	Is this facility legally required to carry malpractice insurance? Enter "Y" for yes or "N" for no.	Y		117.00
118.00	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.	2		118.00
		Premiums	Losses	Insurance
		1.00	2.00	3.00
118.01	List amounts of malpractice premiums and paid losses:	1,391,936	0	0 118.01
		1.00	2.00	
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein.	N		118.02
119.00	DO NOT USE THIS LINE			119.00
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 1, "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2, "Y" for yes or "N" for no.	N	N	120.00
121.00	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter "Y" for yes or "N" for no.	Y		121.00
122.00	Does the cost report contain healthcare related taxes as defined in §1903(w)(3) of the Act? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2 the Worksheet A line number where these taxes are included.	N		122.00
Transplant Center Information				
125.00	Does this facility operate a transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.	N		125.00
126.00	If this is a Medicare certified kidney transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			126.00
127.00	If this is a Medicare certified heart transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			127.00
128.00	If this is a Medicare certified liver transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			128.00
129.00	If this is a Medicare certified lung transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			129.00
130.00	If this is a Medicare certified pancreas transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			130.00
131.00	If this is a Medicare certified intestinal transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			131.00
132.00	If this is a Medicare certified islet transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			132.00
133.00	Removed and reserved			133.00
134.00	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.			134.00
All Providers				
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)	Y	HF8013	140.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA				Provider CCN: 14-0292		Period: From 01/01/2020 To 12/31/2020		Worksheet S-2 Part I Date/Time Prepared: 7/28/2021 9:55 am		
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: ADVENTHEALTH		Contractor's Name: FIRST COAST SERVICE OPTIONS		Contractor's Number: 09001		141.00			
142.00	Street: 900 HOPE WAY		PO Box:				142.00			
143.00	City: ALTAMONTE SPRINGS		State: FL		Zip Code: 32714		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.							145.00		
146.00	Has the cost allocation methodology changed from the previously filed cost report? Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, chapter 40, §4020) If yes, enter the approval date (mm/dd/yyyy) in column 2.					N		146.00		
								1.00		
147.00 Was there a change in the statistical basis? Enter "Y" for yes or "N" for no.								N	147.00	
148.00 Was there a change in the order of allocation? Enter "Y" for yes or "N" for no.								N	148.00	
149.00 Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no.								N	149.00	
				Part A	Part B	Title V	Title XIX			
				1.00	2.00	3.00	4.00			
Does this facility contain a provider that qualifies for an exemption from the application of the lower of costs or charges? Enter "Y" for yes or "N" for no for each component for Part A and Part B. (See 42 CFR §413.13)										
155.00	Hospital			N	N	N	N		155.00	
156.00	Subprovider - IPF			N	N	N	N		156.00	
157.00	Subprovider - IRF			N	N	N	N		157.00	
158.00	SUBPROVIDER								158.00	
159.00	SNF			N	N	N	N		159.00	
160.00	HOME HEALTH AGENCY			N	N	N	N		160.00	
161.00	CMHC				N	N	N		161.00	
								1.00		
Multicampus										
165.00	Is this hospital part of a Multicampus hospital that has one or more campuses in different CBSAs? Enter "Y" for yes or "N" for no.							N	165.00	
				Name	County	State	Zip Code	CBSA	FTE/Campus	
				0	1.00	2.00	3.00	4.00	5.00	
166.00	If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions)								0.00	
								1.00		
Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act										
167.00	Is this provider a meaningful user under §1886(n)? Enter "Y" for yes or "N" for no.							Y	167.00	
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)								168.00	
168.01	If this provider is a CAH and is not a meaningful user, does this provider qualify for a hardship exception under §413.70(a)(6)(ii)? Enter "Y" for yes or "N" for no. (see instructions)								168.01	
169.00	If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)							9.99	169.00	
							Beginning	Ending		
							1.00	2.00		
170.00	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)									170.00
							1.00	2.00		
171.00	If line 167 is "Y", does this provider have any days for individuals enrolled in section 1876 Medicare cost plans reported on Wkst. S-3, Pt. I, line 2, col. 6? Enter "Y" for yes and "N" for no in column 1. If column 1 is yes, enter the number of section 1876 Medicare days in column 2. (see instructions)					N		0		

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 14-0292	Period: From 01/01/2020 To 12/31/2020	Worksheet S-2 Part II Date/Time Prepared: 7/28/2021 9:55 am
			Y/N 1.00	Date 2.00
General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format.				
COMPLETED BY ALL HOSPITALS				
Provider Organization and Operation				
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)	N		1.00
		Y/N 1.00	Date 2.00	V/I 3.00
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.	N		2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)	Y		3.00
		Y/N 1.00	Type 2.00	Date 3.00
Financial Data and Reports				
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	N		4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.	N		5.00
			Y/N 1.00	Legal Oper. 2.00
Approved Educational Activities				
6.00	Column 1: Are costs claimed for nursing school? Column 2: If yes, is the provider is the legal operator of the program?	N		6.00
7.00	Are costs claimed for Allied Health Programs? If "Y" see instructions.	N		7.00
8.00	Were nursing school and/or allied health programs approved and/or renewed during the cost reporting period? If yes, see instructions.	N		8.00
9.00	Are costs claimed for Interns and Residents in an approved graduate medical education program in the current cost report? If yes, see instructions.	N		9.00
10.00	Was an approved Intern and Resident GME program initiated or renewed in the current cost reporting period? If yes, see instructions.	N		10.00
11.00	Are GME cost directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions.	N		11.00
			Y/N 1.00	
Bad Debts				
12.00	Is the provider seeking reimbursement for bad debts? If yes, see instructions.		Y	12.00
13.00	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.		N	13.00
14.00	If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.		N	14.00
Bed Complement				
15.00	Did total beds available change from the prior cost reporting period? If yes, see instructions.		N	15.00
		Part A		Part B
		Y/N 1.00	Date 2.00	Y/N 3.00 Date 4.00
PS&R Data				
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)	N		16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	Y	05/04/2020	17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N		18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		19.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE

Provider CCN: 14-0292

Period:
From 01/01/2020
To 12/31/2020Worksheet S-2
Part II
Date/Time Prepared:
7/28/2021 9:55 am

		Description	Y/N	Y/N	
		0	1.00	3.00	
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:		N	N	20.00
		Y/N	Date	Y/N	Date
		1.00	2.00	3.00	4.00
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		N	21.00
				1.00	
COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)					
Capital Related Cost					
22.00	Have assets been relifed for Medicare purposes? If yes, see instructions				22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.				23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions				24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.				25.00
26.00	Were assets subject to Sec.2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.				26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.				27.00
Interest Expense					
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.				28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions				29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.				30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.				31.00
Purchased Services					
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.				32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.				33.00
Provider-Based Physicians					
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.				34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.				35.00
		Y/N	Date		
		1.00	2.00		
Home Office Costs					
36.00	Were home office costs claimed on the cost report?		Y		36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.		Y		37.00
38.00	If line 36 is yes, was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.		N		38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.		N		39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.		N		40.00
		1.00	2.00		
Cost Report Preparer Contact Information					
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	PATRICK	GILLILAND		41.00
42.00	Enter the employer/company name of the cost report preparer.	AMITA			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	815-451-8283	PATRICK.GILLILAND@AMITAHEALT H.ORG		43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE

Provider CCN: 14-0292

Period:
From 01/01/2020
To 12/31/2020Worksheet S-2
Part II
Date/Time Prepared:
7/28/2021 9:55 am

		3.00		
Cost Report Preparer Contact Information				
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	DIRECTOR OF REIMBURSEMENT		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: 14-0292

Period:
From 01/01/2020
To 12/31/2020Worksheet S-3
Part I
Date/Time Prepared:
7/28/2021 9:55 am

Component	Worksheet A Line Number	No. of Beds	Bed Days Available	CAH Hours	I/P Days / O/P Visits / Trips	
					Title V	
	1.00	2.00	3.00	4.00	5.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30.00	112	40,992	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)		112	40,992	0.00	0	7.00
8.00 INTENSIVE CARE UNIT	31.00	10	3,660	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)		122	44,652	0.00	0	14.00
15.00 CAH visits					0	15.00
16.00 SUBPROVIDER - IPF	40.00	16	5,856		0	16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY						22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
24.10 HOSPICE (non-distinct part)	30.00					24.10
25.00 CMHC - CMHC						25.00
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)		138			0	27.00
28.00 Observation Bed Days						28.00
29.00 Ambulance Trips						29.00
30.00 Employee discount days (see instruction)						30.00
31.00 Employee discount days - IRF						31.00
32.00 Labor & delivery days (see instructions)		0	0			32.00
32.01 Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00 LTCH non-covered days						33.00
33.01 LTCH site neutral days and discharges						33.01

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 14-0292

Period:
From 01/01/2020
To 12/31/2020Worksheet S-3
Part I
Date/Time Prepared:
7/28/2021 9:55 am

Component		I/P Days / O/P Visits / Trips			Full Time Equivalents		
		Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
		6.00	7.00	8.00	9.00	10.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	5,789	1,389	19,264			1.00
2.00	HMO and other (see instructions)	3,436	5,745				2.00
3.00	HMO IPF Subprovider	750	177				3.00
4.00	HMO IRF Subprovider	0	0				4.00
5.00	Hospital Adults & Peds. Swing Bed SNF	0	0	0			5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	0			6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	5,789	1,389	19,264			7.00
8.00	INTENSIVE CARE UNIT	886	147	3,293			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		110	569			13.00
14.00	Total (see instructions)	6,675	1,646	23,126	0.00	402.94	14.00
15.00	CAH visits	0	0	0			15.00
16.00	SUBPROVIDER - IPF	2,080	23	3,287	0.00	27.36	16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)			180			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	430.30	27.00
28.00	Observation Bed Days		32	1,386			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	12	38			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: 14-0292

Period:
From 01/01/2020
To 12/31/2020Worksheet S-3
Part I
Date/Time Prepared:
7/28/2021 9:55 am

Component	Full Time Equivalents	Discharges			Total All Patients	
	Nonpaid Workers	Title V	Title XVIII	Title XIX		
	11.00	12.00	13.00	14.00	15.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)		0	1,178	226	4,636	1.00
2.00 HMO and other (see instructions)			586	1,331		2.00
3.00 HMO IPF Subprovider				14		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	1,178	226	4,636	14.00
15.00 CAH visits						15.00
16.00 SUBPROVIDER - IPF	0.00	0	156	1	397	16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY						22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
24.10 HOSPICE (non-distinct part)						24.10
25.00 CMHC - CMHC						25.00
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: 14-0292

Period:
From 01/01/2020
To 12/31/2020Worksheet S-3
Part II
Date/Time Prepared:
7/28/2021 9:55 am

	Wkst. A Line Number	Amount Reported	Reclassificati on of Salaries (from Wkst. A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
	1.00	2.00	3.00	4.00	5.00	6.00	
PART II - WAGE DATA							
SALARIES							
1.00	Total salaries (see instructions)	200.00	34,912,997	504	34,913,501	910,615.47	38.34
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		0	0	0	0.00	0.00
9.00	SNF	44.00	0	0	0	0.00	0.00
10.00	Excluded area salaries (see instructions)		6,631,323	0	6,631,323	204,849.14	32.37
OTHER WAGES & RELATED COSTS							
11.00	Contract labor: Direct Patient Care		292,349	0	292,349	1,477.00	197.93
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		350,678	0	350,678	2,220.00	157.96
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		5,437,069	0	5,437,069	106,868.52	50.88
14.02	Related organization salaries		0	0	0	0.00	0.00
15.00	Home office: Physician Part A - Administrative		0	0	0	0.00	0.00
16.00	Home office and Contract Physicians Part A - Teaching		0	0	0	0.00	0.00
16.01	Home office Physicians Part A - Teaching		0	0	0	0.00	0.00
16.02	Home office contract Physicians Part A - Teaching		0	0	0	0.00	0.00
WAGE-RELATED COSTS							
17.00	Wage-related costs (core) (see instructions)		5,909,723	0	5,909,723		
18.00	Wage-related costs (other) (see instructions)						
19.00	Excluded areas		1,385,677	0	1,385,677		
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)		952,807	0	952,807		
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: 14-0292

Period:
From 01/01/2020
To 12/31/2020Worksheet S-3
Part II
Date/Time Prepared:
7/28/2021 9:55 am

		Wkst. A Line Number	Amount Reported	Reclassificati on of Salaries (from Wkst. A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
25.53	Home office: Physicians Part A - Teaching - wage-related (core)		0	0	0			25.53
OVERHEAD COSTS - DIRECT SALARIES								
26.00	Employee Benefits Department	4.00	179,470	0	179,470	4,325.00	41.50	26.00
27.00	Administrative & General	5.00	2,429,568	0	2,429,568	18,325.00	132.58	27.00
28.00	Administrative & General under contract (see inst.)		0	0	0	0.00	0.00	28.00
29.00	Maintenance & Repairs	6.00	0	0	0	0.00	0.00	29.00
30.00	Operation of Plant	7.00	911,038	0	911,038	33,271.00	27.38	30.00
31.00	Laundry & Linen Service	8.00	0	0	0	0.00	0.00	31.00
32.00	Housekeeping	9.00	0	0	0	0.00	0.00	32.00
33.00	Housekeeping under contract (see instructions)		1,241,591	0	1,241,591	51,556.12	24.08	33.00
34.00	Dietary	10.00	0	0	0	0.00	0.00	34.00
35.00	Dietary under contract (see instructions)		1,578,522	0	1,578,522	54,402.57	29.02	35.00
36.00	Cafeteria	11.00	0	0	0	0.00	0.00	36.00
37.00	Maintenance of Personnel	12.00	0	0	0	0.00	0.00	37.00
38.00	Nursing Administration	13.00	1,016,928	0	1,016,928	19,892.00	51.12	38.00
39.00	Central Services and Supply	14.00	134,190	0	134,190	5,090.00	26.36	39.00
40.00	Pharmacy	15.00	1,436,235	0	1,436,235	31,554.00	45.52	40.00
41.00	Medical Records & Medical Records Library	16.00	0	0	0	0.00	0.00	41.00
42.00	Social Service	17.00	37,714	0	37,714	1,462.00	25.80	42.00
43.00	Other General Service	18.00	0	0	0	0.00	0.00	43.00

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 14-0292

Period:
From 01/01/2020
To 12/31/2020Worksheet S-3
Part III
Date/Time Prepared:
7/28/2021 9:55 am

	Worksheet A Line Number	Amount Reported	Reclassificati on of Salaries (from Worksheet A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
	1.00	2.00	3.00	4.00	5.00	6.00	
PART III - HOSPITAL WAGE INDEX SUMMARY							
1.00	Net salaries (see instructions)	37,733,110	504	37,733,614	1,016,574.16	37.12	1.00
2.00	Excluded area salaries (see instructions)	6,631,323	0	6,631,323	204,849.14	32.37	2.00
3.00	Subtotal salaries (line 1 minus line 2)	31,101,787	504	31,102,291	811,725.02	38.32	3.00
4.00	Subtotal other wages & related costs (see inst.)	6,080,096	0	6,080,096	110,565.52	54.99	4.00
5.00	Subtotal wage-related costs (see inst.)	6,862,530	0	6,862,530	0.00	22.06	5.00
6.00	Total (sum of lines 3 thru 5)	44,044,413	504	44,044,917	922,290.54	47.76	6.00
7.00	Total overhead cost (see instructions)	8,965,256	0	8,965,256	219,877.69	40.77	7.00

HOSPITAL WAGE RELATED COSTS

Provider CCN: 14-0292

Period:
From 01/01/2020
To 12/31/2020Worksheet S-3
Part IV
Date/Time Prepared:
7/28/2021 9:55 am

		Amount Reported	
		1.00	
PART IV - WAGE RELATED COSTS			
Part A - Core List			
RETIREMENT COST			
1.00	401K Employer Contributions	0	1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution	1,198,660	2.00
3.00	Nonqualified Defined Benefit Plan Cost (see instructions)	0	3.00
4.00	Qualified Defined Benefit Plan Cost (see instructions)	0	4.00
PLAN ADMINISTRATIVE COSTS (Paid to External Organization)			
5.00	401K/TSA Plan Administration fees	0	5.00
6.00	Legal/Accounting/Management Fees-Pension Plan	0	6.00
7.00	Employee Managed Care Program Administration Fees	0	7.00
HEALTH AND INSURANCE COST			
8.00	Health Insurance (Purchased or Self Funded)	0	8.00
8.01	Health Insurance (Self Funded without a Third Party Administrator)	0	8.01
8.02	Health Insurance (Self Funded with a Third Party Administrator)	3,258,451	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	-23,028	10.00
11.00	Life Insurance (If employee is owner or beneficiary)	-85,070	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)	-45,554	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)	85,701	14.00
15.00	'Workers' Compensation Insurance	245,905	15.00
16.00	Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. Non cumulative portion)	0	16.00
TAXES			
17.00	FICA-Employers Portion Only	2,530,445	17.00
18.00	Medicare Taxes - Employers Portion Only	0	18.00
19.00	Unemployment Insurance	70,957	19.00
20.00	State or Federal Unemployment Taxes	0	20.00
OTHER			
21.00	Executive Deferred Compensation (Other Than Retirement Cost Reported on lines 1 through 4 above. (see instructions))	0	21.00
22.00	Day Care Cost and Allowances	0	22.00
23.00	Tuition Reimbursement	58,933	23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)	7,295,400	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: 14-0292

Period:
From 01/01/2020
To 12/31/2020Worksheet S-3
Part V
Date/Time Prepared:
7/28/2021 9:55 am

Cost Center Description		Contract Labor	Benefit Cost	
		1.00	2.00	
PART V - Contract Labor and Benefit Cost				
Hospital and Hospital-Based Component Identification:				
1.00	Total facility's contract labor and benefit cost	292,349	7,295,400	1.00
2.00	Hospital	292,349	7,295,400	2.00
3.00	Subprovider - IPF	0	0	3.00
4.00	Subprovider - IRF			4.00
5.00	Subprovider - (Other)	0	0	5.00
6.00	Swing Beds - SNF	0	0	6.00
7.00	Swing Beds - NF	0	0	7.00
8.00	Hospital-Based SNF			8.00
9.00	Hospital-Based NF			9.00
10.00	Hospital-Based OLTC			10.00
11.00	Hospital-Based HHA			11.00
12.00	Separately Certified ASC			12.00
13.00	Hospital-Based Hospice			13.00
14.00	Hospital-Based Health Clinic RHC			14.00
15.00	Hospital-Based Health Clinic FQHC			15.00
16.00	Hospital-Based-CMHC			16.00
17.00	Renal Dialysis	0	0	17.00
18.00	Other	0	0	18.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA		Provider CCN: 14-0292	Period: From 01/01/2020 To 12/31/2020	Worksheet S-10 Date/Time Prepared: 7/28/2021 9:55 am	
				1.00	
Uncompensated and indigent care cost computation					
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided by line 202 column 8)		0.261674		1.00
Medicaid (see instructions for each line)					
2.00	Net revenue from Medicaid		28,286,630		2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?		Y		3.00
4.00	If line 3 is yes, does line 2 include all DSH and/or supplemental payments from Medicaid?		Y		4.00
5.00	If line 4 is no, then enter DSH and/or supplemental payments from Medicaid		0		5.00
6.00	Medicaid charges		83,690,819		6.00
7.00	Medicaid cost (line 1 times line 6)		21,899,711		7.00
8.00	Difference between net revenue and costs for Medicaid program (line 7 minus sum of lines 2 and 5; if < zero then enter zero)		0		8.00
Children's Health Insurance Program (CHIP) (see instructions for each line)					
9.00	Net revenue from stand-alone CHIP		0		9.00
10.00	Stand-alone CHIP charges		0		10.00
11.00	Stand-alone CHIP cost (line 1 times line 10)		0		11.00
12.00	Difference between net revenue and costs for stand-alone CHIP (line 11 minus line 9; if < zero then enter zero)		0		12.00
Other state or local government indigent care program (see instructions for each line)					
13.00	Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9)		0		13.00
14.00	Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)		0		14.00
15.00	State or local indigent care program cost (line 1 times line 14)		0		15.00
16.00	Difference between net revenue and costs for state or local indigent care program (line 15 minus line 13; if < zero then enter zero)		0		16.00
Grants, donations and total unreimbursed cost for Medicaid, CHIP and state/local indigent care programs (see instructions for each line)					
17.00	Private grants, donations, or endowment income restricted to funding charity care		0		17.00
18.00	Government grants, appropriations or transfers for support of hospital operations		0		18.00
19.00	Total unreimbursed cost for Medicaid, CHIP and state and local indigent care programs (sum of lines 8, 12 and 16)		0		19.00
		Uninsured patients	Insured patients	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)	8,058,881	472,568	8,531,449	20.00
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	2,108,800	472,568	2,581,368	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)	2,108,800	472,568	2,581,368	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)		4,946,762		26.00
27.00	Medicare reimbursable bad debts for the entire hospital complex (see instructions)		331,991		27.00
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)		510,756		27.01
28.00	Non-Medicare bad debt expense (see instructions)		4,436,006		28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)		1,339,552		29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)		3,920,920		30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)		3,920,920		31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-0292

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

Worksheet A

Date/Time Prepared:
7/28/2021 9:55 am

Cost Center Description			Salaries	Other	Total (col. 1 + col. 2)	Reclassificati ons (See A-6)	Reclassified Trial Balance (col. 3 + col. 4)	
			1.00	2.00	3.00	4.00	5.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT		0	0	2,767,809	2,767,809	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		0	0	1,036,111	1,036,111	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	179,470	4,650,820	4,830,290	0	4,830,290	4.00
5.01	01160	COMMUNICATIONS	0	0	0	0	0	5.01
5.04	00570	ADMITTING	0	2,867	2,867	0	2,867	5.04
5.06	00560	OTHER ADMINISTRATIVE AND GENERAL	2,429,568	24,085,547	26,515,115	-168,926	26,346,189	5.06
7.00	00700	OPERATION OF PLANT	911,038	2,321,625	3,232,663	-45,723	3,186,940	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0	166,325	166,325	8.00
9.00	00900	HOUSEKEEPING	0	1,805,778	1,805,778	-169,845	1,635,933	9.00
10.00	01000	DIETARY	0	2,254,834	2,254,834	-1,443,348	811,486	10.00
11.00	01100	CAFETERIA	0	0	0	1,442,438	1,442,438	11.00
13.00	01300	NURSING ADMINISTRATION	1,016,928	191,878	1,208,806	-79,601	1,129,205	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	134,190	280,935	415,125	-121,040	294,085	14.00
15.00	01500	PHARMACY	1,436,235	4,209,991	5,646,226	-4,042,835	1,603,391	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	41,046	41,046	-45	41,001	16.00
17.00	01700	SOCIAL SERVICE	37,714	100,923	138,637	-12	138,625	17.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	10,967,829	2,101,321	13,069,150	-2,631,775	10,437,375	30.00
31.00	03100	INTENSIVE CARE UNIT	2,768,932	667,541	3,436,473	-360,422	3,076,051	31.00
40.00	04000	SUBPROVIDER - IPF	1,994,807	170,536	2,165,343	-52,431	2,112,912	40.00
43.00	04300	NURSERY	0	3,624	3,624	478,560	482,184	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	1,322,289	3,681,477	5,003,766	-3,018,991	1,984,775	50.00
51.00	05100	RECOVERY ROOM	241,031	33,427	274,458	-15,350	259,108	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	63,666	579,000	642,666	1,316,604	1,959,270	52.00
53.00	05300	ANESTHESIOLOGY	61,994	27,765	89,759	-1,284	88,475	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	717,932	998,160	1,716,092	-335,083	1,381,009	54.00
56.00	05600	RADIOISOTOPE	116,177	55,827	172,004	-33,757	138,247	56.00
57.00	05700	CT SCAN	417,530	85,505	503,035	47,204	550,239	57.00
58.00	05800	MRI	81,434	25,442	106,876	-5,862	101,014	58.00
59.00	05900	CARDIAC CATHETERIZATION	714,429	1,137,362	1,851,791	-936,296	915,495	59.00
60.00	06000	LABORATORY	-504	3,412,060	3,411,556	-74,192	3,337,364	60.00
65.00	06500	RESPIRATORY THERAPY	783,218	355,721	1,138,939	-154,913	984,026	65.00
66.00	06600	PHYSICAL THERAPY	0	1,339,647	1,339,647	-178,700	1,160,947	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	305,612	305,612	-130	305,482	67.00
68.00	06800	SPEECH PATHOLOGY	0	43,313	43,313	0	43,313	68.00
69.00	06900	ELECTROCARDIOLOGY	347,805	238,790	586,595	-28,262	558,333	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	15,270	2,080	17,350	0	17,350	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	3,363,685	3,363,685	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	2,205,108	2,205,108	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	3,834,614	3,834,614	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	0	75.00
75.01	03950	INPATIENT RENAL DIALYSI	0	395,349	395,349	-2,208	393,141	75.01
76.00	03050	BACTERIOLOGY & MICROBIOLOGY	0	0	0	0	0	76.00
76.01	03060	WOUND CARE	2,927	78,195	81,122	0	81,122	76.01
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	516,325	220,847	737,172	-18,060	719,112	90.00
91.00	09100	EMERGENCY	2,998,247	2,095,025	5,093,272	-584,204	4,509,068	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE		2,221,579	2,221,579	-2,083,332	138,247	113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	30,276,481	60,221,449	90,497,930	71,831	90,569,761	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	24,093	4,257	28,350	0	28,350	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	1,666,451	1,666,451	0	1,666,451	192.00
192.03	19203	OP PHARMACY	318,970	993,278	1,312,248	0	1,312,248	192.03
194.00	07950	FOUNDATION	0	0	0	0	0	194.00
194.01	07951	MARKETING	0	0	0	0	0	194.01
194.03	07953	THERAPEUTIC DAY SCHOOL	4,293,453	1,840,447	6,133,900	-71,831	6,062,069	194.03
200.00		TOTAL (SUM OF LINES 118 through 199)	34,912,997	64,725,882	99,638,879	0	99,638,879	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-0292

