

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: 14-1335	Period: From 07/01/2019 To 06/30/2020	Worksheet S Parts I-III Date/Time Prepared: 2/26/2021 10:00 am
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PART I - COST REPORT STATUS

Provider use only	1. ☒ Electronically prepared cost report	Date: 2/26/2021	Time: 10:00 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 HARVARD MEMORIAL HOSPITAL (14-1335) for the cost reporting period beginning 07/01/2019 and ending 06/30/2020 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

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

(Signed)

Officer or Administrator of Provider(s)

Title

Date

Cost Center Description		Title V	Title XVIII		HIT	Title XIX	
			Part A	Part B			
		1.00	2.00	3.00	4.00	5.00	
	PART III - SETTLEMENT SUMMARY						
1.00	Hospital	0	284,854	598,141	0	0	1.00
2.00	Subprovider - IPF	0	0	0		0	2.00
3.00	Subprovider - IRF	0	0	0		0	3.00
5.00	Swing Bed - SNF	0	0	0		0	5.00
6.00	Swing Bed - NF	0				0	6.00
7.00	SKILLED NURSING FACILITY	0	1	-1,074		0	7.00
200.00	Total	0	284,855	597,067	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: 14-1335		Period: From 07/01/2019 To 06/30/2020		Worksheet S-2 Part I Date/Time Prepared: 2/26/2021 10:00 am		
1.00		2.00		3.00		4.00					
Hospital and Hospital Health Care Complex Address:											
1.00	Street: 901 GRANT STREET			PO Box:				1.00			
2.00	City: HARVARD			State: IL		Zip Code: 60033-		County: MC HENRY			
		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		HARVARD MEMORIAL HOSPITAL		141335	16974	1	01/01/2004	N	O	O
4.00	Subprovider - IPF										
5.00	Subprovider - IRF										
6.00	Subprovider - (Other)										
7.00	Swing Beds - SNF										
8.00	Swing Beds - NF										
9.00	Hospital-Based SNF		CARE CENTER		146014	99914		01/01/2002	N	P	N
10.00	Hospital-Based NF										
11.00	Hospital-Based OLTC										
12.00	Hospital-Based HHA										
13.00	Separately Certified ASC										
14.00	Hospital-Based Hospice										
15.00	Hospital-Based Health Clinic - RHC										
16.00	Hospital-Based Health Clinic - FQHC										
17.00	Hospital-Based (CMHC) I										
17.10	Hospital-Based (CORF) I										
18.00	Renal Dialysis										
19.00	Other										
							From:	To:			
							1.00	2.00			
20.00	Cost Reporting Period (mm/dd/yyyy)							07/01/2019	06/30/2020		20.00
21.00	Type of Control (see instructions)							2			21.00
							1.00	2.00		3.00	
Inpatient PPS Information											
22.00	Does this facility qualify and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.106(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no.					N	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)					N	N			22.01	
22.02	Is this a newly merged hospital that requires final uncompensated care payments to be determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1.					N	N			22.02	
22.03	Did this hospital receive a geographic reclassification from urban to rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no.					N	N	N		22.03	
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.					3	N			23.00	
				In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of-State Medicaid paid days	Out-of-State Medicaid eligible unpaid days	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.			0	0	0	0	0	0		

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

Provider CCN: 14-1335

Period:
From 07/01/2019
To 06/30/2020Worksheet S-2
Part I
Date/Time Prepared:
2/26/2021 10:00 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.					2		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.					2		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	N	N
46.00	Is this facility eligible for additional payment exception for extraordinary circumstances pursuant to 42 CFR §412.348(f)? If yes, complete Wkst. L, Pt. III and Wkst. L-1, Pt. I through Pt. III.					N	N	N
47.00	Is this a new hospital under 42 CFR §412.300(b) PPS capital? Enter "Y" for yes or "N" for no.					N	N	N
48.00	Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.					N	N	N
Teaching Hospitals								
56.00	Is this a hospital involved in training residents in approved GME programs? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", are you impacted by CR 11642 (or subsequent CR), MA GME payment reduction? Enter "Y" for yes or "N" for no in column 2.					N		
57.00	If line 56 is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y" did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If column 2 is "N", complete Wkst. D, Parts III & IV and D-2, Pt. II, if applicable.							
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: 14-1335

Period:
From 07/01/2019
To 06/30/2020Worksheet S-2
Part I
Date/Time Prepared:
2/26/2021 10:00 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: 14-1335

Period:
From 07/01/2019
To 06/30/2020Worksheet S-2
Part I
Date/Time Prepared:
2/26/2021 10:00 am

	Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))		
	1.00	2.00	3.00	4.00	5.00		
65.00	Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the program name associated with primary care FTEs for each primary care program in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)		0.00	0.00	0.000000	65.00	
			Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))		
			1.00	2.00	3.00		
66.00	Section 5504 of the ACA Current Year FTE Residents in Nonprovider Settings--Effective for cost reporting periods beginning on or after July 1, 2010						
	Enter in column 1 the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)		0.00	0.00	0.000000	66.00	
			Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))		
			1.00	2.00	5.00		
67.00	Enter in column 1, the program name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)		0.00	0.00	0.000000	67.00	
			1.00	2.00	3.00		
70.00	Inpatient Psychiatric Facility PPS						
	Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? Enter "Y" for yes or "N" for no.				N	70.00	
71.00	If line 70 is yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost report filed on or before November 15, 2004? Enter "Y" for yes or "N" for no. (see 42 CFR 412.424(d)(1)(iii)(c)) Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)					0	71.00
	Inpatient Rehabilitation Facility PPS						
75.00	Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF subprovider? Enter "Y" for yes and "N" for no.				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: 14-1335	Period: From 07/01/2019 To 06/30/2020	Worksheet S-2 Part I Date/Time Prepared: 2/26/2021 10:00 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	N	90.00	
91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.	N	Y	91.00	
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.		N	92.00	
93.00	Does this facility operate an ICF/IID facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.	N	N	93.00	
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.	N	N	94.00	
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	95.00	
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.	N	N	96.00	
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	97.00	
98.00	Does title V or XIX follow Medicare (title XVIII) for the interns and residents post stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.00	
98.01	Does title V or XIX follow Medicare (title XVIII) for the reporting of charges on Wkst. C, Pt. I? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.01	
98.02	Does title V or XIX follow Medicare (title XVIII) for the calculation of observation bed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.02	
98.03	Does title V or XIX follow Medicare (title XVIII) for a critical access hospital (CAH) reimbursed 101% of inpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.03	
98.04	Does title V or XIX follow Medicare (title XVIII) for a CAH reimbursed 101% of outpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.04	
98.05	Does title V or XIX follow Medicare (title XVIII) and add back the RCE disallowance on Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.05	
98.06	Does title V or XIX follow Medicare (title XVIII) when cost reimbursed for Wkst. D, Pts. I through IV? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.06	
Rural Providers					
105.00	Does this hospital qualify as a CAH?	Y		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)	Y		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)	N		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: 14-1335	Period: From 07/01/2019 To 06/30/2020	Worksheet S-2 Part I Date/Time Prepared: 2/26/2021 10:00 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		0115.00
116.00	Is this facility classified as a referral center? Enter "Y" for yes or "N" for no.	N		116.00
117.00	Is this facility legally required to carry malpractice insurance? Enter "Y" for yes or "N" for no.	Y		117.00
118.00	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.	2		118.00
		Premiums	Losses	Insurance
		1.00	2.00	3.00
118.01	List amounts of malpractice premiums and paid losses:	166,180	0	0118.01
		1.00	2.00	
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein.	N		118.02
119.00	DO NOT USE THIS LINE			119.00
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 1, "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2, "Y" for yes or "N" for no.	N	N	120.00
121.00	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter "Y" for yes or "N" for no.	Y		121.00
122.00	Does the cost report contain healthcare related taxes as defined in §1903(w)(3) of the Act? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2 the Worksheet A line number where these taxes are included.	N		122.00
Transplant Center Information				
125.00	Does this facility operate a transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.	N		125.00
126.00	If this is a Medicare certified kidney transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			126.00
127.00	If this is a Medicare certified heart transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			127.00
128.00	If this is a Medicare certified liver transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			128.00
129.00	If this is a Medicare certified lung transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			129.00
130.00	If this is a Medicare certified pancreas transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			130.00
131.00	If this is a Medicare certified intestinal transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			131.00
132.00	If this is a Medicare certified islet transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			132.00
133.00	Removed and reserved			133.00
134.00	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.			134.00
All Providers				
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)	Y	HB0764	140.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA				Provider CCN: 14-1335		Period: From 07/01/2019 To 06/30/2020		Worksheet S-2 Part I Date/Time Prepared: 2/26/2021 10:00 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: MERCY HOME OFFICE		Contractor's Name: NGS		Contractor's Number: 00450				141.00
142.00	Street: 1000 MINERAL POINT AVE		PO Box:						142.00
143.00	City: JANESVILLE		State: WI		Zip Code: 53547				143.00
									1.00
144.00	Are provider based physicians' costs included in Worksheet A?								Y
									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.						N		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.								146.00
									1.00
147.00	Was there a change in the statistical basis? Enter "Y" for yes or "N" for no.								N
148.00	Was there a change in the order of allocation? Enter "Y" for yes or "N" for no.								N
149.00	Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no.								N
				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			Y	Y	N	N		
156.00	Subprovider - IPF			N	N	N	N		
157.00	Subprovider - IRF			N	N	N	N		
158.00	SUBPROVIDER								
159.00	SNF			N	N	N	N		
160.00	HOME HEALTH AGENCY			N	N	N	N		
161.00	CMHC				N	N	N		
161.10	CORF				N	N	N		
									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
				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
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)								
168.01	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)								N
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
						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: 14-1335	Period: From 07/01/2019 To 06/30/2020	Worksheet S-2 Part II Date/Time Prepared: 2/26/2021 10:00 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.	Y	A	4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.	N		5.00
			Y/N 1.00	Legal Oper. 2.00
Approved Educational Activities				
6.00	Column 1: Are costs claimed for nursing school? Column 2: If yes, is the provider is the legal operator of the program?	N		6.00
7.00	Are costs claimed for Allied Health Programs? If "Y" see instructions.	N		7.00
8.00	Were nursing school and/or allied health programs approved and/or renewed during the cost reporting period? If yes, see instructions.	N		8.00
9.00	Are costs claimed for Interns and Residents in an approved graduate medical education program in the current cost report? If yes, see instructions.	N		9.00
10.00	Was an approved Intern and Resident GME program initiated or renewed in the current cost reporting period? If yes, see instructions.	N		10.00
11.00	Are GME cost directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions.	N		11.00
			Y/N 1.00	
Bad Debts				
12.00	Is the provider seeking reimbursement for bad debts? If yes, see instructions.	Y		12.00
13.00	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.	N		13.00
14.00	If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.	N		14.00
Bed Complement				
15.00	Did total beds available change from the prior cost reporting period? If yes, see instructions.	N		15.00
		Part A		Part B
		Y/N 1.00	Date 2.00	Y/N 3.00
				Date 4.00
PS&R Data				
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)	N		16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	Y	10/19/2020	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: 14-1335	Period: From 07/01/2019 To 06/30/2020	Worksheet S-2 Part II Date/Time Prepared: 2/26/2021 10:00 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
		Y/N	Date	Y/N
		1.00	2.00	3.00
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N	N	
				1.00
COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)				
Capital Related Cost				
22.00	Have assets been relifed for Medicare purposes? If yes, see instructions		N	22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.		N	23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions		N	24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.		N	25.00
26.00	Were assets subject to Sec.2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.		N	26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.		N	27.00
Interest Expense				
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.		Y	28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions		N	29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.		Y	30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.		N	31.00
Purchased Services				
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.		N	32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.		N	33.00
Provider-Based Physicians				
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.		Y	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.		Y	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.		Y	39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.		Y	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.	JENNY	DABROWSKI	41.00
42.00	Enter the employer/company name of the cost report preparer.	STRATEGIC REIMBURSEMENT GROUP, LLC		42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	630-530-7100	JENNY.DABROWSKI@SRGROUPLLC.COM	43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE

Provider CCN: 14-1335

Period:
From 07/01/2019
To 06/30/2020Worksheet S-2
Part II
Date/Time Prepared:
2/26/2021 10:00 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.	MANAGER	41.00
42.00	Enter the employer/company name of the cost report preparer.		42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.		43.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 14-1335

Period:
From 07/01/2019
To 06/30/2020Worksheet S-3
Part I
Date/Time Prepared:
2/26/2021 10:00 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	10	3,660	27,364.00	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)		10	3,660	27,364.00	0	7.00
8.00 INTENSIVE CARE UNIT	31.00	3	1,098	0.00	0	8.00
9.00 CORONARY CARE UNIT						9.00
10.00 BURN INTENSIVE CARE UNIT						10.00
11.00 SURGICAL INTENSIVE CARE UNIT						11.00
12.00 OTHER SPECIAL CARE (SPECIFY)						12.00
13.00 NURSERY						13.00
14.00 Total (see instructions)		13	4,758	27,364.00	0	14.00
15.00 CAH visits					0	15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY	44.00	12	4,392		0	19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE	46.00	33	12,078			21.00
22.00 HOME HEALTH AGENCY						22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
24.10 HOSPICE (non-distinct part)	30.00					24.10
25.00 CMHC - CMHC						25.00
25.10 CMHC - CORF	99.10				0	25.10
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)		58				27.00
28.00 Observation Bed Days					0	28.00
29.00 Ambulance Trips						29.00
30.00 Employee discount days (see instruction)						30.00
31.00 Employee discount days - IRF						31.00
32.00 Labor & delivery days (see instructions)		0	0			32.00
32.01 Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00 LTCH non-covered days						33.00
33.01 LTCH site neutral days and discharges						33.01

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 14-1335

Period:
From 07/01/2019
To 06/30/2020Worksheet S-3
Part I
Date/Time Prepared:
2/26/2021 10:00 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)	567	15	1,041			1.00
2.00	HMO and other (see instructions)	6	50				2.00
3.00	HMO IPF Subprovider	0	0				3.00
4.00	HMO IRF Subprovider	0	0				4.00
5.00	Hospital Adults & Peds. Swing Bed SNF	0	0	0			5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	0			6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	567	15	1,041			7.00
8.00	INTENSIVE CARE UNIT	28	0	95			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)	595	15	1,136	0.00	152.63	14.00
15.00	CAH visits	0	0	0			15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY	1,237	0	2,111	0.00	7.54	19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE			5,651	0.00	9.23	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)			0			24.10
25.00	CMHC - CMHC						25.00
25.10	CMHC - CORF	0	0	0	0.00	0.00	25.10
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	169.40	27.00
28.00	Observation Bed Days		4	268			28.00
29.00	Ambulance Trips	0					29.00
30.00	Employee discount days (see instruction)			0			30.00
31.00	Employee discount days - IRF			0			31.00
32.00	Labor & delivery days (see instructions)	0	0	0			32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)			0			32.01
33.00	LTCH non-covered days	0					33.00
33.01	LTCH site neutral days and discharges	0					33.01

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 14-1335

Period:
From 07/01/2019
To 06/30/2020Worksheet S-3
Part I
Date/Time Prepared:
2/26/2021 10:00 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	195	6	456	1.00
2.00 HMO and other (see instructions)			3	36		2.00
3.00 HMO IPF Subprovider				0		3.00
4.00 HMO IRF Subprovider				0		4.00
5.00 Hospital Adults & Peds. Swing Bed SNF						5.00
6.00 Hospital Adults & Peds. Swing Bed NF						6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)						7.00
8.00 INTENSIVE CARE UNIT						8.00
9.00 CORONARY CARE UNIT						9.00
10.00 BURN INTENSIVE CARE UNIT						10.00
11.00 SURGICAL INTENSIVE CARE UNIT						11.00
12.00 OTHER SPECIAL CARE (SPECIFY)						12.00
13.00 NURSERY						13.00
14.00 Total (see instructions)	0.00	0	195	6	456	14.00
15.00 CAH visits						15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY	0.00					19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE	0.00				0	21.00
22.00 HOME HEALTH AGENCY						22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
24.10 HOSPICE (non-distinct part)						24.10
25.00 CMHC - CMHC						25.00
25.10 CMHC - CORF	0.00					25.10
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 RELATED COSTS

Provider CCN: 14-1335

Period:
From 07/01/2019
To 06/30/2020Worksheet S-3
Part IV
Date/Time Prepared:
2/26/2021 10:00 am

		Amount Reported	
		1.00	
PART IV - WAGE RELATED COSTS			
Part A - Core List			
RETIREMENT COST			
1.00	401K Employer Contributions	0	1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution	0	2.00
3.00	Nonqualified Defined Benefit Plan Cost (see instructions)	0	3.00
4.00	Qualified Defined Benefit Plan Cost (see instructions)	0	4.00
PLAN ADMINISTRATIVE COSTS (Paid to External Organization)			
5.00	401K/TSA Plan Administration fees	0	5.00
6.00	Legal/Accounting/Management Fees-Pension Plan	0	6.00
7.00	Employee Managed Care Program Administration Fees	0	7.00
HEALTH AND INSURANCE COST			
8.00	Health Insurance (Purchased or Self Funded)	0	8.00
8.01	Health Insurance (Self Funded without a Third Party Administrator)	0	8.01
8.02	Health Insurance (Self Funded with a Third Party Administrator)	0	8.02
8.03	Health Insurance (Purchased)	0	8.03
9.00	Prescription Drug Plan	0	9.00
10.00	Dental, Hearing and Vision Plan	0	10.00
11.00	Life Insurance (If employee is owner or beneficiary)	0	11.00
12.00	Accident Insurance (If employee is owner or beneficiary)	0	12.00
13.00	Disability Insurance (If employee is owner or beneficiary)	0	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)	0	14.00
15.00	'Workers' Compensation Insurance	0	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	0	17.00
18.00	Medicare Taxes - Employers Portion Only	0	18.00
19.00	Unemployment Insurance	0	19.00
20.00	State or Federal Unemployment Taxes	0	20.00
OTHER			
21.00	Executive Deferred Compensation (Other Than Retirement Cost Reported on lines 1 through 4 above. (see instructions))	0	21.00
22.00	Day Care Cost and Allowances	0	22.00
23.00	Tuition Reimbursement	0	23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)	0	24.00
Part B - Other than Core Related Cost			
25.00	OTHER WAGE RELATED COSTS (SPECIFY)		25.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA

Provider CCN: 14-1335

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

Worksheet S-10

Date/Time Prepared:
2/26/2021 10:00 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)		0.355962	1.00
Medicaid (see instructions for each line)				
2.00	Net revenue from Medicaid		3,299,928	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?		N	4.00
5.00	If line 4 is no, then enter DSH and/or supplemental payments from Medicaid		1,948,029	5.00
6.00	Medicaid charges		11,898,203	6.00
7.00	Medicaid cost (line 1 times line 6)		4,235,308	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		10,866	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)	603,087	95,533	698,620
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	214,676	95,533	310,209
22.00	Payments received from patients for amounts previously written off as charity care	0	0	0
23.00	Cost of charity care (line 21 minus line 22)	214,676	95,533	310,209
			1.00	
24.00	Does the amount on line 20 column 2, include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?		N	24.00
25.00	If line 24 is yes, enter the charges for patient days beyond the indigent care program's length of stay limit		0	25.00
26.00	Total bad debt expense for the entire hospital complex (see instructions)		2,652,312	26.00
27.00	Medicare reimbursable bad debts for the entire hospital complex (see instructions)		269,688	27.00
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)		414,904	27.01
28.00	Non-Medicare bad debt expense (see instructions)		2,237,408	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)		941,648	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)		1,251,857	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)		1,251,857	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-1335

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

Worksheet A

Date/Time Prepared:
2/26/2021 10:00 am

Cost Center Description			Salaries	Other	Total (col. 1 + col. 2)	Reclassification ons (See A-6)	Reclassified Trial Balance (col. 3 +- col. 4)	
			1.00	2.00	3.00	4.00	5.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT		0	0	1,092,917	1,092,917	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		1,851,048	1,851,048	-1,092,917	758,131	2.00
3.00	00300	OTHER CAP REL COSTS		0	0	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	34,578	1,732,049	1,766,627	0	1,766,627	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	981,829	2,313,397	3,295,226	-357,516	2,937,710	5.00
6.00	00600	MAINTENANCE & REPAIRS	0	0	0	0	0	6.00
7.00	00700	OPERATION OF PLANT	0	692,455	692,455	0	692,455	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	4,383	4,383	0	4,383	8.00
9.00	00900	HOUSEKEEPING	213,877	109,598	323,475	0	323,475	9.00
10.00	01000	DIETARY	426,920	181,340	608,260	0	608,260	10.00
11.00	01100	CAFETERIA	0	0	0	0	0	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	759,513	76,094	835,607	176,459	1,012,066	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	0	14.00
15.00	01500	PHARMACY	0	0	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	132,718	10,528	143,246	9,723	152,969	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
20.00	02000	NURSING SCHOOL	0	0	0	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0	22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	848,941	177,905	1,026,846	-25,026	1,001,820	30.00
31.00	03100	INTENSIVE CARE UNIT	241,233	31,512	272,745	-1,941	270,804	31.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	559,525	559,525	44.00
46.00	04600	OTHER LONG TERM CARE	1,644,373	534,406	2,178,779	-1,215,408	963,371	46.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	798,560	1,942,021	2,740,581	-1,098,282	1,642,299	50.00
51.00	05100	RECOVERY ROOM	591,631	160,650	752,281	-35,393	716,888	51.00
53.00	05300	ANESTHESIOLOGY	100,268	1,509,777	1,610,045	0	1,610,045	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	844,754	306,056	1,150,810	-36,842	1,113,968	54.00
60.00	06000	LABORATORY	455,776	480,032	935,808	52,225	988,033	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	144,281	65,179	209,460	-1,178	208,282	65.00
66.00	06600	PHYSICAL THERAPY	174,863	5,512	180,375	265,567	445,942	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	241,086	241,086	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	43,613	43,613	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	61,787	13,252	75,039	765,939	840,978	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	551,906	551,906	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	201,621	749,152	950,773	141,117	1,091,890	73.00
76.97	07697	CARDIAC REHABILITATION	24,894	3,417	28,311	19,704	48,015	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
91.00	09100	EMERGENCY	1,062,302	2,195,117	3,257,419	-55,278	3,202,141	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
OTHER REIMBURSABLE COST CENTERS								
99.10	09910	CORF	0	0	0	0	0	99.10
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	9,744,719	15,144,880	24,889,599	0	24,889,599	118.00
NONREIMBURSABLE COST CENTERS								
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
200.00		TOTAL (SUM OF LINES 118 through 199)	9,744,719	15,144,880	24,889,599	0	24,889,599	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-1335

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

Worksheet A

Date/Time Prepared:
2/26/2021 10:00 am

Cost Center Description			Adjustments (See A-8)	Net Expenses For Allocation	
			6.00	7.00	
GENERAL SERVICE COST CENTERS					
1.00	00100	CAP REL COSTS-BLDG & FIXT	0	1,092,917	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	19,303	777,434	2.00
3.00	00300	OTHER CAP REL COSTS	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	597,614	2,364,241	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	1,219,120	4,156,830	5.00
6.00	00600	MAINTENANCE & REPAIRS	0	0	6.00
7.00	00700	OPERATION OF PLANT	572,411	1,264,866	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	4,383	8.00
9.00	00900	HOUSEKEEPING	0	323,475	9.00
10.00	01000	DIETARY	-91,811	516,449	10.00
11.00	01100	CAFETERIA	0	0	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	0	1,012,066	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	14.00
15.00	01500	PHARMACY	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	123,628	276,597	16.00
17.00	01700	SOCIAL SERVICE	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	19.00
20.00	02000	NURSING SCHOOL	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	0	1,001,820	30.00
31.00	03100	INTENSIVE CARE UNIT	0	270,804	31.00
44.00	04400	SKILLED NURSING FACILITY	-12,505	547,020	44.00
46.00	04600	OTHER LONG TERM CARE	-38,682	924,689	46.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	-1,133	1,641,166	50.00
51.00	05100	RECOVERY ROOM	0	716,888	51.00
53.00	05300	ANESTHESIOLOGY	-1,427,886	182,159	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-400	1,113,568	54.00
60.00	06000	LABORATORY	0	988,033	60.00
60.01	06001	BLOOD LABORATORY	0	0	60.01
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0	208,282	65.00
66.00	06600	PHYSICAL THERAPY	0	445,942	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	241,086	67.00
68.00	06800	SPEECH PATHOLOGY	0	43,613	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	48,288	889,266	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	551,906	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	12,605	1,104,495	73.00
76.97	07697	CARDIAC REHABILITATION	0	48,015	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	76.99
OUTPATIENT SERVICE COST CENTERS					
91.00	09100	EMERGENCY	-246,058	2,956,083	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART			92.00
OTHER REIMBURSABLE COST CENTERS					
99.10	09910	CORF	0	0	99.10
SPECIAL PURPOSE COST CENTERS					
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	774,494	25,664,093	118.00
NONREIMBURSABLE COST CENTERS					
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	192.00
200.00		TOTAL (SUM OF LINES 118 through 199)	774,494	25,664,093	200.00

RECLASSIFICATIONS

Provider CCN: 14-1335

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

Worksheet A-6

Date/Time Prepared:
2/26/2021 10:00 am

	Increases					
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
	A - SNF/LONG TERM CARE EXP RECLASS					
1.00	SKILLED NURSING FACILITY	44.00	449,690	109,835		1.00
	TOTALS		449,690	109,835		
	B - IMPLANTABLE DEVICES					
1.00	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	551,906		1.00
	TOTALS		0	551,906		
	C - MANAGER/DIRECTOR RECLASS					
1.00	NURSING ADMINISTRATION	13.00	164,483	11,976		1.00
2.00	MEDICAL RECORDS & LIBRARY	16.00	9,063	660		2.00
3.00	OTHER LONG TERM CARE	46.00	141,339	10,291		3.00
4.00	CARDIAC REHABILITATION	76.97	18,367	1,337		4.00
	TOTALS		333,252	24,264		
	D - INTERCOMPANY TRANSACTIONS					
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	58,293	0		1.00
2.00	ADMINISTRATIVE & GENERAL	5.00	399,064	0		2.00
3.00	OPERATION OF PLANT	7.00	166,800	0		3.00
4.00	ADULTS & PEDIATRICS	30.00	6,278	0		4.00
5.00	INTENSIVE CARE UNIT	31.00	3,023	0		5.00
6.00	ANESTHESIOLOGY	53.00	15,400	0		6.00
7.00	RADIOLOGY-DIAGNOSTIC	54.00	0	13,768		7.00
8.00	RESPIRATORY THERAPY	65.00	3,857	0		8.00
9.00	DRUGS CHARGED TO PATIENTS	73.00	104,649	0		9.00
	TOTALS		757,364	13,768		
	E - SNF AND LTC RECLASS					
1.00	RADIOLOGY-DIAGNOSTIC	54.00	13,167	3,216		1.00
2.00	LABORATORY	60.00	41,973	10,252		2.00
4.00	PHYSICAL THERAPY	66.00	213,463	52,137		4.00
5.00	OCCUPATIONAL THERAPY	67.00	193,761	47,325		5.00
6.00	SPEECH PATHOLOGY	68.00	35,052	8,561		6.00
7.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	38,167	9,322		7.00
8.00	DRUGS CHARGED TO PATIENTS	73.00	113,416	27,701		8.00
	TOTALS		648,999	158,514		
	F - DEPRECIATION					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	1,092,917		1.00
	TOTALS		0	1,092,917		
	G - LOCUM SALARY RECLASS					
1.00	ANESTHESIOLOGY	53.00	1,437,379	0		1.00
2.00	EMERGENCY	91.00	1,779,282	0		2.00
	TOTALS		3,216,661	0		
	H - MEDICAL SUPPLIES CHARGED TO PATIENT					
1.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	718,450		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
	TOTALS		0	718,450		
500.00	Grand Total: Increases		5,405,966	2,669,654		500.00

RECLASSIFICATIONS

Provider CCN: 14-1335

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

Worksheet A-6

Date/Time Prepared:
2/26/2021 10:00 am

	Decreases						2/26/2021 10:00 am
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	A - SNF/LONG TERM CARE EXP RECLASS						
1.00	OTHER LONG TERM CARE	46.00	449,690	109,835	0		1.00
	TOTALS		449,690	109,835			
	B - IMPLANTABLE DEVICES						
1.00	OPERATING ROOM	50.00	0	551,906	0		1.00
	TOTALS		0	551,906			
	C - MANAGER/DIRECTOR RECLASS						
1.00	ADMINISTRATIVE & GENERAL	5.00	333,252	24,264	0		1.00
2.00		0.00	0	0	0		2.00
3.00		0.00	0	0	0		3.00
4.00		0.00	0	0	0		4.00
	TOTALS		333,252	24,264			
	D - INTERCOMPANY TRANSACTIONS						
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	58,293	0		1.00
2.00	ADMINISTRATIVE & GENERAL	5.00	0	399,064	0		2.00
3.00	OPERATION OF PLANT	7.00	0	166,800	0		3.00
4.00	ADULTS & PEDIATRICS	30.00	0	6,278	0		4.00
5.00	INTENSIVE CARE UNIT	31.00	0	3,023	0		5.00
6.00	ANESTHESIOLOGY	53.00	0	15,400	0		6.00
7.00	RADIOLOGY-DIAGNOSTIC	54.00	13,768	0	0		7.00
8.00	RESPIRATORY THERAPY	65.00	0	3,857	0		8.00
9.00	DRUGS CHARGED TO PATIENTS	73.00	0	104,649	0		9.00
	TOTALS		13,768	757,364			
	E - SNF AND LTC RECLASS						
1.00	OTHER LONG TERM CARE	46.00	648,999	158,514	0		1.00
2.00		0.00	0	0	0		2.00
4.00		0.00	0	0	0		4.00
5.00		0.00	0	0	0		5.00
6.00		0.00	0	0	0		6.00
7.00		0.00	0	0	0		7.00
8.00		0.00	0	0	0		8.00
	TOTALS		648,999	158,514			
	F - DEPRECIATION						
1.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	1,092,917	9		1.00
	TOTALS		0	1,092,917			
	G - LOCUM SALARY RECLASS						
1.00	ANESTHESIOLOGY	53.00	0	1,437,379	0		1.00
2.00	EMERGENCY	91.00	0	1,779,282	0		2.00
	TOTALS		0	3,216,661			
	H - MEDICAL SUPPLIES CHARGED TO PATIENT						
1.00	ADULTS & PEDIATRICS	30.00	0	25,026	0		1.00
2.00	INTENSIVE CARE UNIT	31.00	0	1,941	0		2.00
3.00	OPERATING ROOM	50.00	0	546,376	0		3.00
4.00	RECOVERY ROOM	51.00	0	35,393	0		4.00
5.00	RADIOLOGY-DIAGNOSTIC	54.00	0	53,225	0		5.00
6.00	RESPIRATORY THERAPY	65.00	0	1,178	0		6.00
7.00	PHYSICAL THERAPY	66.00	0	33	0		7.00
8.00	EMERGENCY	91.00	0	55,278	0		8.00
	TOTALS		0	718,450			
500.00	Grand Total: Decreases		1,445,709	6,629,911			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-1335

Period:
From 07/01/2019
To 06/30/2020Worksheet A-7
Part I
Date/Time Prepared:
2/26/2021 10:00 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	222,604	0	0	0	0	1.00	
2.00	Land Improvements	838,809	13,500	0	13,500	0	2.00	
3.00	Buildings and Fixtures	0	0	0	0	0	3.00	
4.00	Building Improvements	21,336,776	729,688	0	729,688	0	4.00	
5.00	Fixed Equipment	0	0	0	0	0	5.00	
6.00	Movable Equipment	16,656,527	1,170,607	0	1,170,607	0	6.00	
7.00	HIT designated Assets	0	0	0	0	0	7.00	
8.00	Subtotal (sum of lines 1-7)	39,054,716	1,913,795	0	1,913,795	0	8.00	
9.00	Reconciling Items	0	0	0	0	0	9.00	
10.00	Total (line 8 minus line 9)	39,054,716	1,913,795	0	1,913,795	0	10.00	
		Ending Balance	Fully Depreciated Assets					
		6.00	7.00					
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES							
1.00	Land	222,604	0				1.00	
2.00	Land Improvements	852,309	0				2.00	
3.00	Buildings and Fixtures	0	0				3.00	
4.00	Building Improvements	22,066,464	0				4.00	
5.00	Fixed Equipment	0	0				5.00	
6.00	Movable Equipment	17,827,134	0				6.00	
7.00	HIT designated Assets	0	0				7.00	
8.00	Subtotal (sum of lines 1-7)	40,968,511	0				8.00	
9.00	Reconciling Items	0	0				9.00	
10.00	Total (line 8 minus line 9)	40,968,511	0				10.00	

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-1335

Period:
From 07/01/2019
To 06/30/2020Worksheet A-7
Part II
Date/Time Prepared:
2/26/2021 10:00 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	1,851,048	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	1,851,048	0	0	0	0	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Other	Total (1) (sum				
		Capital-Relate	of cols. 9				
		d Costs (see	through 14)				
		instructions)					
		14.00	15.00				
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	CAP REL COSTS-BLDG & FIXT	0	0				1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	1,851,048				2.00
3.00	Total (sum of lines 1-2)	0	1,851,048				3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-1335

Period:
From 07/01/2019
To 06/30/2020Worksheet A-7
Part III
Date/Time Prepared:
2/26/2021 10:00 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	23,141,376	0	23,141,376	0.564858	0	1.00	
2.00	CAP REL COSTS-MVBLE EQUIP	17,827,134	0	17,827,134	0.435142	0	2.00	
3.00	Total (sum of lines 1-2)	40,968,510	0	40,968,510	1.000000	0	3.00	
Cost Center Description		ALLOCATION OF OTHER CAPITAL			SUMMARY OF CAPITAL			
		Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	Depreciation	Lease		
		6.00	7.00	8.00	9.00	10.00		
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	1,092,917	0	1.00	
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	777,434	0	2.00	
3.00	Total (sum of lines 1-2)	0	0	0	1,870,351	0	3.00	
Cost Center Description		SUMMARY OF CAPITAL						
		Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (2) (sum of cols. 9 through 14)		
		11.00	12.00	13.00	14.00	15.00		
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	0	1,092,917	1.00	
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	0	777,434	2.00	
3.00	Total (sum of lines 1-2)	0	0	0	0	1,870,351	3.00	