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

Worksheet A

Date/Time Prepared:
7/28/2021 9:55 am

Cost Center Description			Adjustments (See A-8)	Net Expenses For Allocation	
			6.00	7.00	
GENERAL SERVICE COST CENTERS					
1.00	00100	CAP REL COSTS-BLDG & FIXT	221,737	2,989,546	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	492,702	1,528,813	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-84,289	4,746,001	4.00
5.01	01160	COMMUNICATIONS	-23,875	-23,875	5.01
5.04	00570	ADMITTING	0	2,867	5.04
5.06	00560	OTHER ADMINISTRATIVE AND GENERAL	-10,886,400	15,459,789	5.06
7.00	00700	OPERATION OF PLANT	-20,215	3,166,725	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	166,325	8.00
9.00	00900	HOUSEKEEPING	0	1,635,933	9.00
10.00	01000	DIETARY	0	811,486	10.00
11.00	01100	CAFETERIA	-215,909	1,226,529	11.00
13.00	01300	NURSING ADMINISTRATION	-1,285	1,127,920	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	268,003	562,088	14.00
15.00	01500	PHARMACY	24,739	1,628,130	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-12,705	28,296	16.00
17.00	01700	SOCIAL SERVICE	-57,014	81,611	17.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	-52,103	10,385,272	30.00
31.00	03100	INTENSIVE CARE UNIT	-13,667	3,062,384	31.00
40.00	04000	SUBPROVIDER - IPF	0	2,112,912	40.00
43.00	04300	NURSERY	0	482,184	43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	-12,500	1,972,275	50.00
51.00	05100	RECOVERY ROOM	0	259,108	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	-420,389	1,538,881	52.00
53.00	05300	ANESTHESIOLOGY	-2,068	86,407	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-512,337	868,672	54.00
56.00	05600	RADIOISOTOPE	0	138,247	56.00
57.00	05700	CT SCAN	-768	549,471	57.00
58.00	05800	MRI	-370	100,644	58.00
59.00	05900	CARDIAC CATHETERIZATION	-28,670	886,825	59.00
60.00	06000	LABORATORY	-3,500	3,333,864	60.00
65.00	06500	RESPIRATORY THERAPY	-8,529	975,497	65.00
66.00	06600	PHYSICAL THERAPY	-239	1,160,708	66.00
67.00	06700	OCCUPATIONAL THERAPY	-432	305,050	67.00
68.00	06800	SPEECH PATHOLOGY	-257	43,056	68.00
69.00	06900	ELECTROCARDIOLOGY	-148,560	409,773	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	17,350	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	-603	3,363,082	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	-1,466	2,203,642	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	-11,174	3,823,440	73.00
74.00	07400	RENAL DIALYSIS	0	0	74.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	75.00
75.01	03950	INPATIENT RENAL DIALYSI	-54	393,087	75.01
76.00	03050	BACTERIOLOGY & MICROBIOLOGY	0	0	76.00
76.01	03060	WOUND CARE	0	81,122	76.01
OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	-229,156	489,956	90.00
91.00	09100	EMERGENCY	-1,316,840	3,192,228	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART			92.00
SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE	-138,247	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-13,196,440	77,373,321	118.00
NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	28,350	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	1,666,451	192.00
192.03	19203	OP PHARMACY	0	1,312,248	192.03
194.00	07950	FOUNDATION	0	0	194.00
194.01	07951	MARKETING	0	0	194.01
194.03	07953	THERAPEUTIC DAY SCHOOL	0	6,062,069	194.03
200.00		TOTAL (SUM OF LINES 118 through 199)	-13,196,440	86,442,439	200.00

RECLASSIFICATIONS

Provider CCN: 14-0292

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

Worksheet A-6

Date/Time Prepared:
7/28/2021 9:55 am

		Increases				
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
	A - BILLABLE SUPPLIES					
1.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	3,363,685		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
	TOTALS		0	3,363,685		
	B - CAFETERIA					
1.00	CAFETERIA	11.00	0	1,442,438		1.00
	TOTALS		0	1,442,438		
	C - NURSERY					
1.00	NURSERY	43.00	342,020	139,153		1.00
2.00	DELIVERY ROOM & LABOR ROOM	52.00	1,389,422	27,595		2.00
	TOTALS		1,731,442	166,748		
	D - RENT AND LEASES					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	254,847		1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	460,998		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
	TOTALS		0	715,845		
	E - DEPRECIATION					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	2,128,765		1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	531,527		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

RECLASSIFICATIONS

Provider CCN: 14-0292

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

Worksheet A-6

Date/Time Prepared:
7/28/2021 9:55 am

Increases					
Cost Center	Line #	Salary	Other		
2.00	3.00	4.00	5.00		
18.00	0.00	0	0		18.00
19.00	0.00	0	0		19.00
20.00	0.00	0	0		20.00
TOTALS		0	2,660,292		
F - RADIOLOGY RECLASS					
1.00	RADIOISOTOPE	56.00	6,604	508	1.00
2.00	CT SCAN	57.00	84,545	6,498	2.00
3.00	MRI	58.00	9,271	713	3.00
TOTALS			100,420	7,719	
G - BILLABLE DRUGS					
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	3,834,614	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
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
TOTALS			0	3,834,614	
I - INSURANCE					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	71,688	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	21,000	2.00
TOTALS			0	92,688	
J - PROPERTY TAX					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	5,351	1.00
2.00		0.00	0	0	2.00
TOTALS			0	5,351	
K - IMPLANTIBLES					
1.00	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	2,205,108	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
TOTALS			0	2,205,108	
M - INTEREST RECLASS					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	307,158	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	22,586	2.00
3.00	OTHER ADMINISTRATIVE AND GENERAL	5.00	0	2	3.00
TOTALS			0	329,746	
N - LINEN					
1.00	LAUNDRY & LINEN SERVICE	8.00	0	166,325	1.00
TOTALS			0	166,325	
P - NEGATIVE SALARIES RECLASS					
1.00		0.00	0	0	1.00
11.00	LABORATORY	60.00	504	0	11.00
TOTALS			504	0	
500.00	Grand Total: Increases		1,832,366	14,990,559	500.00

RECLASSIFICATIONS

Provider CCN: 14-0292

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

Worksheet A-6

Date/Time Prepared:
7/28/2021 9:55 am

		Decreases					7/28/2021 9:35 am	
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.			
	6.00	7.00	8.00	9.00	10.00			
A - BILLABLE SUPPLIES								
1.00	CENTRAL SERVICES & SUPPLY	14.00	0	107,543	0	1.00		
2.00	PHARMACY	15.00	0	68,359	0	2.00		
3.00	MEDICAL RECORDS & LIBRARY	16.00	0	45	0	3.00		
4.00	SOCIAL SERVICE	17.00	0	12	0	4.00		
5.00	ADULTS & PEDIATRICS	30.00	0	515,302	0	5.00		
6.00	INTENSIVE CARE UNIT	31.00	0	324,198	0	6.00		
7.00	SUBPROVIDER - IPF	40.00	0	38,274	0	7.00		
8.00	NURSERY	43.00	0	2,613	0	8.00		
9.00	OPERATING ROOM	50.00	0	748,806	0	9.00		
10.00	RECOVERY ROOM	51.00	0	6,314	0	10.00		
11.00	DELIVERY ROOM & LABOR ROOM	52.00	0	47,485	0	11.00		
12.00	ANESTHESIOLOGY	53.00	0	1,284	0	12.00		
13.00	RADIOLOGY-DIAGNOSTIC	54.00	0	180,211	0	13.00		
14.00	RADIOISOTOPE	56.00	0	34,218	0	14.00		
15.00	CT SCAN	57.00	0	42,429	0	15.00		
16.00	MRI	58.00	0	5,819	0	16.00		
17.00	CARDIAC CATHETERIZATION	59.00	0	500,115	0	17.00		
18.00	LABORATORY	60.00	0	58,988	0	18.00		
19.00	RESPIRATORY THERAPY	65.00	0	141,169	0	19.00		
20.00	PHYSICAL THERAPY	66.00	0	676	0	20.00		
21.00	ELECTROCARDIOLOGY	69.00	0	7,063	0	21.00		
22.00	INPATIENT RENAL DIALYSI	75.01	0	2,208	0	22.00		
23.00	CLINIC	90.00	0	15,415	0	23.00		
24.00	EMERGENCY	91.00	0	515,139	0	24.00		
TOTALS			0	3,363,685				
B - CAFETERIA								
1.00	DIETARY	10.00	0	1,442,438	0	1.00		
TOTALS			0	1,442,438				
C - NURSERY								
1.00	ADULTS & PEDIATRICS	30.00	1,731,442	166,748	0	1.00		
2.00		0.00	0	0	0	2.00		
TOTALS			1,731,442	166,748				
D - RENT AND LEASES								
1.00	OTHER ADMINISTRATIVE AND GENERAL	5.06	0	213	10	1.00		
2.00	OPERATION OF PLANT	7.00	0	390	10	2.00		
3.00	HOUSEKEEPING	9.00	0	3,520	0	3.00		
4.00	DIETARY	10.00	0	260	0	4.00		
5.00	NURSING ADMINISTRATION	13.00	0	650	0	5.00		
6.00	CENTRAL SERVICES & SUPPLY	14.00	0	7,240	0	6.00		
7.00	PHARMACY	15.00	0	210,344	0	7.00		
8.00	ADULTS & PEDIATRICS	30.00	0	31,201	0	8.00		
9.00	SUBPROVIDER - IPF	40.00	0	570	0	9.00		
10.00	OPERATING ROOM	50.00	0	203,711	0	10.00		
11.00	DELIVERY ROOM & LABOR ROOM	52.00	0	51,457	0	11.00		
12.00	RADIOLOGY-DIAGNOSTIC	54.00	0	91	0	12.00		
13.00	MRI	58.00	0	130	0	13.00		
14.00	CARDIAC CATHETERIZATION	59.00	0	1,690	0	14.00		
15.00	LABORATORY	60.00	0	12,254	0	15.00		
16.00	RESPIRATORY THERAPY	65.00	0	13,450	0	16.00		
17.00	PHYSICAL THERAPY	66.00	0	178,024	0	17.00		
18.00	OCCUPATIONAL THERAPY	67.00	0	130	0	18.00		
19.00	ELECTROCARDIOLOGY	69.00	0	390	0	19.00		
20.00	EMERGENCY	91.00	0	130	0	20.00		
TOTALS			0	715,845				
E - DEPRECIATION								
1.00	OTHER ADMINISTRATIVE AND GENERAL	5.06	0	76,027	9	1.00		
2.00	OPERATION OF PLANT	7.00	0	45,333	9	2.00		
3.00	DIETARY	10.00	0	650	0	3.00		
4.00	NURSING ADMINISTRATION	13.00	0	78,951	0	4.00		
5.00	PHARMACY	15.00	0	2,526	0	5.00		
6.00	ADULTS & PEDIATRICS	30.00	0	183,000	0	6.00		
7.00	INTENSIVE CARE UNIT	31.00	0	33,070	0	7.00		
8.00	SUBPROVIDER - IPF	40.00	0	13,375	0	8.00		
9.00	OPERATING ROOM	50.00	0	278,569	0	9.00		
10.00	RECOVERY ROOM	51.00	0	8,941	0	10.00		
11.00	DELIVERY ROOM & LABOR ROOM	52.00	0	745	0	11.00		
12.00	RADIOLOGY-DIAGNOSTIC	54.00	0	44,348	0	12.00		
13.00	RADIOISOTOPE	56.00	0	5,509	0	13.00		
14.00	CT SCAN	57.00	0	588	0	14.00		
15.00	MRI	58.00	0	9,897	0	15.00		
16.00	CARDIAC CATHETERIZATION	59.00	0	6,039	0	16.00		

RECLASSIFICATIONS

Provider CCN: 14-0292

Period:
From 01/01/2020
To 12/31/2020Worksheet A-6
Date/Time Prepared:
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	Decreases						
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
17.00	ELECTROCARDIOLOGY	69.00	0	1,803	0		17.00
18.00	EMERGENCY	91.00	0	50,855	0		18.00
19.00	INTEREST EXPENSE	113.00	0	1,749,858	0		19.00
20.00	THERAPEUTIC DAY SCHOOL	194.03	0	70,208	0		20.00
	TOTALS		0	2,660,292			
	F - RADIOLOGY RECLASS						
1.00	RADIOLOGY-DIAGNOSTIC	54.00	100,420	7,719	0		1.00
2.00		0.00	0	0	0		2.00
3.00		0.00	0	0	0		3.00
	TOTALS		100,420	7,719			
	G - BILLABLE DRUGS						
1.00	CENTRAL SERVICES & SUPPLY	14.00	0	2,266	0		1.00
2.00	PHARMACY	15.00	0	3,761,606	0		2.00
3.00	ADULTS & PEDIATRICS	30.00	0	4,082	0		3.00
4.00	INTENSIVE CARE UNIT	31.00	0	3,154	0		4.00
5.00	SUBPROVIDER - IPF	40.00	0	212	0		5.00
6.00	OPERATING ROOM	50.00	0	21,348	0		6.00
7.00	RECOVERY ROOM	51.00	0	95	0		7.00
8.00	DELIVERY ROOM & LABOR ROOM	52.00	0	726	0		8.00
9.00	RADIOLOGY-DIAGNOSTIC	54.00	0	2,294	0		9.00
10.00	RADIOISOTOPE	56.00	0	1,142	0		10.00
11.00	CT SCAN	57.00	0	822	0		11.00
13.00	CARDIAC CATHETERIZATION	59.00	0	178	0		13.00
14.00	LABORATORY	60.00	0	2,950	0		14.00
15.00	RESPIRATORY THERAPY	65.00	0	199	0		15.00
16.00	ELECTROCARDIOLOGY	69.00	0	19,006	0		16.00
17.00	CLINIC	90.00	0	2,645	0		17.00
18.00	EMERGENCY	91.00	0	11,889	0		18.00
	TOTALS		0	3,834,614			
	I - INSURANCE						
1.00	OTHER ADMINISTRATIVE AND GENERAL	5.06	0	92,688	12		1.00
2.00		0.00	0	0	12		2.00
	TOTALS		0	92,688			
	J - PROPERTY TAX						
1.00	INTEREST EXPENSE	113.00	0	3,728	13		1.00
2.00	THERAPEUTIC DAY SCHOOL	194.03	0	1,623	0		2.00
	TOTALS		0	5,351			
	K - IMPLANTIBLES						
1.00	CENTRAL SERVICES & SUPPLY	14.00	0	3,991	0		1.00
2.00	OPERATING ROOM	50.00	0	1,766,557	0		2.00
3.00	CARDIAC CATHETERIZATION	59.00	0	428,274	0		3.00
4.00	EMERGENCY	91.00	0	6,191	0		4.00
5.00	RESPIRATORY THERAPY	65.00	0	95	0		5.00
	TOTALS		0	2,205,108			
	M - INTEREST RECLASS						
1.00	INTEREST EXPENSE	113.00	0	329,746	11		1.00
2.00		0.00	0	0	11		2.00
3.00		0.00	0	0	0		3.00
	TOTALS		0	329,746			
	N - LINEN						
1.00	HOUSEKEEPING	9.00	0	166,325	0		1.00
	TOTALS		0	166,325			
	P - NEGATIVE SALARIES RECLASS						
1.00		0.00	0	0	0		1.00
11.00	LABORATORY	60.00	0	504	0		11.00
	TOTALS		0	504			
500.00	Grand Total: Decreases		1,831,862	14,991,063			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-0292

Period:
From 01/01/2020
To 12/31/2020Worksheet A-7
Part I
Date/Time Prepared:
7/28/2021 9:55 am

		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	1,869,112	0	0	0	49,112	1.00	
2.00	Land Improvements	647,781	0	0	0	0	2.00	
3.00	Buildings and Fixtures	41,736,871	4,270,153	0	4,270,153	0	3.00	
4.00	Building Improvements	0	0	0	0	0	4.00	
5.00	Fixed Equipment	9,750,189	64,639	0	64,639	0	5.00	
6.00	Movable Equipment	17,409,949	532,747	0	532,747	0	6.00	
7.00	HIT designated Assets	0	0	0	0	0	7.00	
8.00	Subtotal (sum of lines 1-7)	71,413,902	4,867,539	0	4,867,539	49,112	8.00	
9.00	Reconciling Items	0	0	0	0	0	9.00	
10.00	Total (line 8 minus line 9)	71,413,902	4,867,539	0	4,867,539	49,112	10.00	
		Ending Balance	Fully Depreciated Assets					
		6.00	7.00					
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES								
1.00	Land	1,820,000	0					1.00
2.00	Land Improvements	647,781	0					
3.00	Buildings and Fixtures	46,007,024	0					
4.00	Building Improvements	0	0					4.00
5.00	Fixed Equipment	9,814,828	0					
6.00	Movable Equipment	17,942,696	0					
7.00	HIT designated Assets	0	0					7.00
8.00	Subtotal (sum of lines 1-7)	76,232,329	0					
9.00	Reconciling Items	0	0					
10.00	Total (line 8 minus line 9)	76,232,329	0					10.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-0292

Period:
From 01/01/2020
To 12/31/2020Worksheet A-7
Part II
Date/Time Prepared:
7/28/2021 9:55 am

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

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-0292

Period:
From 01/01/2020
To 12/31/2020Worksheet A-7
Part III
Date/Time Prepared:
7/28/2021 9:55 am

Cost Center Description		COMPUTATION OF RATIOS			ALLOCATION OF OTHER CAPITAL		
		Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	
		1.00	2.00	3.00	4.00	5.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	56,469,634	0	56,469,634	0.758876	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	17,942,596	0	17,942,596	0.241124	0	2.00
3.00	Total (sum of lines 1-2)	74,412,230	0	74,412,230	1.000000	0	3.00
Cost Center Description		ALLOCATION OF OTHER CAPITAL			SUMMARY OF CAPITAL		
		Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	Depreciation	Lease	
		6.00	7.00	8.00	9.00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	2,336,291	254,847	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	1,024,229	460,998	2.00
3.00	Total (sum of lines 1-2)	0	0	0	3,360,520	715,845	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	327,673	71,688	-953	0	2,989,546	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	22,586	21,000	0	0	1,528,813	2.00
3.00	Total (sum of lines 1-2)	350,259	92,688	-953	0	4,518,359	3.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 14-0292

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

Worksheet A-8

Date/Time Prepared:
7/28/2021 9:55 am

Cost Center Description		Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted		Wkst. A-7 Ref.	
				Cost Center	Line #		
		1.00	2.00	3.00	4.00	5.00	
1.00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)			0CAP REL COSTS-BLDG & FIXT	1.00	0	1.00
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)			0CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
3.00	Investment income - other (chapter 2)		0		0.00	0	3.00
4.00	Trade, quantity, and time discounts (chapter 8)		0		0.00	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)		0		0.00	0	5.00
6.00	Rental of provider space by suppliers (chapter 8)		0		0.00	0	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)	A	-23,875	COMMUNICATIONS	5.01	0	7.00
8.00	Television and radio service (chapter 21)	A	-16,341	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	-3,785,653			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	-978,040			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		0		0.00	0	16.00
17.00	Sale of drugs to other than patients		0		0.00	0	17.00
18.00	Sale of medical records and abstracts		0		0.00	0	18.00
19.00	Nursing and allied health education (tuition, fees, books, etc.)		0		0.00	0	19.00
20.00	Vending machines		0		0.00	0	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	0	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	RESPIRATORY THERAPY	65.00		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	PHYSICAL THERAPY	66.00		24.00
25.00	Utilization review - physicians' compensation (chapter 21)		0	*** Cost Center Deleted ***	114.00		25.00
26.00	Depreciation - CAP REL COSTS-BLDG & FIXT		0	CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	27.00
28.00	Non-physician Anesthetist		0	*** Cost Center Deleted ***	19.00		28.00
29.00	Physicians' assistant		0		0.00	0	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	OCCUPATIONAL THERAPY	67.00		30.00
30.99	Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS	30.00		30.99
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	SPEECH PATHOLOGY	68.00		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest		0		0.00	0	32.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 14-0292