ADJUSTMENTS TO EXPENSES

Provider CCN: 14-1335

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

Worksheet A-8

Date/Time Prepared:
2/26/2021 10:00 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)		0		0.00	0	7.00
8.00	Television and radio service (chapter 21)	A	-4,009	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	-1,841,812			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	3,470,552			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests	B	-91,811	DIETARY	10.00	0	14.00
15.00	Rental of quarters to employee and others		0		0.00	0	15.00
16.00	Sale of medical and surgical supplies to other than patients		0		0.00	0	16.00
17.00	Sale of drugs to other than patients		0		0.00	0	17.00
18.00	Sale of medical records and abstracts	B	-714	MEDICAL RECORDS & LIBRARY	16.00	0	18.00
19.00	Nursing and allied health education (tuition, fees, books, etc.)		0		0.00	0	19.00
20.00	Vending machines		0		0.00	0	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	0	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	RESPIRATORY THERAPY	65.00		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	PHYSICAL THERAPY	66.00		24.00
25.00	Utilization review - physicians' compensation (chapter 21)		0	*** Cost Center Deleted ***	114.00		25.00
26.00	Depreciation - CAP REL COSTS-BLDG & FIXT		0	CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	27.00
28.00	Non-physician Anesthetist		0	NONPHYSICIAN ANESTHETISTS	19.00		28.00
29.00	Physicians' assistant		0		0.00	0	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	OCCUPATIONAL THERAPY	67.00		30.00
30.99	Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS	30.00		30.99
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	SPEECH PATHOLOGY	68.00		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest		0		0.00	0	32.00
33.00	OTHER OPERATING REVENUE	B	-450	ADMINISTRATIVE & GENERAL	5.00	0	33.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 14-1335

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

Worksheet A-8

Date/Time Prepared:
2/26/2021 10:00 am

Cost Center Description		Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted		Wkst. A-7 Ref.	
				Cost Center	Line #		
		1.00	2.00	3.00	4.00	5.00	
34.00	ILLINOIS UNALLOWABLE REAL ESTAT	A	-7,822	OPERATION OF PLANT	7.00	0	34.00
35.00	LOBBYING EXPENSE	A	-5,992	ADMINISTRATIVE & GENERAL	5.00	0	35.00
37.00	HOSPITAL TAX	A	-686,175	ADMINISTRATIVE & GENERAL	5.00	0	37.00
39.00	CASH DISCOUNTS	B	-86	ADMINISTRATIVE & GENERAL	5.00	0	39.00
42.00	SNF TAX	A	-15,553	SKILLED NURSING FACILITY	44.00	0	42.00
43.00	CARE CENTER TAX	A	-41,634	OTHER LONG TERM CARE	46.00	0	43.00
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		774,494				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: 14-1335

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

Worksheet A-8-1

Date/Time Prepared:
2/26/2021 10:00 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		4.00	EMPLOYEE BENEFITS DEPARTMENT	HOME OFFICE EMPLOYEE BENEFIT	664,540	66,926 1.00
2.00		5.00	ADMINISTRATIVE & GENERAL	HOME OFFICE ADMIN & GENERAL	2,882,287	1,042,726 2.00
3.00		7.00	OPERATION OF PLANT	HOME OFFICE OPERATION OF PLA	584,242	0 3.00
3.01		71.00	MEDICAL SUPPLIES CHARGED TO	HOME OFFICE MEDICAL SUPPL	48,288	0 3.01
3.02		16.00	MEDICAL RECORDS & LIBRARY	HOME OFFICE MEDICAL RECORDS	124,342	0 3.02
3.07		5.00	ADMINISTRATIVE & GENERAL	MED DIRECTOR DIRECT ALLOC	72,349	0 3.07
3.09		73.00	DRUGS CHARGED TO PATIENTS	SUPPLY CHAIN	12,605	0 3.09
3.10		91.00	EMERGENCY	MED DIRECTOR DIRECT ALLOC	56,667	0 3.10
3.11		44.00	SKILLED NURSING FACILITY	MED DIRECTOR DIRECT ALLOC	3,048	0 3.11
3.12		46.00	OTHER LONG TERM CARE	MED DIRECTOR DIRECT ALLOC	2,952	0 3.12
3.14		2.00	CAP REL COSTS-MVBLE EQUIP	HIT ASSETS FROM JVL	19,303	0 3.14
3.16		53.00	ANESTHESIOLOGY	PHYSICIAN BENEFITS	43,925	0 3.16
3.17		91.00	EMERGENCY	PHYSICIAN BENEFITS	65,656	0 3.17
4.00		0.00			0	0 4.00
5.00			TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.		4,580,204	1,109,652 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	MERCY HOME OFFI	100.00	6.00
7.00		0.00		0.00	7.00
8.00		0.00		0.00	8.00
9.00		0.00		0.00	9.00
10.00		0.00		0.00	10.00
100.00	G. Other (financial or non-financial) specify:				100.00

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

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

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

Provider CCN: 14-1335

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

Worksheet A-8-1

Date/Time Prepared:
2/26/2021 10:00 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	597,614	0		1.00
2.00	1,839,561	0		2.00
3.00	584,242	0		3.00
3.01	48,288	0		3.01
3.02	124,342	0		3.02
3.07	72,349	0		3.07
3.09	12,605	0		3.09
3.10	56,667	0		3.10
3.11	3,048	0		3.11
3.12	2,952	0		3.12
3.14	19,303	9		3.14
3.16	43,925	0		3.16
3.17	65,656	0		3.17
4.00	0	0		4.00
5.00	3,470,552			5.00

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

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

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

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

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

6.00	HEALTH SYSTEM		6.00
7.00			7.00
8.00			8.00
9.00			9.00
10.00			10.00
100.00			100.00

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

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

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 14-1335

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

Worksheet A-8-2

Date/Time Prepared:
2/26/2021 10:00 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	AGGREGATE-ADMINISTRATIVE & GENERAL	87	87	0	0	0	1.00
2.00	50.00	AGGREGATE-OPERATING ROOM	44,645	1,133	43,512	0	0	2.00
3.00	53.00	AGGREGATE-ANESTHESIOLOGY	1,471,811	1,471,811	0	0	0	3.00
4.00	54.00	AGGREGATE-RADIOLOGY-DIAGNOSTIC	400	400	0	0	0	4.00
5.00	91.00	AGGREGATE-EMERGENCY	1,938,848	368,381	1,570,467	0	0	5.00
6.00	0.00		0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			3,455,791	1,841,812	1,613,979			200.00
	Wkst. A Line #	Cost Center/Physician Identifier	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	5.00	AGGREGATE-ADMINISTRATIVE & GENERAL	0	0	0	0	0	1.00
2.00	50.00	AGGREGATE-OPERATING ROOM	0	0	0	0	0	2.00
3.00	53.00	AGGREGATE-ANESTHESIOLOGY	0	0	0	0	0	3.00
4.00	54.00	AGGREGATE-RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	4.00
5.00	91.00	AGGREGATE-EMERGENCY	0	0	0	0	0	5.00
6.00	0.00		0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			0	0	0	0	0	200.00
	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment		
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00	5.00	AGGREGATE-ADMINISTRATIVE & GENERAL	0	0	0	87		1.00
2.00	50.00	AGGREGATE-OPERATING ROOM	0	0	0	1,133		2.00
3.00	53.00	AGGREGATE-ANESTHESIOLOGY	0	0	0	1,471,811		3.00
4.00	54.00	AGGREGATE-RADIOLOGY-DIAGNOSTIC	0	0	0	400		4.00
5.00	91.00	AGGREGATE-EMERGENCY	0	0	0	368,381		5.00
6.00	0.00		0	0	0	0		6.00
7.00	0.00		0	0	0	0		7.00
8.00	0.00		0	0	0	0		8.00
9.00	0.00		0	0	0	0		9.00
10.00	0.00		0	0	0	0		10.00
200.00			0	0	0	1,841,812		200.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-1335

Period:
From 07/01/2019
To 06/30/2020Worksheet B
Part I
Date/Time Prepared:
2/26/2021 10:00 am

Cost Center Description			CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
			Net Expenses for Cost Allocation (from Wkst A col. 7)	BLDG & FIXT	MVBLE EQUIP		
			0	1.00	2.00	4.00	4A
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT	1,092,917	1,092,917			1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	777,434		777,434		2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	2,364,241	0	0	2,364,241	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	4,156,830	131,046	8,878	487,218	4,783,972
6.00	00600	MAINTENANCE & REPAIRS	0	0	0	0	0
7.00	00700	OPERATION OF PLANT	1,264,866	217,368	86,781	0	1,569,015
8.00	00800	LAUNDRY & LINEN SERVICE	4,383	12,615	1,270	0	18,268
9.00	00900	HOUSEKEEPING	323,475	4,969	442	37,891	366,777
10.00	01000	DIETARY	516,449	33,625	16,164	75,634	641,872
11.00	01100	CAFETERIA	0	18,075	0	0	18,075
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0
13.00	01300	NURSING ADMINISTRATION	1,012,066	6,062	58,152	149,365	1,225,645
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	0
15.00	01500	PHARMACY	0	0	0	0	0
16.00	01600	MEDICAL RECORDS & LIBRARY	276,597	23,277	0	25,118	324,992
17.00	01700	SOCIAL SERVICE	0	0	0	0	0
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0
20.00	02000	NURSING SCHOOL	0	0	0	0	0
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	0
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0
23.00	02300	PARAMED ED PRGM- (SPECIFY)	0	0	0	0	0
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	1,001,820	91,114	20,681	150,400	1,264,015
31.00	03100	INTENSIVE CARE UNIT	270,804	25,093	833	42,737	339,467
44.00	04400	SKILLED NURSING FACILITY	547,020	65,161	7,344	79,668	699,193
46.00	04600	OTHER LONG TERM CARE	924,689	111,933	8,987	121,714	1,167,323
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	1,641,166	109,299	265,922	141,302	2,157,689
51.00	05100	RECOVERY ROOM	716,888	4,369	9,064	104,815	835,136
53.00	05300	ANESTHESIOLOGY	182,159	0	426	43,718	226,303
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,113,568	28,874	222,228	151,991	1,516,661
60.00	06000	LABORATORY	988,033	20,847	8,209	88,182	1,105,271
60.01	06001	BLOOD LABORATORY	0	0	0	0	0
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0
65.00	06500	RESPIRATORY THERAPY	208,282	17,611	10,771	25,561	262,225
66.00	06600	PHYSICAL THERAPY	445,942	49,298	5,877	68,797	569,914
67.00	06700	OCCUPATIONAL THERAPY	241,086	0	3,165	34,327	278,578
68.00	06800	SPEECH PATHOLOGY	43,613	0	572	6,210	50,395
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	889,266	0	5,713	17,708	912,687
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	551,906	0	0	0	551,906
73.00	07300	DRUGS CHARGED TO PATIENTS	1,104,495	7,372	2,835	55,813	1,170,515
76.97	07697	CARDIAC REHABILITATION	48,015	6,826	14,069	7,664	76,574
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0
76.99	07699	LITHOTRIPSY	0	0	0	0	0
OUTPATIENT SERVICE COST CENTERS							
91.00	09100	EMERGENCY	2,956,083	19,836	19,051	448,408	3,443,378
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					0
OTHER REIMBURSABLE COST CENTERS							
99.10	09910	CORF	0	0	0	0	0
SPECIAL PURPOSE COST CENTERS							
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	25,664,093	1,004,670	777,434	2,364,241	25,575,846
NONREIMBURSABLE COST CENTERS							
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	88,247	0	0	88,247
200.00		Cross Foot Adjustments					0
201.00		Negative Cost Centers		0	0	0	0
202.00		TOTAL (sum lines 118 through 201)	25,664,093	1,092,917	777,434	2,364,241	25,664,093

COST ALLOCATION - GENERAL SERVICE COSTS

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Cost Center Description			ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
			5.00	6.00	7.00	8.00	9.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	4,783,972					5.00
6.00	00600	MAINTENANCE & REPAIRS	0	0				6.00
7.00	00700	OPERATION OF PLANT	359,486	0	1,928,501			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	4,185	0	32,676	55,129		8.00
9.00	00900	HOUSEKEEPING	84,034	0	12,872	8,008	471,691	9.00
10.00	01000	DIETARY	147,063	0	87,100	0	21,819	10.00
11.00	01100	CAFETERIA	4,141	0	46,821	0	11,729	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	280,815	0	15,701	0	3,933	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	0	14.00
15.00	01500	PHARMACY	0	0	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	74,461	0	60,294	0	15,104	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
20.00	02000	NURSING SCHOOL	0	0	0	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0	22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	289,606	0	236,015	7,248	59,123	30.00
31.00	03100	INTENSIVE CARE UNIT	77,777	0	64,998	17	16,282	31.00
44.00	04400	SKILLED NURSING FACILITY	160,196	0	168,789	4,349	42,283	44.00
46.00	04600	OTHER LONG TERM CARE	267,452	0	289,943	5,322	72,632	46.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	494,361	0	283,118	10,423	70,923	50.00
51.00	05100	RECOVERY ROOM	191,343	0	11,316	2,605	2,835	51.00
53.00	05300	ANESTHESIOLOGY	51,850	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	347,491	0	74,793	2,984	18,736	54.00
60.00	06000	LABORATORY	253,235	0	54,000	406	13,527	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	60,080	0	45,619	2,736	11,428	65.00
66.00	06600	PHYSICAL THERAPY	130,576	0	127,697	2,126	31,989	66.00
67.00	06700	OCCUPATIONAL THERAPY	63,827	0	0	1,874	0	67.00
68.00	06800	SPEECH PATHOLOGY	11,546	0	0	339	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	209,111	0	0	369	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	126,450	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	268,184	0	19,096	1,097	4,784	73.00
76.97	07697	CARDIAC REHABILITATION	17,544	0	17,682	24	4,429	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
91.00	09100	EMERGENCY	788,939	0	51,383	5,202	12,872	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
OTHER REIMBURSABLE COST CENTERS								
99.10	09910	CORF	0	0	0	0	0	99.10
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	4,763,753	0	1,699,913	55,129	414,428	118.00
NONREIMBURSABLE COST CENTERS								
192.00	19200	PHYSICIANS' PRIVATE OFFICES	20,219	0	228,588	0	57,263	192.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	4,783,972	0	1,928,501	55,129	471,691	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

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Period:
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Cost Center Description			DIETARY	CAFETERIA	MAINTENANCE OF PERSONNEL	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	
			10.00	11.00	12.00	13.00	14.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY	897,854					10.00
11.00	01100	CAFETERIA	261,845	342,611				11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0			12.00
13.00	01300	NURSING ADMINISTRATION	0	22,871	0	1,548,965		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	0	14.00
15.00	01500	PHARMACY	0	0	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	6,727	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
20.00	02000	NURSING SCHOOL	0	0	0	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0	22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	80,853	31,524	0	266,562	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	7,002	0	66,797	0	31.00
44.00	04400	SKILLED NURSING FACILITY	247,197	23,055	0	85,929	0	44.00
46.00	04600	OTHER LONG TERM CARE	302,515	28,222	0	105,165	0	46.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	29,109	0	189,805	0	50.00
51.00	05100	RECOVERY ROOM	0	22,871	0	230,232	0	51.00
53.00	05300	ANESTHESIOLOGY	0	17,337	0	33,689	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	28,069	0	12,103	0	54.00
60.00	06000	LABORATORY	0	21,771	0	8,027	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0	5,687	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	18,958	0	40,802	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	9,937	0	37,017	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	1,804	0	6,696	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	5,962	0	7,299	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	14,340	0	21,669	0	73.00
76.97	07697	CARDIAC REHABILITATION	0	2,263	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
91.00	09100	EMERGENCY	5,444	45,102	0	437,173	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
OTHER REIMBURSABLE COST CENTERS								
99.10	09910	CORF	0	0	0	0	0	99.10
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	897,854	342,611	0	1,548,965	0	118.00
NONREIMBURSABLE COST CENTERS								
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	897,854	342,611	0	1,548,965	0	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

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Cost Center Description			PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	NONPHYSICIAN ANESTHETISTS	NURSING SCHOOL	
			15.00	16.00	17.00	19.00	20.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
12.00	01200	MAINTENANCE OF PERSONNEL						12.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY	0					15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	481,578				16.00
17.00	01700	SOCIAL SERVICE	0	0	0			17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0		19.00
20.00	02000	NURSING SCHOOL	0	0	0		0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0			21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0			22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	0			23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	0	38,424	0	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	3,293	0	0	0	31.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
46.00	04600	OTHER LONG TERM CARE	0	0	0	0	0	46.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	297,876	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	79,043	0	0	0	54.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	9,149	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
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
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
91.00	09100	EMERGENCY	0	53,793	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
OTHER REIMBURSABLE COST CENTERS								
99.10	09910	CORF	0	0	0	0	0	99.10
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	481,578	0	0	0	118.00
NONREIMBURSABLE COST CENTERS								
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	0	481,578	0	0	0	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

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Cost Center Description			INTERNS & RESIDENTS		PARAMED ED PRGM	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	
			SERVICES-SALAR Y & FRINGES APPRV	SERVICES-OTHER PRGM COSTS APPRV				
			21.00	22.00	23.00	24.00	25.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
12.00	01200	MAINTENANCE OF PERSONNEL						12.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY						15.00
16.00	01600	MEDICAL RECORDS & LIBRARY						16.00
17.00	01700	SOCIAL SERVICE						17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS						19.00
20.00	02000	NURSING SCHOOL						20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0					21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV		0				22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)			0			23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	0	0	0	2,273,370	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	575,633	0	31.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	1,430,991	0	44.00
46.00	04600	OTHER LONG TERM CARE	0	0	0	2,238,574	0	46.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	0	3,533,304	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	1,296,338	0	51.00
53.00	05300	ANESTHESIOLOGY	0	0	0	329,179	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	2,079,880	0	54.00
60.00	06000	LABORATORY	0	0	0	1,456,237	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0	0	0	387,775	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	931,211	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	391,233	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	70,780	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	1,135,428	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	678,356	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	1,499,685	0	73.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	118,516	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
91.00	09100	EMERGENCY	0	0	0	4,843,286	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					0	92.00
OTHER REIMBURSABLE COST CENTERS								
99.10	09910	CORF	0	0	0	0	0	99.10
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	0	0	25,269,776	0	118.00
NONREIMBURSABLE COST CENTERS								
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	394,317	0	192.00
200.00		Cross Foot Adjustments	0	0	0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	0	0	0	25,664,093	0	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-1335

Period:
From 07/01/2019
To 06/30/2020Worksheet B
Part I
Date/Time Prepared:
2/26/2021 10:00 am

Cost Center Description		Total	
		26.00	
GENERAL SERVICE COST CENTERS			
1.00	00100	CAP REL COSTS-BLDG & FIXT	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	5.00
6.00	00600	MAINTENANCE & REPAIRS	6.00
7.00	00700	OPERATION OF PLANT	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	8.00
9.00	00900	HOUSEKEEPING	9.00
10.00	01000	DIETARY	10.00
11.00	01100	CAFETERIA	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	12.00
13.00	01300	NURSING ADMINISTRATION	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	14.00
15.00	01500	PHARMACY	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	16.00
17.00	01700	SOCIAL SERVICE	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	19.00
20.00	02000	NURSING SCHOOL	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	23.00
INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS	30.00
31.00	03100	INTENSIVE CARE UNIT	31.00
44.00	04400	SKILLED NURSING FACILITY	44.00
46.00	04600	OTHER LONG TERM CARE	46.00
ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	50.00
51.00	05100	RECOVERY ROOM	51.00
53.00	05300	ANESTHESIOLOGY	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	54.00
60.00	06000	LABORATORY	60.00
60.01	06001	BLOOD LABORATORY	60.01
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	62.30
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
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
76.97	07697	CARDIAC REHABILITATION	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	76.98
76.99	07699	LITHOTRIPSY	76.99
OUTPATIENT SERVICE COST CENTERS			
91.00	09100	EMERGENCY	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	92.00
OTHER REIMBURSABLE COST CENTERS			
99.10	09910	CORF	99.10
SPECIAL PURPOSE COST CENTERS			
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	118.00
NONREIMBURSABLE COST CENTERS			
192.00	19200	PHYSICIANS' PRIVATE OFFICES	192.00
200.00		Cross Foot Adjustments	200.00
201.00		Negative Cost Centers	201.00
202.00		TOTAL (sum lines 118 through 201)	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-1335

Period:
From 07/01/2019
To 06/30/2020Worksheet B
Part II
Date/Time Prepared:
2/26/2021 10:00 am

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	0	0	0	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	4,456	131,046	8,878	144,380	5.00
6.00	00600	MAINTENANCE & REPAIRS	0	0	0	0	6.00
7.00	00700	OPERATION OF PLANT	22,298	217,368	86,781	326,447	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	350	12,615	1,270	14,235	8.00
9.00	00900	HOUSEKEEPING	480	4,969	442	5,891	9.00
10.00	01000	DIETARY	747	33,625	16,164	50,536	10.00
11.00	01100	CAFETERIA	0	18,075	0	18,075	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	202	6,062	58,152	64,416	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	14.00
15.00	01500	PHARMACY	0	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	508	23,277	0	23,785	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	19.00
20.00	02000	NURSING SCHOOL	0	0	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	8,486	91,114	20,681	120,281	30.00
31.00	03100	INTENSIVE CARE UNIT	0	25,093	833	25,926	31.00
44.00	04400	SKILLED NURSING FACILITY	2,347	65,161	7,344	74,852	44.00
46.00	04600	OTHER LONG TERM CARE	2,872	111,933	8,987	123,792	46.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	49,040	109,299	265,922	424,261	50.00
51.00	05100	RECOVERY ROOM	812	4,369	9,064	14,245	51.00
53.00	05300	ANESTHESIOLOGY	0	0	426	426	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	6,063	28,874	222,228	257,165	54.00
60.00	06000	LABORATORY	13,627	20,847	8,209	42,683	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	60.01
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	3,615	17,611	10,771	31,997	65.00
66.00	06600	PHYSICAL THERAPY	1,171	49,298	5,877	56,346	66.00
67.00	06700	OCCUPATIONAL THERAPY	1,011	0	3,165	4,176	67.00
68.00	06800	SPEECH PATHOLOGY	183	0	572	755	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	199	0	5,713	5,912	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	59,549	7,372	2,835	69,756	73.00
76.97	07697	CARDIAC REHABILITATION	0	6,826	14,069	20,895	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS							
91.00	09100	EMERGENCY	4,695	19,836	19,051	43,582	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				0	92.00
OTHER REIMBURSABLE COST CENTERS							
99.10	09910	CORF	0	0	0	0	99.10
SPECIAL PURPOSE COST CENTERS							
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	182,711	1,004,670	777,434	1,964,815	118.00
NONREIMBURSABLE COST CENTERS							
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	88,247	0	88,247	192.00
200.00		Cross Foot Adjustments				0	200.00
201.00		Negative Cost Centers				0	201.00
202.00		TOTAL (sum lines 118 through 201)	182,711	1,092,917	777,434	2,053,062	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-1335

Period:
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To 06/30/2020Worksheet B
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Cost Center Description			ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
			5.00	6.00	7.00	8.00	9.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	144,380					5.00
6.00	00600	MAINTENANCE & REPAIRS	0	0				6.00
7.00	00700	OPERATION OF PLANT	10,850	0	337,297			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	126	0	5,715	20,076		8.00
9.00	00900	HOUSEKEEPING	2,536	0	2,251	2,916	13,594	9.00
10.00	01000	DIETARY	4,439	0	15,234	0	629	10.00
11.00	01100	CAFETERIA	125	0	8,189	0	338	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	8,475	0	2,746	0	113	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	0	14.00
15.00	01500	PHARMACY	0	0	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	2,247	0	10,546	0	435	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
20.00	02000	NURSING SCHOOL	0	0	0	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0	22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	8,741	0	41,279	2,640	1,704	30.00
31.00	03100	INTENSIVE CARE UNIT	2,347	0	11,368	6	469	31.00
44.00	04400	SKILLED NURSING FACILITY	4,835	0	29,521	1,584	1,219	44.00
46.00	04600	OTHER LONG TERM CARE	8,072	0	50,712	1,938	2,093	46.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	14,920	0	49,518	3,797	2,044	50.00
51.00	05100	RECOVERY ROOM	5,775	0	1,979	949	82	51.00
53.00	05300	ANESTHESIOLOGY	1,565	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	10,488	0	13,081	1,087	540	54.00
60.00	06000	LABORATORY	7,643	0	9,445	148	390	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	1,813	0	7,979	996	329	65.00
66.00	06600	PHYSICAL THERAPY	3,941	0	22,334	774	922	66.00
67.00	06700	OCCUPATIONAL THERAPY	1,926	0	0	682	0	67.00
68.00	06800	SPEECH PATHOLOGY	348	0	0	123	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	6,311	0	0	134	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	3,816	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	8,094	0	3,340	399	138	73.00
76.97	07697	CARDIAC REHABILITATION	530	0	3,093	9	128	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
91.00	09100	EMERGENCY	23,807	0	8,987	1,894	371	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
OTHER REIMBURSABLE COST CENTERS								
99.10	09910	CORF	0	0	0	0	0	99.10
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	143,770	0	297,317	20,076	11,944	118.00
NONREIMBURSABLE COST CENTERS								
192.00	19200	PHYSICIANS' PRIVATE OFFICES	610	0	39,980	0	1,650	192.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	144,380	0	337,297	20,076	13,594	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-1335

Period:
From 07/01/2019
To 06/30/2020Worksheet B
Part II
Date/Time Prepared:
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Cost Center Description			DIETARY	CAFETERIA	MAINTENANCE OF PERSONNEL	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	
			10.00	11.00	12.00	13.00	14.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY	70,838					10.00
11.00	01100	CAFETERIA	20,659	47,386				11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0			12.00
13.00	01300	NURSING ADMINISTRATION	0	3,163	0	78,913		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	0	14.00
15.00	01500	PHARMACY	0	0	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	930	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
20.00	02000	NURSING SCHOOL	0	0	0	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0	22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	6,379	4,360	0	13,580	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	968	0	3,403	0	31.00
44.00	04400	SKILLED NURSING FACILITY	19,503	3,189	0	4,378	0	44.00
46.00	04600	OTHER LONG TERM CARE	23,867	3,903	0	5,358	0	46.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	4,026	0	9,670	0	50.00
51.00	05100	RECOVERY ROOM	0	3,163	0	11,729	0	51.00
53.00	05300	ANESTHESIOLOGY	0	2,398	0	1,716	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	3,882	0	617	0	54.00
60.00	06000	LABORATORY	0	3,011	0	409	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0	787	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	2,622	0	2,079	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	1,374	0	1,886	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	250	0	341	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	825	0	372	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	1,983	0	1,104	0	73.00
76.97	07697	CARDIAC REHABILITATION	0	313	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
91.00	09100	EMERGENCY	430	6,239	0	22,271	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
OTHER REIMBURSABLE COST CENTERS								
99.10	09910	CORF	0	0	0	0	0	99.10
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	70,838	47,386	0	78,913	0	118.00
NONREIMBURSABLE COST CENTERS								
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	70,838	47,386	0	78,913	0	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-1335

Period:
From 07/01/2019
To 06/30/2020Worksheet B
Part II
Date/Time Prepared:
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Cost Center Description			PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	NONPHYSICIAN ANESTHETISTS	NURSING SCHOOL	
			15.00	16.00	17.00	19.00	20.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
12.00	01200	MAINTENANCE OF PERSONNEL						12.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY	0					15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	37,943				16.00
17.00	01700	SOCIAL SERVICE	0	0	0			17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0		0		19.00
20.00	02000	NURSING SCHOOL	0	0		0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0		0		21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0		0		22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0		0		23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	0	3,027		0		30.00
31.00	03100	INTENSIVE CARE UNIT	0	259		0		31.00
44.00	04400	SKILLED NURSING FACILITY	0	0		0		44.00
46.00	04600	OTHER LONG TERM CARE	0	0		0		46.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	23,470		0		50.00
51.00	05100	RECOVERY ROOM	0	0		0		51.00
53.00	05300	ANESTHESIOLOGY	0	0		0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	6,228		0		54.00
60.00	06000	LABORATORY	0	0		0		60.00
60.01	06001	BLOOD LABORATORY	0	0		0		60.01
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0		0		62.30
65.00	06500	RESPIRATORY THERAPY	0	0		0		65.00
66.00	06600	PHYSICAL THERAPY	0	721		0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0		0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0		0		68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0		0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0		0		73.00
76.97	07697	CARDIAC REHABILITATION	0	0		0		76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0		0		76.98
76.99	07699	LITHOTRIPSY	0	0		0		76.99
OUTPATIENT SERVICE COST CENTERS								
91.00	09100	EMERGENCY	0	4,238		0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
OTHER REIMBURSABLE COST CENTERS								
99.10	09910	CORF	0	0		0		99.10
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	37,943		0	0	118.00
NONREIMBURSABLE COST CENTERS								
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0		0		192.00
200.00		Cross Foot Adjustments				0	0	200.00
201.00		Negative Cost Centers	0	0		0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	0	37,943		0	0	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-1335

Period:
From 07/01/2019
To 06/30/2020Worksheet B
Part II
Date/Time Prepared:
2/26/2021 10:00 am

Cost Center Description			INTERNS & RESIDENTS		PARAMED ED PRGM	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	
			SERVICES-SALAR Y & FRINGES APPRV	SERVICES-OTHER PRGM COSTS APPRV				
			21.00	22.00	23.00	24.00	25.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
12.00	01200	MAINTENANCE OF PERSONNEL						12.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY						15.00
16.00	01600	MEDICAL RECORDS & LIBRARY						16.00
17.00	01700	SOCIAL SERVICE						17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS						19.00
20.00	02000	NURSING SCHOOL						20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0					21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV		0				22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)			0			23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS				201,991	0	30.00
31.00	03100	INTENSIVE CARE UNIT				44,746	0	31.00
44.00	04400	SKILLED NURSING FACILITY				139,081	0	44.00
46.00	04600	OTHER LONG TERM CARE				219,735	0	46.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM				531,706	0	50.00
51.00	05100	RECOVERY ROOM				37,922	0	51.00
53.00	05300	ANESTHESIOLOGY				6,105	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC				293,088	0	54.00
60.00	06000	LABORATORY				63,729	0	60.00
60.01	06001	BLOOD LABORATORY				0	0	60.01
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS				0	0	62.30
65.00	06500	RESPIRATORY THERAPY				43,901	0	65.00
66.00	06600	PHYSICAL THERAPY				89,739	0	66.00
67.00	06700	OCCUPATIONAL THERAPY				10,044	0	67.00
68.00	06800	SPEECH PATHOLOGY				1,817	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT				13,554	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS				3,816	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS				84,814	0	73.00
76.97	07697	CARDIAC REHABILITATION				24,968	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY				0	0	76.98
76.99	07699	LITHOTRIPSY				0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
91.00	09100	EMERGENCY				111,819	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					0	92.00
OTHER REIMBURSABLE COST CENTERS								
99.10	09910	CORF				0	0	99.10
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	0	0	1,922,575	0	118.00
NONREIMBURSABLE COST CENTERS								
192.00	19200	PHYSICIANS' PRIVATE OFFICES				130,487	0	192.00
200.00		Cross Foot Adjustments	0	0	0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	0	0	0	2,053,062	0	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-1335

Period:
From 07/01/2019
To 06/30/2020Worksheet B
Part II
Date/Time Prepared:
2/26/2021 10:00 am

Cost Center Description		Total	
		26.00	
GENERAL SERVICE COST CENTERS			
1.00	00100	CAP REL COSTS-BLDG & FIXT	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	5.00
6.00	00600	MAINTENANCE & REPAIRS	6.00
7.00	00700	OPERATION OF PLANT	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	8.00
9.00	00900	HOUSEKEEPING	9.00
10.00	01000	DIETARY	10.00
11.00	01100	CAFETERIA	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	12.00
13.00	01300	NURSING ADMINISTRATION	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	14.00
15.00	01500	PHARMACY	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	16.00
17.00	01700	SOCIAL SERVICE	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	19.00
20.00	02000	NURSING SCHOOL	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	23.00
INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS	30.00
31.00	03100	INTENSIVE CARE UNIT	31.00
44.00	04400	SKILLED NURSING FACILITY	44.00
46.00	04600	OTHER LONG TERM CARE	46.00
ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	50.00
51.00	05100	RECOVERY ROOM	51.00
53.00	05300	ANESTHESIOLOGY	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	54.00
60.00	06000	LABORATORY	60.00
60.01	06001	BLOOD LABORATORY	60.01
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	62.30
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
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
76.97	07697	CARDIAC REHABILITATION	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	76.98
76.99	07699	LITHOTRIPSY	76.99
OUTPATIENT SERVICE COST CENTERS			
91.00	09100	EMERGENCY	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	92.00
OTHER REIMBURSABLE COST CENTERS			
99.10	09910	CORF	99.10
SPECIAL PURPOSE COST CENTERS			
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	118.00
NONREIMBURSABLE COST CENTERS			
192.00	19200	PHYSICIANS' PRIVATE OFFICES	192.00
200.00		Cross Foot Adjustments	200.00
201.00		Negative Cost Centers	201.00
202.00		TOTAL (sum lines 118 through 201)	202.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-1335

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

Worksheet B-1

Date/Time Prepared:
2/26/2021 10:00 am

Cost Center Description			CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
			BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (DOLLAR VALUE)				
			1.00	2.00	4.00	5A	5.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT	80,055					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		729,567				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	0	13,345,065			4.00
5.00	00500	ADMINISTRATIVE & GENERAL	9,599	8,331	2,750,112	-4,783,972	20,880,121	5.00
6.00	00600	MAINTENANCE & REPAIRS	0	0	0	0	0	6.00
7.00	00700	OPERATION OF PLANT	15,922	81,438	0	0	1,569,015	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	924	1,192	0	0	18,268	8.00
9.00	00900	HOUSEKEEPING	364	415	213,877	0	366,777	9.00
10.00	01000	DIETARY	2,463	15,169	426,920	0	641,872	10.00
11.00	01100	CAFETERIA	1,324	0	0	0	18,075	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	444	54,572	843,101	0	1,225,645	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	0	14.00
15.00	01500	PHARMACY	0	0	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,705	0	141,781	0	324,992	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
20.00	02000	NURSING SCHOOL	0	0	0	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0	22.00
23.00	02300	PARAMED ED PRGM- (SPECIFY)	0	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	6,674	19,408	848,941	0	1,264,015	30.00
31.00	03100	INTENSIVE CARE UNIT	1,838	782	241,233	0	339,467	31.00
44.00	04400	SKILLED NURSING FACILITY	4,773	6,892	449,690	0	699,193	44.00
46.00	04600	OTHER LONG TERM CARE	8,199	8,434	687,023	0	1,167,323	46.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	8,006	249,547	797,587	0	2,157,689	50.00
51.00	05100	RECOVERY ROOM	320	8,506	591,631	0	835,136	51.00
53.00	05300	ANESTHESIOLOGY	0	400	246,766	0	226,303	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,115	208,545	857,921	0	1,516,661	54.00
60.00	06000	LABORATORY	1,527	7,704	497,749	0	1,105,271	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	1,290	10,108	144,281	0	262,225	65.00
66.00	06600	PHYSICAL THERAPY	3,611	5,515	388,326	0	569,914	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	2,970	193,761	0	278,578	67.00
68.00	06800	SPEECH PATHOLOGY	0	537	35,052	0	50,395	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	5,361	99,954	0	912,687	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	551,906	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	540	2,660	315,037	0	1,170,515	73.00
76.97	07697	CARDIAC REHABILITATION	500	13,203	43,261	0	76,574	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPS	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
91.00	09100	EMERGENCY	1,453	17,878	2,531,061	0	3,443,378	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
OTHER REIMBURSABLE COST CENTERS								
99.10	09910	CORF	0	0	0	0	0	99.10
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	73,591	729,567	13,345,065	-4,783,972	20,791,874	118.00
NONREIMBURSABLE COST CENTERS								
192.00	19200	PHYSICIANS' PRIVATE OFFICES	6,464	0	0	0	88,247	192.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	1,092,917	777,434	2,364,241		4,783,972	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	13.652077	1.065610	0.177162		0.229116	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)			0		144,380	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)			0.000000		0.006915	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: 14-1335