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

Worksheet A-8

Date/Time Prepared:
7/28/2021 9:55 am

Cost Center Description		Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted		Wkst. A-7 Ref.	
				Cost Center	Line #		
		1.00	2.00	3.00	4.00	5.00	
33.00	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	33.00
33.01	MISC REVENUE	B	-2,676,627	OTHER ADMINISTRATIVE AND GENERAL	5.06	0	33.01
33.02	MISC REVENUE	B	-3,874	OPERATION OF PLANT	7.00	0	33.02
33.03	MISC REVENUE	B	-215,909	CAFETERIA	11.00	0	33.03
33.04	MISC REVENUE	B	-5,159	MEDICAL RECORDS & LIBRARY	16.00	0	33.04
33.05	MISC REVENUE	B	-20,700	PHARMACY	15.00	0	33.05
33.06	MISC REVENUE	B	-706	DELIVERY ROOM & LABOR ROOM	52.00	0	33.06
33.07	MISC REVENUE	B	-45	RADIOLOGY-DIAGNOSTIC	54.00	0	33.07
33.08	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	33.08
33.09	MISC REVENUE	A	0	RESPIRATORY THERAPY	65.00	0	33.09
33.10	MISC REVENUE	A	-33,716	CLINIC	90.00	0	33.10
33.11	MISC REVENUE	A	-63,852	EMERGENCY	91.00	0	33.11
33.12	LOBBYING	A	-18,038	OTHER ADMINISTRATIVE AND GENERAL	5.06	0	33.12
33.13	LEGAL FEES	A	-407	OTHER ADMINISTRATIVE AND GENERAL	5.06	0	33.13
33.14	OTHER ADJUSTMENTS (SPECIFY) (3)	A	0		0.00	0	33.14
33.15	OTHER ADJUSTMENTS (SPECIFY) (3)	A	0		0.00	0	33.15
33.16	OTHER ADJUSTMENTS (SPECIFY) (3)	A	0		0.00	0	33.16
33.17	OTHER ADJUSTMENTS (SPECIFY) (3)	A	0		0.00	0	33.17
33.18	HOSPICE	A	-2,101	RADIOLOGY-DIAGNOSTIC	54.00	0	33.18
33.19	HOSPICE	A	-768	CT SCAN	57.00	0	33.19
33.20	HOSPICE	A	-370	MRI	58.00	0	33.20
33.21	HOSPICE	A	-3,500	LABORATORY	60.00	0	33.21
33.22	HOSPICE	A	-8,339	RESPIRATORY THERAPY	65.00	0	33.22
33.23	HOSPICE	A	-239	PHYSICAL THERAPY	66.00	0	33.23
33.24	HOSPICE	A	-432	OCCUPATIONAL THERAPY	67.00	0	33.24
33.25	HOSPICE	A	-257	SPEECH PATHOLOGY	68.00	0	33.25
33.26	HOSPICE	A	-789	ELECTROCARDIOLOGY	69.00	0	33.26
33.27	HOSPICE	A	-603	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	33.27
33.28	HOSPICE	A	-1,466	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	33.28
33.29	HOSPICE	A	-11,174	DRUGS CHARGED TO PATIENTS	73.00	0	33.29
33.30	HOSPICE	A	-54	INPATIENT RENAL DIALYSI	75.01	0	33.30
33.31	HOSPICE	A	-2,250	EMERGENCY	91.00	0	33.31
33.32	HOSPICE	A	-42,822	ADULTS & PEDIATRICS	30.00	0	33.32
33.33	HOSPICE	A	-13,667	INTENSIVE CARE UNIT	31.00	0	33.33
33.34	PROPERTY TAX	A	-6,304	CAP REL COSTS-BLDG & FIXT	1.00	13	33.34
33.35	STATE ASSESSMENT	A	-5,054,684	OTHER ADMINISTRATIVE AND GENERAL	5.06	0	33.35
33.37	ADVERTISING & MARKETING	A	-10,000	OTHER ADMINISTRATIVE AND GENERAL	5.06	0	33.37
33.38	ADVERTISING & MARKETING	A	-480	PHARMACY	15.00	0	33.38
33.39	ADVERTISING & MARKETING	A	-1,895	SOCIAL SERVICE	17.00	0	33.39
33.40	ADVERTISING & MARKETING	A	-639	ADULTS & PEDIATRICS	30.00	0	33.40
33.41	ADVERTISING & MARKETING	A	-190	RESPIRATORY THERAPY	65.00	0	33.41
33.42	ENTERTAINMENT	A	-2,041	OTHER ADMINISTRATIVE AND GENERAL	5.06	0	33.42
33.43	ENTERTAINMENT	A	-1,285	NURSING ADMINISTRATION	13.00	0	33.43
33.44	ENTERTAINMENT	A	-257	RADIOLOGY-DIAGNOSTIC	54.00	0	33.44
33.45	ENTERTAINMENT	A	-1,934	EMERGENCY	91.00	0	33.45
33.46	AMBULANCE	A	-429	CENTRAL SERVICES & SUPPLY	14.00	0	33.46
33.47	AMBULANCE	A	-17,976	EMERGENCY	91.00	0	33.47
33.48	CHARITABLE & COMMUNITY SERVICE	A	-31,150	OTHER ADMINISTRATIVE AND GENERAL	5.06	0	33.48
33.49	CHARITABLE & COMMUNITY SERVICE	A	-1,895	SOCIAL SERVICE	17.00	0	33.49
33.50	SELF INSURANCE	A	-84,289	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.50
33.52	GAIN-LOSS	A	-840	INTEREST EXPENSE	113.00	0	33.52
33.53	FEDERAL AND STATE TAX	A	-35,000	OTHER ADMINISTRATIVE AND GENERAL	5.06	0	33.53
33.54	FEDERAL AND STATE TAX	A	-13,352	INTEREST EXPENSE	113.00	0	33.54
33.55	NON ALLOWABLE BORROWING	A	-27	INTEREST EXPENSE	113.00	0	33.55

ADJUSTMENTS TO EXPENSES

Provider CCN: 14-0292

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

Worksheet A-8

Date/Time Prepared:
7/28/2021 9:55 am

Cost Center Description		Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted		Wkst. A-7 Ref.	
				Cost Center	Line #		
		1.00	2.00	3.00	4.00	5.00	
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-13,196,440				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: 14-0292

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

Worksheet A-8-1

Date/Time Prepared:
7/28/2021 9:55 am

	Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in wks. A, column 5	
	1.00	2.00	3.00	4.00	5.00	
A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:						
1.00	1.00	CAP REL COSTS-BLDG & FIXT	MIDWEST HOME OFFICE	2,839	0	1.00
2.00	2.00	CAP REL COSTS-MVBLE EQUIP	MIDWEST HOME OFFICE	16,990	0	2.00
3.00	5.06	OTHER ADMINISTRATIVE AND GEN	MIDWEST HOME OFFICE	8,540,336	0	3.00
3.01	14.00	CENTRAL SERVICES & SUPPLY	MIDWEST HOME OFFICE	210,356	0	3.01
3.02	15.00	PHARMACY	MIDWEST HOME OFFICE	45,919	0	3.02
3.03	16.00	MEDICAL RECORDS & LIBRARY	MIDWEST HOME OFFICE	25,853	0	3.03
3.04	1.00	CAP REL COSTS-BLDG & FIXT	MIDWEST HOME OFF INT	20,515	0	3.04
3.05	1.00	CAP REL COSTS-BLDG & FIXT	AHS HOME OFFICE	95,775	0	3.05
3.06	2.00	CAP REL COSTS-MVBLE EQUIP	AHS HOME OFFICE	475,712	0	3.06
4.00	5.06	OTHER ADMINISTRATIVE AND GEN	AHS HOME OFFICE	4,075,536	4,576,170	4.00
4.01	14.00	CENTRAL SERVICES & SUPPLY	AHS HOME OFFICE	58,076	0	4.01
4.02	16.00	MEDICAL RECORDS & LIBRARY	AHS HOME OFFICE	998	34,397	4.02
4.03	113.00	INTEREST EXPENSE	AHS HOME OFFICE	329,773	453,801	4.03
4.04	5.06	OTHER ADMINISTRATIVE AND GEN	AHS HOME OFFICE	2,802,199	12,756,841	4.04
4.05	1.00	CAP REL COSTS-BLDG & FIXT	AMITA HOME OFFICE	108,912	0	4.05
4.06	5.06	OTHER ADMINISTRATIVE AND GEN	AMITA HOME OFFICE	90,473	57,093	4.06
4.07	0.00			0	0	4.07
4.08	0.00			0	0	4.08
4.09	0.00			0	0	4.09
4.10	0.00			0	0	4.10
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.			16,900,262	17,878,302	5.00

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

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

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

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

6.00	B	0.00	ADVENTHEALTH	0.00	6.00
7.00	B	0.00	AMITA HEALTH	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: 14-0292

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

Worksheet A-8-1

Date/Time Prepared:
7/28/2021 9:55 am

	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	2,839	9		1.00
2.00	16,990	9		2.00
3.00	8,540,336	0		3.00
3.01	210,356	0		3.01
3.02	45,919	0		3.02
3.03	25,853	0		3.03
3.04	20,515	11		3.04
3.05	95,775	9		3.05
3.06	475,712	9		3.06
4.00	-500,634	0		4.00
4.01	58,076	0		4.01
4.02	-33,399	0		4.02
4.03	-124,028	0		4.03
4.04	-9,954,642	0		4.04
4.05	108,912	9		4.05
4.06	33,380	0		4.06
4.07	0	0		4.07
4.08	0	0		4.08
4.09	0	0		4.09
4.10	0	0		4.10
5.00	-978,040			5.00

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

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

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

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

6.00	HOME OFFICE		6.00
7.00	HOME OFFICE		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: 14-0292

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

Worksheet A-8-2

Date/Time Prepared:
7/28/2021 9:55 am

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	5.00	OTHER ADMINISTRATIVE AND GENERAL	1,093,287	1,093,287	0	0	0	1.00
2.00	50.00	OPERATING ROOM	12,500	12,500	0	0	0	2.00
3.00	52.00	DELIVERY ROOM & LABOR ROOM	386,213	386,213	0	0	0	3.00
4.00	54.00	RADIOLOGY-DIAGNOSTIC	509,934	509,934	0	0	0	4.00
5.00	59.00	CARDIAC CATHETERIZATION	28,670	28,670	0	0	0	5.00
6.00	69.00	ELECTROCARDIOLOGY	147,581	147,581	0	0	0	6.00
7.00	90.00	CLINIC	165,855	165,855	0	0	0	7.00
8.00	91.00	EMERGENCY	1,163,413	1,163,413	0	0	0	8.00
9.00	5.00	OTHER ADMINISTRATIVE AND GENERAL	201,075	0	201,075	179,000	1,365	9.00
10.00	17.00	SOCIAL SERVICE	124,824	0	124,824	179,000	832	10.00
11.00	30.00	ADULTS & PEDIATRICS	36,000	0	36,000	237,100	240	11.00
12.00	52.00	DELIVERY ROOM & LABOR ROOM	100,838	0	100,838	237,100	591	12.00
13.00	53.00	ANESTHESIOLOGY	25,971	0	25,971	260,300	191	13.00
14.00	69.00	ELECTROCARDIOLOGY	534	0	534	179,000	4	14.00
15.00	90.00	CLINIC	53,337	0	53,337	179,000	276	15.00
16.00	91.00	EMERGENCY	183,826	0	183,826	197,500	1,226	16.00
200.00			4,233,858	3,507,453	726,405		4,725	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	OTHER ADMINISTRATIVE AND GENERAL	0	0	0	0	0	1.00
2.00	50.00	OPERATING ROOM	0	0	0	0	0	2.00
3.00	52.00	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	3.00
4.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	4.00
5.00	59.00	CARDIAC CATHETERIZATION	0	0	0	0	0	5.00
6.00	69.00	ELECTROCARDIOLOGY	0	0	0	0	0	6.00
7.00	90.00	CLINIC	0	0	0	0	0	7.00
8.00	91.00	EMERGENCY	0	0	0	0	0	8.00
9.00	5.00	OTHER ADMINISTRATIVE AND GENERAL	117,469	5,873	0	0	0	9.00
10.00	17.00	SOCIAL SERVICE	71,600	3,580	0	0	0	10.00
11.00	30.00	ADULTS & PEDIATRICS	27,358	1,368	0	0	0	11.00
12.00	52.00	DELIVERY ROOM & LABOR ROOM	67,368	3,368	0	0	0	12.00
13.00	53.00	ANESTHESIOLOGY	23,903	1,195	0	0	0	13.00
14.00	69.00	ELECTROCARDIOLOGY	344	17	0	0	0	14.00
15.00	90.00	CLINIC	23,752	1,188	0	0	0	15.00
16.00	91.00	EMERGENCY	116,411	5,821	0	0	0	16.00
200.00			448,205	22,410	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	OTHER ADMINISTRATIVE AND GENERAL	0	0	0	1,093,287		1.00
2.00	50.00	OPERATING ROOM	0	0	0	12,500		2.00
3.00	52.00	DELIVERY ROOM & LABOR ROOM	0	0	0	386,213		3.00
4.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	509,934		4.00
5.00	59.00	CARDIAC CATHETERIZATION	0	0	0	28,670		5.00
6.00	69.00	ELECTROCARDIOLOGY	0	0	0	147,581		6.00
7.00	90.00	CLINIC	0	0	0	165,855		7.00
8.00	91.00	EMERGENCY	0	0	0	1,163,413		8.00
9.00	5.00	OTHER ADMINISTRATIVE AND GENERAL	0	117,469	83,606	83,606		9.00
10.00	17.00	SOCIAL SERVICE	0	71,600	53,224	53,224		10.00
11.00	30.00	ADULTS & PEDIATRICS	0	27,358	8,642	8,642		11.00
12.00	52.00	DELIVERY ROOM & LABOR ROOM	0	67,368	33,470	33,470		12.00
13.00	53.00	ANESTHESIOLOGY	0	23,903	2,068	2,068		13.00
14.00	69.00	ELECTROCARDIOLOGY	0	344	190	190		14.00
15.00	90.00	CLINIC	0	23,752	29,585	29,585		15.00
16.00	91.00	EMERGENCY	0	116,411	67,415	67,415		16.00
200.00			0	448,205	278,200	3,785,653		200.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0292

Period:
From 01/01/2020
To 12/31/2020Worksheet B
Part I
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Cost Center Description			CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	COMMUNICATIONS	
			Net Expenses for Cost Allocation (from Wkst A col. 7)	BLDG & FIXT	MVBLE EQUIP		
			0	1.00	2.00	4.00	5.01
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT	2,989,546	2,989,546			1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	1,528,813		1,528,813		2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	4,746,001	9,475	4,845	4,760,321	4.00
5.01	01160	COMMUNICATIONS	-23,875	0	0	0	5.01
5.04	00570	ADMITTING	2,867	23,214	11,871	0	5.04
5.06	00560	OTHER ADMINISTRATIVE AND GENERAL	15,459,789	178,464	91,264	332,975	5.06
7.00	00700	OPERATION OF PLANT	3,166,725	427,944	218,845	124,859	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	166,325	0	0	0	8.00
9.00	00900	HOUSEKEEPING	1,635,933	31,386	16,051	0	9.00
10.00	01000	DIETARY	811,486	87,598	44,796	0	10.00
11.00	01100	CAFETERIA	1,226,529	50,905	26,032	0	11.00
13.00	01300	NURSING ADMINISTRATION	1,127,920	12,412	6,348	139,371	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	562,088	101,076	51,689	18,391	14.00
15.00	01500	PHARMACY	1,628,130	35,319	18,061	196,837	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	28,296	22,906	11,714	0	16.00
17.00	01700	SOCIAL SERVICE	81,611	9,120	4,664	5,169	17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	10,385,272	693,459	354,627	1,265,843	30.00
31.00	03100	INTENSIVE CARE UNIT	3,062,384	71,040	36,329	379,485	31.00
40.00	04000	SUBPROVIDER - IPF	2,112,912	105,956	54,184	273,390	40.00
43.00	04300	NURSERY	482,184	0	0	46,874	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	1,972,275	209,922	107,351	181,221	50.00
51.00	05100	RECOVERY ROOM	259,108	14,450	7,389	33,034	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,538,881	31,268	15,990	199,147	52.00
53.00	05300	ANESTHESIOLOGY	86,407	3,932	2,011	8,496	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	868,672	129,857	66,407	84,631	54.00
56.00	05600	RADIOISOTOPE	138,247	24,612	12,586	16,827	56.00
57.00	05700	CT SCAN	549,471	0	0	68,810	57.00
58.00	05800	MRI	100,644	30,960	15,833	12,431	58.00
59.00	05900	CARDIAC CATHETERIZATION	886,825	97,120	49,666	97,913	59.00
60.00	06000	LABORATORY	3,333,864	74,238	37,964	0	60.00
65.00	06500	RESPIRATORY THERAPY	975,497	11,583	5,924	107,341	65.00
66.00	06600	PHYSICAL THERAPY	1,160,708	15,089	7,716	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	305,050	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	43,056	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	409,773	48,773	24,942	47,667	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	17,350	0	0	2,093	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	3,363,082	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	2,203,642	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	3,823,440	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	74.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	75.00
75.01	03950	INPATIENT RENAL DIALYSI	393,087	0	0	0	75.01
76.00	03050	BACTERIOLOGY & MICROBIOLOGY	0	0	0	0	76.00
76.01	03060	WOUND CARE	81,122	34,632	17,710	401	76.01
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	489,956	72,722	37,189	70,763	90.00
91.00	09100	EMERGENCY	3,192,228	184,718	94,462	410,913	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					92.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	77,373,321	2,844,150	1,454,460	4,124,882	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	28,350	0	0	3,302	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	1,666,451	23,688	12,114	0	192.00
192.03	19203	OP PHARMACY	1,312,248	3,577	1,829	43,715	192.03
194.00	07950	FOUNDATION	0	4,240	2,168	0	194.00
194.01	07951	MARKETING	0	5,638	2,883	0	194.01
194.03	07953	THERAPEUTIC DAY SCHOOL	6,062,069	108,253	55,359	588,422	194.03
200.00		Cross Foot Adjustments					200.00
201.00		Negative Cost Centers		0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	86,442,439	2,989,546	1,528,813	4,760,321	-23,875 202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0292

Period:
From 01/01/2020
To 12/31/2020Worksheet B
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Cost Center Description			ADMITTING	Subtotal	OTHER ADMINISTRATIVE AND GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	
			5.04	5A.04	5.06	7.00	8.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	01160	COMMUNICATIONS						5.01
5.04	00570	ADMITTING	37,952					5.04
5.06	00560	OTHER ADMINISTRATIVE AND GENERAL	0	16,062,492	16,062,492			5.06
7.00	00700	OPERATION OF PLANT	0	3,938,373	898,532	4,836,905		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	166,325	37,947	0	204,272	8.00
9.00	00900	HOUSEKEEPING	0	1,683,370	384,057	64,589	0	9.00
10.00	01000	DIETARY	0	943,880	215,344	180,264	0	10.00
11.00	01100	CAFETERIA	0	1,303,466	297,383	104,756	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	1,286,051	293,410	25,543	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	733,244	167,288	208,001	0	14.00
15.00	01500	PHARMACY	0	1,878,347	428,541	72,681	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	62,916	14,354	47,138	0	16.00
17.00	01700	SOCIAL SERVICE	0	100,564	22,943	18,767	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	4,063	12,703,264	2,898,227	1,427,051	148,983	30.00
31.00	03100	INTENSIVE CARE UNIT	1,051	3,550,289	809,991	146,190	25,467	31.00
40.00	04000	SUBPROVIDER - IPF	734	2,547,176	581,133	218,042	25,421	40.00
43.00	04300	NURSERY	79	529,137	120,722	0	4,401	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	2,661	2,473,430	564,308	431,990	0	50.00
51.00	05100	RECOVERY ROOM	373	314,354	71,719	29,735	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	465	1,785,751	407,416	64,345	0	52.00
53.00	05300	ANESTHESIOLOGY	824	101,670	23,196	8,092	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,874	1,151,441	262,699	267,227	0	54.00
56.00	05600	RADIOISOTOPE	308	192,580	43,937	50,647	0	56.00
57.00	05700	CT SCAN	3,948	622,229	141,960	0	0	57.00
58.00	05800	MRI	433	160,301	36,572	63,711	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	711	1,132,235	258,317	199,860	0	59.00
60.00	06000	LABORATORY	4,920	3,450,986	787,336	152,771	0	60.00
65.00	06500	RESPIRATORY THERAPY	1,122	1,101,467	251,297	23,837	0	65.00
66.00	06600	PHYSICAL THERAPY	667	1,184,180	270,168	31,051	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	112	305,162	69,622	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	35	43,091	9,831	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	1,050	532,205	121,422	100,369	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	31	19,474	4,443	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	633	3,363,715	767,425	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1,493	2,205,135	503,097	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	4,100	3,827,540	873,246	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	0	75.00
75.01	03950	INPATIENT RENAL DIALYSI	181	393,268	89,723	0	0	75.01
76.00	03050	BACTERIOLOGY & MICROBIOLOGY	0	0	0	0	0	76.00
76.01	03060	WOUND CARE	1	133,866	30,541	71,267	0	76.01
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	282	670,912	153,067	149,651	0	90.00
91.00	09100	EMERGENCY	5,801	3,888,122	887,067	380,124	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART		0				92.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	37,952	76,542,008	13,798,281	4,537,699	204,272	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	31,652	7,221	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	1,702,253	388,366	48,746	0	192.00
192.03	19203	OP PHARMACY	0	1,361,369	310,594	7,361	0	192.03
194.00	07950	FOUNDATION	0	6,408	1,462	8,726	0	194.00
194.01	07951	MARKETING	0	8,521	1,944	11,602	0	194.01
194.03	07953	THERAPEUTIC DAY SCHOOL	0	6,814,103	1,554,624	222,771	0	194.03
200.00		Cross Foot Adjustments		0				200.00
201.00		Negative Cost Centers	0	-23,875	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	37,952	86,442,439	16,062,492	4,836,905	204,272	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0292

Period:
From 01/01/2020
To 12/31/2020Worksheet B
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Cost Center Description			HOUSEKEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	
			9.00	10.00	11.00	13.00	14.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	01160	COMMUNICATIONS						5.01
5.04	00570	ADMITTING						5.04
5.06	00560	OTHER ADMINISTRATIVE AND GENERAL						5.06
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING	2,132,016					9.00
10.00	01000	DIETARY	80,532	1,420,020				10.00
11.00	01100	CAFETERIA	46,799	907,602	2,660,006			11.00
13.00	01300	NURSING ADMINISTRATION	11,411	0	77,647	1,694,062		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	92,924	0	19,455	14,598	1,235,510	14.00
15.00	01500	PHARMACY	32,470	0	122,200	91,693	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	21,059	0	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	8,384	0	0	0	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	637,531	381,022	857,312	643,289	0	30.00
31.00	03100	INTENSIVE CARE UNIT	65,310	65,133	235,215	176,494	0	31.00
40.00	04000	SUBPROVIDER - IPF	97,410	65,016	221,245	166,012	0	40.00
43.00	04300	NURSERY	0	0	63,060	47,317	0	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	192,990	0	118,560	88,962	0	50.00
51.00	05100	RECOVERY ROOM	13,284	0	14,561	10,926	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	28,746	0	268,452	201,434	0	52.00
53.00	05300	ANESTHESIOLOGY	3,615	0	7,612	5,712	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	119,383	0	62,865	0	0	54.00
56.00	05600	RADIOISOTOPE	22,627	0	8,889	0	0	56.00
57.00	05700	CT SCAN	0	0	42,119	0	0	57.00
58.00	05800	MRI	28,463	0	6,987	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	89,287	0	50,981	0	0	59.00
60.00	06000	LABORATORY	68,250	0	6,489	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	10,649	0	79,763	0	0	65.00
66.00	06600	PHYSICAL THERAPY	13,872	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	44,839	0	35,802	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	2,321	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	746,278	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	489,232	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	0	75.00
75.01	03950	INPATIENT RENAL DIALYSI	0	0	0	0	0	75.01
76.00	03050	BACTERIOLOGY & MICROBIOLOGY	0	0	0	0	0	76.00
76.01	03060	WOUND CARE	31,838	0	150	0	0	76.01
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	66,856	1,247	47,623	35,734	0	90.00
91.00	09100	EMERGENCY	169,819	0	282,388	211,891	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	1,998,348	1,420,020	2,631,696	1,694,062	1,235,510	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	3,628	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	21,777	0	0	0	0	192.00
192.03	19203	OP PHARMACY	3,288	0	24,682	0	0	192.03
194.00	07950	FOUNDATION	3,898	0	0	0	0	194.00
194.01	07951	MARKETING	5,183	0	0	0	0	194.01
194.03	07953	THERAPEUTIC DAY SCHOOL	99,522	0	0	0	0	194.03
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	2,132,016	1,420,020	2,660,006	1,694,062	1,235,510	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0292

Period:
From 01/01/2020
To 12/31/2020Worksheet B
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Cost Center Description			PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	
			15.00	16.00	17.00	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
5.01	01160	COMMUNICATIONS						5.01
5.04	00570	ADMITTING						5.04
5.06	00560	OTHER ADMINISTRATIVE AND GENERAL						5.06
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	2,625,932					15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	145,467				16.00
17.00	01700	SOCIAL SERVICE	0	0	150,658			17.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	0	15,528	109,880	19,822,087	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	4,017	18,783	5,096,889	0	31.00
40.00	04000	SUBPROVIDER - IPF	0	2,806	18,749	3,943,010	0	40.00
43.00	04300	NURSERY	0	302	3,246	768,185	0	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	10,170	0	3,880,410	0	50.00
51.00	05100	RECOVERY ROOM	0	1,424	0	456,003	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	1,778	0	2,757,922	0	52.00
53.00	05300	ANESTHESIOLOGY	0	3,150	0	153,047	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	7,161	0	1,870,776	0	54.00
56.00	05600	RADIOISOTOPE	0	1,179	0	319,859	0	56.00
57.00	05700	CT SCAN	0	15,090	0	821,398	0	57.00
58.00	05800	MRI	0	1,655	0	297,689	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	2,717	0	1,733,397	0	59.00
60.00	06000	LABORATORY	0	18,805	0	4,484,637	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	4,288	0	1,471,301	0	65.00
66.00	06600	PHYSICAL THERAPY	0	2,549	0	1,501,820	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	429	0	375,213	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	134	0	53,056	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	4,013	0	838,650	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	117	0	26,355	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	2,421	0	4,879,839	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	5,706	0	3,203,170	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,625,932	15,672	0	7,342,390	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	0	75.00
75.01	03950	INPATIENT RENAL DIALYSI	0	691	0	483,682	0	75.01
76.00	03050	BACTERIOLOGY & MICROBIOLOGY	0	0	0	0	0	76.00
76.01	03060	WOUND CARE	0	2	0	267,664	0	76.01
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	1,078	0	1,126,168	0	90.00
91.00	09100	EMERGENCY	0	22,585	0	5,841,996	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0				0	92.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	2,625,932	145,467	150,658	73,816,613	0	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	42,501	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	2,161,142	0	192.00
192.03	19203	OP PHARMACY	0	0	0	1,707,294	0	192.03
194.00	07950	FOUNDATION	0	0	0	20,494	0	194.00
194.01	07951	MARKETING	0	0	0	27,250	0	194.01
194.03	07953	THERAPEUTIC DAY SCHOOL	0	0	0	8,691,020	0	194.03
200.00		Cross Foot Adjustments				0		200.00
201.00		Negative Cost Centers	0	0	0	-23,875	0	201.00
202.00		TOTAL (sum lines 118 through 201)	2,625,932	145,467	150,658	86,442,439	0	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0292

Period:
From 01/01/2020
To 12/31/2020Worksheet B
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Cost Center Description		Total	
		26.00	
GENERAL SERVICE COST CENTERS			
1.00	00100	CAP REL COSTS-BLDG & FIXT	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	4.00
5.01	01160	COMMUNICATIONS	5.01
5.04	00570	ADMITTING	5.04
5.06	00560	OTHER ADMINISTRATIVE AND GENERAL	5.06
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
INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS	30.00
31.00	03100	INTENSIVE CARE UNIT	31.00
40.00	04000	SUBPROVIDER - IPF	40.00
43.00	04300	NURSERY	43.00
ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	50.00
51.00	05100	RECOVERY ROOM	51.00
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	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
69.00	06900	ELECTROCARDIOLOGY	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	73.00
74.00	07400	RENAL DIALYSIS	74.00
75.00	07500	ASC (NON-DISTINCT PART)	75.00
75.01	03950	INPATIENT RENAL DIALYSI	75.01
76.00	03050	BACTERIOLOGY & MICROBIOLOGY	76.00
76.01	03060	WOUND CARE	76.01
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
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
192.03	19203	OP PHARMACY	192.03
194.00	07950	FOUNDATION	194.00
194.01	07951	MARKETING	194.01
194.03	07953	THERAPEUTIC DAY SCHOOL	194.03
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: 14-0292

Period:
From 01/01/2020
To 12/31/2020Worksheet B
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Cost Center Description			CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
			Directly Assigned New Capital Related Costs	BLDG & FIXT	MVBLE EQUIP		
			0	1.00	2.00	2A	4.00
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	9,475	4,845	14,320	4.00
5.01	01160	COMMUNICATIONS	0	0	0	0	5.01
5.04	00570	ADMITTING	0	23,214	11,871	35,085	5.04
5.06	00560	OTHER ADMINISTRATIVE AND GENERAL	0	178,464	91,264	269,728	5.06
7.00	00700	OPERATION OF PLANT	0	427,944	218,845	646,789	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0	0	8.00
9.00	00900	HOUSEKEEPING	0	31,386	16,051	47,437	9.00
10.00	01000	DIETARY	0	87,598	44,796	132,394	10.00
11.00	01100	CAFETERIA	0	50,905	26,032	76,937	11.00
13.00	01300	NURSING ADMINISTRATION	0	12,412	6,348	18,760	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	101,076	51,689	152,765	14.00
15.00	01500	PHARMACY	0	35,319	18,061	53,380	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	22,906	11,714	34,620	16.00
17.00	01700	SOCIAL SERVICE	0	9,120	4,664	13,784	17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	0	693,459	354,627	1,048,086	30.00
31.00	03100	INTENSIVE CARE UNIT	0	71,040	36,329	107,369	31.00
40.00	04000	SUBPROVIDER - IPF	0	105,956	54,184	160,140	40.00
43.00	04300	NURSERY	0	0	0	0	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	209,922	107,351	317,273	50.00
51.00	05100	RECOVERY ROOM	0	14,450	7,389	21,839	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	31,268	15,990	47,258	52.00
53.00	05300	ANESTHESIOLOGY	0	3,932	2,011	5,943	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	129,857	66,407	196,264	54.00
56.00	05600	RADIOISOTOPE	0	24,612	12,586	37,198	56.00
57.00	05700	CT SCAN	0	0	0	0	57.00
58.00	05800	MRI	0	30,960	15,833	46,793	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	97,120	49,666	146,786	59.00
60.00	06000	LABORATORY	0	74,238	37,964	112,202	60.00
65.00	06500	RESPIRATORY THERAPY	0	11,583	5,924	17,507	65.00
66.00	06600	PHYSICAL THERAPY	0	15,089	7,716	22,805	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	48,773	24,942	73,715	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	74.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	75.00
75.01	03950	INPATIENT RENAL DIALYSIS	0	0	0	0	75.01
76.00	03050	BACTERIOLOGY & MICROBIOLOGY	0	0	0	0	76.00
76.01	03060	WOUND CARE	0	34,632	17,710	52,342	76.01
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0	72,722	37,189	109,911	90.00
91.00	09100	EMERGENCY	0	184,718	94,462	279,180	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				0	92.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	2,844,150	1,454,460	4,298,610	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	23,688	12,114	35,802	192.00
192.03	19203	OP PHARMACY	0	3,577	1,829	5,406	192.03
194.00	07950	FOUNDATION	0	4,240	2,168	6,408	194.00
194.01	07951	MARKETING	0	5,638	2,883	8,521	194.01
194.03	07953	THERAPEUTIC DAY SCHOOL	0	108,253	55,359	163,612	194.03
200.00		Cross Foot Adjustments				0	200.00
201.00		Negative Cost Centers				0	201.00
202.00		TOTAL (sum lines 118 through 201)	0	2,989,546	1,528,813	4,518,359	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0292

Period:
From 01/01/2020
To 12/31/2020Worksheet B
Part II
Date/Time Prepared:
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Cost Center Description			COMMUNICATIONS	ADMITTING	OTHER ADMINISTRATIVE AND GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	
			5.01	5.04	5.06	7.00	8.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	01160	COMMUNICATIONS	0					5.01
5.04	00570	ADMITTING	0	35,085				5.04
5.06	00560	OTHER ADMINISTRATIVE AND GENERAL	0	0	270,729			5.06
7.00	00700	OPERATION OF PLANT	0	0	15,143	662,307		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	640	0	640	8.00
9.00	00900	HOUSEKEEPING	0	0	6,473	8,844	0	9.00
10.00	01000	DIETARY	0	0	3,629	24,683	0	10.00
11.00	01100	CAFETERIA	0	0	5,012	14,344	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	0	4,945	3,498	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	2,819	28,481	0	14.00
15.00	01500	PHARMACY	0	0	7,222	9,952	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	242	6,454	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	387	2,570	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	0	3,732	48,871	195,401	466	30.00
31.00	03100	INTENSIVE CARE UNIT	0	965	13,651	20,018	80	31.00
40.00	04000	SUBPROVIDER - IPF	0	674	9,794	29,856	80	40.00
43.00	04300	NURSERY	0	73	2,035	0	14	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	2,444	9,510	59,151	0	50.00
51.00	05100	RECOVERY ROOM	0	342	1,209	4,072	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	427	6,866	8,811	0	52.00
53.00	05300	ANESTHESIOLOGY	0	757	391	1,108	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	1,721	4,427	36,591	0	54.00
56.00	05600	RADIOISOTOPE	0	283	740	6,935	0	56.00
57.00	05700	CT SCAN	0	3,626	2,392	0	0	57.00
58.00	05800	MRI	0	398	616	8,724	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	653	4,353	27,366	0	59.00
60.00	06000	LABORATORY	0	4,519	13,269	20,919	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	1,030	4,235	3,264	0	65.00
66.00	06600	PHYSICAL THERAPY	0	612	4,553	4,252	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	103	1,173	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	32	166	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	964	2,046	13,743	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	28	75	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	582	12,933	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	1,371	8,479	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	3,766	14,717	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	0	75.00
75.01	03950	INPATIENT RENAL DIALYSI	0	166	1,512	0	0	75.01
76.00	03050	BACTERIOLOGY & MICROBIOLOGY	0	0	0	0	0	76.00
76.01	03060	WOUND CARE	0	1	515	9,758	0	76.01
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	259	2,580	20,491	0	90.00
91.00	09100	EMERGENCY	0	5,557	14,950	52,050	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	35,085	232,570	621,336	640	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	122	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	6,545	6,675	0	192.00
192.03	19203	OP PHARMACY	0	0	5,234	1,008	0	192.03
194.00	07950	FOUNDATION	0	0	25	1,195	0	194.00
194.01	07951	MARKETING	0	0	33	1,589	0	194.01
194.03	07953	THERAPEUTIC DAY SCHOOL	0	0	26,200	30,504	0	194.03
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	0	35,085	270,729	662,307	640	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0292

Period:
From 01/01/2020
To 12/31/2020Worksheet B
Part II
Date/Time Prepared:
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Cost Center Description			HOUSEKEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	
			9.00	10.00	11.00	13.00	14.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	01160	COMMUNICATIONS						5.01
5.04	00570	ADMITTING						5.04
5.06	00560	OTHER ADMINISTRATIVE AND GENERAL						5.06
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING	62,754					9.00
10.00	01000	DIETARY	2,370	163,076				10.00
11.00	01100	CAFETERIA	1,377	104,229	201,899			11.00
13.00	01300	NURSING ADMINISTRATION	336	0	5,894	33,852		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	2,735	0	1,477	292	188,624	14.00
15.00	01500	PHARMACY	956	0	9,275	1,832	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	620	0	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	247	0	0	0	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	18,767	43,757	65,071	12,855	0	30.00
31.00	03100	INTENSIVE CARE UNIT	1,922	7,480	17,853	3,527	0	31.00
40.00	04000	SUBPROVIDER - IPF	2,867	7,467	16,793	3,317	0	40.00
43.00	04300	NURSERY	0	0	4,786	946	0	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	5,680	0	8,999	1,778	0	50.00
51.00	05100	RECOVERY ROOM	391	0	1,105	218	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	846	0	20,376	4,025	0	52.00
53.00	05300	ANESTHESIOLOGY	106	0	578	114	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,514	0	4,772	0	0	54.00
56.00	05600	RADIOISOTOPE	666	0	675	0	0	56.00
57.00	05700	CT SCAN	0	0	3,197	0	0	57.00
58.00	05800	MRI	838	0	530	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	2,628	0	3,870	0	0	59.00
60.00	06000	LABORATORY	2,009	0	493	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	313	0	6,054	0	0	65.00
66.00	06600	PHYSICAL THERAPY	408	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	1,320	0	2,717	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	176	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	113,933	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	74,691	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	0	75.00
75.01	03950	INPATIENT RENAL DIALYSI	0	0	0	0	0	75.01
76.00	03050	BACTERIOLOGY & MICROBIOLOGY	0	0	0	0	0	76.00
76.01	03060	WOUND CARE	937	0	11	0	0	76.01
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	1,968	143	3,615	714	0	90.00
91.00	09100	EMERGENCY	4,998	0	21,434	4,234	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	58,819	163,076	199,751	33,852	188,624	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	275	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	641	0	0	0	0	192.00
192.03	19203	OP PHARMACY	97	0	1,873	0	0	192.03
194.00	07950	FOUNDATION	115	0	0	0	0	194.00
194.01	07951	MARKETING	153	0	0	0	0	194.01
194.03	07953	THERAPEUTIC DAY SCHOOL	2,929	0	0	0	0	194.03
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	62,754	163,076	201,899	33,852	188,624	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0292

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Cost Center Description			PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	
			15.00	16.00	17.00	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
5.01	01160	COMMUNICATIONS						5.01
5.04	00570	ADMITTING						5.04
5.06	00560	OTHER ADMINISTRATIVE AND GENERAL						5.06
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	83,209					15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	41,936				16.00
17.00	01700	SOCIAL SERVICE	0	0	17,004			17.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	0	4,484	12,402	1,457,707	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	1,160	2,120	177,286	0	31.00
40.00	04000	SUBPROVIDER - IPF	0	810	2,116	234,736	0	40.00
43.00	04300	NURSERY	0	87	366	8,448	0	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	2,937	0	408,317	0	50.00
51.00	05100	RECOVERY ROOM	0	411	0	29,686	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	513	0	89,721	0	52.00
53.00	05300	ANESTHESIOLOGY	0	910	0	9,933	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	2,068	0	249,611	0	54.00
56.00	05600	RADIOISOTOPE	0	340	0	46,888	0	56.00
57.00	05700	CT SCAN	0	4,357	0	13,779	0	57.00
58.00	05800	MRI	0	478	0	58,414	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	785	0	186,735	0	59.00
60.00	06000	LABORATORY	0	5,430	0	158,841	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	1,238	0	33,964	0	65.00
66.00	06600	PHYSICAL THERAPY	0	736	0	33,366	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	124	0	1,400	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	39	0	237	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	1,159	0	95,807	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	34	0	319	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	699	0	128,147	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	1,648	0	86,189	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	83,209	4,525	0	106,217	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	0	75.00
75.01	03950	INPATIENT RENAL DIALYSI	0	199	0	1,877	0	75.01
76.00	03050	BACTERIOLOGY & MICROBIOLOGY	0	0	0	0	0	76.00
76.01	03060	WOUND CARE	0	1	0	63,566	0	76.01
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	311	0	140,205	0	90.00
91.00	09100	EMERGENCY	0	6,453	0	390,091	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	83,209	41,936	17,004	4,211,487	0	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	407	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	49,663	0	192.00
192.03	19203	OP PHARMACY	0	0	0	13,749	0	192.03
194.00	07950	FOUNDATION	0	0	0	7,743	0	194.00
194.01	07951	MARKETING	0	0	0	10,296	0	194.01
194.03	07953	THERAPEUTIC DAY SCHOOL	0	0	0	225,014	0	194.03
200.00		Cross Foot Adjustments				0		200.00
201.00		Negative Cost Centers	0	0	0	0		201.00
202.00		TOTAL (sum lines 118 through 201)	83,209	41,936	17,004	4,518,359	0	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0292

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Cost Center Description		Total	
		26.00	
GENERAL SERVICE COST CENTERS			
1.00	00100	CAP REL COSTS-BLDG & FIXT	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	4.00
5.01	01160	COMMUNICATIONS	5.01
5.04	00570	ADMITTING	5.04
5.06	00560	OTHER ADMINISTRATIVE AND GENERAL	5.06
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
INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS	30.00
31.00	03100	INTENSIVE CARE UNIT	31.00
40.00	04000	SUBPROVIDER - IPF	40.00
43.00	04300	NURSERY	43.00
ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	50.00
51.00	05100	RECOVERY ROOM	51.00
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	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
69.00	06900	ELECTROCARDIOLOGY	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	73.00
74.00	07400	RENAL DIALYSIS	74.00
75.00	07500	ASC (NON-DISTINCT PART)	75.00
75.01	03950	INPATIENT RENAL DIALYSI	75.01
76.00	03050	BACTERIOLOGY & MICROBIOLOGY	76.00
76.01	03060	WOUND CARE	76.01
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
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
192.03	19203	OP PHARMACY	192.03
194.00	07950	FOUNDATION	194.00
194.01	07951	MARKETING	194.01
194.03	07953	THERAPEUTIC DAY SCHOOL	194.03
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: 14-0292

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

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Date/Time Prepared:
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Cost Center Description			CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	COMMUNICATIONS (NUMBER OF PHONES)	ADMITTING (GROSS CHARGES)	
			BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (SQUARE FEET)				
			1.00	2.00	4.00	5.01	5.04	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT	126,206					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		126,206				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	400	400	34,734,031			4.00
5.01	01160	COMMUNICATIONS	0	0	0	517		5.01
5.04	00570	ADMITTING	980	980	0	0	282,094,191	5.04
5.06	00560	OTHER ADMINISTRATIVE AND GENERAL	7,534	7,534	2,429,568	374	0	5.06
7.00	00700	OPERATION OF PLANT	18,066	18,066	911,038	0	0	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0	0	0	8.00
9.00	00900	HOUSEKEEPING	1,325	1,325	0	0	0	9.00
10.00	01000	DIETARY	3,698	3,698	0	0	0	10.00
11.00	01100	CAFETERIA	2,149	2,149	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	524	524	1,016,928	0	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	4,267	4,267	134,190	0	0	14.00
15.00	01500	PHARMACY	1,491	1,491	1,436,235	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	967	967	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	385	385	37,714	0	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	29,275	29,275	9,236,387	117	30,093,877	30.00
31.00	03100	INTENSIVE CARE UNIT	2,999	2,999	2,768,932	10	7,784,110	31.00
40.00	04000	SUBPROVIDER - IPF	4,473	4,473	1,994,807	16	5,437,155	40.00
43.00	04300	NURSERY	0	0	342,020	0	585,574	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	8,862	8,862	1,322,289	0	19,708,531	50.00
51.00	05100	RECOVERY ROOM	610	610	241,031	0	2,759,314	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,320	1,320	1,453,088	0	3,445,852	52.00
53.00	05300	ANESTHESIOLOGY	166	166	61,994	0	6,104,312	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	5,482	5,482	617,512	0	13,878,486	54.00
56.00	05600	RADIOISOTOPE	1,039	1,039	122,781	0	2,284,347	56.00
57.00	05700	CT SCAN	0	0	502,075	0	29,243,625	57.00
58.00	05800	MRI	1,307	1,307	90,705	0	3,206,915	58.00
59.00	05900	CARDIAC CATHETERIZATION	4,100	4,100	714,429	0	5,265,715	59.00
60.00	06000	LABORATORY	3,134	3,134	0	0	36,444,310	60.00
65.00	06500	RESPIRATORY THERAPY	489	489	783,218	0	8,309,627	65.00
66.00	06600	PHYSICAL THERAPY	637	637	0	0	4,939,483	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	831,846	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	259,584	68.00
69.00	06900	ELECTROCARDIOLOGY	2,059	2,059	347,805	0	7,776,345	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	15,270	0	227,616	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	4,691,019	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	11,058,051	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	30,371,547	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	0	75.00
75.01	03950	INPATIENT RENAL DIALYSI	0	0	0	0	1,338,514	75.01
76.00	03050	BACTERIOLOGY & MICROBIOLOGY	0	0	0	0	0	76.00
76.01	03060	WOUND CARE	1,462	1,462	2,927	0	4,398	76.01
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	3,070	3,070	516,325	0	2,088,891	90.00
91.00	09100	EMERGENCY	7,798	7,798	2,998,247	0	43,955,147	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	120,068	120,068	30,097,515	517	282,094,191	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	24,093	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	1,000	1,000	0	0	0	192.00
192.03	19203	OP PHARMACY	151	151	318,970	0	0	192.03
194.00	07950	FOUNDATION	179	179	0	0	0	194.00
194.01	07951	MARKETING	238	238	0	0	0	194.01
194.03	07953	THERAPEUTIC DAY SCHOOL	4,570	4,570	4,293,453	0	0	194.03
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	2,989,546	1,528,813	4,760,321	-23,875	37,952	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	23.687828	12.113632	0.137051	0.000000	0.000135	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)			14,320	0	35,085	204.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0292

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

Worksheet B-1

Date/Time Prepared:
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Cost Center Description			CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	COMMUNICATIONS (NUMBER OF PHONES)	ADMITTING (GROSS CHAR GES)	
			BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (SQUARE FEET)				
			1.00	2.00	4.00	5.01	5.04	
205.00		Unit cost multiplier (Wkst. B, Part II)			0.000412	0.000000	0.000124	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: 14-0292

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

Worksheet B-1

Date/Time Prepared:
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Cost Center Description			Reconciliation	OTHER ADMINISTRATIVE AND GENERAL (ACCUM. COST)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (TOTAL PATI ENT DAYS)	HOUSEKEEPING (SQUARE FEET)	
			5A.06	5.06	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
5.01	01160	COMMUNICATIONS						5.01
5.04	00570	ADMITTING						5.04
5.06	00560	OTHER ADMINISTRATIVE AND GENERAL	-16,062,492	70,403,822				5.06
7.00	00700	OPERATION OF PLANT	0	3,938,373	99,226			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	166,325	0	26,413		8.00
9.00	00900	HOUSEKEEPING	0	1,683,370	1,325	0	97,901	9.00
10.00	01000	DIETARY	0	943,880	3,698	0	3,698	10.00
11.00	01100	CAFETERIA	0	1,303,466	2,149	0	2,149	11.00
13.00	01300	NURSING ADMINISTRATION	0	1,286,051	524	0	524	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	733,244	4,267	0	4,267	14.00
15.00	01500	PHARMACY	0	1,878,347	1,491	0	1,491	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	62,916	967	0	967	16.00
17.00	01700	SOCIAL SERVICE	0	100,564	385	0	385	17.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	0	12,703,264	29,275	19,264	29,275	30.00
31.00	03100	INTENSIVE CARE UNIT	0	3,550,289	2,999	3,293	2,999	31.00
40.00	04000	SUBPROVIDER - IPF	0	2,547,176	4,473	3,287	4,473	40.00
43.00	04300	NURSERY	0	529,137	0	569	0	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	2,473,430	8,862	0	8,862	50.00
51.00	05100	RECOVERY ROOM	0	314,354	610	0	610	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	1,785,751	1,320	0	1,320	52.00
53.00	05300	ANESTHESIOLOGY	0	101,670	166	0	166	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	1,151,441	5,482	0	5,482	54.00
56.00	05600	RADIOISOTOPE	0	192,580	1,039	0	1,039	56.00
57.00	05700	CT SCAN	0	622,229	0	0	0	57.00
58.00	05800	MRI	0	160,301	1,307	0	1,307	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	1,132,235	4,100	0	4,100	59.00
60.00	06000	LABORATORY	0	3,450,986	3,134	0	3,134	60.00
65.00	06500	RESPIRATORY THERAPY	0	1,101,467	489	0	489	65.00
66.00	06600	PHYSICAL THERAPY	0	1,184,180	637	0	637	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	305,162	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	43,091	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	532,205	2,059	0	2,059	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	19,474	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	3,363,715	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	2,205,135	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	3,827,540	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	0	75.00
75.01	03950	INPATIENT RENAL DIALYSI	0	393,268	0	0	0	75.01
76.00	03050	BACTERIOLOGY & MICROBIOLOGY	0	0	0	0	0	76.00
76.01	03060	WOUND CARE	0	133,866	1,462	0	1,462	76.01
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	670,912	3,070	0	3,070	90.00
91.00	09100	EMERGENCY	0	3,888,122	7,798	0	7,798	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-16,062,492	60,479,516	93,088	26,413	91,763	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	31,652	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	1,702,253	1,000	0	1,000	192.00
192.03	19203	OP PHARMACY	0	1,361,369	151	0	151	192.03
194.00	07950	FOUNDATION	0	6,408	179	0	179	194.00
194.01	07951	MARKETING	0	8,521	238	0	238	194.01
194.03	07953	THERAPEUTIC DAY SCHOOL	0	6,814,103	4,570	0	4,570	194.03
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)		16,062,492	4,836,905	204,272	2,132,016	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)		0.228148	48.746347	7.733767	21.777265	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)		270,729	662,307	640	62,754	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)		0.003845	6.674732	0.024230	0.640994	205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)						206.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0292

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

Worksheet B-1

Date/Time Prepared:
7/28/2021 9:55 am

Cost Center Description			Reconciliation	OTHER ADMINISTRATIVE AND GENERAL (ACCUM. COST)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (TOTAL PATI ENT DAYS)	HOUSEKEEPING (SQUARE FEET)	
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)	5A.06	5.06	7.00	8.00	9.00	207.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0292