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

Worksheet B-1

Date/Time Prepared:
2/26/2021 10:00 am

Cost Center Description		MAINTENANCE & REPAIRS (SQUARE FEET)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	
		6.00	7.00	8.00	9.00	10.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500	ADMINISTRATIVE & GENERAL					5.00
6.00	00600	MAINTENANCE & REPAIRS	0				6.00
7.00	00700	OPERATION OF PLANT	0	54,534			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	924	151,285		8.00
9.00	00900	HOUSEKEEPING	0	364	21,976	53,246	9.00
10.00	01000	DIETARY	0	2,463	0	2,463	36,779 10.00
11.00	01100	CAFETERIA	0	1,324	0	1,324	10,726 11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0 12.00
13.00	01300	NURSING ADMINISTRATION	0	444	0	444	0 13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	0 14.00
15.00	01500	PHARMACY	0	0	0	0	0 15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	1,705	0	1,705	0 16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0 17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0 19.00
20.00	02000	NURSING SCHOOL	0	0	0	0	0 20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	0 21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0 22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	0	0	0 23.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	0	6,674	19,891	6,674	3,312 30.00
31.00	03100	INTENSIVE CARE UNIT	0	1,838	46	1,838	0 31.00
44.00	04400	SKILLED NURSING FACILITY	0	4,773	11,935	4,773	10,126 44.00
46.00	04600	OTHER LONG TERM CARE	0	8,199	14,604	8,199	12,392 46.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	8,006	28,600	8,006	0 50.00
51.00	05100	RECOVERY ROOM	0	320	7,150	320	0 51.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0 53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	2,115	8,190	2,115	0 54.00
60.00	06000	LABORATORY	0	1,527	1,114	1,527	0 60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0 60.01
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0 62.30
65.00	06500	RESPIRATORY THERAPY	0	1,290	7,508	1,290	0 65.00
66.00	06600	PHYSICAL THERAPY	0	3,611	5,835	3,611	0 66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	5,142	0	0 67.00
68.00	06800	SPEECH PATHOLOGY	0	0	930	0	0 68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	1,013	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	540	3,010	540	0 73.00
76.97	07697	CARDIAC REHABILITATION	0	500	65	500	0 76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0 76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0 76.99
OUTPATIENT SERVICE COST CENTERS							
91.00	09100	EMERGENCY	0	1,453	14,276	1,453	223 91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					92.00
OTHER REIMBURSABLE COST CENTERS							
99.10	09910	CORF	0	0	0	0	0 99.10
SPECIAL PURPOSE COST CENTERS							
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	48,070	151,285	46,782	36,779 118.00
NONREIMBURSABLE COST CENTERS							
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	6,464	0	6,464	0 192.00
200.00		Cross Foot Adjustments					200.00
201.00		Negative Cost Centers					201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	0	1,928,501	55,129	471,691	897,854 202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.000000	35.363278	0.364405	8.858712	24.412137 203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	0	337,297	20,076	13,594	70,838 204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.000000	6.185077	0.132703	0.255306	1.926045 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: 14-1335

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

Worksheet B-1

Date/Time Prepared:
2/26/2021 10:00 am

Cost Center Description			CAFETERIA (FULL TIME EQUIVALE)	MAINTENANCE OF PERSONNEL (FULL TIME EQUIVALE)	NURSING ADMINISTRATION (DIRECT NRS ING HR)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	
			11.00	12.00	13.00	14.00	15.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA	11,205					11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0				12.00
13.00	01300	NURSING ADMINISTRATION	748	0	74,484			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0		14.00
15.00	01500	PHARMACY	0	0	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	220	0	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
20.00	02000	NURSING SCHOOL	0	0	0	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0	22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	1,031	0	12,818	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	229	0	3,212	0	0	31.00
44.00	04400	SKILLED NURSING FACILITY	754	0	4,132	0	0	44.00
46.00	04600	OTHER LONG TERM CARE	923	0	5,057	0	0	46.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	952	0	9,127	0	0	50.00
51.00	05100	RECOVERY ROOM	748	0	11,071	0	0	51.00
53.00	05300	ANESTHESIOLOGY	567	0	1,620	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	918	0	582	0	0	54.00
60.00	06000	LABORATORY	712	0	386	0	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	186	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	620	0	1,962	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	325	0	1,780	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	59	0	322	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	195	0	351	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	469	0	1,042	0	0	73.00
76.97	07697	CARDIAC REHABILITATION	74	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
91.00	09100	EMERGENCY	1,475	0	21,022	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
OTHER REIMBURSABLE COST CENTERS								
99.10	09910	CORF	0	0	0	0	0	99.10
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	11,205	0	74,484	0	0	118.00
NONREIMBURSABLE COST CENTERS								
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	342,611	0	1,548,965	0	0	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	30.576618	0.000000	20.795943	0.000000	0.000000	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	47,386	0	78,913	0	0	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	4.229005	0.000000	1.059462	0.000000	0.000000	205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)						206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-1335

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

Worksheet B-1

Date/Time Prepared:
2/26/2021 10:00 am

Cost Center Description			MEDICAL RECORDS & LIBRARY (TIME SPENT)	SOCIAL SERVICE (TIME SPENT)	NONPHYSICIAN ANESTHETISTS (ASSIGNED TIME)	NURSING SCHOOL (ASSIGNED TIME)	INTERNS & RESIDENTS SERVICES-SALAR Y & FRINGES APPRV (ASSIGNED TIME)	
			16.00	17.00	19.00	20.00	21.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
12.00	01200	MAINTENANCE OF PERSONNEL						12.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY						15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,316					16.00
17.00	01700	SOCIAL SERVICE	0	0				17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0			19.00
20.00	02000	NURSING SCHOOL	0	0		0		20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0			0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0				22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0				23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	105	0	0	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	9	0	0	0	0	31.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
46.00	04600	OTHER LONG TERM CARE	0	0	0	0	0	46.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	814	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	216	0	0	0	0	54.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	25	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
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
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPS	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
91.00	09100	EMERGENCY	147	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
OTHER REIMBURSABLE COST CENTERS								
99.10	09910	CORF	0	0	0	0	0	99.10
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	1,316	0	0	0	0	118.00
NONREIMBURSABLE COST CENTERS								
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	481,578	0	0	0	0	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	365.940729	0.000000	0.000000	0.000000	0.000000	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	37,943	0	0	0	0	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	28.832067	0.000000	0.000000	0.000000	0.000000	205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)				0		206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)				0.000000		207.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-1335

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

Worksheet B-1

Date/Time Prepared:
2/26/2021 10:00 am

Cost Center Description			INTERNS & RESIDENTS	PARAMED ED PRGM (ASSIGNED TIME)	
			SERVICES-OTHER PRGM COSTS		
			APPRV (ASSIGNED TIME)		
			22.00		
GENERAL SERVICE COST CENTERS					
1.00	00100	CAP REL COSTS-BLDG & FIXT			1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT			4.00
5.00	00500	ADMINISTRATIVE & GENERAL			5.00
6.00	00600	MAINTENANCE & REPAIRS			6.00
7.00	00700	OPERATION OF PLANT			7.00
8.00	00800	LAUNDRY & LINEN SERVICE			8.00
9.00	00900	HOUSEKEEPING			9.00
10.00	01000	DIETARY			10.00
11.00	01100	CAFETERIA			11.00
12.00	01200	MAINTENANCE OF PERSONNEL			12.00
13.00	01300	NURSING ADMINISTRATION			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY			14.00
15.00	01500	PHARMACY			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY			16.00
17.00	01700	SOCIAL SERVICE			17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS			19.00
20.00	02000	NURSING SCHOOL			20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV			21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0		22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)		0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	31.00
44.00	04400	SKILLED NURSING FACILITY	0	0	44.00
46.00	04600	OTHER LONG TERM CARE	0	0	46.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	51.00
53.00	05300	ANESTHESIOLOGY	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	54.00
60.00	06000	LABORATORY	0	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	60.01
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	73.00
76.97	07697	CARDIAC REHABILITATION	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	76.99
OUTPATIENT SERVICE COST CENTERS					
91.00	09100	EMERGENCY	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART			92.00
OTHER REIMBURSABLE COST CENTERS					
99.10	09910	CORF	0	0	99.10
SPECIAL PURPOSE COST CENTERS					
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	0	118.00
NONREIMBURSABLE COST CENTERS					
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	192.00
200.00		Cross Foot Adjustments			200.00
201.00		Negative Cost Centers			201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	0	0	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.000000	0.000000	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	0	0	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.000000	0.000000	205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)		0	206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)		0.000000	207.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-1335

Period:
From 07/01/2019
To 06/30/2020Worksheet C
Part I
Date/Time Prepared:
2/26/2021 10:00 am

			Title XVIII		Hospital		Cost	
Cost Center Description			Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs			
					Total Costs	RCE		Total Costs
						Disallowance		
			1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	2,273,370		2,273,370	0	2,273,370	30.00
31.00	03100	INTENSIVE CARE UNIT	575,633		575,633	0	575,633	31.00
44.00	04400	SKILLED NURSING FACILITY	1,430,991		1,430,991	0	1,430,991	44.00
46.00	04600	OTHER LONG TERM CARE	2,238,574		2,238,574	0	2,238,574	46.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	3,533,304		3,533,304	0	3,533,304	50.00
51.00	05100	RECOVERY ROOM	1,296,338		1,296,338	0	1,296,338	51.00
53.00	05300	ANESTHESIOLOGY	329,179		329,179	0	329,179	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,079,880		2,079,880	0	2,079,880	54.00
60.00	06000	LABORATORY	1,456,237		1,456,237	0	1,456,237	60.00
60.01	06001	BLOOD LABORATORY	0		0	0	0	60.01
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0		0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	387,775	0	387,775	0	387,775	65.00
66.00	06600	PHYSICAL THERAPY	931,211	0	931,211	0	931,211	66.00
67.00	06700	OCCUPATIONAL THERAPY	391,233	0	391,233	0	391,233	67.00
68.00	06800	SPEECH PATHOLOGY	70,780	0	70,780	0	70,780	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1,135,428		1,135,428	0	1,135,428	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	678,356		678,356	0	678,356	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,499,685		1,499,685	0	1,499,685	73.00
76.97	07697	CARDIAC REHABILITATION	118,516		118,516	0	118,516	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0		0	0	0	76.98
76.99	07699	LITHOTRIPSY	0		0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
91.00	09100	EMERGENCY	4,843,286		4,843,286	0	4,843,286	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	465,441		465,441		465,441	92.00
OTHER REIMBURSABLE COST CENTERS								
99.10	09910	CORF	0		0		0	99.10
200.00		Subtotal (see instructions)	25,735,217	0	25,735,217	0	25,735,217	200.00
201.00		Less Observation Beds	465,441		465,441		465,441	201.00
202.00		Total (see instructions)	25,269,776	0	25,269,776	0	25,269,776	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-1335

Period:
From 07/01/2019
To 06/30/2020Worksheet C
Part I
Date/Time Prepared:
2/26/2021 10:00 am

			Title XVIII		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	3,276,670		3,276,670			30.00
31.00	03100	INTENSIVE CARE UNIT	357,983		357,983			31.00
44.00	04400	SKILLED NURSING FACILITY	869,674		869,674			44.00
46.00	04600	OTHER LONG TERM CARE	1,064,224		1,064,224			46.00
	ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	3,206,803	17,950,685	21,157,488	0.167000	0.000000	50.00
51.00	05100	RECOVERY ROOM	139,488	3,674,818	3,814,306	0.339862	0.000000	51.00
53.00	05300	ANESTHESIOLOGY	0	125,387	125,387	2.625304	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	954,459	11,298,723	12,253,182	0.169742	0.000000	54.00
60.00	06000	LABORATORY	545,467	2,675,105	3,220,572	0.452167	0.000000	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0.000000	0.000000	60.01
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0.000000	0.000000	62.30
65.00	06500	RESPIRATORY THERAPY	90,873	1,178,469	1,269,342	0.305493	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	575,245	910,364	1,485,609	0.626821	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	374,721	0	374,721	1.044065	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	67,788	0	67,788	1.044138	0.000000	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1,477,068	5,183,192	6,660,260	0.170478	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	891,298	1,196,504	2,087,802	0.324914	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,520,076	4,740,175	6,260,251	0.239557	0.000000	73.00
76.97	07697	CARDIAC REHABILITATION	0	175,982	175,982	0.673455	0.000000	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0.000000	0.000000	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0.000000	0.000000	76.99
	OUTPATIENT SERVICE COST CENTERS							
91.00	09100	EMERGENCY	257,924	5,497,765	5,755,689	0.841478	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	10,372	702,723	713,095	0.652705	0.000000	92.00
	OTHER REIMBURSABLE COST CENTERS							
99.10	09910	CORF	0	0	0			99.10
200.00		Subtotal (see instructions)	15,680,133	55,309,892	70,990,025			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	15,680,133	55,309,892	70,990,025			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-1335

Period:
From 07/01/2019
To 06/30/2020Worksheet C
Part I
Date/Time Prepared:
2/26/2021 10:00 am

Cost Center Description			PPS Inpatient Ratio	Title XVIII	Hospital	Cost
			11.00			
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS				30.00
31.00	03100	INTENSIVE CARE UNIT				31.00
44.00	04400	SKILLED NURSING FACILITY				44.00
46.00	04600	OTHER LONG TERM CARE				46.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.167000			50.00
51.00	05100	RECOVERY ROOM	0.339862			51.00
53.00	05300	ANESTHESIOLOGY	2.625304			53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.169742			54.00
60.00	06000	LABORATORY	0.452167			60.00
60.01	06001	BLOOD LABORATORY	0.000000			60.01
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0.000000			62.30
65.00	06500	RESPIRATORY THERAPY	0.305493			65.00
66.00	06600	PHYSICAL THERAPY	0.626821			66.00
67.00	06700	OCCUPATIONAL THERAPY	1.044065			67.00
68.00	06800	SPEECH PATHOLOGY	1.044138			68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.170478			71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.324914			72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.239557			73.00
76.97	07697	CARDIAC REHABILITATION	0.673455			76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0.000000			76.98
76.99	07699	LITHOTRIPSY	0.000000			76.99
OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0.841478			91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.652705			92.00
OTHER REIMBURSABLE COST CENTERS						
99.10	09910	CORF				99.10
200.00		Subtotal (see instructions)				200.00
201.00		Less Observation Beds				201.00
202.00		Total (see instructions)				202.00

Worksheet C
Part I
Date/Time Prepared:
2/26/2021 10:00 am

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COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-1335

Period:
From 07/01/2019
To 06/30/2020Worksheet C
Part I
Date/Time Prepared:
2/26/2021 10:00 am

				Title XIX		Hospital		Cost	
Cost Center Description			Charges			Cost or Other Ratio	TEFRA Inpatient Ratio		
			Inpatient	Outpatient	Total (col. 6 + col. 7)				
			6.00	7.00	8.00				
	INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	0		0			30.00	
31.00	03100	INTENSIVE CARE UNIT	0		0			31.00	
44.00	04400	SKILLED NURSING FACILITY	0		0			44.00	
46.00	04600	OTHER LONG TERM CARE	0		0			46.00	
	ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	0	0.000000	0.000000	50.00	
51.00	05100	RECOVERY ROOM	0	0	0	0.000000	0.000000	51.00	
53.00	05300	ANESTHESIOLOGY	0	0	0	0.000000	0.000000	53.00	
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0.000000	0.000000	54.00	
60.00	06000	LABORATORY	0	0	0	0.000000	0.000000	60.00	
60.01	06001	BLOOD LABORATORY	0	0	0	0.000000	0.000000	60.01	
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0.000000	0.000000	62.30	
65.00	06500	RESPIRATORY THERAPY	0	0	0	0.000000	0.000000	65.00	
66.00	06600	PHYSICAL THERAPY	0	0	0	0.000000	0.000000	66.00	
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0.000000	0.000000	67.00	
68.00	06800	SPEECH PATHOLOGY	0	0	0	0.000000	0.000000	68.00	
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0.000000	0.000000	71.00	
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0.000000	0.000000	72.00	
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0.000000	0.000000	73.00	
76.97	07697	CARDIAC REHABILITATION	0	0	0	0.000000	0.000000	76.97	
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0.000000	0.000000	76.98	
76.99	07699	LITHOTRIPSY	0	0	0	0.000000	0.000000	76.99	
	OUTPATIENT SERVICE COST CENTERS								
91.00	09100	EMERGENCY	0	0	0	0.000000	0.000000	91.00	
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0.000000	0.000000	92.00	
	OTHER REIMBURSABLE COST CENTERS								
99.10	09910	CORF	0	0	0			99.10	
200.00		Subtotal (see instructions)	0	0	0			200.00	
201.00		Less Observation Beds						201.00	
202.00		Total (see instructions)	0	0	0			202.00	

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-1335

Period:
From 07/01/2019
To 06/30/2020Worksheet C
Part I
Date/Time Prepared:
2/26/2021 10:00 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
44.00	04400	SKILLED NURSING FACILITY				44.00
46.00	04600	OTHER LONG TERM CARE				46.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.000000			50.00
51.00	05100	RECOVERY ROOM	0.000000			51.00
53.00	05300	ANESTHESIOLOGY	0.000000			53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000			54.00
60.00	06000	LABORATORY	0.000000			60.00
60.01	06001	BLOOD LABORATORY	0.000000			60.01
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0.000000			62.30
65.00	06500	RESPIRATORY THERAPY	0.000000			65.00
66.00	06600	PHYSICAL THERAPY	0.000000			66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000			67.00
68.00	06800	SPEECH PATHOLOGY	0.000000			68.00
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
76.97	07697	CARDIAC REHABILITATION	0.000000			76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0.000000			76.98
76.99	07699	LITHOTRIPSY	0.000000			76.99
OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0.000000			91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000			92.00
OTHER REIMBURSABLE COST CENTERS						
99.10	09910	CORF				99.10
200.00		Subtotal (see instructions)				200.00
201.00		Less Observation Beds				201.00
202.00		Total (see instructions)				202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 14-1335

Period:
From 07/01/2019
To 06/30/2020Worksheet D
Part II
Date/Time Prepared:
2/26/2021 10:00 am

Cost Center Description			Title XVIII		Hospital	Cost	
			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	531,706	21,157,488	0.025131	1,493,315	37,528
51.00	05100	RECOVERY ROOM	37,922	3,814,306	0.009942	51,526	512
53.00	05300	ANESTHESIOLOGY	6,105	125,387	0.048689	0	0
54.00	05400	RADIOLOGY-DIAGNOSTIC	293,088	12,253,182	0.023919	390,961	9,351
60.00	06000	LABORATORY	63,729	3,220,572	0.019788	385,689	7,632
60.01	06001	BLOOD LABORATORY	0	0	0.000000	0	0
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0.000000	0	0
65.00	06500	RESPIRATORY THERAPY	43,901	1,269,342	0.034586	59,300	2,051
66.00	06600	PHYSICAL THERAPY	89,739	1,485,609	0.060406	110,862	6,697
67.00	06700	OCCUPATIONAL THERAPY	10,044	374,721	0.026804	0	0
68.00	06800	SPEECH PATHOLOGY	1,817	67,788	0.026804	0	0
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	13,554	6,660,260	0.002035	654,509	1,332
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	3,816	2,087,802	0.001828	470,938	861
73.00	07300	DRUGS CHARGED TO PATIENTS	84,814	6,260,251	0.013548	567,209	7,685
76.97	07697	CARDIAC REHABILITATION	24,968	175,982	0.141878	0	0
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0.000000	0	0
76.99	07699	LITHOTRIPSY	0	0	0.000000	0	0
OUTPATIENT SERVICE COST CENTERS							
91.00	09100	EMERGENCY	111,819	5,755,689	0.019428	21,056	409
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	41,355	713,095	0.057994	3,603	209
200.00		Total (lines 50 through 199)	1,358,377	65,421,474		4,208,968	74,267

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

Provider CCN: 14-1335

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

Worksheet D
Part IV
Date/Time Prepared:
2/26/2021 10:00 am

Cost Center Description			Title XVIII		Hospital		Cost	
			Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health	
			1.00	2A	2.00	3A	3.00	
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
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
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
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: 14-1335

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

Worksheet D
Part IV
Date/Time Prepared:
2/26/2021 10:00 am

Cost Center Description			Title XVIII		Hospital	Cost	
			All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7) (see instructions)
			4.00	5.00	6.00	7.00	8.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	0	0	21,157,488	0.000000
51.00	05100	RECOVERY ROOM	0	0	0	3,814,306	0.000000
53.00	05300	ANESTHESIOLOGY	0	0	0	125,387	0.000000
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	12,253,182	0.000000
60.00	06000	LABORATORY	0	0	0	3,220,572	0.000000
60.01	06001	BLOOD LABORATORY	0	0	0	0	0.000000
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0.000000
65.00	06500	RESPIRATORY THERAPY	0	0	0	1,269,342	0.000000
66.00	06600	PHYSICAL THERAPY	0	0	0	1,485,609	0.000000
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	374,721	0.000000
68.00	06800	SPEECH PATHOLOGY	0	0	0	67,788	0.000000
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	6,660,260	0.000000
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	2,087,802	0.000000
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	6,260,251	0.000000
76.97	07697	CARDIAC REHABILITATION	0	0	0	175,982	0.000000
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0.000000
76.99	07699	LITHOTRIPSY	0	0	0	0	0.000000
OUTPATIENT SERVICE COST CENTERS							
91.00	09100	EMERGENCY	0	0	0	5,755,689	0.000000
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	713,095	0.000000
200.00		Total (lines 50 through 199)	0	0	0	65,421,474	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-1335

Period:
From 07/01/2019
To 06/30/2020Worksheet D
Part IV
Date/Time Prepared:
2/26/2021 10:00 am

Cost Center Description		Title XVIII		Hospital		Cost	
		Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
		9.00	10.00	11.00	12.00	13.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0.000000	1,493,315	0	0	0 50.00
51.00	05100	RECOVERY ROOM	0.000000	51,526	0	0	0 51.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	0	0 53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	390,961	0	0	0 54.00
60.00	06000	LABORATORY	0.000000	385,689	0	0	0 60.00
60.01	06001	BLOOD LABORATORY	0.000000	0	0	0	0 60.01
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0.000000	0	0	0	0 62.30
65.00	06500	RESPIRATORY THERAPY	0.000000	59,300	0	0	0 65.00
66.00	06600	PHYSICAL THERAPY	0.000000	110,862	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
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	654,509	0	0	0 71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	470,938	0	0	0 72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	567,209	0	0	0 73.00
76.97	07697	CARDIAC REHABILITATION	0.000000	0	0	0	0 76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0.000000	0	0	0	0 76.98
76.99	07699	LITHOTRIPSY	0.000000	0	0	0	0 76.99
OUTPATIENT SERVICE COST CENTERS							
91.00	09100	EMERGENCY	0.000000	21,056	0	0	0 91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	3,603	0	0	0 92.00
200.00		Total (lines 50 through 199)		4,208,968	0	0	0 200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-1335

Period:
From 07/01/2019
To 06/30/2020Worksheet D
Part V
Date/Time Prepared:
2/26/2021 10:00 am

				Title XVIII		Hospital		Cost	
	Cost Center Description		Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges		Costs		PPS Services (see inst.)	
				PPS Reimbursed Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)			
	1.00	2.00	3.00	4.00	5.00				
	ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0.167000	0	4,296,007	0	0	50.00	
51.00	05100	RECOVERY ROOM	0.339862	0	1,068,279	0	0	51.00	
53.00	05300	ANESTHESIOLOGY	2.625304	0	80,178	0	0	53.00	
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.169742	0	3,318,152	0	0	54.00	
60.00	06000	LABORATORY	0.452167	0	1,694,898	0	0	60.00	
60.01	06001	BLOOD LABORATORY	0.000000	0	0	0	0	60.01	
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0.000000	0	0	0	0	62.30	
65.00	06500	RESPIRATORY THERAPY	0.305493	0	246,233	0	0	65.00	
66.00	06600	PHYSICAL THERAPY	0.626821	0	315,749	0	0	66.00	
67.00	06700	OCCUPATIONAL THERAPY	1.044065	0	0	0	0	67.00	
68.00	06800	SPEECH PATHOLOGY	1.044138	0	0	0	0	68.00	
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.170478	0	1,307,574	0	0	71.00	
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.324914	0	416,690	0	0	72.00	
73.00	07300	DRUGS CHARGED TO PATIENTS	0.239557	0	1,541,225	11,654	0	73.00	
76.97	07697	CARDIAC REHABILITATION	0.673455	0	98,342	0	0	76.97	
76.98	07698	HYPERBARIC OXYGEN THERAPY	0.000000	0	0	0	0	76.98	
76.99	07699	LITHOTRIPSY	0.000000	0	0	0	0	76.99	
	OUTPATIENT SERVICE COST CENTERS								
91.00	09100	EMERGENCY	0.841478	0	1,430,296	0	0	91.00	
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.652705	0	197,389	0	0	92.00	
200.00		Subtotal (see instructions)		0	16,011,012	11,654	0	200.00	
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00	
202.00		Net Charges (line 200 - line 201)		0	16,011,012	11,654	0	202.00	

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-1335

Period:
From 07/01/2019
To 06/30/2020Worksheet D
Part V
Date/Time Prepared:
2/26/2021 10:00 am

				Title XVIII	Hospital	Cost
	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	717,433	0		50.00
51.00	05100	RECOVERY ROOM	363,067	0		51.00
53.00	05300	ANESTHESIOLOGY	210,492	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	563,230	0		54.00
60.00	06000	LABORATORY	766,377	0		60.00
60.01	06001	BLOOD LABORATORY	0	0		60.01
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0		62.30
65.00	06500	RESPIRATORY THERAPY	75,222	0		65.00
66.00	06600	PHYSICAL THERAPY	197,918	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0		68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	222,913	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	135,388	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	369,211	2,792		73.00
76.97	07697	CARDIAC REHABILITATION	66,229	0		76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0		76.98
76.99	07699	LITHOTRIPSY	0	0		76.99
	OUTPATIENT SERVICE COST CENTERS					
91.00	09100	EMERGENCY	1,203,563	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	128,837	0		92.00
200.00		Subtotal (see instructions)	5,019,880	2,792		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	5,019,880	2,792		202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-1335

Period:

Worksheet D

Component CCN: 14-6014

From 07/01/2019
To 06/30/2020Part V
Date/Time Prepared:
2/26/2021 10:00 am

Title XVIII

Skilled Nursing
Facility

PPS

	Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Facility		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
	ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0.167000	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0.339862	0	0	0	0	51.00
53.00	05300	ANESTHESIOLOGY	2.625304	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.169742	0	0	0	0	54.00
60.00	06000	LABORATORY	0.452167	0	0	0	0	60.00
60.01	06001	BLOOD LABORATORY	0.000000	0	0	0	0	60.01
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0.000000	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0.305493	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.626821	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	1.044065	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	1.044138	0	0	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.170478	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.324914	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.239557	0	0	1,442	0	73.00
76.97	07697	CARDIAC REHABILITATION	0.673455	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0.000000	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0.000000	0	0	0	0	76.99
	OUTPATIENT SERVICE COST CENTERS							
91.00	09100	EMERGENCY	0.841478	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.652705	0	0	0	0	92.00
200.00		Subtotal (see instructions)		0	0	1,442	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 - line 201)		0	0	1,442	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-1335

Period:

Worksheet D

Component CCN: 14-6014

From 07/01/2019
To 06/30/2020Part V
Date/Time Prepared:
2/26/2021 10:00 am

Title XVIII

Skilled Nursing
Facility

PPS

Cost Center Description			Costs		
			Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	
			6.00	7.00	
	ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	51.00
53.00	05300	ANESTHESIOLOGY	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	54.00
60.00	06000	LABORATORY	0	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	60.01
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	68.00
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	345	73.00
76.97	07697	CARDIAC REHABILITATION	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	76.99
	OUTPATIENT SERVICE COST CENTERS				
91.00	09100	EMERGENCY	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	92.00
200.00		Subtotal (see instructions)	0	345	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0		201.00
202.00		Net Charges (line 200 - line 201)	0	345	202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

Provider CCN: 14-1335

Period:
From 07/01/2019
To 06/30/2020Worksheet D
Part I
Date/Time Prepared:
2/26/2021 10:00 am

			Title XIX		Hospital	Cost	
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	201,991	0	201,991	1,309	154.31	30.00
31.00	INTENSIVE CARE UNIT	44,746		44,746	95	471.01	31.00
44.00	SKILLED NURSING FACILITY	139,081		139,081	2,111	65.88	44.00
200.00	Total (lines 30 through 199)	385,818		385,818	3,515		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	15	2,315				30.00
31.00	INTENSIVE CARE UNIT	0	0				31.00
44.00	SKILLED NURSING FACILITY	0	0				44.00
200.00	Total (lines 30 through 199)	15	2,315				200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 14-1335

Period:
From 07/01/2019
To 06/30/2020Worksheet D
Part II
Date/Time Prepared:
2/26/2021 10:00 am

Cost Center Description			Title XIX		Hospital		Cost	
			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	531,706	0	0.000000	0	0	50.00
51.00	05100	RECOVERY ROOM	37,922	0	0.000000	0	0	51.00
53.00	05300	ANESTHESIOLOGY	6,105	0	0.000000	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	293,088	0	0.000000	0	0	54.00
60.00	06000	LABORATORY	63,729	0	0.000000	0	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0.000000	0	0	60.01
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0.000000	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	43,901	0	0.000000	0	0	65.00
66.00	06600	PHYSICAL THERAPY	89,739	0	0.000000	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	10,044	0	0.000000	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	1,817	0	0.000000	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	13,554	0	0.000000	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	3,816	0	0.000000	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	84,814	0	0.000000	0	0	73.00
76.97	07697	CARDIAC REHABILITATION	24,968	0	0.000000	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0.000000	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0.000000	0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
91.00	09100	EMERGENCY	111,819	0	0.000000	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	41,355	0	0.000000	0	0	92.00
200.00		Total (lines 50 through 199)	1,358,377	0		0	0	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS					Provider CCN: 14-1335		Period: From 07/01/2019 To 06/30/2020		Worksheet D Part III Date/Time Prepared: 2/26/2021 10:00 am	
					Title XIX		Hospital		Cost	
Cost Center Description					Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health Cost	All Other Medical Education Cost	
					1A	1.00	2A	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS										
30.00	03000	ADULTS & PEDIATRICS		0	0	0	0	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT		0	0	0	0	0	0	31.00
44.00	04400	SKILLED NURSING FACILITY		0	0	0	0	0	0	44.00
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	1,309	0.00		15	30.00
31.00	03100	INTENSIVE CARE UNIT			0	95	0.00		0	31.00
44.00	04400	SKILLED NURSING FACILITY			0	2,111	0.00		0	44.00
200.00		Total (lines 30 through 199)			0	3,515			15	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
44.00	04400	SKILLED NURSING FACILITY		0						44.00
200.00		Total (lines 30 through 199)		0						200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

Provider CCN: 14-1335

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

Worksheet D
Part IV
Date/Time Prepared:
2/26/2021 10:00 am

Cost Center Description			Title XIX		Hospital		Cost	
			Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health	
			1.00	2A	2.00	3A	3.00	
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
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
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
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: 14-1335

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

Worksheet D
Part IV
Date/Time Prepared:
2/26/2021 10:00 am

Cost Center Description			Title XIX		Hospital		Cost	
			All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7) (see instructions)	
			4.00	5.00	6.00	7.00	8.00	
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	0	0	0.000000	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0.000000	51.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0.000000	54.00
60.00	06000	LABORATORY	0	0	0	0	0.000000	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0.000000	60.01
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0.000000	62.30
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0.000000	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0.000000	73.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0.000000	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0.000000	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0.000000	76.99
OUTPATIENT SERVICE COST CENTERS								
91.00	09100	EMERGENCY	0	0	0	0	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	0.000000	92.00
200.00		Total (lines 50 through 199)	0	0	0	0		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

Provider CCN: 14-1335

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

Worksheet D
Part IV
Date/Time Prepared:
2/26/2021 10:00 am

Cost Center Description		Title XIX		Hospital		Cost	
		Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
		9.00	10.00	11.00	12.00	13.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0.000000	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0.000000	0	0	0	51.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	0	0	0	54.00
60.00	06000	LABORATORY	0.000000	0	0	0	60.00
60.01	06001	BLOOD LABORATORY	0.000000	0	0	0	60.01
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0.000000	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0.000000	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	0	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	0	0	0	73.00
76.97	07697	CARDIAC REHABILITATION	0.000000	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0.000000	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0.000000	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS							
91.00	09100	EMERGENCY	0.000000	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	0	0	0	92.00
200.00		Total (lines 50 through 199)		0	0	0	200.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-1335

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

Worksheet D-1

Date/Time Prepared:
2/26/2021 10:00 am

Title XVIII		Hospital	Cost
Cost Center Description			1.00
PART I - ALL PROVIDER COMPONENTS			
INPATIENT DAYS			
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	1,309	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	1,309	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)	1,041	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)	567	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		17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)	2,273,370	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)	0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)	0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)	0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)	0	25.00
26.00	Total swing-bed cost (see instructions)	0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	2,273,370	27.00
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT			
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	28.00
29.00	Private room charges (excluding swing-bed charges)	0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)	0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)	0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)	0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	2,273,370	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)	1,736.72	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	984,720	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)	984,720	41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-1335