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

Worksheet B-1

Date/Time Prepared:
7/28/2021 9:55 am

Cost Center Description			DIETARY (MEALS SERVED)	CAFETERIA (HOURS WORK ED)	NURSING ADMINISTRATION (DIRECT NRS ING)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	
			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
5.01	01160	COMMUNICATIONS						5.01
5.04	00570	ADMITTING						5.04
5.06	00560	OTHER ADMINISTRATIVE AND GENERAL						5.06
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	232,322					10.00
11.00	01100	CAFETERIA	148,488	710,433				11.00
13.00	01300	NURSING ADMINISTRATION	0	20,738	602,981			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	5,196	5,196	5,568,792		14.00
15.00	01500	PHARMACY	0	32,637	32,637	0	3,834,614	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	62,337	228,971	228,971	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	10,656	62,821	62,821	0	0	31.00
40.00	04000	SUBPROVIDER - IPF	10,637	59,090	59,090	0	0	40.00
43.00	04300	NURSERY	0	16,842	16,842	0	0	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	31,665	31,665	0	0	50.00
51.00	05100	RECOVERY ROOM	0	3,889	3,889	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	71,698	71,698	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	2,033	2,033	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	16,790	0	0	0	54.00
56.00	05600	RADIOISOTOPE	0	2,374	0	0	0	56.00
57.00	05700	CT SCAN	0	11,249	0	0	0	57.00
58.00	05800	MRI	0	1,866	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	13,616	0	0	0	59.00
60.00	06000	LABORATORY	0	1,733	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	21,303	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	9,562	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	620	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	3,363,684	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	2,205,108	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	3,834,614	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	0	75.00
75.01	03950	INPATIENT RENAL DIALYSI	0	0	0	0	0	75.01
76.00	03050	BACTERIOLOGY & MICROBIOLOGY	0	0	0	0	0	76.00
76.01	03060	WOUND CARE	0	40	0	0	0	76.01
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	204	12,719	12,719	0	0	90.00
91.00	09100	EMERGENCY	0	75,420	75,420	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	232,322	702,872	602,981	5,568,792	3,834,614	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	969	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
192.03	19203	OP PHARMACY	0	6,592	0	0	0	192.03
194.00	07950	FOUNDATION	0	0	0	0	0	194.00
194.01	07951	MARKETING	0	0	0	0	0	194.01
194.03	07953	THERAPEUTIC DAY SCHOOL	0	0	0	0	0	194.03
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	1,420,020	2,660,006	1,694,062	1,235,510	2,625,932	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	6.112292	3.744204	2.809478	0.221863	0.684797	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	163,076	201,899	33,852	188,624	83,209	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.701940	0.284191	0.056141	0.033872	0.021699	205.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0292

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

Worksheet B-1

Date/Time Prepared:
7/28/2021 9:55 am

Cost Center Description		DIETARY (MEALS SERVED)	CAFETERIA (HOURS WORK ED)	NURSING ADMINISTRATION (DIRECT NRS ING)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	
		10.00	11.00	13.00	14.00	15.00	
206.00	NAHE adjustment amount to be allocated (per Wkst. B-2)						206.00
207.00	NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0292

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

Worksheet B-1

Date/Time Prepared:
7/28/2021 9:55 am

Cost Center Description		MEDICAL RECORDS & LIBRARY (GROSS CHARGES)	SOCIAL SERVICE (TOTAL PATIENT DAYS)	
		16.00	17.00	
GENERAL SERVICE COST CENTERS				
1.00	00100	CAP REL COSTS-BLDG & FIXT		1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT		4.00
5.01	01160	COMMUNICATIONS		5.01
5.04	00570	ADMITTING		5.04
5.06	00560	OTHER ADMINISTRATIVE AND GENERAL		5.06
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	282,094,191	16.00
17.00	01700	SOCIAL SERVICE	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	30,093,877	30.00
31.00	03100	INTENSIVE CARE UNIT	7,784,110	31.00
40.00	04000	SUBPROVIDER - IPF	5,437,155	40.00
43.00	04300	NURSERY	585,574	43.00
ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	19,708,531	50.00
51.00	05100	RECOVERY ROOM	2,759,314	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	3,445,852	52.00
53.00	05300	ANESTHESIOLOGY	6,104,312	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	13,878,486	54.00
56.00	05600	RADIOISOTOPE	2,284,347	56.00
57.00	05700	CT SCAN	29,243,625	57.00
58.00	05800	MRI	3,206,915	58.00
59.00	05900	CARDIAC CATHETERIZATION	5,265,715	59.00
60.00	06000	LABORATORY	36,444,310	60.00
65.00	06500	RESPIRATORY THERAPY	8,309,627	65.00
66.00	06600	PHYSICAL THERAPY	4,939,483	66.00
67.00	06700	OCCUPATIONAL THERAPY	831,846	67.00
68.00	06800	SPEECH PATHOLOGY	259,584	68.00
69.00	06900	ELECTROCARDIOLOGY	7,776,345	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	227,616	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	4,691,019	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	11,058,051	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	30,371,547	73.00
74.00	07400	RENAL DIALYSIS	0	74.00
75.00	07500	ASC (NON-DISTINCT PART)	0	75.00
75.01	03950	INPATIENT RENAL DIALYSI	1,338,514	75.01
76.00	03050	BACTERIOLOGY & MICROBIOLOGY	0	76.00
76.01	03060	WOUND CARE	4,398	76.01
OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	2,088,891	90.00
91.00	09100	EMERGENCY	43,955,147	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	92.00
SPECIAL PURPOSE COST CENTERS				
113.00	11300	INTEREST EXPENSE		113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	282,094,191	118.00
NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	192.00
192.03	19203	OP PHARMACY	0	192.03
194.00	07950	FOUNDATION	0	194.00
194.01	07951	MARKETING	0	194.01
194.03	07953	THERAPEUTIC DAY SCHOOL	0	194.03
200.00		Cross Foot Adjustments		200.00
201.00		Negative Cost Centers		201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	145,467	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.000516	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	41,936	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.000149	205.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0292

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

Worksheet B-1

Date/Time Prepared:
7/28/2021 9:55 am

Cost Center Description		MEDICAL RECORDS & LIBRARY (GROSS CHARGES)	SOCIAL SERVICE (TOTAL PATIENT DAYS)	
		16.00	17.00	
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

COMPUTATION OF RATIO OF COSTS TO CHARGES					Provider CCN: 14-0292	Period: From 01/01/2020 To 12/31/2020	Worksheet C Part I Date/Time Prepared: 7/28/2021 9:55 am	
					Title XVIII	Hospital	PPS	
Cost Center Description			Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs			
					Total Costs	RCE Disallowance	Total Costs	
			1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	19,822,087		19,822,087	8,642	19,830,729	30.00
31.00	03100	INTENSIVE CARE UNIT	5,096,889		5,096,889	0	5,096,889	31.00
40.00	04000	SUBPROVIDER - IPF	3,943,010		3,943,010	0	3,943,010	40.00
43.00	04300	NURSERY	768,185		768,185	0	768,185	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	3,880,410		3,880,410	0	3,880,410	50.00
51.00	05100	RECOVERY ROOM	456,003		456,003	0	456,003	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	2,757,922		2,757,922	33,470	2,791,392	52.00
53.00	05300	ANESTHESIOLOGY	153,047		153,047	2,068	155,115	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,870,776		1,870,776	0	1,870,776	54.00
56.00	05600	RADIOISOTOPE	319,859		319,859	0	319,859	56.00
57.00	05700	CT SCAN	821,398		821,398	0	821,398	57.00
58.00	05800	MRI	297,689		297,689	0	297,689	58.00
59.00	05900	CARDIAC CATHETERIZATION	1,733,397		1,733,397	0	1,733,397	59.00
60.00	06000	LABORATORY	4,484,637		4,484,637	0	4,484,637	60.00
65.00	06500	RESPIRATORY THERAPY	1,471,301	0	1,471,301	0	1,471,301	65.00
66.00	06600	PHYSICAL THERAPY	1,501,820	0	1,501,820	0	1,501,820	66.00
67.00	06700	OCCUPATIONAL THERAPY	375,213	0	375,213	0	375,213	67.00
68.00	06800	SPEECH PATHOLOGY	53,056	0	53,056	0	53,056	68.00
69.00	06900	ELECTROCARDIOLOGY	838,650		838,650	190	838,840	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	26,355		26,355	0	26,355	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	4,879,839		4,879,839	0	4,879,839	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	3,203,170		3,203,170	0	3,203,170	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	7,342,390		7,342,390	0	7,342,390	73.00
74.00	07400	RENAL DIALYSIS	0		0	0	0	74.00
75.00	07500	ASC (NON-DISTINCT PART)	0		0	0	0	75.00
75.01	03950	INPATIENT RENAL DIALYSI	483,682		483,682	0	483,682	75.01
76.00	03050	BACTERIOLOGY & MICROBIOLOGY	0		0	0	0	76.00
76.01	03060	WOUND CARE	267,664		267,664	0	267,664	76.01
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	1,126,168		1,126,168	29,585	1,155,753	90.00
91.00	09100	EMERGENCY	5,841,996		5,841,996	67,415	5,909,411	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1,331,017		1,331,017		1,331,017	92.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	75,147,630	0	75,147,630	141,370	75,289,000	200.00
201.00		Less Observation Beds	1,331,017		1,331,017		1,331,017	201.00
202.00		Total (see instructions)	73,816,613	0	73,816,613	141,370	73,957,983	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0292

Period:
From 01/01/2020
To 12/31/2020Worksheet C
Part I
Date/Time Prepared:
7/28/2021 9:55 am

			Title XVIII		Hospital	PPS	
Cost Center Description			Charges			Cost or Other Ratio	TEFRA Inpatient Ratio
			Inpatient	Outpatient	Total (col. 6 + col. 7)		
			6.00	7.00	8.00		
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	26,570,537		26,570,537		30.00
31.00	03100	INTENSIVE CARE UNIT	7,784,110		7,784,110		31.00
40.00	04000	SUBPROVIDER - IPF	5,437,155		5,437,155		40.00
43.00	04300	NURSERY	585,574		585,574		43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	5,771,548	13,936,983	19,708,531	0.196890	0.000000
51.00	05100	RECOVERY ROOM	955,736	1,803,578	2,759,314	0.165260	0.000000
52.00	05200	DELIVERY ROOM & LABOR ROOM	3,071,901	373,951	3,445,852	0.800360	0.000000
53.00	05300	ANESTHESIOLOGY	1,871,772	4,232,540	6,104,312	0.025072	0.000000
54.00	05400	RADIOLOGY-DIAGNOSTIC	5,295,623	8,582,863	13,878,486	0.134797	0.000000
56.00	05600	RADIOISOTOPE	830,123	1,454,224	2,284,347	0.140022	0.000000
57.00	05700	CT SCAN	10,851,691	18,391,934	29,243,625	0.028088	0.000000
58.00	05800	MRI	1,437,457	1,769,458	3,206,915	0.092827	0.000000
59.00	05900	CARDIAC CATHETERIZATION	3,686,712	1,579,003	5,265,715	0.329185	0.000000
60.00	06000	LABORATORY	22,432,728	14,011,582	36,444,310	0.123055	0.000000
65.00	06500	RESPIRATORY THERAPY	7,931,858	377,769	8,309,627	0.177060	0.000000
66.00	06600	PHYSICAL THERAPY	1,006,597	3,932,886	4,939,483	0.304044	0.000000
67.00	06700	OCCUPATIONAL THERAPY	754,405	77,441	831,846	0.451061	0.000000
68.00	06800	SPEECH PATHOLOGY	248,764	10,820	259,584	0.204389	0.000000
69.00	06900	ELECTROCARDIOLOGY	4,198,599	3,577,746	7,776,345	0.107846	0.000000
70.00	07000	ELECTROENCEPHALOGRAPHY	204,637	22,979	227,616	0.115787	0.000000
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1,952,314	2,738,705	4,691,019	1.040251	0.000000
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	4,201,033	6,857,018	11,058,051	0.289669	0.000000
73.00	07300	DRUGS CHARGED TO PATIENTS	17,922,923	12,448,624	30,371,547	0.241752	0.000000
74.00	07400	RENAL DIALYSIS	0	0	0	0.000000	0.000000
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0.000000	0.000000
75.01	03950	INPATIENT RENAL DIALYSI	1,303,212	35,302	1,338,514	0.361357	0.000000
76.00	03050	BACTERIOLOGY & MICROBIOLOGY	0	0	0	0.000000	0.000000
76.01	03060	WOUND CARE	0	4,398	4,398	60.860391	0.000000
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	7,110	2,081,781	2,088,891	0.539122	0.000000
91.00	09100	EMERGENCY	12,624,396	31,330,751	43,955,147	0.132908	0.000000
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	772,790	2,750,550	3,523,340	0.377771	0.000000
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
200.00		Subtotal (see instructions)	149,711,305	132,382,886	282,094,191		200.00
201.00		Less Observation Beds					201.00
202.00		Total (see instructions)	149,711,305	132,382,886	282,094,191		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0292

Period:
From 01/01/2020
To 12/31/2020Worksheet C
Part I
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Cost Center Description		PPS Inpatient Ratio	Title XVIII	Hospital	PPS
		11.00			
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS			30.00
31.00	03100	INTENSIVE CARE UNIT			31.00
40.00	04000	SUBPROVIDER - IPF			40.00
43.00	04300	NURSERY			43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0.196890		50.00
51.00	05100	RECOVERY ROOM	0.165260		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.810073		52.00
53.00	05300	ANESTHESIOLOGY	0.025411		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.134797		54.00
56.00	05600	RADIOISOTOPE	0.140022		56.00
57.00	05700	CT SCAN	0.028088		57.00
58.00	05800	MRI	0.092827		58.00
59.00	05900	CARDIAC CATHETERIZATION	0.329185		59.00
60.00	06000	LABORATORY	0.123055		60.00
65.00	06500	RESPIRATORY THERAPY	0.177060		65.00
66.00	06600	PHYSICAL THERAPY	0.304044		66.00
67.00	06700	OCCUPATIONAL THERAPY	0.451061		67.00
68.00	06800	SPEECH PATHOLOGY	0.204389		68.00
69.00	06900	ELECTROCARDIOLOGY	0.107871		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.115787		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1.040251		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.289669		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.241752		73.00
74.00	07400	RENAL DIALYSIS	0.000000		74.00
75.00	07500	ASC (NON-DISTINCT PART)	0.000000		75.00
75.01	03950	INPATIENT RENAL DIALYSI	0.361357		75.01
76.00	03050	BACTERIOLOGY & MICROBIOLOGY	0.000000		76.00
76.01	03060	WOUND CARE	60.860391		76.01
OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	0.553285		90.00
91.00	09100	EMERGENCY	0.134442		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.377771		92.00
SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE			113.00
200.00		Subtotal (see instructions)			200.00
201.00		Less Observation Beds			201.00
202.00		Total (see instructions)			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0292

Period:
From 01/01/2020
To 12/31/2020Worksheet C
Part I
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			Title XIX		Hospital		Cost	
Cost Center Description			Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs		Total Costs	
					Total Costs	RCE Disallowance		
			1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	19,822,087		19,822,087	8,642	19,830,729	30.00
31.00	03100	INTENSIVE CARE UNIT	5,096,889		5,096,889	0	5,096,889	31.00
40.00	04000	SUBPROVIDER - IPF	3,943,010		3,943,010	0	3,943,010	40.00
43.00	04300	NURSERY	768,185		768,185	0	768,185	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	3,880,410		3,880,410	0	3,880,410	50.00
51.00	05100	RECOVERY ROOM	456,003		456,003	0	456,003	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	2,757,922		2,757,922	33,470	2,791,392	52.00
53.00	05300	ANESTHESIOLOGY	153,047		153,047	2,068	155,115	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,870,776		1,870,776	0	1,870,776	54.00
56.00	05600	RADIOISOTOPE	319,859		319,859	0	319,859	56.00
57.00	05700	CT SCAN	821,398		821,398	0	821,398	57.00
58.00	05800	MRI	297,689		297,689	0	297,689	58.00
59.00	05900	CARDIAC CATHETERIZATION	1,733,397		1,733,397	0	1,733,397	59.00
60.00	06000	LABORATORY	4,484,637		4,484,637	0	4,484,637	60.00
65.00	06500	RESPIRATORY THERAPY	1,471,301	0	1,471,301	0	1,471,301	65.00
66.00	06600	PHYSICAL THERAPY	1,501,820	0	1,501,820	0	1,501,820	66.00
67.00	06700	OCCUPATIONAL THERAPY	375,213	0	375,213	0	375,213	67.00
68.00	06800	SPEECH PATHOLOGY	53,056	0	53,056	0	53,056	68.00
69.00	06900	ELECTROCARDIOLOGY	838,650		838,650	190	838,840	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	26,355		26,355	0	26,355	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	4,879,839		4,879,839	0	4,879,839	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	3,203,170		3,203,170	0	3,203,170	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	7,342,390		7,342,390	0	7,342,390	73.00
74.00	07400	RENAL DIALYSIS	0		0	0	0	74.00
75.00	07500	ASC (NON-DISTINCT PART)	0		0	0	0	75.00
75.01	03950	INPATIENT RENAL DIALYSI	483,682		483,682	0	483,682	75.01
76.00	03050	BACTERIOLOGY & MICROBIOLOGY	0		0	0	0	76.00
76.01	03060	WOUND CARE	267,664		267,664	0	267,664	76.01
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	1,126,168		1,126,168	29,585	1,155,753	90.00
91.00	09100	EMERGENCY	5,841,996		5,841,996	67,415	5,909,411	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1,331,017		1,331,017		1,331,017	92.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	75,147,630	0	75,147,630	141,370	75,289,000	200.00
201.00		Less Observation Beds	1,331,017		1,331,017		1,331,017	201.00
202.00		Total (see instructions)	73,816,613	0	73,816,613	141,370	73,957,983	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0292

Period:
From 01/01/2020
To 12/31/2020Worksheet C
Part I
Date/Time Prepared:
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			Title XIX		Hospital	Cost	
Cost Center Description			Charges			Cost or Other Ratio	TEFRA Inpatient Ratio
			Inpatient	Outpatient	Total (col. 6 + col. 7)		
			6.00	7.00	8.00		
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	26,570,537		26,570,537		30.00
31.00	03100	INTENSIVE CARE UNIT	7,784,110		7,784,110		31.00
40.00	04000	SUBPROVIDER - IPF	5,437,155		5,437,155		40.00
43.00	04300	NURSERY	585,574		585,574		43.00
	ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	5,771,548	13,936,983	19,708,531	0.196890	50.00
51.00	05100	RECOVERY ROOM	955,736	1,803,578	2,759,314	0.165260	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	3,071,901	373,951	3,445,852	0.800360	52.00
53.00	05300	ANESTHESIOLOGY	1,871,772	4,232,540	6,104,312	0.025072	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	5,295,623	8,582,863	13,878,486	0.134797	54.00
56.00	05600	RADIOISOTOPE	830,123	1,454,224	2,284,347	0.140022	56.00
57.00	05700	CT SCAN	10,851,691	18,391,934	29,243,625	0.028088	57.00
58.00	05800	MRI	1,437,457	1,769,458	3,206,915	0.092827	58.00
59.00	05900	CARDIAC CATHETERIZATION	3,686,712	1,579,003	5,265,715	0.329185	59.00
60.00	06000	LABORATORY	22,432,728	14,011,582	36,444,310	0.123055	60.00
65.00	06500	RESPIRATORY THERAPY	7,931,858	377,769	8,309,627	0.177060	65.00
66.00	06600	PHYSICAL THERAPY	1,006,597	3,932,886	4,939,483	0.304044	66.00
67.00	06700	OCCUPATIONAL THERAPY	754,405	77,441	831,846	0.451061	67.00
68.00	06800	SPEECH PATHOLOGY	248,764	10,820	259,584	0.204389	68.00
69.00	06900	ELECTROCARDIOLOGY	4,198,599	3,577,746	7,776,345	0.107846	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	204,637	22,979	227,616	0.115787	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1,952,314	2,738,705	4,691,019	1.040251	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	4,201,033	6,857,018	11,058,051	0.289669	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	17,922,923	12,448,624	30,371,547	0.241752	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0.000000	74.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0.000000	75.00
75.01	03950	INPATIENT RENAL DIALYSI	1,303,212	35,302	1,338,514	0.361357	75.01
76.00	03050	BACTERIOLOGY & MICROBIOLOGY	0	0	0	0.000000	76.00
76.01	03060	WOUND CARE	0	4,398	4,398	60.860391	76.01
	OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	7,110	2,081,781	2,088,891	0.539122	90.00
91.00	09100	EMERGENCY	12,624,396	31,330,751	43,955,147	0.132908	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	772,790	2,750,550	3,523,340	0.377771	92.00
	SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE					113.00
200.00		Subtotal (see instructions)	149,711,305	132,382,886	282,094,191		200.00
201.00		Less Observation Beds					201.00
202.00		Total (see instructions)	149,711,305	132,382,886	282,094,191		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0292

Period:
From 01/01/2020
To 12/31/2020Worksheet C
Part I
Date/Time Prepared:
7/28/2021 9:55 am

Cost Center Description			PPS Inpatient Ratio	Title XIX	Hospital	Cost
			11.00			
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS				30.00
31.00	03100	INTENSIVE CARE UNIT				31.00
40.00	04000	SUBPROVIDER - IPF				40.00
43.00	04300	NURSERY				43.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.000000			50.00
51.00	05100	RECOVERY ROOM	0.000000			51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000			52.00
53.00	05300	ANESTHESIOLOGY	0.000000			53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000			54.00
56.00	05600	RADIOISOTOPE	0.000000			56.00
57.00	05700	CT SCAN	0.000000			57.00
58.00	05800	MRI	0.000000			58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000			59.00
60.00	06000	LABORATORY	0.000000			60.00
65.00	06500	RESPIRATORY THERAPY	0.000000			65.00
66.00	06600	PHYSICAL THERAPY	0.000000			66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000			67.00
68.00	06800	SPEECH PATHOLOGY	0.000000			68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000			69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000			70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000			71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000			72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000			73.00
74.00	07400	RENAL DIALYSIS	0.000000			74.00
75.00	07500	ASC (NON-DISTINCT PART)	0.000000			75.00
75.01	03950	INPATIENT RENAL DIALYSI	0.000000			75.01
76.00	03050	BACTERIOLOGY & MICROBIOLOGY	0.000000			76.00
76.01	03060	WOUND CARE	0.000000			76.01
OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.000000			90.00
91.00	09100	EMERGENCY	0.000000			91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000			92.00
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: 14-0292

Period:
From 01/01/2020
To 12/31/2020Worksheet D
Part I
Date/Time Prepared:
7/28/2021 9:55 am

			Title XVIII		Hospital	PPS	
Cost Center Description		Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	1,457,707	0	1,457,707	20,650	70.59	30.00
31.00	INTENSIVE CARE UNIT	177,286		177,286	3,293	53.84	31.00
40.00	SUBPROVIDER - IPF	234,736	0	234,736	3,287	71.41	40.00
43.00	NURSERY	8,448		8,448	569	14.85	43.00
200.00	Total (lines 30 through 199)	1,878,177		1,878,177	27,799		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	5,789	408,646				30.00
31.00	INTENSIVE CARE UNIT	886	47,702				31.00
40.00	SUBPROVIDER - IPF	2,080	148,533				40.00
43.00	NURSERY	0	0				43.00
200.00	Total (lines 30 through 199)	8,755	604,881				200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 14-0292

Period:
From 01/01/2020
To 12/31/2020Worksheet D
Part II
Date/Time Prepared:
7/28/2021 9:55 am

			Title XVIII		Hospital	PPS		
Cost Center Description			Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	408,317	19,708,531	0.020718	1,463,698	30,325	50.00
51.00	05100	RECOVERY ROOM	29,686	2,759,314	0.010758	288,003	3,098	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	89,721	3,445,852	0.026037	572	15	52.00
53.00	05300	ANESTHESIOLOGY	9,933	6,104,312	0.001627	502,834	818	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	249,611	13,878,486	0.017985	1,785,645	32,115	54.00
56.00	05600	RADIOISOTOPE	46,888	2,284,347	0.020526	286,065	5,872	56.00
57.00	05700	CT SCAN	13,779	29,243,625	0.000471	3,494,926	1,646	57.00
58.00	05800	MRI	58,414	3,206,915	0.018215	459,125	8,363	58.00
59.00	05900	CARDIAC CATHETERIZATION	186,735	5,265,715	0.035462	1,387,304	49,197	59.00
60.00	06000	LABORATORY	158,841	36,444,310	0.004358	6,951,223	30,293	60.00
65.00	06500	RESPIRATORY THERAPY	33,964	8,309,627	0.004087	2,755,796	11,263	65.00
66.00	06600	PHYSICAL THERAPY	33,366	4,939,483	0.006755	399,126	2,696	66.00
67.00	06700	OCCUPATIONAL THERAPY	1,400	831,846	0.001683	315,078	530	67.00
68.00	06800	SPEECH PATHOLOGY	237	259,584	0.000913	117,824	108	68.00
69.00	06900	ELECTROCARDIOLOGY	95,807	7,776,345	0.012320	1,522,952	18,763	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	319	227,616	0.001401	69,825	98	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	128,147	4,691,019	0.027318	307,103	8,389	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	86,189	11,058,051	0.007794	1,580,637	12,319	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	106,217	30,371,547	0.003497	5,569,743	19,477	73.00
74.00	07400	RENAL DIALYSIS	0	0	0.000000	0	0	74.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0.000000	0	0	75.00
75.01	03950	INPATIENT RENAL DIALYSI	1,877	1,338,514	0.001402	574,128	805	75.01
76.00	03050	BACTERIOLOGY & MICROBIOLOGY	0	0	0.000000	0	0	76.00
76.01	03060	WOUND CARE	63,566	4,398	14.453388	0	0	76.01
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	140,205	2,088,891	0.067119	2,274	153	90.00
91.00	09100	EMERGENCY	390,091	43,955,147	0.008875	3,973,497	35,265	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	97,839	3,523,340	0.027769	227,308	6,312	92.00
200.00		Total (lines 50 through 199)	2,431,149	241,716,815		34,034,686	277,920	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS					Provider CCN: 14-0292		Period: From 01/01/2020 To 12/31/2020		Worksheet D Part III Date/Time Prepared: 7/28/2021 9:55 am		
					Title XVIII		Hospital		PPS		
Cost Center Description					Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health Cost	All Other Medical Education Cost		
					1A	1.00	2A	2.00	3.00		
INPATIENT ROUTINE SERVICE COST CENTERS											
30.00	03000	ADULTS & PEDIATRICS		0	0	0	0	0	0	30.00	
31.00	03100	INTENSIVE CARE UNIT		0	0	0	0	0	0	31.00	
40.00	04000	SUBPROVIDER - IPF		0	0	0	0	0	0	40.00	
43.00	04300	NURSERY		0	0	0	0	0	0	43.00	
200.00		Total (lines 30 through 199)		0	0	0	0	0	0	200.00	
Cost Center Description					Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days		
					4.00	5.00	6.00	7.00	8.00		
INPATIENT ROUTINE SERVICE COST CENTERS											
30.00	03000	ADULTS & PEDIATRICS		0	0	20,650	0.00	5,789	30.00		
31.00	03100	INTENSIVE CARE UNIT		0	0	3,293	0.00	886	31.00		
40.00	04000	SUBPROVIDER - IPF		0	0	3,287	0.00	2,080	40.00		
43.00	04300	NURSERY		0	0	569	0.00	0	43.00		
200.00		Total (lines 30 through 199)		0	0	27,799		8,755	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	
40.00	04000	SUBPROVIDER - IPF		0						40.00	
43.00	04300	NURSERY		0						43.00	
200.00		Total (lines 30 through 199)		0						200.00	

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

Provider CCN: 14-0292

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

Worksheet D
Part IV
Date/Time Prepared:
7/28/2021 9:55 am

Cost Center Description			Title XVIII		Hospital		PPS	
			Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health	
			1.00	2A	2.00	3A	3.00	
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
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	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
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	0	75.00
75.01	03950	INPATIENT RENAL DIALYSI	0	0	0	0	0	75.01
76.00	03050	BACTERIOLOGY & MICROBIOLOGY	0	0	0	0	0	76.00
76.01	03060	WOUND CARE	0	0	0	0	0	76.01
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	0	92.00
200.00		Total (lines 50 through 199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

Provider CCN: 14-0292

Period:
From 01/01/2020
To 12/31/2020Worksheet D
Part IV
Date/Time Prepared:
7/28/2021 9:55 am

			Title XVIII		Hospital	PPS		
Cost Center Description			All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7) (see instructions)	
			4.00	5.00	6.00	7.00	8.00	
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	0	19,708,531	0.000000	50.00
51.00	05100	RECOVERY ROOM	0	0	0	2,759,314	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	3,445,852	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	6,104,312	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	13,878,486	0.000000	54.00
56.00	05600	RADIOISOTOPE	0	0	0	2,284,347	0.000000	56.00
57.00	05700	CT SCAN	0	0	0	29,243,625	0.000000	57.00
58.00	05800	MRI	0	0	0	3,206,915	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	5,265,715	0.000000	59.00
60.00	06000	LABORATORY	0	0	0	36,444,310	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	8,309,627	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	4,939,483	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	831,846	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	259,584	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	7,776,345	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	227,616	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	4,691,019	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	11,058,051	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	30,371,547	0.000000	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0.000000	74.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	0.000000	75.00
75.01	03950	INPATIENT RENAL DIALYSI	0	0	0	1,338,514	0.000000	75.01
76.00	03050	BACTERIOLOGY & MICROBIOLOGY	0	0	0	0	0.000000	76.00
76.01	03060	WOUND CARE	0	0	0	4,398	0.000000	76.01
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0	2,088,891	0.000000	90.00
91.00	09100	EMERGENCY	0	0	0	43,955,147	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	3,523,340	0.000000	92.00
200.00		Total (lines 50 through 199)	0	0	0	241,716,815		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-0292

Period:
From 01/01/2020
To 12/31/2020Worksheet D
Part IV
Date/Time Prepared:
7/28/2021 9:55 am

Cost Center Description			Title XVIII			Hospital		PPS	
			Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)		
			9.00	10.00	11.00	12.00	13.00		
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM	0.000000	1,463,698	0	2,084,222	0	50.00	
51.00	05100	RECOVERY ROOM	0.000000	288,003	0	386,067	0	51.00	
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	572	0	590	0	52.00	
53.00	05300	ANESTHESIOLOGY	0.000000	502,834	0	607,210	0	53.00	
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	1,785,645	0	1,049,400	0	54.00	
56.00	05600	RADIOISOTOPE	0.000000	286,065	0	316,279	0	56.00	
57.00	05700	CT SCAN	0.000000	3,494,926	0	3,242,478	0	57.00	
58.00	05800	MRI	0.000000	459,125	0	322,402	0	58.00	
59.00	05900	CARDIAC CATHETERIZATION	0.000000	1,387,304	0	697,532	0	59.00	
60.00	06000	LABORATORY	0.000000	6,951,223	0	1,414,432	0	60.00	
65.00	06500	RESPIRATORY THERAPY	0.000000	2,755,796	0	114,262	0	65.00	
66.00	06600	PHYSICAL THERAPY	0.000000	399,126	0	9,464	0	66.00	
67.00	06700	OCCUPATIONAL THERAPY	0.000000	315,078	0	7,072	0	67.00	
68.00	06800	SPEECH PATHOLOGY	0.000000	117,824	0	1,312	0	68.00	
69.00	06900	ELECTROCARDIOLOGY	0.000000	1,522,952	0	656,797	0	69.00	
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	69,825	0	5,232	0	70.00	
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	307,103	0	430,484	0	71.00	
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	1,580,637	0	1,832,680	0	72.00	
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	5,569,743	0	1,626,647	0	73.00	
74.00	07400	RENAL DIALYSIS	0.000000	0	0	0	0	74.00	
75.00	07500	ASC (NON-DISTINCT PART)	0.000000	0	0	0	0	75.00	
75.01	03950	INPATIENT RENAL DIALYSI	0.000000	574,128	0	35,302	0	75.01	
76.00	03050	BACTERIOLOGY & MICROBIOLOGY	0.000000	0	0	0	0	76.00	
76.01	03060	WOUND CARE	0.000000	0	0	488	0	76.01	
OUTPATIENT SERVICE COST CENTERS									
90.00	09000	CLINIC	0.000000	2,274	0	204,348	0	90.00	
91.00	09100	EMERGENCY	0.000000	3,973,497	0	3,672,192	0	91.00	
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	227,308	0	353,415	0	92.00	
200.00		Total (lines 50 through 199)		34,034,686	0	19,070,307	0	200.00	

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-0292

Period:
From 01/01/2020
To 12/31/2020Worksheet D
Part V
Date/Time Prepared:
7/28/2021 9:55 am

			Title XVIII		Hospital		PPS	
Cost Center Description			Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges		Costs		
				PPS Reimbursed Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0.196890	2,084,222	0	0	410,362	50.00
51.00	05100	RECOVERY ROOM	0.165260	386,067	0	0	63,801	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.800360	590	0	0	472	52.00
53.00	05300	ANESTHESIOLOGY	0.025072	607,210	0	0	15,224	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.134797	1,049,400	0	0	141,456	54.00
56.00	05600	RADIOISOTOPE	0.140022	316,279	0	0	44,286	56.00
57.00	05700	CT SCAN	0.028088	3,242,478	0	0	91,075	57.00
58.00	05800	MRI	0.092827	322,402	0	0	29,928	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.329185	697,532	0	0	229,617	59.00
60.00	06000	LABORATORY	0.123055	1,414,432	0	0	174,053	60.00
65.00	06500	RESPIRATORY THERAPY	0.177060	114,262	66	0	20,231	65.00
66.00	06600	PHYSICAL THERAPY	0.304044	9,464	0	0	2,877	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.451061	7,072	0	0	3,190	67.00
68.00	06800	SPEECH PATHOLOGY	0.204389	1,312	0	0	268	68.00
69.00	06900	ELECTROCARDIOLOGY	0.107846	656,797	0	0	70,833	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.115787	5,232	0	0	606	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1.040251	430,484	0	0	447,811	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.289669	1,832,680	0	0	530,871	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.241752	1,626,647	0	13,763	393,245	73.00
74.00	07400	RENAL DIALYSIS	0.000000	0	0	0	0	74.00
75.00	07500	ASC (NON-DISTINCT PART)	0.000000	0	0	0	0	75.00
75.01	03950	INPATIENT RENAL DIALYSI	0.361357	35,302	0	0	12,757	75.01
76.00	03050	BACTERIOLOGY & MICROBIOLOGY	0.000000	0	0	0	0	76.00
76.01	03060	WOUND CARE	60.860391	488	0	0	29,700	76.01
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0.539122	204,348	0	0	110,169	90.00
91.00	09100	EMERGENCY	0.132908	3,672,192	7,613	0	488,064	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.377771	353,415	0	0	133,510	92.00
200.00		Subtotal (see instructions)		19,070,307	7,679	13,763	3,444,406	200.00
201.00		Less PBP Clinic Lab. Services-Program			0	0		201.00
		Only Charges						
202.00		Net Charges (line 200 - line 201)		19,070,307	7,679	13,763	3,444,406	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-0292

Period:
From 01/01/2020
To 12/31/2020Worksheet D
Part V
Date/Time Prepared:
7/28/2021 9:55 am

			Title XVIII		Hospital		PPS		
Cost Center Description			Costs						
			Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)					
			6.00	7.00					
	ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0					50.00
51.00	05100	RECOVERY ROOM	0	0					51.00
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	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	12	0					65.00
66.00	06600	PHYSICAL THERAPY	0	0					66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0					67.00
68.00	06800	SPEECH PATHOLOGY	0	0					68.00
69.00	06900	ELECTROCARDIOLOGY	0	0					69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0					70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0					71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0					72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	3,327					73.00
74.00	07400	RENAL DIALYSIS	0	0					74.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0					75.00
75.01	03950	INPATIENT RENAL DIALYSI	0	0					75.01
76.00	03050	BACTERIOLOGY & MICROBIOLOGY	0	0					76.00
76.01	03060	WOUND CARE	0	0					76.01
	OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0					90.00
91.00	09100	EMERGENCY	1,012	0					91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0					92.00
200.00		Subtotal (see instructions)	1,024	3,327					200.00
201.00		Less PBP Clinic Lab. Services-Program	0						201.00
		Only Charges							
202.00		Net Charges (line 200 - line 201)	1,024	3,327					202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 14-0292

Period:

Worksheet D

Component CCN: 14-S292

From 01/01/2020

Part II

To 12/31/2020

Date/Time Prepared:

7/28/2021 9:55 am

Title XVIII

Subprovider -

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	408,317	19,708,531	0.020718	0	0	50.00
51.00	05100	RECOVERY ROOM	29,686	2,759,314	0.010758	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	89,721	3,445,852	0.026037	0	0	52.00
53.00	05300	ANESTHESIOLOGY	9,933	6,104,312	0.001627	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	249,611	13,878,486	0.017985	38,588	694	54.00
56.00	05600	RADIOISOTOPE	46,888	2,284,347	0.020526	6,674	137	56.00
57.00	05700	CT SCAN	13,779	29,243,625	0.000471	73,464	35	57.00
58.00	05800	MRI	58,414	3,206,915	0.018215	25,991	473	58.00
59.00	05900	CARDIAC CATHETERIZATION	186,735	5,265,715	0.035462	0	0	59.00
60.00	06000	LABORATORY	158,841	36,444,310	0.004358	529,296	2,307	60.00
65.00	06500	RESPIRATORY THERAPY	33,964	8,309,627	0.004087	128,693	526	65.00
66.00	06600	PHYSICAL THERAPY	33,366	4,939,483	0.006755	67,971	459	66.00
67.00	06700	OCCUPATIONAL THERAPY	1,400	831,846	0.001683	46,240	78	67.00
68.00	06800	SPEECH PATHOLOGY	237	259,584	0.000913	10,202	9	68.00
69.00	06900	ELECTROCARDIOLOGY	95,807	7,776,345	0.012320	52,839	651	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	319	227,616	0.001401	3,924	5	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	128,147	4,691,019	0.027318	368	10	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	86,189	11,058,051	0.007794	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	106,217	30,371,547	0.003497	554,837	1,940	73.00
74.00	07400	RENAL DIALYSIS	0	0	0.000000	0	0	74.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0.000000	0	0	75.00
75.01	03950	INPATIENT RENAL DIALYSI	1,877	1,338,514	0.001402	22,242	31	75.01
76.00	03050	BACTERIOLOGY & MICROBIOLOGY	0	0	0.000000	0	0	76.00
76.01	03060	WOUND CARE	63,566	4,398	14.453388	0	0	76.01
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	140,205	2,088,891	0.067119	0	0	90.00
91.00	09100	EMERGENCY	390,091	43,955,147	0.008875	162,595	1,443	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	3,523,340	0.000000	0	0	92.00
200.00		Total (lines 50 through 199)	2,333,310	241,716,815		1,723,924	8,798	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS				Provider CCN: 14-0292 Component CCN: 14-S292		Period: From 01/01/2020 To 12/31/2020		Worksheet D Part IV Date/Time Prepared: 7/28/2021 9:55 am	
				Title XVIII		Subprovider - IPF		PPS	
Cost Center Description				Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health	
				1.00	2A	2.00	3A	3.00	
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM		0	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM		0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM		0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY		0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC		0	0	0	0	0	54.00
56.00	05600	RADIOISOTOPE		0	0	0	0	0	56.00
57.00	05700	CT SCAN		0	0	0	0	0	57.00
58.00	05800	MRI		0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION		0	0	0	0	0	59.00
60.00	06000	LABORATORY		0	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY		0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY		0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY		0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY		0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY		0	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY		0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT		0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS		0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS		0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS		0	0	0	0	0	74.00
75.00	07500	ASC (NON-DISTINCT PART)		0	0	0	0	0	75.00
75.01	03950	INPATIENT RENAL DIALYSI		0	0	0	0	0	75.01
76.00	03050	BACTERIOLOGY & MICROBIOLOGY		0	0	0	0	0	76.00
76.01	03060	WOUND CARE		0	0	0	0	0	76.01
OUTPATIENT SERVICE COST CENTERS									
90.00	09000	CLINIC		0	0	0	0	0	90.00
91.00	09100	EMERGENCY		0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART		0	0	0	0	0	92.00
200.00		Total (lines 50 through 199)		0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS				Provider CCN: 14-0292 Component CCN: 14-S292		Period: From 01/01/2020 To 12/31/2020		Worksheet D Part IV Date/Time Prepared: 7/28/2021 9:55 am	
				Title XVIII		Subprovider - IPF		PPS	
Cost Center Description				All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7) (see instructions)	
				4.00	5.00	6.00	7.00	8.00	
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM		0	0	0	19,708,531	0.000000	50.00
51.00	05100	RECOVERY ROOM		0	0	0	2,759,314	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM		0	0	0	3,445,852	0.000000	52.00
53.00	05300	ANESTHESIOLOGY		0	0	0	6,104,312	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC		0	0	0	13,878,486	0.000000	54.00
56.00	05600	RADIOISOTOPE		0	0	0	2,284,347	0.000000	56.00
57.00	05700	CT SCAN		0	0	0	29,243,625	0.000000	57.00
58.00	05800	MRI		0	0	0	3,206,915	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION		0	0	0	5,265,715	0.000000	59.00
60.00	06000	LABORATORY		0	0	0	36,444,310	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY		0	0	0	8,309,627	0.000000	65.00
66.00	06600	PHYSICAL THERAPY		0	0	0	4,939,483	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY		0	0	0	831,846	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY		0	0	0	259,584	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY		0	0	0	7,776,345	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY		0	0	0	227,616	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT		0	0	0	4,691,019	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS		0	0	0	11,058,051	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS		0	0	0	30,371,547	0.000000	73.00
74.00	07400	RENAL DIALYSIS		0	0	0	0	0.000000	74.00
75.00	07500	ASC (NON-DISTINCT PART)		0	0	0	0	0.000000	75.00
75.01	03950	INPATIENT RENAL DIALYSI		0	0	0	1,338,514	0.000000	75.01
76.00	03050	BACTERIOLOGY & MICROBIOLOGY		0	0	0	0	0.000000	76.00
76.01	03060	WOUND CARE		0	0	0	4,398	0.000000	76.01
OUTPATIENT SERVICE COST CENTERS									
90.00	09000	CLINIC		0	0	0	2,088,891	0.000000	90.00
91.00	09100	EMERGENCY		0	0	0	43,955,147	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART		0	0	0	3,523,340	0.000000	92.00
200.00		Total (lines 50 through 199)		0	0	0	241,716,815		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

Provider CCN: 14-0292

Component CCN: 14-S292

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

Worksheet D
Part IV
Date/Time Prepared:
7/28/2021 9:55 am

			Title XVIII		Subprovider - IPF		PPS	
Cost Center Description			Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
			9.00	10.00	11.00	12.00	13.00	
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0.000000	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0.000000	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	38,588	0	0	0	54.00
56.00	05600	RADIOISOTOPE	0.000000	6,674	0	0	0	56.00
57.00	05700	CT SCAN	0.000000	73,464	0	0	0	57.00
58.00	05800	MRI	0.000000	25,991	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	0	0	0	0	59.00
60.00	06000	LABORATORY	0.000000	529,296	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.000000	128,693	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	67,971	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	46,240	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	10,202	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	52,839	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	3,924	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	368	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	554,837	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0.000000	0	0	0	0	74.00
75.00	07500	ASC (NON-DISTINCT PART)	0.000000	0	0	0	0	75.00
75.01	03950	INPATIENT RENAL DIALYSI	0.000000	22,242	0	0	0	75.01
76.00	03050	BACTERIOLOGY & MICROBIOLOGY	0.000000	0	0	0	0	76.00
76.01	03060	WOUND CARE	0.000000	0	0	0	0	76.01
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0.000000	0	0	0	0	90.00
91.00	09100	EMERGENCY	0.000000	162,595	0	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)		1,723,924	0	0	0	200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS				Provider CCN: 14-0292		Period: From 01/01/2020 To 12/31/2020		Worksheet D Part II Date/Time Prepared: 7/28/2021 9:55 am	
				Component CCN: 14-S292					
				Title XIX		Subprovider - IPF		TEFRA	
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	408,317	19,708,531	0.020718	0	0	50.00	
51.00	05100	RECOVERY ROOM	29,686	2,759,314	0.010758	0	0	51.00	
52.00	05200	DELIVERY ROOM & LABOR ROOM	89,721	3,445,852	0.026037	0	0	52.00	
53.00	05300	ANESTHESIOLOGY	9,933	6,104,312	0.001627	0	0	53.00	
54.00	05400	RADIOLOGY-DIAGNOSTIC	249,611	13,878,486	0.017985	0	0	54.00	
56.00	05600	RADIOISOTOPE	46,888	2,284,347	0.020526	0	0	56.00	
57.00	05700	CT SCAN	13,779	29,243,625	0.000471	0	0	57.00	
58.00	05800	MRI	58,414	3,206,915	0.018215	0	0	58.00	
59.00	05900	CARDIAC CATHETERIZATION	186,735	5,265,715	0.035462	0	0	59.00	
60.00	06000	LABORATORY	158,841	36,444,310	0.004358	0	0	60.00	
65.00	06500	RESPIRATORY THERAPY	33,964	8,309,627	0.004087	0	0	65.00	
66.00	06600	PHYSICAL THERAPY	33,366	4,939,483	0.006755	0	0	66.00	
67.00	06700	OCCUPATIONAL THERAPY	1,400	831,846	0.001683	0	0	67.00	
68.00	06800	SPEECH PATHOLOGY	237	259,584	0.000913	0	0	68.00	
69.00	06900	ELECTROCARDIOLOGY	95,807	7,776,345	0.012320	0	0	69.00	
70.00	07000	ELECTROENCEPHALOGRAPHY	319	227,616	0.001401	0	0	70.00	
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	128,147	4,691,019	0.027318	0	0	71.00	
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	86,189	11,058,051	0.007794	0	0	72.00	
73.00	07300	DRUGS CHARGED TO PATIENTS	106,217	30,371,547	0.003497	0	0	73.00	
74.00	07400	RENAL DIALYSIS	0	0	0.000000	0	0	74.00	
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0.000000	0	0	75.00	
75.01	03950	INPATIENT RENAL DIALYSI	1,877	1,338,514	0.001402	0	0	75.01	
76.00	03050	BACTERIOLOGY & MICROBIOLOGY	0	0	0.000000	0	0	76.00	
76.01	03060	WOUND CARE	63,566	4,398	14.453388	0	0	76.01	
	OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	140,205	2,088,891	0.067119	0	0	90.00	
91.00	09100	EMERGENCY	390,091	43,955,147	0.008875	0	0	91.00	
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	3,523,340	0.000000	0	0	92.00	
200.00		Total (lines 50 through 199)	2,333,310	241,716,815		0	0	200.00	