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

Worksheet D-1

Date/Time Prepared:
2/26/2021 10:00 am

Cost Center Description		Title XVIII		Hospital		Cost	
		Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)						42.00
Intensive Care Type Inpatient Hospital Units							
43.00	INTENSIVE CARE UNIT	575,633	95	6,059.29	28	169,660	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)					1,015,804	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					2,170,184	49.00
PASS THROUGH COST ADJUSTMENTS							
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)					0	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					0	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)					0	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					0	53.00
TARGET AMOUNT AND LIMIT COMPUTATION							
54.00	Program discharges					0	54.00
55.00	Target amount per discharge					0.00	55.00
56.00	Target amount (line 54 x line 55)					0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)					0	57.00
58.00	Bonus payment (see instructions)					0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket					0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket					0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)					0	61.00
62.00	Relief payment (see instructions)					0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)					0	63.00
PROGRAM INPATIENT ROUTINE SWING BED COST							
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)					0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)					0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)					0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)					0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)					0	69.00
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY							
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)						70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)						71.00
72.00	Program routine service cost (line 9 x line 71)						72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)						73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)						74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)						75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)						76.00
77.00	Program capital-related costs (line 9 x line 76)						77.00
78.00	Inpatient routine service cost (line 74 minus line 77)						78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)						79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)						80.00
81.00	Inpatient routine service cost per diem limitation						81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)						82.00
83.00	Reasonable inpatient routine service costs (see instructions)						83.00
84.00	Program inpatient ancillary services (see instructions)						84.00
85.00	Utilization review - physician compensation (see instructions)						85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)						86.00
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
87.00	Total observation bed days (see instructions)					268	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					1,736.72	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)					465,441	89.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-1335

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

Worksheet D-1

Date/Time Prepared:
2/26/2021 10:00 am

		Title XVIII		Hospital		Cost	
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	201,991	2,273,370	0.088851	465,441	41,355	90.00
91.00	Nursing School cost	0	2,273,370	0.000000	465,441	0	91.00
92.00	Allied health cost	0	2,273,370	0.000000	465,441	0	92.00
93.00	All other Medical Education	0	2,273,370	0.000000	465,441	0	93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-1335 Component CCN: 14-6014	Period: From 07/01/2019 To 06/30/2020	Worksheet D-1 Date/Time Prepared: 2/26/2021 10:00 am
		Title XVIII	Skilled Nursing Facility	PPS
Cost Center Description			1.00	
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		2,111	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		2,111	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)		2,111	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions)		1,237	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			17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period			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)		1,430,991	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)		1,430,991	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)		1,430,991	37.00
PART II - HOSPITAL AND SUBPROVIDERS ONLY				
PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS				
38.00	Adjusted general inpatient routine service cost per diem (see instructions)			38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)			39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)			40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)			41.00

COMPUTATION OF INPATIENT OPERATING COST				Provider CCN: 14-1335 Component CCN: 14-6014	Period: From 07/01/2019 To 06/30/2020	Worksheet D-1 Date/Time Prepared: 2/26/2021 10:00 am	
				Title XVIII	Skilled Nursing Facility	PPS	
	Cost Center Description	Total	Total	Average Per	Program Days	Program Cost (col. 3 x col. 4)	
		Inpatient Cost	Inpatient Days	Diem (col. 1 ÷ col. 2)			
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)						42.00
Intensive Care Type Inpatient Hospital Units							
43.00	INTENSIVE CARE UNIT						43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00
Cost Center Description							
						1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)						48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)						49.00
PASS THROUGH COST ADJUSTMENTS							
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)						50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)						51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)						52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)						53.00
TARGET AMOUNT AND LIMIT COMPUTATION							
54.00	Program discharges						54.00
55.00	Target amount per discharge						55.00
56.00	Target amount (line 54 x line 55)						56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)						57.00
58.00	Bonus payment (see instructions)						58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket						59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket						60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)						61.00
62.00	Relief payment (see instructions)						62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)						63.00
PROGRAM INPATIENT ROUTINE SWING BED COST							
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)						64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)						65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)						66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)						67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)						68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)						69.00
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY							
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)					1,430,991	70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)					677.87	71.00
72.00	Program routine service cost (line 9 x line 71)					838,525	72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)					0	73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)					838,525	74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)					0	75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)					0.00	76.00
77.00	Program capital-related costs (line 9 x line 76)					0	77.00
78.00	Inpatient routine service cost (line 74 minus line 77)					0	78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)					0	79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)					0	80.00
81.00	Inpatient routine service cost per diem limitation					0.00	81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)					0	82.00
83.00	Reasonable inpatient routine service costs (see instructions)					838,525	83.00
84.00	Program inpatient ancillary services (see instructions)					508,052	84.00
85.00	Utilization review - physician compensation (see instructions)					0	85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)					1,346,577	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: 14-1335
 Component CCN: 14-6014

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

 Worksheet D-1
 Date/Time Prepared:
 2/26/2021 10:00 am

Title XVIII

 Skilled Nursing
 Facility

PPS

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

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-1335

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

Worksheet D-1

Date/Time Prepared:

2/26/2021 10:00 am

Title XIX		Hospital	Cost
Cost Center Description			1.00
PART I - ALL PROVIDER COMPONENTS			
INPATIENT DAYS			
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	1,309	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	1,309	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)	1,041	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)	15	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		17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)	2,273,370	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)	0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)	0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)	0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)	0	25.00
26.00	Total swing-bed cost (see instructions)	0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	2,273,370	27.00
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT			
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	28.00
29.00	Private room charges (excluding swing-bed charges)	0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)	0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)	0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)	0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	2,273,370	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)	1,736.72	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	26,051	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)	26,051	41.00

COMPUTATION OF INPATIENT OPERATING COST			Provider CCN: 14-1335	Period: From 07/01/2019 To 06/30/2020	Worksheet D-1 Date/Time Prepared: 2/26/2021 10:00 am
			Title XIX	Hospital	Cost
Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)
	1.00	2.00	3.00	4.00	5.00
42.00 NURSERY (title V & XIX only)					42.00
Intensive Care Type Inpatient Hospital Units					
43.00 INTENSIVE CARE UNIT	575,633	95	6,059.29	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)					26,051 49.00
PASS THROUGH COST ADJUSTMENTS					
50.00 Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)					0 50.00
51.00 Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					0 51.00
52.00 Total Program excludable cost (sum of lines 50 and 51)					0 52.00
53.00 Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					0 53.00
TARGET AMOUNT AND LIMIT COMPUTATION					
54.00 Program discharges					0 54.00
55.00 Target amount per discharge					0.00 55.00
56.00 Target amount (line 54 x line 55)					0 56.00
57.00 Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)					0 57.00
58.00 Bonus payment (see instructions)					0 58.00
59.00 Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket					0.00 59.00
60.00 Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket					0.00 60.00
61.00 If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)					0 61.00
62.00 Relief payment (see instructions)					0 62.00
63.00 Allowable Inpatient cost plus incentive payment (see instructions)					0 63.00
PROGRAM INPATIENT ROUTINE SWING BED COST					
64.00 Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)					0 64.00
65.00 Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					0 65.00
66.00 Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)					0 66.00
67.00 Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)					0 67.00
68.00 Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)					0 68.00
69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)					0 69.00
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY					
70.00 Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)					70.00
71.00 Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)					71.00
72.00 Program routine service cost (line 9 x line 71)					72.00
73.00 Medically necessary private room cost applicable to Program (line 14 x line 35)					73.00
74.00 Total Program general inpatient routine service costs (line 72 + line 73)					74.00
75.00 Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)					75.00
76.00 Per diem capital-related costs (line 75 ÷ line 2)					76.00
77.00 Program capital-related costs (line 9 x line 76)					77.00
78.00 Inpatient routine service cost (line 74 minus line 77)					78.00
79.00 Aggregate charges to beneficiaries for excess costs (from provider records)					79.00
80.00 Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)					80.00
81.00 Inpatient routine service cost per diem limitation					81.00
82.00 Inpatient routine service cost limitation (line 9 x line 81)					82.00
83.00 Reasonable inpatient routine service costs (see instructions)					83.00
84.00 Program inpatient ancillary services (see instructions)					84.00
85.00 Utilization review - physician compensation (see instructions)					85.00
86.00 Total Program inpatient operating costs (sum of lines 83 through 85)					86.00
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST					
87.00 Total observation bed days (see instructions)					268 87.00
88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					1,736.72 88.00
89.00 Observation bed cost (line 87 x line 88) (see instructions)					465,441 89.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-1335

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

Worksheet D-1

Date/Time Prepared:
2/26/2021 10:00 am

		Title XIX		Hospital		Cost	
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	201,991	2,273,370	0.088851	465,441	41,355	90.00
91.00	Nursing School cost	0	2,273,370	0.000000	465,441	0	91.00
92.00	Allied health cost	0	2,273,370	0.000000	465,441	0	92.00
93.00	All other Medical Education	0	2,273,370	0.000000	465,441	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT			Provider CCN: 14-1335	Period: From 07/01/2019 To 06/30/2020	Worksheet D-3 Date/Time Prepared: 2/26/2021 10:00 am	
			Title XVIII	Hospital	Cost	
Cost Center Description			Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS		1,667,649		30.00
31.00	03100	INTENSIVE CARE UNIT		190,805		31.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.167000	1,493,315	249,384	50.00
51.00	05100	RECOVERY ROOM	0.339862	51,526	17,512	51.00
53.00	05300	ANESTHESIOLOGY	2.625304	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.169742	390,961	66,363	54.00
60.00	06000	LABORATORY	0.452167	385,689	174,396	60.00
60.01	06001	BLOOD LABORATORY	0.000000	0	0	60.01
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0.000000	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0.305493	59,300	18,116	65.00
66.00	06600	PHYSICAL THERAPY	0.626821	110,862	69,491	66.00
67.00	06700	OCCUPATIONAL THERAPY	1.044065	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	1.044138	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.170478	654,509	111,579	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.324914	470,938	153,014	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.239557	567,209	135,879	73.00
76.97	07697	CARDIAC REHABILITATION	0.673455	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0.000000	0	0	76.98
76.99	07699	LITHOTRIPSY	0.000000	0	0	76.99
OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0.841478	21,056	17,718	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.652705	3,603	2,352	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		4,208,968	1,015,804	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)		4,208,968		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 14-1335 Component CCN: 14-6014	Period: From 07/01/2019 To 06/30/2020	Worksheet D-3 Date/Time Prepared: 2/26/2021 10:00 am	
		Title XVIII	Skilled Nursing Facility	PPS	
Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDIATRICS		0		30.00
31.00	03100 INTENSIVE CARE UNIT		0		31.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.167000	0	0	50.00
51.00	05100 RECOVERY ROOM	0.339862	0	0	51.00
53.00	05300 ANESTHESIOLOGY	2.625304	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.169742	14,904	2,530	54.00
60.00	06000 LABORATORY	0.452167	32,794	14,828	60.00
60.01	06001 BLOOD LABORATORY	0.000000	0	0	60.01
62.30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0.000000	0	0	62.30
65.00	06500 RESPIRATORY THERAPY	0.305493	422	129	65.00
66.00	06600 PHYSICAL THERAPY	0.626821	253,618	158,973	66.00
67.00	06700 OCCUPATIONAL THERAPY	1.044065	246,329	257,183	67.00
68.00	06800 SPEECH PATHOLOGY	1.044138	36,743	38,365	68.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.170478	17,318	2,952	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.324914	377	122	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.239557	120,723	28,920	73.00
76.97	07697 CARDIAC REHABILITATION	0.673455	0	0	76.97
76.98	07698 HYPERBARIC OXYGEN THERAPY	0.000000	0	0	76.98
76.99	07699 LITHOTRIPSY	0.000000	0	0	76.99
OUTPATIENT SERVICE COST CENTERS					
91.00	09100 EMERGENCY	0.841478	401	337	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0.652705	5,688	3,713	92.00
200.00	Total (sum of lines 50 through 94 and 96 through 98)		729,317	508,052	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)		729,317		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-1335	Period: From 07/01/2019 To 06/30/2020	Worksheet E Part B Date/Time Prepared: 2/26/2021 10:00 am
		Title XVIII	Hospital	Cost
				1.00
PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)			5,022,672 1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)			0 2.00
3.00	OPPS payments			5,915,940 3.00
4.00	Outlier payment (see instructions)			0 4.00
4.01	Outlier reconciliation amount (see instructions)			0 4.01
5.00	Enter the hospital specific payment to cost ratio (see instructions)			0.000 5.00
6.00	Line 2 times line 5			0 6.00
7.00	Sum of lines 3, 4, and 4.01, divided by line 6			0.00 7.00
8.00	Transitional corridor payment (see instructions)			0 8.00
9.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200			0 9.00
10.00	Organ acquisitions			0 10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)			5,022,672 11.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
12.00	Ancillary service charges			0 12.00
13.00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, line 69)			0 13.00
14.00	Total reasonable charges (sum of lines 12 and 13)			0 14.00
Customary charges				
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis			0 15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)			0 16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)			0.000000 17.00
18.00	Total customary charges (see instructions)			0 18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)			0 19.00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)			0 20.00
21.00	Lesser of cost or charges (see instructions)			5,072,899 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)			5,915,940 24.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25.00	Deductibles and coinsurance amounts (for CAH, see instructions)			20,460 25.00
26.00	Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)			2,874,392 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)			2,178,047 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)			2,178,047 30.00
31.00	Primary payer payments			860 31.00
32.00	Subtotal (line 30 minus line 31)			2,177,187 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)			399,858 34.00
35.00	Adjusted reimbursable bad debts (see instructions)			259,908 35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			317,725 36.00
37.00	Subtotal (see instructions)			2,437,095 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)			2,437,095 40.00
40.01	Sequestration adjustment (see instructions)			40,699 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			1,798,255 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)			598,141 43.00
43.01	Balance due provider/program-PARHM (see instructions)			0 43.01
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2			0 44.00
TO BE COMPLETED BY CONTRACTOR				
90.00	Original outlier amount (see instructions)			0 90.00
91.00	Outlier reconciliation adjustment amount (see instructions)			0 91.00
92.00	The rate used to calculate the Time Value of Money			0.00 92.00
93.00	Time Value of Money (see instructions)			0 93.00
94.00	Total (sum of lines 91 and 93)			0 94.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-1335 Component CCN: 14-6014	Period: From 07/01/2019 To 06/30/2020	Worksheet E Part B Date/Time Prepared: 2/26/2021 10:00 am
		Title XVIII	Skilled Nursing Facility	PPS
			1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES			
1.00	Medical and other services (see instructions)		345	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)		0	2.00
3.00	OPPS payments			3.00
4.00	Outlier payment (see instructions)			4.00
4.01	Outlier reconciliation amount (see instructions)			4.01
5.00	Enter the hospital specific payment to cost ratio (see instructions)			5.00
6.00	Line 2 times line 5		0	6.00
7.00	Sum of lines 3, 4, and 4.01, divided by line 6		0.00	7.00
8.00	Transitional corridor payment (see instructions)		0	8.00
9.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200		0	9.00
10.00	Organ acquisitions		0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)		345	11.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
12.00	Ancillary service charges		1,442	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)		1,442	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)		1,442	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)		1,097	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)		345	21.00
22.00	Interns and residents (see instructions)		0	22.00
23.00	Cost of physicians' services in a teaching hospital (see instructions)		0	23.00
24.00	Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)		0	24.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25.00	Deductibles and coinsurance amounts (for CAH, see instructions)		0	25.00
26.00	Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)			26.00
27.00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions)		345	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)		345	30.00
31.00	Primary payer payments		0	31.00
32.00	Subtotal (line 30 minus line 31)		345	32.00
ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)				
33.00	Composite rate ESRD (from Wkst. I-5, line 11)		0	33.00
34.00	Allowable bad debts (see instructions)		0	34.00
35.00	Adjusted reimbursable bad debts (see instructions)		0	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		0	36.00
37.00	Subtotal (see instructions)		345	37.00
38.00	MSP-LCC reconciliation amount from PS&R			38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	39.00
39.50	Pioneer ACO demonstration payment adjustment (see instructions)			39.50
39.97	Demonstration payment adjustment amount before sequestration		0	39.97
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)		0	39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION		0	39.99
40.00	Subtotal (see instructions)		345	40.00
40.01	Sequestration adjustment (see instructions)		6	40.01
40.02	Demonstration payment adjustment amount after sequestration		0	40.02
40.03	Sequestration adjustment-PARHM pass-throughs			40.03
41.00	Interim payments		1,413	41.00
41.01	Interim payments-PARHM			41.01
42.00	Tentative settlement (for contractors use only)		0	42.00
42.01	Tentative settlement-PARHM (for contractor use only)			42.01
43.00	Balance due provider/program (see instructions)		-1,074	43.00
43.01	Balance due provider/program-PARHM (see instructions)			43.01
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		0	44.00
TO BE COMPLETED BY CONTRACTOR				
90.00	Original outlier amount (see instructions)			90.00
91.00	Outlier reconciliation adjustment amount (see instructions)			91.00
92.00	The rate used to calculate the Time Value of Money			92.00
93.00	Time Value of Money (see instructions)			93.00
94.00	Total (sum of lines 91 and 93)			94.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 14-1335

Period:
From 07/01/2019
To 06/30/2020Worksheet E-1
Part I
Date/Time Prepared:
2/26/2021 10:00 am