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

 Provider CCN: 14-0292
Component CCN: 14-S292

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

 Worksheet D
Part IV
Date/Time Prepared:
7/28/2021 9:55 am

Cost Center Description			Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health	
			1.00	2A	2.00	3A	3.00	
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
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	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
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	0	75.00
75.01	03950	INPATIENT RENAL DIALYSI	0	0	0	0	0	75.01
76.00	03050	BACTERIOLOGY & MICROBIOLOGY	0	0	0	0	0	76.00
76.01	03060	WOUND CARE	0	0	0	0	0	76.01
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	0	92.00
200.00		Total (lines 50 through 199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS				Provider CCN: 14-0292 Component CCN: 14-S292		Period: From 01/01/2020 To 12/31/2020		Worksheet D Part IV Date/Time Prepared: 7/28/2021 9:55 am	
				Title XIX		Subprovider - IPF		TEFRA	
Cost Center Description				All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7) (see instructions)	
				4.00	5.00	6.00	7.00	8.00	
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM		0	0	0	19,708,531	0.000000	50.00
51.00	05100	RECOVERY ROOM		0	0	0	2,759,314	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM		0	0	0	3,445,852	0.000000	52.00
53.00	05300	ANESTHESIOLOGY		0	0	0	6,104,312	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC		0	0	0	13,878,486	0.000000	54.00
56.00	05600	RADIOISOTOPE		0	0	0	2,284,347	0.000000	56.00
57.00	05700	CT SCAN		0	0	0	29,243,625	0.000000	57.00
58.00	05800	MRI		0	0	0	3,206,915	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION		0	0	0	5,265,715	0.000000	59.00
60.00	06000	LABORATORY		0	0	0	36,444,310	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY		0	0	0	8,309,627	0.000000	65.00
66.00	06600	PHYSICAL THERAPY		0	0	0	4,939,483	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY		0	0	0	831,846	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY		0	0	0	259,584	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY		0	0	0	7,776,345	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY		0	0	0	227,616	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT		0	0	0	4,691,019	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS		0	0	0	11,058,051	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS		0	0	0	30,371,547	0.000000	73.00
74.00	07400	RENAL DIALYSIS		0	0	0	0	0.000000	74.00
75.00	07500	ASC (NON-DISTINCT PART)		0	0	0	0	0.000000	75.00
75.01	03950	INPATIENT RENAL DIALYSI		0	0	0	1,338,514	0.000000	75.01
76.00	03050	BACTERIOLOGY & MICROBIOLOGY		0	0	0	0	0.000000	76.00
76.01	03060	WOUND CARE		0	0	0	4,398	0.000000	76.01
OUTPATIENT SERVICE COST CENTERS									
90.00	09000	CLINIC		0	0	0	2,088,891	0.000000	90.00
91.00	09100	EMERGENCY		0	0	0	43,955,147	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART		0	0	0	3,523,340	0.000000	92.00
200.00		Total (lines 50 through 199)		0	0	0	241,716,815		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS				Provider CCN: 14-0292 Component CCN: 14-S292		Period: From 01/01/2020 To 12/31/2020		Worksheet D Part IV Date/Time Prepared: 7/28/2021 9:55 am	
				Title XIX		Subprovider - IPF		TEFRA	
Cost Center Description				Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
				9.00	10.00	11.00	12.00	13.00	
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM		0.000000	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM		0.000000	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM		0.000000	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY		0.000000	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC		0.000000	0	0	0	0	54.00
56.00	05600	RADIOISOTOPE		0.000000	0	0	0	0	56.00
57.00	05700	CT SCAN		0.000000	0	0	0	0	57.00
58.00	05800	MRI		0.000000	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION		0.000000	0	0	0	0	59.00
60.00	06000	LABORATORY		0.000000	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY		0.000000	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY		0.000000	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY		0.000000	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY		0.000000	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY		0.000000	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY		0.000000	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT		0.000000	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS		0.000000	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS		0.000000	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS		0.000000	0	0	0	0	74.00
75.00	07500	ASC (NON-DISTINCT PART)		0.000000	0	0	0	0	75.00
75.01	03950	INPATIENT RENAL DIALYSI		0.000000	0	0	0	0	75.01
76.00	03050	BACTERIOLOGY & MICROBIOLOGY		0.000000	0	0	0	0	76.00
76.01	03060	WOUND CARE		0.000000	0	0	0	0	76.01
OUTPATIENT SERVICE COST CENTERS									
90.00	09000	CLINIC		0.000000	0	0	0	0	90.00
91.00	09100	EMERGENCY		0.000000	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART		0.000000	0	0	0	0	92.00
200.00		Total (lines 50 through 199)			0	0	0	0	200.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-0292	Period: From 01/01/2020 To 12/31/2020	Worksheet D-1 Date/Time Prepared: 7/28/2021 9:55 am	
Cost Center Description		Title XVIII	Hospital	PPS	
PART I - ALL PROVIDER COMPONENTS				1.00	
INPATIENT DAYS					
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)			20,650	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)			20,650	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)			19,264	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period			0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)			0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period			0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)			0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions)			5,789	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)			0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)			0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period			0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)			0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)			0	14.00
15.00	Total nursery days (title V or XIX only)			0	15.00
16.00	Nursery days (title V or XIX only)			0	16.00
SWING BED ADJUSTMENT					
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period			0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period			0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period			0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period			0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)			19,830,729	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)			0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)			0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)			0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)			0	25.00
26.00	Total swing-bed cost (see instructions)			0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)			19,830,729	27.00
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT					
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)			0	28.00
29.00	Private room charges (excluding swing-bed charges)			0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)			0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)			0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)			0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)			0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)			0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)			0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)			0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)			19,830,729	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)			960.33	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)			5,559,350	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)			0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)			5,559,350	41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-0292

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

Worksheet D-1

Date/Time Prepared:
7/28/2021 9:55 am

		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	5,096,889	3,293	1,547.80	886	1,371,351
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)					5,983,107
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					12,913,808
PASS THROUGH COST ADJUSTMENTS						
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)					456,348
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					277,920
52.00	Total Program excludable cost (sum of lines 50 and 51)					734,268
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					12,179,540
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)					1,386
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					960.33
89.00	Observation bed cost (line 87 x line 88) (see instructions)					1,331,017

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-0292

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

Worksheet D-1

Date/Time Prepared:
7/28/2021 9:55 am

Cost Center Description		Title XVIII		Hospital	PPS	
		Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00
COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	1,457,707	19,830,729	0.073507	1,331,017	97,839
91.00	Nursing School cost	0	19,830,729	0.000000	1,331,017	0
92.00	Allied health cost	0	19,830,729	0.000000	1,331,017	0
93.00	All other Medical Education	0	19,830,729	0.000000	1,331,017	0

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-0292 Component CCN: 14-S292	Period: From 01/01/2020 To 12/31/2020	Worksheet D-1 Date/Time Prepared: 7/28/2021 9:55 am
		Title XVIII	Subprovider - IPF	PPS
Cost Center Description			1.00	
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		3,287	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		3,287	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.		0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)		3,287	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)		2,080	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)		3,943,010	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)		3,943,010	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)		3,943,010	37.00
PART II - HOSPITAL AND SUBPROVIDERS ONLY				
PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS				
38.00	Adjusted general inpatient routine service cost per diem (see instructions)		1,199.58	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		2,495,126	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)		0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)		2,495,126	41.00

COMPUTATION OF INPATIENT OPERATING COST			Provider CCN: 14-0292	Period: From 01/01/2020 To 12/31/2020	Worksheet D-1
			Component CCN: 14-S292		Date/Time Prepared: 7/28/2021 9:55 am
			Title XVIII	Subprovider - IPF	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)					312,707
49.00 Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					2,807,833
PASS THROUGH COST ADJUSTMENTS					
50.00 Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)					148,533
51.00 Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					8,798
52.00 Total Program excludable cost (sum of lines 50 and 51)					157,331
53.00 Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					2,650,502
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)					
71.00 Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)					
72.00 Program routine service cost (line 9 x line 71)					
73.00 Medically necessary private room cost applicable to Program (line 14 x line 35)					
74.00 Total Program general inpatient routine service costs (line 72 + line 73)					
75.00 Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)					
76.00 Per diem capital-related costs (line 75 ÷ line 2)					
77.00 Program capital-related costs (line 9 x line 76)					
78.00 Inpatient routine service cost (line 74 minus line 77)					
79.00 Aggregate charges to beneficiaries for excess costs (from provider records)					
80.00 Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)					
81.00 Inpatient routine service cost per diem limitation					
82.00 Inpatient routine service cost limitation (line 9 x line 81)					
83.00 Reasonable inpatient routine service costs (see instructions)					
84.00 Program inpatient ancillary services (see instructions)					
85.00 Utilization review - physician compensation (see instructions)					
86.00 Total Program inpatient operating costs (sum of lines 83 through 85)					
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: 14-0292 Component CCN: 14-S292		Period: From 01/01/2020 To 12/31/2020		Worksheet D-1 Date/Time Prepared: 7/28/2021 9:55 am	
		Title XVIII		Subprovider - IPF		PPS	
Cost Center Description		Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00	Capital-related cost	234,736	3,943,010	0.059532	0	0	90.00
91.00	Nursing School cost	0	3,943,010	0.000000	0	0	91.00
92.00	Allied health cost	0	3,943,010	0.000000	0	0	92.00
93.00	All other Medical Education	0	3,943,010	0.000000	0	0	93.00

Health Financial Systems		ADVENTIST GLENOAKS HOSPITAL		In Lieu of Form CMS-2552-10	
COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-0292	Period: From 01/01/2020	Worksheet D-1	
		Component CCN: 14-S292	To 12/31/2020	Date/Time Prepared: 7/28/2021 9:55 am	
		Title XIX	Subprovider - IPF	TEFRA	
Cost Center Description					
					1.00
PART I - ALL PROVIDER COMPONENTS					
INPATIENT DAYS					
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)			3,287	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)			3,287	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.			0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)			3,287	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)			23	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)			569	15.00
16.00	Nursery days (title V or XIX only)			110	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)			3,943,010	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)			3,943,010	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)			3,943,010	37.00
PART II - HOSPITAL AND SUBPROVIDERS ONLY					
PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS					
38.00	Adjusted general inpatient routine service cost per diem (see instructions)			1,199.58	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)			27,590	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)			27,590	41.00

COMPUTATION OF INPATIENT OPERATING COST				Provider CCN: 14-0292	Period: From 01/01/2020 To 12/31/2020	Worksheet D-1	
				Component CCN: 14-S292		Date/Time Prepared: 7/28/2021 9:55 am	
				Title XIX		Subprovider - IPF	TEFRA
	Cost Center Description	Total	Total	Average Per	Program Days	Program Cost (col. 3 x col. 4)	
		Inpatient Cost	Inpatient Days	Diem (col. 1 ÷ col. 2)			
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)	0	0	0.00	0		42.00
Intensive Care Type Inpatient Hospital Units							
43.00	INTENSIVE CARE UNIT	0	0	0.00	0	0	43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00
Cost Center Description							
							1.00
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					0	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					27,590	49.00
PASS THROUGH COST ADJUSTMENTS							
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)					0	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					0	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)					0	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					27,590	53.00
TARGET AMOUNT AND LIMIT COMPUTATION							
54.00	Program discharges					1	54.00
55.00	Target amount per discharge					0.00	55.00
56.00	Target amount (line 54 x line 55)					0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)					-27,590	57.00
58.00	Bonus payment (see instructions)					0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket					0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket					0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)					0	61.00
62.00	Relief payment (see instructions)					0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)					0	63.00
PROGRAM INPATIENT ROUTINE SWING BED COST							
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)					0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)					0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)					0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)					0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)					0	69.00
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY							
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)						70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)						71.00
72.00	Program routine service cost (line 9 x line 71)						72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)						73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)						74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)						75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)						76.00
77.00	Program capital-related costs (line 9 x line 76)						77.00
78.00	Inpatient routine service cost (line 74 minus line 77)						78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)						79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)						80.00
81.00	Inpatient routine service cost per diem limitation						81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)						82.00
83.00	Reasonable inpatient routine service costs (see instructions)						83.00
84.00	Program inpatient ancillary services (see instructions)						84.00
85.00	Utilization review - physician compensation (see instructions)						85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)						86.00
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
87.00	Total observation bed days (see instructions)					0	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					0.00	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)					0	89.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-0292

Period:

Worksheet D-1

Component CCN: 14-S292

From 01/01/2020
To 12/31/2020Date/Time Prepared:
7/28/2021 9:55 am

Title XIX

Subprovider -
IPF

TEFRA

Cost Center Description		Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00	Capital-related cost	0	3,943,010	0.000000	0	0	90.00
91.00	Nursing School cost	0	3,943,010	0.000000	0	0	91.00
92.00	Allied health cost	0	3,943,010	0.000000	0	0	92.00
93.00	All other Medical Education	0	3,943,010	0.000000	0	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT			Provider CCN: 14-0292	Period: From 01/01/2020 To 12/31/2020	Worksheet D-3 Date/Time Prepared: 7/28/2021 9:55 am	
			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		8,204,036		30.00
31.00	03100	INTENSIVE CARE UNIT		2,327,755		31.00
40.00	04000	SUBPROVIDER - IPF		0		40.00
43.00	04300	NURSERY				43.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.196890	1,463,698	288,187	50.00
51.00	05100	RECOVERY ROOM	0.165260	288,003	47,595	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.810073	572	463	52.00
53.00	05300	ANESTHESIOLOGY	0.025411	502,834	12,778	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.134797	1,785,645	240,700	54.00
56.00	05600	RADIOISOTOPE	0.140022	286,065	40,055	56.00
57.00	05700	CT SCAN	0.028088	3,494,926	98,165	57.00
58.00	05800	MRI	0.092827	459,125	42,619	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.329185	1,387,304	456,680	59.00
60.00	06000	LABORATORY	0.123055	6,951,223	855,383	60.00
65.00	06500	RESPIRATORY THERAPY	0.177060	2,755,796	487,941	65.00
66.00	06600	PHYSICAL THERAPY	0.304044	399,126	121,352	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.451061	315,078	142,119	67.00
68.00	06800	SPEECH PATHOLOGY	0.204389	117,824	24,082	68.00
69.00	06900	ELECTROCARDIOLOGY	0.107871	1,522,952	164,282	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.115787	69,825	8,085	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1.040251	307,103	319,464	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.289669	1,580,637	457,862	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.241752	5,569,743	1,346,497	73.00
74.00	07400	RENAL DIALYSIS	0.000000	0	0	74.00
75.00	07500	ASC (NON-DISTINCT PART)	0.000000	0	0	75.00
75.01	03950	INPATIENT RENAL DIALYSI	0.361357	574,128	207,465	75.01
76.00	03050	BACTERIOLOGY & MICROBIOLOGY	0.000000	0	0	76.00
76.01	03060	WOUND CARE	60.860391	0	0	76.01
OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.553285	2,274	1,258	90.00
91.00	09100	EMERGENCY	0.134442	3,973,497	534,205	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.377771	227,308	85,870	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		34,034,686	5,983,107	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)		34,034,686		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 14-0292 Component CCN: 14-S292	Period: From 01/01/2020 To 12/31/2020	Worksheet D-3 Date/Time Prepared: 7/28/2021 9:55 am	
		Title XVIII	Subprovider - IPF	PPS	
Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDIATRICS		18,885		30.00
31.00	03100 INTENSIVE CARE UNIT		0		31.00
40.00	04000 SUBPROVIDER - IPF		3,438,122		40.00
43.00	04300 NURSERY				43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.196890	0	0	50.00
51.00	05100 RECOVERY ROOM	0.165260	0	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.810073	0	0	52.00
53.00	05300 ANESTHESIOLOGY	0.025411	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.134797	38,588	5,202	54.00
56.00	05600 RADIOISOTOPE	0.140022	6,674	935	56.00
57.00	05700 CT SCAN	0.028088	73,464	2,063	57.00
58.00	05800 MRI	0.092827	25,991	2,413	58.00
59.00	05900 CARDIAC CATHETERIZATION	0.329185	0	0	59.00
60.00	06000 LABORATORY	0.123055	529,296	65,133	60.00
65.00	06500 RESPIRATORY THERAPY	0.177060	128,693	22,786	65.00
66.00	06600 PHYSICAL THERAPY	0.304044	67,971	20,666	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.451061	46,240	20,857	67.00
68.00	06800 SPEECH PATHOLOGY	0.204389	10,202	2,085	68.00
69.00	06900 ELECTROCARDIOLOGY	0.107871	52,839	5,700	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0.115787	3,924	454	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	1.040251	368	383	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.289669	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.241752	554,837	134,133	73.00
74.00	07400 RENAL DIALYSIS	0.000000	0	0	74.00
75.00	07500 ASC (NON-DISTINCT PART)	0.000000	0	0	75.00
75.01	03950 INPATIENT RENAL DIALYSI	0.361357	22,242	8,037	75.01
76.00	03050 BACTERIOLOGY & MICROBIOLOGY	0.000000	0	0	76.00
76.01	03060 WOUND CARE	60.860391	0	0	76.01
OUTPATIENT SERVICE COST CENTERS					
90.00	09000 CLINIC	0.553285	0	0	90.00
91.00	09100 EMERGENCY	0.134442	162,595	21,860	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0.377771	0	0	92.00
200.00	Total (sum of lines 50 through 94 and 96 through 98)		1,723,924	312,707	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)		1,723,924	0	202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT

Provider CCN: 14-0292

Period:
From 01/01/2020
To 12/31/2020Worksheet E
Part A
Date/Time Prepared:
7/28/2021 9:55 am

		Title XVIII	Hospital	PPS	
				1.00	
PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS					
1.00	DRG Amounts Other than Outlier Payments			0	1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1 (see instructions)			8,847,282	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1 (see instructions)			2,964,283	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)			57,950	2.03
2.04	Outlier payments for discharges occurring on or after October 1 (see instructions)			25,946	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)			117.72	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)			6.43	30.00
31.00	Percentage of Medicaid patient days (see instructions)			31.96	31.00
32.00	Sum of lines 30 and 31			38.39	32.00
33.00	Allowable disproportionate share percentage (see instructions)			20.89	33.00
34.00	Disproportionate share adjustment (see instructions)			616,859	34.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0292	Period: From 01/01/2020 To 12/31/2020	Worksheet E Part A Date/Time Prepared: 7/28/2021 9:55 am	
		Title XVIII	Hospital	PPS	
			Prior to 10/1	On/After 10/1	
			1.00	2.00	
Uncompensated Care Adjustment					
35.00	Total uncompensated care amount (see instructions)		0	0	35.00
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)	708,425	745,748		35.02
35.03	Pro rata share of the hospital uncompensated care payment amount (see instructions)	530,351	187,970		35.03
36.00	Total uncompensated care (sum of columns 1 and 2 on line 35.03)	718,321			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)	13,230,641			47.00
48.00	Hospital specific payments (to be completed by SCH and MDH, small rural hospitals only. (see instructions))		0		48.00
				Amount	
				1.00	
49.00	Total payment for inpatient operating costs (see instructions)		13,230,641		49.00
50.00	Payment for inpatient program capital (from Wkst. L, Pt. I and Pt. II, as applicable)		983,838		50.00
51.00	Exception payment for inpatient program capital (Wkst. L, Pt. III, see instructions)		0		51.00
52.00	Direct graduate medical education payment (from Wkst. E-4, line 49 see instructions).		0		52.00
53.00	Nursing and Allied Health Managed Care payment		0		53.00
54.00	Special add-on payments for new technologies		59,544		54.00
54.01	Islet isolation add-on payment		0		54.01
55.00	Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line 69)		0		55.00
56.00	Cost of physicians' services in a teaching hospital (see instructions)		0		56.00
57.00	Routine service other pass through costs (from Wkst. D, Pt. III, column 9, lines 30 through 35).		0		57.00
58.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 11 line 200)		0		58.00
59.00	Total (sum of amounts on lines 49 through 58)		14,274,023		59.00
60.00	Primary payer payments		2,612		60.00
61.00	Total amount payable for program beneficiaries (line 59 minus line 60)		14,271,411		61.00
62.00	Deductibles billed to program beneficiaries		1,012,000		62.00
63.00	Coinurance billed to program beneficiaries		116,303		63.00
64.00	Allowable bad debts (see instructions)		353,602		64.00
65.00	Adjusted reimbursable bad debts (see instructions)		229,841		65.00
66.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		295,219		66.00
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)		13,372,949		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)		-14,526		70.93
70.94	HRR adjustment amount (see instructions)		-3,931		70.94
70.95	Recovery of accelerated depreciation		0		70.95

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0292	Period: From 01/01/2020 To 12/31/2020	Worksheet E Part A Date/Time Prepared: 7/28/2021 9:55 am
		Title XVIII	Hospital	PPS
		FFY (yyyy)	Amount	
		0	1.00	
70.96	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period prior to 10/1)	0	0	70.96
70.97	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period ending on or after 10/1)	0	0	70.97
70.98	Low Volume Payment-3		0	70.98
70.99	HAC adjustment amount (see instructions)		0	70.99
71.00	Amount due provider (line 67 minus lines 68 plus/minus lines 69 & 70)		13,354,492	71.00
71.01	Sequestration adjustment (see instructions)		88,140	71.01
71.02	Demonstration payment adjustment amount after sequestration		0	71.02
71.03	Sequestration adjustment-PARHM pass-throughs		0	71.03
72.00	Interim payments		13,405,034	72.00
72.01	Interim payments-PARHM		0	72.01
73.00	Tentative settlement (for contractor use only)		0	73.00
73.01	Tentative settlement-PARHM (for contractor use only)		0	73.01
74.00	Balance due provider/program (line 71 minus lines 71.01, 71.02, 72, and 73)		-138,682	74.00
74.01	Balance due provider/program-PARHM (see instructions)		0	74.01
75.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		589,618	75.00
TO BE COMPLETED BY CONTRACTOR (lines 90 through 96)				
90.00	Operating outlier amount from Wkst. E, Pt. A, line 2, or sum of 2.03 plus 2.04 (see instructions)		0	90.00
91.00	Capital outlier from Wkst. L, Pt. I, line 2		0	91.00
92.00	Operating outlier reconciliation adjustment amount (see instructions)		0	92.00
93.00	Capital outlier reconciliation adjustment amount (see instructions)		0	93.00
94.00	The rate used to calculate the time value of money (see instructions)		0.00	94.00
95.00	Time value of money for operating expenses (see instructions)		0	95.00
96.00	Time value of money for capital related expenses (see instructions)		0	96.00
		Prior to 10/1	On/After 10/1	
		1.00	2.00	
HSP Bonus Payment Amount				
100.00	HSP bonus amount (see instructions)		0	100.00
HVBP Adjustment for HSP Bonus Payment				
101.00	HVBP adjustment factor (see instructions)	0.0000000000	0.0000000000	101.00
102.00	HVBP adjustment amount for HSP bonus payment (see instructions)		0	102.00
HRR Adjustment for HSP Bonus Payment				
103.00	HRR adjustment factor (see instructions)	0.0000	0.0000	103.00
104.00	HRR adjustment amount for HSP bonus payment (see instructions)		0	104.00
Rural Community Hospital Demonstration Project (\$410A Demonstration) Adjustment				
200.00	Is this the first year of the current 5-year demonstration period under the 21st Century Cures Act? Enter "Y" for yes or "N" for no.			200.00
Cost Reimbursement				
201.00	Medicare inpatient service costs (from Wkst. D-1, Pt. II, line 49)			201.00
202.00	Medicare discharges (see instructions)			202.00
203.00	Case-mix adjustment factor (see instructions)			203.00
Computation of Demonstration Target Amount Limitation (N/A in first year of the current 5-year demonstration period)				
204.00	Medicare target amount			204.00
205.00	Case-mix adjusted target amount (line 203 times line 204)			205.00
206.00	Medicare inpatient routine cost cap (line 202 times line 205)			206.00
Adjustment to Medicare Part A Inpatient Reimbursement				
207.00	Program reimbursement under the \$410A Demonstration (see instructions)			207.00
208.00	Medicare Part A inpatient service costs (from Wkst. E, Pt. A, line 59)			208.00
209.00	Adjustment to Medicare IPPS payments (see instructions)			209.00
210.00	Reserved for future use			210.00
211.00	Total adjustment to Medicare IPPS payments (see instructions)			211.00
Comparison of PPS versus Cost Reimbursement				
212.00	Total adjustment to Medicare Part A IPPS payments (from line 211)			212.00
213.00	Low-volume adjustment (see instructions)			213.00
218.00	Net Medicare Part A IPPS adjustment (difference between PPS and cost reimbursement) (line 212 minus line 213) (see instructions)			218.00

LOW VOLUME CALCULATION EXHIBIT 4

Provider CCN: 14-0292

Period:
From 01/01/2020
To 12/31/2020Worksheet E
Part A Exhibit 4
Date/Time Prepared:
7/28/2021 9:55 am