		Title XVIII		Hospital		Cost
		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		1,571,115		1,988,484	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
Program to Provider						
3.01	ADJUSTMENTS TO PROVIDER	03/06/2020	129,162		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	03/06/2020	190,229	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)		129,162		-190,229	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)		1,700,277		1,798,255	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		284,854		598,141	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		1,985,131		2,396,396	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: 14-1335
 Component CCN: 14-6014

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

 Worksheet E-1
 Part I
 Date/Time Prepared:
 2/26/2021 10:00 am

Title XVIII

 Skilled Nursing
 Facility

PPS

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		577,206		1,413	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
Program to Provider						
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
Provider to Program						
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		577,206		1,413	4.00
TO BE COMPLETED BY CONTRACTOR						
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
Program to Provider						
5.01	TENTATIVE TO PROVIDER		0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
Provider to Program						
5.50	TENTATIVE TO PROGRAM		0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		1		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		1,074	6.02
7.00	Total Medicare program liability (see instructions)		577,207		339	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: 14-1335

Period:
From 07/01/2019
To 06/30/2020Worksheet E-1
Part II
Date/Time Prepared:
2/26/2021 10:00 am

		Title XVIII	Hospital	Cost
				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: 14-1335	Period: From 07/01/2019 To 06/30/2020	Worksheet E-3 Part V Date/Time Prepared: 2/26/2021 10:00 am
		Title XVIII	Hospital	Cost
		1.00		
PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PART A SERVICES - COST REIMBURSEMENT				
1.00	Inpatient services		2,170,184	1.00
2.00	Nursing and Allied Health Managed Care payment (see instructions)		0	2.00
3.00	Organ acquisition		0	3.00
4.00	Subtotal (sum of lines 1 through 3)		2,170,184	4.00
5.00	Primary payer payments		0	5.00
6.00	Total cost (line 4 less line 5). For CAH (see instructions)		2,191,886	6.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
7.00	Routine service charges		0	7.00
8.00	Ancillary service charges		0	8.00
9.00	Organ acquisition charges, net of revenue		0	9.00
10.00	Total reasonable charges		0	10.00
Customary charges				
11.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis		0	11.00
12.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR 413.13(e)		0	12.00
13.00	Ratio of line 11 to line 12 (not to exceed 1.000000)		0.000000	13.00
14.00	Total customary charges (see instructions)		0	14.00
15.00	Excess of customary charges over reasonable cost (complete only if line 14 exceeds line 6) (see instructions)		0	15.00
16.00	Excess of reasonable cost over customary charges (complete only if line 6 exceeds line 14) (see instructions)		0	16.00
17.00	Cost of physicians' services in a teaching hospital (see instructions)		0	17.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT				
18.00	Direct graduate medical education payments (from Worksheet E-4, line 49)		0	18.00
19.00	Cost of covered services (sum of lines 6, 17 and 18)		2,191,886	19.00
20.00	Deductibles (exclude professional component)		182,820	20.00
21.00	Excess reasonable cost (from line 16)		0	21.00
22.00	Subtotal (line 19 minus line 20 and 21)		2,009,066	22.00
23.00	Coinsurance		0	23.00
24.00	Subtotal (line 22 minus line 23)		2,009,066	24.00
25.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)		15,046	25.00
26.00	Adjusted reimbursable bad debts (see instructions)		9,780	26.00
27.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		12,479	27.00
28.00	Subtotal (sum of lines 24 and 25, or line 26)		2,018,846	28.00
29.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	29.00
29.50	Pioneer ACO demonstration payment adjustment (see instructions)		0	29.50
29.99	Demonstration payment adjustment amount before sequestration		0	29.99
30.00	Subtotal (see instructions)		2,018,846	30.00
30.01	Sequestration adjustment (see instructions)		33,715	30.01
30.02	Demonstration payment adjustment amount after sequestration		0	30.02
30.03	Sequestration adjustment-PARHM		0	30.03
31.00	Interim payments		1,700,277	31.00
31.01	Interim payments-PARHM		0	31.01
32.00	Tentative settlement (for contractor use only)		0	32.00
32.01	Tentative settlement-PARHM (for contractor use only)		0	32.01
33.00	Balance due provider/program (line 30 minus lines 30.01, 30.02, 31, and 32)		284,854	33.00
33.01	Balance due provider/program-PARHM (lines 2, 3, 18, and 26, minus lines 30.03, 31.01, and 32.01)		0	33.01
34.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		0	34.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-1335 Component CCN: 14-6014	Period: From 07/01/2019 To 06/30/2020	Worksheet E-3 Part VI Date/Time Prepared: 2/26/2021 10:00 am
		Title XVIII	Skilled Nursing Facility	PPS
				1.00
PART VI - CALCULATION OF REIMBURSEMENT SETTLEMENT - ALL OTHER HEALTH SERVICES FOR TITLE XVIII PART A PPS SNF SERVICES				
PROSPECTIVE PAYMENT AMOUNT (SEE INSTRUCTIONS)				
1.00	Resource Utilization Group Payment (RUGS)			675,531 1.00
2.00	Routine service other pass through costs			0 2.00
3.00	Ancillary service other pass through costs			0 3.00
4.00	Subtotal (sum of lines 1 through 3)			675,531 4.00
COMPUTATION OF NET COST OF COVERED SERVICES				
5.00	Medical and other services (Do not use this line as vaccine costs are included in line 1 of W/S E, Part B. This line is now shaded.)			5.00
6.00	Deductible			0 6.00
7.00	Coinsurance			88,473 7.00
8.00	Allowable bad debts (see instructions)			0 8.00
9.00	Reimbursable bad debts for dual eligible beneficiaries (see instructions)			0 9.00
10.00	Adjusted reimbursable bad debts (see instructions)			0 10.00
11.00	Utilization review			0 11.00
12.00	Subtotal (sum of lines 4, 5 minus lines 6 and 7, plus lines 10 and 11)(see instructions)			587,058 12.00
13.00	Inpatient primary payer payments			0 13.00
14.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0 14.00
14.50	Pioneer ACO demonstration payment adjustment (see instructions)			0 14.50
14.99	Demonstration payment adjustment amount before sequestration			0 14.99
15.00	Subtotal (see instructions)			587,058 15.00
15.01	Sequestration adjustment (see instructions)			9,851 15.01
15.02	Demonstration payment adjustment amount after sequestration			0 15.02
15.75	Sequestration for non-claims based amounts (see instructions)			0 15.75
16.00	Interim payments			577,206 16.00
17.00	Tentative settlement (for contractor use only)			0 17.00
18.00	Balance due provider/program (line 15 minus lines 15.01, 15.02, 15.75, 16, and 17)			1 18.00
19.00	Protested amounts (nonallowable cost report items) in accordance with CMS 19 Pub. 15-2, chapter 1, §115.2			0 19.00

CALCULATION OF REIMBURSEMENT SETTLEMENT

Provider CCN: 14-1335

Period:
From 07/01/2019
To 06/30/2020Worksheet E-3
Part VII
Date/Time Prepared:
2/26/2021 10:00 am

		Title XIX	Hospital	Cost	
			Inpatient	Outpatient	
			1.00	2.00	
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR XIX SERVICES				
	COMPUTATION OF NET COST OF COVERED SERVICES				
1.00	Inpatient hospital/SNF/NF services		26,051		1.00
2.00	Medical and other services			0	2.00
3.00	Organ acquisition (certified transplant centers only)		0		3.00
4.00	Subtotal (sum of lines 1, 2 and 3)		26,051	0	4.00
5.00	Inpatient primary payer payments		0		5.00
6.00	Outpatient primary payer payments			0	6.00
7.00	Subtotal (line 4 less sum of lines 5 and 6)		26,051	0	7.00
	COMPUTATION OF LESSER OF COST OR CHARGES				
	Reasonable Charges				
8.00	Routine service charges		0		8.00
9.00	Ancillary service charges		0	0	9.00
10.00	Organ acquisition charges, net of revenue		0		10.00
11.00	Incentive from target amount computation		0		11.00
12.00	Total reasonable charges (sum of lines 8 through 11)		0	0	12.00
	CUSTOMARY CHARGES				
13.00	Amount actually collected from patients liable for payment for services on a charge basis		0	0	13.00
14.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)		0	0	14.00
15.00	Ratio of line 13 to line 14 (not to exceed 1.000000)		0.000000	0.000000	15.00
16.00	Total customary charges (see instructions)		0	0	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)		0	0	17.00
18.00	Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 16) (see instructions)		26,051	0	18.00
19.00	Interns and Residents (see instructions)		0	0	19.00
20.00	Cost of physicians' services in a teaching hospital (see instructions)		0	0	20.00
21.00	Cost of covered services (enter the lesser of line 4 or line 16)		26,051	0	21.00
	PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be completed for PPS providers.				
22.00	Other than outlier payments		0	0	22.00
23.00	Outlier payments		0	0	23.00
24.00	Program capital payments		0		24.00
25.00	Capital exception payments (see instructions)		0		25.00
26.00	Routine and Ancillary service other pass through costs		0	0	26.00
27.00	Subtotal (sum of lines 22 through 26)		0	0	27.00
28.00	Customary charges (title V or XIX PPS covered services only)		0	0	28.00
29.00	Titles V or XIX (sum of lines 21 and 27)		26,051	0	29.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT				
30.00	Excess of reasonable cost (from line 18)		26,051	0	30.00
31.00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)		26,051	0	31.00
32.00	Deductibles		0	0	32.00
33.00	Coinurance		0	0	33.00
34.00	Allowable bad debts (see instructions)		0	0	34.00
35.00	Utilization review		0		35.00
36.00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)		26,051	0	36.00
37.00	PAYMENT		-26,051	0	37.00
38.00	Subtotal (line 36 ± line 37)		0	0	38.00
39.00	Direct graduate medical education payments (from Wkst. E-4)		0		39.00
40.00	Total amount payable to the provider (sum of lines 38 and 39)		0	0	40.00
41.00	Interim payments		0	0	41.00
42.00	Balance due provider/program (line 40 minus line 41)		0	0	42.00
43.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, chapter 1, §115.2		0	0	43.00

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

Provider CCN: 14-1335

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

Worksheet G

Date/Time Prepared:
2/26/2021 10:00 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	5,111,861	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	13,529,575	0	0	0	4.00
5.00 Other receivable	183,571	0	0	0	5.00
6.00 Allowances for uncollectible notes and accounts receivable	-8,913,453	0	0	0	6.00
7.00 Inventory	972,172	0	0	0	7.00
8.00 Prepaid expenses	10,346	0	0	0	8.00
9.00 Other current assets	0	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)	10,894,072	0	0	0	11.00
FIXED ASSETS					
12.00 Land	222,604	0	0	0	12.00
13.00 Land improvements	852,309	0	0	0	13.00
14.00 Accumulated depreciation	-691,503	0	0	0	14.00
15.00 Buildings	22,066,464	0	0	0	15.00
16.00 Accumulated depreciation	-16,507,372	0	0	0	16.00
17.00 Leasehold improvements	0	0	0	0	17.00
18.00 Accumulated depreciation	0	0	0	0	18.00
19.00 Fixed equipment	0	0	0	0	19.00
20.00 Accumulated depreciation	0	0	0	0	20.00
21.00 Automobiles and trucks	0	0	0	0	21.00
22.00 Accumulated depreciation	0	0	0	0	22.00
23.00 Major movable equipment	17,827,134	0	0	0	23.00
24.00 Accumulated depreciation	-14,455,643	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)	9,313,993	0	0	0	30.00
OTHER ASSETS					
31.00 Investments	0	0	0	0	31.00
32.00 Deposits on leases	0	0	0	0	32.00
33.00 Due from owners/officers	0	0	0	0	33.00
34.00 Other assets	48,443	0	0	0	34.00
35.00 Total other assets (sum of lines 31-34)	48,443	0	0	0	35.00
36.00 Total assets (sum of lines 11, 30, and 35)	20,256,508	0	0	0	36.00
CURRENT LIABILITIES					
37.00 Accounts payable	283,739	0	0	0	37.00
38.00 Salaries, wages, and fees payable	1,037,495	0	0	0	38.00
39.00 Payroll taxes payable	0	0	0	0	39.00
40.00 Notes and loans payable (short term)	0	0	0	0	40.00
41.00 Deferred income	0	0	0	0	41.00
42.00 Accelerated payments	0	0	0	0	42.00
43.00 Due to other funds	152,307	0	0	0	43.00
44.00 Other current liabilities	2,919,036	0	0	0	44.00
45.00 Total current liabilities (sum of lines 37 thru 44)	4,392,577	0	0	0	45.00
LONG TERM LIABILITIES					
46.00 Mortgage payable	0	0	0	0	46.00
47.00 Notes payable	0	0	0	0	47.00
48.00 Unsecured loans	0	0	0	0	48.00
49.00 Other long term liabilities	12,006,208	0	0	0	49.00
50.00 Total long term liabilities (sum of lines 46 thru 49)	12,006,208	0	0	0	50.00
51.00 Total liabilities (sum of lines 45 and 50)	16,398,785	0	0	0	51.00
CAPITAL ACCOUNTS					
52.00 General fund balance	3,857,723	0	0	0	52.00
53.00 Specific purpose fund	0	0	0	0	53.00
54.00 Donor created - endowment fund balance - restricted	0	0	0	0	54.00
55.00 Donor created - endowment fund balance - unrestricted	0	0	0	0	55.00
56.00 Governing body created - endowment fund balance	0	0	0	0	56.00
57.00 Plant fund balance - invested in plant	0	0	0	0	57.00
58.00 Plant fund balance - reserve for plant improvement, replacement, and expansion	0	0	0	0	58.00
59.00 Total fund balances (sum of lines 52 thru 58)	3,857,723	0	0	0	59.00
60.00 Total liabilities and fund balances (sum of lines 51 and 59)	20,256,508	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 14-1335

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

Worksheet G-1

Date/Time Prepared:
2/26/2021 10:00 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		7,969,284		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		5,804,837				2.00
3.00	Total (sum of line 1 and line 2)		13,774,121		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)		13,774,121		0		11.00
12.00	Deductions (debit adjustments) (specify)	0		0		0	12.00
13.00	OTHER	9,905,532		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)		9,905,532		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		3,868,589		0		19.00
		Endowment Fund		Plant Fund			
		6.00	7.00	8.00			
1.00	Fund balances at beginning of period	0		0			1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)						2.00
3.00	Total (sum of line 1 and line 2)	0		0			3.00
4.00	Additions (credit adjustments) (specify)		0				4.00
5.00			0				5.00
6.00			0				6.00
7.00			0				7.00
8.00			0				8.00
9.00			0				9.00
10.00	Total additions (sum of line 4-9)	0		0			10.00
11.00	Subtotal (line 3 plus line 10)	0		0			11.00
12.00	Deductions (debit adjustments) (specify)		0				12.00
13.00	OTHER		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: 14-1335

Period:
From 07/01/2019
To 06/30/2020Worksheet G-2
Parts I & II
Date/Time Prepared:
2/26/2021 10:00 am

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
PART I - PATIENT REVENUES					
General Inpatient Routine Services					
1.00	Hospital	3,489,078		3,489,078	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	0		0	5.00
6.00	Swing bed - NF	0		0	6.00
7.00	SKILLED NURSING FACILITY	869,674		869,674	7.00
8.00	NURSING FACILITY				8.00
9.00	OTHER LONG TERM CARE	1,064,224		1,064,224	9.00
10.00	Total general inpatient care services (sum of lines 1-9)	5,422,976		5,422,976	10.00
Intensive Care Type Inpatient Hospital Services					
11.00	INTENSIVE CARE UNIT	368,609		368,609	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)	368,609		368,609	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	5,791,585		5,791,585	17.00
18.00	Ancillary services	9,591,112	49,892,243	59,483,355	18.00
19.00	Outpatient services	0	6,035,750	6,035,750	19.00
20.00	RURAL HEALTH CLINIC	0	0	0	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY				22.00
23.00	AMBULANCE SERVICES				23.00
24.00	CMHC				24.00
24.10	CORF	0	0	0	24.10
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	OTHER (SPECIFY)	0	0	0	27.00
27.01	PROFESSIONAL FEES	0	3,465,155	3,465,155	27.01
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	15,382,697	59,393,148	74,775,845	28.00
PART II - OPERATING EXPENSES					
29.00	Operating expenses (per Wkst. A, column 3, line 200)		24,889,599		29.00
30.00	ADD (SPECIFY)	0			30.00
31.00	BD	3,035,843			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)		3,035,843		36.00
37.00	DEDUCT (SPECIFY)	0			37.00
38.00		0			38.00
39.00		0			39.00
40.00		0			40.00
41.00		0			41.00
42.00	Total deductions (sum of lines 37-41)		0		42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer to Wkst. G-3, line 4)		27,925,442		43.00

STATEMENT OF REVENUES AND EXPENSES

Provider CCN: 14-1335

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

Worksheet G-3

Date/Time Prepared:
2/26/2021 10:00 am

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	74,775,845	1.00
2.00	Less contractual allowances and discounts on patients' accounts	44,272,831	2.00
3.00	Net patient revenues (line 1 minus line 2)	30,503,014	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	27,925,442	4.00
5.00	Net income from service to patients (line 3 minus line 4)	2,577,572	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	91,161	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	OTHER OPERATING REVENUE	39,648	24.00
24.50	COVID-19 PHE Funding	3,085,590	24.50
25.00	Total other income (sum of lines 6-24)	3,216,399	25.00
26.00	Total (line 5 plus line 25)	5,793,971	26.00
27.00	GRANT	-10,866	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	-10,866	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	5,804,837	29.00