		Title XVIII		Hospital		PPS	
		W/S E, Part A line	Amounts (from E, Part A)	Pre/Post Entitlement	Period Prior to 10/01	Period On/After 10/01	Total (Col 2 through 4)
		0	1.00	2.00	3.00	4.00	5.00
1.00	DRG amounts other than outlier payments	1.00	0	0	0	0	0
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1	1.01	8,847,282	0	8,847,282		8,847,282
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	2,964,283	0		2,964,283	2,964,283
1.03	DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October 1	1.03	0	0	0		0
1.04	DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1	1.04	0	0		0	0
2.00	Outlier payments for discharges (see instructions)	2.00					
2.01	Outlier payments for discharges for Model 4 BPCI	2.02	0	0	0	0	0
2.02	Outlier payments for discharges occurring prior to October 1 (see instructions)	2.03	57,950	0	57,950		57,950
2.03	Outlier payments for discharges occurring on or after October 1 (see instructions)	2.04	25,946	0		25,946	25,946
3.00	Operating outlier reconciliation	2.01	0	0	0	0	0
4.00	Managed care simulated payments	3.00	0	0	0	0	0
Indirect Medical Education Adjustment							
5.00	Amount from Worksheet E, Part A, line 21 (see instructions)	21.00	0.000000	0.000000	0.000000	0.000000	
6.00	IME payment adjustment (see instructions)	22.00	0	0	0	0	0
6.01	IME payment adjustment for managed care (see instructions)	22.01	0	0	0	0	0
Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA							
7.00	IME payment adjustment factor (see instructions)	27.00	0.000000	0.000000	0.000000	0.000000	
8.00	IME adjustment (see instructions)	28.00	0	0	0	0	0
8.01	IME payment adjustment add on for managed care (see instructions)	28.01	0	0	0	0	0
9.00	Total IME payment (sum of lines 6 and 8)	29.00	0	0	0	0	0
9.01	Total IME payment for managed care (sum of lines 6.01 and 8.01)	29.01	0	0	0	0	0
Disproportionate Share Adjustment							
10.00	Allowable disproportionate share percentage (see instructions)	33.00	0.2089	0.2089	0.2089	0.2089	
11.00	Disproportionate share adjustment (see instructions)	34.00	616,859	0	462,049	154,810	616,859
11.01	Uncompensated care payments	36.00	718,321	0	1,128,418	304,570	1,432,988
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	13,230,641	0	9,781,032	3,449,609	13,230,641
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	13,230,641	0	9,781,032	3,449,609	13,230,641
16.00	Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable)	50.00	983,838	0	-238,985	1,222,823	983,838

LOW VOLUME CALCULATION EXHIBIT 4

Provider CCN: 14-0292

Period:
From 01/01/2020
To 12/31/2020Worksheet E
Part A Exhibit 4
Date/Time Prepared:
7/28/2021 9:55 am

				Title XVIII		Hospital	PPS	
		W/S E, Part A line	Amounts (from E, Part A)	Pre/Post Entitlement	Period Prior to 10/01	Period On/After 10/01	Total (Col 2 through 4)	
		0	1.00	2.00	3.00	4.00	5.00	
17.00	Special add-on payments for new technologies	54.00	59,544	0	0	59,544	59,544	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	9,542,047	4,731,976	14,274,023	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	908,604	0	-220,533	1,129,137	908,604	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	1,819	0	-633	2,452	1,819	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	0.0808	0.0808	0.0808	0.0808		24.00
25.00	Disproportionate share adjustment (see instructions)	11.00	73,415	0	-17,819	91,234	73,415	25.00
26.00	Total prospective capital payments (see instructions)	12.00	983,838	0	-238,985	1,222,823	983,838	26.00
		W/S E, Part A line	(Amounts to E, Part A)					
		0	1.00	2.00	3.00	4.00	5.00	
27.00	Low volume adjustment factor				0.000000	0.000000		27.00
28.00	Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)	70.96			0		0	28.00
29.00	Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)	70.97				0	0	29.00
100.00	Transfer low volume adjustments to Wkst. E, Pt. A.		N					100.00

HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULATION EXHIBIT 5

Provider CCN: 14-0292

Period:
From 01/01/2020
To 12/31/2020Worksheet E
Part A Exhibit 5
Date/Time Prepared:
7/28/2021 9:55 am

		Title XVIII		Hospital		PPS	
		Wkst. E, Pt. A, line	Amt. from Wkst. E, Pt. A)	Period to 10/01	Period on after 10/01	Total (cols. 2 and 3)	
		0	1.00	2.00	3.00	4.00	
1.00	DRG amounts other than outlier payments	1.00					1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1	1.01	8,847,282	8,847,282		8,847,282	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	2,964,283		2,964,283	2,964,283	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	57,950	57,950		57,950	2.02
2.03	Outlier payments for discharges occurring on or after October 1 (see instructions)	2.04	25,946		25,946	25,946	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	0.2089	0.2089	0.2089		10.00
11.00	Disproportionate share adjustment (see instructions)	34.00	616,859	462,049	154,810	616,859	11.00
11.01	Uncompensated care payments	36.00	718,321	1,128,418	303,738	1,432,156	11.01
Additional payment for high percentage of ESRD beneficiary discharges							
12.00	Total ESRD additional payment (see instructions)	46.00	0	0	0	0	12.00
13.00	Subtotal (see instructions)	47.00	13,230,641	9,781,864	3,448,777	13,230,641	13.00
14.00	Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see instructions)	48.00	0	0	0	0	14.00
15.00	Total payment for inpatient operating costs (see instructions)	49.00	13,230,641	9,781,864	3,448,777	13,230,641	15.00
16.00	Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable)	50.00	983,838	-238,985	1,222,823	983,838	16.00
17.00	Special add-on payments for new technologies	54.00	59,544	0	59,544	59,544	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			9,542,879	4,731,144	14,274,023	19.00

HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULATION EXHIBIT 5

Provider CCN: 14-0292

Period:
From 01/01/2020
To 12/31/2020Worksheet E
Part A Exhibit 5
Date/Time Prepared:
7/28/2021 9:55 am

		Title XVIII		Hospital		PPS	
		Wkst. L, line	(Amt. from Wkst. L)				
		0	1.00	2.00	3.00	4.00	
20.00	Capital DRG other than outlier	1.00	908,604	-220,533	1,129,137	908,604	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	1,819	-633	2,452	1,819	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	0.0808	0.0808	0.0808		24.00
25.00	Disproportionate share adjustment (see instructions)	11.00	73,415	-17,819	91,234	73,415	25.00
26.00	Total prospective capital payments (see instructions)	12.00	983,838	-238,985	1,222,823	983,838	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	-14,526	2,788	-17,314	-14,526	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	-3,931	0	-3,931	-3,931	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: 14-0292	Period: From 01/01/2020 To 12/31/2020	Worksheet E Part B Date/Time Prepared: 7/28/2021 9:55 am
		Title XVIII	Hospital	PPS
				1.00
PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)		4,351	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)		3,444,406	2.00
3.00	OPPS payments		3,121,788	3.00
4.00	Outlier payment (see instructions)		9,211	4.00
4.01	Outlier reconciliation amount (see instructions)		0	4.01
5.00	Enter the hospital specific payment to cost ratio (see instructions)		0.000	5.00
6.00	Line 2 times line 5		0	6.00
7.00	Sum of lines 3, 4, and 4.01, divided by line 6		0.00	7.00
8.00	Transitional corridor payment (see instructions)		0	8.00
9.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200		0	9.00
10.00	Organ acquisitions		0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)		4,351	11.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
12.00	Ancillary service charges		21,442	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)		21,442	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)		21,442	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)		17,091	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)		4,351	21.00
22.00	Interns and residents (see instructions)		0	22.00
23.00	Cost of physicians' services in a teaching hospital (see instructions)		0	23.00
24.00	Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)		3,130,999	24.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25.00	Deductibles and coinsurance amounts (for CAH, see instructions)		1,536	25.00
26.00	Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)		517,363	26.00
27.00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions)		2,616,451	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)		2,616,451	30.00
31.00	Primary payer payments		108	31.00
32.00	Subtotal (line 30 minus line 31)		2,616,343	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)		104,196	34.00
35.00	Adjusted reimbursable bad debts (see instructions)		67,727	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		83,621	36.00
37.00	Subtotal (see instructions)		2,684,070	37.00
38.00	MSP-LCC reconciliation amount from PS&R		0	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	39.00
39.50	Pioneer ACO demonstration payment adjustment (see instructions)		0	39.50
39.97	Demonstration payment adjustment amount before sequestration		0	39.97
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)		0	39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION		0	39.99
40.00	Subtotal (see instructions)		2,684,070	40.00
40.01	Sequestration adjustment (see instructions)		17,715	40.01
40.02	Demonstration payment adjustment amount after sequestration		0	40.02
40.03	Sequestration adjustment-PARHM pass-throughs		0	40.03
41.00	Interim payments		2,684,103	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)		-17,748	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: 14-0292

Period:
From 01/01/2020
To 12/31/2020Worksheet E-1
Part I
Date/Time Prepared:
7/28/2021 9:55 am

		Title XVIII		Hospital		PPS
		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		12,945,994		2,600,412	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		271,905		83,691	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	10/16/2020	187,135		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
Provider to Program						
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		187,135		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)		13,405,034		2,684,103	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		0		0	6.01
6.02	SETTLEMENT TO PROGRAM		138,682		17,748	6.02
7.00	Total Medicare program liability (see instructions)		13,266,352		2,666,355	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: 14-0292

Period:

Worksheet E-1

Component CCN: 14-S292

From 01/01/2020
To 12/31/2020Part I
Date/Time Prepared:
7/28/2021 9:55 am

Title XVIII

Subprovider -
IPF

PPS

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider				0	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		1,978,980		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	11/24/2020	52,077		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
Provider to Program						
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		52,077		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)		2,031,057		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		0		0	6.01
6.02	SETTLEMENT TO PROGRAM		14,312		0	6.02
7.00	Total Medicare program liability (see instructions)		2,016,745		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: 14-0292	Period: From 01/01/2020 To 12/31/2020	Worksheet E-1 Part II Date/Time Prepared: 7/28/2021 9:55 am	
		Title XVIII	Hospital	PPS	
				1.00	
TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS					
HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION					
1.00	Total hospital discharges as defined in AARA §4102 from Wkst. S-3, Pt. I col. 15 line 14				1.00
2.00	Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, 8-12				2.00
3.00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2				3.00
4.00	Total inpatient days from S-3, Pt. I col. 8 sum of lines 1, 8-12				4.00
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200				5.00
6.00	Total hospital charity care charges from Wkst. S-10, col. 3 line 20				6.00
7.00	CAH only - The reasonable cost incurred for the purchase of certified HIT technology Wkst. S-2, Pt. I line 168				7.00
8.00	Calculation of the HIT incentive payment (see instructions)				8.00
9.00	Sequestration adjustment amount (see instructions)				9.00
10.00	Calculation of the HIT incentive payment after sequestration (see instructions)				10.00
INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH					
30.00	Initial/interim HIT payment adjustment (see instructions)				30.00
31.00	Other Adjustment (specify)				31.00
32.00	Balance due provider (line 8 (or line 10) minus line 30 and line 31) (see instructions)				32.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0292 Component CCN: 14-S292	Period: From 01/01/2020 To 12/31/2020	Worksheet E-3 Part II Date/Time Prepared: 7/28/2021 9:55 am
		Title XVIII	Subprovider - IPF	PPS
			1.00	
	PART II - MEDICARE PART A SERVICES - IPF PPS			
1.00	Net Federal IPF PPS Payments (excluding outlier, ECT, and medical education payments)		2,133,772	1.00
2.00	Net IPF PPS Outlier Payments		4,949	2.00
3.00	Net IPF PPS ECT Payments		0	3.00
4.00	Unweighted intern and resident FTE count in the most recent cost report filed on or before November 15, 2004. (see instructions)		0.00	4.00
4.01	Cap increases for the unweighted intern and resident FTE count for residents that were displaced by program or hospital closure, that would not be counted without a temporary cap adjustment under 42 CFR §412.424(d)(1)(iii)(F)(1) or (2) (see instructions)		0.00	4.01
5.00	New Teaching program adjustment. (see instructions)		0.00	5.00
6.00	Current year's unweighted FTE count of I&R excluding FTEs in the new program growth period of a "new teaching program" (see instuctions)		0.00	6.00
7.00	Current year's unweighted I&R FTE count for residents within the new program growth period of a "new teaching program" (see instuctions)		0.00	7.00
8.00	Intern and resident count for IPF PPS medical education adjustment (see instructions)		0.00	8.00
9.00	Average Daily Census (see instructions)		8.980874	9.00
10.00	Teaching Adjustment Factor $\{((1 + (\text{line 8/line 9})) \text{ raised to the power of } .5150 - 1\}$.		0.000000	10.00
11.00	Teaching Adjustment (line 1 multiplied by line 10).		0	11.00
12.00	Adjusted Net IPF PPS Payments (sum of lines 1, 2, 3 and 11)		2,138,721	12.00
13.00	Nursing and Allied Health Managed Care payment (see instruction)		0	13.00
14.00	Organ acquisition (DO NOT USE THIS LINE)		0	14.00
15.00	Cost of physicians' services in a teaching hospital (see instructions)		0	15.00
16.00	Subtotal (see instructions)		2,138,721	16.00
17.00	Primary payer payments		0	17.00
18.00	Subtotal (line 16 less line 17).		2,138,721	18.00
19.00	Deductibles		95,480	19.00
20.00	Subtotal (line 18 minus line 19)		2,043,241	20.00
21.00	Coinsurance		47,520	21.00
22.00	Subtotal (line 20 minus line 21)		1,995,721	22.00
23.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)		52,958	23.00
24.00	Adjusted reimbursable bad debts (see instructions)		34,423	24.00
25.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		44,363	25.00
26.00	Subtotal (sum of lines 22 and 24)		2,030,144	26.00
27.00	Direct graduate medical education payments (see instructions)		0	27.00
28.00	Other pass through costs (see instructions)		0	28.00
29.00	Outlier payments reconciliation		0	29.00
30.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	30.00
30.50	Pioneer ACO demonstration payment adjustment (see instructions)		0	30.50
30.99	Demonstration payment adjustment amount before sequestration		0	30.99
31.00	Total amount payable to the provider (see instructions)		2,030,144	31.00
31.01	Sequestration adjustment (see instructions)		13,399	31.01
31.02	Demonstration payment adjustment amount after sequestration		0	31.02
32.00	Interim payments		2,031,057	32.00
33.00	Tentative settlement (for contractor use only)		0	33.00
34.00	Balance due provider/program (line 31 minus lines 31.01, 31.02, 32 and 33)		-14,312	34.00
35.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		0	35.00
TO BE COMPLETED BY CONTRACTOR				
50.00	Original outlier amount from Worksheet E-3, Part II, line 2		4,949	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: 14-0292	Period: From 01/01/2020 To 12/31/2020	Worksheet E-4 Date/Time Prepared: 7/28/2021 9:55 am	
		Title XVIII	Hospital	PPS	
				1.00	
COMPUTATION OF TOTAL DIRECT GME AMOUNT					
1.00	Unweighted resident FTE count for allopathic and osteopathic programs for cost reporting periods ending on or before December 31, 1996.			0.00	1.00
2.00	Unweighted FTE resident cap add-on for new programs per 42 CFR 413.79(e)(1) (see instructions)			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 A	Managed Care	Total	
		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)	8,755	4,186		26.00
27.00	Total Inpatient Days (see instructions)	25,882	25,882		27.00
28.00	Ratio of inpatient days to total inpatient days	0.338266	0.161734		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: 14-0292	Period: From 01/01/2020 To 12/31/2020	Worksheet E-4 Date/Time Prepared: 7/28/2021 9:55 am	
		Title XVIII	Hospital	PPS	
			1.00		
	DIRECT MEDICAL EDUCATION COSTS FOR ESRD COMPOSITE RATE - TITLE XVIII ONLY (NURSING SCHOOL AND PARAMEDICAL EDUCATION COSTS)				
32.00	Renal dialysis direct medical education costs (from Wkst. B, Pt. I, sum of col. 20 and 23, lines 74 and 94)		0		32.00
33.00	Renal dialysis and home dialysis total charges (Wkst. C, Pt. I, col. 8, sum of lines 74 and 94)		0		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)		15,721,641		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)		2,612		40.00
41.00	Total Part A reasonable cost (sum of lines 37 through 39 minus line 40)		15,719,029		41.00
Part B Reasonable Cost					
42.00	Reasonable cost (see instructions)		3,448,757		42.00
43.00	Primary payer payments (see instructions)		108		43.00
44.00	Total Part B reasonable cost (line 42 minus line 43)		3,448,649		44.00
45.00	Total reasonable cost (sum of lines 41 and 44)		19,167,678		45.00
46.00	Ratio of Part A reasonable cost to total reasonable cost (line 41 ÷ line 45)		0.820080		46.00
47.00	Ratio of Part B reasonable cost to total reasonable cost (line 44 ÷ line 45)		0.179920		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: 14-0292

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

Worksheet G

Date/Time Prepared:
7/28/2021 9:55 am

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
CURRENT ASSETS						
1.00	Cash on hand in banks	2,619,435	0	0	0	1.00
2.00	Temporary investments	0	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	34,393,507	0	0	0	4.00
5.00	Other receivable	1,011,836	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-21,919,170	0	0	0	6.00
7.00	Inventory	1,973,945	0	0	0	7.00
8.00	Prepaid expenses	0	0	0	0	8.00
9.00	Other current assets	2,401,984	0	0	0	9.00
10.00	Due from other funds	0	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	20,481,537	0	0	0	11.00
FIXED ASSETS						
12.00	Land	1,820,000	0	0	0	12.00
13.00	Land improvements	647,781	0	0	0	13.00
14.00	Accumulated depreciation	-380,685	0	0	0	14.00
15.00	Buildings	46,007,024	0	0	0	15.00
16.00	Accumulated depreciation	-22,349,455	0	0	0	16.00
17.00	Leasehold improvements	0	0	0	0	17.00
18.00	Accumulated depreciation	0	0	0	0	18.00
19.00	Fixed equipment	9,814,828	0	0	0	19.00
20.00	Accumulated depreciation	-7,747,183	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	17,942,596	0	0	0	23.00
24.00	Accumulated depreciation	-15,889,811	0	0	0	24.00
25.00	Minor equipment depreciable	0	0	0	0	25.00
26.00	Accumulated depreciation	0	0	0	0	26.00
27.00	HIT designated Assets	0	0	0	0	27.00
28.00	Accumulated depreciation	0	0	0	0	28.00
29.00	Minor equipment-nondepreciable	0	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	29,865,095	0	0	0	30.00
OTHER ASSETS						
31.00	Investments	929,020	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	4,858,487	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	5,787,507	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	56,134,139	0	0	0	36.00
CURRENT LIABILITIES						
37.00	Accounts payable	2,606,101	0	0	0	37.00
38.00	Salaries, wages, and fees payable	485,252	0	0	0	38.00
39.00	Payroll taxes payable	3,219,155	0	0	0	39.00
40.00	Notes and loans payable (short term)	0	0	0	0	40.00
41.00	Deferred income	0	0	0	0	41.00
42.00	Accelerated payments	0	0	0	0	42.00
43.00	Due to other funds	0	0	0	0	43.00
44.00	Other current liabilities	22,220,283	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	28,530,791	0	0	0	45.00
LONG TERM LIABILITIES						
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	8,317,148	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	3,088,793	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	11,405,941	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	39,936,732	0	0	0	51.00
CAPITAL ACCOUNTS						
52.00	General fund balance	16,197,407				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)	16,197,407	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	56,134,139	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 14-0292

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

Worksheet G-1

Date/Time Prepared:
7/28/2021 9:55 am

		General Fund		Special Purpose Fund		Endowment Fund	
		1.00	2.00	3.00	4.00	5.00	
1.00	Fund balances at beginning of period		14,882,370		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		14,061,949				2.00
3.00	Total (sum of line 1 and line 2)		28,944,319		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)		28,944,319		0		11.00
12.00	CHANGE IN UNRESTRICTED NET ASSETS	12,746,912		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)		12,746,912		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		16,197,407		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	CHANGE IN UNRESTRICTED NET ASSETS		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: 14-0292

Period:
From 01/01/2020
To 12/31/2020Worksheet G-2
Parts I & II
Date/Time Prepared:
7/28/2021 9:55 am

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
PART I - PATIENT REVENUES					
General Inpatient Routine Services					
1.00	Hospital	27,156,111		27,156,111	1.00
2.00	SUBPROVIDER - IPF	5,437,155		5,437,155	2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	0		0	5.00
6.00	Swing bed - NF	0		0	6.00
7.00	SKILLED NURSING FACILITY				7.00
8.00	NURSING FACILITY				8.00
9.00	OTHER LONG TERM CARE				9.00
10.00	Total general inpatient care services (sum of lines 1-9)	32,593,266		32,593,266	10.00
Intensive Care Type Inpatient Hospital Services					
11.00	INTENSIVE CARE UNIT	7,784,110		7,784,110	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)	7,784,110		7,784,110	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	40,377,376		40,377,376	17.00
18.00	Ancillary services	95,955,535	101,197,984	197,153,519	18.00
19.00	Outpatient services	13,414,032	31,330,751	44,744,783	19.00
20.00	RURAL HEALTH CLINIC	0	0	0	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY				22.00
23.00	AMBULANCE SERVICES				23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	PHARMACY	0	4,205	4,205	27.00
27.01	PHYSICIAN REVENUE	0	315,900	315,900	27.01
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	149,746,943	132,848,840	282,595,783	28.00
PART II - OPERATING EXPENSES					
29.00	Operating expenses (per Wkst. A, column 3, line 200)		99,638,879		29.00
30.00	BAD DEBT	2,435,394			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)		2,435,394		36.00
37.00	NON RECURRING EXPENSES	15,193,413			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)		15,193,413		42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer to Wkst. G-3, line 4)		86,880,860		43.00

STATEMENT OF REVENUES AND EXPENSES

Provider CCN: 14-0292

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

Worksheet G-3

Date/Time Prepared:
7/28/2021 9:55 am

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	282,595,783	1.00
2.00	Less contractual allowances and discounts on patients' accounts	193,734,537	2.00
3.00	Net patient revenues (line 1 minus line 2)	88,861,246	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	86,880,860	4.00
5.00	Net income from service to patients (line 3 minus line 4)	1,980,386	5.00
OTHER INCOME			
6.00	Contributions, donations, bequests, etc	0	6.00
7.00	Income from investments	0	7.00
8.00	Revenues from telephone and other miscellaneous communication services	0	8.00
9.00	Revenue from television and radio service	0	9.00
10.00	Purchase discounts	0	10.00
11.00	Rebates and refunds of expenses	0	11.00
12.00	Parking lot receipts	0	12.00
13.00	Revenue from laundry and linen service	0	13.00
14.00	Revenue from meals sold to employees and guests	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	0	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	0	20.00
21.00	Rental of vending machines	0	21.00
22.00	Rental of hospital space	0	22.00
23.00	Governmental appropriations	0	23.00
24.00	EHR REVENUE; OTHER OPER; NON OPER	9,906,810	24.00
24.50	COVID-19 PHE Funding	2,174,753	24.50
25.00	Total other income (sum of lines 6-24)	12,081,563	25.00
26.00	Total (line 5 plus line 25)	14,061,949	26.00
27.00	OTHER EXPENSES (SPECIFY)	0	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	0	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	14,061,949	29.00

CALCULATION OF CAPITAL PAYMENT		Provider CCN: 14-0292	Period: From 01/01/2020 To 12/31/2020	Worksheet L Parts I-III Date/Time Prepared: 7/28/2021 9:55 am
		Title XVIII	Hospital	PPS
		1.00		
PART I - FULLY PROSPECTIVE METHOD				
CAPITAL FEDERAL AMOUNT				
1.00	Capital DRG other than outlier		908,604	1.00
1.01	Model 4 BPCI Capital DRG other than outlier		0	1.01
2.00	Capital DRG outlier payments		1,819	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)		61.73	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)		6.43	7.00
8.00	Percentage of Medicaid patient days to total days (see instructions)		31.96	8.00
9.00	Sum of lines 7 and 8		38.39	9.00
10.00	Allowable disproportionate share percentage (see instructions)		8.08	10.00
11.00	Disproportionate share adjustment (see instructions)		73,415	11.00
12.00	Total prospective capital payments (see instructions)		983,838	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